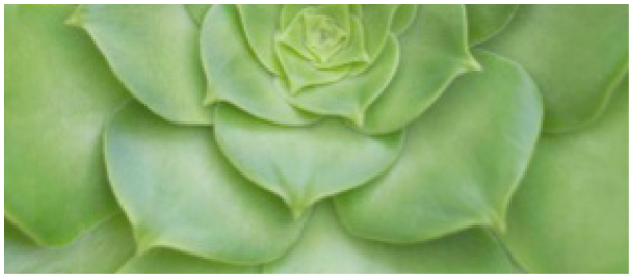

Psychological Approaches

EXECUTIVE SUMMARY REPORT

AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MR L

December 2023

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INTRODUCTION

1. The external investigation by Psychological Approaches into the care and treatment of Mr L was commissioned in March 2023 by NHS England. We would like to thank the Trust Patient Safety[1] team for their help in supporting this investigation. We also extend our thanks to those we interviewed whose accounts were extremely helpful to the panel. The full investigation report has been made available to all the relevant stakeholders. This Executive Summary has been written in line with the Terms of Reference for the investigation for the purposes of publication in the public domain, in order to ensure that any learning is made widely available.

The victim and his family

2. Psychological Approaches would like to extend their sincere condolences to the victim's family. We are immensely grateful to the family for participating in this investigation. We have noted and responded to their questions that fall within the scope of this report.

The person receiving care and support from mental health services

3. The clinical record indicates that Mr L was a 31 year old man who was living independently at the time of the serious incident. He was under the care of the community mental health team (CMHT) and had been struggling to manage his mental health and substance misuse for more than ten years.

4. Mr L kindly agreed to participate in this investigation, and was able to provide consent.

5. We are grateful to Mr L's family who met with the investigation panel and posed some questions for our investigation as well as providing us with some more background information regarding Mr L's early life and his difficulties.

The incident

6. The homicide took place in 2022, the victim being an adult man who lived nearby to Mr L with whom he was acquainted. Mr L was arrested and resided in high secure hospital for a period of assessment. He was found not to meet the criteria for diminished responsibility and pleaded guilty to the charge of murder for which he received a mandatory life sentence.

[1] That is, the Trust that provided mental health services to Mr L prior to the homicide.

BACKGROUND TO Mr L's CARE AND SUPPORT

7. This investigation has been commissioned to review the delivery of care and support from 19th September 2021 to the day of the serious incident almost one year later.

8. Mr L presented to the hospital Emergency Department in September 2021, having been found on train tracks; he was hostile when restrained and expressed suicidal ideas. He reported having taken substances. His behaviour was noted to be chaotic at the time and an admission required due to his challenging and unpredictable presentation. He was transferred to a private healthcare provider the same day. This inpatient bed was commissioned by Mr L's local mental health trust, as a local bed was not available at the time. Mr L remained on the private hospital ward for three months until he was discharged back to his flat in his local community.

9. Mr L's behaviour over the first four weeks in hospital was described as chaotic, intermittently elated or manic, with evidence of racially abusive and sexually disinhibited behaviour and poor adherence to boundaries. Over time, he responded to medication and benefitted from having no access to illicit substances, and his behaviour settled. He was discharged with a diagnosis of '*Mental & behavioural disorders due to multiple/psychoactive drug use*' and a secondary diagnosis of '*mixed personality disorder*'. His medication had been changed from Olanzapine 10mg twice daily on admission (although he had stopped his medication at least one month prior to this admission) to 20mg once a day, this being the maximum dosage recommended by the British National Formulary. There was a brief reference in the clinical notes to the question of depot medication (injection rather than tablets) at this point, although it is not clear whether or not Mr L was asked about this option. His risk to others and self were all assessed as low.

10. Mr L was spoken to for his 72 hour follow up, after discharge, and then met with his care coordinator (CCO) four days later. He reported having just got into an argument with his family after drinking alcohol. Thereafter he was followed up on a fortnightly basis by his care coordinator and in addition, Mr L liaised regularly with the team if he required a prescription for his medication. He continued to report alcohol and cannabis use, but his mental state appeared to be stable.

