



P psychological **A** approaches

LEARNING SUMMARY

INDEPENDENT INVESTIGATION OF THE CARE AND TREATMENT OF Mr N

August 2025

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EXECUTIVE SUMMARY

The incident

1. This independent investigation was commissioned by NHS England under their Serious Incident Framework 2015¹ and completed concurrently with a Domestic Homicide Review (DHR).
2. Mr N had several presentations in crisis to A&E where he was assessed by the liaison psychiatry team in NHS Trust 1.
3. Mr N was referred to and accepted for care by a local young people's community mental health service crisis resolution and home treatment team (CR&HTT), provided under the 'umbrella' of a wider NHS Trust 2.
4. He made progress in their care and was discharged to the care of his GP.
5. Just over a month later Mr N was charged with the murder of a close relative Mr P.
6. Mr N was understood to be estranged from his family but unbeknown to services he had apparently renewed contact with Mr P.
7. Mr N was convicted of manslaughter and was ordered to be detained under Section 37/41 of the Mental Health Act 1983 (MHA)².
8. Some months prior to the homicide Mr N had moved areas but not changed GP. He remained registered with his original GP, which was out of area to both Trusts 1 and 2. He was not

¹ [NHS England » Serious Incident framework](#)

² Section 37/41 of the Mental Health Act 1983 refers to a hospital order with restrictions. This order is made by the Crown Court when a person convicted of an imprisonable offence needs to be treated in hospital for a mental disorder they are suffering from, in the interests of their own health and safety or for the protection of other people. The court might add section 41 restrictions if it thinks that it's necessary for the protection of the public from serious harm. When deciding whether to add section 41 restrictions, the Crown Court must consider the seriousness of the offence committed, any previous offences you may have committed, and the risk of you committing more offences in the future. A section 37/41 lasts until you are discharged by the Mental Health Tribunal or by your responsible clinician. If your responsible clinician thinks you should be discharged, they will need to get permission from the Ministry of Justice. <https://www.legislation.gov.uk/ukpga/1983/20>

actively receiving services from his original GP as they were geographically distant.

Impact of the pandemic

9. During the time covered by this investigation, health services were under significant pressure due to the global COVID-19 pandemic. Significant changes in process had been in place for over 12 months, including operational decisions about home visits and virtual contacts. There were additional staffing pressures related to high COVID-related absence and increased referrals into the service, of increasing complexity. Health, police, and social care services met regularly during this period as a 'Partnership Operational Group' to ensure a good understanding across the system of the challenges faced by each organisation and the impact on service users.

Findings and Conclusions

Compliance with local policies, national guidance, and relevant statutory obligations

10. In order to inform risk assessments, the young people's community service staff were expected by their managers to have contacted probation to request information about Mr N's offending history, although this was not clearly outlined in their local policy at the time. They reported they were unable to do so due to staffing shortages.
11. Staff did not escalate this difficulty in gaining information to managers as expected. Though again this expectation was not clearly outlined in their local policy.
12. There was a system problem in that when records were requested from child and adolescent mental health services (CAMS) they incorrectly reported that he was not known to them. The record system has since been completely replaced, preventing recurrence of this issue.
13. The NHS Trust had a Safeguarding Adults Policy in place. The young people's community service staff did not identify any safeguarding needs for Mr N despite known information about childhood trauma and vulnerabilities. Mr N was noted to have financial issues, and on two occasions, he shared with staff that

he had no food. The response to this was limited. There is no evidence that staff considered options for support or intervention in relation to Mr N's contextual safeguarding risks.

14. This incident took place at a time when community mental health services were in the early stages of a transition away from CPA for community patients towards the 'Community Mental Health Framework for Adults'³.
15. The young people's community service CR&HTT operational policy said that all patients should be cared for under CPA. Given the complexity of his needs, Mr N should have been cared for under CPA or the new Community Mental Health Framework for Adults, with his care being coordinated by an identified member of the team.

The effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and their family

Care plan

16. A care plan was completed by the young people's community service CR&HTT, which included very basic information and was not updated during the period of engagement with the service or at discharge. The young people's community service accepted in their own local investigation that this level of care planning was unacceptable.
17. Despite the lack of a well-informed, holistic care plan there is evidence that the care delivered was to some extent effective. The team worked hard to promote his involvement in his care with some measure of success. Mr N began to engage with the team. He expressed a wish to re-start medication and sought and received their help with his social care needs.
18. During most contacts, the focus of care planning was Mr N's mental health. Decision making and actions did not reflect the wider concerns, significantly the substance misuse, the contextual risk, individual vulnerabilities, trauma, and the offending history.
19. Both in planning and delivery of care there was little account taken of information other than that provided by Mr N. Nor was

³ <http://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults>

there any reflection of how his lack of skills in everyday living, such as his inability to tolerate the frustrating process of changing GP, would impact on his care.

