An independent investigation into the care and treatment of a mental health service user Mr H

Executive Summary

February 2021

Final Report

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Niche Health & Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance, and quality, including undertaking independent investigations following very serious incidents.

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Our Draft Report has been written in line with the terms of reference set out in the independent investigation into the care and treatment of Mr H. 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Events which may occur outside of the timescale of this review will render our report out-of-date.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.

This is a confidential report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Different versions of this Draft Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the 'Final Report' should be regarded as definitive.

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The Incident

1.1 There was an altercation between Mr H and Mr B, who were both residents in a same building which was divided in apartments. Mr B was causing a nuisance and Mr H challenged him about this. In the argument that followed Mr H punched Mr B once and he fell. Mr B declined to accept medical help at the time of the incident. However, the next day he was found collapsed by a Community Police Officer and he later died.

1.2 We would like to express our condolences to Mr B's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised, regarding the care and treatment of Mr H.

1.3 Mr H was arrested on 23 May 2018 but was not charged with the offence at that time. He was assessed under the Mental Health Act (MHA) and detained to hospital under Section 2 MHA.[1] There was a review of Mr H's detention under the MHA on 15 June 2018 and his detention was rescinded. Following this he was arrested for a second time on 15 June 2018. He was subsequently charged with manslaughter.

1.4 Following a trial in September 2018 Mr H was sentenced to four years in prison for manslaughter.

Mental health history

1.5 Mr H had a diagnosis of schizophrenia with a history of substance and alcohol misuse. He was under the care of a mental health Trust in the North of England.

1.6 He first came into contact with mental health services in 2016 whilst in prison. Although his mother had raised concerns with mental health services immediately before this detention at the end of 2015. Whilst in prison he was assessed by prison mental health in-reach services and prescribed olanzapine.[2]

1.7 From June 2016 until May 2018 Mr H was under the care of Complex Community Treatment Team (CCTT) 1. He was cared for under the Care Programme Approach (CPA) and received medical reviews.

1.8 Mr H had a chaotic, transient lifestyle moving between adjacent small towns until he was sentenced to prison December 2017. This resulted in his engagement with the CCTT1 being inconsistent. Also, because of his frequent

[1] *Detention for up to 28 days for an assessment of the patient's mental health.* https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act/

[2] *Olanzapine is an atypical antipsychotic primarily used to treat schizophrenia and bipolar disorder. For schizophrenia, it can be used for both new onset disease and long-term maintenance.* https://bnf.nice.org.uk/drug/olanzapine.html

change of address he was referred to the neighbouring CCTT on two occasions, but these referrals were not accepted, and he remained under the care of CCTT1.

1.9 Mr H had been prescribed olanzapine while in prison. This was changed to aripiprazole[3] in January 2017 when he complained of weight gain during a medical review completed by the CCTT1. However, Mr H was not compliant with prescribed medication while in the community, relying on drugs he purchased on the streets (e.g. pregabalin[4]) to manage his mental health. When we met with him, he told us that he also used cannabis to help manage his symptoms.

1.10 Mr H settled in nearby City at the beginning of 2018. He moved into a building that had been split into apartments. He registered with a local GP. The original CCTT1 referred Mr H to CCTT2 on 12 March 2018 and the transfer of care was completed at a 'transfer of care CPA' meeting on 11 May 2018. At this meeting Mr H's medication options were discussed with him and after some time for reflection it is reported by the team that he accepted a prescription for olanzapine.

Forensic history

1.11 Mr H was known to the criminal justice system prior to this offence. Mr H's offending history began in 2000 with 38 convictions for 63 offences. These included theft and kindred offences, offences relating to the police/court/prison and offences against the person.

1.12 In the two years prior to the homicide Mr H was imprisoned twice. In May 2016 he breached the conditions of his license following early release from prison in February 2016 and was returned to prison to complete a sentence of 210 days for theft and assault. In March 2017 he was sentenced to 26 weeks in prison for breach of a non-molestation order. He served half of this sentence and was released at the end of June 2017.

