An independent investigation into the care and treatment of Patient D

February 2025

FOR PUBLICATION

Report Advisory Notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and serious incidents. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where it is relevant to quote the opinion of a psychiatrist or doctor or where a specific act has been documented. We do advise caution for those who may be triggered by reading information which might be distressing, particularly, and ask that they are helped to read this report in a safe and supported way.

Author: Niche Health and Social Care Consulting

Conveyed to: NHS England
On: 6 February 2025

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of Patient D. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report cannot be used or published without the permission of NHS England. No other party may place any reliability whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the 'Final Report' should be regarded as definitive.

Niche Health & Social Care Consulting Ltd
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

Contents

1 Incident and background

Incident

1.1 In early 2020 the police were called to an incident in a public place. A man was found with stab wounds and died from his injuries. Patient D was arrested.

1.2 Patient D was initially charged with murder. However, following psychiatric assessments, the Crown accepted a plea of guilty of manslaughter on the grounds of diminished responsibility. He was sentenced to an indefinite hospital order under Section 37/41 of the Mental Health Act.[1]

Mental health history

1.3 Patient D had some contacts with mental health services prior to 2018. He had a short acute hospital admission in 2010. However, he did not attend any appointments made for him with child and adolescent services[2] to support him in the community following his discharge from hospital.

1.4 Over five years following discharge, Patient D experienced challenges with his mental health. He was prescribed anti-depressants by his GP and referrals were also made for him to access talking therapies. Records note a suspicion that Patient D might have obsessive compulsive disorder[3] (OCD).

1.5 In early 2018 Patient D was seen by the Mental Health Liaison team (MHLT) when he attended the emergency department (ED) asking for help with his mental health. He was experiencing thoughts of suicide and was struggling to control feelings of anger towards other people. The MHLT concluded that he may have an underlying condition. They considered potential diagnoses, including attention deficit hyperactivity disorder[4] (ADHD) and autism spectrum disorder[5] (ASD). The plan from this was for the MHLT to offer Patient D ongoing appointments while referring him to other services.

1.6 Patient D attended an initial appointment with an MHLT practitioner and was referred to the ADHD service. A few weeks after referral in 2018, the ADHD team huddle discussed his referral. The meeting agreed an assessment was appropriate, but it was decided a referral to the affective disorders team[6] (ADT) was more relevant in the first instance because of "*comorbidities and risk*" (which we assume to mean his mental health presentation and suicide risk). However, this referral was not accepted by the ADT.

1.7 Patient D attended two further appointments with the MHLT practitioner and an appointment with the MHLT junior doctor.

1.8 A few weeks later Patient D attended an appointment with the MHLT consultant psychiatrist for the first time. This was after an experienced mental health liaison practitioner reported their concern about his presentation. Before the appointment, the consultant psychiatrist reviewed MHLT's

[1] "*This is a Section 37 hospital order with Section 41 restrictions added. Only the Crown Court can add Section 41 restrictions. It might add them if it thinks that it is necessary for the protection of the public from serious harm … 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*". MIND: The Courts and Mental Health https://www.mind.org.uk/information-support/legal-rights/courts-and-mental-health/section-37-41/

[2] NHS services that assess and treat young people with moderate to severe mental health difficulties. Children and young people's mental health services - NHS

[3] "*Obsessive compulsive disorder (OCD) is a mental health condition where a person has obsessive thoughts and compulsive behaviours*". https://www.nhs.uk/mental-health/conditions/obsessive-compulsive-disorder-ocd/overview/

[4] "*ADHD is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse*". https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

[5] Autistic people may act differently to other people. For more information see What is Autism? https://www.nhs.uk/conditions/autism/what-is-autism/

[6] The affective disorders community intervention teams help people (aged 18 to 65 years) with various mental health issues including anxiety, depression, mood disorders and personality problems.

contact with Patient D. The consultant psychiatrist considered whether Patient D was experiencing a first episode of psychosis. The outcome of the appointment with the consultant psychiatrist was a referral to the early intervention in psychosis[7] (EIP) service and a prescription for an antipsychotic, in the meantime.

1.9 The MHLT consultant psychiatrist had a follow-up call with Patient D. Patient D said that the antipsychotic had "*slowed his thoughts right down*". This is a recognised impact of the medication prescribed. However, it is not clear how long Patient D took the medication because he was not given any further prescriptions for antipsychotic medication.

1.10 The EIP service completed an assessment with Patient D, which was within the expected national guidance time frame. The conclusion from this assessment was that Patient D was not experiencing a first episode of psychosis and the referral was, therefore, not accepted by the team. No further action was taken, and Patient D was discharged back to the care of his GP. The GP then referred him to a primary care link worker, and he was assessed by a community psychiatric nurse. However, Patient D said he was not concerned about his mental health, and he declined support from the team. This was despite him having intrusive and disturbing thoughts and thoughts of making threats to others.

1.11 The MHLT discharged Patient D from their service because all the referrals they had made for Patient D had been completed.

1.12 A few months later Patient D became homeless and started living in a tent in the city centre. The police contacted the street triage team[8] (STT) seeking information about him.

1.13 The following day Patient D self-presented to the police station and while he was in custody, the liaison and diversion team[9] met with him. Patient D declined a mental health assessment and said he was already involved with mental health services (he may have believed this, but it was not the formal position). He told the practitioner that he was living in a tent. However, he had an appointment booked with the local authority to discuss his housing issues the following day.

1.14 Patient D contacted his GP, and he sought a medical certificate to defer his further education due to his mental health challenges. He told his GP that he was still misusing substances. He had stopped his anti-psychotic following the EIP assessment, but continued to be prescribed an antidepressant.

