Psychological Approaches

SERIOUS INCIDENT INVESTIGATION EXECUTIVE SUMMARY

THE CARE AND TREATMENT OF Mr P

December 2023

Table of Contents

INTRODUCTION

1. Mr P is convicted of murdering Ms B, in a violent attack. Police investigating the incident believe that Mr P and Ms B were in a relationship, although the exact nature of the relationship is not clearly understood.

2. The external investigation by Psychological Approaches into the care and treatment of Mr P was commissioned in January 2023 by NHS England. A Domestic Homicide Review (DHR) was also commissioned by the local Community Safety Partnership. We would like to thank the Trust Patient Safety 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.

3. 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.

BACKGROUND

4. During the focus period[1], Mr P received Care Co-ordination from the Community Mental Health Team (CMHT), and input from the Adult Liaison Psychiatry Service (ALPS), Intensive Support Service (ISS), Crisis Service, Crisis Assessment Unit (as an inpatient) the Inpatient Centre (as an inpatient), and Street Triage.

5. Mr P first came into contact with adult community mental health services in 2011 when he was age 20 years. His first psychiatric admission was in 2013. Records indicate that, at this point in time, Asperger's syndrome/autism was viewed as the primary[2] problem.

6. By 2014, Mr P was subject to the Care Programme Approach (CPA)[3], which is a framework for providing mental health care in the community to those with more severe mental health needs. There is reference in his clinical records to an

[1] In line with the DHR terms of reference, the focus period for this report is April 2021 to June 2022 though earlier events are referenced where they are required for clarity or have significant bearing on more recent events.

[2] The term 'primary' is used here to indicate the most significant diagnosis known at this point in time. This may have been a preliminary view. It is common once people enter assessment/treatment for the diagnostic picture to change/develop.

[3] Care for people with mental health problems (Care Programme Approach) - Social care and support guide - NHS (www.nhs.uk).

allegation of rape from a fellow patient and that Mr P was in a relationship with a fellow patient. It is not certain (as names are not recorded) but is indicated in the clinical records that these two concerns relate to the same woman. The woman was appropriately supported by the clinical team in relation to the rape allegation, and supported to contact the police. The police took no further action. The police could provide no information on why no further action was taken.

7. In August 2014, whilst an inpatient, it was noted in the clinical record that Mr P arrived on the ward acutely psychotic and that he had received a number of different possible diagnoses previously, including personality disorder, drug-induced psychosis and Asperger's syndrome. The clinical team agreed that it was likely he had a personality disorder, but also requested that a referral be made to the Autism Diagnostic Service. This was subsequently rejected by Mr P, and no assessment was made. There was no record of any exploration with Mr P as to why he did not want the referral, although it is recorded the benefits were explained. On enquiry with the service, we found they held no record of Mr P having ever been referred to them. There is also a reference at this time to a referral for assessment of ADHD, but no outcome is recorded. It appears that no referral was made; however, we were unable to determine the reason.

8. In 2015, records began to mention Mr P experiencing delusional symptoms and expressing suicidal and homicidal thoughts. He was prescribed Olanzapine, an antipsychotic medication, during a brief hospital admission, though he did not appear to take it regularly[4].

9. In 2016, Mr P was again offered but rejected a referral for assessment of autism/Asperger's syndrome. Again, there was no record of any exploration with Mr P as to why he did not want the referral, although it is recorded the benefits were explained. His diagnosis was now recorded as personality disorder, and in March 2016, following discharge from a hospital admission, a referral was made

[4] Antipsychotic medication can only be given against an individual's wishes in very specific circumstances using the relevant legal authority none of which were relevant at this time. E.g.

- admitted to hospital under some sections of the Mental Health Act. This is sometimes called being sectioned
- discharged from hospital under certain sections of the Mental Health Act, and you are being treated on a community treatment order (CTO)
- assessed under the Mental Capacity Act as not having capacity to consent to treatment. You may be given medical treatment if it is assessed to be in your best interests.

to the PD Network[5]. The PD Network responded by saying that he should focus on addressing his substance misuse at this point in time.

10. In 2016, Mr P was convicted of Grievous Bodily Harm (GBH) on a 16-year-old girl. Little detail was recorded about the offence in his clinical records. He was imprisoned, where his diagnosis was noted as emotionally unstable personality disorder. He was prescribed olanzapine again and sodium valproate, a mood stabiliser which Mr P said at the time, helped with his agitation and suicidal behaviour.

