An independent investigation into the care and treatment of a mental health service user (MN) in Cheshire

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Executive summary

NHS England North commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, MN (not his actual initials) in November 2017. Niche is a consultancy company specialising in patient safety investigations and reviews.

The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services[2]. The terms of reference for this investigation are given in full in Appendix A.

The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to reduce the chance of recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring. The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

MN and another (A) killed Mr Stephen O'Brien on 31 August 2016 with a single stab wound. We would like to express our condolences to Mr O'Brien's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way to addressing any outstanding issues and questions raised regarding the care and treatment of MN.

MN had been known to mental health services run by Cheshire and Wirral Partnership NHS Foundation Trust (the Trust or CWP) intermittently for several years and was in receipt of care from the Early Intervention in Psychosis Team (EIT) and the Substance Misuse Service (SMS) at the time of the homicide. He had been living at the YMCA for approximately six months but was in the process of moving out to stay in his mother's flat.

After the first trial and before a planned second trial MN pleaded guilty to manslaughter and was sentenced to seven years in prison. The other perpetrator was found guilty of murder at the first trial.

At the time of commencement of the independent investigation, there was no comprehensive internal investigation as the Trust was asked not to interview staff because of police procedures. However the Trust completed a 72-hour review and a chronology, both of which were shared with the independent investigation. Subsequently the trust have completed their own internal investigation.

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[1] *NHS England Serious Incident Framework March 2015.* https://improvement.nhs.uk/resources/serious-incident-framework

[2] *Department of Health Guidance ECHR Article 2: Investigations into mental health incidents* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

The independent investigation commenced in November 2017. A number of Trust clinical and governance staff were interviewed and records were reviewed.

The investigation concluded with the following recommendations.

Recommendations

Recommendation 1
The Trust should ensure that any service user in receipt of the Care Programme Approach should have a comprehensive assessment and care plan recorded within three months of referral, to include social and family history, genogram (if family dynamics could be an issue), any earlier episodes of violence or aggression, and education and work.

Recommendation 2
The Trust should ensure that if a service user is receiving care and treatment from more than one Trust service there should be collaboration and joint meetings between these services, and consideration given to a shared care plan.

Recommendation 3
The Trust should develop a protocol to support clinicians on when to decide to use depot antipsychotic medication in patients with active psychosis who are unable to dependably use oral antipsychotics.

Recommendation 4
Where a patient has an active psychosis and fails to engage in treatment, the Trust should ensure that he or she should be considered for assessment under the MHA, and that this discussion is documented in the notes.

Recommendation 5
The Trust should develop a policy and guidance on the discharge of patients who are failing to engage but are actively psychotic and have a moderate risk of violence exacerbated by substance misuse.

Recommendation 6
The Trust should develop guidance on when contact with relatives/partners becomes essential as part of the care of patients. This is particularly needed when patients fail to engage yet are clearly ill and, when safeguarding criteria for doing so without the patient's permission are reached.

Recommendation 7
The Trust should, in the event of any future serious incident, take active steps to identify learning at an early stage. There should also be more formal and regular communication with other agencies, including the police, to ensure that all parties are aware of progress in relation to the management of the incident; this may be through a multi-agency Incident Co-ordination Group which could meet in person or by telephone.

Recommendation 8
The Trust should ensure that the Board receives regular updates on the progress of all serious incident investigations. The roles of the Quality Committee and the Weekly Meetings of Harm in relation to learning and the tracking of progress need to be confirmed.

This is the third case in the last two years that Niche have independently investigated where the internal initial investigation has been delayed or prevented by an ongoing police investigation. This prevents the organisation from proceeding to quickly put changes in place to prevent recurrence. We therefore make the following recommendation for NHS England to act upon.

Recommendation 9
NHS England should engage with the National Police Chiefs' Council to complete their review of the 2006 Memorandum of Understanding and provide interim guidance to the NHS in order to facilitate the early investigation of serious incidents in health care.

Good practice

We believe that practitioners in both the Early Intervention Team and the Substance Misuse Service worked actively to foster a therapeutic relationship and to encourage and facilitate MN's engagement and that there was evidence that this was starting to have some impact.

1. Independent investigation

Approach to the investigation

1.1 The independent investigation follows the NHS England Serious Incident Framework[3] (March 2015), which aims to help the NHS move away from attributing blame and instead find the causes when things go wrong, and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services[4]. The terms of reference for this investigation are given in full in Appendix A.

1.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring. The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

1.3 The investigation was carried out by Sue Simmons for Niche, with expert advice provided by Dr Andrew Leahy, Consultant Psychiatrist, Professor Liz Hughes and Emma Foreman, Associate Director, Niche. The investigation team will be referred to in the first person in the report.

1.4 The report was peer reviewed by Nick Moor, Partner, Niche.
NHS England wrote on two occasions to MN before the beginning of the investigation to seek his permission for access to his clinical records. They did not receive a reply. The records were later released by the Trust's Caldicott Guardian to Niche.

1.5 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[5]. We referred to written records from the Trust, MN's GP, multi-agency safeguarding meetings, Trust policies and guidelines and the Trust's 72-hour review and chronology.

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[3] *NHS England Serious Incident Framework March 2015.* https://improvement.nhs.uk/resources/serious-incident-framework

[4] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

[5] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

1.6 As part of our investigation we interviewed the following members of Trust staff:
- Head of Clinical Governance
- Complaints and Incidents Manager
- Consultant Psychiatrist, Early Intervention Team
- Team Manager, Early Intervention Team
- Young Person's Support Co-ordinator, Substance Misuse Service
- Care Co-ordinator, Early Intervention Team (by email)

We also had a telephone discussion with MN's YMCA keyworker.

1.7 A full list of all the documents we reviewed is at Appendix B.

1.8 We would like to thank the members of staff of the Trust for their help and co-operation during this investigation.

1.9 As far as possible we have endeavoured to eliminate or minimise hindsight or outcome bias[6] in this process. We have endeavoured to work with the information which was available to the team at the time. However, where hindsight has informed some of our judgements, we have identified this.

1.10 The draft report was shared with NHS England, the Trust, and NHS South Cheshire Clinical Commissioning Group. This provided the opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Mr O'Brien's family

1.11 Contact with Mr O'Brien's family was made through the Victim Support Homicide Case Worker. Members of the family wished to be informed about the final report. We therefore met with the family on 18 December 2018 and shared the final report with them.

Contact with MN's family

1.12 Contact for MN's family was made in the first instance by NHS England. Members of the family expressed an interest in seeing the report before publication but did not want to meet with the investigator or NHS England. A copy of the report was therefore shared with them.

Contact with MN

1.13 We wrote to MN during the investigation, having ascertained his location, explained the purpose of the investigation and requested to meet him. A follow up letter was also sent which included an offer to discuss the final report. We received a telephone call from his care co-ordinator (CCO) to say that he did not want any contact. We have therefore not been able to meet him.

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[6] *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)*

Structure of the report

1.14 Section 2 describes the Trust and section 3 the details of the incident. Section 4 provides background detail about MN.

1.15 Section 5 sets out the details of the care and treatment provided to MN, including comment and analysis. We have included a full chronology of his care in Appendix C in order to provide the context in which he was known to services in Cheshire.

1.16 Section 6 examines and discusses the Trust's governance systems, while section 7 sets out our overall analysis and recommendations.

2. Cheshire and Wirral NHS Foundation Trust

2.1 The Trust provides mental health, learning disability and community physical health services for Cheshire and the Wirral. The Trust's mental health service is divided into three areas. MN received his care in the Central and Eastern Cheshire area. In this patch, at the time of the incident the substance misuse service was provided by the Trust, but in the other two areas it was provided by third sector organisations.

3. Details of the incident

3.1 On the evening of Wednesday 31 August, 2016, Mr Stephen O'Brien, a 51 year old man was attacked by two men, MN and A, and stabbed in the chest. Mr O'Brien later died from his injuries. Both MN and A received custodial sentences for the attack, with MN convicted of manslaughter and A convicted of murder.The attackers were friends who had both lived in the local YMCA. MN was known to substance misuse services (SMS) which were then provided by Cheshire & Wirral Partnership NHS Foundation Trust (CWP or the Trust). MN, then aged 20, had also been in contact with the early intervention in psychosis team (EIT) on and off since 2014. This meant that MN's care fulfilled the criteria for an independent investigation. A's care did not.

3.2 It is thought that Mr O'Brien was known to A and that there had been some previous tension between the two, possibly involving family members.

3.3 Following their arrest A gave no comment to the police regarding the incident. However MN was reported to have been cooperative throughout the investigation process. He was assessed in custody by the criminal justice liaison team who noted no significant change in his mental health. Both A and MN admitted to being present at the time of the incident and to having seen Mr O'Brien being stabbed; but both accused the other.

3.4 Mr O'Brien died of a single stab wound to the chest. Forensically it is believed that A delivered the stab wound, however it is believed that MN took the role of back-up and aggressor to A. It is reported that both had a morbid fascination with knives.

Outcome of the trial

3.5 A was found guilty of murder. The trial jury were unable to return a verdict on MN. A retrial was planned; however, MN pleaded guilty to manslaughter prior to the retrial and was sentenced to seven years in prison. There was no inquest because of the criminal proceedings. However, the coroner later confirmed that Mr O'Brien had died of a single stab wound to the chest.

