# An independent investigation into the care and treatment of a mental health service user (Mr N)

## February 2022

**Executive summary**

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Our report has been written in line with the terms of reference as set out in the proposal for an independent investigation into the care and treatment of Mr N. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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# Foreword

This report concerns the care and treatment of Mr N who killed 'L' on 16 August 2016. Although this report concerns the care and treatment of Mr N and does not tell the story of 'L', he should be remembered, as a young life tragically cut short.

We found in this investigation that the killing of 'L' was not predictable. However, we believe that it was preventable.

The services involved have developed action plans to implement the recommendations from this report and we urge services involved in the care of young people with serious mental health problems and a history of substance misuse to take note of this report and its findings.

Services are now more aware of the endemic problems of 'county lines' drug gangs and their exploitation of vulnerable young people, especially when they have mental health problems. However, more work remains to be done to ensure that services work together to address this problem, so that young people with such a background are treated and supported in the community and not left vulnerable to exploitation, despite the risks they may initially present to others.

In July 2018, the Health Service Investigation Branch (HSIB) published a report into the care and treatment of a young person who committed suicide as they transitioned between Children and Adolescent Mental Health Services and adult mental health services. A recommendation was made about the responsibilities of NHS England and NHS Improvement to work with the commissioners of mental health services to ensure that the care of a young person before, during, and after transition is shared in line with best practice, including joint agency working.

We have identified further areas for improvement relevant to all wider health and social care systems involved with the care and treatment of young people with mental health problems, and we make an additional four recommendations to be taken forward nationally and for all services to consider:

**Arrangements and decision-making regarding accommodation for 18+ care leavers after discharge from an inpatient mental health service.**

We found a lack of effective interagency working between NHS mental health services and local authority 'Looked After Children' structures. This resulted in unstable accommodation, contributing to a lack of effective assessment and care planning. The unregistered accommodation was a 'last resort' solution, which in our view, was only necessary because of a lack of proactive assessment, care, and treatment.

**Regional Recommendation 1**

The North West London Integrated Care System to seek assurance that all planning for care leavers discharged from mental health in-patient services formally involves the relevant local authority. Furthermore, to seek assurance that the application of Section 117 Mental Health Act has been considered for patients who have been detained under Section 3 MHA.

**Identification of and interventions for young people at risk from bullying and undue influence.**

Despite system-wide programmes in place to identify and intervene in Child Criminal Exploitation, grooming and radicalisation, we found a lack of curiosity about the 'red flags' in this case. It was clearly possible for these issues to be 'hiding in plain sight' in 2016, but systems should be much more aware of the issues at hand, and the risks posed to vulnerable young people by these criminal gangs.

**Regional recommendation 2**

The North West London Integrated Care System should seek assurance that an understanding of the risks to vulnerable young people of 'county lines', and gang related threats is embedded in all services and systems dealing with the mental health of young people. This will help to ensure there are no opportunities for misperception and that vulnerable young people with serious mental health and substance misuse problems receive appropriate and timely services that meet their needs.

**Antipsychotic depot prescription and administration to under 18s**

As part of our background research, we have found that licensed medications for the treatment of psychosis for under 18s are very limited. Despite this it is clear they are widely prescribed as oral preparations, and less commonly as depot prescriptions. The safety and clinical data in this age group is also limited, and there are no depot medications licensed for the treatment of psychosis in under 18s. More research is needed to guide the use of antipsychotic oral and depot medication in under 18s.

**National recommendation 1**

NHS England & Improvement should work with the relevant organisations to develop guidance for the prescribing of oral and injectable anti-psychotics for the treatment of psychosis for under 18s.

**Nick Moor,**
**Partner,**
**Investigations & Governance,**
**Niche Health & Social Care Consulting**

# Executive summary

## Mr N

1.1 Mr N was born in the UK. He is the only child of his parents, Ms N and Mr I. Mr N's mother came to the UK from Africa. It is reported that his parents divorced, and Mr N continued to be cared for by his mother while his father maintained contact with him.

