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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user Mr A in Manchester

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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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1 Executive summary

1.1 Mr A had contact with numerous adult mental health services provided by the then Greater Manchester West Mental Health NHS Foundation Trust (GMW) now the Greater Manchester Mental Health NHS Foundation Trust (GMMH, or the Trust) and Mersey Care NHS Foundation Trust from 2011 onwards.

1.2 Phillip Owen was found dead at his home on 30 October 2016. Mr A was subsequently arrested and charged with Phillip's murder and was later found guilty of manslaughter. Phillip's family has expressly asked that he be referred to by his name throughout this report.

1.3 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 (Mr A). Niche is a consultancy company specialising in patient safety investigations and reviews.

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

1.5 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

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

1.7 We would like to express our condolences to all the families affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr A.

Mental health history

1.8 Mr A was first admitted to hospital in August 2014 and he had six further admissions between May 2015 and November 2016. Of these seven hospital admissions four were as an informal patient, and on three occasions he was detained under Section 2 of the Mental Health Act. During one long period in hospital Mr A's detention was converted to Section 3 of the Mental Health Act.

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

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

1.9 Mr A took a significant overdose of paracetamol in June 2016 and attempted to hang himself whilst in prison in October 2016.

1.10 Mr A was treated by prison mental health services in 2013 and again in 2016 and it was whilst in prison in 2016 that significant concerns were expressed about his risks to other people on release from prison.

Offence and sentence

1.11 On 29 October 2016 Phillip Owen had spent the evening in the pub with some friends, it was there that he met Mr A. It was reported in the media that shortly after Phillip and Mr A had left the pub Phillip sent a text message to a friend in which he said "I helped this homeless person. Now he's here. I'm scared.". It was also reported that the following morning Phillip's neighbour heard him say "stop it" three times and that after that the neighbour did not hear Phillip's voice again, but the neighbour did hear another voice talking and singing.

1.12 Phillip's neighbour became worried when they did not receive a response to text messages and calls to Phillip. The neighbour went to Phillip's house that evening (30 October) and found him dead. Phillip had one fatal stab wound.

1.13 Following police investigation Mr A's DNA was found on items in Phillip's flat.

1.14 The police searched for Mr A and located him in hospital where he had been admitted on 1 November for treatment as an informal patient.

1.15 Mr A was charged with Phillip's murder and in October 2017 Mr A was convicted of manslaughter. Mr A was sentenced to an indefinite hospital order to treat his mental illness. Mr A has been detained in a secure hospital.

Internal investigation

1.16 The Trust undertook an internal investigation that we have reviewed. The internal investigation was undertaken by three senior managers from the organisation.

1.17 The report identified nine key concerns relating to:

- The discrepancy in opinion between [the consultant, care coordinator and team manager] about whether a decision had been made to discharge [Mr A] from the care of the Trafford Early Intervention Team.
- The decision to discharge was documented at a meeting where there was no medical input.
- Poor note keeping from the Multi Professionals meeting and the Multi Disciplinary Meetings to reflect the complex decision making which was evident in the interviews undertaken for this review. See recommendation 5.
- Despite [the care coordinator and team manager] highlighting the need to instigate actions prior to discharge, these things were not actually in place before discharge happened.

- The diagnosis of Paranoid Schizophrenia remained on Paris despite the diagnosis changing on the letters from [the consultant] as from 4th August 2016. This is an issue for teams who may need to provide emergency care and who may not have time to negotiate all the letters within the PARIS system.
- There seemed to be uncertainty regarding how the change in diagnosis from [the consultant] was then translated into the diagnosis field in PARIS.
- There was evidence of ongoing ineffective communication between [the consultant] and other members of the team in relation to decision making.
- The medical input to the team appears to have been an issue with [the consultant] feeling his input to the team is not effectively utilised and this requires resolution (see appendix 12).
- Based on our review of [Mr A], early discharges from EIS should be reviewed.

1.18 The internal investigation team made seven recommendations:

- The findings of this review will be presented by the investigating team at a multi-disciplinary team Positive Learning Event by end of April 17.
- Each directorate to agree a system for how diagnoses are updated on PARIS by the Admin Manager by 27.3.17.
- For Trafford Directorate to review the medical input to Trafford Early Intervention Team in conjunction with all team members by Head of Operations and Lead Consultant by 27.3.17.
- The Community team manager to ensure that the process of discharge is followed as per the service Operational policy. The Community Team manager to complete an audit by end of March 2017 to offer assurance this process is being correctly implemented.
- A structured proforma to record multi-disciplinary team meetings and Professional Meetings will be developed by the Community Service Manager by 28th March 2017 to ensure that team meetings and Multi Professional meetings reflect the decision-making process which underpin care decision. Compliance of this will then be audited quarterly by the Community Services.
- The Trust EIS Steering Group to review the EIS policy in relation to early discharge panel from EIS by end of April 2017.
- MO:DEL and the governance team to share learning with the custodial services with which they interface. A Positive Learning Event to be held by end of April 17.

Independent investigation

1.19 This independent investigation has reviewed the internal process and has studied clinical information, witness statements, interview transcripts and

policies. The team has also interviewed staff who had been responsible for Mr A's care and treatment and spoken with Mr A, his family, and Phillip's family.

1.20 We have provided an assessment of the internal investigation and associated action plan, including oversight by Central Manchester Clinical Commissioning Group of the improvements required.

1.21 We have also reviewed the communication between the Trust and Mr A's family and the Trust and victim's family and provide comment on the timeliness and appropriateness of those communications.

Conclusions

1.22 The role of an early intervention team is to treat psychosis, regardless of the reason for the psychosis being present. The Panel has seen no evidence indicating that the early intervention team considered whether Mr A's psychosis was present *in addition* to his substance misuse, rather than because of it. It is the view of the Panel that there was a failure by the Trust to properly understand the nature of Mr A's psychosis because staff perceived Mr A as a troubled drug user.

1.23 There was a lack of consistency in implementing Mr A's treatment plans and there was also disagreement between staff in the early intervention team and ward-based staff about Mr A's diagnosis.

1.24 Mr A remained unmedicated for a number of months. In the period of time leading up to Phillip's death Mr A was not in receipt of any medication except for when he was in inpatient or prison settings.

1.25 It is the view of the Panel that had Mr A's psychosis been properly assessed and treated then this would have reduced the risk of his violent and aggressive behaviour. It is also the view of the Panel that the decision not to act upon the clear recommendation made by the consultant forensic psychiatrist for a Mental Health Act assessment was a significant missed opportunity.

1.26 However, it is difficult for the Panel to say that had Mr A been properly assessed and treated, it would have reduced Mr A's risk sufficiently for Phillip's death to have been avoided.

Recommendations

1.27 This independent investigation has made 11 recommendations (10 for the Trust and one for the Trust and their commissioners) to address in order to further improve learning from this event.

1.28 The recommendations have been given one of three levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.
- **Priority Three:** the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One

Recommendation 1

The Trust must ensure that clarity is provided to early intervention team staff about what approach to take when there is diagnostic uncertainty (either within a single team or between teams involved in a patient's care and treatment).

Recommendation 2

The Trust must ensure that clarity is provided to the early intervention team about the process for seeking a second opinion and/or formal consultation with another clinician or team (in particular the forensic team) when a patient has not responded to treatment for a prolonged period of time and where risks are escalating.

Recommendation 3

The Trust and relevant local authorities must ensure that where systems do not already exist:

- when there are doubts or differences of opinion about the use of the Mental Health Act, a formal discussion that involves an AMHP takes place and is properly recorded;
- the AMHP teams on duty during normal working hours and out of hours have a system to record all requests for Mental Health Act assessments, even when it is expected that a clinical team will contact the next shift.

Recommendation 4

The Trust must ensure that all clinical teams follow trust safeguarding policies when they are made aware of safeguarding concerns about children or adults, and that appropriate referrals are made to the relevant social care department.

Recommendation 5

The Trust and Salford Royal NHS Foundation Trust must ensure that when recording that a patient is being treated under the DoLS framework the appropriate documentary detail is in place to apply the Mental Capacity Act lawfully.

Priority Two

Recommendation 6

The Trust must assure itself and its commissioners that when actions are implemented there is sufficient evidence of the effectiveness of the outcome or change in practices.

Recommendation 7

The Trust must ensure that it fulfils its responsibilities under Duty of Candour and that appropriate guidance and oversight is provided to staff to enable them to execute the responsibility appropriately.

Recommendation 8

The Trust must ensure that an appropriate prescribing plan is developed and implemented when patients are at risk of becoming homeless or not registered with a GP.

Recommendation 9

The Trust must ensure that when care plans are developed patients and their carers are given the opportunity to contribute to the content, in accordance with Trust policy.

Recommendation 10

The Trust and their commissioners must be assured that the investigation, management and oversight of serious incidents and associated action plans is appropriately undertaken.

Priority Three

Recommendation 11

The Trust must assure themselves that when patients are entered into a clinical trial there is evidence to indicate that they are an appropriate candidate for that trial.

2 Independent investigation

Incident – death of Mr Phillip Owen

2.1 On 29 October 2016 Phillip Owen had spent the evening in the pub with some friends, it was there that he met Mr A. It was reported in the media that shortly after Phillip and Mr A had left the pub Phillip sent a text message to a friend in which he said "I helped this homeless person. Now he's here. I'm scared.". It was also reported that the following morning Phillip's neighbour heard him say "stop it" three times and that after that the neighbour did not hear Phillip's voice again, but the neighbour did hear another voice talking and singing.

2.2 Phillip's neighbour became worried when they did not receive a response to text messages and calls to Phillip. The neighbour went to Phillip's house that evening (30 October) and found him dead. Phillip had one fatal stab wound.

2.3 Following police investigation Mr A's DNA was found on items in Phillip's flat.

2.4 The police searched for Mr A and located him in hospital where he had been admitted on 1 November for treatment as an informal patient.

2.5 Mr A was charged with Phillip's murder and in October 2017 Mr A was convicted of manslaughter. Mr A was sentenced to an indefinite hospital order to treat his mental illness. Mr A has been detained in a secure hospital.

2.6 Phillip's family has expressly asked that he be referred to by his name throughout this report.

Approach to the investigation

2.7 The independent investigation follows the NHS England Serious Incident Framework[3] (March 2015) and Department of Health guidance[4] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.8 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

2.9 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

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

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

2.10 The investigation was carried out by Naomi Ibbs, Senior Associate for Niche, with expert advice provided by Dr Andrew Leahy, Consultant Psychiatrist and Dr Huw Stone, Consultant Forensic Psychiatrist.

2.11 The investigation team will be referred to in the first-person plural in the report.

2.12 The report was peer reviewed by Nick Moor, Director, Niche.

2.13 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[5].

2.14 NHS England contacted Mr A at the start of the investigation, explained the purpose of the investigation and sought his consent to access to relevant records. Mr A gave his consent, and this was used to obtain all information used in relation to him.

2.15 We used information from the Trust, Mr A's GP surgery and Central Manchester Clinical Commissioning Group to complete this investigation.

2.16 We spoke to and met both Mr A's family and Phillip's family. Both families have seen the report prior to publication and have confirmed that they are happy with the level of personal information about them to be included in the published report.

2.17 As part of our investigation we interviewed:

- Lead Investigator for the serious incident (internal) investigation;
- Clinical Advisor (Consultant Forensic Psychiatrist) to the internal investigation;
- Service Advisor (Service Manager) to the internal investigation;
- Consultant Psychiatrist, early intervention team;
- Team Manager, early intervention team;
- Care Coordinator, early intervention team;
- Community Mental Health Nurse, community mental health team;
- Approved Mental Health Professional;
- Mental healthcare unit manager, HMP Manchester;
- GP Clinical Lead, HMP Manchester.

2.18 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview. Interviewees were invited to review the transcript and to "add or amend it as necessary, then sign it to signify that you agree to its accuracy and return it to Niche". Interviewees were further advised that if we did not receive the signed transcript within two

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

weeks, we would assume that the interviewee accepted the contents as accurate. We undertook ten interviews and four transcripts were returned to us.

2.19 We also spoke to the Quality Lead at Central Manchester Clinical Commissioning Group.

2.20 We attempted to speak to the probation service, but we did not receive a response to our requests.

2.21 A full list of all documents we referenced is at Appendix B, and an anonymised list of all professionals is at Appendix D.

2.22 The draft report was shared with NHS England, the Trust, the GP surgery and Central Manchester Clinical Commissioning Group. This provided 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 the victim's family

2.23 Contact for the victim's family was with Phillip's mother and step-father. We met with them towards the end of the investigation to explain the investigation process and invited them to contribute to the terms of reference. They did not wish to make any amendments to the terms of reference. We did not meet with them earlier because there was a delay in NHS England receiving their contact details from the police.

2.24 It was clear to that the impact of Phillip's death on his mother, step-father and siblings remains significant. Phillip's mother told us that she still felt very angry and distressed about her son's death. Phillip's mother and step-father told us that in their view Phillip's death could have been avoided if Mr A had received the proper treatment from mental health services. They recognised that this investigation would not change things for them, but Phillip's mother told us that she just wanted Mr A not to kill anyone again.

2.25 We met with Phillip's family when we completed the report to explain our findings, provide a detailed rationale for each recommendation and to answer any questions they had. Phillip's mother told us that she found our report helpful and that she was hopeful that the recommendations would protect Mr A and other patients.

2.26 NHS England contacted Phillip's father who advised that he did not wish to be involved in the investigation but that he wanted to see a copy of the report before it was published.

Contact with the perpetrator's family

2.27 Contact with the perpetrator's family was with Mr A's mother. We wrote to her at the start of the investigation with the offer to meet with us so that we could explain the process of the investigation and invite them to share any specific concerns about Mr A's care and treatment. We met with Mr A's mother to explain the investigation process and invited her to contribute to the terms of

reference. They did not wish to make any amendments to the terms of reference.

2.28 Mr A's mother told us about Mr A's childhood and teenage years. Mr A's mother also described how Mr A's mental illness had affected him after he left home. We have set out the relevant information that Mr A's mother gave us at the start of Section 3.

2.29 We met with Mr A's family when we completed the report to explain our findings, provide a detailed rationale for each recommendation and to answer any questions they had.

2.30 Mr A's mother and his grandfather told us that they were relieved at our findings and sought assurance that the Trust had accepted our findings. We confirmed that this was the case. Mr A's mother told us that she hoped that the changes the Trust would now make would ensure that no other family would experience what they had.

Contact with the perpetrator

2.31 We met with Mr A towards the end of the investigation. We did not meet with him earlier because he was too unwell to talk to us. Mr A provided us with his views of his care and treatment and we have set these out in Section 3.

2.32 We communicated with Mr A's clinical team about him reading the draft report. He did not wish to read it in any depth, but made a comment about a factual accuracy point, which was actioned.

Structure of the report

2.33 Section 3 provides detail of Mr A's background. Section 4 provides a summary of the care and treatment provided to Mr A with the full detail in Appendix C.

2.34 We have included an anonymised summary of those staff involved in Mr A's care for ease of reference for the reader. These can be found at Appendix D.

2.35 Section 5 examines the communication the Trust had with Mr Owen's family and Mr A's family after the death of Mr Owen.

2.36 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.37 Section 7 examines the issues arising from the care and treatment provided to codename and includes comment and analysis.

2.38 Section 8 sets out our overall conclusions and recommendations.

3 Background of Mr A

Childhood and family background

3.1 Mr A was born in 1990 and is one of four children.

3.2 Mr A's GP records show that his mother took him to see the GP in 2005 and 2006 because of behavioural issues at school. Mr A's GP first referred Mr A to the child and adolescent mental health services (CAMHS) in January 2006.

3.3 Mr A was offered an appointment in April 2006 with a consultant clinical psychologist (CCP1) which he attended but indicated that he did not feel able to attend further appointments. CCP1 advised Mr A's GP that he had concerns that Mr A had ADHD and that he was considering a referral to a specialist multi-disciplinary assessment clinic.

3.4 In July 2006 CCP1 referred Mr A to a CAMHS psychiatrist in Trafford for a diagnostic opinion and consideration of trial of medication. Mr A was seen in August and September by a locum associate specialist (LAC1) who wrote to Mr A's GP in October to advise that Mr A's behaviour was consistent with the criteria for diagnosis of ADHD. LAC1 noted that Mr A had been using a specialist behavioural centre that had resulted in some improvements to his behaviour. LAC1 prescribed Mr A Concerta XL 36mg daily and asked the GP to continue prescribing.

3.5 During 2007 Mr A was seen on six occasions by a consultant child and adolescent psychiatrist (CC&A1) in Trafford. Mr A's medication was changed a number of times in an attempt to identify the appropriate medication at the optimum dose. He was tried on a combination of Strattera and Concerta XL.

3.6 In March 2008 CC&A1 wrote to Mr A's GP to advise that he had spoken to Mr A and his mother on the telephone when they had informed him that Mr A had stopped taking his medication just before Christmas and he seemed to be coping. It had been agreed that CC&A1 would not offer any further appointments, but Mr A's parents had been informed that they could contact the CAMHS team directly should they need further help.

3.7 In October 2008 Mr A's GP re-referred him to Trafford CAMHS because he was having increased difficulties at home and on his college course and was keen to re-start medication. CCP1 responded in November 2008 to Mr A's GP to advise that given Mr A was approaching his 18th birthday the CAMHS team felt it was more appropriate for Mr A to approach one of the specialist counselling services for young people in Trafford. Information was provided about two different services that Mr A could approach and the letter was copied to Mr A's parents.

3.8 It is not clear from Mr A's GP records whether he contacted either of these counselling services.

Views of Mr A's mother

3.9 It appears that Mr A has had difficulties since he was a small child. Mr A's mother (Mrs L) told us that when Mr A was a toddler she had to strap him to her back when she was cleaning the house, because the activity distressed him so much. Mrs L said that Mr A was always a loner but seemed happy with his own company. Mr A often would walk and talk in his sleep and if he was woken during this time he would "go bonkers".

3.10 Mrs L said that she had taken Mr A to see a psychiatrist when he was a teenager because of his difficulties. At this point Mr A was diagnosed with ADHD. Mrs L had to set a structure for Mr A and he was very sensitive to noise, he found they "annoyed" him.

3.11 Mrs L told us that Mr A had witnessed and been subject to domestic abuse in the family home. Mrs L said that Mr A's father had been very controlling in the family home and that this had a significant impact on Mr A's behaviour. Mrs L later separated from Mr A's father. The parental split resulted in Mr A and his siblings suffering from anxiety and panic attacks. (This information is very different from the clinical records that state that Mr A "had a happy childhood").

3.12 Mrs L said that her view was that staff did not understand why Mr A took drugs and that she felt staff "just saw him as a druggie". Mr A had told his mother that he didn't like taking the prescribed medication because it made him feel "duh…it's a dangerous world out there and I can't watch my back…".

3.13 Mrs L stated that she had contacted the Trust on the day that Mr A assaulted her and told staff that Mr A was either going to hurt someone, or someone would hurt him. However, staff told her that they had to wait for something to happen. Mrs L told us that she felt this was wrong, and that even after something happened (when Mr A had assaulted her) staff didn't change their approach.

3.14 Mr L told us how she had tried to support Mr A before he had assaulted her. The assault resulted in an injunction being in place preventing Mr A from having contact with her.

3.15 Mrs L told us that when Mr A tried to hang himself in October 2016 whilst at HMP Manchester clinical staff did not share this information with her (she learned of this information after Mr A was released from prison). Mrs L also said that she was not informed that Mr A was being released from prison. When Mr A was released from prison he was told that he had to be at a probation appointment but did not know how to get to the location. Mr A had been dropped off at his flat (by mental health staff) but had no means of getting into the flat.

Mr A's views

3.16 When we met with Mr A in October 2018 he initially said that he couldn't remember much of his past, including his care under the mental health services. However, he was able to answer questions about his mental health

and said that he had been told that he had ADHD in school, because he couldn't pay attention in class. He agreed that although he was prescribed medication, he did not take it.

3.17 Mr A recalled, when asked, that he had been under the early intervention service team when he was younger but couldn't remember which year it was.

3.18 Mr A described the symptoms he experienced which led to his referral to the early intervention team. He said he was talking about "God and spirits", he said that he had always believed in these, but that it had become "more intense" at this time. He said that when he was living in his own flat, he saw black shadows flying around the room and was reading about God, and that he saw all this as a sign from God. He recalled on one occasion, when he was in the flat, his then care coordinator, EIT4, visited him and he was hearing voices. He became convinced that EIT4 could hear them as well and that she knew what was going on, so he chased her out of the flat. He was subsequently detained under the Mental Health Act.

3.19 Mr A said that he had "smashed up" six televisions in his flat because he was "arguing with them all the time". This was because he thought that people on certain channels on the television could communicate with him and he was talking back to them. He also described "possessing energy". He described seeing spirits from people who had died and was paranoid about the traffic outside his flat.

3.20 Mr A described feeling very scared by all these experiences and that he had thought, "if that could happen, then what else might happen?". He tried to burn incense sticks to try and get rid of the spirits, but this didn't work. He also admitted that he would only "tell them bits", referring to the early intervention team.

3.21 Mr A repeatedly said that the staff in the early intervention team did not listen to him and did not help him, though he could not give any specific examples. He said that he would ring them up and say that he was going to kill himself or someone else, he really believed that it would happen, and he felt out of control and described these urges as "horrible". He admitted that this usually led to his admission to hospital as a result. He said that his family were always able to recognise when he was unwell, but he would say "I'm alright".

3.22 Mr A said that he had smoked cannabis every day. He still does not think that this affected his mental health, in fact he described it as "self-medicating" as he felt it helped him. He did admit that when he used cocaine and amphetamines, they did make his mental health worse and his psychotic symptoms increased. He also admitted to us that when he was in the community he did not believe that medication would help him. He said the medication he was prescribed, slowed him down and did not work.

3.23 Mr A said that he was initially discharged in 2014 to a hostel and then moved onto a supported flat. He had many complaints about the accommodation he was living in. He said it was supposed to be a mental health supported accommodation, but when he told that them about any problems, they did not sort them out.

3.24 Mr A talked about the overdose that led to his admission to hospital in June 2016. He had taken 79 paracetamol tablets, he said, to "block out all the voices" and said he thought that "it was time to go".

3.25 Mr A said that he remembered being remanded to HMP Manchester in October 2016 because he had attacked his mother. He said that when he came out of prison "everything was everywhere" and he could not understand what was going on. He said the he hadn't watched television for six or seven days in prison and that "everyone was going their own way". Mr A said that he thought he was given some oral clopixol tablets when left prison, but he did not take them. We asked him if he tried to see his GP and he said, "I didn't think like that".

3.26 Mr A said that when he was released from prison he knew he was supposed to see probation but said he did not have any money to get there. He had to go to his grandfather's house, because he had been told that he could not have any contact with his mother. Mr A said that he was aware that his grandfather was worried about his mental state and that his grandfather had tried to contact mental health services. Mr A told us that he thought that someone from mental health services would come to see him whilst he was at his grandparent's house, but they didn't turn up, so he left.

3.27 Mr A admitted that looking back, he could accept that he was mentally ill but at the time he had not been able to recognise it. He said that he believed a lot of things at this time, which was "too much to handle". He believed that he was possessed by spirits and was being "guided" and that he talked much more about these issues in late 2016 than at other times. Mr A told us that he believes that he should have seen someone from mental health services and that he was not aware at the time that he had been discharged from the early intervention team.

3.28 Mr A said that since being admitted to a secure hospital, being treated with clozapine and not using cocaine and amphetamines, he has got much better, and realises that he should have received help like this in the past. He told us that he feels sad that he only received the right help after he had committed such an tragic offence.

Forensic history

3.29 We have not seen a detailed summary of Mr A's contact with criminal justice services because it was not present in any of Mr A's risk assessments. We were unable to obtain it from the probation service because they did not respond to our request to participate in this investigation. However, from our review of his records we can see that Mr A:

- had a custodial sentence at HMP Lancaster for three and a half months in 2010, possession of a knife (self-reported to the early intervention team in May 2011);
- received a suspended sentence and a 12-month supervision order in February 2011, 55 hours unpaid work, and referral to an addressing

substance related offending programme (reported to early intervention team staff by Mr A’s probation officer in February 2011);

- received five or six cautions for a variety of reasons, the most prominent being for criminal damage and affray (self-reported to the early intervention team in May 2011);
- a supervision order given in late 2011 for smashing a window (self-reported to the extended services team in January 2012);
- a custodial sentence (location unknown) estimated as summer 2011 for carrying a knife (self-reported to the extended services team in January 2012);
- received a custodial sentence at HMP Forest Bank on 24 September 2012 for conspiracy to commit robbery, he was released from prison on 7 December 2012 and remained on licence until 12 December 2013 (information from Greater Manchester Probation Trust found in Trust clinical records);
- was recalled to prison (HMP Manchester) in September 2013 for breach of his licence; it appears that he was released from prison again in September 2013.

4 Care and treatment of Mr A

4.1 Mr A had contact with numerous adult mental health services provided by the Trust and Mersey Care NHS Foundation Trust from 2011 onwards.

4.2 Mr A was first admitted to hospital in August 2014 and he had six further admissions between May 2015 and November 2016. Of these seven hospital admissions four were as an informal patient, and on three occasions he was detained under Section 2 of the Mental Health Act. During one long period in hospital Mr A's detention was converted to Section 3 of the Mental Health Act.

