Summary

Throughout the 2 years he was under the care of Nottinghamshire Healthcare NHS Foundation Trust (NHFT), it is clear from Valdo Calocane (VC's) records that he was acutely unwell. VC showed symptoms of psychosis, including presenting as guarded, and having little understanding or acceptance of his condition throughout his care under NHFT. Problems with him not taking his medicine were also recorded from early on.

Our review found:

- If the decision had been made to treat VC under section 3 of the Mental Health Act (MHA) 1983, during his fourth admission to hospital, further options would have been available for his care and treatment in the community
- There was a series of errors, omissions and misjudgements, all of which were compounded by the symptoms of VC's illness.

  Key among these were:

  - the decision to discharge VC back to his GP in September 2022
  - inconsistent approaches to risk assessment for VC
  - poor care planning and engagement with VC and his family.

A core part of our review was to consider whether the evidence we gathered from VC's care records indicated wider patient safety concerns or systemic issues in Nottingham. While we did not find any widespread patterns with 10 other cases that we reviewed as a benchmark, many of the issues we have identified are consistent with the problems we found in our wider review of the quality of care and safety of services at NHFT.

NHS England's Independent Homicide Review will provide a more detailed scrutiny of VC's wider interaction with mental health services. The scope of NHS England's review is broader than this review, and may well identify other areas of VC's care that fell short.

Key findings

Risk assessment and record keeping

- Inconsistent approaches to risk assessment was an issue in both VC's case and the 10 benchmarking cases, and reflected findings from our wider review of NHFT. As well as minimising or omitting key details, there were other issues particular to VC's case, including:
    - While some key risks were identified, risk assessments minimised or omitted key details and did not outline the seriousness and the immediate threat of the risks and the known issues that would increase the risk to himself and others.
    - Risks around his capacity to consent may not have been managed adequately as, in light of his symptoms, not all opportunities to assess his capacity to consent to treatment in the community were taken.
    - Before he was discharged back to the GP in September 2022 from the early intervention in psychosis team, there does not appear to have been an updated risk summary.

Care planning and engagement

- In line with the findings from our wider review of NHFT, VC received a timely referral into mental health services after his first arrest. While our first report highlighted issues with people being allocated a care co-ordinator in a timely way, we found that VC was allocated a care co-ordinator from the early intervention in psychosis (EIP) team promptly. This person remained his primary care co-ordinator until April 2022 when his care was transferred to 2 community psychiatric nurses.
- Care plans for VC and the 10 benchmarking cases we looked at followed national guidance. However, teams did not always take a holistic approach, which hampered their ability to identify risk factors and create person-centred care plans. This reflected concerns raised in our first report around inconsistent care planning.
- There were issues with VC's engagement with services throughout the 2 years he was under the care of NHFT. We found similar issues in 3 out of the 10 benchmarking cases. While teams took steps to follow up and re-engage people, we found large gaps between visits in the records for both VC and the 3 benchmarking cases.
- While VC's family contacted NHFT services to raise their concerns, the information they provided was not consistently acted on and did not always work well. We also identified issues of families feeling excluded, not listened to or that staff weren't communicating effectively in our wider review of care at NHFT.
- While VC received timely admission to hospital in most cases, delays around his third admission led to VC being admitted to an out-of-area PICU (psychiatric intensive care unit) bed. Concerns over the use of out-of-area beds was also a wider issue that we identified in our first report.
- In September 2022, VC was discharged back to his GP due to non-engagement. However, there was no evidence that VC's family was consulted or that the GP, police or university were consulted. This reflected findings of our wider review where we found a lack of GP involvement in discharge planning.

Medicines management and optimisation

- In line with the Mental Health Act Code of Practice, VC's preferences were at the forefront in decisions around the choice of medicine and treatment regime. However, his decisions and wishes were not always balanced with other information.
- From the beginning of the 2 years, there was an obvious pattern of VC not taking his medicine while in the community. Records also show that medicine had been found in his flat, suggesting that he wasn't taking it. This is similar to 3 of the 10 benchmarking cases we looked at, where we found issues with medicines monitoring.
- Despite multiple hospital admissions and evidence that VC was still symptomatic on the treatment prescribed, there was no real change to his care and treatment. NICE guidelines are clear that people with schizophrenia whose illness has not responded adequately to treatment, should have their diagnosis and treatment reviewed to ensure it is at an adequate dosage and for the correct duration.

Discharge planning

- No problems were identified for the first 2 discharges between local NHS hospitals and community services for VC. This reflects some of the findings from our review of 10 benchmarking cases, which found that, of the 4 patients discharged from NHFT, 3 were handled well.
- There were differences between the records we reviewed from the trust and the independent hospital in relation to the third discharge in October 2021. At this discharge, VC was unable to access specialist crisis team care. Problems around communicating discharge decisions and difficulties in transitions of care between inpatient and community services were also issues we identified in our wider review of NHFT.

- There is no evidence of discussion around the value of depot medicine or a community treatment order (CTO) until his fourth admission. NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. Giving VC a depot injection and placing him on CTO would have allowed for recall to hospital, but as he was being held under section 2 of the MHA it was not legally possible to discharge him using a CTO.
- The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour. The decision to discharge VC back to his GP in September 2022 did not adequately consider or mitigate the risks of relapse and violence or his lack of engagement with services. This reflects the findings from our wider review of NHFT, which found that discharge planning was not robust, and that there was a 'lack of clarity of thinking' in relation to discharge decisions.