

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>(1) NHS Birmingham and Solihull Clinical Commissioning Group ('CCG'). (2) NHS England. (3) Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care. (4) Clive Heaphy, Acting Chief Executive, Birmingham City Council ('BCC'). (5) Roisin Fallon-Williams, Chief Executive, Birmingham and Solihull Mental Health Foundation NHS Trust ('BSMHFT'). (6) Dave Thompson, Chief Constable, West Midlands Police ('WMP').</p>
1	<p>CORONER</p> <p>I am James Bennett Area Coroner for Birmingham and Solihull.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 06/08/2018 I commenced an investigation into the death of Nigel Byron Abbott. The investigation concluded at the end of an inquest on 30th September 2019.</p> <p>My conclusion was a narrative conclusion, as follows:</p> <p>'Nigel Abbott was killed by another person unknown to him. That person had been suffering from a serious mental illness and had not been detained in hospital when he should have been. The mental health services had the means to detain him. Had he been detained within a reasonable amount of time the death would not have occurred.</p> <p>Systemic failings contributed to Nigel's death, namely:</p> <ol style="list-style-type: none"> 1) There was a lack of psychiatric inpatient beds in Birmingham. 2) There were no section 140 beds in Birmingham. 3) The <i>Joint Memorandum of Understanding for Mental Health Professional Requesting Police Assistance with Mental Health Act Assessments and s.135 Warrants</i> was ambiguous and misunderstood. 4) The <i>Home Treatment Standard Operational Procedure</i> was inadequate and failed to provide the necessary safeguards. 5) There was a lack of leadership within the HTT. 6) There was a lack of resources within the HTT. 7) There was no adequate system for mental health professionals to communicate with each other and therefore they did not communicate effectively. 8) As a consequence of (4) – (7), no Doctor was tasked to review the person on 27 July in accordance with the <i>Home Treatment Standard Operational Procedure</i>. 9) There was no adequate system to record and react to the family's telephone calls in which they raised concerns.

	<p>Further, specific failings by an AMHP contributed to Nigel's death, namely:</p> <ol style="list-style-type: none"> 1) She decided not to contact the person's family. 2) She did not escalate her concerns. 3) She closed the person's case. 4) She did not alert the out-of-hours AMHP that she had requested a new referral. <p>These specific failings were contributed to by the above systemic failings.'</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 27 July 2018 Nigel Abbott left his home to walk the short distance to meet his friend at a local public house. Shortly before 23.00hrs, the familiar route took him along Turchill Drive, Walmley. A stranger ran out of his house and commenced a frenzied and prolonged assault on Nigel. He was punched to the head, had his head stamped on, was struck about his head with his own walking stick and a spirit level, and was stabbed in the neck 52 times with two small kitchen knives. Having been alerted by 999 calls the police arrived and interrupted the assault. Nigel was already deceased outside no.81 Turchill Drive. A paramedic formally confirmed death at 23.01hrs.</p> <p>The background to the assault is as follows.</p> <p>The person was aged 29, a tradesman and lived with his partner and two children. He was a healthy and fit person competing professionally as a Thai boxer. Between 2003-2006 he was formally reprimanded, warned and cautioned by the police for Actual Bodily Harm x 2 and Battery. He was otherwise a law-abiding person.</p> <p>Both he and his family could not have known he was genetically pre-disposed to develop schizophrenia.</p> <p>Without any warning, in July 2018 he suffered a sudden and dramatic decline in his mental health. It began on 11 July when he reported that a man in a van had stopped him in his car and threatened him with a knife in connection with an on-going work-related dispute. This event remains unverified. It is likely there was a stressful event around this time - a known trigger for schizophrenia - but the precise details remain unclear.</p> <p>Over the next two weeks he displayed increasingly erratic and bizarre behaviour. He put two kitchen knives next to his bed. He developed unshakeable and entrenched beliefs focussed around him being blessed by God and that he was the 'chosen one'. He would refer to the devil. He would repeatedly say 'you are either with me or against me'. He believed televisions and his tattoos were talking to him. He became increasingly fixated with (verified) wild fires in Greece and a (verified) forthcoming astronomical event known as a 'blood moon'. He believed he did not need to eat or drink. He stopped working and sleeping. He was driving fast and through red traffic lights, believing that they were changing to green specifically for him as he approached them. His family were extremely concerned and tried to persuade him to get medical help but he refused.</p> <p>On 26 July 2018 his mother asked a family friend, who was a nurse, to informally visit him. His brother persuaded him to see his General Practitioner, who recognised he was having a psychotic episode, and at approximately 17.00hrs made an urgent referral to the Crisis team. It was agreed he needed an initial assessment within 24 hours and arrangements would be made via the brother. A Home Treatment Team ('HTT') nurse inadvertently telephoned the man. He repeated his psychotic beliefs and was angry at</p>