1.13 Mr H was under the supervision of the probation service following his release from prison.

1.14 In March 2018 Mr H was banned from the City Job Centre following an incident involving one of the security guards, but this did not result in criminal charges.

Accommodation

1.15 Following Mr H's release from prison in June 2017 he returned to live at the family home. He did not remain at the address for very long and was reported to be living in an adjacent town at an unidentified address. In January 2018 Mr

[3] *Aripiprazole is an atypical antipsychotic. It is primarily used in the treatment of schizophrenia and bipolar disorder.* https://bnf.nice.org.uk/drug/aripiprazole.html

[4] *Pregabalin is used to treat epilepsy and anxiety.* https://www.nhs.uk/medicines/pregabalin/

H reported as homeless in the City. The local authority provided Mr H with the opportunity to stay at a hostel. He did not stay at the hostel and he lost the placement. He was also given two appointments for assessments for supported accommodation; however, he did not attend these appointments.

1.16 Mr H and his partner then moved into the accommodation where the incident occurred. Mr H told us as part of the investigation that he was placed there by the local authority, but this is not supported by the local authority records.

1.17 We believe that Mr H and his partner moved into this accommodation because the landlord would provide tenancies without the need for a bond or references.

1.18 The accommodation was a private rented property, divided into apartments. The investigation has been told that at the time of the incident the property was not fully occupied. The local police believe that there was a plan to change the use of the property and consequently the number of residents was being run down. They reported that at the time of the homicide there were a mix of people living at this accommodation with mental health, substance misuse and other social problems.

1.19 This accommodation was on the 'radar' of blue light services[5] which received regular calls from the property. In 2017 the Ambulance Service attended the property 17 times. Eight of these could be attributed to drug use and six to violent incidents (one assault, two domestic assaults, two stabbings and one head injury). The ambulance calls received in 2018 prior to the homicide are detailed below:

Type of incident	Number
Vomiting blood	1
Drug related	1
Assault	1
Headache/swollen tongue	1

1.20 The calls received from this accommodation in 2018 prior to the homicide by Police are detailed below:

Type of incident	Number	Arrests
Criminal damage	1	
Assault	1	
Theft	1	
Lost/recovered property/person found	1	
Hoax call	1	
Suspicious circumstances	2	
Robbery	1	2
Concern for safety	1	
Police generated activity	1	
Public order	1	

[5] https://medical-dictionary.thefreedictionary.com/blue+light+emergency. *A popular term for those emergency services (police, fire services, emergency responders) in the UK.*

1.21 The investigation was told by a local police officer that the accommodation had been well known to the police for as long as they could remember.

1.22 The investigation was unable to identify the landlord and therefore was not able to interview them.

Conclusions

1.23 Mr H did not engage with mental health services in the community, despite the best efforts of the CCTT1 and the probation officer. He missed multiple arranged appointments with his care coordinator (CCO1) from the CCTT1. Furthermore, he was not open with mental health services about many aspects of his life including where he was living, his compliance with prescribed medication and his drug use. Whilst the CCTT1 had a good working relationship with the probation officer, with open channels of communication, this did not mitigate Mr H's reluctance to share information.

1.24 Mr H's lifestyle choices, especially his lack of a stable address, with him moving between two adjacent small towns and the nearby City, posed a challenge to mental health services. He spent periods of time registered under the care of a GP in an area other than the one he was living. This caused difficulties because provision of community mental health services is based on GP.

1.25 Notwithstanding this, CCTT1 provided Mr H with good, responsive care when he was prepared to engage.

1.26 By his own admission Mr H did not comply with prescribed medication when he was in the community. Also, there is no evidence to support the proposition that he was compliant with his prescribed medication or collecting a prescription from his GP on a regular basis.

1.27 When Mr H was seen by CCTT2 for a medical review on 11 May 2019, medication options were discussed with him and he was told that he would require a blood test before this could be provided. This was because he did not have any physical health checks while under the care of CCTT1. The NICE Guidance[6] describes the baseline investigations that should be completed prior to starting a patient on anti-psychotic medication, and the requirement for ongoing monitoring of a patient's physical health. Mr H initially declined a blood test and was not provided with a prescription for medication. He was given some information leaflets about anti-psychotic medication and given some time to reflect. CCTT2 contacted Mr H daily and after he had some time to reflect, he requested a prescription.

