Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Review of Homicides

August 2018 to September 2020

February 2021 (Updated August 2021)

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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 twelve CNTW service users who have been charged with either murder or manslaughter within the identified time period (August 2018 to September 2020).

This work has been 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 twelve 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 twelve, 7 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 Therefore, this report will provide a brief overview of the incident, table top findings, recommendations and inquest conclusion where available.

There are some reports where further access to records has not been possible (Cases 5 and 6) 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.

There are also 2 reports where Panel Review had not yet taken place at time of first writing (Feb 2021), but has since been added post-panel review in this update to ensure the report is now completed (Cases 11 and 12).

The review has been completed and report produced by:

Claire Taylor
Head of Clinical Risk and Investigations

Reviewing demographics, mental health contacts and mental health learning.

Dr Margaret Orange
Associate Director (Addictions Governance)

Reviewing addictions contact, impact and addiction/substance misuse learning.

Case 1	Incident Date: **06/09/2018**	**Coroners Conclusion**: Inquest pending
SI: **314829**	**RiO:** 289685	**Service:** South Locality Care Group EIP South Tyneside

Summary:
A 19 year old service user was charged with murder following an incident on the 6 September 2018 when a shopkeeper was stabbed. On the 13 March 2019 he pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order, to be detained indefinitely.

Overview of service user:

The service user has a history of Attention Deficit Hyperactivity Disorder (ADHD) being diagnosed at the age of 12. In June 2017 he was urgently referred to CAMHS by his GP due to thoughts that he wanted to harm people. He had reported carrying weapons around with him and his mother found him paranoid. He asked his mother to take him to the doctor and this subsequently led to admission. Prior to this there had been nothing of significance in relation to primary care contact.

During admission he became hostile and demanded his discharge, he was detained under Section 2 of MHA. He quickly settled stating his violent thoughts had stopped and he was discharged at Tribunal on 9th August 2017 although the clinical team considered he required further assessment in hospital.

He was transitioned into the EIP service following a diagnosis of drug induced psychosis and was a community patient in this service at the time of the incident.

Findings of the internal investigation:

Follow up (Disengagement):
The patient disengaged from service contact and as a result was not seen for a period of 148 days before the incident. As a result there was no contemporary understanding of his mental health status.

Risk Assessment/Management:
There were occasions, such as when non - engagement became apparent, where changes of risk warranted the creation of a new / updated FACE risk assessment and this did not occur.

Carer support:
The needs of the mother had been considered within service contact, however there was no evidence that she had been offered a carers assessment.

Pathways (Transitions):
Transition between CAMHS and Adult ADHD Services was not timely or effective.

Communication:
In instances where a child with a diagnosis of ADHD is in hospital for reasons other than their ADHD and they are being transferred to Adult services, ADHD care and treatment should be integrated into the overall approach to transition with immediate effect.

Pathway (Referrals):
Referral between forensic CAMHS and adult forensic services needs to be streamlined.

Core documentation (Validation):
Student nurse entries in the clinical record were not always validated, therefore there was no evidence demonstrating appropriate accountability by registered practitioners.

Care Coordination:
The process of Care Coordination was influenced by the perceived wellness of the patient. An approach to the ongoing assessment, care and treatment pathway was therefore limited.

Additional Learning/External Issues;
The victim was a random member of the public unknown to the patient. There is limited guidance on the approach towards involvement and information sharing with the victim's family.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
Information from court report: started using cannabis infrequently aged 15, approx. weekly. Increased cannabis use aged 16 to daily. At age 17 introduced cocaine and ecstasy, once weekly with daily use of cannabis Regular and frequent use of alcohol prior to prison- 2l vodka every 2 days.
Drug and alcohol issues were recognised in August 2017 (Ferndene) with a drug induced psychosis, harmful use of Cannabis. Alcohol AUDIT was undertaken at this time, with a low risk score being recorded, with no necessity for any further action at this point. Following disclosure of a 3 year history of Cannabis use, was advised to self-refer to drug services in South Tyneside.
Admitted to increase in alcohol use in August 2018. Drug and Alcohol intoxication and risk was recognised as a risk prior to the incident with advice being given to parent in relation to emergency service use if required. Alcohol AUDIT was not repeated at this point and routine enquiry around drug use was not undertaken to understand current drug of choice and frequency – regularly referred to as illicit drug use in the electronic patient record but no further clarification.

Was the incident/act related to addiction difficulties?
Query from police post incident to ask if alcohol could have exacerbated mental health, it was clarified that this was possible. They advised they had taken blood samples.

Was the individual known to Addiction Services at the time of the incident?
No formal referrals made to addiction services, no correspondence from addiction service. It is unclear if service user, following advice, ever made self-referral to drug services as this was not followed up/reviewed.

Addictions Learning:

- **Self-referral** - Service user was advised to self-refer to addiction services. Good practice is for the mental health service to refer with consent. This learning should be incorporated into the forthcoming review of Dual Diagnosis Policy

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

- **Routine enquiry** around drug and alcohol use was not undertaken.
- **Terminology** is an issue where drug use is recorded as 'illicit'/'substance use'/'drug use' but no clarification of substances, amounts, frequency or duration of use
- **Alcohol AUDIT** was not undertaken at opportunistic points in the treatment journey

Case 2	Incident Date: 09/04/2019	Coroners Conclusion: Inquest pending
SI: 339458	**RiO:** 36645	**Service:** North Locality Care Group Central and South Northumberland Psychosis/Non Psychosis Team

Summary:
Service user arrested and charged with the murder of her mother on 9 April 2019 following an incident that occurred between the 4 April and the 8 April 2019.The trial concluded March 20 with a Hospital Order with Restrictions (no limits) patient not fit to plead.

Overview of service user:
The service user has been known to mental health services since 1997, when she was first referred to Children and Young Persons Services (CYPS). She remained with this team for 3 years.

Following discharge from CYPS she had no involvement with mental health services for an 8 year period, but was seen in 2009, following an incident of self-harm. She was subsequently referred to drug and alcohol services, but did not engage well and was discharged.

She was seen for a 6 year period by EIP, from 2009-2015. Following this, she moved out of CNTW's area for a period of several months, and, she was seen by the local CTT.

She was referred back to South Central Northumberland CTT in 2016, but prior to being seen was admitted to hospital, having been detained under S2 MHA.

Following discharge from hospital, she was seen by the CTT from 2016 – August 2018. In April 2018, she was again detained under S2 MHA and admitted to hospital for a 7 week period. There had been a delay in discharging her from hospital, due to being homeless and she continued to be homeless at the point of discharge. Following discharge she was seen for a short period by CTT whilst placed in hostel accommodation. In August 2018 the CTT considered her to be well, only having social needs therefore decided to discharge her from their service.