4.3 Table 1 below provides a summary of which services were involved.

Table 1: Summary of service involvement

Date	Service	Summary of involvement
January to June 2011	Trafford Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	No signs of paranoia, diagnosis of ADHD, but prescription for zopiclone. [6] Discussion with Mentally Disordered Offenders Team regarding potential referral to psychology for anger management. Discharge to primary care for ongoing review of medication, GP to refer to Trafford Extended Services for support with ADHD.
August 2011 to March 2012	Trafford Extended Services, Greater Manchester Mental Health NHS Foundation Trust	Mr A encouraged to reduce his cannabis intake, GP asked to prescribe atomoxetine[7] 40mg. Mr A later said he did not want to take medication and did not want to attend any further outpatient appointments. Referral closed and GP informed.
September to December 2012	HMYOI Lancaster Farms, Mersey Care NHS Foundation Trust	Query regarding possible emerging psychosis, later appeared less likely. GP informed and advised that no onward referral had been made to a community mental health team because Mr A would not have met the criteria.
March to June 2013	Mental Health Criminal Justice Team, Greater Manchester Mental Health NHS Foundation Trust	Some evidence of post-traumatic stress disorder, no evidence of psychosis. Internal referral to the primary care psychological therapy services that was not accepted because Mr A's presentation was too complex.

[6] *Zopiclone is a medication to aid sleep. It is usually prescribed for short periods of time.*

[7] *Atomoxetine (also known as Strattera) is a medicine used to treat ADHD.*

Date	Service	Summary of involvement
August to September 2013	HMP Manchester, Mersey Care NHS Foundation Trust	Residual signs of psychosis noted, but responding to olanzapine. Antidepressant medication also prescribed. Referral made to Mentally Disordered Offenders Team, based at St Joseph's Approved Premises. [8]
September 2013 to January 2014	Mentally Disordered Offenders Team, Greater Manchester Mental Health NHS Foundation Trust	Mr A was living in Approved Premises. His presentation in prison considered to have been indicative of schizophrenia and olanzapine continued to be prescribed. Mr A appeared to respond well to the support and treatment programme and family commented that they had noticed a significant improvement in his mental health.
January to August 2014	Trafford Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Mr A was living in supported accommodation. He was initially accepted onto the caseload as an extended assessment[9] but after admitting that he had been hearing voices and feeling paranoid he was accepted "fully" onto the caseload. Mr A had three different care coordinators within six months. Mr A required support to register with a GP and was not consistent in the information he gave to staff (sometimes he said that he had been taking his medication, and other times he said he had not taken it for some time, therefore it is clear to the Panel that there were times when Mr A was not truthful and staff did not pick up on this).
August to December 2014	Brook Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust First admission	Admitted on Section 2, Mental Health Act. Medication: olanzapine, haloperidol and procyclidine. Detained on Section 3, Mental Health Act from 15 September. Established diagnosis of paranoid schizophrenia treated with olanzapine, diazepam and risperidone. Early December, unescorted community leave used for large periods of the day, Mr A would return late and heavily intoxicated.

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[8] *Approved Premises are premises or bed spaces that are managed either by the National Probation Service or by independent organisations. They provide a structured environmentto support offenders' rehabilitation, as well as restrictions (including a curfew) that places controls on residents' behaviour.*

[9] *An extended assessment is a three-month assessment at the end of which a decision is made about the diagnosis and whether or not the team should stay involved. Early Intervention Team operational policy.*

Date	Service	Summary of involvement
		Discharge summary stated diagnosis of paranoid schizophrenia treated with risperidone 4mg.
January to May 2015	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Medication initially continued as prescribed by the Brook Ward team. In April Mr A reported not having taken medication for two months (contrary to information given at Care Programme Approach meeting in February) and using large amounts of cannabis. Concern expressed to early intervention team staff by supported accommodation staff about Mr A's paranoid behaviours and lack of compliance with medication.
May to June 2015	Brook Ward and Irwell Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust Second admission	Detained on Section 2, Mental Health Act on 12 May. Initially refused to accept medication and presentation resulted in him being transferred to Irwell Ward, a psychiatric intensive care unit. Returned to Brook Ward on 1 June. Plan to discharge from Section 2 the following day, one week's ward leave given.
1 to 17 June 2015	Early Intervention Team and Home-Based Treatment Team, Greater Manchester Mental Health NHS Foundation Trust	Support provided from both teams during leave from inpatient ward. Staff from supported accommodation provider expressed concerns about Mr A's behaviour. Mr A denied any drug use when asked by Trust staff but on other occasions presented as heavily intoxicated with cannabis.
June to July 2015	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Crisis plan to be shared with supported accommodation provider, Mr A frequently under the influence of substances. Inconsistent reports to staff about whether he was taking his medication
July to August 2015	Brook Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust Third admission	Informal admission on 29 July. Medication: risperidone and as required lorazepam and haloperidol. 7 days trial leave on 11 August and fortnightly depot injection started on 13 August. Discharged from inpatient care on 21 August.
August to December 2015	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Depot injections administered between September and mid-November with good effect. Diagnosis recorded as query paranoid schizophrenia. Mid-November Mr A stated he no longer wanted to accept depot injections and that he did not want to address

Date	Service	Summary of involvement
		his drug use with Phoenix Futures[10] (a drug and alcohol service). Supported accommodation staff reported concerns that Mr A was relapsing in early December, Mr A's mother reported similar concerns the following week and reported that Mr A had said he would kill someone.
16 to 31 December 2015	Brook Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust Fourth admission	Mental Health Act assessment conducted on 16 December but Mr A agreed to informal admission. Depot injection refused so staff noted that he should be placed on Section 3, Mental Health Act[11] if refusal continued. Community leave granted during which Mr A used substances. Mr A was discharged on 31 December at his request. No medication provided on discharge because he had refused depot injections. Diagnosis recorded as paranoid schizophrenia.
January to March 2016	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Mr A often appeared to be under the influence of substances and the early intervention team decided that staff should visit him at home in pairs because of perceived risk. Mr A continued to receive a depot injection.
8 to 17 March 2016	Brook Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust Fifth admission	Admitted as an informal patient on 8 March to Brook Ward after presenting to a police station convinced that he had committed a crime. Inpatient plan was for Mr A not to have any leave and that a Mental Health Act assessment should be conducted if he wanted to leave. Detained on Section 5, Mental Health Act on 12 March that was then rescinded on 14 March. Discharged on 17 March, diagnosis paranoid schizophrenia, fortnightly depot injection.
March to June 2016	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Possible forensic assessment discussed, but never followed up. Depot injection refused on the grounds that it was painful. No alternative medication offered by the consultant psychiatrist because of Mr A's continued drug use. Concerns about dangerous power tools being in Mr A's flat and evidence of continued drug use.

[10] Phoenix Futures is a charity that supports people to overcome drug and alcohol problems. They provide residential, prison, community and specialist services.

[11] Section 3 of the Mental Health Act allows for a patient to be detained in hospital for up to six months and to be treated without the patient's consent, with approval from a second opinion approved doctor.

Date	Service	Summary of involvement
18 to 23 June 2016	Psychiatric Liaison Team, Salford Hospital, Greater Manchester Mental Health NHS Foundation Trust	Overdose of paracetamol – 79 tablets. Treated at Salford Hospital by general hospital staff with support from psychiatric liaison team. Presented as paranoid but attempts made to conduct a Mental Health Act assessment were unsuccessful because of sedation. Eventually determined that Mr A lacked capacity and he was detained under the Mental Capacity Act/Deprivation of Liberty Standards.[12]
23 June to 12 July 2016	Brook Ward and Irwell Ward, Moorside Hospital, Greater Manchester Mental Health NHS Foundation Trust Sixth admission	Admission to a mental health unit discussed and Mr A was detained on Section 2, Mental Health Act on 24 June to Brook Ward. Transferred to Irwell Ward, psychiatric intensive care unit on 27 June because of risks to himself and others. Absconded from Irwell Ward and was later returned to ward by police. Section 17 leave granted from 4 July and after returning smelling of cannabis, Mr A was discharged on 12 July.
July to October 2016	Early Intervention Team, Greater Manchester Mental Health NHS Foundation Trust	Mr A distressed following discharge because his GP would not prescribe medication. Considered to be high risk of suicide. Early intervention team offered referral to Trafford Extended Services. Substance Misuse Rehabilitation Unit considered and a referral made. Mr A continued to use cannabis and other illicit substances. Meeting with police on 17 August to discuss a management plan and it was agreed Mr A would be taken to custody not hospital if he were in contact with the police again. Concerns expressed by Mr A's mother in late August about Mr A relapsing. Concerns denied by Mr A when approached by early intervention team staff. Concerns expressed by Mr A's mother in late September because he had been crying a lot and had assaulted his younger brother in the street. Abusive text messages also sent to his mother.

[12] *The Deprivation of Liberty Standards (DoLS) are part of the Mental Capacity Act and aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.*

Date	Service	Summary of involvement
		Serious assault on his mother on 27 September after which Mr A's mother eventually agreed to press charges. Community meeting held 29 September, consultant psychiatrist expressed view that Mr A's psychosis was drug induced and that offending behaviour was as a result of intoxication not mental illness. Noted that three-year time limit with the early intervention team would be early 2017 and that substance misuse could be the focus of work with Mr A after discharge from the early intervention team. Mr A arrested for the assault on his mother. MO:DEL[13] team contacted by the police because of Mr A's behaviour in the cells. Advised to let any effects of illicit substances wear off prior to medical assessment. 30 September discussed by early intervention team and noted that no evidence of psychosis at assessment the previous night. Early intervention team looking at discharge.
September to October 2016	HMP Manchester, Mersey Care NHS Foundation Trust	Attempted to hang himself on 3 October. Moved to the healthcare wing. Reviewed by consultant forensic psychiatrist who considered that Mr A was suffering an active psychotic illness and prescribed quetiapine 300mg. Court hearing on 13 October resulted in Mr A being released from prison the following day. Consultant forensic psychiatrist extremely concerned about risks in the community and contact made with the AMHP hub to request a Mental Health Act assessment when released.
14 to 31 October 2016	Not on the caseload of any service of Greater Manchester Mental Health NHS Foundation Trust or other mental health provider	Mr A released from prison. Staff from the early intervention team advised his grandfather that he had been discharged from the early intervention team. Out of hours contact details provided. Decision by early intervention team not to arrange a mental health act assessment.

[13] *The MO:DEL (Manchester Offenders: Diversion Engagement and Liaison Team) Team is a multi-disciplinary criminal justice liaison and diversion team covering the whole of Manchester. The team works with offenders who have co-morbid mental health problems, learning disability and other complex needs such as substance misuse, homelessness and interpersonal difficulties.*

Date	Service	Summary of involvement
		Referral from early intervention team to community mental health team after Mr A had been closed to the early intervention team. Concerns expressed by Mr A's family about his mental state, there were some unsuccessful attempts by early intervention team and community mental health team staff to visit Mr A at home.
1 to 2 November 2016	Birch Ward, Royal Bolton Hospital, Early Intervention Team, the Trust Seventh admission	Mr A's family contacted the early intervention team a number of times on 1 November expressing concern about his mental state. Family advised by early intervention team to take Mr A to A&E for assessment. Assessment by psychiatric liaison staff resulted in an informal admission to Birch Ward. Ward staff contacted by police in the early hours of 2 November to advise that they needed to arrest Mr A for a serious offence.

5 Discussion and analysis of Mr A's care and treatment

5.1 Our findings are broadly consistent with that of the internal investigation team, however we have identified nine themes that we explore in more detail below.

Diagnosis and treatment

5.2 Mr A had been under the care of a number of teams run by the Trust over the six years prior to the death of Mr Owen. Mr A had a diagnosis of paranoid schizophrenia and there was a general view held by staff in the community that the psychosis was drug-induced. It was clear to the Panel that this view was not shared by staff in inpatient services because Mr A's diagnosis was always recorded as paranoid schizophrenia on his inpatient discharge correspondence.

5.3 Mr A was a known user of illicit substances and on a number of occasions staff tried to encourage him to accept support from substance misuse services. Mr A rejected these offers until August 2016 when he asked for a referral to an inpatient rehabilitation unit. However, in October 2016 Mr A stated that he no longer wanted to be admitted to the unit.

5.4 Mr A had been under the care of the early intervention team since January 2013. During the two years and nine months that his care and treatment was the responsibility of the early intervention service he had periods of time when he was acutely unwell and was admitted to hospital.

5.5 Mr A frequently would report being non-compliant with his treatment, and on occasion it is clear that the self-reporting of his compliance was at odds with his previous reports, or was contrary to information provided by staff from other agencies. It is the view of the Panel that there was a lack of professional curiosity in properly understanding the true picture of Mr A's compliance. Professional curiosity is about not taking information at face value. It is about asking questions, exploring the background, checking information with other individuals or agencies and seeking to understand the nature and context of behaviours.

5.6 Mr A's discharge summaries (written after a period of time being treated in hospital) note that his diagnosis was paranoid schizophrenia and that his admissions to hospital were often a result of relapse due to non-compliance with prescribed medication.

5.7 It is of note that inpatient staff recorded a diagnosis of paranoid schizophrenia with no reference to a view of it being drug-induced.

5.8 In December 2015 Mr A was being treated as an inpatient at Moorside Hospital. Mr A had refused to accept his depot injection and ward staff had noted that if this position continued Mr A should be placed on Section 3 Mental Health Act. There were concerns about his use of illicit substances, yet Mr A continued to be allowed unescorted leave off the ward. Within six days of these concerns being noted and with no significant change to his presentation, Mr A was discharged on 31 December because he wanted to leave the ward.

5.9 In April 2016 Mr A's Consultant Psychiatrist (CP3) noted a different diagnosis (just 16 days after the inpatient diagnosis of paranoid schizophrenia) of mental and behaviour disorder due to multiple drug use. CP3 noted that Mr A was not on any medication at that time (the ward-based team had discharged Mr A on a fortnightly depot injection, but Mr A did not want to receive it). And CP3 noted that he would not prescribe an alternative medication to the depot injection "due to [Mr A's] continued drug used". CP3's letters are the only documents that show Mr A's diagnosis as mental and behaviour disorder due to multiple drug use. All other risk assessments care plans and discharge notifications show a diagnosis of paranoid schizophrenia.

5.10 The Trust Dual Diagnosis Policy reference the policy implementation guidance issued by the Department of Health in 2002 that states:

"Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focussed and integrated care…"

5.11 Mr A was offered treatment for his psychosis by way of depot injections and oral medication. Mr A was often reticent to accept the depot injections and much later (April 2016) admitted to staff that the injections hurt him. It was after this that CP3 did not offer alternative medication. For CP3 not to offer alternative medication is not indicative of patient focussed care, and it was not an appropriate response to Mr A's described difficulty with the depot injection medication. It is the view of the panel that CP3 should have considered suitable alternative oral medications and discussed these with Mr A.

5.12 The team did make referrals to substances misuse organisations, but Mr A did not want to engage with these services (until August 2016). Substance misuse services tend to operate on a self-referral basis because of the requirement for the service user to be motivated to change.

5.13 The Trust Early Intervention Team operational policy specifies the definition of psychosis and in doing so notes that the symptoms "must be present for a period of over seven days duration over the last 12 months (or if less than this then the improvement must be attributable to antipsychotic treatment)".

5.14 The exclusion criteria set out in the same policy includes individuals "whose psychotic symptoms clearly occur only in the context of acute intoxication (ie when a clear link is observed between the remission of symptoms with cessation of drug or alcohol use within seven days. In such scenarios the team will direct service users to other services)".

5.15 In September 2016 Mr A was entered into a clinical trial for the treatment of schizophrenia. The Panel has struggled to understand the rationale for this decision, given that his clinical team at that time (the early intervention team) had stated they believed that Mr A's diagnosis was drug induced psychosis. In addition, the Panel consider that Mr A would have been an inappropriate candidate for the trial because there was good evidence that he was unreliable in taking his medication and he would have been unlikely to cooperate with the trial process. See our Recommendation 11.

5.16 The account given in Mr A's records by the inpatient staff and the general progress of his illness by October 2016 suggest that Mr A did have a psychotic condition. The panel shares the view of the inpatient staff and considers Mr A's symptoms of were consistent with a diagnosis of schizophrenia. The diagnosis of paranoid schizophrenia was made by the inpatient staff who clearly stated this on more than one occasion. In addition, Mr A's early history would suggest risk factors for the development of psychosis (e.g. traumatic childhood events, use of cannabis).

5.17 It is unclear to the Panel why CP3 would stop all medication for a client who he continued to see within the early intervention service. This position was maintained from April 2016 onwards, yet the Panel has not been able to find any evidence of CP3 indicating that Mr A should be discharged from the team's caseload. The Panel found no evidence that CP3 sought to discuss the difference in his approach to that of the inpatient doctors treating Mr A. Equally, the Panel has found no evidence that full consideration was given to the fact that Mr A's offending behaviour could be due to a diagnosis of paranoid schizophrenia and intoxication of illicit substances.

5.18 It is clear to the Panel that Mr A's presentation worsened significantly when he was under the influence of drugs, but it is also clear to the Panel that his presentation was worsening notably in the six months prior to Mr Owen's death. The Panel has considered the degree of hindsight bias that might be present in these statements and has concluded that the evidence would have been available at the time to any clinician who had undertaken a longitudinal assessment (a full and detailed review) of Mr A's mental state and mental health history. This is good practice if a patient does not appear to be responding to a treatment regime.

5.19 Mr A also made two significant attempts to end his life:

- June 2016 – when he took nearly 70 paracetamol tablets and cut his legs with a knife;
- October 2016 – when he attempted to hang himself in prison.

5.20 Yet when Mr A was released from prison and the forensic consultant psychiatrist had expressed significant concerns about Mr A's risk, such that he had personally called the duty Approved Mental Health Professional (AMHP[14]) to arrange this, the early intervention team did not support the request.

5.21 Mr A had been detained on Section 3 in late 2014. This opened up the opportunity for staff to consider the use of a community treatment order. We cannot find evidence that this option had been considered by any of the teams treating Mr A. This would have been a useful tool to manage Mr A's compliance and risks in the community given that there were concerns about

[14] *Approved Mental Health Practitioner (AMHP) is a mental health professional who has been approved by a local social services authority to carry out specific duties under the Mental Health Act. They are responsible for coordinating assessments, and admissions to hospital.*

his compliance, particularly with medication, and the interaction of this with his substance misuse.

5.22 We also consider that the team should have done a full review of Mr A's presentation over time (a longitudinal review). We heard from Mr A's care coordinator that in her view his presentation did not change much during the period of time he was under the care of the early intervention team. The response from early intervention team staff was broadly the same during this period of time. We know that making the same intervention to the same problem is likely to elicit the same response.

5.23 It is our view that a longitudinal review of Mr A's presentation would have been a useful approach to consider what other interventions (particularly appropriate medication) would have been helpful in improving his mental state. Members of the Trafford early intervention team could have done this review, or probably more effectively, it could have been done by a peer team. See our Recommendation 2.

Care planning

5.24 Mr A was initially managed on Care Programme Approach when he was referred to the early intervention team in January 2011. In January 2012 a decision was made by Trafford Extended Services to move Mr A to standard care. This decision was made following consultation with the team manager, but the Panel has not seen any evidence to indicate the rationale for the decision.

5.25 The Trust Care Programme Approach Policy describes that standard care is appropriate for clients who have more straight forward needs and it is likely that they:

- require the support or intervention of one agency or discipline, or have no problems with access to other agencies or support;
- more able to self-manage their mental health problems;
- have an active informal support network;
- on assessment there is little evident risk;
- are more likely to maintain appropriate contact with services.

5.26 The same policy describes clients requiring Care Programme Approach as having characteristics likely to be:

- severe mental disorder with a high degree of clinical complexity;
- current or potential risks including (but not exclusively): suicide, self-harm, harm to others (including history of offending), self-neglect, vulnerable adult;
- non-physical co-morbidity eg substance, alcohol or prescription drug misuse;

- multiple service provision from different agencies including: housing, employment, criminal justice.

5.27 In the opinion of the Panel Mr A met the criteria for Care Programme Approach. However, as we have stated earlier, we have not seen any evidence to indicate the rationale for the decision to move to standard care in January 2012.

5.28 The evidence the Panel has reviewed indicates that by January 2014 Mr A was again being managed on Care Programme Approach. However, the Panel has seen no evidence to indicate when the decision was taken to move Mr A from standard care or the rationale.

5.29 Mr A's care plans addressed all aspects of his mental health, physical health, and social care needs. The plans meet the standards set out in the Care Programme Approach Policy in place at the time (policy dated October 2011).

5.30 Mr A's relapse and crisis plans noted that signs of him becoming unwell included:

- an escalation of religious and grandiose beliefs;
- talking about energy, spirits, warriors or demons;
- increased agitation;
- bizarre posturing;
- increased aggression, irritability and hostile behaviour;
- increased substance use;
- disengagement from services.

5.31 Mr A's final care plan developed by the early intervention team, dated 30 September 2016, stated that the care plan was a Section 117 aftercare plan and that he was due to be discharged from the early intervention team in early 2017. It was noted that Mr A had not provided his views of the care plan because he was in prison but that the early intervention team was working with Mr A and his family at that time to plan onward referral.

5.32 However, shortly after this care plan was written the decision was made to discharge him from the early intervention team caseload, with no other mental health team input in place. The final care plan was written with a significant emphasis on encouraging Mr A to take responsibility for his actions but without him having the opportunity to input to the plan. This was not good practice, was not in accordance with Trust policy and did not consider Mr A's aftercare needs in accordance with the Mental Health Act. See our Recommendation 9.

5.33 Bedspace staff were responsible for supporting Mr A to manage his tenancy. However, Bedspace staff had described difficulties with Mr A tolerating staff being in his flat to clean it when he was present and had refused support from staff with budgeting and meal planning. There was concern at this time that

Mr A's actions (the number and frequency of visitors, substance misuse and inability to keep his flat clean and tidy) could place him at risk of being evicted.

5.34 Although we state above that the care plans met some of the standards set out in the relevant Trust policy, it is our impression that the content of the care plans have not been written from the perspective of Mr A. Mr A's care plans were often written in this way indicating to the Panel that there was a lack of emphasis on person centred planning.

5.35 The Panel has found limited evidence that early intervention team staff sought to properly triangulate information provided by Mr A's family or staff from other agencies with that provided by Mr A. In addition, there are numerous occasions when Mr A reported one set of information to his care team, only to contradict himself at a subsequent meeting. It was clear to the Panel that the information provided by Mr A was inconsistent and it therefore could have been clear to Mr A's treating team, had they reviewed and analysed the information. The Panel considers that there was a lack of professional curiosity about Mr A's continued poor mental state.

Risk assessments

5.36 The Trust uses the Standard Tool for Assessment of Risk (STAR) that provides an initial risk screening tool with full risk assessments to be completed where indicated by the initial risk screening.

5.37 Table 2 below summarises the risk assessments that the Panel has seen in Mr A's records.

Table 2 - Summary of completed risk assessments

Date	Completed by	Summary
21 January 2011	Early intervention team	STAR – risk of violence to others referenced in risk management plan.
3 February 2011	Early intervention team	STAR – three-month custodial sentence 2009/10 for assault and possession of a knife noted, risk of violence to others referenced in risk management plan.
2012	n/a	No risk assessments completed in 2012.
March/April 2013	Mental health criminal justice team	Bolton Assessment Tool - undated but completed after a referral in March 2013 from probation services. STAR risk screen indicated a forensic history of risk to others, managed at that time through license conditions.
4 July 2013	Crisis resolution home treatment service	STAR – harm to self and others, no protective factors identified. High risks of accidental injury and violence.

Date	Completed by	Summary
October 2013	Mental health criminal justice team	START – risks identified as recent release from prison, potential non-compliance with medication, illicit substance use. Risks reduced by engagement with mental health services, compliance with medication, abstinence from illicit substances.
19 August 2014	Mental health liaison service	Summary document refers to STAR risk assessment completed on 4 February 2014. The Panel has not seen evidence of this document. The Panel considers that the date has been misquoted, and it is actually the STAR risk assessment completed in February 2011.
21 August 2015	Brook ward	STAR – harm to self and others, document cites incidents in June and July 2015. Protective factors noted as supported accommodation, family and compliance with medication. Risk management plan lists medication and follow up by early intervention team.
31 December 2015	Brook ward	STAR – risks to self and others, no specific incidents noted since August 2015. Risk management plan lists follow up by early intervention team.
8 March 2016	Mental health liaison team	STAR – risks to self and others (including command hallucinations). Recent incident of self-report to police that Mr A was responsible for a serious offence. No evidence from police that such an offence had been committed. Management plan cites admission to Brook Ward.
17 March 2016	Brook ward	STAR – recent illicit substance use, aggression towards another patient. Management plan cites discharge to community with follow up from early intervention team. Care coordinator to arrange forensic assessment, professionals meeting to be held two weeks later.
21 March 2016	Early intervention team	STAR – additional information that Mr A had supplied illicit substances to another patient on Brook Ward and that patient had become very ill. Moderate risks for self-neglect and absconding. Management plan cites that home visits should be done by two members of staff, staff to establish why Mr A had a

Date	Completed by	Summary
		chainsaw at his flat and why he allegedly assaulted his friend.
5 May 2016	Early intervention team	STAR – risks to self from Mr A and others, multiple visitors to Mr A's flat taking illicit substances. Moderate risks of accidental injury, violence and self-neglect. Management plan cites that staff should review Mr A regularly.
13 May 2016	Early intervention team	STAR – risks to self and others, no new information. Moderate risks of accidental injury, violence and self-neglect. Management plan cites that staff should review Mr A regularly to assess his mental state and then act accordingly.
24 June 2016	Brook ward	STAR – a number of risks to self and others indicated, no detail of current risks at that time, and no summary of level of current risks. Document incomplete, but signed off as complete on 9 July 2016.

