Niche
PATIENT SAFETY

An independent investigation into the care and treatment of a mental health service user Mr S in TEWV and BHFT

November 2017

Author: Sue Denby, Lead Investigator

First published: 23 November 2017

Niche Health & Social Care Consulting Ltd 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.

Niche Patient Safety Ltd
Emerson House
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: www.nichepatientsafety.co.uk

Contents

1 Executive summary

1.1 NHS England North commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr S. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 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.

1.3 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.

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

1.5 Tees, Esk and Wear Valleys NHS Foundation Trust (referred to as TEWV hereafter) and Berkshire HealthCare NHS Foundation Trust (referred to as BHFT hereafter) are the main focus of the independent investigation.

1.6 Mr S was alleged to have killed the victim on 24 December 2015. He had been introduced to the victim through his stepfather who also lived in Slough. Prior to this, he had been residing in the TEWV catchment area. At the time of the offence, Mr S was residing in Slough, staying at the victim's house.

1.7 Mr S remained under the care of the TEWV Early Intervention in Psychosis Team (EIPT) at the time of the offence but had disengaged from services and moved to Slough without the knowledge of the team in late November 2015. He was referred by TEWV to BHFT in 11 December 2015 when they became aware he had moved.

1.8 Whilst the TEWV referral was being processed, a GP referral to the BHFT Crisis Resolution Home Treatment team (CRHTT) on 23 December 2015 and subsequent telephone discussions with Mr S and the stepfather on 24 December 2015 resulted in a plan for the CRHTT to visit him for assessment and medication purposes. Two visits to Mr S on the 24 December were unsuccessful, as he was not residing at the address of his stepfather. A third visit was planned for later in the evening of 24 December 2015 to the correct address where Mr S was staying with the victim.

[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 The stepfather made a call to the emergency services at 03.14 am on 24 December 2015 requesting assistance, medication for Mr S as his mental state was deteriorating, and he said that Mr S had already assaulted him.

1.10 Mr S called the emergency services at 6.35 pm on 24 December 2015 and reported that the victim was *"breathing but he's not conscious"* and then almost immediately corrected this to say, *"No he's not breathing"*.

1.11 When paramedics arrived, a knife was found lying on the floor near to the victim's head. Mr S stated to the paramedics *"I stabbed him in the throat and I'm really sorry".*

1.12 Paramedics found the victim on the floor inside the address, with a single stab wound to the neck from the left to the right that severed both carotid arteries and jugular veins.

1.13 We would like to express our condolences to the victim's family. 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 S.

Mental health history

1.14 In March 2013 Mr S's brother became concerned about the fact that he had started to exhibit bizarre behaviour. Mr S became mute, uncommunicative, did not eat or drink, and was not sleeping. He was admitted informally following a GP referral and a TEWV crisis assessment to Roseberry Park Hospital (RPH), Middlesbrough. His diagnosis at this time was severe depressive episode with psychosis and mental and behavioural disorders due to use of cannabis; psychotic disorder.

1.15 He was discharged to his brother's home, prescribed an oral antidepressant (fluoxetine)[3] and an antipsychotic (olanzapine)[4] and as he was thought to be suffering from a first episode psychosis he was referred to the TEWV EIPT.

1.16 His care in the community by the EIPT at this time was characterised by Mr S needing a lot of support to maintain his independent living. He often spent long periods in bed, had poor personal hygiene, needed to be prompted to take his medication and was smoking cannabis.

1.17 Due to this, because his brother could not cope with him, Mr S moved from his brother's home to a local hostel, in the TEWV catchment area. This did not improve matters and he was absent for most of the time before the EIPT found that he had moved to his mother's address which at the time was in Slough.

[3] Fluoxetine is prescribed for depression, bulimia nervosa, and obsessive-compulsive disorder (OCD). http://patient.info/medicine/fluoxetine-oxactin-prozac-prozec

[4] Olanzapine belongs to a group of medicines called antipsychotics. It is prescribed to relieve the symptoms of schizophrenia, http://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa

1.18 On 11 October 2013, his mother expressed concerns about his use of cannabis and said that he was not taking his medication.

1.19 Soon after he was taken into custody on suspicion of dealing Class B drugs. After being questioned, he was bailed until 14 April 2014. He was later charged with conspiring to supply a controlled drug (cannabis) with one of his brothers.

1.20 Following this his mental health deteriorated. He was distracted, spending a lot of money on cannabis and was concerned he had raped his friends six-year-old sister when he was nine years old. He was admitted again to RPH this time as a detained patient, and during his admission he commenced on depot[5] flupentixol decanoate and was referred to a local rehabilitation unit. It was decided that he should not be allowed unsupervised contact with children whilst his admission of rape was investigated.

1.21 Mr S was discharged in June 2014 having made improvements in his ability to care for himself. He was stable and had complied with this medication regime. His discharge diagnosis was paranoid schizophrenia.

1.22 However, on the 4 July 2014 Mr S was arrested and bailed on suspicion of possession of a Class B substance with intent to supply. Following this he appeared to deteriorate. He was letting people into his flat, had spent a lot of money, had been served notice by his landlord and other tenants in the flats had expressed an interest in obtaining an ASBO.[6]

1.23 The care coordinator found him a place at a local hostel for people with complex problems however he did not stay there and his place was withdrawn. He went to stay with his mother in Teeside.

1.24 In April 2015 he was sleeping a lot but presented well with no evidence of psychosis. His depot medication was reduced in an attempt to increase his motivation. However, later in April he was arrested for breach of attendance at the magistrate's court.

1.25 In June 2015 his mother expressed concerns that his mental health had deteriorated. Following an argument, he threatened to cut her throat if she called the police, had shouted at her and made her go over to a cricket ground and pick up cigarette ends.

1.26 In July 2015 Mr S's compliance with his medication started to deteriorate. He was arrested for breach of his bail conditions and appeared in Teeside Magistrates Court. He was bailed to attend Reading Crown Court.

[5] Depot medication is a special preparation of the medication, which is given by injection. The medication is slowly released into the body over a number of weeks.

[6] ASBO'S are civil orders to protect the public from behaviour that causes or is likely to cause harassment, alarm or distress. An order contains conditions prohibiting an individual from carrying out specific anti-social acts or (for example) from entering defined areas.

1.27 In August 2015 he was arrested on suspicion of theft of cigarettes and breach of his bail conditions. On 5 August he was also arrested on suspicion of assault on his mother who said he had kicked her down the stairs and had threatened her with a knife after arguments about cigarettes. His mother later changed the locks to her house, however the charges against him were dropped.

1.28 As he could not return to his mother's address for her own safety, he was remanded in custody. He was released on 20 August 2015, however during this time in custody, he did not have his depot medication and the EIPT were not informed of his release.

1.29 Between August and November 2015 he was again staying with his mother and his compliance with his depot medication was not consistent. On 11 November 2015 the TEWV advanced practitioner met with Mr S and managed to get him to agree to take his depot medication although at a lower dose of 40 mg every three weeks. This was the last date Mr S received his medication.

1.30 In early December 2015, the EIPT found that Mr S had moved to Slough, Berkshire following a telephone conversation with his brother. As result the care coordinator referred Mr S to BHFT common point of entry (CPE).

Relationship with the victim

1.31 Mr S was introduced to the victim by his stepfather who lived in Slough. The victim did not know Mr S and the victim allowed him to stay at his flat at the request of Mr S's stepfather.

Offence

1.32 On the 24 December 2015 Mr S was arrested by police on suspicion of a murder in Slough, Berkshire.

1.33 Mr S was still under the care of the TEWV EIPT. Prior to and at the time of the offence he was residing in Slough. He had been referred by TEWV to BHFT mental health services via the common point of entry (CPE).

1.34 The stepfather made a call to the emergency services at 03.14 am on the 24th December 2015 requesting assistance and medication for Mr S as his mental state was deteriorating and he said that Mr S had already assaulted him.

1.35 Mr S called the emergency services at 6.35 pm and reported that the victim was *"breathing but he's not conscious"* and then almost immediately corrected this to say *"No he's not breathing"*.

1.36 Paramedics found the victim on the floor inside the address, with a single stab wound to the neck from the left to the right that severed both carotid arteries and jugular veins.

1.37 Mr S is thought to have killed the 48-year-old victim (who was the person Mr S had been staying with) at or around 6.38 pm, at the victim's address in Slough.

1.38 Paramedics called the police. Mr S was found waiting outside the property when the police arrived at the scene, and having been identified, was arrested.

Sentence

1.39 Mr S pleaded guilty to manslaughter with diminished responsibility at Reading Crown Court on 14 June 2017. At a hearing at the same court on 22 June 2017 Mr S was sentenced under the Mental Health Act, to an indefinite hospital order (section 37 with section 41 restrictions).

Internal investigation

1.40 TEWV undertook an internal investigation with an external reviewer. Three recommendations were made:

R1 There will be a process whereby calls or messages left on care coordinators' mobile 'phones whilst they were not at work i.e. on annual leave, are being picked up and addressed by the team.

R2 That any referral made to an external or internal service indicates clearly the level of urgency.

R3 Ensure that the level of risk identified is proportionate to the narrative details.

1.41 BHFT undertook an internal investigation with an external reviewer. Eleven recommendations were made:

R1 Managers to review and clarify relevant CPE systems and ensure all staff are made aware of what those systems are and how they should be implemented.

R2 Clear written guidance to be produced for CPE staff regarding systems for flagging and monitoring referrals.

R3 Managers to review processes for liaison with Slough CMHT.

R4 Managers to ensure there is consistent guidance regarding the involvement of CPE, Community Mental Health Team (CMHT) and CRHTT in the patient pathway for Care Programme Approach transfers (CPA)[7]

[7] CPA is used to plan many people's mental health care where they have complex needs.

R5 Managers to review training and supervisory support needs of staff in relation to the specific issues identified relating to information gathering and recording.

R6 Managers to take steps to ensure that all staff, including agency staff, record the time of all key events.

R7 Managers to review practice in relation to task allocation by team leads in CRHTT, with due weight given to continuity where there is potential high risk.

R8 Wherever possible the member of staff who arranges a visit should also be the person who undertakes the visit. CRHTT also need to review process and practice to ensure that information is not lost where maintaining a consistent clinician is not possible.

R9 Managers to take steps to ensure that staff undertaking visits routinely telephone the patient (or carer, or relative if appropriate) beforehand to confirm arrangements for a visit.

R10 There is a need for training to raise staff awareness of good practice in safeguarding 'adults at risk'.

R11 Managers to review CRHTT 'No Response' policy for consistency with CCR BPD006 (CMHT Guidelines issued to all teams regarding no response to visits and where there are concerns that the person is at risk or vulnerable to harm) and ensure staff are made fully aware.

1.42 The BHFT internal investigation was satisfactory and made appropriate recommendations.

Independent investigation

1.43 This independent investigation has drawn upon the internal process and has studied clinical information and other relevant information and documents. We held two workshops with TEWV and BHFT clinical and managerial staff to understand the timeline and to seek further information in relation to queries against this. We also spoke to members of the victim's and Mr S's family.

1.44 Assurance has been sought against the recommendations for both TEWV and BHFT to review the progress that both trusts have made in implementing their action plans.

Conclusions

1.45 It is our view that the homicide was not predictable. Risk assessments were regularly undertaken and Mr S was not thought by TEWV to be a risk to others apart from his mother, although he had voiced concerns that he would hurt others. His mother was subject to safeguarding initially from a concern that she may be being exploited for tobacco, alcohol and money and then later on due to the risk of assault. It is our view that she was advised

appropriately about safety measures including involvement of the police and consideration of safe houses.

1.46 It is our view that had certain interventions taken place the outcome may have been different. TEWV and BHFT both had knowledge that the depot medication was overdue and both organisations could have initiated joint planning to ensure this was administered in a timely way as soon as possible following referral. Joint planning could potentially not only have ensured depot administration, but also that other interventions (e.g. housing) and monitoring (of mental state) were in place, hence potentially averting the eventual sequence of events.

1.47 Given that medication was prescribed at a lower dose, and that this was in effect sub-therapeutic after 13 weeks, Mr S was clearly at increased and significant risk of relapse. Mr S himself, the GP, his stepfather, brother and uncle all requested on 23 and 24 December 2015 that the depot should be administered due to their concerns about the deterioration of his mental health.

1.48 The BHFT internal investigation indicates that on 24 December 2015 at 1.20pm the victim telephoned the Community Health Hub in Wokingham asking for help for Mr S. Mr S came on the line and said "*I need my antipsychotics; I was supposed to get them yesterday"*.

1.49 Community health staff informed CPE of this call and at 1.42 pm a CPE nurse telephoned the victim who explained that Mr S was staying with him and had been aggressive and was "*not compos mentis ... he's all over the place ... he's getting worse ... he is self harming*." The nurse asked to speak to Mr S and the victim indicated that Mr S was sitting on the sofa "*totally silent"* and unable to speak to the nurse. This picture of Mr S echoes his past presentation when overtly acutely psychotic.

1.50 However, it is not clear whether the administration of the depot injection at an early stage following referral would have been a sufficient measure alone to have prevented the homicide from occurring as it is likely that risk to others included a combination of issues associated with his medication compliance, chaotic living arrangements and drug use.

1.51 It is our view that the care coordinator made continuous efforts to support Mr S to live a stable, independent life however the fact that Mr S moved to Slough and was staying with the victim was not within the control of the care coordinator and the extent of his drug use at this time was unknown.

1.52 We acknowledge the view of the victim's partner that the homicide was both predictable and preventable.

1.53 The key issues highlighted in this review relate to relatively basic operational and good practice issues, especially relating to information sharing and communication.

Recommendations

1.54 This independent investigation has made six recommendations for TEWV to address in order to further improve learning from this event.

Recommendation 1:
TEWV must develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE[8] guidance on coexisting severe mental illness and substance misuse: community health and social care services.

Recommendation 2:
TEWV must review the EIPT operational policy to set out agreed methods and expectations around multidisciplinary working, to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and at least annually, where patients are receiving antipsychotic medication.

Recommendation 3:
TEWV must review the TEWV EIPT job plans to ensure consistent medical input to the team.

Recommendation 4:
TEWV must develop a schedule of audit for crisis plans and take action taken as required so that they meet the CPA policy standard.

Recommendation 5:
TEWV must review the TEWV CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence, e.g. by ‘phone.

Recommendation 6:
TEWV must take action Trust wide to ensure that any referral made to an external or internal service indicates clearly the level of urgency.

[8] NICE stands for the national institute for health and social care excellence and it provides evidence-based guidance, advice and information services for health, public health and social care professionals.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015)[9] and Department of Health guidance[10] 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.

2.2 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.

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

2.4 The investigation was carried out by Sue Denby, Lead Investigator for Niche, with expert advice provided by Dr John McKenna, Consultant Forensic Psychiatrist. The investigation team will be referred to in the first person plural in the report.

2.5 The report was peer reviewed by Carol Rooney, Head of Investigations, Niche.

2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[11].

2.7 As part of our investigation we interviewed:

- The partner of the victim.
- The brother of the victim.
- The author of the TEWV internal investigation report.
- The author of the BHFT internal investigation report.
- The mother of Mr S

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

[10] 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

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

2.8 We held a meeting with the following staff from TEWV:

- Responsible clinician.
- Team manager.
- Advanced practitioner.
- Care coordinator.
- Locality manager.

2.9 We held a meeting with the following staff from BHFT:

- CRHTT east health care assistant.
- CRHHT east late shift team lead.
- CRHTT east nurse three.
- CRHTT manager.
- CPE manager.
- Clinical directors covering CRHTT.
- Urgent and unscheduled care manager.

2.10 It was not possible to interview the following staff from BHFT as they were agency staff no longer working for the trust. We do not think that this adversely impacted on the process or the learning outcomes of this independent investigation:

- CPE nurse.
- CRHTT night shift lead.
- CRHTT east nurse one.
- CRHTT east nurse two.
- CRHTT HCA 3.

2.11 A full list of all documents we referenced is at Appendix B.

2.12 The draft report was shared with NHS England, TEWV and BHFT and other stakeholders. 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.

2.13 TEWV provides a range of mental health, learning disability and eating disorders services around County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton, Richmondshire and the Vale of York.

2.14 BHFT provides specialist mental health and community health services operating from over 100 sites across the county of Berkshire. Services include:

- Inpatient rehabilitation wards at community hospitals.
- Community nursing, health visiting and allied health.
- Mental health and learning disability community-based services.
- Community dentistry.
- Children's services.
- Mental health inpatient services

Contact with the victim's family

2.15 Contact for the victim's family was through individual meetings with his partner and brother.

2.16 The partner told us of the distress she had experienced following his death at not being recognised as his partner. This meant she was not involved as she wanted to be with the police, in his funeral arrangements or in respect of his belongings. She complained to the police about this and has received an apology.

2.17 The brother told us that he grew up with the victim in children's homes and had resumed contact with the victim three years ago after a thirty-year gap after discovering that his brother had cancer. The police regard the brother as the victim's formal next-of-kin.

2.18 The partner knew Mr S's stepfather as he lives near her. The victim had met him two or three months beforehand, however neither the partner nor the brother knew Mr S and Mr S did not know the victim. They knew that the stepfather had a room available, but they say that he asked the victim to provide Mr S with a place to stay even though the victim only had a one-bedroom flat.

2.19 Both the partner and the brother describe a situation whereby Mr S was taking the victim's food (which was specially prepared, blended and kept refrigerated in advance as he could not tolerate normal food due to cancer of his jaw), tobacco, alcohol and belongings which caused arguments between Mr S and the victim.

2.20 The partner and the brother of the victim provided questions for the independent investigation that have been covered by the terms of reference.

2.21 Both the partner and the brother told us they had not had sight of any internal incident investigation reports from TEWV or BHFT.

2.22 We met with the partner and the brother to provide feedback prior to publication of the report. The victim's partner was distressed and angry with the wider investigation process. We acknowledge that she did not agree with the findings of the independent investigation, and her view was that the homicide was both predictable and preventable.

Contact with the perpetrator and his family

2.23 We contacted the responsible clinician (RC) for the perpetrator at the start of the investigation, explained the purpose of the investigation and asked to meet him. The RC indicated that the perpetrator was too ill to engage in the process and did not have capacity.

2.24 Contact was made with Mr S's mother and an individual meeting was held with her on 23 February 2017.

2.25 She told us that Mr S's father committed suicide before he was born. Mr S and his mother were close and she *"wrapped him in cotton wool"* because he was a sickly child.

2.26 She went into a refuge 22 years ago. At this point, her three elder sons including Mr S were living with their father in Slough and she lived in Teeside with her two daughters and another son. Mr S came back to live with his grandma and then his mother again when he was aged 11 years old.

2.27 She felt that whilst under the care of TEWV he wasn't looking after himself, was hearing voices and was vulnerable, easily led and had people staying in his flat. She told us that she could call the care coordinator if she needed to but wasn't invited to CPA meetings as one of his brothers was the main person involved in his care.

2.28 She told us that her son had a lot of things offered to him by TEWV but that he hadn't taken them up. He was asleep a lot and wouldn't wash and she and her other sons *"got fed up with him".* She explained that left to his own devices he wouldn't look after himself, and for example, wouldn't buy toilet paper or eat unless she fed him. Her general view overall was that the mental health services could have done more for him.

2.29 She said that he was *"a fiend for cannabis"* and wanted it all the time. She thought he may also be using other drugs, such as *"crack".* She told us that *"He was wasn't a violent man, was intelligent and clever, kind and caring and had been through a lot. He was picked on and was taken advantage of".*

2.30 She also told us however about how Mr S *"took her hostage and battered her"* and *"tried to throw her down the stairs"* and although she rang the police she didn't want to press charges. The police referred him to the mental health services.

2.31 She explained that her son was a Muslim, as were his brothers, however he could not go to the mosque because he would not wash. When he left Teeside to move to Slough he said he was *"going to sleep in mosques".*

2.32 He ended up staying in Slough firstly with his stepfather. His stepfather let Mr S stay a while, however the house was not his, it was his brothers, and he said he had to leave. Mr S then went to stay with the victim, although he did not know him.

2.33 She told us that she had been in contact with Mr S by telephone and was planning to see him towards the end of March 2017. She said that she would like the opportunity to read the report at the appropriate time.

2.34 We understood that the perpetrator's brothers had disengaged from Mr S, and did not wish to be involved in the investigation. During the process of writing the report, we were informed by the police that the perpetrator's stepfather was a bound witness. We were advised by the police that if required, it would be more appropriate for us to contact him after he had given evidence, however we did not feel that this was necessary.

Structure of the report

2.35 Section 3 sets out the details of the care and treatment provided to Mr S from March 2013 to the 24 December 2015. We have included a full chronology of his care at Appendix C in order to provide more detailed information about the services he received from both TEWV and BHFT.

