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An independent investigation into the care and treatment of Mr S in Devon – summary report

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Our Report has been written in line with the Terms of Reference as set out in the independent investigation into the care and treatment of Mr S. 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Events that may occur outside of the timescale of this review will render our report out-of-date.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. However where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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Contents

1 Executive summary

Incident

1.1 Mr S had been known to mental health services since his teenage years. During this time, he was under the care of a community mental health team (CMHT) and received a range of psychological interventions. He was discharged from the psychological therapy service and the CMHT in November 2018.

1.2 In the summer of 2019 Mr S went to the home of his parents and fatally stabbed his father on the doorstep.

1.3 The following day a member of the public found Mr S unresponsive in a parked car. The police have not identified anyone else as a person of interest with regard to the death of Mr S's father.

Investigation

1.4 NHS England and NHS Improvement South West commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Mr S's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.5 The independent investigation follows the NHS England Serious Incident Framework (March 2015)[1] and Department of Health guidance on Article 2 of the European Convention on Human Rights[2] and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

1.6 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learnt effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required that could help prevent similar incidents.

1.7 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.8 We would like to express our condolences to all the parties affected by this incident. It is our sincere wish that this report does not add to their pain and

[1] Serious Incident Framework (2015) https://www.england.nhs.uk/patient-safety/serious-incident-framework/

[2] ECHR Article 2: investigations into mental health incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr S.

Relevant health history

1.9 Mr S had been under the care of mental health services in the South of England since his teenage years. He initially had a diagnosis of borderline personality disorder, but over time this changed to a diagnosis of emotionally unstable personality disorder[3] (EUPD) and post-traumatic stress disorder[4] (PTSD). As a teenager he had attempted to end his life and had a history of self-harm.

1.10 As a teenager Mr S had shared information with mental health services about alleged childhood trauma, and management of this trauma was a key feature of the therapeutic interventions accessed by Mr S as an adult.

1.11 Mr S was born female and had been under the care of gender identity services and completed a transition from female to male. He had been discharged by the service and in the years immediately prior to the incident he was under the care of psychological services and the CMHT.

1.12 The interventions Mr S accessed from the psychological services included cognitive behavioural therapy (CBT),[5] dialectical behavioural therapy (DBT)[6] and eye movement desensitisation and reprocessing (EMDR).[7] These therapies were used to support Mr S to develop coping strategies for his emotional responses to alleged childhood trauma.

1.13 Mr S was managed by the CMHT under the Care Programme Approach (CPA) until the beginning of 2017, when he was stepped down to non-CPA care.

1.14 The lead professional met with Mr S four times after his step down to non-CPA care, once in spring 2017, twice in autumn 2017 and in November 2018 his discharge from CMHT care.

[3] https://www.evidence.nhs.uk/search?q=emotionally+unstable+personality+disorder Emotionally unstable personality disorder is characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour.

[4] https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/ Post-traumatic stress disorder is an anxiety disorder caused by very stressful, frightening or distressing events.

[5] CBT is a short-term form of behavioural treatment. It helps people problem-solve. CBT also reveals the relationship between beliefs, thoughts and feelings, and the behaviours that follow.

[6] DBT is a type of therapy specifically designed to treat people with borderline personality disorder.

[7] EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences.

1.15 In the autumn of 2017 Mr S was describing self-harm and thoughts to end his life. The CMHT doctor reviewed Mr S's prescribed fluoxetine[8] at this time, but no change was made to the prescribed dose.

1.16 Mr S was offered forty sessions of psychological therapy which began in the summer of 2017. Mr S expressed the desire to use therapy to understand his relationship with his father better and to process past trauma.

1.17 The plan for these sessions was to provide Mr S with EMDR based therapy. However, after three sessions this was changed because Mr S reported that directly addressing traumatic memories increased his distress to an intolerable level.

1.18 The remainder of the therapeutic sessions had a focus on the more generic processing of his experience of trauma, with specific focus on his relationship with his parents as he remembered them up to that point in time.

1.19 As the therapy progressed Mr S began to report memories of significant historical risk factors relating to experience of alleged harm to himself and others. Mr S reappraised his relationship with his parents and was reporting increasing levels of anger towards them, in particular his father.

1.20 Mr S completed 37 sessions of the planned therapy, at which point the Clinical Psychologist determined that Mr S would benefit from a therapeutic break in therapy and discharged Mr S.

1.21 Following Mr S's discharge by psychological therapy services he was seen by the lead professional and two junior doctors from the CMHT. He was discharged from CMHT care at this appointment. A discharge letter was sent to his GP.

1.22 In spring 2019 Mr S contacted the gender identity clinic, requesting an appointment with the manager. He wanted to explain the '"real" reasons for his original gender reassignment request. An appointment was made for him, which he cancelled and did not rearrange.

