# An independent investigation into the care and treatment of E

## Learning Summary

July 2024

# Executive summary

## Incident

1.1 E had been in an 'on and off' relationship with T for several years. Although E was officially homeless, she could often be found at T's flat.

1.2 In 2021 E called a friend telling them she had killed her partner. Her friend then called the police. Police officers attended T's flat where they found T unresponsive. Ambulance services were called but failed to revive T. A post-mortem found the medical cause of T's death was pressure to the neck and blunt force abdominal trauma. In addition, the pathologist found numerous older injuries.

1.3 E was arrested a short time later and charged with the murder of T. She was subsequently convicted of murder after entering a guilty plea. She was sentenced to life imprisonment with a minimum term of more than 20 years.

## Investigation

1.4 NHS England (North West) commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of mental health service user E. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.5 The independent investigation follows the NHS England Serious Incident Framework (SIF, March 2015)[1] and Department of Health guidance Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services.[2]

1.6 This investigation was carried out alongside a domestic homicide review (DHR).

1.7 This document is a summary intended to highlight learning for health agencies.

## Findings and conclusions

1.8 E had been in contact with mental health and social services from adolescence. She had a complex history of childhood sexual exploitation, exposure to domestic abuse and violence, and was known to be a significant user of drugs and alcohol, especially the novel psychoactive substance, Spice.[3] Records document that E was diagnosed with a learning disability, Asperger's syndrome,[4] autism,[5] bipolar affective disorder[6] and emotionally unstable personality disorder (EUPD).[7]

1.9 E was detained under the Mental Health Act 1983 (MHA) in 2018 and spent time in hospital. After she was discharged, she lost contact with mental health services until she was accepted onto the community mental health team (CMHT) caseload in early 2020.

1.10 E was allocated a care coordinator under the Care Programme Approach[8] two months later. Between then and the incident in 2021 (a period of 15 months) she was allocated to four different

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[1] NHS England (March 2015) Serious Incident Framework

[2] Department of Health (2015) Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services

[3] Synthetic cannabinoids, colloquially known as 'Spice', are a class of structurally diverse novel psychoactive substances that were originally designed to mimic the effects of the main psychoactive compound in cannabis.

[4] "*Historically, Asperger syndrome was used as a diagnostic term for some autistic people who did not also have a diagnosis of a learning disability. Broadly, it is now agreed that what was referred to as Asperger syndrome is part of the autism spectrum and there is no need for a separate term*". National Autistic Society (accessed 2024) Asperger's Syndrome (Asperger's)

[5] "*Autism is a lifelong developmental disability which affects how people communicate and interact with the world*". National Autistic Society (accessed 2024) What is Autism?

[6] "*Bipolar disorder is a mental health condition that affects your moods, which can swing from 1 extreme to another. It used to be known as manic depression*". NHS (2023) Overview – Bipolar Disorder

[7] EUPD is also known as borderline personality disorder. "*Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm*". NICE (2009) Clinical guidance [CG78] Borderline Personality Disorder: Recognition and Management

[8] The Care Programme Approach (CPA) is used to describe the approach used to assess, plan, review, and co-ordinate the range of treatment, care and support needs for people who have complex needs, coordinated by a care coordinator. .

care coordinators, but rarely saw any of them. Other services working with E included Centrepoint,[9] Change Grow Live (CGL)[10] and a city centre specialist GP practice for homeless people.

1.11 Although E was the subject of multiple safeguarding referrals and safeguarding strategy meetings, services were unable to establish meaningful engagement with E. Service responses were reactive, focusing on dealing with her vulnerability, drug misuse, risk of sexual exploitation, risk of being violent towards T, and trying to keep her safe and find temporary accommodation. She was seen by her care coordinators on six occasions in the 15months that she was under the care of the city community mental health team (CMHT).

1.12 Services were also concerned about the risk of domestic violence perpetrated by E on T. Police were called on several occasions, and there were instances where E had assaulted or stabbed T. Both E and T were discussed at a Multi-Agency Risk Assessment Conference (MARAC) on several occasions.

