Psychological
Approaches

AN INDEPENDENT INVESTIGATION

INTO THE CARE AND TREATMENT

OF AB

December 2022

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INTRODUCTION

The external investigation by Psychological Approaches into the care and treatment of AB was commissioned in May 2022 by NHS England, London, under the NHS Serious Incidents Framework (2015). We would like to thank the Quality & Patient Safety Manager for the Acute Mental Health Service Line in West London NHS Trust for all her help in supporting this investigation. We also extend our thanks to those we interviewed and the agencies who provided electronic records and information, all of which was extremely helpful to the panel.

The person

1. AB did not wish to participate in this investigation, and although family members have been written to, there has been no contact with them to date. Although her pathway of care included a number of brief screening assessments, she was only seen twice face to face for a longer session.

2. From the information recorded in the patient record, AB reported a happy childhood, although she struggled with the transition to secondary school. She studied drama at university but took a year out with mental health difficulties before completing her degree. Her father died in 2016, and her relationship with her mother and two sisters was not always easy.

3. AB had a number of jobs, but in the year leading up to the serious incident, she was studying to be a social worker at university; this was clearly important to her, and juggled study with caring for her young daughter as single parent. There were difficulties in her relationship with her ex-partner, her daughter's father.

4. In late adolescence, AB struggled at times with suicidal thoughts, particularly when she consumed large quantities of alcohol and cannabis. This resulted in her only conviction which was for drink driving in 2013. She had intermittent but brief contact with mental health services, usually presenting with low mood, or anxiety and agitation. She continued to use substances heavily at times but reduced her use very considerably when her daughter was born.

5. At the time of the serious incident, AB was on the waiting list for a review of her diagnosis by Ealing Crisis, Assessment and Treatment Team. The last professional to talk to her prior to the incident was her GP who had a telephone conversation with AB to renew her prescription of anti-depressant medication; she was said to have some low mood still but no suicidal thoughts.

The incident

6. On Sunday 22nd March 2020 around midday, AB drove her car onto the pavement hitting a pedestrian, and then hit him a second time trapping him under the vehicle. She got

out of the car and was chased by the second victim who – realizing AB had a knife in her hand – tried to run from her, fell and was stabbed by her multiple times. AB was subsequently tasered by the police and restrained by them. On 23rd March, the first victim died in hospital. The second victim suffered a cut to his hand but was saved from serious injury by his protective clothing. AB's two-year-old daughter was in the car at the time of the incident. At the time of her arrest, AB was noted to be screaming that her mother was a paedophile, and a passer-by heard her state '*I stabbed him, he's a paedophile'*.

7. At the time of writing this report, AB has been convicted of one count of manslaughter on the grounds of diminished responsibility, and one count of causing grievous bodily harm.

BACKGROUND TO AB'S CARE AND SUPPORT

9. A detailed chronology of AB's care and support is provided in Appendix I to this report. The summary is drawn from the electronic patient record held by West London NHS Trust (WLT), from the GP notes, and from a briefing note provided by Ealing Social Services.

2008

10. The first contact with AB was when she was aged 17/18, and her boyfriend at the time referred her to Ealing Social Services in relation to his concerns about her mental health. No further information is available.

11. Two months later, AB is again referred to Ealing Social Services by her school. The referral stated that AB was living with her boyfriend and that her mother was planning to enrol her in a boarding school in Ghana and '*leave her there'*. There is no further information available to suggest that this threat was followed up by Social Services.

2013

12. AB (aged 22) attended Accident and Emergency by ambulance, together with family members. She was intoxicated and expressing suicidal thoughts. She was seen by the Ealing Liaison Psychiatric Services Team at Ealing hospital, and her mother was also interviewed. A full history was taken, with the conclusion that there was no evidence of mental illness and the primary trigger to the current situation was substance misuse (alcohol and cannabis). She was referred to the GP for follow up and an appointment made with the drug and alcohol nurse for two days' time, which AB duly attended; she was then referred to community substance misuse services and there was no further contact with the trust.

2016 - 2020

13. A police merlin report (dated 24th September 2016) stated that police were called to AB's flat as she had expressed suicidal thoughts to her friend when she was intoxicated with alcohol. She denied any suicidal intention. Her WLT notes state that she had been referred to Improving Access to Psychological Therapies (IAPT), but the referral had been rejected on the grounds that her needs were best met by substance misuse services. She was reviewed by Single Point of Access and discharged. However, two weeks later a routine referral to SPA was made by the GP, and she was screened by SPA seven days later (19th October, 2016). AB reported symptoms of depression triggered by childhood issues which she did not wish to elaborate; she also reported binge drinking and unstable mood. She denied any risk concerns, and risks to self and others were rated as low. SPA referred her to the Ealing Recovery Team (ERT) for review, and a crisis plan was discussed with her.

14. AB was invited to an assessment by the ERT Transitions team for 13th February 2017, which she attended, and a full assessment of her difficulties was made by one of the nurses and a colleague. It was concluded that she had problematic alcohol and cannabis

use, and that she was suffering from a depressive episode with anxiety and marked agitation. She was not taking prescribed medication for her depression, but she was taking St John's Wort[1]. There were a number of psychosocial stressors identified including details of childhood sexual abuse within the family and an incident where AB was sexually assaulted by a man outside the family; an estranged friend of hers had recently taken her life. AB's risk to self was rated as medium at that time and her risk of harm to others was rated as low. She was signposted to a number of services, a crisis plan was conveyed to her, and she was referred to see the team ERT psychiatrist in the outpatient clinic.

15. Although subsequent entries in the patient electronic record do not give a clear account of events, it seems that AB did not attend follow up appointments in March, May and August of 2017. Reference is made to a voicemail being left by the team, and in August, Duty made a further phone call to AB, leaving a message with her sister. The entry on 30th August states that there was a plan for Duty to make a home visit and that if AB no longer required the ERT service she should be discharged; however no further information about this is available. On 11th January 2018, AB again did not attend her outpatient appointment.

16. On 22nd February 2018, AB rang ERT admin and said that she had recently moved accommodation and had not been aware of any of her appointments. She reported that she was pregnant and that her baby was due on 29th March 2018; she gave permission for ERT to refer her to the Perinatal Clinic.

17. The Perinatal Mental Health Services Team (PMHST) received the referral on 22nd February 2018, and AB was offered an appointment on 6th March 2018 which she did not attend. The perinatal nurse followed up with telephone call to AB that day, who said she had not received the appointment letter. AB refused the offer of another appointment, saying that she did not require any service at that point in time and that she had started counselling through her local church. She reported that she was coping well – much better than during the previous year – and that her living situation was much better. She was discharged from the PMHST with the recommendation to ERT that she be followed up by the duty team to check on her progress.

18. AB approached her GP in August 2018 with a request for written support for her appeal against the Housing Benefit office's decision not to backdate her housing payments. She was seen by the GP surgery nurse later that month and the notes record that she had '*no thoughts of self-harm, baby looks happy and well cared for*'.

