Niche PATIENT SAFETY

NHS England

An independent investigation into the care and treatment of a mental health service user (B) in Greater Manchester

Executive summary March 2017

Author: Carol Rooney, Head of Investigations

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Niche Health & Social Care Consulting Ltd (formerly Niche Patient Safety 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.

The independent investigation team would like to offer their deepest sympathies to the family of A. It is our sincere wish that this report does not contribute further to their pain and distress.

Niche Health & Social Care Consulting Ltd
Emerson House
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: www.nichepatientsafety.co.uk

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1 Introduction

1.1 NHS England, North regional office, 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 (B). Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The investigation team comprised Carol Rooney, Head of Investigations and Dr Huw Stone, Consultant Forensic Psychiatrist. The investigation team will be referred to in the first person plural in the report. The report was peer reviewed by Nick Moor, Director, Niche.

1.3 The terms of reference for this investigation include the care and treatment of B by Pennine Care NHS Foundation Trust (PCFT) Mersey Care NHS Foundation Trust (Mersey Care) and Greater Manchester West Mental Health NHS Foundation Trust (GMW). The full terms of reference are at Appendix A.

1.4 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2]

1.5 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.

1.6 The investigation process will also identify areas where improvements to services might be required which could improve quality and help prevent similar incidents occurring.

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

1.8 The investigation team would like to express our sincere condolences to the family of Adam.

B's mental health history

1.9 B had previously been treated by PCFT child and adolescent mental health services and had been under the care of PCFT mental health services in March 2002 after behaving bizarrely in police cells following an arrest. His

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[2] *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*

initial diagnosis was first onset schizophrenia, compounded by a long history of polydrug abuse.

1.10 B was admitted to Birch Hill Hospital in Greater Manchester aged 18 in March 2002 from police custody, and he spent three weeks in hospital. He did not continue taking medication after discharge. He was assessed in June 2002 at YOI Lancaster Farms and a diagnosis of paranoid schizophrenia was confirmed. However the assessing forensic psychiatrist also stated that he believe that B 'offends independently of his mental illness, although if his mental illness was uncontrolled this could lead to an increase in offending behaviour'.

1.11 He was transferred from Hindley YOI to The Spinney in Atherton, Manchester in March 2004 under Section 47 of the Mental Health Act[3] (MHA) 1983 after he became psychotic in prison, and he remained there until May 2004.

1.12 Following further serious assaults and a deterioration in his mental state he was transferred to Ashworth high secure hospital in January 2005 and was unsettled until Clozapine[4] was prescribed in July 2006. He was transferred back to the Edenfield unit in Manchester in August 2008 on a notional Section 37[5] of the Mental Health Act 1983.

1.13 He committed an offence whilst on leave from hospital in July 2010, and was sentenced in December 2010 to 11 months for actual bodily harm and possession of an offensive weapon. He was transferred from hospital to prison in December 2010 to serve his sentence. He was released from prison on 9 November 2011, and part of the release conditions were that he would reside in a bail hostel in Manchester and receive psychiatric treatment. Following the end of his probation licence period, a CPA meeting was held and accommodation was sourced in Greater Manchester. He remained under the care of community mental health services through 2012 and 2013, being maintained on Clozapine.

1.14 B was assessed in custody after being arrested in June 2014 and was challenging and uncooperative. He was detained under Section 3 MHA, and admitted to the Cobden unit psychiatric intensive care unit (PICU) at Stepping Hill Hospital on 9 June 2014, and was then transferred to Hollingworth Ward, Birch Hill Hospital on 30 June 2014.

1.15 B was arrested on 20 December 2014 after entering a stranger's garden and making threats to stab him when approached. After arrest an urgent forensic assessment was requested but the advice given was that a medium secure referral would be required before they would consider

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[3] The provisions of the Mental Health Act 1983 shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. Section 47 relates to the transfer of prisoners to hospital. http://www.legislation.gov.uk/ukpga/1983/20/part/I

[4] Clozapine is an antipsychotic drug used as a sedative and in the treatment of schizophrenia. http://www.thefreedictionary.com/clozapine

[5] Notional Section 37 is when a prisoner transferred to prison for mental health treatment is deemed to require ongoing treatment, but has come to the end of their sentence. http://www.legislation.gov.uk/ukpga/1983/20/section/47

assessing in custody. Due to the logistical issues of arranging this a bed was located at Cobden PICU.

