

Review of Homicides

August 2018 to September 2020

February 2021 (Updated August 2021)

Executive Summary

1. Introduction

The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report (2019) reports during 2007-2017 there were 732 mental health patients convicted of a homicide offence in the United Kingdom. The number of convictions has fallen steadily during this period.

This review will examine the care and treatment of 12 CNTW service users who have been charged with either murder or manslaughter within the identified time period (August 2018 to September 2020).

This work was carried out at the request of the Executive Director of Nursing and Operations following an apparent increase in the number of homicides. The report will also specifically look at any links identified with drug and alcohol difficulties/co-morbid diagnosis. On this basis, the report specifically aims to address a number of key questions around addictions:

- If present, how significant the addiction difficulties were prior to the incident?
- Was the incident/act related to addiction difficulties?
- Was the individual known to Addiction Services at the time of the incident?

All 12 homicides have been or are in the process of being reviewed internally via the Trust serious incident process with an independently appointed Lead Investigator.

Of the 12, seven have been confirmed to fit the criteria for an Independent Investigation commissioned by NHSE. The Independent Investigations are all in different stages and none have yet reached the point of publication.

The method utilised to review the cases was via a “table top” exercise.

There are some reports where further access to records has not been possible (two cases) and a wider review has not been undertaken therefore, they are identified for completeness in the full report but the learning is not fully reflected in the analysis.

2. Findings of the Review

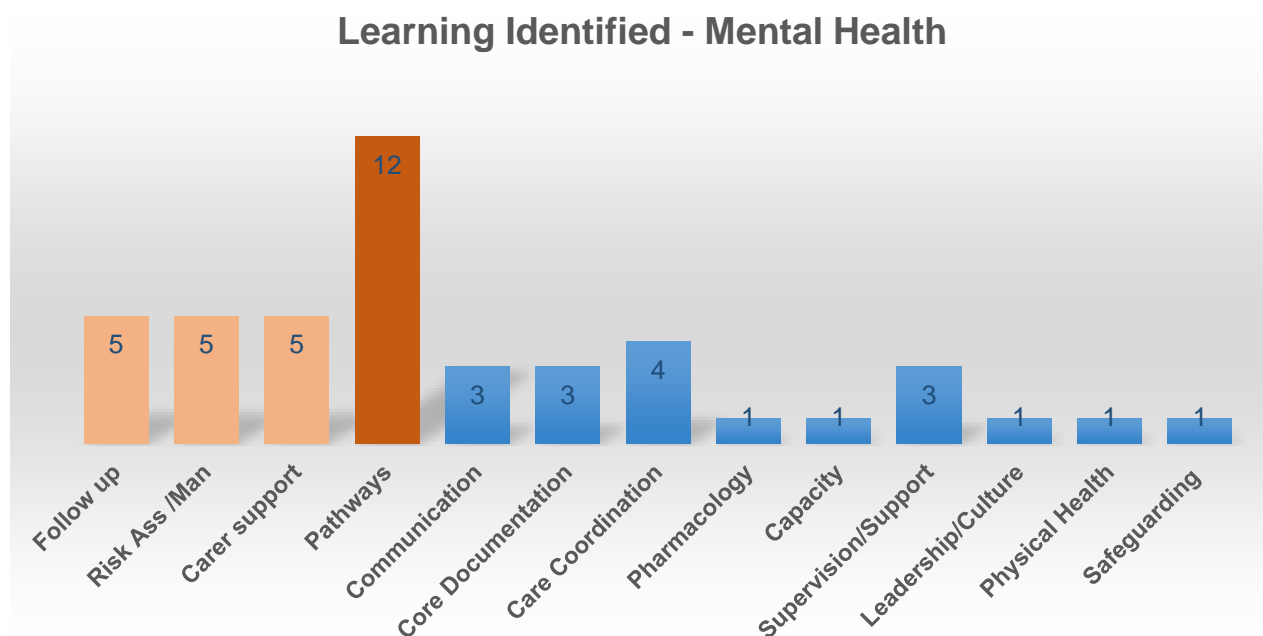
All of the cases have, or will be reviewed individually, resulting in an individual action plan where appropriate. The purpose of this report is to examine the cases and subsequent findings as a culmination, exploring any similarities and reoccurring learning for both Mental Health and Addiction Services. Where there is reoccurring learning, examining this as a theme will support subsequent recommendations for service improvement.