She was assessed by CRHT (Crisis Team) in September 2018, but was not offered homebased treatment, or hospital admission, with the plan being to refer to

the CTT. However, she self-referred to the CTT in October 2018, and she was allocated a Care Coordinator. The service user remained open to the CTT at the time of the incident.

Findings of the internal investigation:

Pathways (Discharge from inpatient services):
There were concerns within the clinical team about the vulnerability of the service user being discharged from hospital in May 2018. At that time, the new Care Coordinator was unknown to her, having had her case transferred to them without a formal handover.

Pathways (Discharge from community services):
The decision to discharge from the clinical team in August 2018 was considered premature in the context of a developing perception of personality issues overshadowing other factors, including limited post hospital discharge contact and knowledge of the service user, the service user having an extensive mental health history, no evidence of ongoing stability and significant social care needs. There was some evidence that assumptions were made that when historical risk information is on RiO, everyone is aware of this.

Risk Assessment/Management:
When the service user was re-assessed by the clinical team she was not subject to a comprehensive assessment (inclusive of FACE), despite not being seen by the clinical team for 124 days, this approach did not recognise the dynamic nature of mental illness, including risk.

Carers Support (assessment):
At the point of/or prior to the service user being discharged from both the ward and the clinical team, the needs of her mother were not assessed or fully recognised, despite safeguarding advice to do so. There was no contemporary evidence of mother being offered a carer needs assessment.

Pharmacology (Medication review):
At the time of the incident, the clinical team had limited timely access to medical/medication review. This was alongside evidence of pressure associated with service demand.

Pathways (Waiting list):
The clinical team treatment waiting list monitoring guidance was not followed.

Supervision and support (Clinical Supervision):
A random sample of performance data relating to supervision within the CTT did not provide assurance of a high level of compliance to the policy requirement to undertake regular supervision at the time of the incident.

Pathways (Episodic care):
The approach in delivering an episodic model was not responsive to the service user's needs at times of vulnerability.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?

- Jan 2019 - notes state drug and alcohol use is affecting mental health (cannabis and alcohol currently)

- September 2018 – assessment highlights ongoing use of alcohol and cannabis however, does not see this as problematic
- May 2018, states no plans to engage with addiction services
- April 2018 – Alcohol AUDIT score 5 – low risk, however, this was not repeated
- Jan 2018 – Notes highlight if appropriate, encourage self-referral to NRP
- 2018 – reported history of opiate use – also living in a hostel situation with significant exposure to drug and alcohol use

Was the incident/act related to addiction difficulties?
Unknown.

Was the individual known to Addiction Services at the time of the incident?
Not known at time of incident – previous referral which was not engaged in 2009. Advice to self-refer to NRP in 2018 however, no review.

Addictions Learning:

- **Risk assessment** - Drug/alcohol use not seen as problematic in the context of mental health therefore not regularly reviewed or included in risk assessment
- **Self-referral** to addiction services was encouraged – there should be recognition that self-referral is not a test of motivation therefore referral by professional is always the preferred option
- **Self-referral** advice was not followed up – if the service user does prefer to self-refer, this should be reviewed at subsequent appointments to check progress

Case 3	**Incident Date:** 31/03/2019	**Coroners Conclusion:** Inquest pending
SI: 338365	**RiO:** 149818	**Service:** South Locality Care Group South Tyneside CCT and Personality Disorder Services

Summary:
The patient was arrested on suspicion of murder of her partner. The victim was the patient's partner, who was found in the patient's home with a single puncture wound to the neck area. October 2019 found guilty of manslaughter, sentenced to 14 years imprisonment

Overview of service user:
A 44-year-old woman, with a diagnosis of emotionally unstable personality disorder (ICD-10) and co-morbid depression and anxiety features. She had been known to services since 2010, under the care of the Community Treatment Team and for a period of time the PD Hub (2015-2016). Further support sessions were provided by the PD Hub (4 sessions) when she was identified as needing this.

Her social and personal history can be characterised by trauma and exposure to negative life events, including episodes in care at a young age: dysfunctional and on occasions, violent relationships with partners, resulting on one occasion in a period in prison. She had difficult familial relationships with her children, one of whom spent time in care and one who was adopted. A key factor observed was that she often went from 'crisis to crisis' compounded by her emotional reactions, emotional regulation and mood. This includes reported difficulty in leaving her

home at times, thoughts of self-harm/suicidal ideation and the acknowledged verbal aggression/anger to others.

Contact and visits by the Community Treatment Team were offered on a fortnightly basis by the Care Coordinator and support worker to complete WRAP plan, to identify problems and consider options and effective solutions, to support NL in activities of daily living and social inclusion. Her last contact with the service was on the 26th March 2019.

Findings of the internal investigation:

Risk Assessment/Management:
A key finding identified was the quality of FACE risk assessment and management plans, including management of significant risk areas, review and formulation and the case work supervision process which needs to be robust and ensure that all patients are reviewed.

Core Documentation (Alcohol AUDIT):
The alcohol AUDIT tool was not completed, although the patient had been offered referral to drug and alcohol services and had declined.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?

- Aug 2018 – Concerns around binging and vulnerability under influence noted on several occasions - appears to have been long term issue
- 2017 – Whilst on Longview ward, reported to use alcohol/illicit substances as a maladaptive coping mechanism in the past
- 2017 – Noted last time to have used ‘hard drugs’ was 3-4 years ago (Cocaine)

Was the incident/act related to addiction difficulties?
Unknown.

Was the individual known to Addiction Services at the time of the incident?
Not at time of incident.
2017 – Whilst on Longview ward, reported to have been seen at NECA (a charity based drug service) in the past.
No clear discussion or referral to addiction services.
Alcohol AUDIT never completed despite multiple entries highlighting alcohol concerns.

Addictions Learning:

- **Pathways** - Referral to addiction services was not discussed as part of comprehensive review and care plan
- **Alcohol AUDIT** was not used to appropriately screen and refer for alcohol related issues

Case 4	Incident Date: 14/05/2019	Coroners Conclusion: Inquest pending
SI: 343972	**RiO:** 319718	**Service:** Service South Locality Care Group Sunderland West Community Treatment Team

Summary:
Thirty year old male service user arrested and charged with the murder of a 54 year old male. December 2019 found guilty of murder sentenced in January 2020 to life imprisonment with a minimum of 26 years to serve.

Overview of service user:
Service User has been known to services since 2012, via the psychiatric liaison service. His involvement with services has included periods of inpatient admissions. In September 2016, he was referred to the community treatment team for care co-ordination. In October 2017 he was placed on a Community Treatment Order (CTO). He remained on this order until 2019. At the time of the incident he was open to services, with support from a named psychiatrist, care co-ordinator and community support worker. In terms of CPA he remained on Enhanced CPA.