4. Background of MN

Summary of social, family and mental health history

From age 12 to 17

4.1 There is a reference in the GP notes to a referral to the Attention Deficit Hyperactivity Disorder (ADHD) team in October 2006 when MN was 10 years old. However, there is no further information on this in the Trust or GP notes.

4.2 In February 2009 MN was referred by his family support worker to the Child and Adolescent Mental Health Service (CAMHS). At that time MN was 12 years old and attending a state boarding school for children with special educational needs. He boarded four nights a week and returned to his aunt's home at weekends. He had self-harmed three times and was emotionally unsettled and sometimes verbally and physically aggressive. His family support worker was concerned about his behaviour at school and home. He attended his initial CAMHS assessment with his aunt. His family support worker also attended some of his appointments.

4.3 There is limited family history and only a partial genogram in the clinical records. MN had been living with his aunt. He had limited contact with his mother and it is not recorded whether MN had any contact with his father.

4.4 At his first CAMHS appointment MN appeared to be an angry and distressed child, with low self-esteem and worries that his aunt could die. He did not like being a boarder at school. He had cut his arms for some time and was comfort eating resulting in some weight gain. Following his CAMHS assessment MN ran away from school twice and on the second occasion he was brought back by police, who said that his attitude to them was 'very poor'. There was concern that he could self-harm further.

4.5 In further CAMHS appointments MN was often seen with his family support worker. After one appointment in April 2009 MN caused significant problems at school, including breaking three windows, running away and self-harming.

4.6 After a calmer period MN again became more unsettled at school and said that he would like to be a day pupil. In July 2009 (aged 13) MN took an overdose of eight or nine co-codamol tablets, and was admitted to the children's ward, where he was medically assessed by a CAMHS senior house officer. MN told the doctor that he had taken the overdose impulsively so that he would not have to go back to school. There was also some suggestion that he may have been caught shoplifting. It was decided that he did not require further medical intervention but should continue to see the CAMHS mental health practitioner.

4.7 MN was referred to the Preventing Offending Panel (POP - a Youth Offending Service initiative). There was some reference in the notes of the CAMHS mental health worker who attended the meeting to the use of a BB gun (a type of air gun) although this may have belonged to a friend. There was a further POP meeting in October and then his case was closed.

4.8 During the autumn of 2009 there was a compromise concerning MN staying at school. For a few weeks he stayed two nights per week and returned home on the other nights. By December he was not staying overnight at school and only attending on odd days. At that time, it was noted that he was very angry and had long-term attachment issues. In a team discussion it was considered that he might benefit from individual sessions with a male therapist. However, in March 2010 his situation was again discussed in a team meeting and it was agreed that there were no mental health issues, that many other agencies were involved and that CAMHS was no longer appropriate for MN at that time. A discharge letter was written in April 2010 (when he was age 14) which noted that he was a 'vulnerable youngster' who would need continuing support from other agencies and that CAMHS would be willing to see him again if the need arose.

4.9 MN did not complete his schooling. It was recorded in 2016 that he was not working and did not feel well enough to consider work opportunities. He had very few leisure activities or friends.

From age 17 to 20

4.10 MN had four episodes of care by EIT of between three- and six-months duration, from early in 2014 to the time of the attack. He was discharged due to lack of engagement on three occasions. MN has a history of a previous assault, making threats to kill himself, possession of an offensive weapon and a knife in a public place, and three incidents with a previous pregnant girlfriend which resulted in a Multi-Agency Risk Assessment Conference (MARAC) and a pre-birth assessment by Social Services. He was also reported to have been violent to his mother, and to animals in the past.

4.11 When MN was 17, he was seen by a CAMHS practitioner seconded to the Youth Engagement Service for a pre-custody health assessment. It was noted that he was using large amounts of cannabis and appeared to have 'reduced emotional management skills'. There followed a period in custody in early 2014 for breaching the conditions of the Youth Offending Service. On his release MN was again seen by a CAMHS nurse in the Youth Engagement Service who referred him to the EIT.

4.12 He was assessed by the EIT on 12 February 2014. He was then living with his mother in her one-bedroom flat. MN described having suicidal thoughts in prison and said that he heard a male voice and screaming when there was nobody there. He said he had used cannabis daily from a young age. In March his EIT care co-ordinator (CCO) and a CAMHS member of staff visited him together at home. Again, he talked about his fears for his mother and said he was hearing voices. The plan was to start him on anti-psychotic medication and for him to have weekly contact with EIT. However, he did not start medication until sometime later as he feared side effects.

4.13 It appears that MN had moved out of his aunt's house and in with his mother on his release in Feb 2014. In March 2014 MN's mother told staff that she could not continue to have him staying with her as the flat was too small and it was having an impact on the mental health of both of them. MN subsequently spent a few nights in hotels or with friends, before his mother agreed he could stay

until his 18th birthday at the end of April 2014. His mother told staff that he had said that he thought she might be poisoning him and was reluctant to take his medication. It is not recorded how much longer MN lived in his mother's flat, but it appears that he was there beyond April 2014 for a further short period.

4.14 This first episode of EIT care lasted until August 2014, when MN was discharged as a result of his failure to engage. There had been many missed appointments. During this and subsequent episodes of care the team made many attempts to develop a therapeutic relationship with him, made many home visits and arranged to pick him up and accompany him to appointments.

4.15 It is not clear when MN met and moved in with his girlfriend. However, on 23 Feb 2015 he contacted EIT and said he had split up with his girlfriend and he had nowhere to sleep that night. Later in 2015 he moved into the YMCA, but there is a record that on 1 July he was again staying at his mother's address.

4.16 There were three further episodes of care with the EIT, and he was on the team caseload at the time of the homicide.

4.17 During the two years between August 2014 and August 2016 MN continued to lead his rather chaotic life, moving between his mother's flat, his girlfriend's house and the YMCA. He continued to describe hearing voices, and some delusional thinking.

4.18 On 21 July 2015 MN's case was presented at a MARAC meeting, as the alleged perpetrator of domestic abuse. At that meeting it was recorded that MN's girlfriend was four months pregnant.

4.19 MN's girlfriend's baby was born in December 2015. There was a detailed multi-agency child protection plan as a result of which MN was only able to see his baby at the family centre on a weekly supervised basis. These sessions were facilitated and supervised by his YMCA key worker. MN had had three spells of residence at the local YMCA. The last episode had started in February 2016.

4.20 In May 2016 MN had an outpatient appointment with the EIT consultant who followed up with a letter to his GP outlining his diagnosis and risk assessment (see risk assessment section). He was prescribed olanzapine but did not take this until the end of May. He continued to take his olanzapine somewhat erratically for the next few months and told staff that it made him feel calmer.

4.21 Shortly afterwards in May 2016 he began to engage with the drug service as he wanted to be drug free so that he could live with his girlfriend and baby.

4.22 In June there was a further child protection plan which included further requirements for MN, including continuing appointments with his mental health worker, engagement with his drugs worker, and work on domestic abuse behaviours.

4.23 In August 2016 it was noted that he was spending more time at his mother's rather than at the YMCA. There were discussions between him and the EIT

team about attending a course at college, the Recovery College[7], and cross-fit classes. He told his drugs worker that he had reduced his cannabis use but felt this had made him more anxious.

4.24 On 26 August he told his drugs worker that he had gone on ‘a bit of a mad one’ and had taken other drugs, including pregabalin[8]. He felt anxious about going out on his own. Weekly contact was to continue. On 30 August (the day before the homicide) his CCO helped him move some of his belongings from the YMCA to his mother’s flat where he intended to stay. His CCO noted that he remained paranoid and anxious and that he was sniffing and sweating markedly. He had not told the YMCA staff that he was moving out.

[7] *The Recovery College aims to provide a range of recovery, educational and self-care workshops, many of which are co-produced and co-delivered by people who have experience of mental health conditions.*

[8] *Pregabalin is a prescription only drug used to treat epilepsy and anxiety.*

5. Care and treatment of MN

Summary of contact with Trust services

As can be seen from the table below MN had contact with six different trust services over the course of seven years, from the age of 12 to the age of 20.

Dates of involvement with services	Service	Outcome
26 Feb 2009 – 9 April 2010	Child and adolescent mental health service	Discharged. Noted that he was a vulnerable youngster but with no overt mental health problems. Would need continuing support.
28 November 2013 – 10 February 2014	Youth engagement service	CAMHS worker seconded to YES. Seen in connection with offending behaviour. Referred to EIT.
12 February 2014 – 26 August 2014	**Early intervention team** (episode 1)	Discharged due to lack of engagement.
22 & 23 January 2015	**Criminal justice liaison team**	Assessed in court. Said that he would be willing to re-engage with EIT. Therefore re-referred.
January 2015 – 24 April 2015	Early intervention team (episode 2)	Discharged due to lack of engagement.
25 June 2015	Criminal justice liaison team	Seen in court. Plan to re-refer to EIT.
25 June 2015 – 3 March 2016	Early intervention team (episode 3)	Discharged due to lack of engagement and concordance.
16 December 2016 – 8 January 2016	**Drug service**	Discharged due to lack of engagement.
8 February 16 – date of homicide	YMCA	Resident during this period.
6 May 2016 – date of homicide	Drug service	Ongoing intervention
31 July 2016	Crisis intervention service	Called crisis line on Sunday afternoon. Crisis team alerted EIT the following day.
12 May 2016 – date of homicide	Early intervention team (episode 4)	Ongoing intervention
2 September 2016	Criminal Justice Liaison Team	Assessment in custody after the homicide.

