

**PSYCHOLOGICAL APPROACHES CIC**

AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr B

OWHR 007

13 October 2024

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# CONDOLENCES

The investigation panel would like to offer their condolences to the victim’s family at this difficult time. We are grateful to those who have participated in this investigation.

The family of the alleged perpetrator had made significant efforts to obtain the care and treatment they felt that their family member needed. They expressed their distress, stating that they did not feel able to take part in this investigation.

It is our sincere wish that this report does not add to the pain experienced by the families but makes a contribution to addressing the issues and questions raised by this homicide.

# EXECUTIVE SUMMARY

From 2013, Mr B’s first contact with psychiatric services, until the homicide, his psychiatric inpatient and outpatient care was provided by a single Mental Health NHS Foundation Trust (the Trust). In 2013, when he was 22, he is recorded to have made threats to kill and was imprisoned in that year for breach of his curfew. He was remanded to prison in 2014 for carrying a bladed article and making threats to kill but his deteriorated mental state necessitated transfer under the Mental Health Act (MHA) to a medium secure unit (MSU) from October 2015 to February 2017. At the time of this admission, his previous convictions were recorded as violent disorder, attempted robbery, theft, non-compliance and breach of public disorder and breach of community bail sentences. He was further convicted of the charges for which he had been remanded and was sentenced to hospital under section 37 MHA.

He was diagnosed to have schizophrenia, an enduring mental illness. This was complicated by cannabis misuse and chequered adherence to his oral antipsychotic medication. He needed considerable and sustained support in the community. For over three years, he was managed by the forensic community team. In July 2020, his disturbed behaviour caused his arrest for burglary.

In October 2020, his care was handed over to the Community Mental Health Team (CMHT). He served a brief prison sentence for burglary in February 2021. His mental state deteriorated in August 2021. Efforts were made to augment his antipsychotic prescription but with very limited concordance. During 2022, Mr B expressed the belief that there was a conspiracy against him. He reported hearing voices. In September and December 2022 his family expressed grave concerns about his mental state. On a background of threatening other residents and causing major destruction at his accommodation, he was admitted under the MHA to the acute ward between 19 January and 28 February 2023. He was re-established on oral medication and discharged to a shared house with support and returned to the care of the CMHT. He was seen by the CMHT consultant on 14 March – when he requested a reduction in his medication - and 12 May 2023, when he said he had stopped taking it.

Between 2 May and 3 July 2023 there were 13 recorded attempts by the CMHT or his care co-ordinator to telephone Mr B, but only one of these was answered and it was not possible for his care co-ordinator to meet with him. There is no recorded liaison with a housing support worker or with Mr B’s family. On 10 July 2023, the housing support worker terminated his tenancy due to his disturbed behaviour and conveyed him to the A&E Department, but Mr B left the hospital before being assessed. The following day, another resident called the housing support worker who found Mr B back at the property, at the scene of a homicide in the back garden. The worker called the police and stayed with Mr B until they arrived. Mr B was arrested at the property.

# Findings

This independent review has made the following three findings:

1. Mr B needed the structure and containment provided within a predictable, in-person and secure relationship with a care co-ordinator. The CMHT did not recognise this need. Indeed, for a short period, his support in the community was provided by a Support Time Recovery Worker who could not have been expected to have the requisite level of skills. Overall, there were deficits in staff supervision, skills and capability.
2. The usual procedures for recognising and managing risk, and for engaging service users with their own care – specifically, risk assessment and care planning protocols – were not followed.
3. There was a lack of communication between the CMHT and other parts of the service. Mr B’s level of disorder was not highlighted to services which could have provided him with increased support. There was a lack of liaison with the housing provider and with the family, so opportunities to share information and to obtain collateral information were missed. Similarly, there was a lack of a two-way liaison between the in-patient service and the CMHT.