Risk assessment

20. A risk assessment was completed by Good Hope Hospital Psychiatric Liaison on 5/5/21 and uploaded to Mr N's young people's community service CR&HTT record. A further risk assessment was completed by the young people's community service CR&HTT staff on 6/5/21. There is no evidence of any further updates to the formal risk assessment document during Mr N's time with the CR&HTT. However, his risk was reviewed at each MDT, and the decision was documented in the MDT notes, though not, as already described, leading to a revised care plan.
21. Mr N had incorrectly self-reported to the team that he was on remand, charged with attempted murder. Because the CR&HTT staff were unable to obtain, or did not request, relevant information from other services, they did not know the details or the circumstances and the charges against him.
22. In the absence of a revised and considered care plan some changes were made to Mr N's care in response to the risk he posed to others. Staff documented the need to visit him in pairs at home, and at one point to see him in clinic only. These were inadequate responses to the potential risk and may have left team members in unsafe situations. Having a wider knowledge of Mr N's history and previous risk assessments could have mitigated the potential risk to staff or others.
23. A fully informed risk assessment and care plan may have led to the young people's community service CR&HTT taking a more cautious approach to treatment, discharge and follow-up of Mr. N. We found no evidence that it would have led to the subsequent homicide being predictable.

The appropriateness of the treatment of Mr N in light of any identified health needs/treatment pathway

24. In the period under review, Mr N was assessed on three occasions by the psychiatric liaison team in Trust 1, during presentations in crisis at the Emergency Department. On each occasion, Mr N was expressing ideas that he wanted to hang himself. However,

during the assessment, he established rapport and no evidence of mental illness was elicited, so he was discharged back to the care of his GP. The team did not comment that his registered GP was in a neighbouring city, but otherwise, their management was appropriate. On the third occasion, Mr N was appropriately referred to the young people's community service CR&HTT for a more detailed assessment of his mental state.

25. During Mr N's period under the care of the young people's community service CR&HTT (5 May 2021 to 16 June 2021), he seemed to respond to their contact with him. He expressed a wish to re-start medication and sought their help with his need for a food bank and an application for benefits. He seemed to become more able to engage with their phone calls and visits over the course of the six weeks.
26. The clinical records confirm that the young people's community service staff contacted CAMHS services on two occasions in 2021 to ask for information about Mr N's past history. On both occasions they were told he was not known to CAMHS, despite the period of time that Mr N had spent in the care of both CAMHS and Mental Health Early Intervention services. The authors understand that CAMHS now has new systems for record-keeping.
27. In view of Mr N's clear account of his psychiatric care as an adolescent, and having been unable to access the CAMHS records, the independent investigators expect that the young people's community service staff would have asked if Mr N's GP held this information. There is no record that such enquiries were made.
28. A greater awareness of Mr N's history might have helped his team at the young people's community service CR&HTT understand the significance of the symptoms experienced at his medical review on 26 May 2021, when Mr N disclosed that he was experiencing auditory hallucinations and also the abnormal experience that mundane things (such as the sound of a car engine) has special significance for him. These symptoms confirm that Mr N was, at the very least, at risk of developing a psychotic illness.
29. Furthermore, intoxication with alcohol and street drugs had been a documented component of his presentations in crisis, but there is no evidence that the young people's community service CR&HTT staff considered referral to substance misuse services.

30. His disordered mental state, his history of substance misuse and his social precariousness all rendered him extremely vulnerable. The need remained to clarify the diagnosis and consider what level of support he would need, especially in view of the forthcoming court case. These complex tasks required a multi-disciplinary approach which is not available in general practice. The discharge to the care of his distant GP after six weeks was inappropriate. Mr N should have had a longer period in psychiatric services, not only for the purposes of diagnosis and social support but also to establish the impact of his dose of anti-psychotic medication.

Best Practice

31. The work undertaken by the young people's community service CR&HTT staff to support Mr N was commendable. His initial lack of engagement was overcome, and he became more accepting of their help.
32. The intervention by the GP to ensure that Mr N was seen in the Emergency department when he presented in crisis on 4th May 2021 was robust and helpful. The subsequent letter to Mr N, advising him to register with a new practice in his area, was appropriate.