1.15 Three months later his GP made another referral to mental health services because Patient D had problems with ongoing intrusive thoughts, and queried the need for an ADHD assessment. The access team[10] completed an assessment with Patient D three weeks later. The outcome was that there was insufficient evidence to warrant a referral for ADHD assessment or to the ADT. Patient D was to self-refer to talking therapies for cognitive behavioural therapy (CBT). This aim was to support him with his OCD and his symptoms of anxiety. Patient D had previously disclosed that he misused substances and he was advised to self-refer to substance misuse services if he wanted support with his drug use. We assume Patient D must have taken this advice and referred himself to substance misuse services (but we cannot confirm this) as he was subsequently recorded as being on a drug reduction plan[11].

1.16 A few months into 2019 Patient D's GP made a referral to the access team for an assessment of Patient D's mental health and requested a referral to the ADT for ADHD. The access team completed an assessment with him two months later. The conclusion from this assessment was that Patient D did not "*meet the criteria for a longitudinal assessment of his mental health by secondary*

[7] Community mental health service for people aged 14 to 65 who are having some experiences that they may find unusual and/or distressing.

[8] The street triage team provides a service to assist the police officers with their decision making if there have been concerns about someone's mental health.

[9] The liaison and diversion service offers assessment and advice for people of all ages, who come into contact with the Criminal Justice System and experience mental health problems, learning disabilities, or may need support with other vulnerabilities.

[10] The access service provides mental health assessment for adults to support referral to appropriate services.

[11] NHS. Medicines A to Z: Methadone https://www.nhs.uk/medicines/methadone/

care community mental health services". However, Patient D requested an assessment for ADHD, so the access team made a referral to the ADT for a diagnostic assessment to determine if Patient D met the criteria for an ADHD assessment.

1.17 This time Patient D was accepted by the ADT for a diagnostic assessment and was allocated a lead professional from the team to manage his care and treatment. His first meeting with them was in mid 2019.

1.18 During this appointment Patient D disclosed that he had been misusing other substances. He was on a drug reduction plan supervised by substance misuse services. He had not slept for 48 hours, and he was anxious because his flat (we do not know the precise date he was provided with accommodation) had been searched by the police because allegations of drug dealing had been made. Patient D denied that he had been arrested or cautioned, although he did have to report to the police station later that day.

1.19 In Summer 2019 he told his GP that he was living in a tent in the city centre – it is not clear when he shared this information with the lead professional.

1.20 Patient D was placed on the waiting list for an ADHD assessment at this time. The ongoing plan was for the lead professional to continue to provide him with support until the ADHD assessment was completed.

1.21 The lead professional encouraged Patient D to keep a diary of his mental health and wellbeing.

1.22 The lead professional had contact with Patient D, either face-to-face or by phone on the following dates:

- Mid to late 2019. In this appointment, Patient D said he was buying pregabalin[12] off the streets. He had financial challenges and was using food banks. In his diary, he referenced thoughts of self-harm and suicide. Patient D was unhappy in his accommodation and said his neighbours were noisy. However, he was caring for a stray cat which was seen as a protective factor.
- Late 2019. In this appointment, Patient D described problems at his accommodation because of noisy neighbours and people ringing his doorbell. He denied using substances and of having thoughts of self-harm or suicide. The lead professional agreed to make a referral to Steps to Recovery which is a peer support group.
- Late 2019. This appointment was arranged to introduce Patient D to a mental health recovery support group, with the support of the lead professional. Patient D decided not to access the service because the service model involved group-based work, although he was willing to access the group dedicated to supporting people with their benefits. He was in the process of appealing an application for a Personal Independence Payment[13] (PIP). At this appointment there were signs of self-harm; Patient D had scratches on his head. He denied substance misuse. The lead professional noted he could be impulsive and "*was at risk of death by misadventure".*

1.23 Three days later Patient D called an ambulance because he was having thoughts of suicide. The ambulance service sought advice from the STT. They shared information about Patient D and his mental health problems and his risk so as to support the ambulance service to make a decision about what action to take. No further action appears to have been taken. However, STT shared information about the call with the ADT and Patient D was contacted the following day by the ADT duty worker to check on him.

[12] *Pregabalin is used to treat epilepsy and anxiety. It is also taken to treat nerve pain. Nerve pain can be caused by different conditions including diabetes and shingles, or an injury*". https://www.nhs.uk/medicines/pregabalin/ It is also a 'street' drug https://www.drugwise.org.uk/pregabalin/

[13] "*Personal Independence Payment (PIP) can help people with extra living costs if you have both: a long-term physical health or mental health disability, and difficulty doing certain everyday tasks or getting around because of your condition*". https://www.gov.uk/pip

1.24 Later in 2019 the lead professional spoke to Patient D over the phone. Patient D was having financial difficulties and he was offered practical advice about support available through support groups provided by the Trust.

1.25 A week later the lead professional noted concerning signs of psychosis; when asked Patient D denied any thoughts of suicide.

1.26 Near the end of 2019 Patient D met with the lead professional. In this meeting, he said he had been experiencing thoughts of suicide, but he said his pet was a protective factor in his life. In this appointment, Patient D also told the lead professional he had a weapon and *"if people triggered him, he could not guarantee the response"*. He told the lead professional that the police had found the weapon the last time they had searched his home but had not done anything about it. The lead professional said they were going to take advice from the wider team about the weapon. Patient D agreed to take the weapon to the police station later that day. Patient D had ongoing problems with his neighbours and was due to see the housing officer the following day to discuss the issues and explore some solutions.

1.27 In addition to having contact with the lead professional and the ADT, Patient D asked for support from the crisis resolution and intensive home treatment[14] (CRHT) team during the first week in December 2019. He was experiencing suicidal thoughts, although he said he would not act on them. Patient D was advised to speak to his lead professional at the appointment planned for two days later.