19. The electronic patient record shows no evidence that AB was followed up by Duty, but she did have an outpatient appointment with Dr B (from the ERT) for 4th October 2018, which AB attended. Dr B assessed AB and concluded that she was suffering from mixed personality disorder (dependent, histrionic and emotionally unstable types) and obsessive-compulsive disorder (OCD), with the risk of becoming overanxious and low in

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[1] St John's Wort is a popular herbal remedy promoted for the treatment of depression, which can be purchased over the counter (without prescription).

mood at times; she noted AB's reported difficulties in relationships and in coping with stressors. Dr B advised AB about her diagnoses and treatment options; she explained that she did not meet criteria for secondary mental health care, and that the doctor intended to discharge her from ERT and refer her back to her GP. Dr B made an on-line referral to IAPT with contact details given to AB to follow up the referral. The referral was on the basis that AB would benefit from cognitive behavioural therapy for the treatment of her OCD. Dr B considered that AB could be referred for psychotherapy for her personality difficulties after receiving help for her OCD in the first instance. The discharge letter from ERT was sent on 10th December 2018.

20. On the 21st June 2019, AB's GP referred her back to SPA given that IAPT had again rejected the online referral at the point of triage, this time on the basis that AB's diagnosis of personality disorder meant that she was excluded from IAPT[2]. AB questioned the diagnosis and the GP considered AB likely to be suitable for primary care talking therapies. SPA forwarded this referral directly to the primary care mental health service (PCMHS) for review. The GP notes record that AB was no longer using cannabis or alcohol, there were no thoughts of suicide or of harming her child, her family was supportive; the main symptoms were '*anxious, reduced patience*'. The initial referral was accepted by PCMHS, and an appointment sent by PCMHS for 10th July 2019 which AB did not attend. The clinical psychologist in PCMHS reviewed the patient record and advised that there were limited options in PCMHS for talking therapies other than some groupwork; he suggested the adult psychotherapy service as another potential option. Two further attempts were made in October 2019 by PCMHS to see AB for an appointment, but she did not attend.

21. On 9th September 2019 the GP again referred AB back to SPA, but SPA confirmed that the PCMHS was the appropriate service to assess AB's needs. On 18th October, the GP referred AB back to SPA asking for a second opinion, at the request of AB, in relation to the diagnosis. SPA attempted to triage the case by ringing AB, but were unable to get through to her, and so sent a text message.

22. On 16th October 2019, AB attended the GP surgery, presenting with depressed mood; she had reported her daughter's father to social services as she was worried about his behaviour, but the matter had been escalated when AB failed to respond to social services' request for information/meetings. The GP observed that the '*child very active and happy whilst in room*' and advised AB to get back in touch with the primary mental health care psychologist.

23. On 8th November 2019, SPA triaged the case in a telephone conversation with AB. She reported that she was doing well at the present time, that she was studying full time at university to be a social worker, and that she had been taking anti-depressant medication (Sertraline) for '*a couple of months*' as '*a preventative*'. She said she had no time to attend therapy sessions, although she had signed up for counselling at the

[2] Exclusion criteria, IAPT Services (WLT) – Referral criteria: '*a diagnosed personality disorder or personality traits that would make engagement in a brief psychological intervention likely to be ineffective, unhelpful and contravene NICE guidance*.'

university for extra support. AB reiterated her wish for her diagnosis of personality disorder and OCD to be reviewed as she did not agree with it. AB felt it was a '*mistake*' to go and speak to someone about her low mood as it had given her a '*label*' with which she was unhappy.

24. SPA referred AB to the Ealing Crisis and Treatment Team (ECATT) for a routine medical/diagnostic review on 8th November 2019. She was placed on the waiting list. In December 2019, PCMHS closed the referral to their service. No further contact was made prior to 22nd March 2020 when the serious incident took place.

Ealing Social Services records: September to December 2019

25. AB came to the attention of Ealing Social Services (ESS) – for the second time (see paragraph 22 above) - in September 2019 when she presented at St Mary's Hospital in relation to her daughter who she believed had been sexually abused by her daughter's biological father, and she was seeking a physical examination of her daughter to evidence her concerns. St Mary's Hospital made the referral to ESS and a Child and Family Assessment was undertaken. After an appropriate level of investigation and liaison with police and medical consultants, it was concluded that the threshold was not met for a full Child Protection Investigation. The GP had provided information regarding AB's mental health history in a letter dated 1st November 2019 to the social worker, and ESS were aware that she had not warranted ongoing care from secondary mental health services, and that she was on a waiting list for a review of her diagnosis; they were also aware of the nature of her diagnosis. AB maintained that she had remained abstinent from substances since becoming pregnant with her daughter. No contact was made with WLT by ESS. In discussion with PA regarding the notes made on the ESS file, it seemed that there was some consideration of whether AB had transferred issues of her own family history of childhood sexual abuse onto her daughter's father; that is, that she might '*continue to feel worried about her daughter in her father's care even if she is completely safe'*. There was also a passing comment about a perceived deterioration in AB's mental health that may bring into question her capacity to care for her child, but this observation is not elaborated upon in the notes and no mental health referral was made.

26. Social Care involvement ended on 23rd December 2019.

ANALYSIS IN RELATION TO THE TERMS OF REFERENCE

27. To identify whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

28. We have considered the Terms of Reference that are specific to AB first (also detailed in Appendix II).

29. We have chosen to respond together to the three Terms of Reference that relate to the trust's internal investigation plan, the action plan progress, and the processes for quality assurance together, as they are overlapping in their scope. These can be found at the end of this section of the report.

Specific terms of reference

To consider AB's contact with health and social care in the events leading up to the incident (22nd March 2020) with particular attention to:

Examining the care and treatment of AB from consideration of her first contact with mental health services up until the date of the incident.

30. A detailed chronology is laid out in Appendix I and a narrative account of AB's pathway of care is described in the 'Background to AB's care and support' section of this report.

31. AB's early contact with services appeared to represent isolated incidents of distress. The 2008 episode when she was aged 17 involved the Local Authority, and the matter was closed by Ealing Social Services without follow up. The 2013 episode involved the Accident & Emergency department and psychiatric liaison services; AB's family were interviewed, and she received a follow up appointment with a specialist substance misuse nurse, and signposting to the appropriate community service.

In our view, the care and support provided in these two episodes was appropriate.

32. 2016 marks the commencement of a three-and-a-half-year period (September 2016 to March 2020) during which time AB was open to WLT for almost three years. In our view, there were a number of problems relating to care and support provided by WLT over this period, which we characterise as 'drift' in the referral process; a challenging experience in trying to access care; and diagnosis-related difficulties.

'Drift'

33. In relation to 'drift' it is important to acknowledge that AB missed several appointments that were offered to her. This may have been in part due to confusion regarding her change in home address, although we do not rule out the possibility that AB had mixed or changing feelings about her wish to seek therapeutic help.

34. Following an SPA screen in October 2018, it took 117 days for AB to be seen for assessment, rather than the requisite 28 days for a non-urgent referral.

35. Between March 2017 and February 2018, AB was offered four appointments that she did not attend. The electronic record for 30th August 2017 said that a home visit would be made by Duty and if AB no longer required the ERT she should be discharged. No home visit was made. The Recovery Team Operational Policy for that period does not specify processes to manage DNAs (did not attend). However, WLT's general DNA policy (December 2020) advises that the service user should be telephoned if they fail to attend their appointment, and on the second DNA, not only will the service user be telephoned but also other potential sources of information will be sought. A further follow up appointment should not be routinely offered until contact has been made with the service user. GPs should be informed of DNAs within five working days.