Assessment, care planning and the Care Programme Approach

5.1 The service with which MN had most contact was the EIT. This is a specialist team which sees new referrals to the mental health service between the ages of 14 and 65 who are exhibiting symptoms of psychosis. Service users can stay with the team for up to three years. MN had four separate episodes of care with the EIT and was discharged from three of these care episodes as a result of lack of engagement. There was evidence in the notes that decisions about his discharge were made in the weekly multi-disciplinary team meeting. There was no systematic assessment, including social, family, school, employment, mental state, physical health etc, until he was seen by the consultant in May 2016. He was seen twice by the EIT consultant during 2016 and a comprehensive assessment was recorded. Prior to this the notes contained a wealth of information relevant to such an assessment, but this information was not pulled together, and therefore was not easily accessible.

5.2 It was the impression of the EIT consultant and MN's CCO that, although MN had not engaged in earlier years, he was beginning to engage in his treatment plan during 2016. Latterly he had started exploring the possibility of doing some voluntary work.

5.3 In the light of MN's chaotic life style, non-compliance with medication, history of psychotic symptoms and paranoid thinking, the EIT did on at least one occasion give consideration to triggering a Mental Health Act assessment in order to assess him and review his treatment. However, it was thought that his lack of engagement was more of a lifestyle choice rather than a result of an acute psychotic illness and a wish to hide away from treatment. Further, he did agree at different times to start medication but then did not continue with it, and he was aware that his paranoid thinking was part of his illness. In the light of these considerations it was agreed that an MHA assessment would not be requested. However, we were told that if either MN's mother or his girlfriend had contacted the service to say they were worried about his mental health the information would have been taken very seriously, possibly triggering an MHA assessment. This would also have happened had there been a significant change in his mental state or concerns about risk to himself or others. It appears that the consideration and discussion about the appropriateness or otherwise of an MHA assessment was not recorded on Carenotes although it may have been recorded in team meeting minutes.

5.4 In May 2016 he began to engage with the drug service. There was a member of the drug service team who was allocated to work with the YMCA hostel, providing both individual sessions and a drop-in session for self-referral. MN saw his drugs worker a number of times at the YMCA although he missed many appointments when he was not in when she visited.

5.5 During his episodes of care with EIT MN had three different CCOs from within the team. Each of these demonstrated significant commitment to working with him even though his commitment was variable. The staff attempted to arrange appointments in the team base or in his home. They also arrived without notice at his home or at the YMCA to see if he would meet with them or arranged to meet in a cafe or in the park. On occasion they arranged transport for his appointments to see the consultant or his GP. He had a chaotic lifestyle and

often did not attend for arranged appointments. Much of the time appeared to be spent on endeavouring to establish trust and a therapeutic relationship with him and in helping him in very practical ways, including reminding him of and escorting him to appointments. This would have made working in partnership with him on care planning and review very difficult. There was only one EIT care plan identified in the records.

Comment

5.6 In both services it appears that MN was fairly well known. However, there was no comprehensive mental health assessment recorded until May 2016. It is also our belief that, because of his disrupted education (in addition to the normal areas of a mental health assessment) MN's literacy level should have been reviewed. It may also have been appropriate to consider an assessment for adulthood attention deficit hyperactivity disorder (ADHD).

5.7 There is evidence in the records that MN's CCOs and the wider team were all proactive in attempting to engage him in partnership working. This included dropping in unannounced, encouraging him to engage in physical activities or classes, escorting him to appointments and arranging meetings in different settings. The drugs service also took steps to engage with him, despite many missed appointments. The model of attachment to the YMCA appeared to be good practice. It is unfortunate that there are no documented discussions with MN about why he did not attend his appointments and what he hoped to gain from his contact with the mental health service.

5.8 Although there appeared to be good care provided by SMS there was no recorded care plan in Carenotes. This may have been as a result of difficulty in establishing a working relationship with him. There were several months between May and August 2014 when both services were seeing MN fairly regularly. Both teams entered details of their contact in Carenotes and had full access to each other's records. However, there was no joint appointment or shared plan, or suggestion of trying to set one up. The SMS has a very detailed Operational Policy in which service users with mental health problems are prioritised, but it appears that the plan did not make provision for shared care between the substance misuse service and other mental health teams.

5.9 It was clear that the EIT collectively considered the value of requesting a MHA assessment at least once during MN's contact with their service but decided not to proceed. It was unfortunate that the process of decision making and the decision itself were not recorded in his individual record as it could have been useful at a later date.

5.10 MN was discharged from EIT in March 2016 as a result of his lack of engagement. However, it appears from the records that he was still psychotic at this stage. In our opinion a proposal to discharge him should have led to documented discussions about alternative courses of action, including the use of the MHA.

5.11 MN accepted the anti-psychotic olanzapine during 2016 and reported that it made him feel calmer, but he appeared to take it somewhat sporadically. However, there does not appear to be any reference in the notes to any

discussion about the possibility of using a depot anti-psychotic. This would generally be considered when someone with a psychosis struggles with oral medication.

5.12 The Trust has a comprehensive and detailed Safeguarding Children Policy. It was noted that both EIT and SMS staff attended multi-agency MARAC and safeguarding meetings and recorded their attendance and the outcomes of the meetings in Carenotes. Child protection plans were uploaded onto Carenotes. The care and interventions provided by both the EIT and SMS were key and appropriate elements of the child protection plan.

5.13 Both the EIT and the drug service had some variable contact with MN's ex-girlfriend and his mother when they visited him at home. Occasionally his mother may have been asked to give him a message. On one occasion she said she would look after his medication for him. However, neither his girlfriend nor his mother was offered involvement in family meetings or educational groups, although these were available. In addition, it appears that the team did not make contact with his mother or his ex-girlfriend to gather further information about his presentation or any concerns they may have had.

Forensic history known to the Trust's services

5.14 This table sets out the information held in Trust records of MN's involvement with the criminal justice system.

Dates	Service	Source		Notes
11 Aug 09	CAMHS	Clin records p73	Preventing offending panel (POP)	MN referred to this Youth Offending Service initiative, possibly connected to the use of a BB gun with a friend.
13 Oct 09	CAMHS	Clin records p76	POP meeting	Second POP meeting attended by same CAMHS practitioner. Reference to referral to Youth Engagement Service.
28 Nov 13 **(age 17)**	Youth engagement service (YES)	Clin records p8	Seen by CAMHS nurse in YES for pre-custody health assessment	Noted that he had heavy cannabis use and reduced emotional management skills.
Dec 13 – 3 Feb 14	YES	Clin records p8 and Carenotes p121	Two-month period of custody	Following earlier arrest for assault MN ordered to engage with Youth Offending Service but breached the terms and was sent for custodial sentence.
7 Feb 14	YES	Clin records p8 and Carenotes p217-218	Seen by same CAMHS nurse following period of custody	Detailed report. Had been on an Assessment, Care in Custody & Teamwork (ACCT) plan while in prison because of concerns that he could self-harm.
5 Aug 14	MARAC	Carenotes p209	Extract from MARAC notes	MN moved in with mother in Feb 14 on his release from prison. Reported that he had 'smashed up the house' and been violent towards her.
25 June 15	CJLT	Carenotes p205	Assessment in court	Seen by CJLT member of staff, following arrest for possession of a bladed weapon in the street.
21 Jul 15	MARAC	Carenotes p130 & 203	MARAC meeting	MN case presented at MARAC meeting, as alleged perpetrator of domestic abuse.
9 Oct 15	CJLT	Carenotes p202	Arrest	Arrested for alleged burglary.
12 Oct 15	CJLT	Carenotes p202	Release	MN did not appear in court. Advised that he was released without further action on 9 October.
19 Oct 15	EIS to attend	Care notes p93	Second MARAC meeting	Noted that further MARAC meeting to be on 20 October 15.
No further forensic references until homicide				

Risk assessment

5.15 The main risk assessment tool used within the Trust's adult mental health services is CARSO (Clinical assessment of risk to self or others)[9]. There is a single-page form called CARSO Summarised View of Risk on Carenotes.

5.16 Risks to himself or others were referenced a number of times in the clinical records, including references to threatening behaviour, domestic violence, charges of assault, and self-harm. For example, in March 2014 MN's mother said that he had told her he thought she might be poisoning him and was reluctant to take his medication. In August 2014 she reported to a MARAC[10] meeting that he had smashed up her house and been violent towards her. She was very frightened of him. She further alleged that he had displayed extreme cruelty to animals although when and where this had happened was not noted. This was recorded in Carenotes as third party information.

5.17 There were also MARAC meetings and later child protection meetings which Trust staff were actively involved. The MARAC plans were not included in Carenotes appropriately as the multi-agency focus was on the safety of the victim. However, the child protection plans were included.