11. In July 2017, Mr P had his first psychiatric appointment following his release from prison in April. He was on enhanced CPA[6]. Records note he presented with some signs of psychosis with affective features. He was prescribed olanzapine and sodium valproate, though reluctant to take it. He described smoking cannabis daily. The GBH was discussed. Mr P said he felt bad about it, but there is no record of motivation for, or circumstances of the assault in the clinical record. As we were unable to interview the relevant clinician, we could not determine why this detail was not recorded.

12. In November 2019, Mr P was admitted to hospital and subsequently discharged with a diagnosis of psychosis, dissocial personality disorder and alcohol and substance misuse. During this admission, it was noted that he should not be seen by lone females due to historic risk (GBH conviction) and that he was no longer seeing the female he had previously met as an inpatient and that Mr P alleged she had assaulted him. Mr P did not wish to report this alleged assault.

13. In January 2020, during an inpatient admission, the Trust made a referral to the local Multi-Agency Risk Assessment Conference (MARAC)[7]. A flag was kept on all multi-agency records, for a period of twelve months, regarding the risk Mr P posed and that it had been discussed at MARAC, and to notify the MARAC Co-ordinator (mental health provider) of any repeat incidents.

14. On the 13th of January 2020, a mental health team multi-professional meeting took place between the CMHT and ISS teams to review Mr P's care. They clearly identified that little was known about his personal history and that they needed to obtain more detailed information to develop a working formulation of

[5] The PD Network offers psychologically informed therapy in the form of both group and individual work. They also offer a consultation service for CMHT staff to help them work more effectively with people with a diagnosis of PD

[6] CPA is no longer in use but at the time people on enhanced CPA generally had more complex needs than those on standard CPA.

[7] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. MARAC FAQs General FINAL.pdf (safelives.org.uk)

his difficulties and provide a rationale for referral to ADHD service or PD Network.

They agreed to:

- Review his medication. olanzapine seems helpful but will he take it?
- Obtain a more comprehensive history to clarify diagnosis.
- Risk management through escalation to ISS or inpatient admission with clear goals.
- Consider respite accommodation.
- Further meeting in a few weeks.

15. On the 17th January 2020 Mr P's GP confirmed that there was no record of him ever having been diagnosed with Asperger's as a child or as an adult. This includes confirmation from CAMHS in 2007 (age 16) that they have no record of a diagnosis. We understand from Mr P and his family that a diagnosis was made through Mr P's school with health input. We are unable to explain why the GP was apparently not made aware of this.

16. In September 2020, Mr P was admitted to hospital informally following a deliberate overdose. He was finding the COVID-19 pandemic and living alone stressful, using drugs and alcohol, but recognised that these made him paranoid. During this admission, he frequently went on leave and the MARAC was updated to support this. Following new concerns a further MARAC took place. At discharge, Mr P was noted as planning to stay off alcohol and not experiencing psychotic symptoms. He was discharged to his home address, although it was recorded that he intended to go elsewhere.

17. In May 2021, age 30, there were a number of apparent suicide attempts by Mr P. He had a brief admission to the crisis assessment unit and was subsequently followed up by the CMHT. His diagnosis is recorded as Dissocial Personality Disorder and History of drug-induced psychosis.

18. By September 2021, he appeared to be doing well, engaging in community activities with Mind. The CMHT begin to plan discharge. In a CPA meeting on the 10th September, it was noted that Mr P was in a relationship. The forename of his 'girlfriend' was recorded, which is the same as that of Ms B. This was information provided by Mr P at a CPA meeting and not verified by anyone else. It appears that clinicians did not recognise the importance of gathering information about this 'relationship' given Mr P's history. After failing to attend two planned discharge meetings, Mr P was discharged back to the care of his GP in his absence in December 2021.

19. In January 2022, Mr P presented to the Crisis service. It was noted he was experiencing several external stressors, including a relationship breakdown and was admitted to hospital informally. He was discharged on the 24th of January

with follow-up support from ISS daily. At discharge, it was noted that he was in a relationship with someone who also has mental health problems and that he struggles to support her. It is unclear in the record whether this refers to Ms B or someone else. Again, it appears that clinicians did not recognise the importance of gathering information about this 'relationship', given Mr P's history.

20. Two days later, on the 26th January, Mr P is doing well, and he wishes to reduce contacts with ISS as they frustrate him. This is agreed, and an appointment set for the 29th January. However, on the 27th January, Mr P contacted ISS, feeling suicidal. Police records show Mr P also contacted the police, and when they attended his home, he was found to be drunk. He became aggressive towards the police and was arrested (subsequently convicted of assault and given a conditional discharge). He was assessed in custody by ISS, who concluded his risks had not changed and he could continue under their care in the community.