1.28 In his next appointment Patient D said that he was not sleeping, had been anxious with thoughts of suicide. However, he said he had no current thoughts of self-harm or suicide. He was depressed. The lead professional planned to talk to the team about a medication review. There are no details of a conversation with the wider team.

1.29 There was confusion about the location of the next appointment and, as a result, the lead professional and Patient D did not meet or speak on the phone. The lead professional planned to discuss Patient D in the daily decision-making meeting (DDM). But there is no record of any discussion or outcome. The lead professional did contact the GP practice, who said that Patient D had last been seen the previous month.

1.30 Prior to the Christmas break a student social worker from ADT spoke to Patient D over the phone. He was not sleeping and they discussed strategies to help with this.

1.31 During the festive period the ADT made two unsuccessful attempts to speak to Patient D on the phone.

1.32 In the New Year the lead professional met with Patient D. He was feeling down, was anxious and they noted other symptoms of psychosis. He was experiencing intrusive thoughts that were preventing him from forward planning, but again he identified his pet as a protective factor. He disclosed that he had used substances in the last week to help him sleep and there was a further discussion about a referral for a medication review. Patient D said that he had researched ASD and felt he had the traits. Although there is no detail in his clinical record of the traits he described. The lead professional discussed this with Patient D's GP who said there was no historical diagnosis of ASD.

1.33 Two weeks later Patient D was not at home when the lead professional visited as planned, and he did not respond to a phone call. This appointment was rescheduled.

1.34 Four days later Patient D was again not at home when the lead professional visited and he did not respond to a phone call.

[14] Provides community specialist triage, assessment and intense home treatment for people aged over 16 years who need urgent mental health care.

1.35 A few weeks later the lead professional met with Patient D. They identified some short-term goals together and Patient D was able to demonstrate forward planning. He was anxious about how long he had been waiting for the ADHD assessment. The lead professional (a social worker) planned a joint appointment with a colleague with more medical (psychiatric) experience. Patient D was not seen by any medical personnel following this meeting.

1.36 A month later, the lead professional had a telephone conversation with Patient D who was in the process of moving to another property. The lead professional was not able to help him with the move because of the emerging issue with Covid 19, but they arranged to speak again the following week.

1.37 In addition to support from the lead professional Patient D was receiving support from a primary care wellbeing practitioner, which had been arranged by his GP the previous year.

1.38 Shortly after this, the GP used the Trust template for an adult referral to Trust services and shared this by email with the lead professional. It is not clear if the GP was actually making a referral for a Trust service or was making the lead professional aware of their concerns about Patient D's anxiety and ADHD symptoms. In the referral the GP states, "*He denies any current use of recreational drugs or alcohol".* The lead professional did not reference this referral in their phone call with Patient D following this.