11. Mr L had a planned clinical review with the CMHT psychiatrist in March 2022. The psychiatrist considered his history and his presentation to be indicative of someone who may have Attention Deficit Hyperactivity Disorder (ADHD); this was a diagnosis that had been considered when he was a child although the family had not taken the matter forward as they had not thought it severe enough. The psychiatrist prescribed Atomoxetine (a medication prescribed for ADHD) and reviewed him three weeks later. Mr L reported that the medication was assisting him and he had cut back on his cannabis and alcohol use.

12. It was in May 2022 that the situation appeared to deteriorate, with details reported by Mr L's family. A home visit by the duty team took place the following day and it was

thought that Mr L may be responding to auditory hallucinations and relapsing in terms of his mental health. They attempted to re-visit on a number of occasions over the next nine days, with no response.

13. Towards the end of May 2022, a Mental Health Act (MHA) assessment was initiated, but eventually did not go ahead as a review by Mr L's CCO concluded that his mental health had settled. The CCO then contacted Mr L's family to discuss the situation and supported them in relation to their concern that the family was at risk from him. The situation escalated again towards the end of June 2022, with concerns raised that Mr L had made further threats to the family, and he had threatened his neighbours with a hammer, demanding money from them. Mr L was then arrested for criminal damage and taken into custody.

14. A Trust psychiatrist then undertook an assessment for Mr L's detention in hospital under the MHA. The psychiatrist considered that Mr L presented with symptoms of a non-organic psychosis and noted that he had spent enough time in custody to rule out the influence of intoxication on his mental state. Mr L was admitted to the hospital acute ward in the first week of July 2022 under Section 2 of the MHA.

15. Mr L's behaviour on the ward was unpredictable and escalated over the course of a few days to the point where he was placed in seclusion. His behaviour remained challenging and culminated in him damaging property and assaulting three members of staff. Throughout the team noted no evidence of psychotic symptoms and his diagnosis was noted as primarily one of dissocial personality disorder (although his discharge summary stated that the diagnoses were both dissocial personality disorder and Mental & behavioural disorders due to multiple/psychoactive drug use). The reviewing psychiatrist considered that substance misuse and dissocial personality issues could be treated in the community and criminal behaviour should be dealt with by the police. The police were called, arrested Mr L and took him to the police station. The community team was not contacted by the ward throughout Mr L's inpatient stay.

16. The next day Mr L was given unconditional bail until his court date in three weeks time, and he returned to his home address against the advice of the community team. There were two further incidents over the next two weeks, when the police were called in response to Mr L's aggressive behaviour in the local area. Police were assured by the Trust's crisis team that Mr L remained under the care of the CMHT, and Mr L was charged with criminal damage and assault. He refused to meet with the Trust liaison and diversion service and it was recorded that there was no role for mental health services at this time due to Mr L's recent re-diagnosis of personality disorder. An attempt was made to visit him at home by the CMHT but he was not there. A few days later, the homicide took place.

KEY FINDINGS AND LEARNING POINTS

Examples of good practice

34. In our view, the CCO's liaison with Mr L's family was an example of good practice: the CCO knew the family well, communicated regularly, understood the nature and degree of the risk posed by Mr L, and provided support to the family in this regard.

Diagnosis / formulation

18. All the interviewees agreed that during the period of time under consideration, there was uncertainty regarding Mr L's diagnosis. This uncertainty should have been reflected more clearly in Mr L's clinical record. In terms of personality disorder, there was no comprehensive review available of Mr L's childhood development, offending or other problematic behaviours, or psychosexual and relationship history. It is also important to exclude other possible conditions that might present with some overlapping or similar traits. For example, there can be considerable overlap between neurodivergent traits and personality disorder.

19. However, we concluded that the CMHT's management of the possible presence of a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was appropriate and in line with good clinical practice.

20. Learning point: in the absence of diagnostic clarity, it would have been helpful for there to be a clearer integrated formulation[2] regarding the nature of Mr L's difficulties considered from a longer term viewpoint. This could have included the function that some of his more problematic behaviours served, the drivers to increasing risk, the triggers to his numerous crises, and a summary of his needs which could have informed the plan of care.

