Shared learning bulletin

Matricide by a mental health service user George

This document provides an overview of the findings from an independent review into the care and treatment given to George who seriously assaulted his elderly mother leading to injuries which resulted in her death. Teams who might benefit from this bulletin include inpatient and community adult mental health services including street triage, substance misuse services and psychiatric liaison teams. A separate bulletin is available in relation to the domestic homicide review for this case.

Case background

George had intermittent, often fleeting, contact with the community mental health services over a period of over ten years and a significant history of serious drug misuse. For most of this period he had a mental health key worker (an RMN) from the jointly run local substance misuse service. George had a very supportive family and his mother, who lived in independent living accommodation, saw him regularly. He was discharged from a mental health hospital two months before the homicide, but in subsequent weeks became increasingly paranoid. He called the police, ambulance and mental health services on numerous occasions during this period. His GP and family had also asked for help for him. George had previously been aggressive towards his mother and a few weeks before the homicide had locked her in his flat.

Key Findings

Diagnosis George's symptoms were persistently considered by professionals to result from his substance misuse; although there was evidence to suggest that when he was not taking illicit substances his mental health was still deteriorating. Services did not take opportunities to complete a longitudinal assessment of his drug use and reported episodes of psychosis for diagnostic and prescribing purposes.

Family engagement and support There was a breakdown in the relationship of trust between the family and Trust services in the weeks before the incident. The Trust response to their requests for help in the preceding months was inadequate and the family described feeling abandoned by services. In addition, their view was that George was using substances to help him manage his mental health symptoms which jarred with the professional view that his mental health difficulties were caused by substance misuse.

Lack of regard for the safety of George's mother and family None of the agencies who came into direct contact with George and his mother considered the nature of their relationship beyond her being a supportive parent. No consideration was given to there being any element of coercive control in the relationship, nor how the relationship might have changed over the 20 years that the family was in contact with services as his mother aged, and her potential vulnerability increased.

Identifying and responding to mental health deterioration Drug misuse workers did not understand the extent of George's mental health issues or support him to access the support he needed to manage them; neither did they sufficiently communicate the extent of George's mental health problems in the months before the homicide, to his mental health team. The Trust intensive community team had access to a range of records from other mental health teams, and the GP and family, all expressing concerns about George's deteriorating mental health, but they did not consider this, and no action was therefore taken. Rather, he was discharged from the service for non-attendance without being seen face to face.

Interagency communication Inter-agency communication was insufficient. There was a lack of collaborative working with substance misuse service .There was also no mechanism in place to facilitate information sharing between police and health services. Individual staff within the street triage team did not have independent access to both police and health service record keeping systems.

Risk management No consideration was given to the potential risks of George carrying a knife for protection when on leave from the ward. No risk management plan was developed regarding his documented high risk of harm/violence towards others.

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Critical Learning Points

1. Mental health services should not assume that longstanding psychotic symptoms are due to the misuse of illicit substances without carrying out an objective assessment of these issues over time.
2. Where families ask the mental health service for support due to an ongoing deterioration in a loved-one's mental health this should be proactively investigated, and families informed of the steps taken.
3. Services need to recognise that, as carers age they become potentially more vulnerable. In addition, the safety of carers/family members should always be considered when a service user is displaying coercive, controlling or violent behaviour.

Learning Quadrant

Individual practice

- Am I clear what NICE guidance and Trust policy prescribes in terms of the care and treatment of patients with a dual diagnosis of severe mental illness and substance misuse?
- If a dual diagnosis service user's mental health deteriorates, do I ensure that I share all relevant information with colleagues in both mental health and substance misuse services?
- Do I challenge or investigate further, when a patients psychotic symptoms are assumed to be based on the use of illicit substances?
- Do I listen to families concerns about a deterioration in their loved one's mental health and ensure that action is taken, and keep them updated on this if appropriate?
- Do I recognise how the needs and vulnerabilities of carers may change over time and take this into account in relation to care planning, risk assessment and safeguarding?

Governance focused learning

- How are we assured that our mental health service and substance misuse services are working effectively together?
- How are we assured that appropriate action is taken in response to relatives asking for help? Do we monitor the reasons that people are turned down for this support i.e. where no immediate action is taken?
- How are we assured that patients are not discharged from our service due to reasons of non -engagement, when they are still in urgent need of mental health care and treatment?
- How are we assured that our staff are able to identify and support carers struggling with a service userwho exhibits coercive, controlling or violent behaviour?

Board assurance

- As a Board member how do I know that concerns raised by families of people with an SMI are listened to and acted upon?
- As a Board member am I assured that our mental health and substance misuse services (funded by the Trust or otherwise) are working effectively and efficiently together?
- As a Board member how do I know that elderly carers of vulnerable patients are being adequately supported by our services?
- Where patients have been under the care of the substance misuse servicefor many years, how do I know that their substance misuse issues are periodically fully reviewed?
- As a Board member how do I know that any patients assessed as high risk have a current risk management plan available on discharge?

System learning points

- Do we have clear channels of communication, including regular contact and clear protocols between the mental health services and substance misuse service?
- Is record sharing between the Police and the Trust effective in ensuring that all members of the street triage team have timely access to the information they require, and have an agreed approach on collaborative record keeping?
- Have we recognised and responded to the need for system wide collaboration and learning in relationto serious incidents?
- Does the local domestic abuse strategy include appropriate focus on the impact of mental ill health, substance misuse and the risks faced by elderly, particularly female, carers?

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