Opportunities for Learning

33. The Action Plan in the Individual Management Report by the young people's community service identified eight learning points. The panel were in full agreement on these points:
- a. CR&HTT Standard Operating Procedures (SOP) should be updated to include a requirement to make every attempt to contact relevant agencies for additional information.
 - b. Review of Crisis Team capacity against Crisis Team Standard Operating Procedure.
 - c. Review of Crisis Team clinical capacity against Crisis Team Standard Operating Procedure.
 - d. Review of the young people's community service CR&HTT discharge pathways, and SOPs to reflect updated pathways if required.
 - e. Audit of impact of recently delivered Contextual Safeguarding Training.

- f. Review of CR&HTT pathway for patients with drug and alcohol pathways.
- g. Conduct audit of the CR&HTT Crisis Team care plans
- h. Escalation Guidance to be developed and disseminated.

34. Additionally, the independent investigators identified a further learning opportunity for the young people's community service CR&HTT staff, who had adopted a strategy of going to visit Mr N in pairs because he had told them he was charged with a violent offence. This response is not adequate in the absence of a full risk assessment because it may expose staff to unexpected threat.

Conclusion

35. Mr N experienced adversity in his childhood and adolescence, developing symptoms suggestive of a psychotic illness while in his teens. His engagement with psychiatric services was sporadic and often precipitated by crises complicated by alcohol use. He was able to benefit from an intensive psychiatric care package, including antipsychotic medication and robust social support. However, this service had incomplete information to inform their care planning and risk assessment. They discharged Mr N to what was, in effect, no care, one month before the homicide, despite clear indications that he required further input from mental health services.

Systems Learning

- Teams need to ensure that care planning and risk management are informed by all the relevant information.
- There should be a well-understood escalation process for staff to use if they encounter difficulty accessing relevant information, including previous records.
- Staff visiting risky patients should have a personal safety plan informed by a full risk assessment and utilising a range of safety practices. Two people are not necessarily safer than one!
- Discharge/transfer processes need two-way communication. In complex cases, they should prevent discharge unless the recipient of any referral is going to actively pick up the case and provide the support needed.
- Administrative processes in health services (registering, making appointments, etc.) should take into account people's mental

health needs, other vulnerabilities and skills deficits and provide flexibility or support to ensure that people can navigate the necessary processes.

Recommendations

Recommendation 1

Within three months. The young people's community service CR&HTT Standard Operating Procedures should be updated to include a clear requirement to make every attempt to contact all relevant agencies, including police & probation if applicable, for additional information to inform care plans and risk assessments. Actions to take if information is not accessible should also be included.

Recommendation 2

Within three months. The young people's community service CR&HTT Standard Operating Procedures should be updated to include specific information on safely discharging a patient out of area. This must include ensuring that the professional receiving the patient will actively pick up the referral.

Recommendation 3

Within three months. Trust 2 should ensure that Contextual Safeguarding Training provides information for safeguarding both adults and children.

Recommendation 4

Within six months. Through the production and implementation of a joint working protocol or similar. The young people's community service CR&HTT should ensure that treatment pathways for patients with drug and alcohol needs work in coordination with mental health services, so that patients with multiple needs can access both services.

Recommendation 5

Within one month. The young people's community service CR&HTT should ensure that all patients in its care have an up-to-date care plan incorporating actions from a current risk assessment and based on all the available information, including, from family, the service user and non-health agencies such as police and probation services.

Recommendation 6

Within three months. The young people's community service CR&HTT Lone working policy and safety practices for staff should ensure that the safety of their staff is informed by an up-to-date clinical risk assessment and consideration given to a range of options to increase safety.

APPENDIX 1

Learning Document

Background

Introduction

This document provides an overview of key findings from an independent investigation into the NHS care of a young man (Mr N) who killed a close relative.

Agencies and teams who might benefit from this bulletin

- Community Mental health Teams
- Mental health liaison teams
- Mental health commissioners
- GPs

Case background

- Mr N experienced adversity in his childhood and adolescence, developing symptoms suggestive of a psychotic illness in his teens.
- His engagement with psychiatric services was sporadic and often precipitated by crises complicated by alcohol use.
- He was able to benefit from a psychiatric care package, including antipsychotic medication and robust social support. However, this service had incomplete information to inform their care planning and risk assessment.
- Mr N was understood to be estranged from his family, but unbeknownst to services, he had renewed contact with them.

- Communication with his GP was a paper exercise, and in effect, Mr N was discharged from community mental health services to no care, one month before the homicide.

