An independent investigation into the care and treatment of Adult 1

April 2024

Executive Summary

Report Advisory Notice

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

EXECUTIVE SUMMARY

Author: Niche Health and Social Care Consulting Ltd

Conveyed to: NHS England
On: 10 April 2024

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

Our Final Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of Adult 1. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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

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USE OF ITALICS IN THE TEXT OF THE REPORT

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

1 Executive summary

Incident

1.1 In June 2021 Adult 1 fatally attacked Adult 2 and seriously wounded another family member at the family home. Adult 1 was arrested and assessed as not fit to be interviewed because of underlying concerns about his mental health.

Investigation

1.2 NHS England commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Adult 1's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.3 The investigation follows the NHS England Serious Incident Framework (SIF)[1] (March 2015). The terms of reference for this investigation are given in full in Appendix A.

1.4 The main purpose of an independent investigation is to ensure that mental health related homicides are investigated so that lessons can be learned effectively and recurrence is prevented. The investigation process can also identify areas where improvements to services might be required to help prevent similar incidents occurring.

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

1.6 We would like to express our condolences to all the parties affected by this incident. We sincerely hope this report does not add to their pain and distress, and that it goes some way to addressing any outstanding issues and questions raised about the care and treatment of Adult 1.

Relevant mental health history

1.7 The period of care and treatment being reviewed is the contact with primary care (GP) services from 2015 and the contacts with mental health (Mental Health Trust 1) and other NHS and social care services from 2020.

1.8 Adult 1 had six contacts with primary care services when he felt unwell or "*not quite right*" from 2015 to 2019, three of which related to mental health issues. The last of these resulted in a referral to a talking therapies provider (Provider 1), which at the time was the provider of NHS funded psychological therapy for people with mild to moderate anxiety or low mood. Adult 1 did not respond to a request by Provider 1 for further information, and he was discharged. When this was followed up by his GP in Town 1, Adult 1 said he did not want the referral.

1.9 There was no further contact with services until late May 2020 when Adult 2 first contacted the GP expressing significant concern about his presentation. By this time Adult 1 was mute. The GP made a referral to the integrated community mental health team 1 (ICMHT1) in late May 2020 and an assessment was arranged for six days later in June 2020. As a result of the assessment the multidisciplinary team (MDT) discussed referral to the early intervention team (EIT) for further assessment or an extended assessment with ICMHT1.

1.10 Adult 1's behaviour deteriorated over the following few days and emergency services (police and ambulance) were called by his family on two evenings in early June 2020. On the second evening the decision was made to take Adult 1 to Hospital 1 (a general hospital) for further assessment of his physical and mental health. Adult 1 initially agreed to go to hospital but then changed his mind.

[1] NHS England (March 2015) Serious Incident Framework https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

He was assessed by ambulance staff to not have capacity at that time and he was taken to hospital under the Mental Capacity Act (MCA).[2]

1.11 On arrival at Hospital 1 Adult 1 was taken to the emergency department where his physical health was assessed. A mental health assessment was then requested from the psychiatric liaison team who attended in the early hours of the following day. The psychiatric liaison team concluded that a Mental Health Act (MHA) assessment was required, and they contacted the duty approved mental health professional (AMHP). The MHA assessment took place on that afternoon and the decision was made to detain Adult 1 to Hospital 2 (a mental health hospital). He was admitted to the ward at about 7pm the same day.

1.12 Adult 1 remained an inpatient for nine days during which time he remained mute, speaking perhaps on a single occasion. He was assessed by the EIT three days after admission, the assessment concluded "*it did not feel appropriate to offer ongoing support through the [EIT] at this point as his symptoms appear not to have lasted over the two week threshold and lessened on there [sic] own accord without the use of medication*". Adult 1 was discharged to his father's address in Town 2 (about 20 miles/40 minutes from Town 1) in mid-June 2020 after his detention was rescinded. No follow-up contact was made with him by mental health services after his discharge from hospital. This was not in line with Trust policy.

1.13 In late August 2020 Adult 2 contacted home treatment team 1 (HTT1) and reported that Adult 1 had been found lying close to a cliff edge and had to be removed by his father. She expressed concern about the lack of follow-up after Adult 1 had been discharged from hospital. Staff advised her to contact ICMHT1 after the bank holiday weekend which she did. She was told that a GP referral was needed.

1.14 In early to mid-September 2020 Adult 2 spoke to the GP in Town 1 and repeated the concerns she had shared with mental health staff. The GP contacted Adult 1's stepmother who also reported some concerns about his safety. The GP advised that Adult 1 should be registered with a GP local to his father and stepmother's address. Despite the advice to Adult 1's stepmother about GP registration, the Town 1 GP referred Adult 1 to ICMHT1 in mid-September 2020. ICMHT1 staff attempted to contact Adult 1 on the telephone numbers provided and after nine days sent an opt-in letter[3] to Adult 1 to both Adult 2's and his father's addresses.