5.38 None of the risk assessment that the Panel has seen provide full information about Mr A's forensic history. This is of concern because there is evidence that Trust staff were in contact with both the police and the probation service in a collaborative approach to manage Mr A's offending behaviour. There was sufficient opportunity for Trust staff to obtain a detailed summary of Mr A's forensic history. Had this information been available it would have provided a more complete picture of Mr A's risks and would therefore have been able to be used to better inform an appropriate risk management plan.

5.39 In April 2015 Mr A assaulted his younger brother (aged 14 years at the time). The Panel has found no evidence that Mr A's risk assessment was reviewed or revised following this incident. Indeed, at his next appointment with CP3 on 8 May there is no mention at all of the incident, the only reference to anything untoward is CP3 noting that Mr A said that he had not taken his medication (at that time he was prescribed risperidone) for two weeks. There is evidence in Mr A's notes that other staff in the early intervention team were aware of the assault and therefore this information was available to CP3.

5.40 In March 2016 it was suggested that a forensic opinion be sought on how to manage Mr A's care and treatment. The Panel found two references to this (in addition to the reference listed in the table above), one on 23 March when it was noted that this should be considered, and one on 30 March when it was noted that that a forensic assessment had been planned.

5.41 The Panel has found no evidence of any correspondence regarding this forensic assessment, nor have we found any evidence that a forensic assessment took place.

5.42 We consider this to be a significant missed opportunity. Had a forensic assessment actually been conducted at that time, it would have provided an opportunity for a fresh opinion to be provided about Mr A's diagnosis and treatment plan. We will never know with certainty what the outcome of such an assessment at that time would have been, however a fresh assessment of the diagnostic and treatment issues would have been valuable to everybody. Indeed, given that Mr A was not responding to treatment after a lengthy period it should have been considered essential to consult with others. Given the escalating risks, seeking a forensic assessment would have been sensible. See our Recommendation 2.

5.43 Following this missed opportunity, Mr A's risks increased notably between April and September 2016:

- April – chainsaw noted in his flat. referenced in risk assessment dated 5 May, amber for risk of violence;
- May – chainsaw and large knives noted in his flat, referenced in risk assessment dated 12 May, amber for risk of violence;
- June – Mr A took a significant overdose of paracetamol, after which he was detained on Section 2 Mental Health Act. The risk assessment completed at the point of discharge on 11 July was not fully completed and the RAG rating of risks is blank;
- July – Mr A intimidated a member of ward staff when they were off duty and in public. Mr A was also let into the mental health unit by other patient/s and he later admitted it was to deal drugs. The intimidation of a member of staff was noted on a vulnerable adult referral form completed by the police on 2 August;
- August – Mr A admitted to drug debts, the police recommended that a safety strategy meeting be arranged, and Mr A threatened to do something that meant he would be sent to prison;
- September – Mr A was abusive towards his mother, assaulted his brother in the street, sent abusive texts to his mother, and then strangled his sister's cat and seriously assaulted his mother. A referral to Children's Social Care was made but we cannot find any review of Mr A's risk assessment around this time.
- October – Mr A tried to hang himself whilst in prison, and two weeks after the court released him into the community he killed Mr Owen. We can find no evidence that Mr A's risk assessment was reviewed at this time.
- November – Mr A's family reported that he was behaving in a very disturbed fashion. The advice from staff was to take Mr A to A&E or ask for an assessment under the Mental Health Act.

5.44 As can be seen from Table 2 above Mr A's risk assessment was not reviewed after June 2016, when he had taken the overdose. This is despite the records indicating that his risk assessment would be reviewed after he had assaulted his mother in September 2016.

5.45 There was detailed information in Mr A's clinical records to indicate when he was becoming unwell. However, it appears that at times this information was not heeded in order to prompt appropriate interventions from staff to keep Mr A and others safe.

5.46 The recommendation by the consultant forensic psychiatrist at HMP Manchester that a Mental Health Act assessment be arranged when Mr A was released from prison in October 2016 was not acted upon. The fact that the consultant rang the AMHP team himself to pass on his concerns is unusual and indicative of the level of concerns held by clinical staff at HMP Manchester.

5.47 It appears to the Panel that there was a reluctance to consider a Mental Health Act assessment, particularly in October (when Mr A was released from prison) and November (when his family were reporting extreme behaviour). It is the view of the Panel that the early intervention team should have taken proactive action on both these occasions and arranged an assessment under the Mental Health Act, rather than expecting Mr A's family to request it. Of course, we cannot comment on what the outcome of that assessment might have been, but staff would at least have been working with first-hand information. See our Recommendation 3.

Safeguarding

5.48 There are seven occasions when Trust staff were aware of safeguarding concerns relating to Mr A's family members:

- April 2015 – Mr A had assaulted his younger brother and EIT4 made a referral to children's social care via the multi-agency referral and assessment team;
- June 2016 – Mr A had threatened to assault his mother after he had been admitted to hospital following a significant overdose of paracetamol;
- 8 September 2016 – Mr A had been abusive to his mother the previous day;
- 23 September – Mr A had recently assaulted his 14-year-old brother in the street, punching and hitting him;
- 26 September – Mr A had sent abusive texts to his mother;
- 27 September – Mr A seriously assaulted his mother, rendering her unconscious and early intervention team staff contacted the police regarding an assault charge;
- 29 September – Mr A's mother expressed concerns about Mr A's grandparents because Mr A was demanding food and money from them and was intimidating them.

5.49 There are five occasions when Trust staff took no action regarding the safeguarding concerns of Mr A's family members, and one occasion when

although the police were contacted regarding a criminal investigation, no additional safeguarding referral was made.

5.50 Given the degree of concerns and in particular the escalation of concerns in September 2016 we consider that these were missed opportunities to safeguard Mr A's family.

5.51 We have seen evidence that on other occasions Trust staff have followed the relevant child or adult safeguarding policies. Therefore, we do not consider that this issue is endemic in the organisation.

5.52 See our Recommendation 4.

Use of the Mental Capacity Act

5.53 When Mr A was admitted to hospital in June 2016 after he had taken an overdose of paracetamol he was assessed by the mental health liaison team. The advice from the mental health liaison team was clear that if Mr A tried to leave the ward he should be detained on Section 5(2) Mental Health Act.

5.54 Section 5(2) Mental Health Act gives doctors the ability to detain someone in hospital for up to 72 hours. Any doctor can apply these holding powers but in order for a patient to continue to be detained after the 72 hours the patient must receive a full Mental Health Act assessment.

5.55 However, when Mr A indicated he was no longer willing to consent to remain in hospital and receive treatment general nursing staff contacted the mental health liaison team who noted "members of the Liaison team had gone to the ward to see [Mr A] and that he had been detained under MCA/ DoLS" (at 14.44) and later that Mr A "had been placed under the MCA/DoLS (Mental Capacity Act /Deprivation of Liberty Standards) framework" (at 21.54).

5.56 It is not clear to us that Mr A had been under Mental Capacity Act Deprivation of Liberty Safeguards. We have seen no evidence that any application was made by the hospital (the managing authority) which should have occurred if he was to be detained urgently. There is also no evidence of any mental capacity or best interest assessment.

5.57 In any event it is not clear why the MCA/ DoLS framework would have been used, since it had already been suggested that Mr A could be detained under Section 5(2) Mental Health Act.

5.58 On the basis of the evidence the Panel has reviewed we consider it most likely that Mr A was treated under Section 5 Mental Capacity. Section 5 Mental Capacity Act[15] provides protection for a person receiving treatment

[15] *5. Acts in connection with care or treatment*

(1)If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—

(a)before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and

(b)when doing the act, D reasonably believes—

under the Mental Capacity Act if it is in the patient's best interests. The Mental Capacity Act Code of Practice[16] states that this is likely to include:

Healthcare and treatment

- carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
- providing professional medical, dental and similar treatment • giving medication • taking someone to hospital for assessment or treatment • providing nursing care (whether in hospital or in the community)
- carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example, physiotherapy or chiropody)
- providing care in an emergency.

5.59 It is not clear why the Mental Capacity Act/ DoLS framework would have been used, since it had already been agreed that Mr A could be detained under Section 5(2) Mental Health Act.

5.60 The Trust records about Mr A's legal status at this time are not clear. Mental health liaison staff refer to him remaining on the acute physical hospital ward under the DoLS framework, but the entries are not specific about the details of the assessment made or Mr A's legal status.

5.61 See our Recommendation 5.

Discharge from the early intervention team

5.62 On 14 October Mr A was discharged from the caseload of the early intervention team. Mr A's care coordinator (EIT4) wrote to Mr A's GP to advise him that Mr A had been discharged and that he had been supported by the service for the previous three years. She also noted that CP3 had reviewed Mr A in August and had not recommended medication because Mr A's diagnosis was drug induced psychosis. EIT4 also stated that she had not

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(i)that P lacks capacity in relation to the matter, and

(ii)that it will be in P's best interests for the act to be done.

(2)D does not incur any liability in relation to the act that he would not have incurred if P—

(a)had had capacity to consent in relation to the matter, and

(b)had consented to D's doing the act.

(3)Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.

(4)Nothing in this section affects the operation of sections 24 to 26 (advance decisions to refuse treatment).

http://www.legislation.gov.uk/ukpga/2005/9/section/5

[16] *MCA Code of Practice*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

received any correspondence from HMP Manchester in relation to Mr A's recent detention there.

5.63 However, CFP2's summary completed at HMP Manchester, dated 10 October is present in Mr A's trust records. CFP2 stated that Mr A was displaying an active psychotic illness and highlighted that Mr A had talked about feeling energy in his hands. There had also been communication with the duty AMHP about CFP2's request for a Mental Health Act assessment.

5.64 The discharge from the early intervention team appears to have been enacted with no discussion with CP3 or other members of the early intervention team.

5.65 On Friday 30 September at the early intervention team meeting it was noted that the team should consider discharging Mr A. Neither EIT4 nor CP3 were present for this discussion.

5.66 On Monday 3 October at the early intervention team meeting there was no further reference to discharging Mr A. Neither CP3 nor EIT4 were present for the discussion. It was however noted that Mr A had been remanded to prison and was due to appear via video link at court on 13 October. This view was repeated at a multi-disciplinary team meeting two days later when both CP3 and EIT4 were present.

5.67 On Friday 7 October Mr A was again discussed at the early intervention team meeting when it was noted that the team needed to liaise with the outreach team before Mr A's case was closed to the early intervention team. EIT4 was present but CP3 was not. EIT4 noted later that day that she had sent a referral to the community screening team for Mr A's needs within the community to be assessed. EIT4 also noted that she had spoken to clinical staff at HMP Manchester who had informed her that Mr A was on the healthcare wing after he had tried to hang himself.

5.68 On Wednesday 12 October Mr A was again discussed at the multi-disciplinary team meeting. Again CP3 was not present for the discussion (we learned later from CP3 that he was on sick leave at that time). It was noted that Mr A had been in court the previous day but the outcome was not known at that point. The following day the Trust was advised that the court had imposed a community order that required Mr A to engage with probation and mental health services.

5.69 We can find no evidence that Mr A's increase in mental health needs whilst in prison and request by a Consultant Forensic Psychiatrist that Mr A be assessed under the Mental Health Act prompted a review of the consideration to discharge Mr A.

5.70 CP3 told us that he was not involved in any discussions to discharge Mr A from the early intervention team. Other members of the team were adamant that the decision had been fully discussed by the multi-disciplinary team. The team manager also told us that CP3 was often not present for multi-disciplinary team discussions, something that we can see from the records that was the case. There is evidence to indicate that the discussions about discharging Mr A from the early intervention team caseload took place whilst CP3 was not present at the meeting.

5.71 The decision to discharge Mr A from mental health services at a time when the court had made it a requirement of Mr A's community order was, in our view, wholly inappropriate. The Panel has questions about the court decision not to wait for the information that they had requested prior to deciding about sentencing. The questions fall outside the remit of our investigation so we have asked NHS England to raise these with the appropriate agency. The issue of discharge from the early intervention team was identified in the internal serious incident report and an associated recommendation was made. We have already commented implementation of the action plan and therefore we have not made any further recommendations here.

5.72 It is important to note that we do recognise that EIT4 and other members of the early intervention team continued to liaise with colleagues and other agencies on Mr A's behalf. However, this left Mr A without structured oversight of his mental state at a time when he was at significantly increased risk to himself and others.

Communication between teams and agencies

Internally

5.73 The Panel has seen evidence that Mr A was referred to the Mentally Disordered Offenders team on 21 January 2011. The referral form states that the referral was accepted but the Panel has seen no evidence of any follow up work undertaken by the Mentally Disordered Offenders team. The only records the Panel has seen are those completed by early intervention team staff referring to discussions with a staff member from the Mentally Disordered Offenders team.

5.74 The Panel is concerned about the lack of communication between teams in the Trust regarding the disagreement about Mr A's diagnosis. Given the circumstances of inpatient teams diagnosing paranoid schizophrenia and the early intervention team diagnosing drug induced psychosis the Panel would have expected to have seen significantly more dialogue about this between the relevant teams.

5.75 It is the opinion of the Panel that a more collaborative approach to Mr A's care and treatment might have enabled a more consistent (and arguably appropriate) treatment plan to have been put into place for Mr A. See our Recommendation 1.

Primary care

5.76 The Panel reviewed the correspondence from the Trust to Mr A's GP and in the main found that there was timely and detailed communication to Mr A's GP nearly every time he had an outpatient appointment or was discharged from a service provided by the Trust.

5.77 It is important that correspondence from the Trust to GPs is clear, and that where there is an expectation that staff in primary care undertake a task this is explicit in the communication. The Panel has found that when Mr A was discharged from the Trafford early intervention team in May 2011 the letter

was not sufficiently clear regarding the issue of referral to Trafford Extended Services.

5.78 It is the Panel's view based upon the evidence we have seen that the expectation from the early intervention team was for Mr A's GP to make the referral to Trafford Extended Services. However, this was not clearly indicated within the letter to Mr A's GP and indeed Mr A's GP was of the view that Mr A had been discharged from the Trust with no medication and no plans for further assessment or management. This view was communicated in a letter to a community mental health team in August 2011, following which the community mental health team forwarded the letter to Trafford Extended Services.

5.79 The Panel has found one occasion when a discharge summary was not provided in a timely fashion and this related to an assessment conducted by the rapid intervention team on 1 November 2016. The summary of the intervention was not provided to Mr A's GP until 1 March 2017. The Panel has not found other evidence of delayed communication such as this and therefore we consider this to be an exceptional error and therefore we have not made any recommendations associated with this.

5.80 There are a number of occasions when the clinical records indicate that Mr A required support with registering with a GP. The evidence reviewed by the Panel indicates that each time this issue arose, it was not identified in a proactive way, thereby placing Mr A's mental state at risk because he was unable to access prescriptions. It is the view of the Panel that a proactive approach in recognising that this would be a support need for Mr A would have been more beneficial.

5.81 The Panel is concerned at the expectation that the Trust placed on primary care to continue to monitor and prescribe medication for Mr A at a time when he was not registered with a GP and his living arrangements were chaotic. We recognise that this is not an issue that is present in isolation in this case, nor for this Trust. However, expecting a prescribing and monitoring function to be picked up by primary care, when a primary care provider is not identified for a patient, significantly increases the risks for the patient involved. See our Recommendation 8.

Probation services

5.82 The probation service has not responded to the Panel's requests to discuss this case with them. Therefore, the Panel has not been able to understand what records that the probation service has about information was shared between their organisation and the Trust. Niche has discussed this issue with NHS England and it was agreed that this report would be shared without further requests for information being made.

5.83 The earliest communication between the Trust and probation was in February 2011 when the early intervention team social worker contacted Mr A's probation officer. The evidence the Panel has seen indicates that the social worker established that Mr A had recently been handed a suspended sentence and supervision order but there is no record of the detail of the

offence in any of Mr A's care planning or risk assessment documents completed at that time.

Police

5.84 The Panel can see that there was frequent communication between Trust staff and the police. The focus of this communication was often as a consequence of Mr A being detained by the police in a public place, although latterly there appear to have been more discussions about how agencies should manage Mr A's presentation. There were two formal multi-agency meetings documented:

- July 2015 – multi agency planning meeting involving Mr A, Trust staff, and staff from Phoenix Futures, HOST (housing options search provider in Trafford), and Pomona Gardens. The focus of the discussion was Mr A's continued substance use and his ability to manage an independent tenancy. The result of this meeting was that the priority of Mr A's housing allocation was downgraded from Band 1 (urgent need) to Band 2[17].
- September 2016 – multi agency planning meeting involving Trust staff, staff from Bedspace, the police and Intuitive Recovery. The meeting was called in response to Mr A's assault on his mother and the violence towards his sister's cat. The result of this meeting was that essential repairs would be made to Mr A's flat and a police marker was placed on the addresses of Mr A's mother, father and grandparents.

5.85 It is the view of the Panel that Mr A's level of risk, the involvement of the police and the view expressed by CP3 regarding Mr A's offending behaviour being present as a result of use of illicit substances, rather than mental illness, should have prompted referral to forensic services.

Other agencies

5.86 There was frequent documented liaison between Trust staff and other agencies supporting Mr A including Bedspace, Pomona Gardens, Intuitive Recovery.

5.87 When Mr A was remanded to HMP Manchester a member of staff from the MO:DEL team advised the in reach mental health team at HMP Manchester of Mr A's diagnosis, substance use, care team and recent risk history.

5.88 The Panel is concerned about the way in which, in October 2016, the court asked for information about the services working with Mr A prior to making a disposal decision. The mental health practitioner in the criminal justice liaison team spent some time collating relevant information about Mr A's care plan and service input. However, before the mental health practitioner was able to provide this information to the court he was advised that the court was unable to wait for his response and he was informed that the court had imposed a six-month community order. Had the court waited for the information prior to making the decision they would have been aware that the early intervention

[17] https://www.traffordhomesearch.co.uk/AllocationSchemeSummary.aspx

team was in the process of closing Mr A's referral to their team. We are not able to comment upon the actions of the judicial system, however had this request come from NHS staff we would be criticising the fact that a decision was taken prior to receiving essential information that had been requested.

5.89 The Panel has seen evidence that information was provided to Trust staff by clinical staff at HMP Manchester. However, there is a discrepancy between information that was recorded on the clinical system at HMP Manchester and what was recorded in Trust records, about the importance of a Mental Health Act assessment being arranged for Mr A when he was released from prison. The Panel has seen and heard evidence that clinical staff at HMP Manchester were sufficiently concerned about Mr A's mental state that they secured agreement from the prison governor to keep Mr A in prison overnight on 13 October 2016 in order to plan for Mr A to be properly supported with regards to his mental health when he was released from prison.

5.90 It is of concern to the Panel that the AMHP team were unable to accept a referral for a Mental Health Act assessment for Mr A when they were contacted on 13 October regarding an assessment for the following day. There should be a process by which one team has the ability to be able to pass on information to the next team on duty. See our Recommendation 3.

Engagement of services with Mr A and his family

5.91 Staff did make significant attempts to engage with Mr A and to keep him engaged with services.

5.92 Engagement with Mr A and his extended family was good. Mr A's mother clearly knew how to contact staff when she had concerns, as did Mr A's grandfather.

5.93 It is however the view of the Panel that Trust staff placed too much reliance upon information provided by Mr A's family when he was released from prison when deciding that the consultant forensic psychiatrist request for a Mental Health Act assessment would not be followed through.

5.94 See our Recommendation 3.

6 Duty of Candour

6.1 Duty of Candour applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred. A notifiable patient safety incident includes the death of a service user.

6.2 We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour, introduced in April 2015. The Regulation is also a contractual requirement in the NHS Standard Contract.

6.3 In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

6.4 To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person."

6.5 Duty of Candour is referenced within the Trust Being Open Policy. In Section 4 of this policy it states:

Where harm has been caused to an individual following the event of an adverse incident service users and or carers can expect to be treated with

compassion and understanding by Trust staff from the outset. Service users and or carers can expect to be fully informed of the issues surrounding the incident and its consequences ideally on the same day the incident occurred where information is known. This will usually be offered as a face to face meeting and may take place either on Trust premises or the individuals home where appropriate. This meeting will be undertaken with sympathy, respect and consideration by a senior health care professional.

6.6 The policy goes on to say that the following should be offered to the service user and carer:

- a sincere and compassionate statement of regret for the distress that they are experiencing;
- a factual explanation of what happened;
- a clear statement of what is going to happen from then onwards;
- a plan about what can be done to resolve, repair or redress the harm done.

6.7 The policy states that the member of staff identified to lead the Being Open discussions should be a senior healthcare professional from the service user's multi-disciplinary team, and that contact should take place as soon as is practicably possible after the basic clinical facts being established. In addition, a face to face meeting with the service user or carer should be offered within five days of the serious incident occurring.

6.8 The regulations are clear that the "relevant person" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

Communication with Mr A or his family

6.9 The Trust has confirmed that they hold no information relating to their execution of Duty of Candour responsibilities in relation to Mr A or his family. Indeed, in the Duty of Candour section of the internal investigation report it notes:

"I've been holding off this as I am not sure whether an apology should be issued at this stage or, in fact, what the apology should consist of."

6.10 It is of concern to the Panel that this statement was not identified, and guidance provided to the internal investigation team during the course of finalising and approving the report. It is also of concern that this was not highlighted and addressed by the clinical commissioning group when they reviewed the internal investigation report.

6.11 Whilst it would be very challenging to apply Duty of Candour law in relation to Mr A, the Trust should consider in retrospect whether Duty of Candour should have been applied at the point when either:

- they commissioned an investigation into Mr A's care and treatment; or

- the investigation report was finalised and there were recommendations made about the care and treatment provided to Mr A.

6.12 See our Recommendation 7.

Communication with Mr Owen's family

6.13 The Trust has confirmed that they hold no information relating to their execution of Duty of Candour responsibilities in relation to Mr Owen's family.

6.14 The lead internal investigator told us that although it was never voiced, there appeared to be an expectation that the investigation team should involve the family of the victim. We were told that no contact was made with Mr Owen's family because at that point in time, the team did not know whether or not Mr A had committed the offence.

6.15 As discussed at 6.9, the only documentation concerning the Duty of Candour in the internal investigation report notes:

"I've been holding off this as I am not sure whether an apology should be issued at this stage or, in fact, what the apology should consist of."

6.16 It is of concern to us that this statement was not identified, and guidance provided to the internal investigation team during the course of finalising and approving the report.

6.17 In the version of the internal investigation report that we received in October 2018, this section has been changed and simply reads "not at this point of the investigation".

6.18 Mr Owen's family do not strictly fulfil the criteria of the definition of a "relevant person" within the regulations. Mr Owen was not a service user of the Trust and therefore the Trust had no direct responsibility for his wellbeing. The Trust earlier justified its position for not writing to Mr Owen's family at the time of the internal investigation on the basis that it was not clear whether Mr A was responsible for Mr Owen's death. Therefore, it would be in the spirit of the legislation for the Trust to have written to Mr Owen's family at the conclusion of the trial.

6.19 When this was highlighted to the Trust (that no contact had been made with the victim's family) they wrote to them in April 2019 with an apology and explanation for the delay, and have offered the family the opportunity to meet with the Trust for them to explain the findings of the internal investigation wiuth them.

7 Internal investigation and action plan

7.1 The Trust first became aware of the death of Mr Philip Owen when the police contacted staff at Moorside Hospital where Mr A was being treated as an inpatient on a mental health ward. The police advised ward staff that Mr A needed to be arrested during the night because he was a suspect in the homicide of a local man. An incident report was completed shortly after Mr A had been arrested.

7.2 The investigation was allocated to three senior managers in the Trust:

- Clinical Lead for Early Intervention Services, Mr F (Lead Reviewer)
- Clinical Lead for Adult Forensic Services, Dr H (Panel Member)
- Community Services Manager, Ms F (Panel Member)

7.3 We understand that the lead reviewer had not previously undertaken a root cause analysis investigation and that he received some one-to-one training with a senior manager from the governance team in order to equip him with some knowledge of investigation tools and techniques.

7.4 We have provided the terms of reference for the internal investigation at Appendix E. We understand that although the investigation team had the opportunity to amend the terms of reference they did not feel the need to do so.

7.5 The internal investigation team interviewed four members of staff and four individuals from other organisations, see Table 3 below.

Table 3 - Interviews conducted by the internal investigation team

<table>
<tr><th>Role</th><th>Team</th><th>Organisation</th></tr>
<tr><td>Team Leader</td><td rowspan="3">Trafford early intervention service</td><td rowspan="4">Greater Manchester West NHS Trust (organisation now known as Greater Manchester Mental Health NHS Foundation Trust)</td></tr>
<tr><td>Care Coordinator</td></tr>
<tr><td>Consultant Psychiatrist</td></tr>
<tr><td>Mental Health Practitioner</td><td>MO:DEL team</td></tr>
<tr><td>Practitioner</td><td>-</td><td>Intuitive Thinking</td></tr>
<tr><td>Practitioner</td><td>-</td><td rowspan="2">Bedspace</td></tr>
<tr><td>Practitioner</td><td>-</td></tr>
</table>

7.6 Notes were retained from these interviews and we have had access to these. The internal investigation team also received a written statement from one member of staff.

7.7 We note that there were revisions to the serious incident report, however the Trust template does not include an element of version control. This means

that anyone viewing the document cannot be sure which version they are reading or whether any further versions exist. Indeed, when we interviewed members of the internal investigation panel they had reviewed at least two different 'final' versions of the report. We were told that one of those versions had been downloaded from the incident management system and should therefore be the absolutely final version of the report. However, this was watermarked with 'draft' and had a number of reviewing notes. Two versions that internal investigation panel members brought with them were different from each other and different from the version we have been provided with.