being telephoned, was irritated, and hung up. She contacted the out-of-hours Doctor for an assessment that evening.

With considerable effort his family persuaded him to wait at his mother's house. Arranged via the brother, at approximately 23.00hrs the Doctor, a Specialist Registrar Psychiatrist, and a mental health nurse assessed him. They quickly concluded he was suffering from first episode psychosis. He was unknown to the mental health services so there was no history to inform them how he might behave. He lacked capacity and needed a full Mental Health Act 1983 ('MHA') assessment with a view to being detained under section 2. The Doctor briefly considered and dismissed the use of section 4 – a rarely used section. The bed manager confirmed there were no psychiatric unit beds available.

In relation to the specific issue of risk to others:

- The brother warned the Doctor and nurse they needed to be careful because his brother was 'handy'.
- They were told he was a trained Thai boxer.
- That he had old charges or convictions for Actual Bodily Harm and Grievous Bodily Harm.
- They found him to be a physically imposing man, who was at times extremely irritated and hostile.
- His psychotic beliefs about being the 'chosen one' were entrenched and they avoided challenging him. He reported a Clairvoyant (verified) had told him 4-5 years earlier 'the devil is going to put a spanner in the works'.
- They were told he had been driving fast and through red lights believing they were specifically changing to green for him.
- He reported no thoughts to harm anyone, but stated that if anyone gets in his way 'I know what I am capable of'.
- He described himself as a 'ticking time bomb'.
- The severity of his mental illness led them to anticipate a general acute psychiatric ward would offer inadequate safeguards and that he would need to be admitted to a psychiatric intensive care unit ('PICU').
- They anticipated the police would be required to help facilitate the full MHA assessment and extract him to a PICU.

They concluded his reported history of erratic driving presented a risk to other people. They did not believe he presented a general risk of violence.

They asked him to take anti-psychotic medication but he refused. They asked him to remain at his mother's house but he refused. They asked his brother to block his car in. At approximately 00.00hrs he drove off, alone, but in a controlled manner. They considered but rejected informing the police. They did not check to see whether he actually drove home. The Doctor did not contact the out-of-hours Consultant for advice. The bed manager should have been asked to prioritise him but wasn't. In the early hours of 27 July the Doctor and nurse completed their RIO notes and section 2 recommendation.

The Approved Mental Health Practitioner ('AMHP') service had responsibility for co-ordinating the full MHA assessment. The nurse made an informal call to the out-of-hours AMHP. The nurse should have referred him to the AMHP service immediately but did not do so. This caused a delay of approximately 10 hours. A day-shift HTT nurse sent the referral at 10.08hrs. It did not mention the urgency when it should have done so. The referral stated he had not shown any signs of violence, but cited his statement that

if anyone gets in his way 'he knows what he's capable of' and there were potential risks to others because he was hostile and irritable.

