INDEPENDENT ASSURANCE REVIEW

Assurance of the investigation report and action plan relating to the care and treatment received by PS prior to homicide

Learning document

Contents

Section 1: Introduction

1.1 This summary reviews the findings of an independent assurance review conducted to evaluate the care and treatment provided to PS by mental health services. The review was initiated after a tragic incident involving PS, which highlighted significant failures in care coordination, clinical management, and service pathways. The incident underscores the need for improvements to address gaps in mental health care delivery.

1.2 The assurance review involved an extensive examination of documentation, interviews with relevant stakeholders, and an analysis of policies and procedures in place at the time of the incident. The review aimed to identify the root causes of failures, assess the adequacy of the trust's internal investigation, and provide actionable recommendations for improvement.

Section 2: Background and history

2.1 PS was an individual with a history of anxiety and depression, characterised by escalating mental health concerns and periods of disengagement from services. His initial contact with mental health services occurred when he self-referred to the Improving Access to Psychological Therapies (IAPT) service, seeking cognitive behavioural therapy (CBT). This referral was made at the suggestion of his general practitioner (GP) and was intended to address symptoms of anxiety and depression.

2.2 Over a period of several weeks, PS exhibited concerning changes in his mental health presentation, including paranoia, ruminations about possession, and wandering the streets at night. These symptoms were identified by his GP as potential signs of emerging psychosis, prompting an urgent referral to the Single Point of Access (SPA) team. However, procedural inefficiencies and communication breakdowns led to a delay in triaging this referral and addressing PS's deteriorating condition.

2.3 During this time, PS attended appointments with various healthcare providers, including the IAPT and Crisis Assessment and Treatment Team (CATT). Despite multiple interactions with services, there was insufficient continuity of care and inadequate recognition of his escalating risk. PS's complex presentation, coupled with fragmented service delivery, culminated in a tragic incident that raised serious questions about the effectiveness of the care he received.

Section 3: Incident overview

3.1 The incident involved PS attacking JL, a spiritual healer whom he had consulted prior to the event. JL sustained life-threatening injuries and subsequently died. PS was later arrested and charged with manslaughter on the grounds of diminished responsibility. He was detained in a secure hospital under provisions of the Mental Health Act.

3.2 At the time of the incident, PS was under the care of mental health services, but significant lapses in care coordination and risk management were evident. The investigation revealed that several opportunities for early intervention and risk mitigation were missed, including inadequate response to urgent referrals and failure to appropriately assess and manage PS's psychotic symptoms.

3.3 The trust's internal investigation into the incident took considerably longer than the agreed time frames, highlighting additional challenges in governance and accountability. The delayed reporting and action planning further compounded the issues identified.

Section 4: Review findings

Service coordination and pathway management

4.1 The review highlighted issues in managing referrals and coordinating care across multiple services. The SPA, designed to serve as the central intake system, failed to efficiently triage urgent referrals. Delays in communication and a lack of integration between electronic patient record systems contributed to fragmented care. For instance:

- PS's urgent referral from his GP, highlighting potential psychotic symptoms, was not actioned promptly.
- The lack of interoperability between systems used by the SPA, IAPT, and CATT teams prevented clinicians from accessing comprehensive patient histories, leading to missed opportunities for timely intervention.

Clinical care and risk assessment

4.2 The clinical care provided to PS was inconsistent and did not align with best practices for managing emerging psychosis. Key findings include:

- **Inadequate risk assessment:** Risk assessments conducted by the IAPT, RAID (Rapid Assessment Interface and Discharge), and CATT teams failed to fully consider PS's escalating symptoms and their potential link to psychosis.
- **Disjointed care pathways**: PS's care was characterised by fragmented transitions between services, with limited communication or follow-up. For example, the IAPT practitioner's attempts to re-engage PS after missed appointments did not take into consideration the escalation in his presentation as outlined by the GP.
- **Medication management**: PS experienced frequent changes in medication, including self-adjustments to dosages, without consistent oversight. This lack of coordination heightened the risk of adverse outcomes.

Cultural and Spiritual Considerations

4.3 PS's faith and cultural context played a significant role in his mental health presentation but were not adequately considered by the clinical teams involved in his care. Key issues include:

- **Lack of cultural competence**: Clinicians demonstrated limited awareness of the potential impact of PS's spiritual beliefs on his mental health. For instance, his reports of demonic possession were dismissed as anxiety-related without further exploration.
- **Missed opportunities for specialist input**: The trust's spiritual care team was not consulted, despite the clear intersection of PS's faith and mental

health concerns. This omission represents a missed opportunity to provide holistic and culturally sensitive care.