1.15 In early October 2020 Adult 2 contacted the Town 1 GP with concerns about his presentation - he was destroying all his correspondence and was still mute. The GP noted that Adult 1 had not yet been registered with another GP surgery.

1.16 Four days later Adult 1 registered with Town 2 Surgery and was seen (accompanied by his stepmother) for an appointment in late October 2020. It was documented that he remained mute, had started using his left hand and that there were some concerns about risky behaviours. Adult 1 did not want to be referred to Provider 1 or to the ICMHT, however, three days after the appointment, the Town 2 GP wrote to the local ICMHT (ICMHT2) for advice.

1.17 The referral for advice to ICMHT2 was made the same day but was not triaged until late November 2020; an opt-in letter was sent to Adult 1 the following day. There was no response to the opt-in letter and Adult 1 was subsequently discharged from the caseload in early December 2020, the discharge letter to the Town 2 GP was sent the following day.

1.18 In mid-December 2020 a virtually identical referral for advice was sent by the Town 2 GP to ICMHT2. The only difference was a correction to the house number for Adult 1. The referral was triaged two days later and the decision was made that, because Adult 1 had not responded to

[2] Adult 1's maternal family has advised that at the request of the ambulance crew, Adult 1's maternal grandfather accompanied him to hospital, and remained with him until his admission to Hospital 2 20 hours later.

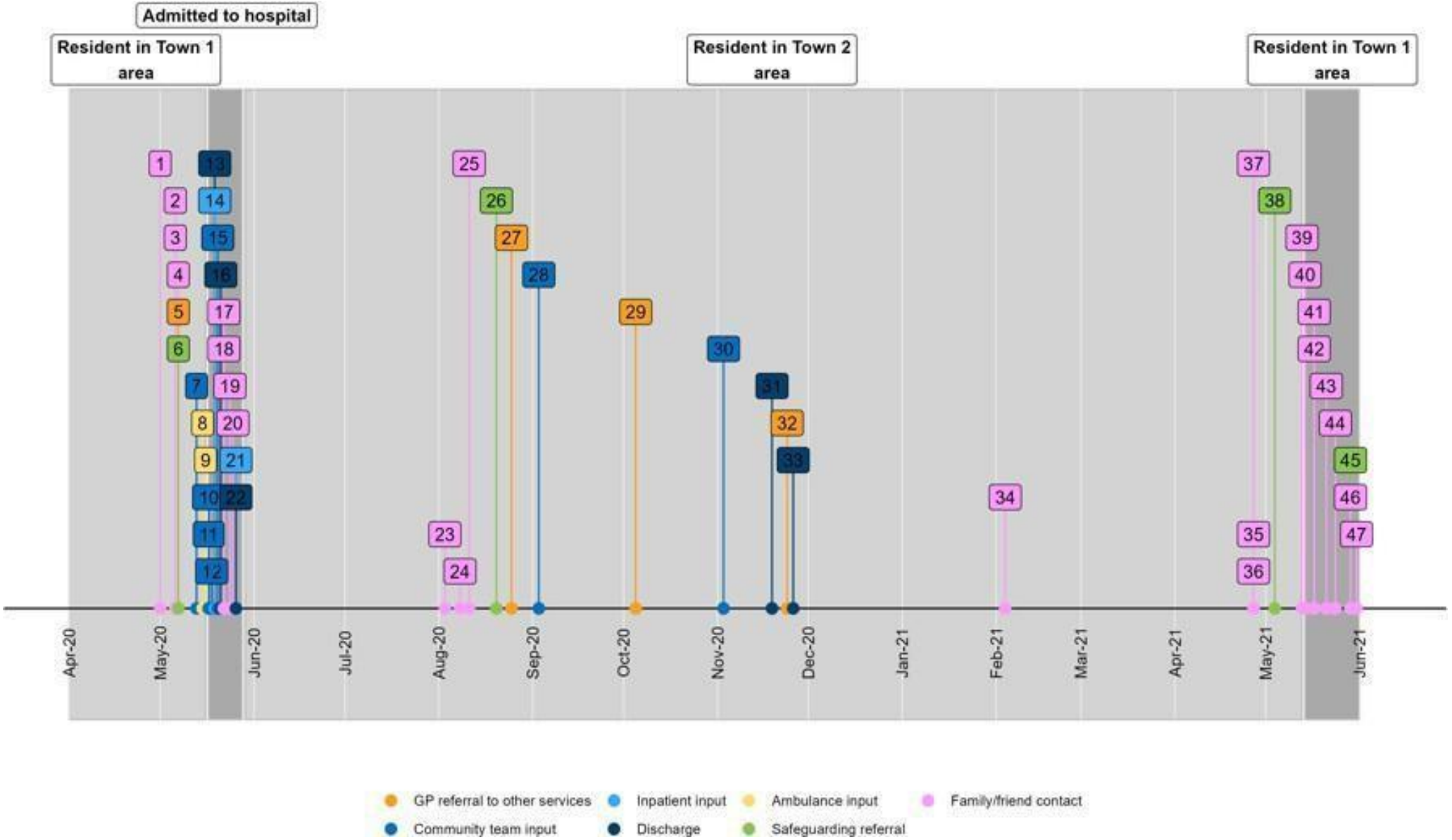
[3] An opt-in letter provides an opportunity for a patient to contact the Trust to confirm that they wish to proceed with a referral to mental health services.

telephone calls or letters from the previous two referrals, the referral would be closed and Adult 1 discharged back to the care of the GP.