2.36 Section 4 examines the issues arising from the care and treatment provided to Mr S and includes comment and analysis.

2.37 Section 5 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.38 Section 6 sets out our overall analysis and recommendations.

3 The care and treatment of Mr S

Childhood and family background

3.1 Mr S was born in Stockton, County Durham, Teeside. He has seven maternal half-siblings; five brothers and two sisters (the eight children apparently had three fathers) with two brothers living in the northeast. He is described as a partially observant Muslim, having reportedly converted from Christianity in his late teens. Two of Mr S's siblings are reported to have served prison sentences for drug offences.

3.2 In 1993 and 1994, medical correspondence states that Mr S lived at home with his mother, her partner, and two siblings. Mr S and his mother moved to Slough in or around June 1995 when he was aged three.

3.3 His mother moved and later in childhood, Mr S moved back to Stockton, to live with his paternal grandmother.

3.4 It has been recorded that Mr S's early life was coloured by periods of instability and the influence of his older brothers. During this time, he was under the care of his grandmother who was strict but looked after him well.

3.5 It is reported that Mr S starting using cannabis at the age of 14 years of age. His ex-girlfriend has described him as being somebody who rarely showed his emotions, and reported that he drank heavily when the stressors at home became too much for him.

3.6 More recently, Mr S's mother lived alone in a one-bedroomed flat in Thornaby. The TEWV internal serious incident report describes his relationship with his mother as having been 'enmeshed', 'complex' and 'at times volatile', and states that Mr S was 'strongly influenced by his siblings'.

Training and employment

3.7 Mr S left school aged sixteen years, after gaining several GCSEs (at grades D and E). He then attended college to study general construction, but reportedly left after losing interest. He then started a 'protocol course' (run via a job centre), but left for financial reasons. Mr S obtained a job as a cleaner in a restaurant, and then worked as a painter and decorator for six months. He then remained unemployed (although several records report that he never worked after leaving school).

Contact with criminal justice system

3.8 On 4 April 2014 Mr S was arrested in Stockton-On-Tees for the offence of possession with intent to supply cannabis. He attended Middlesbrough police station on 20 August 2014 in relation to the matter and was released without charge with no further action contemplated.

3.9 On 10 April 2014 Mr S was charged with conspiracy to supply Class B drugs (cannabis resin). This was in relation to offences alleged to have taken place in Slough between 4 July 2012 and 14 February 2013. This arrest was undertaken by the Serious and Organised Crime Unit of Thames Valley Police and arose from fingerprints being found on certain packaging.

3.10 The offences related to a period of time when he was residing in Slough but at the time of his arrest he was residing in Teeside; and so he appeared at a Cleveland Police station where he was charged and bailed to appear at Slough Magistrates Court on 22 April 2014 where he was bailed to 21 July 2014 at Reading Crown Court.

3.11 Mr S was administratively re-bailed from 21 July 2014 to 22 August 2014 when he failed to attend court; on 26 September 2014 he was re-bailed to 1 October 2014; re-bailed to 26 April 2015 and then further re-bailed to 15 April 2015. On the 15 April 2015 he failed to attend the court and an arrest warrant was issued.

3.12 On 18 April 2015 Mr S was arrested on this warrant for breach of attendance at the Magistrates Court. Mr S remained in custody for the weekend in case his condition deteriorated. He was further bailed until 20 April 2015.

3.13 On 30 April 2015Mr S was arrested in Middlesbrough for breach of bail conditions, specifically he had failed to sign on at the Police station, and he was subsequently produced before the court the next morning. It is understood he was again bailed to 22 June 2015.

3.14 On 7 and 8 July 2015 the care coordinator was called to say that Mr S had been arrested for breach of his bail conditions and was due to appear in Teesside Magistrates Court the following day.

3.15 On 9 July 2015 Mr S appeared in Teeside Magistrates Court in relation to the charges related to conspiracy to supply Class B drugs (cannabis resin). He was released on bail to attend Reading Crown Court on 7 August 2015. Reading Crown Court is the Crown Court with the local jurisdiction for Slough offences which are *"either way"* or *"indictable only*".

3.16 On 3 August 2015 Mr S was arrested on suspicion of theft of cigarettes from shops and breach of his 'tag'. This was in relation to shoplifting offences committed on 30, 31 and 1 August 2015. Ms S was charged and bailed to attend court.

3.17 On 5 August 2015 Mr S was arrested on suspicion of assault on his mother. His mother stated that Mr S had kicked her in the ankles, verbally abused her and tried to push her down the stairs. They had been arguing over cigarettes. He also allegedly threatened her with a kitchen knife and to kill her. Mr S was released without charge but he was charged in relation to his bail conditions and was held overnight and produced before Teeside Magistrates Court the next morning.

3.18 Mr S appeared at Teeside Magistrates Court on 14 August 2015 in relation to the shoplifting offences committed on 30, 31 and 1 August 2015. Mr S pleaded guilty and he received a conditional discharge for 12 months.

3.19 On 20 August 2015 Mr S was released from custody. It appears that charges relating to supply of cannabis were dropped during summer 2015.

3.20 On 28 August 2015 the trial relating to the offence of conspiracy to supply Class B drugs (cannabis resin) came before Reading Crown Court. The prosecution offered no evidence in relation to Mr S however the trial proceeded in regard to the other defendants.

3.21 The record from Reading Crown Court states that Mr S was informed of no further action at Teeside Crown Court. This suggests he was not ordered to appear at Reading Crown Court. He was however imprisoned for a total of four days for offences of failing to surrender to custody.

3.22 On 9 October 2015 Mr S's solicitor confirmed that all cases against Mr S had been dropped and that they had closed the file.

Psychiatric history

First admission between 5 March and 8 May 2013

3.23 On Friday 1 March 2013 Mr S, age twenty years, moved from Slough to Teeside to live with his brother one and his partner to help his older brother two valet cars. He reported to brother one that he had been unhappy living in London (with his mother and younger brother three) after witnessing one of his friends being 'tasered' by the police, saying that this had frightened him and made him afraid to leave the house.

3.24 Soon after, on 3 March, he started to exhibit bizarre behaviour: he became mute, uncommunicative, did not eat or drink, and was not sleeping. Brother one reported that he was normally a talkative and social person. Mr S's notes refer to a *"rapid deterioration in his mental state"* over a three-day period. This suggests that Mr S's mental health can rapidly deteriorate, and that when unwell he can present as mute or uncommunicative.

3.25 Two-days later brother one took Mr S to his GP, who referred him to the local healthcare provider, who in turn referred him to the local crisis team. The GP noted that he was *"completely mute … lived in London, visiting brother, brother does not know him much, but knows that he was using cannabis in London … not sleeping for two nights, not eating … looks anxious".* It was reported that on that day he had stood on one spot without moving for five hours.

3.26 After a MHA assessment in brother one's home, Mr S was admitted to Roseberry Park Hospital (RPH) on an informal basis. There were documented concerns about risk to health and of self-neglect, with 'risk to others' being recorded as 'unknown'. A urine test indicated positive for cannabis. Mr S presented as nearly mute, exhausted and unkempt.

3.27 An oral antipsychotic medication (olanzapine) was prescribed from 10 March, at a dose of 10 mg daily. Mr S was referred a week later to the EIPT as he was regarded as likely to be experiencing a first episode psychosis.

3.28 On 27 March, whilst on day leave with brother one, he tried to run out of his brother's house, stating that he was going to jump off a bridge. After returning to the ward, Mr S told two staff members that *"I hear voices all the time and get confused sometimes, I don't really know what I want and feel very confused".* He stated that he had a difficult relationship with his mother but did not feel comfortable talking about it at the time, and commented that the voices sometimes told him to do things.

3.29 Mr S was prescribed an antidepressant (fluoxetine) as well as olanzapine. On the eighth of May, Mr S was discharged. The recorded diagnoses were

'severe depressive episode with psychosis' and 'mental and behavioural disorders due to use of cannabis, psychotic disorder' (ICD 10 - F12.5)[12].

3.30 The discharge summary states that he went to his own home in Thornaby (which appears to be mistaken as he went to live with brother one), and that he was being prescribed olanzapine 15 mg and fluoxetine 40 mg daily. He was under the supervision of the EIPT.

Community services between 8 May and 27 November 2013

3.31 On 24 June, the EIPT advanced practitioner visited Mr S at home with the care coordinator. Brother one reported that Mr S was experiencing problems coping with his poor hygiene, reluctance to assist with tidying and chores, and lethargy including spending long periods of time in bed. He also reported smelling cannabis in the house. Mr S denied all of the comments made by his brother, and any plans to hurt himself or others. The advanced practitioner agreed to reduce the olanzapine dose to 10 mg at night, on the basis that he was complaining of poor motivation and sedation, and there were no positive symptoms.

3.32 Three days later while the EIPT care coordinator was visiting Mr S at home, brother one arrived home early and stated that he could no longer cope with him living in the house. When the care coordinator suggested that some extra support could be put in place, brother one stated that it would not work as he did not trust Mr S. The care coordinator agreed to make contact about emergency housing, and the paperwork was prepared for a panel for emergency accommodation.

3.33 The next day Mr S moved to a local hostel in Stockton. Two weeks later the hostel contacted the care coordinator to report that Mr S was not attending to his personal hygiene, that his room was dirty and smelt badly, and that he needed to be prompted to take his medication and attend his GP for repeat prescriptions. Brother one advised the care coordinator that he had found Mr S a flat.

3.34 The care coordinator was informed that Mr S's flat in Thornaby was owned by his uncle, a local landlord. Mr S requested that he move into his uncles' accommodation against the advice of the care coordinator. His uncle told the care coordinator that he was keen for Mr S to move in otherwise he would let the house go. A brother was helping Mr S to move. It was arranged that a support worker would visit him twice weekly. The hostel agreed to hold his bed for two weeks.

3.35 On 27 September 2013 the care coordinator made an electronic care record entry noting that Mr S had been absent since the beginning of September and was not responding to telephone calls. He was thought to be in Slough and after contacting his mother, this was confirmed. Records suggest that he stayed in Slough for about six weeks.

[12] ICD10 is the international statistical classification of diseases and related health problems.

3.36 Early in October the EIPT community nurse returned a call from Mr S's mother, who expressed her concerns about his wellbeing. He reportedly had increased his cannabis use, had not taken his medication for over ten days, had run through a door at home, and had slept on a pavement. Mr S was due to return to Stockton with brother one.

3.37 The electronic care notes indicate that on 16 October, the EIPT occupational therapist was telephoned by a medical practitioner from a crisis team in Slough to advise that Mr S had been held in custody after an alleged assault on his mother, and was to be released that day. The care coordinator spoke with Mr S's mother, who reported that he had assaulted her by kicking her and pulling her hair, after she had refused to give him money to buy cannabis. She had agreed not to press charges, but had refused to let him back into her home. Mr S however appears to have made admissions as he received a caution for the offence.

3.38 Mr S's mother reported that he had only washed once in six weeks, that he had smeared faeces all over the walls, and that she had noticed him pulling funny faces. Mr S was staying with friends nearby but later returned to his flat in Thornaby.

3.39 Early in November when the EIPT community nurse visited Mr S (at his flat in Thornaby) he stated that his voice hearing experience had increased and that he was willing to take medication to help. He was still buying and using cannabis with friends to keep him distracted. He asked about starting antipsychotic medication and fluoxetine again, and the care coordinator agreed to contact the advanced practitioner about this.

3.40 On 11 November, brother one reported that Mr S was in custody and did not have access to medication. A later approved mental health professional (AMHP) report states that he was arrested by the serious organised crime division from London on suspicion of dealing Class B drugs. After being questioned, he was bailed until 14 April 2014.

3.41 On 14 November, when the advanced practitioner visited him at home, Mr S reported that his mental health was *"ok",* and that he continued to regularly use cannabis and occasionally alcohol. He also stated that he had not taken olanzapine for at least six weeks and had taken fluoxetine infrequently. In the absence of current psychotic symptoms, it was agreed by the advanced practitioner not to then prescribe any further psychotropic medication, but to provide ongoing monitoring and assessment of his mental health.

3.42 On 27 November, the care coordinator visited Mr S and requested that the crisis team conduct an assessment. He was reported to be distracted, only giving one-word answers, spending £240 a fortnight on cannabis, and stealing convenience food and chocolate bars. He claimed to be distressed after telling his brother he raped a girl (his friend's six-year old sister) when he was nine years old. The care coordinator informed her manager about this as per the TEWV safeguarding policy.

3.43 Thames Valley Police have no record in regards to any admission to or allegation against Mr S for a rape committed whilst a child. They cannot confirm he was resident in Slough when he was nine years old and it is possible that records may be available elsewhere. Research has therefore not corroborated Mr S's admission.

Second admission between 27 November 2013 and 12 June 2014

3.44 Mr S was assessed that day under the Mental Health Act (MHA)[13] at brother one's home, and was regarded as presenting with catatonic schizophrenia[14] in the context of ongoing cannabis misuse. Mr S was detained under Section 2 of the Mental Health Act 1983[15] at RPH, where he was prescribed oral olanzapine 10mg daily.

3.45 The consultant psychiatrist recorded that there may be some risk of harm to others, including an assault on his mother. Mr S had been non-compliant with medication, having discontinued olanzapine two months previously and fluoxetine two weeks earlier.

3.46 The short term plan was to increase the olanzapine dose to 20 mg, and eventually to give Mr S a test dose of depot flupentixol decanoate (a long-term injectable antipsychotic). The care coordinator visited Mr S to discuss the disclosures he made on 27 November about the young girl with the safeguarding team, but concluded that his mental state needed to improve before this could be pursued.

3.47 Mr S agreed to accept a depot injection, and this was administered. On 18 December, he was reviewed by the consultant psychiatrist, who reduced the olanzapine dose to 15 mg and advised that he would continue with the depot injection. Mr S was also made subject to Section 3 of the MHA 1983.[16]

3.48 Mr S was reviewed in early January 2014 and presented with delusional beliefs, elated and labile mood, disjointed thoughts, perplexity and suspiciousness, and reported hearing voices. He was being prescribed olanzapine 15 mg daily and flupentixol decanoate 60 mg fortnightly.

3.49 On 9 January, a hospital manager's appeal was attended by the care coordinator, who agreed to discuss the allegation that Mr S raped a six-year-old girl when she was nine years old with the safeguarding team. She also recommended that Mr S might benefit from spending some time in a local

[13] The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. http://www.legislation.gov.uk/ukpga/1983/20/section/1

[14] The predominant clinical features seen in the catatonic subtype of schizophrenia involve disturbances in a person's movement. Affected people may exhibit a dramatic reduction in activity, to the point that voluntary movement stops, as in catatonic stupor.

[15] Section two of the MHA is when a patient is detained and admitted to hospital for assessment for a period not exceeding 28 days.

[16] Section three of the MHA is when a patient is detained and admitted to hospital for treatment not exceeding six months

rehabilitation unit. The panel agreed that detention under Section 3 of the MHA 1983 should be upheld.

3.50 An application form was completed for admission to a local rehabilitation unit and he was subsequently offered a place on 5 February. The safeguarding team recommended no unsupervised contact with children until further assessment was completed; discuss with Mr S again to try to get more information about the child; the care coordinator to contact social services in London to find out if the incident had been reported or if the child or family were known to services; and, when considering leave beware of any access to children by Mr S. On 17 January, Mr S's leave plan was amended highlighting that he should not have unsupervised access to children. On 20 January, the olanzapine dose was reduced to 10 mg.

3.51 On 17 February the care coordinator wrote to Slough children's services in an attempt to clarify if the alleged incident between Mr S and the six-year-old girl had been registered. The reply stated that the files were paper copies and had been requested, and that any relevant information would be forwarded in due course.

3.52 On 10 April Mr S was accompanied to the police station, where he was charged with an offence of conspiring to supply a controlled drug (cannabis). On 22 April Mr S was escorted to Slough Magistrates Court, where he was unconditionally bailed until 21 July to reappear in Reading Crown Court. Two of his half-brothers attended the hearing and it was noted that one of the brothers was to appear charged with the same offence as Mr S.

3.53 On 15 May a CPA meeting was held in preparation for Mr S's discharge into the community. The possibility of use of a community treatment order (CTO)[17] was discussed. There was a recognised risk of non-compliance, although it was noted that Mr S had complied with his bail conditions. The risks identified related to self-neglect through not attending to his personal hygiene, not paying his bills, not eating properly and relapse if he again started to take cannabis.

3.54 Mr S was administered a prescribed depot of 80 mg flupentixol every three weeks and the Section 3 of the MHA was rescinded. After discussion with the multi-disciplinary team, it was concluded that Mr S did not meet the criteria for ongoing detention and it was agreed that a CTO would not offer him any added benefits upon discharge. The plan was that Mr S would stay as an informal patient with extended periods of leave.

3.55 On 12 June, Mr S was discharged from the local rehabilitation unit. He was assessed as having made improvements in his ability to care for himself, and had shown some progress in dealing with his bills. His mental health was reported to have been stabilised and he had complied with his treatment

[17] A CTO is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

regime and medication although he still believed that he was not suffering from a mental illness. The discharge diagnosis was paranoid schizophrenia.

3.56 Following rescinding of the Section 3 and his subsequent discharge Mr S would have the benefit of aftercare from the relevant local authority under Section 117[18] of the MHA. This fact was clearly documented in the electronic care record and in his care plan, which contained relevant supporting information to indicate that the duties in respect of Section 117 were being discharged.

Community services between June and December 2014

3.57 On 4 July, Mr S was arrested on suspicion of possession of a Class B substance with intent to supply. When he was reviewed in custody, he showed no signs of psychotic symptoms and was able to demonstrate his ability to understand and communicate as part of the decision making process. After being interviewed by the police, Mr S was released on bail.

3.58 On 26 September, the care coordinator was telephoned by Mr S's solicitor expressing his concerns that he was only days away from having a warrant issued for his arrest as he had failed to attend his court appearance on 22 August.

3.59 On 13 November, it was noted that Mr S had grazing to his arms and face, and he explained that brother one had taken his cigarettes and beer as he thought he should not use them all at once. The care coordinator spoke with Mr S about appointeeship,[19] which in principle he agreed to.

3.60 On 21 November, the care coordinator received a call from brother one stating that Mr S had been letting people into his flat, that they had smashed it up, and that as a result Mr S was homeless. Brother one said he had asked eleven young men to leave the flat, and reported that Mr S had spent over £900 in the previous two to three weeks. Mr S had been served two months' notice by his landlord, and other tenants in the flats had expressed an interest in getting an ASBO.

3.61 On 26 November when Mr S was reviewed, he expressed no concerns and stated that he had not heard voices since the previous year, that he felt all right in mood, and that he was tolerating the depot injection. He did not agree that he suffered from paranoid schizophrenia. Concerns were raised about him letting people into his house. Mr S admitted to having one 'joint' a day and alcohol occasionally.

3.62 The plan was for Mr S to continue to be prescribed a depot of flupentixol decanoate 80 mg every three weeks with medical review as needed, including

[18] Section 117 places a joint duty on the relevant CCG and LSSA to provide (or arrange for the provision of), in co-operation with relevant voluntary agencies, after-care services for certain classes of detained patient. It applies to patients who were detained under s3, s37, s37/41, s45A, s47, s47/49, s48/49. It begins when they cease to be detained and (whether or not immediately after so ceasing) leave hospital. The duty continues until the CCG and LSSA are satisfied that such services are no longer required.

[19] An appointee looks after and manages someone else's money.

a discussion about a possible reduction in the dose of his depot injection if weight gain was an issue.

3.63 On 19 December the care coordinator spoke with Mr S's landlord, who confirmed that he wanted him to leave the flat by 21 January 2015. Mr S stated that he would move back to Slough, although admitted he would prefer to stay where he could see his family. On 22 January, the care coordinator made a referral to a local hostel for people with complex mental health issues, which was accepted.

No fixed abode or staying at mother's address between March and August 2015

3.64 On 23 March, when the community nurse called to administer Mr S's depot injection, he was not available at his mother's house, and the hostel confirmed that he had not stayed there for the previous five days. The hostel considered his bed abandoned and withdrew it as he spent so much time at his mother's. Mr S was formally homeless. On 7 April when the community nurse visited, Mr S was asleep and his mother had just got up. The community nurse agreed to arrange a CPA meeting to discuss further as he was sleeping so much and was not motivated to help himself.

3.65 On 17 April at the planned CPA meeting Mr S presented well and demonstrated examples of his music, and there was no evidence of psychosis. There was some discussion on how to increase Mr S's functioning. It was agreed to reduce his depot injection to 70 mg from 80 mg every three weeks and he repeated his desire to return to Slough.