Findings of the internal investigation:

Pathways (Transfer between inpatient and community):
Following review of the transfer process it was identified that a discussion between the RCs had not taken place. On this occasion it did not happen however it was noted there is a process in place.

Core Documentation:
The CPA review form was not completed to Trust standard. This resulted in a missed opportunity for sharing contemporaneous information about the patient's medication and risk factors with primary care.

Risk Assessment and Management:
There were 65 risk assessments but the last 7 pulled the same information through and were not edited as per Trust standard.

Care Coordination (Care planning):
The care plan was not reviewed at time of discharge from CTO.

Supervision and support (Scaffolding):
The team did not consider the wider support available to support the case.

Supervision and support (Clinical Supervision):
It was noted that supervision occurred frequently, however it is recommended that more robust and accurately recorded clinical and caseload supervision would support care co-ordination when planning care.

External issue (communication):
The investigation highlighted that recommendations for changes to medication that had been sent to the GP practice were not actioned.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?

Reference to addiction in September 2017 – referral to Wear Recovery for Relapse Prevention via in-patient ward. Contact number unavailable – case closed with a letter to service user with information to self-refer.
2018 –recognition that illicit substance use increases risk and possible referral to PDP highlighted regarding this. Continued refusal to be referred to specialist addiction services.
Recognition that risks increased with the use of illicit substances and alcohol but reported to be abstinent prior to incident. However, intermittent use throughout notes and refusal to engage with wear recovery when offered referral.
Last alcohol AUDIT taken May 2018, score of 10 suggesting increasing risk.

Was the incident/act related to addiction difficulties?
Unknown.

Was the individual known to Addiction Services at the time of the incident?
Not at time of incident. Previous referral which was not taken up 2017.

Addictions Learning:

- **Pathways** – referral to addiction services was made but contact number was not accurate and this led to closure of case via addiction services. Contacts could have been clarified through a range of other sources
- **Routine Enquiry** – lack of clear questioning and recording around drug/alcohol use, information difficult to locate
- **Terminology -** Continual reference to illicit substances but difficult to navigate the RiO record to understand exactly what these were. When searched – street diazepam and cocaine identified in historical progress notes

Case 5	**Incident Date:** 19/08/2019	**Coroners Conclusion:** Inquest pending
SI: 2019/1764 (Legacy)	**RiO:** Cumbria Case N/A	**Service:** North Cumbria Locality Care Group Allerdale CMHART

Summary:
A 45 year old male was arrested in connection with the death of his 69 year old mother, at their home. The service user pleaded guilty to manslaughter by reason of diminished responsibility and sentenced to life with a minimum of 11 years to serve.

Overview of service user:
The patient first had first contact with Adult Mental Health services in May 1994 where it was considered the patient appeared to be floridly psychotic, actively hallucinating and described a number of first rank symptoms, which in the absence of any history of drug abuse, supported a diagnosis of Schizophrenia.

At the time of his arrest, the patient was under the care of Allerdale Community Mental Health and Recovery Team (CMHART). His last face to face service contact prior to the incident on 22 January 2019 was with his Care Coordinator from the Allerdale CMHART on 16 January 2019, where his father was also present. The patient's father had been expressing concern about his son's mental

health and had requested medication for his son alongside a review of his presenting mental state. The patient had also reiterated a need for a review of medication, stating that he was not able to cope with anxiety, voices and hallucinations.

Findings of the internal investigation:

Leadership and Culture (CMHT):
Leadership and culture within the CMHT was not conducive to the provision of contemporary recovery focussed mental health services.

Care co-ordination (CPA):
The process of care co-ordination within CPA was for a significant time period, the responsibility of an Associate Practitioner who was working outside their scope of practice. The role of the care co-ordinator was not always clear to the staff who were holding that responsibility.

Carer Support:
The needs of the parents of the patient were not assessed or fully recognised despite them requesting support. There was no evidence that they had been offered a carers' assessment.

Risk Assessment and Management:
The assessment and management of clinical risk was not robust in relation to the patient's care and treatment and there was limited assurance regarding the current approach to supporting staff across the organisation.

Follow up (Disengagement):
The patient disengaged from service contact and as a result was not seen or monitored regularly in the period before the serious incident. As a result there was limited, contemporary understanding of his mental health status and a failure to escalate and address his non-compliance in a timely manner.

Capacity (CMHT):
The patient was not able to access a medical review in a timely manner, in addition there was evidence of wider service pressures associated with high waiting times for care co-ordination. This was in the wider context of the evidence based fidelity model of AOT no longer being available.

Pathways (Discharge process from inpatient to CMH):
Discharge from the ward to the CMHT was not effective in ensuring CPA/care co-ordination/Section 117 responsibilities were met, including continuity of the patient receiving medication.

Communication (Interagency):
There was confusion between the police and the NHS regarding interpretation of the MDO protocol post incident. The police were not familiar with NHS escalation procedures.

Physical Health:
The assessment and intervention of the patient's physical health needs were challenging.

Carer support (Duty of Candour):
The Trust has a duty to be open and transparent in relation to care and treatment. The outcome of the investigation should be made available to the family of the patient's mother.

Drug and Alcohol Issues:

Unable to review notes for drug/alcohol issues.

Case 6	**Incident Date:** 18/06/19	**Coroners Conclusion:** Inquest pending
SI: 2019/13576 (Legacy)	**RiO:**	**Service:** North Cumbria Locality Care Group/Lancashire Health Care Trust

Summary:
Whilst we are aware of this serious incident, there has been an inability to access reports and records for further analysis of this case.

Case 7	**Incident Date:** 30/07/2019	**Coroners Conclusion:** Inquest pending
SI: 354424	**RiO:** 35005	**Service:** North Locality Care Group NRP and recent contact with IRS/Street Triage and discharged from Fellside Ward on the 07/06/2019.

Summary:
A 73 year old female visited her son at his home address and without provocation, it was reported that he started to shout abuse at her. It is reported he then grabbed her around the neck, punching her in the face accusing her of killing his father. At the same time of this attack, his dog reportedly bit her on both arms. The victim was attended to by paramedics and was taken to Northumberland Specialist Emergency Care Hospital (NSECH) with bleeding and serious injuries. She was transferred to Neurosurgery at the Royal Victoria Infirmary (RVI), but unfortunately she subsequently died from her injuries 5 days later, on 4th August 2019. The service user was described as violent on arrest and was originally charged with wounding his mother with intent, however following her death, this was revised to murder. The trial has now been listed for 14/12/2020.