A Senior Practitioner allocated his case to an AMHP. Mid-morning the AMHP read the RIO notes made by the HTT Doctor and nurse. She was clear that the man needed to be detained and he presented a real risk of harm to other people. She was not prepared to conduct the assessment and detain the man, without police assistance and the ability to immediately take him to a psychiatric unit. She discussed what to do with a different Senior Practitioner. He had no prior knowledge of the case. They incorrectly understood that outside of a 999 call situation the police required 24 hours' notice. A multi-agency Memorandum of Understanding to request police assistance contained ambiguous wording. They anticipated the police would be too busy to execute a warrant because it was the weekend. They did not contact the police to ask them. They agreed the court would be unlikely to grant the warrant until a bed was available.

At a midday bed management meeting the HTT Acting-Team Manager asked for him to be prioritised. The general AMHP service was not represented. It was agreed the Place of Safety, if free, would be made available for the MHA assessment pending a bed being found. The HTT should have informed the AMHP about the availability of the Place of Safety but didn't. The HTT should have informed the AMHP he was a priority but didn't. It was agreed a section 135 warrant would be required. The HTT requested the AMHP apply for a section 135 warrant at 14.27hrs. The Senior Practitioner who allocated the AMHP at 10.08hrs knew about this request. He did not inform the AMHP. The AMHP remained unaware of the request.

The AMHP telephoned the bed manager direct and was told it was unlikely a bed would be available that day. There was no discussion about using the Place of Safety as agreed at the bed management meeting.

The AMHP telephoned the HTT at 12.35hrs but no clinicians were available. At 15.35hrs a HTT nurse returned her call. The AMHP said it was an 'urgent' assessment but because the man presented a risk to other people she was not prepared to undertake a MHA assessment until there was a bed available. It was the responsibility of the HTT to locate a bed. This update from the AMHP should have resulted in the HTT making a determined effort to locate a bed, but it didn't. There was no discussion about using the Place of Safety as agreed at the bed management meeting.

The AMHP was told the man's family had been calling repeatedly. The AMHP should have telephoned the family but decided not to because she had no update for them. This was a missed opportunity to check on the man's risk. The AMHP did not escalate her concerns within the HTT when she should have. The AMHP did not escalate her concerns with the bed manager when she should have. The AMHP did not escalate her concerns within the AMHP service when she should have. The AMHP was about to finish her shift and incorrectly caused his case to be closed. The AMHP instructed the HTT nurse to send a new referral to the out-of-hours AMHP. Having caused the case to be closed the AMHP should have alerted the out-of-hours AMHP but didn't. The AMHP's rationale for her actions was long standing frustration with the challenging environment in which the mental health professionals were working. The AMHP's actions were not in accordance with recognised practice and were contrary to her code of conduct.

At approximately 17.00hrs the out-of-hours AMHP checked the list of requests for a MHA assessment. The man should have been on the list but wasn't and she left the

office to assess a different person. She remained unaware the man needed a MHA assessment until a bed manager asked her to progress it, but the man had already killed Nigel.

The HTT nurse had made the second referral at 18.01hrs. The nurse should have requested a section 135 warrant but did not do so. The nurse should have requested urgency but did not do so. It contained contradictory statements about risk: 'risk self very vulnerable, no known risk to others' and 'at risk to others due to his agitation'. The HTT nurse and an AMHP service care facilitator spoke at approximately 18.17hrs and 20.09hrs. The HTT nurse stated the family had reported the situation was continuing to deteriorate. The out-of-hours AMHP was not informed.

The family had understood a bed would be found early on 27 July. The man had not slept all night. With considerable effort, his family persuaded him to consent to treatment. He packed a bag at home and at approximately 8.00hrs went to his father's house. Between 8.24hrs and 20.06hrs his family telephoned the HTT over 60 times. The overwhelming majority of their calls were not answered. When answered they explained he was willing to voluntarily present at hospital and that his mental health was worsening. They were told no bed was available. After 16.30hrs the family had one further call connect at 20.06hrs. They were told the HTT were waiting for an update on a bed.

The HTT Standard Operational Procedure required a Doctor to review the man on 27 July. There is no evidence a Doctor was made aware of the man on 27 July. He should have been reviewed by a Doctor in accordance with this procedure but wasn't.