3.66 On 18 April Mr S was arrested on a warrant for breach of attendance at the magistrate's court. There were no concerns expressed by the sergeant or liaison and diversion worker that suggested further screening was required. Mr S remained in custody for the weekend in case his condition deteriorated.

3.67 On 1 May the care coordinator visited Mr S who reported that his mother was on holiday with two of his brothers, that his mobile telephone had been stolen and he would text her with his new number. The care coordinator later received a call from the police informing her that Mr S had been arrested for breaching his bail conditions and that he would appear in court the next day. Mr S was granted bail following his court appearance.

3.68 On 6 June, community nurse two visited Mr S to administer his depot injection at the reduced dose of 70 mg.

3.69 On 24 June the care coordinator contacted the safeguarding adults team regarding concerns about Mr S's escalating abuse towards his mother and her concerns about her vulnerability and ability to protect herself. The

safeguarding adults team suggested a referral to the first contact adult[20] service which was received.

3.70 On 26 June the community nurse visited Mr S and administered the depot injection. His mother told the community nurse during his visit that she thought that Mr S was not well, and was being influenced by his older brother. On the previous day he had threatened to cut her throat if she called the police. He advised that if that were to happen again the police would need to be involved *"as it was a domestic situation rather than mental health".* The care coordinator also received a telephone call from Mr S's mother, saying she was upset because he had made her go over to the cricket ground at the weekend and pick up cigarette 'dog ends'. She stated that she felt ashamed, and that Mr S had shouted at her. She also requested help to complete a carer's allowance form. The care coordinator was advised by the social worker that his mother was open to the safeguarding vulnerable adults team, and agreed to contact her allocated worker about these incidents.

3.71 On 7 and 8 July the community nurse recorded that Mr S was not available for his depot injection. The care coordinator was called to say that Mr S had been arrested for breach of his bail conditions and was due to appear in Teesside Magistrates Court the following day. Mr S was reported to be pleasant and amenable and there was no requirement to assess his mental state. He was to remain in custody overnight. The liaison and diversion court report recorded that Mr S had a history of potential risk to self and others, and highlighted the need for Mr S to receive his overdue depot injection as soon as possible after the court appearance.

3.72 On 9 and 17 July, when community nurse two made a 'cold call' to administer Mr S's depot he obtained no reply. However, he successfully administered this on 21 July and it was due to be administered again on 11 August 2015. Mr S appeared in court and was released on bail to attend Reading Crown Court as this was the court with the jurisdiction over the location in which the offence was committed.

3.73 When the care coordinator visited Mr S on 3 August, he informed her that his mother was in hospital in Slough due to her mental health difficulties. The care coordinator noted that all the pictures in the room and the clock had been turned upside down. When Mr S was asked about this, he laughed. His main concern was his lack of money. On the same day, Mr S was arrested on suspicion of theft of cigarettes from shops and breach of his 'tag'.

In custody between the 5 and 20 August 2015

3.74 On 5 August Mr S was arrested on suspicion of assault on his mother. The care coordinator spoke to his mother who was upset and stated that Mr S had kicked her in the ankles, verbally abused her and tried to push her down the stairs. They had been arguing over cigarettes. She alleged that he also threatened her with a kitchen knife and to kill her.

[20] Middlesbrough Council safeguarding access team. https://www.middlesbrough.gov.uk/social-care-and-wellbeing/safeguarding/safeguarding-adults

3.75 The care coordinator spoke with the police and requested that due to his mother's vulnerability Mr S should not be released to her address. She gave the contact details to Mr S's mother for places of safety and refuge, and also made enquiries about housing for Mr S. The police advised the care coordinator to discuss the issues with the local vulnerable person's team. Mr S was released without charge in relation to the assault on his mother but was charged in relation to breaching his bail conditions, was held overnight and produced before Teeside Court the next morning. On assessment he was not deemed to be ill at that time, but he was frustrated about being held in custody.

3.76 The custody diversion team contacted the care coordinator stating that Mr S could not be released without an address, and asking if he could be given an address in absentia. This was not agreed. He could not be released to his mother's address due to the seriousness of the threats, use of a weapon, previous assault on his mother, and the volatile nature of their relationship and was therefore remanded in custody. The liaison and diversion team stated that Mr S had at that time full capacity.

3.77 Mr S was released without charge in relation to the alleged assault on his mother but was charged in relation to breaching his bail conditions, was held overnight and produced to Teeside Court the next morning 6 August 2015.

3.78 The liaison and diversion services assessment report states that *"his care is currently coordinated by the care coordinator in the EIPT services and he is described as being stable and symptom free with the aid of a depot injection which he is compliant with"* and he was *"deemed to have full capacity as he is able retain, recall and weigh up information given hence demonstrating the ability to make informed choices and decisions"*

3.79 Mr S appeared at Teeside Magistrates Court on 14 August 2015 in relation to the shoplifting charges committed on 30, 31 July and 1 August 2015. He pleaded guilty and received a conditional discharge for 12 months.

3.80 The care coordinator contacted HMP Holme House prison mental health in-reach services where Mr S was remanded on 14 August 2015 to provide them with her and the EIPT contact details. The electronic care records do not detail a discussion about his depot medication which was due 11 August 2015.

3.81 On the 28 August the care coordinator discussed the overdue depot medication with the EIPT psychological therapist and the advanced practitioner. A decision was taken to administer the usual dose of 70 mg that day. The care coordinator contacted Holme House and was advised that he was no loner detained with them having been released from custody 20 August 2015.

3.82 The care coordinator recorded that she had faxed the *"depot card"* to Holme House on 14 August 2015 but that this was not administered prior to his release and that Holme House also failed to inform the EIPT team of his release. Mr S was administered his depot medication on 28 August 2015.

3.83 It appears that charges relating to supply of cannabis were dropped during summer 2015.

Homeless and staying at mother's address from 21 August 2015

3.84 On 28 August the care coordinator discussed with the advanced practitioner her concerns about Mr S not having had his depot injection. However, this was administered on 3 September and 24 September at his mother's address.

3.85 On 9 October, the care coordinator attended a briefing with adult protection in response to the safeguarding alert raised. Mr S's mother said that he had gone out to get a takeaway and some cannabis. The flat was filthy, with rubbish and clothes lying around. She said that he was awaiting surgery to his knuckles, having punched a frozen bottle of coca cola. Mr S's solicitor confirmed that all cases against Mr S had been dropped and that they had closed the file.

3.86 On 16 October, Mr S failed to attend an appointment with community nurse two for his depot injection. He returned in the evening to find Mr S and his mother arguing. Mr S stated that he did not want his injection, and that because he did not hear voices any longer, he did not see the point in taking medication. The community nurse agreed with Mr S that a medication review should be arranged.

3.87 On 22 October, the community nurse visited to administer the depot, but Mr S failed to attend. His mother had changed all the locks to her house and said she had not seen Mr S for two days.

Community services November 2015

3.88 On 3 November, the community nurse called to visit Mr S at his mother's address but he was not at home and had not been seen for two weeks. It was assumed that he was staying with his mother. On 5 November, the care coordinator sent a text to Mr S stating that he needed a review of his medication as he had not had his depot injection. He replied by text saying *"Hug",* which was out of character. Brother three rang the care coordinator saying that he had received a text from Mr S saying *"goodbye and pray for me today",* and reported that he had last seen him on the 26 October. When the care coordinator visited Mr S's mother's address, she stated that Mr S had just left and had presented as *"weepy"* and said that he needed to go away for a while.

3.89 The care coordinator called the police, advising them of Mr S's diagnosis and that he had failed to have his depot. The care coordinator received a reply from a text she had sent him saying that he was fine and that he was about to meet the police to demonstrate that he was fine and well. Mr S agreed to meet her on the following day to talk about his medication.

3.90 On 11 November, the advanced practitioner and the care coordinator visited Mr S and his mother at his mother's address. Mr S blamed the depot injection

for making him sleepy, and was uncertain as to whether he wished to continue with the medication.

3.91 Following discussion Mr S agreed to commence his depot at a reduced dose of 40 mg every three weeks. This was the last time he received his depot before his arrest. The care coordinator was to continue to engage Mr S with EIPT. A CPA update was completed, in which the risks were recorded as non-attendance, potential for relapse if patient not treated, ongoing family difficulties, violence towards his mother, delivering regular support, and his poor physical health.

3.92 The advanced practitioner wrote to the GP on 12 November and recorded that Mr S was due to transfer to the psychosis services in March 2016. It is thought that Mr S moved to Slough in late November, that he had been staying with the victim for around four weeks, and that the victim was known to Mr S's ex-stepfather and brother two.

Community services between the 1 and 24 December 2015

3.93 On the second of December, Mr S did not attend an appointment for his depot injection which therefore was from this point overdue. It was at or around this point that the team were informed he had moved to Slough.

3.94 On the fifth of December, when the care coordinator telephoned Mr S, a stranger answered, saying that they had Mr S's phone SIM card and provided her with brother one's telephone number. She then had a missed call from brother one stating that he was worried about Mr S and he thought that he was just visiting Slough. Brother one stated that Mr S's phone had been taken forcibly and that he could not get into contact with him. Brother one was advised by the care coordinator that if he had concerns about his brother's safety, he should contact the police and that she would continue to try to contact Mr S.

3.95 On Friday 11 December a TEWV community nurse visited Mr S's mother and was provided with address one in Slough where Mr S was residing on a temporary basis. At this point, Mr S had not been seen by TEWV staff for a month since 11 November 2015, and his recently reduced three-weekly depot was already overdue from the 3 December 2015.

3.96 Information from the brother and partner of the victim indicate that Mr S's stepfather lived at address one and asked the victim if Mr S could stay with the victim at address two in Slough, even though they understood that the stepfather had room for Mr S to stay with him. The victim was said to be reluctant but the stepfather allegedly persuaded him otherwise.

3.97 As there was no way of knowing if Mr S was returning from Slough, the TEWV care coordinator made a referral to the common point of entry (CPE) for BHFT adult mental health services for CPA transfer and continued support. The TEWV care coordinator 'cut and pasted' information from the meeting with the advanced practitioner which was also regarded as Mr S's CPA meeting on the

11 December 2015 and included the risk assessment and an emergency CPA document with the referral.

3.98 The TEWV care coordinator told us that the main issues of concern were his vulnerability, the deterioration of his mental health, substance misuse and the fact that he was un-medicated. The medication was detailed in the medication section of the referral as being flupentixol decanoate 70 mg every three weeks, which was incorrect.

3.99 The changes made to his medication by the advanced practitioner were detailed in the body of the text under relevant history and symptoms as being flupentixol decanoate 40 mg every three weeks last given 11 November 2015 which was correct.

3.100 The TEWV care coordinator did not mark the referral as urgent or think he was a risk to others and although we were told that she thought that BHFT needed to undertake a follow up appointment with Mr S within two weeks, this wasn't stated on the referral. The referral did not therefore provide clarity on what was required or being requested i.e. a short term intervention or a CPA transfer.

3.101 The BHFT CPE is the single point of entry via a central control hub in Wokingham operating between the hours of 8 am to 8 pm Monday to Friday. Outside of these hours the service diverts to the crisis resolution and home treatment team. Practitioners in the CPE are aligned locally to the six localities of Newbury, Reading, Wokingham, Slough, Windsor and Maidenhead and Bracknell for local triage and face to face assessments but deployed by the Wokingham control hub. The CPE operational manual states that all adult referrals will be screened on receipt of referral and red, amber, green (RAG) rated based upon level of risk as follows:

- Crisis referrals can only be made by a GP and require a response within 4 hours.
- Urgent Referrals require an initial contact within 24 hours.
- Amber Referrals require an initial contact to be attempted between 72 hours and an assessment to be undertaken within14 days.
- Routine Referrals require an initial assessment completed within 28 days.
- Crisis referrals must be clinician to clinician discussion.
- GP to be written to on discharge or exit from CPE with details of actions taken.
- All patients seen for a face to face assessment will be asked to complete a CPE service satisfaction rating.

3.102 The referral was logged and added to the BHFT services CPE waiting list at 4.30 pm and the referral was reviewed at about 6.30 pm by the shift lead in

the central Wokingham hub as being a CPA transfer request. It was noted by BHFT that Mr S was 'un-contactable' and that the given reason for the referral from TEWV was 'generic assessment of mental health'.

3.103 We were told that their view of the referral information was that it was of poor quality, did not carry any sense of urgency and it was difficult to understand what was being asked for. The central Wokingham hub shift lead therefore dealt with the referral as a CPA transfer and linked into Slough locality CPE to progress.

3.104 As BHFT did not find any indication at the time that this was an urgent or a crisis referral it was not treated as such. Mr S was described as potentially vulnerable to exploitation and as being homeless with risks recorded as being substance misuse, housing problems and non-compliance with treatment. They told us that their understanding of the risk issues associated with the referral were that Mr S was suffering with psychosis, that he was relapsing, his medication was overdue and that Mr S had moved to his stepfather's address one and would need support.

3.105 It was noted by BHFT in the referral that the issue of self-reported inappropriate sexual behaviour in front of a female child had been reported to Slough social services, with no reply having been received at that point. No risk to others, or of violence, were recorded other than this alleged incident and the assault on his mother. The referral risk section stated *"When psychotic he has had suicidal thoughts as a result of worrying he may harm somebody or had harmed somebody. Some concerns about self-care. He can be vulnerable to exploitation."*

3.106 If it is clearly a crisis referral, we were told that BHFT would expect a telephone call from the referrer or more clarity on the referral form. BHFT told us that, as an example, TEWV had the option of telephoning the Slough locality team to advise that the depot was overdue. We concur with this view.

3.107 The CPE central hub would normally request further background information for a CPA transfer request, while the locality CPE lead would decide how to progress the referral. A CPA transfer request would usually require CPA and risk assessment documentation in order for the CMHT to decide whether to accept the transfer. It was known that Mr S was subject to CPA and the diagnosis of first episode psychosis was also known. We were told that these two elements of information would usually be sufficient to transfer the case directly to the locality team rather than holding the case in CPE.

3.108 The referral went into what is known as the 'shift lead pot'. This is actually a 'referrals in' folder within the BHFT electronic care notes system. Referrals put in to the 'shift lead pot' allows the shift lead to risk rate the referral by using the risk matrix in the CPE operational manual. If a referral is put into the 'shift lead pot' they are seen as complex, a priority and are reviewed at each shift handover until resolution. Keeping the referral in the 'shift lead pot' would also ensure that the CPA transfer information was requested. We view this as an appropriate decision to have taken.

3.109 The referral was risk rated as ‘amber’ meaning that CPE would respond within 48 - 72 hours following receipt of the referral with an assessment within 14 days. As it was being dealt with as a CPA transfer the central Wokingham hub shift lead emailed the CPE team lead for Slough locality on 12 December 2015 to request a review of the referral and for advice about the process for transfer of care to Slough CMHT. The plan was recorded as a request for the CPE administrator to contact the referrer and request updated full risk assessment and CPA information from TEWV.

3.110 However, the email correspondence from the central Wokingham hub to the CPE team lead for Slough did not mention that the depot medication was overdue and it was not known that the CPE team lead for Slough CMHT was on leave. This meant that the CPE team lead did not review the email until on or after Wednesday 21 December 2015. The central Wokingham hub shift lead was not aware of this as there was no out of office message or automated email indicating that deputising arrangements were in place.

3.111 The referral remained in the ‘shift lead pot’ and we were informed that despite the CPE team lead for Slough CMHT being on leave, the referral should still have been picked up through the process of review of referrals in the ‘shift lead pot’ at every shift handover. However, at the time, the ‘shift lead pot’ was not being reviewed daily as it should have been, and every case was not reviewed every day. Since then BHFT have issued new guidance and as well as a daily check, every month the administrator prints off a list of the referrals in the ‘shift lead pot’ and emails the relevant people to ensure that actions are taken.

3.112 At the time there was only one team lead for the Slough locality and we were told that they were the busiest locality in terms of referrals. In practical terms, this meant they had approximately three to four minutes available per referral to make a decision.

3.113 Apart from the initial email to the CPE team lead for Slough CMHT, they were not contacted further by the central Wokingham CPE hub, and remained unaware of the referral. It was seemingly assumed that the email had been received, and it also appears that there was no routine process in place that would pick up whether the referral had been processed. The referral therefore remained in the ‘shift lead pot’ for eleven days.

3.114 The BHFT report states that further information was requested from TEWV but not provided. We found that three telephone calls were made by the central Wokingham hub CPE staff to the TEWV team on 16, 23 and 24 December. The TEWV EIPT psychological therapist returned the call made on the 23 December, at 12 midday. Separately an EIPT community nurse from TEWV contacted BHFT on 23 December to enquire about progress of the referral. He was informed that this had not been allocated as yet as further information was awaited from the care coordinator.

3.115 The TEWV EIPT psychological therapist explained to BHFT that Mr S had been difficult to engage and that he had not received his depot medication for some time. He indicated that TEWV would look to discharge him if he was to

remain in Slough, noted that BHFT were aware of his depot medication being overdue and would manage his care as needed. It was planned that the TEWV care coordinator would contact them on her return from leave.

3.116 On the morning of 16 December the BHFT CPE team administrator telephoned TEWV to ask that the care coordinator provide an updated full risk assessment and CPA. A TEWV colleague took this message and said that the care coordinator would return the call around 11.30 am. The BHFT report states that there is no evidence that TEWV returned the call. We were told by TEWV that telephone messages taken by the team secretary would have been written in a message book at the time. This practice has now been ceased and all messages are recorded directly into the electronic care record.

3.117 The TEWV care coordinator told us she was not aware of this message being left for her. She had a period of unplanned sick leave followed by annual leave from 21 December 2015. TEWV cover unexpected absence such as this by allocating another care coordinator to the patients, advising them accordingly, and by use of their duty worker arrangements to take calls and undertake any urgent pieces of work. In addition, TEWV would use the out of hours' crisis team if necessary.

3.118 At 5.45 pm on 21 December, Mr S called the TEWV care coordinator on her work mobile 'phone and left a voice message identifying himself to her and saying that he thought he needed his medication (this information is not recorded in Mr S's care records, but was information offered by the care coordinator in a later interview for the TEWV internal serious incident investigation). Mr S said in his message *"I'm doing really great by the way but I feel like I might need my medication. I'm down south basically if you want to know where I am, just call me, whatever and I'll get in touch … so thank you very much, I'll see you when I see you. Bye. God bless".* At the time the voicemail was left, the care coordinator was on annual leave and so she did not pick the message up until after the homicide.

3.119 It appears that Mr S's GP practice tried to telephone Mr S on 22 December 2015, however the number they were provided with was not in use.

3.120 On the morning of Wednesday 23 December 2015, the BHFT CPE team administrator telephoned the TEWV care coordinator and left a voicemail asking her to call back. BHFT were not aware that the TEWV care coordinator was on leave. Also on 23 December 2015 a TEWV community nurse made a call to BHFT mental health services, who confirmed that they had received the referral form but they had not at that point allocated the case. It is unclear whether this was in response to the call from TEWV or made independently.

3.121 The brother of the victim told us that he saw him on 23 December 2015 as it was his birthday. During the visit the brother said that Mr S *"Kept ringing and asking if he could come back".* The victim kept refusing. Both the brother and the partner of the victim told us he was frightened of Mr S, did not want him to stay and had asked him to leave because he was helping himself to the victim's food, tobacco, alcohol and belongings which was causing arguments.

3.122 At 4.47 am Mr S was referred to the Slough crisis resolution and home treatment team (CRHTT) by an out-of-hours GP. Mr S's stepfather had contacted the GP requesting that Mr S be given a depot injection as he was showing signs of relapse.

3.123 The BHFT internal serious incident investigation quoted the GP (whose call was recorded) as saying that Mr S had *"smacked the stepfather three times on the face and he's violent and he needs some help now … the stepfather is in trouble and he's getting all the trouble from the patient but I couldn't reason him out and I need your help. He needs some injection … I think because his depot injection is running out … he's causing trouble including violence, I think we ought to do something".*

3.124 The call was taken by a CRHTT east health care assistant (HCA) and during the call she also spoke to Mr S and his stepfather. Mr S's stepfather told her that his depot medication was due. The BHFT internal serious incident investigation quotes the stepfather as having said: *"We need bit of help here … he's lost the plot … he needs that drug now, it lasts maximum four weeks, it's been five six weeks".*

3.125 The stepfather stated during this call that he was not staying with Mr S, but that Mr S was staying at the house of a friend of his, and told the staff member *"get in touch with me on this number - I will get through to him somehow".* This friend was the victim. The BHFT internal serious incident investigation says that Mr S told the CRHTT east health care assistant that he had got *"angry with my stepdad for no good reason … I need the depot now basically".*

3.126 The CRHTT east health care assistant told us that she did not regard this call as a crisis referral needing a response within four hours, according to the CPE operational manual, given the early hours of the morning in which it was received, and allocated it for discussion in the am shift handover and with the senior member of staff on duty who was a band 6 agency worker.