1.16 He was detained under Section 3 MHA and admitted to Cobden PICU on 21 December 2014. B was seen in Cobden PICU by a consultant from the GMW Forensic service on 27 January 2015. The view was that B clearly had a long standing history of paranoid schizophrenia, with a dissocial personality disorder, and when unwell he posed 'a significant risk to others'. A key challenge was noted to be his management in the community. The view was that B had an enduring mental illness of paranoid schizophrenia and when unwell was a potential significant risk to others. These suggestions were made:

- A community treatment order[6] (CTO) was suggested as appropriate at the point of discharge
- Clozapine could be supported as long as he is engaging well, but he should come into hospital, if not be recalled, if there are concerns at an early stage
- 'Clopixol[7]' depot was suggested as an alternative if clozapine compliance was an issue
- A referral to MAPPA[8] was suggested to enable joint working, acknowledging that the police may not accept it
- He needs long term 'assertive type follow up in the community'.

1.17 B was transferred to Birch Hill Hospital in January 2015, and discharge was agreed under a Community Treatment Order. A discharge checklist completed on 27 February 2015 noted that he was on CPA, the factors decreasing risk were: compliance with medication, contact with services, CTO; and factors increasing risk were: illicit substance misuse, unstable mental state.

1.18 B did not attend the 7 day follow up meeting that had been arranged for 4 March 2015, and he was not contactable by phone or by visiting his flat. Staff spoke to him by phone on 12 March 2015, 13 days after discharge. He was reminded to attend for blood tests and to collect medication.

1.19 B did not attend to collect medication on 16 March 2015, and sent a message to staff saying he was unwell. He was phoned on 18 March 2015 to remind him of his outpatient appointment on 25 March 2015, and it was checked that he could attend the treatment support clinic to have blood tests and receive clozapine.

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[6] *Section 17A.Community treatment orders. The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below. A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment. An order under subsection (1) above is referred to in this Act as a "community treatment order" http://www.legislation.gov.uk/ukpga/1983/20/section/17A*

[7] *An antipsychotic medicine given by injection. http://patient.info/medicine/zuclopenthixol-clopixol*

[8] *Multi-agency public protection arrangements. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2*

1.20 It is a requirement of the PCFT Care Programme Approach (CPA) policy that all patients discharged from hospital on CPA are followed up face to face by staff within 7 days. B did not attend the 7 day follow up meeting that had been arranged for 4 March 2015, and he was not contactable by phone or by visiting his flat. Staff spoke to him by phone on 12 March 2015, 13 days after discharge. He was reminded to attend for blood tests and to collect medication.

1.21 B did not attend to collect medication on 16 March 2015, and sent a message to staff saying he was unwell. He was phoned on 18 March 2015 to remind him of his outpatient appointment on 25 March 2015, and it was checked that he could attend the treatment support clinic to have blood tests and receive Clozapine. He did not attend either appointments, and the decision was made to exercise powers of recall to hospital on 25 March. PCFT services were informed of his arrest on suspicion of murder on 26 March 2015.

1.22 On 25 March 2015 B was at a party in a public house in Rochdale with his partner at the time. The victim Adam came to the pub with a woman he had met who knew other customers. Just after midnight the woman was involved in an altercation with another customer (who was a friend of B) and she threw a drink over him. B was noted to be standing up earlier, and appearing aggressive towards Adam. This situation ended without further incident, and though Adam was not directly involved, the landlord asked him to leave which he did, and then Adam shook hands with the landlord just outside. B and his partner followed them out, and the landlord and partner attempted to usher B back inside.

1.23 B did not come back inside, and while Adam was bending down to talk to a taxi driver though a car window B punched him on the side of his head. Adam fell to the ground, and did not regain consciousness. They attended and attempted resuscitation whilst waiting for the ambulance. Adam was transferred to Royal Oldham Hospital and declared deceased at 02:25 hours on 26 March 2015.

1.24 On 16 January 2016 at Manchester Crown Court B pleaded guilty to manslaughter and was sentenced to six years imprisonment to be followed by five years on licence.

Family

1.25 B was brought up in the Greater Manchester area and is an only child. His parents divorced when he was two and he lived with his mother for the majority of his childhood. His father died when he was sixteen, after a long history of alcohol and substance misuse. B's mother had periods of admission to hospital with mental health issues.