Care and support provided

21. Overall we considered the care and support provided to Mr L by both the CMHT and the ward to have been reasonable in terms of frequency, responsiveness to requests, and in terms of the knowledge and experience held by key staff members.

22. However, it would have been advisable for the CMHT to have been more responsive to Mr L's seriously escalating behaviour in the two to three months prior to the homicide, particularly in reviewing the situation during Mr L's last three weeks in the community. The electronic patient record and the evidence from interview suggest that the team were overly reliant on waiting for the outcome of the pending court case before reviewing the risk assessment and the plan of care.

[2] We use the term *formulation* throughout this report to describe an understanding of an individual's difficulties, that integrates diagnostic considerations with a broader developmental perspective and a range of psychological and social factors.

23. Learning point: the change in diagnostic emphasis from one of mental and behavioural disturbance due to multiple/psychoactive drug use to one of dissocial personality should have led to a review of Mr L's care plan. Reviewing the formulation and risk assessment – as we highlight elsewhere in this report – remain an important consideration in determining an individual's needs. We note that the Trust's Single Operating Procedures (SOP) for the CMHTs provides a pathway for Cluster 8 (individuals with non-psychotic chaotic and challenging disorders): there may have been opportunities to consider this pathway for Mr L.

Substance misuse

24. Substance misuse was recognised by all professionals as a significant factor in driving Mr L's presentation to services and the instability of his mental state. However, there was a lack of detail and depth to the assessment of his substance misuse problems which was evident from the minimal detail in the clinical records and in our interviews. We accept that any assessment was hampered by Mr L's differing accounts of which substances he was using (alcohol, crack cocaine, heroin or cannabis), when he was using and to what extent.

25. Learning point: we recognise the difficulty that mental health teams face in persuading individuals to engage with substance misuse services when they may be resistant or at least ambivalent about desisting from substance misuse. Enhancing the training, support offer, and co-working opportunities to mainstream mental health teams in this area is likely to improve the teams' confidence and skills in assessing and motivating service users to contemplate engagement with the specialist provision.

Communication within the Trust

26. Attempts should have been made by the inpatient team to include the CCO in the discharge decision-making process, particularly given the escalation in events on the ward, and the relatively unusual nature of the discharge plan (that is, a transfer to police custody). It may have been helpful to have developed a contingency plan for the situation in which Mr L was not kept in police custody following his discharge from hospital.

27. In the community, complex cases were discussed at the weekly multi-disciplinary team meeting, and we were told that Mr L was discussed in that forum on more than one occasion. We note that the clinical record does not contain any reference to these discussions. These are an important part of the clinical record which highlights shared reflections and decisions.

28. Learning point: in our view it would be beneficial to have a clearer system for prioritizing service users for discussion in the community team, with an agile and

dynamic system for rag-rating risk and care concerns that is reviewed more than once a week. These discussions should always be noted in the clinical record.

29. There is no one system in the NHS for allocating patients to a risk category or prioritisation level. Terminology includes rag-rating, zoning and traffic light systems. The definitions of categories ranging from low to high risk can differ across services and according to need. Systems tend to emphasise current presentation and needs more than historical risk and needs and are not a substitute for a comprehensive risk assessment. Nevertheless, the importance of rag-rating and regular multi-disciplinary discussion in relation to those patients who are higher risk (currently) is generally accepted. The two main reasons for this approach are:

- ***Prioritisation of cases, particularly when caseloads are high***
- ***Clear criteria to support staff in making decisions about current risks and the need for wider consultation regarding a patient.***

Risk management

30. Mr L's offending behaviour and risks were identified in the clinical record, and included a number of violent assaults of low to moderate severity, and some inappropriate sexual behaviour and harassment of females.

31. In our view, specific and current risk concerns were well managed as they occurred. However, we were not able to identify a risk assessment regarding violence to others that was comprehensive, in terms of identifying the full range of concerns that had been raised over the years, nor the underlying drivers/themes and triggers for risk. There was only one formal risk assessment completed in the electronic patient record, and this was completed during Mr L's inpatient stay in July 2022 and was focused predominantly on Mr L's recent behaviour in hospital.