Investigation and governance

4.4 The internal investigation into the incident revealed several shortcomings in governance and accountability. These include:

- **Delays in investigation and reporting**: The trust's internal investigation took an extended period to complete, delaying the implementation of necessary improvements.
- **Lack of stakeholder engagement**: Key stakeholders, including PS's family and GPs, were not sufficiently involved in the investigation process.
- **Inadequate action planning**: The recommendations arising from the investigation were primarily process-focused, with limited emphasis on measurable outcomes or change.

Section 5: Conclusion

5.1 The case of PS underscores critical gaps in mental health service delivery, including failures in care coordination, risk assessment, and cultural competence. By addressing these shortcomings, mental health services can better support individuals with complex needs and prevent similar incidents in the future. This review serves as a call to action for meaningful reform and continuous improvement in mental health care practices.

Section 6: Recommendations

Analysis of the findings from the assurance review have been captured throughout the main report. Examples of good practice have been highlighted and opportunities for learning and improvement have been shared, this report focuses on a summary of key areas where the trust should prioritise improvement.

The areas for improvement detailed below have been agreed with the trust. The trust has responsibility for developing associated action plans, ensuring actions are SMART (Specific, Measurable, Assignable, Realistic and Time-bound) with clear ownership and timescales.

In summary, the review makes the following recommendations:

Serious Incident investigations / Learning responses under PSIRF

6.1 National changes in the approach to investigating serious incidents with the introduction of the patient safety incident response framework (PSIRF), since this incident provides the trust with an opportunity to develop these changes further. The FM team understand that the trust started their PSRIF journey in January 2024.

6.2 With the introduction of its revised incident reporting and serious incidents requiring investigation policy, the trust should take the opportunity to ensure that the quality of investigations is strengthened, this should include:

- drafting clear terms of reference, having consulted with appropriate interested parties such as service users, families, and all key decision-makers along the pathway, including those from other organisations
- extend this collaborative approach to the investigation process itself by engaging with all interested parties to construct a comprehensive timeline of events / journey maps
- ensuring all those conducting investigations are properly trained in investigation techniques and how to apply the principles of human factors in line with the standards outlines in PSIRF
- the trust should ensure that actions address all findings and recommendations/safety actions, are outcome-based and measurable
- the trust should ensure that serious incident action plan evidence is rigorously and independently tested before it is signed off as complete

Risk identification, assessment and management

6.3 The trust should review the guidance available to healthcare professionals and the wider NHS such as *Religion or Belief: A practical guide for the NHS, January 2009* and engage with local organisations such as MIND. The trust should then critically appraise its mental health services and make the changes necessary to ensure staff are able to deliver appropriate interventions and effective service delivery that is sensitive to religious, cultural and social differences. This should consider those situations where cultural stigma and shame might be associated with accessing mental health support and therapies.

6.4 The culmination of this work should result in policy and process enhancement together with a more tailored training programme that includes the cultural needs of the religious communities who access its services.

6.5 The trust is advised to revisit, and strength test its clinical risk assessment and escalation processes, including staff training. The work should take full account of this case and the learning from the assurance review when examining its response to religious, cultural and social differences.

NHS Talking Therapies (formerly IAPT)

6.6 The trust should review all relevant NICE guidance and quality standards, and The Improving Access to Psychological Therapies Manual, version 6, published by NHS England in February 2023. Following this review, the trust should assure themselves that its current service provision, associated policies and staff training is in line with up-to-date national guidance. Practitioners should continue to assess service users frequently for changes in their levels of risk. This process should continue during a

period of disengagement, which may indicate an increasing level of risk is emerging. Practitioners should understand when, on the basis of risk, a service user's care and treatment should be escalated or transferred to secondary care services. The trust should ensure this pathway is well understood and that transition works smoothly.

Records management

6.7 The review team explored the changes in the electronic patient systems since the investigation.

6.8 The trust should adopt a regular programme of auditing its patient records management systems (A, B and C) so that it can monitor whether staff are complying with the additional checks introduced following the investigation. The trust should seek to gain robust assurance as to the effectiveness of the changes described in its action plan.