1.39 A short while later Patient D stabbed the victim. Patient D was arrested and initially charged with murder.

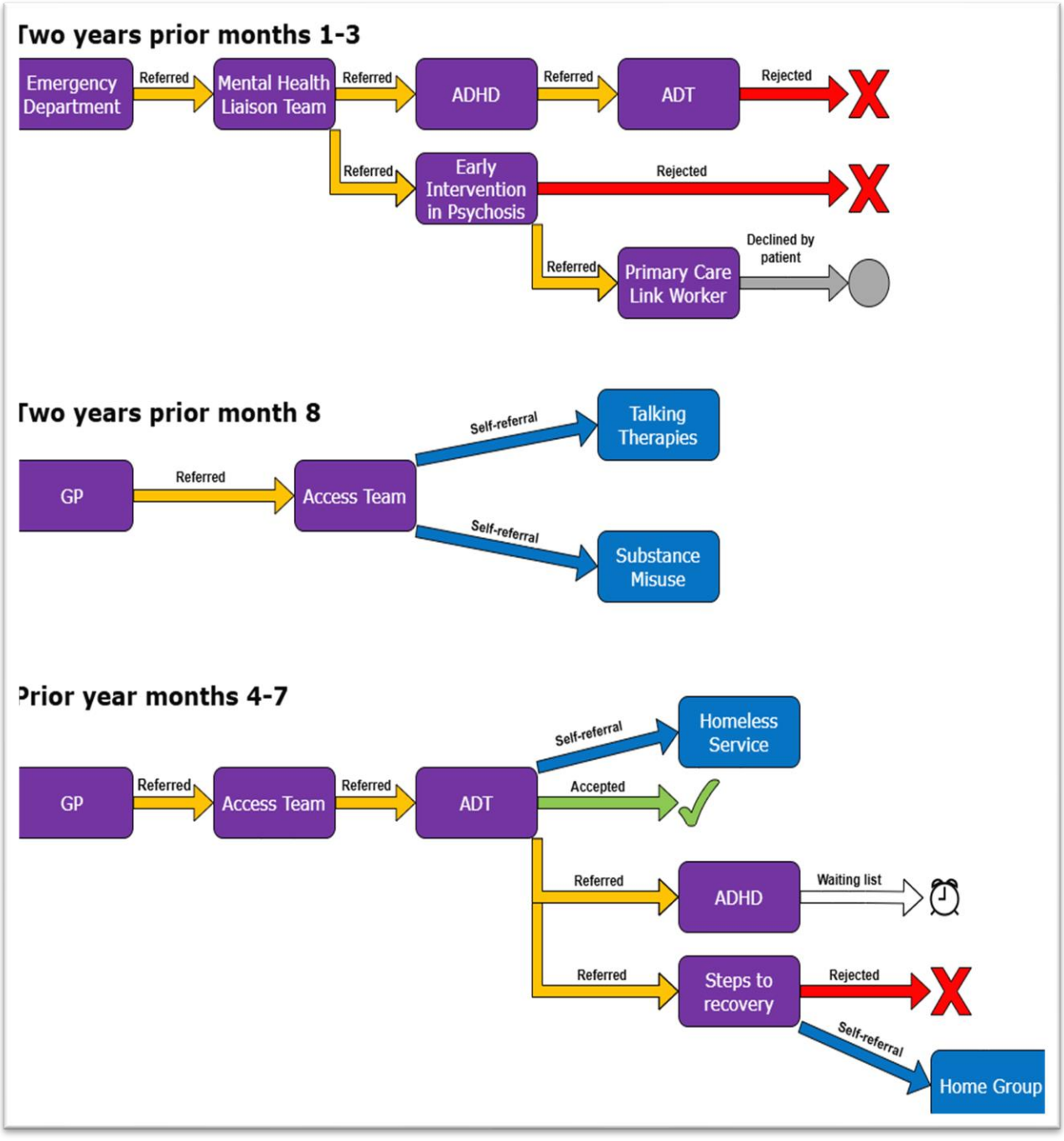
2 Findings

Care and treatment

2.1 From his teenage years Patient D experienced challenges with his mental health. He approached Trust services a number of times for help with his mental health as an adult before being accepted by the ADT for support whilst he was waiting for an ADHD assessment.

2.2 The table below illustrates the contact Patient D had with Trust services in the two and a half years prior to the incident, and the referrals and outcomes from these contacts.

Table one: Patient D referrals and outcomes



2.3 In addition, Patient D had been signposted, referred or advised to seek help from a wide range of services. This signposting was made by Trust and GP services.

2.4 Patient D presented with a range of symptoms indicating signs of psychosis. In addition, he had a developing history of substance misuse.

2.5 It is our opinion that services at this time viewed Patient D's symptoms through the lens of a potential ADHD or ASD diagnosis. This resulted in an element of confirmation bias,[15] and meant the services did not consider alternative diagnoses or carry out a comprehensive assessment of his mental health.

2.6 There was also a lack of medical oversight. The only medical assessments completed were by an MHLT higher-grade trainee doctor[16] and the MHLT consultant psychiatrist. The consultant psychiatrist prescribed an antipsychotic and referred Patient D to EIP. Furthermore, the ADT lead professional noted on three occasions that Patient D required medical input: However, there is no evidence that the lead professional sought medical support for Patient D.

2.7 The EIP assessment was completed by a social worker and was based on a questionnaire. There was no medical input to the assessment. Whilst questionnaires can support assessments they are not a replacement for clinical judgement. The assessment concluded that Patient D was not experiencing the symptoms of early episode psychosis and the referral was declined.

2.8 We believe that the assessment was discussed by the EIP MDT, but this would have only provided limited medical oversight of the assessment and the decision not to accept Patient D onto the team's caseload. A more prudent approach would have been to accept Patient D for an extended assessment.

2.9 While under the care of the ADT, Patient D was managed by a lead professional who was a social worker. They did not update Patient D's clinical management (safety) plan or share any of the emerging risks with the agencies supporting Patient D in the community. These risks included Patient D disclosing:

- he was on a drug reduction plan
- he was in possession of a weapon
- the police had searched his flat in relation to suspicions of drug dealing.

2.10 ADT and other services did not consider the impact Patient D's drug use might be having on his mental health and other aspects of his life.

Multiple referrals to services in 2018 and 2019

2.11 Patient D was referred but assessed as not meeting the criteria for Trust services on four occasions in the two years prior to the incident.:

- the ADHD service
- the ADT
- the EIP
- then he was assessed by the access team and advised to self-refer to talking therapies and substance misuse services

[15] Confirmation bias is "… *people's tendency to process information by looking for, or interpreting, information that is consistent with existing beliefs*". https://www.britannica.com/science/confirmation-bias

[16] Higher-grade trainee doctors are doctors in any postgraduate speciality training programme. They will have been working as a doctor for 2-11 years.

2.12 A further referral was made by his GP just before the incident that requested support from Trust services. This was passed to the lead professional. However, it is unclear if any action had been taken in response to this referral by the time of the homicide. This is because the homicide was committed within the 28 day time frame for dealing with non-urgent referrals.

2.13 Patient D was provided with support by the wellbeing practitioner at this GP surgery. They planned to refer him to the Richmond Fellowship, the Citizens Advice and to Welfare Rights. They also provided him with information about drop in services which he would assess for support with his mental health needs, and more practical issues such as benefits, housing and meaningful occupation.

2.14 Patient D was signposted to a number of services that needed him to self-refer. These services included talking therapies and the substance misuse service. There is limited information about whether Patient D sought support from these services, apart from a drug and recovery service letter to Patient D's GP a few months earlier to confirm that he had been reviewed in a non-medical prescriber clinic and was being prescribed a drug replacement. Patient D did tell the ADT lead professional that he was on a drug reduction programme.

Diagnostic uncertainty

2.15 Over the year prior to the incident, services viewed Patient D's symptoms through the lens of a potential ADHD or ASD diagnosis. Consideration was not given to other diagnostic options and a comprehensive assessment of his mental health needs was not carried out.

2.16 Patient D had experienced periods of anxiety and depression for which he had received medication and referrals to talking therapies.

2.17 Patient D had coexisting substance misuse. However, Trust services lacked professional curiosity about this and they did not contact the substance misuse service for information or consider joint working. Nor did the disclosure of substance misuse lead to a reconsideration of Patient D's symptoms and potential diagnosis.

2.18 Patient D disclosed his drug use to Trust services on a number of occasions, including when:

- Patient D told the lead professional that he had been using heroin and was on a methadone reduction programme.
- he told the lead professional that he had used hash and pregabalin to help him sleep.

2.19 While under the care of the MHLT it was noted that his presentation was different at the different appointments he attended with three different members of the team. One of the doctors queried an ADHD diagnosis, and another made a referral to EIP.

2.20 On separate occasions the MHLT and the ADT lead professional did not complete an autism screening tool with Patient D to determine if he was experiencing any symptoms suggestive of ASD.

