Birmingham and Solihull
Mental Health
NHS Foundation Trust

Roisin Fallon-Williams
Chief Executive Officer
Trust Headquarters, B1
50 Summer Hill Road
Brimingham B1 3RB

Mr James Bennett
Assistant Coroner, Birmingham and Solihull
Birmingham Coroner's Court
50 Newton Street
Birmingham
B4 6NE

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Dear Mr Bennett,

REGULATION 28 PREVENTION OF FUTURE DEATH REPORT – STEPHEN HARTE DECEASED

On 4 September 2018 you commenced an investigation into the death of Stephen Keith Harte. The investigation concluded at the end of an Inquest with a jury on 13th February 2019. The jury's conclusion was the death was Drug Related. At 4.33hrs on 18 August 2018 Stephen Harte was found unresponsive in his room at the Tamarind Centre (a medium secure mental health unit). Despite emergency medical treatment he could not be resuscitated, and he was pronounced deceased at the scene. A post-mortem blood test revealed he had taken a recognised fatal dose of heroin. Mr Harte had a long history of illicit drug use but appeared to have been abstinent since 2016.
During the course of the inquest the evidence revealed matters giving rise to concern as follows:-

1) The potential routes for drugs to enter the medium secure unit. This included:

(a) Residents are allowed unsupervised telephone calls to order food from external 'takeaways' of their choice and the food is not searched upon arrival. Historically, residents were only allowed to order from an approved list of 'takeaways'. However, following a Care Quality Commission inspection the CQC deemed this was too restrictive and asked that the unit relax its rules. The evidence was unclear whether the CQC had similarly asked other units to relax their rules.

Following the CQC inspection of Birmingham and Solihull Mental Health NHS Foundation Trust in March 2017, the Trust received notification from the CQC that it was in breach of regulation 13 due to the restrictions that it had in place for service users to select takeaway food from establishments with a hygiene rating of 4 and above. This was considered to be a 'blanket restriction'. The CQC stated in their report '*The trust had taken a blanket approach to searches and ordering of food from take away restaurants. The decisions made at board level in relation to the restrictions did not take account of individual risk assessment or patient choice'*. The Trust was required to remove this restriction and service users now have the ability to order takeaway food from any establishment of their choice. We note that this regulation 28 report has been issued to the CQC and await their response to you on this matter.

(b) Those residents allowed unsupervised leave are not typically searched upon their return. They walk though a scanner, but this is unlikely to reveal small quantities of drugs on their person.

The Trust Policy on the searching of service users in our secure care inpatient wards states that a search **will** be conducted on all service users returning from unescorted leave. This is in addition to service users walking through the scanner. We recognise that service users may at times secrete drugs in body cavities and that our regular search approach may not identify these. In addition to this, we have therefore implemented a wide range of additional controls to detect any drugs entering the unit. These include:-

- A full urine drug screen across site if there is any suspicion that drugs are on the unit
- Random environmental searches ie room/ ward searches are conducted on the wards again based on intelligence, positive responses from the drug dog or just ward based regular random searches
- Service users have at least one random monthly drug screen, but may vary dependent on individualised risk and care plans
- The drug dog attends fortnightly. We are working closely with our local police liaison officer to see whether we can use their police dogs on the premises in addition to our regular search dog
- Random change of clothes search following service users returning from unescorted community leave if particular concerns are noted about individualised patients
- Testing of the waste water supply to try to detect whether substances are potentially in the unit.
- Increased security on site including the perimeter of the grounds of our inpatient unit
- The purchase of an amnesty box specifically for drugs. This idea came from a presentation at the Physical Health link workers day, from a gentleman from City Hospital who spoke about how an A&E department trialled it and it was successful
- Implementation of a monthly substance misuse meeting

In addition to the above, we now have a substance use strategy in place in our secure care services. The substance use programme in the BSMHFT secure services is a multidisciplinary and multisite programme. It supports the patients throughout their care pathway. The programme operates on principles of harm minimisation. The intervention starts before admission to the units, at time of assessment.

a) Assessment :

