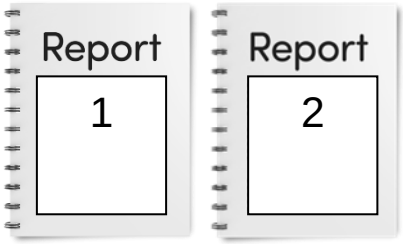
Looking at mental health care in Nottingham, part 2

August 2024

Easy read version of ‘Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, part 2’

Summary

In January 2024, the government asked us to check what mental health care was like for people who live in the Nottingham area.



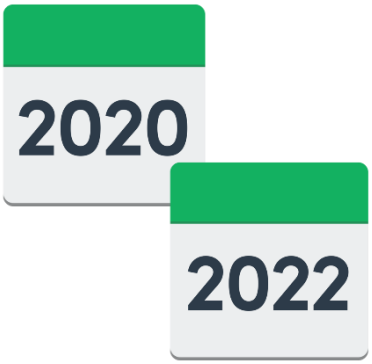
We did this check in 2 parts.

In March 2024, for the first part, we put a booklet on our website that looked at what we found out about mental health care when we checked Nottinghamshire Healthcare NHS Foundation Trust hospital.

This new easy read booklet looks at the second part.

This booklet looks at whether the criminal trial (or court case) of Valdo Calocane showed that there are any other problems with mental health services in the Trust.

The trial convicted Valdo Calocane for killing 3 people in June 2023.



For the 2 years that Valdo Calocane was being cared for by Nottinghamshire Healthcare NHS Foundation Trust hospital, he was very ill and showed signs of psychosis.

People with psychosis can be aggressive and guarded, or be uneasy with other people.

There were problems with him not taking his medicine.

The second part of our check of mental health services found that there were 4 main problem areas:

- Checking risks and keeping records

- Care plans and engaging with each other

- Medicines

- Moving between services.

Checking risks and keeping records

Different ways of checking risks to people's safety were a problem in Valdo Calocane's case and 10 other cases we looked at.

As well as missing information, there were other problems in Valdo Calocane's case, including:

- Safety checks left out how serious the risks to himself and others were

- There were not enough checks to see if he was able to agree to treatment (if he had the capacity to consent to it)

- There did not seem to be a new safety check when he was discharged (moved) from the care of a special psychosis team to his local GP doctor in September 2022.

Care plans and engaging with each other

Valdo Calocane was supported by mental health services and given a care co-ordinator at the right time.

Care plans were written in the right way, but teams did not always talk to each other enough to find out if there were any safety risks or to make sure people get person-centred plans.

Sometimes the time between Valdo Calocane's visits to mental health services was too long. This also happened with some other people's cases we looked at.

Valdo Calocane's family contacted the hospital to say they were worried that his illness was getting worse, but this was not always acted on well. This happened to other families too.

People were sent to hospitals away from where they live too often – and this also happened to Valdo Calocane.

There did not seem to be a new safety check when he was discharged (moved) from the care of a special psychosis team to his local GP doctor in September 2022.

When Valdo Calocane was discharged back to his GP in September 2022, no one talked to his family, or his GP, or the police or the university where he was a student.

Medicines

Decisions about Valdo Calocane's medicines were not always balanced well between his wishes and the changes in his illness.

There were not enough checks that Valdo Calocane was taking his medicines when he was out of hospital – this also happened in some other people's cases we looked at.

Moving between services

We did not find any problems with how Valdo Calocane was discharged (moved) from local NHS hospitals to community services the 1st and 2nd times. When we looked at other people's care, this was usually handled well.

The 3rd time Valdo Calocane was discharged (moved) from hospital, he could not get specialist care and there were problems with passing the right information between hospitals and community services. This also happened with some other cases we looked at.

Giving Valdo Calocane an injection of antipsychotic medicine and putting him on a community treatment order means he could have been sent back to hospital. But this was not talked about until the 4th time he was put in hospital.

During Valdo Calocane's treatment and contact with the police, there were signs he might get unwell again and a risk that his behaviour could become aggressive.

When he was discharged (moved) to his GP in September 2022, the risks of him becoming violent or not keeping in contact with medical staff were not fully thought about.

In other cases we looked at in Nottingham, we found there needs to be more planning when people are discharged (moved) from hospital and clearer information on why they have been moved.

Find out more

You can see the full version of our report on our website at: www.cqc.org.uk.

If you want to give feedback on your care – it can be good or bad – fill out our form at: www.cqc.org.uk/givefeedback.

Or you can call us on:

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