2.21 The access team and ADT's thinking that Patient D may have been experiencing the symptoms of ADHD or ASD stopped them considering other possible diagnoses.

Lack of medical oversight

2.22 Patient D's lead professional was a social worker and noted that Patient D might benefit from some medical input on several separate occasions. However, there is no evidence of medical oversight of his care and treatment. His mental state was not reviewed by a psychiatrist. He was not offered a medication review.

2.23 The EIP assessment of Patient D was completed by a social worker. There was no medical assessment of Patient D by a psychiatrist to support the team's decision not to accept Patient D, either for an extended assessment or for treatment from the team.

2.24 The only medical assessments completed for Patient D was by the MHLT higher-grade trainee doctor and the MHLT consultant psychiatrist. The MHLT consultant psychiatrist prescribed quetiapine and referred him to the EIP. This was an experienced medical professional who believed the proposition that Patient D was experiencing first-episode psychosis requiring further investigation.

Early intervention in psychosis

2.25 The EIP assessment was completed with Patient D by a social worker. This was a questionnaire completed during the only appointment he had with EIP.

2.26 Furthermore, this assessment did not consider the clear symptoms of psychosis identified by the MHLT consultant psychiatrist. And the EIP did not have a conversation with the MHLT consultant about their professional view of Patient D, his presentation and his symptoms.

2.27 Given Patient D's history of contact with mental health services and the lack of clarity about whether he had experienced hallucinations it would have been prudent for EIP to have accepted Patient D for an extended assessment of his mental state to determine if there were any elements of early psychosis.

Substance misuse services were provided in isolation of other services

2.28 Patient D shared information with mental health services about his substance misuse. However, services lacked any professional curiosity about this and the impact it had on his mental health and wellbeing.

2.29 The first GP referral to the access team for an assessment of Patient D's mental health and needs, and an appropriate onward referral noted that Patient D did not have a problem with alcohol and has "*never indulged in drug taking*".

2.30 When the GP made a further referral to the Trust for support for Patient D they stated that *"He denies any use of recreational drugs or alcohol".* However, it is not clear if this was a referral for a service or a way of making the lead professional aware of their concerns about Patient D's anxiety and ADHD symptoms. It is clear from the GP's clinical record that they were aware of Patient D's history of drug use and addiction.

2.31 When the lead professional became aware that Patient D was on a drug reduction programme, they did not seek additional information from substance misuse services. Joint working between mental health services and substance misuse services was a missing critical link in providing comprehensive care.

2.32 The lead professional did not consider the police search of Patient D's flat or the problems he was describing with his neighbours in the context of substance misuse and any associated lifestyle choices.

2.33 There were at least two occasions when Patient D disclosed using illicit substances to help him sleep.

2.34 We would have expected the lead professional to have sought information and support from one of the members of staff who was qualified, knowledgeable and skilled in identifying and working with service users with dual substance misuse and mental health problems.

Lack of comprehensive care planning and lack of CPA

2.35 Patient D was cared for on 'standard care' by the ADT and this resulted in him not being escalated for medical review or clinical formulation.

2.36 The simple care plan written for Patient D by the lead professional was not shared with Patient D's GP.

2.37 As Patient D's needs and risks emerged, his CPA status was not reviewed, and he was not considered for care coordination and CPA.

2.38 The lead professional responsible for Patient D's care and support was a social worker. A lead professional with more medical experience might have been better placed to have met Patient D's care and treatment needs. This skills gap was acknowledged by the lead professional just before the incident when they told Patient D they would arrange an interview with a colleague with more medical expertise.

2.39 Patient D needed a multi-agency approach to his care and treatment, and this could have best been provided under CPA. He was receiving support from substance misuse services, housing services, the primary care wellbeing practitioner through his GP, and an advocate. There was minimal inter-agency communication and CPA would have supported this communication.

Weak risk assessment and management

2.40 The last safety summary, and safety and harm minimisation plan, were completed for Patient D eight months before the incident and were not updated with new or emerging risks.

2.41 There were at least 12 points at which the safety summary and safety and harm minimisation plans should have been updated. This included, when Patient D disclosed thoughts of harming others, which were reported to the police, when he disclosed thoughts of taking his own life (several occasions), he disclosed he had a stockpile of an anti-depressant medication, he disclosed he was being disturbed by people ringing his doorbell and by loud noises in his accommodation, when the lead professional identified signs of self-harm, when the lead professional identified that Patient D could be impulsive and "*therefore remains at risk of death by misadventure",* when he was found to have a weapon, when he disclosed he was using illicit substances to help him sleep and when he disclosed some bizarre thoughts.

2.42 Information about emerging risks was not shared with other agencies supporting Patient D in the community, e.g. his advocate, the wellbeing practitioner and the GP.

Inter-agency communication

2.43 There was limited evidence of information sharing between Trust services and the GP. The Trust services updated the GP outcome of assessments completed with Patient D in eight months prior to the incident. However, they did not share information about Mr D's risk. The only information shared with the Trust by the GP was via referrals.

Lack of application of safeguarding processes

2.44 The lead professional made appropriate reports to the police about Patient D's risk to others on two occasions. However, there is no evidence that they sought advice from the multidisciplinary team (MDT) or the Trust safeguarding team.

2.45 Information about Patient D's vulnerability or his risks were not shared with the other organisations or agencies who were working with him.

2.46 While the ADT lead professional was aware that Patient D was under the care of other agencies and that his potential risks were escalating, they did not complete a review with him or consider whether he would be better managed under the Care Programme Approach (CPA).[17]

[17] "*The Care Programme Approach (CPA) is a package of care for people with mental health problems*". https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

Trust internal investigation and report

2.47 The investigation was not completed in line with the expectations of the Trust's Serious Incident Policy. The investigation was completed as a Structured Case Review (SCR)[18]. There is no reference in the Trust Serious Incident Policy to the use of SCR in these types of cases.

