An independent investigation into the multi-agency care and supervision of H

July 2023

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Our Report has been written in line with the Terms of Reference for the investigation into the care and treatment of H This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

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1 Executive summary

1.1 NHS England Midlands and East commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent multi-agency review on behalf of the statutory services involved (mental health, police, probation and prison services) into the care, treatment and management of H who committed a number of stabbings in Birmingham city centre on 6 September 2020. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 This review will incorporate the NHS England Serious Incident Framework[1] (March 2015) and the 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] The terms of reference for this investigation are given in full in Appendix A.

1.3 The overarching aim of this review is to ensure that, where possible, statutory services with a duty for cooperation and the protection of public safety learn any lessons necessary to improve services and safety so as to reduce the likelihood of recurrence. This includes identifying common risks and opportunities to improve patient and public safety and making recommendations for organisational and system learning.

Incident

1.4 In the early hours of the morning on 6 September 2020 H began a series of attacks with a knife in Birmingham city centre. These attacks were carried out in four locations at:

- 12.20am – one person with a superficial injury to their neck.
- 12.50am – one person critically injured and one with an injury to their shoulder.
- 1.50am – one person fatally injured and one person with life changing injuries.
- 2.00am – one person critically injured and two further people sustained stab injuries.

1.5 It is reported that H's knife broke following the attack at 12.50 and he went into a local takeaway and asked for another knife. The staff refused to provide him with one and he took a taxi to the shared accommodation where he resided to pick up another knife. He then returned to the city centre in the taxi.

1.6 On 16 November 2021 at Birmingham Crown Court, H pleaded guilty to one count of manslaughter, four counts of attempted murder, and three counts of wounding. H made these pleas on the grounds of diminished responsibility.[3]

1.7 When sentencing H, the judge identified H as a "*significant risk" to* the public, sentenced him to life imprisonment and ordered he serve a minimum of 21 years. The judge made a Section 45a Mental Health Act (MHA) order and H was initially to

[1] NHS England (March 2015) Serious Incident Framework. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
[2] Department of Health (2015) Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in mental Health Services. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents
[3] Coroners and Justice Act 2009 Partial Defence to Murder: Diminished Responsibility. https://www.legislation.gov.uk/ukpga/2009/25/part/2/chapter/1/crossheading/partial-defence-to-murder-diminished-responsibility

be detained to a secure hospital. Section 45a allows for an offender suffering from a mental health disorder to be detained to hospital, but once the offender is deemed to no longer require treatment, they can be transferred to serve the remainder of their sentence in prison.

H's background

1.8 H was born in Birmingham in March 1993. He was brought up by his mother and had no contact with his father from the age of 10. He was brought up with a number of half sisters and brothers.

1.9 H's account of contact with his family cannot be considered reliable. He told services on a number of occasions that he had no contact with his family. When he completed a housing referral in April 2020, he said his family had "passed away", while also requesting prison transfers to be close to his family, so that they could visit him.

1.10 He also said that he was in contact with one of his brothers while at Elliott House approved premises (AP)[4] at the end of 2018.

1.11 He described his childhood as "difficult" to services that came into contact with him. He attended high school until the age of 14 and described "getting kicked out of school" for fighting.

1.12 H told services that he was "kicked out of the family home at 15 years of age … for reportedly stabbing his elder brother in a fight". However, a National Probation OASys[5] assessment highlighted that H had disclosed that he had been bullied by one of his elder brothers, who was believed to have been a member of a local gang.

1.13 After he left the family home he lived in a number of hostels. He is reported to have been the member of a local gang. His offending behaviour began in 2007, and he was arrested multiple times between 2007 and 2017 for offences including robbery, possession of an offensive weapon, assault of a police officer, bail-related offences and possession of cannabis.

1.14 It is unclear if H has ever been in paid employment. He did report having been employed briefly in manual jobs. But on other occasions he told staff he had never been in paid employment and Jobseeker's Allowance was his sole source of income.

1.15 As a result of his offending behaviours, H spent most of the time between April 2011 and April 2020 in prison.

1.16 H had several brief relationships with women that came to the attention of the authorities because of allegations of domestic abuse. He has been in one longer-term relationship and has one child. This relationship also came to the attention of the authorities because of an allegation of domestic abuse and an allegation that H caused harm to the child as a baby.

1.17 H reported that he used cannabis daily and occasionally used cocaine. He did not report excessive use of alcohol. In 2013, H was recognised to have mental health problems, with a diagnosis of paranoid schizophrenia. When in prison he was under

[4] Approved premises (APs) offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence from custody. This is typically following serious violence and/or sexual offences. APs thus act as a half-way house between prison and home, and have two main roles:

- to support the resettlement and rehabilitation of individuals who have committed serious offences.
- to support the safety of other people in individuals' early months in the community

https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/specific-types-of-delivery/approved-premises/

[5] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service to measure the risks and needs of criminal offenders under their supervision. Identified needs of offenders in custody and the community from OASys

the care of the mental health in-reach teams (MHIT).[6] In the community he was under the care of the early intervention in psychosis (EIP) team provided by Forward Thinking Birmingham (FTB) and more latterly a community mental health team (CMHT) provided by Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT).

Good practice

1.18 The response of the CMHT in Birmingham to the referral from the GP in September 2020 is to be commended. When the referral was received H was living in another part of the city, outside the catchment area for the team.

1.19 However, the team acknowledged that he was open to them and offered him an appointment with the consultant psychiatrist in a timely manner. CMHT care coordinator 2 reviewed H's record and recognised that there was a high risk of him not attending the planned appointment. They made best endeavours to contact him over the phone to encourage him to attend the appointment. They also tried to contact his recorded next of kin (his mother). When these attempts to contact him failed, they liaised with the clinical lead for the team and completed a home visit.

1.20 CMHT care coordinator 2 showed resilience by persevering when H did not answer the door and then challenging him when he claimed to be called "*James*". They offered to transport him to the appointment in the afternoon. When he refused they took appropriate action by putting him on the phone to the consultant psychiatrist. During interviews with staff, we were told that CMHT care coordinator 2 made several phone calls before they were able to contact the consultant psychiatrist, who was with another patient, but they persevered.

1.21 HMP Stoke Heath MHIT (provided by Shropshire Community Health NHS Trust) made multiple attempts to provide HMP Parc MHIT (provided by Swansea Bay University Health Board) with a handover of care when H transferred in September 2019.

Findings

Prison mental health services

1.22 H moved between prisons and there was no continuity in the assessment of his mental health and care needs. There is no evidence that any of the prison MHITs reviewed the historical assessment information available to them on the SystmOne[7] records, with each team in each prison commencing a new assessment. H was not managed using the Care Programme Approach (CPA)[8] or the Mental Health (Wales) Measure.[9]

1.23 None of the MHITs in contact with H were assertive in monitoring and supporting H's compliance with medication prescribed for his mental health problems. H spent periods of time unmedicated because he would not accept medication. When he did

[6] The aims of prison mental health in-reach were related to providing an equivalent service to a Community Mental Health Team, with a primary focus on serious mental illness, but a widening role. From Ricketts, Brooker and Dent-Brown *"Mental health in-reach teams in English prisons: Aims, processes and impacts"* December 2007 International Journal of Prisoner Health 3(4):234-247.
[7] SystmOne is the electronic health record system used in prison healthcare in England and Wales.
[8] The Care Programme Approach (CPA) is a package of care for people with mental health problems. NHS (2021) Care for People with Mental Health Problems (Care programme Approach). https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
[9] Welsh Assembly Government (2010) The Mental Health (Wales) Measure. http://www.wales.nhs.uk/sitesplus/documents/861/100707mentalhealthfactsheeten.pdf#:~:text=The%20Mental%20Health%20%28Wales%29%20Measure%20has%20been%20laid,and%20treatment%20of%20people%20with%20mental%20health%20problems

take his medication, it was rarely for more than a few days. However, we also note that prisoners cannot be compelled to take medication for mental health conditions whilst in prison.

1.24 The MHITs were also not assertive in their management of H and did not follow up with cell visits or escalate to wider discussions when he had failed to attend planned appointments.

1.25 The MHITs lacked professional curiosity about aspects of H's behaviour:

- The occasions when he was in his cell, with his head under a blanket, unwilling to engage with staff were not considered in the context of his mental health.
- They did not consider if any of the incidents in prison involving H might be related to his mental health and paranoid thoughts.

1.26 There was limited collaboration and communication between the statutory services responsible for H's mental health care:

- CMHT care coordinator 1 in Birmingham did not have direct contact with the MHIT when H was detained to HMP Stoke Heath. It would have been good practice to do so. This is included in the BSMHFT Care Management & CPA/Care Support Policy.
- CMHT care coordinator 1 in Birmingham relied on H's probation officer or CPN1 from the prison discharge service provided by BSMHFT Forensic Services for information about H.
- CPN1 from the prison discharge service did not record the outcome from the multi-agency public protection arrangements (MAPPA)10 meeting in October 2019 in the clinical notes.
- HMP Stoke Heath MHIT provided a clinical handover to an administrative worker for the HMP Parc MHIT. We would have expected clinical staff from HMP Parc MHIT to engage with HMP Stoke Heath MHIT to complete the handover. It is one of the standards in the "Service Specification Integrated Mental Health Service For Prisons in England" [11]
- Neither CPN1 from the prison discharge service nor H's CMHT care coordinator 1 in Birmingham made contact with the MHIT at HMP Parc when they became aware he had been transferred there. It would have been good practice to do so and is included in the BSMHFT Prison Discharge Service specification and the BSMHFT Care Management & CPA/Care Support Policy.
- HMP Parc MHIT did not contact H's local CMHT prior to his release, despite the details for the team being available in SystmOne and in two places in the multidisciplinary team (MDT) minutes. This should have happened and is

[10] The Criminal Justice Act 2003 (CJA 2003) provides for the establishment of multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.
https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

[11] NHS England: Service Specification Integrated Mental Health Service For Prisons in England. 2018
Standard 36 When a patient is transferred to another prison, the mental health team, provides a comprehensive handover to the receiving prison's mental team before the transfer takes place.
https://www.england.nhs.uk/wp-content/uploads/2018/10/service-specification-mental-health-for-prisons-in-england-2.pdf

seen as good practice in the Standards for Prison Mental Health Services[12], and the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.[13]

Management of clinical risk

1.27 Few formal assessments of H's clinical risk were completed and there was no longitudinal view of the risk H posed to others because of his mental health problems. H's risk to others was only considered in the context of his criminal behaviours.

Management under MAPPA

1.28 H's offence in 2015 was MAPPA eligible and he was managed under Category 2 level 1 arrangements. This sentence expired in May 2018. The 2017 offence was not MAPPA eligible. The Probation Service referred H for Category 3 management in October 2018 where it was assessment by probation and police that level 2 management was appropriate.

1.29 He was removed from MAPPA in October 2019 without up-to-date information from HMP Parc prison services or the MHIT being requested by or provided to the MAPPA meeting.

1.30 The last time MAPPA had reviewed information from the prison services had been in November 2018 and no information was provided to any of the MAPPA meetings from the MHITs regarding H's mental state.

1.31 There was an expectation that CPN1 from the prison discharge service from BSMHFT Forensic Services would act as the conduit for information flowing between prison MHITs and MAPPA. However, this was not effective and did not ensure that information was available to MAPPA meetings for patients where prison mental health care was being provided by a non-Trust provider.

Release from HMP Parc

1.32 H's release from HMP Parc was impacted by the implementation of Covid-19 restrictions in March 2020. This meant that some services were not allowed into HMP Parc; including the MHIT and the St Giles Trust Resettlement team.[14] This resulted in limited planning for release with H and no coordination with local services in Birmingham.

1.33 Notwithstanding the belief that H would be released from prison to no fixed abode and that he had told services he planned to go to live in North Wales, HMP Parc MHIT failed to liaise with the CMHT care coordinator 1 in Birmingham and notify them of H's release. This was not in line with the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010, or the Royal College of Psychiatrists

[12] Standards for Prison Mental Health Services – Fourth Edition. Quality Network for Prison Mental Health Services. September 2018
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2

[13] Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf

[14] St Giles Trust is a registered charity that helps people who are "*held back by poverty, exploited, abused, dealing with addiction or mental health problems, caught up in crime or a combination of these issues and others*."
https://www.stgilestrust.org.uk/

Standards for Prison Mental Health Services, or the HMP Parc MHIT Operational Policy.

1.34 The local CMHT in Birmingham did act promptly when H was referred to the service by his GP in August 2020. They identified his historic pattern of non-engagement and, having failed to make telephone contact with him, completed an unplanned home visit on 3 September 2020. CMHT care coordinator 2 and the support worker showed tenacity when H answered the door and claimed to be someone else. Once H had eventually confirmed who he really was, they entered his home and tried to encourage him to attend a meeting with the team consultant psychiatrist that afternoon. When it became apparent that H would not attend the appointment, they telephoned the team consultant psychiatrist for support. H spoke to the consultant psychiatrist and stated he was not willing to attend the appointment that afternoon because he had no money. However, he was willing to attend an appointment the following week.

1.35 The consultant psychiatrist had previously met H in December 2018 and described him as quiet on the September 2020 call. However, they felt he was willing to engage in some form of treatment because he was willing to accept medication and attend the appointment the following week. It was the opinion of CMHT care coordinator 2 who assessed H that day and the consultant psychiatrist that H's presentation at that time was not so unwell as to warrant admission to hospital, or further, an assessment (MHAA) for compulsory admission under the Mental Health Act, either in degree or nature.

Missed opportunities

1.36 There were four missed opportunities for services to gain a better understanding of H, his mental health needs and his risk, and allow for a planned release from prison at the end of his sentence.

1.37 It would have been good practice for the prison mental health services to have been involved in or, at the very least, to have informed the probation Advice and Forensic Formulation to Inform Risk Management (AFFIRM) assessments and reviews completed in April 2017 and November 2018. This would have supported a better shared understanding of H's mental health problems and risks.

1.38 H should have been referred for a further OPD consultation prior to release in November 2018, supported by mental health services, so that all staff working with H after his release would have information, assistance, and a structured pathway plan on how best to engage with him. This was a missed opportunity to bring together key staff working with H to discuss and agree their approach to encourage the greatest likelihood of engagement and cooperation.

1.39 The third missed opportunity was in August 2019 when the HMP Stoke Heath MHIT considered referring H to medium secure mental health services. They decided not to make this referral because H was compliant with his medication. However, this compliance was for five days. A referral might have resulted in H being transferred from prison to medium secure mental health services under section 47 of the MHA. In any event, the referral would have facilitated a thorough assessment of his mental health and risk.

1.40 The final missed opportunity was the removal of H from MAPPA in October 2019. This decision was flawed because no up-to-date information from HMP Parc or the HMP Parc MHIT was made available to the meeting. H was added to the meeting list at short notice and HMP Parc and HMP Parc MHIT were not invited to attend. It is unclear to us why the meeting had to be held so quickly, given the next review of H's

recall was not due to be held until January 2020. It would have been prudent for Mr H to have been managed as a MAPPA nominal and consideration to have been given to an application for Executive release. The evidence provided to this investigation does not support the assertion that consideration was given to Executive release. We acknowledge that it may have not been granted and are aware that it would have only allowed for Mr H's supervision until sentence end date (SED). However, this would have been an opportunity to support Mr H's release to the Birmingham area and provided an opportunity for him to engage with local mental health services.

Conclusions

1.41 Although the scope of this investigation in the terms of reference covers the period from 2015 up to the events of 6 September 2020, we have reviewed records concerning H's contact with health and criminal justice services from 2007 onwards, as the investigation team considered this to be relevant.

1.42 This review has concluded that H was not appropriately treated and medicated from 2011 to 2020 and we have identified a number of reasons for this.

1.43 H consistently did not engage with any of the statutory services he came into contact with, from the police, prison, and probation service to local community mental health services.

1.44 This pattern of non-engagement with services resulted in him being discharged from MAPPA in October 2019, because the panel could not see a role for itself. It also resulted in H remaining in prison until his sentence ended. The consequence was that he was released from HMP Parc in April 2020, subject to no statutory supervision from any of the criminal justice services – police or probation.

1.45 Furthermore, his observed mental health symptoms were not considered to be of a degree or nature to reach the threshold for assessment or detention under the MHA, by the National Probation Service or by mental health services. He was released from prison to no fixed abode, so services did not know where he had gone. He had told services he was going to North Wales but, in reality, he returned to the Birmingham area on the day of his release.

1.46 There is no evidence that H made any attempt to address his mental health problems or his criminal behaviour.

1.47 Following his recall to prison in December 2018 it was determined by probation services and the parole board that his risks could not be managed in the community and he was to remain in prison until sentence end. In addition, he was discharged from management as a MAPPA managed offender in October 2019 without up-to-date information from mental health and prison services.

Recommendations

1.48 In November 2021 the Criminal Justice Joint Inspection, Care Quality Commission and Healthcare Inspectorate Wales published *"A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders".* [15] In summary this report found:

[15] Criminal Justice Joint Inspection, Care Quality Commission and Healthcare Inspectorate Wales; "A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders", November 2021 https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf

- **Poor information exchange.** Significant problems in information exchange occur in every agency in the CJS and at every stage of an individual's criminal justice journey.
- **Committed staff but many need better training and supervision.** Staff are committed, passionate, resilient and want to help people to lead more fulfilling and happy lives. While differing learning and development opportunities for staff exist across the CJS, not all of these are making a difference to better equip practitioners and managers to deliver high-quality services.
- **Court reports need improvement and more sentences should include treatment.** Information provided to courts, for example by Liaison and Diversion (L&D)[16] assessment reports, pre-sentence reports and psychiatric reports, varies in quality.
- **Assessment and diversion services in police custody have improved but they need to link to the rest of the criminal justice system.** There is very good coverage of L&D services across England and Wales in police custody. L&D provision in courts is not always on site and, indeed, during the pandemic the majority of assessment work has been carried out remotely. Assessments completed by L&D staff are not widely shared with partner agencies in the CJS.
- **A shortage of good-quality mental health provision and unacceptable delays to access it.** This has worsened during the pandemic. Individuals reported that probation and prison are the two agencies most likely to give them the mental health support they need. However, help is often not timely and access to services has been a substantial problem during the pandemic.
- **Mental health provision in prison has improved but post-release treatment and support are poor.** Healthcare practitioners appropriately use nationally approved screening tools to assess the mental health needs of prisoners arriving in custody.
- **Cross-system management and leadership need to be better.** Each agency in the CJS has a range of management information systems, but cross-system data is not systematically collected and analysed to promote joint working and improve mental health outcomes.

1.49 This report made 22 recommendations to improve these aspects of service delivery and support for people with mental health problems in contact with the criminal justice service. Our investigation into the multiagency care and supervision of H had found that there was an overlap with these findings in many areas.

1.50 In particular, in order to improve services, we have made the following recommendations:

Recommendation 1: The service description for the BSMHFT Prison Discharge Service is dated 2016 and requires review because it no longer reflects the remit and work of the service. There is lack of clarity about the scope and remit of the CPNs within the prison discharge service or the role of the CMHT care coordinators. It is not clear which role has responsibility for the liaison with prison MHITs and MAPPA.

[16] Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/about/

BSMHFT must develop an up-to-date service description/operational policy for the prison discharge service that:

- **clearly defines the service offer;**
- **describes how the service interfaces with other BSMHFT services;**
- **describes the roles and responsibilities of each team member; and**
- **describes the responsibilities, scope and remit of the CPNs within the prison discharge service and care coordinators for service users detained in prison, to ensure effective liaison with prison MHITs and MAPPA.**

Recommendation 2: The West Midlands MAPPA Strategic Management Board did not complete a serious case review into this incident because this review was being completed. However, this review has not had access to the source material from the probation service.

The West Midlands MAPPA Strategic Management Board (SMB) must reconsider its decision not to complete a serious case review. A serious case review would be an opportunity to look in more detail at the issues we have raised and to ensure that lessons learned are shared with the SMB and all those involved in the MAPPA chairing and panel meeting process.

Recommendation 3: H was discharged from MAPPA without up-to-date information from the relevant prison or MHIT.

West Midlands MAPPA SMB must provide guidance for MAPPA chairs to ensure that discharge from MAPPA should only happen with full information from all services involved.

Recommendation 4: The Mental Health In-reach Team in HMP Parc is not resourced adequately to meet the demands placed upon it.

Cwm Taf Morgannwg Health Board, as commissioners of Secondary Care Mental Health Services into HMP Parc until 31 March 2023, and then providers of Secondary Care Mental Health Services thereafter, and NHS Wales must, as a matter of urgency, act on the 2021 Health Needs Assessment for HMP Parc to ensure that the mental health services, especially the mental health in-reach team, have sufficient capacity and resources to meet demand.

Recommendation 5: There needs to be effective oversight of, and clear provision of escalation routes for concerns about, health and social care provision to HMP Parc.

HMP Parc Prison Health, Wellbeing & Social Care Partnership Board should routinely seek assurance that health and social care services are meeting the requirements of the Mental Health (Wales) Measure 2010, the HM Inspectorate of Probation Effective Practice Guide: Mental Health (2022) and other relevant guidance, and that where there are concerns about resources and/ or the quality of services, these are escalated quickly to the appropriate body for resolution.

2 Independent investigation

Events of 6 September 2020

2.1 At 12.20am on 6 September 2020, H began a series of attacks with a knife in Birmingham. These attacks left one young man dead and his friend with life changing injuries. He also stabbed a further six people, two of whom were left in a critical condition.

2.2 On 16 November 2021 at Birmingham Crown Court, H pleaded guilty to one count of manslaughter, four counts of attempted murder, and three counts of wounding. H made these pleas on the grounds of diminished responsibility.[17]

2.3 The judge identified H as a "*significant risk*" to the public and sentenced him to life imprisonment and ordered he serve a minimum of 21 years. The judge also made a Section 45a MHA (1983) order and H was initially to be detained to a secure hospital. This section allows for an offender suffering from a mental health disorder to be detained to hospital, but once the offender is deemed to no longer require treatment, they are to be transferred to serve the remainder of their sentence in prison.

Approach to the investigation

2.4 NHS England Midlands and East commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent multi-agency review into the care and treatment provided by the NHS and other relevant agencies to H, the perpetrator of an incident of multiple stabbings in the Birmingham area on the night of 6 September 2020, and to make such recommendations as may seem appropriate to improve practice and public safety. Niche is a consultancy company specialising in patient safety investigations and reviews.

2.5 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and the Department of Health guidance on Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services. The final agreed terms of reference for this investigation are given in full in Appendix A.

2.6 This investigation was supported by a memorandum of understanding (MOU) between the organisations who had contact with H:

- NHS England Midlands and East
- West Midlands Police
- National Probation Service – West Midlands
- NHS England Health and Justice
- HMP Parc (G4S)
- HMP Stoke Heath
- HMP Brinsford
- HMP Birmingham
- Birmingham and Solihull Clinical Commissioning Group
- Birmingham & Solihull Mental Health NHS Foundation Trust

[17] Coroners and Justice Act 2009 Partial Defence to Murder: Diminished Responsibility. https://www.legislation.gov.uk/ukpga/2009/25/part/2/chapter/1/crossheading/partial-defence-to-murder-diminished-responsibility

2.7 The MOU set out the principles and process for the multi-agency review into the care, treatment and services provided by the NHS and other agencies relevant to H, from his first contact with mental health services up to the time of the first incident.

2.8 The overarching aim of this multi-agency review is to ensure that, where possible, statutory services with a duty for cooperation and the protection of public safety learn any lessons necessary to improve services and safety so as to reduce the likelihood of recurrence.

2.9 While other agencies shared their records for H with this review, West Midlands Police and the National Probation Service, West Midlands provided chronologies of their contact with H and individual management reports.

2.10 This investigation has required the review of many hundreds of pieces of information and interviews and meetings with over 30 people from the full range of services and agencies involved.

2.11 The draft report was shared with:

- West Midlands Police
- National Probation Service, West Midlands
- HMP Parc
- HMP Stoke Heath
- HMP Birmingham
- HMP Brinsford
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Forward Thinking Birmingham
- Cwm Taf Morgannwg Health Board

2.12 This provided an opportunity for those organisations that had contributed significant pieces of information, and those we interviewed, to review and comment on the factual accuracy of our review.

The review team

Dr Huw Stone. Dr Huw Stone worked as a consultant forensic psychiatrist for over 25 years in secure services for adults and adolescents, in prisons and community forensic services. He retired from the NHS in 2019. Dr Stone was the Independent Clinical Advisor to the National Oversight Group for High Secure services from 2014 – 2021. Dr Stone jointly developed and led with a colleague, the Quality Network for prison mental health services in the Royal College of Psychiatrists, from 2016 - 2022. Since 2016, Dr Stone has been a specialist member of the Parole Board of England and Wales.

Lis Pace. Lis has more than 20 years' experience in the probation service, both as a practitioner and senior manager. Since leaving the probation service in 2010, Lis has specialised in providing independent reports and has completed investigations across a range of criminal justice agencies. She had a particular interest in AP, mental health and substance misuse (dual diagnosis), and MAPPA.

Gary Goose. Gary is former police officer who, during his career, attained the rank of detective chief inspector and led high-profile investigations. He was one of the senior investigators in the Soham murder investigation, leading the police response to the families of both of the victims. At the conclusion of his police career, Gary was

engaged by the local authority becoming Assistant Director for Community Service and held the lead role for a local community safety partnership.

Elizabeth Donovan. Elizabeth has worked in health and social care settings for over 20 years and has extensive experience of investigating patient safety incidents. She was Head of Investigations for a large NHS Trust prior to joining Niche.

Nick Moor. Nick is a former mental health and general nurse, and he has led and directed many investigations into adverse events in healthcare. He chaired the recent West Midlands investigation into the care and treatment of P after release from prison and has led and supervised many investigations after a homicide perpetrated by people in contact with mental health services, including several following releases from prison. Nick has extensive experience of reviewing governance arrangements and testing evidence supplied by organisations as assurance of implementation.

Contact with the families and the victims of the incident

2.1 The investigation spoke initially with all victims and families. Six of these did not want further involvement but wished to be kept up to date with progress. We have done this.

2.2 The families of Jacob Billington, who died, and Michael Callaghan, who received life changing injuries have been met with on a much more frequent basis, and regularly updated on progress of the report. Understandably they have been frustrated with the time this review has taken, and we apologise for this.

2.3 We hope that this report provides some understanding of the circumstances that led to H leaving HMP Parc with no planned contact with statutory services, and six months later to the tragic events of 6 September 2020.

2.4 They have provided an impact statement below.

Statement form Jo Billington, Jacob's mother

Jacob was 23 when he was killed, simply walking down the street in Birmingham. Jacob was in Birmingham with friends to celebrate the birthday of his friend who was studying in the city. The last time I saw him, he was running out of the house to get in the car with his mates, waving, laughing and saying he would be careful.

I think it is very important for everyone reading this report to have the sheer horror of Jacob's death right at the front of their minds when they consider the narrative of this report and its recommendations. Jacob was stabbed with such force that the knife severed both the main arteries in his neck, going straight through his neck and out the other side. He bled to death on the street of a strange city, with his friends trying frantically to save him. Jacob's lifelong friend Michael was gravely injured and will suffer the horrendous consequences of his injuries for the rest of his life. Jacob's killer attacked eight people on that night, and simply went home to bed.

Jacob was a fantastic young man who was happy and popular. He loved music and was a talented musician. He was funny and brilliant company. He worked for the University where he had been a student. His life was just getting started.

I cannot believe that Jacob has gone. The pain we all feel does not get any easier. He has left a massive whole that cannot be filled. He has left two younger sisters behind, one who was in her final year at university at the time, and one who was just aged 13. Both girls have struggled with their loss. Jacob's wider family and friends have been left utterly devastated.

As Jacob's Mum, I have been left utterly heartbroken by his killing, and the subsequent discoveries about how much the different agencies knew about this man.

I want to talk here about how the legal processes and the independent investigation have impacted on our family and all the people who loved Jacob most.

We waited 14 months for the offender to be sentenced. The Judge was very critical in his sentencing report about the level of care and monitoring of this individual. Very little information was provided to us at the time of the incident and during the court proceedings, despite my asking over and over. I felt like I was a nuisance who had no right to be asking questions. At the height of my shock and confusion, I had my phone calls and emails to agencies ignored. I felt the NHS, Prison and Probation services did not consider they had any responsibility to us as a grieving family.

So finally, after a two and a half year wait, we have this report. This is an unacceptably long time to wait for answers. The wait has been horrendous, with every question having the answer that we must wait for the report. Now we finally have it, it catalogues a massive amount of astonishing failings and incompetence. It speaks to a terrifying lack of concern, or even interest in how dangerous this man was. Few people checked, few kept adequate records or assessed his risk effectively, or even at all. We are told about "missed opportunities". These are not missed opportunities, these are people not doing their job, these are procedures not being followed and a catastrophic lack of professional standards, leading to a young man losing his life.

In my opinion this report, in my opinion, has some very weak recommendations that fail to get to the heart of what went wrong here – different organisations not seeking or sharing information as they are required to do, and procedures and working practices not being followed. There appear to be no consequences at all for the agencies involved, and I am not satisfied in any way the failings identified in this report will not continue to happen. It is hard to feel reassured that anything will change at all. The situation in Birmingham is not safer than on the night Jacob died.

This report does not clearly define the really poor standard of record keeping, risk assessment and care planning. I believe Jacob's death was completely preventable, and the organisations involved with the offender and his "care" need to fully examine the consequences of their role in this case. I will continue to push for this to honour my lovely son, and the value his life held for us all.

I will not allow Jacob to be seen simply as collateral damage in poorly run, managed and monitored Prison, Probation and Mental Health services. They completely failed the public in their duty to keep us safe.

Jacob was horrifically killed simply walking down the street. This could have been you, or your child. All the agencies knew about the offender, they knew he was dangerous and violent, that he didn't comply with medication, and he had made multiple threats to hurt people. In the end, he carried out those threats. Eight innocent people have had their lives changed forever. I will never see what Jacob would have become. He died due to a catalogue of errors and poor practice, and this I simply can't forgive.

Jo Billington
Mother of Jacob

Statement from Keith Billington, Jacob's father

Jacob was my first child and my parents first grandchild. He was much loved, much wanted, and now - much missed.

When Jacob started school, he made great friends, and they were with him to the end. He excelled at school gaining excellent GCSEs and A Levels and was involved in school life taking part in school choir, and orchestra. He loved moving to Sheffield to study Geography, again making new and great friendships and doing well, securing a 2:1 degree.

Jacob had worked hard since he was sixteen. He had worked in a number of jobs to provide an additional income while he studied. He first worked for Waitrose before taking a job at Crosby Lakeside Activity Centre alongside Abbie and Adam; working behind the bar and developing excellent customer service skills.

He was not a young man looking for handouts. Jacob took his responsibilities seriously! Jacob's income funded his passions in life - music, festivals and concerts. He financed guitars and amplifiers which he would use when he joined his friends in the Vedettes. Jacob recognised you get out of life what you put in! He worked hard and he played hard.

He was on the cusp of the next phase of his life when he would take everything he had learnt; the skills, the experience, the friendships and networks to build a great life for himself and his future family. But he had the misfortune to meet someone without any responsibility; who took him away from us!

I miss my SON! I Miss our chats, his Humour, his sense of charm. I miss going for a beer with him and I miss my future with him!

Claire and I will watch Adam, Abbie and Ruby grow, celebrating their lives and their successes. But now we will always have an empty chair at the kitchen table. We have been robbed of the endless possibilities that Jacob would have brought; the fun, chaos and laughter.

Growing up Jacob was risk averse. When he started at primary school, he didn't want to let go of my hand. When we went to watch Everton he would grab hold of my hand as we left the game; so he wouldn't be lost in the big crowd. When he played football, for Marina Sands, he played on the wing, wanting always to be involved but wanting to stay out of trouble. Jacob would always avoid trouble.

What he met in Birmingham; coming face to face with evil, being hurt and dying on the floor of a strange city. Not being able to hold his hand and tell him – we are going to be ok mate…. it's the hardest thing and will continue to be hard.

Telling my Dad that Jacob had been murdered and six weeks later my Dad died. The knife that killed my son also killed my dad!

The impact is far reaching and long lasting.

Abbie, Adam, Ruby and Claire have been deeply affected by this. My family and friends have been affected. Jacob's friends have been affected. The whole community of Crosby in Liverpool has been affected.

We carry the hurt with us, like we carry his memory…

Keith Billington
Father of Jacob

Statement from Anne Callaghan, Michael's mother

Ever since that 5.30am phone call of 6th September 2020, our family life has been one of devastation, grief, anxiety, and sheer ongoing horror at what happened. I still struggle to grasp someone attempted to murder my son, and that his friend died in the same senseless, tragic incident. I grieve for Jacob and the loss his family and friends endure. I can't imagine what Michael and the brave young men there saw, or what they had to do; I am so thankful for their courage and clear-headedness.

Michael was on top of the world on 5th September 2020. He had thoroughly enjoyed his university years in Sheffield with Jacob, and since his graduation in 2019 had been putting his heart and soul into song writing for his band The Vedetts, with Jacob on drums and two other friends. They were working hard getting The Vedetts established, making great progress despite the pandemic. They secured a growing presence across social media sharing videos performing their songs. They played two small festivals in August 2020 to enthusiastic crowds, with Michael lead singer. Mark, Alice, many of our extended family and I were so happy and proud to see him and his friends doing what they loved with their developing talent and confidence shining through. Michael's songs are lyrical and tuneful crowd-pleasers; we all loved them, getting to know them well and singing along. Now, with only one working arm, he cannot play the guitar, and the damage to his vocal cords affects his breathing, so he is unable to sing and project his voice like he used to. His song writing has stopped. I cannot express the sadness I feel observing this, and I know he grieves it sorely.

Michael's capacity to work has been catastrophically hit by his injuries. He is a Master of Aerospace Engineering from the University of Sheffield, and his potential earnings and pension contributions over his working life will now be dramatically less than expected for someone with that level of qualification and career prospects. Incredibly he returned to his job but then had to resign as he found it unsustainable due to extremely high levels of fatigue and an adverse effect on his recovery. He is currently focused on further rehabilitation Michael worked conscientiously throughout his education, and we supported him to help him look forward to a secure life; that night in September 2020 cruelly took this away.

We are all badly traumatised by what happened. The shock was terrible and tangible, and went right across our family, Michael's former girlfriend of eight years, friends and communities; their kindnesses and support have been immeasurable. We were utterly devastated about Jacob, and Michael very nearly lost his life many times over. On September 6th he had two life-saving operations. The first in the early hours was vascular surgery repairing his severed carotid artery and jugular vein; the damaged vagus nerve could not be repaired. He had lost an enormous volume of blood and that afternoon suffered a 'catastrophic' 'inevitable' stroke; his second operation of the day, a 'last resort' craniectomy, removed a large piece of his skull to stop swelling inside his head crushing his brain stem. We were told he may only have 24/48 hours to live. He got through that, then developed pneumonia so severe he was medically paralysed completely to prevent his vascular repairs being compromised. On Day 11 we were told he would 'probably' survive but given meagre hope he would have any quality of life; the word 'vegetable' was used. After two weeks he started to come out of his coma and begin to engage with his environment. Covid restrictions meant that for three weeks in Birmingham we only saw him 5 times, and only then because his condition was so critical. Michael then transferred to the Walton Centre in Liverpool. Here he woke up properly, completely paralysed on his left side, and learned about Jacob. I am tormented by what he saw, what he experienced, and by what he has lost.

After more surgery and extensive, exhausting, COVID-restricted and difficult rehabilitation, we have now moved onto the phase of rebuilding our lives. Michael's recovery so far is miraculous and there is so much to celebrate. However, I am deeply concerned about what

the future holds for him; a constant chain of worries runs through my head, and I rarely relax. I could write a book about the horror, shock, difficulties, anxieties and triumphs we have been through, and continue to go through, but this is Michael's life and for him to tell. He has proved himself to be so resilient, totally focused on working towards the best possible recovery that can be achieved. I know many people, including me, consider Michael to be the strongest person they know.

I have been personally affected. I had to take early retirement from my full-time teaching job with management responsibilities to balance the various medical and legal needs around Michael while he was incapacitated. My career, my expected pension pot and our family income has been significantly and adversely impacted.

We wish to express our enormous gratitude for the expertise, support and care Michael has received from everyone in the National Health Service and elsewhere who have helped him. These public services have been essential to Michael and us all; it has been inspiring to see these wonderful public servants working so hard to meet his needs despite the shoestring budgets they are provided with and the constrictions of the pandemic. I also want to publicly thank Michael's neuro-physiotherapist who worked with him at the Walton Centre and still does so in a private capacity. She provides multi-disciplinary care on her own; she is our guru.

Jacob's Mum is now my good friend, and she is an inspiration. This process has not been about Michael, Jacob or the other victims, yet it has had an enormous impact on them, especially Jacob's family, as other processes wait for its findings.

I want to live in a civilised society, and I acknowledge the need for a justice system that adequately looks after the needs of convicted criminals; I just don't understand why victims of crime with life-changing injuries get such a raw deal from the State. Why, when Michael is an innocent victim, is the system so burdensome and demoralising to navigate? We have had to apply for Universal Credit, PIP and Blue Badges; they should be granted simply in the same way Michael's NHS care was provided, responding to need.

This investigation has identified a woeful lack of communication, with uninformed and reckless decision-making regarding MAPPA and the management of H during his time in and release from prison; parts of this horrific narrative suggest statutory regulations may not have been met. I still have questions about decisions made on 3rd September 2020 that have not been answered to my satisfaction. I despair at what I'm told about the difficulty in diagnosing a psychotic episode, red flags that don't seem to count, and dealing only with what is presented and ignoring significant and concerning information on the risks he posed to others.

My son can no longer play his guitar, banjo or piano two-handed, have a game of football or tennis with his friends, go running, hike, or drive. He has lost his livelihood. The thought that individuals took highly risky decisions that resulted in a clearly dangerous man being released unsupervised, with no known whereabouts, is almost impossible to bear.

Criminals like H have been around for time immemorial; surely it is the government's job to protect the public. I believe this incident was clearly predictable and preventable. It has devastated the lives of eight people and all those who care for them; Jacob and Michael are seemingly tolerable statistics to those who resource the system. How Jacob's family cope I don't know. Their forbearance and dignity is astonishing. He was a truly wonderful young man who made everyone enjoy his company and feel he was their special friend. Jacob was Michael's best friend, and he will be missed forever.

Anne Callaghan
Mother of Michael Callaghan

Contact with H and his family

2.5 This review was told by West Midlands Police that they had had limited contact with H's family. They provided us with the contact details for his mother and siblings.

2.6 We wrote to H's mother and the sibling with whom he had the most contact, inviting them to be involved in the review. They did not reply to this approach.

2.7 Members of the review team met with H on 20 July 2022 via an MS Teams call. Prior to this he had not been deemed well enough by his treating team. Although the panel had initially tried to meet with H in person, this had to be cancelled due to a Covid-19 infection on the ward. The panel explained the purpose of the review to H. H was asked if there were any questions that he would like the review to address. He did not have any questions that fell within the remit of this review.

2.8 Dr Stone met with H on July 2022 via an MS Teams call. In this call H did not have any questions that he wanted the review to address. However, he did comment that he thought it would have been better if he had been released from a prison local to Birmingham in April 2020. He believed that this would have given him access to accommodation and a GP.

2.9 In both of these calls, H had limited recollection of the support he had received from the prison and community mental health services.

2.10 H has also contacted the review team from time to time to ask for an update on progress of this review.

2.11 We provided a copy of the draft report to H in January 2023, and met with him in person later that month to share the investigation findings and recommendations.

Structure of the report

- **Section 3** provides details of H's background, personal history, forensic history and the events between April 2020 and August 2020.
- **Section 4** sets out the details of H's mental health care and treatment.
- **Section 5** examines H's release from HMP Parc and the post-release arrangements.
- **Section 6** examines the management of H's release from HMP Parc the post-release arrangements.
- **Section 7** provides discussion and analysis of West Midlands Police contact with H.
- **Section 8** provides discussion and analysis of probation services contact with H.
- **Section 9** provides discussion and analysis of the use of MAPPA in relation to H.
- **Section 10** provides discussion and analysis of H's mental health care and treatment.
- **Section 11** sets out our conclusions and recommendations.

3 About H

Personal background

3.1 H was born in Birmingham in March 1993. He described a "*difficult childhood*" to services. It is reported that he has a total of nine half-siblings. His mother raised H and his siblings on her own. H says that his last contact with this father was when he was 10 years old.

3.2 H attended high school until the age of 14. He reported "*getting kicked out of school*" for fighting and he did not receive any formal education after this. H told services that he was "*kicked out of the family home at 15 years of age by his mother for reportedly stabbing his elder brother in a fight*".

3.3 H said that after he was kicked out of school, he began to commit offences and "*mix with the wrong crowd*." This resulted in him spending much of the next 10 years in and out of prison.

3.4 After he left the family home H lived in hostels and this was linked to him becoming a member of a local gang. The OASys[18] record completed in June 2020, noted that H disclosed that he was bullied by his elder brother and that his brother was believed to be a member of a different Birmingham gang.

3.5 This review has not been able to conclude if H had any paid employment during the times when he was not in prison, although there were reports that he had worked as a cleaner.

3.6 H has had several short-term relationships with women and one long-term relationship. A child was born during this long-term relationship. This later gave services cause for concern because the mother was underage when the child was conceived.

3.7 While the child was an infant there were allegations that H caused it some harm. This resulted in safeguarding action being taken to protect the child and their mother. Following this H was not allowed unsupervised access to, or to live with children under the age of 18.

3.8 The OASys report prepared in June 2020 referred to allegations of domestic violence made by women who had been in intimate relationships with H. However, the victims and witnesses had not been willing to provide statements and no prosecutions were brought.

3.9 H was a self-reported user of cannabis, saying that it helped him to relax and "*cope with the voices and stresses of people being after him*." Following his arrest for this offence, H told services that he was an occasional user of cocaine, but he denied using any in the five months prior to the offence. He said that he only drank alcohol occasionally.

3.10 In September 2020, when the social worker completed an assessment with him following the incident, H denied any family history of mental illness. However, in the past he had told prison staff that a close family member had been in a psychiatric hospital for the last 15 years. He was unsure exactly why but said that they "*had done something serious*."

[18] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service to measure the risks and needs of criminal offenders under their supervision.

Offending history

3.11 H has a long history of offending, beginning in his mid-teens. H was arrested on at least 21 occasions, although not all of these arrests resulted in him being charged. Below is a table of H's contact with the West Midlands Police from 2007 up to September 2020.

Date	Incident	Outcome
April 2007	**Arrest 1** H was 14 years old. He was thought to match the description of a male involved in a robbery. H was arrested.	Released without further action
May 2007	**Arrest 2** Suspected of being one of a group of youths involved in a robbery with a threat with a penknife. H was arrested after being identified by the victim. He denied the offence in interview.	Released without further action
May 2007	The police identified H as permanently excluded from school and it was believed he was actively involved in shoplifting in the city centre.	No action taken based on this information
July 2007	H had been at a bus stop when there was a confrontation with a group of youths. This appeared to be about H being in an area 'owned' by a local gang.	No action taken based on this information
December 2007	**Arrest 3** H suspected of theft and arrested. H admitted to the theft in interview.	Charged with theft and bailed to court
November 2008	**Arrest 4** H suspected of approaching the victim from behind, trying to snatch their handbag and dragging them to the floor. The victim was kicked to the head, which caused facial injuries. H denied the offence.	Released without further action
February 2009	**Arrest 5** H suspected of robbery. Three victims were approached and asked for their phones by a group of male offenders. The victims handed over their phones and they were told they would be stabbed if they "*grassed."* H was searched and found to have possession of a home-made weapon, consisting of a metal ring with a nail taped to it.	Charged with possession of an offensive weapon, obstructing a police constable and bail-related offences. Remanded in custody and placed before the courts
May 2010	**Arrest 6**	Community resolution

Date	Incident	Outcome
	H attacked the victim, punching him twice to the face with his fist. The victim received bruising and a cut to the face.	and a letter of apology to the victim from H
23 March 2011	**Arrest 7** H was a suspect in two robbery offences carried out on the same day, followed by several robbery offences with the same modus operandi over several weeks after this.	
	H snatched a gold chain from the victim's neck from behind, said, "*Thanks*" and ran off. 4 hours later, H was the suspect in an attempted robbery. He attempted to grab the victim's necklace and push them to the floor. H made off without the necklace.	Charged with robbery. Not charged with this offence
28 March 2011	H was a suspect in an attempted robbery. He attempted to grab the victim's necklace and push them to the floor.	
31 March 2011	H was a suspect in a robbery. He approached the victim from behind, snatched a gold chain from around their neck and made off.	
8 April 2011	H was a suspect in a robbery. He snatched a chain from the victim's neck, causing the chain to break, but causing no injury and made off.	
11 April 2011	**Arrest 8** H was a suspect in ripping a chain from the victim's neck.	Charged and convicted.
14 April 2011	**Arrest 9** H was the suspect in the robbery of an 83-year-old. He unsuccessfully attempted to grab a chain from around her neck.	
15 April 2011	**Arrest 10** H was arrested for the series of robberies committed in March and April as outlined above	
21 April 2011	In custody H told the custody sergeant he was to be tested for bipolar disorder and he was seeing his GP regarding feelings of depression, but had no medication prescribed. H said he had suicidal thoughts but had never tried to harm himself and did not feel suicidal at that time. This is the first time that H made reference to having any mental health issues while in custody. H said he smoked cannabis and had done so the day before. He denied any alcohol issues. H was placed on "*level 2 observations*". The custody record notes that he was calm and compliant throughout.	Charged with four robberies and three attempted robberies.

Date	Incident	Outcome
	H saw a doctor while in custody, he was fit to be detained and interviewed. The doctor updated that H had disclosed suicidal thoughts most days, but that he was feeling okay at that time. H continued on level 2 observations. H admitted two of the robberies and one attempted robbery but denied all other offences. He saw a health care professional again and was deemed fit to be detained, interviewed and charged.	
July 2011	H found guilty of two robberies and two attempted robberies.	Sentenced to two years in a Young Offender Institution (YOI).[19]
June 2012	**Arrest 11** Dispute over a bus fare. Police National Computer (PNC)[20] check completed. H subject to recall to prison and arrested. He was found to be in possession of a small bag of herbal cannabis. H arrested for possession of cannabis. A lock knife was found where H had sat in the police car. H arrested for possession of a bladed article. When completing the medical welfare questions H stated that he may have bipolar disorder but did not have a formal diagnosis and was not on medication. H's recall was valid. He had been released from prison on 3 April 2012 when the earliest he should have been released was 15 April 2013.	H given a caution for possession of cannabis. Not progressed because unable to prove H had deposited the knife in the police car. H was returned to prison
10 July 2012	There were concerns about H's mental health while he was in the YOI. He was under assessment for this and had claimed to have had thoughts of killing others, including family members, such as his mother, raping his sister and self-harming.	
18 June 2013	**Arrest 12** H was arrested for other matters, plus the previous offences. He was charged with the offences and failing to answer bail.	Remanded in custody. Convicted of the charges
1 August 2013	Police officers observed H and a female shouting and swearing at each other outside Birmingham Children's Hospital.	

[19] A type of secure accommodation that children may be placed in if they are in custody. Young offender institutions are for boys aged 15 – 17 and young adult men aged 18 – 21.
[20] The Police National Computer (PNC) is a system that stores and shares criminal records information across the UK.