3.127 Her advice to the GP was to manage the safety in the house first, and to call the police if safety was a concern, however the GP said that Mr S had calmed down, was no longer violent and was not an immediate risk. She informed the GP that his depot medication could not be administered immediately and the GP agreed to the plan to administer the depot the following morning.

3.128 The stepfather told the CRHTT east health care assistant that he was not staying with Mr S but that he was staying at the house of a friend of his. The stepfather told the CRHTT east health care assistant to *"get in touch with me on this number, I will get through to him somehow".* She told us that she could not remember whether she was provided with the address Mr S was residing at and did not record an address in the electronic care record.

3.129 The CRHTT east health care assistant entry at 05.00 am includes the plan for the CRHTT to arrange for the depot to be prescribed, collected from pharmacy and administered. At about 05.15 am the GP telephoned the night

shift CRHTT lead to confirm his agreement with the depot medication to be arranged in the morning.

3.130 At 07.30 am the referral was discussed at the handover meeting, where it was agreed that CRHTT east nurse one would attempt to gain further information. At 10.30 am the CRHTT east nurse one made an entry in the electronic care record after attempting to telephone Mr S who did not respond, and then telephoning the stepfather at 09.51 am. The stepfather told her that Mr S had been in Slough for almost two months, that he thought Mr S was relapsing, his behaviour had been erratic, he had been quite aggressive the previous night, and that Mr S had not had his depot for about three to four weeks.

3.131 The CRHTT east nurse one spoke to Mr S and recorded that he was laughing intermittently and said *"I don't know why I'm laughing",* he felt that life wasn't worth living *"because of my mental health issues"* but denied thoughts of harm to self, saying *"I value my life; I don't have thoughts of wanting to kill myself*". Mr S gave the CRHTT east nurse his care coordinator's number however when she tried to phone it went straight to voicemail.

3.132 The BHFT report notes that the stepfather described Mr S as "not too good" and stated that he needed his injection and had been violent the previous night. Mr S himself is reported as having said he was: *"going all over the place, like, thinking all the time".* The CRHTT east nurse one stated that she would make further inquiries and call back.

3.133 At 10.04 am CRHTT east nurse one contacted Slough CMHT, who said they had no information about Mr S. At 10.17 am the CRHTT east nurse one telephoned TEWV and left a message for the care coordinator to ring back. At 10.19 am the CRHTT east nurse one called Slough CPE, and established that they were waiting for information from TEWV and intended to pass the case on to the Slough CMHT.

3.134 At about 10.30 am the CRHTT east nurse one discussed the case with the CRHTT psychiatrist and also the team lead who was the early shift lead nurse for that day. The advice given was for the crisis team to visit to assess the current presentation and request for review with the CRHTT consultant psychiatrist as oral medication might be prescribed if appropriate after assessment.

3.135 At around 10.50 am CRHTT east nurse one called Mr S's stepfather to advise that a visit would be arranged that day with a view to prescribing oral medication. The BHFT internal investigation notes that the stepfather repeated during the above call that Mr S had been aggressive during the night, and asked whether a doctor would be visiting. He was told that nurses would visit first and that *"the doctor will start him on something"* that day.

3.136 It was then decided that a male CRHTT east nurse two, accompanied by a male CRHTT HCA two, would visit Mr S. It is unclear why the visit was to the stepfather's address, when the stepfather had stated that Mr S was not staying with him. According to the BHFT internal serious incident investigation the visit took place between 11 am and noon however the visit

was recorded by the male CRHTT east nurse two in the electronic care record at 2.15 pm.

3.137 The entry states that CRHTT east nurse two and CRHTT HCA two attended address one. The front door was wide open. The stepbrother of Mr S met them and said that Mr S did not live there and only visited. A man arrived shortly afterwards who introduced himself as Mr S's uncle and said he was assaulted for no reason by Mr S. He told them to visit Mr S at his friend's house address two, said he had real concerns about him and wanted them to see him as soon as possible.

3.138 CRHTT east nurse two and CRHTT HCA two explained that it was not appropriate to just turn up at a person's address especially because Mr S had recently been aggressive to others. He was advised to call the police if he felt threatened or at risk of being assaulted. The plan was recorded as to reattempt CRHTT assessment after making 'phone contact with Mr S.

3.139 We were told by BHFT that the staff undertaking this visit made an error of judgement and we concur with this view. They could have escalated the concerns by calling the team lead to discuss how to proceed. Neither staff member was carrying a personal alarm or safety device, and we are of the view that the CRHTT need to clarify and confirm the emergency contact arrangements for staff undertaking home visits.

3.140 At about 1.20 pm the victim telephoned the community health hub in Wokingham, asking for help for Mr S and said he needed medication. Mr S came on the 'phone line and said, *"I need my antipsychotics, I was supposed to get them yesterday".* CPE were advised of this call by community health staff.

3.141 At 1.30 pm at the handover meeting with the CRHTT east afternoon shift lead, it was agreed that the same CRHTT east nurse two would visit Mr S's address, this time accompanied by female CRHTT east nurse three. At about 1.40 pm a CPE nurse received a phone call from the victim who advised her that Mr S was staying with him, provided his address two, and said that Mr S had been aggressive, and was *"not compos mentis … he's all over the place … he's getting worse … he is self-harming …".* When the CPE nurse asked to speak Mr S the victim said that he was sitting on the sofa totally silent and unable to speak to the nurse. When asked if he thought he or Mr S were in immediate danger he replied: *"not right at this minute".*

3.142 CPE advised CRHTT of this contact with the victim at about 2.00 pm by 'phoning male CRHTT east nurse two (who had already tried to visit Mr S) and recording his address two and telephone number in the electronic record.

3.143 At 2.20 pm CRHTT east nurse two recorded that he had received a phone call from a TEWV EIPT psychological therapist responding to a phone call from CRHTT who informed him that Mr S was currently under their care. The psychological therapist made CRHTT aware that they had struggled over the past year to engage with Mr S on a consistent basis and that he would often miss his arranged depot injection.

3.144 He said that Mr S had gone to Slough without their knowledge, and that he would be discharged if he was staying in Slough. It was agreed that this would be formalised with a transfer of care to the local EIPT and that more detailed information would be given by the care coordinator about him on her return from leave.

3.145 At 5.15 pm CRHTT east nurse two and CRHTT nurse three undertook a home visit to address one again and obtained no answer (although dogs were barking and lights were on in the house). They tried to phone Mr S without success.

3.146 They told us that when they discovered Mr S was not at address one they decided not to attempt a visit at address two because they didn't feel safe to do so. Police involvement was not considered because they had not yet assessed Mr S and that the police usually ask the services to undertake the first assessment. CRHTT east nurse three recorded the plan as being to telephone Mr S in the morning to arrange an initial assessment.

3.147 CRHTT east nurse three told us that they could have telephoned Mr S prior to the visit and could also have checked they had the correct address by looking in the electronic care record. They had undertaken a previous timed crisis referral for assessment visit about 4.00 pm before the attempted visit to Mr S and had a further four assessments outstanding that day to undertake. BHFT told us that at that point a phone call should also have been made to the team lead at base to discuss and take advice however instead of a phone call they decided to go back to the team base to discuss as they had a one-hour gap in their schedule of visits.

3.148 Once back at base they recorded the outcome of their visit on the electronic care record as having taken place at 5.15 pm with the entry being made at 6.00 pm. The plan at this point was to undertake a further visit before 8.00 pm utilising the CRHTT east night staff to do this. We were told that there was capacity to do so and the night staff had only one other assessment to undertake.

3.149 At just after 8 pm CRHTT east nurse two recorded that after discussion with the late shift team lead it was agreed that an assessment needed to be carried out that evening, referring to the entry at 2.04 pm reporting that Mr S had been self-harming. These concerns had been raised some six hours earlier, and well before the second attempted visit.

3.150 The two nurses who had made the second visit were due to go off duty at 9.00 pm. At around 8.55 pm CRHTT east were advised that Mr S had been arrested.

3.151 As part of the BHFT internal investigation a tele conference with the police brought to the attention of the external reviewer that the victim, Mr S and the stepfather had been drinking excessively until 3.00 am on the 23 and 24 December 2015. Mr S had punched his stepfather impulsively and appeared to be in a trance like state.

4 Arising issues, comments and analysis

Medication

4.1 Mr S had a history of non-compliance with oral medication since referral in March 2013. In December that year he was prescribed and accepted depot medication.

4.2 Mr S was consistently administered his depot medication of 80 mg every three weeks during 2014, apart from two occasions when it was administered slightly later than prescribed due to his non-attendance at the agreed appointments. The community nurse was persistent in ensuring Mr S received his depot despite the challenges this presented.

4.3 Mr S was offered a review in November 2014 to discuss the possibility of a reduction in his medication if it was causing side effects such as weight gain and drowsiness during the day.

4.4 In April 2015 the depot medication prescription was reduced from 80 to 70 mg every three weeks following a review, given that he had not experienced voices or unusual thoughts for over twelve months and to improve his level of motivation. This was in agreement with Mr S in a care plan meeting.

4.5 Mr S did not attend his appointment to administer his injection in July 2015 and so this was given two weeks later than planned. In August Mr S was remanded in custody after assaulting his mother and as a result his depot injection due on the 10 August was not administered until the 3 September 2015.

4.6 On the 16 October 2015 Mr S told the community nurse that he didn't want to have his depot injection because he didn't hear voices anymore. The community nurse told Mr S that he would arrange a medication review. Whilst this was being arranged Mr S did not attend for his next depot injection due on the 22 October 2015.

4.7 On 11 November 2015 the advanced practitioner was asked to undertake a review with Mr S due to concerns about compliance. We found that this was good practice and a timely intervention. The advanced practitioner found no significant risk factors and Mr S told him that he last heard a voice in August 2015.

4.8 Following the review, the advanced practitioner amended the prescription to reduce the depot injection further to 40 mg and this was administered. This was the last time Mr S received his last depot injection prior to the incident.

4.9 We were told that the advanced practitioner would undertake a medication review following a team request and discussion that would generate options. The advanced practitioner may also be asked to undertake a medication review without this discussion taking place, that they would normally be able

to anticipate the situation in hand and discuss the plan with the consultant in the team beforehand.

4.10 However, neither the advanced practitioner not the consultant could recall a discussion having taken place although the decision was recorded in the electronic care record and in a letter to the GP. We were concerned about this given that Mr S had not seen a psychiatrist for seven months or a consultant for twelve months, and view this lack of a discussion as a lost opportunity to review the risk issues associated with the change.

4.11 Accordingly, we recommend that the EIPT operational policy sets out agreed methods and expectations around multidisciplinary working, so as to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and review patients at least annually where they are receiving antipsychotic medication. This is usual good practice and may be undertaken through the CPA process or the annual physical health assessment.

4.12 Despite the lack of a recorded discussion with the consultant we found the decision the advanced practitioner took to be reasonable. This is because the decision was taken in the context of his poor compliance with medication, it was following negotiation with Mr S as he was expressing his reluctance to continue at all with the depot medication and it was planned to observe and review Mr S as a result of this change.

4.13 We found that TEWV has a clear non-medical prescribing policy and a trust lead for this both of which were in place at the time. We were told that the advanced practitioner role in TEWV is well established, and the decision taken about the reduction of medication for Mr S was within the scope of the job role and the competence of the advanced practitioner.

4.14 In terms of the medical input to the EIPT were told that the EIPT and psychosis teams are now managed as one service and have sessional medical input, which is proactive and flexible according to clinical need. We found however that this may result in inconsistent medical input and recommend that job plans and operational procedures are reviewed to address this.

4.15 Over a fourteen-month period between 14 July 2014 and 24 September 2015 Mr S received 1,480 mg of depot (equivalent to an average of just under 22 mg per week, or just over 65 mg per three weeks). The longest gap during this period between 21 July and 3 September 2015 was just over six weeks.

4.16 There was then a gap of nearly seven weeks which was longer than any previous gap, and following this Mr S was then administered the lower dose of 40 mg. By the time he was referred to BHFT on 11 December 2015 this 40 mg was the only medication he had received for just over eleven weeks (i.e. equivalent to less than 4 mg per week), and hence he was much less medicated at that point than he had been for over a year.

4.17 On 21 and 24 December 2015 respectively, Mr S called the TEWV care coordinator and spoke to the BHFT CRHTT east health care assistant to request his depot medication.

4.18 By the time he presented to BHFT CRHTT on 24 December 2015, he had received just 40 mg in thirteen weeks (whereas on average he would previously have received 280 mg during such a timescale).

4.19 The lower end of the range of 'usual maintenance' doses according to the British National Formula (BNF)[21] for this depot is 50 mg every four weeks with the interval between treatment discontinuation and symptom recurrence being highly variable.

4.20 Good practice would assume that careful observation of signs of relapse should ensue when a four weekly prescription of depot medication has not been administered for a period of thirteen weeks. It is generally accepted that risk of relapse is increased overall after about three months. Mr S's history suggests that he can deteriorate rapidly, and is uncommunicative and mute when unwell. We noted that on 24 December 2015 the victim described Mr S as *"being totally silent and unable to speak"*

4.21 We found that the potential risks associated with the depot medication being overdue were not communicated effectively in the referral correspondence from TEWV to BHFT. The response from BHFT was therefore not seen as urgent. However, despite this we found it difficult to determine whether the lack of administration of the depot medication contributed to the incident occurring.

Use of a community treatment order (CTO)

4.22 In May 2015 in preparation for Mr S's discharge into the community the possible use of a CTO was discussed. There was a recognised risk of non compliance with medication although Mr S was noted as being compliant at that time with his bail conditions. The risks related to self-neglect, not paying his bills and relapse if he started to take cannabis again.

4.23 After discussion with the multidisciplinary team it was decided that Mr S did not meet the criteria for detention and it was agreed that a CTO would not offer him any additional benefits.

4.24 The key purpose of a CTO is to reduce the likelihood of re-admission. We found therefore that the decision made seems to have been a reasonable and defensible one in the circumstances pertaining at the time, and in retrospect, seems to have had no measurable bearing on the later outcome.

Care plans, safeguarding and risk to self and others

[21] The BNF reference books are practical, evidence-based information for healthcare professionals who prescribe, dispense, and administer medicines

4.25 We found that TEWV had an appropriate care programme approach and harm minimisation policy in place.

4.26 Following rescinding of the Section 3 in June 2014 and his subsequent discharge Mr S would have the benefit of aftercare from the relevant local authority under Section 117 of the MHA. This fact was clearly documented in the electronic care record and in his care plan which contained relevant supporting information to indicate that the duties in respect of Section 117 were being discharged.

4.27 Care provided to Mr S was in line with the values and principles outlined in the TEWV CPA policy for people in contact with secondary mental health services who have complex characteristics, and involved Mr S and his family wherever possible and appropriate. Care provided was in line with NICE[22] guidance on early intervention in psychosis, psychosis and schizophrenia and co-existing mental illness and substance misuse.

4.28 The care coordinator built up trust and confidence with Mr S and took a proactive and co-ordinated approach to co-ordinating and managing Mr S's care and supported him to have choices and make decisions to determine his wellbeing and recovery. Support, information and advice was offered to his family. He attended his annual physical health checks in October 2014 and 2015, a dentist appointment in June 2015 and was able to discuss his weight gain associated with his medication with EIPT.

4.29 Care plans describe interventions regarding physical health, accommodation, mental health, potential risk to children, risks of non-attendance, lack of insight, self-neglect, cannabis use, vulnerability, carers' views, alcohol and drug use, vocation and activity, finance and medication. In June 2015 family work was suggested by the care coordinator to help support Mr S and his mother in their communication with each other which they agreed to think about.

4.30 Each action in the care plan had a contingency and the care plan itself had a crisis action section. For all of these the action was to contact the care coordinator, the team or the duty system with telephone numbers provided. This does not adhere to the TEWV CPA policy on crisis plans where it asks that crisis plans have warning signs, relapse indicators and actions. It is not known whether this is just a EIPT or a TEWV wide issue and it is therefore our view that crisis plans should be audited and action taken as required to meet the CPA policy standard.

4.31 Formal clinical risk assessments were undertaken for Mr S and updated on a regular basis. However, the last formal risk assessment in the electronic care record was on 12 June 2014. Following this assessments of risk were recorded in the electronic care record as a narrative rather than in the formal risk assessment.

[22] NICE stands for the national institute for health and social care excellence and it provides evidence-based guidance, advice and information services for health, public health and social care professionals.

4.32 We found that risks were detailed and actions to mitigate were explained in detail in the electronic care record. However formal clinical risk assessments were not scored consistently or updated after risk incidents occurring according to the clinical risk management policy, and we found that the risk assessments did not translate through to the formal care plan. We found that this was not conducive to a clear formally recorded picture of risk over time with mitigating actions.

4.33 Risk to self was primarily concerned with self-neglect and Mr S's vulnerability to exploitation. The care coordinator worked hard to ensure that Mr S had the full range of support available to him to enable him to live independently and elicited help from family members in doing so where appropriate. However, Mr S was not always able to utilise the support offered to him and he was difficult to engage.

4.34 Mr S led a chaotic life and in November 2014 it was reported that he had been letting people into his flat, spending a lot of money and as a result Mr S was homeless. Despite concerns about his vulnerability in this respect, Mr S was not subject to a formal safeguarding process.

4.35 We found that TEWV had safeguarding and supporting harm minimisation policies in place. The safeguarding policy requires updating from May 2016. Although an alert was not formally raised and discussed as per the policy, we are of the view that Mr S's risks to self were recognised and managed appropriately despite not formally being subject to a formal safeguarding process.

4.36 We note that the TEWV quality account annual report 2015 - 16 states that the Trust has agreed a learning culture framework and implemented processes for learning from safeguarding. They have also disseminated learning lessons bulletins to staff and received positive feedback about the impact of these on front-line-staff and their practice.

4.37 The formal care plans refer only to a potential risk to children following Mr S telling his brother in November 2013 that he raped a girl (his friend's six-year old sister) when he was nine years old. Subsequently after discussion with the safeguarding team it was recorded in the electronic care record that he should have no further unsupervised contact with children until further assessment.

4.38 We found that the risk to others was recorded as being focussed on his mother commencing early in his treatment history after referral to TEWV in March 2013. The narrative in the initial risk assessment at this time did not indicate risk to others. However, following his admission to RPH Mr S indicated that he was scared he would hurt others.

4.39 The risk assessment undertaken in November 2013 following Mr S's arrest by the police for assaulting his mother appropriately indicated a history of harm to her. It was at this point that the risk to his mother included issues associated with his chaotic living arrangements, and medication compliance.

4.40 The risks to his mother escalated and further risk assessments in 2013 and 2014 state that Mr S assaulted his mother, with narrative providing further information about the factors associated with the risk including money and cigarettes. She did not want to press charges.

4.41 A narrative medical review in June 2014 at the point of preparing Mr S for discharge from the inpatient unit to the community indicated Mr S's main risks as being lack of insight, leading to poor engagement, poor compliance with medication, self-neglect and vulnerability. Risk to others was not included in this or recorded in the inpatient electronic case notes.

4.42 In March 2015 Mr S told staff he had a difficult relationship with his mother but did not feel comfortable talking about it. He commented that the voices sometimes told him to do things.

4.43 By 6 May 2015 the already difficult relationship with his mother appeared to be deteriorating and the care coordinator expressed concerns about his mother's ability to protect herself and referred her to the safeguarding team. The referral narrative explained that the mother could not cope with his behaviour. He had moved in with her without invitation, slept all day and was taking her money and cigarettes.

4.44 In May and June 2015 his relationship with his mother deteriorated further. Following an argument Mr S had threatened to cut her throat if she contacted the police. Mr S alleged further that his mother had threatened to stab him and a friend. In a separate incident Mr S had made her pick up dog ends from a cricket ground, shouted at her and threatened to cut her throat if she called the police.

4.45 On 5 August 2015 he was arrested following an allegation that he kicked his mother, verbally abused her, tried to push her down the stairs, threatened her with a knife and to kill her. On assessment, he was not deemed to be mentally ill at this time and had capacity to understand his actions and the potential consequences.

4.46 He was remanded in custody, as he was homeless and due to the risk to his mother could not return there. His mother was advised to call the police if she felt threatened in the future, was provided with details of safe houses and refuges and the care coordinator made enquiries about housing on behalf of Mr S. The care coordinator contacted the safeguarding team again to advise them accordingly as the alert was still open from the previous occasion. A referral to the 'first contact' team was advised.