Internal investigation

1.23 The Trust commissioned an internal investigation, which was completed in May 2020. However, this failed to meet standards expected in the NHS England SIF.

1.24 The investigation relied on generic Terms of Reference which required supplementing with incident-specific points which would have provided the investigation with a sense of purpose and direction. This would have included

[8] Fluoxetine is an antidepressant used to treat mental health conditions including depression and obsessive compulsive disorder. https://www.nhs.uk/medicines/fluoxetine-prozac/

providing a clear timeframe for the investigation, and identifying the issues to be considered, e.g. safeguarding and risk.

1.25 The investigation and report did not take into account the dual nature of the incident. The focus of the investigation was on Mr S taking his life, the investigation did not acknowledge that this was also a homicide.

1.26 There is no evidence available that there was any appropriate specialist clinical input into the investigation.

1.27 The internal report contains no critical analysis of the care and treatment provided for Mr S against Trust policy expectations. However, there are contributory factors which are described in terms of Mr S's characteristics. This could be considered as holding Mr S responsible for the incident because of his experience of alleged childhood abuse, the trauma resulting from this and the impact that it had on his life. 'Blaming' the patient in this way is not acceptable in an investigation into a safety incident.

1.28 The investigation did not identify a root cause, recommendations or lessons learned. In our view, this was because of its failure to complete a critical analysis of the care and treatment provided to Mr S by Trust services.

1.29 The internal investigation did not meet the requirements of the Duty of Candour. The investigation identified several reasons for not making contact with the family including:

- The highly sensitive nature of the information Mr S shared with services about his childhood.
- That it was alleged that Mr S was responsible for the death of his father.
- When alive Mr S had not wanted any information about his care and treatment shared with his family.
- The Trust did not want to cause the family any further distress.
- And, that Mr S was not under the care of services at the time of the incident and there was no identified service to write a letter to the family.

Conclusions

1.30 While Mr S was under the care of the CMHT and the psychological services, risk assessment and management did not meet Trust policy expectations. There was a paucity of historical information available to the lead professional and Clinical Psychologist about Mr S's historic risk.

1.31 As Mr S's thinking and perception of his father shifted the Clinical Psychologist did not identify that there was any potential for an increase in risk to himself and others.

1.32 The Clinical Psychologist's approach to therapy did not support a clear understanding of his risk and any changes in his level of risk. A considerable amount of the work that Mr S did in relation to his timelines was 'blind to therapist' which meant the Clinical Psychologist did not have a full understanding of the nature of the alleged traumatic events Mr S was exploring, or the impact that this might have on his risk.

1.33 There is no evidence of a collaborative approach by the lead professional and Clinical Psychologist when considering Mr S's risk assessment and management. In addition, there were failings in the assessment of Mr S's risk:

- No longitudinal assessment.
- Risk assessment focused on recent risk of self-harm or suicide, and only one entry reflecting any potential harm to others.

1.34 Over time services had not had sight of Mr S's potential risk to others, especially his parents, despite him talking about risk to others in therapy sessions. The Clinical Psychologist did not consider any change in risk when Mr S's thinking and perception of his parents shifted, nor that, consequently, there was the potential for an increase in his risk to himself and others.

1.35 Mr S's discharge from psychological therapies lacked a structure. There is no reference in the clinical notes as to how the goals identified at the beginning of the therapy were achieved. The discharge was described as a "therapeutic break," but there was no clear plan for what Mr S would achieve during the break or how he could access the service again.

1.36 The lead professional did not follow the care plan written in spring 2018 and maintain contact with Mr S every four to five weeks.

1.37 The discharge from the CMHT was in response to Mr S's discharge from psychological therapies. At the CMHT discharge meeting there was an acceptance that Mr S had some ongoing risk, but this was perceived in terms of risk to self (not others) and assessed as a low risk.

1.38 It is our view that Mr S was not given sufficient time to adjust to life without contact with psychological therapies before he was discharged from the CMHT and, by default, all mental health services.

1.39 We have concluded that deficits in care planning, risk assessment and management resulted in Mr S's premature and hurried discharge from both services.

1.40 We consider that it would have been prudent for the CMHT to have maintained Mr S on their caseload for a further three to six months to monitor his mental health and risk. Stability during this period could then have resulted in discharge.

1.41 When Mr S renewed contact with the gender identity clinic in spring 2019, he was not open to any Trust services, and the clinic did not identify the need to share the information about his request for an appointment with the CMHT or psychological therapy services.

1.42 Mr S cancelling the appointment with the gender identity clinic in May 2019 was not out of character for him; and there was a reasonable expectation that he would rearrange the appointment when it was convenient to him.

1.43 It is clear from the relapse and crisis plans completed in 2017 and 2018 that Mr S was well aware of the services available to him should he experience a relapse in his mental health. Based on his previous behaviours, there is no reason to believe that he would not have reached out to services had he felt the need to.

Recommendations

1.44 This independent investigation has made eight recommendations for the Trust to address to further improve learning from this event.