36. The PMHST recommended that the duty team in ERT follow AB up in March 2018, but this did not take place. She was not then offered an appointment until October 2018, when she met with Dr B. She was discharged from ERT in December 2018.

37. SPA was again asked to triage AB on 8th November 2019, in response to her request for a review of the diagnosis. They made the referral to ECATT for such a review on the same day. She should have been seen within 28 days but by the time of the incident – 132 days later – she had not received any communication from the service.

Challenging experience to try and access care

38. AB's experience of seeking help for her mental health difficulties exemplifies some of the difficulties of a pathway of care that is predicated on a referral and assessment system which requires the patient to fit with the team criteria. AB received multiple

screening assessments, face to face assessment sessions from two different staff members and was found not suitable for all three services to which she was referred.

39. AB was referred to IAPT on two occasions, 2016 and 2019, but was not seen on either occasion as she was screened out on the basis of referral information. In 2016 she was considered more appropriate for substance misuse services; in 2019 she was rejected on the grounds of her personality disorder diagnosis. This accords with local and national guidance regarding suitability for IAPT.

40. Although the ERT made considerable efforts to engage with AB (see above comments), they concluded – almost two years after receiving the referral – that she was not suitable for secondary mental health care. She was discharged by ERT to the GP before the outcome of the referral to IAPT had been ascertained.

41. Between June and November 2019, AB's GP made four referrals back to SPA. It was not possible for the GP to refer AB back to the ERT for a view as to next steps even though they knew her; it was correct procedure for her to be spoken to by SPA in the first instance. On the first occasion, AB was referred by SPA to PCMHS but she did not attend an appointment and the team psychologist felt it unlikely that they could meet her needs. On the second occasion, SPA again signposted PCMHS as the appropriate service. On the third occasion, when the GP requested a review of the diagnosis on AB's behalf, SPA left AB a text message as they could not get through to her. The GP re-sent the referral to SPA again in November, and SPA referred her to ECATT, and she was placed on the waiting list.

Diagnosis-related difficulties

42. Unfortunately, Dr B declined the request to talk with the investigation panel and so we have not been able to explore Dr B's interview with AB that resulted in a diagnosis of mixed personality disorder (dependent, histrionic and emotionally unstable types) and obsessive-compulsive disorder (OCD). Previously assessors had identified substance misuse as the key area of concern, and the GP had observed AB presenting variously with anxiety and depressed mood.
43. It is not our role to take a firm view on the appropriate diagnosis. However, we do consider, having read all the clinical records, that it is reasonable to arrive at a provisional view that AB may have been suffering at that time from emotionally unstable personality difficulties. It is not clear from the patient electronic record how Dr B arrived at determining the three subtypes of personality disorder after her one-hour interview and there is no information in the electronic record that provides the detail underpinning the diagnosis of OCD.
44. In our view it would be reasonable to expect a secondary mental health service to be aware that the criteria for IAPT are rigidly adhered to and exclude personality disorder, even if it is co-morbid with another disorder such as OCD. At the very least, it would have been appropriate to liaise with IAPT to enquire before discharging the patient. Dr

B took the opportunity to respond by email to a draft version of this section of the report. She said in her response that she '*was aware of the criteria for IAPT and referred AB to IAPT for treatment for anxiety symptoms which was her main priority and difficulty at the time… There are patients with same presentation that IAPT have accepted without any direct discussion as the request is for treatment for anxiety disorder and it was felt that personality difficulties would not affect the effectiveness of IAPT treatment*'.

45. The expectation that a review of the diagnosis of personality disorder requires a psychiatrist – rather than any clinically experienced multi-disciplinary team member – played a significant role in causing the delay in offering an appointment. This was due to staffing difficulties at the time. This procedure is no longer in place.

Learning points

There are a number of learning points in relation to this Term of Reference which have, to some extent, been picked up by the Trust's internal action plan and resolved. We return to these themes below.

Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS and associated services that had contact with AB.

46. We have covered this area in the section above in relation to the health services: IAPT primary care and secondary care.

47. To reiterate, in brief, referral forms were completed as required and initial screening processes were responsive. Discharge processes from the ERT were followed in 2018. Problems occurred when AB was discharged back to her GP and/or signposted to services for which she was then deemed unsuitable. When referred back to WLT, there was no requirement at that time for ERT to re-open a case that had been closed to them for several months.

48. When AB was placed on the ECATT waiting list in November 2019, she was deemed low risk and therefore there was no requirement to follow her up.

In conclusion, although AB's difficulty in accessing a service that met her needs was unsatisfactory, no referral or discharge processes were breached at the time. The area of concern relates to the safety processes for those who are either on a waiting list – as AB was from November 2019 onwards – or who are open to a team but not being seen, as was the case for AB between March 2017 and February 2018.

Examine the effectiveness and appropriateness of the management of AB risks whilst waiting for mental health assessment.

49. As AB was not accepted into any service for ongoing care and support, no formal risk assessment screening measures were used. This was in line with service policy. Her risks were considered when she was being screened or assessed and, in our view, appropriate conclusions were reached.

50. At no point was there a concern that AB did not have capacity, nor was there any reason to suspect that her history was more complex than it at first appeared. The various services therefore relied largely on her self-report in relation to risk issues. This was in line with reasonable practice.

51. AB's risk to others was always assessed as low, and there was no evidence from her history or presentation to suggest otherwise. We comment on risk to her baby and safeguarding in the appropriate section below.

52. The risk to herself was assessed as medium in February 2017; this was a period when she had problematic substance misuse, she was anxious and depressed and subject to a number of stressors in her life. On all other occasions, she was assessed as low risk to self.

53. Even in the period when she was subject to social services assessment (October to December 2019) a few weeks before the serious incident, no concerns were apparently raised regarding risk to self or others.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Local policies

54. We have referred to breaches of local policies in our responses to Terms of Reference above. In summary:
    - SPA responded appropriately, within set timescales, on each occasion that AB was referred to them.
    - The waiting time to assessment – 28 days – was breached on both occasions; that is, when AB was referred to ERT in 2016 and when AB was referred to ECATT in 2019.
    - AB was not seen by ERT between February 2017 and February 2018, although she was offered four outpatient appointments during that one-year period, none of which she attended. This is a breach of WLT DNA (did not attend) policy, as AB was not spoken to on the telephone, only one phone message was left – with her sister –

and the third and fourth appointments offered were outside procedure; furthermore, the GP was not contacted regarding the missed appointments.

- AB was assessed as not meeting criteria for secondary mental health care by ERT in October 2018. This was in line with the WLT operational policy for recovery teams (policy dated January 2017). The eligibility criteria relevant to AB's presentation states:

  '*severe personality disorder where the condition gives rise to a history of severe social disability, risk of self-harm, self-neglect or a serious risk of danger to others, and where these can be shown to benefit from continued contact and support*.' (page 14).

- She was assessed – probably reasonably so – as not meeting the severity required for secondary mental health care.
- One of the significant reasons for delay in AB being reviewed by the ECATT, after she was referred to them in November 2019 was unavailability of psychiatry team members (a conclusion of the internal investigation report). This was in line with the WLT ECATT policy at the time.