1.2 In 2014 Mr N was accommodated by the local authority under Section 20 Children Act 1989.[1] He returned to the care of his mother in April 2016, with be support from the Local Authority Leaving Care Team.

## The homicide

1.3 At about 15.30 in the afternoon of 16 August 2016, L was sitting at a table in the office at the accommodation with an administrative assistant who was visiting the property. Mr N entered the room, he approached L and removed a large knife from his bag. He slashed/stabbed at L aiming for his upper back. To escape, L went out through the open office window. Mr N followed him onto the street where he stabbed him repeatedly in the back.

1.4 Mr N walked away and after a short distance he disposed of the knife over a high wall. He disposed of the jumper and jogging bottoms that he was wearing in a car park.

1.5 Despite the efforts of a local resident and the emergency medical team L was declared dead at the scene at 16.37.

1.6 The police were provided with Mr N's description by a witness to the attack and Mr N. He was found and arrested at for attempted murder.

1.7 Mr N pleaded not guilty to the murder of L but guilty to manslaughter. He was detained on a Hospital Order under Section 37 Mental Health Act (MHA) with a restriction order under Section 41 MHA[2], without limit of time.

## Relationship with the victim

1.8 L was already a resident at the semi-independent accommodation when Mr N moved in, having been placed there by the local authority. It provided accommodation for up to four young people at a time.

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[1] *Provision of accommodation for children: general.*

*(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of:*

*(a)there being no person who has parental responsibility for him;*

*(b)his being lost or having been abandoned; or*

*(c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.* http://www.legislation.gov.uk/ukpga/1989/41/section/20

[2] *Powers of courts to order hospital admission or guardianship, with limits on discharge.* http://www.legislation.gov.uk/ukpga/1983/20/section/37

1.9 There was limited information available to the investigation about the relationship between the two boys. However, after the homicide the Leaving Care team were made aware of tensions between Mr N and L by the accommodation provider.

1.10 Mr N had attended A&E the day before the homicide for a superficial injury to his mouth, but he did not stay for treatment. It is unclear how this injury was sustained. Information available after the homicide suggested that there may have been an incident involving L, but the team was unable to substantiate this.

## Mental health history

1.11 Mr N was under the care of Trust 1 Child and Adolescent Mental Health Services (CAMHS) prior to his being detained under the Mental Health Act to a secure unit (the Unit) in November 2015. The Unit was a service provided by Trust 2. Mr N was under the care of Trust 2 community services at the time of the homicide.

1.12 Mr N had been using cannabis from the age of 12 and continued to do so up to the homicide. His offending history began at the age of 14 and by the time he was admitted to the Unit he had convictions for a variety of criminal offences.

1.13 Prior to his admission to the Unit Mr N was accommodated by the local authority under Section 20 of the Children Act (1989). This ended prior to his discharge from the Unit to his mother's address in April 2016. However, he remained under the care of the local authority Leaving Care team.

1.14 While detained to the Unit Mr N was diagnosed with first episode psychosis and commenced on a depot injection.[3] Mr N was discharged from the Unit six weeks before his 18th birthday. The Early Intervention in Psychosis team (EIP) at Trust 2 did not accept patients under the age of 18, so Mr N was discharged to the temporary care of Trust 2 CAMHS, with a plan to transfer him to EIP on his 18th birthday.

1.15 Mr N was cared for under the Care Programme Approach (CPA) by Trust 2 CAMHS. However, he did not have a named care coordinator; care was provided by a junior doctor from the team. Mr N attended some appointments with them. His first depot post-discharge was provided by the Recovery team. The CAMHS junior doctor made arrangements for subsequent depots and Mr N received his last depot on 1 June 2016. EIP accepted responsibility for his depots from this point onwards.

1.16 While under the care of CAMHS Mr N committed some criminal offences which included shoplifting, taking a car without permission and criminal damage. His mother reported being unable to manage him.