Overview of service user:

At the time of the incident the service user was open Northumberland Recovery Partnership (NRP) services and was being treated for longstanding health needs as a consequences of illicit drug use. He was first referred by his General Practitioner (GP) to specialist mental health services in July 2000 and after significant contact with services, his formulation led to a diagnosis of Opiate Dependency and Mental and Behavioural Disorders due to multiple drug use and other psychoactive substances, psychotic disorder, predominantly hallucinatory. Following Crisis Team involvement, he had required a period of informal inpatient care during May/June 2019. This admission had followed concerns regarding the service user's level of paranoia, delusional beliefs, perceived level of risk and the

fact that he had started to keep a knife with him for his own protection. Following discharge from hospital on 7th June 2019 he had been referred to the Step Up function (part of the Community Treatment Team (CTT)), however for reasons of non-engagement, he was discharged by CTT on 28th June 2019 (3 weeks later) without being seen. Service User was seen on one occasion (20th June 2019) by NRP after discharge from Hospital, this was the last time he was seen by a clinician, and this was 40 days before the attack on his mother.

Findings of the internal investigation:

Pathways (Dual Diagnosis):
Responsibilities across treatment pathways relating to dual diagnosis were not clear. There was no dual diagnosis care plan developed at the point of hospital discharge inclusive of lead responsibilities.

Pathways (Discharge Planning):
The in-patient pathway on Fellside Ward did not provide clear accountability and delivery of a robust pathway leading to discharge (inclusive of active carer involvement).

Care Coordination:
There was limited compliance to the requirements of the process of CPA within inpatients and the community settings. Furthermore, the engagement and DNA policies were not followed by CTT (Step Up).

Carer Support (Family):
The needs of the family were not fully recognised and they were frustrated at their inability to navigate services and obtain support at times of significant distress.

Follow up (Lack of Assertive Engagement):
The patient had not been engaging with the CTT. During Police contact the Street Triage Team response was influenced by the Police Officer on scene's reports that the patient's presentation had improved. The opportunity to assertively engage was not recognised despite a number of key risk indicators suggestive of relapse.

Safeguarding:
The Safeguarding response did not provide robust challenge to the incident reported (incident number 348743).

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
Service User's substance misuse and associated psychotic illness, combined with limited engagement with services, represented a complex and challenging picture to those clinicians offering treatment. As a result, it is determined that Service User's risk to himself and others was longitudinal.

Was the incident/act related to addiction difficulties?
Whilst there was ongoing substance misuse, it is difficult to know if service user was intoxicated at the time of the incident or what impact this had.

Was the individual known to Addiction Services at the time of the incident?
Yes - At the time of the incident the service user was open Northumberland Recovery Partnership (NRP) services and was being treated for longstanding substance misuse issues.

Addictions Learning:

- **Follow up (Addictions)** – Service User did not attend appointment for Addictions medical review and this fact was not communicated within NRP, therefore no further appointment was organised and he was not seen again prior to incident.
- **Physical Health Monitoring (Addictions)** – It was identified that NICE Guidelines around physical health monitoring (ECG) when prescribed >Methadone 100mg was not consistently adhered to due to equipment issues – this was noted on the Risk Register.

Case 8	**Incident Date:** 12/04/2020	**Coroners Conclusion:** Inquest pending
SI: 391661	**RiO:** 542004 and 534308	**Service:** North Cumbria Locality Care Group ALIS East

Summary:
12 April 2020 – Former patient (37 year old, male), last known to services April 2019, was found deceased at home. 15 April 2020 - two former service users have been charged with his murder.
Trial listed for 09/11/20.

Overview of service user:

542004

Service user was seen by Community Mental Health Assessment & Recovery Team (CMHART) for an assessment and twice by ALIS/HT between 2018-2020

He had been referred into CMHART on four separate occasions but only attend on one occasion for assessment, in Feb 2019. At this stage it was felt not to be appropriate for CMHART and signposted to other services.

He was seen by Assessment and Liaison Integrated service (ALIS) in Nov 2019. At this time he reported suicidal thinking daily, and was placed on the 72 hour pathway within Home treatment. At the same time he became homeless and partner (with) children moved into local hostel and he moved into men's hostel. He only attended one appointment within home treatment, despite seven other appointments offered with transport.

Service user reported long standing issues with mood and suicidal thinking, related to his mother's death when he was aged 16 years. Previous self-harming noted and known perpetuator of domestic violence with current partner (children services were involved with the family too).

534308

Service user has been known to services since 2017.

In 2017 he was open to LD team due to anxiety anger management, ADHD. A referral was made to ASC and first step and discharged from LD team on 15/5/17.

A further referral was made to LD from Glenmore Trust on 17/10/19 this was rejected as they were asking for support around healthy eating advice was given on how to explore this.

On 23/4/19 Police made a referral via SPA and spoke directly to a practitioner they were in attendance as service user threatening to use a knife to self-harm. Current issues at college and with neighbours. Police felt happy to leave and he agreed to be contacted later in the day.

Several messages left for service user, however he did not answer phone discharged with a list of contact numbers sent out.

27/6/19 service user contacted the team wanting to talk. Had an argument with flat mate did not want to be seen by team. No further involvement from team at his request.

27/7/19 Flat mate called SPA without agreement from service user. Service user had self-harmed using scissors. Ambulance called. NWAS in attendance contacted the team service user had argued with flat mate agreed to be contacted later.

Team rang back service user felt ok didn't want to talk acknowledged that he struggles with his anger didn't want any further contact from team.

30/7/19 Police contacted SPA argument with flat mate refused input from team.

04/09/19 Police contacted again argument with flat mate lead to self-harm did not want input from team.

10/10/19 Police contact argument with flat mate and threat that she would evict him. Open to ASC, team contacted social worker to inform of contact as service user did not want follow up from Mental health and wanted to talk to his own care team.

04/03/2020

Evidence in RIO notes that a referral had been made to First Step but that they felt his needs would be meet by CMHRT. Plan on 25/03/2020 was that:

GP to refer to ADHD service.

Discuss with social worker if appropriate for a HAWK.

Appropriate for care act assessment. Closed to CMHRT.

Findings of the internal investigation:

In relation to the care and treatment for service user 524004; Due to established organisational processes and competent practices within monitored services, no systemic issues were identified that had potential to cause serious harm. Conversely, **practitioner efforts to maintain contact, including rearranging appointments while working with a resistant client was considered to be an area of good practice.**

The case did highlight the increasing challenges being faced by the mental health services, when they attempt to respond to young adults who are resistant to committing to programmes. It reinforced the significance of treatment integrity within community mental health services.

Therefore, any of the planned treatments or programmes thought likely to help people like the service user, can only be successful if rigorously and properly

implemented. This demands that services have the flexibility to cope with varying problems but also a commitment from the service user to engage with them.