National guidance

55. The criteria for IAPT are set nationally and are not subject to local negotiation. National policy is reflected in the WLT IAPT policy (Referral Criteria, 2019). Exclusions include:

    '*Drug and alcohol misuse as a primary problem, or a level of misuse suggestive of dependency'.*

    A diagnosed personality disorder or personality traits that would make engagement in a brief psychological intervention likely to be ineffective, unhelpful and contravene NICE guidance.'

56. Additional guidance from the National Institute for Health and Care Excellence (NICE, 2015) on quality standards for 'borderline and antisocial' personality disorder[3] suggests that a patient with a diagnosis of BPD should be offered care within specialist services and be able to access evidence-based treatment for co-morbid conditions (such as OCD) within that service. They also suggest that brief psychological interventions as offered by IAPT should not be used.

Relevant statutory obligations

57. The only statutory obligation of relevance in this case is the requirement of the Local Authority (Social Services) to investigate safeguarding concerns, as brought to their attention. This took place between October and December 2019. We have already identified the lack of communication from Ealing Social Services to WLT as a learning point in this investigation.

[3] https://www.nice.org.uk/guidance/qs88

To review GP's input into the care and treatment.

58. The GP reported she had a reasonably good relationship with AB, and this is supported by the electronic record; it is clear that AB turned to her GP to assist with mental health matters and disclosed concerns to her.

59. There was 3-4 month delay in receipt of the full medical records from the time AB registered with the practice; this meant that initially the GP did not know about her history of problematic substance misuse. On the screening questionnaire when joining the practice, AB denied any history of problems with alcohol or drugs. However, there were no adverse effects resulting from the delay in receiving the notes, and no reason why the GP should not have relied on AB's self-report.

60. There were no concerns regarding the primary care received by AB, it was of a standard expected, appropriate to the presentation. The required referrals were made in a timely manner with follow-up where there was a delay in appointments due to waiting times. The safeguarding referral completed by Accident and Emergency was noted and an appropriately detailed report provided at the request of Children's Social Services.

Learning point
In our view, the GP was left in an isolated situation, trying to access mental health services in response to AB's requests but without effective support from either IAPT or secondary mental health care.

To review antenatal and peri-natal care and follow-up for mother and baby.

61. There is little information available to us regarding antenatal care. AB changed GPs in her third trimester when she moved accommodation.

62. ERG learned about AB's pregnancy in February 2018 and immediately referred her – with her permission – to the Perinatal Clinic at Imperial Healthcare. She was offered an appointment by PMHST within two weeks, and although she did not attend, the nurse followed up with a telephone call to AB. AB did not want further input from perinatal services, but the discharge letter back to ERT was thorough, no concerns were raised, but there was a clear recommendation for follow up from ERT duty desk.

63. The GP observed that the baby '*looks happy and well cared for'* (28/8/18) and was '*very active and happy whilst in room*' (16/10/19). AB clearly reported that she had only smoked cannabis on one occasion and had drunk alcohol modestly since the birth of her daughter.

64. Even when presenting to Accident & Emergency in October 2019 with expressed concerns regarding the well-being of her child, there was no indication at this time, or with subsequent social services conversations, that AB was expressing or raising concerns that she might harm the baby or could not cope with the demands of childcare. An appropriate safeguarding alert was raised with Ealing Social Services, but it is important to note that this was in relation to the possible abuse of AB's daughter by the baby's father.

65. There was a failure of ERG to follow up the perinatal recommendation in a timely manner.

In summary, in the brief contact AB had with services, there was no behaviour of concern or self-reported concerns regarding her parenting and/or care of her child that might have warranted more intrusive questions or concerns that could have led to a safeguarding alert being raised.

To understand the safeguarding procedures following the allegations made by AB about her partner and the appropriateness and effectiveness of any follow ups

66. We have commented above upon the appropriate safeguarding referral by Accident & Emergency at St Mary's Hospital to Ealing Social Services in October 2019. We have also commented on the appropriate sharing of information with ESS by AB's GP, by letter, on 1st November 2019. Social Services concluded that the threshold for a full Child Protection investigation was not met. However, it was thought that AB may have become preoccupied with her ex-partner's care of the baby as a result of transference[4], and that concerns were raised that AB's mental health may have deteriorated around the time that the case was closed on 23rd December 2019.

Learning point

No communication was made by ESS to WLT at all; that is, neither the outcome of the assessment, nor the concerns raised. This is an important failure of communication, as it could possibly have led to a review of AB on the waiting list and prompted a contact with her.

[4] A term used in psychoanalysis to describe emotions that were originally felt in childhood being transferred onto someone in the present.

Where possible to review information sharing between agencies involved in AB's care – such as mental health services, Drug and Alcohol Services, GP, Ambulance Services, ED, Police, Local Authority and to consider the effectiveness of such communication.

67. Communication and information sharing has already been commented upon in the above sections.

Examples of good practice:

68. In our view, police contact in 2013 and 2016 were isolated incidents in which they were called because AB was intoxicated and had suicidal thoughts. There was appropriate communication with Accident & Emergency, and this was picked up by psychiatric liaison and, later, SPA.

69. There was evidence of good practice in terms of the referral to peri-natal care and the responsiveness of the peri-natal nurse.
70. There was evidence of appropriate communication to social services by Accident & Emergency and by the GP.

71. The GP notes contained notification of AB's attendance at Accident & Emergency.

Learning points where communication could have been improved:

72. IAPT rejected AB on both occasions that she was referred to the service, signposting her back to her GP, and without discussing the case with ERG or ensuring that AB was offered an alternative service. This matter has been addressed by IAPT (see Terms of Reference relating to the progress with the action plan, below).
73. It would have been helpful if Dr B (ERT) had discussed AB with IAPT before referring her if there was uncertain regarding AB's eligibility for the service. IAPT criteria are explicit and consistently applied; it was likely she would not meet their criteria.

To consider any gaps in provision of services from agencies involved.

74. We have already highlighted the difficulty that AB (and the GP) experienced in relation to accessing mental health services that might have met her needs.

75. We provide a little more information regarding WLT's transformation of services from the situation that was present in 2016-20 (as described in this report) to the current configuration of community services within WLT (Ealing). This can be found in Appendix III.

76. With the current configuration of community mental health services, a referral to SPA would now be directed towards the MINT[5] service for an assessment. It is also possible for GPs to send referrals direct to MINT via their electronic record system (SystmOne). We received different views as to whether this would have resulted in an intervention being provided by MINT, or whether AB – as she presented at the time – would now be assessed by MINT and signposted back to the GP or to voluntary sector services.

77. Exclusion criteria for MINT includes (Operational Policy, January 2022):

    '(people) who only require psychological therapy and have a low risk profile'

Learning point

We remain unclear as to whether AB would meet the criteria for inclusion in MINT therapeutic interventions or whether she would be deemed insufficiently complex and too low risk to warrant the service.

To understand the impact on services during Covid-19

78. The serious incident took place the day before England went into full lockdown as a result of the Covid pandemic. Therefore, the pandemic had little impact on the care and support provided to AB.

79. It is reasonable to consider that the pandemic has had an impact on the speed with which the internal investigation was initiated and completed. This was particularly the case in 2020 and 2021.

80. We recognise that the community service line for WLT is struggling to establish their MINT teams. This will have been influenced in part by the impact of the pandemic on services, including the difficulty in recruiting and retaining staff, as well as triggering an increased demand on community services that has been difficult to manage.