1.19 Between February and June 2021 Adult 1's maternal family contacted services a number of times with concerns about his presentation and they asked for advice and support for him.

1.20 Figure 1 provides a high-level timeline of key events and key contacts between May 2020 and June 2021 that we consider to be pertinent to the findings. Table 1 provides a brief narrative for the information in Figure 1. All community mental health contacts were with teams provided by Mental Health Trust 1 (the Trust).

Figure 1: High-level timeline of key events and key contacts between May 2020 and June 2021 pertinent to the findings



EXECUTIVE SUMMARY

Table 1: Brief narrative of key events and key contacts in Figure 1

Number	Date	Event
1	May 2020	Call from Adult 2 to Town 1 GP, Adult 1 not talking or eating, looked very unwell. Adult 2 was advised to contact police if she was concerned about his welfare
2	May 2020	Call from Adult 2 to Town 1 GP, GP to chase mental health team
3	May 2020	Letter from maternal grandfather to Town 1 GP, he was extremely concerned about Adult 1
4	May 2020	Call from Adult 2 to Town 1 GP, she was very concerned about Adult 1
5	May 2020	Town 1 GP referral to ICMHT1
6	May 2020	Adult safeguarding referral to County 1 Council from Adult 2
7	June 2020	ICMHT1 assessment at home
8	June 2020	Ambulance called to maternal family home, no further action
9	June 2020	Ambulance called to maternal family home, mental health assessment required, patient transported to Hospital 1
10	June 2020	Psychiatric liaison assessment
11	June 2020	MHA assessment completed, patient detained under Section 2 MHA[4] and admitted to Hospital 2
12	June 2020	EIT triage
13	June 2020	ICMHT1 decided to close referral because Hospital 2 had referred Adult 1 to EIT
14	June 2020	Ward review by Hospital 2, judged that the section was likely to be lifted in a few days
15	June 2020	Assessment by EIT
16	June 2020	Discharge from EIT caseload
17	June 2020	Letter to ward at Hospital 2 from maternal grandfather
18	June 2020	Telephone call to ward at Hospital 2 from maternal grandmother
19	June 2020	Adult 2's diary/timeline was hand delivered to the ward at Hospital 2
20	June 2020	Letter to ward at Hospital 2 from maternal grandmother
21	June 2020	MDT ward review at Hospital 2
22	June 2020	Adult 1 was discharged from Section 2 MHA, discharged from ward at Hospital 2 and collected by his father

[4] Section 2 of the MHA allows for the detention of an individual for up to 28 days for assessment and treatment. See Mental Health Act (1983) Section 2: Admission for Assessment https://www.legislation.gov.uk/ukpga/1983/20/section/2

Number	Date	Event
23	August 2020	Adult 2 contacted patient advocacy and liaison service (PALS)[5] with concerns about Adult 1's welfare, housing and support in the community.
24	August 2020	Telephone call to HTT1 from Adult 2, who was concerned there had been no community follow-up
25	September 2020	Adult 2 contacted ICMHT1 and left a message for staff to call her about concerns; staff returned the call and left a message
26	September 2020	Adult safeguarding referral to County 1 Council from Adult 2
27	September 2020	Urgent Town 1 GP referral to ICMHT1
28	September 2020	ICMHT1 opt-in letter sent
29	October 2020	Town 2 GP referral to ICMHT2, following GP appointment with Adult 1 on 23 October 2020
30	November 2020	ICMHT2 opt-in letter sent
31	December 2020	Discharge from ICMHT2
32	December 2020	Town 2 GP referral to ICMHT2
33	December 2020	No further action with referral to ICMHT2 because there was no new information
34	February 2021	Call from Adult 2 to ICMHT2 asking if Adult 1 was open to services
35	May 2021	Call from Adult 2 to Town 2 GP surgery
36	May 2021	Call from Adult 2 to mental health connect helpline[6], concerns included that Adult 1 was planning to leave the country three days later
37	May 2021	Call from maternal grandfather to mental health connect helpline, concerns included that Adult 1 was planning to leave the country three days later
38	May 2021	Adult safeguarding referral to the Council from a referrer documented as anonymous (however, it is clear that was Adult 2)
39	June 2021	Adult 2 called the MHA office (MHAO) - exact date unknown

[5] "*PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.*" https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