Date	Incident	Outcome
	H's child, six months old, was in hospital with facial injuries. Hospital staff believed the injuries to be non-accidental. The female arguing with H was the child's maternal aunt. To prevent further disorder between family members, officers tried to stop H entering the hospital, and he became volatile and aggressive. **Arrest 13** H was arrested and taken to custody. The police were informed that the child's injuries were non-accidental. H's account of playing with the child when she banged her head on his chest was inconsistent with the injuries received. **Arrest 14** H was arrested for sexual activity with a child,[21] as the child's mother was 15 years old when she became pregnant. H was placed on level 3 observations while in custody because he had mental health problems and he had had thoughts of killing people in the past. He had a diagnosis of schizophrenia. H was seen by a doctor in custody. He was deemed fit to be detained and dealt with. H denied hurting the child and maintained the story provided to the hospital. When arrested, H was in possession of cannabis, which he said he intended to smoke himself. H admitted the public order offence. He stated he was upset about his child. He denied assaulting the arresting officers. H admitted being the child's father and having sexual intercourse with the child's mother. He maintained she was 16 years old, even though the dates proved this was not possible and, as a friend of the girl's brother, he should have been aware of her age.	Bailed with conditions
5 Sept 2013	**Arrest 15** H was reported to have assaulted a girlfriend, causing a cut, swollen lip and bruising to her face. They argued over family	No further action

[21] Sexual activity with a child
(1) A person aged 18 or over (A) commits an offence if—
(a) he intentionally touches another person (B),
(b) the touching is sexual, and
(c) either—
(i)B is under 16 and A does not reasonably believe that B is 16 or over, or
(ii)B is under 13.
Sexual Offences At (2003) https://www.legislation.gov.uk/ukpga/2003/42/part/1/crossheading/child-sex-offences

Date	Incident	Outcome
	matters. H had lashed out and punched her in the face twice. H was arrested. He had a cut to his fist. The victim attended the police station but refused to provide further details and would not support a prosecution. She did agree to complete a domestic abuse, stalking and honour (DASH) risk assessment[22] and was graded as at standard risk. She was signposted to domestic violence support groups, but she did not want further support from police. She stated she was frightened of H and that he had a bad temper. A safeguarding officer reviewed the assessment and increased the risk to medium due to the short time the couple had been in a relationship. At interview, H said an argument led to a scuffle. He could not say if he struck her and denied doing so deliberately. He admitted causing the injury to her lip when shown an image.	Safeguarding team contacted the victim
9 Sept 2013	H failed to answer bail. The Crown prosecution Service (CPS) authorised charges for public order, possession of cannabis and assault of police officers relating to arrest 13.	Charged with public order, possession of cannabis and assault of a police officer
3 March 2014	The police were called to a couple having an argument in the street. This was H and his ex-partner. She said H had approached her in the street. They argued, he slapped her face and punched her chest. She did not want to provide a statement, but she did sign the entry in the officer's pocket notebook outlining H's actions. The victim refused to complete a DASH risk assessment. A warning marker was placed on her home address. Further arrest enquiries were conducted over the week that followed. Officers liaised with officers from the public protection unit (PPU), who also wanted to charge H with the offences committed on 1 August 2013.	H placed on PNC as wanted for offences from 1 August 2013
April 2014	H was alleged to have threatened a relative of his ex-girlfriend. There was some thought that H might have been in possession of a firearm.	H was placed on PNC as wanted for this offence

[22] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

Date	Incident	Outcome
	Police were called the address of the relative, but H left before the police arrived. The police completed their enquires and recorded the matter as harassment. H's ex-girlfriend and child were present at the time of the incident. The social services emergency duty team were liaised with, and a referral was made.	
26 May 2014	Two victims walking along a canal tow path were threatened by youths with a small revolver; phones and other items were taken from them. Officers searched the area, but the offenders could not be found. H and another male were identified by one of the victims. H and the other suspect's fingerprints were checked against the fingerprint lifts taken from items in the female victim's bag, but no match was found. Several arrest attempts were made for H, but he could not be located.	
18 June 2014	**Arrest 16** H was arrested for the domestic assault on the 5 September 2013 on his then girlfriend, as well as the series of robberies previously mentioned.	No further action due to lack of supporting evidence
27 Aug 2014	**Arrest 18** H and others were suspected of shoplifting and were detained at a shopping centre. The suspects would not initially engage with officers; they provided false details and denied the offence. They were arrested, and their details confirmed in custody. **Arrest 19** H was found in possession of cannabis. Arrested for possession of cannabis and obstructing the police. A nurse saw H in custody. He claimed to be diabetic and to have had low blood sugar while in the police van, so the nurse saw him before he was taken through into the custody block. He did not have a diabetes diagnosis. He said he had schizophrenia, and his medication was up to date. He denied any feelings of self-harm or suicide. H said he used cannabis daily. He was deemed fit to be detained and interviewed. A 14-year-old had been involved in the shoplifting, and a child abuse non-crime number was obtained. H had previously been given bail conditions to have no contact with children under 16 years. H was 20 years old at the time.	No further action taken. No further action taken due to the small amount found on H

Date	Incident	Outcome
	Children's services were contacted, and advice was offered to the child's mother.	
28 August 2014	**Arrest 17** H was located and interviewed, but denied the offence committed in May 2014. ID procedures were conducted, and the other suspect was picked out by the victims, H was not.	No further action, little evidence linking H to the offence
29 Sept 2014	H was served with a child abduction notice[23]. He signed this and accepted a copy of it. It was valid until 16 March 2016.	
12 Feb 2015	H was convicted at Stafford Crown Court of two robberies, escaping lawful custody, possession of a knife or bladed article and failing to surrender to custody. This was the culmination of the arrests from June 2014 onwards. H pleaded guilty to all offences.	42-month prison sentence
19 Feb 2017	H's partner reported that he had become aggressive with her and began to strangle her and punch her a number of times in the face and body. She fled the property and called the police. She provided a statement and completed a DASH risk assessment. She reported that she was scared he would kill her, and that this the was second time he had assaulted her. He had threatened to kill her in the past. In the previous assault he had strangled her, but she forgave him, and the relationship continued. A warning marker was placed on her home address and a National Centre for Domestic Violence referral was made. It was noted, when intelligence checks were completed, that there was no domestic offending history reported between H and this partner. **Arrest 20** The attending officers attempted to arrest H, but he could not be located. He was placed on the PNC as wanted for the assault and was arrested later that day. A risk assessment was completed, and he was to be seen by the Criminal Justice Liaison and Diversion (CJLD)[24] nurse to assess his mental health and medication requirements. During interview, H denied the offence.	

[23] The Crown Prosecution Service (CPS) uses a Child Abduction Warning Notice to challenge incidents where, young people, under the age of 16 (or 18 if in local authority care), place themselves at risk of significant harm due to their associations, and the forming of inappropriate relationships. https://www.cps.gov.uk/legal-guidance/child-abuse-non-sexual-prosecution-guidance

[24] The Criminal Justice Liaison and Diversion service are a specialised team provided by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) to work within police custody suites, Birmingham Magistrates Court, and the community. The team consists of Allied Health Professionals, Support Time & Recovery workers (STR) and peer mentors, who assess vulnerable individuals with complex needs who are being brought into the Criminal Justice System having been accused of criminal activity. https://www.bsmhft.nhs.uk/our-services/secure-care-and-offender-health/criminal-justice-liaison-and-diversion-team/#:~:text=Our%20service%20can%20be%20accessed,301%204409%20or%2007768%20308222.
Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/about/

Date	Incident	Outcome
	The victim withdrew her support for the charge. The decision was made to take no further action. A release risk assessment care plan was completed on H's release from custody.	
16 Mar 2017	Bail hostel staff reported that H had made threats to stab and shoot another resident and his girlfriend at a named address nearby. H was causing damage at the hostel, and he was known for carrying knives. H had told the victims that he could get a firearm. The male victim believed he had previously heard gun shots in the garden at night and believed that H had access to some kind of gas-powered gun. The log was reviewed by the force control room because it was a report of potential firearms. The advice was for officers to visit and to establish the facts, as no firearm had been seen. Intelligence checks were completed, and they noted H's offending history. It was established that the victims were safeguarded by staff at another address, but that H was believed to be causing damage at another address. The police attended and spoke to the victims. In view of the ongoing threat of criminal damage, an early arrest attempt of H was to be made to prevent further damage and negate the threat to the victims. Officers spoke to the victims on their arrival. There had been an argument with H and H said he would get a gun and shoot them. But no gun was seen. Both victims reported hearing what sounded like an air compression gun in the past. Other hostel residents said they had seen H with a gun. Staff informed police officers that H was thought to carry knives to protect himself and they had previously seen him with a knife. The victims were offered safeguarding advice, which included not to return to the property at that time. Later, officers reattended and the victims had returned to their property despite being advised against this. They had found their locked and secure room had been trashed, items smashed and damaged, an untidy search completed and a gold watch, to the value of £1,000, had been stolen. The following offences were recorded for this incident: a common assault on the female victim, threats to kill made to both victims, and a burglary. Statements were taken from the victims.	

Date	Incident	Outcome
	A threat to life warning (known as an Osman warning)[25] was issued to the victims and a marker was placed on their home address. H was placed on the PNC as wanted. In the early hours of the following morning the female victim called 999 to report that H had returned to the property. Officers attended but could not find H. The victims had locked themselves in the property, putting a chair against the front door. The victims refused to leave the property until H was arrested.	
16 Mar 2017	**Arrest 21** H was located and arrested later that day. A quantity of cannabis and an imitation Glock style gun were found in H's rucksack during his arrest. On booking H into custody, it was noted that H had no medical issues. However, H disclosed that he had mental health problems, did take medication and had taken his medication that day. As a result, H was to see the CJLD nurse regarding his tablets and mental health. H was placed on level 1 observation. After two hours in custody, H was being argumentative. H was not seen by the CJLD nurse. Instead, the CJLD nurse removed the request from the system, noting an assessment was not required; H engaged well, no issues were raised, and he was deemed to be fit and well. H denied supply of a class B drug but admitted possession for personal use. He admitted possession of the firearm but made no comment to the possession being in a public place. H denied any threats to kill, denied assault and made a counter allegation that the victim had in fact assaulted him. Due to delays, H could only be detained in custody for 40 minutes more. Because of this an inspector was spoken to, and it was agreed that H would be emergency charged. The inspector agreed to this on the basis that the charging request was with the CPS and the matter had been investigated diligently. H was charged with possession of an imitation firearm and possession with intent to supply a class B drug. The charge was later confirmed by the CPS lawyer. H was remanded in custody and placed before the courts.	

[25] Also known as death threat warnings, and named after a high-profile case, Osman v United Kingdom, Osman warnings (also letters or notices) are warnings of a death threat, or a high risk of murder issued by British police or legal authorities to the possible victim. They are used when there is intelligence of the threat, but there is not enough evidence to justify the police arresting the potential murderer. For more information see https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-58257%22]}

Date	Incident	Outcome
	H was remanded in custody at court for the offences charged.	
April 2017	H was convicted of the drug and firearm offences committed around 17 March 2017 and received a 36-month prison sentence.	36-month prison sentence

3.12 H was released from custody on licence[26] on four occasions, but he was returned to prison on three occasions either because he did not comply with the conditions of his licence, or because he committed another offence.

Date	Release/recall	Reason for release/recall
Dec 2011	Release on licence until 15 April 2013	
March 2012	Recall to custody	Breach of licence conditions
April 2012	Released on licence	The police have records that H did not comply with the conditions of his licence but there is nothing to indicate he was recalled
June 2012	Recall to custody	Breach of licence conditions
August 2016	Released on licence	
March 2017	Recall to custody	Committed further offences
Nov 2018	Released on licence	
Dec 2018	Recall to custody	Breach of licence conditions
22 April 2020	Released from HMP Parc at sentence end subject to no restrictions or supervision	

[26] Licence conditions are the set of rules individuals must follow if they are released from prison but still have a part of their sentence to serve in the community. The aim of a period on licence is to protect the public, to prevent reoffending, and to secure the successful reintegration of the individual back into the community. They are not a form of punishment and licence conditions must be considered necessary and proportionate. https://www.gov.uk/government/news/licence-conditions-and-how-the-parole-board-use-them

4 Contact with criminal justice and mental health services

2007 to 2015

4.1 Although the scope of this investigation in the terms of reference covers the period 2015 up to the events of 6 September 2020, the following pages covering the period 2007 to 2015 is included for background information and context as this was also considered relevant by the investigation team.

4.2 During 2007 West Midlands Police became aware that H had been permanently excluded from school and was believed to be actively involved in shoplifting in the city centre.

4.3 H was arrested three times in 2007, suspected of being involved in robberies. West Midlands Police did not charge H for two of the alleged offences. But at the end of 2007 he was charged with theft.

4.4 H had no recorded contact with West Midlands Police again until November 2008. He was arrested in association with the attempted theft of a handbag. He denied the offence and no action was taken against him.

4.5 In February 2009 H was arrested and charged with possession of an offensive weapon, obstructing a police officer and bail-related offences. He was remanded in custody.

4.6 In May 2010 H was arrested for punching someone. This was resolved through community resolution and H provided the victim with a letter of apology.

4.7 H was suspected by the police of multiple thefts of chains and necklaces from women in March and April 2011. At the end of April 2011, he was charged with four robberies and three attempted robberies and detained in custody. Following a trial in July 2011, H was sentenced to two years in a YOI.

4.8 H was initially detained in HMP Brinsford. While at HMP Brinsford H was referred to the primary care mental health team (PCMHT) because he reported low mood and thoughts of killing himself and his family. However, he did not attend any of the appointments he was offered with PCMHT.

4.9 While detained in HMP Brinsford, H was involved in a number of incidents. These included:

- two incidents of self-harm;
- abusive behaviour towards a prison officer, and inappropriate comments to a female officer;
- negative behaviour; and
- surly behaviour – he considered he had a right to please himself.

4.10 In July 2011, H came under the supervision of the National Probation Service.

4.11 He was released on licence in April 2012 and recalled in June 2012 for a breach of his licence. While in the community on licence, H attended 10 out of the 11 appointments planned with the probation service.

4.12 A mental health assessment was completed in HMP Brinsford[27], during which H reported hearing voices and having visual hallucinations. Following this assessment, H spent 18 days on the prison healthcare wing and was prescribed olanzapine 5mg,[28] which had been increased to 15mg by August 2012.

4.13 By November 2012 H's compliance with medication was described as erratic, as was his engagement with the PCMHT. These challenges continued into 2013.

4.14 In April 2013 H told services that he had not been taking the prescribed olanzapine but had been 'palming it' and disposing of it. Later in April 2013, 39 olanzapine tablets were found in H's cell.

4.15 H was referred to EIP services in May 2013. However, two days after the referral was accepted it was closed. The reason given was that "*the client declined an assessment*."

4.16 Prior to H's release from prison in June 2013, H had not attended appointments with the PCMHT for six weeks. The plan was to refer him to the local mental health team once he had a confirmed address for release.

4.17 Following his release H was not under the supervision of the probation service, this was because he had remained in prison to sentence end.

4.18 West Midlands Police were aware of the concerns about H's mental health while he was detained in HMP Brinsford, He claimed to have thoughts of killing others, including family members, thoughts of rape and thoughts of self-harm.

4.19 In August 2013, H was arrested for injuring to his six-month-old child and for sexual activity with a child, because the mother was under the age of 16 when the child was conceived. In September 2013, H failed to answer to bail.

4.20 West Midlands Police were called to an argument on the street between H and an ex-partner in September 2013. It was alleged that H had assaulted his ex-partner. H was arrested for this offence in June 2014, but no charges were brought.

4.21 West Midlands Police had a number of concerns about H in April and May 2014, including threats to harm a relative of his ex-partner and suspecting that he was involved in an armed robbery. Although there was insufficient evidence to support the suspicion of armed robbery.

4.22 H was arrested in June 2014 and charged with a public order offence possession of cannabis and assault of a prison officer. In addition, he was arrested following a report he had assaulted his partner, but this did not result in a charge because his partner would not support a prosecution.

4.23 In August 2014 H was arrested on suspicion of shoplifting with a group of males, and a female under the age of 16. H was also arrested for possession of cannabis. No charges were brought against H at this time.

4.24 The female under the age of 16, was given the opportunity to disclose any concerns they might have had about their relationship with the group of males, but they were adamant that they were just friends. Children's services were contacted, and the

[27] Health care in HMP Brinsford is provided by Practice Plus group, which is contracted by the NHS to provide healthcare in over 45 prisons.

[28] Olanzapine helps to manage symptoms of mental health conditions such as:

- seeing, hearing, feeling or believing things that others do not, feeling unusually suspicious or having muddled thoughts (schizophrenia)
- feeling agitated or hyperactive, very excited, elated, or impulsive (mania symptoms of bipolar disorder)

Olanzapine does not work straight away. It may take several days, or even weeks, for some of your symptoms to start improving. https://www.nhs.uk/medicines/olanzapine/

child's mother provided with advice. The following month H was served with a child abduction notice which he signed; this remained valid until 16 March 2016.

4.25 In November 2014, H was part of a group accused of robbery and assault in Stafford. Following the incident H had boarded a train to Birmingham. When the train was searched, a kitchen knife was found wrapped in H's bandana. Following his arrest H ran away from the detaining officers. He was arrested six days later.

4.26 H was remanded in HMP Birmingham, with a court date planned for 12 February 2015. While detained in HMP Birmingham, he was seen by the PCMHT. During this appointment H reported experiencing vivid dreams, in which he saw himself harming others and himself. His mood was changeable, although he described getting angry easily. He said that he was hearing voices that told him to harm others,

4.27 H was transferred to HMP Dovegate at the beginning of December 2014. He was seen by a psychiatrist following the transfer who questioned if H's offence might be related to his mental health and whether a transfer to hospital might be required. The plan was to monitor his mental health and, if it deteriorated, to consider a transfer.

January 2015 to March 2017

4.28 In January 2015 H continued to refuse medication unless it was 'in-possession',[29] and his engagement with MHIT was poor.

4.29 H moved wings because of a fight on the wing. Consideration was given to moving him a second time, when other prisoners were overheard planning to assault him.

4.30 H came under the supervision of the National Probation Service again and in February 2015 the Probation Service completed a pre-sentence report for H. This identified that the offences in December 2014 were financially motivated. The probation officer believed that H was attempting to minimise his actions by being vague when asked about the offences.

4.31 The report identified H's previous offences as:

- 2007 theft;
- 2007 failure to surrender to bail;
- 2011 two robberies and one attempted robbery;
- 2014 failure to surrender to bail, and;
- 2014 possession of a class C drug, resisting a police officer and use of threatening words.

4.32 He had also received cautions in 2007 for attempted robbery and 2012 for possession of a class B drug.

4.33 At the time of the offences, it was believed that H had been working part-time as a cleaner and was in receipt of Job Seekers Allowance. H was struggling to manage his finances and told the probation officer that he saw robbery as a means to supplement his income so that he could spend money on his child.

4.34 H provided the probation officer with a confusing account of his personal relationships. He described having a two-year-old child and said social services were involved with her, although there was no Child Protection Plan in place. The probation officer believed that H was due to face trial for assault occasioning actual

[29] Medicine is said to be held in-possession if a person (usually in a prison or other secure setting) is responsible for holding and taking it themselves. https://www.nice.org.uk/guidance/ng57/chapter/recommendations#in-possession

bodily harm against his child in August 2013. It was also noted that there had been domestic violence police call outs to incidents involving H.

4.35 In a self-assessment questionnaire, H identified the following problems: mixing in bad company, being bored and going to places that got him into trouble. The probation officer identified that these issues would need to be addressed if his risk for reoffending was to be addressed.

4.36 H used mixing "*with the wrong people*" as the reason for his current, and previous, serious offending and his expulsion from school. The probation officer identified that H needed to take more responsibility for his decisions.

4.37 H told the probation officer that between the ages of 16 and19 he had carried a knife because of the area he lived in and his perceived need for protection.

4.38 H said that he was prescribed medication for schizophrenia, but he was vague about this medication and how the illness affected him.

4.39 Using the OASys risk assessment tool,[30] the probation officer identified that H posed a high risk of serious harm. His current offences were aggressive, with physical violence that could have escalated further had the victims not cooperated. The conviction for possession of a bladed article further exacerbated this. The nature of the serious harm that H posed was aggression and violence by way of assault or robbery, likely directed towards the general public, including children and elderly females. He was identified as having limited protection factors[31]; he had no stable accommodation, had a lack of finances and, at the time, had no contact with his child.

4.40 This report identified that his risk for inflicting serious harm would be reduced if he completed some accredited courses to address his thinking and behaviour. It was also suggested that completion of some victim-focused work would help him understand the impact of his actions on others.

4.41 It went on to identify that he would benefit from engaging with employment, training and education, gaining stable accommodation and avoiding associating with pro-criminal peers.

4.42 The Risks of Serious Recidivism[32] tool calculated that H was at medium risk of serious reoffending in the next two years.

4.43 On 12 February 2015 H was convicted of:

- two robberies;
- escaping lawful custody;
- possession of a bladed article in a public place; and
- failing to surrender to custody.

4.44 He was sentenced to 42 months in custody after he pleaded guilty to all of the offences.

[30] Used by HM Prison Service and the National Probation Service to measure the risks and needs of offenders under their supervision. https://www.gov.uk/government/statistics/identified-needs-of-offenders-in-custody-and-the-community-from-the-offender-assessment-system-30-june-2021/identified-needs-of-offenders-in-custody-and-the-community-from-the-offender-assessment-system-30-june-2021

[31] Protection factors are believed to reduce a person's chance of reoffending.

[32] The Risk of Serious Recidivism tool will generate a summary score to indicate the likelihood of the offender committing a seriously harmful reoffence within two years.

4.45 H was transferred to HMP Birmingham in February 2015. He remained willing to accept medication only when he was in crisis and was referred to the MHIT (provided by BSMHFT). H failed to attend a number of planned appointments with MHIT, including one with the team consultant psychiatrist, although the team did see him twice before his transfer to HMP Dovegate in June 2015.

4.46 His transfer of care was supported by a phone call between the MHITs at HMP Birmingham and HMP Dovegate (provided by Practice Plus Group). The HMP Birmingham team had concluded that H had experienced first episode psychosis and that he had been symptom free while at HMP Birmingham. They said that H's prescribed medication had been stopped because H had been diverting it.[33] Their intention had been to discharge him from the care of MHIT to the care of the GP, but H was transferred before this was done.

4.47 There were a number of incidents involving H in the next five months:

- March 2015 – H was given a warning for refusing to return to his cell.
- April and May 2015 – H made threats to harm prison staff.
- July 2015 – H was considered to be the victim of bullying in prison.

4.48 HMP Dovegate placed H on the PCMHT waiting list and in July 2015 he was seen by the team, following reports that he had been involved in fighting on the wing. H told the team that he was feeling anxious and continued to experience auditory and visual hallucinations. H was concerned that rumours in the prison about his previous offences might cause him problems. The mental health practitioner agreed to discuss his concerns with the prison staff.

4.49 For the remainder of 2015, H did not engage with mental health services. When he was seen at the end of December, he told mental health staff that he continued to hear voices but that he was able to manage them. H was eligible for release on licence in March 2016, and the mental health practitioner suggested that they develop a resettlement plan with the offender manager unit (OMU) and H was happy with this idea.

4.50 H's poor engagement with mental health services and his refusal to take medication continued into 2016.

4.51 H met with a mental health practitioner in June 2016. H wanted to know what the plan was for his release. He was told that a referral would be made to a local CMHT once he had an address for his release, and that consideration was being given to a placement at Elliott House AP in Birmingham.

4.52 H met with a mental health practitioner five days before his release on licence. A referral was made to Forward Thinking Birmingham (FTB)[34] based on H's proposed release address.

4.53 On 10 August 2016, H was release with a standard license condition that he 'only reside as approved.' This condition was in place until 2018. H was released to live at an approved premises.

4.54 In September 2016 H was being supported in the community by his GP, while waiting for a decision about the referral FTB. The GP requested that H be seen as soon as possible because H had no prescribed antipsychotic medication.

[33] Where a legally prescribed drug is transferred from the person for whom it is prescribed to another person for illicit use.
[34] Birmingham city's mental health partnership, for 0- to 25-year-olds. https://forwardthinkingbirmingham.nhs.uk/

4.55 H was offered an appointment with FTB on 19 October 2016. Notes record that H did not attend this appointment. FTB tried on several occasions to contact him on his mobile and another appointment was to be made for him.

4.56 The probation service wrote to H's GP, providing them with information about H's paranoid schizophrenia and his medication.

4.57 At the end of November 2016, H's GP provided him with a prescription for two weeks of olanzapine 5mg.

4.58 FTB spoke to H at the beginning of December 2016, he told them that his GP had prescribed olanzapine. H did not attend any planned appointments with FTB in December 2016 and January 2017.

4.59 H's probation officer (PO1) arranged for a joint appointment with the FTB practitioner and H at the beginning of February 2017. The plan from this appointment was for H to be offered an appointment with the FTB consultant psychiatrist.

4.60 The following week PO1 contacted FTB. They had seen H and were concerned about his mental health. They were concerned that H had said he would not take his medication and that he was using cannabis. H had said that "*they are trying to kill us*." When asked who he meant by "*us*" he said, "*black people*". He also told PO1 about difficulties in his childhood, including an alleged assault on him by his brother, who he claimed was a member of a street gang. H discussed how people looking at him or his "*baby momma*" the wrong way could trigger him, and he could imagine stabbing them.

4.61 PO1 was concerned about the frank manner in which H spoke about his thoughts and paranoia. The plan from the conversation between PO1 and FTB was for a joint appointment with H and for the concerns to be discussed with the FTB consultant psychiatrist.

4.62 Ten days later H attended a joint meeting with PO1 and the FTB practitioner at the probation office. They explored the option of weekly meetings at the probation office because H was required to attend probation under the terms of his licence, and it would support his engagement with mental health services. In addition, H would be required to attend an appointment with the FTB psychologist/psychiatrist.

4.63 H continued to experience some paranoia but was feeling better. An OASys entry stated that H "*also reports experiencing voices telling him to kill people and one occasion relating to rape. Stated that he is aware that the voices are not real and feels he is able to control them*."

4.64 On 19 February 2017, H's ex-partner reported to the police that she had been assaulted by H. She said it was the second time he had assaulted her, and she was afraid he would kill her. A warning marker was placed against her address. It was noted that when intelligence checks were completed there was no domestic offending history reported between her and H.

4.65 H was arrested the following day. However, his ex-partner withdrew her support for a prosecution and the police decision was to take no further action. H was released from police custody without charge.

4.66 In the following three weeks H attended one of the three meetings arranged with him. In mid-March FTB told the probation service that H had claimed his bedroom door had been kicked in and he wanted alternative accommodation. When H was seen by FTB the next day, he claimed to have been sleeping rough for five days. He said that he was taking his prescribed olanzapine a few days a week, "*when I have a bad*

day." He would not answer any questions about hallucinations, paranoia or his other psychotic symptoms.

4.67 On 16 March 2017 West Midlands Police were called to the premises. It was alleged that H had made threats to stab and shoot another resident and his girlfriend. There was also an allegation that the sound of gun shots had been heard in the garden of the hostel at night. It was believed that H had access to some sort of gas-powered gun.

4.68 The offences recorded for this incident were:

- common assault on a female victim;
- threats to kill both victims; and
- burglary.

4.69 H was seen by the court liaison and diversion (L&D) team following his arrest, and H agreed for referrals to be made to FTB and Change Grow Live.[35]

March 2017 to April 2020

HMP Birmingham 17 to 28 April 2017

4.70 This arrest triggered H's recall to prison on 20 March 2017. PO1 contacted FTB on 22 March 2017 and told them H had been arrested for possession of a firearm and possession of cannabis with an intent to supply and had been recalled to prison.

4.71 H was seen in reception at HMP Birmingham and a prescription for olanzapine 5mg for seven days was issued by the doctor, a referral was made to the PCMHT at HMP Birmingham, and an assessment was completed on 28 March 2017. Because of the nature of the offence a referral was to be made to Forensic Psychiatry in HMP Belmarsh. This referral ended on 28 April 2017 when he transferred to HMP Stoke Heath. However, H remained in the caseload of the forensic service.

4.72 On 19 April 2017, an AFFIRM was completed by the offender personality disorder (OPD) team, following a meeting with PO1. The intention was to provide PO1 with a psychological perspective of the presenting problem. This was identified as "*Displays erratic engagement with probation, has been evicted from a hostel placement due to his behaviour towards other residents, he is not complying with his medication and is 'doing the bare minimum'*".

4.73 H did not attend an appointment with the PCMHT or the Trust Forensic Outreach Team (forensic community team) on 21 April 2017. The forensic community team plan was to offer another appointment.

4.74 H appeared in Birmingham Crown Court on 24 April 2017 charged with:

- possession of an imitation firearm; and,
- possession with the intent to supply a class B drug (cannabis).

4.75 H was sentenced to 36 months and seven months imprisonment to run consecutively. He was returned to HMP Birmingham.

4.76 On 26 April 2017 H was involved in two incidents in the prison:

- he made inappropriate comments towards female staff; and

[35] A service that supports people with alcohol and illicit substance misuse. https://www.changegrowlive.org/drug-and-alcohol-service-birmingham

- he was involved in fighting with another prisoner.

4.77 On 28 April 2017 he was transferred to HMP Stoke Heath.

HMP Stoke Heath 28 April 2017 to 30 May 2018

4.78 During the reception assessment H said he had been diagnosed with mental health problems in 2011 and prescribed olanzapine. The practitioner who completed the assessment noted that olanzapine had not been prescribed since March 2017. There were no concerns at this assessment about the intention to self-harm or to harm others. There were minor concerns about H's thoughts and behaviours. An appointment was booked for him to see the doctor on 11 May 2017 to discuss olanzapine. And he was referred to the PCMHT.

May 2017

4.79 In May 2017 FTB discharged H due to the length of his custodial sentence. They informed the GP and PO1 about the discharge.

4.80 On 19 May 2017 PO1 met with H via video link and completed an initial sentence plan. PO1 noted that H had been in prison for four weeks and had not been seen by healthcare.

4.81 In a phone call with the prison offender supervisor (OS)[36] on 25 May 2017, PO1 raised concerns about H's mental health. They followed this phone call with an email.

4.82 PO1 described H as displaying paranoid behaviour on occasions. H would stop taking his medication because he believed "*they're trying to kill us*." By "*us*" he meant black people and he also asked, "*why is it white people are asking you all these questions trying to fuck with your head*". H had also made references to hearing voices telling him to kill people and on one occasion to rape someone, but he knew the voices were not real and he could deal with them. PO1 also told the OS that H's brother was a member of a street gang, and that H had some gang affiliations.

4.83 The prison PCMHT completed a mental health assessment with H on 31 May 2017. He had not taken olanzapine since March. H had not engaged with mental health services in the past and had been in and out of prison. At that time there were no issues with his mental health and no risks to himself or others were identified. A referral was made to the prison MHIT (provided by North Staffordshire Combined Healthcare NHS Trust).

June 2017

4.84 H was discussed at the MHIT MDT meeting on 1 June 2017. A request was to be made for his notes from FTB and he was placed on the team waiting list. The team was aware of his diagnosis, that he had not had any medication since March 2017 and that he would require psychiatric review.

4.85 PO1 received an email from West Midlands Police confirming H's offences and sentence details. The police noted a "*concerning trend regarding the possession of firearms, it is not inconceivable that H may make a step up from the possession of imitation firearms to the possession of Section 1 firearm*".

4.86 The police went on to identify gang links through his association with gang nominals, but that were not directly linked to offences. The West Midlands Police and PO1 agreed that H should be managed on MAPPA level 1 (see Section 9).

[36] The allocated member of staff who worked with him on a day-to-day basis in prison.

4.87 On 16 June 2017, PO1 contacted the MHIT. They were told that the assessment completed by the PCMHT on 31 May 2017 suggested that H did not need to be seen urgently and that he would be seen by the team before the beginning of July. PO1 requested feedback on this assessment.

4.88 The MHIT noted that PO1 was concerned about H because H had been hostile towards them in a video call.

4.89 H was allocated to MHIT Practitioner 1's caseload on 23 June 2017 and they completed an assessment with H five days later. H was low in mood and experiencing paranoid thoughts. He said he had experienced visual hallucinations the previous year; he attributed this to stress at the time. He described hearing a voice similar to his own and said people were putting thoughts into his head. He did not disclose any past incidents of self-harm or any current thoughts of self-harm.

July 2017

4.90 MHIT Practitioner 1 reviewed H's medical records before an appointment planned with H for 6 July 2017. They noted that he had been under the care of the MHIT in the past and had experienced psychotic symptoms that led to a diagnosis of paranoid schizophrenia. In addition, they noted that H had a history of non-compliance with medication and non-engagement with mental health services.

4.91 H did not attend the meeting planned for 6 July 2017, or ones planned for 11 and 17 July 2017. MHIT Practitioner 1 contacted the wing for an update on H. They were told he was sleeping a lot during the day and was struggling with the rules on the wing.

4.92 H attended the healthcare wing on 20 July 2017 and saw MHIT Practitioner 1. H wanted to know why he had not been offered another appointment. He was told this was because he had missed three appointments and the practitioner planned to see him on the wing on 24 July 2017.

4.93 A video interview was arranged for 13 July 2017 between H, PO1 and the police Offender Supervisor (OS). H was late for this meeting. H was not complying with his sentence plan because he said it was of no benefit to him. The PO1 explained to H that the plan was reducing his risk and preparing him for release.

4.94 At this interview H requested a transfer to HMP Featherstone, although he did not follow this up by making an official request.

4.95 He told the meeting that he had been seen by the mental health team but was not prescribed any medication. H walked out of the meeting. The plan was for the OS to liaise with the mental health team. But when they spoke to the MHIT they were told that H had been prescribed medication and was refusing to take it.

4.96 H was seen on 24 July 2017 by MHIT Practitioner 1. He said he was bored in prison and the practitioner was to chase work and education opportunities for H. H also requested a transfer to another prison.

4.97 H was challenging his mental health diagnosis, saying he felt he had bipolar disorder. Although he was able to describe low mood, he was not able to describe any compulsive behaviour that would have supported this diagnosis. He told the practitioner that he was seeing shadows and hearing voices. He also said he was experiencing paranoid thoughts, but he attributed this to being in prison.

4.98 During the appointment, medication options were discussed with H. H thought that olanzapine made him tired and did not have any other effect. H was to think about his medication options and was given another appointment in a couple of weeks' time.

4.99 Following the appointment, MHIT Practitioner 1 chased work and education options for H and explored options about a prison transfer. They were told that another category C prison would not accept H at that time, and a transfer to a category D prison would not be an option because of the nature of his offences.[37]

August 2017

4.100 H did not attend a planned appointment with MHIT Practitioner 1 on 9 August 2017 and there is no record of the outcome for an appointment planned for 16 August 2017.

September 2017

4.101 In an appointment with MHIT Practitioner 1 on 12 September 2017, H reported seeing shadows and hearing derogatory voices. Although he said they were not as bad as they had been in the past. He continued to feel paranoid but was not sure if this was related to being in prison. He continued to ask for a transfer to a prison closer to Birmingham. He remained unsure about taking medication.

4.102 The plan from this appointment was to continue to assess H's mental health and he was given another appointment with the practitioner for 27 September 2017.

4.103 On 14 September 2017 PO2 took over responsibility for H and wrote to him to introduce themselves.

4.104 The wing contacted MHIT on 22 September 2017. There had been an incident on the wing; H had been swearing at wing staff, and H was being placed on 'basic' under the Incentives and Earned Privileges (IEP) regime.[38] He was requesting that he be allowed to keep his television to support his mental health. The MHIT care coordinator who was happy to support his request "as a distraction".

4.105 In the appointment on 27 September 2017 MHIT Practitioner 1 asked H about the incident on the wing; he said that he had been placed on 'basic' for swearing.[39] He said that he was hearing voices (a crowd), seeing shadows and experiencing paranoid thoughts. He believed that people were out to get him and were talking about him. He said that his mood was worse than in the past. The practitioner considered H guarded when talking about his symptoms. H remained ambivalent about taking medication.

4.106 The outcome from this appointment was to offer H an appointment with the consultant psychiatrist on 19 October 2017 for a medication review, and an appointment with MHIT Practitioner 1 on 12 October 2017.

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[37] In the UK there are four categories of prison for adult male prisoners (those aged 18 and over). Category A is highly secure and for prisoners whose escape would be highly dangerous to the public or national security. Category B is for prisoners who do not need maximum security but for whom escape needs to be made very difficult. Category C is for prisoners who cannot be trusted in open prisons but who are unlikely to escape, and category D (often known as open prisons) are for prisoners who can be trusted not to escape.

[38] The Incentives Policy Framework provides a system of privileges, which is a key tool for incentivising prisoners to abide by the rules and engage in the prison regime and rehabilitation, including education, work and substance misuse interventions – whilst allowing privileges to be taken away from those who behave poorly or refuse to engage. There are three levels.

1. **Basic** level is for those prisoners who have not abided by the behaviour principles. To be considered suitable for progression from Basic, prisoners are expected to adequately abide by them.
2. **Standard** level is for those prisoners who adequately abide by the behaviour principles, demonstrating the types of behaviour required.
3. **Enhanced** level is for those prisoners who exceed Standard level by abiding by the behaviour principles and demonstrating the required types of behaviour to a consistently high standard, including good attendance and attitude at activities and education/work and interventions.

https://www.gov.uk/government/publications/incentives-policy-framework and
https://www.legislation.gov.uk/uksi/1999/728/article/8/made

[39] For an explanation of the basic regime in prison see: http://www.mojuk.org.uk/MOJUK%202013/Basic%20Regime.htmlC

October 2017

4.107 In the appointment with MHIT Practitioner 1 on 12 October 2017, H continued to describe symptoms similar to those discussed in previous appointments. He wanted a transfer to a prison closer to his family but was aware a period of good behaviour was required before this would be agreed.

4.108 H did not attend the appointment with the consultant psychiatrist on 19 October 2017; the plan was to offer him another appointment.

4.109 When H attended an appointment with MHIT Practitioner 1 on 26 October 2017, he was noted to be experiencing low-level paranoid thoughts, seeing shadows and hearing voices. H remained unsure about medication, but he did want support from mental health services

November 2017

4.110 FTB discharged H back to the care of his GP because he was going to be in prison for the next three years.

4.111 H was seen on the wing by a primary healthcare nurse for injuries sustained in a fight on 22 November 2017, but no treatment was required. Following this fight, he was moved to the segregation unit. He was seen by the primary care nurses while he was in the segregation unit.

4.112 Consultant psychiatrist 1 was not able to access H on 30 November 2017 to complete a review because H was on the segregation unit.

December 2017

4.113 H was seen by MHIT Practitioner 1 on 27 December 2017. He attributed fighting to feeling under threat in prison and described feeling paranoid and experiencing hallucinations – seeing shadows and hearing voices. But he said he was able to manage these symptoms.

4.114 He continued to remain unsure about medication. The MHIT Practitioner 1agreed to speak to the prison about a transfer to another prison.

January 2018

4.115 H attended appointments with MHIT Practitioner 1 on 2 January 2018 and 15 January 2018, during which he said he was struggling with his mental health. He continued to feel paranoid and to experience hallucinations but said that he could manage them. MHIT Practitioner 1 noted that they did not observe any psychotic symptoms.

4.116 H was seen on the segregation unit by primary care nurses on 22 January 2018 following a fight on the wing. He had small cuts to his hands and forearms. H was referred for confinement to his cell.

4.117 On 22 January 2018, an annual probation review was requested for H by the annual review team; this was due on 20 March 2018.

4.118 On 25 January 2018, H attended an appointment with consultant psychiatrist 1. He described paranoid thoughts and hearing voices. The voices were commentary, command and thought echo in nature. He described how others could control his thoughts and also some disturbances of visual perception, smell and taste.

4.119 H was willing to take medication, but he was worried that medication would make him drowsy and put him at risk of assault. He was provided with a prescription for aripiprazole 5mg, with a plan for this to be reviewed in three weeks' time.

4.120 The parole review process commenced in January 2018 when the Parole Board requested reports from Probation to support the review. The Parole Board required the reports to be available in March 2018.

4.121 When H was seen by MHIT Practitioner 1 on 31 January 2018 he had not been taking the aripiprazole because he said he did not know that it had been prescribed.

February 2018

4.122 On 6 February, H was subject to adjudication, and he requested MHIT to support his request for the return of his television. MHIT did not support this request because of his poor compliance with medication.

4.123 There was a case consultation with the offender personality disorder team on 7 February 2018. PO2 discussed H with the team, and they agreed to send PO2 the formulation developed with PO1. The OPD plan was to be reviewed when there was more information available about H's mental health.

4.124 On 9 February 2018 PO2 completed a review of the re-release report. They did not support release because although H had made some positive progress in engaging with substance misuse work, he had six adjudications and was not engaging with the sentence plan. Future release would need to be to probation AP to allow for daily oversight of H.

4.125 PO2 completed an OASys on 24 February 2018. This identified that H's mental health was linked to harm, but it was considered to be linked to his offending at that time. This risk assessment identified that he posed a high risk to the public, a medium risk to children and a medium risk to known adults. His risk was specified in relation to potential violence and robberies.

4.126 H did not attend any planned appointments with MHIT Practitioner 1 in February 2018. There was a plan in place for H's care to be taken over by MHIT Practitioner 2, but he failed to attend appointments planned with them.

4.127 H's prescription for aripiprazole was cancelled by the prison GP because of his non-compliance. Consultant psychiatrist 1 was in agreement with this decision when they reviewed it.

March 2018

4.128 H was visited in his cell by MHIT Practitioner 2 on 7 March 2018. He was on his bed and his hands were over his face. He continued to decline medication. There were no identified concerns about his risk to self or others.

4.129 The MHIT were finding it difficult to complete an assessment with H because he would not attend appointments or engage with the team. Although he continued to say that he wanted support from the team.

4.130 There is no record of the outcome of an appointment planned with H for 13 March 2018.

4.131 The Parole Board decision on 19 March 2018 was that H was not ready for release. There was little evidence of change in the parole dossier; H continued to be a challenging prisoner in custody. There had been a number of incidents in the previous year, including an assault on a member of staff and use of threatening and abusive behaviour towards staff. The Parole Board also referred to his refusal to take his prescribed medication for paranoid schizophrenia.

April 2018

4.132 At an appointment with MHIT Practitioner 2 on 5 April 2018, H said that the aripiprazole had helped to reduce his voices, He told them that he had been prescribed olanzapine in the community, but he had only taken it when he chose to.

4.133 During this appointment H was described as being quieter than usual. But there were no signs or symptoms of psychosis, although H said that he was hearing voices and had done for years "*on and off*."

4.134 H refused to attend an appointment with consultant psychiatrist 1 on 12 April 2018. The plan was to offer him another appointment.

May 2018

4.135 MHIT Practitioner 2 was running late on 2 May 2018 and H would not wait to see them. He was to be offered another appointment. There were no concerns reported about H at the time.

4.136 H declined to attend an appointment with MHIT Practitioner 2 on 21 May 2018. The practitioner planned to see him week beginning 4 June 2018.

HMP Oakwood – 30 May 2018 to 9 November 2018

4.137 On 30 May 2018, H transferred to HMP Oakwood. The occupational therapist from the HMP Stoke Heath MHIT provided a handover to the MHIT team at HMP Oakwood (from Practice Plus Group). They said that H had been under the care of a CPN and psychiatrist but that his engagement had been sporadic. He had a diagnosis of schizophrenia and had been prescribed olanzapine in the past but at the time of his transfer of care he was not prescribed any medication for his mental health.

June 2018

4.138 In June 2018, the resettlement team at HMP Oakwood requested access to H's NDelius record.[40]

4.139 On 11 June 2018, PO2 completed ab update of H's risk flags, which lead to an automatic review of the risk tier recorded.

4.140 On 13 June 2018 the police agreed with Probation that ZM should be managed at level 1 MAPPA, pending his release from prison.

4.141 The prison OS met with H on 15 June 2018 to sign his sentence plan.

4.142 There is no record of the MHIT at HMP Oakwood having contact with H in June 2018. It is recorded that he was seen by healthcare for a dislocated thumb on 14 June 2018 and on 29 June 2018 for treatment when H had been grabbed by another prisoner.

July 2018

4.143 H did not attend an appointment in clinic with MHIT Practitioner 4 on 6 July 2018. It was noted that he had previously been under the care of a psychiatrist and a referral to HMP Belmarsh was noted. The plan from this appointment was for a practitioner to complete a follow up and for him to be placed on the waiting list for an assessment.

4.144 H attended an appointment with MHIT Practitioner 4 on 16 July 2018. No paranoia was noted but H discussed paranoid ideas with the practitioner. He said he was seeing shadows and experiencing command voices telling him to harm himself and others, although he said he was not going to act on these voices. He said that the

[40] National Delius (NDelius) is the main case management system that holds probation information on service users.

voices were telling him people were talking about him, and he would approach them to find out if this was true.

4.145 H said that he was a gang member and had been involved in fights in prison with rival gang members. He had been involved in at least two fights since being moved to HMP Oakwood and at the time of the appointment had just completed three weeks 'basic.' He was to remain on the 'basic' wing.

4.146 H disclosed that his initial diagnosis had been bipolar disorder but mental health care at HMP Brinsford had given him a diagnosis of schizophrenia. H thought that he was under the care of FTB in the community. He said that his compliance with medication was poor, and he only took it when he felt like it. He said he would only accept medication if he was allowed his medication in-possession.

4.147 The plan from this appointment was for H to be placed on the waiting list to be seen by the consultant psychiatrist and to ask FTB for information about H.

4.148 A medication in-possession assessment was completed by another practitioner and agreed for 28 days.

August 2018

4.149 . In August PO2 liaised with West Midlands Police Violent OM team and a police officer completed a report for the MAPPA process regarding ZM. This contained an assessment of whether H should be managed under MAPPA. It was recommended that due to ZM's mental health diagnosis and history of armed violent offending, H should be managed as a level 2 offender.

4.150 This identified that H showed a consistent and entrenched pattern of violent offending. This included a reported history of violence in relationships. The information available to the police suggested that H had thoughts of harming others, and this was linked to a diagnosis of paranoid schizophrenia. He was sporadically compliant with the medication prescribed for his mental health problems.

4.151 The referral recommended management at MAPPA category three, level 2.[41] The police officer supported H's release to Elliott House AP, on the understanding that he would have access to mental health services.

4.152 On 8 August 2018, PO2 assessed that an AP was necessary and had reserved a bed in Elliott House. H was reluctant due to its location and claimed he would be at risk due to previous gang affiliations. Probation and police explored this.

4.153 MHIT Practitioner 4 completed a CPA review for H on 16 August 2018. This was limited to identifying H's diagnosis of schizophrenia and that he had last been seen by a consultant psychiatrist in January 2018. He had been prescribed aripiprazole in the past, but his compliance was sporadic, and this medication was stopped. H was requesting a medication review.

4.154 The CPA plan from this review was for:

- H to be able to build a therapeutic rapport with his key worker and be able to discuss his experiences freely without fear of being judged.
- H to be able to recognise any triggers and relapse indicators that suggested he was becoming unwell and seek appropriate support at the appropriate time to prevent a deterioration in his mental health.

[41] For information on MAPPA categories and levels see: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--3/multi-agency-public-protection-arrangements-mappa-accessible-version

- H to remain under the care of MHIT Practitioner 4 while he was at HMP Oakwood.
- MHIT Practitioner 4 to be responsible for CPA coordination and ensure H had regular appointments with the psychiatrist for mental health and medication reviews as required.
- MHIT Practitioner 4 to liaise with the CMHT in H's local area when H was ready for release, to ensure a full package of care was in place prior to him returning to the community.
- Ensuring H was referred to appropriate services as and when the need arose.