# Recommendations

These findings are the basis for the following five recommendations for the Mental Health NHS Foundation Trust:

1. For individual practitioners, the Trust should implement clinical supervision, as separate from managerial supervision, so that each care co-ordinator has the opportunity to reflect on the issues raised during their work with service users under the supervision of a more senior clinician.
2. Multi-disciplinary teams should address deficits in communication with housing workers and family members. Staff have a duty to satisfy themselves that, where service users are placed in supported accommodation, their needs are being met and risks are assessed and managed.
3. The Trust should monitor the provision of clinical supervision to care co-ordinators.
4. The Trust should continue to address structural issues with service provision, characterized by ‘silo thinking’ which leads to a failure to request increased levels of care from other parts of the service.
5. The Trust should ensure that appropriate processes are in place to agree contingency arrangements for staffing shortages.

# Work done by the Trust after the homicide

During the interviews with the investigator, staff described the Trust’s response to the homicide. There was a Care Quality Commission visit shortly afterwards and the Trust has undertaken a number of initiatives since:

* The structure of the CMHTs will include clinical leads placed in all the working-age adult CMHTs.
* It is planned to do more robust clinical caseload supervision, with a template, recorded elsewhere but also as a brief note on the electronic patient record. This will be audited.
* There is a new level of liaison for forensic step-down referrals (or following release from prison). These referrals must be shared with the Clinical Service Manager and the Clinical Director/Associate Director/Head of Nursing for a review of the notes, a decision on appropriateness of the referral for CMHT care and to consider care planning, responses to concerns and crisis planning.
* In the summer of 2023, the Trust piloted a locality bed model for gatekeeping inpatient admissions. When the CMHT has a concern, they can liaise with the home treatment team (HTT). Also, the HTT is working with in-patient wards to support appropriate and timely discharge, so permitting new admissions in a timely manner. This has reduced out-of-area placements, reduced the waiting list for admission and, anecdotally, facilitated closer working across pathways. It is hoped that these new ways of working will reduce the barriers between parts of the service that are perceived to have developed over the years following the adoption of the ‘functional split’ model of delivery of care.
* Workers from the local alcohol and substance misuse service have started attending CMHT multi-disciplinary team meetings over the last six to 12 months. A Clinical Service Manager has been asked to liaise with CMHTs to offer support with this development and ensure that it is happening.
* The Trust is still working with the CPA Framework for the time being but will be undertaking a piece of work to scope the changes required in line with the NHS England Care Programme Approach position statement of March 2022. Audits have revealed concerns around the quality of care planning so they are adopting a new Care Plan tool, the Dialog Plus care plan (DIALOG+), which is more holistic.

## Observations on the Trust’s Response

The Trust made an audit available to the investigator of the Risk Assessments and CPA Care Plans for one CMHT dated January 2024. Five were audited, one for each care co-ordinator in the team. In the opinion of the investigator, this shows a lack of quantitative data relating to the quality of care plans.

The Trust’s implementation of a new process of liaison for referrals from forensic services and prisons seems to place reliance on the availability of the Clinical Service Manager and the Clinical Director/Associate Director/Head of Nursing. The investigator suggests that this process of liaison should be supported by a review of referral criteria and processes within the multi-disciplinary teams.