1) There are specific parts in the admission assessment documentations dealing with the substance use. This helps to identify the immediate needs and identifies patients in need of more detailed substance use assessment.
2) Every eligible patient will have an initial substance use assessment completed post admission.
3) Where a need is identified a comprehensive assessment will be undertaken by the specialist members of substance use programme.
4) In addition substance use issues are identified as part of risk reduction work, mental illness work and physical health assessments.

b) Treatment

1) The treatment starts as early as possible and is directed through the care plans. Treatment is delivered through CBIT model. Based on the needs group as well as individual treatments being available. The treatments are delivered by professionals trained in CBIT. The groups run in two phases- phase 1 is focussed on psychoeducation and phase 2 on relapse prevention.

2) Random and regular drug screening is available. We use oral fluid or urine samples. The samples are tested using state of art machines and can test more than a 1000 substances depending on needs and suspicions.
3) In addition to staff delivered interventions, every patient will be offered peer delivered interventions through a 12 step NA programme that is run within the hospitals.
4) Individual patients will have needs based pharmacological interventions.
5) Substance use treatment is delivered as part of risk reduction work where necessary.
6) Relapse prevention work is also available in the community on 1-1 basis.

c) Education:

1) An educational programme relating to substance use runs regularly including 2 day training sessions for clinical staff at all levels (level 2) and supplementary ward based training sessions.
2) Supervision is on offer for nursing staff members on the ward and other members of the substance use programme.
3) Patient education through the CBIT level 1 and key worker sessions is available.
4) The no abstinence (NA) education programme has developed a specific poster highlighting the risks of opiate use after a period of abstinence The NA programme serves to improve patient education from peers and other ex users.
5) Bespoke training programmes are available around specific substance use issues.

d) Resources:

1) Currently the substance use programme has two dedicated band 7 nurses and two dedicated band 5 substance use practitioners. The programme is led by a consultant forensic psychiatrist and supported in advisory and development capacity by a psychologist, an occupational therapist, a senior nurse and a pharmacist. Every ward has a minimum of one identified substance use lead.
2) Specific guidelines are developed and regularly updated on various aspects of substance use.

Reduction in risk of deaths by a drug overdose strategy

A separate strategy is in development around reduction of harm from drug overdose. This strategy development process predates the incident leading to Mr Harte's death.

1) The first step was development of patient and staff information leaflets about the risk of opiate use after a period of abstinence. The leaflet was co produced by the substance use lead and a patient. The leaflet has been available in the Trust since the Summer of 2018.
2) One of the significant outcomes has been the development of a very comprehensive risk assessment tool to identify patients all high risk of drug overdose.
3) The proposed strategy for reducing the clinical risk of overdose at high risk times for example during external leave and discharge, includes identification of high risk individuals early in the admission, administration of a specifically developed risk assessment for suitable patients, offering targeted educational sessions to the identified individuals, consideration of starting the patients on opiate replacement in patients where the risk of opiate use continues to be high. The strategy is also considering making available naloxone to patients to reduce risk of death on discharge.

   The strategy is yet to be finalised, however it is anticipated that this will be approved and in place from January 2020.

3) I also heard evidence that staff are not typically searched upon entering the unit. They also walk thought the scanner, but this is unlikely to reveal small quantities of drugs on their person. Further, whilst they are required to leave personal belongings in lockers, they are allowed to take their own food on to the unit which is also not searched.

Our current arrangement within our inpatient facilities is that staff are not typically searched upon entering the unit and that this would only occur if we had clear grounds for concern that particular staff members were facilitating access to drugs on the unit. We do however have the drug dog which visits our secure care and acute care wards and would detect any traces of drugs or illicit substances on members of staff.

It may be of interest to note that since April 2019, there has been one incident of illicit substances being detected within our secure care ward environments, in comparison to a total of 9 incidents during the previous six months. We continue to monitor the impact of our approach to minimise the risk of drugs entering the unit. We hope that the additional controls that we describe above will continue to have a sustained impact on safety within our secure care inpatient wards and would like to take this opportunity to both thank you for bringing this to our attention and to express our sincere condolences once again to the family of Mr Harte.

Yours sincerely

Roisin Fallon-Williams
Chief Executive Officer