[3] *A depot injection is a long-lasting injection of antipsychotic medication.*

1.17 A professionals meeting was held on 29 June 2016, attended by EIP, CAMHS and the local authority social worker, SW1. SW1 thought that there were signs that Mr N's mental health was deteriorating: non-compliance with his medication, increasing criminality and challenging behaviour towards mother. The plan from this meeting was for his care to be transferred to EIP, for EIP to look for alternative accommodation for Mr N, and for consideration to be given to an assessment under the MHA.

1.18 Mr N did not engage with EIP, attend planned medical reviews or receive his depot. The team did review Mr N in weekly multidisciplinary team (MDT) meetings, but no assertive plans were developed to engage with Mr N.

1.19 By the 18 July 2016, his mother was not willing to allow Mr N to live at her address. Following an appearance in court he was accommodated at a bail hostel. The hostel was not aware of Mr N's mental health problems. The hostel became concerned about his behaviour and following a phone call with the EIP care coordinator they ended the tenancy on 4 August 2016.

1.20 Mr N was now homeless. He returned to live with his mother while the local authority looked for alternative accommodation.

1.21 The local authority followed its agreed process to find accommodation for Mr N. There was only one provider willing to provide Mr N with accommodation and support. This was an unregulated accommodation provider.

## Findings

### The Unit

1.22 Mr N was treated in line with NICE guidance, 'psychosis and schizophrenia in children and young people: recognition and management'.[4] The psychiatric assessments completed on the Unit resulted in a revised diagnosis and medication regime for Mr N.

1.23 A thorough psychological assessment was completed by the Unit psychologist. This brought together information from psychological assessments completed by other services in the past, in addition to psychological assessments completed while Mr N was on the Unit.

1.24 The Unit psychologist completed a Structured Assessment of Violence Risk in Youth (SAVRY)[5] for Mr N. We have not been able to establish how widely this was shared with community services. We were told that it was shared with the CAMHS consultant along with the Unit discharge summary. However, the SAVRY was not uploaded to Mr N's electronic clinical record until September

[4] *NICE: Psychosis and schizophrenia in children and young people: recognition and management. Clinical guideline [CG155] Published date: 23 January 2013 Last updated: 26 October 2016.* https://www.nice.org.uk/guidance/cg155

[5] *Borum, R., Lodewijks, H. P. B., Bartel, P. A., & Forth, A. E. (2021). The Structured Assessment of Violence Risk in Youth (SAVRY). In K. S. Douglas & R. K. Otto (Eds.), Handbook of violence risk assessment (pp. 438–461). Routledge/Taylor & Francis Group.*

2016, so we are unclear if this assessment was available to the CAMHS junior doctor and EIP.

1.25 Family therapy was provided for Mr N and his parents. This supported the Unit to develop a good relationship with them. However, they did not fully explore with the family the impact of their cultural background on their understanding of mental illness and Mr N's need for treatment, especially his need for medication. Furthermore, Mr N discussed the view that his local community had about mental health issues in a psychology appointment, but there is no evidence that this was shared with the wider team.

1.26 Mr N was involved in the discussions and decision making about his medication options. He recognised he could be non-compliant with medication in the community and agreed to a long-lasting anti-psychotic (depot).

1.27 The Unit did not recognise that it was rare for a young person to be prescribed depot medication and that community services might not have been equipped to provide this. The discharge plan did not explore how Mr N would access his depot beyond the provision of the first depot post-discharge.

1.28 Mr N was provided with opportunities to leave the ward on escorted and unescorted leave. Mr N absconded a number of times while on leave from the ward. The Unit did not demonstrate any professional curiosity about what Mr N did or where he went when he absconded from the Unit. They did not complete any assessments of Mr N's risk and vulnerability when he absconded from the ward.

1.29 There were plans made for home leave and overnight leave, but these did not happen. No carer or risk assessments were completed with regard to Mr N returning to live with his mother.

