Shared learning bulletin

Independent investigation into the care and treatment of mental health service user Ben

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of Ben (a pseudonym) over the period of August 2016 to August 2018. Ben assaulted his mother in summer 2018 and was convicted of manslaughter. An internal investigation into Ben's care and treatment was undertaken by the NHS provider and a Domestic Homicide Review was commissioned. The independent investigation focused on the aspects of care and treatment that were not addressed by other investigations, assessing the quality of the internal investigation and the progress of their action plan.

Case background

Ben had been under the care of community mental health services since 2007. He was diagnosed with complex past trauma/emotionally unstable personality disorder (EUPD); obsessive compulsive disorder (OCD); depressive episodes with anxiety and harmful use of alcohol. He also had a hearing impairment. Ben lived in supported accommodation and an appointeeship was in place to help manage his finances; there were concerns that he was vulnerable to financial exploitation. In May 2018, it was agreed that the appointeeship was no longer required following complaints by Ben about the associated restrictions.

Over the period of August 2016 to August 2018, Ben's care and treatment was reviewed regularly. At appointments in July and August 2018, he spoke positively about a volunteer role and seeking to move into his own accommodation. Some concerns were noted about how Ben's benefits were being spent, but no detail was documented.

Ben was known to the police prior to the incident; his forensic history from November 2015 to September 2016 included arrests for criminal damage and an assault on his mother. Records indicate that Ben was both a victim and perpetrator of assaults, often linked with excessive consumption of alcohol. In the summer of 2018, Ben had been drinking alcohol with his mother at her home when there was an altercation and Ben punched his mother. Despite emergency treatment in hospital, Ben's mother died 12 days later. In October 2018, Ben was charged with unlawfully killing his mother, convicted and sentenced to four and a half years in prison for manslaughter.

Key findings

Risk assessment

Risk assessments were not always completed in accordance with Trust policy. When risk assessments were undertaken, they did not document all known risks and more detailed risk assessments (Level 2 and Level 3) were not completed.

Treatment plans

Ben's treatment was compliant with NICE guidelines for EUPD and OCD. His medication was regularly monitored and reviewed, and clinically appropriate changes made at Ben's request, for example a change to depot injection.

Care continuity

Ben had been under the care of the same community mental health team since 2007. Although he had been allocated to three care coordinators over the period of August 2016 to August 2018, he had been seen by the same consultant psychiatrist throughout this time.

Communication

Ben's hearing impairment meant that he found telephone calls difficult. Staff did not always respect his request for communication by text message when they were not in a face-to-face setting with him.

Family engagement

Ben's family was not always involved in his care planning. While this may have been appropriate, the rationale for doing so was not always documented.

Trust internal investigation

The internal investigation was of a high quality, and we agreed with the findings. However, we found one aspect of Ben's care and treatment (risk assessments) that was not identified as a concern. Although the action plan and associated evidence provided showed that significant work had been undertaken, it was insufficient to demonstrate the implementation of learning specifically related to the recommendations in the internal investigation report. The evidence provided by the local Clinical Commissioning Group shows a high degree of scrutiny and oversight of the investigation report and action plan progress.

Critical Learning Points

1. The Trust must ensure that mechanisms are in place and used by staff to use preferred methods of communicating with patients, particularly when the preference is linked to a known disability.
2. The Trust must ensure that risk assessments include all known risks and that they are completed in accordance with Trust policy.
3. The Trust must develop and implement a structured process to monitor the implementation of action plans and ensure that robust evidence is available to demonstrate effective progress.

Learning Quadrant

Individual practice

- Do you appropriately document a patient's communication needs and preferences?
- Do your risk assessments extract appropriate detail on the patient's history, recent events, and any family concerns?
- Do you routinely discuss the quality of risk assessments as part of peer review or supervision processes?

Governance focused learning

- Is there a systematic approach to ensuring patients' communication preferences are appropriately addressed at each contact?
- Do you routinely monitor the quality of risk assessments and compliance with policy requirements?
- Do you assess the quality of evidence provided to support action plans?

Board assurance

- Do you receive patient feedback and complaints information to allow themes such as communication and family engagement to be examined?
- How do you receive assurance on the appropriate and timely completion of action plans following serious incident investigations?

System learning points

- Is there a consistent process across the integrated care system to gaining assurance on the implementation of recommendations following a serious incident?
- Is the Integrated Care Board working with NHS Trusts to develop the approach under the Patient Safety Incident Response Framework requirements?