NHS England and NHS Improvement

niche HEALTH & SOCIAL CARE CONSULTING

Learning Lessons Bulletin

Independent mental health homicide investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of Mr J, who was convicted of the homicide of a man involved in a drug transaction.

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Services**
- **Substance Misuse Services**
- **Mental health commissioners**

Case background

Mr J was initially referred to secondary mental health services by his GP, three years before this incident. He presented with thoughts of self-harm and thoughts of harming others but denied having acted on these. He described a history of using illicit drugs. He was accepted onto the caseload of the Trust's Early Intervention in Psychosis Team (EIT); the impression at assessment was of a mental and behavioural disorder due to street drug use.

He was asked to leave the family home and became estranged from his family and was at risk of homelessness. A residential drug rehabilitation placement broke down, and he was placed in social housing accommodation. He reported being afraid of people who continually called to his flat, whom he said had a grudge against him. He would not give any names, and these were not reported to the police or addressed under safeguarding policies.

Mr J continued to use illicit substances while under the care of the EIT. He was discharged after three years of contact with the EIT, without a discharge Care Programme Approach review meeting.

One month after discharge Mr J was arrested along with four other men following the homicide of a man involved in a drugs transaction. Mr J was convicted of manslaughter and received an eight-year prison sentence.

Key Findings

Treatment plans

Care plans were not reviewed using outcome measures, or in a timely and meaningful way. Interventions did not adhere to expectations of relevant NICE guidance.

There was no formal review of diagnosis during his care, and no medical reviews were carried out for a year, despite there being plans for discharge.

For the first two years that Mr J was supported by the Early Intervention team, care coordinator contact was consistent and regular, but for his final year, whilst Mr J was on the Open Access pathway there were longs gaps of multi- disciplinary contact with limited effective engagement.

Better interagency working could have provided Mr J with support particularly with regards to his vulnerability to pressure from peers and others in the local drug culture. In 2017, there was less awareness of the emerging phenomena of criminal exploitation known as 'county lines' and 'cuckooing' in relation to drug dealing.

With the perspective of hindsight, it could be seen that Mr J was at risk of exploitation by drug dealers, particularly as he spoke of people threatening him and being afraid to talk to the police because of threats to his family.

Formal safeguarding procedures were not followed through He would not disclose any names, and because of this it was felt that the police could not be informed.

Discharge process

The CPA policy was not followed in the planning of Mr J's discharge; there was no medical review or discharge planning meetings.

His GP was not invited to contribute to discharge plans and was later informed that discharge had taken place. Neither the accommodation provider, substance misuse service or housing were involved in discharge planning.

EIT had developed an informal step in the discharge planning process which had not been agreed by the Trust and was not described in the operational policy.

Partnership working

The Trust did not have an agreed partnership working arrangement with substance misuse services in the locality. This meant that it was not clear how communication about Mr J's care should be shared.

EIT did not contact the police to discuss Mr J's vulnerability, and there was no strategy to address working with vulnerable people who did not want police involvement.

Care plans did not incorporate contact with all agencies involved in Mr J's care, and there were missed opportunities to develop a care plan which included perspectives from all the other agencies involved.

Service Factors

The pathways for communication between the providers of substance misuse services and the Trust locally were not well established.

The EIT operational policy had not been reviewed in a timely way, and the service had developed informal pathways of care that were not monitored.

There was a lack of oversight of the quality of the service, particularly in relation to regular medical reviews, care coordinator contacts and the implementation of the CPA policy.

Good practice

EIT provided care informed directly by NICE guidance on recognising and managing psychosis and schizophrenia in adults.

EIT liaised directly with the Council's Housing department to assist Mr J with housing issues, and provided practical support to Mr J.

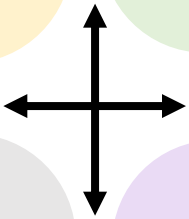
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do your care plans contain clear instructions for communication with other agencies?
- If the individual mentions that they are afraid of other people in the community, how much professional curiosity should you use? Do you press for more detail or do you take it at 'face value' that they are drug dealers, and no action can be taken because they are not named?
- How do you know that these are real fears or expressions of mental health issues? What would trigger you to undertake a fresh look at risks?

Team focussed learning

- Do you have proper arrangements for supervision of care coordinators?
- Are your operational policies in date and reviewed regularly?
- Does your discharge planning include: psychiatric review with clear diagnosis and recommendations for future care; liaison with primary care, substance misuse and housing providers; clear guidance on who is responsible for which elements of the care plan; and a complete discharge summary and care plan with contingency management?



Governance and Board assurance questions

- How are you assured that CPA policies are followed appropriately?
- How are you assured that care coordinators are fully equipped, supported and supervised to deliver this challenging and important role?
- How do you know that risk management plans are collaboratively developed, understood and shared with all involved in the care of people in EIT?
- Are there information sharing agreements and joint working practices with other key agencies e.g. housing, police.

System learning

- How are you supporting improved information sharing between agencies and services?
- Does the system have robust multi-agency processes to support complex and challenging individuals in the community? What would improve this?
- Is the system providing enough appropriate support for complex individuals living in the community?
- Are the resources properly skilled and competent to deal with this behaviour?