1.26 B has one child who was born in August 2013, with whom he has no contact. His mother died in October 2015 and his maternal grandparents maintain contact with him.

Internal investigation

1.27 Pennine Care NHS Foundation Trust undertook an internal investigation for the Trust. This has been reviewed by the investigation team.

1.28 The internal investigation made eight individual recommendations and PCFT has implemented an action plan.

1.29 We find that the recommendations made in the internal report did address the contributory factors found through the investigation.

Independent investigation

1.30 This independent investigation has drawn upon the internal process and has studied clinical information, police information, internal reports, and organisational policies. We met with clinical staff who had been in contact with B, and senior staff from the Trust and the supported housing support provider.

1.31 B met with us to discuss the report findings, and was concerned at the level of personal detail about him, and the report has been amended because of this.

1.32 We met with B's maternal grandparents. They gave us their view that B's care plans in the community should have been monitored more closely.

1.33 We met with Adam's parents who asked to be kept informed of the outcome of the investigation. After reading the report, they commented that they hoped B's future care teams are expected to read it for a good understanding of his presentation.

1.34 Our independent investigation has concluded that it was certainly predictable that B would be violent again in the future and that the manner of his violence would be impulsive and unplanned.

1.35 Our view is that the homicide of Adam was preventable, taking the longer term view of B's journey through mental health services. However we consider that it was not preventable by PCFT based on information available to them at the time.

1.36 We believe that if different decisions had been made earlier in his care, he would have been more likely to have been engaged and treated compulsorily. He would therefore have been less likely to commit impulsive acts of violence.

Good Practice

We wish to highlight the following areas of good practice:

1.37 Clinical staff reported that they felt well supported after the homicide.

1.38 The engagement of and communication with families after the homicide was sensitively managed and communication remained open through the independent investigation.

1.39 The internal report was well structured and provided a comprehensive detailed root cause analysis of the care of B.

1.40 We have found PCFT to be open and receptive to the lessons learned from the independent investigation, and able to show evidence of lessons learned from the internal investigation.

2 Findings

2.1 We have reviewed B's care from first contact with adult mental health services, in order to provide background context and understanding of his presentation. We have however focused in detail on the periods of 2014 and 2015 and before his arrest on 26 March 2015.

2.2 We grouped the issues of concern regarding B's care into the following headings:

- the recommendations of the forensic assessment (including the requirements of the CTO) should have been more focussed
- the planning for discharge and CTO should have been more structured,
- arrangements for ensuring all patients have a care coordinator and up to date care plans were not robust
- HCR 20 risk assessments lacked detail
- care plans did not take all his needs into consideration
- CPA overview was lost following his discharge to prison from medium secure services

2.3 Where concerns have been addressed by the internal review recommendations we have noted these and not repeated them.

2.4 PCFT made eight internal recommendations, and have provided evidence that most of these recommendations have been met. The recommendations made in this independent investigation are to supplement the work already undertaken by the Trust.

2.5 We have made 10 recommendations based on our findings and analysis.

3 Overall analysis and recommendations

3.1 From reviewing the notes we consider that B appears to have a constant anxiety and depression driven by paranoia, and his signs of relapse are much more subtle than the norm in paranoid schizophrenia. At times of relapse he seems to become less in touch with reality, more impulsive, and his violence is more random, but he does not always exhibit the classic first rank symptoms. We hope that this formulation and longitudinal perspective can contribute to future risk assessment and management, in spite of his own insistence that he is not mentally ill.

3.2 The internal investigation by PCFT identified many areas of learning, which we support and have expanded upon. We have made ten recommendations for wider systems learning, having had the advantage of reviewing the care provided by Mersey Care, PCFT, GMW and primary care.

3.3 Since this incident PCFT has taken significant steps to improve the management of risk within CMHTs, and has also significantly revised and improved its processes for the assessment and management of clinical risk.

3.4 PCFT has recognised that there were gaps in the care of B, which could be improved, and has taken steps to address these.

3.5 We wish to highlight the following areas of good practice:

- Clinical staff reported that they felt well supported after the homicide.
- The engagement of and communication with families after the homicide was sensitively managed and communication remained open through the independent investigation.
- The internal report was well structured and provided a comprehensive detailed root cause analysis of the care of B.
- We have found PCFT to be open and receptive to the lessons learned from the independent investigation, and able to show evidence of lessons learned from the internal investigation.