Following the AAR and looking at the information provided in the electronic clinical records (RIO), it was unclear as to the involvement and connection to the homicide being investigated.
Records indicate that the service user spent a period of time at Johns Street Hostel. This is also where the other alleged perpetrator, resided for a period of time.

The service user was not open to the Mental Health Team at the time of the incident. There was no direct evidence or collaboration of the incident and connection with the other charged individual for this death from the information available on the electronic patients notes (RIO).

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. Additionally, there was evidence of 'joined up' working was evident with other services and risk management to mitigate risks to others was in place. The service user was difficult to engage through mental health services and as such did not receive treatment but only assessment at the time of need and crisis. Intervention teams consistently attempted to offer continuity of care and allow for opportunities for him to attend his appointments.

Risks were also managed through children's services, violence to others through MARAC with his partner moving into a women's refuge with support around mental health. Additionally, they were recorded as an alert on the electronic records. His children were open to the Children Safeguarding Team and there is evidence of discussion and joint working processes.

It has to be acknowledged that the service user did not engage in treatment for a significant period for it to be sustainable and provide positive outcomes.
The services demonstrated compliance with the Trust's policies and procedures including:

- The Safe Exit Policy, which was followed due to non-engagement
- The electronic notes and documentation, the GRiST risk assessment was also completed appropriately

In relation to the care and treatment for service user 534308:
The specific findings as identified in this review concern the presentation of service user 534308, his individual coping strategies, the wider social context of his home environment and his apparent reliance on cannabis. There is also reference to a possible personality disorder (anti-social initially and reference in 2019 to emotionally unstable personality disorder).

The documentation review, and the AAR meeting and the subsequent report noted these contacts, referring to the following observations.
We considered these to be an example of good practice.

- Appropriate referrals and responses to the service user's contact and involvement with services. Significant number of services were involved or were identified which could have assisted him in managing and working through the issues pertinent to him

- Although the service user had limited intervention and treatment with Mental Health Services, the assessment and documentation outlined a clear and descriptive summary of identified needs and main issues. It also provided a clear plan regarding additional support

- Competent multi professional working, across the wider system, including between First Step and CMHART in March 2020. There was additionally good evidence of communication and co-ordination between the Community Team, First Step and AB's social worker. Advice was also provided to the Police on the occasions they attended the service user's home address

- Wider system support. Social care input and involvement, including the allocation of a social worker. He was starting to engage with and receive support from housing, and from the Glenmore Trust

- No recommendations are made in relation to the care and treatment provided to both service users. The review did not identify any service-related areas that contributed to the incident. The contributory factors analysis undertaken confirmed that the main features of this case pertained to patients/clients' factors

No specific learning or recommendations were identified for services or the Trust as a whole.

It has been confirmed by NHSE that this case does not fit the criteria for an independent investigation.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
542004
There were no formal referrals to addiction services in CNTW.
Alcohol AUDIT had never been completed.
November 2019 – denied alcohol use, admitted daily cannabis use
534308
Alcohol AUDIT had never been completed.
April 2019 – reported no alcohol or drug use at latest contacts. Reported historical drug use.

Was the incident/act related to addiction difficulties?
Unknown in both cases.

Was the individual known to Addiction Services at the time of the incident?
542004

There were no formal referrals to addiction services in CNTW. It is unclear if there was any engagement in addiction services outside of CNTW but there was no clear indication of this in the RiO record.

534308
RiO records that this service user was known to Cumbria Drug Services (Unity – provided by GMMH) but had been discharged. States issues were around cannabis only, which would have prompted the offer of low level Recovery Support.

Addictions Learning:

- **Alcohol AUDIT** – this had not been completed in 542004
- **Alcohol AUDIT** – this had not been completed in 534308

Case 9	**Incident Date:** 29/04/2020	**Coroners Conclusion:** Inquest pending
SI: 394847	**RiO:** 86183	**Service:** Northumberland Recovery Partnership (NRP)

Summary:
Patient (37 year old, male) has been arrested and charged with the murder of a patient (34 year old, male), following an incident on 29 April 2020. He has been remanded to HMP Durham, trial listed for 26/10/20.

Overview of service user:

Service user is a 37 year old man who has spent much of his adult life involved with Addictions Services. He has also had periodic contacts with Community Mental Health Services and Crisis Teams, initially with a diagnosis of depression and subsequently EUPD alongside Post Traumatic Stress Disorder.

It has proven difficult to engage with him in any meaningful mental health engagement while he was actively abusing substances. He was often allusive and difficult to contact until he alerts services following a significant incident. His presentations appeared to deteriorate over the last 12 months following a significant event and changes in peer group. There were increased chaotic presentations, increased risk and alcohol use emerged, complicating ongoing illicit drug use.

In September 2019, he was discharged from the Community Treatment Team due to these difficulties in engaging him in meaningful treatment due substance use. It was suggested that he engages with addiction services fully to address his alcohol and substance use with a view to re-referral following this. Efforts over the last 12 months have been around assertive attempts to sustain in addictions treatment with evidence clearly indicating the benefits of maintaining Opiate Substitution Prescribing, which despite poor engagement, was maintained throughout.

Findings of the internal investigation:

No specific recommendations have been highlighted.
This was a particularly challenging case as the service user was receiving care and treatment from a number of organisations and could be extremely difficult to

engage. 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. Documentation was maintained to a high standard and the use of alerts was effective in highlighting safeguarding and risk concerns.

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.**

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
37 year old man who has spent much of his adult life involved with Addictions Services -It had proven difficult to engage service user in any meaningful mental health engagement while he was actively abusing substances.

There was a circularity of referral and none-engagement with addiction and mental health services and services became somewhat impotent in preventing incidents as it was at the point of deterioration they had less contact with service user.

Was the incident/act related to addiction difficulties?
Unclear, service user was regularly under the influence and engaged with a peer group who also used illicit substances and alcohol. A high level of risk indicators were present in the 18m leading up to the incident, however, AAR agreed, it was impossible to predict when or what may occur. Good practice in managing risk and maintaining in addiction treatment was recognised.

Was the individual known to Addiction Services at the time of the incident?
Yes - Efforts in the 18 month preceding the incident were around assertive attempts to sustain in addictions treatment with evidence clearly indicating the benefits of maintaining Opiate Substitution Therapy (OST), which despite poor engagement, was maintained throughout.

Addictions Learning:

Positive practice - 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

Case 10	**Incident Date:** 25/07/2020	**Coroners Conclusion:** Inquest pending
SI: 408300	**RiO:** 435121	**Service:** Sunderland Psychological Wellbeing Service

Summary:
Patient (26 year old, male) was arrested for s20 GBH on his brother who was injured and hospitalised in a coma – he has since died and patient has been arrested for murder.