Due to a failure of mental health professionals to correctly record and communicate effectively with each other and the family, no mental health assessment took place. In addition the processes in place at the time were inadequate and failed to provide the necessary safeguards. Mental health professionals became procedurally driven by the lack of an available bed. No one mental health professional or organisation had the complete picture.

This is against a background of (1) the demand for mental health beds in Birmingham increasing significantly (2) there being no section 140 beds in Birmingham (3) the HTT and AMHPs having to operate significantly beyond their recognised capacity (4) the HTT was being led by an Acting-Team Manager and Locum-Consultant Psychiatrist, there was a lack of proactive leadership on 27 July.

Mid-evening the man was taken home. As the evening progressed his partner was so concerned about his presentation she discretely removed and hid the two knives he had placed next to his bed and all kitchen knives except two small kitchen knives. These were later used during the assault. Having gone to bed alone, shortly before 23.00hrs, he woke her up and made her go into the back garden and run around together. He was fixated with the 'blood moon' and repeating 'you are either with me or against me'. By coincidence, Nigel Abbott walked past the front window. He shouted 'that's the devil' and ran after Nigel and killed him. After a post-mortem the cause of death was blunt force trauma to the head.

He was arrested on suspicion of murder. He was assessed and sectioned under the MHA. He reported being God and at war with the devil. He was diagnosed with a severe form of untreatable schizophrenia. The severity of his mental illness could only be explained by genetic predisposition. He was charged with murder. Based on the agreed

evidence of two expert consultant forensic psychiatrists, on 14 February 2019 a Crown Court jury found him not guilty 'by reason of insanity', meaning he was found not responsible for his actions.

5

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern.

1. Previous Prevention of Future Death Reports

The Birmingham and Solihull Coroners issued nine relevant Prevention of Future Death reports ('PFDs') in the 12 months preceding this inquest. Four of the deaths pre-dated the death of Nigel Abbott (27 July 2018) and five post-dated his death. All nine PFDs were issued after his death. Namely:

No.	Name of Deceased	Date of Death	Date of Report
1	Simon Graham	4 May 2018	4 October 2018
2	Bradley Morgan	13 May 2018	4 October 2018
3	Michael Cooper	22 June 2018	4 October 2018
4	Michael Wheeler	26 July 2018	4 October 2018
5	Stephen Jackson	11 August 2018	4 October 2018
6	Claire Ryder	12 August 2018	4 October 2018
7	William Edge	18 August 2018	4 October 2018
8	Stephen Kennedy	8 October 2018	7 February 2019
9	Anthony Watson	22 October 2018	12 February 2019

NB. The PFDs and responses are available publicly on the Chief Coroner's website.

All nine PFDs shared commonality of circumstances – the deceased was known to the mental health services, had taken their own life, and the lack of an inpatient psychiatric bed had featured in the chronology. PFDs no.1-7 were issued as one batch on 4 October 2018 (some of the seven pre-dated the corresponding inquest) because the strain on the system of mental health services had become apparent to the Birmingham and Solihull Coroners, and in their judgment, there was an on-going risk of future deaths from chronic underfunding of mental health services in Birmingham. NHS England and Birmingham and Solihull CCG responded pointing to additional investment and funding.

Two further PFDs were issued on 7 and 12 February 2019. In the judgment of the Birmingham and Solihull Coroners there remained an on-going risk of future deaths from chronic underfunding of mental health services in Birmingham. PFD no.8 was sent to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care. A response was delegated to Jackie Doyle-Price MP, Minister with portfolio responsibility for mental health services. She acknowledged that nationally the number of mental health beds had reduced and pointed to additional national investment and funding.

2. [REDACTED] concerns

On 22 March 2019 [REDACTED], wife of Nigel Abbott, emailed Rt Hon Teresa May, Prime Minister setting out her concerns about her husband's death. An undated response was again delegated to Jackie Doyle-Price MP, Minister with portfolio responsibility for mental health services. She acknowledged the above PFDs and specific concerns raised by the Care Quality Commission about BSMHFT in its latest report, adding 'It is clear that this situation is not acceptable and that there is an urgent need for improvement to prevent further incidents. I have asked my officials to keep me updated on the situation'.