1.28 We consider this to be good practice within the NICE Guidance that requires patients commencing on anti-psychotic medication to have baseline and regular ongoing physical health checks. Mr H had been unmedicated for some

[6] *Psychosis and schizophrenia in adults: prevention and management.* https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-use-antipsychotic-medication

time and had had no physical health checks, he was provided with information about his medication choices and given time to consider his options. The medical review identified no risks with regard to him remaining unmedicated and the team maintained contact with Mr H. Mr H initially declined a blood test for a physical health check but following a period of reflection he said that he would accept a blood test and was provided with a prescription.

1.29 Mr H was provided with appropriate care by Trust, but it is possible that he may have benefitted from a more assertive approach to engage with him and monitor his compliance with prescribed medication. Mr H's lifestyle choices limited his contact with mental health services, moving between towns and the City, ultimately settling in the City. Furthermore, he was not open with services about his lifestyle choices, he could be vague about his living arrangements and services regularly did not have an up to date address for him. He was also not open with services about his drug use and latterly the support he was receiving from drug services.

1.30 Following the incident Mr H was appropriately detained under Section 2 MHA and detained to a Psychiatric Intensive Care Unit (PICU).

1.31 The inpatient team provided Mr H with care that was in line with the relevant NICE guidance and stabilised him on a depot before reviewing and rescinding his detention in 2019.

Recommendations

1.32 This independent investigation has made a total of four recommendations for the Trust to address in order to further improve learning from this event. Two are new recommendations for the Trust and two relate to the Trust:

Recommendation 1
The Trust must review the current pathways in CCTTs to determine if the identified needs of patients who meet the threshold for an assertive outreach approach are being met.

Recommendation 2
The Trust must provide clear guidance to staff on the identification and management of patients who are not engaging with mental health services, this must include how engagement will be monitored and reviewed.

1.33 We reviewed the recommendations from two recent independent investigations into the care and treatment of patients under the care of the Trust. The findings and recommendations resonated with this investigation. This has resulted in us making a recommendation about the management of recommendations from these previous investigations:

Recommendation 3
The Trust must revise and refresh the action plans for these investigations to assess progress and whether actions are still appropriate to meet the original recommendations. Action owners should also be revised and refreshed and revised timelines for delivery of their actions agreed with approval from the CCG and the new Integrated Care System (ICS). Action plans should be monitored by an appropriate (sub) committee and action owners held to account for action implementation.

1.34 There was a delay in the Trust completing an internal investigation into this incident due to the ongoing police investigation. This prevented the Trust from identifying early learning opportunities. This is against current guidance, and also the forthcoming revised Memorandum of Understanding between the Department of Health and the Association of Police Officers. Therefore, we made the following recommendation:

Recommendation 4
NHS England and Improvement (NHSE&I) should work with the Department of Health and Social Care (DHSC) to agree and 'sign off' the revised 'Memorandum of Understanding' with the National Police Chiefs' Council (NPCC) to support investigations into serious incidents in healthcare settings. In the meantime, the Trust and the local Constabulary should agree a local memorandum of understanding to inform the management of health care incidents that are also subject to criminal investigation.

Good practice

1.35 CCO1 maintained a professional relationship with Mr H's probation officer that supported the flow of information between the agencies; they worked well together and were responsive to Mr H's changing needs.

1.36 Mr H received appropriate care from the Trust prison mental health in-reach team to meet his mental health needs while in prison. In 2016 he was given regular medical reviews and established on anti-psychotic medication. In 2017 he was assessed for 'in possession',[7] allowing him to take responsibility for his medication. The prison mental health services made appropriate referrals to community mental health services so that Mr H had access to support on his release from prison.

1.37 CCO1 maintained good communication with the prison during Mr H's detention in 2017 to ensure that they were aware of the treatment Mr H was receiving and the plans for his release. They also tried to work in partnership with Mr H to develop a relationship with him.