1.13 E received a custodial sentence in 2021 E again came under the supervision of probation services. E was not seen by her care coordinator after her release from prison.

1.14 Because of her complex background and the early involvement of both mental health and social services with E when she was a teenager, what E needed was a radical, focused and compassionate approach by services that would lead to a structured care package that would help E keep herself (and T) safe and would support her contact with therapeutic services to deal with her traumatic background and drug and alcohol misuse. This did not happen.

1.15 Instead, her CMHT was swamped: dealing with a staffing crisis, significantly high caseloads with very high acuity[11] and complex morbidity.[12]

1.16 The CMHTs were also working within an overly complex and inadequately resourced Section 75 agreement[13] with the council. This meant that all safeguarding duties for any person with mental health needs were referred to the CMHTs.

1.17 Senior management in the Trust did not pay sufficient attention to the significant pressures faced by the CMHTs or to the added complexities of the Section 75 agreement, and the inability of the services to respond appropriately to safeguarding issues.

1.18 In addition, the allocated CMHT carried one of the highest total caseloads of those within the Trust, and some of the highest case numbers per member of staff.

1.19 Although all the services involved (Centrepoint, CGL, police, probation and the GP) were concerned about E and her risks and vulnerability, the agencies involved felt they had fulfilled their responsibility once they had submitted yet another safeguarding referral. Services were not held to account in safeguarding strategy and MARAC meetings. Actions were often information gathering exercises instead of being positive steps to keep E safe. Concerns were not escalated, and options including escalation via a local specific pathway designed to be used in situations where there is a concern that an individual's lifestyle choices or behaviour was likely to result in serious harm, or even death, and where current agency involvement had not been effective in managing the risk, or consideration for an application to use the inherent jurisdiction of the High Court were never pursued.

1.20 E never received an adequate formulation[14] or consistent contact and assessment to complete a proper formulation and diagnosis. We know that by late 2020, learning disability services recorded that it was unlikely that E had a learning disability. Similarly, her GP noted that, following an AQ-10

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[9] Centrepoint is the UK's leading youth homelessness charity aiming to provide security to young people.
[10] Change, Grow, Live is a national charity that helps people change direction with their lives. Originally set up to support people who had contact with criminal justice services, it now also provides structured support for people with addiction issues.
[11] Acuity pertains to the severity of an individual's mental health condition. It specifically reflects the intensity of symptoms they are experiencing.
[12] Mental health morbidity reflects the severity of mental health conditions and their impact on individuals' lives, emphasizing the need for timely care and support.
[13] Section 75 NHS Act 2006 enables NHS bodies and local authorities to enter into arrangements so that NHS bodies can carry out local authorities' health-related functions together with their NHS functions. In this case that includes the safeguarding elements of the Care Act 2014. National Health Service Act 2006 (2022) Arrangements Between NHS Bodies and Local Authorities
[14] A clinical formulation is "*a concise summary of the origins and nature of a person's problems, together with opinion on what may go wrong in the future and what steps should be taken to improve matters*". Baird J, Hyslop A, Macfie M, Stocks R, Van der Kleij T (2017) Clinical formulation: Where It Came From, What It Is and Why It Matters. *BJPsych Advances*. 23(2), pp.95–103.

assessment[15] it was unlikely that E had either autism or Asperger's syndrome. Nevertheless, the same list of her diagnoses continued to be used, although later, EUPD was the most consistent diagnosis. However, there is no evidence that any psychiatrist or psychologist developed a formulation that would have supported this.

1.21 Despite the diagnosis of EUPD, E was not accepted by clinical psychology services or receive a trauma informed approach to her care which could have helped her.

1.22 Concerns about E's mental capacity, especially her vulnerability and risk of sexual exploitation, were frequently raised in safeguarding referrals. However, there was no evidence that E's mental capacity was ever appropriately and properly assessed in line with the Mental Capacity Act 2005 (MCA) and the MCA Code of Practice.[16]

1.23 E and T were under the care of different CMHTs and care coordinators. The care coordinators did not meet to consider how to jointly offer care to both E and T and there was no Trust guidance to support this.