Overview of service user:

Service user first became known to mental health services at the end of October 2016 following taking an impulsive mixed overdose which he attributed to social stressors impacting on his mental wellbeing. DR initiated his own rescue, shortly after taking the overdose, and was taken to the local accident and emergency department by his (adoptive) mother. At the time, he was offered an assessment by the PLT (Psychiatric Liaison Team) and he reported a six month deterioration in his mood. Following assessment a referral was made to the SPWS (Sunderland Psychological Wellbeing Service) for support in managing his low mood, he was prescribed antidepressant medication by his GP and he began to take practical steps to address other stressors (debt, unemployment) also contributing to his low mood. Whilst with SPWS, he attended a psychoeducational class to support him in learning strategies to manage his mood: he engaged well with this class and mutually agreed discharge on 12th January 2017.

On 18th March 2019 the service user self-referred to SPWS on the advice of his GP and was triaged the following day: during triage he described a new symptom of auditory hallucination and a referral was agreed to the EIP (Early Intervention in Psychosis) Team for further assessment. On 19th March 2019 the CMHT (Community Mental Health Team) received a paper referral from his GP and following a discussion between the Teams it was agreed that the referral to EIP was still considered the most appropriate plan for the service user. Following an assessment with EIP on 20th March 2019, it was identified that there was no evidence to support a first episode of psychosis: he was placed on the waiting list for one to one Hi Intensity Therapy within SPWS. He commenced treatment on 7th October 2019. His goals for therapy were to manage social anxiety and panic attacks, to increase low mood and motivation and to improve sleep. Risk was rated as low, it was reviewed and details were documented in every attended therapy appointment within the clinical contact notes. He attended 12 of 15 appointments offered to him and engaged well in therapy. At discharge on 7th April 2020 he reported his mood was bright and stable, his sleep had improved and his confidence in social situations had improved. The self-rating scale scores indicated recovery.

Findings of the internal investigation:

No system or services issues were identified in this review that had the potential to cause serious harm. The significant findings, therefore, focus on the examples of **good practice** as highlighted in this report. To summarise, they are:

- Effective communication between services during DR's engagement across the teams. This is particularly highlighted in his treatment episodes of March 2019

- The timeliness of assessments and the actions taken by the Initial Response Service the EIP team and SWSP in March 2019, which ensured that the issues presented by DR at that time were addressed, avoiding any detrimental confusion and duplication of services

- Good record keeping and clinical documentation. There was evidence of comprehensive assessments and plans, incorporating an individualised and person-centred approach. Particular reference is made to the clinical notes completed during his last period of engagement with SPWS

Robust systems and procedures, including the waiting list ‘backdating’ in March 2019 to ensure he received the appropriate service as soon as possible and the management of potential areas of risk.

No key issues or areas of learning were identified, following an examination of documentation, and as examined in the AAR.

No recommendations are made in relation to the care and treatment provided to this service user. The review did not identify any service-related areas that contributed to the incident. The contributory factors analysis undertaken confirmed that the main features of this case pertained to patient/client factors. Furthermore, the service displayed effective and robust working practices.

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
October 2016 – Denied ever using illicit drugs.
March 2019 – RiO highlights impact alcohol has on mental health. Declined any support for this but did commit to reduce.
No Alcohol AUDIT undertaken.

Was the incident/act related to addiction difficulties?
Unknown.

Was the individual known to Addiction Services at the time of the incident?
No referrals to addiction services.

Addictions Learning:

- **Alcohol Audit –** not undertaken despite clear indication of impact on mental health
- **Pathways –** need for support not revisited, scaffolding support was not considered

Case 11	Incident Date: 03/08/2020	Coroners Conclusion: Inquest pending
SI: 409680	**RiO:** 473153	**Service:** Sunderland Addictions Wear Recovery

Summary:

Service user has been arrested for murder and subsequently charged with manslaughter. He has been named responsible for an assault where the victim has died. The assault occurred on 01/08/2020 and he was taken into custody on 03/08/2020.
Sentenced to imprisonment 5 years and 4 months.

Overview of service user:

Service user has had 5 referrals to Wear Recovery, his first referral being 21/02/2018. Referrals were received from prison as part of release plans on numerous previous occasions he failed to engage. His current referral was opened 27/11/2019 after he represented within three months of being closed due to non-engagement.

His engagement with Wear Recovery was poor. He would frequently miss appointments and since referring in November 2019 he missed numerous appointments and did not start on opiate substitute medication until 28/01/2020. He later disengaged from treatment and did not collect his OST from the pharmacy last collection 7/2/20. Multiple attempts were made to reengage him before he represented on 15/04/2020. An instant urine screen tested positive for buprenorphine, amphetamine and cannabis. Service user attended his titration appointment on 21/04/2020 and remained on his Opiate substitute medication (Buprenorphine) until the time of this incident.

He engaged with Wear Recovery until 28/05/2020 when he started to miss telephone appointments. Contact was re-established as he attended the service on 28/5/20 and rang in June to report COVID19 symptoms. In July he missed a planned telephone appointment. However, he continued to collect his OST medication regularly and the pharmacy reported no concerns.

Service user had previously been assessed by mental health services in prison, low mood and anxiety noted at the time. GP records state PTSD, physical and sexual childhood abuse noted.

His notes reflect 3 MARAC referrals, custodial sentences for burglary and attempted arson, GBH and section 18. Probation advised he was a medium risk to staff (police officers). There was no issues noted by Wear recovery staff when attending appointments. He has not been observed to attend the service with the victim, however they lived in the same area, no other link known by the service.

Findings of the internal investigation:

The review and the AAR did not identify any issues of concern or for service improvement. From this review and from the AAR, good practice was identified in both the care and treatment of Mr LW and with regard to the victim of the incident On examination of the documents and in discussion with practitioners, the following areas of good practice were noted:

- The core documentation viewed was felt to be of a good standard. There were clear records which detailed the contacts and liaison with professionals external to the Trust including the probation services

- Face to Face review was offered during COVID-19 in relation to perceived risks of disengagement and attempts to safely maintain service user in treatment – this approach is in line with evidence based and best practice in drug treatment

- Optimising of medication (OST) due to ongoing positive drug tests – again, this approach is in line with evidence based and best practice in drug treatment. Furthermore, Naloxone was offered to service user to support effective harm reduction and reduce the risk of fatal overdose

- There was a clear offer of evidence-based drug treatment to include Opiate Substitution Therapy (OST) and Psychosocial interventions (PSI)

- There was a consistency of service offer, despite service user's lack of engagement in an effective programme. The practitioners within the service sustained motivation to explore, offer and continue contact despite minimal motivation from service user

- The support provided to service user's brother was highlighted as good practice and this has been maintained following the incident

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
July 2019; Alcohol AUDIT undertaken – Score of 0.
Admitted to using illicit buprenorphine alongside his prescription of OST.
Also using illicit amphetamines.
No Face-Face just prior to incident as self-isolating for COVID – 19 symptoms.