7.8 When we highlighted this to the Trust after we had conducted the interviews we were provided with another version of the report. The only difference in this version from the version we were provided at the beginning of the investigation was that the wording in the section referring to Duty of Candour had been amended and the watermark said 'final' rather than 'draft'.

7.9 The report does not have page numbers and is therefore difficult to navigate. It also does not include information about the root cause analysis tools used by the panel in reaching their conclusions.

7.10 The NHS England Serious Incident Framework provides guidance about the serious incident investigation report. It states that reports should:

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- Include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials, document name, computer file path and page number in the footer;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should however be considered by the Caldicott Guardian and where required confirmed by legal advice;
- Include evidence and details of the methodology used for an investigation (for example timelines/cause and effect charts, brainstorming/brain writing, nominal group technique, use of a contributory factor Framework and fishbone diagrams, five whys and barrier analysis);
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable;
- Include a description of how patients/victims and families have been engaged in the process;
- Include a description of the support provided to patients/victims/families and staff following the incident.

7.11 The Trust internal report does not meet the standards set out by NHS England. We suggest that the Trust reviews the way in which reports are quality assured to ensure that reports are of an appropriate standard.

7.12 The internal investigation report identified nine key concerns:

- The discrepancy in opinion between [the consultant, care coordinator and team manager] about whether a decision had been made to discharge [Mr A] from the care of the Trafford Early Intervention Team.
- The decision to discharge was documented at a meeting where there was no medical input.
- Poor note keeping from the Multi Professionals meeting and the Multi Disciplinary Meetings to reflect the complex decision making which was evident in the interviews undertaken for this review. See recommendation 5.
- Despite [the care coordinator and team manager] highlighting the need to instigate actions prior to discharge, these things were not actually in place before discharge happened.
- The diagnosis of Paranoid Schizophrenia remained on Paris despite the diagnosis changing on the letters from [the consultant] as from 4th August 2016. This is an issue for teams who may need to provide emergency care and who may not have time to negotiate all the letters within the PARIS system.
- There seemed to be uncertainty regarding how the change in diagnosis from [the consultant] was then translated into the diagnosis field in PARIS.
- There was evidence of ongoing ineffective communication between [the consultant] and other members of the team in relation to decision making.
- The medical input to the team appears to have been an issue with [the consultant] feeling his input to the team is not effectively utilised and this requires resolution (see appendix 12).
- Based on our review of [Mr A], early discharges from EIS should be reviewed.

7.13 The internal investigation team made seven recommendations:

R1 The findings of this review will be presented by the investigating team at a multi-disciplinary team Positive Learning Event by end of April 17.

R2 Each directorate to agree a system for how diagnoses are updated on PARIS by the Admin Manager by 27.3.17.

R3 For Trafford Directorate to review the medical input to Trafford Early Intervention Team in conjunction with all team members by Head of Operations and Lead Consultant by 27.3.17.

R4 The Community team manager to ensure that the process of discharge is followed as per the service Operational policy. The Community Team manager to complete an audit by end of March 2017 to offer assurance this process is being correctly implemented.

R5 A structured proforma to record multi-disciplinary team meetings and Professional Meetings will be developed by the Community Service Manager by 28th March 2017 to ensure that team meetings and Multi Professional meetings reflect the decision-making process which underpin care decision. Compliance of this will then be audited quarterly by the Community Services.

R6 The Trust EIS Steering Group to review the EIS policy in relation to early discharge panel from EIS by end of April 2017.

R7 MO:DEL and the governance team to share learning with the custodial services with which they interface. A Positive Learning Event to be held by end of April 17.

7.14 Whilst we support the recommendations, we consider that they do not address system learning and are focussed too closely on processes rather than considering the wider system factors that contributed to the behaviours of individuals working with Mr A. We explore this further in Section 8.

Analysis of Trust action plan

7.15 We have reviewed the Trust action plan that was updated on 10 May 2017. All actions on the plan are marked as complete.

7.16 **Recommendation 1**. The findings from the internal investigation were discussed at a local learning event in April 2017 and discussed in the early intervention team steering group in May 2017.

7.17 **Recommendation 2**. There are different systems in place across the teams serving Bolton and Salford. The teams using each approach have given assurances that their own system works. The Trust has sought assurances from the Trafford team that diagnoses are reviewed on the electronic patient record at the point of outpatient appointment, Care Programme Approach review and inpatient discharge. However, these assurances have been given via email and there does not appear to be a system in place to audit the process in order to provide evidence of assurance. See our Recommendation 6.

7.18 **Recommendation 3**. Medical staffing was discussed at a meeting held in March 2017. The conclusion of that discussion was that the current arrangements of 5 sessions (0.5 wte) at staff grade level and 8 sessions (0.8 wte) at consultant level was considered to be sufficient medical input to the team. It appears that at the time of the discussion the staff grade post was vacant, because there is a reference to a recruitment process being underway. The structure of multi-disciplinary team meetings had also been reviewed and there was an expectation that the consultant would prioritise attendance at those meetings. It appears that the new consultant is working well with the team and there is a new system of regular meetings between the senior leaders (team manager, clinical lead and consultant) to ensure that consistent leadership is provided to all members of the team.

7.19 **Recommendation 4**. There were a number of team meetings held to ensure that staff understood the early discharge process. The issue was also

discussed in supervision between the community services manager and the team manager. An audit of discharge documentation was undertaken to establish the efficacy of the discharge planning process. The audit included cases where the service user had been discharged to primary care during the period 1 April 2016 and 31 March 2017. There were 44 service users that met the inclusion criteria. The findings can be summarised as follows:

- 88% of discharges had been discussed. For those cases where the discharge had not been discussed: two cases there was no evidence of medical input to the discharge, for three cases the medical input was after the discharge had been completed.
- 98% of cases had discharge letters sent to the GP.
- 52% of cases had risk assessments updated.
- 41% of cases had updated Care Programme Approach care plans updated.
- The lack of completion of risk assessment and care plans was found to be mainly due to the practice of one team member. This would be managed through supervision.

7.20 A further audit was undertaken covering the period 1 April 2017 to 31 March 2018. There were 23 service users that met the inclusion criteria. The findings can be summarised as follows:

- 100% of discharges had been discussed with the doctor present.
- 96% of cases had discharge letters sent to the GP. 86% of those letters were comprehensive, 14% provided a brief outline and one letter was only partially completed and it was unclear where the letter was being sent.
- 92% of cases had risk assessments updated.
- 91% of cases that required Care Programme Approach paperwork had updated care plans. Two cases did not require Care Programme Approach.
- There were no outstanding actions identified and it was noted that there was evidence of high standards of documentation and person-centred work.

7.21 We are therefore assured that the required improvements have been made and that the Trust is auditing the position.

7.22 **Recommendation 5**. The community services manager has consulted with senior staff regarding the content for a proforma and an agreed document was implemented in March 2017. An audit of minutes of the multi-disciplinary team meetings was planned for May 2017 but we have not seen the results of this audit. We are therefore unable to comment on the degree to which this recommendation has been implemented. We suggest that the Trust brings the findings of this audit to the attention of Central Manchester Clinical Commissioning Group in order either to provide assurance that its use is

effective, or to agree a further action plan in order to ensure that it is effective. See our Recommendation 10.

7.23 **Recommendation 6**. The issue of early discharge from early intervention services was discussed by the early intervention steering group and an agreement was made to amend the operational policy. We have reviewed both the old policy and the new policy and can see the previous statement covering discharge of service users who "make a full recovery within the three-year period" has been removed from the new policy. The final paragraph in the section referring to discharge before three years refers to discharge of service users who require ongoing care and treatment after the three-year period. This paragraph is repeated in the following section. It does not appear that this reflects the implied decision at the steering group regarding the process for service users to access extended assessment. The Trust should review and clarify this section of the policy. See our Recommendation 10.

7.24 **Recommendation 7**. A learning event was held, and this was followed up with email confirmation that the learning was also shared in the Court User's Group in May 2017. We cannot see evidence that this learning was Trust wide, nor can we see how well the learning has been embedded within the organisation. In addition, it is unclear to us what practice has changed or how these changes have improved the experiences for service users, families and staff. The Trust should assure themselves and their commissioners that the required changes have been implemented and are effective. See our Recommendation 10.

Conclusions of review of internal investigation and action plan

7.25 It is our view that the internal investigation did meet most of the terms of reference set by the Trust. However, the report did not meet the standards set out in the NHS England Serious Incident Framework and the lead investigator was unclear about what was required because he had never undertaken a serious incident investigation before. The Trust must ensure that all staff involved in serious incident investigations are equipped with the necessary skills and knowledge. See our Recommendation 10.

7.26 In addition, it is our view that further evidence is required in order to provide assurance that the recommendations have been implemented and that the changes are effective. See our Recommendation 10.

Clinical Commissioning Group monitoring of action plan

7.27 Bolton Clinical Commissioning Group was responsible for the management of serious incidents for the Trust under a tripartite arrangement (between Bolton, Salford and Trafford Clinical Commissioning Groups). This arrangement was implemented following a change in the contractual arrangements for the Trust provider in place for the approval of the internal investigation report and action plan, and monitoring progress of Trust actions.

7.28 Bolton Clinical Commissioning Group was responsible for formally closing STEIS entries for incidents reported by the Trust, as the lead commissioner

for the provider contract. We understand that at the time that Bolton Clinical Commissioning Group inherited the additional governance arrangements, there was a backlog of serious incidents and that no extra resources were made available to deal with the additional associated governance arrangements.

7.29 The responsibility for the management and oversight of serious incidents has now passed to Manchester Health & Care Commissioning (a partnership between Manchester City Council and Manchester Clinical Commissioning Group.) At the time of this change a number of concerns were raised about the lack of evidence of the commissioning oversight that had been undertaken previously.

7.30 The incident report was discussed at the tripartite Serious Incident Review Group meeting on 25 April 2017, but it appears that there are no formal minutes of that meeting.

7.31 In September 2017 we can see that an update on progress of the investigation was provided (we believe by the clinical commissioning group, but it is not clear from the information we have received). The update notes that the investigation was delayed due to the police investigation and that formal approval from Bolton Clinical Commissioning Group had been sought to extend the deadline for the final report. It appears that the final report was then due by 31 March 2017, however by 6 April it was noted that the report had not yet been signed off by the Trust Board.

7.32 The Trust shared a report with Bolton Clinical Commissioning Group on 10 April 2017, however in June 2017 it was identified that this version still had track changes and therefore a question was raised by the clinical commissioning group as to whether it was indeed the final version.

7.33 In August 2017 it was noted that Bolton Clinical Commissioning Group had closed the incident and that this appeared to be because "there was a consensus that the incident occurred as a result of primarily substance abuse rather than any MH issues or actual MH diagnosis". Central Manchester Clinical Commissioning Group then asked for copies of the notes from the meeting where closure of the incident had been agreed but they were advised by Bolton Clinical Commissioning Group that no minutes were taken at the meeting and the individual manager did not recall a discussion at the meeting about closing the incident.

7.34 We understand that there is now a closure checklist that is completed for every serious incident before it can be closed down on the national reporting system. The checklist is based upon the standard set out within the NHS England Serious Incident Framework and invites a yes/no response as well as additional commentary. We have been provided with a blank copy of this checklist.

7.35 We were told that commissioners have received an internal audit report that led to the development of an action plan. We have not seen copies of either the report of the action plan, so we are unable to comment upon any progress that the clinical commissioning group has made in responding to any concerns the audit report may have highlighted.

7.36 It is clear that at the time there was a lack of rigour by Bolton Clinical Commissioning Group in managing this incident report. Bolton Clinical Commissioning Group has since revised their internal processes for the management of serious incidents. We have not made a recommendation in relation to this because responsibility for the management and oversight of serious incidents has now passed to Manchester Health & Care Commissioning.

7.37 However, it is our opinion that more work is required by Manchester Health & Care Commissioning to provide assurance that the management and oversight of serious incidents is now being appropriately undertaken.

7.38 See our Recommendation 10.

8 Conclusions and recommendations

8.1 Mr A had been treated for many years by different services provided by the Trust. Throughout this time his diagnosis was recorded as paranoid schizophrenia but there were different views as to whether his psychotic experiences were due to illness exacerbated by drug misuse or solely to drug misuse. Therefore, the treating team did not believe Mr A's presentation could be managed by long term detention under the Mental Health Act.

8.2 Mr A had not been in receipt of regular antipsychotic treatment for many months prior to the death of Mr Owen. It is our view that the lack of effective treatment for psychosis contributed to Mr A's increasing aggression and violence.

8.3 It is our view that Mr A had probably been chronically psychotic at least throughout the three years that he was under the early intervention service. This is confirmed by his fairly frequent admissions to hospital and by the notes from these admissions which usually described psychotic symptoms initially. The type and persistence of his symptoms would not, in our opinion, be consistent with a diagnosis of drug induced psychosis and we would agree with the diagnosis from his admission in June 2016, paranoid schizophrenia. It is also clear that Mr A did not take anti-psychotic medication for any significant length of time in the community. His improvement since admission to a medium secure hospital and his treatment with clozapine, would appear to confirm this.

8.4 We are particularly concerned about the decision not to proceed with a Mental Health Act assessment without any first-hand knowledge of Mr A's mental state since release from prison. We acknowledge that it is impossible to be certain about the outcome of a Mental Health Act assessment, as clearly recommended by the consultant forensic psychiatrist from HMP Manchester. However, a face to face assessment might have led to a closer examination of risk, and detailed enquiry into Mr A's mental state whilst in prison.

8.5 In addition, the change in diagnosis in the community following his last admission to hospital led the early intervention team to the subsequent decision to discharge Mr A from their service, without first securing further care under a community mental health service. That Mr A was discharged during the short time he was in prison is difficult to understand and justify.

8.6 As part of our terms of reference we have been asked to consider whether this incident could have been predictable or preventable.

Predictability and preventability

8.7 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

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

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].

8.8 Prevention[20] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

8.9 From March 2016 onwards there was clear evidence that the level of Mr A's violence and aggression were increasing. This culminated in the attacks on his brother, sister's cat, and the assault on his mother that rendered her unconscious.

8.10 Mr A's levels and frequency of violence had increased such that serious harm to others was increasingly likely. However we acknowledge that staff could not have predicted that Mr A would have killed Mr Owen in the way that he did in October 2016.

8.11 Early intervention team staff held the view that Mr A's psychosis was only present when he had been taking illicit substances. This was the driving force for the belief by the team (with the exception of the doctor) that he should be discharged from early intervention services. Yet, when Mr A was released from prison he had been under the care of clinical staff in the healthcare unit where it would have been significantly more difficult for him to have had access to illicit substances. We do acknowledge here that it would not have been impossible, but having heard from healthcare unit staff it is clear that in Mr A's case it would have been very unlikely that he would have had access to illicit substances whilst on the healthcare unit.

8.12 There was a significant missed opportunity to engage Mr A in active, effective therapy when CP3 chose not to prescribe an alternative antipsychotic medication in April 2016. Mr A had not been compliant with oral medication and inpatient staff had recommended that he be maintained on a depot injection, given fortnightly. Mr A told staff that he found the injections painful and rejected ongoing depot injections. Mr A had been detained on Section 3 and therefore it is our view that staff should have properly considered the benefits of a community treatment order, thus providing a more structured framework to properly monitor the effectiveness of antipsychotic medication.

8.13 Mr A remained un-medicated for a number of months, In the period of time leading up to the incident Mr A was not in receipt of any medication except for when he was in inpatient settings (either at Moorside Hospital or in the healthcare unit at HMP Manchester).

8.14 It is our view that had Mr A been properly medicated then it would have reduced the risk of his violent and aggressive behaviour. However, it is

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[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*

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

difficult for us to say that this would have reduced it sufficiently for Mr Owen's death to have been avoided.

Recommendations

8.15 This independent investigation has made 11 recommendations (10 for the Trust and one for the Trust and their commissioners) to address in order to further improve learning from this event.

8.16 The recommendations have been given one of three levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.
- **Priority Three:** the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One

Recommendation 1

The Trust must ensure that clarity is provided to early intervention team staff about what approach to take when there is diagnostic uncertainty (either within a single team or between teams involved in a patient's care and treatment).

Recommendation 2

The Trust must ensure that clarity is provided to the early intervention team about the process for seeking a second opinion and/or formal consultation with another clinician or team (in particular the forensic team) when a patient has not responded to treatment for a prolonged period of time and where risks are escalating.

Recommendation 3

The Trust and relevant local authorities must ensure that where systems do not already exist:

- when there are doubts or differences of opinion about the use of the Mental Health Act, a formal discussion that involves an AMHP takes place and is properly recorded;
- the AMHP teams on duty during normal working hours and out of hours have a system to record all requests for Mental Health Act assessments, even when it is expected that a clinical team will contact the next shift.

Recommendation 4

The Trust must ensure that all clinical teams follow trust safeguarding policies when they are made aware of safeguarding concerns about children or adults, and that appropriate referrals are made to the relevant social care department.

Recommendation 5

The Trust and Salford Royal NHS Foundation Trust must ensure that when recording that a patient is being treated under the DoLS framework the appropriate documentary detail is in place to apply the Mental Capacity Act lawfully.

Priority Two

Recommendation 6

The Trust must assure itself and its commissioners that when actions are implemented there is sufficient evidence of the effectiveness of the outcome or change in practices.

Recommendation 7

The Trust must ensure that it fulfils its responsibilities under Duty of Candour and that appropriate guidance and oversight is provided to staff to enable them to execute the responsibility appropriately.

Recommendation 8

The Trust must ensure that an appropriate prescribing plan is developed and implemented when patients are at risk of becoming homeless or not registered with a GP.

Recommendation 9

The Trust must ensure that when care plans are developed patients and their carers are given the opportunity to contribute to the content, in accordance with Trust policy.

Recommendation 10

The Trust and their commissioners must be assured that the investigation, management and oversight of serious incidents is appropriately undertaken.

Priority Three

Recommendation 11

The Trust must assure themselves that when patients are entered into a clinical trial there is evidence to indicate that they are an appropriate candidate for that trial.

Appendix A - Terms of Reference

Terms of Reference for Independent Investigations under NHS England's Serious Incident Framework 2015

The Individual Terms of Reference for independent investigation 2016/29151 are set by NHS England. There will be further opportunity for families and other stakeholders to inform these.

Purpose of the investigation

To identify whether there were any gaps or deficiencies in the care and treatment that [Mr A] received, which could have predicted or prevented the incident occurring. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required with the aim to prevent similar incidents from occurring.

The investigation is to be conducted in accordance with the following Terms of Reference:

- Review the Trust's internal investigation report including:
  - assessment of the key lines of enquiry
  - adequacy of findings
  - contact with affected families
  - if recommendations are appropriate
- Review progress of the Trust's internal action plan identifying if measurable outcomes have been achieved and how learning from the internal investigation has been embedded within the organisation
- Compile a comprehensive chronology of events leading up to the homicide
- Conduct a proportionate review of the care, treatment and services provided by the NHS and other relevant agencies from the perpetrator's first contact with services to the time of their offence identifying both areas of good practice and areas of concern
- Review the engagement of Early Intervention, CMHT and Dual Diagnosis Services with the service user and consider the adequacy of the patient pathway, clinical formulation/diagnosis, treatment options and discharge processes in line with national standards and best practice
- Consider the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others when risk taking behaviours appeared to be increasing (including risks associated with domestic violence)
- Examine the effectiveness of the perpetrator's care plan including the involvement of the service user and their family

- Based on overall investigative findings, constructively review any gaps in the interface between NHS services and also agencies external, identify potential opportunities for improvement
- 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
- Review and assess compliance against appropriate local policies, national guidance and relevant statutory obligations
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement
- Review the NHS commissioners' processes for quality assuring the Trust's serious incident investigation against the requirements of the Serous Incident Framework identifying both good practice and areas requiring improvement
- Provide a written report to NHS England that includes outcome focussed 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
- Support relevant stakeholders to develop an outcome based action plan based on the recommendations
- Assist NHS England in undertaking a brief post investigation evaluation
- Within 6-12 months of the reports publication conduct an assessment on the implementation of the reports associated action plan, in conjunction with the CGG and Trust, providing a short written report, that may be made public

Appendix B – Documents reviewed

Trust documents

- Action plan
- Adult Inpatient Operations Policy 2015
- Audit of discharges from early intervention service in Trafford April 2016
- Audit of discharges from early intervention service in Trafford 2017/18
- Being Open Policy
- Care Programme Approach Policy October 2011
- Clinical records (including those records pertaining to Mr A's care and treatment whilst at HMP Manchester)
- Clinical Risk Policy
- Correspondence relating to notes from MARAC meetings
- Draft Care Programme Approach Policy July 2018
- Dual Diagnosis Policy
- Early Intervention Operational Policy December 2016
- Early Intervention Operational Policy December 2017
- Incident Policy
- Incident, Accident and Near Miss Policy and Procedure
- Record Management Policy
- Records Management Strategy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Safeguarding Vulnerable Adults Policy
- Serious incident report
- Trafford Extended Services service specification
- Trafford Extended Services Operational Procedure
- Trafford Directorate Adult Inpatient Operational Policy December 2017

Other documents

- GP records

Appendix C – Detailed chronology of Mr A's care and treatment

Date	Information
2011 – First contact with adult mental health services	
January 2011	Mr A's GP made an urgent referral to the community mental health team in Flixton. The GP noted that Mr A had previously been under the care of Trafford CAMHS and had been diagnosed with ADHD which had been treated with Concerta XL. It was noted that he had been released from prison in early 2010 following a conviction for assault and that he was experiencing escalating feelings of aggression at that time. The GP also spoke to the community mental health team and advised that Mr A had admitted smoking cannabis throughout his waking hours and that Mr A had described hearing a voice in his head telling him to hurt others.
21 January 2011	An urgent mental health assessment was arranged for 21 January in the Section 136 suite at Trafford General Hospital. At the assessment Mr A spoke about thoughts of hurting other people and said that the triggers were other people ignoring him and his needs not being met. He spoke about delusional ideas about the devil and the government and that he felt frustrated that the government was "listening to alumni". Mr A was not considered to be appropriate for the caseload of the crisis resolution and home treatment team and he was therefore referred to the early intervention team and to a service working with young offenders (MDO - Mentally Disordered Offenders).
February 2011	The early intervention team assessed Mr A in early February and he was accepted onto the team's caseload. Mr A reported hearing command voices and that he regularly carried a knife. Staff explored the possibility of support from drug services, but Mr A said that he did not want to get involved with them. It was noted that Mr A was to be offered follow up appointments with the team psychiatrist and team social worker later that month. We can see that appointments with the team social worker were offered throughout February, March and April.
17 February 2011	Mr A was seen by the early intervention team locum staff grade psychiatrist (SGP1) when he reported hearing voices that told him to harm people. Mr A admitted using large amounts of cannabis and SGP1 noted that Mr A was "brittle in his emotions". The plan was for Mr A to engage with the early intervention team who would also provide support for him to engage with the substance misuse team. No antipsychotic medication was prescribed at that time. The team social worker liaised with Mr A's probation officer (Mr A had mentioned that he had a meeting with his probation officer) and established that Mr A had been given a suspended sentence and a supervision order.

February to April 2011	Mr A was offered fortnightly appointments with the early intervention team social worker throughout February, March and April. Mr A did not always attend the meetings and gave a variety of excuses for his absence. At this time Mr A was homeless and the probation service was trying to support him in securing accommodation.
5 May 2011	The early intervention team consultant psychiatrist (CP1) reviewed Mr A. It was noted that he was not taking any medication at that time and continued to have issues with anger management. He had been released from prison a year previously after having served three and a half months. Mr A reported that he used to carry a knife for protection because of the risks in the area he lived. He said that he no longer kept a knife but that at that time he would carry a glass bottle of coke. It was noted that Mr A had received a number of police cautions for criminal damage and affray. Staff noted that there were no signs of paranoia and determined that Mr A was not suitable for the early intervention team because he had a diagnosis of ADHD. It was however decided to prescribe zopiclone[21] 7.5mg and to discharge Mr A to primary care. A summary of the review meeting was sent to Mr A's GP in which the doctor stated that the GP should assess and determine whether to issue any further prescriptions for zopiclone. CP1 advised that Mr A was more appropriate for Trafford Extended Services (specialising in patients with a diagnosis of ADHD). It appeared that the expectation was for Mr A's GP to refer him to Trafford Extended Services, however this was not an explicit request. CP1 was the consultant psychiatrist for both the early intervention team and Trafford Extended Services and therefore there would be a degree of continuity for Mr A. In addition, the early intervention team social worker said that she would stay in touch with Mr A until his care was transferred to Trafford Extended Services.
29 June 2011	Mr A was discharged from the early intervention team to his GP. It was noted that a referral to Trafford Extended Services would be made because Mr A's diagnosis was ADHD. The early intervention team social worker noted that CP1 would write to Mr A's GP reminding him to refer Mr A to Trafford Extended Services. The Panel has not found evidence to support that any such letter was sent.
2 August 2011	Mr A's GP wrote to the community mental health team asking for Mr A to be seen. The GP stated that Mr A had been discharged into the community with no medication or plans for further assessment or management. The letter was reviewed by the community mental health team who forwarded it to Trafford Extended Services and advised the GP that this was the action they had taken.
1 December 2011	Mr A was seen by a specialty doctor (SD1) at Trafford Extended Services on 1 December.