4.47 Charges against Mr S were dropped and he was released from custody on October 2015. Although his mother contacted two refuges and changed the locks to her house, he appeared to be staying with her again in November 2015.

4.48 We found that the TEWV care coordinator identified the risk factors of Mr S's chaotic life and lack of engagement by making continuous efforts to engage

Mr S and support him to live independently, working closely with his brothers and mother to do so.

4.49 The care coordinator also attempted to address the risk factors associated with his mother's vulnerability within the difficult context of Mr S's chaotic life by advising her appropriately, providing details of safe houses and refuges and safeguarding her.

4.50 Mr S continued with chaotic living arrangements following his move to Slough when he moved in with the victim who was a friend of his stepfather. Similar arguments ensued between Mr S and the victim about Mr S taking his money, cigarettes and alcohol. The victim had asked Mr S to leave.

TEWV referral to BHFT

4.51 The care coordinator did not complete the referral urgency section of the referral form. The referral form essentially 'cut and pasted' the letter resulting from the CPA meeting on 11 November, and notes that this was the date Mr S had last received a depot injection. The 'cut and paste' information used for the referral was lengthy and did not provide sufficient focus on the overdue depot medication. We believe that the care coordinator should have telephoned BHFT CPE to advise them of this fact in addition to the written referral.

4.52 The system of recording messages in a book was not robust and failed to alert the care coordinator to the fact that BHFT CPE was seeking contact with her about the referral. The message left for the care coordinator on 16 December was not responded to as the care coordinator was not aware the message had been left. The message left on 23 December for the care coordinator was not responded to as she was on leave. However, a TEWV community nurse called BHFT separately on 23 December to check that BHFT had received the referral.

4.53 The system for receiving and responding to messages, and the use of allowing patients to leave messages on individual team members' mobile 'phones were not robust.

BHFT receipt of referral from TEWV

4.54 Our view is that the receipt of the referral, the fact it was viewed as complex, placed in the 'shift lead pot' for review at every shift handover and risk rated as an amber referral were all appropriate decisions to take.

4.55 BHFT has a CPE operations manual in place with clear response targets. The CPE met the target of screening the referral on receipt and RAG rating it based upon level of risk. Amber referrals require an initial contact to be attempted within 72 hours and assessment within 14 days. The referral would have flagged up as a potential breach of the amber referral target on 23 December 2015. However, contact was made on the 24 December.

4.56 We found that BHFT made three reasonable attempts to contact TEWV about Mr S on the 16, 23 and 24 December 2015.

4.57 It was appropriate for BHFT to take a view that this was a CPA transfer given the information provided, however even though the information provided from TEWV could have been clearer, the depot medication dose and date due details were provided in the referral information but this information was not treated with any degree of urgency by BHFT.

4.58 The team lead for Slough did not have an out of office message or automated email indicating that deputising arrangements were in place. Although we understand that there was only one team lead for Slough at the time, and they were viewed as being the busiest locality, we found that this was an omission in the cover arrangements that could have been avoided.

4.59 Similarly, we found that they did not have robust systems in place to ensure that the 'shift lead pot' was reviewed as it should have been and no routine process in place that would pick up whether the referral had been processed. The referral therefore remained in the 'shift lead pot' for eleven days.

4.60 We found that the HCA's response to the referral from the GP to the Slough CRHTT on 23 December 2015 and the subsequent plan agreed with the shift lead and with the GP was reasonable and appropriate. It was clear at this point that Mr S was not staying at his stepfather's address although Mr S's address was not recorded in the electronic care record. His stepfather provided his own mobile phone number as a means of contacting Mr S.

4.61 We found that the CRHTT east nurse one took reasonable action to progress the plan by seeking further information and through a discussion with the doctor and the team lead. The CRHTT east nurse one spoke to the stepfather to advise him about the planned visit but did not document the address for Mr S which was an omission.

4.62 CRHTT east nurse two and CRHTT east HCA two were asked to undertake the visit. They were both male nurses which was appropriate given the circumstances. However, they visited the stepfather's address one and Mr S was not there.

4.63 CRHTT east nurse two and CRHTT nurse three again visited the stepfather's address one later that afternoon despite being told the correct address during the first visit by Mr S's uncle. The correct address two was a distance of a few minutes by foot from address one.

4.64 It is not clear why this happened and we view this sequence of events surrounding the documentation and checking the correct address prior to an attempted visit as a failure of practice in the CRHTT.

4.65 A decision was taken by CRHTT east nurse two and CRHTT east HCA two to return to the team base rather than phoning the team lead to escalate the concern and discuss how to proceed. We view this as a failure of judgment.

Substance misuse services

4.66 Mr S had a history of smoking cannabis since he was fourteen years old. Records indicate that educational approaches were considered and we were

told that the usual process would be to offer input from substance misuse services. We view the actions taken by the care coordinator in terms of supporting Mr S to live independently as good practice in terms of supporting Mr S with his substance misuse.

4.67 The care plan for Mr S addressed the issue of his alcohol and drug use with the aim of helping Mr S understand the links between use of alcohol and drugs and his mental health. However, Mr S expressed a view to the care coordinator that he was not interested in using substance misuse services and he thought that cannabis was helpful. Referrals to specialist substance misuse services were outlined in his care plan but evidence to support this was not found in the electronic care record.

4.68 We were told that each team in TEWV has a dual diagnosis lead and the trust is looking to commission dual diagnosis training with York University. The leads are supported by specialist dual diagnosis practitioners working in the different areas of the trust. TEWV is also looking to directly employ substance misuse workers within the teams. These integrated developments for people with severe mental illness and substance misuse are noted.

4.69 The 2016 national confidential inquiry[23] into suicide and homicide by people with a mental illness found that most patients who committed homicide had a history of alcohol and drug misuse and that services for drug and alcohol misuse, and dual diagnosis services to maintain engagement with patients who are likely to lose contact are crucial. Specialist alcohol and drug services should be available, with the ability to manage clinical risk, working closely with mental health services, with agreed arrangements for dual diagnosis patients.

4.70 TEWV have a substance misuse policy that is due for review in March 2017. We view this policy as not being adequate for purpose and recommend that the opportunity is taken to develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE[24] guidance on coexisting severe mental illness and substance misuse: community health and social care services.

Family involvement in care

4.71 It is our view that the care coordinator involved the brothers and the mother as far as possible in the care of Mr S. Care provided to Mr S was in line with the values and principles outlined in the TEWV CPA policy for people in contact with secondary mental health services who have complex characteristics, and involved Mr S and his family wherever possible and appropriate.

[23] The national confidential inquiry is commissioned by the healthcare quality improvement partnership (HQIP).

[24] NICE stands for the national institute for health and social care excellence and it provides evidence-based guidance, advice and information services for health, public health and social care professionals.

5 Internal investigation and action plan

TEWV

5.1 TEWV commissioned an internal investigation for this incident with an external reviewer following a delay in the process to allocate the case after the 72-hour incident report. The first internal investigation meeting was therefore held on 3 May 2015.

5.2 The internal investigation was not commissioned jointly with the local authority. TEWV said that in hindsight it would have been helpful to do so as information regarding Mr S was contained on local authority systems also. The independent investigation has not reviewed local authority information but has taken a view based on the care plan and the electronic care records as to the discharge of Section 117 MHA responsibilities towards Mr S.

5.3 The TEWV internal investigation included the head of service and consultant psychiatrist as part of the review team for assurance of factual accuracy. The internal investigation team included attendance at the internal investigation meeting and comprised:

- External reviewer.
- Care coordinator.
- Community nurse.
- Advanced practitioner.
- Psychological therapist.
- Team manager.
- Consultant psychiatrist.
- Senior registrar.
- Head of adult services.

5.4 The internal investigation standard terms of reference do not include family involvement, however the investigation itself identified the family as stakeholders and referred to the need to involve the family. A set of questions posed by the brother were responded to as part of the investigation. TEWV agreed that contact and engagement with the family should be added to the standard terms of reference in future internal investigations.

5.5 The internal investigation was approved on 23 June 2016 at the Trust directors panel comprising:

- Medical director.
- Director of HR.
- Non-executive director.
- Head of patient safety.
- Head of compliance.
- Senior administrator.

5.6 The internal investigation noted two areas of good practice:

- The daily 'huddle' operated by the EIPT facilitating good team working/communication.
- The care coordinator was proactive in their approach to engage with Mr S.

5.7 The internal investigation found that there was substantial evidence that the EIPT worked very much as a team and that information was shared about the patient on a regular basis through the daily 'huddle' which offered the opportunity for risks and concerns to be identified and acted upon. We were told that the daily 'huddle' is an opportunity every morning at 9.30 am with the team manager, psychologist, advanced practitioner and a medical staff member to identify any issues, problems and urgent appointments required.

5.8 We did not reach the same conclusions about the EIPT working very much as a team given the difficulties BHFT had in contacting them in the absence of the care coordinator. The daily 'huddle' appears to be a positive development, however our view is that it was too early in the process to identify this as good practice given that attendance at the 'huddle' and actions regarding Mr S were not recorded. We understand that a protocol has now been developed with clear lines of accountability and the trust has identified this as a three-year development strategy for all teams.

5.9 We agree that both the care coordinator and the community nurse were proactive in their approach to engage with Mr S. The electronic care records indicate assertive work on behalf of both members of staff to ensure that he had support to live independently and receive his depot medication. This was not always easy given that he was difficult to engage and maintain contact with.

5.10 The internal investigation identified one care and service delivery problem:

- The use of mobile 'phones where when care coordinator is off work then any messages/calls are not picked up.

5.11 The internal investigation made two contributory findings in respect of this:

- There was no process for calls/messages left on care coordinators' mobile 'phones whilst they were not at work i.e. on annual leave being picked up and addressed by the team.

- There was no indication on the referral from trust mental health team as to the urgency of the referral to the southern mental health services.

5.12 We found that the issue of the referral not indicating the urgency to be a separate care and service delivery problem rather than a contributory factor.

5.13 The internal investigation identified further learning in one area:

- The numerical scoring of the risk assessment did not match the narrative details.

5.14 The internal investigation made three recommendations as a result:

R1 There will be a process whereby calls or messages left on care coordinators' mobile phones whilst they were not at work i.e. on annual leave, are being picked up and addressed by the team.

R2 That any referral made to an external or internal service indicates clearly the level of urgency.

R3 Ensure that the level of risk identified is proportionate to the narrative details.

5.15 The associated action plan was developed by the EIPT locality manager and agreed in July 2016. We sought assurance in respect of the recommendations and actions by seeking information from the EIPT team members and the locality manager at the workshop 11 November 2016 as follows:

R1 We were told that the practice of team members issuing their work mobile 'phone numbers to individual patients was immediately stopped unless it is part of an agreed plan of care and treatment. A protocol for the use of work mobile 'phones was circulated in July 2016 following approval at the quality assurance group. The protocol specifies that calls, text messages and voicemails can only be responded to during the staff member's normal working hours. The co-produced care plan will also include an agreed course of action when a message is not responded to in an agreed period of time such as contacting the team office number. This will enable an appropriate response during periods of planned or unplanned absence for the care coordinator. Minutes of the adult directorate quality meeting June and August 2016 record the discussion, agreement and dissemination of the new policy.

R2 The action associated with this recommendation was through individual supervision with the care coordinator. We found this action to be not appropriate as it is clearly a trust wide issue. Although further trust wide

action was requested, the assurance has not been obtained to support this.

R3 We agree with the internal investigation about the correlation of the risk scores with the narrative however the internal investigation did not include the finding that the risk assessments did not translate into the care plans. The trust recognised the need to review the process for risk assessment and management and initiated the trust harm minimisation project which runs until end of March 2017.

5.16 The harm minimisation project aim is to significantly overhaul the trust's approach to clinical risk assessment and management and a new harm minimisation policy has been in place since June 2016. This emphasises the development of an individualised formulation, ideally one produced and shared with the service user, providing a detailed understanding of potential factors that contribute towards harms and what protects these from happening. In conjunction with the new policy, revised risk learning has commenced and is planned to continue until March 2017. Records indicate a current 78 percent attendance rate for the EIPT and psychosis teams. We recommend that the clinical risk information is audited to ensure it meets the new standards.

BHFT

5.17 BHFT commissioned an internal investigation with an external reviewer and standard terms of reference. The standards terms of reference included a review of the communication between agencies, services, friends and family but were not specific about engagement with the family in the process.

This was however addressed by the external reviewer with efforts made to meet family members and he was able to discuss the investigation with Mr S's stepfather and his half sister.

5.18 The internal investigation external author interviewed the following:

- CRHTT psychiatrist
- CPE team lead
- CRHTT health care assistant
- CRHTT nurses involved on 23 and 24 December 2015

5.19 The internal investigation identified four care and service delivery problems:

- Delay in referring the case to the Slough CMHT or taking interim action to arrange medication.
- Shortfalls in practice in information gathering and recording. Some key information was not obtained and, or not, recorded. Time of first visit not known and not recorded.

- Lack of continuity leading to information being misunderstood or overlooked. Shortfall in practice regarding contacting the patient, carer and relative before a visit.

- Practice shortcomings that contributed to delayed response.

5.20 The internal investigation identified the following three contributory factors to the care and service delivery problems:

- Systems not fully understood by staff or not properly implemented by staff. Systems not supported by clear written guidance. Individual skills, supervision, training needs.

- Teamwork ethos not balanced by sufficient attention to continuity in cases where there is potential high risk. Individual skills, supervision, training needs.

- Individual professional practice or compliance issues. Lack of awareness of 'adults at risk' issues. Lack of awareness of best practice following a 'no reply' visit.

5.21 The internal investigation made eleven recommendations:

R1 Managers to review and clarify relevant CPE systems and ensure all staff are made aware of what those systems are and how they should be implemented.

R2 Clear written guidance to be produced for CPE staff regarding systems for flagging and monitoring referrals.

R3 Managers to review processes for liaison with Slough CMHT.

R4 Managers to ensure there is consistent guidance regarding the involvement of CPE, CMHT and CRHTT in the patient pathway for CPA transfers.

R5 Managers to review training and supervisory support needs of staff in relation to the specific issues identified relating to information gathering and recording.

R6 Managers to take steps to ensure that all staff, including agency staff, record the time of all key events.

R7 Managers to review practice in relation to task allocation by team leads in CRHTT, with due weight given to continuity where there is potential high risk.

R8 Wherever possible the member of staff who arranges a visit should also be the person who undertakes the visit. CRHTT also need to review process and practice to ensure that information is not lost where maintaining a consistent clinician is not possible.

R9 Managers to take steps to ensure that staff undertaking visits routinely telephone the patient (or carer, or relative if appropriate) beforehand to confirm arrangements for a visit.

R10 There is a need for training to raise staff awareness of good practice in safeguarding 'adults at risk'.

R11 Managers to review CRHTT 'No Response' policy for consistency with CCR BPD006, and ensure staff are made fully aware.

5.22 The internal investigation did not identify any areas of good practice.

5.23 We found the internal investigation findings to be satisfactory and good assurance was provided in respect of all the recommendations and actions. Ten of the recommendations are completed with R5 CRHTT bespoke training being rolled out to the team and therefore remaining in progress.

6 Overall analysis and recommendations

Predictability and preventability

6.1 Predictability is "*the quality of being regarded as likely to happen, as behaviour or an event".*[25] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[26]

6.2 It is our view that the homicide was not predictable. Risk assessments were regularly undertaken and Mr S was not thought by TEWV to be a risk to others apart from his mother, although he had voiced concerns that he would hurt others. His mother was subject to safeguarding initially from a concern that she may be being exploited for tobacco, alcohol and money and then later on due to the risk of assault and was advised appropriately about safety measures including involvement of the police and safe houses..

6.3 Prevention[27] 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 the knowledge, legal means and opportunity to stop the incident from occurring.

6.4 We acknowledge the view of the victim's partner that the homicide was both predictable and preventable.

6.5 It is our view that had certain interventions taken place the outcome may have been different. TEWV and BHFT both had knowledge that the depot

[25] http://dictionary.reference.com/browse/predictability

[26] 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

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

medication was overdue and both organisations could have initiated joint planning to ensure this was administered in a timely way as soon as possible following referral. Joint planning could potentially not only have ensured depot administration, but also that other interventions (e.g. housing) and monitoring (of mental state) could have been in place, hence potentially averting the eventual sequence of events.

6.6 Given that medication was prescribed at a lower dose, and that this was in effect sub-therapeutic after 13 weeks, Mr S was clearly at increased and significant risk of relapse. Mr S himself, the GP, his stepfather, brother and uncle all requested that the depot should be administered due to their concerns about the deterioration of his mental health and on the 24 December 2015 he was described as sitting on the sofa totally silent and unable to speak to the nurse. This picture of Mr S echoes his past presentation when overtly acutely psychotic.

6.7 However, it is not clear whether the administration of the depot injection at an early stage following referral would have been a sufficient measure alone to have prevented the homicide from occurring as it is likely that risk to others included a combination of issues associated with his medication compliance, chaotic living arrangements and drug use.

6.8 It is our view that the care coordinator made continuous efforts to support Mr S to live a stable, independent life however the fact that Mr S moved to Slough and was staying with the victim was not within the control of the care coordinator and the extent of his drug use at this time was unknown.

6.9 This independent investigation has made six recommendations for TEWV to address in order to further improve learning from this event.

Recommendation 1:
TEWV must develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE[28] guidance on coexisting severe mental illness and substance misuse: community health and social care services.

Recommendation 2:
TEWV must review the EIPT operational policy to set out agreed methods and expectations around multidisciplinary working, to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and at least annually where patients are receiving antipsychotic medication.

[28] NICE stands for the national institute for health and social care excellence and it provides evidence-based guidance, advice and information services for health, public health and social care professionals.

Recommendation 3:
TEWV must review the TEWV EIPT job plans to ensure consistent medical input to the team.

Recommendation 4:
TEWV must develop a schedule of audit for crisis plans and take action taken as required so that they meet the CPA policy standard.

Recommendation 5:
TEWV must review the TEWV CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence e.g. by ‘phone.

Recommendation 6:
TEWV must take action Trust wide to ensure that any referral made to an external or internal service indicates clearly the level of urgency.

Appendix A – terms of reference

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Mr S's first contact with services to the time of his offence.
- Review the appropriateness of the treatment of Mr S in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of Mr S harming himself or others.
- Examine the effectiveness of the Mr S's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation

Supplemental to Core Terms of Reference

- Conduct an evidence based review of whether previous independent report recommendations have been fully implemented.
- Support the commissioners (CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England North.