Was the incident/act related to addiction difficulties?
Unknown.

Was the individual known to Addiction Services at the time of the incident?
Yes – engaged with Wear Recovery and in receipt of OST prescribing (Buprenorphine 24mg) – optimised dosing.

Addictions Learning:

The pressures on the services during COVID-19, the various demands currently faced and the changing of practice to adhere to current guidelines and regulations were highlighted in the LAAR. In examining the documentation and in light of recent SI reviews, the LAAR highlighted that it may prove of value for CNTW to consider the recommendations identified below:

- **Learning -** Undertake a brief modified thematic analysis of previous cases which may indicate some underlying demographic factors which confound the ability of services to work with those individuals who have multiple issues/needs and complex motivational factors. We consider that this may be beneficial in identifying possible ways forward and service approaches, learning from a collective and systematic overview

- **Risk Assessment/Formulation** - Exploration of the utility of engagement methodology (including Trauma informed approach as highlighted by commissioners in previous reports). We recognise the continuing trend of 'difficult to engage' individuals where an examination of additional approaches, supporting the specific remit of the teams, in managing the issues presented to them. This should be assisted by holistic formulations

- **Risk Assessment/Formulation** - Individual service user formulations to be reviewed prior to handover. Training needs analysis to be included in handover to CGL

Case 12	**Incident Date:** 11/09/2020	**Coroners Conclusion:** Inquest pending
SI: 416005	**RiO:** 79543	**Service:** Central Locality Group Gateshead CTT

Summary:
Service User (on waiting list) arrested and charged with murder. Service User was convicted of murder in February 2021 and was sentenced in April 2021. Service User received a life sentence with a minimum term of 19 years to be served. His partner was also convicted of perverting the course of justice.

Overview of service user:

Notes indicate an initial referral in 1998 to Forensic Adolescent Services, which was discharged after eight weeks (there are no records held electronically on this period). The next recorded contact is in 2009 when service user is referred to Gateshead CTT, possibly by Gateshead CJLD services. He was initially seen by CTT SHO, and subsequently referred to the Community Forensic PD Team. The Team planned to allocate a CPN in order to support, as well as providing ongoing review via a consultant. The notes do not indicate the outcome of this referral to Forensic Services, but they do highlight overall poor engagement with services, and it appears he was discharged from CTT in December 2010.

Next contact with CNTW services was in 2015, when he contacted IRS services. He reported an increase in anxiety and stated that he was unable to leave the house. At the conclusion of the call he agreed to discuss the option of Talking Therapies with his GP.

The next recorded contact with services is on 27th October 2019, when the service user contacted CNTW CRHT. He complained of experiencing an increase in 'voices' telling him to kill himself. He was assessed at home. The result was a forward referral to Gateshead CTT, with a recommendation to consider involving

Forensic Community Services. There was no perceived need for home based treatment at that time.

The referral from CRHT was discussed at CTT on 31st October 2019, with a clinical lead designated to write to the service user's probation officer recommending that they refer to Forensic Community PD Services for further treatment.

On the 24th January 2020, he contacts Newcastle and Gateshead CRHT complaining that he is worried about increasing suicidal ideation. He spoke with a team member via telephone, and was advised to discuss with his Probation Officer a referral to Forensic PD Team.

On the 11th May 2020, a referral via the GP is discussed at Gateshead CTT Single Point of Access meeting. The referral is from the GP (dated 27th March 2020) stating that neither the GP nor Probation can refer to the Forensic PD Community Team due to commissioning issues, and as a result are making a referral to the CTT.

As a result, the service user is offered an appointment for assessment with Gateshead CTT on 1st June. He attended, and it was identified as a case for engagement with CPN and Consultant to address issues around anxiety, low mood and self-esteem. It was also noted that issues around childhood trauma may need to be treated following initial stabilisation. A potential for a referral to Forensic Psychology was also identified dependent upon initial engagement with a care coordinator. Although there was a lack of imminent risk, due to the history of self-harm and violence, risk was RAG rated as Amber.

He was placed upon the waiting list for allocation to a CPN. In accordance with waiting list management procedures, he was successfully contacted by a clinician on 30th July. A subsequent attempt at contact was made on the 27th August, but without success.

Findings of the internal investigation:

The investigation did not identify a single or a root causal chain to this incident, however the ARR and the review have noted the following areas of additional findings and subsequently learning. The key points to consider have been identified as those pertaining to the delay in processing referrals and the impact on assessments and potential interventions, the wider commissioning issues concerning the referral processes between the probation service and the forensic service and the follow up practice for clients who the service have had difficulties maintaining contact.
The additional findings are:

Pathway:
There was a significant delay in the referral being processed from the date of the GP referral on 27th March 2020 to 11th May 2020 when the referral was 'uploaded' onto the Single Point of Access system. Subsequently this manifested in a significant delay in the assessment process. This was identified by the clinicians at that time.

Pathway:

As recognised during the review and in the AAR report, there appears to be a discrepancy in the forensic/probation referral interface. This is in relation to the acceptance of referrals. The Forensic Personality Disorder Team can only consider referrals from the statutory National Probation Service as opposed to those from the private sector providers. Whilst we acknowledge the reform of the probation service in 2021 may address this area, it is further noted that the referral route in place prior to and at the time of the June 2020 assessment delayed the assessment process significantly. The finding also recognises the difficulties in understanding the overall referral process.

Communication:
In the referral initially made to the Gateshead Community Treatment Team on 30th October 2019, it was advised that Service User's Probation officer was contacted and asked to make a referral to the Forensic Community Mental Health Team. This was due to several factors including risk of re-offending, risk to others, psychopathic personality, lack of remorse and lack of motivation to change. However, it appears that there is no evidence that this was followed up. If the status of the referral had been known and had not occurred, it may have been then beneficial and practicable to discuss the case further at the Single Point of Access meeting to see if an alternative plan may have been constructed. This may have delayed a potential assessment.

Follow up:
Following a brief contact with the Crisis Team on 24th January 2020, Service User should attempt to contact his Probation Worker on 27th January 2020 to see if he had been referred to the Forensic Service. This again may be seen as a missed opportunity for services to establish that this referral had not gone ahead. This consequently delayed the assessment process further. This is in light of the GP referral to the services until 27th March 2020. It appeared that it was Service User who should ascertain and clarify the progress of the referral.