1.24 A previous investigation from 2019 recommended that the Trust provide an assertive care pathway for the cohort of high-risk services users who were at risk of disengagement from services, had complex needs, and often forensic histories with a background of drug abuse.

1.25 Had this recommendation been properly implemented and such a pathway available to E, it may have led to a different outcome.

## Recommendations

1.26 The independent investigation team made 13 recommendations.

**Recommendation 1: Provision of trauma informed care for people with complex emotional and relational needs**

**E had a complex history of trauma related to her childhood and adolescence. This resulted in a chaotic lifestyle, substance and alcohol misuse, a risk of sexual exploitation and a risk of domestic abuse as a victim and a perpetrator. She did not receive any therapeutic support to address these underlying problems. In 2021 the Trust did not have a care pathway in the CMHTs for people with EUPD, and staff were not skilled in the delivery of trauma informed care.**

The Trust must develop and resource a pathway to support the delivery of trauma informed care in the CMHTs. This should include appropriate expertise from senior clinicians to support staff.

It should be monitored and evaluated within 12 months of its introduction to ensure that service users with complex emotional and relational needs receive a safe service which supports them in the community.

**Recommendation 2: Safeguarding policy and processes**

**Trust policies and operating procedures for CMHTs do not provide any guidance on how to carry out the safeguarding requirements of the Section 75 agreement with the city council.**

The Trust must develop agreed guidance with clear processes as part of the Trust safeguarding policy and the CMHT Standard Operating Procedure (SOP). These processes must explain how practitioners should deliver the safeguarding functions of the Section 75 agreement.

[15] "*The autism spectrum quotient (AQ-10) tool is recommended for use with adults with possible autism who do not have a moderate or severe learning disability. This may help identify whether an individual should be referred for a comprehensive autism assessment*". NICE (2012) Clinical Guidance [CG142] Autism Spectrum Disorder in Adults: Diagnosis and Management

[16] Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice

**Recommendation 3: Escalation of safeguarding concerns**

**It appears to this investigation that services and agencies involved assumed that the completion of a safeguarding referral was in itself sufficient to safeguard E, when this was not the case. Agencies raising repeat referrals should have escalated their concerns through the Trust escalation process as outlined in the Trust Safeguarding Adults at Risk Policy, or through the Safeguarding Adult Board if no action was taken on the safeguarding concerns they raised.**

- The Safeguarding Partnership should immediately share the current expectations of their escalation process with key agencies to alert them to the actions required if there are concerns that safeguarding risks are not being mitigated.
- The Trust and the Safeguarding Partnership should work together and consult with other agencies to develop a clear, shared protocol for escalating concerns. This should include what to do when there are repeated safeguarding referrals for the same person and the actions taken are not mitigating the risk.

**Recommendation 4: Responsibility for delivery of safeguarding and Care Act assessments under the Care Act 2014**

**The council and the Trust have a Section 75 agreement, which means the Trust delivers the adult safeguarding functions of the Care Act 2014 for people with mental health problems. The council believed that having this agreement meant they had delegated the duty and the responsibility for the delivery of safeguarding functions. This is not the case; the council retain overall duty and responsibility for safeguarding. So, for example, this means that while the Trust completes Care Act assessments on behalf of the council, the council needs to ensure the quality of these assessments. We could not find evidence that the council sought assurance on the quality and delivery of adult safeguarding functions.**

- The council and the Trust must seek proper legal advice before signing and agreeing to the draft proposed Section 75 agreement. We recommend that this Section 75 agreement clarifies the council's responsibilities for the delivery of safeguarding functions under the Care Act 2014, and also the role of the Trust in delivering Care Act duties on behalf the council. This must then be used to inform routine quality and performance meetings between the Trust and the council.
- The council should review the performance of this contract, including the specification for assessing whether the Trust has the resources to deliver the agreement and what revisions might be required.