21. Subsequently, Mr P was released to the care of ISS. When asked how he had been feeling, Mr P mentioned an unnamed woman that he was currently involved with, stating she makes him want to kill himself. Mr P added that she was not an ex but needed to be.

22. Mr P was followed up by ISS until the 13th of February, when he was discharged back to the CMHT. During this period, he reported ending his relationship because his partner had *'smacked him about the head'*. It is unclear in the record whether this refers to Ms B or someone else. Again, it appears that clinicians did not recognise the importance of gathering information about this 'relationship', given Mr P's history.

23. On the 28th of February 2022 Mr P attended hospital, reporting he had been assaulted by his 'girlfriend' and had concussion. No obvious signs or injury were recorded by the hospital, and a DASH assessment was not undertaken by them. It is also recorded that Mr P did not want to report the alleged assault to the police. However, police records indicate that the incident was reported to them, they noted slight injury and that Mr P refused to name his assailant or engage with the support offered.

24. Over subsequent days, there were several presentations at A&E with suicidal thoughts. He had not been seen by the CMHT since discharge from ISS due to staff sickness and a joint review with the CMHT and ISS was arranged for the 6th of March. There is no record that ISS had risk assessed their inability to provide care due to sickness, though at interview, they told us this was their usual practice.

25. Following that joint review, emergency respite was arranged for Mr P at supported accommodation for people with mental health needs. However, this

could only be temporary, and Mr P was discharged back to his home with follow-up from ISS on the 15th March[8].

26. On the 23rd March, Mr P was transferred back to the care of the CMHT with a new Care Coordinator identified. Efforts were made to engage Mr P with community activities and to support him in gaining alternative accommodation, which had been a long-term wish. There is no indication in the care plan as to how frequently the CMHT intended to see Mr P.

27. On the 20th of April, the mental health services SPA were contacted, asking for Mr P to return to the crisis accommodation as 'something had happened' which made it unsafe for him to return home. The risks at the time were identified as overdose or risk of death by misadventure. Risk to his 'ex-girlfriend' was not considered. The crisis placement was not felt appropriate, and contact with the care coordinator was encouraged. It is understood that at this point in time, Mr P was prescribed antipsychotic medication but was not taking it.

28. Attempts were made by the care coordinator to contact Mr P on the 22nd April and 3rd May to no avail. On the 13th May the care coordinator met with him. Mr P was struggling with low mood, feeling unsafe related to a woman he had had a relationship with. A medication review was offered but Mr P did not think this would help. He felt he needed to move house and keep himself occupied. This was the last contact between mental health services and Mr P prior to the homicide[9].

29. On the 16th May, the care coordinator was making arrangements for Mr P to be put in touch with the Community Support Team (CST) to support community activities.

30. At this time, further information was made available to the care coordinator regarding potential risk to/from others. There is no evidence that a MARAC was considered in light of this information.

31. The following day a community mental health team MDT meeting took place. The records summarised that Mr P was in crisis a lot, autism diagnosis identified, no medication at time. Wants to return home but feels unable due to a complaint to the police by a woman. The agreed plan was to continue the referral to CST for a male worker and for the care coordinator to discuss a referral for an autism assessment with Mr P. An appointment was subsequently made for the CST worker and his care coordinator to meet with Mr P on the 10th

[8] At this point in time the respite was solely around meeting Mr P's mental health needs. It was not related to his close proximity to Ms B or any concerns he expressed about that relationship.
[9] On 3rd May a warrant was out for Mr P's arrest. Subsequently an injunction was in place to prevent contact with Ms B. Mental health services were not contacted by WYP.

June. The CMHT did not contact the police to gain further information in relation to this disclosure of allegations against Mr P.

32. The CMHT were subsequently notified by the police custody mental health liaison and diversion team that Mr P was in custody, charged with murder.

KEY FINDINGS

Care and treatment

Trust response to Incident

33. Given that NHSE were commissioning an independent investigation, the NHS Trust did not undertake a local investigation into this incident. They did collate a timeline of events which gathered together information from clinical records between September 2021 and June 2022. No formal analysis of that information took place, and no statements were collected from the staff involved.

34. The process for commissioning an independent mental health homicide review is time-consuming, and six months passed between the homicide and the commencement of this investigation. Whilst this investigation did not pick up any learning which should have led to immediate changes in practice by the Trust, it is possible that if a similar approach is taken with other serious incidents, opportunities to learn lessons earlier could be missed.

35. We also found that with the passage of time between incident and investigation a number of key staff moved on from the Trust and so were not available for us to interview and, because statements had not been collected at the time, we were unable to access the reflections/thoughts of those staff which has left gaps in the information available to this report.