1.30 The Unit's response to Mr N's assertions that he was being bullied by peers whilst on the Unit were not adequate.

1.31 The discharge from the Unit did not consider the NICE guidance on transitions. This contains advice about the risk of transferring children and young people between services and warns against transitions between multiple services in a short period of time.

1.32 Mr N was discharged from the Unit six weeks before his 18th birthday and he became the victim of 'birthday services', i.e., the imposition of strict age criteria which excludes a patient from accessing a service. Mr N was discharged to the care of CAMHS with an ad hoc agreement for them to support Mr N's depot and then to transfer his care to EIP.

1.33 There was no relapse plan in place with clear relapse indicators identified or a contingency plan, other than to take Mr N to A&E should he deteriorate.

**Trust 2 CAMHS**

1.34 The CAMHS team could be viewed as a 'holding' service until Mr N's care and treatment could be transferred to EIP on Mr N's 18th birthday.

1.35 The junior doctor from the Trust 2 CAMHS made extensive efforts to engage him and to ensure his depot medication was administered. The CAMHS junior doctor developed a rapport with Mr N, and Mr N did attend some planned appointments. They also met with his mother.

1.36 Trust 2 CAMHS did not complete a CPA review for Mr N when he was discharged to the care of the EIP. Had a CPA review been completed in line with the Trust policy it would have allowed for the team to articulate the challenges in providing Mr N with his depot, as an unmet need.

1.37 The CAMHS junior doctor did complete thorough mental health state assessments for Mr N, and these are clearly recorded in the clinical notes.

1.38 The CAMHS junior doctor completed a good transfer of care to EIP. Although this was completed over the phone, there was a professionals meeting prior to this with EIP and the local authority social worker.

1.39 The Trust 2 CAMHS did not routinely provide depots and the initial dose was provided by an adult community team. The CAMHS junior doctor endeavoured to provide Mr N with his depot despite several challenges, which included the CAMHS service not providing depots and not understanding the prescribing process.

1.40 CAMHS did not update the Trust risk assessment in line with the Clinical Risk Policy. There was a requirement to do this when Mr N transitioned from the Unit; when high risk incidents were reported to the team i.e., criminality; and when he missed his depot.

**Trust 2 EIP**

1.41 EIP accepted Mr N for an extended assessment of his mental health needs. However, in our view EIP staff spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Unit.

1.42 Mr N had an identified care coordinator and was being cared for under CPA. However, they did not complete an assessment or CPA review for Mr N. Nor did they have any face to face contact with Mr N or his mother while Mr N was under their care. It was agreed on 3 June 2016 that the EIP Support Time and Recovery worker would work with Mr N. This did not happen and was a missed opportunity for the team to develop a relationship with Mr N.

1.43 Mr N was reviewed weekly by the EIP MDT, and he was placed in the 'red zone'.[6] However, this did not result in the team taking a more assertive approach to engage with him.

[6] *Indicating he had a high level of need.*

1.44 EIP did not update the Trust risk assessment in line with the Clinical Risk Policy. There was a requirement to do this when Mr N transitioned from CAMHS; and the increased risk indicators were:

- Mr N was not engaging with EIP;
- he missed his depot;
- his criminality increased, and
- there were reports that Mr N had spat at his mother when she would not give him money.

1.45 No risk assessments were completed for Mr N after he left the Unit so there was no assessment made of his risk to others.

1.46 EIP were not assertive in their approach to the care and treatment provided to Mr N. He was placed in the 'red zone' for the whole of the time he was under the care of EIP. However, the strategies and plans were not comprehensively documented. No timeframe was identified for escalation if Mr N did not engage with the team. The plan remained the same from week to week.

1.47 EIP were rigid in their approach and not assertive with Mr N about the provision of the depot. They were reliant on Mr N attending the team base and would not provide a depot at home because Mr N was not known to them, and this was identified as a risk.