4.155 The goals for this CPA care plan were:

- To maintain H's mental health at a stable level and improve his ability to function effectively within the prison regime.
- For H to gain insight into his mental health and for him to be able to monitor it.
- For H to be fully informed about, and understand, his treatment, what the treatment is used for, and the benefits and side effects.
- To reduce the negative impact symptoms had on H, to promote recovery and to maintain mental health and wellbeing.
- For H to engage in relapse prevention work, so that he could identify all his relevant relapse signatures.

4.156 Elliott House AP requested additional medical information about H from PO2. They approved the referral that they had received for H and reserved a bed for him for release.

4.157 On 31 August 2018, the MHIT shared information with the probation service about H's mental health needs. This included the last psychiatric review letter from consultant psychiatrist 1. This information was intended to support the search for suitable accommodation for H on his release from prison. This information was shared with Elliott House AP. The email chain states that H was under the care of FTB when in the community. However, he had been discharged by FTB at the beginning of this sentence.

September 2018

4.158 There is no record of any MHIT contact with H in September 2018.

4.159 PO2 emailed MHIT Practitioner 4 and the prison OS on 18 September 2018, to request an update about H and his treatment, as it was three weeks before his planned release. They believed that H should have had a medical review after he stopped taking his medication in January 2018.

October 2018

4.160 H did not attend an appointment planned with the police OM on 2 October 2018.

4.161 On 3 October 2018 PO2 completed a referral for MAPPA. It was agreed that H would be considered MAPPA category 3, level 2 and was listed for a MAPPA panel meeting on 5 November 2018. Category 3 offenders are, "*Other dangerous offenders - who*

have been cautioned for/or convicted of an offence which indicates that he or she is capable of causing serious harm AND which requires multi-agency management".[42]

4.162 The police OM met with H and the community rehabilitation company (CRC) caseworker on 4 October 2018. H would be of no fixed abode on release from prison, but work was being done to secure accommodation due to his high risk. H said he had affiliations with a Birmingham street gang. He said he had a diagnosis of schizophrenia, he was unmedicated and was not engaging with mental health services. H heard voices and suffered from paranoia, which resulted in him fighting with others.

4.163 The police OM made a referral to mental health services to obtain an appointment for him before release.

4.164 On 8 October 2018, a NOMIS[43] report identified that H was a risk to females because of making inappropriate comments and the way he looked at female staff.

4.165 On 9 October 2018, the resettlement team notified the MHIT that H was not engaging with them. The team did not know where he intended to live when he was released from prison.

4.166 H was seen by consultant psychiatrist 2 on 9 October 2018. The consultant reviewed H's SystmOne record, and the previous assessments completed by other consultant psychiatrists prior to the appointment.

4.167 During the appointment H reported hearing voices, both male and female telling him to "*kill 'em … stab 'em … they are talking about you*." H said that he believed people were talking about him and this resulted in him getting into fights. The last fight had been in June 2018, although he said he was confronting people on a weekly basis.

4.168 H believed he was receiving messages through songs and the television, as a result he no longer watched television. He said that his paranoid ideas were triggered by auditory hallucinations,

4.169 H was described as having positive plans for the future and he was willing to engage with mental health services. The probation service was exploring the option of H going to Elliott House AP on release. H was reluctant to do this because it was located in a gang area, and he wanted to leave the gang culture behind. He wanted to move to the outskirts of the West Midlands, and this was discussed in the context of him getting to know a new CMHT.

4.170 Consultant psychiatrist 2 completed an assessment of H's risk. He was identified as being vulnerable to harm from others when confronting people who he believed were talking about him.

4.171 The plan from this appointment was to prescribe aripiprazole 5mg and to review in two weeks' time. H was not granted in-possession, because of his history of non-compliance. MHIT Practitioner 4 was to liaise with the resettlement accommodation and refer to the appropriate CMHT in anticipation of his release.

4.172 On 11 October 2018, a note was added to Ndelius that H had a ViSOR record.[44]

4.173 H refused to engage with the probation resettlement worker on 30 October 2018 and declined support from a peer support worker.

[42] MAPPA categories and levels
[43] Prison National Offender Management Information System
[44] ViSOR is the key tool for the management of offenders and other persons posing a risk of harm to the public. It is a multi-agency system used by the police and probation service.

November 2018

4.174 Elliott House AP confirmed a bed for H on 2 November 2018.

4.175 MHIT Practitioner 4 referred H to the Trust single point of access on 2 November 2018 and he was accepted by the local CMHT in Birmingham, who were to liaise with the HMP Oakwood mental health team.

4.176 H was discussed at an initial MAPPA meeting on 5 November 2018. This meeting was attended by the National Probation Service, West Midlands Police, adult social care and CPN1 from the prison discharge service; with apologises from HMP Oakwood staff and victim liaison officers.

4.177 Although HMP Oakwood staff did not attend the meeting, they did provide the meeting with an update. The update stated there had been some behavioural concerns about H and adjudications following fighting with other prisoners. H had received numerous negative entries and incentive and earned privileges (IEP)[45] warnings for his poor attitude and behaviour. At the time he was unemployed in prison because he was on a 'basic' regime.

4.178 It was reported to the panel that H had been referred for the Thinking Skills Programme[46] but there was no evidence that he had completed it. He had not completed any offence-focused work to reduce his risk. It was noted that he would benefit from completing Resolve/Kaizen[47] accredited work to address violence, but there was no time to do this before his release.

4.179 The update also informed the panel that H has been referred to Kingstanding & Erdington CMHT.

4.180 CPN1 from the prison discharge service was to provide the MAPPA meeting with information about H's contact with mental health services. H had been seen by the prison MHIT on 31 October 2018, he was due to be seen again on 6 November 2018 and it was suggested that depot medication[48] would be recommended in the community because of H's history of non-compliance. However, the meeting recognised that he would need to agree with this and be willing to engage with the CMHT.A "*full update will be obtained from this meeting*."

4.181 The probation service reported that a bed had been secured at Elliott House AP for H's release but plans for "move-on" to other accommodation had not been made. It was agreed that due to H's alcohol dependency he would be allowed alcohol up to the legal drive limit, but should he exceed this warning letters and recall should be considered. It is to be noted that this is the first reference to his alcohol use in H's official records.

4.182 West Midlands Police were to escort H from prison to Elliott House AP on his release from prison.

4.183 The MAPPA panel also considered safeguarding for H's ex-partners and children.

4.184 H was reported to be engaging with the mental health team, but he had not engaged with the substance misuse team. The MAPPA meeting agreed that a police officer would meet H when he was released from prison and take him to Elliott House AP. In

[45] For information about the basic regime see: http://www.mojuk.org.uk/MOJUK%202013/Basic%20Regime.html
[46] An accredited offending behaviour programme that addresses thinking and behaviour associated with offending with the objective of reducing general reconviction rates.
[47] Cognitive behavioural therapy informed offending behaviour programme which aims to improve outcomes related to violence in adult males who are of medium risk of offending.
[48] Depot medication is an injection of slow-release antipsychotic medication.

addition, the police were to contact all his ex-partners and make them aware of his imminent release.

4.185 H did not attend the appointment with consultant psychiatrist 2 planned for 6 November 2018. He was noted to be non-compliant with medication, but his mental health was stable. There had been no reports of him confronting others.

4.186 A peer mentor tried to engage with H on 7 November 2018, but H declined.

4.187 On 7 November 2018, the contact details for PO2 were shared with children's services.

4.188 H was due for release to Elliott House AP on Friday 9 November 2018. MHIT Practitioner 4 was to see him before his release to ensure that his mental health was stable and there was an appropriate discharge plan in place.

4.189 H did not attend a planned appointment with MHIT Practitioner 4 on 8 November 2018.

4.190 The police OM created a police trigger plan for H on 8 November 2018. This was created to safeguard potential victims and to recall H to prison should he abscond from Elliott House AP. It included actions for Elliott House AP, the police contact centre and any allocated police resource. H's ex-partners had been contacted by the police and markers placed on their addresses.

Elliott House AP – 9 November 2018 to 24 December 2018

4.191 On 9 November 2018, the police OM met H and took him from the prison to Elliott House AP. They explained to H the role and purpose of MAPPA. In addition, they explained the conditions of his licence to him. H questioned them and was described as being "*somewhat*" in denial about his offending history, apart from one of the incidents with an ex-partner. H was questioned about his gang links, and he said he was not active.

4.192 H told the OM that he had not seen any professionals for his mental health while in prison and had no prescribed medication. It was noted that H appeared to be withdrawn at times.

4.193 Elliott House AP completed an AP induction with H the day he arrived at the premises. It was noted that H was not happy about the rules and regulations associated with his placement at Elliott House AP.

4.194 He was also seen at Elliott House, on 9 November 2018, by PO2. They went through H's licence conditions with him. H did not agree with a number of the conditions. He did not agree that he posed a risk to children or females in relationships. PO2 records that a "*heated debate*" took place and they agreed to disagree.

4.195 The Elliott House AP staff spoke to H and explained to him that the conditions would not last forever. The notes specify that H was "*a lot calmer this evening*."

4.196 The hostel regime was discussed with H again on 10 November 2018. However, H returned to the hostel seven minutes late for curfew. He said that he had been to see a member of his family, taken a different route back to the hostel and it had taken him longer than expected. He was reminded that he should contact the hostel if he thought he was going to break his curfew.

4.197 PO2 met with H at Elliott House AP on 12 November 2018 to go over the hostel rules and regulations. H said he was clear about the expectations. Following this meeting,

PO2 was told that H was making female staff at the hostel uncomfortable because of the way he was looking at them.

4.198 On 13 November 2018, the forensic community team gathered additional information about H from FTB and the GP. They also made arrangements for a joint appointment with the CMHT.

4.199 A safeguarding check, completed on 14 November 2018, confirmed that H had a link to a child previously known to Birmingham Children's Trust, but that the case was closed. A link to another child was also identified but there are no details available about this child or H's relationship with them.

4.200 H attended an appointment with PO2 at the probation office on 14 November 2018. He was not able to stay long; he said he had an interview booked at the Job Centre. He said that a family member had given him money for his taxi fare. PO2 challenged this because H said he had no contact with his family. H declined to identify the family member as his next of kin.

4.201 PO2 asked H if he had any issues with female staff in custody and H said no. PO2 said they were aware of concerns about his behaviour towards two female staff at the hostel. H stated the information was incorrect. When further challenged, H became agitated and accused PO2 of calling him a liar. H was noted to have become irritable and verbally challenging.

4.202 PO2 challenged H about his conduct towards them and stated they would not tolerate the way they were being spoken to. They suggested it would be better to have a change of probation officer and H agreed with this suggestion.

4.203 Following this meeting PO2 sent an email to staff at Elliott House AP. They confirmed speaking to H about his conduct towards female staff. H responded that he had no idea what they were talking about, that all the staff at Elliott House AP praised him on how well he is doing and that PO2 was the only one "*giving him attitude*".

4.204 The Elliott House AP staff had a follow-up conversation with H about the meeting with PO2.

4.205 A drugs test was completed on 14 November 2018; H tested negative for illicit substances.

4.206 Police intelligence checks completed at this time did not confirm a link between H and domestic abuse.

4.207 H returned to Elliott House AP with alcohol on 15 November 2018. He said he did not realise that alcohol was not allowed on the premises.

4.208 That day the police OM visited Elliott House AP. The staff disclosed that H was smoking cannabis and they believed he may have been dealing drugs. The OM met with H and advised him about his cannabis use and the suspicion that he was dealing drugs. He was warned that he was putting his bed at Elliott House AP at risk and could be returned to prison.

4.209 On 16 November 2018, H was late for curfew and the police were contacted at 7.40pm. They instigated the trigger plan. Five minutes later H returned to Elliott House AP; the police and management were informed of his return.

4.210 The following day H was not back at Elliott House AP at 7pm. Staff phoned him, and he said he was lost but would be back in 15 minutes. When he had not returned by 7.15pm the on-call manager for Elliott House AP was informed and it was agreed he

would be given until 8pm to return. H returned to Elliott House AP at 7.45pm; the on-call manager was informed.

4.211 H met with PO2 at the probation office on 21 November 2018. H was noted to be uncooperative in the appointment. On two occasions he had to be asked to remove the earpiece for his phone.

4.212 When asked if staff at Elliott House AP had spoken to him about his attitude towards female staff, He said they had. H said the staff had told him there was nothing to worry about and everything was all right. PO2 asked H if this was what the staff had said, and he confirmed it was.

4.213 PO2 asked H if he still had an issue with them, to which he replied yes. He confirmed that he wanted a change of probation officer. PO2 was to speak to the senior probation officer as the situation was unworkable if H would not engage.

4.214 On 21 November 2018, a case consultation (level 1) was attended by PO2, H's key worker from Elliott House AP and the psychologist from the OPD team.

4.215 The meeting reviewed H's circumstances. He had been released on licence to Elliott House AP. He had a diagnosis of schizophrenia and reported hearing voices. He was described as being quite guarded and reluctant to disclose information to staff. There were concerns about his cannabis use and him potentially bringing cannabis into the hostel to sell. At that time, he was not accepting medication for his mental health problems. It was also noted that there was a history of domestic violence against partners.

4.216 The meeting reviewed the previous formulation developed with PO1 while H was in custody. They discussed whether looking into peer mentorship may be helpful if H was suspicious and mistrustful of staff. In addition, they discussed being transparent and providing clear feedback as close to an incident of problematic behaviour as possible, in order to model honesty and transparency and to increase H's sense of trust in services.

4.217 The recommendations from the formulation from the AFFIRM completed on 19 April 2017 were reviewed. H could access a mental health awareness group at Elliott House AP. He had a licence condition to attend Change Grow Live[49] to address his substance misuse. H would be meeting with the forensic community team consultant psychiatrist working at the Elliott House AP the following day, so the meeting hoped further information would be available regarding support available to H.

4.218 On 21 November 2018 H failed to attend a GP appointment, despite Elliott House AP staff reminding him about the appointment twice.

4.219 H tested negative when tested for illicit substances on 21 November 2018.

4.220 On 22 November 2018, H attended an appointment with the forensic community team consultant psychiatrist and CPN. H engaged minimally in this appointment and would not provide any more information about the voices he was hearing beyond saying "*the usual*."

4.221 The forensic community team consultant psychiatrist's impression from this appointment was that H had a well-established diagnosis of paranoid schizophrenia, there was some evidence of positive symptoms, and he was not taking any medication. There were no acute concerns about an elevated risk to self or others, and his history of violence was in the context of acquisitional offending.

[49] Change, Grow, Live are a national health and social care charity, set up to help people with challenges including drugs and alcohol, housing, justice, health and wellbeing n https://www.changegrowlive.org/

4.222 The plan from this appointment was to liaise with the CMHT and to restart medication. The GP was to be asked to complete baseline bloods and an electrocardiogram (ECG).

4.223 H did not discuss his mental health problems with the GP when he attended for an initial screening appointment.

4.224 H tested positive for cannabis when tested for illicit substances on 24 November 2018.

4.225 H did not return to Elliott House AP for 7pm on 26 November 2018, H had called shortly before his curfew time to say that a family member was in hospital, and he was currently walking back.

4.226 This was discussed with the on-call manager, and it was agreed to give H until 8pm before activating the trigger plan. H returned to Elliott House AP at 7.45pm and the on-call manager was informed about his return.

4.227 On 27 November 2018 H failed to attend a key worker session at Elliott House AP and the plan was to issue a warning letter.

4.228 On 28 November 2018 Elliott House AP requested feedback from the CPN about the appointment on 22 November 2018.

4.229 They were told, "*It was difficult to get him out of bed but did attend eventually. His engagement throughout was very minimal and often answered with just a few grunts*."

4.230 H had been offered medication to help him with his auditory hallucinations, but he refused it stating he would look at it when he saw his own doctor with his CMHT.

4.231 The GP was aware of the future CMHT appointment and had said they would ask the CMHT to see H sooner due to his current condition and his reluctance to take medication.

4.232 The Elliott House AP told the CPN that the manager was planning to issue a warning for not attending a key appointment. His trigger plan had been activated once but as H had returned to Elliott House this had been cancelled.

4.233 The AP warning letter was issued.

4.234 On 28 November 2018 there was a three-way meeting between PO2, Elliott House staff and H. The Elliott House AP staff provided clarification that they had asked PO2 to speak to H about his behaviour towards female staff. H accepted this but remained unhappy with the way PO2 had spoken to him.

4.235 H said he understood his licence conditions when police explained them to him and the issues around non-contact with the named females but said he did not understand why PO2 was saying he was a danger to women when the women identified in his licence were phoning him.

4.236 H added it was only PO2 who had a problem with him. He also said that PO2 asked him a question and when he replied, they would ask him the same question again as if he was a liar. H did not like the way PO2 spoke to him, no one else spoke to him that way and he said that they were the only probation officer he had not got on with. H made it clear that he would not continue working with PO2. PO2 said they did not want to continue working with H and it would be in the interest of his mental wellbeing if he was reallocated.

4.237 On 28 November 2018, a gold chain with a broken clasp was found in H's bedroom.

4.238 The police OM visited Elliott House the following day. They were informed by Elliott House AP staff that H had been late for curfew four times. This was discussed with H; he was advised to make better choices. H asked for a curfew extension, he was told this would not be supported because of the breaches. His positive test for cannabis was discussed with him, and he was told this could result in his recall to prison.

4.239 PO2 completed an OASys for H on 30 November 2018. This had initially been completed on 26 November 2018 and was returned to PO2 by their line manager for amendments. It was resent on 29 November 2018 and countersigned by the manager on 30 November 2018.

4.240 H tested positive for cannabis on 1 December 2018.

4.241 The Elliott House AP notes for H identify that he had an appointment booked with Erdington CMHT for 14 December 2018. They report that H claimed to hear voices most days and was staying in his room to combat them. He was said to feel uncomfortable when he left his room. He told staff he was occasionally taking a friend's olanzapine prescription. He was due to see the forensic community team consultant psychiatrist the following week, and staff were to get him up in time for the appointment.

4.242 The police OM visited Elliott House AP on 6 December 2018 to see H. H would not meet with them, and he said he was hearing voices. Elliott House AP thought the voices were being used to avoid meetings and appointments he did not want to attend.

4.243 On 6 December 2018, the CMHT care coordinator arranged an appointment with H for 14 December 2018. This appointment was also with the CMHT consultant psychiatrist. Details of the plan for this appointment were shared with the forensic community team.

4.244 H was allocated to PO3 on 7 December 2018.

4.245 The CMHT care coordinator contacted Elliott House AP on 7 December 2018 and confirmed that H had an appointment with them on 14 December 2018.

4.246 H requested that his signing in and curfew be reviewed because he had been at Elliott House AP for a month. He was told that this would need to be discussed with his probation officer.

4.247 H tested positive for cannabis on 7 December 2017.

4.248 On 10 December 2018, H was issued with a warning by Elliott House AP for playing loud music. He also tested positive again for cannabis.

4.249 H was 29 minutes late for his curfew on 11 December 2018. He was 30 minutes late for curfew the following day.

4.250 On 13 December 2018, there was a case discussion between PO3 and the police OM. Both agreed that the current signing in and curfew conditions should apply to H. Should H be compliant with these conditions, consideration would be given to the restrictions on his licence being relaxed.

4.251 They discussed the ongoing issues with H not wanting to take his medication and not attending appointments because he said he was hearing voices. They thought that while hearing voices might be genuine, H did use them as a deflection to avoid issues.

4.252 It was noted that H had been cooperative with the police, but this was not the same for the other agencies involved with him. They noted that there may be issues with H when working with female officers.

4.253 H attended an appointment with the forensic community team consultant psychiatrist on 14 December 2018. In the appointment H said he was fine; his mental health was the same as usual. He said he had been hearing voices for about seven years but was reluctant to discuss them in any detail. He denied any thoughts of harming others but did say that he got angry towards others. He was open about his paranoid thoughts, he thought that everyone was probably out to get him.

4.254 He said he had been taking a friend's aripiprazole and using cannabis. The consultant's impression was that his presentation was the same as it had been in the previous appointment.

4.255 The plan from this appointment was for the forensic community team from BSMHFT to liaise with the CMHT about prescribing for H, because he was not willing to accept a prescription from the forensic community team. The forensic community team was to ensure that H attended the planned appointment with the CMHT the following day and to arrange a joint appointment with the CMHT care coordinator.

4.256 H tested positive for cannabis on 13 December 2018. There was also a strong smell of cannabis coming from his bedroom that evening.

4.257 The police OM visited H at Elliott House AP on 13 December 2018. They discussed the amount of time H was spending in bed, he was not getting up until 1pm. H said the voices he was hearing had not changed in their nature or level. H said that he had been prescribed medication. No other issues were discussed with H.

4.258 H was late for his appointment with the CMHT care coordinator and the CMHT consultant psychiatrist on 14 December 2018 at the CMHT base. He had been involved in an altercation with some youths at a bus stop. He believed that they were talking about him and approached them. He denied that he had been aggressive and attacked them. He said they had pulled a knife on him, and his trousers had a slash/rip in them, although his skin was not broken.

4.259 At this appointment H accepted a prescription for a 28-day supply of aripiprazole 10mg. The local pharmacy was out of stock and the Elliott House AP were asked to check if he had obtained some from another pharmacy. The CMHT care coordinator made an appointment to see H in two weeks' time and the CMHT consultant psychiatrist was to see him in three months.

4.260 The CMHT care coordinator provided feedback to the Elliott House AP staff about the appointment. They said that H presented as unsettled, hearing voices and seeing shadows. He had been reluctant to accept medication but had taken a prescription for aripiprazole 10mg. In the call they discussed one of the occasions that H had returned to late to the hostel. H had told that staff that this was because he had been involved in a fight with two unknown men who had pulled a knife on him. The hostel staff agreed to update the care coordinator on the Monday about H's medication.

4.261 H was offered a further appointment with the CMHT care coordinator for 28 December 2018. The CMHT care coordinator intended to continue their assessment of H and his mental health needs.

4.262 H returned to Elliott House 10 minutes late for his curfew on 14 December 2018.

4.263 On 15 and 16 December 2018, there was a strong smell of cannabis coming from H's bedroom.

4.264 H had not collected his prescribed medication by 16 December 2018 but planned to collect it the following day.

4.265 H requested home leave over Christmas and PO3 left a voicemail for the person he would like to stay with while on leave.

4.266 On 17 December 2018, H was asked to hand in his prescribed medication to Elliott House AP staff. He said he did not know he was required to do this and had taken some of the medication.

4.267 There was an incident at Elliott House AP involving H on 18 December 2018. He returned to the hostel through a back entrance and did not sign in. He later left the building without signing out. When he returned, staff spoke to him and reminded him about the requirement to sign in and out of the building.

4.268 Following this the staff noticed a lot of paperwork on the floor in the foyer, which had come from the noticeboards. A review of CCTV footage showed H disrupting the paperwork. When challenged about this he said he "*didn't know*" about it.

4.269 On 18 December 2018 there was a strong smell of cannabis from H's bedroom.

4.270 The police visited the home of one of H's ex-partners on 18 December 2018 because it was close to the address, he proposed to go to for home leave. The police were told that since H's release he had been seen riding a bicycle past the address.

4.271 The police determined that the property proposed for H's home leave over Christmas was not appropriate because it did not have a telephone landline to support the monitoring of his curfew.

4.272 Later that day the police OM visited Elliott House AP and spoke to H. H said he smelt of cannabis because he had smoked a spliff at 3pm. H talked about having taken his medication but said he did not want to take it because it made him sleepy. However, he said it was helping him with the voices. H was not responsive when told his leave might not be possible.

4.273 Following this the police OM sent an email to PO3 and Elliott House AP stating that the address provided for home leave was not appropriate. Probation agreed with this assessment and did not approve home leave.

4.274 H tested positive for cannabis on 19 December 2018.

4.275 The forensic community team consultant psychiatrist was to see H on 20 December 2018 and PO3 asked the Elliott House AP staff to make sure he got up and attended the appointment. The staff made several attempts to get H up, but he would not respond when they knocked on his door. H did not attend the appointment.

4.276 Later on, 20 December 2018, the manager of Elliott House AP sent an email to PO3 questioning H's suitability to remain at Elliott House AP. They said that H was not engaging with mental health services, and he was not complying with the hostel rules. H was to be given one more opportunity to comply or his bed at Elliott House AP would be withdrawn.

4.277 Also on 20 December 2018, the police OM replied to an email from PO3 about H smoking cannabis, failing to hand in his medication and general non-compliance. PO3 wanted to know what compliance action was being considered, as it appeared the bed at Elliott House AP might be withdrawn.

4.278 A welfare check was completed at Elliott House AP at 11.21pm on 20 December 2018, H was not on the premises.

4.279 H was issued with a licence warning letter on 21 December 2018 about his use of cannabis. On 21 December 2018 at 11pm a warning was issued by Elliott House AP to H because he was playing loud music in his room.

4.280 On 22 December 2018 H tested positive for cannabis and Elliott House AP staff referred H to PO3 for enforcement action. The following day there was a strong smell of cannabis coming from H's room.

4.281 The duty officer at Elliott House AP contacted the on-call manager on 23 December 2018 because H had not returned by his curfew time. They noted that H was being managed at MAPPA level 2 and had a 15-minute trigger plan in place and that there had been come previous compliance issues.

4.282 At 7.20pm the decision was taken to initiate recall. This was because of H's risks and his continued non-compliance with Elliott House AP rules.

4.283 At 8.34pm H contacted Elliott House AP. He said that his curfew had been extended to 11pm for the 23 and 24 December 2018. The staff checked and there was no evidence available about this agreement. The decision was taken to process H's recall to prison.

4.284 At 8.51pm H was at Elliott House. He had jumped over the back fence and let himself in through the back door. H was asked to put his bike in the shed, but he said he was going out again because his police OM had authorised for him to stay out until 11pm. Against the advice of staff he left Elliott House AP on his bike at 8.55pm.

4.285 This breach of curfew resulted in H being recalled to prison on 24 December 2018 and returned to prison on 25 December 2018.

4.286 The forensic community team consultant psychiatrist completed a discharge summary for H on 27 December 2018 and sent a copy to the CMHT and HMP Birmingham MHIT.

HMP Birmingham – 24 December 2018 to 24 January 2019

4.287 Once back in custody, H was processed through reception at HMP Birmingham on 26 December 2018. His diagnosis was recorded as paranoid schizophrenia and bipolar disorder. His prescribed medication was aripiprazole 5mg.

January 2019

4.288 The HMP Birmingham MHIT received a referral for H from forensic community team and the resettlement team[50] on 2 January 2019. H was seen on the wing the following day. The wing staff reported having concerns about H. He would not associate with other prisoners when his cell was unlocked, and he was not attending to his personal hygiene. The practitioner noted that a probation risk assessment completed on 30 November 2018 stated that, "*H has been diagnosed with paranoid schizophrenia. He has been prescribed aripiprazole but is not taking any medication*."

4.289 PO3 made an entry on NDelius on 4 January 2019. This identified that H had been seen the previous day for basic custody screening. H declined all prison training and employment opportunities offered to him. He also declined a referral to the prison resettlement service. The prison staff had been made aware of H's risk to females, including inappropriate comments and looking at female staff inappropriately.

4.290 Elliott House AP sent a discharge summary to the MHIT on 4 January 2018. It identified that H had been difficult to engage with, was hearing voices and

[50] Birmingham Prison has an active resettlement unit which helps prisoners with housing, benefits and employment issues supported by staff from Job Centre Plus and Citizens Advice. https://www.gov.uk/guidance/birmingham-prison

experiencing other psychotic symptoms. H had been restarted on medication, aripiprazole. He had also exhibited some bizarre behaviour while at Elliott House AP, e.g., ripping things off the noticeboard. He had been recalled to prison for a breach of his curfew, and he had also tested positive for cannabis. The plan from this discharge summary was for follow up by the MHIT and for H to re-engage with the CMHT on release from prison.

4.291 A further referral to MHIT was completed by the prison resettlement team on 4 January 2019.They noted that it had been difficult to speak to H because there was a prison officer close by, due to H's risk to female staff. Since his admission to HMP Birmingham, H was still not mixing with other prisoners or attending to his personal hygiene. As part of the referral, they shared the probation risk assessment completed on 30 November 2018. In this H was described as:

- having a diagnosis of paranoid schizophrenia;
- not taking his prescribed medication;
- presenting as paranoid;
- hearing voices telling him to kill people and one relating to rape;
- being aware that the voices were not real;
- his voice being exacerbated by stress; and
- using cannabis and this having a detrimental effect on his mental health.

4.292 H was seen by a MHIT practitioner on 7 January 2019. However, H would not engage with the appointment, and he said he did not want to engage with mental health services. He said he did not want to see a psychiatrist. He said that he was hearing voices but that they were getting better, and he could control them. He would not disclose what the voices were saying to him. At that time, he did not want to mix on the wing. He was given another appointment for 23 January 2019.

4.293 A CPA review was completed for H on 14 January 2019. H continued to be reluctant to engage with services, but there were no overt signs of mental health issues observed, and H was willing to take medication when he needed it. H was not willing to attend appointments at the MHIT CPN clinic and he did not want to be monitored on the wing. He wanted to be left alone.

4.294 H did not attend an appointment at the MHIT CPN clinic on 23 January 2019.

4.295 HMP Birmingham provided HMP Stoke Heath with notes about H, which were reviewed by MHIT Practitioner 2.

HMP Stoke Heath – 24 January 2019 to 12 September 2019

January 2019

4.296 At reception screening on arrival at HMP Stoke Heath, H was identified as experiencing an ongoing episode of paranoid schizophrenia. He was prescribed aripiprazole, which was recorded as in-possession. It was also recorded that he was taking his medication.

4.297 H was seen by his prison key worker in his cell on 26 January 2019. He remained under his bed covers and was unresponsive when spoken to.

4.298 H was discussed by the MAPPA panel on 29 January 2019. He was being managed on MAPPA level 2. The meeting was attended by the National Probation Service, West Midlands Police, CPN1 from the prison discharge service from BSMHFT and victim liaison officers. The MAPPA panel noted that H had a new probation officer (PO3) and he had been recalled to prison. However, this panel was told that PO3 was aiming for a further release in 2019 and a bed had been reserved for H at Elliott House AP. CPN1 from the prison discharge service from BSMHFT was to liaise with HMP Birmingham for an intervention and medication plan. H was to continue to be managed at MAPPA level 2 until April 2019. A six-month review period was requested.

4.299 There was no prison service representative or report available for this meeting. Nor was any information available from the MHIT. This was because H had moved prisons between the invitations being sent out and the date of the meeting,

4.300 On 30 January 2019, the prison OM made a referral to the St Giles Trust. H had been no fixed abode when he came into prison, and he required support to find accommodation.

4.301 The probation OASys assessment completed following his recall, identified that Probation assess H as presenting a high risk of serious harm.

4.302 On 31 January 2019, H was seen in the wing by the MHIT Practitioner 2. H repeated that he did not wish to engage with mental health services, and he did not want to see a doctor. His voices were getting no better, but he could deal with them and control them.

4.303 H told the practitioner that he did not want to mix on the wing because of what the noises on the wing did to his head.

4.304 It was noted that H was under the care of a CMHT in the community and was subject to CPA.

4.305 The plan from this appointment was to monitor for signs of relapse and medication compliance. He was placed on the waiting list for the health care clinic.

February 2019

4.306 On 1 February 2019, the forensic community team shared information about H with the Trust discharge planner and the CMHT care coordinator. This was to support the management of H under the MAPPA process (see Section 9 of this report for further information). There was a request for the CMHT care coordinator 1 to liaise with HMP Stoke Heath mental health services about H.

4.307 On this date the MAPPA CPN also shared information with HMP Stoke Heath about H's clinical need and medication, and they provided the contact details for the CMHT. They also updated the CMHT care coordinator 1 about H's whereabouts and the plan for him.

4.308 In the next few days there were a number of incidents on the wing:

- H misused his cell bell;
- H refused to attend for work;
- H tried to hide and run away from staff during lock up;
- H did not follow instructions from prison staff at lock up; and
- H caused damage to his cell.

4.309 H's prison key worker met with H on 5 February 2019. He was on basic regime because of these incidents. The key worker described H as not being motivated to engage with them.

4.310 H attended an appointment with MHIT Practitioner 2 on 5 February 2019. He was distant and dismissive. His television had been taken away because of incidents on the wing, and he wanted this to be returned and to be excused work and education. H made threats to harm himself if he did not get his television back. H said that there had been trouble with other prisoners the last time he was in HMP Stoke Heath, and he just wanted to keep his head down and get transferred to a category D prison. In England and Wales, prisons are organised into four categories, A to D. Prisoners are detained to a category based on their risk of escape, the risk of harm to the public should they escape and the threat they present to the control and stability of the prison. HMP Stoke Heath is a category C prison. Category C prisons are closed prisons for prisoners who the staff think will not escape but the prisoner cannot be trusted in an open prison. Category C prisons are training and resettlement prisons; most prisoners are located in a category C. They provide prisoners with the opportunity to develop their own skills so they can find work and resettle back into the community on release. Category D prisons are open prisons for prisoners who can be reasonably trusted not to escape.

4.311 MHIT Practitioner 2 noted that they had known H for some time and had not witnessed clear evidence of acute psychosis, and that H rarely spoke about his symptoms and did not appear to be distracted or responding to unseen stimuli. The plan from this appointment was for an ongoing assessment.

4.312 H wrote to PO3 on 7 February 2019 asking for a move to a prison with open conditions.

4.313 The following day PO3 and H's police OM went to HMP Stoke Heath to see H. H refused to leave his cell to meet with them.

4.314 A referral was made for a forensic assessment for H on 13 February 2019. But this referral did not result in a forensic assessment being completed.

4.315 H was seen by MHIT Practitioner 2 on 25 February 2019. H appeared to be disgruntled and did not want to engage or talk. His reported problems with other prisoners had been investigated by the prison staff, but there was no evidence to support his allegations.

4.316 The goals from this appointment were to maintain H's mental health, improve his ability to function in the prison environment, for H to gain some insight into his mental health issues and for his mental state to be monitored.

4.317 H agreed to engage with relapse prevention work to identify his mental health relapse indicators. He was reluctant to engage with the team, but he was taking his medication.

4.318 H was to remain under the care of MHIT Practitioner 2 until April, when another provider was taking over the service provision. The CPN was responsible for CPA, regular appointments and medication reviews. They were also to liaise with the community CMHT prior to H's release from prison to ensure that there was a package of care in place.

4.319 On 28 February 2019, the CMHT care coordinator 1 requested an update from the MHIT.

March 2019

4.320 H declined to attend an appointment with MHIT Practitioner 2 on 4 March 2019. However, the practitioner saw him on the wing on 5 March 2019 when H was collecting his medication. At this time, it was reported that H was having little contact with wing staff. He was asking for a transfer to another prison because the last time he was in HMP Stoke Heath he had assaulted a prison officer. He said he was hearing voices, but he was not distressed or observed to be responding to unseen stimuli.

4.321 The plan was for the MHIT to assertively follow up with H if he did not attend planned appointments with the team. They were to ask the CMHT care coordinator 1 to provide care plans, risk assessments and a summary of care.

4.322 MHIT Practitioner 2 was moving to another role (the provider of the service was changing at the beginning of April 2019) and there was a plan for a robust transfer of care to a colleague.

4.323 On 9 March 2019, the prison authorities suspected H of being in possession of a mobile phone.

4.324 H did not attend an appointment with MHIT Practitioner 2 on 19 March 2019. The practitioner completed a risk management plan. This identified H's historic risk. This management plan included the following information:

- 2011/12 comments about thoughts to kill his family and rape his sister. His hostility to prison staff and two clinicians.
- There had been no suicide attempts or self-harm, but H had banged his head on purpose and in 2012 he punched a wall and broke his hand.
- H had no current thoughts of self-harm, but this could change suddenly.
- HMP Dovegate had often reported injuries from fighting.
- H had a history of sexually disinhibited behaviour, but this had not been fully explored.
- H's offences had involved a rifle, a shotgun and larger firearm discharge.
- He had been found in possession of a knife.

4.325 H submitted a complaint to the prison authorities on 20 March 2019 that he was suffering from paranoid schizophrenia, bipolar, depression and anxiety and being in prison was affecting his mental health. He was also unhappy that he was not in the parole process. He said prison officers were worried about him not coming out of his cell. In addition, he disclosed he had hit a wall in 2018 and broken his knuckle.

4.326 The response planned was for the prison offender management team to look into H's request for transfer, and for officers to speak to him about hitting the wall.

4.327 A close family member of H was detained to HMP Stoke Heath, and the prison authorities suspected that during association on the wing there had been some drug use.

4.328 A medication review was completed on 25 March 2019 by consultant psychiatrist 2. H was not compliant with his prescribed oral medication and the plan was to see him in clinic to consider a depot.

4.329 The MHIT Practitioner 3 was introduced to H on 26 March 2019. They noted that there were care plans and a risk plan in his notes. H had made a complaint about the prison and asked for a transfer. At this time, he had no thoughts of self-harm. He had

attended the dispensary hatch for his medication the previous evening, but none had been available.

4.330 H's release date was updated to 22 April 2020 on 28 March 2019.

4.331 The prison authorities noted concerns about H's mental health on 28 March 2019.

April 2019

4.332 MHIT Practitioner 3 saw H on the wing on 2 April 2019. H was requesting an increase in his medication dose because he felt his voices were becoming more intense. He said he would attend an appointment with the psychiatrist if one was made for him. He continued to request a transfer to another prison. The plan was for MHIT Practitioner 3 to meet with H the following week.

4.333 H had contact with prison staff on 3 April 2019. H did not engage well during the contact. He was upset at being in HMP Stoke Heath. The staff tried to encourage H to come out of his cell more. However, he said he preferred to remain in his cell to reduce the chance of getting into trouble.

4.334 H submitted a second complaint to the prison authorities on 8 April 2019. He felt his mental health was getting worse and this could have a lasting effect on his wellbeing. He said he had made numerous requests for a transfer and his mental health was deteriorating because of this.

4.335 H was seen in his cell by MHIT Practitioner 3 on 9 April 2019. H had not been taking his medication, although he had attended the dispensary hatch the previous evening. He said the prison officers were not always letting him out of his cell to collect his medication. He was given advice about how to manage the situation and reminded about the importance of his medication. H was given an appointment with the consultant psychiatrist 1 for 18 April 2019, and he said he would be happy to attend.

4.336 On 10 April 2019 H's cell was searched and a weapon was found. He had sharpened a toilet brush handle to a point. H was given an exceptional downgrade and placed on basic regime.

4.337 There were emerging concerns about H, and he was discussed at the MHIT MDT meeting on 11 April 2019. He was asking for an increase in his medication dosage, but this was not supported by his behaviour of poor compliance. There were reports from the wing that he was carrying weapons, had delusional thoughts and that his paranoia was increasing. The plan was for the MHIT consultant psychiatrist to complete a review with H and for the team to exercise caution around him.

4.338 On 12 April 2019, the prison authorities suspected that H had formed a group and was involved in bullying on the wing.

4.339 H was abusive to the prison staff on 14 April 2019 and the evening meal was delayed because of his actions. H was cautioned about the consequences of his behaviour.

4.340 H was discussed at the MAPPA meeting on 16 April 2019. There was no update about H from prison services or the MHIT. CPN1 from the prison discharge service did not make a record of this meeting in H's clinical notes.

4.341 The Parole Board had refused release before sentence end date, as such he would be released at sentence end date without any supervision by probation. The only other avenue would be via a request for executive release via the Public Protection Casework Section but as Probation assessed that his risk could not be managed safely in the community this application was not made. Clearly however, if H could not be released early because his risk could not be managed safely in the community, then this implies that when he was eventually released at Sentence End

Date, that his risk remained at this level. As part of the MAPPA review meeting, PO3 stated that a further period on licence would be more suitable for H than being released without restrictions, and thus he would arrange a further visit to offer a further opportunity for H to re-engage. If he did, then an Executive release could be considered as a means for him to be released on a further period of licence. However, the MAPPA meeting acknowledged that H's previous engagement had been poor in a community setting.

4.342 H continued to submit complaints about being in prison and ask for a transfer. He said his mental health was worsening, and he thought he might harm someone if he left his cell. He wanted to transfer to a different prison or to be put into seclusion for the safety of others. He had recently been downgraded to the basic regime for possession of a bladed article (a sharpened toilet brush) and he threatened that someone would get hurt because he was tired of trying to control his mental health by himself in prison.

4.343 A member of staff from MHIT went to the wing on 18 April 2019 to encourage H to attend the appointment with the consultant psychiatrist 1, but H refused. During the meeting H lay on his bed with a towel over his head, which he only lifted to identify who had entered his cell.

4.344 Consultant psychiatrist 1 reviewed the information available about H and the plan was for the team to continue to support H, assess his mental state and encourage him to take his medication. They were told to book another appointment with consultant psychiatrist 1 for H if needed "*even at short notice*". H's aripiprazole was increased to 10mg at his request.

4.345 An alert was put on SystmOne on 23 April 2019 that no lone female should work with H.

4.346 On 23 April 2019, the prison authorities noted that H's mental health was deteriorating, he was requesting a prison transfer and he would not come out of his cell because he might hurt someone.

4.347 H was seen in his cell by MHIT Practitioner 3 and an occupational therapist on 25 April 2019. He was on his bed, under a duvet and would not lift the duvet to engage with the staff. He said mental health staff would not help him and that he wanted a transfer to another prison. He was encouraged to take his medication and he was told to tell the wing staff if he wanted to see anyone from the mental health team and they would come to see him.

4.348 The feedback from wing staff was that members of the same Birmingham gang that H was associated with had been moved off the wing. H denied carrying a weapon on the wing and was waiting for adjudication.

4.349 MHIT Practitioner 3 had not been able to complete a full mental state assessment and they were to try again at a later date.

4.350 The plan from this was to review H's mood and mental state at least once a week. He was to remain on the primary care key workers caseload for joint working with the secondary care mental health team.

May 2019

4.351 At the beginning of May, the wing staff told the MHIT they thought H was improving, he was interacting with staff and had asked to be the wing cleaner. MHIT Practitioner 2 attempted to see H on the wing twice but was not able to because of issues on the wing.

4.352 H was seen on the wing by his prison key worker on 7 May 2019. H was more talkative than usual but still said very little.

4.353 When MHIT Practitioner 3 saw H in his cell on 14 May 2019 he was again on the bed, under a duvet with the lights off. He said he had been fine since the last time he had been seen, but there had been no change in his mental health and his answer about taking his medication was unclear. He said that he did not need to see a psychiatrist.

4.354 The wing staff reported that his behaviour had been inconsistent. One day he would come out of his cell and speak to people, and then the next day he would not speak to anyone. In the main he had limited interaction with others. MHIT Practitioner 3 tried unsuccessfully to get information from security about the weapons found in H cell. MHIT Practitioner 3 checked H's medication chart and found he had taken five doses of medication in the previous 13 days. The practitioner planned to discuss H with the MHIT.

4.355 On 16 May 2019, the MHIT MDT discussed H and the concerns about his presentation and non-compliance with medication. Following this, consultant psychiatrist 1 went to see H, but he declined to see them. He was to be offered another appointment, was to be subject to regular review and encouraged to take his medication.

4.356 On 17 May 2019, the prison security team shared information with MHIT about the weapons found in H's cell – two sharpened pieces of plastic.

4.357 H was seen on the wing by MHIT Practitioner 3 on 20 May 2019. H said he was okay and was taking his medication. However, the medication chart indicated that he had not been collecting his medication. H was not able to explain why he had refused to see the psychiatrist and said to tell them "*not to bother again*." He said he did not want to see MHIT Practitioner 3 either.

4.358 The plan from this was to discuss H at the Prison Safety Intervention Meeting (SIM)[51] to see if a Challenge Support and Intervention Plan (CSIP)[52] would be appropriate.

4.359 H was discussed at the MHIT MDT meetings on 21 and 23 May 2019, where a need to continue with a longitudinal assessment was identified and a CSIP referral was completed and submitted by MHIT Practitioner 3.

4.360 H would not engage with MHIT Practitioner 3 when they visited him on the wing on 30 May 2019. Again, H was under his duvet, and he rolled away from MHIT Practitioner 3. H would not answer any of the questions put to him. He was told about the concerns for his mental health and that this could get worse if he did not take his medication. The safeguarding team were contacted for feedback on the CSIP referral, but the key worker was unable to get a reply. The plan from this meeting was for a joint visit with the consultant psychiatrist on the 4 June 2018

June 2019

4.361 H refused to see MHIT Practitioner 3 and consultant psychiatrist 1 on 4 June 2019. The psychiatrist noted that they were familiar with H, having first met him when he was in HMP Brinsford, and they had reviewed his notes and assessments on SystmOne. H had an established diagnosis of paranoid schizophrenia. He had previously been prescribed olanzapine, but this had been changed to aripiprazole

[51] A multidisciplinary safety risk management meeting, chaired by a senior manager. https://pogp.hmppsintranet.org.uk/wp-content/uploads/2021/07/SIM-meeting-2.pdf

[52] Used to manage prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews.

because he was complaining of sedation. However, he had been taking his medication intermittently and had not been compliant for several weeks.

4.362 There were concerns about H's mental health, and he was only coming out of his cell occasionally.

4.363 H had turned away when consultant psychiatrist 1 entered his cell and it had not been possible for the psychiatrist to determine if H was psychotic or not, nor was it possible to complete an assessment of his risk.

4.364 H was discussed in the MHIT MDT meeting on 6 June 2019. A letter was completed for HMP Birmingham healthcare in case it was needed. It was agreed that the Assessment, Care in Custody and Teamwork (ACCT)[53] process would be started to monitor H, although when the team checked a CSIP had been opened.

4.365 A nurse from healthcare saw H in his cell on 8 June 2019 when he was vomiting. He was advised to attend healthcare should his condition worsen.

4.366 H was reprimanded by the prison staff on 8 June 2019 for the misuse of his cell bell.

4.367 H was seen again by a nurse from healthcare in his cell on 9 June 2019 when he was complaining of shortness of breath and feeling sick. H was requesting an inhaler for his asthma. He was provided with a prescription for an inhaler the following day. He was advised to ring his bell or report sick the following morning if he felt unwell.

4.368 H was discussed at the prison Safety and Intervention Meeting (SIM)[54] on 11 June 2019, this was attended by MHIT Practitioner 3. A Challenge, support and intervention plan (CSIP)[55] had been opened. It was noted that H had taken two doses of his medication and had submitted a complaint form requesting an alternative medication.

4.369 A member of prison staff visited H on 12 June 2019 to open a CSIP, but he would not engage with them. H said he was not taking his prescribed medication because of the way it made him feel and the side effects. He requested a prescription for olanzapine. This information was shared with MHIT Practitioner 3 who said that they would go to see H on the wing with consultant psychiatrist 1.

4.370 On 12 June 2019, the prison staff told the MHIT that H was not taking his medication, he was complaining about the side effects and asking for olanzapine.

4.371 The following day he was discussed by the MHIT MDT, which was attended by consultant psychiatrist 1, and a prescription for olanzapine 10mg was provided. consultant psychiatrist 1 agreed to see H "*as and when requested*".

4.372 H was seen by MHIT Practitioner 3 on the wing on 14 June 2019. He agreed to take the olanzapine. He was asking for a prison transfer because the officer he had hit last time he was detained in HMP Stoke Heath was now his prison OM.

4.373 H requested to see MHIT Practitioner 3 on 17 June 2019. He was lying on his bed, with his head under a towel, in the dark. He said he had been taking the olanzapine for three days and it was not working. He asked for a sleeping tablet. The practitioner

[53] Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm. https://www.gov.uk/government/publications/the-assessment-care-in-custody-and-teamwork-process-in-prison-findings-from-qualitative-research

[54] Weekly meeting to discuss and review all violent incidents, and prisoners (perpetrators and victims) subject to a Challenge, Support, and Intervention Plan.