[5] Please see the glossary in Appendix III for a more detailed explanation of the transformation of services from ERG and PCMHS to a single MINT service.

Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

Review the progress that the trust has made in implementing the action plan.

To review the Trust Serious Incident internal report, and trust's process for quality assurance and sign off. To understand any changes and the sustainability of these since this incident.

81. WLT undertook a Level 2 Homicide Review (internal investigation), the report of which was signed off in March 2021. It is not clear when the investigation commenced but staff were interviewed in June 2020. Three ECATT staff were interviewed and the current SPA Manager. Although the chronology in the internal investigation report commenced in 2013, the focus of the investigation appeared to be exclusively on the period from 21st June 2019 (when AB's GP re-referred her to SPA) to the date of the incident.

82. It is important to note that the onset of the pandemic and subsequent lockdown had an impact on the internal investigation process and the speed with which it was concluded. This does not affect the following observations regarding the details of the investigation, but should be held in mind when reviewing the timeline for sign off (detailed in paragraph 84 below).

83. In our view, the scope of the investigation was unduly restricted, thereby reducing the potential for learning. There were considerable opportunities to consider:
    - The pathway for AB from when she was first screened by SPA on 19th October 2016 to the serious incident in 2020. This pathway – as we describe below – was complex and unsatisfactory in some respects. It included difficulties with the interface between primary and secondary mental health care, and IAPT, including the reliance on the GP to try and navigate access to mental health services.
    - Garnering the views of a wider group of staff (for example, the primary care psychologist), including the evidence that might have been offered by the clinician (Dr B) from WLT who had had face to face contact with AB.
    - Communication between social services and WLT in the months leading up to the serious incident.
    - Evidence from the IAPT lead could have been included at a much earlier stage in the internal investigation, rather than inviting comment after recommendations had been made. Their view, with which we concur, was that it would have been preferable for them to have participated in the main process of the investigation as an interviewee, and to have contributed to drafting a recommendation that affected their service.

84. In interview, the Head of Quality NHS North West London Integrated Care Board provided us with the following timeline for the sign off of the internal investigation report:

- The WLT investigation report arrived on 25th March 2021, one year after the incident. This should normally have been sent within 60 days of the incident[6].
- The ICB reviewed it in May 2021 and sent it back to the trust with some queries.
- The ICB reviewer chased a response, but the answers to questions were only provided in April 2022.
- The ICB lead reported making several attempts to arrange a closure meeting with WLT, but this was only achieved on 31st August 2022.

A more detailed timeline has been provided by the Head of Quality NHS North West London ICB and can be found as a separate table in Appendix I, at the end of the chronology of care.

The action plan

85. Within its limited scope the internal investigation report arrived at understandable and reasonable conclusions regarding three delivery problems, which then informed their action plan. This is discussed in more detail in the next section.

86. The internal investigation report laid out three recommendations for action, as summarised in the table below.

	Service delivery problem	Local action	Outcome
1.	There should be a review of policies, and how they are reflected in current practice, to ensure good and safe waiting list practice.	Regular audits assigned to lead nurses to regularly review caseloads.	Reviewing as part of clinical improvement group (CIG)
2.	Improve collaboration between ECATT and Ealing IAPT	Interface pathway document; implementation on meetings minutes.	Monitored and evaluated as part of clinical improvement group in Ealing IAPT
3.	Improve collaboration between ECATT and Ealing IAPT and improve communication with patient & referrer	Job plan task assigned to senior CBT therapist	Individual line management meetings

87. We found it difficult to match up the Service Delivery Problems as described in the main body of the internal investigation report, with the action plan.

Learning point
We suggest that actions plans should be written 'smartly' to facilitate clarity and the evidencing of impact.

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[6] It is important to note that the pandemic commenced in early Spring 2020, and during the height of the emergency – including periods of lockdown – there were national changes to prioritisation within the NHS, with the timescales for completion of internal investigations being removed.

88. The internal investigation report noted that considerable progress had already been made in relation to both the length and the safe management of the waiting lists by June 2021. They noted that ECATT had become service led rather than medically led as it was before – the absence of available medical staff being a key reason why AB remained so long on the waiting list. This change in operational procedures had provided further efficient management of patients who were waiting.

89. We were provided with a slide presentation (dated 14th July 2022) reviewing and updating the action plan. This included clear evidence for:
    - The reduced waiting time for patients to be seen by ECATT, between November 2019 and July 2020, resulting in waits of less than 28 days for everyone on the waiting list.
    - Changes to processes so that individuals with risk concerns are seen by ECATT and those deemed low risk can be sent directly to MINT for assessment.
    - MINT now operates a zoning meeting to manage risk.
    - Ealing IAPT and ECATT now have well established interface meetings, which take place fortnightly.

90. The action that does not appear to have been clearly evidenced is the regular review of non-urgent patients who are on the waiting list for assessment for more than 28 days. We received unclear responses as to whether fortnightly checks routinely took place or whether this was reserved for high-risk patients. However, WLT were able to provide us with some recent waiting list data for Ealing MINT: around 42% of referred patients were seen within the 28 day timescale, but 6% waited at least six months; of those who are currently waiting for their first appointment, around 75% have waited longer than 28 days. This data should be interpreted with caution as WLT have been undergoing a major transition of electronic patient record system and it has been difficult to combine the two systems into one.

91. These process changes detailed above were all confirmed by the relevant staff who were interviewed by our panel. Furthermore, IAPT services have now allocated 0.2wte of a liaison lead for each of the new MINT teams, and they attend the MINT triage meetings on a weekly basis. This facilitates discussion regarding the optimal pathway for a patient.

92. All interviewees raised their awareness of current concerns regarding the inability of MINT services to manage the level of demand on their service; this was leading to long waiting times for patients. There was consensus regarding the nature of the difficulties which fell into two areas:
    - Difficulties recruiting resulting 35-40% vacancies across MINT teams, particularly in terms of registered staff.
    - Ongoing use of two electronic patient record systems, resulting in duplication of record-keeping and a heightened risk of poor communication/reduced access to information.

    These observations replicate those highlighted in the recent *Care Quality Commission inspection report (July 2022): WLT Community-based mental health services of adults of working age.*

93. We received somewhat divergent views on the extent of the current difficulties. For example:
    - We were told that the waiting list for the Ealing MINT psychology team had been closed, but other interviewees were unaware of this.
    - The GP reported a poor experience currently in trying to access MINT and said that psychiatry consultations – previously available to GPs in terms of contacting a Consultant Psychiatrist for advice by telephone or email - were no longer available. The clinical director assured us that funding had been agreed for more psychiatry with 1.0wte for each Primary Care Network.
    - The IAPT leads said they had repeatedly raised concerns regarding patients whose needs could not be met by IAPT but who were not appropriately supported by MINT teams.
    - When we pressed all interviewees as to whether AB – as she presented then - would have fallen between services as they are ***currently*** configured, we received a variety of responses from complete assurance that she would have been seen and treated, to a view that she may well have been sent back to the GP as not suitable.