Key Findings

Referral Arrangements

Mr N had moved areas but not changed GP. He remained registered with his original GP but was not actively receiving services from them as they were geographically distant.

After a series of presentations in A&E Mr N was appropriately referred to a community mental health team and received treatment and support for a period.

Even with some support from his CMHT Mr N had been unable to complete the process to register with a new GP.

At discharge, a letter was sent to Mr N's GP to transfer his care to them despite the clinical team knowing that he was not resident in that area and not accessing that service.

Information Sharing

The community mental health team did not/could not access records from Mr N's CAMHS history nor from his probation officer despite Mr N consenting. This meant that the CMHT did not have the full facts about his previous psychotic symptoms, offending history, history of trauma and vulnerability.

Risk assessment and management

The risk assessment was limited because it was not based on the full information available. In response to risk concerns for staff visiting Mr

N at home, it was agreed that two staff should visit instead of one. This response is not adequate in the absence of a full risk assessment because it may expose staff to unexpected threat.

Care Planning

A care plan was completed, which included very basic information and was not updated during the period of engagement or at discharge. It did not reflect the wider concerns, significantly the substance misuse, the contextual risk, individual vulnerabilities, trauma, and the offending history.

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Systems Learning

- Teams need to ensure that care planning and risk management are informed by all the relevant information.
- There should be a well understood escalation process for staff to use if they encounter difficulty accessing relevant information including previous records.
- Staff visiting patients should have a personal safety plan informed by a full risk assessment and utilising a range of safety practices. Two people are not necessarily safer than one!
- Discharge/transfer processes need two-way communication. In complex cases, they should prevent discharge unless the recipient of any referral is going to actively pick up the case and provide the support needed.
- Administrative processes in health services (registering, making appointments, etc.) should take into account people's mental health needs, other vulnerabilities and skills deficits and provide flexibility or support to ensure that people can navigate the necessary processes.

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APPENDIX 2

Glossary of Terms

Acronyms/Terms Used in the Report	
CCG	Clinical Commissioning Group
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health team
CPA	Care Programme Approach is a package of care that is used by secondary mental health services. Patients will have a care plan and someone to coordinate their care if they are under CPA. All care plans must include a crisis plan.
CPN	Community Psychiatric Nurse
DHR	Domestic Homicide review
DNA	Did not attend
ED	Emergency Department
GP	General Practitioner
MDT	Multi-Disciplinary Team
NHS	National Health Service
Olanzapine	Olanzapine is a drug which treats psychotic illness
O/P	Outpatient appointment
Psychosis	Psychosis (also called a 'psychotic experience' or 'psychotic episode') is when you perceive or interpret reality in a very different way from people around you. You might be said to 'lose touch' with reality. The most common types of psychotic experiences are hallucinations, delusions and disorganised thinking and speech.
RCA	Root Cause Analysis is a type of investigation process used to aid learning from incidents
Risperidone	Risperidone is a drug which treats psychotic illness
Safeguarding	Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality health care.
S/B	Seen by

SAR	Safeguarding Adults Review
Section 2 of the Mental Health Act, MHA	Section 2 is the section of the MHA which is used for people with a mental disorder who need to be detained for a short time for assessment and possibly medical treatment if it is necessary for their own health or safety or for the protection of other people.
Section 3 MHA	A section 3 is used for people who have had their mental health assessed before and are already receiving mental health treatment if it is necessary for them to be detained for their own health or safety or for the protection of other people.
Section 136 MHA	This section of the Mental Health Act gives the police authority to bring someone who appears to be mentally disturbed from a public place to a place of safety (such as a hospital) for assessment.
Sertraline	Sertraline is an SSRI antidepressant which treats depression and anxiety.
SOP	Standard Operating Procedures

APPENDIX 3

Terms of Reference

The investigation is to be conducted in partnership with the Domestic Homicide Review into the death of Mr N's close relative.

The investigation will examine the NHS contribution into the care and treatment of Mr N from his first contact with specialist mental health services up until the date of the incident.

1. Critically examine and quality assure the NHS contributions to the Domestic Homicide Review.
2. Examine the referral arrangements, communication, and discharge procedures of the different parts of the NHS that had contact with the service user.
3. Review and assess compliance with local policies, national guidance, and relevant statutory obligation.
4. Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and their family.
5. Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway.
6. To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families.
7. To provide a written report to NHS England that includes measurable and sustainable recommendations that have been co-produced with the affected organisations, to be published either with the multi-agency review or as a standalone report.
8. To develop a Learning Document for wider circulation of the learning from the investigation.