It is important to highlight that in the fuller report, there were a number of cases identified with positive practice in the findings alongside additional learning. These included (taken from reports);

- Despite complexities of mental health and substance misuse and inability to therapeutically engage, positive practice was identified in relation to the service offer and assertive approach
- Mental Health Services worked hard to offer continuity of care and allow for opportunities for the service user to attend his appointments
- Mental health services responded, undertaking appropriate assessments at the time of referral
- The investigation highlighted that all agencies communicated well together and there was evidence of joint decision making during times of increased crisis presentation and the recognition of risk factors
- It was felt that all teams were committed to work collaboratively and flexibly to try and keep the service user engaged in care and treatment. This case was identified as an excellent example of multi-agency joint working with a patient with multiple issues
- The service displayed effective and robust working practices

The additional learning which was identified has been separated for ease of understanding into Mental Health Learning and Substance Misuse/Addictions Learning although it should be recognised that a significant proportion of the substance misuse learning is in relation to the understanding of addictions in the wider Trust.

Mental Health Learning:



The area of learning which most appears is that of **Pathways**. Pathways learning particularly references smooth and timely transitions or referrals between services including in-patient to community services and also referral to other specialisms. Timeliness of waiting lists and also discharge arrangements were highlighted within

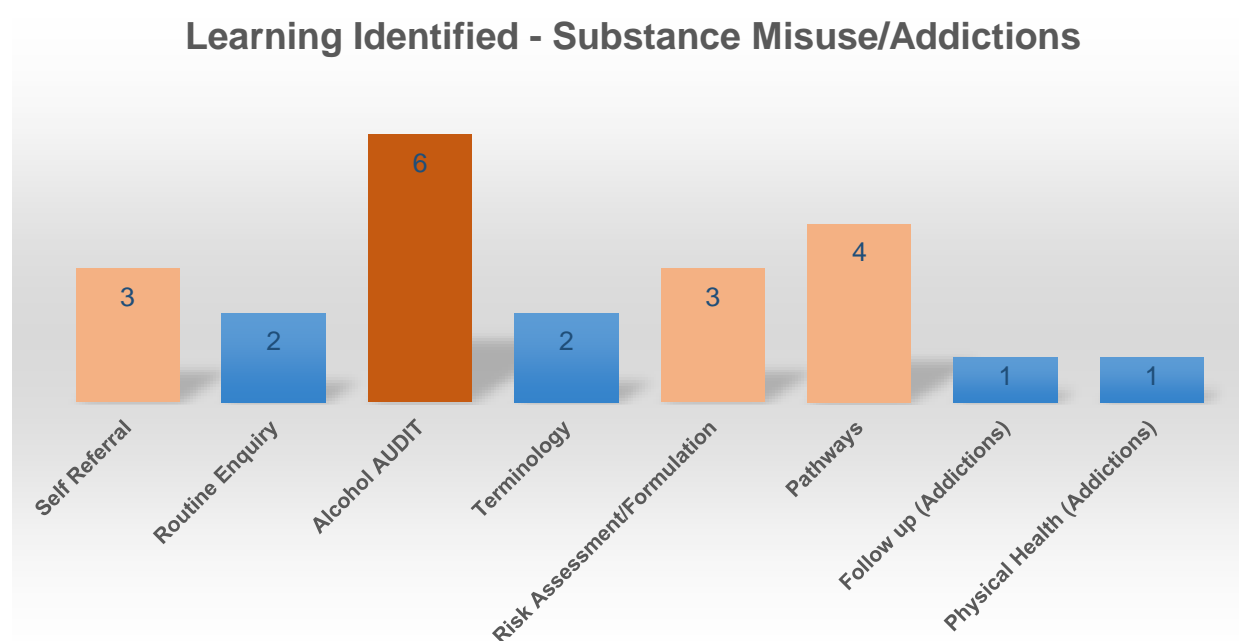
this theme alongside a learning around the appropriateness of episodic care in one case.

Following this, **Risk assessment and Management** was identified as a recurring learning, including the need for updating of risk assessment rather than pulling through previous risk assessment, staff should edit appropriately at each review. Quality of the risk assessment was also highlighted in the context of ensuring appropriate risk management planning.

Carer Support was the other recurring issue across this review. Reference to the needs of family not being fully considered and a failure to provide or refer for a carer assessment was highlighted. The need to support carers in navigating complex service provision was also highlighted.

Follow up support was also a repeat theme with particular reference to limited contact/ lack of assertive approach upon disengagement, limited response to non-engagement and a lack of documentation for unsuccessful engagement attempts.

Substance Misuse/Addictions Learning:



The failure to undertake **Alcohol AUDIT**, often despite information to suggest an increase use of alcohol, was the main theme emerging from examining these cases. It is important to highlight that this was not necessarily identified in the original review of cases and therefore a further learning may be in the need for us to ensure this area is addressed by lead clinicians in every After Action Review, not just those in addiction services as this will then support staff understanding of the need to introduce and embed this into practice across the Trust.

Pathways into addiction services should also be made as smooth as possible, with correct contact information being made available, ensuring those service users with coexisting mental health conditions have collaborative care plans between mental health and addiction services and also, where appropriate, particularly if service users are not engaging with addiction services, scaffolding support and advice is still sought and utilised.