32. ***Learning point: building staff skills and confidence in developing a risk formulation (rather than listing behaviours) would aid more meaningful risk assessment and management, as well as easier risk communication between teams.***

Multi-agency liaison

33. We do consider there to have been opportunities for greater liaison between the Trust services and the police and the housing officials. There was, for example, information held by the housing officer on the estate where Mr L was resident that highlighted the extent to which Mr L's behaviour was extremely intimidating and out of control at times and placed other residents at risk.

34. Learning point: Mr L did not meet the criteria for Multi-agency Public Protection Arrangements[3] (MAPPA). However, it may be helpful for the Trust to consider multi-agency liaison for those individuals who do not meet the threshold for MAPPA or MARAC but who require a coordinated multi-agency approach to managing their risk and mental health.

[3] MAPPA is a multi-agency forum for consideration of individuals with sexual and violent convictions. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance**).**

SUMMARY

35. Mr L is an individual who suffered from some neuro-developmental difficulties in early childhood. His behaviour clearly deteriorated in early adulthood as a result of intermittently heavy alcohol and illegal substance misuse. During the period of time in focus for this investigation, it seems likely that Mr L was initially compliant with his regular medication but then stopped taking it; and although he was not reliable in reporting his illegal substance misuse, there is some indication that this increased significantly around this time. Ultimately his behaviour became so disordered, and his mental state fluctuation so extreme, that he was sectioned under the Mental Health Act and admitted to hospital in July 2022.

36. There had been questions regarding the appropriate psychiatric diagnosis for Mr L for some time. There was also a lack of clarity as to the role played by medication in improving Mr L's mental health or reducing his risk. Nevertheless, Mr L was discharged from his relatively brief admission to hospital in July 2022, with diagnoses of dissocial personality disorder and Mental & behavioural disorder, multiple/psychoactive drug use.

37. The two months prior to the homicide represented an escalating picture of disturbance from Mr L. There was police involvement regarding inappropriate and aggressive behaviour in the three weeks that Mr L was in the community following his discharge from hospital. This offending/antisocial behaviour was not of a severity to warrant ongoing detention in custody or immediate admission to hospital. However, there was no change to the risk assessment or the care package provided by mental health services, in response to this escalation in behaviour.

38. We have responded to the agreed Terms of Reference and identified some learning points during the course of this investigation. In our view, Mr L was a complex individual who presented services with several significant challenges, and whose behaviour was very difficult to manage at times. We have identified three broad systemic issues that we consider important in leading to improvements in care and support in the future.

39. We have referred to potential improvements with the formulation of an individual's difficulties and with risk assessment, that could lead to improvements in the management of complex cases. This includes a greater emphasis on a longitudinal perspective, more curiosity regarding the full range of factors influencing behaviour, and risk summaries that lend themselves more easily to safety planning approaches.

40. This investigation highlights some of the problems associated with teams working independently from each other, with the potential for individuals with complex difficulties to fall outside of service criteria, or to be excluded from some service provision. Building a pathway of care that promotes joint working between teams and a shared understanding of patients will help to reduce this area of risk.

41. Although there is robust multi-agency provision for individuals who have a history of severe offending behaviour of a violent or sexual nature, there are no statutory multi-

agency services for those who do not meet this threshold. A local system by which complex individuals with multiple needs can be discussed between agencies in a consistent manner could be very helpful in enabling the agencies to improve their communication and shared management of the individual.

NEXT STEPS (Recommendations)

42. We held a recommendations meeting with the Trust on 1st December 2023, which was attended by a number of relevant service leads. We note that the areas recommended for consideration by the investigation team were in line with the Trust's existing thinking and some proposed actions to improve service design and patient safety are already planned or underway.

Below are some of the current Trust activities of relevance:

Risk summaries/formulation

- The Trust is changing its electronic patient record, which will allow it to develop a system for recording easily accessible risk summaries and improved safety planning.
- The Trust is already planning a Trust-wide training programme in 2024 in relation to risk formulation and safety planning.
- The Trust plans to introduce daily huddles in the community teams, with a clear escalation and stepped care model that can respond to the dynamic nature of risk in the caseloads.

