An independent investigation into the care and treatment of Adult 1

Introduction

This document provides an overview of the findings from an independent investigation into the care and treatment given to Adult 1, a mental health service user, who fatally attacked a family member, Adult 2, in 2021. Agencies and teams who might benefit from this bulletin include adult community and inpatient mental health services, safeguarding teams, adult social care services, ambulance services and GP/primary care teams.

Case background

- Adult 1 fatally attacked Adult 2 and seriously wounded another family member at the family home. Adult 1 was arrested and assessed as not fit to be interviewed because of underlying concerns about his mental health.
- Adult 1 had six contacts with primary care services when he felt unwell or "not quite right" in the preceding years, three of which related to mental health needs. The last of these resulted in a referral to a talking therapies provider (Provider 1), which at the time was a provider of NHS funded psychological therapy for people with mild to moderate anxiety or low mood. Adult 1 did not respond to a request by Provider 1 for further information, and he was discharged. When this was followed up by his GP Adult 1 said he did not want the referral.
- There was no further contact with services for about another year when Adult 2 first contacted the GP expressing significant concern about Adult 1's presentation, as by this time he was mute. The GP made a referral to the integrated community mental health team (ICMHT1) and an assessment was arranged for six days later. As a result of the assessment the multidisciplinary team (MDT) discussed referral to the early intervention team (EIT) for further assessment or an extended assessment with ICMHT1.
- Adult 1's behaviour deteriorated over the following few days and emergency services (police and ambulance) were called by his family on two evenings. On the second evening, the decision was made to take Adult 1 to a general hospital for further assessment of his physical and mental health. Adult 1 initially agreed to go to hospital but then changed his mind. Adult 1 was assessed by ambulance staff to not have capacity at that time, and he was taken to hospital under the Mental Capacity Act (MCA).
- On arrival Adult 1 was taken to the emergency department where his physical health was assessed. A mental health assessment was requested from the psychiatric liaison team who attended in the early hours of the following day. The psychiatric liaison team concluded that a Mental Health Act (MHA) assessment was required. The MHA assessment took place that afternoon and the decision was made to detain Adult 1 to a mental health hospital. He was admitted to the ward that evening.
- Adult 1 remained an inpatient for nine days during which time he remained mute, speaking on a single occasion. He was assessed by the EIT three days after admission, the assessment concluded it was not appropriate to offer ongoing support at this point, incorrectly stating that the symptoms had not been present for more than two weeks. Adult 1 was discharged to his parent's address after his detention was rescinded. No

follow-up contact was made with him by mental health services after his discharge from hospital. This was not in line with Trust policy.

- Two months later Adult 2 contacted the home treatment team and reported that Adult 1 had been found lying in a dangerous place and had to be removed by his parent. She expressed concern about the lack of follow-up after Adult 1 had been discharged from hospital. Staff advised her to contact ICMHT1 after the weekend which she did. She was told that a GP referral was needed.
- Two weeks later Adult 2 spoke to the GP and repeated the concerns she had shared with mental health staff. The GP contacted Adult 1's step parent who also reported some concerns about his safety. The GP advised that Adult 1 should be registered with a GP local to his parent and step parent's address. Despite the advice to Adult 1's step parent about GP registration, the GP referred Adult 1 to ICMHT1. ICMHT1 staff attempted to contact Adult 1 on the telephone numbers provided and after nine days sent an opt-in letter to Adult 1 to both parental addresses.
- Two weeks later Adult 2 again contacted the GP with concerns about Adult 1's presentation – he was destroying all his correspondence and was still mute. The GP noted that Adult 1 had not yet been registered with another GP surgery.
- Four days later Adult 1 registered with a new GP and was seen (accompanied by his step parent) for an appointment. It was documented that he remained mute, had started using his left hand and that there were some concerns about risky behaviours. Adult 1 did not want to be referred to Provider 1 or to the ICMHT, however, three days after the appointment, the new GP wrote to the local ICMHT (ICMHT2) for advice.
- The referral for advice to ICMHT2 was made the same day but was not triaged for a further month; an opt-in letter was sent to Adult 1. There was no response to the letter and Adult 1 was subsequently discharged from the caseload two weeks later, the discharge letter to the new GP was sent the following day.
- At the same time a virtually identical referral for advice was sent by the new GP to ICMHT2. The only difference was a correction to the house number for Adult 1. The referral was triaged two days later and the decision was made that, because Adult 1 had not responded to telephone calls or letters from the previous two referrals, the referral would be closed and Adult 1 discharged back to the care of the GP.
- Over the following six months prior to the incident Adult 1's maternal family contacted services a number of times with concerns about his presentation and they asked for advice and support for him.