# BACKGROUND

1. During the period from October 2020 to the date of the homicide (11 July 2023), Mr B received care co-ordination from the Community Mental Health Team (the CMHT). He was seen by the Criminal Justice Liaison & Diversion Service on 19 January 2023 and admitted on that day under Section 2 of the MHA to an acute psychiatric ward until 28 February 2023. On 1 March 2023 he received a home visit from the Home Treatment Team (HTT) who discharged him back to the CMHT.
2. Mr B was born in the United Kingdom. His mother left during his early childhood. They regained contact after some time, but it seems he had little contact with her. He has made allegations that he was sexually abused by someone close to him when he was three.
3. He has reported that he lived with his father and they remained in regular contact. He is close to his older sister. He had an older brother who had a diagnosis of schizophrenia but he died from a heroin overdose a few years ago.
4. Mr B has said that he was expelled and excluded from schools many times, and that he got into fights; that he took some GCSEs and attended college. He has had very short periods of employment. He has had relationships, but no children. He has previously endorsed ideas of taking his life.
5. His first contact with mental health services was in 2013, at 22, when he was assessed at a magistrate’s court, but no records are available.
6. Later in 2013, he attended A&E feeling low and suicidal and threatening to kill his mother’s boyfriend. It was concluded that there was no evidence of mental illness and the police were called because of his threats to kill. Subsequently, he was referred to mental health services by his GP because he was still having thoughts of killing his mother’s partner. Psychological assessment was arranged, but Mr B did not attend the appointments.
7. A year later, in November 2014, police were called because Mr B was in the street with a carving knife. He appeared intoxicated and behaviourally disturbed; he was making threats to kill his neighbour. His relative reported that Mr B had not recovered from the loss of his brother a year previously. Mr B was assessed for admission but his disturbance was thought to be secondary to cannabis misuse. He was charged with making threats to kill and possession of a bladed article.
8. He was remanded into custody but between December 2014 and October 2015 his mental state gave cause for concern, including throwing boiling water over a cell mate. He appeared strange, staring blankly, laughing inappropriately and isolating himself. His personal hygiene deteriorated.
9. In October 2015 he was admitted to medium secure psychiatric services (MSU). At this time, his forensic history included convictions for violent disorder, attempted robbery, theft, non-compliance and breach of public disorder and breach of community bail sentences.
10. He was given a diagnosis of schizophrenia, an enduring mental illness, and assessed as having partial insight. He said he had been ill and had depression and had experienced auditory hallucinations in the past (unknown voices telling him to kill people). He said that he first started hearing voices when he was three years old.
11. At court in February 2016, it transpired that Mr B’s neighbour had felt so threatened by him that he had been living elsewhere. Mr B was sentenced to hospital under section 37 of the Mental Health Act (MHA) and a five-year restraining order was imposed to prevent contact with his neighbour.
12. Mr B had an uneventful multi-disciplinary in-patient rehabilitation in the MSU over a period of 16 months. He was stabilised on a combination of oral medication: olanzapine (an antipsychotic) 20mg and mirtazapine (an antidepressant) 30mg daily (subsequently increased by his GP to 45mg daily). In February 2017 he was discharged to shared accommodation. Until October 2020, he was under the follow-up of the forensic community team.
13. Mr B needed intensive support in the community because he remained symptomatic, hearing voices; he readily stopped his medication and his illness was complicated by cannabis misuse. He was encouraged to consider college courses, or voluntary work. He had historical debt from the period before his admission and he was helped to agree a repayment plan. He was seen by occupational therapy and the substance misuse team, with whom he had partial engagement. He was offered psychological help but he did not want this. There was liaison with housing officers over his multiple housing issues and also to promote communication between the health and housing components of his community support.
14. There were periods when his mental state deteriorated. On one of these occasions (April 2019) the family contacted his community psychiatric nurse to share their concerns that Mr B was using cannabis. Later in 2019, he appeared disinhibited (October) and he started gambling.
15. During the Spring of 2020 plans were made for Mr B’s handover to the CMHT. In June, a police officer was called to the front gate of the local prison where Mr B was shouting and making threats to harm a prison officer. Mr B appeared to be elated and his neighbours disclosed that his behaviour had been disturbed. He was arrested for burglary in July, at which time his mental state seemed bizarre. He was charged and released on bail. His contact with mental health services was erratic.
16. Later in July, Mr B seemed to recover from this deterioration but in August he was assaulted and sustained a fractured jaw. He did not wish to involve the police.
17. The handover to the CMHT from the forensic community team took place in October 2020. Mr B had an in-person appointment at the CMHT on 27October and his subsequent follow up was by telephone until he was imprisoned at the end of January having been found guilty of burglary. In January, he consented to sharing his medical information with probation. In prison, there was liaison between his care co-ordinator and the prison mental health in-reach services.
