Shared learning bulletin

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

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of Mr D over a nine-day period, before and after a mental health homicide in 2020.

Case background

Mr D was referred to Trust services by his GP two days prior to the incident; he was anxious and believed he was being spied on by his neighbour (Mr J) with malicious intent. Mr D had not engaged Trust services before and had no documented history of poor mental health. He did have some underlying physical health problems.

Mr D was seen on the day of referral by the Home Treatment Team (HTT) who noted that he was experiencing paranoid thoughts about his neighbour. An urgent review with a consultant psychiatrist was arranged and took place the following day (day 2). The HTT consultant psychiatrist concluded that Mr D needed a hospital admission, but did not have the capacity to consent to this, and a Mental Health Act (MHA) assessment was warranted. The MHA assessment was scheduled for the next day (day 3) but Mr D committed the offence before this could be undertaken. Following his arrest, there were differing opinions amongst healthcare professionals as to whether Mr D should be processed via the criminal justice system or forensic services (under the MHA); the decision was taken that he should be processed via the criminal justice system with a recommendation to the Court that he be diverted to secure services. However, Mr D became physically unwell that night and was transferred to acute services. He remained in hospital until day 9 when it was deemed he could be discharged to police custody.

Key findings

Risk assessment and management

The HTT's initial assessment of Mr D was prompt and comprehensive. Mr D's risk management plan primarily addressed his physical health concerns rather than his risk to self or others (e.g., his neighbour). The risk management plan was not updated after the second assessment.

Assessment of capacity

The capacity assessment on day 2 was not documented in line with Trust policy or national guidelines. Consent to admission was conflated with consent to treatment; these should have been considered separately. It was appropriate to refer Mr D for a MHA assessment given he was considered to lack capacity.

Family involvement

The HTT did not involve Mrs D appropriately in her husband's assessment and care planning. This is not in line with Trust policy. The HTT placed too much emphasis on the role of Mrs D as a protective factor in preventing Mr D from harming himself or others; despite concerns about his capacity and insight.

Decision-making

The decision to process Mr D under the criminal justice system with the expectation he would be diverted to secure services, as opposed to admission under the MHA, was convoluted and contrary to the Trust's own guidelines for accessing secure services.

Liaison between teams

Communication between the Approved Mental Health Professional (AHMP) hub, the Trust's out-of-hours service and the police was inconsistent and ineffective. There was an absence of coordination or collective understanding of the intended care plan.

Trust investigation and action plan

The Trust's internal investigation provided a reasonable summary of events, but lacked sufficient detail, underpinning analysis and reference to expected practice. Recommendations were not comprehensive and further work is required on the associated action plan. The report authors were not involved in the quality assurance process for the report.

Critical Learning Points

1. Families supporting an individual must be involved in HTT mental health assessments. In instances where a family member is not involved, the assessing staff should document their rationale.
2. Service user crisis plans should include planning for the service user's safety and the safety of others in the event of the service user's mental health deteriorating.
3. Capacity assessments for each separate decision must be documented by clinicians in line with the legal requirements of the Mental Capacity Act (MCA) and associated policies.
4. Providers should ensure, in collaboration with forensic services, that their protocols for accessing secure beds are adhered to by clinicians. Key considerations should include when protocols should be triggered, efficient direction to a secure bed where required, and escalation pathways if a bed is not available. The criminal justice system should not be used as an alternative route to access a secure bed.
5. Mental Health Act specific records and medical recommendations created by Trust staff, even if not used, must form part of the service user's enduring medial record.
6. Investigation report authors must be involved in the investigation quality assurance processes in line with transitioning PSIRF arrangements.

Learning Quadrant

Individual practice

- Do assessments extract appropriate detail on risks; are they addressed comprehensively by a management plan?
- How do you ensure and document the involvement of families in care planning?
- Do you know what to do if you require a secure bed – and how to escalate if one isn't available?
- How do you ensure a coordinated approach between different teams and agencies?

Governance focussed learning

- Is there a system to ensure capacity assessments are documented in line with expected practice?
- Is there a clear process for staff to access secure beds, and escalate if necessary?
- Do you regularly share learning from complex cases?
- Do policies/procedures require the involvement of families in assessment and care planning?

Board assurance

- Are you confident that teams are clear about the legal and regulatory requirements relating to capacity assessments?
- How do you gain assurance that risk assessments and care planning are undertaken to the required standards?
- How do you ensure a high quality of investigations and action plans?

System learning points

- Is the ICB developing an approach to ensuring the robustness of Trust investigation reports and action plans as part of PSIRF requirements?
- How does the ICB maintain oversight of risks arising from cases involving complex liaison between mental health services, the police and prison health services?