1.48 The EIP team did not make sufficient efforts to engage with the police, courts and social workers in the face of a deteriorating situation, and no direct contact was made with Mr N.

1.49 EIP did not recognise that Mr N's non-compliance with his medication was a relapse indicator.

**Alcohol and substance misuse management**

1.50 Mr N declined offers of support from mental health services to manage his substance misuse. He was offered but did not attend a session with the local authority substance misuse worker, but he did not continue to engage with them.

1.51 Given Mr N's history of substance misuse mental health services did not consider Mr N to be a dual diagnosis patient and he was not offered an assessment, treatment and advice as such.

**Transition between the services**

1.52 The NICE guidance 'transition from children's to adults' services for young people using health or social care services'[7] should have informed Mr N's discharge from the Unit, as he was six weeks short of this 18th birthday.

[7] *Transition from children to adults' services for young people using health or social care services. NICE guideline [NG43] (2016).* https://www.nice.org.uk/guidance/ng43

1.53 Had this been used to inform the process, better consideration might have been given to:

- ensuring that Mr N received appropriate support with his psychosis;
- his social and personal circumstances, especially the appropriateness of him returning to live with his mother;
- addressing outcomes including education, community inclusion, health and well-being, including his emotional health; and,
- his independent living and housing options**.**

1.54 The guidance is clear that 'the point of transfer should not be based on a rigid age threshold and take place at a time of relative stability for the young person.' Mr N's rapid transfer through CAMHS to EIP was based on the application of a rigid age threshold and there was no period of stability for Mr N.

1.55 The series of rapid transfers between services is not in keeping with the NICE guidance that states young people should 'routinely receive care and treatment from one single multidisciplinary team (MDT); are not passed from team to team unnecessarily; do not undergo multiple assessments unnecessarily.'

**Application of the Mental Health Act**

1.56 The MHA was correctly applied to Mr N throughout his detention at the Unit.

1.57 However, there was no justification to support the admission to a medium secure mental health unit. We would have expected to see a discussion at the CAMHS national network meeting, but there was no record of such a discussion in the clinical notes. The decision to admit was made by the individual clinicians.

1.58 Consideration was not given to Mr N's right to a referral for support from social care under Section 117[8] MHA following his discharge from the Unit.

**Inter-service and agency communication**

1.59 There was clear evidence that the Unit worked collaboratively with all the agencies in the community who supported Mr N. Although neither the Unit nor the local authority social worker considered Mr N's entitlement to an assessment of his social care needs under Section 117 MHA. The Trust 2 CAMHS junior doctor worked collaboratively with the local authority social worker.

1.60 EIP were not proactive in seeking communication with or information from the Leaving Care team and was reliant on the Leaving Care team contacting them.

[8] *Section 117 MHA is the duty of the CCG and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies.* *http://www.legislation.gov.uk/ukpga/1983/20/section/117*

### Safeguarding

1.61 Trust safeguarding policies were not followed when information about sexual, financial and physical vulnerability were reported involving Mr N.

1.62 For example, services did not demonstrate an awareness of the possibility that Mr N was vulnerable to gang involvement. They did not explore this with Mr N.

1.63 They did not seek information from the police when presented with information that may have suggested that Mr N was involved in gang activity.

### Mental health services and accommodation

1.64 We have concluded that Mr N's mother was not able to manage him and the breakdown of the placement in the family home was inevitable.

1.65 The EIP care coordinator agreed at the professionals meeting on 29 June 2016 to start to look for supported accommodation for Mr N, but we have not been able to find any evidence that they did this.

1.66 The EIP care coordinator was aware in August 2016 that Mr N had been asked to leave the bail hostel and the local authority were seeking an alternative placement for him. They agreed to look for accommodation for Mr N that would have met his mental health needs, but they did not do this. This was a missed opportunity to source accommodation for Mr N that would have met his mental health needs.

### Local authority process for placement

1.67 The local authority supported Mr N's return to live with his mother, completing home visits to monitor the situation and sharing concerns with mental health services.