**Recommendation 5: Safeguarding action plans and escalation if risks remain.**

**Safeguarding action plans for E did not outline steps to be taken if the safeguarding risks increased or include how to escalate concerns. Action plans coming from safeguarding strategy meetings were not updated and staff given actions were not held accountable for the delivery of those actions. This resulted in delays for the completion of many actions.**

- The Trust must ensure that safeguarding action plans outline steps to be taken if safeguarding risks increase or if actions taken do not mitigate the risk. This must include how the concerns can be escalated, up to and including referral to multi agency public protection arrangements (MAPPA),[17] escalation to the high-risk protocol and the inherent jurisdiction of the High Court where necessary.
- The Trust must ensure that actions coming from a safeguarding meeting are completed and staff understand and act on their responsibilities.
- There must be a feedback loop from staff to highlight when an action cannot be followed up, for example, as part of staffing concerns alerts/caseload demands.

[17] "*The Criminal Justice Act 2003 … provides for the establishment of multi-agency public protection arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders*". HM Prison & Probation Service (2022) MAPPA Guidance p.1

**Recommendation 6: Mental capacity assessments**

**Trust documentation for the assessment of mental capacity does not include the need to assess whether the person has an impairment or disturbance of the function of the brain as a result of a mental illness and where this leads to a lack of capacity. This is known as the two-stage test. In addition, staff carrying out assessments did not fully understand the requirements of the MCA (2005) and the need for assessments of capacity to be decision-specific (by which is meant, based on the person's capacity to make a particular decision at the time it needs to be made).**

- The Trust must ensure that mental capacity assessment forms include the two-stage test of mental capacity.
- The Trust must ensure that staff using the forms and completing mental capacity tests are fully trained and competent to do so.

**Recommendation 7: Incident reporting**

**Between May 2020 and August 2021 E was involved in many incidents and exposed to many risks. None of these were recorded on the Trust patient safety incident system, Datix.**

- The Trust should review and consult with staff about whether incident guidance is clear for CMHTs, and the expectations are realistic.
- The incident system must be readily accessible to community-based staff.
- The Trust must ensure that CMHT staff report all relevant incidents affecting service users in the community, including near misses, especially when the police have been involved

**Recommendation 8: Attendance at MARAC**

**It was not clear who attended MARACs about E and T, or how informed they were about their care.**

The Trust must ensure that staff attending MARACs are properly briefed about a service user's care and risks, and they must record the outcome of the MARACs in the clinical records. The Trust should confirm whether the clinical records support the clear recording of MARAC discussions and actions and are easily available to staff.

**Recommendation 9: Prison mental health in reach team (MHIT), community mental health teams (CMHTs) and the Care Programme Approach (CPA)**

**E was released from prison to no fixed abode. The CMHT and the MHIT had not met or discussed and agreed a package of care to support her on release from prison. This was in breach of the Trust CPA policy. The CMHT SOP does not include any guidance for practitioners about working with service users on their caseload who are in prison.**

The Trust should ensure that CPA policy and the CMHT SOP includes guidance on how the care coordinators and MHITs should work together to support prisoners who are being released, including meeting to develop an agreed package of care to support them and meet their needs.

**Recommendation 10: CMHT caseloads and resources**

**Some CMHTs receive a disproportionately high number of referrals relative to their resident population. Many of these also have higher and more complex morbidity and acuity. In addition, there are no shared care protocols which means that consultant psychiatrists have high caseloads of patients receiving standard care because there is no alternative provision for patients who need monitoring and cannot be discharged. These issues affect the ability of some of the CMHTs to effectively deliver community mental health care.**

- The Trust and commissioners must work together to ensure that CMHTs have the appropriate resources to deliver the functions required of them.

- The Trust and commissioners must develop a shared care protocol with GPs so that, where appropriate, service users on standard care can be discharged back to the care of their GP and removed from the CMHT and psychiatrist caseload.