Follow up:
It appeared that there were no documented follow up contacts for the unsuccessful contacts from the CTT after 27th August 2020**.**

However, the following were identified as good areas of practice

- The assessment of 1st June 2020 and associated documentation were comprehensive and detailed

- On occasions when the team met with or communicated with Service User, there was evidence of good engagement

Drug and Alcohol Issues:

If present, how significant the addiction difficulties were prior to the incident?
It was documented that Service User in the past used illicit substances, and specifically dependence on opiates. Service User received drug addiction therapy via his GP in 2015. In 2019, Service User reported, that at that point, he had not used substances for two years

Was the incident/act related to addiction difficulties?
No evidence to suggest this

Was the individual known to Addiction Services at the time of the incident?

No

Addictions Learning:

No identified learning for Addiction Services.
Wider system –

- **Alcohol AUDIT -** There was no Alcohol AUDIT undertaken by mental health services
- **Pathway -** A risk of resuming substance misuse was identified but there was no referral to Addiction Services for Relapse Prevention – it is unclear if mental health services are aware of this pathway/offer

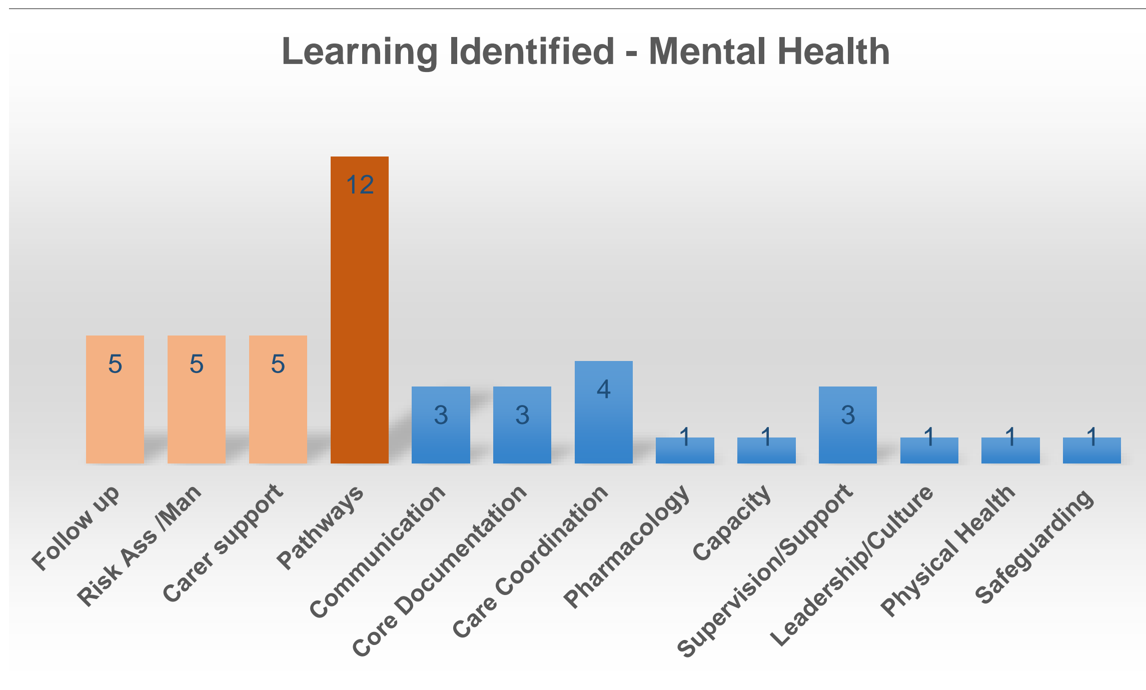
Findings of the Review

All of the cases have been 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 there are a number of cases identified with positive practice in the findings alongside additional learning and these should also be used for learning purposes.

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:



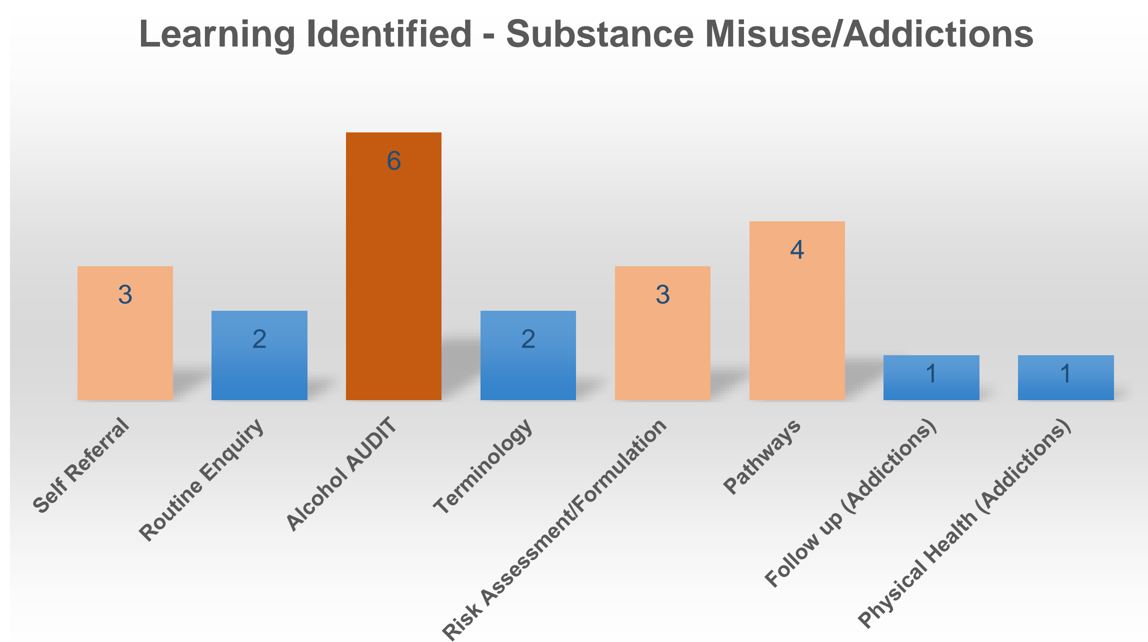
The area of learning which most appears is that *of **Pathways***. Pathways learning particularly references smooth and timely transitions or referrals between services including in-patient to community services and also referral to other specialisms. Timeliness of waiting lists and also discharge arrangements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

There was also one recommendation highlighting the need for a thematic review of learning across addiction incidents to identify any lessons learnt around underlying demographic factors which confound the ability of services to work with those individuals who have multiple issues/needs and complex motivational factors.

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 patients 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 the 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.