An independent investigation into the care and treatment of a patient of mental health services prior to a homicide

Introduction

This provides an overview of the findings from an independent investigation into the care and treatment given to a mental health service user, who fatally attacked a family member in 2021. Agencies and teams who might benefit from this bulletin include adult community mental health services, prison mental health services and safeguarding teams.

Case background

- The patient was subject to a restraining order preventing him from having contact with two family He fatally attacked one of them in May 2021 and was subsequently found guilty of murder.
- Before 2020 he had been in intermittent contact with mental health services for several years.
- During 2020, the patient who was in his early twenties, was arrested and assessed by the Criminal Justice Liaison and Diversion Service (CJLDS). Following concerns about his presentation, a Mental Health Act (MHA) assessment was requested. It was deemed he did not present a sufficient risk to be detained under the MHA and he was remanded to prison.
- While in prison his presentation was described as “odd” and he was difficult to engage. The prison mental health team provided him with some intensive support and requested a specialist review to determine whether he had a learning disability and/or autism. This review concluded he did not have a learning disability. However, there remained questions about whether his presentation was due to undiagnosed autism or behaviours emerging because of drug and alcohol misuse.
- A psychiatric report was requested by the court, and this was completed by a Trust Integrated Community Mental Health Team (ICMHT) consultant psychiatrist. The report concluded it was likely he had experienced periods of transient psychosis previously and that he had a strong family history of psychotic illness. The report documented a history of aggression and violence and noted that there was a relationship between his mental disorder and a “degree of violence risk”.
- He was released from prison in late 2020 and remained in the community for seven days before being arrested for breaching a restraining order at the home of the individual he was subsequently found guilty of murdering. The CJLDS attempted to assess him, but he refused to engage and he was again remanded to prison.
- At this time, ICMHT staff were attempting to identify his whereabouts to try to engage him in a mental health assessment. They were informed he was in prison again, a few weeks after he was remanded.
- A month later he was seen by a prison locum consultant psychiatrist who concluded that he was presenting with a psychotic disorder and antipsychotic medication was prescribed.
- He was released from prison shortly after this and arrangements made with the community consultant psychiatrist for him to attend an appointment with them six days after his release from prison.
- At the ICMHT assessment the same month, the consultant psychiatrist documented that a working diagnosis was “simple schizophrenia” and that ICMHT staff would provide support to him and attempt to keep him engaged with services, contact his family and probation officer for collateral history, arrange a professionals’ meeting “in due course” and continue the prescribed medication.
- ICMHT staff attempted to see the patient, but he was not seen again until two months later when he met with ICMHT and probation staff. By this time concerns had been raised about him being threatening towards two family members. It was reported he was evasive and minimised

the impact of his actions during the appointment. However, ICMHT documented the threshold for an MHA assessment had not been met.

- The same month he was arrested for breaching the restraining order at the address of the family member he subsequently murdered. The CJLDS was asked to assess him, but he refused to engage, and the referral was discharged. He was remanded to court the following day and the court adjourned the case for one month on the condition he attended appointments with the ICMHT.
- Following this, ICMHT saw him again. Arrangements were made to see him again the following week, but he did not attend.
- Further concerns were raised by Trust staff about him being the perpetrator of abusive and threatening behaviour towards another family member and their partner, both of whom were known to him. ICMHT staff informed the police and his probation officer.
- He was next seen by the ICMHT a month later. At this appointment, he told staff that he felt it was okay to be violent towards others and acknowledged threatening a family member and their partner but minimised the impact of his behaviours on others. There was no documented provisional diagnosis, formulation, or plan (including risk assessment or arrangements for follow up) following this meeting.
- He was arrested the same month on suspicion of the murder. He was subsequently convicted of this.

Key Findings

Care planning and risk assessments

- The working diagnosis of a psychotic disorder was not well understood by the ICMHT. There was an absence of an explicit and shared understanding among the ICMHT staff about the purpose of their engagement with the patient and whether he had been accepted onto the ICMHT caseload. There is no evidence that his care and treatment was planned in accordance with Trust policy.
- Documented plans to obtain collateral information from his family were not followed through.
- There was a missed opportunity to use the information provided by other professionals to develop a detailed risk assessment and risk management plan in the three months prior to the incident. No risk assessment or risk management plan were completed.

Medication management

- Medication was prescribed in accordance with national guidance, but there was no evidence of proactive monitoring of his concordance with the treatment regime after his release from prison.

Interface between Trust services and other teams

- There were missed opportunities for greater multi-agency engagement between the ICMHT and probation when the patient breached the restraining order; and between the ICMHT and adult social care when the patient was identified as the perpetrator of abuse.

Adult safeguarding

- Adult safeguarding concerns with the patient as the person at risk were raised appropriately. However, significant concerns about his risk to others were not documented in a risk assessment or care plan. This was not in accordance with expected practice or Trust policy.

Absence of referral for substance misuse

- It was unclear from the records how much staff felt drug use was an influencing factor in his behaviour, but we found no evidence that staff considered a referral to substance misuse services.

Autism assessment

- The psychiatric report requested by the court recommended a full assessment for autistic spectrum disorder. The Trust did not implement this recommendation.