Appendix B - documents reviewed

1	BHFT	Risk assessment training compliance
2	BHFT	Risk workshop schedule
3	BHFT	Slough allocation meetings 17/6, 26/8 and 9/9/2016
4	BHFT	Wokingham patient safety and quality governance meeting 11/6/16
5	BHFT	Locality governance meeting terms of reference
6	BHFT	Template agenda patient safety and quality governance meeting
7	BHFT	CHRTT safeguarding adult training compliance
8	BHFT	CHRTT operational manual
9	BHFT	Did not attend policy and protocol
10	BHFT	Risk power-point presentation for induction
11	BHFT	Clinical risk policy
12	BHFT	Risk matrix
13	TEWV	Harm minimisation policy
14	TEWV	Harm minimisation training records
15	TEWV	Harm minimisation power point training material
16	TEWV	Dual diagnosis policy
17	TEWV	Medicines management policy
18	TEWV	Non medical prescribing policy
19	TEWV	CPA policy
20	TEWV	Safeguarding Policy ratified September 2016
21	TEWV	Quality account 2015-16
22	TEWV	Mobile 'phones protocol July 2016 and the quality assurance group minutes regarding mobile 'phones June and August 2016
23	NICE	Guidance on psychosis and schizophrenia
24	BNF	Antipsychotic medication guidance on prescribing
25	NICE	November 2016 guidance on coexisting severe mental illness and substance misuse: community health and social care services.
26	HQIP	2016 national confidential inquiry into suicides and homicides of people with a mental illness. Making Mental Health Care Safer: Annual Report and 20-year Review. October 2016. University of Manchester.
27	TEWV	Clinical Notes
28	TEWV	Internal investigation
29	BHFT	Clinical notes
30	BHFT	Internal Investigation
31	Elm Tree GP Surgery	Clinical notes

Appendix C - chronology

Date/Time	Event
01/03/2013	Mr S moved from the south back to the Trust local area to work with his brother valeting cars. He is reported not to have had any previous mental health issues. He reported to his brother that he had been unhappy living in London (with his mother and younger brother) after witnessing one of his friends being 'tasered' by the police, saying that this had frightened him and made him afraid to leave the house. During the first couple of days, Mr S was quiet and low in mood. It appears that he stayed with brother one over at least some of the weekend.
03/03/2013	Mr S started to exhibit bizarre behaviour. He became mute, uncommunicative, would not eat or drink and was not sleeping. His brother reported that Mr S was normally a talkative and social person. On Sunday 3 March, he started to exhibit bizarre behaviour: he became mute, uncommunicative, did not eat or drink, and was not sleeping. Mr S's brother reported that he was normally a talkative and social person. Mr S's notes refer to a *"rapid deterioration in his mental state*" over a three-day period.
1st Admission. Informal – 05/03/2013 to 08/05/2013	Mr S was taken to his General Practitioner by brother two who referred him to a local healthcare provider who then referred Mr S to the local crisis team. Mr S remained uncommunicative for 5 days after admission but occasionally responded with *"yes"* or *"no".* The GP noted that Mr S was: "*completely mute … lived in London, visiting brother, brother does not know him much, but knows that he was using cannabis in London … not sleeping for two nights, not eating … looks anxious*". It was reported that on that day he had stood on one spot without moving for five hours. After a MHA assessment in J's home, Mr S was admitted to Roseberry Park Hospital (RPH) on an informal basis. There were documented concerns about risk to health and of self-neglect, with 'risk to others' being recorded as 'unknown'. A urine test indicated positive for cannabis. Mr S presented as nearly mute, exhausted and unkempt. He was essentially uncommunicative for five days after

	admission, bar occasionally responding 'yes' or 'no'. He weighed 89 kg.
05/03/2013	Mr S registered with a local General Practitioner who saw Mr S for nondependent cannabis abuse.
10/03/2013	Olanzapine (antipsychotic) was prescribed from 10 March, at a dose of 10 mg daily. On 11 March, Mr S asked a health care assistant if she could get him a ticket to go to South Korea so that he could be tortured. When asked why, he did not respond. On 18 March, whilst on leave in the hospital grounds Mr S asked his brother to *'beat'* him and *'kill'* him because he wanted to '*die, die, die'*. By 19 March, Mr S was referred to the Early Intervention in Psychosis Team (EIPT), i.e. he was regarded as likely to be experiencing 'first episode psychosis'.
25/04/2013	Mr S reported voice hearing.
27/03/2013	On 27 March, whilst on day leave with his brother. he tried to run out of his brother's house, stating that he was going to jump off a bridge. After returning to the ward, Mr S told two staff members that "*I hear voices all the time and get confused sometimes, I don't really know what I want and feel very confused*". He stated that he had a difficult relationship with his mother but did not feel comfortable talking about it at the time, and commented that the voices sometimes told him to do things. A clinical entry states: "*28 March. Mr S expressed thoughts of jumping into traffic when he was out on leave with his family".*
02/04/2013	Home leave for day with his brother who reported that the leave went well and that Mr S engaged with his family. Visit was made to the ward by Community Nurse 1.
23/04/2013	Mr S had overnight leave and his Care coordinator, Social Worker1 agreed to visit him at home the following day. Leave went well and further periods of overnight night leave were agreed.
05/04/2013	Mr S reported paranoid ideas and auditory hallucinations, but his account was changeable. He was prescribed fluoxetine (antidepressant) because of longstanding low mood. By this time, the olanzapine dose was 15 mg.
12/04/2013	On 12 April, Mr Ss care coordinator, (an EIPT social worker and AMHP), reported that he stated that he heard voices that were unclear. On 23 April, he had overnight leave and she agreed to visit him at home the following day: "*still*

	experiences voices". The leave went well, and further periods of overnight night leave were agreed. His mental state had improved significantly. On 2 May, she commenced an assessment using a semi-structured assessment tool (Comprehensive Assessment of At-Risk Mental States; CAARMS). (By 10 May, she concluded that Mr S met the threshold for psychosis.)
08/05/2013	Mr S was discharged from hospital with continued support from the Early Intervention in Psychosis Team. Mr S's diagnosis was recorded as severe depressive episode with psychosis. Mental and behavioural disorders due to use of cannabis-psychotic disorder F12.5. The discharge summary states that he went to his own home in Thornaby (which appears to be mistaken - he went to live with his brother), and that he was being prescribed olanzapine 15 mg and fluoxetine 40 mg daily. He was under the supervision of EIPT.
10/05/2013	CAARMS was completed by Mr S's care coordinator and Mr S was found to meet the threshold for psychosis.
16/05/2013	Mr S saw his GP, accompanied by his brother.
17/05/2013	when the care coordinator undertook a home visit, it was agreed that a vocational assessment would shortly be carried out by Community Nurse two.
14/06/2013	Mr S seen by GP and prescription given for Fluoxetine 20mg tablets and Olanzapine 15mg tablets.
24/06/2013	On 24 June, the advanced practitioner, visited Mr S at home, with the care coordinator. Brother one reported he was experiencing problems coping with his poor hygiene, reluctance to assist with tidying and chores, and lethargy (including spending long periods of time in bed). He also reported smelling cannabis in the house. Mr S denied all of the comments made by his brother, "*and there were obvious tensions between the two*". He denied any plans to hurt himself or others. The advanced practitioner agreed to reduce the olanzapine dose (to 10 mg at night), on the basis that he was complaining of poor motivation and sedation, and that there were no positive symptoms.
27/06/2013	Visit by Care coordinator. Brother one stated that he could no longer cope with Mr S living in the house. When Mr S's care coordinator suggested that some extra support could be put into the house brother one stated that it wouldn't work as

	he did not trust Mr S. Care coordinator agreed to make contact about emergency housing for Mr S. The paperwork was prepared for a panel for emergency accommodation. FACE, the Care Plan and assessment were checked and updated. Care coordinator agreed to transport Mr S to his new accommodation on Friday 28 June 2013
27/06/2013	Failed to attend GP appointment. Mr S registered with a new GP 09/07/13.
28/06/2013	Mr S moved to hostel accommodation.
03/07/2013	Mr S was not available when his care coordinator visited. The occupational therapist also called Mr S as per a pre-arranged appointment but he Mr S did not answer her call.
17/07/2013	Call from the hostel informing care coordinator that Mr S was not attending to his personal hygiene; his room was dirty and smelt badly, needed to be prompted to take his medication and attend his General Practitioner for repeat prescriptions'. Brother one informed his care coordinator that he had found Mr S a flat.
24/07/2013	Care coordinator was informed that Mr S had a flat that was owned by his uncle who was a local landlord. Mr S showed no insight into his apparent inability to look after himself or the need to sort out furniture or benefits before he moved out of the hostel.
26/07/2013	Mr S requested that he move into his uncles' accommodation on the following Monday against the advice of his Care coordinator. His Uncle spoke with his Care coordinator and stated that he was keen for Mr S to move in otherwise he would let the house go. Mr S was advised that he would need to change his General Practitioner and it was arranged that Support Worker 2 would visit him twice weekly. Hostel agreed to hold his bed for two weeks.
30/07/2013	Mr S left hostel accommodation. The care coordinator visited Mr S but he did not answer the door or phone. Contact was made with brother one who stated that Mr S would be in bed. Mr S answered the door after a period of loud knocking by his care coordinator.
08/08/2013	Attempted visit by Mr S's care coordinator as pre-arranged on the phone but Mr S was not at home.
09/08/2013	Care coordinator visited Mr S with a support worker. Mr S was helped with unpacking and with an application for benefits.
09/08/2013	Brother one rang the care coordinator as he was concerned that Mr S was smoking cannabis again.

09/08/2013	Mr S was accompanied by a support worker for shopping for household items.
16/08/2013	Mr S was visited by the care coordinator who escorted him to register with a local General Practitioner. Evidence of cannabis being used in flat. Mr S stated that he smoked “cheese” which is quite a lot stronger than “haze”.
19/08/2013	Care coordinator called Mr S to remind him of his appointment.
23/08/2013	Visit to Mr S by his care coordinator. Mr S said that he did not have sufficient money for the gas meter and had no gas until he was paid that day. He admitted to sometimes forgetting to take his medication. A later entry regarding the period when he lived at his flat includes: “*stopped medication during this period …lack of basic fixtures and furnishings in flat, no attempt to engage in accessing these with EIP”.*
27/09/2013	Care coordinator reported that Mr S had been absent since the beginning of September and not responding to telephone calls. His mother confirmed that Mr S was in the south.
10/10/2013	Care coordinator unable to get a response from Mr S after knocking on his door or by telephoning him. She repeated the visit in the afternoon but there was still no response from Mr S. Care coordinator planned to contact brother one.
11/10/2013	Mr S was reported to have increased his cannabis use and had not taken his medication for over 10 days. Mr S was reported by his mother to have run through a door at home and to have slept on a pavement. When the community nurse spoke with him, he recorded that he had a normal tone of speech, that he admitted running through a door (which was ‘*silly’*), and he was able to reiterate discussion. On 14 October,
14/10/13	Community Nurse two contacted Mr S, who was still in Slough waiting for a lift from his brother. Mr S was due to return home to Stockton with brother one. Mr S and his mother were both given the Slough crisis team telephone number.
16/10/2013	Occupational Therapist 1 received a call from the Crisis Team, Doctor 1, in the south informing them that Mr S had been held in custody after an assault on his mother and was to be released that day.
23/10/2013	Care coordinator spoke with Mr S’s mother who reported that Mr S had assaulted her by kicking her and pulling her hair. This had happened when she had refused to give him money to buy

	cannabis. She had agreed not to press charges but had refused to let Mr S back into her home. Mr S was staying with friends around the corner. She reported that Mr S had only washed once in six weeks and had smeared faeces all over the walls. She also reported that she had noticed Mr S pulling funny faces.
25/10/2013	The care coordinator obtained no reply when she visited Mr S's address, and she sent him a letter confirming an appointment for 30 October. She also wrote to the GP: "*Mr S has recently spent some time with his mother and other family members in Slough … is chaotic in his lifestyle and engagement is difficult".* In her letter, the care coordinator noted that Mr S had reported that some thoughts in his head were not his, that he sometimes thought that others could read his mind and hear his thoughts, that people might have been out to get him or were watching him, that he could move things with his mind, and that he had heard voices. A later entry states: "*On return to Stockton, chaotic lifestyle recommenced, superficially engaged with EIPT".*
30/10/2013	The care coordinator attempted to see Mr S at home, she also tried brother one's home address. The plan then was to meet with co-workers for Mr S to discuss future actions for re engagement.
08/11/2013	The community nurse contacted brother one to establish if he had any contact with Mr S. Stated that he saw Mr S on a daily basis and he seemed *"ok"* but that Mr S's self-care was still poor. A visit was made to Mr S. Mr S admitted that his voice hearing experience had increased, that he was willing to take medication to help with his voice hearing. The community nurse agreed to discuss this with the team.
08/11/2013	The care coordinator visited Mr S at home. He admitted hearing voices had increased often kept him awake at night. He was still buying cannabis although trying to smoke with friends to keep him distracted. Mr S asked about starting anti-psychotic medication and fluoxetine again and the care coordinator agreed to contact the advanced practitioner.
11/11/2013	Brother one reported that Mr S was in custody and did not have access to medication. A later AMHP report states that "*he was arrested at 4 a.m. … by the Serious Organised Crime Division from London on suspicion of dealing Class B drugs".*
12/11/2013	The community nurse attended the police station

	as the 'appropriate adult', after Mr S had been arrested on suspicion of involvement in supplying drugs. After being questioned, he was bailed until 14 April. It is recorded that throughout the two-hour interview there was no evidence of distraction. As the community nurse escorted Mr S home, he started laughing that his associates had probably already left the country. In discussion with the reviewer (i.e. post-incident), the community nurse commented on his surprise at how focused Mr S was during the interview and on how he had everything in relation to the drugs charge '*well calculated'* and '*detailed'*. His presentation was completely different in that he was focused and motivated.
14/11/2013	The advanced practitioner visited Mr S at home. Mr S reported that mental health was *"ok",* continuing use of cannabis and drinking alcohol occasionally. Stated had not taken olanzapine for at least six weeks and had taken fluoxetine infrequently. Mr S was not showing any current psychotic symptoms. The advanced practitioner agreed not to prescribe any further psychotropic medication at that time but to provide ongoing monitoring and assessment of his mental health.
21/11/2013	The care coordinator visited Mr S at home. He talked about his experiences of psychosis and stated that he thought his brother was an actor and not his brother at all and that the television was speaking to him. He described the voices currently as chatting to each other about game ratings and giving him advice. Stated voices more intense since his recent arrest. Described first started selling cannabis along with sweets and deodorant. He started to smoke cannabis at 14 years old but avoided 'bong' for some time believing that it was 'crack'. He also described the police as raiding his mother's house in relation to dealing when he was aged seven years old.
26/11/2013	Brother one called the community nurse with concerns about Mr S's mental state and use of cannabis, and described him as acting bizarrely and relapsing. The community nurse agreed to contact the care coordinator. He attended his GP (complaining of headache), who noted: "*saying psychiatrist has stopped medication".*
27/11/2013	The care coordinator visited Mr S after a call from the Crisis Team. Mr S reported to be distracted, only giving one word answers, spending £240 a fortnight on Cannabis and stealing convenience

	food. He claimed to be distressed after telling his brother he raped a girl when he was 9 years old (it is not known whether this was delusional but Mr S's care coordinator informed her manager). The care coordinator requested the crisis team assess Mr S. Mr S was undecided as to whether a hospital admission would help him and felt that perhaps the mosque could sort his head out.
2nd Admission section 2 MHS 27/11/2013 to 12/06/2014	Mr S was assessed under the Mental Health Act 1983 at brother one's home, and was regarded as presenting with catatonic schizophrenia in the context of ongoing cannabis misuse: "*unable to sleep at night, walking the streets at night, reduced speech, not eating … spends all of his time at his brothers … who tries to encourage him to eat and sees to his domestic and prompts his personal hygiene needs. [He] has seen a deterioration… the care coordinator… reported he has no insight into his illness and has stopped his medication and is unable to sleep and is not eating or drinking properly and presents as paranoid and unaware of his difficulties … has lost his [property] keys…withdrawn and struggles to verbally communicate … very tearful and appeared anxious … He was asked if he was feeling frightened, he nodded 'yes' … stated that he has been hearing voices which have been scaring him. [stated] medication has not been helping him … smoking cannabis helps him … kept changing his mind [about admission]"* The care coordinator reported that Mr S had been non-compliant with medication, having discontinued olanzapine two months previously and fluoxetine two weeks earlier. Mr S was detained under Section two MHA at RPH, where he was prescribed olanzapine (10 mg daily).
28/11/2013	Application form for a Mental Health Tribunal completed.
03/12/2013	The consultant psychiatrist (in a formulation meeting) recorded that there may be some risk of harm to others, including an assault on his mother.
04/12/2013	Mr S's medication was reviewed. Short term plan to increase the Olanzapine to 20mg and eventually to give a test dose of 20 mg of depixol. The care coordinator visited Mr S to discuss his disclosures about the 6-year-old girl with the safeguarding team but his mental state needed improvement before this could be pursued. The

	Mental Health Tribunal upheld section two of the Mental Health Act 1983.
10/12/2013	Mr S agreed to accept a depot injection and this was administered.
18/12/2013	Mr S reviewed by consultant psychiatrist who reduced Mr S's olanzapine to 15 mg and promethazine to 25 mg and advised that Mr S was to continue with his depot injection. Mr S was placed on section three of the Mental Health Act 1983 after assessment.
19/12/2013	Mr S requested appeal against Section 3 of the Mental Health Act 1983. It was noted that he: "*continues to present as bizarre at times … staring into space for long periods of time… on occasion required prompts to carry out simple tasks …preoccupied at times".*
23/12/2013	Three nights leave over the Christmas period requested - upon review leave was declined.
31/12/2013	Mr S granted one nights leave to stay with brother one.
04/01/2014 to 05/01/2014	Mr S had unescorted leave to stay with brother one.
07/01/2014	Mr S reviewed by consultant psychiatrist on the ward. Presented with delusional beliefs, elated and labile mood, disjointed thoughts, perplexity and suspiciousness and reported hearing voices. He was being prescribed olanzapine 15 mg daily and flupenthixol decanoate 60 mg fortnightly
09/01/2014	A hospital managers appeal was attended by Mr S's care coordinator. Care coordinator agreed to discuss the issue for disclosure of Mr S *"raping"* a six-year-old girl when was nine years old with the safeguarding team. She also recommended that Mr S might benefit from spending some time in a local rehabilitation unit. The hospital managers appeal panel agreed that Mr S's Section three of the Mental Health Act should be upheld.
14/01/2014	Application completed for admission to local Rehabilitation Unit.
15/01/2014	Care coordinator visited ward. The Safeguarding Team recommended that after the incident related to Mr S's friend's sister aged six years that (where he self-reported alleged rape: • No unsupervised contact with children until further assessment completed. • Discuss with Mr S again to try to get more information about the child i.e. Name, address and school etc.

	• Mr S's care coordinator to contact Social Services in London to find out if the incident had been reported or if the child or family were known to services When considering leave be aware of any access to children by Mr S.
17/01/2014	Leave plan amended highlighting that Mr S should not have unsupervised access to children.
20/01/2014	The olanzapine dose was reduced to 10 mg.
24/01/2014	Mr S visited by the care coordinator. Assessed to see if he would benefit from a period of rehabilitation and offered a place in a local rehabilitation facility.
05/02/2014	Mr S transferred under section three of the Mental Health Act 1983 to a local rehabilitation facility. Mr S was described as: "*settled … engages well with staff and with peers …requires ongoing prompts with ADLs …fully compliant with medication …no agitation or aggression".*
13/02/2014	Mr S disagreed with continuing detention, and wanted to return home. His brother and staff were concerned about his slowed and muddled thinking, and his self-management. His poor motivation was linked to a risk of severe self-neglect in the community (e.g. diet, cleaning, laundry, money management).
17/02/2014	The care coordinator wrote to the local children's services in an attempt to clarify if the alleged incident between Mr S and the six-year-old girl was registered. The reply stated that the files were paper copies and had been requested and that any relevant information would be forwarded in due course.
18/02/2014	Mr S threatened to harm staff if he was not allowed home.
20/02/2014	Section 3 of the Mental Health Act upheld by Mental Health Tribunal. Mr S stated that he disagreed with his diagnosis of Paranoid Schizophrenia, didn't see the purpose of rehabilitation and that he wanted the section to be lifted so he could go home.
03/03/2014 & 27/03/2014	Mr S was accompanied by his care coordinator on visits to his flat.
01/04/2014	Mr S requested that an appeal should be submitted to the hospital managers
02/04/2014	Court appearance Middlesbrough
10/04/2014	Mr S accompanied to the police station. His

	solicitor was present; Mr S accepted the charge brought against him for conspiring to supply a controlled drug, Class B cannabis. It was explained to Mr S that the case would be transferred to Crown Court at a later date.
16/04/2014	Mr S assessed by consultant psychiatrist to establish if he was well enough to attend the court hearing. Consultant Psychiatrist 3 was of the view that Mr S was well enough to attend the hearing. Mr S tested positive for cannabis.
22/04/2014	Mr S escorted to the Magistrates Court in the south. He was unconditionally bailed until 21st July 2014 to reappear in Crown Court in Reading. It had been suggested that a video link might be appropriate. Two of his half-brothers were attending the hearing and it was noted that one of the brothers was to appear charged with the same offence as Mr S.
25/04/2014	A hospital managers hearing was held for his section three under the Mental Health Act 1983 was upheld by the panel.
02/05/2014	A review by consultant psychiatrist reported that he did not show any positive symptoms of psychosis but that his insight remained limited. The notes highlight that the community team were looking at discharge care packages that could be put in place.
15/05/2014	A CPA meeting was held in preparation for Mr S's discharge into the community. The possibility of discharging Mr S on a community treatment order {CTO} was discussed. There was a recognized risk of non-compliance, although it was noted that Mr S had complied with his bail conditions. The risks identified related to self-neglect (through not attending to his personal hygiene, not paying his bills and not eating properly) and to relapse if he again started to take cannabis. It was decided that an occupational therapist would support Mr S on home leaves. The community team were to put together a plan which needed to go panel to obtain the required funding, and were to visit Mr S three times a week to check on his mental health.
03/06/2014	Mr S's section 3 of the MHA 1983 was rescinded by consultant psychiatrist. After discussion with the Multi-Disciplinary Team it was concluded that Mr S did not meet the criteria for ongoing detention and it was agreed that a Community Treatment Order (CTO) would not offer Mr S any added benefits upon discharge. Mr S to stay as an informal Mr S with extended periods of leave.