36. In 2023, the NHS Trust completed a management report for the DHR, which focused on information pertaining only to domestic abuse. This report identified specific learning and made recommendations for change.

Diagnosis and Needs

37. In Mr P's adult mental health records, the following diagnoses are referred to: Asperger's syndrome, autism, ADHD, mental & behavioural disorder, drug-induced psychosis, emotionally unstable personality disorder, psychosis with affective features, alcohol & substance misuse, and dissocial personality disorder. There are also descriptions of paranoid and psychotic beliefs. A diagnosis of depression in childhood is also mentioned. The record is often unclear whether these are diagnoses which are being considered or confirmed.

Diagnoses change frequently, and there is no clarity on a longer-term position or how each possible diagnosis is connected with his presentation, leading to an overall lack of diagnostic clarity.

38. In terms of personality disorder (PD), there was no comprehensive review available of Mr P's childhood development, offending or other problematic behaviours, or psychosexual and relationship history. It is particularly important to establish conduct disorder (behavioural difficulties) in childhood if a diagnosis of dissocial personality disorder is to be made. It is also important to exclude other possible conditions that might present with some overlapping or similar traits. For example, there is considerable overlap between ADHD, Autism and PD.

39. The possibility that Mr P had autism, be it Asperger's syndrome or another form, is regularly revisited in the clinical records. Sometimes being referred to as his primary problem, and a formal diagnosis and at others as a query. We understand that he was diagnosed at school around age 11 or 14 years, and Mr P reported he had been diagnosed with Asperger's syndrome following a short stay in the local acute hospital. This investigation found that Mr P's GP and Child & Adolescent Mental Health Services (CAMHS) had no record of him ever being formally diagnosed with autism.

40. The lack of a formal diagnosis does not necessarily mean Mr P did not have autism. There was clear evidence that in 2014 and 2016, mental health teams made efforts to encourage Mr P towards undergoing a formal assessment, but he refused. There is nothing recorded to indicate why Mr P did not want an autism assessment. It was good practice that the crisis team in 2020 contacted the GP seeking clarification on a diagnosis. Although we spoke to Mr P, it remains unclear why, when offered, he rejected referrals for formal assessment.

41. In the absence of diagnostic clarity, it would have been helpful for there to be a clearer integrated formulation[10] regarding the nature of Mr P's difficulties considered from a longer-term viewpoint and informed by a more expansive developmental history. This could have included the function that some of his more problematic behaviours served, and the drivers to increasing risk as well as the triggers to his numerous crises. This formulation may also have assisted teams in making sense of Mr P's suicidal behaviour, as well as helping them to consider whether there was simply a deliberate and conscious motivation to his behaviour (that is, a desire to be admitted to hospital) or as was more likely a complex set of underlying psychological issues involved.

[10] 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.

42. With complex cases, there is often a lack of diagnostic clarity, or differences of view regarding diagnosis. It is clear from the Trust's electronic patient record that they use the HoNOS[11] system for considering an appropriate patient care plan. This system emphasises patient need rather than patient diagnosis, which supports a formulation-based approach to considering needs.

43. In January 2020 a joint MDT meeting between ISS and the CMHT clearly recognised the need to gather more detailed information on Mr P's background in order to develop a formulation of his needs but this does not appear to have been followed up and no outcome is recorded other than the clarification from the GP on lack of a formal diagnosis of autism. No referral to the PD Network or ADHD services is recorded. We were unable to determine why the follow-up didn't take place but noted that the COVID-19 pandemic commenced shortly afterwards, which led services to focus on meeting immediate needs only for a significant time.

44. A formal diagnosis of autism could have supported diagnostic clarity and understanding of some of Mr P's behaviours and potentially given access to additional support. However, as already discussed in paragraph 39, there was clear evidence in 2016 that the potential benefits of a formal diagnosis had been clearly explained to Mr P, and he did not wish to proceed. We also note that in May 2022, his care coordinator was intending to revisit the possibility of formal diagnosis with Mr P and that he still had the opportunity to access the Autism Hub but had not previously found it useful.

Substance Misuse

45. The NICE guideline on 'Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings CG120[12] sets out how secondary mental health services should assess and record the use of illicit substances and their effects on people. Substance misuse was recognised by all professionals as a significant factor in driving both Mr P'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.

46. The care plan in relation to substance misuse appeared to consist mainly of encouragement to engage with substance misuse services which was often but not always rejected by Mr P. At interview we were told that there are opportunities for CMHT's to seek advice from substance misuse teams on

[11] HoNOS (Health of the National Outcome Scales) measures the health and social functioning of people with severe mental illness.
[12] Recommendations | Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings | Guidance | NICE

working with people who are difficult to engage but that this was not thought necessary in Mr P's case. We believe that support from specialist services could have assisted staff in motivating Mr P to address the issues and in formulating risk reduction strategies.