[6] The Mental Health Trust 1 mental health connect helpline is a free call service available 24 hours a day, 365 days a year. It provides advice to anyone concerned about someone in crisis. Identifiable data - source redacted

Number	Date	Event
40	June 2021	Adult 2 called ICMHT1
41	June 2021	Maternal family friend called the mental health connect helpline
42	June 2021	Adult 2 had contact with PALS
43	June 2021	Letter from maternal grandfather to MHAO
44	June 2021	Adult safeguarding referral to the Council from the Trust using information in a complaint letter from Adult 2
45	June 2021	Adult 2 emailed PALS
46	June 2021	Call from Adult 2 to PALS
47	June 2021	PALS emailed Adult 2
Not numbered	June 2021	Criminal justice liaison and diversion (CJLD) service assessment

Findings

1.21 While Adult 1 was not in the care of Trust services at the time of the incident, our review of the records held by NHS organisations and County 1 Council identified a number of missed opportunities for services to assess Adult 1 following his discharge from inpatient and community services in June 2020.

1.22 We cannot say what the outcome of any assessments would have been if the concerns raised by Adult 1's family had been responded to appropriately.

Use of the Mental Health Act

1.23 When contact was made with the mental health connect helpline and the ICMHT, Adult 2 was not told her rights as the nearest relative (NR) - specifically that she could formally request an MHA assessment and how to make the request.

1.24 Adult 2's right to request an MHA assessment was dismissed or not given due consideration when contact was made with the mental health connect helpline. The responses to her requests were not in line with the MHA and the MHA 1983 Code of Practice.

1.25 Concerns raised by family members and other professionals were not given due consideration and were not responded to as requests for an MHA assessment.

1.26 Despite the concerns raised repeatedly by Adult 2 and family in early June 2020, the Trust agreed a crisis plan without seeing or assessing Adult 1. This plan left Adult 1's maternal family unsupported and without access to mental health support services over the weekend. The plan relied on emergency services responding if a crisis occurred before the planned assessment a few days later.

1.27 The crisis team did not record their rationale for not completing an MHA assessment at home after discussion with ambulance staff. Recording this would have ensured practice was in accordance with the least restrictive principles of the MHA.

1.28 Following admission to hospital under Section 2 of the MHA, the MDT care plan did not meet the criteria set out under the MHA Code of Practice because it did not specifically address Adult 1's

circumstances. The care plan did not focus on the reasons for admitting a patient under the MHA instead concentrating on "*ending detention as soon as possible*".[7]

1.29 Section 17[8] leave was not always recorded correctly. Adult 1's views on leave were not recorded in line with the MHA Code of Practice. The ward recorded Adult 1 as having Section 17 leave in mid-June 2020 at 6pm when he had been discharged from inpatient care three days earlier. It is unclear how this error occurred.

1.30 Information provided to the NR about Adult 1's detention and discharge was not recorded. The clinical notes do not record whether Adult 1 made an application to the First Tier Tribunal (Mental Health).

Mental health care, treatment and diagnosis

1.31 The only clinically unusual feature recorded during Adult 1's admission was his mutism. In our opinion, it is likely that awareness of the views and descriptions of his relatives, especially Adult 2, should have alerted the clinical team to the possibility of other diagnosis (particularly given the descriptions of long-term changes). However, neither the inpatient team nor the EIT clinicians took steps to consider these views, even when direct representations were made to the service by family members.

1.32 A patient being detained under the MHA is done only when the appropriate criteria are met. Therefore, it was not appropriate that Adult 1 was discharged from inpatient care in June 2020 with no follow-up support in the community.

1.33 However, more relevant to Adult 1's case is the lack of response from the Trust to concerns raised by maternal family members about Adult 1 between the point of discharge from inpatient care (and community services) in June 2020 and the incident in June 2021.

1.34 The Trust's discharge policy states that all patients "*discharged to their place of residence, temporary residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 72 hours of discharge*". There are three exemptions listed in the policy, none of which were applicable to Adult 1.

1.35 Adult 1 was discharged from hospital with no diagnosis. Because of this there was no treatment plan for us to assess. The clinical notes about the admission do not record any evidence of mental disorder. However, it is possible that if information recorded before the admission and the further accounts provided by family members had been taken into consideration, the conclusion may have been caveated or recorded as provisional rather than definitive.

Use of the Mental Capacity Act

1.36 Adult 1 was taken to hospital under the MCA and remained in hospital for 10 hours more than the time set out in the Trust Mental Health Connect Helpline and Crisis Hub Standard Operating Procedure (SOP). This means he was deprived of his liberty for longer than the standard specified in the SOP. The delay appears to have been caused by his case not being seen as a priority by the AMHP out-of-hours service, because he was in a 'safe place' (albeit deprived of his liberty). We were told that there is only one AMHP on duty out of hours, therefore staff have to prioritise community assessments against assessments of people who are already in a 'safe place'.