[55] CSIP is used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence. Mandated since November 2018. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/05/Glossary_website-1.pdf

agreed to ask the prison GP to provide zopiclone 7.5mg for three nights. The practitioner noted an improvement in H, he was engaging with staff and complying with his medication. The plan was to discuss H at the HMP Stoke Heath Integrated Care (SHIC) mental health MDT.

4.374 MHIT Practitioner 3 was not able to see H when they visited the wing on 26 June 2019 because the wing was in lock down. The wing staff had no concerns about H, he had been leaving his cell more often and was not subject to an ACCT. It was reported that he had taken his prescribed olanzapine for 12 consecutive days.

4.375 MHIT completed a secondary care mental health plan for H on 26 June 2019, this was to provide support with severe and enduring mental health problems by:

- engaging with the secondary care mental health worker and agreeing planned therapeutic interventions;
- getting H to attend physical health screening;
- providing H with information about his medication, why it was prescribed and the side effects;
- encouraging H to engage with staff and HAWKs[56] when he was feeling low in mood;
- encouraging H to refrain from using illicit substances;
- offering mental and physical health education and promotion and referring him to other healthcare organisations as appropriate;
- visiting H every 13 weeks, with an end date of 19 December 2019; and
- reviewing this plan on 26 September 2019.

July 2019

4.376 H was seen by MHIT Practitioner 3 on 2 July 2019. He was on his bed, in darkness and did not lift his duvet to answer questions. He said he was happy on his medication and declined to attend the appointment with the psychiatrist that day.

4.377 The CMHT care coordinator 1 asked the probation service for an update on H on 8 July 2019.

4.378 On 17 July 2019, H was given a wing cleaning job. His prison key worker noted that his mental health remained an issue.

4.379 Also on 17 July 2019, H was alleged to have been in possession of a weapon, with a plan to threaten a prison officer for keys and to bully other prisoners.

4.380 On 18 July 2019, intelligence within the prison resulted in H's cell being searched. The prison found suspected PS paper.[57]

4.381 A review of H's medication chart on 19 July 2019 showed H remained compliant with his medication. MHIT Practitioner 3 spoke to the wing staff who had no concerns about H and an appointment was booked for him to attend the clinic on 22 July 2019.

4.382 MHIT Practitioner 3 saw H on the wing on 22 July 2019. H was requesting a transfer to another prison. He stated that he believed this would be considered if he complied with his medication for one month. He said keeping him at HMP Stoke Heath was

[56] A peer support service.
[57] Paper impregnated with illicit substances.

making him worse. He said the olanzapine was no more effective than the aripiprazole, but he declined an appointment with the psychiatrist to discuss this.

4.383 On 29 July 2019 H approached MHIT Practitioner 3 and requested a referral to the gym. They agreed to this and discussed the benefits of this to his mental health.

August 2019

4.384 A bladed weapon was found in H's cell on 14 August 2019. The belief was that H and another prisoner planned to use the weapon to threaten a member of prison staff for their keys. He was subject to an exceptional downgrade and again placed on basic.

4.385 H was seen in the segregation unit by a worker from the PCMHT on 15 and 16 August 2019. H would not engage with the worker. He asked to see MHIT Practitioner 3 and was told they would be available the following week.

4.386 On 22 August 2019, H attended a clinic appointment with MHIT Practitioner 3. He was in the segregation unit at the time. H said that a knife had been found in his cell and the staff thought he was going to take an officer hostage. He denied this. He said he "*wanted out of jail*" but he denied any specific plan to harm anyone. He said that he was experiencing voices, but they were no worse. He felt his current medication was working and he did not want the dose increased. He declined a review with the consultant psychiatrist. H asked the practitioner to chase up his request for a transfer to another prison. Actions from this meeting were for MHIT Practitioner 3:

- to write a letter supporting H's request to transfer to another prison;
- to chase the referral to the remedial gym;
- to contact prison education allocations to see if H could have a place on either music or radio;
- to write a note for the segregation and reintegration unit (SRU) for adjudication, explaining H had been requesting a transfer to another prison for some time; and
- to meet with H again the following week.

4.387 MHIT Practitioner 3 noted that there had been a vast improvement in H's mental health and that it would be a good time for him to move to another prison.

4.388 H was discussed at the MHIT MDT meeting that day. He was noted to have responded well to the change in his medication and had engaged well with the team since the change.

4.389 On 19 August 2019, the prison authorities were concerned that H was receiving large amounts of outside payments.

4.390 On 21 August 2019 H was found with a television in his cell while on basic. His basic was then extended by seven days.

4.391 On 27 August 2019 MHIT Practitioner 3 checked H's medication charts. He found H had only taken five out of the 27 prescribed doses. They planned to see H the following week and discuss this with the MDT.

4.392 H attended the mental health clinic on 27 August 2019 without an appointment and was seen by MHIT Practitioner 3. H wanted help with his request for a prison transfer. When challenged about not taking his medication he said he did not want it. Encouragement was given to comply.

4.393 MHIT Practitioner 3 chased up the prison transfer request and remedial gym referral. Transfer paperwork for HMP Oakwood was to be resent and H was to start in the gym the following day.

4.394 H was next seen by MHIT Practitioner 3 for a planned appointment on 29 August 2019. His compliance with medication continued to be poor and H suggested that he was letting it all build up so that he could do something that would get him out of prison. He requested support from the key worker to move wings and suggested if he did not get moved, he might hurt a member of staff on the wing. The service had a new consultant psychiatrist (2), but H declined an appointment with them. Furthermore, he stated "*If I'm not transferred out soon. I am going to stop coming to see you*."

4.395 During this appointment, female MHIT practitioner 3 noted that they felt uncomfortable with H. They thought he was fully aware that if he did not take his medication, he would become unwell, and they were concerned about his risk to others. These concerns were shared with the wing and security. An incident report was completed, and an entry put in the healthcare observation book. There was a plan to discuss H at the MDT. The prison authorities identified the reports of H's behaviour towards the mental health staff as potential threats to harm staff.

4.396 Concerns about H were discussed at the MHIT MDT meeting on 30 August 2019, and it was agreed that a referral would be made to Reaside Clinic Medium Secure Unit (MSU) provided by BSMHFT.[58]

4.397 That day MHIT Practitioner 3 chased up H's request for a transfer to another prison. There was a possibility of a transfer to HMP Parc, but H would need to be mentally stable and compliant with his medication. MHIT Practitioner 2 was to discuss this with consultant psychiatrist 1 and review H at the beginning of the following week.

4.398 The HMP Stoke Heath MHIT attempted to contact the MHIT at HMP Parc on 10 and 11 September 2019, to complete a handover of care because H was due to transfer there on 12 September 2019.

September 2019

4.399 On 2 September 2019 H attended the mental health clinic without an appointment. He was seen by MHIT Practitioner 3. H said he was close to prison transfer and did not want anything to get in the way of this. It was noted that H appeared to be more relaxed, and the practitioner did not feel uncomfortable with him. H was encouraged to take his medication and he agreed to an appointment with the psychiatrist.

4.400 MHIT Practitioner 2 attended the prison SIM meeting on 3 September 2019. They provided the meeting with a summary of the current situation with regard to H.

4.401 H was reviewed by consultant psychiatrist 3 on 5 September 2019. He declined the offer of a referral for a psychology appointment. He was willing to continue with the prescribed medication, olanzapine 10mg. His risks to self were considered to be low and his risk to others medium. The outcome from this appointment was for H to be discharged back to primary care. However, MHIT Practitioner 3 was to keep H on their caseload and support him with anxiety management.

4.402 On 6 September 2019, MHIT Practitioner 2 noted that the referral to Reaside MSU was now not required because H was compliant with his prescribed medication.

[58] Reaside Clinic provides assessment, treatment and rehabilitation to service users with severe mental health problems who have committed a criminal offence or who have shown seriously aggressive or threatening behaviour. The service provides care through secure inpatient units and specialist community teams.

HMP Parc 12 September 2019 – 22 April 2020

September 2019

4.403 The HMP Parc Prisoner Offender Unit requested H's prison records when he was transferred. H had two outstanding adjudications when he was transferred to HMP Parc.

4.404 During his reception screening at HMP Parc on 12 September 2019, H self-reported a diagnosis of paranoid schizophrenia, which was controlled by medication. He was told about the mental health pathway should he require support. H said that he managed his own medication in the community and that he that he did not have a CPN or care worker. His admission medication was noted to be olanzapine 10mg and he was allowed to be in-possession.

4.405 An HMP Parc assisted living plan was completed for H on 13 September 2019 by a mental health nurse from the PCMHT (provided by G4S). This identified that H's mental health was stable, and he was compliant with his medication, but he would require support from a registered mental health nurse (RMN). It was also identified that he would require a care plan review on 13 October 2019 and 20 November 2020.

4.406 On 16 September and 17 September 2019, there were a number of emails between PO3 and the police OS. These identified that:

- H had been transferred to HMP Parc because of non-compliance issues;
- H had closed down any desire to engage with services; and
- PO3 was questioning if H should be held under Statutory Procedures for Public protection and to protect himself.

4.407 H was allocated a prison OS on 17 September 2019.

4.408 On 19 September 2019, H asked to be seen by mental health services but there was no information available on the system about him and the request was sent back.

4.409 The prison OM met with H on 24 September 2019. H would not engage with the OM. He said that he was aware he would be remaining in prison to sentence end and he was not willing to engage with anyone.

4.410 H was seen by a pharmacy technician on 24 September 2019 because he was not compliant with his medication. He went on to establish a pattern of non-compliance with his medication despite regular prompts from the pharmacy technicians.

4.411 HMP Stoke Heath MHIT Practitioner 3 was able to provide a verbal handover to the administrative support for the MHIT at HMP Parc on 30 September 2019. They followed this up with an email to the same member of staff. They entered the details of this email onto SystmOne.

4.412 They provided the contact details for H's care coordinator, community psychiatrist and CMHT in Birmingham. They also provided details about previous threats to staff, weapons, his gang life and that H had been difficult to engage. They informed the HMP Parc MHIT that H had requested a transfer because of gang related issue at HMP Stoke Heath. They told HMP Parc that H had occasions of poor compliance with medication and that this needed to be monitored.

October 2019

4.413 At the beginning of October 2019 an alert was placed on SystmOne about H's risk to women and advice was issued that there was to be no lone female working with H.

4.414 H was discussed at the MHIT MDT meeting on 1 October 2019. He was allocated two CPNs (CPN1 and CPN2) to work with him, CPN1 was to take the lead with H. The contact details for his home CMHT were included in the minutes of the meeting. A similar conversation took place at the MHIT MDT meeting on 8 October 2019. He was discussed again on 15 October 2019, CPN 1 was not available, so CPN2 and CPN3 were to see H on 16 October 2019.

4.415 H's prison key worker tried to engage with H, but a lack of engagement was noted.

4.416 H did not attend an appointment with the CPN2 and CPN3 in clinic on 16 October 2019. Feedback was sought from the staff on the wing. They said H had not left his cell for a week and his food was being taken to him. The wing staff did not think he was deliberately isolating himself. It was their view that H "*can't be bothered*" to come out of his cell.

4.417 H was reviewed at a MAPPA panel meeting on 17 October 2019. There was no update available from the prison or the HMP Parc MHIT because H had been a late addition to the agenda and the standard two weeks' notice was not provided. And no invitation or request for an update was received by HMP Parc.

4.418 The MAPPA panel heard that H was not engaging with the probation service. This, combined with his poor behaviour in custody, resulted in the probation service being unable to support his re-release, which made it likely he would remain in prison to his sentence end date.

4.419 It was noted that H needed to be encouraged to engage with the prison resettlement team so they could support him with accommodation for his release.

4.420 The panel heard that H had also refused to engage with the West Midlands Police.

4.421 The "*panel agreed that due to H's continued refusal to engage with any support offered there is no added benefit for continuation at level 2. Any outstanding actions will be updated to ViSOR within the agreed time frame*."

4.422 The plan from this meeting was for:

- CPN1 from the prison discharge service to contact the prison MHIT regarding attempted re-engagement;
- the police to chase the outstanding Prisoner Intelligence Notification System (PINS) list;
- the probation officer to encourage H to engage with the resettlement team; and
- the completion of a MAPPA Form J59 (however, with no restrictions upon release, one would not have been required).

4.423 We have also been told that there was a requirement for the CPN from the prison discharge service to provide the CMHT care coordinator 1 in Birmingham with an update from this MAPPA meeting and inform them that H had been removed from MAPPA.

4.424 CPN1 and CPN2 visited H in his cell on 22 October 2019. H said he had not attended the appointment on 16 October 2019 because he was attending an education session. He told the CPNs that he was avoiding contact with other prisoners to avoid altercations. He told them that he continued to hear voices, but they were not distressing him. He said he had no intention of harming himself or

[59] A MAPPA form J should be completed for MAPPA offenders who have a restriction in place via a probation licence and/or a Police Order.

others. It was noted that he did not engage well in the conversation and his answers were monosyllabic. H said he would attend appointments with the team if they were in the afternoon. The plan from this meeting was to continue to monitor H's mental health and to offer him afternoon appointments.

4.425 H was seen twice in October 2019 by the pharmacy technicians because he was not complying with his medication.

4.426 On 28 October 2019 PO3 left the team and H was transferred to PO5.

November 2019

4.427 In November 2019 H was seen twice by the pharmacy technicians; their role was to dispense prescribed medication on the wing, to encourage prisoners to comply with their medication and to report any issues to the care team, which in this case was the MHIT. H was seen by the technicians because he was not compliant with his medication and did not attend a planned appointment with the CPNs on 28 November 2019. He was to be offered another appointment.

4.428 On 27 November 2019 H requested to see the prison OS and they went to see him. H asked for a transfer to HMP Berwyn for local release to Wrexham, However, HMP Parc was considered to be a local release for Wrexham and the transfer was not agreed.

4.429 That day there were a number of emails between PO3 and the HMP Parc OS. The OS told PO3 that, "*He's told me that he'd like to live in the Wrexham area on release to remove himself from the gang culture of Birmingham*".

4.430 PO3 was no longer responsible for H but was willing to provide an overview. They said that H had been reviewed at the MAPPA panel four weeks previously and removed from the MAPPA process. H would not be released until his sentence ended and he would not be subject to any controls on release. Contact details for PO5 were shared with the OS.

December 2019

4.431 On 4 December 2019, H attended an appointment with CPN1 and CPN4. H said that he continued to see shadows and hear voices, but they were less distracting than they had been in the past. He was wearing blue gloves and said this was because of obsessive compulsive disorder. He described feeling his mood dipping. He said that when his mood dipped, he could do stupid things and gave an example of taking prison officers hostage. But he said he had no thoughts of this at the time of the appointment.

4.432 H told the CPNs that he was meant to be on a higher dose of olanzapine and said his previous team had told him he could request an increase in his dose if his mental health was deteriorating.

4.433 H said that he had been approved for a transfer to HMP Berwyn and he expected to be transferred in the new year. HMP Berwyn is a category C prison in the Wrexham area of North Wales.

4.434 The CPN's noted that H was not observed responding to unseen stimuli and that he had described no delusional ideation. The plan from this appointment was to see him again in two weeks.

4.435 H did not attend an appointment with the CPNs on 19 December 2019 and there was no follow-up plan recorded.

4.436 H would not engage with this prison key worker in a session on 19 December 2019. When the key worker saw H on 21 December 2019, H said he was okay and

appeared to be in good physical health. H made an enquiry about a transfer to another prison.

4.437 H was seen twice in December 2019 by the pharmacy technicians because he was not compliant with his medication. In addition, he did not attend a pharmacy appointment or an appointment for blood tests.

January 2020

4.438 PO5 contacted the prison OM on 6 January 2020 for an update on H because they were required to complete an annual parole report for H. They were told that H had some negative behaviour entries in his record, and he was one of a number of prisoners who were suspected of using cannabis.

4.439 The prison OM also completed a parole report for H. This report was written based on H's previous prison records because his behaviour had been very stable while at HMP Parc, with only one adjudication.

4.440 The following day, PO5 completed an OASys review for H. Much of this was pulled through from previous OASys entries and up-to-date information in the review was very brief. The sentence plan was generic. H's motivation for change was reassessed and updated to reflect his presentation.

4.441 PO5 also completed a review of re-release report. Early release was not supported for H because of his disengagement in custody and his not taking any positive steps to lower his risks post-release.

4.442 On 7 January 2020 H was seen by his prison key worker who noted H was making some progress, but again H had not been willing to talk to the key worker.

4.443 H was placed on basic on 13 January 2020. This was because he had accrued more than 10 IEP points.

4.444 The wing staff requested healthcare see H on the wing on 13 January 2020, because he was believed to be having a fit. He was seen by RMN1 from the PCMHT. Although his body was shaking, H was able to talk to the nurse. Advice was provided about him using the medication prescribed for his asthma.

4.445 The resettlement worker from the St Giles Trust visited H and discussed his plans for release. H told them that he wanted to live in Wrexham following his release, close to a family friend. On 28 January 2020 H was supported by a peer support worker to complete a housing application for Wrexham.

4.446 H was seen twice in January 2020 by the pharmacy technicians because he was not compliant with this medication.

February 2020

4.447 H told the prison key worker that he was "*fine*" when he saw them on 1 February 2020.

4.448 H did not attend an appointment with CPN1 on 5 February 2020. There was no explanation from the wing staff about H's non-attendance and the plan was to rebook when appropriate.

4.449 An assisted living plan was completed with H on 10 February 2020. H asked for support to find accommodation in Wrexham.

4.450 On 16 February 2020 H told his prison key worker that he was "*feeling great mentally*".

4.451 On 18 February 2020 H requested an exemption from work on mental health grounds. CPN3 reviewed this request and concluded that MHIT were not able to agree to an exemption from work. It was difficult for MHIT to comment on H's suitability for work because he had not been attending appointments with the team. The wing staff were asked to encourage him to attend appointments.

4.452 H was seen five times in February 2020 because he was not compliant with his medication. It was noted that following conversations with the pharmacy team, he would attend the dispensary hatch for his medication.

4.453 On February 2020, the CMHT care coordinator 1 asked PO5 for an update on H. They were told that H had been transferred to HMP Parc in September 2019. H was due to be released on 23 April 2020 and he would not be subject to any restrictions.

4.454 In February 2020, H was seen by staff from the St Giles Trust who provided the resettlement service for the prison. H requested resettlement in the Wrexham area, however, he lacked the local connection to support this and a referral for accommodation in the area was not completed.

March 2020

4.455 It was noted on 4 March 2020 that CPN1 was not available, and H was to be seen by other members of the team. However, when H did not attend a planned appointment on 11 March 2020, he was seen briefly on the wing by CPN1and CPN2.

4.456 When H was seen he said that he was struggling with this mental health, and he thought that he should be on medication for post-traumatic stress disorder (PTSD). His medication was reported to be having a positive effect on his symptoms of schizophrenia but not on his mood. H said he had a historic diagnosis of bipolar disorder. However, no evidence of mood disorder was observed by CPN1, and H did not appear to be experiencing any psychotic symptoms.

4.457 H told CPN1 that he was feeling anxious, could not have anyone walking behind him, felt intimidated and "*snapped*" at people. He said that he was scared of people on the wing, but this contradicted his assertion that he had no altercations or problems on the wing. He said he had not been attending appointments because he could not leave his cell due to his anxiety.

4.458 However, the officers on the wing reported that there were no problems with H on the wing.

4.459 The plan from this appointment was to book H an appointment with the MHIT consultant psychiatrist for a medication review and to contact his community CMHT to discuss his discharge plan.

4.460 H's session with his prison key worker for 9 March 2020 was cancelled because of tuberculosis (TB) testing on the wing.

4.461 H did not attend the appointment with the MHIT consultant psychiatrist on 12 March 2020 for a medication review. The psychiatrist noted that there was no need for a further appointment, and they were to discuss the transfer of care plans with CPN1 before H's planned release on 22 April 2020.

4.462 On the 18 March 2020, CPN1 recorded on SystmOne that all staff had been reallocated to support the NHS with the Covid-19 response and the MHIT would no longer be working in the prison. The following day (19 March 2020) CPN1 commenced a mental health measure care and treatment plan questionnaire for H.

4.463 H was seen three times in March 2020 by the pharmacy technicians because of non-compliance with his medication.

April 2020

4.464 On 2 April 2020, responsibility for H transferred from PO5 to PO6.

4.465 The PCMHT continued to go into the prison wings in HMP Parc in April 2020, and H was seen by the RMNs from the team.

4.466 H was seen by RMN2 on 4 April 2020 as it had been noted that he had been seen twice by the pharmacy technicians because he had missed his medication, which had been identified when the PCMHT reviewed his medication chart. H was not able to provide an explanation for his non-compliance but said he would attend for his medication that evening.

4.467 The probation team accommodation officer reviewed H's records on 7 April and asked PO5 if they knew why H was requesting accommodation in Wrexham. They identified that if H was directed to return to Birmingham another form would need to be completed for him.

4.468 On 11 April 2020, RMN3 completed a risk assessment and identified mild concerns about the risk of deliberate and intentional self-harm. Following this visit RMN3 sent an email to the MHIT manager. In this they said that they were concerned about H. He was not taking his medication. He was not coming out of his cell and when they saw him, he had a blanket over his head. They queried if he was experiencing paranoia and/or depression. They noted that he was due for release the following week and asked for advice and information about his release plans.

4.469 RMN4 saw H in his cell the following day. H was reluctant to engage with RMN4. He said that he did not want to take his medication, but he would take it when he was released. H was told to contact healthcare should he need any support.

4.470 Following this RMN4 spoke to another prisoner who said he had known H in HMP Dovegate, he said that H just wanted to keep his head down and get ready for release.

4.471 H was seen by RMN2 on 13 April 2020. He told them that he was not going to take his medication until he left the prison the following week. He told the RMN that he planned to live in North Wales when he was released and that he had accommodation. It was noted that H was reluctant to engage in the conversation, provided brief answers and became irritable. He was adamant he was fine and did not want any support from the mental health team.

4.472 On 14 April 2020, the MHIT team manager contacted the PCMHT. The team manager said that they were covering CPN1's caseload and wanted to know who H's OM was. The PCMHT stated that H planned to live in North Wales following his release and he would need to be referred to a local CMHT, and a discharge summary would need to be sent to his GP.

4.473 There was an email from the Probation Service the following day stating that H was being released at sentence end date and, as such, would not be able to be supervised by the probation service. It specified that he was no longer subject to MAPPA processes. They advised that for H to secure accommodation in North Wales, he would need to prove a local connection. They also provided the contact details for the police OM.

4.474 H was seen by RMN5 on 21 April 2020. This was a review prior to his release the following day. H told the RMN that everything was okay and that he did not need any support prior to this release. He told them that he had been referred to his local CMHT and an appointment would be made for him to see them. He said that he would take his prescribed medication once he was released from prison.

4.475 H was released from HMP Parc on 22 April 2020. The MHIT sent an email to the probation OM requesting a release address for H on 30 April 2020.

Post-release contact with services

May 2020

4.476 On 1 May 2020, the MHIT established that services did not have any details about H's plans after his release, beyond a belief that he may have gone to Wrexham because he had told the St Giles resettlement team and PCMHT that this was his intention. It was not known why he wanted to live there or what his connection with the area was.

4.477 The MHIT practitioners were not able to see details of H's CMHT on SystmOne. They noted that H's engagement with mental health services in prison had been minimal and he had declined support prior to his release. As the MHIT were not allowed into the prison due to restrictions caused by the Covid 19 pandemic, the MHIT practitioners relied upon SystmOne to update them with information regarding the prisoners they were in contact with. There had been no significant concerns about H's presentation in the week prior to his release recorded on SystmOne. They discussed this with the MHIT team manager.

4.478 On 5 May 2020 the MHIT CPN3 identified H's last known GP in Birmingham. They made a phone call to the GP and although H was no longer registered with the practice the GP was happy for his discharge summary to be shared with them and they would pass it onto services as appropriate.

4.479 CMHT care coordinator 1 contacted West Midlands Probation Service on 18 May 2020 requesting an update on H. They wanted to contact H to book an appointment to complete an assessment and make appropriate referrals for him. PO6 told the CMHT care coordinator that they did not know where H was living, although they were aware that he had completed a housing application to live in Wrexham. However, they doubted that this application had been successful, and it was believed that the responsibility for housing H was with Birmingham.

4.480 On 26 May 2020, the care coordinator completed an NHS Spine[60] check for H. This did not show a change of GP, and he appeared to be registered to the GP he was known to at the end of 2018.

4.481 On 28 May 2020, the CMHT care coordinator had a conversation with the Trust safeguarding team and was advised to make a safeguarding referral for H's seven-year-old child because H was "*missing*".

June 2020

4.482 The CMHT care coordinator had a discussion with the local authority Children's Advice & Support Service Birmingham (CASS)[61] on 1 June 2020 about their concerns for H's child. The CMHT care coordinator disclosed that H had been released from prison and was not subject to supervision. They also detailed that he had a diagnosis of paranoid schizophrenia and a history of offences that included possession of cannabis, firearms and ammunition, robberies against women, threats against neighbours, domestic violence against female partners and he was known to carry a knife. In addition, there had been concerns in the past about non-accidental injury to his child. The CMHT care coordinator was to follow up this conversation with an email.

[60] https://digital.nhs.uk/services/spine NHS staff can consult this to find out which GP a patient is registered with.
[61] CASS provides a single point of contact for professionals and members of the public who want to access support or raise concerns about a child. https://lscpbirmingham.org.uk/index.php/safeguarding-concerns/cass

4.483 On 2 June 2020, the CMHT care coordinator obtained the last known contact details for H's next of kin, his mother, from the NHS Spine. They also contacted the last known GP surgery. They told the surgery that H had recently been released from prison and there had been concerns in the past about the potential threat he posed to his child. They provided the surgery with the child's name and date of birth.

4.484 CASS investigated the information provided by the CMHT care coordinator. While some of the information shared by the CMHT care coordinator was incorrect, CASS was able to locate H's child and their mother. CASS confirmed that H did not know the address for the mother and child, and he had not had contact with them.

4.485 On 11 and 12 June 2020 the CMHT care coordinator tried the phone numbers they had obtained for H's next of kin, without success.

4.486 In June P06 closed H's OASys.

4.487 H was discussed at the CMHT MDT meeting on 23 June 2020. The team discussed the actions that the CMHT care coordinator had taken to find H. We were told during interviews that the CMHT care coordinator had considered asking the benefits agency if they had an address for H. We have not seen any evidence that this was done.

July 2020

4.488 H did not make contact with any services in July 2020. At this time H was lost to services.

August 2020

4.489 On 13 August 2020 H re-registered with a new GP. A triage phone call was completed with him on 17 August 2020. In this call H said that he had been released from prison with two weeks of olanzapine and since then he had been using a friend's olanzapine.

4.490 H reported that his mood was okay. He was experiencing regular hallucinations and voices telling his to do things, but he did not provide additional detail about this.

4.491 He told the GP that he had been in prison for three years for drug and firearms offences, but that he was not subject to supervision from probation services.

4.492 The GP noted that H had been under the care of a CMHT.

4.493 H told the GP that he was living in a housing association property.

4.494 The GP was unable to provide H with a prescription for olanzapine because it was more than four months since his last prescription and H had a history of non-compliance with prescribed medication. The plan from this call was to refer H back to the CMHT.

4.495 On 19 August 2020, the GP completed a non-urgent referral to the BSMHFT single point of access. In the referral, they identified that H had been released from prison and was not under probation supervision. That H had previously been under the care of a CMHT and had been prescribed olanzapine. They said that H was experiencing hallucinations and hearing voices but provided no detail about them.

4.496 The GP was unwilling to provide H with a prescription for olanzapine because of H's previous poor compliance and requested a mental health assessment and Consultant Psychiatrist review of H's medication.

4.497 The GP identified concerns about a risk of self-neglect, concordance with existing mental health treatment, H's current behaviour of risk taking (although no detail was provided about this) and his history of misuse of drugs. They did not have any

concerns about his risk of suicide or self-harm, exploitation by others or his history of depression. They were unable to comment on any previous suicide or self-harm events or previous episodes of violence or aggression. Nor were they able to confirm if the home environment was safe to visit.

4.498 They provided details of a CPA review completed in 2016 when H had been released from prison. At this time, his diagnosis was bipolar affective disorder.

4.499 On 25 August 2020, the CMHT offered H an outpatient appointment for 3 September 2020.

September 2020

4.500 CMHT care coordinator 1 was no longer working with the CMHT, and H was allocated to CMHT care coordinator 2 who made two unsuccessful phone calls to H's next of kin (his mother) on 1 September 2020.

4.501 On 2 September 2020 CMHT care coordinator 2 attempted to contact H to remind him about the appointment with following day, without success. In the clinical record CMHT care coordinator 2 noted that they contacted Elliott House AP who told them that H had left the hostel several months previously.

4.502 CMHT care coordinator 2 made two further unsuccessful attempts to contact H's next of kin.

4.503 Following this CMHT care coordinator 2 liaised with the CMHT clinical lead about the lack of contact with H or his next of kin. Based on the team's previous experience of H, it was agreed there was a chance he would not attend the appointment planned for the following day and it was agreed that CMHT care coordinator 2 would complete a home visit to the address provided by the GP in their referral, supported by a support worker from the team

4.504 On 3 September 2020, CMHT care coordinator 2 and a support worker from the CMHT completed a home visit to see H.

4.505 It took H a long time to answer the door and he initially told them that his name was James. He was hostile and guarded with the staff during the visit.

4.506 H said that he would not attend the appointment with the consultant psychiatrist that afternoon. This resulted in him being assessed over the phone by the CMHT consultant psychiatrist, who had seen H in December 2018

4.507 H told the consultant psychiatrist that he was hearing voices that could be distressing but he did not want to talk about the content. He said he had been taking a friend's olanzapine. The psychiatrist noted that it was difficult to complete a full assessment.

4.508 The plan agreed with H was that the GP would be advised to prescribe olanzapine 10mg and that H would be given a face-to-face appointment with the CMHT consultant psychiatrist for 24 September 2020, which he said he was willing to attend.

5 Discussion and analysis of West Midlands Police contact with H

5.1 West Midlands Police is the second largest police force in the country, covering an area of 348 square miles and serving a population of 2.8 million. "*The force deals with more than 2,000 emergency calls for help every day, as well as patrolling the streets and responding to incidents 24-hours-a-day, seven days a week*". The force covers the three major centres of Birmingham, Coventry and Wolverhampton.[62]

5.2 West Midlands Police employs approximately seven thousand police officers, plus police support officers and other support staff.

Police OM 2017 to 2020

5.3 There is evidence of early good communication between agencies working with H, particularly between August 2018 and February 2019.

5.4 The police and the probation service had agreed that H should be managed under the MAPPA process. They clearly set out the risks that they felt he presented at the time and agreed the decision to manage H through the MAPPA process.

5.5 The police OM developed a trigger plan for H on 8 November 2018 at the request of the MAPPA meeting. A trigger plan is an agreed force response to an incident. H's trigger plan was created to safeguard potential victims and recall him to prison if he absconded from the AP.

5.6 The trigger plan included actions for staff at Elliott House AP, West Midlands Police contact centre and any allocated police resources. The Elliott House AP actions included a police log number, with staff required to contact police and quote the log number, which provided immediate information to the police to assist them in responding to the situation.

5.7 The trigger plan also included background information, licence conditions and useful contacts.

5.8 The police OM collected H from prison on 9 November 2018 and accompanied him to Elliott House AP. This is unusual and we consider this to be good practice given H's identified risk.

5.9 While H was released on licence there was proactive partnership working to manage H at Elliott House AP. The police OM visited Elliott House AP six times while H was resident. One of these was a joint visit with the probation officer 2. In addition, they shared information via email with other agencies; particularly with H's probation officer and his AP key worker. H displayed continued non-compliance with his licence by not keeping his curfew and using cannabis. Despite this non-compliance H expected a curfew extension and home leave for the festive period.

5.10 In December 2018, knowing the OM was on leave over Christmas, H informed staff at Elliott House AP that his leave extension had been agreed by the police OM, knowing this to be untrue. This displayed an attempt to manipulate staff from different agencies to gain a benefit for himself. Due to the partner agencies close contact and joint working, his deception was identified, and his normal curfew enforced.

[62] West Midlands Police. About Us. https://www.west-midlands.police.uk/about-us/our-force

5.11 This period provides good examples of the police involvement with H's management. The knowledge they built up as a result of their involvement with him meant quicker resolution of issues as they arose.

5.12 The police attended the MAPPA meeting held in October 2019 where the decision to remove H from MAPPA was made. The police did not object to that decision and were therefore party to it. From the information available to this review, it appears that no proactive police interventions took place with H from this moment on.

5.13 The police have no evidence of any risk management plan being created to manage his release. There is no evidence of any plan for proactive single agency management by police in readiness for his release from custody.

5.14 This review has not been able to determine why nothing was put in place to attempt to proactively manage H when he came to the end of his sentence. His risk had been identified and he had previously been successfully managed under MAPPA. As we discuss in the next section (paragraph 6.145 and 146 , Probation input after H's recall to custody) West Midlands Probation Service had developed local guidance that directed staff to inform relevant agencies that probation service input was ending and to identify if someone has particular issues linked to their risk of harm (such as mental health, substance misuse) which need to be followed up after they are released.

5.15 Furthermore, his risk had not reduced and there was a possibility that, because had served his full sentence before release and failed to engage with any agency, there had been an increase in his risk, heightening the need for a proactive management plan.

5.16 H was released at the end of his sentence in April 2020. The PO had stated in the MAPPA meeting that it was felt that a period on license would be more suitable than being released without restrictions although it is acknowledged that previous engagement has been poor when in a community setting.

5.17 However, he had a history of non-compliance with licence conditions, having been recalled to prison on more than one occasion. The police OM and probation officer 3 planned to visit H in prison after his final recall in February 2019, but he would not see them. The visit was conducted to try to engage with ZM and to further assess whether a re-release could be supported However, H would not engage, it was not possible to do this.

5.18 There is no record of H's release date in police records and the police were unable to confirm that the police OM was aware of his release date. The police told us that the OM would have tracked H on Corvus,[63] and the PINS would have generated an email to the police OM notifying them of H's release date.

5.19 H was released from HMP Parc in April 2020. As he was at Sentence End Date he was released with no licence and with no means for the police to attempt to engage with him.

5.20 Following his release from prison H was monitored on the Corvus police system but gaining any information from this was reliant on H coming to the attention of the service by engaging in criminal activity.

5.21 Given what had been known previously about his propensity to offend and his management through MAPPA, there were advantages of tracking H on Corvus. But it

[63] Corvus is the police intelligence software that provides a master record for criminals and suspects.

is an inherently passive and reactive form of management, simply giving the police the opportunity to increase their intelligence about his activities.

5.22 However, H was released from prison on his sentence end date and was not subject to any form of supervision, nor was he obliged to engage with agencies such as the police if they were to offer him any support.

H and gangs

5.23 Scrutiny of police reports and documents indicate little evidence to connect H to gangs. West Midlands Police define a gang as "*A relatively durable, predominantly street-based group of young people who (1) see themselves (and are seen by other) as a discernible group, (2) engage in criminal activity and violence, (3) lay claim over a territory (not necessarily geographical but can include an illegal economy territory), (4) have some form of identifying structural feature; and (5) are in conflict with other, similar gangs*".[64]

5.24 During his early years of suspected offending, H was thought to be involved with groups of other youths carrying out offences such as robberies and distraction thefts, though this appears not to have been substantiated. H spoke of gang affiliation in his later contact with police; however, the police have no evidence to show a clear entrenched association with any particular gang.

5.25 Due to his mental health problems causing possible vulnerability, H could have been open to radicalisation, but there is no evidence of this having happened.

5.26 H's interactions with the police, prior to his last prison sentence, provides evidence that the police had acted positively. When he was identified as a suspect of a crime, he was arrested, and a number of those arrests resulted in charges and convictions.

H and safeguarding[65] and domestic abuse

5.27 Excellent safeguarding for H's ex-partners was in evidence when he was due out of prison on licence in 2018. The MAPPA meeting set an action for the police OM to speak to H's ex-partners and make disclosures to assist in safeguarding them. The police OM visited all H's ex-partners, made appropriate disclosures and provided safeguarding advice.

5.28 The police OM then placed warning markers on all the women's addresses and created a trigger plan for H, which linked the licence conditions and the women's details for easy reference. This was good practice.

5.29 One of H's ex-partners did not want their details included on the licence, because they did not want H to be reminded about them. The police considered their request and arranged to have them removed from H's licence.

5.30 The police OM completed visits with members of H's family and his ex-partners prior to H's home leave planned for the Christmas period in 2018.

5.31 However, the police did not notify H's ex-partners that he had been released from prison in April 2020.

[64] West Midlands Police – Gangs. https://www.west-midlands.police.uk/your-options/gangs

[65] Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

5.32 There were instances when domestic abuse was reported and there is evidence that the police took positive steps to safeguard any named victims. They recognised safeguarding as integral to their role alongside gathering evidence to investigate offences. Safeguarding efforts continued irrespective of whether there was a resultant prosecution following reports made to them. DASH based risk assessments were offered to the women who were suspected of being subject to domestic violence by H. If the victim refused to cooperate, the DASH risk assessment was completed by the attending officers in line with policy.

5.33 DASH was introduced to policing in 2009 and it became mandatory to complete the risk assessment with a domestic violence victim in 2017. In 2018 it became mandatory for officers to complete the risk assessment even if the victim refused; based on the circumstances of the incident and previous history known on police systems. DASH was replaced by the domestic abuse risk assessment (DARA) in 2019. Based on the outcome of the DASH or DARA assessment, a risk of standard, medium or high would be identified and safeguarding completed according to the risk.

5.34 The police also used Clare's Law[66] to share information about H with a potential partner. In addition, they used an Osman warning where potential victims were considered to be at risk.

Healthcare while in police custody

5.35 Liaison and Diversion (L&D) services are based within police custody settings. L&D identify people in custody who have a mental health issue, learning disability, substance misuse issues or other vulnerability. The service can support people through the criminal justice pathway, refer them for appropriate health or social care support and, if appropriate, divert them away from the criminal justice system, into a more suitable setting.

5.36 H was assessed by the L&D team at Birmingham Magistrates Court on 20 March 2017. He engaged in the assessment and was happy to continue with the court proceedings and return to prison.

5.37 When H was taken into custody he was placed under the appropriate level of observations.

Monitoring post-release April 2020

5.38 As H was released at sentence end date and not on licence, there was no requirement for Probation to inform the police. However, the police OM would have been aware of the sentence end date from previous MAPPA meetings.

5.39 The police would have become aware of H in the community if he committed an offence as Corvus would have generated an email to the police OM.

[66] Clare's Law is named after Clare Wood, who was murdered by George Appleton, an ex-boyfriend, in Salford, England in February 2009.
Appleton had seriously abused women in the past and Greater Manchester Police were aware of his violent history, Wood's family stated that she would not have entered into a relationship with Appleton had she known of his violent past. This is not a law in statute, but the Domestic Violence Disclosure Scheme recognises two procedures for disclosing information using common law powers: the 'right to ask' is triggered by a member of the public applying to the police for a disclosure. The 'right to know' is triggered by the police making a proactive decision to disclose information to protect a potential victim.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

Findings – West Midlands Police

1. West Midlands Police supported the MAPPA process, they:
   - liaised with probation;
   - provided reports for all the MAPPA meeting; and
   - attended all the MAPPA meetings held for H.
2. West Midlands Police provided H with transport to Elliott House AP when he was released from prison on licence in November 2018. This was to ensure that H arrived at the premises and understood the conditions attached to his release and the tenancy at the AP. This is unusual and we consider this to be good practice given H's identified risk.
3. West Midlands Police worked proactively with the other agencies to support and manage H while he was accommodated at Elliott House AP in 2018.
4. West Midlands Police were not formally informed of H's release from prison in April 2020 by HMP Parc.
5. West Midlands Police did not complete a single agency risk management plan for H following his release in April 2020.
6. West Midlands Police safeguarding of H's ex-partners was excellent when he was released from prison in November 2018. This included:
   - Clare's law disclosures;
   - markers being placed on addresses; and
   - the use of Osman warnings.

6 Discussion and analysis of National Probation Service contact with H

History of contact with probation

6.1 H had been under the supervision of the West Midlands Probation Service on two separate occasions prior to his prison sentence. The first time was in 2012 when he was released on licence following a conviction for robbery in 2011. H was recalled to prison after 10 weeks for breaching the rules of the supervised accommodation where he was living.

6.2 H was next under probation supervision when he was released on licence on 10 August 2016. H was recalled to prison following his arrest for further offences on 20 March 2017.

6.3 These further offences resulted in a prison sentence of 43 months (36 months for robbery, and a consecutive seven months for an assault) on 24 April 2017. H's then probation officer, PO1, anticipated that they would be asked to prepare a pre-sentence report to assist the court in its sentencing decision, but no such report was requested. The purpose of a pre-sentence report is to provide the court with an independent assessment of the reasons why someone has offended, the level of risk they pose and to whom, and to evaluate the sentencing options available.[67]

6.4 In line with the agreed terms of reference for this review our focus has been H's contact with services between April 2017 and September 2020.

Contact with H while in prison – PO1

6.5 PO1 was familiar with H from his previous time on licence and remained responsible for him until September 2017. It is our opinion that PO1 demonstrated a good understanding of H's level of compliance when managing his case in 2016 – 2017. At interview they were able to provide several good examples of attempts at joint working with other agencies. This included, making joint appointments so H could meet with PO1 and the CPN at the probation office.

6.6 It was PO1's judgement that H was able to comply with licence conditions and was responsive to and cooperative with their supervision at this time. This judgement is supported by the fact that H remained on licence in the community between August 2016 and March 2017.

6.7 H was arrested in March 2017, and this resulted in his recall to prison. He was remanded in custody to HMP Birmingham. He was charged with possession of a controlled drug with intent to supply and possession of an imitation firearm and was due to appear in court on 24 April 2017

6.8 Before H's court appearance, PO1 discussed his case with the personality disorder team which is a specialist team in the probation service. A number of actions were identified during this case discussion, including referring H to Elliott House AP and liaising with the MHIT regarding a psychiatric assessment. However, the court did not request a psychiatric assessment or a pre-sentence report from PO1, and on 24 April

[67] We have found inconsistencies in the offences recorded in the Probation records in several places. Alongside this, these do not tally with the records provided by West Midlands Police. Therefore, we have provided a list of offences 'as best as we understand it'.

2017 H was sentenced to a total of 43 months, some of which was concurrent, so he was to serve a maximum of 36 months imprisonment.

6.9 Between April 2017 and September 2017, PO1 completed two video link interviews with H. The first on 19 May 2017 was to discuss with him the initial sentence plan[68] that they were required to complete, to identify what objectives would inform the work H needed to do in prison to address his offending and prepare him for release. The initial sentence plan identified that H would focus on the following areas while in prison:

- "Offence-focused work to reduce risk – to liaise re: programmes he may be suitable for, would benefit from anger management.
- Emotional wellbeing – to engage in intervention through healthcare.
- Substance abuse – to engage in cannabis awareness and any other substance misuse courses to raise awareness.
- Employment, training and education – to engage in music, IT & business courses when available.
- Maintain good behaviour.
- Accommodation – to secure prior to release."

6.10 At the end of this discussion, it was reported that H became hostile towards PO1. He claimed that they had "*stitched him up*" and he wanted a new probation officer. It is unclear if this was in relation to his reluctance to accept the sentence plan objectives or some other issues that he may have had. However, we have concluded that given H's range of issues and problems, PO1 correctly identified the areas that H needed to focus on if he were to change his behaviour and reduce the risk of reoffending in future.

6.11 PO1 told this review that H had not had any appointments with prison healthcare since his arrival at the prison, and that H did not feel his mental health was very good, stating that he was hearing voices and had feelings of paranoia. Furthermore, H was not in receipt of medication. H also told PO1 that he had not seen the prison-based OS.[69]

6.12 PO1 followed this up with a phone call to the OS on 25 May 2017. The OS said he had seen H on at least two occasions. He told PO1 that H's first healthcare appointment was planned for 30 May 2017. The OS had tried to bring this appointment forward without success. H had also told the OS that he was hearing voices, and it was the OS's view that his mental health needed to be more stable before he could be referred for any of the offending behaviour programmes outlined in the initial sentence plan objectives.

6.13 The OS also told PO1 that H had claimed that his older brother was a member of a street gang in Birmingham and that he had some gang affiliation himself.

6.14 In May 2017, PO1 completed the MAPPA screening process. They discussed H with the police and were informed that some intelligence existed to suggest H had formerly had some gang affiliation. However, there was no information available about this after 2014. As a result, PO1 concluded that at that time gang membership

[68] All prisoners who are sentenced should receive a sentence plan. This provides prisoners with a list of goals and courses to complete during their sentence which will help reduce their risk, and ultimately assist them when they are released into the community. https://www.gov.uk/government/publications/sentence-planning-psi-192014-pi-132014
[69] The allocated member of staff who worked with him on a day-to-day basis in prison.

was not a current or significant factor in H's case. Based on the information available we would support this view.

6.15 Following the MAPPA screening process and discussion with the police, H was registered as a MAPPA level 1 case[70] because he was in prison at this time. This would need to be reviewed six months prior to his release to decide what level of MAPPA management H might need on release. (See Section 9 of this report for further discussion of MAPPA.)

6.16 On 14 June 2017, PO1 met with the OPD team, to try and agree a case formulation for working with H. This was completed in line with the Offender Personality Disorder Pathway Strategy,[71] which provided the framework for a joint initiative between the National Offender Management Service and the NHS.

6.17 The case formulation is an aspect of the framework and is intended to provide staff with a better understanding of the offender and their behaviours, to help staff develop the specific skills needed to work with challenging and non-compliant offenders with mental health issues. Unfortunately, PO1 did not have current information about the stability of H's mental health, and it was not possible to conclude the case formulation discussion until this was obtained.

6.18 PO1 completed a second video link interview with H on 13 July 2017. Before this, PO1 spoke to the prison MHIT. They confirmed that H had been seen and was on the waiting list for an appointment with the consultant psychiatrist because he had displayed "*no clinical evidence of urgency*." In the video link interview, H told PO1 and the OS that he was not prepared to cooperate with the sentence plan discussed at the last video link because it did not benefit him. He confirmed that he had been seen by healthcare but had not been prescribed any medication. H then walked out of the interview.

6.19 The OS agreed to contact the healthcare team to find out if H had been prescribed medication but refused to take it, or whether none had been prescribed.

Contact with H while in prison – PO2

6.20 On 14 September 2017, PO2 became the supervising officer for H. They wrote to H, who was now in HMP Stoke Heath, on 18 September 2017 to introduce themselves.

6.21 H had been recalled to prison in March 2017, when he was charged with possession of a controlled drug with intent to supply and possession of an imitation firearm. H's recall was subject to a minimum annual review[72] and in January 2018 the parole Board initiated this process when they requested reports from PO3.

6.22 To give H the opportunity to contribute to this report, PO2 held a video link interview with him on 6 February 2018. It is important to note that H could not be released at this time as he was still serving his custodial sentence from 24 April 2017. However, he was entitled to have his recall reviewed annually, regardless of any other sentence he may be serving. This limited the recommendations that PO2 could make, as they could not recommend H's release.