[21] *Zopiclone is a medication to aid sleep. It is usually prescribed for short periods of time.*

5 December 2011	SD1 wrote to Mr A's GP to provide a summary of the appointment. SD1 noted that Mr A continued to experience outbursts of energy, was unable to concentrate on one task and was easily distracted. He had been deemed to be a disruptive child who got into trouble with memory problems. Mr A continued to struggle with poor motivation and was unable to keep his room tidy, but he denied any self-harm or thoughts of harming himself or others. Mr A admitted to using cannabis (mostly influenced by his peers) and he was reducing his intake from daily to two to three times a week. CP1 asked Mr A's GP to prescribe atomoxetine[22] 40mg, advised that Mr A had been encouraged to further reduce his cannabis intake, and that he would see Mr A again three months later. The progress note entry also indicates that the extended services team felt that Mr A would benefit from attending the coping skills group.
2012 – Trafford Extended Services and HMP YOI Lancaster Farms	
4 January 2012	ADHD clinic staff noted that Mr A was due to have a follow up appointment at the ADHD clinic in March and that an appointment should be arranged by the Trust. Staff contacted him by phone and were informed that Mr A had moved to a new flat in Stretford. Arrangements were made to meet him there the following day. However, Mr A was not at home the following day and when staff contacted him he stated he had forgotten about the appointment. Mr A told staff that he had settled in his new flat and that he had tried taking his new medication for about five or six days but that it made him feel "weird", hot and sweaty. Mr A was advised to attend a follow up appointment in March to discuss his symptoms with the doctor. Mr A told the member of staff that he was still under his court order to attend probation appointments and that the order was due to finish in February. Mr A told staff that the order had been given because he had smashed a window in a petrol station "around September time last year", shortly after he had been released from prison (it is not clear which prison). Mr A said that he had been in prison because he had been found guilty of carrying a knife. Mr A admitted he "sort of" still carried a knife, but that sometimes he carried a tin of baked beans to defend himself when he was feeling paranoid. Staff advised Mr A that he should not bring any weapons to clinical appointments. Mr A said he would not bring weapons to appointments and agreed to a home visit two days later (6 January).
6 January 2012	Mr A was not at home for the appointment.
11 January 2012	A mental health worker from Trafford Extended Services (MHW2) spoke with SD1 regarding Mr A's medication because Mr A had reported negative side effects to MHW2. SD1 offered to see Mr A in his clinic when Mr A attended for his appointment with Mr M1 that morning to discuss alternative medication. SD1 advised MHW2 that Mr A should discontinue atomoxetine if he continued to experience side effects.

[22] *Atomoxetine (also known as Strattera) is a medicine used to treat ADHD.*

	However, Mr A did not attend the appointment with MHW2 so SD1 was unable to see him. Mr A's case was discussed at the multi-disciplinary team meeting that day, and in a separate discussion with MHW2's manager it was agreed that it was no longer appropriate for Mr A to be managed on Care Programme Approach and that he should be moved to standard care.
18 January to 22 February 2012	Mr A's case was discussed at the weekly multi-disciplinary team meetings between 18 January and 22 February (six meetings) when it was noted that an outpatient appointment had been arranged with SD1 on 23 February. Throughout this time there was no contact with Mr A and he did not attend his appointment with SD1 on 23 February.
29 February to 7 March 2012	Mr A's case was again discussed at the weekly multi-disciplinary team meetings on 29 February and 7 March. It was noted that he had not attended the coping skills group but that a further appointment with SD1 would be offered.
12 March 2012	TES staff telephoned Mr A to find out if he wanted to attend the coping skills group. He said he did not want to attend and neither did he want to attend any further outpatient appointments because he was not taking his medication. There is no evidence indicating why staff did not explore this further with Mr A. However, it was noted that this would be discussed at the next multi-disciplinary team meeting.
14 March to 28 March 2012	Mr A's case was discussed at the weekly multi-disciplinary team meeting. It was noted that he did not want any further contact from the service and had declined to attend the coping skills group. It was agreed that his case needed to be closed and that the team should write to Mr A's GP to update them. The same information was noted at multi-disciplinary team meetings held on 21 March and 28 March.
	There is no evidence indicating any other actions taken by Trust staff after the end of March.
2012 – HMP YOI Lancaster Farms	
24 September 2012	Mr A received a custodial sentence for conspiracy to commit robbery.
18 October 2012	Mr A was seen by CFP1, a consultant forensic psychiatrist at HMYOI Lancaster Farms. It is unclear why CFP1 was asked to see Mr A. The Panel discussed this and found that the most likely conclusion was because Mr A had told inreach staff that he had been diagnosed with ADHD and had been prescribed medication. Mr A reported that he had been given an 18-month sentence for conspiracy to attempt robbery and that he was hoping to be released after 14 months. CFP1 noted that Mr A had sustained a number of injuries in prison. Mr A reported that he had been knocked out aged 16 years and again when he was 17 years old, both occasions had occurred when he had been fighting. CFP1 noted that Mr A had reported a diagnosis of ADHD but found nothing in his presentation to suggest

	that was a current problem. CFP1 noted that Mr A may have been experiencing an emerging psychosis, however he was concerned that the description of Mr A's eyes "glazing over" might have been indicative of an absence seizure that could be correlated to the head injuries he had previously suffered.
23 October 2012	CFP1, consultant forensic psychiatrist, referred Mr A for a CT scan regarding possible seizures and queried whether Mr A had an emerging psychosis. The plan was to see Mr A four weeks later to discuss his diagnosis, but Mr A's scan was not due to take place until 17 December so CFP1 was unable to use the information to inform the diagnosis when Mr A was seen again on 15 November. However, CFP1 did note that Mr A's presentation in November appeared "less suggestive of an emerging psychosis".
7 December 2012	Mr A was released from prison and remained on licence until 12 December 2013.
13 December 2012	The mental health team at HMYOI Lancaster Farms wrote to Mr A's GP to advise that although Mr A had disclosed experiencing paranoid thoughts, seeing shadows and some auditory hallucinations, his presentation later changed and therefore no medication had been prescribed. In addition, no referral had been made to a community mental health team because Mr A would not have met the criteria.
2013 – Mental Health Criminal Justice Team	
18 March 2013	The Greater Manchester Probation Trust referred Mr A to the mental health criminal justice team. The purpose of the referral is not clear; however, the referral form notes that Mr A was currently living in a bail hostel and that those arrangements would end on 21 March 2013 after which he would be homeless unless further accommodation was found.
1 April 2013	Mr A attended A&E complaining of hallucinations. He did not wait for a diagnosis and no treatment was provided.
3 April 2013	The referral from probation was accepted by the mental health criminal justice team and a criminal justice team worker (CJT1) met with Mr A on 3 April. CJT1 noted that there was no evidence that indicated Mr A needed further assessment from mental health services, but that there was some evidence of post-traumatic stress disorder, resulting from Mr A being stabbed in 2012. CJT1 noted that Mr A was prepared to work with primary mental health services and wrote to Mr A's GP confirming that he had assessed Mr A following a referral from his probation officer. Mr A had presented with "heightened sensitivity and anxiety, anger and poor impulse control". Although CJT1 had noted post-traumatic stress disorder type symptoms from an incident in 2012, there was no evidence of psychosis and therefore Mr A did not meet the criteria for care coordination by the mental health criminal justice team. CJT1 advised that he had referred Mr A to primary care psychological therapy service for an opinion about whether he would be suitable for their service.

5 April 2013	The primary care psychological therapy service wrote to Mr A's GP advising that Mr A had already been referred to and accepted for a mental health assessment by the criminal justice team. Therefore, he would be discharged from the primary care psychological therapy service. It appears at this time that Mr A was not receiving support from any mental health service.
24 April 2013	Mr A attended A&E because of a laceration to his neck. The wound was stitched, and Mr A's GP was advised that the sutures should be removed five to seven days later.
15 May 2013	The primary care psychological therapy service wrote to CJT1 to advise that Mr A's complex presentation was not suitable for primary care intervention. CJT1 was advised to contact a consultant psychiatrist specialising in ADHD, for further discussion.
20 June 2013	Mr A was assessed at A&E. Staff noted no evidence of serious mental illness and discharged Mr A to the care of his GP. It was noted that the crisis team would contact the criminal justice team and that Mr A had agreed to accept support regarding his housing because he was homeless at that time.
26 June 2013	Mr A did not attend his appointment with CJT2 from the criminal justice team. It appeared that Mr A had been at the probation service offices that morning and was aware of his appointment with the Trust but chose not to attend. CJT2 recorded that Mr A had received a number of assessments from Trust services that had found he was not suffering from mental illness and that he had been offered services regarding his diagnosis of ADHD but again had chosen not to accept the support. CJT2 recorded that the criminal justice team would close his case and inform his probation officer.
3 July 2013	Mr A's grandfather accompanied Mr A to A&E and requested a psychiatric assessment. Mr A was assessed by a worker from the crisis team. Mr A was accompanied by his aunt who reported that Mr A had told her that he knew that his parents "wanted him dead" and that Mr A had said he wanted to die. During the course of the assessment the crisis team was contacted by Mr A's probation officer who advised that Mr A had breached his license and had been recalled. Mr A was not considered detainable under the Mental Health Act and therefore the probation officer contacted the police to arrest Mr A for breach of his license.
10 July 2013	Records show that Mr A was then taken to HMP Manchester because mental healthcare staff there contacted his GP on 10 July to obtain a medical history for him.
8 August 2013	Mr A was assessed by CFP2, a Consultant Forensic Psychiatrist. CFP2 noted that Mr A was "showing residual signs of psychosis", but that olanzapine appeared to be treating the symptoms and that Mr A had also been prescribed antidepressants. Once accommodation had been arranged for Mr A on release from prison, CFP2 would refer Mr A to the relevant community mental health team.

15 August 2013	CFP2 wrote to the community mental health team to ask that they provide follow up care when Mr A was released from prison on 19 September.
3 September 2013	CJT3, a mental health worker from the criminal justice team, assessed Mr A on the inpatient wing at HMP Manchester. CJT3 noted that Mr A remained mentally unwell with low mood and low motivation. It was noted that Mr A had been reviewed by the CFP2 who had prescribed anti-depressant medication as well as anti-psychotic medication (olanzapine). There were no plans to move him from the inpatient wing at that time, but Mr A was advised that he would be supported by staff to move to St Joseph's (an Approved Premises[23]) on his release from prison. CJT3 noted that he would provide support provided that it was coordinated and managed by probation staff.
18 September 2013	CL1, the clinical lead for the prison GP service wrote to Mr A's community GP providing a summary of the care and treatment that Mr A had received whilst in prison. CL1 advised that Mr A had been prescribed olanzapine 10mg, sertraline 50mg, and procyclidine 5mg. A very similar letter was sent two days later that omitted the reference to procyclidine.
19 September 2013	Mr A was released from prison on 19 September and he went to live at St Joseph's Approved Premises in Eccles. The Trust provided a team supporting individuals who were placed at St Joseph's. This was known as a mentally disordered offenders' team.
23 September 2013	An appointment was made for Mr A with a support worker from St Joseph's Mentally Disordered Offenders Team on 23 September, but he did not attend and later told staff that he had other appointments that he needed to attend that day.
7 October 2013	Mr A was seen by CP2 a Consultant Psychiatrist in the mentally disordered offenders' team. CP2 wrote to Mr A's GP and indicated that his impression was that although there was some diagnostic uncertainty Mr A had been treated effectively with olanzapine whilst in custody, during which time he had apparently not had access to illicit drugs because he had been detained on the hospital wing in the prison. CP2 therefore advised that this was indicative of a diagnosis of schizophrenia and that he would continue to prescribe olanzapine 20mg daily.
29 October 2013	Mr A attended a group activity provided by the mentally disordered offenders team but appeared to be under the influence of substances and seemed quite sedated. He left after about five minutes.
7 November 2013	Mr A attended a group activity and again appeared to be under the influence of substances. It was noted that probation staff would be

[23] *Approved Premises are premises or bed spaces that are managed either by the National Probation Service or by independent organisations. They provide a structured environmentto support offenders' rehabilitation, as well as restrictions (including a curfew) that places controls on residents' behaviour.*

	made aware of Mr A's presentation. Later that day CP2 spoke to CJT3 about Mr A's medication. It was noted that he had been taking sertraline whilst in custody but that it had not been continued on his release. CP2 felt there was no clinical reason to re-initiate it but that he would continue to monitor Mr A whilst he was a resident at St Joseph's.
19 November 2013	Mr A attended a drug and alcohol awareness group organised by the mentally disordered offenders' team. Staff noted that he engaged well and shared experiences about his own drug and alcohol use.
29 November 2013	Mr A met with his mentally disordered offenders team support worker (CJSW1). Mr A reported that he was managing well and that his family had noticed a significant improvement in his mental health since he was released from prison. Mr A said he would be moving on from St Joseph's but was unsure when.
12 December 2013	CJSW1 noted that Mr A would be moving to Pomona Gardens (a service for single, homeless people). CJSW1 had discussed Mr A's case with the relevant community mental health team who had asked for a referral with a copy of Mr A's care plan, risk assessment and a consultant-to-consultant transfer letter. It was noted that Mr A's move was likely to take place six weeks later and that a professionals' meeting had been arranged for 10 January 2014.
2014 – Mental Health Criminal Justice Team and Trafford Early Intervention Team	
3 January 2014	Mr A failed to attend an appointment with CJT3, despite CJT3 confirming the time of the appointment the previous day. CJT3 was unable to locate Mr A despite searching and staff at St Joseph's reported concerns that Mr A had appeared low in mood.
10 January 2014	At a professionals' meeting it was confirmed that Mr A had been offered a place at Pomona Gardens effective from 20 January. CJT3 identified that the relevant team covering Pomona Gardens address was Trafford North community mental health team. A referral with relevant information was sent. Mr A's case was discussed at a multi-disciplinary team meeting of the Trafford community mental health team later that day. It was noted that Care Programme Approach arrangements would need to be transferred and Mr A's care coordinator was confirmed 11 days later. It is not clear from the records when Mr A was moved back to Care Programme Approach after he was moved to standard care in January 2012. The care plan created on 5 November 2013 indicated that Mr A was being managed on standard care.
3 February 2014	A discussion with the early intervention team resulted in Mr A being accepted onto their caseload. Later that day unsuccessful attempts were made to contact Mr A on his mobile. Early intervention team staff then contacted staff at Pomona Gardens and informed them that Mr A had been offered an appointment the following day and that Mr A should contact the early intervention team if he was unable to attend.

4 February 2014	Mr A did attend that appointment with a support worker from the early intervention team, STAR1. Mr A presented as "warm and friendly" and described hearing voices and feeling paranoid in the past. He described feeling as though he had been in a game where other people could read his thoughts and that the only way to get out was to end his life. Mr A also talked about believing that the television had been talking to him and that it had been linked to the CIA or MI5. STAR1 noted that Mr A's previous feeling that people were out to get him may have been legitimate, given his claim that he had been stabbed in the neck the previous year. STAR1 recorded that Mr A had a happy childhood (contrary to other reports) and that his relationship with both his parents (who were separated) was good. He reported that he had significantly cut down on his cannabis use and that he no longer heard voices. Mr A said that he had not taken any medication for seven days.
6 February 2014	At a multi-disciplinary team meeting it was agreed to accept Mr A on extended assessment (a three-month assessment at the end of which a decision is made about the diagnosis and whether or not the team should stay involved). The plan was to restart Mr A on a reduced dose of medication, olanzapine 10mg.
11 February 2014	EIT1, social worker with the Trafford early intervention team visited Mr A at Pomona Gardens. EIT1 noted that Mr A's flat had no electricity and was "very cold and untidy". Pomona House staff had told EIT1 that Mr A had been advised to use the office telephone to arrange for a free pack (containing duvet, towels etc) from Trafford Housing, but that Mr A had not done so. Mr A had also been encouraged to buy credits so that he had electricity but again he had not done so. It appears that there were no concerns that he could not afford to do so, because he had been collecting his benefit payments regularly. Mr A denied any psychotic symptoms and said that his mood had been "good and stable" and said that he continued to use about £10 of cannabis every two days. EIT1 asked Pomona House staff to support Mr A to register with a GP and arranged to see Mr A again on 20 February. EIT1 noted that Mr A had given permission to talk to his mother.
20 and 21 February 2014	Mr A did not attend appointments with EIT1 on 20 February and SGP2, staff grade psychiatrist, on 21 February. Mr A said that he had forgotten and had overslept. Mr A told EIT1 that he was not taking his medication because he had not registered with a GP so EIT1 asked Pomona Gardens' staff to support Mr A with registering with a GP surgery.
26 February 2014	On 26 February SGP2 and EIT1 visited Mr A at home. Mr A denied any psychotic symptoms and SGP2 noted that Mr A appeared tired. Mr A agreed to discuss increasing his activities and confirmed he would complete registration with a GP surgery later that day, as he had been having problems doing so. SGP2 recommended reducing the dose of olanzapine to 10mg. A follow up appointment was planned for 7 March and it was agreed that EIT1 would arrange structured activities. The following day SGP2 sent a fax to Cornbrook

	Medical Practice to request an urgent amendment to Mr A's prescription of olanzapine.
27 February 2014	Mr A's case was discussed by the early intervention team multi-disciplinary team at their meeting on 27 February. Staff discussed the fact that Mr A had not taken medication for three to four weeks and that it did not appear that he was experiencing psychotic symptoms. It was agreed that Mr A would be offered an extended assessment over six months.
18 March 2014	When EIT1 arrived for the appointment with Mr A on 18 March staff at Pomona Gardens told him that Mr A had admitted being less than truthful regarding his mental state for fear of being detained under the Mental Health Act. Mr A had been hearing voices and feeling paranoid, Mr A had argued with the voice that would make derogatory comments and kept him from sleeping at night. Mr A had told Pomona Gardens staff that he believed an exorcism would help him. Mr A reported that he had collected his medication two days' previously and that he was still using "weed". EIT1 offered a referral to support him with reducing his drug use but Mr A declined. Given this disclosure the early intervention team later decided to accept Mr A "fully" onto their caseload.
1 April 2014	At an appointment with early intervention team staff Mr A reported increased auditory hallucinations and said that he had been doubling his medication so had run out of medication four days previously. EIT1 arranged for Mr A's GP to call him later that day to discuss his medication. EIT1 also informed Mr A that a new care coordinator would be allocated because he would be leaving.
25 April 2014	EIT2 telephoned Pomona Gardens to introduce himself as Mr A's new care coordinator. Staff at Pomona Gardens reported no concerns regarding Mr A's mental state but EIT2 asked staff to ask Mr A to contact him because to Mr A's mobile appeared not to be receiving calls.
6 May 2014	EIT2 met with Mr A and arranged an outpatient appointment for 9 May. Mr A said that he would not be able to attend that appointment so EIT2 attempted to reschedule it. The earliest alternative appointment was not until 20 June and therefore EIT2 noted he would discuss the matter with CP3.
28 May 2014	SGP2 visited Mr A at home. In a letter regarding the appointment sent to Mr A's GP at Cornbrook Medical Practice SGP2 reported that Mr A lacked motivation and was still using cannabis which was causing increased paranoia. Mr A had reported that he continued using the drug because it made him more relaxed, however he was concerned about the impact on his mental health when he stopped using the substance. SGP2 advised that he had observed nothing to cause concern and that Mr A had a stable mental state with minimal residual psychotic symptoms. Medication to continue to be olanzapine 20 mg, support to continue to be provided by the early intervention team support worker and the team would assess Mr A's motivation to be referred to substance misuse services.

9 June 2014	EIT2 met with Mr A who reported that he had not taken cannabis for 11 days and was finding this hard but was able to think more clearly. Mr A reported he knew his medication was good for him and did not want to return to a psychotic state. Mr A appeared motivated and was progressing well, expressing an interest in applying for an apprenticeship in construction. Mr A felt that a referral to Phoenix Futures[24] (a drug and alcohol service) was unnecessary because he only drank occasionally and was not taking cannabis any longer. The Panel found no evidence that EIT2 sought to verify this information with Pomona Gardens staff.
July 2014	A month later EIT2 contacted Pomona Gardens staff to inform them he would be leaving the service and that a new care coordinator would be allocated to Mr A. (It is of note that this was the second care coordinator to leave in three months.)
23 July 2014	Mr A's new care coordinator was confirmed to be EIT3 who first met with Mr A on 23 July. At this time Mr A's tenancy at Pomona Gardens had been extended by two months and he had started bidding on properties. Mr A told EIT3 that he had stopped taking his medication three weeks previously and felt that he no longer needed olanzapine, although he would take it occasionally if he was unable to sleep. Pomona Gardens staff advised that Mr A had been aggressive to a member of staff, which was unusual behaviour for him.
24 July 2014	At the early intervention team multi-disciplinary team meeting it was agreed that EIT3 would identify if Mr A had collected his prescriptions from the pharmacy.
28 July 2014	EIT3 identified that Mr A was a temporary patient with his GP and his registration had expired on 4 June. The last prescription that had been issued was on 2 June and Mr A's behaviour was reported by the GP to be chaotic, therefore the GP had had presumed that Mr A had never taken his medication. PGSW1, support worker from Pomona Gardens, confirmed that Mr A had been using cannabis at least once a week.
30 July 2014	Staff noted that Mr A had become stressed about information being shared between PGSW1 and EIT3 prior to the previous appointment. PGSW1 advised Mr A about the usual arrangements for information to be shared between agencies. Mr A felt his daily gym commitment was sufficient and that it had a positive impact on sleep and physique. Mr A described feeling significant anxieties when he was outside of Pomona Gardens. Mr A said that he was concerned EIT3 would think he was crazy, and the voices that were present when he was anxious helped him to stay calm. Mr A told EIT3 that he did not want to take medication anymore because he had seen people who had been on medication for a long time and he did not want to be like them ("zoned out").

[24] *Phoenix Futures is a charity that supports people to overcome drug and alcohol problems. They provide residential, prison, community and specialist services.*

18 August 2014	Staff from Pomona Gardens contacted EIT3 to express concern that Mr A was deteriorating. Mr A believed he was possessed by the devil, throwing stones at people in the street, and had a fight with another resident. Pomona Gardens staff advised that they believed Mr A had gone to his mother's house, but they did not have her contact details to be able to check. EIT3 contacted Mr A's mother who said that she had not seen Mr A for two days at which time she was very concerned about him. EIT3 contacted the police to report Mr A as missing. EIT3 spoke to the police again who confirmed that if Mr A was found by the police he would be taken to a place of safety and that a Mental Health Act assessment would be completed if required.
19 August 2014	The following day (19 August) Mr A was taken to A&E at Manchester Royal Infirmary (he had been picked up following concerns about his mental health). However, Mr A refused to get out of the ambulance and because he was known to services in Trafford, he was taken to the Section 136 Suite in Trafford. Mr A was assessed under the Mental Health Act and detained on Section 2. Mr A presented as confused, distracted and thought disordered. He was unable to recall attending A&E and told staff "My life has been going for ages, everything is like a film". Mr A reported experiencing tactile hallucinations, and hearing voices telling him to punch other people. Mr A said he felt medication was not important to him because it "slowed him down". When staff questioned Mr A about throwing stones he reported "my arm felt soulful…everyone is connected to me". Mr A was admitted to Brook Ward, Moorside Hospital where the plan was noted to be: • nursed on level three (general) observations; • organise an ECG and possible referral to cardiology; • urine drug screen to be arranged; • olanzapine 10mg to be prescribed. Mr A told staff that he wanted help and that he had been "tipped over the edge by the murder last week as he knew the [perpetrator] and the person in hospital".
20 August 2014	Mr A gave permission for EIT3 to enter his flat to collect some belongings. EIT3 noted that Mr A's flat was unkempt and smelly. Mr A also gave permission for his mother to enter his flat in order to clean it, in accordance with the tenancy agreement. When Mr A spoke to his allocated nurse (WN1) he appeared restless and was incongruently smiling and laughing at times, his speech was delayed and his mood got worse when staff tried to discuss his family. The nurse also noted that Mr A appeared thought disordered but he denied any hallucinations. Mr A indicated that he had no intention of stopping using cannabis and he refused to engage with the risk assessment. Mr A described himself as "a paranoid schizophrenic".

	WN1 noted that staff needed to obtain a urine drug screen and that Mr A could use his as required medication when needed.
21 August 2014	Observations were increased to level two (every 15 minutes) in response to Mr A's agitated and confrontational behaviour. These were reduced again on 4 September. On 15 September Mr A's detention was reviewed and the Section 2 was converted to Section 3[25]. Medication was increased to olanzapine 20mg, with as required medication of lorazepam 1-2mg, haloperidol 5mg and procyclidine 5mg.
August to October 2014	Mr A's presentation varied over this time between being angry, agitated and highly stimulated to settled, calm and engaging. Ward staff recorded that it appeared that Mr A's presentation worsened when he had been using alcohol and illicit substances during periods of unescorted leave from the ward. Unescorted leave from the ward was withdrawn on these occasions and then later reinstated. The Panel considered the withdrawal of leave to have been appropriate.
20 October 2014	Ward staff spoke with staff from Pomona Gardens who advised that Mr A's tenancy was due to end on 18 January. It was noted that whenever Mr A was discharged from hospital, he would only be able to stay at Pomona Gardens until then. Pomona Gardens staff suggested that Mr A's tenancy be terminated whilst he was an inpatient, because this would enable him to apply for another tenancy when he was discharged. Ward staff discussed this with Mr A who said that he did not wish to end his tenancy early and staff noted that Mr A felt aggrieved that things appeared to be being arranged behind his back.
24 October 2014	A medical report prepared by SGP2 stated that Mr A had an "established diagnosis of paranoid schizophrenia". His medication at that time was olanzapine 5mg daily, diazepam 4mg daily and risperidone 4mg daily.
28 October 2014	A meeting was held on the ward with Mr A, ward staff and staff from Pomona Gardens. Mr A was advised that his tenancy agreement had been terminated on 20 October because the end date of the last licence had passed whilst he was in hospital. Pomona Gardens staff advised that when Mr A had a clear discharge date his housing needs could be reassessed, and a new housing application made. The immediate consequence of this was that Mr A was not able to go on Section 17 leave because staff believed that the leave destination was specified as Pomona Gardens (it was later clarified that this was not the case).
20 November 2014	On 20 November ward staff noted that Mr A had completed a housing application with support from ward staff.