1.37 On several occasions Adult 1 was assessed by Mental Health Trust 1 staff and found to be lacking capacity. The assessments were not documented in accordance with Trust policy.

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[7] Department of Health (2015) Mental Health Act 1983 Code of Practice, section 1.16. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

[8] Mental Health Act (1983) Section 17: Leave of Absence from Hospital https://www.legislation.gov.uk/ukpga/1983/20/section/17

Assessments under the Care Act 2014

1.38 It is evident from the safeguarding referrals in May 2020, September 2020, May 2021 and June 2021 that Adult 2 was requesting support and an assessment of need for Adult 1. It is also clear that there were concerns about risks, his capacity and self-neglect. He was also not engaging with his family or with attempts to assess or support him.

1.39 These referrals were sent as adult safeguarding, but also clearly identified elements of social care need relating to Adult 1's poor mental health.

1.40 The third referral made in late May 2021 was received by a safeguarding practitioner at County 1 Council. In the first instance neither the safeguarding practitioner nor the ICMHT took them as a requirement to assess Adult 1's needs under the Care Act 2014.[9] They were viewed and treated as safeguarding referrals. When the safeguarding referral was triaged by County 1 Council however, the local authority social worker identified that Adult 1 needed an assessment of his care needs under the Care Act 2014 because of concerns about his mental health.

1.41 When the local authority safeguarding triage worker determined that Adult 1's needs fell into the category of care management rather than adult safeguarding, they could not refer directly into Mental Health Trust 1. We were told that the local authority worker had to pass the referral back to the GP, with a suggestion or recommendation for the next steps. In our view, this is a convoluted route for a Care Act 2014 assessment. We believe this was a significant risk and also a barrier to individuals trying to access mental health support.

1.42 In addition, when the GP made referrals to the ICMHTs for mental health assessment, the Trust did not consider whether the concerns identified triggered a duty to assess Adult 1 under the Care Act 2014. The Trust assessed Adult 1 only once through the home treatment service and failed to assess him on another two occasions.

1.43 The Trust did not complete a Care Act 2014 assessment for Adult 1.

1.44 Given the Section 75[10] agreement between the Trust and County 1 Council, it was not clear why he was not assessed, when the triage team at the council identified that Adult 1 required a needs assessment. Operation and examination of the Section 75 agreement was not within the scope of this review. However, we were informed that delegated adult social care functions, including Care Act 2014 assessments, formed part of that partnership arrangement.

1.45 While it is recognised that individuals should usually consent to assessment, Section 11 of the Care Act 2014 states that a local authority:

"*must carry out a needs assessment if—:*

(a) the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or

(b) the adult is experiencing, or is at risk of, abuse or neglect"[11]

1.46 Under the Section 75 agreement, the Trust had a duty to complete a Care Act 2014 assessment on behalf of the council when they were alerted to Adult 1's possible care and support needs. As noted above, under Section 11 of the Care Act 2014, the fact that Adult 1 refused to engage did not cancel this duty and it is our view that the Trust should have made more robust efforts to assess Adult 1.

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[9] Care Act (2014) Section 9: Assessment of an Adult's Needs for Care and Support https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted

[10] National Health Service Act (2006) Section 75: Arrangements Between NHS Bodies and Local Authorities. This enables NHS bodies and local authorities to commission health or social care services from each other (including assessment under the MHA). For more information see https://www.legislation.gov.uk/ukpga/2006/41/section/75

[11] Care Act (2014) Section 11: Refusal of Assessment https://www.legislation.gov.uk/ukpga/2014/23/section/11/enacted

1.47 An assessment under the Care Act 2014 provides an opportunity for services to intervene, to assess and support an individual who has an appearance of need, to understand these needs and to consider how these needs may be impacting on their life and personal goals. Section 11 provides this opportunity in specific circumstances even when someone does not wish to engage.

1.48 Following the third safeguarding referral (late May 2021), the local authority triage worker identified the clear need for a Section 11 Care Act 2014 needs assessment, but this was not communicated effectively. The local authority worker spoke to the GP and chased a referral to the Trust. This referral was for consideration of Adult 1's mental health needs, and as discussed above, under a Section 75 agreement would have included consideration under the Care Act 2014 of both Adult 1's health and social care needs. The local authority worker also shared the information and their decision, but the referral ended up with adult social care. We can only speculate on whether the inability to make direct referrals into the Trust impacted this process. Whatever the reason, the failure to be clear about the referral pathway meant that no one completed a Care Act 2014 assessment for Adult 1.

1.49 Adult 1 was a young man who was displaying behaviour his family reported as changed, bizarre and out of character. Adult 1 had made significant changes to his lifestyle, including fasting, isolating himself from his family and society, placing himself in odd positions for lengthy periods of time, becoming mute and living outside in a tent. Adult 1's family described social isolation, reduced speech, neglect of personal hygiene, secretive and suspicious behaviour, and a lack of his usual humour, concentration and motivation. Adult 1s family told staff he was unable to work because of his "*bizarre behaviour, unreliability and lack of cleanliness*".[12]

1.50 By failing to even consider whether Adult 1 had needs under the Care Act 2014, no one fully considered the impact of this changed behaviour on Adult 1's life, including his ability to study, work or achieve his life ambitions.