Internal investigation report and subsequent action plan

- The Trust completed an action plan following the internal investigation and provided limited evidence to us of progress. There was insufficient evidence to demonstrate progress across the actions.

Recommendations

There were five recommendations which are applicable to NHS Trusts.

Recommendation 1: Care planning post prison release

There was an absence of an explicit and shared understanding across the ICMHT about the working or provisional diagnosis ascribed by two separate consultant psychiatrists. This resulted in a lack of structured and proactive approaches to working with the patient with a psychotic disorder.

The Trust must ensure that staff have a clear and shared understanding within a team about a patient's diagnosis and risk assessment and this leads to robust care planning.

All patients with a psychotic disorder on an ICMHT caseload on release from prison must have a care plan that records diagnostic decisions from prison health care.

Recommendation 2: Adult safeguarding concerns

Significant concerns about the patient's risk to other vulnerable adults were not reflected in risk assessments, risk management plans or care plans.

The Trust must ensure that when concerns are raised about a patient's risk to other vulnerable adults, the risks are appropriately reflected in risk assessments, risk management plans and actions required are recorded in care plans.

The Trust should ensure that where patients are assessed as being a risk to others that action is taken as a result to mitigate this. The development of a series of steps for staff to follow may be helpful as guidance.

Recommendation 3: Multi-agency working

Plans for a multi-agency multi-professional meeting were not progressed. This was a missed opportunity to agree a structured approach to managing the patient's behaviours after he was released from prison.

The Trust must ensure that when actions are identified in internal meetings for a multi-agency approach, there is a process in place to ensure these are documented in care plans, allocated to a named individual and implemented.

Recommendation 4: Autism assessment

The Trust did not implement the recommendation in the court report for an autism assessment.

The Trust must ensure that when an assessment for autism is recommended the assessment is completed and appropriate post-diagnostic support provided where appropriate, in accordance with the Autism Act 2009.

Recommendation 5: Implementation of the action plan developed following the internal investigation

The Trust was not able to provide sufficient evidence that the action plan that was developed from the internal investigation recommendations had been implemented.
The Trust must ensure that appropriate evidence is sought to demonstrate effective implementation of the action plan developed following the internal investigation. A completed action plan with associated evidence should be submitted to the ICB for detailed review and sign off within three months of the publication of this report.

Learning Quadrant

Individual/Team practice

- Do I/we as a team have a clear and shared understanding of a patient's diagnosis?
- Do I/we have a clear and shared understanding of a patient's risk?
- Have I/we recognised the patient's potential risk to others and reflected these concerns in the risk assessments, risk management plans and care plans?
- Have I/we obtained collateral information from the family and other relevant parties and documented this?
- When completing a care plan, have I/we included all the information provided by relevant agencies including their diagnostic decisions?
- Have I/we evidenced that the care and treatment planned for patients is in line with Trust policy?
- Have I/we used the information provided by the family and other professionals to develop detailed risk assessment and risk management plans?
- Have I/we considered if a referral to other services is needed, for example when there is evidence of substance misuse?
- When an assessment is recommended by other professionals, have I/we actioned this and offered appropriate support?
- Have I/we documented and implemented the actions allocated to me/us in meetings?

Governance focused learning

- How are we assured care and treatment plans are in line with Trust policy?
- Are we assured care plans record diagnostic decisions made by other agencies?
- Do we have robust assurance processes for care plans and risk assessments?
- Are we assured information from other agencies is always included in care plans?
- How are we assured detailed care plans, risk assessments and risk management plans are developed?
- How are we assured medication concordance is sufficiently monitored?
- Is there clear guidance for staff to follow to ensure action is taken to mitigate the potential risk patients may pose to others?
- How are we assured actions are taken when patients are assessed as being a risk to others?
- Are we compliant with the Trust policy when documenting the risk to others in care plans and risk assessments?
- How are we assured that agreed actions are documented in care plans and implemented?
- Are we assured current practice is in accordance with the Autism Act 2009?
- Are we assured recommendations from action plans are implemented and embedded? Can we provide evidence for this?

Board assurance

- Do we have sufficient quality and oversight structures to provide assurance that we are completing high quality care plans and risk assessments?
- Are there quality and monitoring processes to provide assurance that collateral information from families and other professionals is proactively sought by staff?
- Do we have sufficient oversight and monitoring processes to ensure the management of requests for an autism assessment is in line

System learning points

Are we confident that:

- there is a clear system for managing referrals?
- we have clear pathways for referrals to be allocated to caseloads?
- we have a robust system in place for managing the information received from the family and other professionals?
- we have a clear system for managing recommendations for clinical assessments made by other professionals?

with the Autism Act 2009 and does current practice reflect this?

- Do we have sufficient oversight and monitoring processes of action plans following an internal investigation?
- How are we assured we can provide sufficient evidence to demonstrate the progress of an action plan?
- we have an agreed process with other professionals when implementing a multi-agency approach?
- we have a robust system in place for medication management and monitoring compliance?
- autism assessments are timely?

https://www.england.nhs.uk/south/publications/ind-invest-reports/south-west/an-independent-investigation-into-the-care-and-treatment-of-a-patient-of-mental-health-services-prior-to-a-homicide/