**Recommendation 11: Other related investigations**

**The investigation into the care and treatment of a mental health service user (L)[18] following a homicide recommended that the Trust identify the cohort of patients most at risk of disengagement from services, who have complex needs and often forensic histories with a background of drug abuse. This does not seem to have worked for E.**

- The Trust, integrated care board and commissioners should revisit this previous recommendation and ensure that this cohort of service users can access an appropriate pathway.
- In addition, the Trust, police, and, where appropriate, probation and other agencies should routinely meet to discuss those high-risk service users who are not subject to management under MAPPA.

**We note there are recommendations from other investigations which have also identified similar learning for this Trust.**

The Trust and commissioners must work together to develop a safety plan in line with the patient safety incident response framework (PSIRF) guidance,[19] that encompasses all the learning from this, other incidents and the DHRs from their area.

**Recommendation 12: Multiple diagnoses**

**E had multiple diagnoses that were unconfirmed, including an unsubstantiated diagnosis of a learning disability. These all impacted on the CMHT's ability to provide appropriate support and care. E was not seen by a psychiatrist after she had been discharged from her inpatient admission.**

The Trust should develop guidance for staff so that where there are multiple unconfirmed diagnoses and/or complex issues impacting on the delivery of care, staff are supported to seek psychiatrist oversight and review.

**Recommendation 13: Working with two service users in a relationship.**

**E and T were known to have been in a relationship for some time. Both E and T received mental health care from CMHTs and had care coordinators under the CPA. There is little evidence that the care coordinators communicated, and no evidence that they ever considered working together to help manage the complexities of E and T's care and the impact each had on the others' mental health. There is no Trust policy or guidance which would help direct staff in how to care for two service users in a relationship who are in receipt of care under the CPA, and how to share information and plan care accordingly.**

The Trust should develop and embed guidance to help direct staff when they are caring for two service users who are in a relationship and in receipt of care under the CPA. This should include:

- Clarification of lead roles.
- How often care coordinators should meet and communicate.
- The nature and features of care planning.
- How to involve other agencies.
- How to communicate to the two service users and guidance on what to say about joint care planning.
- The limits of confidentiality and clarification of what can and cannot be shared and with whom.

[18] Niche Health and Social Care Consulting (November 2018) An Independent Investigation into the Care and Treatment of a Mental Health Service User (L) in Greater Manchester Recommendation 6, p.14.
[19] The PSIRF is 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*". NHS England (accessed 2024) Patient Safety Incident Response Framework

Learning quadrant

**Individual practice**

- If I am concerned about a service user, am I seeing them enough? Am I escalating any concerns I have?
- If I am care coordinating a service user who is in a relationship with another servicer user, have I discussed how to work together with the other care coordinator and my team?
- Have I checked that reported diagnoses are accurate and supported by a formulation?
- Do I really understand mental capacity and the implications for Care Act assessments?
- Have I spoken to the mental health in reach team if one of the service users on my caseload is in prison? Have we discussed how to meet their needs when released from prison?

**Governance focused learning**

- Are safeguarding alerts leading to changes to keep someone safe?
- How do we manage our section 75 agreements?
- How do services manage individuals who repeatedly place themselves at risk? Do we have an escalation process including access to legal advice and the courts?
- Are we sure our services properly understand mental capacity assessments?
- Do we have a policy to guide staff on how to work with two service users in a relationship?

**Board assurance**

- Do we have the correct information to monitor safeguarding concerns?
- Are we managing high risk individuals appropriately?
- Do we respond to MARAC appropriately?
- Are we appropriately resourced to deliver our Section 75 agreements?
- Are we listening to concerns from staff about workload?
- Do we understand why staff are leaving posts?

**System learning points**

- Do safeguarding alerts and referrals lead to action? What do we do if they don't?
- What are we doing about service users with repeated safeguarding alerts?
- Do we have escalation processes for agencies to raise concerns about safeguarding?
- What does the system do about high-risk individuals who are not under MAPPA? How do we manage the risks and work with other agencies?
- Do the right people attend MAPPA and MARAC meetings?
- How does the system respond to individuals who repeatedly place themselves at risk?

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