1.51 A good Care Act 2014 assessment would have considered the impact of all these changes on Adult 1, would have assessed his capacity to make decisions, and would have determined whether the risks to himself and/or others outweighed the risk of leaving him to continue - to do nothing.

1.52 We believe this failure to assess was a failure to support Adult 1, a failure to determine whether he was 'in need' and required intervention, or whether he was not in need and had the capacity to make decisions, even if they were unwise.

Adult safeguarding

1.53 Adult safeguarding referrals were made in May 2020, September 2020, May 2021 and June 2021 (discussed above). In the third safeguarding referral (May 2021) the Trust identified that Adult 1 was at risk of radicalisation.[13] However they did not follow policy and discuss this with the safeguarding team, and the nuances of these concerns were missed among the wider concerns about Adult 1's self-neglect.

1.54 Concerns about Adult 1's brother were also missed, and it is unclear why a referral was not made to the children's safeguarding team.

1.55 It is our opinion that the Trust did not manage its delegated duties under the Section 75 agreement effectively. However, alongside the Trust's duty to assess, we also believe the Council should have made more effort to assure itself that its delegated functions were being conducted appropriately.

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[12] After receipt of the draft report Adult 1's maternal family told us that their *"overriding concern [about Adult 1 at the time] was that the combination of starving himself whilst camping in a secret location would lead to him dying without them even knowing".*

[13] "*Radicalisation is when an individual or group adopt extreme political, social or religious views that can lead to violence. This is why the term is often used when referring to those who carry out or encourage acts of terrorism.*" https://www.surreycc.gov.uk/children/support-and-advice/families/support-and-advice/keeping-your-family-safe/radicalisation#:~:text=What%20is%20radicalisation%3F,or%20encourage%20acts%20of%20terrorism .

EXECUTIVE SUMMARY

Illicit substance use

1.56 Adult 1 consistently reported the minimal use of psychoactive drugs and no recent significant drug use. The use of psychedelic drugs is relatively unusual, as opposed to more commonly used substances such as cannabis or stimulants. But, given the different account provided by family members, and that one of the differential diagnoses[14] at the time of detention was psychosis, we regard the failure of clinical staff to test for drugs or to consider that drugs could play a role, to be a missed opportunity to rule out (or in) substance misuse as a potential healthcare need.

1.57 However, this situation is not incompatible with relevant National Institute for Health and Care Excellence (NICE) guidance,[15] which states that people admitted to inpatient mental health services should be "*assessed for current substance misuse*", but that testing should only be considered as part of assessment for people with "*psychosis and coexisting substance misuse*". As Adult 1 had not been given a diagnosis of psychosis - which we discuss further in the full report - he would not have met the criteria in this guidance.

Information from the privately funded counsellor

1.58 The privately funded counsellor (Counsellor 1) advertised themselves as a registered member of the British Association for Counselling and Psychotherapy (BACP) for several months after their registration had lapsed. They did not appear on the BACP list of registered members searched by the panel between November 2022 and February 2023. At factual accuracy review, Counsellor 1 advised that their registration lapsed after they had missed a renewal email and that their registration was lapsed between November 2022 and March 2023.

1.59 No records of the content of counselling sessions were kept by Counsellor 1. However, BACP expectations did not specifically require practitioners to retain records of the content of counselling sessions at the time.

1.60 There was no communication with any clinical professionals from the Trust, but Counsellor 1 did discuss Adult 1 with his stepmother. Counsellor 1 has advised that Adult 1 was aware that sessions were being arranged through his step-mother.

1.61 It is unclear from the information provided what type of counselling was being provided to Adult 1. At factual accuracy review, Counsellor 1 advised that they are a person-centred counsellor and as such the sessions were led by what Adult 1 wanted to bring to each session.

Internal investigation and action plan

1.62 The Trust conducted an internal investigation after the decision was taken that the incident should be reported on the Strategic Executive Information System (StEIS).[16] The Trust was an early adopter of the NHS England Patient Safety Investigation Response Framework (PSIRF),[17] the investigation framework that will replace the NHS England SIF. At the time of the investigation into Adult 1's care and treatment, the Trust was transitioning from the NHS England SIF to the PSIRF. Therefore, the report was a hybrid of the two approaches to serious incident investigation.

1.63 There were four versions of the internal investigation report:

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[14] Oxford Dictionary defines differential diagnosis as "*The process of differentiating between two or more conditions which share similar signs or symptoms*."

[15] NICE (23 March 2011) Clinical Guideline [CG120] Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings https://www.nice.org.uk/guidance/cg120

[16] StEIS is NHS England's web-based serious incident management system that is used by all organisations providing NHS-funded care.