47. 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.

Medication

48. Given the already described lack of diagnostic clarity, it is unsurprising that there was also a lack of clarity about the role of prescribed medication. Mr P was variously prescribed antipsychotic medication, usually olanzapine, sometimes augmented with a mood stabiliser such as sodium valproate. In addition, he was occasionally prescribed benzodiazepines to assist with anxiety and medication to help him sleep.

49. NICE guidance on personality disorder and antipsychotics is clear that such medication is not a treatment for personality disorder but can be used to treat 'comorbid conditions' such as the persistent paranoia apparently experienced by Mr P.

50. The views of Mr P fluctuated in relation to the usefulness of antipsychotic medication. Mr P was also very inconsistent in taking medication in the community so it is difficult to say definitively if it was helpful. However, on balance, it was more often recorded as helpful and associated with periods of mental stability than not and was frequently recorded as a driver for Mr P to seek admission to hospital in order to be given olanzapine consistently. At times of crisis, the ISS team also placed an emphasis on taking antipsychotic medication regularly to maintain/regain stability. In this context we would have expected to see consistent prescribing and taking of antipsychotic medication feature more strongly in the ongoing care plan with the CMHT. Though we recognise that even with consistent care planning Mr P's ambivalence to taking medication may have remained.

Suicidality

51. Mr P frequently expressed suicidal thoughts, and many of his mental health crises culminated in suicidal behaviour, taking overdoses etc. We found that staff worked hard to gain Mr P's trust in this regard, and he usually reached out

to services for help. Staff recognised that this reduced but did not eradicate the risk. Whilst not all staff recognised the complex drivers of Mr P's suicidal behaviour, some saw it solely as instrumental to gaining admission to hospital, we saw frequent evidence of flexibility in the care plan being used to keep Mr P safe.

Care Planning

52. Although clear, consistent, long-term care planning was hampered by the lack of diagnostic clarity and formulation of needs, there were a number of positive aspects to the care plan and delivery.

    - Mr P was routinely involved in the planning of his care.
    - Hospital admissions were short-term and used with the clear goal of managing risk during a crisis, in line with NICE guidance on personality disorder.
    - The positive impact of community activity was well recognised, and efforts were consistently made to engage Mr P in such.
    - Despite the lack of a formal diagnosis, some autistic traits, such as sensory sensitivity, were recognised and incorporated into care.

53. We found that both inpatient and community teams recognised that Mr P found transitions difficult and demonstrated sensitivity to this in their discharge and transfer planning. They were clear and consistent in their message when transitions were approaching and gave him additional time and support to adjust.

54. The Trust follows the NHS England position statement in relation to the Care Programme Approach[13]. This approach shifts the focus from generic care co-ordination to a personalised and meaningful intervention-based care with a named key worker, improved support for carers and a more accessible, responsive, and flexible system. Of the five criteria, the care for Mr P included:

    - A named key worker, with a multi-disciplinary team that was accessed, for example, in terms of reviewing the care plan.
    - Responsivity and flexibility to a reasonable extent in relation to Mr P's needs.
    - An approach to care that was agreed with Mr P (given his inconsistent motivation for care and support from mental health services).

55. Although some unspecified counselling/therapy had been offered by a non-health organisation in the past, during the focus period, there was a limited offer

[13] https://www.england.nhs.uk/wp-content/uploads/2021/07/B0526-care-programme-approach-position-statement-v2.pdf

of meaningful intervention-based care for Mr P, whether this related to his psychological and personality difficulties or his substance misuse problems. However, we acknowledge that it is likely that Mr P's uncertain motivation for support meant that such interventions may not have been successful.

56. The staff we spoke to felt that the pathway for the care and treatment of people with personality disorders was unclear and mainly focused on crisis resolution rather than treatment and long-term support.

57. In the absence of a formal diagnosis, what should have happened is that clinicians should have worked with Mr P and his family to incorporate his specific needs in relation to his apparently neurodivergent[14] presentation into his overall care plan. There was some evidence of this when his care coordinator discussed sensory sensitivity with him, and when in January 2022, Asperger's[15] was incorporated into his police safety plan in order to reduce the possibility of violence when in contact with the police and flagged on the police system. However, more could have been done, including seeking support from specialist services in relation to care planning for Mr P or training for staff.