1.68 The local authority completed a comprehensive referral for a placement through the Access to Resources Team (ART) at the end of July 2016. The final placement was the only provider to offer to accommodate Mr N.

1.69 We do not consider that the unregulated status of this accommodation was a directly influencing factor in the homicide.

## Conclusions

1.70 Mr N was not provided with an acceptable level of support by mental health services in the community after his discharge from the Unit.

1.71 The plan put in place to allow him to access his depot while under the care of CAMHS was weak. In our view it was only because of the perseverance of the CAMHS junior doctor that Mr N received three depot injections between his discharge from the Unit on the 25 April 2016 and his transfer of care to EIP on 29 June 2016.

1.72 EIP were not assertive in their approach to his care and support. They failed to see Mr N face to face, provide him with a medical review or administer his depot injection.

1.73 The Unit did not give enough consideration to Mr N and his mother's support needs when considering his discharge to her address. His mother demonstrated an ambivalence about his mental health needs and need for medication.

1.74 The EIP care coordinator did not look for alternative accommodation for Mr N as they had agreed they would at the professionals meeting on 29 June 2016. They left responsibility for accommodating Mr N to the criminal justice service and local authority. The result was that when Mr N was no longer able to remain at his mother's, he was moved to a bail hostel and then to the final placement without any further assessment of his mental health, or consideration of his support needs by mental health services.

## Good practice

1.75 We would like to commend the work of the junior doctor in Trust 2 CAMHS team for his work as de facto care coordinator. They developed a relationship with Mr N that resulted in Mr N attending appointments and accepting his depot.

1.76 They navigated the prescribing and dispensing process to ensure that Mr N received his depot while under the care of CAMHS.

## Recommendations

1.77 Since the report was finalised the Trust no longer provides an inpatient CAMHS service, hence recommendations 11,12 and 15 are no longer applicable.

**Recommendation 1**
The Trust must ensure that there is a clear system for ensuring that capacity assessments are completed and recorded where indicated.

**Recommendation 2**
The Trust CAMHS service must ensure that all patients under its care that are subject to CPA have a named care coordinator.

**Recommendation 3**
The Trust must revise the EIP Zoning Policy to more clearly define the care and treatment that a patient in the red zone can expect, to support a more assertive approach.

**Recommendation 4**
The Trust should develop a performance matrix to monitor and improve compliance with the Trust CPA policy, and this matrix must identify patients who have transferred between services and if a CPA was completed.

**Recommendation 5**
The Trust must revise the current arrangements to ensure that missed depots are reported to the care coordinator within 48 hours and what plans need to be put in place to provide the missed depot.

**Recommendation 6**
The Trust must ensure that there is a clear and transparent process in place that will support all patients to be provided with a depot, irrespective of the team providing care and treatment. These arrangements must identify the criteria for providing a depot in a patient's home.

**Recommendation 7**
Trust medicine management policies for long acting antipsychotic injections should provide guidance for their use in young people.

**Recommendation 8**
The Trust to review the approach that it takes to young people with established substance misuse issues and to develop a dual diagnosis approach to these patients.

**Recommendation 9**
The Trust must benchmark its approach to discharging patients against the NICE guidance on the Transition of Children and Young People.

**Recommendation 10**
The Trust CAMHS to review its approach to transferring patients and to benchmark itself against the NICE guidance on the Transition of Children and Young People, to use the findings to develop a robust patient centred approach to transfer and discharge.

**Recommendation 11**
The Wells Unit operational policy should include the expectation that all admissions make reference to the clinical rationale for the level of security.

**Recommendation 12**
The Trust must ensure that the expectations of Section 117 MHA are applied when patients are discharged from out of area CAMHS forensic admissions.

**Recommendation 13**
The Trust should audit current risk assessments completed in CAMHS and EIP against the Clinical Risk Policy, and then develop a plan to improve performance and quality.