05/06/2014	The care coordinator attended a 'Validation Forum' to request a package of support for Mr S when he returned home. A support package was agreed - starting with a support worker input (after he returned home) of three hours per week, with a view to an additional three hours a week for social integration. The package of care was initially agreed for a 12-week period with an extension after that time. Mr S was to officially take two weeks leave from the unit, apparently at his request.
12/06/2014	Mr S was discharged from the local rehabilitation unit, following a 'discharge CPA' that he did not attend (presumably, he was still on leave). He was assessed as having made improvements in his ability to care for himself, and had shown some progress in dealing with his bills. His mental health was reported to have been stabilised and he had complied with his treatment regime and medication - although still believed that he was not suffering from a mental illness. The discharge diagnosis was paranoid schizophrenia, and the discharge summary noted that Mr S: "*continues to lack motivation to participate in rehabilitation activities … there has been limited progress … it has been agreed that Mr S does not meet the criteria for ongoing detention and that CTO will not offer any added advantage in managing him in the community … main risks continue to be lack of insight … prone to self-neglect and vulnerability …"* A nursing report noted an improvement: "*on being able to support and look after himself … was more readily to accept his old routines that he would do whilst in his own home which involved him sleeping through most of the day … he did not believe he suffered with an actual mental health illness [sic] … If he declines [depot] a review with the consultant is to be arranged …"*
13/06/2014	7 day follow up visit. The care coordinator reviewed Mr Stat home, discussing with him his finances and access to gas and electricity, and his understanding of his package of care. She noted that there was a 'bong' on the table, which Mr S acknowledged. She agreed to see him weekly, and Mr S agreed to this plan.

19/06/2014	Discharge CPA
19/06/2014	7 day follow up visit no psychotic symptoms
24/06/2014	Mr S was visited at home by the psychological therapist and support worker. He was administered a depot injection, and reported no concerns about his mental health.
26/06/2014	When visited at home by his care coordinator Mr S presented with no psychotic symptoms, and was pleasant with good eye contact. Arrangements were made so he could access a fridge and microwave. A citizen card had been secured for him, and the care coordinator agreed to collect this.
01/07/2014	Visit by care coordinator. Mr S was pleasant and denied any psychotic symptoms. Care coordinator noticed that there was bong and grinder for cutting weed plus a couple of 'rizzlas' on Mr S's dining table. He denied having had any Cannabis since being discharged from hospital.
04/07/2014	Mr S arrested for the alleged offence of possession of a Class B substance and with intent to supply. Clinical Lead 1 reviewed Mr S in custody where he showed no signs of psychotic symptoms and was able to demonstrate his ability to understand and communicate as part of the decision making process. Mr S was interviewed by the police and then released on bail.
09/072014	Home visit to Mr S by his Care coordinator. There was a strong smell of cannabis in Mr S's home. A discussion took place about where Mr S would prefer to be hospital, home or Prison. Mr S stated he would prefer to stay at home but would prefer prison to hospital. Two of his brothers had been to prison and didn't rate it. Mr S stated that smoking cannabis chilled him and had no effect on his voice hearing or paranoia.
14/07/2014	Community nurse administered his depot injection.
17/07/2014	Planned visit to Mr S by his care coordinator but Mr S was not at home.
24/07/2014	Visit by care coordinator. Mr S complained of toothache and she agreed to source a dentist for him.
05/08/2014	The community nurse administered his depot Injection.
14/08/2014	Home visit by care coordinator to begin work on his Lifeline Model pack 5. He reported understanding the rationale for completing the lifeline.
22/08/2014	Mr S failed to attend court as required.

27/08/2014	The community nurse administered his depot Injection.
29/08/2014	Two visits by the care coordinator but Mr S was not at home.
05/09/2014	The care coordinator completed a referral form on behalf of Mr S to the direct payments support service for the provision of support to help him maintain his own hygiene and help him with his laundry.
10/09/2014	Letter sent to Mr S from Care coordinator to confirm appointment to discuss social support.
11/09/2014	Care coordinator sent letter to housing benefits to clarify Mr S's benefit entitlement. This letter states that Mr S's ESA benefits were paid into his brother's account, and that they had a joint tenancy.
15/09/2014	Visit by community nurse. Depot injection administered.
19/09/2014	Care coordinator discussed benefits with Housing on behalf of Mr S. Care coordinator received a telephone call from Mr S's solicitor expressing concerns about Mr S and explained that Mr S was only days away from having a warrant issued for his arrest as he had failed to attend his court appearance on 22 August 2014. Mr S had also missed two appointments with the forensic psychiatrist. Care coordinator explained that Mr S was receiving both care and medication. Mr S's solicitor stated that he would be visiting Mr S on Thursday 25 September at 2.15pm.
19/09/2014	Care coordinator visited Mr S and talked to him about missing his court appearance and appointments with Forensic Psychiatrist. He asked if he could go back into the rehabilitation centre he was discharged from 12 June for a break.
25/09/2014	Student Nurse visited Mr S to administer his depot injection accompanied by the community nurse.
26/09/2014	Home visit by care coordinator. Care coordinator received a call from forensic psychiatrist stating that due to Mr S's negative symptoms he would be recommending that Mr S was not fit to plead. He advised that he thought that the prosecution would contest his decision and that there will be a 'fit to plead hearing' in Reading. Mr S asked if he could go back into the Rehabilitation Centre for a break. It was explained that this would not be possible because it was part of the hospital and he was not ill enough at that time. The care coordinator was telephoned by Mr S's solicitor expressing his concerns that he was only days away from having

	a warrant issued for his arrest (as he had failed to attend his court appearance on 22 August). She also contacted brother one to arrange for a washing machine to be plumbed in, and to inform him of the support application made on behalf of Mr S.
03/10/2014	Visit by care coordinator. Mother expressed concerns about Mr S's inability to look after him.
07/10/2014	Depot injection administered by student nurse. accompanied by the community nurse.
08/10/2014	Failed to attend appointment with consultant psychiatrist.
10/10/2014	Pre-arranged care coordinator visits but Mr S was not at home. She made a 'cold call' later that day and came across Mr S as he was leaving his flat with a friend. She informed him that she would rearrange the psychiatric appointment, and also advised that a personal assistant could not be recruited in his flat as it would need a "*proper clean"*. She also sent a letter to the Personal Independence Payment New Claims, chasing an application for payment to Mr S.
15/10/2014	Mr S attended a wellbeing clinic for an annual physical health check.
25/10/2014	Visit by Care coordinator- Mr S was not at home. And his mother advised he was with brother one.
27/10/2014	Mr S not at home to receive depot injection.
29/10/2014	Mr S received depot injection by Community Nurse.
13/11/2014	Care coordinator spoke with Mr S about appointeeship which in principle he agreed to, explained to Mr S that a psychiatrist appointment was made for 26November 2014. Care coordinator met the manager from a local care agency and explained that she was in the process of obtaining quotes to get Mr S's house cleaned. Mr S had grazing to his arms and face, and explained that his brother had taken his cigarettes and beer as he thought he should not use them all at once.
19/11/2014	Mr S received depot injection by Community Nurse.
21/11/2014	Care coordinator received a call from brother one stating that Mr S had been letting people into his flat and that they had smashed it up and so he was homeless. Brother one had to ask 11 young men to leave the flat. Brother one stated that Mr S had spent over £900 in the past 2-3 weeks. Mr S was served two months' notice by his landlord. Other tenants in the flats had expressed an

	interest in getting an ASBO on Mr S.
26/11/2014	Reviewed by Consultant Psychiatrist. Mr S expressed no concerns and stated that he had not heard voices since the previous year, felt alright in mood and was tolerating his depot injection. Concerns raised about him letting people into his house and also his inability to manage his finances. Admitted to having one joint a day and alcohol occasionally. Plan was to continue on flupenthixol decanoate 80mg every three weeks. After a discussion with Mr S's care coordinator, consultant psychiatrist agreed to review Mr S to discuss a possible reduction in the dose of his depot injection if weight gain was an issue. Agreed that care coordinator should seek alternative accommodation for Mr S and involve an Occupational Therapist to help structure Mr S's day. "*In November 2014 Mr S and his brother argued about the way Mr S spends his money and Mr S chased his brother and threw himself at his brother's car … very bruised ankle and cuts and abrasions to his body"*.
10/12/2014	Mr S not at home to receive his depot injection from the community nurse.
11/12/2014	Mr S not at home to receive his depot injection from community nurse.
12/12/2014	Received depot injection from community nurse.
19/12/2014	Care coordinator advised by Mr Ss' landlord who confirmed that he wanted Mr S to leave the flat by 21January 2015.Mr S stated that he would move back down south although admitted he would prefer to stay where he could see his family.
24/12/2014	Visit by care coordinator Mr S not at home
30/12/2014	Visit by care coordinator Mr S not at home
31/12/2014	The community nurse contacted brother one, who confirmed that Mr S had spent Christmas with him but that he had not seen him for a few days. He stated that the only thing Mr S was interested in was smoking cannabis.
02/01/2015	Community nurse made a cold call to Mr S's home but he was not there so planned to speak with his care coordinator. Later visit by care coordinator and the community nurse administered his depot injection.
12/01/2015	GP surgery tried to contact Mr S without success. The support worker visited Mr S to take him to Housing Options, but he was not at home.
15/01/2015	Visit by care coordinator Mr S not at home.
16/01/2015	Visit by care coordinator Mr S not at home.
19/01/2015	Visit by the community nurse. Depot injection

	administered
20/01/2015	Visit from Occupational Therapist- Mr S not at home.
21/01/2015	GP surgery tried to contact Mr S to make an appointment for a mental health review but Mr S's mobile phone was switched off. A clinical entry states: *Ongoing cannabis use and antisocial behaviour resulting in eviction*", and another states: "*21 Jan. Evicted from flat*".
22/01/2015	The care coordinator made a referral for Mr S to a local hostel for complex mental health issues. The hostel accepted the referral.
25/01/2015	Local hostel informed Mr S's care coordinator that Mr S had not arrived at the hostel. Mr S's family confirmed that Mr S had refused to go the hostel. His care coordinator reiterated that he could not stay with his mother and he agreed to go and look at the hostel accompanied by his Care coordinator.
29/01/2015	The community nurse visited Mr S at his mother's home. He talked to Mr S about concerns raised by his family and services and his unwillingness to engage with services. Throughout the conversation Mr S demonstrated capacity to understand decisions. He stated that he might go back to the local hostel and requested that he retained his current care coordinator.
06/02/2015	The care coordinator found Mr S was not there when she visited the hostel. Staff reported that they did not see him often and that his personal care was an issue. She then visited Mr S's mother, where Mr S was present. His main issues focused on his rap lyrics and maybe needing support to go to the mosque.
10/02/2015	The community nurse visited Mr S to administer his depot injection.
18/02/2015	GP surgery tried to contact Mr S but his mobile phone was switched off.
23/02/2015	The community nurse received a call from Mr S's landlord stating that he wanted his personal belongings removed from his flat (by then, five weeks had passed since Mr S moved into the hostel).
26/02/2015	Care coordinator visited him at his mother's house. Mr S said everything was ok but his mother disagreed. She stated that brother one was on holiday in Mexico and Mr S did not have access to any money
03/03/2015	Received depot Injection. His mother stated that brother one was still abroad and Mr S still did not

	have access to his money. Mr S stated that he was considering going back to Slough.
23/03/2015	Mr S not available at mother's house to receive depot injection and the hostel confirmed that he had not stayed there for the previous five days. An undated entry notes: *"his bed at homeless was considered abandoned and withdrawn as he spent much time at his mum's".*
24/03/2015	Received depot injection.
27/03/2015	Visit from care coordinator. She noted that he had not taken up any support from the support worker, and that he had not paid his rent at the hostel. The community nurse also spent time looking at possible bank accounts for Mr S and rap music opportunities locally. He delivered the information to Mr S.
07/04/2015	The community nurse visited Mr S, Mr S was asleep and Mr S's mother had just got up. He discussed Mr S's lack of motivation and lack of motivation to help himself. Mr S's mother agreed to find a bank that would take Mr S but remarked *"we are very lazy us mentally ill people".* The community nurse agreed to arrange a CPA meeting to discuss further.
15/04/2015	Received depot injection.
17/04/2015	A planned CPA meeting was attended by the community nurse, the care coordinator, a junior doctor and Mr S. Mr S presented well and demonstrated examples of his music, and there was no evidence of psychosis. There was some discussion on how to increase Mr S's functioning. It was agreed to reduce his depot injection to 70 mg (from 80 mg) every three weeks. It was noted that Mr S was no longer living at the hostel, and that he repeated his desire to return to Slough. The care coordinator planned to see him after two weeks to facilitate his attendance at a Sports / Motion Project. A care plan dated 17 April describes interventions regarding physical health, accommodation (managing his own flat independently), mental health, various risks (non-attendance, lack of insight, self-neglect, cannabis, vulnerability ["*currently checking information regarding his potential risk to children*"]), carer's viewpoint ("*she lives with Jo*"), alcohol and drug use, vocation and activity, finance and medication. Mr S was formally homeless, but living at his mother's flat.
18/04/2015	Mr S was arrested on a warrant for breach of attendance at the magistrate's court. There was a

	request for screening following the arrest. There were no concerns expressed by the sergeant or liaison and diversion worker that suggested further screening was required. Mr S was to remain in custody for the weekend in case his condition deteriorated. A risk assessment document completed in April 2015 includes: "*eats convenience food and snacks … chaotic and unplanned lifestyle … does not appear to be washing himself or clothes or taking care of flat … has been assessed as having social needs but social services will not put support into the flat as considered a health and safety issue to staff. Nor will they fund a hygienic clean … now living with mum [who] complains that he does not wash regularly or change his clothes …* *[fortnightly ESA] is spent within 3-4 days … is reliant on others to provide him with food, money for electricity etc. … steals from shops to eat … money is largely spent on cannabis according to his brother … fails to prioritise food and heating over cannabis and cigarettes ... at his mother's he continues to prioritise cigarettes and cannabis and is accused of stealing money and cigarettes by [her] … is still homeless".*
01/05/2015	Visit from care coordinator- review of care plan. Care coordinator later received a call from the police informing her that Mr S had been arrested for breaking his bail conditions and would appear in court the next day. She advised the police that Mr S's depot injection was due the following Tuesday in the event of him being remanded in custody. There is a note in Mr S's records by Community nurse summarising his condition, highlighting when his depot was due and stating he would need to be accompanied by an appropriate adult for interview. Mr S was granted bail following his court appearance.
08/05/2015	Community nurse visited Mr S to administer his depot injection and administered 80 mg of flupenthixol decanoate (this was not the 70mg as agreed at the review meeting on the 17 April 2015).
06/06/2015	The community nurse administered his depot at the reduced dose of 70mg.
26/05/2015	Mr S administered reduced dose of 70mg depot injection. His mother said she thought he was not well. Following an argument yesterday 25/05/15

	he threatened to cut her throat of she went to the police. Mr S said that his mother had previously threatened to stab him and a friend – and went on the describe other incidents when his mother has been under the influence of alcohol. Advised this was a matter for the ;police and not a mental heath issue
11/06/2015	Care coordinator visited Mr S to find Mr S, his mother and friends there and all were drinking. She did not stay and agreed to visit another time. Mr S's mother remarked that Mr S's lack of respect had got worse since he had been tagged. There is no information in the Trust's electronic care records as to when Mr S was tagged. She complained that Mr S smelled and that his clothes were at the local hostel. Mr S's care coordinator suggested that they may be interested in family work to help support them in their communication and they agreed to think about it. As a result of the concerns raised by Mr S's mother Mr S's care coordinator contacted safeguarding adults who suggested a referral to 'First Contact'.
24/06/2015	As a result of the concerns raised by Mr S's mother, the care coordinator contacted the safeguarding adults team, who suggested a referral to 'First Contact'. It is reported that there were concerns about Mr S's "*escalating abuse*" towards his mother and her raising concerns about her vulnerability and ability to protect herself. The First Contact' team acknowledged receipt of the referral.
26/06/2015	The community nurse visited Mr S and administered the revised dose of 70 mg depot injection. Mr S's mother told him during his visit that she thought that Mr Ss' health had deteriorated as he had threatened to cut her throat if she called the police the day before. He advised that if that were to happen again the police would need to be involved as it was a domestic situation rather than mental health. Mr S's care coordinator also received a telephone call from Mr S's mother and she was upset because Mr S had made her go over to the cricket ground at the weekend and pickup dog ends of cigarettes. She stated that she felt ashamed. She also stated that Mr S shouted at her. She also requested help to complete a carers allowance form. The care coordinator was advised by Social Worker 2 that Mr S's mother was open to the safeguarding vulnerable adults team. She agreed to contact her allocated worker.

26/06/2015	Care coordinator received a call from brother three expressing his concerns about Mr S and his mother living together as they were going through thousands of pounds on alcohol, cigarettes, drink, food and cannabis. Mr S's care coordinator made a phone call to Adult Safeguarding and they agreed to offer Mr S's mother support and assessment
29/06/2015	No record of depot being administered.
07/07/2015	Mr S not available for depot injection.
08/07/2015	Mr S not available to receive depot injection. Mr S had been arrested for breach of his bail conditions and was due to appear in the north Magistrates Court the following day. Mr S was reported to be pleasant and amenable and there was no requirement to assess his mental state. He was to remain in custody overnight. Mr S requested that brother one and his solicitor were informed. Liaison and diversion court report recorded that Mr S had a history of potential risk to self and others. It also highlighted the need for Mr S to receive his overdue depot injection as soon as possible after the court appearance.
09/07/2015	Mr S not available to receive depot injection. Mr S appeared in court but was released on bail to attend Reading crown court. The referral to liaison and diversion was closed.
17/07/2015	Mr S not available to receive depot injection.
20/07/2015	Depot injection administered.
03/08/2015	Care coordinator visited Mr S and he informed her that his mother was in hospital in the south due to her mental health difficulties. Care coordinator noted that all the pictures in the room had been turned upside down and the clock. When Mr S questioned about it he laughed. His main concern was his lack of money. Mr S was arrested for theft of cigarettes from shops and breach of his tag.
03/08/2015	Mr S was arrested for assault on his mother and a request was made about his mental health at that time.
05/08/2015	Mr S's Care coordinator visited his mother who was upset. She stated that Mr S had kicked in the ankles, verbally abused her and tried to push her down the stairs. They were arguing over cigarettes. He also threatened her with a kitchen knife and to kill her. Mr S's mother asked *"what would happen if he did kill me"* Mr S's Care coordinator spoke with the police and requested that due his mother's vulnerability Mr S should not be released to her address. She gave the contact

	details to Mr S's mother for places of safety/refuge. She also made enquiries about housing for Mr S. The police advised Mr S's care coordinator to discuss the issues with the local vulnerable person's team. Mr S was to be held in custody overnight. Upon assessment Mr S was not deemed to be ill at that time just frustrated about being held in custody
06/08/2015	Care coordinator received a call from the Custody Diversion Team stating that Mr S could not be released without an address and asking if he could be given an address in absentia. This was not agreed. Mr S was not charged in relation to the alleged assault on his mother but could not be released to his mother's address as a result of her vulnerability, seriousness of the threats, use of a weapon, previous assault on his mother, and the volatile nature of their relationship. Mr S was charged in relation to breaching his bail conditions and was held overnight and produced before Teeside Court 060815. It was noted that Mr S's mother had made contact with two local women's refuges. The details had been given to her by Mr S's Care coordinator. The Liaison and Diversion Team in their report stated that Mr S had at that time full capacity.
20/08/2015	Mr S was released from the local prison. Information had been faxed to the prison that Mr S required his depot injection but this had not been administered by the prison prior to Mr S's release. The prison also failed to inform the EIPT of his release.
28/08/2015	The care coordinator discussed with the advanced practitioner her concerns about Mr S not having had his depot injection.
03/09/2015	Received depot injection at his mother's address.
24/09/2015	Received depot injection at his mothers address.
09/10/2015	The care coordinator attended a briefing with safeguarding adult protection in response to safeguarding alert raised. Mr S was not there. His mother said that he had gone out to get a takeaway and some cannabis. The flat was filthy with rubbish and clothes lying around. His mother admitted to smoking dog ends which could have been cannabis and it was noted that the cigarette she was smoking at the time smelled like cannabis. Mr S's mother stated that all the cases against her son had been dropped and that he was awaiting surgery to his knuckles having punched a frozen bottle of coca cola. Care

	coordinator spoke with Mr S who reiterated that all cases against him had been dropped and he said he was having treatment for his fracture on the following Wednesday. The care coordinator rang Mr S's solicitor who confirmed that all cases against Mr S had been dropped and that they had closed the file.
16/10/2015	Failed to attend an appointment with the community nurse for his depot injection. He returned in the evening to find Mr S and his mother arguing. Mr S stated that he did not want his injection. He stated that he didn't hear voices any longer so didn't see the point in taking medication. The community nurse agreed with Mr S that a medication review should be arranged.
22/10/2015	The community nurse 2 visited Mr S to administer his depot injection but Mr S failed to attend. His mother had changed all the locks to her house and had not seen Mr S for two days.
30/10/2015	The care coordinator visited Mr S as arranged but he was not there. She called brother who stated he had spoken with Mr S 30 minutes previously and provided his new telephone number. The 'phone when called went onto voice mail.
03/11/2015	The community nurse called to visit Mr S but he was not at home, had not been seen for two weeks and the assumption was he was staying with his mother. This was because previously Mr S's mother had always allowed him back into her home to live with her. Mr S did not attend his occupational therapy appointment. A further letter was sent to Mr S with a new appointment date of 7 December 2015.
05/11/15	The care coordinator sent a text to Mr S stating that he needed a review of his medication as he had not had his depot injection. He replied by text saying *"Hug"* which was out of character. The brother rang Mr S's care coordinator saying that he had received a text from Mr S saying *"goodbye and pray for me today"* He reported last seeing Mr S on the 26 October 2015. The care coordinator visited Mr S's mothers house and she stated that Mr S had just left but had presented as *"weepy"* and stated he needed to go away for a while. Mr S's care coordinator returned to the office spoke with her manager who advised that it should be reported to the police. Mr S's care coordinator called the police informing them of his diagnosis and that he had failed to have his depot injection. The care coordinator sent Mr S a further text at