Barriers to Effective Care

58. In early 2020, during a multi-disciplinary review of his care, the question was posed as to whether Mr P was able to live independently. In our view this was a very pertinent question and one which may have placed some of his behaviours in a clearer context. At interview, some professionals in ISS/CMHT told us that they saw a reluctance/inability to live alone as a prominent and ongoing feature in Mr P's presentation. However, they told us there was no long-term residential supported accommodation available that could meet his complex needs.

59. On the 13th February 2022, when Mr P was discharged by ISS back to the care of the CMHT, he was not seen as planned due to staff sickness. Whilst this was not ideal and, potentially, precipitated further presentations at A&E, it was for a relatively short period and by the 6th March, the situation was resolved by a joint review with both teams. After this time, Mr P was allocated a new care coordinator and was seen more regularly going forward. There was, however, no clear indication in the care plan on how regularly the team planned to see Mr P.

[14] Neurodivergent can be used to describe someone who has a neurodiverse condition, for example, autism. This means their brain processes information differently. An autistic young person could identify as neurodivergent but so could someone who has a diagnosis of ADHD or Dyslexia, for example. Terminology_Guide_EC_-formatted (autismeducationtrust.org.uk)

[15] In the non – clinical context of the police alert system it is acceptable to use the terms Asperger's/autism more loosely as they are likely to be recognised by officers as indicating additional health/support and communication needs.

60. At interview staff told us there was no specific training on offer for working with people who have autism, nor were there clear links to specific organisations that could support mental health staff in working with autism. There was awareness of organisations that provided support to people with autism, which could still be accessed without a formal diagnosis.

61. In relation to personality disorder, staff also told us that there was a lack of training provision; however, they felt better prepared for working with this group due to previous experience.

Interagency working and communication

Safeguarding Adults

62. The NHS Trust Safeguarding Adults procedure instructs staff to inform their manager that a person has been abused, and the Domestic Violence and Abuse Procedure directs staff to offer a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) checklist, and support the victim to contact domestic abuse services, as well as discussing a Safety Plan. Guidance is given to refer to the Trust Safeguarding policy, as well as seeking advice from the safeguarding team.

63. We found positive examples of multi-agency working. In January 2020 when a MARAC meeting was held after a referral from the NHS Trust. A further MARAC took place in September 2020 following renewed concerns from the NHS Trust. In May 2022, the care coordinator acknowledged the two previous MARAC plans and a DASH checklist was needed, but the DASH was not completed.

64. In May 2021, when he was an inpatient, staff appropriately contacted the Trust safeguarding team for advice as Mr P was spending a lot of time with another female service user. The female service user's team had been informed of this potential risk.

65. There was a lack of accuracy in the documentation, in relation to the identity of the woman/girlfriend/partner/ex-partner. Staff did not always appear to ask for a name, in order to seek clarity whether it was the same person or different people. There is also mention of people in the plural, which could include Ms B, but again, there is no evidence that clarity was sought as to who these people are.

66. There is no evidence that health staff considered safeguarding and completing a DASH in relation to Mr P when he reported being assaulted by his partner. This should have involved a discussion with Mr P about the assault and any

other domestic abuse risks to him or even between him and his partner. There should also have been further exploration when staff became aware in May 2022, that 'the woman' alleged to have assaulted him, lived nearby. This is the first time a location for the 'woman' is mentioned. Whilst we acknowledge that Mr P may have been reluctant to divulge information, it is possible that some of the context of this conflict could have been elicited. Was it one assault or several? What led up to it etc? If information is not shared, it is important that staff record when they have attempted to gain information.

67. The same applies to when staff were made aware on 16th May 2022, of a complaint about him in relation to stalking and damage to property. More information and context was needed here. It is also the first time in the documentation that there is information indicating that the woman is the alleged victim of Mr P's actions. There is no documentation to indicate that the Safeguarding team was contacted about this for advice. We now know from the DHR review that in fact, Mr P had been arrested in May following allegations of rape, stalking and criminal damage in relation to Ms B and that a condition of his bail was that he should not contact her. Police did not involve or consult with mental health services whilst Mr P was in their custody, despite knowing he had significant mental health issues and was known to services[16].

Safeguarding Children

68. A multi-agency strategy meeting was convened by Children's Social Work Services on the 29th April because of concerns that children with whom Mr P had contact may be at risk from him through being exposed to his violence towards others. The police, primary care, health and social care services were invited and attended. Mental health services are not routinely invited to such meetings, and they were not invited to this meeting despite the police being aware that Mr P was known to mental health services and had significant mental health needs.

Carers Support

69. In September 2020, the MARAC plan was amended to support new leave arrangements and a safety plan was put in place. This raises concerns that the potential risks of this new leave arrangement were not properly considered. We believe the arrangements were not appropriate. Alternative leave arrangements should have been sought rather than amending the MARAC plan.