[25] *Section 3 of the Mental Health Act allows for a patient to be detained in hospital for up to six months and to be treated without the patient's consent, with approval from a second opinion approved doctor.*

December 2014	In early December Mr A was informed that he had been placed on the waiting list for a flat at Pomona Gardens. Early intervention team staff had started discussing Mr A in their multi-disciplinary team meetings in preparation for his discharge from hospital. They noted that they expected to hear within one to two weeks regarding a tenancy start date. Over the next couple of weeks Mr A was given unescorted community leave for six hours a day, and often would return late and heavily intoxicated.
23 December 2014	On 23 December Mr A was discharged from Section 3 and the ward to Pomona Gardens and it was noted that the early intervention team would complete the seven-day follow up. The discharge summary stated that Mr A's diagnosis was paranoid schizophrenia and his medication was risperidone 4mg. It is not clear to the Panel when Mr A's medication was changed because the Panel found that ward round records and progress notes did not always specify exactly which medication Mr A was or was not taking. Mr A appeared to settle well at Pomona gardens and staff there reported no concerns about his mental state.
2015 – Trafford Early Intervention Team, Home-based Treatment Team and hospital admissions	
January 2015	In January EIT2 (a previous care coordinator for Mr A working in the Trafford early intervention team) met with Mr A who reported to be happier now he was living in the community. EIT2 noted that Mr A continued to smoke small amounts of cannabis but there was no evidence of psychosis or low mood. Mr A said that he had run out of medication so EIT2 advised Mr A to contact his GP to collect a prescription. EIT2 spoke to the team consultant psychiatrist (CP3) to arrange for a prescription for risperidone for the following two weeks. EIT2 later took Mr A's medication to him because Mr A had not completed his registration with the GP practice and needed to do so.
February 2015	In February EIT2 supported Mr A to register at the GP practice. EIT2 informed the GP practice that Mr A's medication had not changed since discharge from hospital.
20 February 2015	A Care Programme Approach meeting was held when it was noted that Mr A had good insight but that his mood had been affected by the death of a friend. Mr A continued to use cannabis, but he was compliant with his medication. No delusional thoughts were recorded, and Mr A was working with support staff regarding a possible job through the Prince's Trust. Mr A's diagnosis was recorded as paranoid schizophrenia and although the notes indicate that he had been detained on Section 3 Mental Health Act there is no reference to Section 117 aftercare arrangements.
9 March 2015	EIT4 met with Mr A to introduce herself as his new care coordinator. Mr A said that he did not need any support at that time and that he had decided not to complete the Prince's Trust course as this was a repeat of something he had done previously. Mr A denied experiencing psychotic symptoms or low mood and said that his

	sleep and appetite were "fine". Mr A said that he was not bidding for properties nor seeking training or work at that time.
April 2015	In early April EIT4 spoke to Pomona Gardens staff who reported that Mr A had told them that he had not taken his medication for two months and that he was using approximately £120 of cannabis.
8 April 2015	EIT4 met with Mr A who reported that he had stopped taking his medication two weeks previously because he believed he no longer needed it. However, he reported experiencing recent paranoid thoughts and delusional beliefs. Mr A reported experiencing tactile hallucinations and said that he was concerned about these experiences. Mr A said he was happy to receive support from the early intervention team and Pomona Gardens but declined an appointment with psychology staff and declined support for his substance use. Mr A agreed to start budgeting better in preparation for moving accommodation.
9 April 2015	Staff at Pomona Gardens contacted early intervention team staff expressing concern about Mr A's non-compliance with medication and paranoid behaviours. It was noted that Mr A was in the urgent category for housing and would be supported to obtain any housing benefit. EIT4 noted she would review the decision by social services to prevent Mr A visiting his mother's home (a decision apparently made previously in order to protect Mr A's younger brother). Mr A reported that he had been using "spice" which he acknowledged may have contributed to his recent presentations.
29 April 2015	EIT4 contacted the Multi-Agency Referral and Assessment Team (MARAT)[26] at Mr A's request. The MARAT worker advised that there had been no involvement from children's services since 2010 and therefore Mr A could visit his mother's address, but he was not to have unsupervised contact with his younger brother due to Mr A's previous violent behaviour. EIT4 was advised to inform Mr A's mother of her (mother's) safeguarding responsibility to her younger son.
8 May 2015	CP3 saw Mr A again when Mr A reported that he had not taken his medication for two weeks but could not provide a reason. CP3 advised Mr A's GP to continue prescribing risperidone 4mg daily.
11 May 2015	Mr A was taken to Manchester Royal Infirmary A&E by ambulance after he had telephoned the police stating that he had thoughts of hurting other people. Mr A was talking about spirits and channelling power. On assessment by mental health liaison staff Mr A was glaring at staff and refused an informal admission to Moorside Hospital (the mental health unit provided by the Trust). It was therefore agreed that he would attend an appointment with CP3 the following morning and that an assessment under the Mental Health Act would be conducted. There was no evidence or rationale

[26] *The Multi-Agency Referral and Assessment Team (MARAT) is the 'front door' for Trafford's children and young people's service. MARAT accepts referrals for children and young people that are deemed to be in need of a certain level of support and undertakes child protection enquiries where appropriate. trafford.gov.uk*

	available to the Panel to indicate why a Mental Health Act assessment was not undertaken that day.
12 May 2015	Mr A did attend the appointment with CP3 and was accompanied by EIT4. Mr A denied experiencing any psychotic symptoms and CP3 made no changes to Mr A's medication. Mr A was also assessed by an AMHP and following this the relevant recommendations were made to detain Mr A under Section 2 Mental Health Act. Mr A absconded from the assessment and later returned to Pomona Gardens. Staff there contacted mental health staff and arrangements were made for police to attend in order to reduce the risk to clinical staff. Mr A initially refused to go to hospital and became agitated but was eventually conveyed to Brook Ward, Moorside Hospital by ambulance. On admission to Brook Ward Mr A was guarded and said that he had been admitted to hospital because he had told someone about his thoughts of "evil spirits". Mr A admitted to using 1g of amphetamine the previous day but refused to describe how often he used amphetamines.
13 May 2015	Mr A refused his medication and was aggressive and threatening towards staff. This resulted in him being restrained and he was administered haloperidol 5mg and lorazepam 2mg by injection. Mr A was then transferred to the psychiatric intensive care unit ward (at Moorside Hospital) and his mother was informed of the move.
14 May 2015	Mr A's urine drug screen tested positive for amphetamine, cocaine and marijuana.
15 May 2015	Mr A gave permission for EIT4 to access his flat to collect some of his belongings. It was reported that Mr A appeared to have slept well and that he felt calmer. Staff queried whether Mr A had experienced a bad reaction to the amphetamine he had taken. Mr A was informed of the concerns of staff at Pomona Gardens about his ability to manage independent living. Mr A said that he did not want to have long term supported living and that he wanted his own tenancy. EIT4 agreed to explore what options were available to him, to make a referral to occupational therapy and to apply for funding for creative support. Mr A appeared settled on the psychiatric intensive care unit and was generally compliant with requests from staff.
20 May 2015	It was noted that Mr A could be transferred back to an acute ward when a bed became available.
26 May 2015	A ward round meeting was held when the role of the home-based treatment team was discussed. Mr A reported that he felt frustrated because he had not had any leave whilst on the psychiatric intensive care unit. Staff noted that they had seen improvements in Mr A's mental state when he had been compliant with his medication. The plan was noted for three hours leave on three consecutive days and then overnight leave for the following three days (Friday to Sunday) with support from the home-based treatment team. It was also noted that Mr A's detention under the Mental Health Act was due to expire on 8 June and that if the periods of leave were successful Mr A

	would be discharged to the community directly from psychiatric intensive care.
30 and 31 May 2015	The visits by home-based treatment team staff on 30 and 31 May went ahead as planned and no concerns were noted.
1 June 2015	Mr A returned to the ward and was transferred to the acute ward. The following day Mr A was discussed in the ward round meeting when it was noted that he would be discharged from Section 2 and given a week's leave with support from the home-based treatment team. Mr A would be discharged from inpatient care the following week if his mental state remained stable. Medication at that time was risperidone 4mg.
4 June 2015	Staff from Pomona Gardens contacted EIT4 to express concern about Mr A. He had appeared to be under the influence of drugs the previous night and had not slept, he was restless and grimacing with a fixed stare, and expressing delusional beliefs. Mr A initially denied taking drugs but later admitted to taking amphetamines. He stated that his presentation was not caused by the drugs. EIT4 updated the home-based treatment team and Brook Ward (acute ward). EIT4 (early intervention team) and a member of staff from the home-based treatment team) met with Mr A later when Mr A reported that he had not taken any more drugs. Mr A also described being "connected to spirits", that they were "good" and they only told him to do good things.
7 and 8 June 2015	Four different home-based treatment team staff met with Mr A at home as part of the plan to support Mr A whilst on leave from the ward. Mr A denied any psychotic symptoms and said that he was sleeping and eating well. Mr A denied any more drug use and staff noted there was nothing of significance to report.
9 June 2015	On 9 June Mr A was discharged from inpatient care with input from the home-based treatment team and early intervention team staff. The discharge notification was completed and faxed to Mr A's GP.
10 June 2015	The home-based treatment team attempted to contact Mr A to arrange a seven-day follow up appointment. Mr A could not be contacted on his mobile so it was agreed that EIT4 would follow this up.
11 June 2015	Staff from the home-based treatment team made a "cold call" to Mr A at home. Mr A was heavily intoxicated with cannabis and staff were unable to engage with him because of this. Mr A said that he was mentally well and denied any psychotic symptoms or concerns stating that "I'm not feeling like killing someone now". Staff noted no evidence of risks to himself or others at that time.
12 June 2015	Mr A said he would not be at home for the appointment with the early intervention team. However, he did provide his mother's contact details so that the home-based treatment team could contact her to offer her a carer's pack.

15 June 2015	Home-based treatment team staff discussed Mr A in the multi-disciplinary team meeting when they noted that Mr A would be discharged from the home-based treatment team the following day.
17 June 2015	Mr A was aggressive and hostile towards staff and property at Pomona Gardens. The police and ambulance service were called, and Mr A was taken to A&E (it is not stated in the records which hospital) via ambulance after he had been hostile, aggressive and violent at Pomona House. Mr A had threatened to harm himself and others and alleged that he had a knife, although police later clarified that they had not found one on Mr A's person. Mr A left A&E before the on-call doctor and AMHP arrived. The following day EIT4 discussed the situation with CP3 who asked EIT4 to visit Mr A at home and to consider assessment under the Mental Health Act if Mr A continued to present as a risk to himself and others. When EIT4 visited Mr A he denied thoughts to harm himself or other people and said that he kept hearing voices saying "I'm here Son" and these voices made him cry. EIT4 recorded that Mr A had no overt psychotic symptoms and noted that the plan was for Mr A to: • abstain from amphetamines; • contact Phoenix Futures for support for substance misuse; • contact Pomona Gardens staff if he had any concerns about his mental health; • borrow money from his family in order to obtain electricity. Also, that Pomona Gardens staff to arrange a food parcel and require Mr A to pay for the damage he had caused. It was noted that there was no role for home-based treatment team at that time and that all of Mr A's risks were low but that they might increase with continued substance misuse.
25 June 2015	On 25 June Mr A was again under the influence of substances that meant that staff were unable to properly engage with him. Mr A reported having energy in his hands but denied any psychotic symptoms although staff noted he was laughing incongruently. Mr A agreed to meet Phoenix Futures for support with substance misuse.
26 June 2015	The early intervention team multi-disciplinary team meeting discussed Mr A's case. It was agreed that Mr A's crisis plan would be shared with Pomona Gardens staff so that they could share it with ambulance staff if required. It was noted that the crisis plan would also be shared with A&E staff. In addition, if Mr A were to be involved in any criminal offences in the future, a criminal behaviour order should be considered.
July 2015	Mr A continued to be under the influence of substances when meeting with early intervention team staff throughout July and was intermittently keen to live independently and keen to return to the structure of being in hospital. One consequence of this was that his

	priority status on the housing list was downgraded because of concerns about his ability to manage an independent tenancy. Mr A was to remain at Pomona Gardens until 22 December.
29 July 2015	Pomona Gardens staff contacted EIT4 to say that Mr A had asked to see someone from the early intervention team that day. When EIT4 arrived Mr A admitted that since his discharge from hospital he had heavily used spice, neglected his self-care and had not slept for several days due to the energy in his hands. Mr A said that he had been travelling to where his friend was killed at weekends and had experienced anxiety. Mr A also said that he felt possessed. Mr A said that he had been compliant with his medication, but stated that he had previously admitted to early intervention team staff that he had stopped taking it. Mr A said that he had access to guns and was unable to prevent himself acting on thoughts to shoot and stab people. Mr A agreed an informal admission to hospital and stated that Pomona Gardens was not a good environment for him, stating he wanted to distance himself from friends who used legal highs. Mr A agreed to admission to hospital (Brook Ward, Moorside Hospital) that day and on admission he was prescribed risperidone 4mgs and as required lorazepam and haloperidol.
11 August 2015	Mr A was given one week's leave and was expected to return to the ward on 13 August for a depot injection and the ward round meeting on 18 August. Mr A complied with both of these requirements and following the ward round meeting it was agreed that he would be discharged on 20 August and that he would have overnight leave until then. It was noted that risperidone would be stopped, and his care coordinator would organise for a depot injection to be given in the community. On discharge from the ward Mr A told staff at Pomona Gardens that he was not ready to engage with Phoenix Futures at that time. Staff at Pomona Gardens informed Phoenix Futures who in turn informed EIT4.
21 August 2015	Mr A received clopixol 200mg and was formally discharged from inpatient care.
25 August 2015	EIT4 met with Mr A who reported that he had felt sedated since the depot injection but also admitted that he had been using cannabis and synthetic cannabinoids; it was therefore unclear what the cause of his sedation was. Mr A declined any psychology input and spoke of spirits entering and leaving his hands and being able to see "entities". Mr A said that he would like to build up towards independent living.
14 September 2015	Mr A again presented as drowsy but denied any substance use prior to the appointment. Mr A asked EIT4 to complete a risk assessment for accommodation on his behalf because he did not wish to complete it. Mr A said that he was apprehensive about his accommodation but stated that he did not need support. However, Mr A did ask for some diazepam because he was "stressed out with his thoughts". EIT4 gave advice about the long-term use of diazepam and advised Mr A to see his GP. EIT4 also reminded Mr A

	of his appointment with CP3 on 15 October. EIT4 noted that the occupational therapy report and support and recovery plan would be sent to Creative Support[27] for their feedback.
September 2015	At meetings with early intervention team staff Mr A continued to present as under the influence of illicit substances throughout the rest of September.
15 October 2015	On 15 October CP3 met with Mr A who was supported by staff from Pomona Gardens. CP3 recorded Mr A's diagnosis as query paranoid schizophrenia and mental and behavioural disorder due to multiple drug use. CP3 advised that Mr A should attend Moorside clinic for his fortnightly depot injection and asked Mr A's GP to prescribe procyclidine 5mg twice daily. The plan for Mr A's accommodation was discussed and it was noted that Creative Support was unable to meet the needs of Mr A. Mr A agreed for a referral to Bedspace[28] which was completed that day. Mr A was prescribed procyclidine.
November 2015	Mr A refused to accept his depot injections in November.
16 November 2015	When EIT4 met with Mr A Mr A said that he had felt more motivated since he had stopped his depot injection. It was reported that Mr A had been shopping and tidied flat and that he had not used spice for two weeks. EIT4 noted Mr A had no delusional thoughts and there were no risks. EIT4 indicated that an appointment would be arranged with CP3 and a pre-panel discussion to explore Mr A's accommodation options.
19 November 2015	On 19 November Phoenix Future advised that they would not be offering support to Mr A because he did not wish to make changes to his drug use. Phoenix Futures suggested that EIT4 make a referral to Blu Sci, an organisation providing activities and support to young people with mental health needs. EIT4 later discussed Mr A's case in the multi-disciplinary team meeting. EIT4 advised that Mr A did not want to see anyone else until CP3 was available and expressed concern that this would mean he would be unmedicated for four weeks.
25 November 2015	EIT4 supported Mr A to attend his appointment with Bedspace when it was noted that new accommodation would be available on 7 December. EIT4 recorded that Mr A engaged well and that there had been positive changes to his mental state since he stopped taking synthetic drugs. The following day EIT4 received confirmation of the funding for Mr A's support by Bedpsace.
7 December 2015	Pomona Gardens staff contacted EIT4 expressing concerns that Mr A was displaying signs of relapse. When EIT4 saw Mr A later that day he was staring into space and was grinding his teeth, had a fixed stare and was holding his hands in an unnatural position. Mr A denied using drugs and declined support that evening. EIT4 spoke to

[27] *Creative Support is a charitable organisation that promotes the independence, inclusion and wellbeing of people with care and support needs.*

[28] *Bedspace is an organisation that provides accommodation and support to vulnerable people.*

	Mr A's mother who said that she would try to support Mr A in his new accommodation over the following few days. However, the following day Mr A arrived at Pomona Gardens in the early hours of the morning demanding to be let into his old flat.
10 December 2015	EIT4 spoke to Mr A's mother who stated that Mr A had been behaving bizarrely. CP3 offered Mr A an appointment later that day which was also attended by EIT4. Mr A said that he was "telling them what they wanted to hear", declined a referral to psychology and stated he wanted to remain medication free. Mr A also minimised the concerns expressed by Pomona Garden staff and his mother. A support plan was made with Bedspace who also agreed to support Mr A to register with a GP.
15 December 2015	Mr A's mother telephoned EIT4 to express concerns about Mr A stating he "was going to kill someone". Mr A's mother had been advised by out of hours staff to take Mr A to A&E, but Mr A had refused to go to hospital and Mr A's mother did not want to leave him on his own. EIT4 advised she was due to see Mr A later that day and Mr A's mother should call the police if she had any immediate concerns. Later that day EIT4, an agency worker from the early intervention team and a member of staff from Bedspace met with Mr A in his flat. The flat was untidy, and Mr A had broken a mirror in anger. There had been a number of complaints about Mr A's behaviour but when these were discussed Mr A smiled and minimised the incidents. However, he did agree to a referral to the home-based treatment team. EIT4 recorded that she had seen empty packets of synthetic drugs in Mr A's flat and that she had given him advice about the impact of these on his mental health.
16 December 2015	After a Mental Health Act assessment was arranged the following day, Mr A agreed to an informal admission and stated, "I am hearing voices, I got angry at the lady who looks after me". He was admitted to Brook Ward at Moorside Hospital. On admission Mr A refused to allow for bloods to be taken or for a physical examination to be conducted and would not engage in conversation stating, "You guys aren't doing anything to me". It was agreed that Mr A's risk level would be determined following assessment and that day staff would review his medication. Mr A would be managed on general observations and would have to be escorted when leaving the ward.
19 December 2015	Ward staff agreed that Mr A could have unescorted leave off the ward for up to 30 minutes and that a urine drug screen should be completed on his return to the ward. It was noted that if Mr A did not return, the doctor on duty and police were to be informed.
23 December 2015	Mr A refused his depot injection and admitted to using cannabis. Ward staff noted that if he continued to refuse his depot injection Mr A should be placed on Section 3 Mental Health Act.

25 and 26 December 2015	On 25 and 26 December the on-call doctor was asked to review Mr A because of concerns about his use of illicit substances. The plan was to continue four hourly physical observations and hourly checks. It was noted that Mr A would continue to have unescorted leave off the ward. On the evidence above the Panel is unclear why Mr A's leave was not revoked, given his use of substances. Mr A continued to appear under the influence of illicit substances until 29 December.
31 December 2015	Mr A said that he wished to leave the ward. It was noted that he was an informal patient and therefore discharge was agreed. The plan was for the early intervention team to follow up within seven days and it was noted that Mr A did not require medication on discharge because he was receiving depot injections. Mr A's discharge notification recorded his diagnosis as paranoid schizophrenia and advised that his medication was fortnightly depot injections to be administered at Moorside Hospital by community staff.
January to August 2016 – multiple inputs from Trust teams, police, and other agencies	
4 January 2016	An early intervention team worker (EIT5), received a telephone call from Mr A's mother expressing concerns about his behaviour. EIT5 contacted Mr A who was tearful and said he was under a lot of pressure. An urgent appointment was offered but Mr A declined it. EIT5 noted he planned to complete a joint visit with Bedspace staff the following day. However, it appears that the joint visit did not take place until 6 January (two days later).
6 January 2016	Mr A attended an appointment for his depot injection an hour early and in an agitated state. Initially he agreed to have the injection only if it was self-administered but he later agreed to staff administering the depot. Later that day a joint visit took place between EIT5, and a support worker (BSW1) Bedspace. Mr A admitted to hearing voices but said they were positive and were not distressing him. He denied using illicit substances prior to the appointment. Mr A was given advice about his diet, because he was eating mostly fast food. It was noted that BSW1 would support Mr A to register with a GP and provide Mr A with seven and a half hours of support over two days. The plan was for the multi-disciplinary team to discuss Mr A's case and for a further joint visit to take place later that week (8 January).
15 January 2016	We can find no evidence that the joint visit took place on 8 January, however on Friday 15 January EIT5 visited Mr A because he had not seen him since the previous week. Mr A had three visitors in his flat so EIT5 did not enter the property. However, EIT5 noted that Mr A's eyes were glazed so it was "very apparent" that he had used substances.
20 January 2016	Mr A did not attend his appointment for his depot injection. Mr A's case was discussed at the early intervention team meeting when it was noted that staff needed "to be careful when visiting him" and that joint visits only should take place.

22 January 2016	Early intervention team staff attended Mr A's property but were unable to see him. The doors to his flat were locked; the windows were shut and curtains drawn.
26 January 2016	Early intervention team staff (EIT5 and STAR2, support time and recovery worker) visited Mr A at home. Mr A asked why they were at his flat and appeared aggressive and irritable. Mr A was given the option of talking with staff then or attending the team base that Friday. EIT5 noted that it appeared that Mr A was still using illicit substances and that he did not want visitors to his flat because of this. It was considered that Mr A was unlikely to be compliant with the depot injection and that staff should always visit in pairs, because of Mr A's continued use of substances. It is the view of the Panel that this should have triggered an assessment for detention on Section 3 Mental Health Act.)
29 January 2016	EIT5 and STAR2 met with Mr A. It was noted that another male was living at Mr A's flat but also that Mr A appeared not to have used any drugs because he was bright in appearance. Mr A asked that visits took place at his home and agreed to depot injections. Staff noted that Mr A had some insight into his mental illness but that his risk was high when he was unwell and using drugs.
February 2016	In February EIT5 and STAR2 met with Mr A at home on two occasions. EIT5 administered Mr A's depot injection on 12 February. On 24 February Mr A did not attend for his depot injection so EIT5 visited him at home two days later to administer the injection.
8 March 2016	Mr A attended a police station and reported that he had committed a crime. He appeared distressed and was convinced he had done something wrong. The police contacted Mr A's care coordinator who advised taking Mr A to A&E at Trafford General Hospital. Mr A was then assessed by the mental health liaison team and an informal admission was agreed. (It is not clear to the Panel from the available evidence whether staff formally considered whether Mr A had capacity to agree to an informal assessment). Mr A was restless and unsteady and appeared to be under the influence of substances which he later admitted. The plan was for Mr A to be nursed on ten-minute observations and to be escorted when leaving the ward. A full physical health check, bloods and an ECG would be arranged when Mr A was less agitated. Mr A was prescribed lorazepam 2mg and it was noted that day staff would need to monitor a rash under Mr A's eye.
9 March 2016	The following day Mr A's urine drug screen tested positive for cannabis, benzodiazepines and amphetamines. He continued to appear under the influence of drugs expressing delusional beliefs and focussing on his hands. Mr A was discussed in the early intervention team multi-disciplinary team meeting when it was noted that the police had confirmed that they were unable to substantiate Mr A's confession. It was agreed that EIT5 would attend the ward round meeting.