1.45 A further recommendation has been made for the NHS Devon Clinical Commissioning Group (CCG)[9] to further improve learning from this and future serious incidents.

[9] Changed to NHS Devon Integrated Care Board from July 2022

Recommendation One

The Trust must provide assurance that when staff in psychological therapies are transitioning between roles there is a formal review of clinical caseload, and the practitioner's job plan reflects their workload and commitments.

Recommendation Two

The Trust must complete a review of current policy and advice to staff within psychological therapies about collaborative working with other services, to ensure that appropriate communication plans are in place.

Recommendation Three

The Trust must review the Standard Operating Procedures for the CMHTs and psychological services and ensure there are quality standards about the frequency and quality of communication with GPs.

Recommendation Four

The Trust must provide assurance that there is a process in place to measure the efficacy of clinical supervision available in Psychological Therapies.

Recommendation Five

The Trust to complete a comprehensive review of risk assessment practices, to include:

- how staff are trained to complete the risk assessment tool on electronic patient record (EPR).
- the importance of carrying forward historic risk; and
- individual staff responsibility to ensure that risk assessments they complete are comprehensive, relevant and accurate.

Recommendation Six

The Trust must review and revise the advice and guidance available to staff with regard to management of reports of non-recent abuse in line the latest available national guidance, including the British Psychological Society guidance document on the management of disclosures of non-recent child abuse.

Recommendation Seven

The Trust must ensure that there are systems in place to ensure that serious incident reports meet the standards of the SIF.

Recommendation Eight

The Trust must ensure that there are systems in place to ensure that family members who experience a serious incident (such as this) are contacted and supported in line with NHSE standards and are offered the opportunity to be involved in the investigation.

Recommendation Nine

NHS Devon CCG (and its successor organisation) must ensure that the quality assurance process for the review of serious incident investigations meets NHS England standards.

Appendix A – Terms of Reference

Independent investigation into the care and treatment received by Mr S provided by Devon Partnership NHS Trust.

Purpose of the review:

- to independently assess the quality of the care and treatment provided to Mr S against best practice, national guidance and Trust policy;
- to review the quality of the independent Level 2 internal investigation and its resulting action plan against the same standards;
- to comment on any resulting, embedded change to practice, service provision or systems across the organisation, or local health provision; and
- to identify further opportunities for learning that may be applicable on a local, regional or national basis.

The outcome of this review will be managed through corporate governance structures in NHS England, the Clinical Commissioning Group and the provider's formal Board sub-committees.

Terms of Reference

The Devonshire Partnership Trust (DPT) commissioned an independent Level 2 RCA investigation. This investigation will build on that review in the following areas:

1.1 Produce a chronology (from January 2017) of Mr S's contact with mental health, primary health care and third sector services to determine if his health care needs and risks were fully understood and that is reflected in the most recent treatment plans.

1.2 Provide an overview chronology of all Mr S's contact with mental health services.

1.3 Review the quality of the mental health treatment/care plans in place for Mr S at the time of the incident against best practice and national guidelines.

1.4 Review the quality of the longitudinal risk assessments, contingency and crisis plans in place for Mr S at the time of the incident, with particular reference to harm to self and others.

1.5 Review communications/liaison between primary and secondary care services.

1.6 Identify any factors that hindered the risk assessment and management processes, and what plans were put in place to mitigate those risks.

1.7 Review the quality of inter-agency and inter-service liaison, communication and planning if appropriate.

1.8 Review the application of the CPA, including discharge planning, in line with provider guidance, national policy and best practice.

1.9 Determine whether there were any missed opportunities to engage other services and/or agencies to support Mr S.

1.10 Having assessed the above, comment on relevant issues that may warrant further investigation.

1.11 Make recommendations for the provider, CCG and/or NHS England, as appropriate.

Review the provider's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan, and identify:

2.1 If the investigation satisfied its own Terms of Reference.

2.2 If the investigation was completed in a timely manner.

2.3 If all root causes and potential lessons have been identified, SMART recommendations made and shared within the organisation.

2.4 Whether recommendations are appropriate, comprehensive and flow from the lessons learned and root causes.

2.5 Review whether the subsequent action plan reflects the identified contributory factors, root causes and recommendations, and that those actions are comprehensive.

2.6 Review any progress made against the action plan.

2.7 Review processes in place to embed any lessons learned, and review whether those changes have had a positive impact on the safety culture of the provider services.

2.8 Review whether the provider's clinical governance processes in managing the Level 2 investigation were appropriate and robust.

2.9 Review whether the CCG governance/assurance processes in managing the commissioning of the Level 2 investigation and its subsequent recommendations were appropriate and robust.

2.10 Make further recommendations for improvement to patient safety and/or governance processes as appropriate.

2.11 Review the provider's application of its Duty of Candour to the family of the perpetrator/the victim.

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