5.18 Although there was risk information in the records and active staff involvement in multi-agency risk focused meetings, there appears to be only one specific use of the CARSO Summarised View of Risk. This was completed on 26 May 2016 when MN was seen in outpatients by the EIT consultant who recorded a primary diagnosis of schizophrenia and a secondary diagnosis of mental and behavioural disorder due to use of cannabinoids.

5.19 This risk assessment noted that MN continued to experience paranoid and auditory hallucinations, although he denied command hallucinations. He often felt people were looking at him and intended to harm him and he felt angry and easily irritated. He denied active intent to harm others. He had a low threshold for losing his temper and acting impulsively including impulses to harm others when he felt threatened. However, he reported that he did not feel the need to carry a weapon as he recognised that the voices and delusional ideas were part of his illness. He used cannabis regularly which contributed to his mental health issues and potentially increased risk of harm to others, and he had a history of poor engagement with mental health services and treatment offered for his illness.

5.20 He had self-harmed when in custody, cutting his arms with a plastic knife. He had also made threats to kill himself when in police custody but later said that he made these threats because he was angry at being arrested. He denied any suicidal thinking or intent at the time of the assessment.

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[9] The Clinical Assessment of Risks to Self and Others is a clinical decision support tool to aid practitioners in their assessment and management of the risk of both intentional and unintentional harm to self and harm to others in adults of working age using mental health services. It is intended to support and not replace clinical judgement.

[10] Multi Agency Risk Assessment Conferencing (MARAC) is a monthly meeting focused on increasing the safety of high risk victims and their children. Up to date information is shared and a risk management plan developed. In this case it appears that the MARAC meetings were convened to look at protecting MN's mother and girlfriend.

5.21 The CARSO risk assessment also noted that MN had a history of aggression and domestic violence towards his mother. He was awaiting trial at that time for an attack on a family member.

5.22 It was assessed that there was an ongoing moderate likelihood of violence towards others, based on past history. The risk would be increased in the following circumstances:
- Increased use of illicit drugs and legal highs
- Increased vulnerability due to social stressors
- Poor engagement with mental health services

5.23 However no relationship was identified between risk and mental disorder. He did not experience voices telling him to harm others and previous incidents of violence appeared to have arisen from family disputes and/or social circumstances.
The risk management plan included:
- Treatment with anti-psychotic medication
- Social support and boundaries provided by YMCA
- Abstaining from illicit substances
- Involvement of criminal justice system and social services

Comment

5.24 There were various references to potential risk to self or others in the records. However, with the exception of the EIT consultant's CARSO summary, there were few notes which pulled risk information into one place. By the time of the consultant's risk assessment MN had been known to the mental health service for seven years (although this was not continuous). There was sufficient risk information in the records for staff to make a reasoned judgement, but this information was largely scattered and not located in one place. This could have diluted the usefulness of such information as it could not be viewed as a whole.

5.25 We are concerned that the reference to animal cruelty in Carenotes (recorded from a MARAC meeting) does not appear to have been given significant weight in subsequent risk assessments. There is no record of this issue being discussed with MN and it is not referred to in the CARSO summary or in notes from child protection meetings. It appears that the staff providing his care were unaware of the allegation. Indeed, shortly before the homicide a member of staff discussed the possibility of MN doing some voluntary work, possibly with animals. It is now well established that there is a link between cruelty to animals (particularly in adolescence) and violent behaviour[11], and we believe that MN's mother's allegation should have been explored and recorded, so that it could inform a comprehensive risk assessment.

5.26 A documented discussion of the potential value of an assessment using the Mental Health Act would have been indicated given the risk assessment and

[11] *Hodges C. The Link: Cruelty to Animals and Violence Towards People. Michigan State University College of Law. 2008.*

the presence of an active psychosis.[12] It is clear he had a psychosis, problems with substance misuse and a developmental history suggesting conduct disorder, attachment problems and possibly impaired impulse control.

5.27 As a result he was more likely to use violence as a problem-solving method both impulsively and in general. We are aware of the ethical dilemma here as the MHA cannot be used simply because of substance misuse. In addition, it is always better to work with someone rather than force treatment upon them. Nevertheless, we understand that such a discussion did take place but was not recorded in his Carenotes. We believe that it should have been fully documented and repeated at a later date if necessary.

YMCA and relationship with other perpetrator

5.28 MN and the other perpetrator (A) met while both were staying at the local YMCA. Staff at the YMCA have described MN as occasionally threatening to other residents but not to the extent of warranting eviction. He tended to isolate himself from other residents and was on occasion suspicious and anxious. He was generally respectful and polite to staff. However, when together the two of them occasionally 'ganged up' on other residents. In the staff's view MN behaved quite differently when with A.

5.29 MN has a good relationship with his keyworker, who facilitated and supervised his contacts with his baby. His focus while he stayed at the YMCA was to do what he needed to do to increase his contact with his baby.

Communication and multi-agency working

5.30 Over the past few years the Trust has used fully integrated electronic records (Carenotes) which are used for all professional groups. Letters to GPs and other agencies are also uploaded onto the system. All staff in the early intervention service and in the east sector substance misuse service recorded assessments, care plans and reviews in these notes. For the period of time from May 2016 to the time of the homicide, MN was in contact with both the drug service and the early intervention service. Both teams recorded in the same electronic record and therefore had access to each other's records. The Trust's policy on dual diagnosis[13] draws on the Department of Health Good Practice Guide and states that in the case of someone with a severe mental illness and substance misuse, the care co-ordination should be carried out by the mental health service, with the input and support of the substance misuse service. Two of the relevant standards are:

1. The nominated CCO or lead professional is responsible for developing the plan of care with input from other providers involved.
2. To minimise omission, contraindication or duplication in the provision of care for those with dual needs and where more than one service is involved, an

[12] *There is evidence that the longer psychotic symptoms are left untreated the worse the eventual outcome.*

[13] *Cheshire and Wirral Partnership NHS Foundation Trust. Dual Diagnosis Pathway. June 2015.*

integrated (and when needed multi-agency) care plan is required that incorporates both mental health and substance misuse needs.

5.33 Although there were shared records and clear awareness of each other's input there was no integrated care programme approach (CPA) plan or review.

5.34 There was also evidence in the records of telephone communication and regular communication with other agencies, including social services and the YMCA. The YMCA staff told us they felt they could feedback any concerns to the mental health worker and the drugs worker. Both Trust staff visited regularly but MN was often not there. There were good communication channels between the EIT staff, the drug service and the YMCA team. The YMCA team said they thought they were given all the information they needed and felt part of the wider multi-agency team. The YMCA team are given risk information prior to anyone becoming a resident and they felt that they were aware of all the issues of domestic violence and threatening behaviour in MN's case.

Comment

5.35 Although there was clear evidence of shared record keeping there did not appear to be any joint working between the EIT and the drug service during the final few months, in terms of joint meetings or a shared care plan. It is our belief that this resulted in part from MN's lack of engagement. Both the CCO and the drugs worker worked hard to develop a relationship and facilitate his engagement. However, there does not appear to have been any attempt to develop a shared understanding of the relationship between MN's substance use, his mental health and his emotional responses. Such an understanding may have helped the services to work with MN to address some of his difficulties.

5.36 During this period MN had a chaotic lifestyle. In our view it would have been very difficult to engage him in care planning or review, and the existence of an integrated care plan may have made no significant difference to his mental health or substance misuse. Nevertheless, there were some fairly informal attempts at joint working between the EIT CCO and the drugs worker. For example, MN's CCO would on occasion visit him at the YMCA at the same time as the drugs worker conducted her drop-in session, so that he could liaise with her and YMCA staff.

5.37 It is clear that the staff of the EIT and the drug service were endeavouring to establish a therapeutic relationship with MN and deployed a number of strategies to that end. However, it is arguable that they were working without any clear, comprehensive plan based on assessment of his mental health, his substance misuse and his risk. This absence of a clear plan would have resulted in a lack of focus to their work and difficulties in determining when their efforts had been successful.

6. The Trust's governance systems

The Trust's governance processes in relation to the NHS England Serious Incident Framework

6.1 The reporting requirements and information exchange within the Serious Incident Framework Standard Operating Model has three defined stages, the first two of which are relevant to this review:

Stage one. Providers report an incident through the NHS serious incident management system (STEIS), conduct an initial review and produce a 72-hour report:

6.2 The Trust has an Incident Reporting and Management Policy[14] that was implemented in December 2015. This has been reviewed in line with key national reports and the NHS England Framework for Serious Incidents[15]. The policy includes the process for determining the level of incident, the requirement for associated investigations (internal and external), alongside 'Being Open, Apologising and Duty of Candour'. The document also references an annual compliance review but there is no evidence to support these having been undertaken.

6.3 The policy sets out the incident process in a quick reference flowchart. Any serious incident is followed up by a 72-hour patient safety review which is taken to the weekly meeting of harm. This meeting is generally attended by the Director of Nursing, the Medical Director and locality Clinical Services Managers.

6.4 The Trust draft 72-hour report was discussed at the meeting of harm on 6 September 2016, where further updates of the initial review were requested. The updated 72-hour report was submitted on 13 September 2016. The Trust then commissioned a chronology (undated) which set out the key episodes of MN's care. It was noted that MN had taken an overdose whilst in custody after the homicide and that a mental health assessment would be undertaken once he returned from hospital. At the meeting on 13 September 2016 it was reported that the investigation was on hold pending the police investigation. It appears that there were no further discussions on this case at the meeting of harm after 13 September 2016.