Key findings

While Adult 1 was not in the care of Trust services at the time of the incident, our review of the records held by NHS organisations and the County Council identified a number of missed opportunities for services to assess Adult 1 following his discharge from inpatient and community services a year before the incident.

We cannot say what the outcome of any assessments would have been if the concerns raised by Adult 1's family had been responded to appropriately and if this would have changed the course of events.

Use of the Mental Health Act

- Adult 2 was not told her rights as the nearest relative (NR) – specifically that she could formally request an MHA assessment and how to make the request.

- Adult 2's right to request an MHA assessment was dismissed or not given due consideration and the responses to her requests were not in line with the MHA and the MHA 1983 Code of Practice.
- Concerns raised by family members and other professionals were not given due consideration and not responded to as requests for an MHA assessment.
- Despite the concerns raised repeatedly by Adult 2 and family, the Trust agreed a crisis plan without seeing or assessing Adult 1. This plan left Adult 1's family unsupported and without access to mental health support services over the weekend. The plan relied on emergency services responding if a crisis occurred before the planned assessment a few days later.
- The crisis team did not record their rationale for not completing an MHA assessment at home after discussion with ambulance staff.

Mental health care, treatment and diagnosis

- Adult 1 was discharged from inpatient care in summer 2020 with no follow-up support in the community.
- There was a lack of response from the Trust to concerns raised by family members between the point of discharge from inpatient care and the incident taking place.
- Adult 1 was discharged from hospital with no diagnosis, information recorded before admission and accounts provided by family members were not taken into consideration. Because of this, there was no treatment plan to assess.

Use of the Mental Capacity Act

- Adult 1 was taken to hospital under the MCA and remained in hospital for more than the time set out in the Trust Mental Health Connect Helpline and Crisis Hub Standard Operating Procedure (SOP).
- MCA assessments were not documented in accordance with Trust policy.

Assessments under the Care Act 2014

- Safeguarding referrals were not taken as a requirement to assess Adult 1's needs under the Care Act 2014.
- The pathway for a Care Act 2014 assessment was unclear and a barrier to individuals trying to access mental health support.
- The Trust did not consider whether the concerns identified triggered a duty to assess Adult 1 under the Care Act 2014. Adult 1's refusal to engage does not cancel this duty and the Trust should have made more robust efforts to assess Adult 1.
- The Trust did not complete a Care Act 2014 assessment for Adult 1.
- Under the National Health Service Act (2006) Section 75 agreement, the Trust had a duty to complete a Care Act 2014 assessment on behalf of the council when they were alerted to Adult 1's possible care and support needs.

Adult safeguarding

- Adult safeguarding referrals were not completed following Trust policy and not discussed with the safeguarding team, meaning the nuances of these concerns were missed among the wider concerns.
- Concerns about Adult 1's family member X were missed, and a referral was not made to the appropriate safeguarding team.

- The Trust did not manage its delegated duties under the Section 75 agreement effectively and the Council should have made more effort to assure itself that its delegated functions were being conducted appropriately.

Illicit substance use

- There was a missed opportunity to rule out (or in) substance misuse as a potential healthcare need as clinical staff failed to test for drugs or to consider that drugs could play a role in his situation/diagnosis.

Duty of candour and being open

- The Trust was an early-adopter organisation for PSIRF and took a hybrid approach to investigation reports. There was no clear policy to guide staff and their communication with Adult 1's maternal family after the first draft report was shared and could have been improved.