3. [REDACTED]

[REDACTED] is a Consultant Forensic Psychiatrist and the Chief Mental Health Legislation Officer for BSMHFT. His evidence included, in summary:

- Section 4 of the Mental Health Act 1983 ('admission for assessment in cases of emergency') is a rarely used provision. He was unaware of it being used nationally with a combination of a section 12 approved Dr and the nearest relative. This is a training and education issue. Following Nigel Abbott's death he emailed all relevant Drs in the Trust reminding them that section 4 is available to be used in urgent cases where there are problems with resources.
- Section 140 of the Mental Health Act 1983 requires every Clinical Commissioning Group to specify hospital(s) in their area which can, from time to time, receive patients in cases of special urgency. This has been on the statute book since 1983 however there remain no section 140 beds in Birmingham and Solihull. For 4 years he has been pursuing Birmingham and Solihull CCG to provide section 140 beds.
- He did not agree with the Birmingham and Solihull CCG response to the batch of seven PFDs issued on 4 October 2018 (see above). He said 'deaths are occurring in Birmingham because of a lack of resources' and the mental health services in Birmingham are in a 'massive crisis'. This had not been laid out in the Birmingham and Solihull CCG's response to the PFDs.
- There are on-going 'systemic issues' and he is 'seriously concerned'. This is not a secret but an open fact. There is no lack of effort but there remains a 'perfect storm' due to the 'paucity' of resources. This creates a prohibitive environment for clinicians and AMHPs. Further context is that the number of psychiatric patients in Birmingham and Solihull has gone up whilst simultaneously cuts have been made to mental health funding in Birmingham and Solihull

4. [REDACTED]

[REDACTED] is a Consultant Psychiatrist and a Clinical Director within BSMHFT. He has three HTTs within his portfolio. He was BSMHFT's lead psychiatrist on its Root Cause Analysis investigation. His evidence included, in summary:

- There are on-going 'system failures' within the mental health services in Birmingham. The service is 'broken.' In the Birmingham local health economy – mental health, police, social care – the leaders are 'weak and incompetent'.
- Birmingham and Solihull CCG does not adequately fund mental health services in Birmingham, and does not distribute what funding it does provide appropriately.
- Modelling has demonstrated Birmingham needs 40+ more psychiatric beds.
- The system failures impact on the decision making of clinicians who have consequently developed 'learned helplessness' – they have learnt that there is 'no point' in asking for a bed.

5. Generally

I heard evidence from a number of front line mental health Drs, nurses and AMHPs and senior witnesses from BSMHFT, BCC and WMP. The evidence included, in summary:

- Drs, nurses, AMHPs and police officers do not understand the *Joint Memorandum of Understanding for Mental Health Professional Requesting Police Assistance with Mental Health Act Assessments*. WMP's mental health lead officer Inspector ██████████ stated its wording was ambiguous and he would 'bin it and start again'. The MoU is still being used.
- The HTT, bed managers and AMHP services are operating caseloads significantly beyond their recognised capacity:
 - Referral rates to the 5 HTTs in Birmingham and Solihull have increased from 7238 in 2014/2015 to 9282 in 2018/2019.
 - The 5 HTTs have resources to manage a caseload of 250-300 however are actually managing around 500.
 - The AMHP service carried out 2680 MHA assessments between April 2017 and March 2018. This increased by 49% - 4002 - between April 2018 and March 2019.
 - The 5 HTTs have vacancies for front line nurses and at a leadership level that cannot be filled, in part due to the unattractive working conditions.
 - The number of AMHPs has decreased by 17% whilst the number of detentions under the MHA has increased by 47%.
 - At the time of the incident there were 24 patients waiting in the community for a bed. 16 had been fully assessed under the MHA and detained. 9 had received initial assessments under the MHA and deemed detainable.

A similar picture is continuing.

- Generally, front line mental health professionals – Drs, nurses, bed managers, AMHPs – are working in an extremely challenging environment which impacts negatively on their attitudes and working practices.