6.5 The Incident Reporting and Management Policy requires the allocation of an investigation manager and family liaison lead once the 72-hour review has been completed so that family members and/or the service user can be informed of the incident, with Duty of Candour completed on Datix. In the MN case, the review form states that the Trust were awaiting further information from the police regarding whether contact could be made with the family members, and it appears that there was no contact at an early stage from the Trust with the families of the victim or perpetrators.

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[14] Cheshire and Wirral NHS Foundation Trust. Incident reporting and management policy. December 2015

[15] NHS England. Serious Incident Framework. March 2015 https://improvement.nhs.uk/resources/serious-incident-framework

Stage Two. Providers conduct an internal investigation and produce an investigation report within 60 days:

6.6 In 2006 the NHS, Health and Safety Executive (HSE) and the Association of Chief Police Officers (now replaced by the National Police Chiefs' Council (NPCC)) agreed and signed a Memorandum of Understanding (MoU) which set out the responsibilities of the three organisations in investigating serious untoward incidents. This is referred to in the Trust's Incident Reporting and Management Policy which says:

'The trust will co-operate and work within memoranda of understanding which have been agreed by the NHS and other national bodies including the (former) National Patient Safety Agency (NPSA), the Health and Safety Executive, the Counter Fraud and Security Management Service, the Police and the Crown Prosecution Service'.

6.7 The 2006 MoU was withdrawn by the HSE and the Police in 2014 and is described as being under review by NHS England. However, the principles and aims of this MoU continue to be valid and are reflected in current guidance including the Serious Incident Framework[16] and NPCC guidance for investigating officers[17]. The NPCC document was developed with significant contributions from the Department of Health and NHS England.

6.8 In relation to this case, there was confirmation from the police that the Trust was not to conduct its own internal investigation at the time of the 72-hour review. However, the 2006 MoU and the police guidance also say that it may be appropriate to set up an incident co-ordination group, the purpose of which is to provide strategic oversight of a patient safety incident involving the NHS and the police. While there is evidence to support on-going communications with the police, there was no establishment of this group.

6.9 In November 2016, the Trust signed up to a local MoU. This was specific to this homicide and was agreed in order to clarify the actions that CWP could undertake while the police investigation was still underway. It contains the following statement:

'It was agreed that Cheshire and Wirral Partnership NHS Foundation Trust could prepare for an internal investigation by completing a chronology of the clinical notes for MN (and two others). Clinical staff must not be interviewed by (the Trust) until notified by (the police) major crime directorate. This is likely to be after the Court hearing which has been listed for a three-week trial commencing 06/02/2017.'

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[16] *NHS England. Serious Incident Framework. March 2015. Relevant organisations (i.e. those who co-commission and /or co-manage care) should develop a memorandum of understanding or develop, in agreement with one another, incident investigation policies about investigations involving third parties so that there is a clear joint understanding of how such circumstances should be managed. The Department of Health Memorandum of Understanding: investigating patient safety incidents involving unexpected death or serious untoward harm (2006) provides a source for reference where a serious incident occurs and an investigation is also required by the police, the Health and Safety Executive and/or the Coroner. However this guidance is currently under review*

[17] *NPCC 2015 An SIO's Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings.*

6.10 The Trust complied with the MoU, and therefore no staff were interviewed. The first trial was delayed and the jury were then unable to reach a verdict in relation to MN and a retrial was planned. However, MN pleaded guilty to manslaughter in June 2017 and was sentenced in July 2017 without a further trial. In February there had been communications between NHS England, NHS South Cheshire CCG and the Trust about the proposal to go straight to independent review in the case of MN, because of the delay to the trial. This was reversed in April when it became clear that there was probably going to be a retrial, when NHS England requested that the Trust commence an internal investigation. However, the police said that they did not wish this to happen as they were as yet unclear about whether any staff would be called as witnesses.

6.11 The decision not to proceed with an internal investigation but to go straight to an independent investigation in the case of MN was finally made in September 2017 by NHS England. It appears from communications between NHS England, the CCG and the Trust that the decision not to proceed with an internal investigation was made with the full knowledge and agreement of all three parties.

6.12 The Trust proactively requested updates on proceedings from the CCG and the police but did not enquire beyond May 2017, when they were told that the police could not give them further information. Equally, the police did not communicate that MN had pleaded guilty to manslaughter. The Trust only found out about the trial outcome on 06 September 2017 when they were contacted by the CCG and in October 2017 when they received a note from the coroner's office stating the cause of death and confirming that there would not be an inquest. At that point NHS England had already commissioned this independent investigation and it was agreed that the Trust would not pursue an internal process.

6.13 There is a lack of clarity with regard to the responsibility of the police and the Trust in this situation. The absence of an Incident Coordination Group may be relevant, as there was no established channel for communication. Equally, the terms of reference for the weekly meeting of harm, for example, state that the meeting will undertake a review of investigations which are breaching timescales and will agree extensions as required; but their role in terms of monitoring this type of suspected homicide review which has extended investigation timelines is unclear. Similarly, we have not been provided with evidence or terms of reference for the Quality Committee but have been told that this reviews learning rather than the process itself.

6.14 An immediate communication bulletin was sent to board members and Governors following the suspected homicide with an update to the Board meeting held in private in November 2016. We have not been provided with the minutes of this meeting so cannot comment on the level of discussion or whether any actions were requested.

6.15 Further written updates were not received by the Board until November 2017 when there was confirmation that the police investigations had been concluded, thus enabling a healthcare investigation to take place. In January 2018 board members were told that Niche had been commissioned by NHS England to undertake an independent investigation. There was a further update about this

independent investigation and the internal investigation into the care and treatment of the other perpetrator in March 2018. In addition, we have been told that this independent investigation report will go to the Board.

Learning

6.16 The 72-hour review form references appropriate assessments, care planning and interventions but does not include any immediate learning. The box on the 72-hour report was not used as fully as it could have been.

6.17 A meeting of the Incident Coordination Group at the conclusion of any investigation into a patient safety incident would provide an opportunity to consider what went well and what could be improved. Learning from such de-briefings would allow the national and local arrangements to be improved. As stated above, we are not aware that these meetings took place.

6.18 However, the Trust has developed Share Learning Bulletins which are sent to all clinical practitioners in line with good practice. These include aspects of care which went well and also key learning points from national guidance, inspections and serious incidents. In January 2017, this was also used as a staff reminder to encourage reporting of all near-misses and actual incidents through Datix.

6.19 Incidents are additionally included in locality data packs, with learning included in the Learning from Experience reports and discussed at Learning from Experience groups.

Comment

6.20 It was unfortunate that the local Memorandum of Understanding was not agreed until approximately three months after the homicide. It appears that with the exception of the 72-hour report and the chronology there were limited steps taken to identify local or trust-wide learning points although we were told that the EIT less formally identified some learning points which they implemented locally.

6.21 Further, there appears to have been limited communication between the police and the Trust before, during and after the trial. Despite the MoU's statement that the Trust could begin its own review once the trial was completed, the Trust was not initially told that the trial was over. They were therefore unable to commence their internal review. The police requested that the Trust follow up their enquiry at a later date, but this does not appear to have happened.

6.22 As a result there was a delay in the Trust being able to investigate this incident, and a consequent delay in putting in place measures which might reduce the likelihood of recurrence.

6.23 The Family Liaison role is described in the serious incident policy but there could be greater clarity on communications that are required, or permitted, with

the families of victims or perpetrators following a homicide or during other criminal proceedings. We understand that work on this has already started.

7. Overall findings, analysis and recommendations

7.1 MN had approximately seven years of intermittent contact with six different mental health services, during his rather disrupted and challenging childhood and adolescence. He led a chaotic life; his education was disrupted and his family and social life fragmented. It appears that he did not have substantive employment since leaving school. In addition, he used cannabis frequently and in large amounts. There was also a history of violence. During his contact with the EIT he was diagnosed with schizophrenia and prescribed oral anti-psychotic medication, which he took intermittently. He did report that the medication made him feel calmer. He was the father of his ex-girlfriend's baby and he wished to have contact with his baby and possibly live with his ex-girlfriend at some future date. However, there were active child protection measures in place, which required him to engage with treatment for his mental ill-health and drug use. In May 2016 he was assessed by his consultant as presenting a moderate risk of violence to others.

7.2 In August 2016 he and a friend stabbed Mr O'Brien who died shortly afterwards. MN pleaded guilty to manslaughter. He was given a prison sentence of seven years.

7.3 There appears to be no evidence that there was a direct link between the homicide and MN's psychosis, and it appears that the court did not find any direct link. In our view it is possible that this violent action had more to do with his tendency towards violence and the social milieu in which he found himself.

7.4 This review of his care and treatment has found that, although there was a great deal of sound, professional care provided, there were also some gaps in his care. These included a lack of individualised care planning, an absence of comprehensive risk assessment in the earlier part of his care, and a lack of a clear sense of direction to guide practice.

7.5 In addition there were some delays in the Trust's own internal investigation processes which came about as a result of police instructions.

7.6 These findings have informed our recommendations (see below).

Predictability and preventability

7.7 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event"[18]. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it[19].