Predictability and preventability

3.6 In its document on risk, the Royal College of Psychiatrists scoping group observed that:

‘Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction

because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.'[9]

3.7 Similarly, the PCFT clinical risk assessment policy states:

'Clinical risk assessment and the management of that assessed risk is a dynamic and continual process based on a formulaic approach. The judgement of the professional is integral to good risk formulation and in the production of a risk management plan with service users.

3.8 The National Confidential Enquiry reports that there was an average of 31 homicides by people with schizophrenia in England each year between 2003 and 2013. More than half of the perpetrators were not adhering to their medication or had missed their last contact with the mental health service.[10]

3.9 At court in January 2016, B was found guilty of manslaughter and sentenced to six years imprisonment with a further five years on licence. Although a psychiatric report was prepared for his trial, he received a custodial sentence, which suggests the court considered he was not in need of medical attention at the time. Psychiatric opinion has been that while B certainly has a history of violence and criminal activity separate to his mental disorder, his impulsivity and the degree of his violence has been worsened when he is experiencing psychotic symptoms.

3.10 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.[11] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[12]

3.11 We consider that it was certainly predictable that B would be violent again in the future and that the manner of his violence would be impulsive and unplanned. This was not helped however by the lack of scenario planning in the GMW HCR20 risk assessments.

3.12 Although he has previous history of trying to strangle a stranger and made threats to kill, his previous violence has been impulsive and unplanned. Impulsive acts of violence have been perpetrated by B both whilst treated with medication and when not actively psychotic. There is nothing in his history that would suggest he was very likely to commit an act of homicide. There are many cases of 'one punch' killings[13] where the perpetrator intended to recklessly assault but not necessarily kill the victim, and B's assault on Adam appears to be in this category.

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[9] *Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23. http://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf*

[10] *. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report July 2015. http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf p34*

[11] *http://dictionary.reference.com/browse/predictability*

[12] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*

[13] *http://www.1pck.org.uk/*

3.13 Prevention[14] means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

3.14 We consider that here are clear reasons why a Section 37/41 MHA should have been considered earlier in 2010, and indeed after the homicide:

- He had previously been treated in a high secure hospital, had a complex diagnosis of schizophrenia and probably personality disorder;
- He had previously shown a good response to treatment in hospital, with both clozapine and CBT;
- It was recognised that he needed to be treated effectively to reduce his risk to others;
- He had committed further offences whilst detained under a Notional Section 37; and,
- He would undoubtedly require the structure of a Section 41 in the community, which is recognised to be far more effective than a CTO.

3.15 We have noted that a more clinically assertive model of care should have been instigated to engage B with services, and provide structured follow up in the community.

3.16 Our view is that the homicide of Adam was preventable, taking the longer term view of B's journey through mental health services. However we consider that it was not preventable by PCFT based on information available to them at the time.

3.17 We believe that if different decisions had been made earlier in his care, he would have been more likely to have been engaged and treated compulsorily. He would therefore have been less likely to commit impulsive acts of violence.

4 Recommendations

We have made ten recommendations.

Recommendation 1:
GMW forensic service should introduce standards which provide a structured evidence based approach to a request for a forensic risk assessment.

[14] http://www.thefreedictionary.com/prevent

Recommendation 2:
PCFT should seek assurance that the current CTO policy is realistic and fit for purpose, and adapt it as required to ensure it is in line with other relevant Trust processes, and then seek assurance that the requirements of the CTO policy are being adhered to and implemented correctly.

Recommendation 3:
PCFT should revise the zoning protocol to include clarity on who should attend from different disciplines, and a minimum meeting interval should be specified. This should then become a policy and its implementation monitored.

Recommendation 4:
PCFT must provide assurance that systems are in place to ensure that all patients on 'CPA plus' have updated care plans.

Recommendation 5
PCFT & NHS HMR CCG should assure themselves they have appropriate resources to meet demands of patients who meet the requirements of CPA plus, and/or an 'AOT approach'.

Recommendation 6:
GMW forensic services should review this report and assure themselves that their working practices with respect to HCR20 are robust.