[70] MAPPA level 1 is ordinary agency management for offenders who can be managed by one or two agencies and that will involve sharing information about the offender with other agencies if necessary and appropriate. Ninety-five per cent of offenders are managed at this level, usually by a single police officer or probation officer, and sometimes mental health services or other appropriate agency being the lead responsible agency.
[71] National Offender Management Service and NHS England (2015) The Offender Personality Disorder Pathway Strategy. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/opd-strategy-nov-15.pdf
[72] GOV.UK (2019) Recall, review and re-release of recalled prisoners. https://www.gov.uk/government/publications/recall-review-and-re-release-of-recalled-prisoners

6.23 Information about this interview indicates that H did not cooperate with PO2.

6.24 Following this failed interview, PO2 sought a further case consultation with the OPD team, but they were unable to assist until further information was available. There was then no further consultation with the OPD team until 21 November 2018 (i.e., after H was released on licence). Although there is evidence that PO2 did obtain further information from the MHIT probation records do not indicate whether this information was shared with the OPD team.

6.25 We have concluded that the probation officers did not make best use of the OPD consultation process to develop a pathway to effectively work with H, who was known to be difficult to engage and to be non-compliant with medication and treatment. H should have been referred for a further OPD consultation prior to release, supported by mental health services, so that all staff working with H after his release would have information, assistance and a structured pathway plan on how best to engage with him. This represents an early missed opportunity to bring together key staff working with H to discuss and agree their approach to encourage the greatest likelihood of engagement and cooperation.

6.26 On 19 March 2018, the Parole Board undertook a statutory review of H's recall to prison. The Board referred to a number of incidents in prison, including being threatening and abusive towards staff, assaulting a member of staff, and refusing to take prescribed medication.

6.27 PO2 did not make contact with H or arrange another video link prior to his release on licence in November 2018. However, PO2 did make a referral to Elliott House, a specialist AP, on 8 August 2018. A place was reserved for H on 23 August 2018, with a request for up-to-date information regarding his mental health. A report provided to PO2 by the healthcare team was then sent to Elliott House AP on 31 August 2018, but a copy of the report was not retained on the probation records, according to the chronology.

6.28 In September 2018, there was further liaison between PO2 and the prison healthcare team about H's non-compliance with medication and a planned medical review. On 18 September 2018, PO2 emailed the prison OS and the CPN who had provided the report in August requesting an update on the medical review. There is no evidence that this was received.

6.29 In September 2018, PO2 completed pre-release planning for H in terms of ensuring he was appropriately accommodated (Elliott House AP agreed to accommodate H in August 2018) and requesting up-to-date information about his mental health and current treatment through liaison with both H's prison OS and the MHIT.

6.30 This information was required by Elliott House AP to support their decision making and planning for H. In preparation for release the OM recognised that agencies were not communicating and referred ZM to level 2 management under category 3 provision. Ideally this would occur 6 months prior to release. The OM had been trying to obtain information in the months preceding release and when they were not given the information, they correctly referred in to MAPPA.

6.31 The probation service's individual management review (IMR) concluded that although this timescale was outside the MAPPA guidance[73], PO2 had still completed important pre-release planning and liaison with other agencies regarding H's mental

[73] Multi-agency public protection arrangements (MAPPA) https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--3/multi-agency-public-protection-arrangements-mappa-accessible-version

health. This delay was not therefore judged to have impacted on the plans for H's release.

6.32 The probation chronology indicates that both PO1 and PO2 did not always receive timely information from the prison healthcare team regarding H. The OM correctly identified this and made the MAPPA referral. The OM was trying to hold partners responsible for sharing information and correctly put this into a MAPPA structure, although this was outside of the timescale suggested by guidance. A MAPPA panel meeting convened six months prior to his release would have ensured that those key information sharing mechanisms and inter-agency planning opportunities were in place much earlier than a few days before his release (the first MAPPA panel meeting was held on 5 November 2018 and H was released on 9 November 2018).

6.33 This review has concluded that delay to the MAPPA referral, subsequent registration and the initial panel meeting were not acceptable and had an impact on the information sharing and the pre-release planning that could be completed prior to H's release.

H's second release into the community on licence

6.34 On 9 November 2018, H was released on licence for a second time and escorted by the West Midlands Police OM to Elliott House AP, where he was given an induction which explained the rules and regulations regarding his residency there.

6.35 While on licence, H was under the supervision of the probation service. He was required to attend appointments as instructed and complete other activities (such as attending groups to address his drug use). There were a range of sanctions for non-compliance, from a warning through to recall to prison to serve some or all of the remainder of his prison sentence.

6.36 H's licence ran from 9 November 2018 to 22 April 2020. He could be recalled to prison at any time during this time, but the probation service must evidence a breach of licence and increase in risk of serious harm.

6.37 Probation Instruction 09/2015,[74] which provided policy and guidance to probation staff about licences and additional conditions, was in place in 2018. This was to ensure that additional licence requirements were legal and proportionate.

6.38 In addition to standard licence requirements, PO2 had asked for a range of additional licence conditions. They focused on the specific risks that H was judged to pose, for example, he was obliged to notify the probation service of any intimate relationships with women who had children under the age of 18 and was not allowed to reside with or be in employment where there might be such children present. He was also obliged to comply with any drug and alcohol tests, a curfew and reporting restrictions while at Elliott House AP.

6.39 However, PO2 did not request an any additional licence conditions in relation to H's mental health treatment. In interview, PO2 explained this was not necessary because a requirement at Elliott House AP was compliance with all appointments, including mental health appointments. We have concluded that this was a proportionate approach to managing H's engagement with mental health treatment.

6.40 However, this condition could not be used to enforce compliance with taking medication, nor could it be imposed unless H agreed to it. No evidence was made

[74] Probation Instruction 09/2015. Licence Conditions and Temporary Travel Abroad.

available to this review that this was ever discussed with H, and this condition is no longer available to be attached to a licence.

6.41 No evidence was made available to this review that the conditions of H's licence were discussed with H prior to his release from prison in 2018. However, he would have been obliged to sign a copy of it as he was leaving prison.

6.42 After his induction at Elliott House AP on 9 November 2018, H met with PO2. PO2 went through H's licence conditions with him to ensure he understood them and to give him the opportunity to ask questions. However, in this discussion, H disagreed with a number of the conditions, especially those relating to non-contact with children. PO2 told us that they had a heated exchange and "*agreed to disagree*".

6.43 We have concluded, the lack of any discussion with H about his licence conditions prior to him leaving custody was a missed opportunity to better prepare him for the restrictions on release.

6.44 We accept that it is the probation service responsibility to set the licence conditions and disclose to /discuss with the person on probation. However, had the MAPPA referral been made earlier, it would have facilitated a multi-agency discussion about his licence conditions and plans for disclosing them to H would have formed part of that meeting. An action would have been agreed about who would be best placed to discuss the conditions, and the reasons for them, with H prior to his release.

AP residency – Elliott House AP

6.45 A member of the AP staff spent constructive time with H at the end of his first day, making clear that restrictions such as the curfew could be lifted, and that such rules were "*not forever*." H was reported to be much calmer that evening, and the following day a staff member advised him that if he had any concerns about his mental health, he should tell staff and they would access support and help for him straight away.

6.46 On 12 November 2018, PO2 returned to Elliott House AP and met with H and one of the AP staff, this time discussing the rules and regulations at Elliott House AP to ensure that H understood them – which he said he did. After their interview, the AP manager asked PO2 to speak with H when they next met, as some female staff members had complained that he made them feel uncomfortable because of how he looked at them.

6.47 On 14 November 2018, PO2 brought up these concerns with H and he became angry and verbally challenging. PO2 told H that this was not acceptable, and they would not tolerate being spoken to in that manner. They suggested a change of probation officer and H agreed to this. The probation IMR observes that there was no evidence of any structured intervention in this session and that PO2 was "*authoritative*", asking direct questions with no evidence of any motivational interviewing.

6.48 The first three interviews between PO2 and H were focused on rules and regulations, with little attempt at encouraging H's engagement, or getting to know him (given that PO2 had not met him when he was in prison).

6.49 In addition, PO2 had not witnessed H behaving inappropriately towards female staff. In our judgement, the additional presence of the AP manager or deputy manager might have taken the focus away from PO2 and reduced the confrontational nature of the discussion. After this discussion, the AP manager told PO2 that they would discuss this issue directly with H. Any discussion that may have taken place is not recorded in the probation records.

6.50 When PO2 met with H on 21 November 2018, H made it clear that he wanted a change of probation officer. PO2 described H's behaviour towards them in this meeting as intimidating, and he was staring at them without speaking. H told them that the AP manager had spoken with him about his behaviour towards female staff but had said that everything was fine.

6.51 The final meeting with PO2 was a three-way meeting with H and the AP manager on 28 November 2018. In the meeting they attempted to discuss H's behaviour towards female staff members, but H continued to refer to his problems with PO2 and how they spoke to him and stated he would not continue to meet with them. PO2 responded that they did not wish to continue to meet with H either and that a change of officer would be the best thing for his mental wellbeing.

6.52 On 7 December 2018, the team manager reallocated H's case to PO3, which was to be co-worked with PO4 (although they did not co-work the case for reasons we have been unable to identify). The breakdown of the relationship between H and PO2 was recorded as the reason for the reallocation.

6.53 The probation IMR author noted that no offence-focused work or constructive intervention had been undertaken with H during this time at the AP, due to the difficult relationship between PO2 and H. There is an action included in the probation IMR action plan to address this area of practice with PO2 to ensure that interventions are offered in each appointment.

6.54 We agree with the judgement of the IMR author, although it is clearly not possible to judge whether or not H would have engaged differently with another probation officer when first released. His initial disagreement with PO2 was because he did not like the additional licence conditions to which he was subject, and he may have reacted in the same way to any probation officer discussing this with him. However, it is our judgement that H should have been given the opportunity to discuss the licence conditions prior to his release, so that he understood the reasons for the extra conditions. Ideally this meeting would have included PO2, so they would have had the chance to meet H before he was released.

6.55 PO3 was allocated H's case on 7 December 2018, and there is no evidence of any contact prior to H's recall to prison on 24 December 2018. At this time there was a requirement for H to have weekly contact with his probation officer because he had been assessed as posing a high risk of causing harm.

6.56 Given the breakdown of the relationship between H and PO2, the importance of PO3 meeting with H as soon as they could to try to build a more constructive relationship was, in our view, a missed opportunity. The absence of appointments with PO3 has not been commented on in the probation IMR, which we believe is an omission.

6.57 PO3 did discuss H with his police OM on 13 December 2018. They completed a review of H's signings and curfew at the AP. It was agreed that they should remain in place but could be relaxed if/when H became more compliant. There was also a discussion about H's non-compliance with his medication.

6.58 The police OM said that H had been cooperative but had not always attended meetings with them at Elliott House AP. H had said that this was because he was hearing voices and that he dealt with this by staying in bed. The police OM believed that this may have been genuine on occasion but at other times may have been an avoidance tactic H used when he did not want to meet with them.

6.59 On 20 December 2018, the AP manager sent an email to PO3 raising concerns about H's lack of engagement and breaches of the AP rules. H was to be given one last chance to cooperate, or his bedspace would be withdrawn. There is no record of

PO3 contacting H directly to try to encourage him to engage with the AP and mental health services. Five days later H was recalled and returned to custody.

6.60 We believe that this was another missed opportunity for PO3 to meet with H, to reinforce to him the importance of working with the AP and of following the rules and requirements, and the possible consequences of not doing so.

Behaviour and compliance in the AP

6.61 H was at Elliott House AP from 9 November 2018 until his recall on 24 December 2018.

6.62 While H was a resident at Elliott House AP there were recurring issues in relation to his compliance with his curfew and his use of cannabis. In addition, there were other reported concerns about his behaviour.

Curfew

6.63 A 7pm curfew was one of H's licence conditions and a failure to return to the AP by this time was a breach of his licence. There is an expectation that probation officers use their professional judgement when determining if a breach of a licence condition warrants any sort of warning.[75] For example, when H was seven minutes late back on his second night at Elliott House AP, it was reasonable for this not to be considered a deliberate breach of the licence, because he was new to the area and told staff he had been lost.

6.64 The details of H's lateness are as follows:

Date	How late?	Reason	Sanction
10 Nov 2018	7 minutes	Lost	No sanction
16 Nov 2018	45 minutes	Lost	Trigger plan activated
17 Nov 2018	45 minutes	Lost	No sanction
26 Nov 2018	45 minutes	At hospital with member of his family	None given*
11 Dec 2018	29 minutes	None given	No sanction
12 Dec 2018	30 minutes	None given	No sanction
14 Dec 2018	10 minutes	None given	No sanction
23 Dec 2018	1 hour 51 minutes	Claimed he had authorised leave until 11pm	Triggered recall to prison

** Out of hours duty manager recommended formal warning be issued.*

6.65 On 26 November 2018, the on-call out of hours duty probation manager emailed the AP manager, PO2 and their line manager to ask that a formal warning be given to H regarding the breaches of the curfew. There is no record of any discussion being

[75] https://www.gov.uk/guide-to-probation/if-you-break-the-rules-of-your-probation

held with H regarding any of the breaches of the curfew up until this point. There is also no record that the requested warning letter was issued to H.

6.66 H continued to breach the curfew requirement on another four occasions, the final one leading to his recall to prison. No action was taken regarding his late return on the previous three occasions, and no warnings were discussed or issued.

6.67 All AP operate a curfew, and individual residents may also have a separate curfew time (usually earlier than the standard 9pm) which is part of their licence conditions and will be in place as part of their risk management plan. So, for example, if someone always commits offences at night, a curfew which prevents them being out at night is sensible and commensurate with the risks they pose and the need to protect potential future victims.

6.68 In H's case, his curfew was 7pm. During his time at the AP, he was not given permission to vary this, and so he should have been back at the AP by 7pm each evening. The curfew can be varied by the probation officer, but this would be in response to progress made and compliance with the existing curfew; thus, at the time of H's recall he remained subject to a 7pm curfew.

6.69 A warning given for a breach of licence conditions would normally be via a letter written by a senior manager or team manager from the probation service and would make clear the gravity of the situation and the consequences of any further breaches of any licence conditions. There are no specified limits on how many warnings from a senior manager can be issued, again this will depend on the circumstances of each breach and if they are believed to show that someone's risk has increased.

Use of cannabis

6.70 H tested positive for cannabis seven time while at Elliott House AP. Furthermore, staff recorded that they smelt cannabis in H's room five times. Using drugs on the premises is a breach of the Elliott House AP rules (and hence another breach of H's licence), while consistently testing positive for cannabis constitutes a breach of the licence condition to "*be of good behaviour and not behave in a way which undermines the purpose of the licence period*."

Date	Issue	Action taken
24 Nov 2018	Tested positive for cannabis	No action
1 Dec 2018	Tested positive for cannabis	No action
7 Dec 2018	Tested positive for cannabis	No action
10 Dec 2018	Tested positive for cannabis	No action
13 Dec 2018	Tested positive for cannabis	AP issued warning
14 Dec 2018	Cannabis smelt in bedroom	No action
15 Dec 2018	Cannabis smelt in bedroom	No action
16 Dec 2018	Cannabis smelt in bedroom	No action
18 Dec 2018	Cannabis smelt in bedroom	No action
19 Dec 2018	Tested positive for cannabis	No action

21 Dec 2018		Formal warning letter
22 Dec 2018	Tested positive for cannabis	Referred to PO3 to consider formal action
23 Dec 2018	Cannabis smelt in bedroom	No action

6.71 There is no evidence of discussions with H about his use of cannabis or of any offers of help and support. The only intervention offered regarding this issue was on 11 December 2018 when an AP staff member asked H if he was using cannabis and he admitted he was.

6.72 Furthermore, there is no evidence of discussions between the probation officers and H with regards to his cannabis use, despite this being identified by PO2 in their OASys assessment as linked to H's offending and risk of harm.

Other behavioural issues

6.73 Elliott House AP issued two AP warnings for not attending his key worker sessions and for playing music too loud. Elliott House AP also noted two events with H that raised concerns.

6.74 On 28 November 2018, H left Elliott House AP on his bicycle wearing gardening gloves and a later room search that day found a gold chain with a broken clasp. This could have been evidence of suspicious/offending behaviour, but this was not discussed with H.

6.75 On 14 December 2018, H reported that he had been involved in a fight with several males, caused by them "*talking about him*"; one of them pulled a knife and threatened him. This was not discussed further with H. There was no professional curiosity shown by staff at the AP or by PO3 about this incident, its circumstances and whether H himself had been at any risk of harm.

6.76 In addition, there were a number of occasions recorded when H would not get out of bed for medical appointments.

Enforcement action

6.77 H was released from prison on licence. Any breach of either the licence or the rules of the AP could result in warnings and enforcement actions.

6.78 Warnings issued by the AP and warnings issued by the probation service are different in terms of their use in enforcement activity. While an offender may breach AP rules by, for example, failing to attend keywork or playing their music too loud, such breaches would not be seen as evidence of non-compliance with their licence or indicate that someone's risk has increased. However, drug dealing or breaking curfew would result in a warning by the probation service.

6.79 We understand that if an offender consistently breaches AP rules, this could lead to a senior manager licence warning, which in turn could lead to recall of the licence if there is no improvement in their behaviour. However, it is to be noted that the AP could remove an offender's bed, and a lack of accommodation would be a breach of licence.

6.80 Probation instructions provide policy and guidance for probation and prison staff working with offenders and cover a range of different topics. In 2018, the probation

instruction 27/2014 (Recall, Review and Re-Release of Recall Offenders) was in place, and this provided the framework for the probation service when considering whether or not to apply for a person's recall to prison. This instruction states that "*As a general rule, offender managers* [OMs] *must consider whether to seek recall in cases where the offender's behaviour indicates that they present an increased RoSH (Risk of Serious Harm) to the public or an imminent risk of further offences being committed*."

6.81 There is no prescribed number of failures or breaches that automatically trigger a request for recall; this is for the probation officer's judgement, in conjunction with their line manager and a senior manager. Alternatives to recall should be sought, unless the risk an offender is judged to pose is of such seriousness that there is no alternative – an example might include the alleged commission of a very serious offence.

6.82 There was no consistent approach to issuing warnings or considering enforcement action across the whole licence. The approach taken was to deal with each breach individually rather than to take a wider holistic view of all H's behaviours.

6.83 This approach allowed H to quickly develop a pattern of breaching his curfew, with apparently no consequences, no warnings issued and no discussions with him regarding possible reasons this was happening. By the end of his first month at the AP, H had been late for curfew on four occasions and tested positive for cannabis three times, and no discussions were held regarding why H might be using drugs again.

6.84 Furthermore, we are of the view that H's breaches of his curfew should have been addressed much more quickly, through face-to-face discussion and formal written warnings. This especially applies when he was 45 minutes late on two consecutive days (16 and 17 November 2018) for the same reason (he was lost).

6.85 We have been unable to find any evidence that either PO2 or PO3 responded to H's deteriorating compliance, either by discussions with him, requesting warning letters or through supervision discussions with their manager to identify if there were actions they should be taking. H's engagement with the probation service did not improve during his time at Elliott House AP, indeed it deteriorated to the point of a change of officer being agreed.

6.86 The first written warning that should have been issued to H was on 26 November 2018 and was requested by the out of hours duty manager who was contacted because of H's lateness. This warning would have been used as an alternative action to recall, designed to warn H of the potential consequences of any further breaches.

6.87 These warning letters are usually written by a senior manager but often delivered in person to the offender, so that their probation officer can use the letter as a trigger for discussion, identifying if there are reasons why someone may not be complying or keeping to the rules, so that a plan can be identified that might make their compliance more likely. However, local policy and practice in the West Midlands may be different, and we were told that such letters are written in a standard format and sent by the allocated probation officer.

6.88 In the case of H, this first warning was not issued, despite it being recommended on 26 November 2018. On 21 December 2018, it is recorded that H was issued a warning regarding his use of cannabis. It is unclear if he had received this warning at the time of his recall to custody, and no probation officer discussion had taken place. Three days later on 24 December 2018, H was absent from the AP and in breach of the curfew again, leading to his recall.

6.89 Taking a holistic view of H's compliance with the licence conditions, we have concluded that there was sufficient evidence of non-compliance to have sought H's return to custody before the 24 December 2018. H was using cannabis on a regular basis, including at the AP, with no questions asked of him as to where he was getting either the drugs from or the funding to pay for them. For the first two weeks, H had tested negative to cannabis when tested at the AP – it would have been helpful for his probation officer to have discussed the reasons for his relapse into cannabis use, and to identify what intervention could be offered.

6.90 Overall, the decision to seek recall on 24 December 2018 was proportionate and reflected the breakdown of the placement and H's cooperation at Elliott House AP.

6.91 However, we have concluded that recall should have been considered at the end of November. Had he been recalled and returned to custody more quickly, H's cannabis use could have been curtailed, and the MAPPA could have reconvened with key agencies involved to try to have in place a very detailed and clear plan for a further period on licence at Elliott House AP.

6.92 In addition, we have concluded that H should have been made aware of the consequences of any continuing/further breaches of the licence as soon as he began to breach the curfew. PO2 and PO3 should have met with H to issue warning letters about his conduct but also to provide him with the opportunity to identify what might help to improve his compliance.

Professional curiosity

6.93 In addition to the inconsistent use of enforcement action against H, we consider that there was a lack of professional curiosity on the part of the AP staff and probation about a number of his behaviours:

- How H may have been funding his cannabis use, given the link between his use of drugs and his risk of harm and reoffending. This link was identified by PO2.
- Where the broken gold chain in his room came from. H had committed offences in the past that included snatching gold chains from the necks of women.
- The incident at the bus stop, when H was attacked by a group of young men he claimed were talking about him. This could have been an early warning sign of a deterioration in his mental health.

6.94 Evidence that H may have been committing offences to fund his drug use should have been raised directly with him. Referrals should have been made to relevant partnership agencies and support given to H to cooperate with any interventions to avoid being returned to custody.

6.95 The probation IMR author also identified this as a wider training need for probation staff – to encourage them to be professionally curious when dealing with offenders.

Licence conditions not addressed by services

6.96 H's licence contained a condition for H to undertake work to address his drug use. There is no evidence available that H was provided with any advice or support about his cannabis use or that he was given an initial appointment for an assessment with the local probation drugs partnership agency to identify if he could be engaged and motivated to address this issue.

Engagement with mental health services in Elliott House AP

6.97 Elliott House AP is a specialist AP. Elliott House AP provides accommodation exclusively to offenders with a diagnosed mental illness. Mental health support is provided by the Trust forensic community team. H was provided with face-to-face appointments on site with a CPN and consultant psychiatrist.

6.98 As part of H's referral to Elliott House AP, PO2 was asked to provide up-to-date information about H's mental health. A report from the HMP Oakwood MHIT CPN was forwarded to Elliott House AP on 31 August 2018. On 18 September 2018, PO2 requested feedback from a medical review which they believed had been held to consider H's refusal to take medication. There is no evidence available that this information was received by the probation service.

6.99 H was released to the AP without prescribed medication on 9 November 2018. He did not access medication until after his appointment with the local CMHT in Birmingham on 14 December 2018. As a result, for the majority of the time he was at Elliott House AP, H was unmedicated.

6.100 In terms of H's mental health and wellbeing while at the AP, on 10 November 2018 H was offered informal support by one of the AP staff who advised him that if he felt unwell or was concerned about his mental health that he should speak with one of the AP staff to access support.

6.101 On 13 November 2018, it is reported that H was seen by the forensic community team CPN at Elliott House AP, but there is no information available about this meeting in probation service records. It is also unclear if PO2 spoke with the CPN to gather information from them regarding H and his engagement during this interview.

6.102 On 21 November 2018, PO2 and an AP staff member discussed H's case at an OPD case consultation session also attended by a psychologist and a probation officer from the personality disorder team.[76] One of the purposes of this meeting was to discuss possible ways of engagement with H who was described as "*guarded*", reluctant to disclose information and mistrustful of staff.

6.103 The meeting heard that there were concerns about H's cannabis use and that he may supply cannabis to other AP residents – although the evidence for this suggestion is not provided, and this allegation is not referenced in any other probation information shared with this review. It was noted that H had an appointment booked with the forensic community team consultant psychiatrist the following day.

6.104 On 28 November 2018, H's AP key worker contacted the forensic community team CPN to ask for feedback from the appointment. They said that H had eventually got out of bed to come to the appointment but said very little, his engagement was described as "*minimal*." H was offered medication to assist with auditory hallucinations but refused, stating that he would prefer to wait until his appointment with the CMHT. The forensic outreach team consultant psychiatrist was to contact the CMHT and try to bring forward H's appointment, given his refusal to take medication and current auditory hallucinations.

6.105 On 6 December 2018, the AP staff noted that H's first appointment with the CMHT was not until 14 December 2018, but that H claimed to hear voices most days and stayed in his room to combat them. H also referred to a friend who was taking

[76] https://researchportal.bath.ac.uk/en/publications/offender-personality-disorder-pathway-screening-tools-evaluation#:~:text=The%20Offender%20Personality%20Disorder%20%28OPD%29%20Pathway%20faces%20the,by%20the%20pathway%20to%20help%20with%20this%20task.

olanzapine and said on occasions he had taken one of tablets, which he believed to be helpful. The AP staff member made a further appointment for H to be seen by the forensic community team consultant psychiatrist at the AP the following week.

6.106 H did attend his appointment at the CMHT on 14 December 2018 although he arrived late for the appointment. He was assessed as "unsettled," hearing voices and seeing shadows. Although initially reluctant to take medication, he later agreed. When the local chemist did not have the medication in stock, H was asked to wait but refused. When he returned to the AP, he had neither the prescription nor the medication. At this point, H had been at the AP for over five weeks with no medication.

6.107 When providing feedback to the AP staff, the CMHT CPN also said that H had disclosed he was late because he had got into a fight with unknown males at a bus stop, one of whom pulled a knife on him. H said the fight had started because they were talking about him. The AP staff did not discuss this incident with H or give any consideration to this presenting as an escalation in his risk.

6.108 Despite being reminded, H did not collect his medication until 17 December 2018 and did not hand it to the AP staff as required, claiming that he did not realise that he had to, and had already taken some. Furthermore, although H was told by the AP manager that it was a requirement of the AP rules that all medication be handed in, there is no evidence that H complied.

6.109 On 20 December 2018, H refused to get up to meet with the forensic community team consultant psychiatrist as arranged. The AP manager emailed PO3 stating that H was at risk of losing his bedspace at the AP due to his ongoing non-compliance and poor engagement.

6.110 There are no other mental health interventions or appointments recorded by probation prior to H being recalled and returned to custody on 25 December 2018. It is also unclear as to whether or not H was taking his medication as prescribed at this time.

6.111 PO3 told us that they remembered H stating that he would not take medication as he believed it would provide a way for the government to track him. PO3 believed they had recorded this on the case records, but we have not been able to verify this. Furthermore, there is no evidence available that PO3 ever met with H prior to his recall to custody, so if this was said by H, we are not clear when.

6.112 However, if H had made this statement, we would judge that these suggested feelings of paranoia which should have been explored further with him by PO3 and the AP staff, and this comment should have been shared with mental health services.

6.113 This constitutes a missed opportunity to engage H in discussion about his mental health and the potential positive impact of compliance with medication.

6.114 The information available from the probation service does not reflect any contact between the probation officers and the mental health services supporting H in the community, although there is evidence of information sharing between AP staff and mental health services.

6.115 In their MAPPA referral, PO2 identified that it was unclear if H's mental health had deteriorated as the result of cannabis use, or whether increased cannabis use may have been evidence of him trying to self-medicate to control symptoms of his declining mental health. They also identified a deterioration in mental health could potentially increase H's risk of harm to others.

6.116 While at the AP, H showed a reluctance to engage with mental health services. He was not willing to accept medication until five weeks after arriving at the AP, and then

when he was prescribed medication by the CMHT he did not hand it in as required by the AP. So, there is no evidence available that he complied with his prescribed medication in his last few days at the AP.

6.117 We have concluded that there was limited dialogue and information sharing between the probation officers and mental health services. There were no multi-agency discussions about how to encourage H to engage with services and medication, especially given evidence of his emerging regular cannabis use, or to address H's alleged fear that the medication was in some way linked to a government tracking system.

Probation input after H's recall to custody

6.118 Following H's recall to prison, PO3 was required to complete a review of the recall within 28 days. The probation instruction (27/2014) makes clear that re-release on licence should only be made when there is evidence of a positive change since the recall has occurred, or there is a reduction in the risk of harm.

6.119 When this first recall review was completed on 11 January 2019 neither of the criteria for re-release could be evidenced. Criteria for re-release concerns behaviour in prison and the willingness to address offending and reduce risks by complying with the sentence plan. Therefore, PO3 could not recommend H be re-released at this time but did identify that H needed to demonstrate a higher level of compliance with mental health services, including becoming medication compliant while in custody, and recommended another review of the recall in six to nine months' time.

6.120 On 8 February 2019, PO3 and H's police OM attended HMP Stoke Heath to visit H, with a view to discussing his recall and to make plans for the future. H refused to leave his cell and the visit did not take place. It is to be noted that H was not obliged to meet with his probation officer while in prison and could refuse visits at any time.

6.121 After this failed visit PO3 did not make any further attempts to visit or video link with H. In October 2019, H was transferred to PO5 who also did not visit or arrange a video link with H.

6.122 The probation service provided this review with information from H's prison-based key worker, who saw H on an approximately monthly basis. H's engagement varied, for example on 7 May 2019 his key worker described him as more talkative than usual, but he had recently received a warning for having been found in possession of an offensive weapon, although no further details are recorded (such as what sort of weapon it was and where it was found).

6.123 On 17 July 2019, H's mental health was described as remaining "*an issue*", although again there is no detail recorded as to why, or how this manifested itself. This information was recorded by the prison on a shared record system so this information would have been available for the probation officers to review.

6.124 The only contact recorded by PO3 was an exchange of information with H's police OM, on 16 September 2019. The police OM asked for information about the reasons for H's recent move to another prison. PO3 confirmed that H had moved to HMP Parc due to ongoing issues of "*non-compliance*" at HMP Stoke Heath. H was said to have been found with an improvised weapon, and to have spent most of his days in his cell, with minimum engagement with staff.

6.125 Following this email exchange, PO3 recorded a case update regarding H and his progress; they commented that H appeared to have "*closed down*" any interaction with professionals who may be involved in his case. PO3 also recorded whether H

should be held under what they called "*Statutory Procedures for Public Protection*" to protect him.

6.126 In our interview with PO3, they clarified that they were referring to detention of H under the MHA in this comment, because there were no means to detain H in prison beyond the date that his prison sentence ended (22 April 2020). However, prior to this comment, PO3 makes no reference to any contact with the prison MHIT to get more details about H's mental health, and thus we are unsure what triggered PO3 to consider that H may have needed to be detained.

6.127 On 17 October 2019, PO3 attended the MAPPA meeting where H was deregistered. The reason for the deregistration was recorded as being due to H's lack of engagement with agencies trying to support him. The probation service was recorded in this meeting as not supporting his re-release on licence due to his lack of compliance and refusal to engage with the probation officer. Shortly after this meeting PO3 left the team, and the case was transferred to PO5.

6.128 The prison OS contacted PO3 for an update about H's release plans on 27 November 2019. They were not aware H had been transferred to PO5. PO3 still worked for the probation service at this time, and updated the OS, explaining that re-release was not being supported and that H would be released at the end of his sentence – although this meant that following his release, he would not be subject to any controls.

6.129 H had told the prison OS that he wanted to be released to the Wrexham area so that he could move away from the gang culture of Birmingham

6.130 The second and final review of H's recall took place in January 2020. PO5 prepared a report reviewing H's progress since the last review in January 2019. PO5 had never met H or had a video link with him. The last time H had met with a probation officer face to face was at Elliott House AP on 28 November 2018 when he met with PO2.

6.131 PO3 did visit H on 8 February 2019, but H refused to leave his cell to meet with him. After this there had been no further attempts to engage with H, either by letter, video link or visits, and we are not clear if H was aware that PO5 had taken over his case in November 2019.

6.132 In our view, this lack of contact resulted in H not having the opportunity to engage with the probation service in discussions about his future plans. Furthermore, it was a missed opportunity to encourage him to engage with the agencies offering support, especially mental health services. While we acknowledge that H did not appear interested in engaging with or working with the probation service, in our judgement, insufficient attempts were made to motivate H to engage further or to discover what factors were inhibiting his engagement.

6.133 The result was that PO5 wrote their report reviewing H's recall without offering him the opportunity to meet with or speak with them. The report is based on a discussion with the prison OS and a review of previous probation records, including the recall report prepared by PO3.

6.134 In their report, PO5 judged that H's risk of harm had not reduced, and that he had not demonstrated any improvement in his attitude or engagement. Reports of poor behaviour, as well as a positive drug test in prison on 13 December 2019 demonstrated the lack of any improvement, although on a positive note, H was said to be employed in the prison.

6.135 PO5 also described H as being medication compliant in the report. However, the report does not describe how long he had been compliant for, H's progress since he had become compliant, or his level of engagement with the prison MHIT.

6.136 PO3 had made extensive reference to H's mental health problems, feelings of paranoia and the need for him to engage with mental health services while in prison in the first recall review report prepared in January 2019. This was therefore an important area on which to focus.

6.137 We are of the view that PO5's report should have included detailed information regarding H's mental health at this time, and also whether he had improved or deteriorated since his recall. H was employed in the prison and was also taking his medication. Both of these are potentially positive developments and, in our view, were a reason to review the probation service's original decision not to recommend re-release on licence.

6.138 However, by the time PO5 prepared the recall review report on 7 January 2020, no accommodation was available for H at Elliott House AP. A re-referral would have been required if he were to be re-released on licence. This referral would have required up-to-date information on his current mental health, and a clear date for release to work towards.

6.139 We were told that there was no guarantee that Elliott House would be able to offer H a bed space at this time. We consider that it would be unlikely a bedspace would have become available for H at Elliott House AP between January and April 2020 (when his sentence was to end) if he had been re-released on licence. This is because there had been no planning for his release, residents would usually spend between three to six months living there, and other referrals would already be waiting for a bedspace to become available.

6.140 Nevertheless, even a short period spent on licence would have required H to return to the Birmingham area, where he was already known to mental health services. He would have been provided with assistance to find move on accommodation once he was due to leave Elliott House AP. This would then have provided greater information sharing opportunities across the agencies involved with him, as well as a move on plan to be in place. There is of course no guarantee that H would have complied with any move on plans.

6.141 Probation Instruction 27/2014 requires the probation officer to provide a review of progress made by a prisoner since their recall, and an up-to-date assessment of their risk. As a minimum therefore we would have anticipated that PO5's recommendation in their recall review report would have been informed by:

- a face-to-face or video link discussion with H, given they had never met H, and he had not seen a probation officer since December 2018;
- extensive consultation with the prison-based mental health services; and
- a discussion with the team manager at Elliott House AP.

6.142 We acknowledge that H may have chosen not to meet with PO5, but an attempt to encourage or facilitate re-engagement should have been made. The failure to do this constitutes a missed opportunity.

6.143 The Parole Board decision was that H should remain in prison until his sentence end date on 22 April 2020. H was reallocated to PO6 on 2 April 2020, and they had no involvement with H prior to his release from prison.

6.144 On 7 April 2020, the Birmingham probation accommodation officer asked PO5 if they knew why a housing application for H would have been sent to Wrexham. However, this query was not followed up by either PO5 or the accommodation officer.

6.145 The West Midlands Probation Service has developed and put in place a Sentence End Date Guide which is designed to assist probation officers managing cases such as H, who leave custody without a licence but who still pose a high risk of causing harm. There was no liaison between the probation service and other agencies such as police, health or HMP Parc and there is no evidence of a 'dedicated release plan.'

6.146 This guide (or pre-release checklist, as it is also called) requires the probation officer to notify all relevant agencies that probation service input is ending and a resettlement plan should be devised to address any accommodation needs and to identify if someone has particular issues linked to their risk of harm (such as mental health, substance misuse) which need to be followed up after they are released.

6.147 No such plan was in place for H. In our view the lack of any resettlement plan, which would have provided a more holistic overview of H's needs, represents another missed opportunity to share up-to-date information across all relevant agencies immediately prior to his release at sentence end date.

6.148 On 22 April 2020, H was released from HMP Parc at his sentence end date.

Findings – probation

1. Probation staff demonstrated a lack of professional curiosity about H.
2. PO2 did not engage with H in a motivational and supportive manner.
3. PO3 and PO5 did not have any face-to-face contact with H.
4. While H was at Elliott House AP on licence, there was inconsistent and inadequate use of sanctions. There is no evidence available that probation attempted to engage with H beyond the use of sanctions. H was allowed to be late for curfew, not engage with mental health services and use cannabis. All of these factors were known to be linked to an increased risk of harm and offending.
5. It is our view that he should have been recalled to prison earlier. This may have allowed for a plan for re-release under licence before the situation deteriorated too far.
6. The recall review report was based on very little up-to-date information.
7. Once it became apparent that H was going to remain in prison to sentence end, the probation service took a 'long arm' approach to the management of H.
8. Probation did not develop a resettlement plan for H, although one is required for high-risk cases being released at sentence end.
9. PO5 did not liaise with mental health services, either prison MHIT or the community CMHT, about H.
10. We identified some issues with the quality of record keeping. We were told at interview by one probation officer that H had told them he was reluctant to take his prescribed medication because the government would be able to monitor him. The Executive Summary and IMR provided by the probation service did not identify this comment and there is no evidence that this information was shared with mental health services.
11. PO5 did not complete a sentence end date checklist prior to H's release from prison in April 2020.
12. All of the above represent missed opportunities either to encourage engagement, share information or plan for H's release, whether on licence or at sentence end.

7 Discussion and analysis of MAPPA and H

Background to MAPPA

7.1 The MAPPA were initially introduced in 2001. They were formalised in 2003 by the Criminal Justice Act 2003 (CJA 2003)77 which provided for the establishment of a MAPPA in each of the 42 criminal justice areas in England and Wales. MAPPAs were designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. There is a requirement that the local criminal justice agencies and other bodies dealing with offenders work together in partnership in dealing with these offenders.

7.2 MAPPA guidance is issued by the Secretary of State for Justice under the CJA 2003 to help the relevant agencies dealing with MAPPA offenders. The agencies are required to have regard to the guidance. If they depart from the guidance there is a requirement for them to demonstrate and record their reasons for this. The relevant guidance in place at the time that H was subject to MAPPA oversight was issued in 2012, but due to a number of amendments the version in place was version 4.2, updated in July 2018 to version 4.3.

7.3 In many areas around the country, each MAPPA has a responsible authority (RA) consisting of the police, prison and probation service for the area. The RA has a duty to ensure that the risks posed by sexual and violent offenders are assessed and managed appropriately. Each RA will ensure that there is a MAPPA coordinator or chair who convenes and manages the regular review meetings that take place once an offender is subject to MAPPA registration. However, we were told in the West Midlands that it is the SMB's duty to have a coordinator and not the RA. In addition, not all offenders have 'regular review meetings' if they are MAPPA registered. The vast majority (approximately 95%) of MAPPA eligible offenders do not have an active Panel. They are reviewed by the RA leading in their management and this is not overseen by the coordinators.

7.4 The MAPPA guidance identifies that other agencies have a duty to cooperate (DTC) with the RA. They should work with the RA on particular aspects of the offender's life. Examples of DTC agencies include education, housing, employment and social care.

7.5 In each area there is a SMB providing a range of governance related functions, including monitoring performance, measuring compliance with the MAPPA key performance indicators and providing a MAPPA report. Members of the SMB include senior representatives from the RA and DTC agencies.

MAPPA pathway

7.6 The first stage of the MAPPA process is identifying relevant offenders based on their caution, or conviction and sentence. The agency with leading statutory responsibility for the offender is responsible for identifying if they are appropriate for management under MAPPA.

7.7 Once it has been identified that the offender is appropriate for management under MAPPA the leading agency should notify the local MAPPA coordinator.

7.8 At the time of H being under MAPPA, there were three identified categories of MAPPA offender:

[77] Since May 2022 a fourth category, that of "Category 4 – Terrorist or terrorist risk offender has been added". https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

- Category 1 – registered sex offenders
- Category 2 – violent offenders or other sexual offenders
- Category 3 – other dangerous offenders.[78,79]

7.9 MAPPA offenders are managed on one of three levels dependent on the extent of agency involvement needed and the number of different agencies involved:

- Level 1 (ordinary agency management) – this requires the sharing of information about the offender but does not require multi-agency meetings.
- Level 2 – the management of the offender requires an active multi-agency approach through MAPPA meetings.
- Level 3 – the management of the offender requires involvement from senior representatives from agencies who have the authority to commit resources as needed.[80]

7.10 The national MAPPA guidance requires offenders who are being managed under MAPPA to be reviewed in terms of their MAPPA level six months prior to their release from prison. If a level has not been set, then this should also be done within the same timeframe.

MAPPA and H

7.11 In May 2017, while H was detained to HMP Stoke Heath, PO1 completed a MAPPA screening document for H. This was in line with the probation service requirement in the Risk of Serious Harm Guidance[81] to complete a MAPPA screening within four weeks of sentencing as part of the wider risk assessment process, the OASys. An OASys is a written assessment carried out by the probation service throughout an offender's time on supervision, which identifies what factors might be causing them to offend (for example, drug or alcohol use), what risk they pose and to whom, and what needs to happen to reduce their risk of harm and risk of reoffending,

7.12 The MAPPA screening form completed by PO1 identified that H would be managed under Category 2 level 1 until sentence end date of the eligible offence which was in May 2018.

7.13 This resulted in a discussion between PO1 and H's police OM, and it was agreed that H would be managed at MAPPA level 1 while he was in prison. We consider this to have been appropriate and in line with the national MAPPA guidance. This is because the agency responsible for H could manage his risk at this time. Managing H at level 1 was not a barrier to agencies sharing information about him or holding discussions about him.

7.14 On 3 October 2018, while detained in HMP Oakwood, H was referred for to MAPPA, this was one month before the date of his release on licence. MAPPA guidance states that this review should take place six months prior to a release date.[82] The probation IMR identified that the delay in this referral could be attributed to PO2 gathering information about H, liaising with other agencies and making plans for his

[78] Criminal Justice Act 2003. https://www.legislation.gov.uk/ukpga/2003/44/contents
[79] HM Prison & Probation Service (2014) MAPPA Guidance. Section 6: Identification and Notification of MAPPA Offenders (6.1). https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance
[80] HM Prison & Probation Service (2014) MAPPA Guidance. Section 1: Introduction – Process (1.12). https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance
[81] HM Prison & Probation Service "Risk of Serious Harm Guidance" 2009 and 2014 supplement.
[82] HM Prison & Probation Service (2014) MAPPA Guidance. Section 7: Levels of Management – Recall (7.12) https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

release to Elliott House AP. Elliott House AP is a specialist AP, managed by the local probation service with support provided by the BSMHFT forensic community team The delay in the MAPPA referral was not considered to be significant by the probation IMR author because plans were being put in place to support H's release.

7.15 However, this review does not share the view of the probation IMR author that the delay in the MAPPA referral had "*little impact*." The probation chronology identified that PO2 was struggling to get information from health services about H and the support that was in place for his release. There would have been significant value in getting health services (who would have been a DTC agency) to attend an initial MAPPA meeting earlier in the process, to ensure that all agencies were sharing up-to-date information regarding H and there was clarity regarding what mental health provision and medication would be in place for his release.

7.16 In their MAPPA referral, PO2 identified a range of concerns regarding H's behaviour, including non-compliance with medication, previous child safeguarding issues, allegations of domestic abuse, a previous conviction for robbery and threats to harm others, which led to their conclusion that the risk of harm posed by H warranted registration as a MAPPA level 2 case. The police endorsed this judgement, and after discussion with the MAPPA coordinator, H was registered as a category 3 offender, reflecting the fact that his offences/sentence did not fit category 1 or 2 (see paragraph 9.8), and he was to be managed at level 2 (paragraph 9.9).

7.17 PO2 used their assessment completed in OASys to inform the risk of harm levels required as part of the MAPPA referral. They judged that H posed a high risk of causing harm to the public, and a medium risk of harm to children, a known adult and staff.

7.18 It is our judgement that the decision to register H at level 2 was in line with the MAPPA national guidance, given the risks identified by PO2 above and the likely multi-agency response needed to meet the complexity of his needs.

7.19 Once a case has been registered at level 2 or level 3, an initial meeting is held to discuss the case, agree what risks the offender may pose and what actions need to be taken and by whom to address these risks. The MAPPA guidance states that the purpose of MAPPA panel meetings is to "*share information to support multi-agency risk assessments and to formulate effective MAPPA risk management plans in order to ensure action is taken to manage the risk of serious harm posed* [by an offender]".[83]

Initial MAPPA panel meeting 5 November 2018

7.20 H's initial meeting was held on 5 November 2018, four days before he was released from prison. There was insufficient time for any necessary inter-agency information sharing and planning to take place prior to his release. Although we note that H had been accepted by Elliott House AP in August 2018 and so he did have a secure and suitable release address that would provide support with his mental health needs.

7.21 This initial MAPPA panel meeting was attended by probation, the police and CPN1 from the prison discharge service representing mental health services. A representative from the prison was not able to attend in person but they did provide written information. This report provided an update regarding H's behaviour, and

[83] HM Prison & Probation Service (2014) MAPPA Guidance. Section 26: Mentally Disordered Offenders and MAPPA – MAPPA Management (26.47) https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

detailed incidents involving H (including fighting with another prisoner) and numerous adjudications and reports for poor attitude and behaviour.

7.22 The MAPPA panel heard that H had not completed any offending behaviour work in prison, although he was now compliant with the mental health team and a referral had been made to the local CMHT in Birmingham prior to his release from prison; however, the health representative at the meeting told the panel that H had a history of non-compliance with medication. The police were to provide H with an escort to ensure that he got to Elliott House AP as instructed.

7.23 This meeting agreed a number of actions for each agency, including for the police to consider disclosing H's release date to former and current partners and to work with the probation service to complete a trigger plan to be followed if H absconded from Elliott House AP.

7.24 PO2 was to obtain an update from the prison MHIT, arrange a prison visit and review if a child safeguarding referral was required. It is our view that PO2 would have had insufficient time to arrange a prison visit because the MAPPA meeting was held four days prior to H's release.

7.25 The MAPPA panel mental health representative was to liaise with the CMHT and obtain an update.

7.26 This review has not had access to the minutes of the MAPPA meetings and are not able to comment on whether all of these actions were completed.

7.27 However, the probation and police IMRs confirm that a trigger plan was put in place prior to H being released from prison. This is a plan that could be activated quickly if H absconded, to try and locate him prior to any offence taking place.

MAPPA review meeting 29 January 2019

7.28 The next MAPPA review meeting was on 29 January 2019, in line with national guidance timescales which require level 2 offenders in the community to be reviewed every 16 weeks. However, H had been recalled and returned to custody in HMP Birmingham, on 25 December 2018.

7.29 No representative from the prison service attended this meeting due to H being moved establishments. H had been transferred from HMP Birmingham to HMP Stoke Heath after the invitations for the meeting had been sent. As a result, the panel did not have any information about H's behaviour or his mental health since his recall.

7.30 The panel meeting was told of the reasons for H's recall to custody and that his probation officer, (now PO3) was not supporting re-release at this time. Their opinion was that H needed to re-engage with mental health services and a medication regime. Elliott House AP had indicated they were willing to offer H further residency and a six-month review of the recall had been requested by PO3.

7.31 When an offender is recalled and returned to prison, they are entitled to have this decision reviewed on a regular basis by the Parole Board, to judge if their risk of harm reduced. Any such reduction in their risk of harm could result in the offender being considered for re-release on licence. However, they may have to remain in prison to complete further work or because the risk they pose is too high to be safely managed in the community.

7.32 The actions identified at this MAPPA panel meeting were for the mental health representative to obtain a full mental health update from the prison, for PO3 to review the sentence plan (contained in OASys to identify what work an offender needed to

do to address their behaviour) and for a joint prison visit to be arranged between the PO3 and the police.