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

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

7.8 MN had some history of violence and aggression, and of carrying an offensive weapon. At the risk assessment recorded by the EIT consultant in May 2016, three months before the homicide, it was noted that 'there was an ongoing moderate likelihood of violence towards others, based on past history'. However, it was not predicted that the violence would be extreme, nor was there any link between violence and mental disorder. It was predicted that there could be further violence at some point, possibly within his own family, if MN's protective factors broke down, but the degree of such violence was not predictable.

7.9 Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"[20]; therefore, for a homicide to have been preventable there would have to be the knowledge, legal means and opportunity to stop the incident from occurring. The multi-agency focus over the year before the homicide had been the safeguarding of his ex-girlfriend and their baby. There had been a comprehensive safeguarding plan which involved, among other agencies, the mental health and substance misuse services. MN appeared to have been attempting to comply with these plans. It is therefore arguable that violence within his immediate family had been prevented. There had not been a focus on the prevention of any violence outside of his immediate family. However, as such violence had not been predicted it could not be prevented by any advance planning.

7.10 The two services were as active as MN would tolerate and took active steps to encourage and facilitate his engagement. We have discussed the possibility of an MHA assessment with the EIT consultant and we believe that the decision not to request an assessment was the right one. If there had been an MHA assessment, we believe it is extremely unlikely to have resulted in a detention and it could have resulted in MN's alienation from the service. However, in our view, there should have been consideration given to more vigorous treatment and this consideration should have been documented.

7.11 MN's tendency to violence predated his substance misuse and his psychosis. Therefore, in our view more vigorous intervention by the mental health service would not have prevented MN's involvement in this tragic incident.

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

Recommendations

7.12 We are proposing that the Trust takes action in relation to the following recommendations.

Recommendation 1
The Trust should ensure that any service user in receipt of the Care Programme Approach should have a comprehensive assessment and care plan recorded within three months of referral, to include social and family history, genogram (if family dynamics could be an issue), any earlier episodes of violence or aggression, and education and work.

Recommendation 2
The Trust should ensure that if a service user is receiving care and treatment from more than one Trust service there should be collaboration and joint meetings between these services, and consideration given to a shared care plan.

Recommendation 3
The Trust should develop a protocol to support clinicians on when to decide to use depot antipsychotic medication in patients with active psychosis who are unable to dependably use oral antipsychotics.

Recommendation 4
Where a patient has an active psychosis and fails to engage in treatment, the Trust should ensure that he or she should be considered for assessment under the MHA, and that this discussion is documented in the notes.

Recommendation 5
The Trust should develop a policy and guidance on the discharge of patients who are failing to engage but are actively psychotic and have a moderate risk of violence exacerbated by substance misuse.

Recommendation 6
The Trust should develop guidance on when contact with relatives/partners becomes essential as part of the care of patients. This is particularly needed when patients fail to engage yet are clearly ill and, when safeguarding criteria for doing so without the patient's permission are reached.

Recommendation 7
The Trust should, in the event of any future serious incident, take active steps to identify learning at an early stage. There should also be more formal and regular communication with other agencies, including the police, to ensure that all parties are aware of progress in relation to the management of the incident; this may be through a multi-agency Incident Co-ordination Group which could meet in person or by telephone.

Recommendation 8
The Trust should ensure that the Board receives regular updates on the progress of all serious incident investigations. The roles of the Quality Committee and the Weekly Meetings of Harm in relation to learning and the tracking of progress need to be confirmed.

This is the third case in the last two years that Niche have independently investigated where the internal initial investigation has been delayed or prevented by an ongoing police investigation. This prevents the organisation from proceeding to quickly put changes in place to prevent recurrence. We therefore make the following recommendation for NHS England to act upon.

Recommendation 9
NHS England should engage with the National Police Chiefs' Council to complete their review of the 2006 Memorandum of Understanding and provide interim guidance to the NHS in order to facilitate the early investigation of serious incidents in health care.

Appendix A – Terms of reference

Terms of Reference for Independent Investigations under NHS England's Serious Incident Framework 2015 (Appendix 1).

The Individual Terms of Reference for independent investigation 2016/23382 are set by NHS England and South Cheshire CCG.

Terms of Reference

- Review the Trust's internal processes against the requirements of the Serious Incident Framework, with reference to the application of the Memorandum of Understanding and family contact, when requested by the police to pause their internal investigation process.
- Consider what opportunities were available to the Trust to implement any identified early learning from this case and if these were utilised effectively.
- Compile a comprehensive chronology of events leading up to the homicide including, where appropriate, the relationship between the two perpetrators.
- Review the care, treatment and services provided by the NHS and other relevant agencies from the perpetrator's first contact with MH services to the time of their offence.
- Review and assess the Trust's compliance with local policies, national guidance and relevant statutory obligations including Care Programme Approach, Dual Diagnosis and Safeguarding Processes.
- Review the appropriateness of the treatment of the perpetrator in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Consider the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others.
- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement.
- Examine the effectiveness of the perpetrator's care plan including the involvement of the service user and their family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement.
- Provide a written report to NHS England that includes measurable, sustainable and outcome focused recommendations.
- Deliver a learning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.
- Within 6-12 months of the report's publication conduct an assessment on the implementation of the reports associated action plan, in conjunction with the CCG and Trust, providing a short, written report, that may be made public.

Appendix B – Documents reviewed

Cheshire and Wirral NHS Foundation Trust documents

- Cheshire East Substance Misuse Service - Operational Policy 2015-2016
- Cheshire East Substance Misuse Procedure for Young Peoples Service Up to Age 25
- Chronology of Events for MN
- Clinical Risk Assessment Policy. December 2012
- Dual Diagnosis Pathway. June 2015.
- Incident reporting and management policy. December 2015
- Interim 72hr Patient Safety Review
- Memorandum of Understanding between Cheshire and Wirral NHS Foundation Trust and Cheshire Constabulary Major Crime Directorate. November 2016
- Safeguarding Children Policy. July 2016
- Weekly meeting of harm notes – 6 September 2016

Other documents

- SO'B - Inquest - email from Coroner's office
- Department of Health Guidelines for the NHS - In support of the Memorandum of Understanding
- DH, HSE & ACPO. Memorandum of Understanding
- NHS England. 72-hour report
- NHS England. Serious Incident Framework. March 201

Appendix C – Chronology

Chronology of the care and treatment of MN based on information taken from clinical records from the Trust and MN's GP.

Date	Service	Event	Information
16 Oct 06 (age 10)		Referral letter	Referred by CAMHS doctor to the Attention Deficit Hyperactivity Disorder (ADHD) team. No further records re this.
Feb 09 **(Age 12)**	CAMHS	Referral letter	MN referred by family support worker to CAMHS. At that time MN was 12 years old and attending a state boarding school for children with special educational needs. He boarded four nights a week and returned to his aunt's home at weekends. He had self-harmed three times and was emotionally unsettled and sometimes verbally and physically aggressive. His family support worker was concerned about his behaviour at school and home.
26 Feb 09	CAMHS	Appt with specialist mental health liaison practitioner	MN attended with his aunt with whom he had lived since a small child, with two of his younger siblings. His parents both had drug problems and could not look after their children. MN appeared to be an angry and distressed child, with low self-esteem and worries that his aunt could die. He did not like being a boarder at school. He had cut his arms for some time and also was comfort eating.
3 Mar 09	CAMHS	Telephone conversation between family support worker and CAMHS team	Recorded that MN had run away from school twice after the CAMHS session and on second occasion had been brought back by police, who said that his attitude to them was 'very poor'. Concern that he could self-harm.
7 Apr 09	CAMHS	Very disruptive day at school	Following CAMHS appt MN caused significant problems at school, including breaking three windows, running away and self-harming.

Date	Service	Event	Information
28 April 09 (age 13)	**CAMHS**	**Seen with family support worker**	**Things have been a bit calmer at home and at school.**
12 June 09	CAMHS	Seen with family support worker	Reported that MN's mother was back in prison. MN more unsettled at school. Would like to be day pupil.
13 July 09	CAMHS	Overdose of 8 or 9 co-codamol. Admitted to children's ward	MN told the CAMHS assessing doctor that he had taken the overdose impulsively so that he would not have to go back to school. Also, apparently after being caught shoplifting. No mental illness identified.
28 July 09	CAMHS	Follow up after overdose	Seen by the same SHO. He appeared more settled and there were apparent plans to look into meeting his wishes re school. No further CAMHS medical interventions but involvement of mental health practitioner to continue.
11 Aug 09	CAMHS	Preventing offending panel (POP)	MN referred to this Youth Offending Service initiative, possibly connected to the use of a BB gun with a friend. Meeting attended by CAMHS primary mental health worker. Further meeting in one month.
25 Sept 09	CAMHS	Summary of current situation	There had been a compromise re MN staying at school. He was now staying two nights per week and returning home on the other nights. Noted that there were many people/agencies involved, and that there were no mental health issues. No role for CAMHS but agreed to keep case open.
13 Oct 09	CAMHS	Record entry	Further POP meeting attended by same CAMHS practitioner. Reference to referral to Youth Engagement Service.