18. Mr B was released on 22 February 2021. He told his care co-ordinator that he had to call his probation officer weekly, but there was no liaison between the CMHT and his probation supervisor. For the next three months, there was telephone contact between Mr B and the CMHT. In early August, Mr B was informed that his care co-ordinator was off due to unforeseen circumstances.
19. In late August 2021, Mr B was admitted to hospital with burns to his face and mouth having drunk boiling water. There did not seem to be any psychotic symptoms (ie, symptoms suggesting he was out of contact with reality). This was followed up by a home visit by a nurse from the CMHT in September. Mr B said he had heard commands (auditory hallucinations) but it was a ‘blip’ and now he was fine. Subsequently, his consultant added a second antipsychotic to Mr B’s prescription but he did not take it because of side-effects. A different antipsychotic was substituted in the clinic in November but Mr B did not take this, either.
20. Mr B was reviewed in person in January and February 2022, and then in May when he disclosed that he had stopped his medication. He had ideas of persecution, that he was the subject of people playing tricks on him and he was hearing voices and using cannabis. He agreed to re-start his medication. He was seen again in June when he seemed stable, but he told his care co-ordinator in July that he had stopped his medication. He did not respond to a phone call in August.
21. In September, his father called the CMHT to report that his son’s flat was ‘trashed’. He believed his son had stopped his medication and was relapsing. Mr B was seen at home by his consultant and a Support Time Recovery Worker (STR worker). The flat was in disrepair. Mr B was agitated and expressed frustration with services, saying that his care co-ordinator had not contacted him. He was told that she had been off work.
22. The STR worker spoke with Mr B at his home address in October. Mr B asked about his care co-ordinator who was off sick. Mr B said he did not need services and wanted to be discharged.
23. In late October, the CMHT received a call from Mr B’s housing support worker saying that Mr B appeared unwell; he had caused major damage to his flat, he had refused access to the contractor to carry out repairs and he had been aggressive towards staff. They were in the process of evicting him.
24. In late November, Mr B was seen in clinic by his consultant and the STR worker. Mr B was not taking his antipsychotic. He held the belief that people were entering his property without his permission. He accepted a much reduced dose of olanzapine (5mg). In December, there was a further call from the housing support worker. Mr B had caused criminal damage to the property and the workmen were scared to go in to carry out repairs. Subsequently, the STR worker spoke to Mr B about alternative properties.
25. Before Christmas, Mr B’s sister called the CMHT to say that Mr B was not making sense; that he was carrying knives and threatening to stab anyone who came to the door, including his father. The next day, the housing worker told the STR worker that she thought there had been failures in Mr B’s care and housing.
26. In January 2023 Mr B was arrested because he had damaged his flat and threatened other occupants of the building. He was assessed by the Criminal Justice Liaison & Diversion Service. Mr B expressed paranoid thoughts about his landlord and neighbours. He was observed to be thought disordered and alluded to auditory hallucinations of neighbours talking to him in a derogatory manner. There were concerns regarding his compliance with medication.
27. He was admitted to the acute ward under Section 2 MHA and re-started on medication. On 15th February, it was reported that he had visited his father and been abusive. In the ward round on 27 February, he requested to be off medications. He was discharged on 28 February on olanzapine 20mg to shared accommodation. During this admission, there was no liaison with the CMHT.
28. On subsequent medical review in March, Mr B requested a reduction in his olanzapine to 15mg. During May, attempts were made to telephone Mr B and he attended a medical review in May where he said he had stopped taking medication. He appeared very angry and was thought to be at risk of relapse.
29. The property to which Mr B had been discharged two months earlier was being returned to the landlord. His housing provider offered an alternative, but Mr B self-referred to a different provider. He completed the application form with only partial information about his mental health difficulties. The assessment of Mr B’s application relied solely on his self-disclosure as there was no referrer. He was offered a room in a shared house with one hour’s support a week and welfare checks as necessary and moved in on 5 May. There is a record of his new address in the CMHT notes but no evidence of liaison between the CMHT and either housing provider.
30. Between 2 May and 3 July 2023 there were 13 recorded attempts by the CMHT or his care co-ordinator to telephone Mr B but he answered only one, on 14 June, when he sounded intoxicated. There was one unannounced home visit on 24 May 2023, but there was no answer.
31. On 10 July, Mr B’s housing support worker told Mr B that he was having a breakdown, that he needed to go to hospital and that his tenancy was being terminated immediately. The support worker drove Mr B to A&E and left him there while he parked his car. Mr B had left by the time the support worker returned to A&E.
32. On 11 July Mr B was arrested at the scene of a homicide.