[17] "*The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety*." Organisations are expected to transition to PSIRF by Autumn 2023. https://www.england.nhs.uk/patient-safety/incident-response-framework/

- Version 1 - shared with the maternal family and, at the same time, with staff internally for review and comment, November 2021.
- Version 2 - shared with the maternal family following the receipt and review of internal staff comments, January 2022.
- Version 3 - responded to comments from the maternal family on version 1 and the updates made to version 2, February 2022.
- Version 4 - was updated following the findings by the domestic homicide review team, July 2022.

1.64 We assessed version 4 of the internal investigation report against the 24 standards in our Investigation Assurance Framework. Our findings were:

- standards met - 11
- standards partially met - eight
- standards not met - five

1.65 The internal investigation report made two recommendations:

R1 "*Key partners within the integrated care system to agree a pathway for escalation of third-party mental health concerns when the person is not on caseload and services do not have consent.*

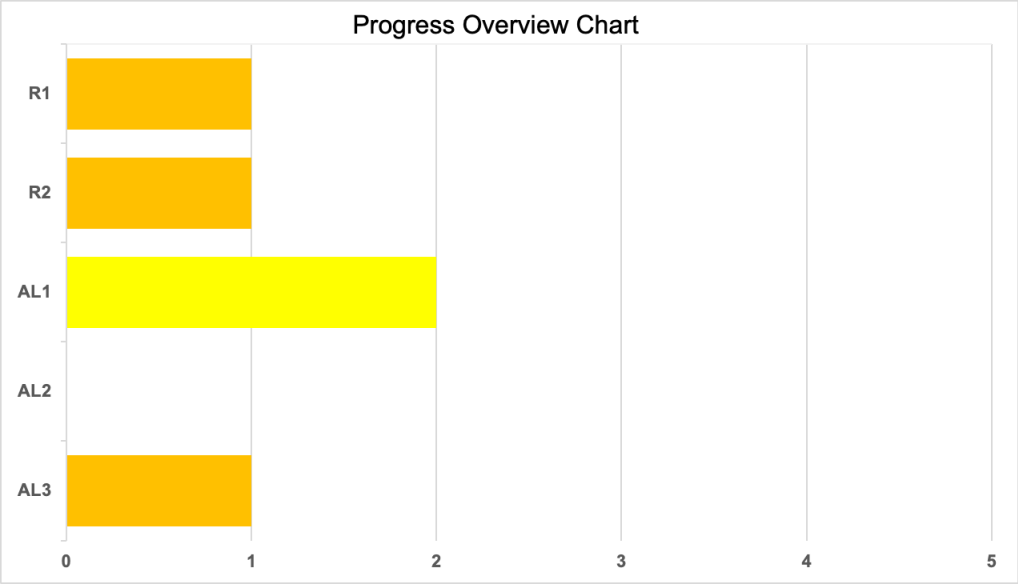
R2 The organisation to ensure that there are appropriate methods of storing, sharing and escalating relevant information that are consistently applied across all services to maintain comprehensive and contemporaneous record keeping."

1.66 When completing the action plan and internal management review for the domestic homicide review the Trust identified three areas of additional learning:

- "*The Trust will review its processes for providing a service for those who present with 'At Risk Mental States' (ARMS) under the Long-Term Plan.*
- *Communication methods with mute patients to be tailored to their needs to ensure equal accessibility to services.*
- *The demographic data of patients will be checked at each new referral to ensure they are accurate, so correspondence goes to the correct address.*"

1.67 The Trust provided evidence of actions for each recommendation and area of additional learning. Of the two recommendations, and three areas of additional learning, we found that action on three of the recommendations/areas of learning had begun and another was significantly progressed. We had insufficient evidence from the Trust to be able to assess the completeness of the remaining area of learning. Our assessment agrees with what the Trust has reported, and our findings are summarised in Figure 2 below.

Figure 2: Action plan progress



Duty of candour and being open

1.68 There was no requirement for the Trust to execute any statutory duty of candour because Adult 1 was not a patient of the Trust at the time of the incident and this had been the case for the preceding 12 months.

1.69 The Trust met the expectations of having contact with Adult 1, Adult 1's maternal family, and Adult 1's father and stepmother. However, in our view, communication with Adult 1's maternal family after the first draft of the internal investigation report was shared could have been improved.

1.70 Adult 1's maternal family received the first draft report at the same time as it was circulated internally for factual accuracy comment and review. At that time the report had not been approved through the usual channels. A significant factor in this decision was that the Trust was taking a hybrid approach to investigation reports because they were an early-adopter organisation for PSIRF and there was no clear policy guiding staff. The Trust has acknowledged this was not good practice and is very sorry for the distress it caused Adult 1's maternal family.

EXECUTIVE SUMMARY

Recommendations

1.71 We have made 13 recommendations for the Trust (one of which also applies to Ambulance Trust 1).

Trust recommendations

Recommendation 1: Information given to relatives about the MHA and the Nearest Relative (NR) rights

Adult 2 was not told her rights as the NR, specifically that she could formally request that the local authority consider the patient's case with a view to making an application for admission to hospital.