[7] *Mr H retained his prescribed his medication and was responsible for taking it as prescribed.*

1.38 The CCTT1 demonstrated a team approach to the management of Mr H in the face of his chaotic lifestyle choices, with him being discussed in the multi-disciplinary team meetings in October and November 2016 when he was not engaging with CCO1.

1.39 Mr H was involved in the decisions made about his medication options by CCTT1. In January 2017 he was concerned about weight gain as a result of taking olanzapine and was prescribe aripiprazole instead.

1.40 CCTT1 made appropriate referrals to transfer Mr H to the care of more local CCTTs in response to his transient lifestyle and as he moved backwards and forwards between the two towns and the City, retaining responsibility for Mr H's care each time a transfer fell through.

1.41 CCO1 liaised with local authority in March 2017 when Mr H identified housing as one of his major issues. They provided information about Mr H's mental health problems to support the search for appropriate accommodation.

1.42 The handover between CCTT1 and CCTT2 is an example of good practice. CCO1 liaised with care coordinator 2 (CCO2) and on 5 April 2018 they agreed that they would both meet with Mr H on the 25 April 2018 to discuss the transfer of his care between the teams and to introduce CCO2. They also agreed that the transfer of care CPA meeting would be held on 11 May 2018. At the meeting on the 25 April 2018, they identified that Mr H needed support with his benefits and housing.

1.43 The inpatient team provided Mr H care in line with NICE Guidance and stabilised him on a depot before reviewing and rescinding his detention in 2019.

Appendix A - The Independent Investigation

NHS England, North, 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 H. Niche is a consultancy company specialising in patient safety investigations and reviews.

The independent investigation follows the NHS England Serious Incident Framework (SiF, March 2015)[8] and Department of Health guidance on Article 2 of the European Convention on Human Rights[9] 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 overall 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 for Niche, with expert advice provided by Dr Mark Potter, consultant psychiatrist.

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

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

Appendix B – Contact with families and Mr H

Contact with the Mr B's family

1.44 We were informed by NHS England that Mr B's family did not want to be involved with this independent investigation.

1.45 We were informed by NHS England that Mr B's family did not want to meet with us prior to publication of the report.

Contact with Mr H's family

1.46 We met with Mr H's mother on 3 March 2020. She told us that whilst she was happy with the care and support provided to Mr H by the CCO1 and CCTT1, she was not happy with the response to concerns she raised with the Crisis Team in November 2015 and May 2017.

1.47 Mr H's mother confirmed details of his illicit substance misuse for the investigation. She told us that he took his prescribed medication when he was living at her address, but she was not sure that he took it when living elsewhere. Mr H's mother told us that she did not think his accommodation was an appropriate place for him to be living because of the types of people housed there.

1.48 We met with (via Microsoft Teams) Mr H's mother on 5 November 2020 to discuss the report and findings.

Contact with Mr H

1.49 NHS England wrote to Mr H at the start of the investigation, explained the purpose of the investigation, and asked if we could meet with him.

1.50 We met with him on 3 February 2020. Mr H told us that he had been happy with the mental health services in a small town in North England whilst under the care of CCTT1, but that his transfer to CCTT2 had caused him some problems because he was not able to immediately access medication when he requested it. This was because he was told he would require a blood test before an anti-psychotic could be prescribed and he did not want a blood test. He told us that he was afraid of needles.

1.51 Mr H told us that he was unhappy in the accommodation in the City. He told mental health services that he had been placed there by the local authority when his partner lost her tenancy. However, the investigation was informed by the local authority that they did not place people at this accommodation and that Mr H would have found this accommodation for himself. This accommodation was the only accommodation available to the couple because it did not require a bond or references. He told us that the other tenants at the property were unhealthy, unstable people and he tried to 'keep himself to himself'.

1.52 Mr H described the challenges he was having with his mental health at the time of the offence. At that time, he believed that he was under surveillance and being followed.

1.53 We offered Mr H the opportunity to meet with us when we met with his mother to discuss the report and findings. Mr H chose not to join this meeting.

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