10 March 2016	Mr A was administered as required medication because he appeared to be agitated and chaotic and he had told staff that his "eyes are burnt out because of spirits". CP4 (the ward Consultant Psychiatrist) reviewed Mr A and advised that nursing observations should continue, and that Mr A should not be allowed any leave, consideration should also be given to conducting a Mental Health Act assessment should Mr A wish to leave the ward. Despite this plan, the following day Mr A requested unescorted leave, that was approved.
12 March 2016	Mr A was detained on Section 5 because he attempted to leave the ward and was threatening violence towards staff and asking to leave.
14 March 2016	Section 5 was rescinded and escorted leave was agreed.
16 March 2016	It was agreed that Mr A would not be detained, and that staff would plan to discharge him.
17 March 2016	Mr A was discussed in the ward round meeting. Mr A's diagnosis was recorded as paranoid schizophrenia and medication was noted as zuclopenthixol decanoate 200mg (depot injection) fortnightly. It was agreed to discharge him from inpatient care and noted that his care coordinator would conduct the seven-day follow up appointment. Mr A's discharge notification indicated that his diagnosis was paranoid schizophrenia and that his medication continued to be depot injection to be administered fortnightly.
23 March 2016	It was noted that consideration should be given to arranging a forensic assessment for Mr A.
24 March 2016	Mr A refused to accept his depot injection and appeared to be under the influence of drugs.
30 March 2016	EIT5 made a joint visit to Mr A with EIT5 and two other members of staff from the early intervention team, Mr A refused to accept his depot injection (at the suggestion of a male visitor present at Mr A's flat).
6 April 2016	On 6 April BSW1 contacted EIT4 to express concerns about Mr A's mental state. BSW1 stated that Mr A had a large number of unknown male visitors in the property and that Mr A had told her that he was not accepting his depot injection and this was causing him to hear voices and experience hallucinations.
7 April 2016	The issue of following up on arranging a forensic assessment was discussed in team meeting on 7 April but the Panel has not seen any evidence that the possibility of a forensic assessment was discussed any further, or that a request for a forensic assessment was made.
8 April 2016	Mr A told EIT5 and EIT6 (a worker in the early intervention team) that he was still using "weed" and that he believed there were ghosts in his property which initially scared him but he "was now at peace with them". Mr A again refused his depot or alternative medication because it made him "feel paranoid" and he found the injection

	painful. Despite the information Mr A gave early intervention team staff recorded there was nothing to indicate an increase in Mr A's risks.
14 April 2016	Mr A attended an appointment with CP3. Mr A said that he continued to use cannabis but spoke confidently about stopping drug use. Mr A again refused a depot injection and CP3 did not offer alternative medication due to Mr A's continued drug use.
27 April 2016	On 27 April the early intervention team multi-disciplinary team meeting noted that Mr A had stopped taking all medication and there were concerns about Mr A's presentation. . Although from the records available to the Panel there was no evidence of any medication being prescribed at this point. It was agreed that EIT5 would visit Mr A to review his mood and to try to prevent admission. When EIT5 arrived at Mr A's home Mr A challenged the reason for staff visiting, raised his voice and stated there were no concerns.
29 April 2016	EIT5 and EIT7 (early intervention team staff member) attempted to meet with Mr A. Mr A had recently relapsed and was taking illicit drugs which was impacting on his behaviour. Mr A did not answer the door and there was no movement from inside his flat. Shortly after this STAR2 recorded that he had been approached by someone whom he believed at the time to have been Mr A's mother who reported that when she went to Mr A's flat recently she had found a large amount of amphetamines and a chainsaw. She had destroyed the amphetamines by flushing them down the toilet. STAR2 informed the police who stated that there were no grounds to visit Mr A because it was not illegal to own a chainsaw. The reason for Mr A to have need for a chainsaw seems not to have been considered, nor the fact that he had a history of violence and was unmedicated.
3 May 2016	EIT4 contacted Mr A's mother who said that she had not met with STAR2 the previous week and that she knew nothing about the chainsaw. (Despite later attempts to clarify who this person was, staff were unable to do so.) Mr A's mother informed EIT4 that Mr A was taking drugs again and had beaten up his friend who was staying with him. Mr A's mother was unable to provide further details and said that the incident had not been reported to the police. She did say that she had seen Mr A the previous day and that he had appeared paranoid. EIT4 completed a safeguarding adult referral and EIT6 liaised with the police regarding Mr A's welfare. EIT6 recorded that the police had seen Mr A and he appeared to be safe and well. Bedspace staff were advised not to visit the property until there was further clarity on the issues.
5 May 2016	EIT7 and two of Mr A's support workers from Bedspace visited Mr A's property. Mr M1 was advised that Mr A was not at home and that Mr A's boiler was being repaired. The property was checked and no chainsaw found. Mr A's support workers from Bedspace remained concerned about Mr A's mental health, he had expressed delusional thoughts about the television, paranoid thoughts and was

	suspicious. Bedspace staff were also concerned about the number of strangers being granted access to the property, and continued drug use.
6 and 9 May 2016	Staff attempted to visit Mr A at home on 6 May and 9 May, but Mr A was not at home. Staff called Pomona Gardens and spoke to staff there who reported that they had seen Mr A the previous Sunday when he had been visiting a resident for food. Pomona Gardens staff also expressed concerns about Mr A.
12 May 2016	On 12 May EIT4 received a telephone call from Bedspace staff who reported that when workmen had entered Mr A's property to repair the boiler, several large knives and a large petrol chainsaw were seen. There were also empty cannabis and legal highs packages and approximately £180 in cash. Mr A had declined to answer any of Bedspace staff's questions throughout the visit. The following day early intervention team staff informed the police about the weapons seen at Mr A's flat by Bedspace staff. Police advised that a marker might be placed on Mr A's property.
May 2016	Early intervention team staff continued to attempt to meet with Mr A throughout May but Mr A was unwilling to engage.
16 June 2016	On 16 June Mr A4 received a call from BSW1 stating that Mr A had presented as distressed, hearing voices and had smashed a bottle against the wall. EIT8 (early intervention team staff) and EIT4 attempted to visit Mr A but he did not answer the door. EIT8 contacted Mr A's mother who agreed to update the early intervention team about Mr A's welfare and reported that Mr A had mentioned having issues sleeping and nightmares relating to a friend that had died. EIT8 later received a further update from Mr A's mother stating Mr A "sounded odd... and had concerns that [Mr A4] was gay". Mr A's mother agreed to contact the police if she had any concerns about the safety of Mr A or the public. BSW1 told early intervention team staff that Mr A was suspicious of his family and that he was receiving no respite from the voices. BSW1 also said that Mr A had used a knife to wave the voices off, had punched a hole in the wall and had smashed the television.
18 June 2016	Mr A's mother telephoned the out of hours team to report that Mr A had taken an overdose of 79 paracetamol tablets. Mr A had told her that he wanted to die and that he could not live with hearing voices. It appeared that Mr A believed his mother was putting voices in his head. Mr A had refused medical treatment but the out of hours team arranged for ambulance and police attendance. EIT9 (early intervention team staff) and EIT10 (early intervention team community mental health nurse) attended Mr A's property where they saw that Mr A was suspicious of his mother and staff and that he had become verbally aggressive. Mr A had a knife on the floor next to where he was sitting, he was holding his stomach and appeared yellow in places. Mr A had cut his legs and EIT10 noted that the wounds looked about a week old. Mr A reported that he had taken the paracetamol two days previously. Mr A was taken to

	hospital by ambulance and EIT10 informed the mental health liaison team at Salford hospital.
19 June 2016	Mr A was taken to the emergency department (by now it was 19 June) at Salford hospital where he tried to hit staff with a fire extinguisher and drip stand and broke a computer. Mr A presented as paranoid and believed that people were calling him gay and a woman abuser. Mr A became agitated and threatened physical violence upon his mother when she arrived at the unit. Mr A was restrained, and lorazepam and haloperidol were administered following advice from on call psychiatrist. Mr A became tearful stating "I need to die, why won't you let me die". Attempts to undertake a Mental Health Act assessment were unsuccessful because Mr A was asleep. Therefore, staff were advised to detain Mr A under S5(2) and to request a Mental Health Act assessment from day staff. Mr A was to be treated on a medical ward until the ten-hour Parvolex[29] treatment was complete, and his mother would remain on the ward until Mr A's treatment started. However, Mr A left the emergency department before he could be transferred to a medical ward. Mr A was reported as a missing patient and it was noted that Mr A's mother would look for him and encourage him to return to hospital. Mr A was located and returned to hospital.
20 June 2016	A further attempt to conduct a Mental Health Act assessment was unsuccessful because Mr A was asleep. Again, a further attempt was planned for the following day. It is the view of the Panel that by this time ward staff could have been asked to ring when he woke up rather than leaving it until the next day.
21 June 2016	It was noted that Mr A had experienced delusional thoughts and "colourful energies and spirits". He had also experienced hallucinations about his friend dying and had heard derogatory voices. The experiences caused him to feel low and led to the overdose. Mr A said that he was not intoxicated when he stole the paracetamol and that he had hoped he would die in his sleep. However, his mother had found him later that day being sick and had called the emergency services. Staff noted that Mr A's presentation was in keeping with drug-induced psychosis. A junior doctor considered that Mr A could maintain his own safety and had capacity to decide to go home, but this would be discussed with the home-based treatment team because it was unclear whether the home-based treatment team could manage Mr A's risks. It was noted that Mr A would be reassessed once the parvolex treatment had finished and he was not sedated with lorazepam. Later that day Mr A demanded that his drips were removed and contacted his mother to ask her to pick him up. Mr A told clinicians treating him to "let him die". Mental health liaison team staff assessed Mr A and determined

[29] Parvolex contains acetylcysteine which is used for the treatment of paracetamol overdose. Parvolex protects the liver from damage by the high levels of paracetamol and is very effective when given during the first eight hours after a paracetamol overdose. The effectiveness reduces as the time interval increases, but it can still help when given up to 24 hours after the overdose.

	that he lacked capacity and therefore he was detained under the Mental Capacity Act/Deprivation of Liberty Safeguards[30].
22 June 2016	Mental health liaison team staff discussed with his mother the risks of Mr A being treated in the community. It was agreed to discuss admission to a mental health unit once Mr A had completed his physical health treatment. Mr A had an abnormal liver function and he had been seen pulling out his drips. Again, the possibility of using the Mental Health Act was considered if Mr A did not agree to admission. Mr A's mother contacted EIT4 to express concerns about Mr A being discharged home to receive community treatment. EIT4 advised that the mental health liaison team at the general hospital was due to review Mr A.
23 June 2016	On 23 June Mr A again left the hospital and was later returned to the emergency admissions unit. It was alleged that he had withdrawn money and had texted his mother to say that he was going to kill himself. A Mental Health Act assessment was arranged, and Mr A was detained on Section 2 Mental Health Act.
24 June 2016	A bed was later identified on Brook Ward, Moorside Hospital where Mr A was admitted on 24 June. Mr A was aggressive and abusive towards staff and refused as required medication. The admission paperwork is not consistent about Mr A's legal status. It refers to the fact that he was admitted on Section 2 Mental Health Act but records that he is an informal patient.
26 June 2016	A referral to the psychiatric intensive care unit was made because Mr A continued to go absent from the ward and present as intoxicated by illicit substances. Mr A was transferred to the psychiatric intensive care ward at 1:00pm on 27 June because of his risks to others and himself. Mr A again absconded from the psychiatric intensive care ward at about 3:00pm by climbing the perimeter fence/wall. Staff informed the police and Mr A's mother. Mr A was returned to the ward at about 8:30pm by police. Inpatient staff advised that two members of staff would accompany Mr A on his cigarette breaks. Mr A's diagnosis was recorded as schizophrenia and his medication was depot injection fortnightly and clonazepam[31] 0.5mg twice daily.
4 July 2016	It was noted that the prescription for clonazepam would stop and that Mr A would have one week's leave from the ward with support from the home-based treatment team.
7 July 2016	Ward staff liaised with EIT4 about Mr A's presentation upon return to the ward. EIT4 agreed that although he had not engaged with the home-based treatment team he could go back out on leave. Mr A said that he wanted to remain on the ward because he struggled with living in the community. EIT4 felt that Mr A would benefit from

[30] The Deprivation of Liberty Standards (DoLS) are part of the Mental Capacity Act and aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

[31] Clonazepam is used to prevent and control seizures, it is also used to treat panic attacks.

	an appointeeship and indicated she would discuss this with Mr A and his family.
10 July 2016	Mr A returned to the ward smelling of cannabis. He reported that his leave had not gone well. Ward staff witnessed Mr A behaving suspiciously with other patients and encouraged Mr A to remain on the ward. Mr A's medication at that time was procyclidine and lorazepam in addition to the fortnightly depot injection.
11 July 2016	A decision was made to discharge Mr A from the ward, but it was noted he should not be informed of the plan until all support arrangements were in place. Mr A was discharged, and a seven-day discharge meeting was planned for 12 July with EIT4. Mr A was not prescribed any oral medication. It was agreed that Mr A would have once weekly support from the early intervention team Bedspace staff.
12 July 2016	Mr A was not at home for the appointment with EIT4.
13 July 2016	Mr A contacted EIT4 in a distressed state because his GP would not prescribe any medication following his urgent appointment. EIT4 also received a call from Mr A's mother reporting that Mr A was unable to stay still, was highly irritable and had a tremor in his hands. Mr A told his mother that he wanted codeine for an overdose or he would source the drugs elsewhere. Mr A's mother said he had contacted his grandparents, aunts and uncles requesting sleeping tablets and money. Mr A's mother said was extremely concerned because she was due to go on holiday and was unable to support her son. EIT4 noted that she would discuss Mr A with CP3 in the multi-disciplinary team meeting, that an urgent review would be arranged, and she would consider a referral to the home-based treatment team. EIT4 also noted that Mr A was at high risk of suicide. The home-based treatment team undertook a joint assessment with the early intervention team and concluded that input from the home-based treatment team was not required because Mr A was reluctant for their involvement. EIT4 contacted Mr A's mother to advise that they had no urgent concerns about Mr A and that a referral to Trafford Extended Services would be offered to Mr A.

21 July 2016	Mr A squared up to a member of staff in public stating "you hurt me in a restraint". Mr A attempted to intimidate the member of staff and another patient but appeared intoxicated and almost got hit by a car. Mr A was aggressive and screamed at the driver. The member of staff informed the hospital ward who then notified EIT4 and the police. EIT4 called Mr A who said that prison was the only place to get him off drugs and that he was on his way to the police station to hand himself in for robberies but did not provide EIT4 with any details of the offences. EIT4 later contacted Mr A who said that he was feeling calmer and agreed to meet EIT4 at Phoenix Futures the following week. Mr A said he was hopeful that he would get placement at the substance misuse rehabilitation unit. EIT4 contacted the Chapman Barker Unit (substance misuse rehabilitation unit) and was advised that they had a ten-week waiting list.
28 July 2016	EIT4 called Mr A to advised that Phoenix Futures were waiting for a response from the Local Authority regarding funding for the rehabilitation placement and that it was expected that a plan would be available the following week. Mr A was informed that he could access the day service support prior to this if he experienced withdrawal symptoms.
2 August 2016	EIT4 visited Mr A at home, his flat smelled strongly of cannabis and there were at least two people in his bedroom. Mr A admitted he was under the influence of cannabis and said that he had fallen out with his uncle and grandfather following their challenge on his bizarre gestures. Mr A reported that he had experienced physical withdrawal symptoms from alcohol but declined medication for this. He said that his drug debts were about £300-£400 and that his dealer refused to supply him with any more. EIT4 advised that there was not yet an outcome on Mr A's application for rehabilitation and Mr A then got upset stating he did not want to go to a rehabilitation unit where there were patients with mental health issues as he did not have an issue with mental health. Mr A denied experiencing any psychotic symptoms.
4 August 2016	Mr A met with CP3 who noted that Mr A did not appear to be under the influence of any substances nor did he display any unusual behaviour. Mr A said that he was keen to obtain a place on the rehabilitation programme and that he continued to use alcohol and cannabis daily. CP3 noted that Mr A only experienced psychotic behaviour when he was under the influence of substances.
5 August 2016	The following day Mr A told EIT4 that he would do something to send him to prison if he did not enter a rehabilitation unit soon. EIT4 noted that Mr A's behaviour had been escalating and that there was no plan to manage it.
10 August 2016	EIT4 completed the referral to Chapman Barker. The plan was for a three-week admission for alcohol detoxification, assess Mr A for Pabrinex, monitor his withdrawal from illicit substances, and monitor mental and physical health. EIT4 noted that when the admission had ended Mr A would be discharged to his home address, have one-to-

	one sessions with EIT4 and receive support from Phoenix Futures and Bedspace.
11 August 2016	The following day Mr A did not attend his appointment with EIT4. Mr A stated there was no point attending this appointment, as they were not finding him a residential rehabilitation placement fast enough. EIT4 noted she would chase the referral to the Chapman Barker Unit and meet with Neighbourhood Police to discuss Mr A's management if he continued to offend.
17 August 2016	EIT4 met with Neighbourhood Police in order to discuss a management plan should Mr A come into contact with the police. EIT4 updated the police regarding Mr A's diagnosis and advised that Mr A should be taken to a custody suite following any future offences. Contact details for the early intervention team and Mr A's mother were confirmed. The police advised EIT4 of local training courses Mr A could take. The same day EIT4 received notification that Mr A had been accepted by the Chapman Barker Unit for a three-week detoxification admission. It was noted that EIT4 would shortly be going on annual leave for two weeks.
18 August 2016	EIT4 and a member of staff from Bedspace visited Mr A who stated he was too tired to be seen. EIT4 left the course information for Mr A and agreed to talk on the telephone later that day regarding cover during her annual leave. When EIT4 called Mr A he reported that he had reduced his alcohol and cocaine intake however he had continued to use cannabis daily. Mr A advised he may not require the detoxification admission but agreed to wait for an assessment. Mr A said he was interested in exploring the intuitive recovery course and denied any concerns.
23 August 2016	Mr A's mother called the out of hours service to report that Mr A's neighbour had heard Mr A responding to voices in his head. Mr A's mother and her partner were advised that the community mental health team could not help at that time. Community mental health team staff began to give Mr A advice regarding crisis pathways however the call was disconnected after a confrontation.
31 August 2016	EIT11 (early intervention team staff) called Mr A who reported no concerns and sounded upbeat. Mr A said that he had company and declined a home visit.
September 2016 – assault on mother	
8 September 2016	EIT4 attended Mr A's flat with staff from Bedspace. Mr A did not answer the door so EIT4 tried calling his mobile. Mr A answered and said that there was an alien in his basement, which was why he was out at a friend's house. Mr A confirmed he was under the influence of substances. Mr A asked EIT4 to call him the following day and said that he would think about going to his course the following week. EIT4 spoke to Mr A's mother who reported that Mr A had been abusive to her the previous day.
19 September 2016	IRC1 (Leader, Intuitive Recovery Course) called EIT4 to report that Mr A had attended two sessions on the course but was struggling to

	focus in a classroom setting. IRC1 advised that Mr A would benefit from one-to-one support. EIT4 telephoned Mr A who confirmed he would like to complete the course with one-to-one support due to issues with concentration. Mr A reported feeling fed up and denied any concerns. EIT4 then telephoned Mr A's mother who advised her son had been visiting her for meals because of a lack of money and that he seemed stressed. Mr A's mother asked if more suitable accommodation could be found for Mr A with floating support available.
23 September 2016	EIT4 contacted Mr A's mother who expressed concerns about Mr A's behaviour because he had been crying a lot and he had approached his 14-year old brother in the street and started hitting him stating "this is for Dad". It was noted that Mr A's brother did not want to press charges. EIT4 advised she would contact the multi-agency referral and assessment team. EIT4 then contacted Mr A who said that he did not want to see anyone official as they were all trying to send him to prison (Mr A was waiting for a court appearance for being drunk and disorderly). Mr A agreed to access out of hours telephone support or attend A&E if required. EIT4 noted that Mr A's risk factors were increased due to his stressors.
26 September 2016	Mr A's mother contacted the early intervention team (EIT12) to report concerns about Mr A. Mr A's mother said that she had not seen Mr A because of his presentation however she had had received abusive texts saying "I wish you die in your sleep tonight" and "I want to die but I can't do it myself". Mr A's neighbour had reported to his mother he had been shouting in his flat and his bedroom window had been smashed. EIT12 telephoned Mr A who was initially defensive and stated he could not provide any details about his weekend except that a brick had been thrown through his window and that he was distressed and upset about what had happened over the weekend. EIT12 noted she would contact Bedspace to secure the property and arrange a joint visit for later that day. Mr A later said that he did not want to stay at his flat so was going to see a friend. Mr A refused to give details and said he could "look after himself". Mr A agreed to phone or text if he wanted a visit. Later still EIT12 contacted Mr A again whose speech was slurred but he denied alcohol or substance use. Mr A said he was not sure how he was going to keep himself safe that night but that he knew how to seek support. EIT12 contacted Mr A's mother with an update.

27 September 2016	EIT4 contacted Mr A who declined an offer of a visit but gave permission for EIT4 to contact his mother and his solicitor to support the court process (Mr A was due to answer bail on 11 October). Mr A was evasive when asked about his mental health and current mood. When EIT4 contacted Mr A's solicitor she was advised that it was expected that his case would be adjourned on 11 October for probation reports to be completed and asked that EIT4 send documentation to confirm Mr A's diagnosis. Later EIT4 received confirmation that the referral to multi-agency referral and assessment team had been received and no further action would be taken with regards to Mr A's family because Mr A only visited his mother's address when his brother was not there. Later that afternoon Mr A's mother contacted EIT12 and was tearful and distressed. She said that Mr A had gone to her home, was hostile towards her and had shouted at her. Mr A had then strangled his sister's cat and had tried to strangle her (his mother). Mr A had pushed his mother into the living room and slammed her head against the sofa. Mr A's mother started hitting him to fight him off after which Mr A had left the house. Mr A's mother said she did not want to press charges but gave permission to EIT12 to inform the police due to the risks.
28 September 2016	EITM1 (early intervention team manager) spoke to Mr A's mother to check on her wellbeing and to offer support. Mr A's mother expressed concern about his mental state but agreed to consider pressing charges regarding the assault. EITM1 noted that Mr A's care plan and risk assessment would be reviewed and that the police would be involved in order to ensure that public safety was managed. EIT4 then contacted the police to discuss whether Mr A could be charged for the assault without his mother giving a statement. It was also agreed that the police would conduct a welfare check on Mr A and that mental health staff would not visit Mr A at home until the police had assessed Mr A's risk. Mr A's mother later contacted EITM1 to confirm that she would be prepared to talk to the police about Mr A's assault on her. EITM1 also contacted the Chapman Barker Unit about Mr A's planned admission. She gave an update on Mr A's drug and alcohol use at that time, and the impact on his mental health.
29 September 2016	A community meeting took place to discuss Mr A's case. Present were staff from the early intervention team, the police, Bedspace and Intuitive Recovery. It was noted that Mr A had been arrested that morning following an incident when he had strangled a cat and assaulted his mother. (It should be noted that Mr A's mother was knocked unconscious during this assault). Mr A's diagnosis was discussed and CP3 stated it was his opinion that Mr A's psychosis was drug induced and that he had seen no evidence to suggest otherwise. Therefore, his offending behaviour was considered to be as a result of his intoxication rather than mental illness. It was noted that Mr A had recently started using alcohol and that during his arrest he had been very aggressive, requiring five police officers to restrain him. He had also made threats to kill his mother. Mr A's

	mother had expressed concerns about the safety of Mr A's grandparents because he often went to them for food and money. It was reported that staff visits to Mr A at his flat could be intimidating and risky and that he got upset and annoyed with Bedpsace staff when they went in to clean his flat. It was noted that Mr A's long-term accommodation issue needed to be addressed and that he would be reluctant to move out of his flat. EITM1 noted that Mr A was coming to the end of his time with the early intervention team and that substance misuse may be an aspect that would be the focus of work with him by other teams, following his discharge from the early intervention team. EIT4 noted that: • Bedspace would arrange for Mr A's boiler to be fixed and the smashed glass in his flat to be removed; • Mr A could not be managed safely on an inpatient ward and would require urgent assessment by the on call forensic psychiatrist whilst in custody; • the police would put a marker on the addresses of Mr A's family and that Mr A's mother would inform a school regarding the safety of Mr A's younger brother (the Panel has seen no evidence to indicate that the Trust made a safeguarding referral at this point). Later that morning the police contacted the MO:DEL[32] team because of concerns about Mr A's mental state and risk. It was reported that Mr A had been arrested for assault, having strangled his mother and thrown her to the floor. After he was arrested he had stripped naked in the police van and was hostile and aggressive towards police custody staff. The MO:DEL team contacted EIT4 who suggested that Mr A be left for a period of time to allow for any illicit substances to lose effect. It was noted that Mr A would be assessed by the forensic medical examiner and that the MO:DEL team would inform Mr A's GP of the outcome of the assessment in custody.
30 September 2016	Mr A's case was discussed at the early intervention team meeting when it was noted that he had been interviewed the previous night but there was no evidence of psychosis. It was reported that he had been uncooperative during the interview, had been charged with assault and battery and was due in court that morning. It was noted that the early intervention team "would look at discharge". The early intervention team received an email from the police advising that the Crown Prosecution Service planned to apply for Mr A to be remanded in custody, either on bail or pending court reports. EIT4 then spoke to Mr A's mother, who agreed that custody seemed to be safest option at that time. CJT3 (MO:DEL staff member) later received confirmation that Mr A had been remanded to HMP

[32] *The MO:DEL (Manchester Offenders: Diversion Engagement and Liaison Team) Team is a multi-disciplinary criminal justice liaison and diversion team covering the whole of Manchester. The team works with offenders who have co-morbid mental health problems, learning disability and other complex needs such as substance misuse, homelessness and interpersonal difficulties.*

	Manchester. He had been reviewed by the forensic medical examiner whilst in police custody who had assessed Mr A as having a history of drug induced psychosis "in line with his own care team". Mr A was processed by the court before the criminal justice team could talk to him, however the court was provided with information about Mr A's history of risks to himself and others. CJT3 spoke to the inreach team at HMP Manchester to inform them of Mr A's diagnosis, substance use, care team and recent risk history, including the overdose in June 2016.
30 September 2016	The inreach team at HMP Manchester conducted an initial assessment on Mr A and noted that he had taken an overdose of 79 paracetamol four months previously and had previously been admitted to a mental health inpatient unit. A referral was made to the inpatient unit at HMP Manchester.
1 to 12 October 2016 – Healthcare unit HMP Manchester and discharge from Trafford Early Intervention Team	
3 October 2016	Mr A's case was discussed by the prison mental health inpatient team when it was agreed that he would be assessed that day by the Prison Psychiatrist (PP1). On assessment by the prison Mental Health Nurse (PMHN1) Mr A said that he didn't like being on the wing because it was "too big and noisy". Mr A told staff that he was feeling "paranoid" and that he was possessed by a "spirit" and that he would assault another prisoner on the wing as a result. Mr A reported that people on the television had been talking to him but he refused to elaborate on these experiences. PMHN1 noted that there appeared to be no conviction or detail behind those expressed experiences and although Mr A appeared "a little bizarre" there was no evidence of thought disorder. Mr A later became agitated and abusive and swore at PMHN1 before leaving the room. Mr A then began to climb the gate and jumped up and down on the floor. Prison officers attended, and Mr A was escorted back to his cell. Mr A was considered to be high risk and was allocated to a single cell, it was noted that staff should see him in pairs only. At about 3:00pm that afternoon Mr A was found in his cell having tied a ligature around his neck using a wire attached to the light. Prison officers had to cut him down and described it as a "serious attempt". On examination at the healthcare centre, staff noted that Mr A was displaying psychotic symptoms and that he had red marks on his neck. Mr A described auditory hallucinations that were derogatory, calling him "nonce" and "gay boy" and said that "spirits" told him to hang himself. It was agreed that Mr A needed to be admitted to the healthcare inpatient unit in the prison with constant one-to-one observations. On the same day Mr A's case was discussed at the early intervention team meeting when it was noted that he had been remanded to prison and was due to appear in court on 13 October. Shortly afterwards the substance misuse team spoke to EIT4 regarding Mr A's referral to the Chapman Barker Unit. EIT4 advised that Mr A was on remand at HMP Manchester and that he had recently stated he no longer wanted to be admitted to the unit.