Recommendations

The independent investigation made a total of 13 recommendations for the Trust, one of which also applies to the ambulance services Trust.

Recommendation 1: Information given to relatives about the MHA and nearest relative (NR) rights

Adult 2 was not told her rights as the NR, specifically that she could formally request an MHA assessment and how to make the request.

The Trust must ensure that relevant organisational policies are aligned to the MHA and the MHA Code of Practice. The Trust must also provide training on the role and rights of the NR to frontline staff to ensure that correct advice is given to NRs.

Recommendation 2: MHA and NR rights

Adult 2's right to request an MHA assessment was dismissed or not given due consideration. The responses to her requests were not in line with the MHA and MHA Code of Practice.

The Trust (or the Council if MHA AMHP assessments are no longer covered by a Section 75 agreement) must ensure that requests from NRs are considered and responded to appropriately. An evaluation of current practice and policy is advised to ensure it is clear about how to manage NR requests for an MHA assessment.

Recommendation 3: MHA and family involvement

Concerns raised by family and other professionals were not given due consideration and were not responded to as requests for MHA assessment.

The Trust must ensure that policy guidance includes the management of requests by family and other professionals, when concerns are expressed about a person's mental health, that the policy is in line with best practice, and that appropriate training is provided to relevant staff.

Recommendation 4: MHA and urgent requests for assessment

The family was left unsupported and without access to mental health support services over a weekend. There was an over-reliance on emergency services responding if a crisis occurred before the planned assessment.
The Trust must ensure that urgent requests for assessment are considered and responded to in line with the least restrictive principle of the MHA. When a date for a mental health assessment has been agreed, patients and families should be provided with a clear plan to follow if a crisis occurs before the assessment takes place.

Recommendation 5: MHA assessments and documentation

The crisis team did not record their rationale for not completing an MHA assessment at home. Recording this would have ensured practice was in accordance with the least restrictive principles of the MHA.
The Trust must ensure that crisis team staff comply with policy expectations by recording their decisions and the actions taken or not taken as part of MHA assessment requests.

Recommendation 6: Section 17 leave standards

There is no evidence of a risk assessment being carried out before Section 17 leave was granted. Section 17 leave was not always recorded correctly.
The Trust must ensure that risk assessments at Hospital 2 are up-to-date and complete before Section 17 leave is agreed. Section 17 leave must also be documented correctly, including the start and return times of the patient, and the patient's presentation on their return from Section 17 leave.

Recommendation 7: MHA and involving the NR at detention and discharge

There is no record of information being provided to the NR about Adult 1's detention and discharge.
The Trust must ensure that the MHA Office communicates with the NR when decisions are made about changes to the patient's detention.

Recommendation 8: Involving families in assessments and care planning

Neither the inpatient team nor the early intervention team (EIT) clinicians sought out family views, even when direct representations were made to the service by family members.
The Trust must ensure that Hospital 2 and EIT staff seek to involve family members (or other relevant third parties), and that family evidence/collateral information is used appropriately, particularly when the patient is unable or unwilling to engage in meaningful interactions themselves.

Recommendation 9: Discharge standards

There was no post-discharge follow up from Hospital 2, which contravenes policy.

The Trust must ensure that when patients are discharged from hospital, post-discharge follow up is conducted in accordance with Trust policy and national guidance.

Recommendation 10: Application of the Mental Capacity Act (MCA)

Adult 1 was taken to hospital under the MCA and remained in hospital for 10 hours more than the time set out in the Trust Mental Health Connect Helpline and Crisis Hub SOP.
The Trust must ensure that the MCA standards, set out in the Trust Mental Health Connect Helpline and Crisis Hub SOP, are met and that there is a clear escalation process for if the standards cannot be met.

Recommendation 11: Application of the MCA

On several occasions Trust staff assessed Adult 1 and found him to be lacking capacity. Ambulance Trust 1 also found him to be lacking capacity on one occasion. But the assessments were not documented in accordance with the policy of either Trust.
The Trust and Ambulance Trust 1 must ensure that assessment of mental capacity is documented in accordance with the relevant Trust policy.