Sustainability of changes since the serious incident

94. WLT is in the midst of transforming their community mental health services, in line with the NHS England national programme: *The Community Mental Health Framework for Adults and Older Adults (2019)*[7]. As evidenced by the recent CQC inspection report, and the evidence provided by our interviewees, this transformation programme has been significantly affected by recruitment challenges which are ongoing at the present time. We are grateful to WLT for sharing with us their updated CQC Action Plan (September 2022). We return to this issue in our Summary section of this report.

Additional learning emerging from the independent investigation process

95. The following issues were identified in the course of our investigation. Our observations do not fall within the agreed Terms of Reference but are relevant to our comments in the above section as they touch on patient safety and learning processes.

96. In the process of setting up our independent investigation, we liaised with WLT in order to ensure that staff were informed about the nature of the investigation and supported while participating. Some concerns emerged over time, as follows:
    - Interviewees were unprepared for the interview, having not read the clinical notes and/or been informed about the nature of the incident.
    - Two interviewees were extremely resistant to contributing to the investigation; one was reassured (and provided excellent help to the investigation) but the other key interviewee refused to participate.

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[7] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

- There was a lack of responsiveness when obstacles to the investigation emerged. This included a trust failure to respond in a timely manner to a repeated request for factual information to evidence a particular action.

Learning point

In our view, our experience of the investigatory process – taken together with observations from the above Terms of Reference - suggests that there are opportunities to address significant deficits in the trust processes and systems for learning from patient safety incidents.

SUMMARY

97. AB was aged 29 when the serious incident occurred in March 2020. She first came to the attention of mental health services when she was seen by psychiatric liaison at the Accident & Emergency department of the local hospital in 2013, aged 22. This appeared to be the result of a psychosocial crisis triggered by recent life events and associated with heavy alcohol and drug misuse. She was signposted appropriately to community substance misuse services. AB again came to the attention of mental health services in 2016, and this signalled the commencement of a prolonged period in which AB – via her GP – attempted to access mental health care that might meet her needs. Her concerns included symptoms of anxiety, agitation and low mood that seemed to fluctuate over time, as well as self-reported difficulties in managing relationships and coping with stress.

98. AB missed a number of appointments with mental health services, some of which may have been due to her moving address and not receiving letters; at other times she turned down the offer of help, for example from peri-natal mental health services to which she was referred at one point when she reported her pregnancy. She may have minimised her difficulties at times. However, overall, she was found not to be suitable for the services to which she was signposted, and this unsatisfactory experience was prolonged by the delays with which secondary mental health care managed her case.

99. AB did eventually receive a diagnosis of personality disorder and obsessive-compulsive disorder. This exacerbated her difficulty in accessing help and after a few months she expressed unhappiness with the diagnostic label and asked her GP to re-refer her secondary mental health services for a review. At the time of the serious incident, AB was on the waiting list of the Ealing Crisis and Assessment Team for a review of her diagnosis of personality disorder and had been waiting 132 days. During this period, she had been assessed by Ealing Social Services in relation to safeguarding concerns raised by AB regarding allegations of possible abuse perpetrated by the father of her young daughter. The case had been closed by Ealing Social Services after a preliminary assessment, as they felt that her concerns did not meet the threshold for a full investigation.

Our investigation highlights some learning regarding the provision of care and support to AB by mental health services. We characterise this broadly as relating to:

- ***Unacceptable delays in the responsiveness of the Ealing Recovery Team in managing the referral of AB to the team and in supporting her during an unnecessarily long assessment process during which she was only seen on two occasions.***
- ***The lack of a pathway of care that met her needs, resulting in a very challenging process for AB – and her GP – in making referrals that repeatedly led to rejection and signposting to other services that was ineffective.***

100. These system issues have been addressed in principle by West London NHS Trust, in the development of a new integrated and holistic mental health service (MINT) that aims to provide care based on the principle of ‘no wrong door’. That is, a patient with

non-urgent care needs should no longer require multiple referrals or fall between services. In practice MINT has struggled with excessive demand for the service and high staffing vacancies, resulting in concerns regarding patient safety. It has been the subject of a critical Care Quality Commission inspection report this year. The Trust has an action plan in place and is working to rectify the current problems.

The question remains, however, as to whether AB – if she were presenting to mental health services now, as she presented back in 2018-20 – would receive an intervention from mental health services or whether she would still fall into the gap between services?

101. It is important to point out that there was no information from the electronic patient records or from our interviews that suggested AB posed a high risk to others or that she was severely mentally ill. There is the possibility that if Ealing Social Services had communicated their observations regarding AB's mental state in December 2019 to secondary mental health services in West London, she may have been contacted by the Ealing Crisis and Treatment Team for a review of her mental health and risk whilst on the waiting list.

NEXT STEPS (Recommendations)

102. In discussion with governance and patient safety leads for West London Trust, we have agreed the following two recommendations.

- WLT should examine the question as to whether a service user similar in presentation to AB might still fall into a gap between services. That is, the non-urgent pathway of care between the GP, MINT, IAPT and any other relevant service identified by WLT should be robustly tested, and any residual gaps identified.

- WLT already have a CQC action plan in place that covers patient safety concerns in relation to non-urgent waiting times and access to MINT services. We are content for WLT to avoid duplication, and to reference progress against the relevant items of the CQC action plan in their action plan in response to this serious incident investigation.

103. In discussion with the Acting Head of Safeguarding, Review & Quality Assurance, Ealing Social Services and WLT, we have agreed the following recommendation.

- ESS should work in partnership with WLT to ensure that information sharing and communication between the two agencies is robust, particularly in terms of ESS staff being confident in when and how to communicate concerns.

We note that ESS may wish to implement learning from this incident internal to the organisation.

APPENDIX I : CHRONOLOGY

DATE (AGE)	EVENT
D.o.b.	17th July 1991
May 2008 (16)	AB referred by her boyfriend to Ealing Social Care due to concerns about her mental health.
July 2008 (17)	A referral of AB by her school to Ealing Social Care, informing that AB was living with her boyfriend, and her mother was planning to leave her at a school in Ghana. No record of follow up and case is closed.
7/5/13 (21)	AB brought by ambulance to A & E, Ealing. Intoxicated, aggressive, suicidal ideas. Seen, with family, by psychiatric liaison team. Assessment made: low risk of self-harm or harm to others; main trigger to current problem was alcohol and illicit substance misuse.
9/5/13	A& E psychiatric liaison confirmed that AB was assessed for substance misuse counselling and referred to appropriate service.
26/9/16 (25)	Screened by Single Point of Access (SPA) following police Merlin report on 24/9/16. Suicidal thoughts, drinking excessively, suffering depression. Discharged from SPA.
10/10/16 (25)	Improving Access to Psychological Therapies (IAPT) review the GP referral to IAPT and conclude it is not suitable and that substance misuse services are more appropriate for AB.
12/10/16 (25)	Referred by GP to SPA (routine plus, 7 days). Depressed periods and binge drinking, escalating to the point where police are called as a result of self-harm concerns. AB denies drug taking or drinking. Seen on 19/10/16 for SPA triage. Low risk to self and others. Referred to Ealing Recovery Team (ERT) for review/diagnostic.
13/2/17 (25)	Appointment with ERT. Seen by Nurse 1. Full assessment made. Risk to self is medium; risk to others low. Plan was for AB to see the Doctor, to consider a psychology referral, and other signposting.
7/3/17	Follow up appointment not attended. Voicemail message left by team.
30/5/17	Appointment offered by ERT (letter in notes) although no indication in electronic record.
1/8/17 (26)	Further appointment which was not attended.