2.48 There were a number of challenges with the investigation:

- there was a delay in allocating the review, it was allocated in four months after the incident but because of work pressures the investigation was not commenced for another three months
- it was completed by an inexperienced Patient Safety Reviewer (PSR)
- staffing on the Patient Safety team was compromised as a result of long-term sickness absences and Covid-19-related challenges, and
- a backlog of incidents requiring investigation and a number of complex investigations that were absorbing team resources
- the PSR responsible for the review was not provided with regular, structured support
- the PSR told us that the advice and support they received from more senior staff was inconsistent
- there was no dedicated clinical input for the investigation

2.49 The scope and ToR for the internal investigation were in two parts. The first (purpose) was generic, without specific reference to Patient D. The second part identified the key issues relating to Patient D to be addressed.

2.50 These specific key lines of enquiry are provided to support and guide the investigation. However, there are flaws in these:

- The start date for looking at mental health history is not early enough to support analysis of the appropriateness of his assessment, care and treatment. We would suggest that a review beginning 18 months earlier would have maximised the opportunities for learning.

- The timeline extends three months beyond the homicide. It is not necessary to consider care and treatment beyond the date of the incident. If the timeline is extended beyond the date of the incident, we would expect to see a clear rationale for this in the report.

- The investigation did not address five key issues: the potential ADHD diagnosis and the impact ADHD would have had on Patient D's impulsivity, a review of the management of Patient D's risk and formulation, the information sharing between agencies and determine if any lapses in care were a factor in the incident occurring.

2.51 The report is difficult to navigate and is split into two sections:

- Section one of the report is a narrative of Patient D's contact with Trust services in the 13 years prior to care identified in the ToR for the internal investigation. To meet the requirements of the ToR it would have been sufficient to have provided a brief overview of Patient D's history of contact with services.

- Section two of the report is completed as a SCR. It is presented as a timeline and assesses the care provided against policies, and procedures, and asks the reviewer to consider if there are any omissions, commissions or mistakes representative of a 'reflective learning' opportunity or are you concerned about an actual or possible serious breach in practice procedure

2.52 There are no references to Root Cause Analysis (RCA) or contributory factor analysis and there was no evidence of RCA to support the findings. These were required by both the NHS England SIF and the Trust Serious Incident Policy at the time this investigation and report were completed.

[18] A structured analysis of care.

2.53 However, the findings of the investigation are set out in a way that indicates thought was given to contributory factors. Nonetheless, we consider them to be flawed.

2.54 A statement in the report identified no significant lapses that influenced or had a direct impact on the incident. We disagree with this and have identified a number of issues that required further exploration before this conclusion could be reached.

2.55 Lapses in care are the influencing factor(s) identified in the course of the care and treatment in the sequence of events leading up to the incident that increased the likelihood of it happening. Although the PSR concluded that the incident was not predictable or preventable (something the ToR did not ask them to determine), they identified five lapses in care.

2.56 The investigation report Identified six additional areas of learning. However, the investigation did not conclude these influenced or directly caused the incident.

2.57 We have identified a number of factors that prevented this internal investigation and report from clearly articulating the lapses identified in Patient D's care and treatment by Trust services. These are:

- The limited timescale identified for the investigation.
- The approach taken to the investigation: part narrative and part SCR.
- The lack of structured analysis of the information available from the SCR.

2.58 As a result of the weaknesses in the approach taken, the investigation and the format of the investigation report only partially considered the key issues to be addressed as identified in the ToR.

Duty of candour

2.59 The Trust did not meet the duty of candour/being open expectations of the NHS or its own policy.

2.60 The Trust Duty of Candour Policy version 1.2 states that the Trust must act in an open, honest and transparent way with service users and/or relevant persons in relation to the care and treatment provided by the Trust.

2.61 The Trust's Serious Incident Policy requires the PSR to contact the families of the victim and perpetrator in conjunction with NHS England and the police, which is in line with being open and the statutory duty of candour best practice. This did not happen.

2.62 This should be done so the serious incident process can be explained and to allow the families to identify any questions they would like the investigation to answer. They should also meet with the families once the investigation is completed to share the findings and learning. This did not happen.

2.63 The investigation report states that contact was not made with:

- the victim's family, because the victim was not under the care of Trust services and the PSR did not have contact details for the family
- Patient D's family, because there were no contact details available on his clinical record
- Patient D, because he was detained to a forensic service provided by another Trust

2.64 None of these are acceptable reasons for not involving the people directly affected by the incident in the investigation. The Trust could have liaised with the police senior investigating officer or the family liaison officer. And there was nothing to prevent contact with Patient D through his care team at the forensic service he was detained to.

2.65 Whilst SIF has been superseded by the PSIRF the engagement of families and patients remains of focal importance to investigations of this type.

Issues requiring further exploration

2.66 We have identified eight significant areas that require more exploration than given by the Trust's internal investigation.

2.67 **Multiple referrals prior to the incident** – the Trust was prevented from considering this issue in detail because of the limited timeline for the investigation. However, the report does identify this as an additional area of learning.

2.68 **Diagnostic uncertainty** – during his contacts with Trust services in the two and a half years prior to the incident, Patient D presented with a wide range of symptoms and none of the assessments that were completed reached a conclusion about his primary presenting issue and a diagnosis. Furthermore, services did not complete an autism screening with Patient D and EIP services did not consider the option of accepting Patient D for an extended assessment.

2.69 **Medical oversight** – there was a lack of medical oversight of Patient D's assessments and care in the two years prior to the incident This was limited to three reviews by the MHLT psychiatrists, and a limited medical presence at some of the team meetings for other services where Patient D was discussed.