6. Home Treatment Team Policies

The lack of psychiatric beds means it is not uncommon for patients who have had a full

MHA assessment and patients who have had an initial assessment to both have to remain in the community whilst a bed is found, sometimes for many weeks. Their risks and safety in the community are managed in accordance with HTT policy, however, the respective policies are not consistent.

For patients who have had a full MHA assessment and been detained, *The Bed Management and Maximising Bed Use Policy* and *Bed Management Acute Admissions and Capacity Utilisation Policy* contain a detailed process requiring the HTT to assess the patient and their family's needs, and put in place a written care plan to provide a safe and appropriate management plan, pending a bed being found. In contrast, for patients who have had an initial assessment and deemed detainable the *Home Treatment Standard Operational Procedure* simply requires them to be 'medically reviewed by [HTT] doctor the next working day' pending a bed being found.

It follows the applicable policy is determined by the technical status of the patient rather than their personal circumstances. The man who killed Nigel Abbott was initially assessed by a section 12 Dr as lacking capacity, in severe first episode psychosis and was detainable. He was predictably a risk to himself and others and refused to stay at his mother's house and take medication. His risk in the community was no different to someone who had actually been detained. However, the difference in status meant the more robust and detailed HTT process, only applicable to patients who have had a full assessment, did not apply.

I heard no explanation as to why *The Bed Management and Maximising Bed Use Policy* and *Bed Management Acute Admissions and Capacity Utilisation Policy* process for managing risks and safety for fully assessed and detained patients in the community, are not replicated in the *Home Treatment Standard Operational Procedure* for patients who have had an initial assessment and deemed detainable.

Summary of Concerns

In summary, the evidence raised five generic on-going matters of concern. The consequence is that acutely unwell people who need to be detained, because of the risk they pose to themselves and others, will remain unnecessarily free in public when in fact the agencies have the mechanism to detain them.

The five generic on-going matters of concern:

- (1) The agencies involved in this area are not working together effectively and there is a misunderstanding around the *Joint Memorandum of Understanding for Mental Health Professional Requesting Police Assistance with Mental Health Act Assessments*.

NB. I issued pre-inquest a PFD dated 31/07/2019 in relation to this concern. Having heard the evidence at the inquest the concern remains - WMP's mental health lead officer Inspector [REDACTED] stated its wording was ambiguous

	<p>and he would 'bin it and start again'. The content of this PFD therefore remains valid.</p> <p>(2) There continues to be a chronic shortage of resources within the mental health services in Birmingham and Solihull. In particular, mental health professionals are operating caseloads well in excess of recommended levels and there is a chronic shortage of psychiatric beds.</p> <p>(3) Birmingham and Solihull CCG have not provided section 140 beds for BSMHFT.</p> <p>(4) Whilst section 4 is available to be used, it is not used.</p> <p>(5) The <i>Home Treatment Standard Operational Procedure</i> is inadequate to safeguard patients in the community who have been initially assessed and deemed detainable but are waiting in the community for a bed. This procedure is inconsistent with the corresponding safeguards for fully assessed and detained patients waiting in the community for a bed.</p> <p>In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report these concerns to you.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 December 2019. I, the Coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to:</p> <p>(1) The Chief Coroner for England and Wales.</p> <p>(2) The following Interested Persons:</p> <ul style="list-style-type: none"> a) [REDACTED], Consultant Psychiatrist. b) [REDACTED], AMHP. c) Family of Nigel Abbott. d) Family of [REDACTED]. <p>(3) The following who may find it useful or of interest:</p> <ul style="list-style-type: none"> a) [REDACTED], Chief Mental Health Legislation Officer for BSMHFT. b) [REDACTED], Consultant Psychiatrist. c) Mind, 15-19 Broadway, Stratford, London E15 4BQ.

	<p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>22/10/2019</p> <p>Signature <i>James Bennett</i></p> <p>James Bennett Area Coroner Birmingham and Solihull</p>