[16] Please note that it is beyond the scope of this investigation to comment further on the actions of other agencies, such as the police. There is potential for this matter to be considered as one component of a wider multi-agency discussion for the Trust action plan.

70. Although the panel felt that the level of contact from the CMHT to Mr P's family was good, we feel more exploration and discussion to understand what could have helped Mr P's carers to access support in a way which met their individual needs and was accessible to them. Discussing with the Trust safeguarding team would have been valuable in addressing any risks and providing support to the staff to work effectively and safely with Mr P's family.

Risk Assessment

71. Mr P provided pieces of information to different staff in different services, in relation to his girlfriend/ex-girlfriend. The completion of this report highlights an emerging pattern of risks and concerns which needed to be considered at the time. Handovers, referrals, MDT reviews and joint reviews between services were key opportunities for checking the documentation available and if there are key risk themes. There is no evidence that this happened effectively.

72. The previous offending, MARACs, and concerns in relation to relationships with women, which were known to health staff, could have been an indication that Mr P posed a risk to other females. Combined with documented, historical risks. Disclosures from Mr P indicated conflict in the relationship with his 'girlfriend', also, which, given Mr P's illicit substance and alcohol use, as well as his poor coping, mental health and known anger issues, could, in its entirety, increase the risks between Mr P and his 'girlfriend'. The context of the relationship should have been considered; the relationship was breaking down, which could pose a stressor to Mr P's well-being and impact upon his behaviour towards this woman. This should be considered in the context of potential domestic abuse in a relationship as part of applying informed professional curiosity.

73. We found that staff were aware of historical risks, and whilst they did consider the implications of these risks for female staff working with him and other patients, they did not do so for other people in Mr P's life in the community, who he talked about, such as his frequent mention of his girlfriend and suggested conflict in the relationship, and that he was spending time with children. There should have been a more explicit appraisal and understanding of previous risk history and risks, and how these may link with current contacts.

74. Regarding the ending of the relationship with Mr P's 'girlfriend' - did Mr P end it or his girlfriend? What was the context? Notes indicate a risk history of thoughts of 'killing others' if not himself, and that his 'blood boils' around other people. The risk was assessed regarding no direct threats but given this previous statement and ongoing difficulties with managing emotions, this is worth considering in the context of Mr P's apparent relationship difficulties and how he may manage conflict here, also given the two previous MARAC plans.

75. Where potential risks were recognised for female staff, they were clearly recorded in the risk assessments and care plans. Though safety plans were not always implemented. We found examples of female staff seeing Mr P alone rather than as indicated in pairs, because of staff shortages.

76. Staff did not act to inform Ms B or those supporting her of potential risks because they had not identified her as a specific person at risk and because they had not translated the relevance of historical risk onto his current relationship.

77. We found that where risks were identified, Mr P and his family were incorporated into the care plan. It was the effectiveness of identifying risks and translating them into new contexts that limited the care planning process in relation to risk.

SUMMARY OF FINDINGS

78. This review has limitations because we have been unable to speak to key clinicians caring for Mr P at the time of the homicide. We were able to speak with Mr P and his family.

79. Mr P presented with a complex set of mental health symptoms compounded by an apparently neurodivergent presentation and drug and alcohol use. We found an absence of diagnostic clarity, not unusual to such cases. It would have been helpful for there to be a clearer integrated formulation regarding the nature of Mr P's difficulties considered from a longer-term viewpoint and based on his specific needs. This could have included the function that some of his more problematic behaviours served, and the drivers for them and any associated increases in risk. This was clearly recognised in early 2020 but not apparently actioned.

80. We found that emphasis was placed on the need for a formal diagnosis of Asperger's/autism. Whilst this could have been helpful, it was more important to incorporate into his care plan Mr P's specific needs in relation to his apparently neurodivergent presentation. We found staff were not well equipped to do this and they did not seek support from specialist services to enable them to meet Mr P's needs.

81. There was some evidence that taking antipsychotic medication consistently was associated with periods of stability in Mr P's presentation. We found that the CMHT care plan did not always support taking medication consistently.

82. Substance misuse was recognised by all professionals as a significant factor in the instability of Mr P's mental state and associated with increased violence and suicidality. We recognise the difficulty that mental health teams face in

persuading individuals to engage with substance misuse services. Developing a minimum level of competence in history taking and motivational interviewing and enhancing the training, support offer, skill mix, and co-working opportunities for 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.

83. Staff felt that the pathway for care and treatment of people with personality disorder was unclear and mainly focused on crisis resolution rather than treatment and long-term support.