2.70 **EIP** – the decision not to accept Patient D for an extended assessment or care and treatment by the team was based on one face-to-face appointment with a social worker from the team and the completion of the CAARMS questionnaire. We consider that decision to be flawed.

2.71 **Substance misuse** – further information about Patient D's substance misuse emerged while he was under the care of the lead professional. They became aware that Patient D was under the care of substance misuse services. But there was a lack of professional curiosity about the impact of Patient D's substance misuse on his mental health, his physical health and other lifestyle issues.

2.72 **Care planning** – Patient D was being supported by a lead professional on standard care. This was not reviewed as Patient D's complexities emerged. The care plan completed seven months before the incident identified that Patient D was on the waiting list for an ADHD assessment. This was not reviewed as Patient D's issues with a range of existing and new risks emerged.

2.73 **Risk assessment and management** – a safety summary and a safety and harm minimisation plan completed with Patient D were not reviewed and updated to reflect Patient D's emerging new risks and the escalations in his known risks.

2.74 **Inter-agency communication** – in the three months preceding the incident, Patient D was supported by a number of agencies. The lead professional had some limited contact with Patient D's advocate and housing officer but did not liaise with the GP or substance misuse services. Furthermore, the lead professional did not liaise effectively with the police and request information about Patient D's contact with them.

Progress against the Trust action plan

2.75 The Trust investigation and report made 11 recommendations for a range of Trust services.

2.76 We assessed the implementation of an action plan, reviewing documentation and completing interviews with staff. We concluded that the Trust had made some progress in the implementation of the recommendations with four actions having been implemented but not yet tested, four actions having been significantly progressed and for three of the actions the Trust provided insufficient evidence to support any progress with the action.

2.77 While the implementation of the generic adult mental health adult pathway, the electronic management tool and the Caseload Supervision Policy, supplemented by the structured decision-making meetings in the ADT has allowed the Trust to demonstrate some actions have been completed, there is insufficient evidence available at this point in time to demonstrate they are embedded and there is sustained improvement.

2.78 We noted that two of the recommendations from the Trust report related to clinical care after Patient D was arrested and were therefore outside the scope of the Trust internal investigation. However, both recommendations sought appropriate improvement in clinical practice.

2.79 Following our review of the Trust action plan we made eight supplementary recommendations, see below:

Recommendations

Recommendations arising from this investigation

Recommendation 1: Support for incident investigators **The investigator was new in post in a patient safety role. They were not experienced in leading investigation reports and there was no structured support available to them. The investigation lacked a clear methodology and was confused about whether the report should use a structured judgement review format, the serious incident process or the new PSIRF principles. Advice given during the Trust assurance process was confused and, as a result, the final report was difficult to read.** The Trust must develop its approach to individual investigations and develop a clear process for producing high-quality reports, that is compliant with PSIRF expectations. This should include: • clear guidance on which methodology to use, namely how the structured judgement review is used (outside mortality review processes) • agreement on which methodology and reporting template to use at the start of the investigation • senior officers being available to provide guidance where clarity is required
Recommendation 2: Assessment process for the EIP service **The EIP assessment was not comprehensive. It failed to gather sufficient information about the wider context and historical presentation of Patient D after referral. This was partly because only a questionnaire was used.** **There is no record of the decision-making process and rationale that found that Patient D did not meet the criteria for EIP services.** **The EIP standard operating procedure did not give sufficient detail about the process of assessment when a service user is referred to the service (namely, an assessment must be completed within 14 days).** The Trust must review the assessment process for service users referred to EIP services. This must include: • a requirement to consider all the information provided by the referrer; this includes making direct contact with the referrer to clarify their clinical opinion of the service user. • clarifying the role of the Comprehensive Assessment of At-Risk Mental States (CAARMS) questionnaire[19] in the EIP assessment process (if still used)

[19] The CAARMS is an instrument for the assessment of features of a service user's mental health and history which could indicate they were at risk of developing first episode psychosis . https://selondonccg.nhs.uk/wp-content/uploads/2022/05/CAARMS-Leaflet-v1.2.pdf

- an expectation that medical involvement will be actively engaged (unless by agreed MDT exception) as part of the multi-professional oversight of the assessment and decision-making process
- the expectation that the MDT decision-making discussion will be recorded in the service user's clinical record; this includes the rationale for the clinical decision and any advice provided back to the referrer and service user about alternative service options

Recommendation 3: Meeting the being open and duty of candour requirements

A similar recommendation was made in a prior investigation. Because the same concern is raised in this case, we have used the same wording for consistency. This may already have formed part of the Trusts improvement programme.

The Trust's internal report stated that the investigator did not have contact with the service user because he was detained to a forensic hospital in a different NHS Trust. They also did not have contact with the service user's family because there were no contact details on the service user's electronic record (despite there being alternative ways of seeking this information, e.g. through the coroner or police). They did not make contact with the victim or his family because he was not known to Trust services. As a result, there is no evidence of reasonable attempts to meet the duty of candour regulations and include the family in the investigation.

- As the Trust implements the PSIRF framework, policies and procedures must include identifying all persons who should be offered the opportunity to contribute to an individual case investigation.
- The procedure should set out reasonable expectations for making contact with families where details are not held on patient records, e.g. through the coroner or police family liaison officer.
- The Trust must monitor the involvement of families by investigators in any investigation involving death, suicide or homicide in meeting duty of candour requirements.

Recommendation 4: Monitoring repeated declined referrals

This recommendation was made in a prior investigation. Because the same concern is raised in this case, we have used the same wording for consistency. This may already have formed part of the Trusts improvement programme.

The service user was referred to Trust services multiple times in the three years prior to the homicide. There was diagnostic uncertainty about the service user's presentation and a number of assessments were completed with him, e.g. triage assessments, ADT assessments and an assessment by EIP. All these assessments failed to result in the service user being given access to services or to effective signposting to alternatives. Criteria for specific services are not clear and decision-making is not documented.