Advice to **self-refer** to addiction services from mental health has previously been discussed and it has been highlighted that best practice would always be for the mental health team to make a professional referral where there is consent. There does sometimes remain a belief that self-referral provides a means of testing motivation but this is not the case and by agreeing to a professional making a referral, we can make use of opportunistic moments to engage service users on an appropriate pathway, despite fluctuating motivation. Again, this was not always discussed in the After Action Review.

Risk Assessment/Formulation was identified in the learning including drug/alcohol use not being seen as problematic in the context of mental health and therefore not regularly reviewed or included in risk assessment or identified in the context of holistic formulation.

3. Recommendations

Recommendation 1 (Mental Health)

Self-referral

In relation to advising self-referral, good practice is for the mental health service to formally **refer** to addiction services at all times providing there is consent to do so. Self-referral should not be used as a test of motivation and agreeing to a referral to addiction services is a positive step which should be actively supported with a referral from a professional.

Where referral is refused, advice should be to self-refer with appropriate written contact points being supplied. This should be reviewed at subsequent appointments wherever possible with the offer to refer.

This learning will be incorporated into the forthcoming review of Dual Diagnosis Policy to support Trust-wide approach and should also be summarised in Safer Care Bulletin.

Recommendation 2 (Mental Health)

Alcohol AUDIT

All mental health services should undertake Alcohol AUDIT. Agreement should be made around standards for Alcohol AUDIT (when this should be completed and review frequency). This should be clarified in the Dual Diagnosis Policy.

Recommendation 3 (Addiction Services/Mental Health)

Alcohol AUDIT

Where appropriate, training should be offered from addiction services to staff who are not familiar with alcohol AUDIT – this could replicate the Alcohol CQUIN training rolled out to in-patient services.

Recommendation 4 (Addictions/Mental Health)

Co-existing drug and alcohol use

Checklists have been used to good effect throughout healthcare. This tool could be used to ensure Addiction and Substance Misuse is managed in a comprehensive and coordinated way in mental health services as well as ensuring that any review of incidents always incorporates a review of substance misuse and expected interventions.

Action to develop a good practice checklist for mental health staff in managing cases where there is co-existing drug and alcohol use. This will incorporate:

- Alcohol Audit
- Routine enquiry – drugs and alcohol (Brief Screening Questions)
- Brief Advice – helpful information
- Scaffolding and Referral Advice

Recommendation 5 (Addictions/SaferCare)

(L)AAR Checklist to incorporate addiction key areas

To develop a checklist for SI Investigators and Lead Clinicians to support understanding of the areas which should be reviewed in any case where there is substance misuse or addiction. This will incorporate:

- Alcohol AUDIT
- Illicit drug use/drug misuse
- Routine enquiry
- Brief advice
- Referral/Scaffolding
- Optimisation of OST
- Offer of Take Home Naloxone

Recommendation 6 (Addictions)

Dual Diagnosis Policy

The Dual Diagnosis Policy is currently under review. To ensure the learning from this report is incorporated into the revised policy with clear guidance around responsibilities in mental health and addiction services for appropriate assessment and referral, to also include clear guidance on the use of scaffolding where there is reluctance for referral.

Recommendation 7 (Mental Health)

Pathways

There is repeated learning around pathways which is particularly evident at critical points in the treatment journey including diagnosis and appropriate pathway, transitions, transfer, referral and discharge.

The learning around critical points in the pathway should be highlighted as a significant area of learning from this report and discuss means of addressing this. This report should also be presented to the Trust Learning and Improvement Group in order to share this learning.

Recommendation 8 (Trust Wide)

Risk Assessment and Management

To feed the findings of this review into the work the Trust has carried out in relation to the use/review of risk assessment.

To support the newly identified work stream specifically relating to narrative risk assessment which is to commence April 2021 for a 24 month period reviewing tools and culture of risk assessment.

Recommendation 9 (Trust Wide)

Carer Support

To consider further work into the introduction and embedding of the '**Getting to Know You**' Document. Not as a documentation issue but as a cultural mind-set of family involvement in a patient's care and treatment. We should also consider this piece of work to be picked up as a theme for the Quality Priority work stream.

Recommendation 10 (Addictions)

Support and Scaffolding for mental health

To ensure where there is a referral from inpatient mental health services, there is a clear process in Addiction Services to assess the service user whilst they are an inpatient and engage in the discharge planning process to ensure a smooth transition on discharge to promote and optimise engagement with Addiction Services.

4. Findings

Findings will be discussed at Trust Governance meetings including Business Delivery Group and Safety Sub Group to develop a coordinated approach to improve services for those presenting with drug and alcohol and mental health difficulties. It will also be reported through our governance system to Quality and Performance Sub Committee of the Board.

The review has been completed and report produced by:

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