30/8/17	Duty follow up phone call, message left with sister. Plan for duty to make a home visit.
11/1/18	Appointment with Dr A not attended.
22/2/18 (26)	Request by Dr A for AB to be followed up by duty. AB called and said she had moved area, had not received appointments, and was eight months pregnant. Referral to perinatal mental health services team (PMHST) made that day.
6/3/18 (26)	AB did not attend appointment with Nurse 2 (PMHST). Telephone call made, and AB reported she was doing well and did not require another appointment. Discharge letter sent, recommending that AB is offered postnatal follow up by the ERT and her GP. PMHST contact Ealing Children and Family Services (AB not known to them at that time).
6/4/18	ERT note the discharge from PMHST. Appointment is in place with Dr B on 4th October 2018.
4/10/18 (27)	AB seen by Dr B. Full assessment, with diagnosis of Obsessive Compulsive Disorder and Mixed Personality Disorder. Mental and behavioural disorders due to use of mixed substances in remission. AB presents as wanting to address her problems of being too sensitive to others and other interpersonal difficulties. She was seen as not requiring secondary mental health care. Discharged and Dr B referred her online to Improving Access to Psychological Therapies (IAPT) for OCD therapy. Dr B considered psychotherapy for personality difficulties could be considered after cognitive behavioural therapy. Discharge letter sent on 31/10/18 and AB finally discharged on 23/11/18.
12/10/18	IAPT triage the referral. Found to be not suitable on the basis of personality difficulties.
19/6/19 (27)	Primary care mental health team (PCMHT) psychologist reviews AB's notes, confirms IAPT's non-acceptance of the referral, and confirms there are limited options for cognitive behaviour therapy in primary care. A group (Coping Skills workshop) is suggested in PCMHT.
21/6/19 (28)	GP referred AB back to SPA (routine) after IAPT refused her due to the personality disorder diagnosis. GP considered primary care talking therapies the appropriate option. SPA forwarded the referral to the primary care mental health service (PCMHS) with a request to review the diagnosis and management plan.

10/7/19	Appointment offered by psychologist in Ealing primary care mental health team (PCMHT). Not attended. AB invited to contact the team. She said she had not received the appointment letter.
9/9/19 (28)	GP re-referred AB back to SPA, having received no response from the June referral. PCMHS confirmed that AB had not engaged. SPA confirms PCMHS is the appropriate service.
September 2019	Referral to Ealing Social Services from St Mary's Hospital in relation to an allegation made by AB in relation to her daughter's father. Investigations take place over the subsequent three months.
2/10/19	Second appointment offered by psychologist, PCMHT; not attended.
18/10/19	GP follows up referral with SPA.
22/10/19	Third appointment offered by psychologist, PCMHT. Not attended, AB discharged.
24/10/19	SPA attempts to book triage call with AB. Appointment confirmed for 8/11/19.
1/11/19	AB's GP writes letter to Social Services with information on her mental health difficulties (diagnosis and current waiting list for review).
8/11/19 (28)	Triage phone call with AB and SPA. AB says she is doing well, the baby is 20 months, she is studying full time to be a social worker. She was unhappy with her diagnoses. She denied any suicidal thoughts or self-harm. She had been taking anti-depressant medication (Sertraline 50mg) for a month. The plan was agreed as a referral to Ealing Crisis and Treatment Team (ECATT) for a routine medical/diagnostic review. Transfer referral made.
23/12/19 (28)	Ealing Social Services end their involvement with AB, concluding that the evidential threshold for child protection has not been reached. Some tentative and non-specific suggestion in the Local Authority record that AB's mental health difficulties may have influenced her concerns relating to the allegations of abuse of her daughter.
22/3/20 (28)	Serious incidents occur. Police custody nurse contacts ECATT to ascertain the status of AB's care under their team.

Head of Quality NHS North West London Integrated Care Board – timeline for signing off the internal investigation		
Date	**Item**	**Comment**
24/03/2020	StEIS notification of the incident	

9/04/2020	72 hr report received	Trust apologised for delay.
25/03/2021	RCA received	
19/05/2021	ICB sent evaluation questions to the Trust	Quality leads at the ICB were on deployed to support with the pandemic since April 2020.
16/02/2022	ICB chased response to the questions	
2/03/2022	ICB chased response to the questions	
6/04/2022	ICB chased response to the questions	
11/04/2022	Partial responses received from the Trust. Request from Trust to keep hold in diary for closure meeting	Key individual on leave so cannot respond to some of the questions.
11/04/2022	ICB Head of Quality put hold in diary for closure meeting for 20/04/2022. According to RCA report, date of last action due 31/03/2021.	Communication with Trust on 11/04/2022 that cannot do a closure meeting with the completed action plan. Pragmatically agreed that the remaining answers to questions will be picked up at closure meeting.
19/04/2022	ICB chased for the completed action plan	Response from Trust that more time required due to clinical priorities and the bank holiday.
19/04/2022	ICB offered following dates for closure meeting (27/28/29th April)	Trust agreed to 29/04/2022
29/04/2022	ICB had to cancel closure meeting. Replanned for 30/06/2022	Trust completed action plan not ready.
10/06/2022	ICB communicated with the Trust.	Requested that the completed action plan would need to be received by 24/06/2022 in order to prepare for the closure meeting.
28/06/2022	Evidence received by the Trust	Head of Quality at ICB reviewed and requested that the service presented the evidence differently as it did not make sense.
15/07/2022	ICB chased the Trust to check on status of the evidence	
20/07/2022	Trust sent evidence. ICB gave a list of dates to reschedule closure meeting.	Evidence was better presented and closure meeting to be planned
04/08/2022	Communication from Trust to state that there is difficulty in finding a	Agreed to plan for 24/08/2022

	suitable date for closure meeting due to admin staff leaving the service.	
24/08/2022	Community from Trust – cancel the closure meeting due to an emergency.	ICB rescheduled meeting to 31/08/2022
31/08/2022	Closure meeting held.	Minutes sent out to the Trust to confirm closure of the action plan.

APPENDIX II: TERMS OF REFERENCE

Psychological
Approaches

2020/5864 INDEPENDENT REVIEW TERMS OF REFERENCE

Purpose of Investigation

To identify whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- Review the progress that the trust has made in implementing the action plan.

Specific terms of reference

To consider AB's contact with health and social care in the events leading up to the incident (22nd March 2020) with particular attention to:

- Examining the care and treatment of AB from consideration of her first contact with mental health services up until the date of the incident.
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS and associated services that had contact with AB.
- Examine the effectiveness and appropriateness of the management of AB risks whilst waiting for mental health assessment.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- To review GP's input into the care and treatment.
- To review antenatal and peri-natal care and follow-up for mother and baby.