**Recommendation 14**
The Trust must review its CPA policy to ensure that where there are multiple agencies providing care and support to a patient the care plan identifies:

- The lead agency for communication between the agencies
- Information and reporting channels
- Reporting intervals
- How urgent information will be effectively shared
- Contingency plans for information sharing when staff are absent from work
- Consideration of the application of Section 117 MHA were applicable.

**Recommendation 15**
The Wells unit must ensure that all patient reported allegations of bullying are appropriately investigated, and safeguarding procedures instigated.

**Recommendation 16**
The Trust must ensure that the policy expectations regarding risks to family members are incorporated into risk assessment and care planning.

**Recommendation 17**
The Trust and Local Authority should complete a review of the current processes in place for identifying children and young people who maybe at vulnerable to child exploitation, county lines drug gangs or general involvement with gangs to ensure that these are in line with current national best practice and local expectations on exploitation.

**Recommendation 18**
The Trust must ensure that all families caring for young people in inpatient services are offered access to a carers assessment.

**Recommendation 19**
The Trust should assure itself that the perspective of families is included in care planning, and appropriate cultural awareness is applied when communicating with families.

**Recommendation 20**
The Trust must provide assurance that appropriate accommodation is addressed in all patients' care planning at the point of discharge from out of area CAMHS forensic admissions.

**Recommendation 21**
The Trust must ensure that there are effective processes in place for working with the local authority to meet the accommodation needs of young people with mental health problems.

## Appendix A – The Independent Investigation

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

The independent investigation follows the NHS England Serious Incident Framework[9] (March 2015) and Department of Health guidance[10] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in appendix A.

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

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

The investigation was carried out by Elizabeth Donovan, senior investigator for Niche, with expert advice provided by Dr Andrew Leahy, consultant child and adolescent psychiatrist. The investigation was supervised by Nick Moor, Partner and Dr Carol Rooney, Associate Director, Niche.

This independent investigation has reviewed the internal investigation report and studied clinical information and policies. The team also interviewed staff who were responsible for Mr N's care and treatment and spoke to his current responsible clinician.

[9] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[10] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

## Appendix B – Contact with families and Mr N

### Contact with L's family

We met with L's mother at the beginning of the investigation, and she shared L's history with us. She did not have any specific questions that she wanted the investigation to explore beyond the terms of reference that were shared with her.

NHS England contacted L's aunt and girlfriend and offered them the opportunity to meet with the lead investigator. Whilst they expressed an interest in meeting with us, they were unable to make arrangements to meet.

Feedback about the draft report was provided to L's mother and Aunt on 22 June 2021 by video call. This was supported by the solicitor representing them. Following this call the solicitor provided written comments on the draft report on behalf of the family. We have responded to the comments made on behalf of the family and where appropriate revised the draft report. Where we have not been able to revise the report, we have shared the rationale for this with the family. We offered L's mother the opportunity to meet with us prior to publication of the report. We will make contact with his aunt and girlfriend and offer to meet with them.

### Contact with Mr N's family

We met with Mr N's mother at the beginning of the investigation, and she shared Mr N's history with us. She did not have any specific questions that she wanted the investigation to answer beyond the terms of reference that we shared with her.

We provided Mr N's mother with initial feedback about the draft report in a phone call with her on 20 May 2021. This was followed up with a face-to-face meeting with her on 22 June 2021. His mother provided us with some feedback on the draft report and where appropriate we revised the draft report. Where we have not been able to revise the report, we have shared the rationale for this with her.

### Contact with Mr N

We wrote to Mr N at the start of the investigation and explained the purpose of the investigation.

We met with Mr N in June 2019 and gave him the opportunity to share his story with us. Mr N did not share any concerns about his care and treatment with us at this meeting.

We met with Mr N on 22 June 2021. His engagement in this meeting was better than the meeting we held with him in 2019. We talked to him about the findings of the report and shared a copy of the report with him and his care team. Mr N did not have any comments to make about the draft report and did not request any revisions.