7.33 No information was available to this review identifying whether the MAPPA meeting as a whole concurred with PO3's assessment that H's re-release should not be supported. Furthermore, we have not seen any evidence that any factors were identified that would have to be in place for re-release to be considered (such as medication compliance and engagement with the CMHT).

7.34 The absence of any up-to-date information regarding H's behaviour and engagement since his return to custody limited the MAPPA panel members ability to form judgements about potential actions for panel members, or what H needed to do to improve the likelihood of him being released for another period on licence.

7.35 The lack of information from the prison service or the prison MHIT hampered planning for managing H's risk and behaviour in the future when considering his re-release on licence. We would have anticipated that this MAPPA review meeting would have been rescheduled to take into account the lack of updated information and knowledge, and the absence of the prison service representative (given the date of this meeting would have been set prior to H's return to custody).

MAPPA review meeting 16 April 2019

7.36 The next MAPPA review meeting was held on 16 April 2019. This was attended by the police and the probation service. CPN1 from the prison discharge service sent their apologies, and HMP Stoke Heath was recorded as not attending and not sending apologies. For the second time there was no updated information about H's conduct in prison, nor his mental health and compliance with any treatment or intervention.

7.37 This review considers a lack of prison representation or a written report regarding H's progress and behaviour and the lack of updated information concerning his mental health and compliance with medication since his recall to be unsatisfactory.

7.38 The panel meeting was updated by PO3 who, accompanied by H's police OM, had attempted to visit H on 8 February 2019 but H refused to see them.

7.39 There had also been a review of his recall to prison by means of an oral hearing[84] and release was refused, as per the recommendation in PO3's report.

7.40 The panel meeting agreed that PO3 should attempt another visit with H to re-engage him and identify if an executive release could be requested. In other words, that the Secretary of State could agree to release H on licence, despite the initial decision not to re-release him.

7.41 In order for this to take place, there has to be evidence of considerable behaviour change shown by the prisoner, as well as full support from the probation officer who has to make a positive recommendation for release.[85]

7.42 The MAPPA meeting noted that if PO3 could encourage H to re-engage, resulting in a positive recommendation for re-release, Elliott House AP would be prepared to offer him another period of residency. The panel considered a period on licence would be more suitable than being released without any restrictions or conditions.

7.43 However, it is not possible to conclude that the MAPPA plan was appropriate and would have offered H a further opportunity for release on licence because there was

[84] probation instruction 27/2014
[85] probation instruction 27/2014)

no evidence available that the risks identified by PO2 had reduced, and therefore H remained at high risk of causing serious harm.

MAPPA review meeting 17 October 2019

7.44 MAPPA panels are not required to review offenders who are in prison every 16 weeks. The next MAPPA review for H was on 17 October 2019. In attendance at this meeting were the probation service, adult social care, CPN1 from the prison discharge service and West Midlands Police. H was added to the meeting list at short notice. It is unclear to us why the meeting had to be held so quickly, given the next review of H's recall was not due to be held until January 2020.

7.45 The short notice resulted in there being no representative from HMP Parc at the meeting. H had been at HMP Parc for a month following his transfer from HMP Stoke Heath. We note that prison services had not contributed to MAPPA panel meetings since November 2018. We consider their absence at this particular meeting to be significant. Prison services were the one agency having day-to-day contact with H following his recall to prison, and therefore would have had information to share about his behaviour and risks.

7.46 In our judgement the MAPPA panel meeting in October 2019 should have been rescheduled to allow the prison to attend and ensure that full and relevant information was available to all agencies at the meeting.

7.47 The meeting was told by PO3 that H continued to refuse to engage with either them or the police and that he had continued to show poor behaviour in prison. The probation IMR states that H had recently moved to another prison (HMP Parc on 12 September 2019) as the result of his poor behaviour and prior to the move was found with an improvised weapon in his cell.

7.48 PO3 would not support further re-release on licence through the executive release process because of H's ongoing poor compliance and refusal to engage. Actions from this MAPPA meeting were for:

- the probation service to continue to try to engage with H, despite his apparent refusal to do so, to better prepare him for eventual release; and
- CPN1 from the prison discharge service to update the local CMHT in Birmingham.

7.49 The MAPPA Executive Summary of this meeting does not refer to any discussion about H's mental health, compliance or engagement with medication or treatment, although a mental health representative (CPN1 from the prison discharge service) was in attendance at the meeting. The Executive Summary records that the MAPPA panel agreed that "*due to H's continued refusal to engage with any support offered there is no added benefit for continuation at level 2*". As a consequence, H was deregistered from the MAPPA process.

7.50 MAPPA guidance states that a category 3 MAPPA registered case should be terminated "*when a level 2 or level 3 MAPPA meeting decides that the risk of harm has reduced sufficiently, or the case no longer requires active multi-agency risk management*".[86]

7.51 Based on the information made available to this review we have not seen any evidence that would have indicated that H's risk of harm had reduced sufficiently or

[86] HM Prison & Probation Service (2014) MAPPA Guidance. Section 6: Identification and Notification of MAPPA Offenders – Termination of MAPPA Offender Status (6.38) https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

that his case no longer required multi-agency involvement by October 2019. The decision to de-register H from MAPPA should have been informed by information from the prison and MHIT.

7.52 Furthermore, none of the reasons that led H to be registered as level 2 MAPPA in October 2018 had been addressed and there is nothing to indicate that there had been any positive developments in the case. H had not cooperated with Elliott House AP or his medication regime between 9 November and 25 December 2018.

7.53 Thus, at the end of his sentence, H was released into the community with no licence, and no MAPPA registration. Had he remained subject to MAPPA registration beyond October 2019, there would have been further information sharing opportunities provided by ongoing panel meetings.

7.54 We consider the decision made by MAPPA to deregister H to be flawed This decision was based on H's refusal to engage with the support offered by criminal justice and mental health services. However, he continued to pose a high risk of causing serious harm and his behaviours and needs still required the provision of a multi-agency approach. This flawed decision was made in the absence of information from the prison service and up-to-date information about his current mental health.

7.55 It is difficult to conclude that the MAPPA decision making on 17 October 2019 was fully informed by all of the key agencies providing up-to-date information to the panel at this meeting.

7.56 MAPPA guidance (13a 34) makes clear that levels of MAPPA management "*should not be reduced where information is missing,* [or] *where a key partner is not represented at a meeting*".[87] We consider that because H had disengaged with the probation service (and therefore PO3 had limited information), the prison represented the 'key partner' who could have provided detailed and up-to-date information regarding H and his behaviour and compliance since recall. In addition, there does not appear to be any relevant information recorded in the Executive Summary regarding H's mental health in terms of engagement, interventions or medication.

7.57 We have concluded that the MAPPA should have continued to provide a mechanism for information exchange and release planning. There were no grounds for H to be deregistered from MAPPA management as a level 2 case in October 2019.

7.58 The MAPPA SMB has not completed a serious case review in this case, because H reoffended after he had been deregistered from the MAPPA; however, a brief review of the case was completed by the MAPPA coordinator and as a consequence, a policy document was reissued to its MAPPA meeting chairs regarding the management of cases which were likely to be released at sentence end date (i.e. without licence, such as H).

7.59 This best practice guidance document was prepared by a senior manager in the West Midlands' Probation Service and is designed to ensure that key concerns are identified and addressed if someone is to be released without a licence – concerns such as homelessness, mental health, drug/alcohol use. In other words, no offender who is judged to pose a high risk to others, would leave prison without some sort of resettlement plan in place, which would be coordinated by the probation officer even if they were not going to supervise the offender after release.

7.60 In a case subject to level 2 or 3 MAPPA registration, the guidance describes the need for information sharing to take place prior to release, and that even after the

[87] HM Prison & Probation Service (2014) MAPPA Guidance. Section 13: Multi-Agency Public Protection Meetings – Management of MAPPA Meetings (13a.38) https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

sentence end date has passed, the probation officer should attend any further MAPPA panel meetings, up to one month after the end of formal supervision.

Post-MAPPA management

7.61 There is no evidence of release plans being put in place by PO5 prior to H's release from prison, as per MAPPA guidance. PO5 (to whom the case had been transferred shortly after the MAPPA meeting in October 2019) did not make any attempt to visit H or to interview him via video link.

7.62 It is the view of this review that had the MAPPA remained in place, there would have been opportunity for multi-agency information sharing and planning up until the point of release as a minimum. Furthermore, there would have been oversight of the MAPPA actions outstanding (such as the probation officer trying to re-engage H).

7.63 We have concluded that H did not meet the criteria for deregistration from MAPPA in October 2019. In addition, because he was still assessed as posing a high risk of harm, rather than deregister him, extra efforts should have been made to engage with him and plan for his release on the basis that he would not be released on any sort of licence in April 2020.

7.64 On that basis, we would recommend that the MAPPA SMB reviews its decision not to complete a serious case review. A serious case review would be an opportunity to look in more detail at the issues we have raised and to ensure that lessons learned are shared with the SMB and all those involved in the MAPPA chairing and panel meeting process.

Findings – MAPPA

1. PO1 completed the MAPPA screening for H in May 2017, and this identified that he met the criteria for MAPPA registration and required management under MAPPA. At this time H was assessed and managed at MAPPA level 1.

2. A referral should have been made to determine if further MAPPA registration was required (and if so at what level) after release, the guidance stating that this ideally takes place 6 months prior to release. This referral was not made until a month before his release. This delay is attributed to PO2 gathering information from other agencies about H and making plans for his release.

3. PO2 reported challenges obtaining information from mental health services about H. There would have been significant advantages to an initial MAPPA meeting that included mental health services representation.

4. This delay in the referral resulted in there being insufficient time for any necessary inter-agency information sharing and planning prior to H's release on licence to Elliott House AP in November 2018.

5. The decision to register H at level 2 was in line with the MAPPA national guidance, given the risks identified by the probation service and the multi-agency response needed to meet the complexity of his needs.

6. The involvement of the prison service in the MAPPA process was limited and unsatisfactory. Particularly significant is the lack of prison input to the October 2019 meeting. The prison service was the one agency having day-to-day contact with H following his recall in December 2018, and they would have had information to share about his behaviours and risks.

7. Prison service participation in MAPPA meetings was limited to the initial meeting in November 2018:
    - 5 November 2018 – the prison service provided a report outlining H's behaviour while in prison, incidents he had been involved in (including fighting with another prisoner, and numerous adjudications and reports for poor attitude and behaviour).
    - 29 January 2019 – no prison service representative at this meeting, H had moved prisons between invitations being sent out and the date of the meeting. This included there being no information available from the MHIT service.
    - 16 April 2019 – no prison representative at this meeting. They did not send any apologises or provide an update for the meeting on H's conduct in prison or on his mental health and compliance with treatment or interventions.
    - 17 October 2019 – no prison service representation at this meeting.

8. PO3's assessment was that H's re-release should not be supported. There was no information available to establish if this view was shared by all of the members of the MAPPA meeting.

9. H was refused early release by the Parole Board and the only possibility of release before sentence end would have been on executive release.

10. Elliott House AP was willing to offer H another residency. We consider that a further period on licence would have been more suitable than H being released at sentence end without any restrictions, conditions or supervision. This would have ensured that mental health, probation and the police would have known the address to which H had been released and should have afforded a greater opportunity for H to be engaged with statutory services.

11. H was added to the MAPPA meeting agenda for 17 October 2019 at short notice. It is our judgement the meeting should have been deferred to allow for information to be obtained from all agencies, especially the prison.

12. H was deregistered from MAPPA, "*due to his continued refusal to engage with any support offered there is no benefit for continuation at level 2*". The MAPPA guidance says offenders such as H should only be deregistered when the MAPPA meeting decides that the risk of harm has sufficiently reduced, or they no longer require active multi-agency risk management. This review has been unable to conclude that H's risk had reduced by October 2019.

13. We have concluded that MAPPA should have continued to provide the mechanism for multi-agency information sharing and release planning.

8 Discussion and analysis of H's release from HMP Parc and post-release arrangements

8.1 It would have been reasonable to have expected H to spend his last months detained to a prison close to the area he planned to be released to. H was detained in HMP Parc and told staff he planned to live in Wrexham following his release. The prison service would consider HMP Parc to be local to the area H was planning to live in following his release.

8.2 This is because prison and probation services in England and Wales are divided into 'prison regions'. The whole of Wales is in one prison region, so HMP Parc is considered local to Wrexham.

8.3 Government guidance on support available to prisoners prior to release from prison states that they should have advice and support on:

- finding somewhere to live;
- getting a job; and
- looking after money.
- Prisoners get additional support if they:
- have abused substances.[88]

8.4 A resettlement worker from the St Giles Trust[89] met with H on the wing in January 2020. They completed a needs-led assessment with H. At that time, his main need was accommodation. H told the worker that he was expecting to be transferred to HMP Berwyn and he would like to live in Wrexham following his release from prison. H told the worker that his next of kin was dead and that he would like to live near to a family friend in Wrexham. He said that he would like to get away from Birmingham and the drug culture.

8.5 H told the resettlement worker that he had a bank account and did not have any debts. He said he did not require help with his finances. He planned to claim benefits on release from prison.

8.6 The resettlement worker planned to see H again at the end of March 2020 to discuss the plans for his release.

8.7 A peer support worker helped H complete a housing application for Wrexham on 28 January 2020. However, this was declined on 10 March 2020 because H could not demonstrate a sufficient local connection to Wrexham.

8.8 On 9 March 2020, the resettlement worker reviewed the arrangements for H and recorded that:

"*H wants resettlement to the Wrexham area to get out of the gang culture in Birmingham, Housing referral completed and his connection there is a family friend X. Benefits appointment to be made nearer the time of release. No further support required*."

[88] GOV.UK. Leaving Prison. https://www.gov.uk/leaving-prison/before-someone-leaves-prison
[89] St Giles Trust https://www.stgilestrust.org.uk/

8.9 The resettlement worker planned to see H again the third week in March 2020. However, the resettlement team stopped going into the prison from 20 March 2020 because of national Covid restrictions.

8.10 A peer support worker supported H to complete an application for benefits seven days prior to his release. On this application H gave his address as No Fixed Abode, Edgbaston, Birmingham.

8.11 H requested a travel warrant to Birmingham from the prison cashier's office.

8.12 However, when the PCMHT asked H about his release plans immediately prior to his release he continued to say that he was planning to go to Wrexham.

8.13 When H arrived in Birmingham, he sought accommodation through the homelessness service Newton Housing Options Centre.[90] Due to the Covid restrictions in place at the time, H was provided with advice over the phone. This took place at 1.05pm on 22 April 2020. A referral was made to Expectations UK[91] for a placement for H at the Aston Hotel. They accepted H and provided him with accommodation with support.

8.14 In his application for the accommodation H disclosed that he had recently been released from HMP Parc. He said that he had spent three years in prison for dealing drugs but had no other history of offences or convictions. He made limited reference to his mental health problems, disclosing that he had a diagnosis of schizophrenia and took olanzapine 10mg once a day. He said that he had no family "*as* [they had] *passed away*".

8.15 H had appointments with a support worker on a weekly basis. While he attended these, in the main, he was guarded and provided very little information about himself or his mental health issues.

8.16 On 1 June 2020, H was cautioned for using cannabis and the accommodation staff began to suspect that he was selling cannabis on the premises. On 2 June 2020, H was seen walking past the manager's office with bin bags. When asked where he was going, he said he was moving into shared accommodation in the Aston area. He did not leave a forwarding address.

8.17 H would appear to have been residing at this second address when the incident occurred. The police described this accommodation as a shared house managed by a housing association.

[90] Newtown Housing Options Centre. https://www.birmingham.gov.uk/info/50094/housing_options/1191/newtown_housing_options_centre

[91] Expectations UK provides accommodation for individuals experiencing homelessness, mental health issues and substance misuse recovery. https://www.expectations-uk.com/

Findings – management of H's release from HMP Parc and post-release arrangements

1. H had served his custodial sentence to sentence end. There was no statutory requirement for supervision of H by the National Probation Service. Furthermore, H could not be subject to any compulsory supervision by mental health services. However, it would have been good practice from Erdington CMHT and HMP Parc to have been in effective communication concerning his planned release and to have worked closely to arrange a suitable plan to support H's engagement with mental health services post-release. AT the minimum this should have been for the HMP Parc MHIT to inform Erdington CMHT and H's care coordinator of his planned release, even though his future address was not known.

2. H was supported to make plans for his release in line with government guidance.

3. H continued to tell staff he was going to live in Wrexham, while making plans to return to Birmingham.

4. As a result of the coronavirus lockdown on 20 March 2020, limited support was available for H's release planning:
    - H was seen for a second time prior to his release by the St Giles resettlement team on 10 March 2020, where he identified that he wanted to resettle to the Wrexham area and a housing referral was completed. However, H was eventually released to NFA.
    - H was supported to apply for benefits by a peer support worker and the resettlement team had no oversight of this at the time.
    - H applied for a travel warrant directly from the prison cashier team not through the resettlement team, his prison OM or the MHIT. This resulted in his intention to return to the Birmingham area being hidden from the staff and teams that would have been able to notify services in Birmingham about his intention to return to the area.

5. H returned directly to Birmingham on release from HMP Parc.

6. H demonstrated personal resilience and resourcefulness by securing accommodation for himself when he arrived in Birmingham.

7. H's behaviour in his first residence after leaving HM Parc, mirrored his behaviours while in prison and at Elliott House AP. He had limited contact with staff, did not engage or make use of the support available to him. It was also reported that he was using cannabis and may have returned to his previous lifestyle.

8. H disclosed to the accommodation he secured for himself that he had a mental health diagnosis and was prescribed antipsychotic medication. We would have expected the accommodation provider to have demonstrated some professional curiosity about H, his diagnosis and medication, although without overt symptoms there was little they could have done.

9 Discussion and analysis of H's mental health care and treatment

Diagnosis and engagement with psychiatrists

9.1 There was evidence from assessments completed in HMP Brinsford in 2012 and HMP Dovegate in 2014, that H had a diagnosis of paranoid schizophrenia. But at times during his 2017–2020 prison sentence, this was not always apparent in the interactions between the MHIT staff and H.

9.2 H was difficult to engage with and reluctant to attend appointments with the mental health staff responsible for his care and treatment.

9.3 As a result of this his contact with psychiatrists was limited in the three years between April 2017 and April 2020. In this period, he was offered 11 appointments with the MHIT psychiatrists and was seen five times, but in one of these appointments he would not cooperate, and it was not possible to complete an assessment. In addition, he was seen three times by community-based psychiatrists while in the community on licence between November and December 2018.

9.4 From reviewing H's SystmOne prison mental health records, a repeated response to H not attending appointments, especially with psychiatrists was to "*book another appointment*," which he invariably did not attend.

9.5 One notable exception was consultant psychiatrist 1 at HMP Stoke Heath who, on several occasions, went to the wing and interviewed H in his cell.

9.6 When H did attend an appointment with a psychiatrist, they were able to elicit very clear symptoms of schizophrenia, more so than other clinical staff were able to. It is disappointing therefore that he was seen so infrequently by psychiatrists, e.g., he was seen in January 2018, when clear symptoms of schizophrenia were noted but was not seen again until October 2018, just before his release on licence.

9.7 During those nine months he had not been compliant with prescribed antipsychotic medication and had often defaulted from appointments with the MHIT, including with psychiatrists. The result was that when he was released on licence, he was untreated and mentally ill.

9.8 Throughout his last prison sentence, there are entries in the medical record to the effect that there was no evidence of psychosis, even though he was often unwilling to see the MHIT staff and who relied on accounts from prison staff that H was "*not exhibiting psychotic symptoms on a day-to-day basis*".

9.9 There was a belief that H was not mentally ill despite the known diagnosis of schizophrenia and his non-compliance with prescribed antipsychotic medication during this sentence. One notable example was in February 2019, when he returned to HMP Stoke Heath, nine months after he left there. An initial assessment by MHIT Practitioner 2 concluded that:

"*I have known H for a period of time and not witnessed any clear evidence of acute psychosis in my clinic. He rarely talks about any clear symptoms and has never appeared distracted or* [as if] *responding to any unseen stimuli.*"

9.10 This is despite the notes from his previous detention to HMP Stoke Heath for June 2017 to January 2018, when he was been seen fairly regularly by MHIT Practitioner 1 who consistently described symptoms of psychosis.

9.11 In January 2018, H was seen by consultant psychiatrist 1 who found very clear symptoms of psychosis and recorded this in the clinical record available to MHIT Practitioner 2. It is difficult to reconcile the view of MHIT Practitioner 2 in February 2019 with this evidence and also the view of the forensic community team psychiatrist at Elliott House AP in December 2018 that he was mentally ill and required treatment with antipsychotic medication.

9.12 On 30 August 2019, prior to H's transfer to HMP Parc, the MHIT meeting noted that MHIT Practitioner 3 had considerable concerns about his mental state. In the previous five months he had been found with a sharpened toilet brush in his cell and was later transferred to the segregation unit after a knife was found in his cell. Throughout this period, H had not been compliant with his antipsychotic medication and would not attend appointments with the practitioner and the consultant psychiatrist.

9.13 Furthermore, at times H disclosed paranoia and hallucinations. He was discussed on several occasions by the MHIT MDT and on 30 August 2019 the decision was made to make a referral to Reaside MSU. However, six days later, on 5 September, it was decided that the referral was not needed because H had been compliant with his medication for five days. Given his history of previous non-compliance over several years, we do not consider this to have been a reasonable length of time to measure compliance and evidence of long-term change to his entrenched pattern of non-compliance.

9.14 He was reviewed by the consultant psychiatrist 3, who was new to the MHIT, on the team on 5 September 2019, who saw him for the first time and noted:

*"Ongoing **threats** to staff, has assaulted staff over hear [sic] in the past. Disengages with services Non-compliant with medication*."

"Mental State Examination. Casually dressed. Reasonable eye contact. No affect of [sic] psychotic symptoms. Good cognition. Good insight."

9.15 The conclusion from this assessment was that H should be referred back to primary care. He was said to be "*Happy to continue with same medication*."

9.16 We were unable to interview this psychiatrist as he had moved to a different country. But MHIT Practitioner 3 told us they had not agreed with this decision, and they agreed to continue to see H.

9.17 H was transferred to HMP Parc one week later 12 September 2019. He was not offered an appointment with the MHIT consultant psychiatrist until April 2020, immediately prior to his release. H did not attend this appointment and consultant psychiatrist 5 concluded there was "*no need for further medical appointment*" and H did not require secondary mental health care. This was despite H not having been seen by a psychiatrist for more than six months and his ongoing non-compliance with medication.

Care Programme Approach and the Mental Health (Wales) Measure 2010

9.18 The Care Programme Approach (CPA)[92] was introduced in April 1991 to provide a framework for person-centred individualised care planning. The original guidance was updated by the publication of Effective Care Planning in Mental Health in October 1999 and Refocusing the Care Programme Approach in 2008.

[92] Department of Health (1990) Health and Social Services Development 'Caring for People'. The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services. Joint Health/Social Services Circular HC (90) 23/LASSL (90) 11

9.19 The latest guidance available on CPA is in the form of a Rethink Factsheet[93] (September 2017) which describes CPA as a framework for assessing secondary mental health needs and coordinating care. CPA should ensure continuity of care, support joint working and information sharing between agencies supporting the patient, who is at the centre of the process.

9.20 Prior to H being returned to prison in 2017 he was under the care of Birmingham EIP team. When he was detained to prison EIP did not complete a transfer CPA or communicate with the prison MHIT. The EIP response was to transfer him back to the care of his GP.

9.21 When patients under community mental health services go into prison, they very often experience a discontinuity in their care between community and prison. The use of CPA can ensure the patient has the appropriate care and support in place immediately and result in reducing their vulnerability.

9.22 It is well known that the initial days and weeks in prison are a vulnerable time, especially for mentally ill prisoners. It is vital that care and treatment is continued from the community into prison and that mentally ill prisoners do not fall into the gaps between mental health teams.

9.23 It would have been good practice for EIP to have held a meeting with the MHIT to complete a handover of care and ensure continuity.

9.24 There are references on SystmOne to H being subject to the CPA when detained in prison.

9.25 In August 2018 while at HMP Oakwood the MHIT completed an assessment of H's needs. This identified that he had a named care coordinator, and a CPA care plan was agreed with him. This identified the need:

- to maintain H's mental health at a stable level and improve his ability to function effectively within the prison regime;
- for H to gain insight into his mental health and monitor his own mental state;
- to reduce the negative impact the symptoms, have on H and to promote recovery when needed, also to be able to maintain his mental health and wellbeing; and
- for H to engage in relapse prevention work in order that he could identify all signatures that were relevant to him.

9.26 However, there is only one CPA review documented on SystmOne. This was completed in March 2019 while he was under the care of the MHIT at HMP Stoke Heath. This does not reference the previous CPA care plan and identifies that H would not cooperate in the assessment. However, this CPA care plan is accompanied by a risk assessment. It notes his previous threats to harm his family and his hostility towards staff. Also, his offences involving firearms and possession of a knife in the community. But there is no risk plan, or crisis or contingency plan.

9.27 The CPA care plan references a single assessment tool dated July 2018 and a letter written by the forensic community team consultant psychiatrist in January 2019. The CPA identified that H was known to the local CMHT and the BSMHFT Prison Discharge Service.

[93] Available to download from https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/

9.28 H's recall to HMP Birmingham identified that H was subject to CPA, under the care of the BSMHFT forensic community team while released on licence. No CPA assessment or care plan was completed for H while he was at Elliott House AP.

9.29 No evidence was made available to this review that a discharge CPA care plan was completed when H transferred to HMP Parc, although HMP Stoke Heath did make direct contact with HMP Parc to handover his care.

9.30 In Wales the Mental Health (Wales) Measure 2010 is a law that covers the support that should be made available for people in Wales with mental health problems. The Measure provides rights to individuals to have a care coordinator appointed to work with them to coordinate their care and treatment and the right to an individualised care and treatment plan to assist their recover. It also places a duty on service providers (Health Boards and Local Authorities) to act in a coordinated way to improve the effectiveness of the mental health services they provide.

9.31 While H was in HMP Parc the CPN responsible for the oversight of his care and treatment in Erdington CMHT was called the care coordinator. However, they did not complete a care assessment or care plan for H.

9.32 We have not seen any evidence that there was an effective care and treatment plan to support H to meet his mental health needs, or that the CPA was used appropriately.

9.33 Better functioning of the CPA framework in prison has been recommended for over 25 years, through a number of policies and strategy documents. In 2020, the Quality Network for Prison Mental Health Services (QNPMHS) published guidance on planning effective mental health care in prison using the CPA.[94] They noted that CPA has been poorly implemented in prisons.

9.34 A more robust use of CPA would have supported continuity of care as H moved between the various mental health teams in prison and the community.

Care planning

9.35 There are very few CPA or non-CPA care plans available relating to H.

9.36 In November 2017, the EIP team plan was to discharge H back to the care of his GP because he had been sentenced to three years in prison.

9.37 In June 2019, the MHIT in HMP Stoke Heath completed a review of H's care plan. This noted that he was to be encouraged to engage with the secondary care mental health worker and agree a plan through therapeutic interventions, and for H to refrain from illicit substances and to agree to drug testing.

9.38 It is to be noted that we observed more care plans relating to the management of H's asthma while in prison then his mental health problems.

9.39 There is no evidence available of a care plan to support H's mental health assessment and care while he was at HMP Parc.

9.40 Planning for H was done on an ad hoc appointment-to-appointment basis, with teams being reactive rather than proactive in their management of H.

[94] QNPMHS (September 2020) Planning Effective Mental Healthcare in Prisons Using the Care Programme Approach and the Community Mental Health Framework https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/qnpmhs-planning-effective-mental-healthcare-in-prisons-using-the-care-programme-approach.pdf?sfvrsn=11163e3d_2

Continuity of care

9.41 Had CPA reviews been held regularly in the various prisons H was detained to, it would have facilitated a more longitudinal view of his care needs, rather than the shorter-term reactive assessments that appear to have characterised his treatment in prison. This is especially true given the number of transfers between prisons that occurred during H's three-year prison sentence.

9.42 It is well recognised that points of transition in the care of patients with enduring mental illness, such as schizophrenia, represent potential risk both for the patient and to other people.

9.43 It is vital that risk assessments, risk management and care planning are considered at transition points, ensuring continuity of care is maintained and information is shared with teams, services and agencies who may be involved in delivering care following transition.

9.44 In the case of H, there was no evidence that these transitions were managed by the use of the CPA or that his risk was reassessed at each of these transition points.

9.45 The issue of transition between different mental health provider teams is particularly relevant to H's case because during the three years of his sentence he moved between five different mental health teams (several of them twice) as a result of five prison transfers. The reason for at least two of these was not clear and did not appear to be advantageous to his mental health care.

9.46 The key dates at which points of transition occurred included:

- Community to HMP Birmingham – 20 March 2017
- HMP Birmingham to HMP Oakwood – 30 May 2018
- HMP Oakwood to Elliott House AP – 9 November 2018
- Elliott House AP to HMP Birmingham – 25 December 2018
- HMP Birmingham to HMP Stoke Heath – 24 January 2019
- HMP Stoke Heath to HMP Parc – 12 September 2019

9.47 The two key transitions are from prison to the community. H was released on licence in November 2017 and at sentence end in April 2020.

9.48 In November 2018, H was released on licence from HMP Oakwood to the specialist mental health AP, Elliott House AP in Birmingham. There is evidence of a good handover from the HMP Oakwood MHIT and referral to the forensic community team and CMHT in Birmingham. The forensic community team visited Elliott House AP each week, this included the consultant forensic psychiatrist for the team.

9.49 However, we have concluded that it is likely H's untreated schizophrenia contributed to his chaotic behaviour in the community. By the time treatment for his schizophrenia was started, it was too late to have a positive impact on his mental state. As a result of his chaotic and non-compliant behaviour he was recalled back to prison after eight weeks on licence in the community.

9.50 Unfortunately, it does not appear that the lessons from his first release on licence were learned by the time of his release at the end of his sentence.

9.51 On H's transfer from HMP Stoke Heath to HMP Parc, a handover was provided, but his mental illness had not been effectively treated prior to his transfer. This continued

while he was at HMP Parc, and his mental illness was not effectively treated prior to his eventual release in April 2020.

9.52 HMP Stoke Heath provided HMP Parc with the contact details for H's CMHT in Birmingham. This information can be found in the last entry on SystmOne made by HMP Stoke Heath MHIT and in the minutes of the MDT meeting at HMP Parc.

9.53 Undoubtedly the Covid-19 pandemic had an effect on the ability of the MHIT in HMP Parc to deliver an effective mental health service in the final five weeks of H's sentence. However, in the six months prior to the pandemic, the pattern of his non-compliance with medication and appointments with the MHIT continued.

9.54 H was discussed at the HMP Parc MHIT Single Point of Access meetings (SPAM) on 1, 8 and 15 October 2019 – although the record for these meetings is the same. At the first meeting H was allocated to CPN1, by 15 October 2019 he had not been seen, so it was agreed that one of the other CPNs on the team would meet with H.

9.55 The Standard Operating Policy for MHIT HMP Parc and the Mental Health (Wales) Measure 2010[95] require the team to request additional information for a prisoner referred to them, complete a recovery assessment and co-work if the prisoner is already in receipt of secondary care mental health services in the community.

9.56 No evidence was made available to this review that the HMP Parc MHIT reviewed H's SystmOne record, gathered additional information about H from other services or completed a recovery assessment with H. Furthermore, despite being made aware by HMP Stoke Heath MHIT that H was care coordinated in the community, no effort was made to make contact with the care coordinator and co-work.

9.57 There is no evidence of team discussions about H's compliance or about treating his mental illness. This is despite clear evidence in the records that the pharmacy technician noted repeated and continuing non-compliance with medication and brought this to the attention of the MHIT.

9.58 On 11 March 2020, CPN1 recorded that H had told him that "*the current medication is having a positive effect on schizophrenia*", but there is no evidence that he was taking that medication or that CPN1 challenged him about this. The CPN's opinion was that there was no evidence of psychosis, yet in the same entry in SystmOne, it stated "*… he is struggling with anxiety and feels that no one can walk behind him as he feels intimidated and snaps at them, believes this is due to PTSD*".

9.59 The following day H was due to see the MHIT consultant psychiatrist, but he did not attend. This was the first appointment made for him with the psychiatrist since his transfer there six months previously and was only one month before his release date. The psychiatrist's notes were:

"Examination: DNA today. On olanzapine 10mg od [once daily]. No need for further medical appointment and no change in his medication. Due for release on 22/4/2020. Discussed with (CPN) to action transfer of care before his release."

9.60 On 18 March 2020, the MHIT was removed from HMP Parc as an "*immediate and urgent response*" to the emerging coronavirus pandemic. The team did go on to work with the prison remotely using digital platforms. However, the PCMHT continued to go into the prison and see prisoners face to face.

9.61 On 11 April 2020, H was assessed by RMN3 from the PCMHT who emailed the MHIT team manager:

"*Just a bit concerned about this man, he is not taking his medication, he is not coming out of his cell laying in bed with blanket over his head. Not sure if he is having good diet and fluid intake. I have asked him that if I bring the medication to the cell would he take it, he refused saying I can't you know what is going on here. maybe paranoid?? appears depressed. He is due for release in a week. Can you guide me on this and also is there anything in place when he is released?*"

9.62 Unfortunately, by this stage it was too late for any intervention to have an effect on H's mental illness as he was released at the end of his sentence 11 days later on 22 April 2020.

HMP Parc

9.63 HM Prison Parc is a large Category B men's private prison and Young Offenders Institution in Bridgend, Mid Glamorgan, Wales, with a capacity of 1699 prisoners.[96] HMP Parc is operated by G4S and is the only privately operated prison in Wales.

9.64 The Mental Health (Wales) Measure 2010[97] is a law passed by the National Assembly for Wales that describes the support and services that should be available for people with mental health problems in living Wales.

9.65 The Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. The measure has four main parts and each places new legal duties on Local Health Boards and Local Authorities to improve service delivery. The four Parts are as follows.

- Part 1 seeks to ensure more mental health services are available within primary care.
- Part 2 gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.
- Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.
- Part 4 offers every in-patient access to the help of an independent mental health advocate.

9.66 The MHIT at HMP Parc is provided by Swansea Bay University Health Board (SBUHB) on a commissioned basis by the Cwm Taf Morgannwg Health Board. The MHIT is based across two prisons: HMP Parc and HMP Swansea. The MHIT Team is a pooled resource that provides a service to both establishments. Historically there were two separate teams, but due to the increased capacity of HMP Parc from its inception to the current day (circa. 600 to circa 1800 prisoner capacity) and a lack of associated funding to the MHIT, the Health Board took mitigating steps to amalgamate the two teams to provide a service across both establishments.

9.67 We understand that there are other challenges facing HMP Parc MHIT. HMP Parc has a prison population more than three times the size of HMP Swansea,[98] with

[96] The "Annual Report of the Independent Monitoring Board at HMP Parc For reporting year 1 March 2020 – 28 February 2021" published in December 2021 states there were 1599 prisoners in HMP Parc at publication https://imb.org.uk/document/parc-2020-21-annual-report/

[97] https://senedd.wales/media/fgjfhrzk/ms-ld8002-e-english.pdf and https://www.legislation.gov.uk/mwa/2010/7/introduction

[98] The Prisoner Survey from HM Inspectorate of Prisons August 202 states there were 370 prisoners in HMP Swansea at time of survey https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/Swansea-prisoner-survey-2020.pdf

corresponding demand on services. There is no primary care psychiatrist available in HMP Parc but there is in HMP Swansea. The MHIT have no dedicated clinical psychology service, and the consultant psychiatrist position for the MHIT was vacant during H's stay, with backfill provided by a locum consultant psychiatrist.

9.68 Although HMP Parc is a privately run prison (by G4S), its health and social care provision is subject to oversight by a Prison Health & Social Care Partnership Board (PHSCPB). We understand from a review of health and social care provision by the Welsh Parliament Health, Social Care and Sport Committee[99] that the PHSCPB took some time to *"effective partnership working arrangements in place".*

9.69 Evidence collated from a range of internal and external reviews and benchmarking highlight issues in the delivery of care and treatment for prisoners with complex mental health needs at HMP Parc and HMP Swansea, as a direct result of the limited staffing resource that cannot meet the ongoing demand.

9.70 For example, the "Report on an unannounced inspection of HMP Parc by HM Chief Inspector of Prisons, 11-22 November 2019".[100]

"The demand for mental health services was high and service provision did not meet demand. Although the support available for mild to moderate problems had improved, the range of specialist interventions and support for prisoners with more complex needs was inadequate and too many patients waited too long to access existing services".

9.71 Similarly, the Royal College of Psychiatrists Prison Quality Network for Prison Mental Health Services (QNPMHS) Review Summary for HMP Parc, dated 05 June 2019, identified the following **Areas for improvement:**

"The team remain stretched, overworked and under-resourced. As mentioned in the previous year's report the staffing levels have remained the same since the secondary mental health service began in 2006, despite the prison population more than doubling. Management described putting in a bid to the Welsh Government for additional funding, and even putting the service on the 'at risk register' as they do not feel they are currently able to provide a satisfactory service that meets the needs of the prison population."

9.72 The more recent HMP Parc Health and Social Care Needs Assessment[101] identified that there are still difficulties in providing a mental health in reach service:

"the in-reach team is clearly very stretched and throughout the pandemic has been largely absent from the establishment offering a remote service."

This report made several recommendations including:

With a lack of talking therapies, the primary mental health response is over dependent on pharmacological responses.	**Recommendation Nine –** The primary mental health provision needs an alternative to medication. It should include talking therapies – we recommend psychological wellbeing. practitioners skilled in interventions such as CBT.

[99] Welsh Parliament: Health, Social Care and Sport Committee. *"Health and social care provision in the adult prison estate in Wales"*
March 2021 https://senedd.wales/media/ct4f03nb/cr-ld14318-e.pdf
[100] https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Parc-web-2019.pdf
[101] HMP Parc Health and Social Care Needs Assessment commissioned by Cwm Taf Morgannwg Health Board. Final Version 3.0 March 2021 https://ctmuhb.nhs.wales/about-us/our-board/board-papers/2021-board-papers/7-july-2021/3-5-1-appendix-3-hmp-parc-health-and-social-care-needs-assessment-pdf/

There is a lack of trauma informed therapy.	**Recommendation Ten –** There needs to be trauma informed interventions. We suggest EMDR.
There is a gap in capacity to diagnose residents, to initiate prescribing and to address needs of those with complex needs (if you adopt the recommendation of psychological informed interventions for this cohort, there will also be supervision needs).	**Recommendation Eleven –** There needs to be both clinical psychologist and psychiatrist input for residents under Part 1 of the MHM. (Both may only need to be quite limited.)
There is a lack of provision for those whose needs fall under Part 2 of the MHM.	**Recommendation Twelve –** There needs to be a review of resourcing, with a view to substantially increasing the resourcing of services for those receiving care under Part 2 of the MHM.
The in-reach team would be more accessible and integrated with other health provision and the prison if based on site	**Recommendation Thirteen –** Services for those receiving care under Part 2 of the MHM should be based in the prison, rather than reaching in.
Gaps in provision would be addressed via a fully integrated mental health response.	**Recommendation Fourteen –** Services for those who fall under Part 1 and Part 2 of the MHM should be integrated.

9.73 The care and treatment provided by the MHIT is informed by the Operational Policy for HMP Parc and Swansea MHIT, version 3 November 2017.

9.74 This identifies the team as a secondary mental health service available to prisoners who meet the following criteria:

- are over the age of 17 years and 9 months;
- are presenting with symptoms of severe and persistent mental disorder who require a further assessment of their mental health needs and require care and treatment planning, and that the service:
  - consider, assess and formulate the individual needs of the prisoner to ensure the most suitable pathway of care is provided;
  - each case will be assessed on an individual basis; and
  - mental health needs are eligible under Part 2 of the Mental Health (Wales) Measure 2010.

9.75 Referrals for all prisoners are managed through the Single Point of Access Meeting (SPAM). Prior to the referral being considered by SPAM there is an expectation that the PCMHT will complete an assessment with the prisoner. An assisted living plan was completed with H by the PCMHT on 13 September 2019. This identified that he had mental health problems, was stable, compliant with his medication and would need support from an RMN.

9.76 There is an expectation that if the prisoner is under mental health services an updated care and treatment plan and risk assessment will be requested. The team did not have this for H, but HMP Stoke Heath had provided handover information about H and signposted the team to SystmOne.

9.77 The Operational Policy expectation is that a prisoner who is accepted by the team will be seen by the most appropriate member of the team within 14 days. Following this appointment, and if required, an appointment would be made with the team psychiatrist.

9.78 The Operational Policy states that, "*If the individual is deemed eligible for secondary care, a care coordinator will be identified within 14 days of the patient being accepted into the service. A Care and Treatment Plan (see Appendix 5) and Risk Assessment (see Appendix 6) will be completed within 6 weeks and distributed to all professionals involved within the following 2 weeks, in accordance with the Mental Health (Wales) Measure. Care and Treatment plans and Risk Assessments will be annually reviewed although if any significant changes occur both documents will need to be reviewed and amended as appropriate*."

9.79 The Mental Health (Wales) Measure outlines the expectations for assessment, care and treatment for people experiencing mental health problems in Wales. There is a requirement that all people requiring care from a secondary care mental health service, such as the MHIT, have a valid care and treatment plan in place.

9.80 From the information we reviewed and also from testimony in interview we identified that the MHIT in HMP Parc was 'stretched' in terms of high demand and limited resources. In addition, CPN1 was off sick for much of the time that H was in HMP Parc. This resulted in the workload being shared with another CPN and the Team Manager.

9.81 H was discussed at the SPAM on 1, 8 and 15 October 2019. The outcome from the first two meetings was for H to be seen by CPN1 and CPN2. The outcome from the third meeting was that he was to be seen by CPN2 and CPN3 the following day.

9.82 H did not engage with the MHIT, the table below illustrates the outcome from all planned appointments:

Did not attend	**Seen in cell**	**Seen in clinic**
16 October 2019		
	22 October 2019 – because had not attended an appointment in clinic	
28 November 2019		
19 December 2019		4 December 2019
5 February 2020		
11 March 2020	11 March 2020 – seen briefly on the wing	

9.83 Furthermore, on 12 March 2020 H did not attend a planned appointment with the MHIT consultant psychiatrist.

9.84 Information is included in the Operational Policy about how to manage prisoners who refuse an assessment from the team. If there is no evidence of mental health illness, other staff, e.g., prison OS and then primary care staff, should be informed and the referral closed. If there is evidence of mental illness the MHIT will continue to try and engage with the prisoner, develop an in-depth background of their history and consult with the MHIT psychiatrist about the pathway for future care.

9.85 While H did not refuse an assessment, he was not engaging with the MHIT. There is limited evidence of assessment by the HMP Parc prison metal health services. One assisted living plan was completed for H. This was completed on 12 September 2019 by an RMN from the PCMHT. This identified:

- mental illness – bipolar and paranoid schizophrenia, and H would require support from an RMN;
- H was compliant with his medication; and
- H's mental health was stable.

9.86 And on 19 March 2020, CPN1 began a mental health measure care and treatment plan for H. However, there is no evidence available to show that H was involved in the completion of the questionnaire or that it was completed prior to his release.

9.87 Furthermore, the team was receiving regular reports from the pharmacists that H was not compliant with his medication. We would have expected to have seen a more robust approach from the MHIT to engaging with H and is not in line with the best practice standards detailed in the Royal College Psychiatrists "Standards for Prison Mental Health Services".[102]

9.88 It is to be noted that once Covid-19 restrictions were put in place and H was supported by the PCMHT he was seen six times in 17 days.

9.89 The MHIT at HMP Parc did not complete any risk assessments for H while he was under the care of the team. However, the PCMHT did complete a case management risk assessment on 11 April 2020 and following this RMN3 raised concerns with the MHIT team manager about H. These concerns were:

- H was not taking his medication;
- H was not coming out of his cell; and
- H was lying on his bed with a blanket over his head.

9.90 However, when they saw him over the next few days, H was more communicative and said he would take his medication once he was released into the community. He told the PCMHT that he was "*returning*" to North Wales and had accommodation to go to.

9.91 There is a policy expectation that the MHIT will provide effective liaison with prison and community agencies regarding continuity of care and management of risk for prisoners being discharged from prison and being transferred to an alternative prison or hospital setting. They are also expected to liaise and work in partnership with appropriate statutory and non-statutory agencies.

9.92 HMP Stoke Heath MHIT provided the team at HMP Parc with the complete contact details for the CMHT supporting H in the community. This was recorded on SystmOne and in three SPAM meeting minutes. Despite this information being available to the team and knowing that H would be due for release in less than eight

[102] Royal College of Psychiatrists "Standards for Prison Mental Health Services – Fourth Edition; Quality Network for Prison Mental Health Services September 2018" Standards 52, 53 and 54
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2
and now Standards 64 and 65 "Standards for Prison Mental Health Services – Fifth Edition"
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/qnpmhs-standards-for-prison-mental-health-services-publication-5th-edition.pdf?sfvrsn=c18ba674_2

months the HMP MHIT did not make contact with H's care coordinator to support his release from prison.

9.93 When CPN1 met with H on 11 March 2020, they recorded that "*states due for release in one month. Will contact community team to inform them of release plan*." CPN1 did not follow through on this plan. The MHIT were not allowed into the prison after 18 March 2020 due to Covid-19 restrictions. However, this should not have prevented the team from contacting H's local CMHT.

9.94 CPN1 was again absent from work in April 2020 and the MHIT team manager had email conversations with the prison OM team and the National Probation Service on 15 April 2020 about plans for H's release. However, this correspondence did not identify a clear picture of plans for H's release. In addition, they did not contact H's known local CMHT. While there was a belief H might have been released to live in North Wales there was no evidence available to suggest that he had secured accommodation, and no one asked him for his release address to support a transfer of care.

9.95 This resulted in the MHIT becoming aware on 30 April 2020 that H had been released from HMP Parc on 22 April 2020. The team followed this up on 1 May 2020 and established that H had been released to no fixed abode and was not registered with a GP. The MHIT practitioner discussed the situation with the MHIT team manager and, based on the information available, it was concluded that it was not possible to refer H to a CMHT.

9.96 However, on 5 May 2020, they made contact with a GP in Birmingham who confirmed that H was registered to them and was willing to accept a copy of H's discharge summary and pass it on to other services as appropriate.

Findings -MHIT HMP Parc

1. The MHIT at HMP Parc did not manage H in line with the Operational Policy for the service and the stipulations of the Mental Health (Wales) Measure 2010. They did not complete an assessment of his care and treatment needs, nor did they complete a risk assessment.
2. They were not assertive in their approach to the management of H. Especially with regard to his non-compliance with medication, which was regularly brought to their attention by the pharmacy technicians.
3. The MHIT did not comply with the Operational Policy for the service because they did not liaise with H's local CMHT about plans for his release. We would have expected them to have contacted H's care coordinator and involved them in the discharge planning process.
4. It is our belief that the high workload, staff sickness and a shortage of permanent key staff led to a suboptimal delivery of mental health in-reach care to H whilst in HMP Parc. This then impacted on the assessment of his mental health, risk management, and follow up engagement with H for his lack of compliance with medication.
5. This was compounded by the restrictions placed on the MHIT by the prison response to Covid19 which in turn led to less effective liaison with Erdington CMHT prior to H's release from prison.
6. However, H was at sentence end, and he had stated he was moving to Wrexham. Even if there had been effective liaison with Erdington CMHT there was little that statutory services could have done at that point, and H could still have 'disappeared' from sight.