- To understand the safeguarding procedures following the allegations made by AB about her partner and the appropriateness and effectiveness of any follow ups
- Where possible to review information sharing between agencies involved in AB's care – such as mental health services, Drug and Alcohol Services, GP, Ambulance Services, ED, Police, Local Authority and to consider the effectiveness of such communication.
- To review the Trust Serious Incident internal report, and trust's process for quality assurance and sign off. To understand any changes and the sustainability of these since this incident.
- To consider any gaps in provision of services from agencies involved.
- To understand the impact on services during Covid-19

APPENDIX III – DOCUMENTATION READ AND INTERVIEWS HELD

Documentation

West London Mental Health
Internal Investigation Report, Serious Incident Level 2 (March 2020)
Patient electronic record
Primary mental health team electronic record
Recovery Team Operational Policy v.2.3
Business continuity plans (Covid-19)
MINT (Mental Health Integrated Network Team) Operational Policy v.7
SPA (Single Point of Access) operating framework v.10 2018
SPA operating framework v.11 2020
Serious Incident Thematic review, February 2001
Ealing Serious Incident Thematic Review Report v.3
Lessons learnt powerpoint presentation, December 2021
IAPT
IAPT Risk Management Single Operating Procedure v.0.5
IAPT Referral Criteria 2019
Transfers of Care from IAPT to MINT teams v.0.4
Ealing Social Services
Briefing note
Mill Hill Surgery
SystmOne electronic patient record 2017-2020
London North West University Healthcare NHS Trust
Emergency Dept notes for 22/3/20
Care Quality Commission
WLT Community-based mental health services of adults of working age. Inspection report July 2022

Interviews

Interviews
Head of Quality, NHS North West London Integrated Care Board
Clinical Psychologist in Primary Care Mental Health services, Ealing
Head of Psychology, Psychological Medicine Service Line,West London NHS Trust
Clinical lead, Ealing Improving Access to Psychological Therapies
Service Manager, Single Point of Access, Ealing

Clinical Director, Community and Recovery, West London
Acting Head of Safeguarding, Review, & Quality Assurance, Ealing Social Services
Director of Children & Families, Ealing Local Authority
GP at the Primary Care practice where AB was registered from 2018 onwards.
Both Consultant Psychiatrists, Ealing Recovery Team. Dr A never met AB.

Glossary

WLT	West London NHS (Mental Health) Trust
ERT	**Ealing Recovery Team** (in place at the time of the 2020 incident but subsequently superseded by MINT in 2021) A specialist multi-disciplinary secondary care service provided by West London NHS Trust, for individuals over the age of 18 suffering with mental health problems which are of a sufficient severity or complexity to require specialist intervention. The service is based on the recovery model principles and evidence-based practice. Referrals to the team are from other services within the trust, often transfers of care from the Single Point of Access (SPA). The service operates in tandem with other trust services, working principally with service users on the Care Programme Approach with complex needs.
IAPT	Improving Access to Psychological Therapies A primary care service for adults (and older adults) over 18 years of age, registered with a GP in the borough, who have anxiety and/or depression, and who are likely to benefit from brief psychological therapy.
OCD	Obsessive Compulsive Disorder
PMHST	Perinatal Mental Health Services Team A service providing specialist community care for women who need ongoing support from 12 months after birth to 24 months, that includes improving access to evidence-based psychological therapies for women and their partners, and mental health checks and signposting to support as required.
PCMHS	Primary Care Mental Health Service (in place at the time of the 2020 incident but subsequently superseded by MINT in 2021)

	A multi-disciplinary service provided by mental health practitioners based in GP practices, for people who require a level of care above that available through general medical (GP) services but who are either stepping down from secondary mental health care, or do not meet the threshold for entry into secondary mental health care.
SPA	Single Point of Access A WLT service providing 24/7/365 access to secondary care mental health, including a clinical advice service for GPs and other potential referrers as well as a triage and signposting function.
ESS	Ealing Social Services
MINT	Mental Health Integrated Network (in place from 2021 onwards) Community-based mental healthcare for adults aged 18+ with a wide range of mental health difficulties. The MINT model focuses on supporting people's mental health, alongside their physical health and social needs, providing joined-up, community-based care tailored for each individual. The service offers a non-emergency response with access to therapeutic intervention and support within 28 days. The integrated model means that there is no longer a split between primary and secondary care services; MINT operates a stepped-approach model based on NHS England's Long Term Plan and the Community Mental Health Framework (https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf). The framework is designed to eliminate exclusions, avoid unnecessary repeat assessments, and design care centred around an individual's needs.

Contact with interested parties

AB was written to by NHS England via her Responsible Clinician in relation to this investigation, and she has declined to be involved.

AB's family was written to by NHS England via West London Trust as no contact details were available to NHS England, and to date no response has been received.

The family of the victim that died, and the surviving victim have been written to and have also spoken with NHS England on the telephone in order for the process to be explained. They have been offered the opportunity to be involved in the investigation but to date no response has been received.

APPENDIX IV: PSYCHOLOGICAL APPROACHES CIC

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies; our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

Lead investigator

Dr Jackie Craissati, Consultant Clinical & Forensic Psychologist, and Director of Psychological Approaches
Dr Craissati has 30 years' experience in working in forensic and prisons directorates and was previously Clinical Director of such a service. Of particular relevance to this investigation is that she is national consultant advisor to the offender personality disorder pathway and specialises in the community management of individuals with serious offending histories and personality difficulties. She currently chairs the board of a mental health trust and was previously chair of the quality committee of the trust; she therefore has a detailed knowledge of matters pertaining to patient safety.

Co-investigators

Dr Nishma Shah MBBS, MRCPCH, MSc (Health Policy, Planning and Financing), MRCGP, DRCOG, MSc (Sports and Exercise Medicine)
Dr Shah is qualified general practitioner since 2008 and currently the Medical Director, Safeguarding Lead and Responsible Officer of the Hurley Group. The Hurley Group provides primary care and urgent care services to combined list size of over 100,000 patients. Dr Shah holds overall responsibility for Clinical Governance across the primary care and urgent care portfolio and the chair of the quarterly Hurley Group Clinical Governance meetings. She is responsible for overseeing quality assurance, training, incident and risk management for the Hurley Group. This includes ensuring clinical practice is in line with local and national guidance.

Dr Shah is also GP appraiser for NHSE conducting between five and ten GP appraisals annually. She holds Part 1 of the RCGP Management of Substance Misuse.

She has considerable experience in conducting serious incident reviews for the Hurley Group working closely with NHSE, NMC and GMC where appropriate. In addition, she has experience in conducting Clinical Harm Reviews for NHSE and has completed Harm Reviews

for NHSE Medical Directorate and commissioning teams, and reviews of deaths in custody as Psychological Approaches' partner.

IAPT & Primary Mental Health Care advisor to the panel: Consultant Psychologist Alison Sedgwick-Taylor

Ms Sedgwick-Taylor is a Consultant Clinical Psychologist with over 25 years of experience in NHS primary mental health care in Gloucestershire. Her specialist interest is improving access to evidence-based care through CBT training, supervision and self-help literature. She commissioned the Gloucestershire IAPT service and then held the clinical lead position for over 10 years, working closely with primary care mental health colleagues. She worked closely on published programmes of CBT training for local staff with the Oxford Cognitive Therapy Centre and University of Bath. This latter programme was awarded a Health Foundation Innovation Award in primary mental health care for medically unexplained symptoms.

Following retirement in the last few years Alison has continued to supervise and train staff in CBT. She is currently leading a training programme for GPs in Mindfulness based Cognitive Therapy (MBCT) and also working with the RCGP to improve access to mindfulness.

PSYCHOLOGICAL APPROACHES METHODOLOGY