	4.37 pm and she received a reply at 4.40 pm saying that he was fine. He stated that he was about to meet the police to demonstrate that he was fine and well. Mr S agreed to meet his care coordinator the following day to talk about his medication. She asked him about his recent drug use as his mother had commented that he had been taking 'whizz'. He replied that he had taken some speed but that he preferred 'green'.
05/11/2015	The community nurse contacted the local hostel but Mr S was not there and had not been seen.
06/11/2015	The care coordinator contacted Mr S but his 'phone went straight to voicemail. She than called Mr S's mother but her 'phone was switched off. She advised the advanced practitioner about a further date for a medication review.
09/11/2015	GP practice tried to contact Mr S but his mobile telephone was unobtainable.
11/11/2015	The advanced practitioner visited Mr S at his mother's home. Mr S stated that there were no problems with his mental health and that he had only had one voice experience in August of 2015. He stated that he was enjoying his music and writing lyrics and wanted to go back to how he was in before. He blamed the depot injection for making him sleepy He was uncertain as to whether he wished to continue with the medication and the risks of sudden cessation were discussed with him. Following discussion, the advanced practitioner felt he had capacity to make an informed decision and he agreed to commence his depot injection on 40mg of flupenthixol decanoate every three weeks. His depot injection was administered by community nurse. His Care coordinator was to continue to engage Mr S with EIPT. A CPA update was completed where the risks were recorded as non attendance, potential for relapse if Mr S was not treated, ongoing family difficulties, violence towards his mother, delivering regular support and his poor physical health. There were no significant risks identified by the advanced practitioner. His depot medication was administered by the community nurse at the reduced dose of 40mg.
12/11/2015	An urgent CPA meeting took place attended by Mr S's care coordinator, the community nurse, the advanced practitioner, Mr S and his mother. The advanced practitioner sent a letter to Mr S's GP with a summary of the meeting with Mr S the previous day and advising him of the change of

	dose of depot injection. Mr S related how he felt unwell and not motivated when on 70 mg of his depot injection. He understood the reason for the medication being prescribed and did not wish for the symptoms to return. Mr S was noted to be overweight and his teeth needed attention He described how smoking cannabis helped his creativity and admitted to sometimes taking amphetamines. It was noted that housing was not high on Mr S's priorities. He said that he was a semi practicing Muslim having converted from Christianity. Mr S was due to transfer to Psychosis Services in March 2016. Risks identified as potential for him to relapse balanced against the damage to the quality of his life from the side effects of medication; ongoing family difficulties where he has been the perpetrator of violence against his mother a vulnerable adult); difficulties of delivering regular support and medication to him when he is of no fixed abode, frequently changes 'phone numbers and does not attempt to contact services and poor physical health. It was noted that he wanted to drastically reduce or stop his medication.
22/11/2015	The care coordinator called Mr S to enquire how he was but the 'phone went into voice mail. It is thought that Mr S moved to Slough in late November. Since his arrest, Mr S has reported "*going to Slough the end of November 2015*". It has also been reported that he had been staying with the victim (described a frail 48-year-old cancer sufferer) for around four weeks, and that the victim was known to Mr S's stepfather.
02/12/2015	Mr S failed to attend his appointment for his depot injection. Mother informed nurse that he had moved to Slough.
05/12/2015	Mr S's care coordinator called him but a stranger answered the phone saying they had Mr S's Sim card but gave the care coordinator brother one telephone number. She had a missed call from brother one stating that he was worried about Mr S and that he thought that Mr S was just visiting the south. Brother one stated that Mr S's 'phone had been taken forcibly and that he could not get into contact with him. Brother one was advised by Mr S's care coordinator that if he had concerns about his brother's safety he should contact the police and that she would continue to try to contact Mr S.
11/12/2015	The community nurse visited Mr S's mother and was given an address where Mr S was residing on

	a temporary basis in down south. There was no way of knowing if Mr S was returning from the south and so Mr S's care coordinator made a written referral to the southern adult mental health services common point of entry (CPE). The risks were recorded as substance misuse, housing problems and non-compliance with treatment. There was no risk to others indicated on this referral. The referral was not marked as urgent. The depot medication details were recorded as 70mg and 40 mg 3 weekly). BHFT recorded receiving the referral on this date.
11/12/2015	BHFT records indicate that at 4.36 pm a referral form was received from a care coordinator from TEWV The referral was marked by CPE BHFT as amber and the form was logged by a team administrator and reviewed by a CPE team lead who summarised the information in the electronic care record at 6.35 pm, recording the plan as follows: "*Plan: Request for CPE admin to contact referrer and request updated full risk assessment and CPA from [TEWV] CPE Team Lead for Slough CPE Locality to request review of referral and advise as to process for transfer of care to Slough CMHT. Referral placed in Shift Lead pot in the interim."* The TEWV external reviewer noted that this completed referral form was very detailed. It stated that Mr S had moved to his stepfather's address and would need support, and that he had last received his depot on 11 November 2015. The referral form essentially 'cut and pasted' the letter resulting from the CPA meeting on 11 November. Under 'risk', Mr S was described as potentially vulnerable to exploitation, and as homeless. It was noted that the issue of self-reported inappropriate sexual behaviour in front of a female child had been reported to Slough social services, with no reply having been received. According to TEWV, no risk to others, or of violence, were recorded other than this incident and the assault on his mother, but the BHFT report notes that the care coordinator stated: "*When psychotic he has had suicidal thoughts as a result of worrying he may harm somebody or had harmed somebody*". At about 6.30 pm on the same evening, the referral was reviewed by a nurse member of the

	duty team (the CPE Team lead) and the referral form completed by BHFT services noted an address (his stepfathers). Of the four referral 'urgency' options (crisis, urgent, amber, routine), this referral was marked 'amber', meaning that CPE would respond within 48 - 72 hours following receipt of referral (with assessment within 3 - 14 days). It was noted that Mr S was "*uncontactable*". The given reason for referral was "*generic assessment of mental health"*. The following entry was made: "*Plan: Request for CPE Admin to contact referrer and request updated full risk assessment and CPA from [TWEV]. E-mail sent to … CPE Team lead for Slough CPE Locality to request review of referral and advise as to process for transfer of care to Slough CMHT. Referral placed in Shift Lead pot in the interim"*.
12/12/2015	The CPE team lead sent an e-mail to the CPE locality lead for Slough asking her to *"look at the referral and advise*". She was then the only locality team lead for Slough (established). This e-mail was reportedly sent on 12 December, but the locality lead has since stated that she did not review this e-mail until on or after Wednesday 21 December, when she went on leave. In the interim, Slough CMHT were not contacted by CPE, and remained unaware of the referral. It was seemingly assumed that the e-mail had been received, and it also appears that there was no routine process that would 'pick up' in real time whether the referral had been processed. The BHFT investigation states that: "*due to misunderstandings and communication problems, the referral to CPE on 11 December 2015 was not passed to the Slough CMHT for action, and no other interim action was taken other than requests to TEWV for more information …* *There is no evidence that any action was subsequently taken within the timescale required by CPE's procedures, or with the necessary degree urgency [sic] given the fact that [Mr S's] medication had been overdue since 2 December"* The BHFT report states that *"further information was requested from TEWV but not provided"*.

	Three telephone calls were made by CPE staff to the TEWV team on 16, 23 and 24 December.
16/12/2015	A Berkshire CPE team administrator telephoned TEWV at 10.57 am and left a message with a member of staff who confirmed that the care coordinator would *"call around 11.30 am".* There is no evidence that TEWV responded.
21/12/2015	Mr S called his Care coordinator at 5:45 pm and left a voice message saying; "*Hello (care coordinator), It's me (Mr S) erm I'm doing really great by the way but I feel like I might need my medication so. I'm in down south basically if you want to know where I am, just call me, whatever and I'll get in touch (inaudible) so thank you very much basically I'll see when I see you. Bye. God Bless".* Mr S's care coordinator informed her manager and Forensic Psychiatrist 2. NB. This information was not recorded in Mr S's notes but was offered by Mr S's care coordinator in interview. She stated that Mr S sounded well and not thought disordered in the voice message. At the time the voicemail was left Mr S's Care coordinator was not at work but on annual leave followed by sick leave and so the message was not picked up until after the incident.
22/12/2015	Mr S's GP practice tried to call Mr S but his mobile telephone number was unobtainable. A letter was sent to Mr S from his GP practice asking that he contact the practice to arrange a review and highlighting that they had been trying to contact Mr S.
23/12/2015	The CPE team administrator telephoned TEWV at 11.31 am and left a message on the Care coordinator's voicemail, asking her to call back. There is no evidence that TEWV responded. TEWV sent an email to the CPE Locality Lead for Berkshire Slough asking her to *"look at the referral and advise"*. The referral was categorised 'Amber' (initial contact within 72 hours, and assessment within 72 hours to 14 days.
23/12/2015	TEWV Community Nurse 2 made a call to Mental Health Services down south who confirmed that they had received the referral form but had not at that point allocated the case. BCFT explained that he was currently under the care of the crisis team after his father had contacted them with concerns about his mental health. He had presented as

	being aggressive and at time thought disordered. They were aware of his medication and said they would manage his care as needed. It was agreed that they would keep in contact about his progress and that the care coordinator would contact them with more details on her return from annual leave.
24/12/215 4.47 am	Mr S was referred to the Slough CRHTT team at 4.47 am on 24 December by an out-of-hours GP (from Mr S's stepfather's address), who had been called by Mr S's stepfather: "*requesting that be given a depot injection as he was showing signs of relapse … Both and the stepfather were spoken to over the phone by the CRHTT …"* The BHFT inquiry has quoted the GP (whose call was recorded) as saying that Mr S had: "*smacked [stepfather] three times on the face and he's violent and he needs some help now … the father is in trouble and he's getting all the trouble from the patient but I couldn't reason him out and I need your help. He needs some injection … I think because his depot injection is running out … he's causing trouble including violence, I think we ought to do something".*
24/12/2015 5.03 am	The call was taken by a CRHTT east health care assistant and during the call she spoke to Mr S and his stepfather. Her clinical entry made at 5.00 am includes the following: "*T/C received from OOHGP … stepfather called OOHGP demanding a doctor to administer his injection tonight … injection is due and he has been showing signs of relapse … lashed out on his stepfather tonight … [GP] asked CRHTT to contact 's stepfather, … T/C made to stepfather …he expressed his disappointment that Mr S had not been receiving his medication since the move to Slough … I asked to speak to him … he appeared calm, but struggled to maintain two-way conversations … responded to direct questioning … the stepfather was advised again about the process of arranging a repeat injection … CRHTT will look into organizing an injection as soon as possible … he was not happy with such arrangement, as he wanted it done immediately tonight, agreed to await a call from CRHTT. Case discussed with senior mental health practitioner.*

	Plan: CRHTT urgent arrangement for depot to be prescribed, collected from pharmacy and administered …" The BHFT inquiry quotes the stepfather as having said: "*we need bit of help here … he's lost the plot … he needs that drug now, it lasts maximum four weeks, it's been five six weeks"* The stepfather stated during this call that he was not staying with Mr S, but that Mr S was staying at the house of a friend of his (stepfather), and told the staff member "*get in touch with me on this number - I will get though to him somehow".* It is not clear to me if Mr S's correct address was recorded during this call, but it does seem clear that the HCA was told that Mr S was not staying with his stepfather. The BHFT inquiry also quotes Mr S as having acknowledged he had got "*angry with my stepdad for no good reason … I need [the depot] now basically."*
24/12/2015 5.16 am	The out-of-hours GP telephoned Berkshire CRHTT night shift team lead confirming his agreement with the action that had been agreed, for depot medication to be arranged in the morning.
7:30 am	The referral was discussed at the 7.30 am handover meeting at which night staff were present together with day staff who were coming on duty. It was agreed that Berkshire CRHTT nurse would try to obtain more information.
Recorded on the electronic care record at 10.32 am with time of contact recorded as 9.51 am	Berkshire CRHTT telephoned the stepfather who stated that Mr S's behaviour had been erratic, he had not had his depot for three to four weeks and wasn't sure if his care had been transferred to Slough stating that he had moved to Slough for *"almost two months",* that he had been *"quite aggressive"* last night. Berkshire CRHTT also spoke with Mr S and asked him for information about his medication and his care coordinator: Mr S was laughing intermittently and on questioning said he didn't feel that life was worth living *"because of my mental health issues"* but was laughing at the same time. He denied thoughts of self harm saying *"I value my life; I don't have*

	thoughts of wanting to kill myself". Plan was for the CRHTT to visit this afternoon for initial assessment and to consider urgent medication review by the consultant; awaiting further information from the care coordinator to clarify if he is subject to Section 117 aftercare arrangements; crisis team number provided for the stepfather and to Mr S.
10.04 am	BHFT telephoned the Slough CMHT who said they had no information about Mr S.
10.17 am	BHFT telephoned the TEWV and left a message for the care coordinator to call back.
10.19 am	BHFT telephoned CPE and established that CPE was waiting for information from TEWV and intended to pass the case onto the Slough CMHT.
Approximately 10.30 am	The case was discussed with CRHTT psychiatrist and team leader and recorded the advice crisis team to visit to visit and assess the current presentation and request for review with the consultant. The psychiatrist advised that oral medication (olanzapine) might be prescribed if appropriate after assessment.
10.45 am	CPE discussed with CRHTT. CPE awaiting documentation from the referrer to facilitate case transfer to Slough. Telephoned TEWV administrator who reported the the care coordinator (referrer) is not available. Requested to speak to another person to assist as the case is urgent. Awaiting call back to request full CPA documentation. CRHTT nurse called the stepfather to advise that a visit would be arranged that day with a view to prescribing medication. The BHC FT report notes that the stepfather repeated during the above call that Mr S had been aggressive during the night, and asked whether a doctor would be visiting. It was then decided that a male CRHTT (agency) nurse, accompanied by a recently appointed male HCA, would visit Mr S.
Between 11.00 am and 12.00 midday (according to the BHFT internal investigation).	It was then decided that a male CRHTT (agency) nurse, accompanied by a recently appointed male HCA, would visit Mr S. The time of the visit is not recorded. I would note that the record entry was made at 2.15 pm and that the TEWV internal investigation report describes this visit as having taken place at about 1.30 pm. The time of the visit was not recorded. It is unclear why the visit was to the stepfather's address, when the stepfather had stated that Mr S was not staying with him (see

	above).
12.15 pm	CPE telephone call to crisis team to inform them that waiting for TEWV EIP to call back. Plan to await CRHTT outcome of visit.
1.20 pm recorded on the electronic care record at 2.22 pm	The victim telephoned the community health referral hub (physical health care number, but service is co-located with CPE) in Wokingham, asking for help for Mr S, who was said to need medication (he also discussed a bed delivery that he was waiting for). Mr S came on the line and said, "*I need my antipsychotics, I was supposed to get them yesterday*". CPE were advised of this call by community health staff.
1.30 pm	At the handover meeting with the CRHTT afternoon shift lead, it was agreed that the same nurse would visit Mr S's address, this time accompanied by a female CRHTT nurse.
1:42 pm	A BHFT CPE nurse telephoned the victim straight back who explained that Mr S was staying with him and had been aggressive and was *"not compos mentis ...he's all over the place...he's getting worse.... he is self-harming"* The nurse asked to speak to Mr S and the victim indicated that Mr S was sitting on the sofa *"totally silent"* and unable to speak. The nurse asked the victim if he felt that he or Mr S were in immediate danger, to which he replied *"not right at this minute".* The CPE nurse explained that she would pass this information to CRHTT.
Time of contact 1.45 pm	CRHTT received a telephone call in return for theirs from TEWV reporting that Mr S remains under their care and that he had a history of disengaging with their service. He reported that he didn't know much about him but would be liaising with the care coordinator when she returns as she was not in today. Plan recorded as awaiting contact from the care coordinator for further information and history about Mr S.
approximately 2 pm	BHFT CPE telephoned the BHFT CRHTT nurse and told him of the victim's telephone call. Her electronic care record entry included his telephone number.
First attempted visit by BHFT CRHTT. The electronic care record entry was logged at 2.17 pm but the visit is thought to have taken place between 11 am and 12 midday	A CRHTT community nurse, made an entry regarding the joint home visit: "*front door … was left wide open … a boy came to meet us … He introduced himself as D and the stepbrother of Mr S … He said he does not live*

	there and only visits him … He said he does not have any concerns about him … we left him a complimentary slip for Mr S to make contact with us … a man arrived shortly who introduced himself as 's uncle and said he was assaulted for no reason by Mr S. He told us to go and visit Mr S at his friend's house … said he had real concerns about him and wanted us to see him asap. We explained that it was not appropriate for us to just turn up at a person's address especially that Mr S has recently been aggressive / violent to others … *Plan: Re-attempt CRHTT assessment after making phone contact with Mr S"*
2.31 pm	TEWV psychological therapist responded to a telephone call from BHFT who informed him that Mr S was currently under their care. Mr S's stepfather had raised concerns about his son's mental health. Mr S had appeared at times aggressive; thought disordered and had tried to attack him. It was explained by the psychological therapist that engagement with Mr S over the past year had been difficult and that Mr S had missed his depot injections. He also explained that Mr S had gone to Slough without the knowledge of EIPT and had missed his depot injections. I. "*in response to them ringing and wishing to speak to a member of the team ...* *currently under care of crisis team … I made them aware that our team had struggled over the past year to engage with on a consistent basis and would often miss his arranged depot injection … he had gone to Slough without our knowledge … it is planned that the care coordinator will contact the team … on her return from annual leave …"* It was explained that Mr S would be discharged if he was staying in Slough. It was agreed that this would be formalised with a transfer of care to the local EIPT and that more detailed information would be given by the care coordinator about him on her return from leave.
Second attempted visit by BHFT CRHTT recorded on the electronic care record at 6 pm. The visit took place at 5.15 pm	On returning to the CRHTT Hub they recorded the failed visit despite several attempts including an attempt to call him on his 'phone (they could hear dogs barking and the lights were on) Plan recorded on RIO as follows *"AM T/C tomorrow to arrange an initial assessment"*.

6.40 pm	The Slough police received a call stating that a man had been found in cardiac arrest. When paramedics arrived Mr S was outside of the address and was holding a kitchen knife and said *"I am sorry, it was me, I'm sorry"* Paramedics found the man on the floor inside of the address with a single stab wound to the neck. Mr S was found waiting inside the property when the police arrived at the scene. He was arrested and later assessed under the Mental Health Act 1983 and detained under Section 2.
8.06 pm	The CRHTT nurse recorded on the electronic care record that he discussed the case with the team lead who advised that a further visit should be made by CRHTT staff *"tonight'".* The CRHTT nurses that had attempted the visit for assessment went off duty at 9 pm.
Recorded on the electronic care record at 8.56 pm. Time of contact 8.56 pm	Berkshire CRHTT nurse received a telephone call from police with the information that Mr S was in custody having been arrested for suspected murder.
25/12/2015	A call was received by TEWV community nurse from the Berkshire southern Social Worker requesting information on Mr S as he was in police custody charged with murder. Mr S was assessed under the Mental Health Act 1983 and detained under Section 2 before being transferred to TEWV.