Date	Service	Event	Information
3 Dec 09	CAMHS	Last appt with CAMHS mental health worker	Since last seen he had not been staying at school, and only attending on odd days. Noted that he was very angry and had long term attachment issues. To be discussed at team meeting with view to referral to individual therapist. He needed to build working relationship ideally with a male therapist.
Jan 10	CAMHS	Record entry	Note that MN now 'closed to POP' and family support worker who had seen MN regularly was to go on maternity leave.
19 Mar 10	CAMHS	Team discussion	Team did not feel that CAMHS was appropriate for MN at that time. Advised that Connexions might be more appropriate for support.
1 Apr 10	CAMHS	Tel call between CAMHS mental health worker and family support worker	New support worker seeing MN regularly. No major issues. MN attending school. Agreed that he would be discharged from CAMHS but would be seen again if mental health issues recur.
9 April 10 **(just under age 14)**	CAMHS	Letter from CAMHS to family support worker	This letter notes that MN was a vulnerable youngster, but that he did not have any overt mental health problems. It was further noted that he would need continuing support from other agencies. CAMHS would not be offering further appointments but would be willing to see him if the need arose.
6 Sept 13-1 Dec 13	YMCA	Resident	Resident at YMCA during this period.
28 Nov 13 **(age 17)**	Youth engagement service (YES)	Seen by CAMHS nurse in Youth Engagement Service for pre-custody health assessment	Noted that he had heavy cannabis use and reduced emotional management skills.

Date	Service	Event	Information
Dec 13 -3 Feb 14	YES	Two-month period of custody	Following arrest for assault MN ordered to engage with Youth Offending Service but breached the terms and was sent for custodial sentence.
7 Feb 14	YES	Seen by same CAMHS nurse following period of custody	Detailed report. MN said that he had been hearing voices before and during custody. Voices told him what to do and he feared that his mother might be harmed if he did not listen to them. No specific plans to harm himself but had cut his arm with a plastic knife in prison. Had been on an Assessment, Care in Custody & Teamwork (ACCT) plan while in prison because of concerns that he could self-harm. Very worried about his mother who was very ill. Denied feeling depressed but appeared objectively sad.
10 Feb 14	YES		
12 Feb 14	EIS	Assessment at EIS	MN described having had suicidal thoughts in prison and fleeting thoughts more recently. Also said he heard a male voice when in prison. Had heard some screaming when nothing there. Also, some ideas that others could poison him. Described daily cannabis use from an early age. Willing to engage with services. At that time was living with mother.
20 Feb 14	CAMHS		Follow up appointment
3 March 14	EIS	Outpatient appt with consultant	MN did not attend.
March 14	EIS	Two missed appointments	Phone messages left.

Date	Service	Event	Information
12 Mar 14	EIT and CAMHS	Joint appointment	MN did not attend meeting. Therefore, two workers from services called round to his home. He talked about his fears for his mother and his hearing voices and believing he should suffer. Plan to start him on anti-psychotic medication (although he missed appointment with consultant). Plan for weekly contact with EIS.
14 Mar 14	CAMHS	Medical cert and ESA claim	Help from CAMHS nurse for sick note, claim for employment and support allowance, and fasting blood test prior to starting medication.
20 Mar 14	CAMHS	Joint appointment at home with CAMHS and youth offending officer	MN's mother told staff that she could not continue to have him staying with her as the flat was too small and it was having an impact on the mental health of both of them.
24 Mar 14	EIT	MN became homeless	Asked to leave by his mother. Referred to housing officer. For the next few nights stayed in hotels or with friends.
28 Mar 14	EIT	Consultant appointment	Appt attended by MN. Similar picture of paranoid thinking and hallucinations. Currently homeless but working with social services to find emergency accommodation. To commence trial of risperidone. 0.5 mg at night.
3 Apr 14	EIS	Missed appointment	Visit to mother's house.
3 Apr 14	CAMHS	Last joint appointment with CAMHS and youth offending team	Home visit. It appears that this was on the same day as the EIT meeting. Staff spoke to his mother who said she had agreed he could stay until his 18 birthday in a month's time. Mother said that he had told her he thinks she may be poisoning him and is reluctant to take his medication. His youth offending order had now finished. There would be no further planned involvement of the YOT or CAMHS.

Date	Service	Event	Information
11 Apr 14	EIT	Outpatient appt with consultant	MN did not attend
14 Apr 14	EIS	Impromptu home visit by care co-ordinator	Quite detailed notes about his current mental state etc. Had not started medication as fearful of possible side effects but was feeling a little better and more able to cope.
23 Apr 14	EIT	Planned home visit by care co-ordinator	Similar presentation although he was expressing further paranoid thoughts.
30 Apr 14 **(age 18)**	EIT	Planned home visit by care co-ordinator	Similar presentation. Described continuing delusional thoughts but appeared calm with good rapport.
2 May 14	EIS	Outpatient appt with consultant	MN did not attend.
7 May and 20 May 14	EIT	Home visits – MN not at home	
6 June 14	CAMHS	Unplanned contact	MN dropped into centre to see youth engagement worker who was not in. Seen by CAMHS member of staff. He said he had been feeling less well and asked staff to contact EIT service on his behalf, which they did. EIT attempted to contact him on his mobile but were unable to reach him.
June 14	EIT	Three further visits to his home but no contact	
9 July 14		Letter from CCO	Letter said that he would be discharged if no contact within next two weeks.
5 Aug 14	MARAC	Extract from MARAC notes	MN moved in with mother in Feb 14 on his release from prison. Reported that he had ‘smashed up the house’ and been violent towards her. She was very frightened of him. She also reported that he had also displayed extreme cruelty to animals.

Date	Service	Event	Information
26 Aug 14	EIS	Discharged from EIS	Letter sent to MN and GP, outlining how to come back to service in future.
22 Jan 15	CJLT	Police information	Police informed criminal justice liaison team that MN was in custody for previous failure to attend court.
23 Jan 15	CJLT	Assessment in court	MN was reported as having been threatening suicide and behaving in a disturbed way. Therefore, assessed by CJLT. Said he was experiencing psychotic symptoms including hearing a dog barking and a woman screaming where there was nobody there. He had not taken his medication. Denied any suicidal thinking and said he would be willing to re-engage with EIS.
Jan 15	EIS	Attempts to contact MN with no success	
6 Feb 15	EIS	Letter from care co-ordinator	Following referral from criminal justice team EIT had been attempting to contact him with no success.
17 Feb 15	EIS	Plan to discharge as no contact made	
23 Feb 15	EIS	Telephone call from MN	MN said he had split up with girlfriend and had nowhere to sleep tonight.
3 Mar 15	EIT	Assessment	Said that he was willing to re-engage and consider medication. Continued to report paranoid feelings and auditory hallucinations.
5 Mar 15	EIS	Care co-ordinator home visit	MN advised about how to get blood tests completed and about outpatient appointment with consultant on 12 March. MN said that he could not use public transport and asked if he could have a lift to and from. CCO1 said he would find out if anyone would be available.

Date	Service	Event	Information
Mar 15	EIS	Further phone calls with no contact made	
12 Mar 15	EIT	Failed outpatient appointment	Member of staff from EIT arranged to pick up MN from home and take to appointment. He was not at home and did not respond to telephone call.
18 Mar 15	EIS	Unscheduled home visit	MN asked to have discussion in CCO's car. Very strong smell of cannabis in house. Said that he would make a further outpatient appointment.
Apr 15	EIT	Further phone calls with no contact made	MN had not contacted the office for a further outpatient appointment.
24 April 15 **(age 19)**	EIS	Discharged from EIS	Team decision to discharge due to lack of engagement. Letters sent to MN and to his GP questioning the nature of his mental health difficulties and his need for input from EIS.
25 June 15	CJLT	Assessment in court	Seen by CJLT practitioner. MN had been arrested for possession of a bladed weapon in the street. Similar reports of hearing voices and feeling paranoid and anxious. Described his mood as 'all over the place'. Had behaved in disturbed way with court staff, punching and scratching himself. Plan to refer back to EIS.
25 June 15	EIS	Accepted onto caseload of EIS	At that time was staying in YMCA.
30 June 15	GP	GP appt	Seen with girlfriend. Still experiencing hallucinations. Asked for referral back to EIS.
1 July 15	EIS	Assessment for EIS	Seen for assessment following attendance in court for possession of a bladed article. At the time was on probation for possession of an offensive weapon (golf club). Recorded that he was staying at his mother's address. MN reported that he had not taken cannabis for several weeks.

Date	Service	Event	Information
1 Jul 15	EIS	Assessment by new CCO2	Assessed as meeting criteria for EIS. Given prescription for olanzapine which his mother will sort out for him.
15 Jul 15	EIS	Home visit by CCO2	Visit to complete physical observations. Meeting on doorstep at MN's request. House smelt strongly of cannabis.
21 Jul 15	MARAC	MARAC meeting	MN case presented at MARAC meeting, as alleged perpetrator of domestic abuse towards mother and girlfriend. Attended by a number of agencies including mental health. MN's girlfriend now four months pregnant. Many services involved. EIT to also become involved.
Sept 15	EIT	Number of attempts to contact MN by phone and home visits with no success	
6 Oct 15	EIS	Home visit	MN continued to express paranoid thinking. House smelt strongly of cannabis. CCO2 had discussion with consultant afterwards. Risperidone prescribed.
9 Oct 15	CJLT	Arrest	Arrested for alleged burglary.
12 Oct 15	CJLT	Release	MN did not appear in court. Advised that he was released without further action on 9 October.
19 Oct 15	EIS to attend	Second MARAC meeting	Listed at MARAC for 20 October 15,
20 Oct 15	EIS	Home visit	MN seen by CCO2 at home. Lengthy discussion about medication and finally MN agreed to take one of his risperidone tablets in her presence. He took one and felt the same, said he would continue to take them daily. Further appointment made.

