Shared learning bulletin

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

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of Mr E over the period from 2017 until 2019. Mr E assaulted Mr C in early 2019 and was convicted of murder.

Case background

Mr E had a diagnosis of paranoid schizophrenia. He had a history of drug use, was unemployed and had unstable housing arrangements. He was known to the police and had previous convictions which included grievous bodily harm.

Mr E was under the care of the community mental health team (CMHT) and was under the Care Programme Approach (CPA). Concerns were raised in 2017 about his behaviour and assessment by forensic services was requested but not progressed. He was subject to two Mental Health Act (MHA) assessments but was found to be not detainable. Mr E was subject to Multi-Agency Public Protection Arrangements (MAPPA) for six months of the same year. He was informally admitted to hospital in 2018 but discharged himself against medical advice a few days later. He was briefly detained in prison during 2018 and received a conditional discharge for another offence the same year, the conditions of which included a Mental Health Treatment Requirement (MHTR). Mr E was last seen by the CMHT a month before the offence; no concerns were identified.

Key findings

Risk assessment and risk management

CMHT staff were aware of Mr E's risks, what increased these, and what steps could be taken to mitigate his risk, but these were not documented in a contemporary risk assessment or risk management plan.

CPA and care planning

The CMHT appropriately arranged CPA reviews in response to changes in behaviour and/or concerns identified. Mr E's care plan was kept up to date, but it lacked sufficient breadth and detail to facilitate meaningful treatment.

Forensic services

The Trust does not have a community-based forensic assessment function and community teams access support on an informal basis. The forensic service did not respond in a timely manner to a request to assess Mr E when he was admitted to hospital in February 2018.

Liaison between internal teams

The inpatient team did not implement the CMHT's treatment plan prior to Mr E discharging himself against medical advice.

Multi-agency working

We identified good interagency working with MAPPA, but a second referral in August 2018 was not processed promptly.

There was good interagency engagement with prison services, but the CMHT were not alerted to Mr E's release from prison. There was limited communication between the CMHT and the probation service; a joint approach was not agreed to monitor Mr E's adherence to the conditions of his MHTR.

Substance misuse services

Mr E's care plan did not reflect his drug use or plans to address this although he was encouraged to access addiction services. The Trust does not have a dual diagnosis service and is reliant on separate substance misuse services; the Trust is taking steps to embed dual diagnosis expertise in CMHTs.

Family engagement

Despite regular engagement with Mr E's mother, the CMHT did not formalise its approach to family engagement and involvement in care planning; this was a missed opportunity. There is no evidence the CMHT formally considered Mr E's mother as his carer or offered her support in this regard.

Trust investigation and action plan

The Trust's investigation was comprehensive and balanced. Further evidence is required to provide assurance that the action plan has been completed.

Critical Learning Points

1. Protocols for the management of Mental Health Treatment Requirements should be agreed and formalised between Trusts and the probation service; these should cover information sharing, milestones for contact/meetings and escalation pathways when concerns are identified.
2. The provision of forensic services support to community teams for access to forensic assessments for high-risk service users should be reviewed.
3. Affected families should be involved in internal investigation processes and have an opportunity to submit feedback on the draft report.
4. CPA policies should reflect best practice guidance in relation to the involvement of the families of service users, beyond those formally considered 'carers', in care planning.
5. The Trust should ensure a service user's plan of care remains continuous if admitted to an inpatient ward from the community, with appropriate liaison and engagement with the community team, and other services as required.
6. The ICB should ensure the Trust has addressed the outstanding elements of its internal investigation action plan within six months of receipt of the independent investigation report.

Learning Quadrant

Individual practice

- Do your risk assessments extract appropriate detail about the patient's history, and family concerns?
- Do your care plans reflect this detail and consider the needs of families?
- Do you routinely discuss the quality of risk assessments and care plans as part of peer review or supervision processes?
- How do you ensure effective liaison between different internal teams and with external agencies?
- Do you know how to access specialist forensic support?

Governance focussed learning

- Are staff supervision processes effective in monitoring the quality of risk assessments/care plans?
- How do you monitor compliance with MHTRs?
- Is there a protocol for liaison with the probation service and do you test compliance?
- Do you monitor the effectiveness of support from the forensic service?
- Does your CPA policy appropriately reflect the involvement of families?

Board assurance

- How are you assured that risk assessments are completed to the required standards?
- Are you confident that liaison with the probation service is effective?
- Are the Trust's arrangements for specialist forensic support effective?
- Have you reviewed provision of dual diagnosis services?
- Are you developing your approach to family engagement as part of the Patient Safety Incident Response Framework (PSIRF)?

System learning points

- Is a protocol in place for mental health services liaison with the probation service in all relevant areas?
- Are specialist forensic services commissioned effectively?
- Does the Trust have sufficient links with MAPPA to ensure comprehensive information sharing in relation to ongoing risk?
- Is the ICB developing its approach to oversight of Trust incident action plans as part of PSIRF requirements?