The Trust must ensure that relevant organisational policies are aligned to the MHA and the MHA Code of Practice. The Trust must also provide training on the role and rights of the NR to frontline staff to ensure that correct advice is given to NRs.

Recommendation 2: MHA and NR rights

Adult 2's right to request that the local authority consider the patient's case with a view to making an application for admission to hospital was dismissed or not given due consideration. The responses to her requests were not in line with the MHA and MHA Code of Practice.

The Trust (or the Council if MHA AMHP assessments are no longer covered by a Section 75 agreement) must ensure that requests from NRs are considered and responded to appropriately. An evaluation of current practice and policy is advised to ensure it is clear about how to manage NR requests for an MHA assessment.

Recommendation 3: MHA and family involvement

Concerns raised by family and other professionals were not given due consideration and were not responded to as requests for MHA assessment.

The Trust must ensure that policy guidance includes the management of requests by family and other professionals, when concerns are expressed about a person's mental health, that the policy is in line with best practice, and that appropriate training is provided to relevant staff.

Recommendation 4: MHA and urgent requests for assessment

The family was left unsupported and without access to mental health support services over a weekend. There was an over-reliance on emergency services responding if a crisis occurred before the planned assessment.

The Trust must ensure that urgent requests for assessment are considered and responded to in line with the least restrictive principle of the MHA. When a date for a mental health assessment has been agreed, patients and families should be provided with a clear plan to follow if a crisis occurs before the assessment takes place.

Recommendation 5: MHA assessments and documentation

The crisis team did not record their rationale for not completing an MHA assessment at home. Recording this would have ensured practice was in accordance with the least restrictive principles of the MHA.

The Trust must ensure that crisis team staff comply with policy expectations by recording their decisions and the actions taken or not taken as part of MHA assessment requests.

Recommendation 6: Section 17 leave standards

There is no evidence of a risk assessment being carried out before Section 17 leave was granted. Section 17 leave was not always recorded correctly.

The Trust must ensure that risk assessments at Hospital 2 are up-to-date and complete before Section 17 leave is agreed. Section 17 leave must also be documented correctly, including the start and return times of the patient, and the patient's presentation on their return from Section 17 leave.

Recommendation 7: MHA and involving the NR at detention and discharge

There is no record of information being provided to the NR about Adult 1's detention and discharge.

The Council must ensure that the NR is provided with information about a patient's detention. The Trust must ensure that the MHA Office communicates with the NR when decisions are made about changes to the patient's detention.

Recommendation 8: Involving families in assessments and care planning

Neither the inpatient team nor the early intervention team (EIT) clinicians sought out family views, even when direct representations were made to the service by family members.

The Trust must ensure that Hospital 2 and EIT staff seek to involve family members (or other relevant third parties) and that family evidence/collateral information is used appropriately, particularly when the patient is unable or unwilling to engage in meaningful interactions themselves.

Recommendation 9: Discharge standards

There was no post-discharge follow up from Hospital 2, which contravenes policy.

The Trust must ensure that when patients are discharged from hospital, post-discharge follow up is conducted in accordance with Trust policy and national guidance.

Recommendation 10: Application of the Mental Capacity Act (MCA)

Adult 1 was taken to hospital under the MCA and remained in general hospital for an extended period of time (greater than 10 hours) without formal assessment under either the MCA or the MHA.

The Trust and the Council must ensure that there is a clear escalation process which has been agreed with RCHT if a patient awaiting an MHA assessment is deprived of their liberty in the emergency department for an extended period of time.

Recommendation 11: Application of the MCA

On several occasions Trust staff assessed Adult 1 and found him to be lacking capacity. Ambulance Trust 1 also found him to be lacking capacity on one occasion. But the assessments were not documented in accordance with the policy of either Trust.

The Trust and Ambulance Trust 1 must ensure that assessment of mental capacity is documented in accordance with the relevant Trust policy.

Recommendation 12: System management of safeguarding referrals

Safeguarding referrals were not robustly followed up when passed back through primary care and we were unable to determine how the Council assured itself that duties conducted on its behalf were completed as required.

The Integrated Care Board (ICB), the Council and the Trust must ensure there are clear pathways for managing a safeguarding adult referral where there is a mental health and social care component; these should be supported by robust and detailed assurance processes.

Recommendation 13: Being open and involving families in serious incidents

There was a lack of clarity about the implementation of new policies and processes in the transition to PSIRF this meant the process was not transparent for families, which led to great distress.

The Trust must ensure there is clarity in the PSIRF policy about involving families in the investigation of incidents and this involvement should be supervised and quality assured. Communication with families must be timely and unambiguous, in accordance with the principles of being open. This is set out in guidance about engaging and involving patients, families and staff involving a patient safety incident.

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