84. We found some positive examples of multi-agency working in relation to safeguarding, but DASH assessments were not always offered, and there was a lack of detail when recording relationships and potential safeguarding issues.

85. Whilst the level of input from the CMHT was good, staff did not always tailor the support for Mr P's carers in a way which made it accessible to them and met their individual needs.

86. There were missed opportunities for other agencies to share significant risk information with the CMHT in May 2022. However, the CMHT had some awareness of Mr P's current 'relationship difficulties' and there should have been a more explicit appraisal and understanding of previous risk history and risks, and how these may have linked with current contacts.

Best Practice

87. Incorporating the police into a safety plan relating to Mr P's individual needs was a positive example of cross-agency communication to keep people safe.

88. We were impressed to see joint visits and Joint MDT meetings with ISS and the CMHT, which we are sure contribute positively to continuity of care.

89. It was good to see that teams recognised Mr P's difficulty with transitions and worked flexibly to support him with this during significant changes in his care.

90. The positive impact of community activity was well recognised, and efforts were consistently made to engage Mr P. With positive examples of joint working with other organisations.

91. It was good practice that the crisis team in 2020 contacted the GP seeking clarification on a diagnosis.

92. In previous years, working with the Trust's safeguarding team and a female service user's clinical team to keep her safe when safeguarding concerns arose on an inpatient ward was an example of good practice.

Opportunities for Learning

93. In the absence of a full local investigation, the Trust would benefit from exploring ways in which they can collate the views of those involved in serious incidents as soon as possible and how early lessons can be learned and acted upon.

94. The Trust should explore ways in which they can maintain safe working practices in the face of staffing pressures.

95. The Trust should work to enhance good standards of record keeping, which not only detail pertinent information to safeguarding, risk and care planning but also to record where information has been sought but refused.

Recommendations

96. Areas for recommendations which have been agreed jointly with the Trust. The Trust will develop a full action plan.

- Developing staff skills in the recognition and management of domestic abuse.
- Increase awareness and knowledge of the need for professional curiosity, gathering detailed information and using historical risk information to review current risk situations.
- Incorporate the use of integrated formulation to develop needs-based care plans.
- Enhancing the competency, training, support offer, skills mix and, co-working opportunities for mainstream mental health teams in assessing and motivating service users to contemplate change and if appropriate, engagement with the specialist substance misuse provision.
- Increasing awareness of pathways of care and treatment for individuals with Personality Disorder.
- Enhancing the training, support offer, and co-working opportunities to mainstream mental health teams working with those with neurodivergent presentations.
- Developing long-term care pathways which support rehabilitation/independent living needs for all people with complex long-term needs, not just those with psychosis.

- The Trust should liaise with the police and social care to support them in improving information sharing with the Trust regarding risk, particularly in relation to domestic abuse processes.

APPENDIX 1

Psychological Approaches Ethos and Team

Psychological Approaches CIC is a not-for-profit community interest company focused on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion. Our ethos is one of collaboration and partnership with other organisations to review and evaluate services to achieve better outcomes. Our independent serious incident investigation team comprises five senior practitioners from a multi-disciplinary background with many decades of experience in forensic mental health services, and clinical governance. We adopt a whole team approach to independent serious incident investigations, with an emphasis on peer review and ratification of findings.

Investigators

Panel Chair
Lisa Dakin, Director – Learning disability and mental health inpatient, prison, and community specialist.

Lisa is a Mental Health & Learning Disability Nurse Consultant and specialist in secure inpatient and prison healthcare, with over 30 years' experience working as a nurse leader in forensic & prison mental health and learning disability services. She was formerly Head of Nursing and Associate Clinical Director for Forensic & Prison services in a large NHS Trust. Lisa has considerable experience of independent incident investigations across complex mental health care pathways including acute, forensic, prison and community services. Lisa has undertaken a number of Mental Health Homicide Reviews (MHHR) on behalf of NHS England including those conducted in parallel with Domestic Homicide Reviews (DHR). Lisa has an MSc in forensic mental health and undertook post graduate training in leading & managing partnership working. She has recently completed Healthcare Safety Investigation Branch (HSIB), Safety Investigation Training at level 2.

Consultant
Dr Elizabeth Kilbey, Consultant Clinical Psychologist,
Dr Kilbey has over 15 years' experience working in the NHS and currently works as a Consultant Psychologist in the Adult Autism Spectrum Disorder Team in a large NHS Trust. She has expert knowledge of service specifications and care pathways for people with ASD. Elizabeth is experienced at undertaking investigations at a local level and supporting more complex investigations.

Advisor to Panel

Dr Jackie Craissati, Consultant Clinical & Forensic Psychologist, and Director of Psychological Approaches

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