Engagement with mental health services

9.97 There is a consistent theme through H's clinical records of a lack of engagement with the various mental health teams. However, it was not clear what strategies to improve compliance and engagement were considered or attempted.

9.98 It did not appear that any of these teams employed the type of 'did not attend' policies that mental health trusts generally have in place to deal with these situations, as it is well recognised that a patient's non-attendance at an appointment might be evidence of mental illness.

9.99 Another aspect of this is that it does appear from the records that H often only attended appointments with MHIT staff if there was something that he wanted, e.g., to be signed off from work, wanting a TV in his cell or asking to transfer to another prison.

9.100 The QNPMHS Standards for Prison Mental Health Teams[103] that were in place during the time of H's sentence includes one which state:

"*The team proactively follows up with patients who have not attended an appointment/assessment or who are difficult to engage*."

[103] QNPMHS Standards for prison Mental Health Services – Edition Four: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2

And:

"*The team proactively follow up with patients who fail to collect or take their medication."*

9.101 While there is some evidence in the SystmOne records that some individual practitioners did work to this standard, it was not consistently adhered to.

9.102 Mental health teams providing H with care and treatment demonstrated a lack of professional curiosity about a number of H's behaviours.

9.103 When they visited H on the wing because he had not attended planned appointments, often his cell was in darkness and his head was under a blanket which he was reluctant to remove. The staff assessing him did not consider if this behaviour was related to him self-managing symptoms of psychosis. They took at face value statements such as he was keeping his head down to complete his sentence. The only occasion there is evidence of professional curiosity about this behaviour was by the RMN3 at HMP Parc prior to his release from prison.

9.104 H's frequent requests to transfer to another prison were viewed by staff in the context of his involvement with Birmingham gangs – with some gang members being detained to the same prison as him. The mental health staff did not consider this in the context of his paranoid thinking. It is to be noted that even while detained to HMP Parc, H sought a transfer to another prison.

9.105 When he became involved in fights in prison, this was again not considered in the context of his paranoid thinking. H told staff that he would approach and challenge people he believed to be talking about him.

9.106 A good example of the failure to consider H's behaviours in the context of his paranoid thinking was when he was involved in the fight at the bus stop on the way to his appointment with the CMHT. H had told staff that when he believed people were talking about him, he would challenge them

9.107 This was a feature in virtually all of the prisons he was in. There is no evidence from the records that staff ever wondered if this was a symptom of his schizophrenia, particularly his well-recognised paranoia. In situations such as this, it is inevitable that the paranoia resumes in the new prison, unless it is effectively treated with antipsychotic medication, which did not happen.

Medication management

9.108 Throughout his period of detention 2017–20 a consistent theme was H's non-compliance with his prescribed antipsychotic medication.

9.109 At various times H was prescribed antipsychotic medication, either olanzapine or aripiprazole. None of the evidence available to this review showed that H took his medication for a sustained period of time. We are of the view that at no time from 2017 to 2020 would we consider him to have been effectively medicated.

9.110 We have concluded that H was not appropriately medicated while in prison or the community. He manipulated services that prescribed and monitored his compliance using a number of strategies:

- non-attendance at appointments;
- only taking medication when he wanted to (using medication PRN);[104]

[104] PRN is pro re nata, which means when required.

- telling mental health staff he was not allowed out of his cell to collect his medication;
- only being prepared to accept medication when he was in-possession;
- complaining about side effects;
- only accepting prescriptions in defined circumstances, e.g., when in the community in November and December 2018 he would not accept a prescription from the forensic community team; and
- stopping taking his medication prior to his release into the community, e.g., at the end of his sentence at HMP Parc.

9.111 The appointments with consultant psychiatrists offered an opportunity to discuss medication with H and address his issues, but as discussed earlier these appointments were sporadic and were not sufficient to manage his non-compliance with medication.

9.112 No evidence was made available to this review that prior to his transfer to HMP Parc in September 2019, H's compliance with medication was consistently monitored and there were regular conversations with H about the need to comply with his prescribed medication.

9.113 However, it is to be noted that the pharmacy technicians at HMP Parc did consistently challenge H's non-compliance with medication. They periodically visited him and talked to him about the need to take his medication and alerted the MHIT to his non-compliance. But this proactive approach did not result in H taking his medication as prescribed.

9.114 Despite his non-compliance with his prescribed medication, H was released from HMP Parc with 14 days' worth of aripiprazole.

9.115 Between April and September 2020, H was lost to mental health services and was unmedicated. When he had a consultation with his GP in August 2020, he told them that he was taking a friend's olanzapine. A claim he repeated when seen by the CMHT in September 2020 when he told the staff that he had occasionally taken a friend's olanzapine.

CMHT care coordination

9.116 The BSMHFT CPA Policy[105] provides guidance for care coordinators about supporting service users on their caseload who are detained to prison. It requires:

"*3.11.1 Where a service user engaged with secondary or tertiary mental health services is detained in prison, the care coordinator/lead clinician must retain their role and make every effort to maintain contact with the service user through liaison with prison-based staff in order to facilitate continuity of care, including if the service user is transferred to another prison. This is essential at the time of release from prison.*

3.11.2 Once the care coordinator/lead clinician is made aware that a service user has been detained in prison, they must contact the prison mental health team and make available the most recent assessment, risk assessment and care plan."

[105] Birmingham & Solihull Mental Health NHS Foundation Trust "Care Management & CPA/Care Support Policy" Version 8 April 2019

9.117 A care coordinator was allocated to H in November 2018, when he was released from prison on licence. Following his recall to prison at the end of December 2018 the care coordinator did not have any direct contact with H. They requested updates from the MHITs and probation:

- 1 March 2019, when they asked the MHIT at HMP Stoke Heath for an update on H;
- 26 April 2019, following contact with the MHIT at HMP Stoke Heath when they noted that H's request for parole had been declined and that his scheduled release date was 22 April 2020;
- 8 July 2019, when they asked the probation service for an update on H's release date and his progress in prison;
- 28 February 2020, when the probation service told the care coordinator that H had been transferred to HMP Parc. They said that prior to the transfer H had not been engaging with mental health or prison services. They also reminded the care coordinator that H had been removed from MAPPA in October 2019. They told the care coordinator that as a result of this, H would not be subject of any type of licence or order following his release from prison on 22 April 2020; and
- 18 May 2020, when they requested an update from the probation service on H's release date and his current known location so that the CMHT could book a medical review to assess H's current medical needs and make appropriate referrals if H was outside of the CMHT area. The probation service informed the care coordinator that H was no longer in prison and that they were not aware of his whereabouts, although there was suggestion that he might be in the Wrexham area.

9.118 We have concluded that the care coordinator did not maintain contact with the prison-based mental health services in line with the expectations of the Trust CPA Policy in a manner that would have facilitated continuity of care and help plan for his post-release care.

9.119 Although the Prison Discharge Service states "staff within the team do not take on a care co-ordination role" many of the tasks listed as services offers could be seen as aspects of care coordination. For example:

- Assessment of mental health risk.
- Accessing local community services in preparation for release back into the community.
- Input into probation post prison follow on management, restrictions, licence conditions and curfews with probation.
- Co-ordination of CPA reviews for those c/o HMP.

9.120 We found that this confuses the tasks and responsibilities and that the service specification needs updating, and the specification and the CPA policy need to clarify the role and expectations of care coordinators and the prison discharge service for service users on CPA who are in prison. We have made a recommendation to that effect.

9.121 While there is evidence that the care coordinator made contact with the MHIT at HMP Stoke Heath in March 2019, there is no evidence that they made any contact

with HMP Parc once they became aware that H had been transferred there and would be released at the end of April.

9.122 The MAPPA meeting held on 29 January 2019 noted that the CMHT was aware of H's recall and his location (HMP Stoke Heath). Following this meeting the Trust discharge coordinator noted on the clinical record, "*I have shared details of clinical need, medication and his CMHT point of contact for Birmingham. I have updated the community care coordinator … from the CMHT*."

9.123 However, the discharge coordinator did not make a record in the clinical record about this and there is no record on the clinical record from the care coordinator confirming that this information had been shared with them.

9.124 Once the care coordinator became aware that H had been released from HMP Parc they were proactive, if unsuccessful, in trying to locate H utilising the NHS Spine to identify a GP who he may have been registered with and for contact details for H's mother. They also contacted children's services to ensure that they were aware of H's release.

9.125 We were told at interview that the care coordinator informally sought information from the benefits agency and housing benefit about H's address, again without success.

Risk assessment and management

9.126 Risk assessment and management is an integral part of good clinical practice. There is a need for clarity and transparency in the process of risk assessment and the sharing of this information with other relevant clinicians, teams and agencies.

9.127 We would have expected all the mental health teams who came into contact with H to have taken a systematic approach to risk assessment and management to identify and manage H's risk effectively and safely. This is a standard of practice detailed in the 'Service Specification for Integrated Mental Health Service For Prisons in England', the Royal College of Psychiatrists 'Standards for Prison Mental Health Services – Quality Network for Prison Mental Health Services' and the 'Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010'.

9.128 There should have been consideration of H's risk completed at every assessment and at key points in his care. Key points would include when his mental health or risk management appeared to be deteriorating and safety concerns increased, when H was transferred between prisons or released into the community, and when concerns were expressed by others about H's presentation.

9.129 We found that there were a limited number of formal risk assessments completed by the mental health services between March 2017 and April 2020. There was a reliance on H's risk being described within the narrative of his clinical record.

9.130 The risk assessment completed by FTB in March 2017, when H was discharged from the EIP service, met the requirement of that organisations policy.

9.131 This identified that H was intermittently compliant with medication and had poor engagement with services. It stated that H could experience acute and florid psychotic symptoms including auditory hallucinations, persecutory delusions, racing thoughts and panic attacks, and that he had hit his father in a fit of panic when he was trying to hide from his imaginary persecutors. It noted that H had a diagnosis of schizophrenia and had been to prison twice for assault and robbery.

9.132 At that time, his protective factors were described as his mother and sister, and that he was adhering to probation restrictions because he did not want to return to prison.

9.133 This risk assessment identified his offending history and significant concerns about H reoffending. His history of risk to children is referenced. The risk assessment states that his mental illness was an influencing factor in his risk to others. His risk to others is summarised in the context of his forensic history of robbery and assault.

9.134 This risk assessment also identifies that H had a history of self-neglect, that he would disengage from services and be non-compliant with treatment. The further details summary for this section of the risk assessment identifies that H had been detained to hospital under Section 2 MHA for 10 days, although we have not been able to find any reference to this detention in the clinical information shared with us. We believe this is incorrect. There is no reference to a hospital admission in either BSMHFT notes or elsewhere in FTB records. Furthermore, H was in HMP Dovegate until 10 August 2016 when he was released on licence, and there are no letters to the GP from a hospital informing them of the admission/ discharge, which we would have expected. A note in the GP records on 23 November 2016 records that H *"says not admitted under mental health act was in prison"*. The risk assessment states that he "*was assumed to have had an acute, transient and self-remitting psychotic episode from which he has made a full recovery without any antipsychotic medication – monitoring for the next few months as he does not want to take medication*." This is further corroborated by the notes in the BSMHFT summary dated 13 November 2018 when H was seen by a Forensic CPN from BSMHFT allocated to Elliott House, which records that H "*says he has been seen by Forward Thinking Birmingham (FTB) but doesn't see for long as then back in custody.*"

9.135 The risk assessment identified that H was misusing cannabis and alcohol.

9.136 The action plan for this risk assessment identified:

Risk	**Action/intervention**	**By whom**
Disengagement from services and probation	EIP to maintain engagement.	EIP and probation
A risk of homelessness – a risk of violence to others	Refer to appropriate agencies regarding housing.	H, St Basils and probation
A risk of non-compliance with his prescribed medication	Continue to engage with probation and referral to psychology.	H, EIP and probation
A risk of continuing to misuse substances as a means of coping	Deliver psychoeducation with regards to medication – referral to substance misuse services, if appropriate	H and EIP

9.137 This risk assessment included a contingency plan with information about how H could contact services both in and out of hours.

9.138 Level 1 risk assessments were completed by the BSMHFT L&D service on 20 March 2017 and the forensic community team on 13 November 2018.

9.139 The consultant psychiatrists who assessed H included a narrative comment about his risk:

- 25 January 2018 – the clinical notes for this appointment do not address H's clinical risks.

- 9 October 2018 – mentioned some risks associated with his mental illness, including his tendency to confront others based on auditory hallucinations, however, he did not act on commands to harm others. He was vulnerable to harm from others as a result of this confrontational behaviour. He was also pushing his cell bell because voices were telling him to do it.
- 22 November 2018 and 13 December 2018 the forensic community team consultant psychiatrist noted, "No acute concerns about elevated risk to self or others although I note his history of violence in the context of acquisitive offending".
- 14 December 2018 the BSMHFT CMHT consultant psychiatrist noted, *"In terms of risk, he denied current thoughts to harm himself or others, his past risky behaviours to others is well documented there is risk to himself or others due to his paranoia as evidenced by the incident today."*

9.140 There was only one formal risk assessment completed by the MHITs who were responsible for H during this period.

9.141 In March 2019, MHIT Practitioner 2 at HMP Stoke Heath completed a risk assessment for H. This identified that:

- In 2011/12 H had made several comments about thoughts to kill his family and rape his sister.
- H had been hostile to staff in the past and staff should meet with him in pairs.
- In 2011 H had been placed on ACCT due to fleeting thoughts of self-harm and suicide. But he had not acted on these thoughts.
- H had banged his head on purpose.
- In 2012 he had punched a wall and broken his hand.
- He had been using cannabis since the age of 16.
- There was a belief that he had previously been part of Birmingham gangs.
- H had a history of assault by rifle and larger firearm discharge.
- He had been caught in possession of a knife.

9.142 The assessment concluded that more information was required. It noted there were concerns about H exhibiting sexually disinhibited behaviour, but this had not been fully assessed because he would only talk about certain aspects of this.

9.143 There was no plan as to how a further assessment was to be completed or how his risk was to be managed while he was in prison.

9.144 There was no review of his risk prior to his transfer to HMP Parc in September 2019.

9.145 HMP Parc MHIT recognised H's risk to staff when it was identified he was a high risk to females and there should be no lone female working. He was discussed at the MHIT MDT meeting the following day when it was agreed he would be reviewed by CPN1 "*due to risk*".

9.146 Following the imposition of Covid-19 regulations, the MHIT were not able to enter HMP Parc. In the last few weeks H was in HMP Parc he was seen by the PCMHT.

9.147 The HMP Parc PCMHT completed a case management risk assessment on 11 April 2020. In this assessment RMN3 identified mild concerns about deliberate and

unintentional self-harm. These concerns prompted them to send an email to the MHIT manager. They were concerned that he was not taking his medication and when H was asked if he would take it if they brought it to his cell, he said he would not. The primary care team noted that he was not coming out of his cell and was laying on his bed with his blanket over his head. They thought that he appeared to be depressed and queried if he was paranoid.

9.148 RMN3 highlighted that H was due for release the following week. They asked the MHIT manager for advice and asked them what arrangements were in place for his release the following week.

9.149 The local CMHT care coordinator 2 in Birmingham did not complete an assessment of H's risk in the appointment on 3 September 2020.

Clinical risk

9.150 The failure to recognise H's symptoms of mental illness resulted in a lack of understanding of the relationship between his mental illness and his risk to others.

9.151 This is despite repeated instructions in the clinical records that H should be seen by two members of staff because of his risk to them – though the historical information on which this was based was not stated.

9.152 In a detailed assessment by the consultant psychiatrist at HMP Oakwood in October 2018, shortly before H's release on licence, it was noted that he had experienced auditory command hallucinations "*kill 'em ... stab 'em ... they are talking about you*". H told them that in the past he had confronted others in response to psychotic symptoms when he believed they had been talking about him and this led to fights – the last fight had been four months earlier.

9.153 H went on to say that these confrontations had occurred weekly, suggesting, the presence of untreated psychosis and a risk to others from his illness. He also disclosed a number of other symptoms characteristic of paranoid schizophrenia. The psychiatrist concluded he undoubtedly had paranoid schizophrenia and that his risk to others was linked to his illness. This assessment and its conclusion did not appear to be referenced by any subsequent assessments or reviews in prison.

9.154 By the summer of 2019, there were other risk behaviours, including keeping weapons in his cell at HMP Stoke Heath. However, this did not lead to a discussion about whether there should be a more assertive approach to H's treatment, such as whether he should be transferred to a secure hospital for treatment.

9.155 On 30 August 2019, the MHIT MDT in HMP Stoke Heath decided to refer H to a Reaside Medium Secure unit (MSU) provided by BSMHFT. Had H been assessed as suitable for admission to the MSU under the requirements of section 47 MHA,[106] it would have been necessary for the Secretary of State to be satisfied, by reports from at least two medical practitioners, that:

[106] Section 47 MHA
Removal to hospital of persons serving sentences of imprisonment, etc.
(1) If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners—
(a) that the said person is suffering from [F1mental disorder]; and
(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment [F2; and
(c) that appropriate medical treatment is available for him;]
the Secretary of State may, if he is of the opinion having regard to the public interest and all the circumstances that it is expedient so to do, by warrant direct that that person be removed to and detained in such hospitalF3. . . as may be specified in the direction; and a direction under this section shall be known as "a transfer direction".
https://www.legislation.gov.uk/ukpga/1983/20/section/47

- H was suffering from a mental disorder;
- that the mental disorder was of a nature or degree which made it appropriate for him to be detained in a hospital for treatment; and,
- that treatment was available for him.

9.156 However, on 6 September 2019 the MDT concluded that this referral was not required because it was said he was compliant with medication again, although this compliance was only for five days. As a result, the referral was not progressed.

9.157 We have concluded that the assessment and management of H's clinical risk while in prison fell short of the expected standards between March 2017 and September 2020. The failings included:

- The lack of a structured systematic approach to risk assessment allowed H's clinical risks to be minimised by the services supporting him.
- There was a failure of MHIT's to review H's SystmOne records to establish a longitudinal view of his risk and ensure robust assessments were completed.
- Services lacked professional curiosity about H's behaviours and attributed a lot of his behaviours to his 'bad' attitude and manipulation to get things he wanted, e.g., the return of his television or a transfer to another prison.
- Services did not adequately follow up when H did not attend appointments with mental health professionals.

9.158 This resulted in mental health services failing to appreciate or understand the nature and degree of H' s mental health symptoms and risk.

Findings – clinical risk

1. The risk assessment and plan completed by EIP in March 2017 was of good quality and compliant with Trust requirements for clinical risk assessment and management. This was the most robust assessment and clear plan for the management of H.
2. Between March 2017 and April 2020 there was no comprehensive assessment of H's clinical risk.
3. Between March 2017 and April 2020 there was no risk management plan in place to manage H's clinical risk.
4. CMHT Care Coordinator 1 did not complete a risk assessment and plan for H when they met with him in December 2018.
5. The referral to be assessed by an MSU was not progressed with over-reliance being placed on H's limited compliance with medication. Had he been assessed as suitable he could have been transferred from prison to an MSU using section 47 MHA.
6. HMP Parc MHIT did not complete a risk assessment and plan for H while he was detained in HMP Parc.
7. The local CMHT care coordinator 2 did not complete a risk assessment and plan for H when they met with him in September 2020.

Working together

9.159 H had a history of challenging behaviour while in prison – several incidents were recorded between 2011 and 2017. These included threatening and abusive behaviour towards prison officers, possession of and use of unauthorised substances, inappropriate comments about female staff, being generally disruptive and not adhering to the prison regime.

9.160 During his March 2017 to April 2020 sentence, H continued to exhibit challenging and disruptive behaviour. In addition, he refused to engage in activities that would address his offending behaviour. This behaviour included fighting with other prisoners, inappropriate comments about female staff, not attending work and being found with weapons in his cell on two occasions.

9.161 Between 24 January 2019 and the beginning of September 2019, H was detained in HMP Stoke Heath. During this time, he consistently requested a transfer to another prison. The MHIT sought to support the process, liaising with the prison OM and H.

9.162 At this time, he also made numerous complaints stating that he had paranoid schizophrenia, that being in prison was having a detrimental effect on his mental health and that he wanted a transfer to another prison. The MHIT were made aware of these complaints by the prison and responded appropriately to them, by completing a review with H and liaising with the prison OM.

9.163 On 20 March 2019, the prison made MHIT Practitioner 2 aware that H had made his second complaint:

"*Looking at his complaint he is saying that he suffers from paranoid schizophrenia, bipolar, depression, and anxiety stating being in this jail is affecting his mental health*

officers are worried because I don't leave my cell and inmates are as well I have already broken my knuckle hitting the wall in my cell if you check my file in 2018 I got into so much trouble because of the same reason, my family cannot see me it's affecting my mental health severely, I need to be shipped out Featherstone, Winson Green, Brinsford my wellbeing should be first priority as for Parole I'm not in the Process as I'm not getting Parole I spoke to my PO, do I need to contact the IMB[107] *[*the Independent Monitoring Board]*this is not right, I want to be shipped out.*"

9.164 Information about this complaint was shared with MHIT Practitioner 3 who was taking over responsibility for H's care.

9.165 MHIT Practitioner 2 and MHIT Practitioner 3 went to see H in his cell the following day. In this visit he did not describe having any current thoughts or ideas to harm himself on the wing that day.

9.166 H made a further complaint on 8 April 2019, this complaint said, "*everyday he is feeling worse and is going to have a lasting effect on his mental health, he has requested a transfer numerous times which is being looked into by OMU and states that his mental health is deteriorating rapidly as a result of this*".

9.167 MHIT Practitioner 3 went to see H in his cell the following day and encouraged him to take his medication to support an improvement in his mental health. They also discussed H's desire to be transferred to HMP Oakwood. Following this MHIT Practitioner 3 contacted the prison OM who said a transfer application for H was in process, but that no decision had been made.

9.168 H continued to make complaints and on 23 April 2019 the prison contacted the MHIT stating that, "*he submits numerous complaints on a regular basis – Complaining as he is still in this jail and he doesn't feel anything is being done reference a transfer, stating his mental health is worsening to the point that if I leave my cell I will hurt someone, I am asking to be put down the block for the safety of officers and other inmates I would rather it be myself than others, he is requesting to either be transferred or to be put in the Block for the safety of others, another complaint states I don't want to see the psychiatrist – he was recently downgraded to 'basic' for having a knife In his possession here at HMP Stoke Heath _because my mental health is deteriorating, I have tried and tried to go about this the right way but nothing is being done, someone will get hurt soon whether its myself or an officer because I am tired of trying to control my mental health myself in this jail.*"

9.169 This information was shared with MHIT Practitioner 3 who went to see H with the occupational therapist on 25 April 2019. Prior to seeing H, they spoke to the wing staff who said that H was coming out of his cell only to collect his meals and occasionally to collect his medication. The officers reported that members of the "*same Birmingham gang*" had been moved off the wing.

9.170 The plan from this contact was for a discussion with the prison OM about a transfer. However, the OM was on annual leave, and it is not clear if this discussion took place. The plan also included reviewing H's mood and mental state at least once a week and for H to remain on the caseload of MHIT Practitioner 3.

9.171 Throughout this period the MHIT supported H's request for a transfer and managed his deteriorating mental health and behaviour.

[107] Independent Monitoring Boards
The Prison Act 1952 and the Immigration and Asylum Act 1999 require the Secretary of State for Justice and the Home Secretary to appoint independent Boards to monitor prisons and places of immigration detention, from members of the local community. The legislation gives members unrestricted access to these establishments and to the prisoners and detained people held in them. https://www.imb.org.uk/

9.172 H was discussed in the following MHIT MDT meetings:

- 16 May 2019, because there were concerns about H's presentation and non-compliance with medication. The outcome was for the consultant psychiatrist to go to see H. H refused to see them and was to be offered another appointment.
- 21 and 23 May 2019. The meetings were provided with information about weapons being found in H's cell and his recent contact with the MHIT. The outcome from these meetings was for the team to continue with a longitudinal assessment of H and for a CSIP referral to be completed.
- 6 June 2019. H had refused to see the consultant psychiatrist on 4 June 2019. The team agreed that a letter would be completed for HMP Birmingham healthcare, to be ready in the event of H requiring a transfer to the medical wing. And that an ACCT would be opened to monitor H. Although, when the team checked with prison staff H had an open CSIP.
- 22 August 2019. H had been seen by the team; he was on the segregation unit after a bladed weapon was found in his cell. The meeting noted he had responded well to a change in his medication in June and was engaging with the team.
- 30 August 2019. H had been seen by practitioners from the team the previous day and there were concerns about his medication compliance and threats to hurt staff. H also made the female practitioner feel uncomfortable. The staff believed that H was aware he would become unwell if he did not take his medication and they were concerned about his risk to others. The outcome from this meeting was for a referral to be made to Reaside MSU. However, on 6 September 2019 MHIT Practitioner 2 noted that the referral to the MSU was not required because H was now compliant with medication.

9.173 We have concluded that the MHIT were proactive in their approach by liaising with the OM to progress the prison transfer request and attending prison safeguarding meetings for H. At the same time, they were discussing concerns about H's deteriorating mental health in MHIT MDT meetings, ultimately concluding H should be referred to the MSU for an assessment.

9.174 However, H's behaviour was always seen through the lens of his desire to move to another prison and not in the context of his deteriorating mental health with incidents being a response to his psychotic symptoms.

9.175 Viewing his behaviours as a symptom of his mental illness should have resulted in the referral to the MSU as a priority, rather than supporting the move to another prison.

9.176 The decision not to progress the referral to the MSU was a missed opportunity to obtain a structured assessment of H's mental illness. Furthermore, HMP Parc MHIT were not made aware that less than a month before his transfer, HMP Stoke Heath MHIT had been considering the MSU. And they were not alerted to his non-compliance with medication. However, this information was available to HMP Parc MHIT in H's SystmOne records.

9.177 We have concluded that the prison and mental health services did not have a shared, agreed and understood view of H and the impact that his mental illness had on his behaviour.

The prison discharge service

9.178 BSMHFT has a prison discharge service. The objective of this service is to promote access to mental health services for mentally disordered offenders leaving HMP establishments nationally, who reside within the Birmingham and Solihull area on their release from prison.

9.179 The service is intended to support ongoing engagement with service users while detained to prison and to prepare for their release.

9.180 The expected outcome is to achieve a seamless approach to meeting patient care and needs on transition from prison to the community, acknowledging all aspects of social, educational and offending issues with an overarching priority to address individual risk to self and others.

9.181 The service has a number of agreed pathways to promote good inter-agency working that include:

- partner agencies and working with MAPPA;
- a protocol for in-reach mental health probation referrals; and
- a protocol for priority prolific offenders, and their primary and secondary care needs.

9.182 The primary focus was for the service to engage with service users prior to their release and complete a thorough mental health needs assessment, risk assessment, safeguarding, education and training, and housing needs plan to present to the local community team who would continue the care pathway post-release.

9.183 However, the team does not take on the role of the care coordinator if the service user is already known to a CMHT and has a care coordinator. This role would remain with the community team.

9.184 In this instance a CPN from the prison discharge service was the conduit between the prison, MHIT, MAPPA and the CMHT. CPN1 from the prison discharge service was present at the MAPPA meetings on 5 November 2018, 29 January 2019 and 17 October 2019.

9.185 Following the first two meetings they made an entry in H's clinical record and identified the actions they were responsible for following the meeting. In November 2018 they were to liaise with the CMHT and Elliott House AP about his impending release on licence. The meeting in January 2019 was after H's recall to prison and CPN1 from the prison discharge service was to liaise with HMP Birmingham for an update on H's interventions and medication management. They determined that H was at that time detained to HMP Stoke Heath and they obtained an update from the HMP Stoke Heath MHIT, which they then shared with the care coordinator and the CMHT.

9.186 However, following the MAPPA meeting in October 2019 there is no evidence that CPN1 from the prison discharge service completed their allocated task of updating the CMHT that H had been removed from MAPPA. Removing H from MAPPA resulted in there being no multi-agency oversight or planning for H and meant that sole responsibility for H following his release from prison in April 2020 would sit with the CMHT.

9.187 CPN1 from the prison discharge service involved in these meetings told this review when we asked to interview them in September 2021 (almost two years after the MAPPA meeting when H was discharged from MAPPA) they had found out that their

entry into RiO (the Trust clinical record system) regarding this meeting had remained as a draft and had not been uploaded as a permanent record. Consequently, the outcome of the MAPPA meeting was not recorded in H's clinical record.

9.188 The MAPPA meeting in October 2019 tasked, "*Health to contact In-Reach team at prison re: attempted re-engagement*". However, there is no evidence that CPN1 from the prison discharge service contacted HMP Parc MHIT to discuss this or made contact with H's CMHT care coordinator to inform them that H had been removed from MAPPA.

9.189 In addition, the Prison Discharge Services Service Specification identifies that the service is a member of the Speciality Priority Forum (SPF). This is a police-led forum for managing serious and prolific offenders with complex health, addiction, social and educational needs with risk assessment always forming a priority. These forums meet monthly and each of the West Midlands local policing units were identified as having its own SPF. In addition, there was an SPF for the multi-agency gang unit, which was set up solely to address serious gang members with complex health, risk, social and offending issues.

9.190 West Midlands Police have told this review that had H fitted the criteria for management by the SPF they would have expected the prison MHIT who attended the MAPPA to have made a referral for H. However, the mental health representative at the MAPPA was CPN1 from the prison discharge service.

9.191 The HMP Parc MHIT had no representation at the final MAPPA meeting so were not in a position to consider a referral to the SPF. We have been told that they did not receive an invitation to attend. Furthermore, not being a local prison, they were unaware of this option as a method managing H's release from prison and ensuring that he was on the radar of the police after his release.

Local CMHT November 2018 to September 2020

9.192 H's care coordinator from Erdington CMHT, care coordinator 1, was not proactive in their management of H. H was allocated to their caseload on 2 November 2018. H was released from prison to Elliott House AP on 9 November 2018, but he was not seen by the CMHT care coordinator 1 until 14 December 2018 in an appointment at the CMHT base.

9.193 H was only willing to accept medication from the CMHT and this delay in him being seen resulted in him being unmedicated for five weeks. It would have been prudent for CMHT care coordinator 1 to have liaised with the forensic community team and Elliott House AP, and for them to have attended H's first appointment with the forensic community team on 22 November 2018.

9.194 During the appointment on 14 December 2018, the CMHT care coordinator 1 did not complete a risk assessment or a care plan with H. The plan from this meeting was for another appointment on 28 December 2018.

9.195 The MAPPA meeting on 1 February 2019 recommended that CMHT care coordinator 1 liaise with HMP Stoke Heath MHIT about H. They did not receive a reply to their request for information.

9.196 Between March 2019 and February 2020, CMHT care coordinator 1 contacted services for updates on H and plans for his release:

- March 2019. Contacted CPN1 from the prison discharge service and PO3 for an update. PO3 replied that H was detained to HMP Stoke Heath. At that time,

it was the probation service's plan to seek a release in June 2019, but at that point his release date was 23 April 2020.

- July 2019. Contacted PO3. There is no record of a reply to this request in the clinical notes.
- February 2020. Contacted PO3 who told them that H was detained to HMP Parc, and his release date was 23 April 2023. PO3 said that H had a new probation officer and provided their contact details. They also provided information about the MAPPA meeting held in October 2019.
- 18 May 2020. Contacted PO5 and they were told that H had been released at the end of his sentence and he was not subject to any form of supervision. They told the CMHT care coordinator 1 that a housing referral for the Wrexham area had been started with H, but they were not sure if it had been completed.

9.197 CMHT care coordinator 1 was not proactive in maintaining contact with the services supporting H while he was in prison. We would have expected to have seen collaborative working with the forensic community team while H was at Elliott House AP and, once he had been recalled to prison, with the MHITs. If the care coordinator was experiencing challenges with this, we would anticipate they could have sought support from CPN1 from the prison discharge service.

9.198 This lack of proactive management was one of the reasons why H was lost to services following his release from HMP Parc.

9.199 Once CMHT care coordinator 1 became aware H had been released and there was no information about his whereabouts, the situation was discussed in the CMHT MDT meeting, and the care coordinator completed a number of actions to try and locate H:

- checked the NHS Spine, but this did not have a new address for H;
- contacted H's last known GP. They had not had contact with H since 2018 and they did not have a new address for H;
- spoke to the Trust safeguarding team and then to the Birmingham Children's Trust to establish if H's child was open to them – she was not and the CMHT care coordinator 1 was to make a referral;
- sent an email to CASS highlighting the information they wanted;
- made a second NHS Spine check to obtain H's next of kin details. The phone number given for the next of kin was not available; and
- obtained another phone number for the next of kin and left a message for them.

9.200 While these attempts to locate H are laudable, the need for this could have been avoided had CMHT care coordinator 1 or CPN1 from the prison discharge service worked more collaboratively with other agencies.

9.201 These enquiries did not result in H being located but the team maintained him on their caseload. When the Trust received a non-urgent referral for H in August 2020, the CMHT agreed to complete an assessment and provide him with care and treatment, despite H no longer residing in the catchment area for the team. They acknowledged that they had knowledge and experience of H and that they were the best placed team to initially respond to this referral. This review considers this to be a point of good practice.

9.202 This review has concluded that the actions taken by the CMHT were appropriate and proportionate given H's presentation when he was assessed by the CPN on 3 September 2020 and the consultant psychiatrist who spoke to H on the telephone and arranged an outpatient appointment.

9.203 The MHA requires practitioners to take the least restrictive approach when caring for patients with mental health problems. H's presentation at that time did not indicate that he would have met the criteria for a MHAA or detention under the MHA. H did not present a significant level of risk due to a mental health disorder that was significant and required immediate action. He had managed to live in Birmingham since his release from prison without coming to the attention of mental health services or the police.

CMHT contact with H September 2020

9.204 This review concluded that the CMHT took a proactive approach to H once it received a referral from the GP on 19 August 2020. This referral was identified as non-urgent by the GP and as such the CMHT had one to four weeks in which to respond. H was offered an appointment with the CMHT consultant psychiatrist for 3 September 2020.

9.205 The team recognised H's history of non-engagement with mental health services and wanted to encourage his attendance at the appointment.

9.206 Their initial attempts to do this were unsuccessful because there was no response to the phone calls they made to H and his mother.

9.207 H had now been allocated to a new care coordinator (CMHT care coordinator 2) and they discussed H with the clinical lead for the team. Following this conversation, it was agreed that they would complete a home visit to H to encourage him to attend the outpatient appointment later that afternoon.

9.208 CMHT care coordinator 2 was tenacious in their approach with H. It took H some time to answer the door and he initially he claimed to be called James, but CMHT care coordinator 2 was able to identify H and gain access to the property and speak with H at length.

9.209 When H said he would not be attending the outpatient appointment that afternoon, they were creative, offered him a lift to the appointment, and encouraged him to speak to the CMHT consultant psychiatrist on the phone. The CMHT care coordinator made several attempts to contact the CMHT consultant psychiatrist, before they eventually answered, as they had been in consultation with someone else. This consultant psychiatrist had previously assessed H when he resided at Elliott House AP in December 2018. At interview the CMHT consultant psychiatrist recollected that on both occasions that H was guarded and wanted to pick and choose when he would take his medication. H admitted he continued to hear voice, but when he was pressed for more information about these, he handed the telephone back to CMHT care coordinator 2. The consultant psychiatrist noted some positive aspects; H was prepared to take medication and H had said he would attend the appointment at the end of the month. They had no reason to suspect he would not attend as he had attended the appointment in 2018.

9.210 Care coordinator 2 recalled that H was guarded at interview, but not suspicious. He was not forthcoming with answers preferring to answer with a "yes" or a "no". H would not allow them into the property, so the conversation was completed in the doorway. At interview the care coordinator commented that their assessment of H was very limited, and they were unable to fully assess his risk.

9.211 When they returned to the team base, we were told there was a discussion with the CMHT consultant psychiatrist. CMHT care coordinator 2 believed that H would attend the appointment on 24 September. The CMHT consultant psychiatrist wanted care coordinator 2 to attend the appointment with H on that day.

9.212 From our review of the records and through triangulation with interview testimony, this review has concluded that there was no indication that H was considering carrying out the stabbings, and there was insufficient evidence of mental illness of a degree and nature that would have required immediate action by the team, e.g., a MHAA. We consider that even if either CMHT care coordinator 2 or the consultant psychiatrist had requested that H be assessed for detention under the MHA, it is extremely unlikely that H would have been assessed, and if he had, not detained. H had requested medication; had said he would take it and was willing to attend an outpatient appointment later in the month. The CMHT consultant psychiatrist had previous contact with H and did not identify any immediate concerns or risks, they were comfortable to provide medication and another outpatient appointment. We consider the approaches used and interventions planned were an appropriate response to H's presentation as far as could have been reasonably ascertained on that day.

Summary of mental health care and treatment

9.213 There was no clear overall clinical case management of H's care during his prison sentence between 2017 and 2020. During this time, he was placed in four different prisons, and so was under care of four MHITs. H also spent two months in an AP, so was effectively under the care of CMHT during that time. Each time he was transferred to a new prison a new assessment would be completed. Furthermore, there is no evidence that the new assessment referenced previous assessments completed by other MHIT teams. This is despite all of the teams having access to his complete record on SystmOne.

9.214 There is evidence of notable practice in relation to handovers of care between prisons, but it is not clear how this information informed the receiving team's plan of treatment for H. An example of this is the contact that HMP Stoke Heath made with HMP Parc following his transfer in September 2019.

9.215 As noted earlier, there were examples of comprehensive and accurate assessments by a number of psychiatrists in different prisons who identified H's diagnosis, his active symptoms and their link to his risk to others. One of the earliest and most detailed of these was in HMP Oakwood in October 2018. However, there is no evidence that this informed or influenced clinical practice by subsequent mental health teams, again, because of the lack of any proactive management of his case.

9.216 It is often stated by specialist forensic mental health services that patients such as H could have their mental illness treated in the criminal justice system rather than by admission to a secure unit following a serious offence.

9.217 It is suggested that treatment in prison would be equivalent to that given in a secure hospital. However, it is unlikely that someone with H's mental illness and risk profile would have had so many transitions between different mental health services if he had been admitted to a secure hospital from court or transferred to a secure hospital during his sentence.

9.218 Also, this case illustrates the fact that, in reality, the only treatment available to a mentally ill prisoner is an offer of antipsychotic medication, which they can refuse to take. The other treatments in secure hospitals, including psychological therapies,

occupational therapies and a graded rehabilitation into the community, are not available in prison.

10 Conclusions and recommendations

10.1 H was known to the police and criminal justice services form a young age, receiving his first caution in 2007, at the age of 14.

10.2 His first custodial sentence was in 2011, when he was sentenced to two years in a YOI for robbery. H continued to offend, receiving a further four custodial sentences for offences including:

- public order offences;
- robbery;
- possession of a knife/bladed article in a public place;
- assault;
- possession of drugs with the intention to supply; and
- failure to surrender to custody.

10.3 Although H was not charged with any offences of domestic abuse, because the women involved in the incidents would not support a prosecution, he was considered a threat to female partners. In addition, he was identified as a risk to female staff who worked with him, reported to have made inappropriate comments and looked at them inappropriately.

10.4 He was released from prison on licence on three occasions, and each time he was subject to recall. He was recalled once because he reoffended (March 2017), and twice for breach of his licence conditions (April 2012 and December 2018).

10.5 H was first diagnosed with a mental illness while in youth custody in 2013. He was diagnosed with paranoid schizophrenia.

Mental health care and treatment

10.6 H did not engage with mental health services in prison or in the community. He was reluctant to take medication and would only take it as and when he chose to, and then only for very short periods of time – often for just a matter of days.

10.7 We have concluded that H was untreated and unmedicated between 2011 and 2020. We have identified a number of reasons for this:

- He regularly moved between prisons and there was no continuity in the assessment of his mental health and his care. Each team commenced a new assessment.
- Prison MHIT's did not review the records available to them about previous assessments and treatment.
- Prison MHIT's were not assertive in monitoring and supporting H's compliance with prescribed medication for his mental health problems.
- Prison MHIT's lacked professional curiosity about a number of H's behaviours:
  - the occasions when he was in his cell, with his head under a blanket, unwilling to engage with staff were not considered in the context of his mental health; and

- they did not consider if any of the violent incidents in prison involving H might be related to his mental health and paranoid thoughts.

- H's assessment, care and treatment were not effectively managed using CPA or the Mental Health (Wales) Measure 2010.

10.8 Few formal assessments of H's clinical risk were completed and there was no longitudinal view of the risk H posed to others because of his mental health problems. H's risk to others was only considered in the context of his criminal behaviours.

10.9 There was a missed opportunity to complete a thorough assessment of H in August 2019 when a referral to an MSU was not followed through because H had been compliant with his medication for five days.

10.10 Furthermore, on 5 September 2019, H was seen by a new consultant psychiatrist (consultant psychiatrist 3). H said he was willing to take medication, and his risk of harm were assessed as low to self and medium to others. The outcome from this appointment was for H to be discharged to the primary care team. MHIT Practitioner 3 was not in agreement with this plan, and they intended to keep H on their caseload and support him to manage his anxiety.

10.11 H's local CMHT did not proactively manage H's release on licence to Elliott House AP. H was accepted by the local CMHT on 2 November 2018. H was released to Elliott House AP on 9 November 2018. However, he was not seen by the CMHT care coordinator and consultant psychiatrist until 14 December 2018.

10.12 The CMHT care coordinator did not have any contact with MHIT at HMP Parc and was not involved in the planning for his release from HMP Parc. While, in part, this could have been because the MHIT did not make contact with them, the CMHT care coordinator did not contact the MHIT for an update about H in the eight months he was at HMP Parc.

10.13 H appears to have had a number of strategies that allowed him to limit his contact with mental health services and the management of his medication. These strategies included:

- non-attendance at appointments;

- only taking medication when he wanted to (using medication PRN);

- telling mental health staff, he was not allowed out of his cell to collect his medication;

- only being prepared to accept medication when in-possession;

- complaining about side effects;

- only accepting prescriptions in specific circumstances, e.g., when in the community in November and December 2018, he would not accept a prescription from the forensic community team; and

- stopping taking his medication prior to his release into the community, e.g., at the end of his sentence at HMP Parc.

10.14 The mental health services that had contact with H did not identify his avoidance strategies or develop a plan to manage them.

10.15 The response from the HMP Parc MHIT to the management and planning for H's release from prison did not meet the expectations of the team's Operational Policy.

The team failed to engage effectively with H and did not complete a mental health measure assessment and plan for H or an appropriate risk assessment. Furthermore, they did not liaise with his CMHT care coordinator to plan for his release or notify them of his release.

10.16 The CMHT care coordinator did not monitor H's progress following his return to prison in December 2018. They did not liaise with the MHITs at HMP Stoke Heath or HMP Parc or plan effectively for his release.

10.17 This review has concluded that CPN1 from the prison discharge service who was the conduit between the MAPPA meeting and mental health services did not discharge their role. They failed to notify H's CMHT care coordinator that H had been removed from MAPPA supervision or liaise with the MHIT at HMP Parc to inform them of H's previous history of non-engagement and risks.

Prison mental health in-reach teams

10.18 H moved between prisons and there was no continuity in the assessment of his mental health and care needs. There is no evidence that any of the prison MHITs reviewed the historical assessment information available to them on the SystmOne[108] records, with each team in each prison commencing a new assessment. H was not managed using the Care Programme Approach (CPA)[109] or the Mental Health (Wales) Measure.[110]

10.19 None of the MHITs in contact with H were assertive in monitoring and supporting H's compliance with medication prescribed for his mental health problems. H spent periods of time unmedicated because he would not accept medication. When he did take his medication, it was rarely for more than a few days.

10.20 The MHITs were not assertive in their management of H, allowing him to miss planned appointments.

10.21 The MHITs lacked professional curiosity about aspects of H's behaviour:

- The occasions when he was in his cell, with his head under a blanket, unwilling to engage with staff were not considered in the context of his mental health.
- They did not consider if any of the incidents in prison involving H might be related to his mental health and paranoid thoughts.

10.22 There was limited collaboration and communication between the statutory services responsible for H's mental health care:

- CMHT care coordinator 1 in Birmingham did not have direct contact with the MHIT when H was detained to HMP Stoke Heath.
- CMHT care coordinator 1 in Birmingham relied on the probation officer or CPN1 from the prison discharge service for information about H.

[108] SystmOne is the electronic health record system used in prison healthcare in England and Wales.
[109] NHS (2021) Care for People with Mental Health Problems (Care programme Approach). https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
[110] Welsh Assembly Government (2010) The Mental Health (Wales) Measure. http://www.wales.nhs.uk/sitesplus/documents/861/100707mentalhealthfactsheeten.pdf#:~:text=The%20Mental%20Health%20%28Wales%29%20Measure%20has%20been%20laid,and%20treatment%20of%20people%20with%20mental%20health%20problems

- CPN1 from the prison discharge service did not record the outcome from the multi-agency public protection arrangements (MAPPA)111 meeting in October 2019 in the clinical notes.
- CPN1 from the prison discharge service did not ask HMP Parc for an update about H.
- HMP Stoke Heath MHIT provided a clinical handover to an administrative worker for the HMP Parc MHIT. We would have expected clinical staff from HMP Parc MHIT to engage with HMP Stoke Heath MHIT to complete the handover.
- Neither CPN1 from the prison discharge service nor H's CMHT care coordinator 1 in Birmingham made contact with the MHIT at HMP Parc when they became aware he had been transferred there.
- HMP Parc MHIT did not contact H's local CMHT prior to his release, despite the details for the team being available in SystmOne and in two places in the multidisciplinary team (MDT) minutes.

National Probation Service

10.23 H engaged with PO1, and they were proactive in their management of H; supporting joint appointments with mental health services, referring H to MAPPA and for an AFFIRM assessment.

10.24 However, H did not engage with the probation officers who supervised him following the departure of PO1. He met with PO2 but was hostile towards them and requested a change of supervisor. He did not meet with any of the probation officers responsible for him after his return to prison in December 2018.

10.25 The National Probation Service accepted that H would remain in prison until his sentence end and that there would be no role for them following his release from prison. The probation service's management of him from this point onwards can at best be described as 'long arm'. They completed reports required of them but did not engage in any proactive management of H by liaising with prison and mental health services and considering the potential for an executive release for H prior to his sentence end.

MAPPA

10.26 H was managed at MAPPA level 1 from 2016 to May 2018.He was referred back in October 2018 and remained in MAPPA until 2019.

10.27 H was recalled to prison in December 2018. Following this the Parole Board declined to support the option of a further early release and it was determined that H should remain in prison to his sentence end.

10.28 He was removed from MAPPA in October 2019 without up-to-date information from HMP Parc prison services or the MHIT being requested by or provided to the MAPPA meeting.

[111] The Criminal Justice Act 2003 (CJA 2003) provides for the establishment of multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

10.29 This was because he was added to the agenda at short notice. Furthermore, there had been no information available to the meeting from either service to support the previous meeting in January 2019. Given there was no up-to-date information from either service, it would have been prudent for the meeting to defer any discussion and decision making about H.

10.30 The last time MAPPA had reviewed information from the prison services had been in November 2018 and no information was provided to any of the MAPPA meetings from the MHITs regarding H's mental state.

10.31 There was an expectation that CPN1 from the prison discharge service from Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) Forensic Services would act as the conduit for information flowing between prison MHITs and MAPPA. However, this was not effective and did not ensure that information was available to MAPPA meetings for patients where prison mental health care was being provided by a non-Trust provider.

10.32 The reason identified for removing H from MAPPA was given as, "*due to his continued refusal to engage with any support offered there is not benefit for continuation at Level 2.*" MAPPA offenders such as H should only be deregistered when the MAPPA meeting decides that the risk of harm has sufficiently reduced, or they no longer require multi-agency risk management. We have seen no evidence that H's risk had reduced by October 2019. We believe that his continued refusal to engage with any support offered was sufficient reason to maintain him on MAPPA and was exactly the type of circumstance that MAPPA was intended to help manage.