Recommendation 12: System management of safeguarding referrals

Safeguarding referrals were not robustly followed up when passed back through primary care and we were unable to determine how the Council assured itself that duties conducted on its behalf were completed as required.
The Integrated Care Board (ICB), the Council and the Trust must ensure there are clear pathways for managing a safeguarding adult referral where there is a mental health and social care component; these should be supported by robust and detailed assurance processes.

Recommendation 13: Being open and involving families in serious incidents

There was a lack of clarity about the implementation of new policies and processes in the transition to PSIRF this meant the process was not transparent for families, which led to great distress.
The Trust must ensure there is clarity in the PSIRF policy about involving families in the investigation of incidents and this involvement should be supervised and quality assured. Communication with families must be timely and unambiguous, in accordance with the principles of being open. This is set out in guidance about engaging and involving patients, families and staff involving a patient safety incident.

Learning Quadrant

Individual/Team practice
- Have I/we informed nearest relatives (NRs) of their rights?
- Have I/we given due consideration and responded appropriately to a NR's request for

Governance focused learning
- Has training been provided on the role and rights of the NR to ensure the correct advice is given?
- Are relevant policies aligned to the MHA and the MHA Code of Practice?

a MHA assessment and are they in line with the MHA Code of Practice?
- Do I/we recognise that concerns raised by families and other professionals need to be considered and responded to in line with Trust policy?
- Have I/we sought the views of the family and other relevant parties and documented this particularly when the patient is unable or unwilling to engage in meaningful interactions themselves?
- Have I/we reflected on the rationale for decisions made and the actions taken and not taken?
- Have I/we provided patients and families with a clear plan to follow if a crisis occurs?
- Am I/Are we clear about my responsibility to document Section 17 leave correctly?
- Is my/our communication with families timely and unambiguous in accordance with the principles of being open?

- Are we assured that current practice and policy is clear on how to manage NR requests for a MHA?
- Does policy guidance include the management of requests by families and other professions when concerns are expressed about a person's mental health?
- Are we compliant with relevant Trust policy when documenting mental capacity assessments?
- Are we assured MCA standards are always met?
- Do we have a clear escalation process if MCA standards cannot be met?
- Are we assured that urgent requests for assessment are responded to in line with the least restrictive principle of the MHA and are we compliant with policy expectations?
- Are we assured risk assessments are up to date and complete before granting Section 17 leave?
- How are we assured that post-discharge follow up is conducted in line with Trust policy and national guidance?
- Do we have robust assurance processes for managing safeguarding referrals?
- Is Trust policy clear about family involvement in the investigation of incidents and are we assured this involvement is supervised?

Board assurance
- Do we have sufficient oversight and monitoring processes to ensure the management of NR requests for a MHA assessment is in line with Trust policy and does current practice reflect this?
- How are we assured that the application of the MCA is in line with the law?
- How are we assured that input from families is proactively sought by staff?
- How are we assured that families are listened to?
- How are we assured that discharge processes are robust and that our duty of care

System learning points
- Do we have an agreed approach to communication with families and other professionals when decisions and changes are made to a service user's care?
- Have we recognised the need for support for patients with mental health difficulties and finding it difficult to engage to be a collaborative approach so there is not an over-reliance on a particular service?
- Do we have a robust system in place for managing safeguarding referrals?
- Do we have clear pathways for managing safeguarding referrals when there

towards patients in this regard is safely enacted?

- As a Board member do I know there is sufficient oversight and quality processes on how safeguarding referrals are managed?
- How are we assured of the quality of family involvement in an investigation of incidents?
- How are we assured that the investigations process is transparent?

is a mental health and social care component?

- Do we have clear channels of communication to ensure duties conducted on our behalf by other agencies are completed as required?

https://www.england.nhs.uk/south/publications/ind-invest-reports/south-west/an-independent-investigation-into-the-care-and-treatment-of-adult-1/