Psychological Approaches

LEARNING LESSONS REPORT

INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MR D

This document provides an overview of findings from an independent investigation into the care and treatment of Mr D, who was convicted of killing an acquaintance of his.

Key background details

Mr D is an individual who experienced an extremely difficult early life, he was placed into care and drawn into a lifestyle characterised by substance misuse and crime. His behaviour could be extremely violent, particularly when under the influence of substances, and he acquired a number of violent convictions, as well as displaying significant aggression to health care staff. Convicted of armed robbery in 2000, Mr D received an indeterminate sentence for the protection of the public and was only released by the parole board back into the community in 2016. In the intervening years, he spent considerable time in secure hospital and in 2011 experienced a manic episode which led to his diagnosis of bipolar affective disorder. With medication, care and some therapeutic input, Mr D settled. At the time of his return to the community in 2016, he was stable, compliant, free of illicit substances, self-aware and highly motivated to make something of his life.

For 18 months following release from prison, Mr D was supported by the forensic community outreach team whilst he was resident in a support hostel in their area. Mr D made good progress and a planned transfer of care to semi-supported and then independent living in his home catchment area was agreed. In the home area, mental health services concluded that Mr D did not meet the threshold for secondary care, but he was assessed as suitable for the primary care recovery team. He remained under the care of this team for a year until the homicide occurred. In the two months leading up to the homicide, Mr D struggled with a number of physical health problems, and his mood deteriorated. He admitted to the illegal purchase of prescribed drugs around this time, but this concern appeared to resolve once his anti-depressant medication was reviewed and increased in dosage. He was seen by his lead clinician nine days prior to the homicide and was noted to be bright in mood. The day before the homicide, he engaged in his work as a lived experience consultant and no concerns were noted by that team.

KEY FINDINGS

Areas of good practice

Overall, the level of care and support provided by mental health services to Mr D over the 2 ½ year period in the community was good. This included:

- Careful planning for his potential release from prison.
- Regular visits, including home visits by the forensic team.
- Close liaison with key services by the forensic team.
- A responsive lead clinician in the home catchment area, who was flexible in working with him.
- A timely review of medication.
- A lead clinician with expertise in substance misuse who followed up on concerns.

Learning points

1. ***There was a lack of clarity as to whether Mr D was managed under the Care Programme Approach (CPA) when with the forensic team.*** This made little difference to the care provided by the forensic team but did influence the response of the home catchment area to the referral for a transfer of care. The assumption that Mr D was not on CPA contributed to the decision that he was not suitable for secondary mental health care in the home catchment area.

2. ***The quality of the risk assessment compiled by the forensic team was poor***. It contained inaccurate information and was overly focused on Mr D's current presentation and immediate risks. When the home catchment area requested further information, it was not forthcoming. As a result, the ***primary care recovery team (PCRT) did not pursue the referring area forensic team's offer of a period of joint care***.

3. The PCRT in the home catchment area were left to provide a service to Mr D, after their secondary care services had rejected the referral. ***The PCRT were conscientious but ill-equipped to support an individual with Mr D's background*** and they did not fully understand the role of probation and the life licence. A more collaborative approach to deciding on how best to meet Mr D's needs would have been helpful.

4. Mr D held a satisfying role as a ***lived experience expert*** which was considered by everyone to be a protective factor. This was undoubtedly the case for the most part, but ***it may have led to some considerable pressure for Mr D to maintain a coping façade*** and mask difficulties that he was experiencing.

CONCLUDING OBSERVATIONS

Thinking about risk

All the healthcare staff focused on Mr D's observable risks in the present and emphasised a range of positive factors in this regard which they considered to be protective. This focus on the present was to the exclusion of a careful consideration of the nature, function and degree of Mr D's violent past. This lack of analysis was then reflected in the limited nature of the written risk assessments. It was particularly striking that at each point of progression

for Mr D, from one clinician to another, one team to another, the importance of his historical risk seemed to become increasingly diluted and vague.

Trust risk summaries tend to be placed at the end of a lengthy document and may not be attended to with the level of analysis that is required. Focusing on a robust but succinct risk formulation at the front of a risk assessment is likely to be a more reliable reminder.

Vulnerability and transitions

Mr D's positive presentation, and his role as lived experience expert, both masked an underlying emotional fragility that was related to past trauma and linked to previous violence. With the professional focus on his current functioning, he progressed from a high support care package to a low support package at a relatively rapid rate; this was particularly marked as he had had very little previous experience of successful independent living in the community. Transitions are a particularly vulnerable time for individuals who have a history of poor attachments and trauma; for many, it is important to increase the level of support around the time of progressive transition in anticipation of the possibility of some instability.

KEY QUESTIONS FOR SERVICES

When receiving referral from another service, have you got the right information to make the right decision?

If a referring service offers a meeting with receiving service, it is good practice for that offer to be taken up.

Is patient access to services based on a collaborative and trusted decision-making process that allocates an individual to the right service according to patient need?

Do your processes and procedures take into account the potential risks associated with transition arrangements?

Are you confident that your teams are always mindful of historical risk factors whilst supporting a patient in the present?

Do your clinical record systems facilitate good risk management by highlighting an easily accessible risk formulation?

Are you confident that your organization has policies in place for providing the right support to your lived experience experts?

Are you confident that your non-forensic services understand how to liaise with local probation services and what it means to be on a licence managed by probation? The same question could be asked of the probation service and its relationship with health services.