4 October 2016	On review on the healthcare wing by PP1 Mr A appeared agitated and defensive, complaining of the presence of spirits. Mr A's observations were reduced to routine and he was prescribed promazine 50mg three times daily.
5 October 2016	Mr A was due to attend another appointment with PP1, but this did not take place due to insufficient prison officers being on duty to escort Mr A from his cell to the appointment. It was noted that his next review was due to take place on 12 October. Mr A's case was discussed at the early intervention team multi-disciplinary team meeting when it was noted that it was likely he would serve a prison sentence.
7 October 2016	Mr A's case was again discussed at the early intervention team meeting. It was noted that the team need to liaise with the outreach team before Mr A's case was closed, and that EIT4 would speak to the initial assessment team regarding the case. EIT4 later made a referral to the community screening team. She also called HMP Manchester and was informed that Mr A was on the healthcare wing following a ligature attempt. EIT4 was informed that Mr A was stable but was under continued observation and recorded advice to early intervention team colleagues indicating if Mr A's mother contacted the early intervention team she was to be advised to speak to the prison, because it was not clear whether Mr A's mother had been informed of his attempt at self-harm. The evidence available to the Panel indicates that the early intervention team took this decision in isolation and did not consult with the prison healthcare staff.
8 October 2016	Mr A was disruptive in his cell and demanded medication. Staff advised that he was not prescribed any medication at that time and therefore nursing staff were unable to administer anything. Mr A continued shouting, making bizarre squawking noises and shouting obscenities, whilst laughing in between. However, prison healthcare staff noted that it appeared Mr A could hold a calm and rational conversation when talking with the patient in the cell next to him.

10 October 2016	After being awake for most of the night when he was shouting and singing, Mr A was reviewed by a member of the prison healthcare team who spent some one-to-one time with him in his cell. Mr A was throwing water through the side of his door and bouncing his chair about his cell. Mr A reported that he was having difficulty sleeping and said that he had not slept for seven days (it was noted that clinical records showed that this was not the case). Mr A told staff that he felt that people were laughing at him, spirits were talking to him, and that he could see faces on the floor. Mr A also said that he had flashbacks to historic abuse and when he hears loud noises this brings it all back to him. Mr A reported that he had no hope for the future and stated he continued to have thoughts of self-harm. Mr A became tearful during the conversation following an angry outburst and said that he wanted help, but other than sleeping tablets was unable to identify what help he feels he needed. Mr A was reviewed later that day by CFP2, Consultant Forensic Psychiatrist who had seen Mr A previously in 2013. Mr A presented as guarded and irritable with paranoid beliefs that people were laughing at him and said that he felt like killing people. Mr A told CFP2 that he was on remand for "slapping his mother". Mr A was unable to say how long he had been in prison but reported seeing faces and spirits all around him and said that people were using fake names. He also reported poor sleep due to "noises in the vents" and "clattering" and said he had an unpleasant taste in his mouth. CFP2 noted that Mr A had marks on his wrists from a razor blade, Mr A said he had not wanted to do it but before he realised what was happening he realised he had cut himself. CFP2 noted that Mr A had used significant amounts of spice and cannabis when he was in the community and that Mr A appeared to be experiencing an active psychotic illness that may have been drug induced. CFP2 prescribed quetiapine 300mg to be increased to 600mg and advised that Mr A would remain in the healthcare wing for risk management and monitoring of his mental state.
12 October 2016	Mr A's case was again discussed at the early intervention team meeting. It was noted that Mr A had been in court the previous day, but that the outcome was not yet known. Mr A had reported that he had seen "evil coming out of a cat" and the early intervention team noted that this experience was drug induced. It was also noted that the view of the probation service was that the best place for Mr A was prison at that time. A referral to the initial assessment team had been made because Mr A had support needs.

13 and 14 October 2016 – release from prison with licence conditions	
13 October 2016	CJT4, a mental health practitioner with the criminal justice team received a call from a legal advisor regarding Mr A. It was noted that the court appeared to be considering bailing Mr A that day and they wanted to know what community services would be in place. However, CJT4 was then informed that the court was unable to wait for a response from the criminal justice team. CJT4 then spoke with EIT4 who confirmed that the early intervention team were in the process of closing Mr A's case because of the perceived link between his substance use and mental health difficulties. CJT4 later contacted EIT4 again to confirm that Mr A had been given a six-month community order with conditions that he did not attend his mother's address and that required him to engage with probation and mental health services. CJT4 also advised that Mr A had told the court that he had started medication during his time in prison. CJT4 noted that EIT4 would discuss this with her manager. PHCM1, the prison Healthcare Unit Manager, was informed that Mr A had been given immediate release by the court. PHCM1 discussed the situation with PP1 who expressed concern about Mr A's current risks to others and himself. It was noted that Mr A should be assessed under the Mental Health Act when released from prison. Following discussions with police and the prison governor it was decided that Mr A's release from prison would be delayed until the following day. The decision was taken because of the following concerns: • unlock levels at that time (the number of prison staff required for Mr A when not in his cell); • the fact he had no accommodation; • mental health concerns. PHCM1 also discussed the situation with CFP2 who suggested that PHCM1 contact the duty AMHP worker that evening, and the community mental health team and Mr A's GP the following day. PHCM1 did contact the duty AMHP team and was advised that the duty team were unable to accept referrals for the following day, and that he would have to call again the following morning. On the same day CL1, from the prison healthcare service wrote to Mr A's GP to advise that Mr A had been started on quetiapine 300mg on 10 October to treat a psychotic relapse, and that he had also prescribed diazapam 2mg/5ml 10ml. Mr A had been provided with seven days of medication on release from prison. The Panel has established that this letter was a computer-generated proforma and that CL1 never met Mr A.
14 October 2016	PHCM1 contacted the AMHP hub and was advised that the Mental Health Act assessment would need to be conducted by Mr A's local team. PHCM1 duly contacted the Trafford community mental health team and asked that someone contact him urgently. PHCM1 also contacted Mr A's GP to inform them of the concerns about Mr A's mental health and that they should contact the

	community mental health team if Mr A should present at the GP surgery. PHCM1 contacted the offender manager unit at the prison and was advised that Mr A would be released from prison that morning. PHCM1 then contacted a senior probation officer at the Trafford probation office to inform him of Mr A's recent self-harming behaviour and risks. PHCM1 recommended that a Mental Health Act assessment be arranged. PHCM1 later spoke to EIT4 who advised that Mr A had presented with chaotic behaviour for the previous six years and that his community-based diagnosis was drug-induced psychosis. PHCM1 advised that the prison inpatient psychiatrist (CFP2) had recommended assessment under the Mental Health Act. EIT4 recommended that PHCM1 contact the duty AMHP. PHCM1 discussed the situation with CFP2 who said that he would contact the duty AMHP himself. Mr A's case was discussed at the early intervention team meeting when it was noted that he had been released from prison and that he had been started on antipsychotic medication whilst in prison. The court had served a six-month order for Mr A to engage with mental health services, but it was felt by the early intervention team that Mr A's offending was strongly linked to substance misuse and therefore involvement with drug services was appropriate. EIT4 later noted that "following multi-disciplinary team discussions and with agreement from community services manager" no further role for the early intervention team had been identified and Mr A would be discharged from the team's caseload. The initial assessment team would contact Mr A to reassess his needs and review the plan with Bedspace. Bedspace were informed of Mr A's release from prison and Mr A's probation officer was informed that Mr A had been discharged from the early intervention team. It was noted that the duty probation officer would meet with Mr A that day. Later CFP2 contacted the duty AMHP to advise that the mental health unit manager (PHCM1) from HMP Manchester had requested a Mental Health Act assessment for Mr A. However, the duty AMHP indicated that their records did not show that a request had been received. CFP2 advised that he had reviewed Mr A on 10 October when Mr A had presented as thought disordered with an active psychosis and although Mr A was not an active suicide risk, he had cut his wrists whilst in prison. There were possible risks to others because Mr A had made some non-specific threats and had been irritable and aggressive with staff whilst on the mental health unit in prison. CFP2 expressed concern that Mr A had been released from prison and said that he felt a Mental Health Act assessment was required and that Mr A required admission to hospital, either to a PICU bed or an acute bed. The duty AMHP then spoke to the unit manager on the healthcare wing at HMP Manchester who advised that Mr A had been remanded to prison after he had assaulted his mother. Mr A had attended court the previous day and had been released on a six-month community order 24 hours later. Mr A was due to meet a probation officer that afternoon and the duty AMHP

	had recorded that PHCM1 reported that Mr A had appeared more settled and "lucid" before release. Shortly after the discussion Mr A's mother contacted EIT4 and reported that Mr A was at his grandparent's home and had called his mother to say that he did not have his house keys. Mr A's mother had told Mr A that he had conditions not to contact her or go to her address and she ended the call. EIT4 contacted Bedspace who had spare keys for Mr A. EIT4 took the keys to Mr A's grandfather who said that Mr A had gone to a friend's house but he would give the keys to Mr A. Mr A's grandfather said that Mr A appeared settled, however EIT4 provided the out of hours contact details to him and told him that Mr A had been discharged from the mental health team. EIT4 also left a note for Mr A to let him know he had been referred to adult social services for his plan at Bedspace to be reviewed. Following this EIT4 contacted the duty AMHP to advise that she had seen Mr A's grandparents and that they had reported Mr A had seemed "settled". EIT4 stated that there was no evidence of psychosis or delusional thoughts, although EIT4 had not seen Mr A so was basing her assessment on reports from Mr A's grandparents. EIT4's view was that Mr A's main need was in relation to drugs and alcohol misuse and that he had been discharged from the early intervention team. The duty AMHP indicated she felt a further assessment was required, however EIT4 advised that Mr A's grandparents knew how to contact services if they had any concerns. The duty AMHP noted that she would not arrange a Mental Health Act assessment at that time but would provide information to the emergency duty team should any issues arise during the weekend.

17 to 30 October – release from prison and death of Mr Owen	
17 October 2016	EIT4 contacted Mr A who agreed to a home visit the following day. Mr A also agreed that a referral to the initial assessment team could be made for a reassessment of his needs and Mr A said that he would contact the probation team to rearrange the appointment that he did not attend the previous week. EIT4 then contacted Mr A's mother who expressed concerns about Mr A using drugs and alcohol since his release from prison. Mr A had been asking his family for money and his father reported that Mr A appeared confused and highly irritable over the weekend. EIT4 noted that Mr A's family knew to contact the police if Mr A approached his mother's property. A referral was made by the early intervention team to the community mental health team for a joint assessment. It was noted that Mr A had been known to the early intervention team prior to him being in prison. However, the prison service had referred Mr A back to the early intervention team because of their concerns about his mental health and they had requested a Mental Health Act assessment but this request "was not felt indicated by Trafford" (the Panel assumes this to mean that the Trafford early intervention team did not support the need for a Mental Health Act assessment). There appeared to be no clear step-down plan from the early intervention team and therefore a joint assessment with the community mental health team was agreed. The duty AMHP later discussed Mr A's case with EIT4 and her manager EITM1. It was noted that the plan was for the early intervention team to discuss Mr A's case in their team meeting and that they were considering a referral to the community mental health team. There were no plans for a Mental Health Act assessment to be requested at that time.

19 October 2016	Mr A was discussed at the early intervention team meeting. It was noted that he had been released from prison and that the initial assessment team had accepted him. It was noted that the community mental health team required a plan for their involvement with Mr A and that EITM1 would be the point of contact for this. Mr A was also referred to MARAC, and a detailed letter sent to his GP but the referral was not noted until 27 October. The community mental health team received a duty referral for Mr A and noted that the early intervention team had closed Mr A to their team. It was also noted that Mr A's mother remained concerned about his mental state and felt that he continued to need assessment in view of the "recent concerns" raised by the prison service and the fact that he had been re-started on antipsychotic medication. The community mental health team discussed the merits of continuing with a joint assessment with the early intervention team because Mr A's diagnosis had been reviewed and a step-down plan implemented accordingly. Later that day EIT4 attended a MARAC meeting. The IDVA[33] advised that Mr A had been going to his grandparent's home every day for showers and food. There were concerns about Mr A's presentation (a "fixed stare") that was similar to his presentation prior to a previous assault. The plan was for the community mental health team to visit Mr A the following day to attempt to engagement him in an assessment. It was noted that the police would organise a strategy meeting for the week commencing 31 October.
20 October 2016	EIT4 went to Mr A's home with a colleague from the community mental health team. Mr A was not at home and EIT4 was informed by a colleague that Mr A was visiting someone at Moorside Unit that morning. EIT4 later spoke to Mr A who confirmed he had been released from prison and that he would be attending his probation appointment at 2:00pm. EIT4 recorded that Mr A seemed "brittle at times" during their telephone conversation but that he had agreed to meet her the following day. EIT4 then spoke to Mr A's probation officer who advised that if Mr A did not attend his appointment that day he would be in breach of his licence and would be recalled to court. EIT4 also spoke to BSW1 from Bedspace who had contacted Mr A "on Monday". Mr A had told BSW1 "not to bother" visiting, however BSW1 had completed a safety check and had noted that the flat continued to "be in a state of disarray".
23 October 2016	Mr A's father contacted EIT4 expressing concern about Mr A. Mr A had been using drugs heavily and appeared with a fixed stare and intimidating manner and had also been talking about death. Mr A had been going to his grandparent's address despite being asked not to come to the house. Mr A and his cousin had been fighting earlier that day and when Mr A's grandmother attempted to intervene she was shoved out of the way by Mr A resulting in a minor injury. The police were informed, and they confirmed they would ensure Mr A's grandmother was safe and identify whether she wanted to make a complaint. The police further reported that Mr A's uncle had seen

[33] *The role of the Independent Domestic Violence Advisor (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children.*

	"wanted" photographs of Mr A at a local petrol station. EIT4 noted that she would inform the community mental health team the following day and that a referral to a secure hospital would be made if Mr A required admission.
24 October 2016	A community mental health nurse from the Trafford West community mental health team (CMHN1) spoke to a duty probation officer who informed her that Mr A had not attended his probation appointment on 20 October. CMHN1 contacted the police who advised that they had attended Mr A's home address that day, but Mr A's mother did not want to give a statement about the incident the previous day. Therefore, there would be no further action from the police. CMHN1 noted she would contact Mr A's probation officer to discuss a possible joint visit to assess Mr A's current mental state.
25 October 2016	CMHN1, Mr A's probation officer, another member of Trust staff (role and team unclear) attempted to visit Mr A. The probation officer reported that Mr A was in breach of his suspended prison sentence and would now be required to appear in court. CMHN1 informed the probation officer that the community mental health team had attempted to assess Mr A's mental health. CMHN1 advised Mr A's family that if they had any safety concerns, they were to contact the police, add if any there were any concerns about his mental health, Mr A should attend A&E. Mr A's father advised that Mr A had not been seen by his family since Saturday and that they did not know his whereabouts. CMHN1 noted she would write to Mr A to ask that he contact the service to arrange an assessment. Mr A's probation officer later contacted the community mental health team to let staff know that Mr A would be issued with a warning letter and that if he did not provide a satisfactory explanation for his absence, the next stage would be a court summons.
26 October 2016	Mr A was discussed at the early intervention team multi-disciplinary team meeting when it was noted that the community mental health team was "still trying to assess" Mr A. It was agreed that EIT4 would continue to help with the transition to a community mental health team.
28 October 2016	Mr A's grandfather contacted CMHN1 to advise that Mr A's benefits had not been paid and Mr A had been staying at his grandparents' address. Mr A's grandfather said that he had been in touch with the probation officer and that Mr A had an appointment on 2 November. Mr A's grandfather reported that Mr A felt that he appeared "normal" at that time but that he did not have money to buy substances. CMHN1 spoke to Mr A and advised that he had been referred to the community mental health team who had been attempting to complete an assessment.
31 October 2016	Mr A was discussed at the early intervention team meeting when it was again noted that the community mental health team was "still trying to assess" Mr A. It was agreed that EIT4 would continue to help with the transition to a community mental health team.

November 2016	
1 November 2016	Mr A's grandfather contacted EIT4 because he was concerned about Mr A who was irritable and demanding because his benefits had been stopped. EIT4 advised Mr A's grandfather to contact Trafford Assist for food parcels and to attend the job centre with Mr A to see if his claim could be processed quicker. EIT4 advised that Mr A had not been assessed by the community mental health team yet and therefore he was not receiving any support from mental health services at that time. EIT4 said that she would ask Bedspace to support him with the job centre as part of Mr A's support hours. Mr A's grandfather confirmed that Mr A had an appointment with his probation officer the following day. An hour later Mr A's grandfather called EIT4 again and reported that Mr A was "going mad" in the garden, shouting about his food being taken by fairies and muttering to himself. Mr A's grandfather asked if Mr A could be admitted to Moorside Hospital if he were to take him there, however EIT4 said that Mr A would need to be taken to A&E to be assessed. Mr A's grandfather felt that Mr A would not agree to attend A&E and therefore EIT4 suggested that he request an assessment or contact the police if he had urgent concerns. It appears that Mr A's grandfather then contacted Mr A's father, who in turn contacted the Access Trafford team to ask for a Mental Health Act assessment to be undertaken. Following discussions between the AMHP, Mr A's grandfather and Mr A's father it was established that Mr A was on his way to A&E and that the AMHP should be contacted if a Mental Health Act was required. Trafford mental health liaison team completed an initial assessment at about 2:00pm, when they recorded that Mr A had a diagnosis of paranoid schizophrenia and that he had previously been admitted to mental health units, and had a forensic history including armed robbery and assault. Mr A had been released from prison two weeks previously, having been convicted of assault on his mother. As a result, Mr A was not allowed to speak to his mother or younger siblings, but had regular contact with his grandfather. A urine drug screen tested positive for cannabis. Mr A agreed to accept help and a hospital admission and therefore was not found to be detainable under the Mental Health Act. A bed was identified at Birch Ward, Royal Bolton Hospital and transport was arranged. At about 3:00pm the Trafford West community team received an email from Mr A's probation officer to advise that following discussions with Mr A's grandfather that day she had arranged a home visit for 2 November. Mr A's probation officer asked that CMHN1, or another member of the community team also attend the appointment. CMHN1 noted that she had spoken with Mr A's grandfather who had reported that Mr A was "not good" at that time. Mr A was later admitted to Birch Ward when it was noted that he was spontaneously laughing and claimed it was "just something I do". Medications prescribed were lorazepam and zopiclone, both of which were to be given on request, at the discretion of nursing staff.

2 November 2016	At about 2:00am ward staff received a telephone call from the police advising that Mr A had to be "arrested urgently" due to an allegation of a serious offence (homicide) and his risk to others. Ward staff were informed that Mr A would have one-to-one observations whilst in custody (by custody staff) and that he would be assessed by the police doctor to determine whether he was fit for interview. If he were found not to be fit for interview, he would be bailed back to a suitable mental health ward for further treatment. Trust staff provided information and advice about Mr A's mental health. Police arrived shortly afterwards, and Mr A was arrested and co-operated with police. Staff noted that he had "now been discharged from Birch Ward. STAR risk assessment to be completed". Community staff noted later that morning that Mr A had been assessed by the forensic medical examiner. The forensic medical examiner reported to community staff that Mr A believed people were "laughing at him like he is a little girl", that he was being watched and followed, and that he reported voices to hit other people. Mr A again reported that he was unable to remember when he last took his medication, that he had been sleeping for many days but taking a double dose of medication. A Mental Health Act assessment was arranged, and a referral made for Mr A to be admitted to a forensic inpatient bed. Mr A's probation officer informed the community team that Mr A had been arrested and that consequently the meeting for that day had been cancelled. It later transpired that Mr A had been arrested because police suspected him of being responsible for the death of Phillip Owen who had been found dead in his own flat on 30 October.

Appendix D – Professionals involved

Pseudonym	Role and organisation
BSW1	Support worker, Bedspace
CC&A1	Consultant child and adolescent psychiatrist, Trafford CAMHS
CCP1	Consultant clinical psychologist, Trafford CAMHS
CFP1	Consultant Forensic Psychiatrist, HMYOI Lancaster Farms
CFP2	Consultant forensic psychiatrist, HMP Manchester
CJSW1	Support worker, criminal justice team
CJT1	Mental health practitioner, criminal justice team
CJT2	Mental health practitioner, criminal justice team
CJT3	Mental health practitioner, criminal justice team
CJT4	Mental health practitioner, criminal justice team Salford
CL1	Clinical lead for primary care, HMP Manchester
CMHN1	Community mental health nurse, Trafford community mental health team
CP1	Specialist registrar doctor, Trafford Extended Services
CP2	Consultant psychiatrist, mentally disordered offenders' team
CP3	Consultant psychiatrist, Trafford early intervention team
CP4	Consultant psychiatrist, Brook Ward, Moorside Hospital
EIT1	Mental health practitioner, Trafford early intervention team
EIT10	Mental health practitioner, Trafford early intervention team
EIT11	Mental health practitioner, Trafford early intervention team
EIT12	Mental health practitioner, Trafford early intervention team
EIT2	Mental health practitioner, Trafford early intervention team
EIT3	Mental health practitioner, Trafford early intervention team
EIT4	Mental health practitioner, Trafford early intervention team
EIT5	Mental health practitioner, Trafford early intervention team
EIT6	Mental health practitioner, Trafford early intervention team

Pseudonym	Role and organisation
EIT7	Mental health practitioner, Trafford early intervention team
EIT8	Mental health practitioner, Trafford early intervention team
EIT9	Mental health practitioner, Trafford early intervention team
EITM1	Team manager, Trafford early intervention team
IRC1	Team Leader, Intuitive Recovery
LAC1	Locum associate specialist doctor, Trafford CAMHS
MHW1	Mental health practitioner, Trafford early intervention team
MHW2	Mental health practitioner, Trafford Extended Services
PGMHN1	Mental health nurse, HMP Manchester
PGSW1	Support worker, Pomona Gardens
PHCM1	Healthcare Unit Manager, HMP Manchester
PP1	Prison psychiatrist, HMP Manchester
SD1	Specialist doctor, Trafford Extended Services
SGP1	Locum staff grade doctor, Trafford early intervention team
SGP2	Specialist registrar, Trafford early intervention team
STAR1	Support time and recovery worker, Trafford early intervention team
STAR2	Support time and recovery worker, Trafford early intervention team
WN1	Ward nurse, Brook Ward, Moorside Hospital

Appendix D – Terms of reference for the internal investigation

1. To establish a clear and complete chronology reviewing significant events from May 2016 up to the time on the incident on 2 November 2016.

2. This investigation will review how comprehensive were local care and treatment plans in enabling the team to effectively meet Mr A's needs in accordance with Trust and National standards. The review will particularly focus on the following areas:

    - The teams approach to the assessment, management and communication of any identified risk relating to Mr A's mental health and offending behaviour with consideration given by staff to the safeguarding of Mr A and those around him. Where relevant the consideration by professionals regarding the incorporating of positive risk taking into Mr A's agreed treatment plan.

    - The appropriateness of decisions made by professionals and considerations given the agreed diagnoses for Mr A and how this was communicated within Mr A's clinical records and with those professionals involved in his care.

    - How effectively did the Trafford GMW staff monitor Mr A's treatment compliance and how assertive were staff in their attempts to engage Mr A in any agreed treatment interventions.

    - How effective was the Trafford EIS decision making in relation to the discharging of Mr A from EIS following the professionals meeting held 29 September 2016 and following him being released from prison in October 2016 with considerations given by the team of his community order and known risk to Mr A and others. How effective were these discharge plans implemented following this decision?

    - How effective was multiagency working implemented by the GMW Trafford EIS with other professionals/agencies involved with Mr A such as the community mental health team, drugs and alcohol services, probation, police, initial assessment team, Bedspace and any other agency identified during this episode of care under review.

3. How effectively did GMW staff engage Mr A's identified carer/family throughout the time period under review and where relevant how GMW professionals implemented the stages within the Trust Being Open and Duty of Candour policy following the serious incident being identified.

4. To make recommendations to address any identified concerns found.

Please note:

Following agreement from [Greater Manchester Police] to the [Assistant Director] of Clinical Governance for [Greater Manchester West NHS Trust] investigation lead to meet with Mr A's family the review lead may consider with Mr A's family extra [terms of reference] that may be required to complete this review. If this is the case the

Investigation Lead should make the [Assistant Director] for Clinical Governance and the Incident Team aware.

The terms of reference were established for the review team by the Trust Executive Serious Incident Panel.