Foreword

This report identifies points where poor decision-making, omissions and errors of judgement contributed to a situation where a patient with very serious mental health issues did not receive the support and follow up that he needed.

While it is not possible to say that the devastating events of 13 June 2023 would not have happened if Valdo Calocane had received that support, what is clear is that the risk he presented to the public was not managed well and that opportunities to mitigate that risk were missed.

For the individuals involved, their families and loved ones, the damage cannot be undone. However, there is action that can, and must, be taken to better support people with serious mental health issues and provide better protection for the public in the future.

It is important to recognise that treatment for people with serious mental health issues is not straightforward – either for those providing it or those receiving it. This report highlights a clear need for improved oversight and guidance at both a provider and a national level.

We have made recommendations for Nottinghamshire Healthcare NHS Foundation Trust that relate specifically to the failings we identified with the care provided to Valdo Calocane. We have also made recommendations for NHS England around the development of new guidance setting out national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.

NHS England will be conducting a more detailed scrutiny of Valdo Calocane's wider interaction with mental health services in its Independent Homicide Review. This has a broader scope than this review, and may well identify other areas of his care that fell short.

This review has focused on one NHS trust but, as highlighted in part 1 of our review, the issues we have identified at Nottinghamshire Healthcare NHS Foundation Trust are not unique. We found systemic issues with community mental health care, including a shortage of mental health staff, a lack of integration between mental health services and other healthcare, social care, and support services, including the police. Without action, this will continue to pose an inherent risk to patient and public safety.

CQC has begun work to look in detail at the standard of care in community mental health across the country to fully understand the gaps in the quality of care, patient safety, public safety, and staff experience in community mental health services. We are also working with NHS England to improve data on the quality and safety of community mental health services.

There must also be wider national action to ensure that people in need get care, treatment and support at the right time in the most suitable environments to prevent more tragedies.

Chris Dzikiti
Interim Chief Inspector of Healthcare