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HEALTH & SOCIAL CARE CONSULTING

Lessons learned Bulletin

Report into the homicide committed by a Recovery Team patient

Introduction

This document provides an overview of the findings from an Trust internal investigation into the care and treatment given to a mental health service user who committed a homicide.

Agencies and teams who might benefit from this bulletin:

- *Adult mental health services and crisis response*
- *GP and primary care services*
- *Accommodation services*
- *The police*

Case background

Mr X had a diagnosis of paranoid schizophrenia and had been a recipient of mental health services for over 30 years. He first came into contact with Trust services in 2009 following a discharge from an out of area hospital on a Community Treatment Order (CTO). He was on the Assertive Outreach caseload until March 2012 when he was moved to the local Recovery Team caseload. Mr X lived in supported living; he changed accommodation in November 2018 at his request.

Mr X had received clozapine medication since 2007. He asked to stop taking it in November 2018. A reduction of clozapine began in December 2018 and the medication was stopped entirely in April 2019.

Mr X killed another resident who lived in the same shared accommodation. Following his arrest, he was initially detained in prison, but later transferred to a secure unit where was he described by his Responsible Clinician as showing a 'classical picture' of relapse following a clozapine withdrawal. He subsequently plead guilty to manslaughter was detained under Section 37 of the Mental Health Act 1983 (MHA) and subject to a Section 41 MHA restriction order.

Key Findings

Risk assessment and management

Mr X's risk was not comprehensively assessed or managed by Trust services. Clinicians failed to consider Mr X's historic risk as part of their assessments. This was despite his history of violent and aggressive behaviour, and inpatient admissions prior to his move to the area in 2009.

Ongoing assessment

Staff considered Mr X was likely experiencing ongoing psychosis in 2017 and 2018 but there is no evidence that they appreciated the implications of this, factored it into the ongoing management of Mr X, or increased their contact with him.

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Findings (continued)

Medicines management

Mr X's clozapine was stopped at his request, but there was no documented assessment of his capacity in relation to this request, or written record of clinical discussions underpinning the decision to withdraw his medication. Staff did not appreciate the importance of clozapine in facilitating Mr X's wellbeing and mitigating his risk of relapse.

Team communication

Staff did not document and communicate the decision to stop Mr X's clozapine with the wider team or his GP.

Supervision and handover

The management of Mr X's clozapine was delegated to a Year 3 core trainee psychiatrist who left the Trust four months before the incident. Mr X did not have medical input after this point and his clozapine withdrawal was not supervised by a named consultant. There was inadequate medical supervision and review of Mr X.

Response to accommodation staff concerns

Trust staff failed to act on concerns raised by accommodation staff due to an inconsistent information sharing and handover processes.

Key learning points

The investigation made 14 recommendations, the key learning from which can be summarised as:

1. **Clozapine management:** Trusts should ensure staff understand the fundamental elements of clozapine management, including service user capacity, consent, risk management and individual responsibilities. This should be underpinned by up-to-date policy, training, and a review of all clozapine patients to ensure their management is undertaken in line with expected practice.
2. **Communication and information sharing:** Trusts should ensure internal and external communication systems are effective, timely and responsive towards service users, their families, other teams and partner organisations. This includes ensuring staff have access to historic service user information, and that high risk service users and their associated management plans are identified to other teams and external agencies.
3. **Working with external agencies:** Trusts should develop joint working practices with the police, Crime Prosecution Service, local authorities and commissioning bodies to ensure regular communication, information sharing, clarity of roles and agreed approaches towards high risk service user management.
4. **Staff supervision, training and support:** Trusts must assure themselves that they have effective supervision, clinical accountability and management processes in place, undertaken and monitored in line with policy and procedure. This should be underpinned by training, regular supervision, policy and guidance.
5. **Management and leadership:** Trusts should review their mental health teams structures and functioning to ensure they support effective team management and clinical leadership. Supervision, clinical accountability and management processes should all be assessed as part of the review to ensure the effective outputs of teams, operated in line with expected practice.

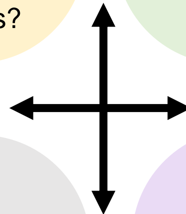
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you explored the service user's history with them?
- Have you reviewed the service user's history before they moved to the Trust?
- Does your risk assessment adequately document the service user's history, recent events, and concerns from other agencies?
- Are you confident you would recognise and manage signs of ongoing psychosis?
- Are you undertaking regular supervision and ensuring all your cases are routinely discussed?
- Are you clear what steps should be taken, and who should be informed, when reducing/stopping a service user's medication?
- How do you ensure decisions pertaining to a service user are shared and acted upon by other health care professionals?

Governance focussed learning

- Are you confident staff are accessing historic patient information?
- How do you ensure risk assessments are comprehensive and reflect patient risk factors including other agency concerns?
- Do you have a system in place to ensure staff supervision is taking place and effective?
- Is there a system in place to ensure adequate monitoring of patients who's medication is changed and/or reduced?
- Do you have a system in place to ensure communications from external agencies are documented and shared promptly?
- Is there a system in place to ensure internal investigation findings are shared with families?



Board assurance questions

- How are you assured that risk assessments are completed to the required standards?
- How are you assured that staff supervision is undertaken inline with required standards?
- How are you assured that staff are supported and managed effectively?
- How are you assured that changes to a patient's medication are managed, monitored and communicated to the required standard?
- How are you assured that staff have access to appropriate guidance and policy?
- Are you confident there is appropriate liaison between Trust services and other agencies in relation to the management of a service user's treatment?

System learning

- How does the Trust ensure Trust policy covers the fundamentals of medicines management, including stopping medication?
- How effective is Trust communication with other agencies (e.g. accommodation providers)?
- Does the Trust provide adequate support and signposting to external agencies to help their management of mental health service users (e.g. accommodation providers and primary care)?
- Do Trust services and third party agencies work together to ensure families' concerns about a service user are captured and managed?
- How does the Trust ensure supervision and management is undertaken in line with expected practice?

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