Date	Service	Event	Information
2 Nov 15	EIT	Attempted GP appointment	Member of EIT staff had made arrangements to take him to GP for fasting blood tests. MN was not at home and did not respond to telephone calls.
4 Nov 15	EIS	Home visit	Progress review. MN had been taking his medication until two days earlier, when he felt 'spaced out and zombie'. Agreed to outpatient appointment with consultant.
9 Nov 15	EIT	Child in need meeting	Meeting attended by MN's CO. MN and girlfriend did not attend.
16 Nov 15	EIT	Outpatient appt with consultant	MN taken to appt by CCO2. Lengthy discussion about plans for birth of baby. Seen by consultant. To continue on a reduced dose of risperidone.
16 Nov 15	EIS	Diagnosis completed by EIT consultant psychiatrist	Primary diagnosis: unspecified nonorganic psychosis
30 Nov 15 am	EIT	Planned visit to GP unsuccessful	Member of EIT staff had made arrangements to take him to GP for fasting blood tests. MN was not at home and did not respond to telephone calls.
30 Nov 15 pm	EIS	Child protection case conference for child of MN and his girlfriend	Attended by CCO2 who escorted MN and his girlfriend to the meeting, after some arguments between them. Meeting went smoothly. Child protection plan drawn up, including contact plan for MN, and for MN to be referred to drug service.
2 Dec 15	EIT	Referral made to community drug team (CDT)	
5 Dec 15		Birth of baby	
14 Dec 15	EIT	Child in need meeting	CCO2 escorted MN to meeting. Further plans for MN to engage with services.
16 Dec 15	Substance misuse service (SMS)	Telephone contact	Drug worker made telephone contact with MN and made appointment for assessment.

Date	Service	Event	Information
22 Dec 15	SMS	Appointment for assessment. MN did not attend	
8 Jan 16	SMS	Further appointments for assessment	MN did not attend two further appointments. He would not be offered further appointments and would be discharged.
8 Feb 16	EIS	CPA review	Attended by CCO2 and consultant. MN did not attend despite reminders and planned transport. It appeared he had not been taking his medication as prescribed. He had also missed a number of appointments. To be discussed in team meeting.
8 Feb 16	YMCA		Moved into single room at YMCA.
9 Feb 16	EIS	Team discussion	Discussion about his lack of engagement and concordance. Agreed to start discharge process.
23 Feb 16	EIT	Telephone discussion	Telephone call from probation officer. MN had moved into YMCA and things were a little more settled. Probation officer was advised that EIT was in process of discharging MN.
3 March 16		Discharged from EIS	Letters sent to MN and GP.
6 May 16 **(age 20)**	SMS	Drug and alcohol recovery assessment	Seen for assessment. Reported that he did not drink alcohol but wanted help to control his substance misuse and to be able to live with girlfriend and baby.
12 May 16	EIS	Appointment for assessment with EIS	Not clear who referred MN back to EIS. MN did not attend this appt. Plan that he should be asked to contact the team if he wants another appt and should then be seen by consultant.
20 May 16	SMS	Contact at YMCA	Seen by drug worker at hostel. MN reported that had reduced cannabis use but that had increased his hallucinations and anxiety.

Date	Service	Event	Information
26 May 16	EIS	Assessment including risk assessment by EIT consultant psychiatrist	This assessment covered current complaint, psychiatric, social/family, forensic and drug histories, physical health, risk, insight, impression and treatment plan. MN described auditory hallucinations and paranoid delusions. He associated his symptoms with varying cannabis consumption and when stressed and around other people. Detailed risk assessment on Care Notes proforma. Noted that MN denied active intent to harm others, but that he had a low threshold for losing his temper and acting impulsively. He was currently awaiting trial for an attack on a family member. Risk of harm to others raised by use of illicit drugs, social stressors and poor engagement with mental health services. However, no relationship identified between risk and mental disorder. Plan included: • Treatment with anti-psychotic medication • Social support and boundaries provided by YMCA • Abstaining from illicit substances • Involvement of criminal justice system and social services
26 May 16		Diagnosis completed by EIT consultant psychiatrist	Primary diagnosis: schizophrenia Secondary diagnosis: mental and behavioural disorder due to use of cannabinoids, dependence syndrome Started anti-psychotic medication.
1 June 16	EIS	Outpatient appt	MN was not taking his prescribed olanzapine but agreed to try it.
3 June 16	SMS	Contact at YMCA	Very brief contact.
8 June 16	EIS	Attempted meeting at YMCA by CCO3	MN was not at hostel, although knew of appointment.

Date	Service	Event	Information
10 June 16	SMS	Meeting at YMCA	Very quiet. Had just read report for child protection meeting. Felt that girlfriend should take out injunction against him. Said he was trying his best. Has continued to reduce cannabis to around £10 per day. Discussed plan to help him reduce further.
14 June 16		Child protection review conference	Attended by EIT mental health nurse Category of concern now physical abuse. Plan placed requirements on MN for his involvement in treatment. No unsupervised contact with child and no visits to his home.
17 June 16	EIT	Assessment for CBT	MN had missed two assessments for CBT and would therefore be taken off the list.
17 June 16	SMS	Contact at YMCA	MN appeared quiet. Said he was concerned that baby 's category had been changed to physical abuse.
22 June 16	SMS	Telephone call from health visitor	HV relayed that MN's girlfriend has expressed concern about his potential for hurting himself or others. Information shared with YMCA.
24 June 16	SMS	Meeting at YMCA	MN appeared brighter. Said that he had started to take prescribed medication.
29 June 16	SMS	Safeguarding core group meeting	Meeting attended by drug team worker.
29 June 16	EIS	Meeting at YMCA	Seen at hostel by CCO3. Said he was getting some benefit from olanzapine. However still anxious and stressed. Upset about breaking up with girlfriend. Family intervention and carer's assessment offered.
6 July 16	EIS	Meeting at YMCA	Seen at hostel by CCO3. Appeared calmer and more positive. Continuing on medication.
8, 15 and 22 July 16	SMS	Scheduled appointments at YMCA	MN did not attend these meetings.

Date	Service	Event	Information
20 July 16	EIS	Scheduled appt at YMCA	MN did not attend this appt with CCO3.
21 July 16	EIS	Outpatient appt with transport arranged	MN did not attend. Letter sent to his GP.
26 July 16	SMS	Safeguarding core group meeting	Meeting attended by drug team worker. Plan to continue to attempt to engage MN.
28 July 16		GP appt	Told GP that he had missed appt with consultant and had run out of olanzapine. Given a two-week prescription.
29 July 16	EIS	Care plan	Care plan covers employment, physical health, mental health, financial, leisure and accommodation needs, and substance misuse. There were proposed interventions in most of these categories. This care plan also contained a contingency plan and the telephone number of the mental health emergency duty team. It was not recorded whether MN was given a copy of the plan.
31 July 16 **Sunday**	Crisis interventi on team	Support line telephone call	MN called the support line at 12.10. Sounded tearful and reported that felt like killing himself. Said that his relationship had broken down and he only saw baby once a week in contact centre. Smoking 10-12 joints of cannabis a day and this is making his mental health worse. General advice offered and MN told that crisis team would contact CCO3 on Monday. MN agreed that he could be safe until then and would phone again if anything changed.

Date	Service	Event	Information
4 Aug 16	EIS	Transport to outpatient appt with consultant	On the journey MN said that he felt 'fed up' with his current situation. He was only able to see his baby for an hour each week, and now realised that he needs help from professionals if he is to move forward and see baby more often. MN attended outpatient appt. He reported that he had been taking his olanzapine regularly. He had felt less paranoid and felt that the voices had less impact. Further prescriptions provided.
3, 9 and 12 Aug 16	EIT	Missed appts	
17 Aug 16	EIS	Meeting at mother's house	Spending more time at mother's now, rather than YMCA. Has restarted medication and feels better. Interested in doing some voluntary work – possibly with animals. Denied any risk to himself or others.
19 Aug 16	SMS	Meeting	MN did not attend
24 Aug 16	EIT	meeting	Discussed plans to consider the Recovery College, cross fit classes and possible courses at college, with EIT assistant practitioner.
26 Aug 16	SMS	Meeting at YMCA	Has reduced cannabis use but reported this made him more anxious. Said he had gone on a 'bit of a made one'. Has been taking other medication not prescribed for him, including pregabalin. Advised about this. Still feeling anxious going out on his own. Agreed to continuing weekly contact.
30 Aug 16	EIS	Seen at YMCA by CCO3	Helped to move some of his belongings to his mother's flat where he intended to stay, received call from a male on mobile and arranged to meet later. Remains paranoid and anxious, and marked sniffing and sweating.
31 Aug 16		Homicide	

Date	Service	Event	Information
2 Sept 16	CJLT		Assessed in custody after taking an overdose of codeine. Medically fit. No significant change in mental health assessment.