The Integrated Care Board and Trust should develop services in line with the requirements of the community mental health framework for adults and older adults[20] that avoid patients being subject to repeat referrals, screenings and assessments across multiple services. This methodology must describe the

[20] The community mental health framework describes how the Long-Term Plan's vision for a place-based community mental health model can be realised, and how community services should be modernised to offer whole-person, whole- population health approach. https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

expectations for medical oversight for patients during assessment and that this is monitored effectively to identify potential patient risk and ensure care plans are adequately reviewed.

Recommendation 5: Supplementary recommendations from the assurance review

The Trust needs to embed the 11 recommendations from the internal investigation into clinical practice. We outline below eight further observations of issues arising from this case that should be included in existing improvement programmes:

- The Trust is to review how sharing information about risk with other agencies could be captured on the Electronic Care Record.
- The Trust is to review how significant incidents and alerts could be captured on the Electronic Care Record.
- When developing the community mental health framework, the Trust should define the care coordinator/lead professional responsibility for service users who are detained on remand or are subject to a prison sentence.
- The STT to consider developing an electronic management tool similar to the one developed for the generic adult pathway.
- The Trust to assure itself that the number of clinical records audited is proportionate to the number of service users triaged by the services. The Trust is to determine the frequency of this audit. The Trust is to determine where the findings of the audit and any resulting action plans are reported.
- The Trust to continue monitoring CRHT call answering. The Trust to set performance targets for CRHT call answering and to monitor this.
- The Trust to monitor and report, both internally and externally, on waiting times for ADHD assessments in light of increasing demand and limited resources.
- The liaison and diversion service to provide assurance that the responsibility of the team to complete safety summaries and Datix reporting is addressed in a service standard operating procedure.

Recommendation 6: Coordination with substance misuse services

Trust services did not liaise with substance misuse services to establish if Patient D was under their care and to ensure a coordinated approach to Patient D's care and treatment.

The Integrated Care Board and Trust should develop services in line with the requirements of the community mental health framework for adults and older adults and ensure that the proposed care model describes how mental health services will work collaboratively with substance misuse services to provide patients with coordinated care and treatment.

Appendix A – Terms of Reference

The ToR for the independent review of case 2020/5854 Patient D, are set by NHS England with input from the Clinical Commission Group and may be developed further in collaboration with the investigation company and identified family members. However, the following ToR will apply in the first instance.

Purpose

With a focus on learning, complete a proportionate review of the Trust's internal investigation into the care and treatment of Patient D, to determine whether the key lines of enquiry were adequately considered and explored. Highlight any areas requiring further examination.

As the review progresses, the lead investigator should highlight any areas requiring wider consideration outside of the initial scope and raise these with NHS England as the commissioner of the review.

The review should include the effectiveness of pathway referrals and multi-agency working when managing risk, in addition to an assurance review of the Trust's action plan from the internal investigation's findings.

Based on the review findings, formulate recommendations which would lead to sustainable and measurable improvements.

Identify and communicate with NHS England and the Trust, any learning opportunities determined by the review and outline what is expected to change as a result.

Involvement of the affected family members and the perpetrator

In partnership with NHS England, ensure that affected families understand the purpose of the review, its scope and its process, and are offered an opportunity to contribute, including helping to develop the ToR.

Involve the families of both the victim and the service user as fully as is considered appropriate, in liaison with victim support, police and other support organisations.

Share the report in an agreed format with the affected families. Ask for their comments and ensure that appropriate support is in place ahead of publication.

Offer Patient D a minimum of two meetings, one to explain and contribute to the investigation process and the second to receive the report findings.

Scope of the assurance and pathway review

The independent review team will determine the historical context and identify significant periods of care provision relevant to the incident.

Taking into account the Trust's chronology of events, source and review any relevant additional documents to develop a comprehensive chronology to review the findings of the internal investigation against.

Undertake a critical analysis of the key lines of enquiry of the Trust's internal investigation to determine whether they were relevant, adequately considered and explored. Highlight any areas requiring further investigation.

The expectation of NHS England is that the following considerations will be included, but that the review will not be limited to:

- Gathering additional information from appropriate personnel, where necessary.
- Identifying any gaps or omissions in care not adequately addressed by the internal investigation.

- Reviewing the adequacy of risk assessments and risk management, including risk assessment during periods of behavioural change or change in personal circumstances, the risk posed to others, specifically in relation to risk of violence, and how this information was shared.
- Considering how Patient D's risk profile influenced his overall care planning.
- Reviewing the appropriateness of the planned interventions of Patient D in light of identified health and/or social care needs. Identifying areas of good practice and opportunities for learning and areas where improvements to services are required.
- Reviewing the referral pathway for Patient D. Identifying gaps and opportunities for improvements and making appropriate recommendations.
- Constructively reviewing internal and inter-agency working and communication, identifying any gaps and potential opportunities for improvement.
- Reviewing and assessing compliance with local policies, national guidance and, where relevant, statutory obligations.

Conduct an assurance review of the Trust's action plan from their internal investigation findings. Outline whether there is sufficient evidence to demonstrate full implementation and embeddedness of the required actions.

Identify any notable areas of good practice and further opportunities for learning determined by the review and outline what is expected to change as a result.

Appendix B – Glossary

ADT	Affective disorder team
ADHD	Attention deficit hyperactivity disorder
CRHT	Crisis resolution and home treatment team
DDM	Daily decision-making meeting
ED	Emergency department
EIP	Early intervention in psychosis team
MDT	Multi-disciplinary team
MHLT	Mental health liaison team
STT	Street triage team

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Read more about us at: **www.nicheconsult.co.uk**

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492.

niche
HEALTH & SOCIAL CARE CONSULTING