10.33 Elliott House AP was willing to offer H another placement. A more prudent approach would have been to maintain H on MAPPA level 2 and to seek multi-agency support for a request for executive release prior to his sentence end date. This would have allowed for a managed approach to H's release, returned him to Birmingham and allowed H to engage with his care coordinator and mental health services. We have not seen any evidence that this was considered.

Release from HMP Parc

10.34 H's release from HMP Parc was impacted by the implementation of Covid-19 restrictions in March 2020. This meant that some services were not allowed into HMP Parc; including the MHIT and the St Giles Trust Resettlement team.[112] This resulted in limited planning for release with H and no coordination with local services in Birmingham.

10.35 Notwithstanding the belief that H would be released from prison to no fixed abode and that he had told services he planned to go to live in North Wales, HMP Parc MHIT failed to liaise with the CMHT care coordinator 1 in Birmingham and notify them of H's release.

10.36 The local CMHT in Birmingham did act promptly when H was referred to the service by his GP in August 2020. They identified his historic pattern of non-engagement and, having failed to make telephone contact with him, completed an unplanned home visit on 3 September 2020. CMHT care coordinator 2 and the support worker showed tenacity when H answered the door and claimed to be someone else. Once H had eventually confirmed who he really was, they entered his home and tried to encourage him to attend a meeting with the team consultant psychiatrist that afternoon. When it became apparent that H would not attend the appointment, they

[112] St Giles Trust is a registered charity that helps people who are "*held back by poverty, exploited, abused, dealing with addiction or mental health problems, caught up in crime or a combination of these issues and others*." https://www.stgilestrust.org.uk/

telephoned the team consultant psychiatrist for support. H spoke to the consultant psychiatrist and stated he was not willing to attend the appointment that afternoon because he had no money. However, he was willing to attend an appointment the following week.

10.37 The consultant psychiatrist had previously met H in December 2018 and described him as quiet on the September 2020 call. However, they felt he was willing to engage in some form of treatment because he was willing to accept medication and attend the appointment the following week. It was the opinion of CMHT care coordinator 2 who assessed H that day and the consultant psychiatrist that H's presentation at that time did not meet the criteria for a Mental Health Act assessment (MHAA), either in degree or nature.

Missed opportunities

10.38 There were three missed opportunities for services to gain a better understanding of H, his mental health needs and his risk, and allow for a planned release from prison at the end of his sentence.

10.39 It would have been good practice for the prison mental health services to have been involved in or, at the very least, to have informed the probation Advice and Forensic Formulation to Inform Risk Management (AFFIRM) assessments and reviews completed in April 2017 and November 2018. This may have supported a better shared understanding of H's mental health problems and risks.

10.40 The second missed opportunity was in August 2019 when the HMP Stoke Heath MHIT considered referring H to medium secure mental health services. They decided not to make this referral because H was compliant with his medication. However, this compliance was for five days. A referral might have resulted in H being transferred from prison to medium secure mental health services. In any event, the referral would have facilitated a thorough assessment of his mental health and risk.

10.41 The final missed opportunity was the removal of H from MAPPA in October 2019. This decision was flawed because no up-to-date information from HMP Parc or the HMP Parc MHIT was made available to the meeting. We consider that it would have been prudent for H to have remained under the supervision of MAPPA and for the panel to have supported a request for executive release[113] to Elliott House AP,[114] the specialist AP in Birmingham. This would have ensured H would have been released with supervision and would have been able to engage with his local CMHT to receive appropriate mental health service support.

Good practice

10.42 The response of the CMHT in Birmingham to the referral from the GP is to be commended. When the referral was received H was living in another part of the city, outside the catchment area for the team.

10.43 However, the team acknowledged that he was open to them and offered him an appointment with the consultant psychiatrist in a timely manner. CMHT care coordinator 2 reviewed H's record and recognised that there was a high risk of him not attending the planned appointment. They made best endeavours to contact him

[113] Executive Release is a process whereby the Secretary of State can grant release on the papers without a parole hearing taking place. It is usually a member of the Public Protection Caseworker Sector (PPCS) that consider and make the decision on behalf of the Secretary of State.
https://insidetime.org/executive-release/#:~:text=In%20simple%20terms%2C%20Executive%20Release,of%20the%20Secretary%20of%20State
[114] Formerly known as probation and bail hostels.

over the phone to encourage him to attend the appointment. They also tried to contact his recorded next of kin. When these attempts to contact him failed, they liaised with the clinical lead for the team and completed a home visit.

10.44 CMHT care coordinator 2 showed resilience by persevering when H did not answer the door and then challenging him when he claimed to be called "James". They offered to transport him to the appointment in the afternoon. When he refused, they took appropriate action by putting him on the phone to the consultant psychiatrist. During interviews with staff, we were told that CMHT care coordinator 2 made several phone calls before they were able to contact the consultant psychiatrist, who was with another patient, but they persevered.

10.45 HMP Stoke Heath made multiple attempts to provide HMP Parc with a handover of care when H transferred in September 2019.

Conclusions

10.46 This review has concluded that H was not appropriately treated and medicated from 2011 to 2020 and we have identified a number of reasons for this.

10.47 H consistently did not engage with any of the statutory services he came into contact with – police, prison, probation, prison and community mental health services.

10.48 This pattern of non-engagement with services resulted in him being discharged from MAPPA in October 2019, because the panel could not see a role for itself. It also resulted in H remaining in prison until his sentence ended. The consequence was that he was released from HMP Parc in April 2020, subject to no statutory supervision from any of the criminal justice services – police or probation.

10.49 Furthermore, his observed mental health symptoms were not considered to be of a degree or nature to reach the threshold for assessment or detention under the MHA, by the National Probation Service or by mental health services. He was released from prison to no fixed abode, so services did not know where he had gone. He had told services he was going to North Wales but, in reality, he returned to the Birmingham area on the day of his release.

10.50 H did not engage with services – mental health, prison services or probation. There is no evidence that he made any attempt to address his mental health problems or his criminal behaviour.

- However, as H had completed his sentence, he had been taken off MAPPA, and his mental health problems were not of a degree to warrant detention under the MHA whilst in prison, statutory services had no mechanism to intervene. This was compounded by the late and ineffective release and discharge coordination between HMP Parc and his former CMHT in Birmingham.

Recommendations

10.51 In November 2021 the Criminal Justice Joint Inspection, Care Quality Commission and Healthcare Inspectorate Wales published "A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders".[115] In summary this report found:

[115] Criminal Justice Joint Inspection, Care Quality Commission and Healthcare Inspectorate Wales; "A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders", November 2021 https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf

- **Poor information exchange.** Significant problems in information exchange occur in every agency in the CJS and at every stage of an individual's criminal justice journey.
- **Committed staff but many need better training and supervision.** Staff are committed, passionate, resilient and want to help people to lead more fulfilling and happy lives. While differing learning and development opportunities for staff exist across the CJS, not all of these are making a difference to better equip practitioners and managers to deliver high-quality services.
- **Court reports need improvement and more sentences should include treatment.** Information provided to courts, for example by L&D assessment reports, pre-sentence reports and psychiatric reports, varies in quality.
- **Assessment and diversion services in police custody have improved but they need to link to the rest of the criminal justice system**. There is very good coverage of L&D services across England and Wales in police custody. L&D provision in courts is not always on site and, indeed, during the pandemic the majority of assessment work has been carried out remotely. Assessments completed by L&D staff are not widely shared with partner agencies in the CJS.
- **A shortage of good-quality mental health provision and unacceptable delays to access it**. This has worsened during the pandemic. Individuals reported that probation and prison are the two agencies most likely to give them the mental health support they need. However, help is often not timely and access to services has been a substantial problem during the pandemic.
- **Mental health provision in prison has improved but post-release treatment and support are poor**. Healthcare practitioners appropriately use nationally approved screening tools to assess the mental health needs of prisoners arriving in custody.
- **Cross-system management and leadership need to be better.** Each agency in the CJS has a range of management information systems, but cross-system data is not systematically collected and analysed to promote joint working and improve mental health outcomes.

10.52 This report made 22 recommendations to improve these aspects of service delivery and support for people with mental health problems in contact with the criminal justice service. Our investigation into the multiagency care and supervision of H had found that there was an overlap with these findings in some areas.

10.53 In particular, in order to improve services, we have made the following recommendations:

Recommendations

Recommendation 1: The service description for the BSMHFT Prison Discharge Service is dated 2016 and requires review because it no longer reflects the remit and work of the service. There is lack of clarity about the scope and remit of CPNs from the prison discharge service or the role of the CMHT care coordinators. It is not clear which role has responsibility for the liaison with prison MHITs and MAPPA.

BSMHFT must develop an up-to-date service description/operational policy for the prison discharge service that:

- **clearly defines the service offer;**
- **describes how the service interfaces with other BSMHFT services;**
- **describes the roles and responsibilities of each of team member; and**
- **describes the responsibilities, scope and remit of CPNs from the prison discharge service and care coordinators for service users detained in prison, to ensure effective liaison with prison MHITs and MAPPA.**

Recommendation 2: The National Probation Service and the West Midlands MAPPA Strategic Management Board did not complete a serious case review into this incident because this review was being completed. However, this review has not had access to the source material from the probation service.

The West Midlands MAPPA Strategic Management Board (SMB) must reconsider its decision not to complete a serious case review. A serious case review would be an opportunity to look in more detail at the issues we have raised and to ensure that lessons learned are shared with the SMB and all those involved in the MAPPA chairing and panel meeting process.

Recommendation 3: H was discharged from MAPPA without up-to-date information from the relevant prison or MHIT.

West Midlands MAPPA SMB must provide guidance for MAPPA chairs to ensure that discharge from MAPPA should only happen with full information from all services involved.

Recommendation 4: The Mental Health In-reach Team in HMP Parc is not resourced adequately to meet the demands placed upon it.

Cwm Taf Morgannwg Health Board, as commissioners of Secondary Care Mental Health Services into HMP Parc until 31 March 2023, and then providers of Secondary Care Mental Health Services thereafter, and NHS Wales must, as a matter of urgency, act on the 2021 Health Needs Assessment for HMP Parc to ensure that the mental health services, especially the mental health in-reach team, have sufficient capacity and resources to meet demand.

Recommendation 5: There needs to be effective oversight of, and clear provision of escalation routes for concerns about, health and social care provision to HMP Parc.

HMP Parc Prison Health, Wellbeing & Social Care Partnership Board should routinely seek assurance that health and social care services are meeting the requirements of the Mental Health (Wales) Measure 2010, the HM Inspectorate of Probation Effective Practice Guide: Mental Health (2022) and other relevant guidance, and that where there are concerns about resources and/ or the quality of services, these are escalated quickly to the appropriate body for resolution.

Appendix A: Terms of reference

Final terms of reference for the independent investigation into multi-agency care and supervision of H following the multiple stabbing in Birmingham on the night of the 6 September 2020.

Purpose

To review the care, treatment and services provided by the NHS and other relevant agencies relevant to the perpetrator of an incident of multiple stabbing in the Birmingham area on the night of the 6 September 2020 and to make any such recommendations as may seem appropriate to improve practice and public safety.

Scope

For the independent investigation panel to understand:

- the chronology of agency interaction (from January 2015) prior to the night, and to describe the circumstances of the night of the 6 September 2020 when H stabbed eight people;
- the interactions H had with agencies prior to the stabbings;
- agency knowledge of H and his history;
- his family circumstances, cultural background and the contact agencies had with his family;
- any follow-up arrangements/ongoing treatment or social care support H was receiving;
- what information was shared between agencies concerning H;
- whether there were any risk indications in the lead up to the 6 September 2020, that H was considering carrying out the stabbings, and whether any interventions were planned to appropriately respond to these risks;
- whether services involved in H's care complied with local policies, national guidance and relevant statutory obligations.

Appendix B: Glossary

AP	Approved premises (APs) offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence from custody. This is typically following serious violence and/or sexual offences. APs thus act as a half-way house between prison and home, and have two main roles: • to support the resettlement and rehabilitation of individuals who have committed serious offences. • to support the safety of other people in individuals' early months in the community.
ACCT	Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm. https://www.gov.uk/government/publications/the-assessment-care-in-custody-and-teamwork-process-in-prison-findings-from-qualitative-research
BSMHFT	Birmingham & Solihull Mental Health Foundation Trust
CASS	Childrens Advice and Support Service provides a single point of contact for professionals and members of the public who want to access support or raise concerns about a child. https://lscpbirmingham.org.uk/index.php/safeguarding-concerns/cass
CCG	Clinical Commissioning Group
CJA (2003)	The Criminal Justice Act 2003 (CJA 2003) provides for the establishment of multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.
CJLD	Criminal Justice Liaison and Diversion service are a specialised team provided by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)
CMHT	Community Mental Health Team
Corvus	Corvus is the police intelligence software that provides a master record for criminals and suspects.
CPA	The Care Programme Approach (CPA) was introduced in April 1991 to provide a framework for person-centred individualised care planning. Department of Health (1990) Health and Social Services Development *"Caring for People. The Care Programme Approach for people with a*

	mental illness referred to the specialist psychiatric services." Joint Health/Social Services Circular HC (90) 23/LASSL (90) 11"
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service (CPS)
DASH	The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).
EIP	Early Intervention in Psychosis An EIP service is a multidisciplinary community mental health service that provides treatment and support to people experiencing or at high risk of developing psychosis.
FTB	Forward Thinking Birmingham Birmingham city's mental health partnership, for 0- to 25-year-olds. https://forwardthinkingbirmingham.nhs.uk/
HMP	Her Majesty's Prison (Now His Majesty's Prison)
IMB	Independent Monitoring Boards The Prison Act 1952 and the Immigration and Asylum Act 1999 require the Secretary of State for Justice and the Home Secretary to appoint independent Boards to monitor prisons and places of immigration detention, from members of the local community. The legislation gives members unrestricted access to these establishments and to the prisoners and detained people held in them.
L&D	Liaison and Diversion service
MAPPA	Multi Agency Public Protection Arrangements. Established in the CJA 2003) Multi-agency public protection arrangements are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance
MDT	Multi-Disciplinary Team
MHA	Mental Health Act (1983) amended 2007. The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder
MHIT	Mental Health Inreach Team, also known as PIR or Prison In Reach. The aims of prison mental health in-reach were related to providing an equivalent service to a Community Mental Health Team, with a primary

	focus on serious mental illness, but a widening role. From Ricketts, Brooker and Dent-Brown *"Mental health in-reach teams in English prisons: Aims, processes and impacts"* December 2007 International Journal of Prisoner Health 3(4):234-247
MOU	Memorandum of Understanding
Ndelius	National Delius (NDelius) is the main case management system that holds probation information on service users
OASys	OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service to measure the risks and needs of criminal offenders under their supervision. Identified needs of offenders in custody and the community from OASys
OM	Offender Manager
P NOMIS	Prison National Offender Management Information System
PCMHT	Primary Care Mental Health Team
PNC	The Police National Computer (PNC) is a system that stores and shares criminal records information across the UK.
PO	Probation Officer (also Prison Officer)
PRN	PRN is pro re nata, which is Latin for "when required."
QNPMHS	Royal College of Psychiatrists Prison Quality Network for Prison Mental Health Services
ROSH	Risk of Serious Harm
Safeguarding	Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1
SystmOne	SystmOne is the electronic health record system used in prison healthcare in England and Wales.
ViSOR	ViSOR is the key tool for the management of offenders and other persons posing a risk of harm to the public. It is a multi-agency system used by the police and probation service.

WMP	West Midlands Police.
YOI	Young Offender Institution A type of secure accommodation that children may be placed in if they are in custody. Young offender institutions are for boys aged 15 – 17 and young adult men aged 18 – 21.
CSIP	Challenge, Support, and Intervention Plan. CSIP is used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence. Mandated since November 2018. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/05/Glossary_website-1.pdf

Appendix C: Answers to questions provided by Mrs J Billington, mother of Jacob Billington

What was the input of the NHS Inreach team on the run up to McLeod's release? Prison Service Instruction paragraph 2.47 states "all prisoners must be examined by a healthcare practitioner in the 24 hours prior to discharge". Did this take place, and what were the recommendations|?
H was seen by RMN2 from the PCMHNs on 4 April 2020 as it had been noted that he had been seen twice by the pharmacy technicians because he had missed his medication. This had been identified when the PCMHT reviewed his medication chart. H was not able to provide an explanation for his non-compliance but said he would attend for his medication that evening. The probation team accommodation officer reviewed H's records on 7 April and asked PO5 if they knew why H was requesting accommodation in Wrexham. They identified that if H was directed to return to Birmingham another form would need to be completed for him. On 11 April 2020, RMN3 completed a risk assessment and identified mild concerns about the risk of deliberate and intentional self-harm. Following this visit RMN3 sent an email to the MHIT manager. In this they said that they were concerned about H. He was not taking his medication. He was not coming out of his cell and when they saw him, he had a blanket over his head. They queried if he was experiencing paranoia and/or depression. They noted that he was due for release the following week and asked for advice and information about his release plans. RMN4 saw H in his cell the following day. H was reluctant to engage with RMN4. He said that he did not want to take his medication, but he would take it when he was released. H was told to contact healthcare should he need any support. Following this RMN4 spoke to another prisoner who said he had known H in HMP Dovegate, he said that H just wanted to keep his head down and get ready for release. H was seen by RMN2 on 13 April 2020. He told them that he was not going to take his medication until he left the prison the following week. He told the RMN that he planned to live in North Wales when he was released and that he had accommodation. It was noted that H was reluctant to engage in the conversation, provided brief answers and became irritable. He was adamant he was fine and did not want any support from the mental health team. On 14 April 2020, the MHIT team manager contacted the PCMHT. The team manager said that they were covering CPN1's caseload and wanted to know who H's OM was. The PCMHT stated that H planned to live in North Wales following his release and he would need to be referred to a local CMHT, and a discharge summary would need to be sent to his GP. There was an email from the Probation Service the following day stating that H was being released at sentence end date and, as such, would not be able to be supervised by the probation service. It specified that he was no longer subject to MAPPA processes. They advised that for H to secure accommodation in North Wales, he would need to prove a local connection. They also provided the contact details for the police OM. H was seen by RMN5 on 21 April 2020. This was a review prior to his release the following day. H told the RMN that everything was okay and that he did not need any support prior to this release. He told them that he had been referred to his local CMHT and an appointment would be made for him to see them. He said that he would take his prescribed medication once he was released from prison. H was released from HMP Parc on 22 April 2020. The MHIT sent an email to the probation OM requesting a release address for H on 30 April 2020.

Were the NHS mental health trust in Birmingham aware he was being released?
His care coordinator in Birmingham had been aware previously. On 27 February 2020, the CMHT care coordinator 1 asked PO5 for an update on H. They were told that H had been transferred to HMP Parc in September 2019. H was due to be released on 23 April 2020 and he would not be subject to any restrictions.
Was the electronic health care record system (EHR?) due to be live be Dec 2019 implemented?
Yes. All prison healthcare in England and Wales now use SystmOne.
From Niche's own recommendations from the Simelane case, you stated that prison healthcare staff formulating a care plan and risk assessment MUST liaise with all agencies involved with the prisoner in the community in order to obtain an accurate profile of their need and the risks to themselves AND OTHERS? Did this happen?
HMP Stoke Heath had provided HMP Parc with full details of his mental health care on transfer there in September 2019. This did not happen prior to H's release from HMP Parc.
This report also mentions a recommendation of setting up a "Mental Health Homicide Oversight Group to ensure action on the recommendations of reports. Chaired by NHS England. Is this happening?
We understand this no longer functions.
I would like full details of his dealings with the Mental Health Trust on his release from Prison. What attempts were made to engage him.
The CMHT care coordinator had a discussion with the local authority Children's Advice & Support Service Birmingham (CASS) on 1 June 2020 about their concerns for H's child. The CMHT care coordinator disclosed that H had been released from prison and was not subject to supervision. They also detailed that he had a diagnosis of paranoid schizophrenia and a history of offences that included possession of cannabis, firearms and ammunition, robberies against women, threats against neighbours, domestic violence against female partners and he was known to carry a knife. In addition, there had been concerns in the past about non-accidental injury to his child. The CMHT care coordinator was to follow up this conversation with an email. On 2 June 2020, the CMHT care coordinator obtained the last known contact details for H's next of kin, his mother, from the NHS Spine. They also contacted the last known GP surgery. They told the surgery that H had recently been released from prison and there had been concerns in the past about the potential threat he posed to his child. They provided the surgery with the child's name and date of birth. CASS investigated the information provided by the CMHT care coordinator. While some of the information shared by the CMHT care coordinator was incorrect, CASS was able to locate H's child and their mother. CASS confirmed that H did not know the address for the mother and child, and he had not had contact with them.

On 11 and 12 June 2020 the CMHT care coordinator tried the phone numbers they had obtained for H's next of kin, without success.

In June P06 closed H's OASys.

H was discussed at the CMHT MDT meeting on 23 June 2020. The team discussed the actions that the CMHT care coordinator had taken to find H. We were told during interviews that the CMHT care coordinator had considered asking the benefits agency if they had an address for H. We have not seen any evidence that this was done.
July 2020

H did not make contact with any services in July 2020. At this time H was lost to services.
August 2020.

On 13 August 2020 H re-registered with a new GP. A triage phone call was completed with him on 17 August 2020. In this call H said that he had been released from prison with two weeks of olanzapine and since then he had been using a friend's olanzapine.
H reported that his mood was okay. He was experiencing regular hallucinations and voices telling his to do things, but he did not provide additional detail about this.
He told the GP that he had been in prison for three years for drug and firearms offences, but that he was not subject to supervision from probation services.
The GP noted that H had been under the care of a CMHT.

H told the GP that he was living in a housing association property.
The GP was unable to provide H with a prescription for olanzapine because it was more than four months since his last prescription and H had a history of non-compliance with prescribed medication. The plan from this call was to refer H back to the CMHT.

On 19 August 2020, the GP completed a non-urgent referral to the BSMHFT single point of access. In the referral, they identified that H had been released from prison and was not under probation supervision. That H had previously been under the care of a CMHT and had been prescribed olanzapine. They said that H was experiencing hallucinations and hearing voices but provided no detail about them.

The GP was unwilling to provide H with a prescription for olanzapine because of H's previous poor compliance and requested a mental health assessment and Consultant Psychiatrist review of H's medication.

The GP identified concerns about a risk of self-neglect, concordance with existing mental health treatment, H's current behaviour of risk taking (although no detail was provided about this) and his history of misuse of drugs. They did not have any concerns about his risk of suicide or self-harm, exploitation by others or his history of depression. They were unable to comment on any previous suicide or self-harm events or previous episodes of violence or aggression. Nor were they able to confirm if the home environment was safe to visit.

They provided details of a CPA review completed in 2016 when H had been released from prison. At this time, his diagnosis was bipolar affective disorder.
On 25 August 2020, the CMHT offered H an outpatient appointment for 3 September 2020.

September 2020
CMHT care coordinator 1 was no longer working with the CMHT, and H was allocated to CMHT care coordinator 2 who made two unsuccessful phone calls to H's next of kin (his mother) on 1 September 2020.

On 2 September 2020 CMHT care coordinator 2 attempted to contact H to remind him about the appointment with following day, without success. In the clinical record CMHT care coordinator 2 noted that they contacted Elliott House AP who told them that H had left the hostel several months previously.

CMHT care coordinator 2 made two further unsuccessful attempts to contact H's next of kin.

Following this CMHT care coordinator 2 liaised with the CMHT clinical lead about the lack of contact with H or his next of kin. Based on the team's previous experience of H, it was agreed there was a chance he would not attend the appointment planned for the following day and it was agreed that CMHT care coordinator 2 would complete a home visit to the address provided by the GP in their referral, supported by a support worker from the team
On 3 September 2020, CMHT care coordinator 2 and a support worker from the CMHT completed a home visit to see H.

It took H a long time to answer the door and he initially told them that his name was James. He was hostile and guarded with the staff during the visit.

H said that he would not attend the appointment with the consultant psychiatrist that afternoon. This resulted in him being assessed over the phone by the CMHT consultant psychiatrist, who had seen H in December 2018

H told the consultant psychiatrist that he was hearing voices that could be distressing but he did not want to talk about the content. He said he had been taking a friend's olanzapine. The psychiatrist noted that it was difficult to complete a full assessment.

The plan agreed with H was that the GP would be advised to prescribe olanzapine 10mg and that H would be given a face-to-face appointment with the CMHT consultant psychiatrist for 24 September 2020, which he said he was willing to attend.

Regarding the contact he had with mental health professionals 48 hours before the murder and other attacks - Why was the view taken to arrange an appointment in three weeks' time. The option to undertake a temporary short-term section would have been available, why was this not evoked? During the sentencing, we were given considerable detail about this meeting - e.g., lied about his identify, said he was taking friends medication, cocaine and cannabis, was seeing shadows and hearing voices. I would like a full and frank explanation of this clinical decision.

On 3 September 2020, CMHT care coordinator 2 and a support worker from the CMHT completed a home visit to see H.

It took H a long time to answer the door and he initially told them that his name was James. He was hostile and guarded with the staff during the visit.
H said that he would not attend the appointment with the consultant psychiatrist that afternoon. This resulted in him being assessed over the phone by the CMHT consultant psychiatrist, who had seen H in December 2018.

H told the consultant psychiatrist that he was hearing voices that could be distressing but he did not want to talk about the content. He said he had been taking a friend's olanzapine. The psychiatrist noted that it was difficult to complete a full assessment.

The plan agreed with H was that the GP would be advised to prescribe olanzapine 10mg and that H would be given a face-to-face appointment with the CMHT consultant psychiatrist for 24 September 2020, which he said he was willing to attend.

It did not appear to either the care coordinator or the assessing psychiatrist that H had a mental disorder of a nature or degree that warranted assessment under the MHA. There were no indications that H was contemplating such harmful acts.

There were limited alternative actions since H was not deemed having a mental disorder of a degree or nature warrant assessment under the MHA, and there was no indication he had come to the attention of statutory services since release from prison, as a result of his mental illness. The only realistic options were to continue to try and engage H and try to persuade him to take medication since he could not be compelled to take his medication or admitted.

Appendix D: Answers to questions provided by Mrs A Callaghan, mother of Michael Callaghan

Which prisons was H incarcerated in following his sentence in 2017?

- HMP Birmingham 17 to 28 April 2017
- HMP Stoke Heath 28 April 2017 to 30 May 2018
- HMP Oakwood – 30 May 2018 to 9 November 2018
- Elliott House AP – 9 November 2018 to 24 December 2018
- HMP Birmingham – 24 December 2018 to 24 January 2019
- HMP Stoke Heath – 24 January 2019 to 12 September 2019
- HMP Parc 12 September 2019 – 22 April 2020

How long did H stay in each of these prisons?

Dates are listed above

What were the reasons behind each of H's prison moves?

We discuss H's prison transfers in detail in the report in paragraphs 4.28 to 4.475.

HM Prison Service frequently move prisoners around from prison to prison. This can be for many reasons including:

- Prisoner requested transfer.
- Move to prison nearer home in preparation for release.
- Transfer for the safety of the prisoner (victim of bullying, gangs etc)
- Transfer for the safety of other prisoners.
- Security of prison service.
- Opportunity for specialist programme or rehabilitation.
- The need to free space in a prison.
- The need to be urgently accommodated.

Reason for H's transfer from each prison:

- HMP Birmingham 17 to 28 April 2017 - short term post sentencing. Moved to HMP Stoke Heath for longer term.
- HMP Stoke Heath 28 April 2017 to 30 May 2018.
- HMP Oakwood – 30 May 2018 to 9 November 2018 – Had requested a move to be closer to family in October 2017.
- Elliott House AP – 9 November 2018 to 24 December 2018 - recalled to HMP Birmingham from licence due to noncompliance with conditions of his licence.
- HMP Birmingham – 24 December 2018 to 24 January 2019 – short term placement due to recall from licence.
- HMP Stoke Heath – 24 January 2019 to 12 September 2019 – moved to HMP Stoke for longer term.
- HMP Parc 12 September 2019 – 22 April 2020. H had been requesting transfer for some time – various reasons included he had hit a prison officer previously in Stoke Heath and they were now his Offender Manager, he had been in trouble with officers in Stoke Heath, he wanted to get away from the 'gang scene', he wanted to keep his head down and get to a Category D (i.e., open) prison. He had said staying in Stoke Heath was making him worse. However, he wanted to stay in the Birmingham prison cluster area and did not request a move to HMP Parc.

Why did MAPPA intervention cease prematurely?

We have discussed this in detail in Section 4 of the report, paragraphs 4.417 to 4.423 (page 62) and then Section 7 of the report, pages 94 to 101.

MAPPA was terminated for H on 17 October 2019. This meeting was held at short notice and went ahead without the involvement of HMP Parc staff and a report from them or mental health services. Minutes of the meeting record that "*panel agreed that due to H's continued refusal to engage with any support offered there is no added benefit for continuation at level 2. Any outstanding actions will be updated to ViSOR within the agreed time frame*."

In our judgement the MAPPA panel meeting in October 2019 should have been rescheduled to allow prison services to provide information to the meeting and ensure that full and relevant information was available to all agencies at the meeting.

Based on the information made available to this review we have not seen any evidence that would have indicated that H's risk of harm had reduced sufficiently or that his case no longer required multi-agency involvement by October 2019. The decision to de-register H from MAPPA should have been informed by information from the prison and mental health services.

Furthermore, none of the reasons that led H to be registered as level 2 MAPPA in October 2018 had been addressed and there is nothing to indicate that there had been any positive developments in the case. H had not cooperated with Elliott House AP or his medication regime between 9 November and 25 December 2018.

It would not be unreasonable to say he was also unmedicated during his stay in Elliott House

At sentence end H was released subject to no supervision. Had he remained subject to MAPPA registration beyond October 2019, there would have been opportunities for further information sharing opportunities provided by ongoing panel meetings.

H was released into the community effectively unmedicated. He was refusing medication prior to his release. Although prior to his release staff had continued to prescribe an anti-psychotic and try to persuade him to take his medication and he was given 14 days medication on release.

Why was MAPPA intervention not geared up if H wasn't cooperating?

We discuss MAPPA in section 7 of the report (pages 94 to 101)

In our judgement the MAPPA panel meeting in October 2019 should have been rescheduled to allow prison and mental health services to provide the panel with up-to-date information and ensure that full and relevant information was available to all agencies at the meeting.

The panel meeting went ahead and removed him from MAPPA because he it was reported that he was not engaging.

We believe this was a mistake.

What did the prison authorities know about H making sharp weapons out of a toilet brush?

This is discussed in paragraphs 4.336 and 4.337, 6.122 and 6.124, 7.47, 9.154, 9.160, and 9.172. When in HMP Stoke Heath, on 10 April 2019 because of a targeted cell search, H's cell was searched and a weapon was found. He had sharpened a toilet brush handle to a point. H was given an exceptional downgrade and placed on basic regime.

We have not been able to establish if any service knew the reason for him fashioning weapons.

When and in which prison did this weapon incident occur?

10 April 2019 - HMP Stoke Heath.

What consequences were there for H making weapons?

He received an exceptional downgrade in IEP ('Incentives and Earned privileges') to Basic regime.

Were there any other similar weapon-related incidents?

In April 2019 there were other reports that he was carrying weapons on the prison wings.

In May 2019 there were reports he had been found in possession of two sharpened pieces of plastic in his cell.

A bladed weapon was found in H's cell on 14 August 2019. The belief was that H and another prisoner planned to use the weapon to threaten a member of prison staff for their keys. He was subject to an exceptional downgrade and again placed on basic.

Who was involved in the decision to release H to no fixed abode without supervision?

There are two issues here.

1- Release without supervision.

2- Release to NFA

Release without supervision.
Once H was removed from MAPPA following the October 2019 MAPPA panel there was no future remit for multi-agency public protection arrangements.

H was at sentence end date in April 2020 having served his sentence and there was no legal framework under which he would be subject to compulsory supervision. He was therefore released without supervision.

Although there had been some concerns about his mental health prior to leaving HMP Parc (mostly about risks to himself) these were not considered serious enough to warrant assessment under the MHA which would have been the only other avenue available to services.

Release to NFA.
H had been NFA when he had come into prison. In February 2020, H was seen by staff from the St Giles Trust who provided the resettlement service for the prison. H requested resettlement in the Wrexham area, however, he lacked the local connection to support this and a referral for accommodation in the area was not completed.

The probation team accommodation officer reviewed H's records on 7 April and asked PO5 if they knew why H was requesting accommodation in Wrexham. They identified that if H was directed to return to Birmingham another form would need to be completed for him.

When H was seen by a primary care mental health nurse (RMN2) on 13 April 2020 he told them that he planned to live in North Wales when he was released and that he had accommodation.

There was an email from the Probation Service on 15 April advising that for H to secure accommodation in North Wales, he would need to prove a local connection. They also provided the contact details for the police Offender Manager in Birmingham.

On 1 May 2020, the Mental Health in Reach Team for HMP Parc established that services did not have any details about H's plans after his release, beyond a belief that he may have gone to Wrexham because he had told the St Giles resettlement team and PCMHT that this was his intention. It was not known why he wanted to live there or what his connection with the area was.

What issues did that panel that released H consider?

There is no panel involved when a prisoner is released at sentence end. Parole Boards do make decisions about who can be safely released to serve the rest of their sentence in the community, this is known as being 'on licence' or probation. In H's case he had served his sentence.

We believe that removing him from MAPPA was a missed opportunity to provide a degree of supervision of H.

What was the panel's rationale that H was not a danger to society considering his record in prison of not reliably taking his medication, of verbalising that he wanted to hurt people, and that he didn't cooperate with the interventions put in place?

H's release from prison was not considered by a 'panel'. Prisoners at sentence end are released into the community because there is no legal framework under which to detain them further.

The MAPPA was the only panel that consider H's risks in the community. He was discharged from MAPPA in October 2019. The MAPPA panel rationale was that he was not engaging with services. We were told that they believed he had originally been put on MAPPA because of a risk to his child, but that as he did not see the child was no longer a risk to them. This was incorrect.

What communications took place between the prison authorities and the prison NHS in preparation for H's release?

The two services work in parallel.

Prison services and primary care mental health services in HMP Parc are provided by G4S.

The St Giles Trust was commissioned to provide resettlement support into HMP Parc.

The HMP Parc MHIT is provided by the NHS had responsibility for liaising with post release mental health services concerning H's mental health care.

H was telling all services (those provided by G4S, the NHS and St Giles Trust) that he was planning to relocate to Wrexham when he was released.

There was no communication between the prison authorities and mental health services about H's release.

However, there was some communication between the Probation service and the MHIT.

The probation team accommodation officer reviewed H's records on 7 April and asked PO5 if they knew why H was requesting accommodation in Wrexham. They identified that if H was directed to return to Birmingham another form would need to be completed for him.

There was an email from the Probation Service the following day stating that H was being released at sentence end date and, as such, would not be able to be supervised by the probation service. It specified that he was no longer subject to MAPPA processes. They advised that for H to secure accommodation in North Wales, he would need to prove a local connection. They also provided the contact details for the police OM.

H was released from HMP Parc on 22 April 2020. The MHIT sent an email to the probation OM requesting a release address for H on 30 April 2020.

Why did the release panel consider H could be safely released without any supervision or support from Mental Health Services?

There is no 'release panel' as such.

H was at sentence end. H accessed support from St Giles Trust (a resettlement charity) to help his resettlement on release.

There was an expectation that H would receive support from a local mental health team following his release. There was no support immediately available to him from mental health services following his release from prison because:

- He was released to NFA. As a result, the MHIT did not know which mental health community team to refer him to.
- The MHIT were unable to locate the contact information they had for the Erdington CMHT and did not share a discharge summary with them.
- There was belief that he was going to live in Wrexham.

It would have been good practice for the MHIT to have engaged Erdington CMHT prior to release in case he chose to return to the Birmingham area.

It would also have been good practice for the care coordinator from the Erdington CMHT to have made contact with the HMP Parc MHIT whilst H was detained to HMP Parc to obtain up to date information about his mental health, medication, and plans for his release.

At H's release, what communication was there between the prison and NHS mental health services?

On 1 May 2020, the MHIT established that services did not have any details about H's plans after his release, beyond a belief that he may have gone to Wrexham because he had told the St Giles resettlement team and PCMHT that this was his intention. It was not known why he wanted to live there or what his connection with the area was.

The MHIT practitioners were not able to see details of H's CMHT on SystmOne. They noted that H's engagement with mental health services in prison had been minimal and he had declined support prior to his release. As the MHIT were not allowed into the prison due to restrictions caused by the Covid 19 pandemic, the MHIT practitioners relied upon SystmOne to update them with information regarding the prisoners they were in contact with. There had been no significant concerns about H's presentation in the week prior to his release recorded on SystmOne. They discussed this with the MHIT team manager.

On 5 May 2020 the MHIT CPN3 identified H's last known GP in Birmingham. They made a phone call to the GP and although H was no longer registered with the practice the GP was happy for his discharge summary to be shared with them and they would pass it onto services as appropriate.

CMHT care coordinator 1 contacted West Midlands Probation Service on 18 May 2020 requesting an update on H. They wanted to contact H to book an appointment to complete an assessment and make appropriate referrals for him. PO6 told the CMHT care coordinator that they did not know where H was living, although they were aware that he had completed a housing application to live in Wrexham. However, they doubted that this application had been successful.

The CMHT care coordinator did not have any contact with MHIT at HMP Parc and was not involved in the planning for his release from HMP Parc. While, in part, this could have been because the MHIT did not contact them, the CMHT care coordinator did not contact the MHIT for an update about H in the eight months he was at HMP Parc.

At H's release, how aware of H's mental health needs were NHS Mental Health services at community and consultancy level?

See above. H was known to his local CMHT in Birmingham, although he had only had one appointment with his care coordinator and consultant psychiatrist in November 2018 when on licence in Elliott House AP.

What steps did NHS Mental Health Services take to locate H between his release and the visit to his home on 3rd September, or was he 'shelved' as no known whereabouts?

We discuss this in detail in paragraphs 4.476 to 4.508, and then 9.204 to 9.212.

The CMHT care coordinator had a discussion with the local authority Children's Advice & Support Service Birmingham (CASS) on 1 June 2020 about their concerns for H's child. The CMHT care coordinator disclosed that H had been released from prison and was not subject to supervision. They also detailed that he had a diagnosis of paranoid schizophrenia and a history of offences that included possession of cannabis, firearms and ammunition, robberies against women, threats against neighbours, domestic violence against female partners and he was known to carry a knife. In addition, there had been concerns in the past about non-accidental injury to his child. The CMHT care coordinator was to follow up this conversation with an email.

On 2 June 2020, the CMHT care coordinator obtained the last known contact details for H's next of kin, his mother, from the NHS Spine. They also contacted the last known GP surgery. They told the surgery that H had recently been released from prison and there had been concerns in the past about the potential threat he posed to his child. They provided the surgery with the child's name and date of birth.

CASS investigated the information provided by the CMHT care coordinator. While some of the information shared by the CMHT care coordinator was incorrect, CASS was able to locate H's

child and their mother. CASS confirmed that H did not know the address for the mother and child, and he had not had contact with them.

On 11 and 12 June 2020 the CMHT care coordinator tried the phone numbers they had obtained for H's next of kin, without success.

H was discussed at the CMHT MDT meeting on 23 June 2020. The team discussed the actions that the CMHT care coordinator had taken to find H. We were told during interviews that the CMHT care coordinator had considered asking the benefits agency if they had an address for H. We have not seen any evidence that this was done.

July 2020

H did not contact any services in July 2020. At this time H was lost to services.

August 2020

On 13 August 2020 H re-registered with a new GP. A triage phone call was completed with him on 17 August 2020. In this call H said that he had been released from prison with two weeks of olanzapine and since then he had been using a friend's olanzapine.

H reported that his mood was okay. He was experiencing regular hallucinations and voices telling his to do things, but he did not provide additional detail about this.

He told the GP that he had been in prison for three years for drug and firearms offences, but that he was not subject to supervision from probation services.

The GP noted that H had been under the care of a CMHT.

H told the GP that he was living in a housing association property.

The GP was unwilling to provide H with a prescription for olanzapine because it was more than four months since his last prescription and H had a history of non-compliance with prescribed medication. The plan from this call was to refer H back to the CMHT.

On 19 August 2020, the GP completed a non-urgent referral to the BSMHFT single point of access. In the referral, they identified that H had been released from prison and was not under probation supervision. That H had previously been under the care of a CMHT and had been prescribed olanzapine. They said that H was experiencing hallucinations and hearing voices but provided no detail about them.

The GP had been unable to provide H with a prescription for olanzapine because of H's previous poor compliance and requested a mental health assessment and Consultant Psychiatrist review of H's medication.

The GP identified concerns about a risk of self-neglect, concordance with existing mental health treatment, H's current behaviour of risk taking (although no detail was provided about this) and his history of misuse of drugs. They did not have any concerns about his risk of suicide or self-harm, exploitation by others or his history of depression. They were unable to comment on any previous suicide or self-harm events or previous episodes of violence or aggression. Nor were they able to confirm if the home environment was safe to visit.

They provided details of a CPA review completed in 2016 when H had been released from prison. At this time, his diagnosis was bipolar affective disorder.

On 25 August 2020, the CMHT offered H an outpatient appointment for 3 September 2020.

September 2020

CMHT care coordinator 1 was no longer working with the CMHT, and H was allocated to CMHT care coordinator 2 who made two unsuccessful phone calls to H's next of kin on 1 September 2020.

On 2 September 2020 CMHT care coordinator 2 attempted to contact H to remind him about the appointment with following day, without success. In the clinical record CMHT care coordinator 2 noted that they contacted Elliott House AP who told them that H had left the hostel several months previously.

CMHT care coordinator 2 made two further unsuccessful attempts to contact H's next of kin.

Following this CMHT care coordinator 2 liaised with the CMHT clinical lead about the lack of contact with H and his next of kin. Based on the team's previous experience of H, it was agreed there was a chance he would not attend the appointment planned for the following day and it was agreed that CMHT care coordinator 2 would complete a home visit to the address provided by the GP in their referral, supported by a support worker from the team

On 3 September 2020, CMHT care coordinator 2 and a support worker from the CMHT completed a home visit to see H.

It took H a long time to answer the door and he initially told them that his name was James. He was hostile and guarded with the staff during the visit.

H said that he would not attend the appointment with the consultant psychiatrist that afternoon. This resulted in him being assessed over the phone by the CMHT consultant psychiatrist, who had seen H in December 2018

H told the consultant psychiatrist that he was hearing voices that could be distressing but he did not want to talk about the content. He said he had been taking a friend's olanzapine. The psychiatrist noted that it was difficult to complete a full assessment.

The plan agreed with H was that the GP would be advised to prescribe olanzapine 10mg and that H would be given a face-to-face appointment with the CMHT consultant psychiatrist for 24 September 2020, which he said he was willing to attend.

It is to be noted that H was living outside the catchment area for the CMHT and as such should have been seen by the local team. Our investigation considers it to have been good practice on the part of Erdington CMHT to have accepted the referral and assertively followed it up.

What level of concern did NHS Mental Health services have about H?

See previous entry for detail.

Mental health services in Birmingham were concerned about H. His care coordinators did make attempts to locate him. Once the referral came through from the GP his new care coordinator made several attempts to contact him and, in the end, made a home visit.
Once back in the community, did Probation Services have any role in locating and supporting H?
Probation services role ceased when H was released at sentence end date.
Were Police Forces in Wales or West Midlands aware of H's status as location unknown to be on the alert to find him?
This is discussed in paragraphs 5.38 and 5.39. As H was released at sentence end date and not on licence, there was no requirement for Probation to inform the police. However, the police OM would have been aware of the sentence end date from previous MAPPA meetings. The police would have become aware of H in the community if he committed an offence as Corvus (the police criminal intelligence system) would have generated an email to the police OM.
When H registered with a GP in August, what sequence of events took place between the GP and NHS Mental Health Services and the making of the appointment with the psychiatrist on 3rd September?
See answer to question 17
Once H was registered, what historic NHS information could the GP access to be able to assess the level of H's mental health needs quickly?
There is some limited information in the NHS Spine available to health care professionals. However, his historic information was available to the GP, including notes that mental health services were trying to locate him.
Did the GP have immediate access to H's prison records - his level of illness, his treatment, his behaviour/incident record, his lack of cooperation with intervention strategies, his verbalisation of wanting to hurt people?
NHS community services do not have access to a patient's prison healthcare records. However, HMP Parc MHIT provided the GP with a discharge letter which contained details of offences, and a summary of contact with MHITs and his conduct in prison.
Did the GP meet H in person as part of the registration process and to prescribe medication?
It was recorded as a 'telephone triage contact' due to Covid 19' on 17 August 2020. At this time health services were minimising all contact with patients across the country as a result of the Covid-19 pandemic.

Did the GP make a referral to NHS Mental Health Services, and if so, when and what level of urgency was requested?
H was referred by the GP on 19 August to the BSMHFT Single Point of Access (SPA). It was identified by the GP as urgent but given a priority to be seen within 1 to 4 weeks.
If it wasn't a GP referral, how was the 3rd of September appointment made?
It was an unannounced home visit in response to the CMHT not being able to make contact with H over the phone and the belief that he would not attend the planned outpatient appointment.
What information did NHS Mental Health Services have to deem sending a Mental Health nurse and an HCA necessary to see H prior to the appointment to encourage him to attend and to offer transport?
H had a new care coordinator who was able to review the Trust clinical record for H. When they were unable to make contact over the phone with H, they had a discussion with the CMHT clinical lead. Based on the team's knowledge of H's previous behaviour they were concerned he would not attend the planned outpatient appointment, and this prompted the home visit.
As H was uncooperative and refusing to attend the appointment on 3rd September, even with an offer of free transportation, what was the psychiatrist's rationale for postponing the appointment for 3 weeks?
We discuss this in the report paragraphs 4.500 to 4.508 and 9.204 to 9.212. H was considered to be reluctant to engage but not 'uncooperative'. He was willing to accept medication and agreed to attend another appt. We don't believe the appointment was postponed; it was arranged for three weeks' time on 24 September which he said he would attend. The consultant's view was that his presentation was similar to when they assessed him in December 2018, and they did not see any increase in his risks. On 3 September 2020, CMHT care coordinator 2 and a support worker from the CMHT completed a home visit to see H. It took H a long time to answer the door and he initially told them that his name was James. He was hostile and guarded with the staff during the visit. The plan agreed with H was that the GP would be advised to prescribe olanzapine 10mg and that H would be given a face-to-face appointment with the CMHT consultant psychiatrist for 24 September 2020, which he said he was willing to attend. It did not appear to either the care coordinator or the assessing psychiatrist that H had a mental disorder of a nature or degree that warranted assessment under the MHA. There were no indications that H was contemplating such harmful acts, and they thought the management plan was prudent and achievable.
What other alternative actions were available to the psychiatrist at H's refusal to attend, and why, individually, were they rejected?
There were limited alternative actions available. The options available would have been: • The consultant to complete a home visit. This was considered unnecessary as H had engaged in an assessment over the phone and there was no reason to believe that the outcome from a face-to-face assessment would have been different. The care coordinator

was present during the phone call to provide feedback to the consultant about H's demeanour.

- An assessment under the Mental Health Act. H was not deemed having a mental disorder of a degree or nature warrant assessment under the MHA, and there was no indication he had come to the attention of statutory services since release from prison, as a result of his mental illness.

The only realistic options were to continue to try and engage H and try to persuade him to take medication since he could not be compelled to take his medication or admitted.