Teams working independently from each other

- The Community Transformation Framework action plan addresses some of the concerns in this area. The Trust is moving towards smaller team groupings within the community services, and this will foster closer multi-disciplinary team working across one or two Primary Care Networks with a stronger pathway of care. A model of 'warm' handovers between primary care and the community teams will improve the communication and management of risk.
- There is an aspiration to build stronger links between the community pathways of care and the three acute inpatient settings in the Trust. Currently PIA (Purposeful Inpatient Admission) aims to make inpatient admissions purposeful and the model includes expectations of greater collaboration with the community teams, both pre and post discharge.

Improving confidence and skills in working with substance misuse

- The Trust is implementing motivational interviewing training trustwide in 2024.
- With the change in substance misuse provider (from the Trust to a voluntary sector provider), the Local Authority has commissioned a dual diagnosis team from the new provider.
- The Trust recognises that there remains a need to provide support and expertise to mental health professionals where a service user with dual diagnosis declines the

offer of a specialist substance misuse service. This is likely to be a particular need for professionals working with individuals with non-opiate based substance misuse.

Multi-agency forum for managing complex individuals with behaviour that is challenging but does not meet the threshold for statutory multi-agency arrangements.

- The Trust's community transformation plan (see above) will assist their staff in developing a greater knowledge of and connection with the range of services in their area.
- The Round Table learning event identified relevant work in this area which needs to be developed to ensure practitioners have clear guidance as to what is available and to whom and where they should focus their networking with other agencies.
- The Trust will need support from the Integrated Care Board, in order to work collaboratively with the local Safeguarding Executive Board to develop this multi-agency work.

43. The Trust will need to develop an action plan that is written in SMART[4] format, drawing on all the above points, and including the following:
    - Relevant actions that are already completed since the serious incident, with evidence of the necessary impact.
    - Relevant actions that are already underway, with timelines for completion.
    - Relevant actions are that are planned but not yet implemented, with timelines.
    - Additional actions arising from our recommendations, not covered by any of the above.

[4] Actions that are specific, measurable, achievable, realistic and timely defined.

APPENDIX I: TERMS OF REFERENCE

Psychological Approaches

Serious Incident Response

- Consider and evaluate the Trust's response following the incident to identify and implement any immediate learning.

Care and treatment /Contact with services

- Compile a detailed chronology of NHS contacts and service access for Mr L, for the period under review, focusing on the provision of mental health care.

- Undertake a critical review and analysis of the mental healthcare and support needs of Mr L; assessing whether these were fully recognised and understood by professionals.

- Comment on whether appropriate care, treatment and support services were offered, identifying areas of good practice and areas of learning.

    - Consider and outline whether there were any organisational or operational barriers to the effective support, assessment, and risk management for Mr L, and how NHS services should respond effectively if similar circumstances occur in the future.

    - To avoid hindsight bias, seek to understand practice from the viewpoint of the individuals and organisations involved at the time, making use of relevant research and case evidence to inform the findings.

Risk Assessment, Care Planning and Safeguarding

- Consider the appropriateness and effectiveness of decision-making processes, including the policies, assessments and tools used to inform decisions, with specific reference to care and treatment pathways.

- Examine the effectiveness of care planning, including whether Mr L, and his family were sufficiently and appropriately involved.

- Review the adequacy of the assessment and management of risk for Mr L, including

    - during periods of behavioural change,

    - the risk he posed to others, specifically in relation to risk of violence,
    - non-compliance with medication,
    - whether risk-related information was communicated, escalated and acted upon appropriately and effectively across services and with external agencies (such as police and housing).

- Consider and comment on any issues relating to safeguarding, including any concerns raised with professionals by Mr L's family, and determine if these were adequately assessed/escalated appropriately.

- Identify whether professionals had the relevant training or knowledge to understand Mr L's health and social needs and identified risks, including those relating to substance misuse and its impact on mental health, and his diagnosis of ADHD.

- Consider whether the service responded effectively following consideration to a diagnosis of ADHD in March 2022, and the ongoing appropriateness of care planning/risk management.

- Determine whether there were any missed opportunities to engage other services and/or agencies to provide additional support Mr L.

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

APPENDIX II: 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.

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