Recommendation 7:
PCFT should evidence that risk assessments are robust and then followed by a clear risk management plan that should be an essential part of CPA care planning.

Recommendation 8:
GMW forensic services should review this report and consider whether it has implications for their practice in relation to recommending Section 37/41 for patients in this situation.

Recommendation 9:
GMW should clarify the requirements of CPA and communicate with the relevant provider prior to transferring a patient to prison to ensure continuity of care.

Recommendation 10:
PCFT should clarify what additional enhanced risk management follows from registration on CPA Plus.

Appendix A – Terms of reference

Terms of Reference for Independent Investigations under HSG (94) 27/NHS England's Serious Incident Framework 2015

The individual Terms of Reference for independent investigation 2015/11721 are set by NHS England North. These terms of reference will be developed further in collaboration with the offeror, and family members. However the following terms of reference will apply in the first instance;

Core Terms of Reference

Review the Trust's internal investigation of the incident to include timeliness and methodology to identify;

- If the internal investigation satisfied the terms of reference
- If all key issues and lessons were identified
- If recommendations are appropriate and comprehensive
- The implementation of the internal action plan through evidence
- If the affected families were appropriately engaged with

- Following review of the internal report, identify additional key lines of enquiry required

- Given the services user's extensive contact with services, determine an appropriate start date to review the care, treatment and services provided by the NHS and other relevant agencies to the time of the offence.

- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk

- Examine effectiveness of discharge planning and transitional arrangements, specifically access to support from CMHTs for high risk patients

- In considering the care of the service user, review the recommendations of the forensic assessment including the requirements of the CTO.

- Consider the interface between Forensic (Specialised Commissioning) and local mental health (CCG Commissioned) services

- Review the risk management training provision, specifically critically evaluate the skills staff have/need in respect to risk assessment, particularly for patients with a diagnosed personality disorder

- When reviewing the care of the service user, consider the impact of service reconfiguration and reduced resources

- Review the adequacy of risk assessments and subsequent risk management, specifically the communication of known high risk information (including safeguarding/domestic violence) and plans for mitigation

- Consider the effectiveness of Community Mental Health and Assertive Outreach services in relation to interventions and service provision given the service users complex needs

- Examine the effectiveness and allocation of the Care Coordinator

- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family

- Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations

- Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the Police and other identified support organisations.

- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement

- Provide a written investigative report to the Investigation Team (NHS England North) that includes measurable and sustainable recommendations.

- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement

- Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference

- Conduct an evidence based review of internal report recommendations to confirm they have been fully implemented.

- Support the Trust to develop an outcome based action plan based on investigation findings and recommendations.

- Support the commissioners (NHS Heywood, Middleton & Rochdale CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.

- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England North.

Appendix B – Profile of the Trusts

Mersey Care NHS Foundation Trust
Provides specialist mental health services in North West England and beyond. The Trust vision is to become the leading organisation in the provision of mental health care, addiction services and learning disability care.
The Trust provides specialist inpatient and community mental health, learning disabilities, addiction management and acquired brain injury services for the people of Liverpool, Sefton and Kirkby, Merseyside. We also provide secure mental health services for the North West of England, the West Midlands and Wales. We are one of only three trusts in the country that provide these services.
Clinical services are provided across more than 30 sites across Merseyside. These teams are supported by a corporate team based at Trust offices in Kings Business Park, Prescot, Merseyside.

Greater Manchester West Mental Health NHS Foundation Trust
Provides inpatient and community-based mental health care and treatment for adults and older people living within the North West. The Trust also provides a wide range of more specialised, or tertiary, services across Greater Manchester, the North West of England and beyond. These include substance misuse services (inpatient and community-based), forensic mental health services for adults and adolescents, child and adolescent mental health services, mental health and deafness services, health and justice services and community psychological therapies.

Pennine Care NHS Foundation Trust
Provides of community and mental health services in Greater Manchester.
Bury, Oldham and Rochdale – community services and mental health for children and adults
Tameside and Glossop – children's and adults mental health, health improvement and intermediate care
Stockport – children's and adults mental health
Trafford – community services and child adolescent mental health services (CAMHS)
Mental health services provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illnesses such as schizophrenia, bi-polar disorder and more.
Community services, including district nursing, health visiting, audiology, podiatry, health improvement and intermediate care.