Report to:	Board of Directors	Meeting Date:	27 March 2019
This Report is provided:	☒ for a decision	☐ to note / for information	☐ as a consent item

Review into the Care and Treatment of SU1

Accountable Director(s):	David Fearnley, Medical Director
Report Author(s):	Steve Morgan, Director of Patient Safety

Alignment to Strategic Objectives:	Our Services	☐ Save time and money	☒ Improve quality (STEEEP)	
	Our People	☒ Great managers and teams	☒ A productive and skilled workforce	☒ Side by side with service users and carers
	Our Resources	☐ Technology that provides better care	☐ Buildings that work for us	
	Our Future	☒ Effective partnerships	☐ Research & innovation	☐ Grow our services

Alignment to the Quality Domains:	STEEEP	☒ Safe	☒ Timely	☒ Effective	☒ Efficient	☐ Equitable	☒ Person-centred
	CQC	☒ Safe	☐ Responsive	☒ Effective	☐ Caring	☒ Well-led	

Purpose of Report:	To provide the Board of Directors with the homicide review report into the care and treatment of SU1.
Recommendation:	The Committee is asked to: 1) Discuss the report 2) Identify any new risks 3) Identify any further assurances it requires 4) Agree for the Quality Assurance Committee to monitor the completion of the action plan

Previously Presented to:			
Committee Name	Date (Ref)	Title of Report	Outcome / Action

Do the action(s) outlined in this paper impact on any of the following issues?		
Area	**Yes**	**If 'Yes', outline the consequence(s)** *(providing further detail in the report)*
Operational Performance	☒	The Board will have significant assurance for operational performance.
Provider Licence Compliance	☐	
Legal Requirements	☒	Good governance standards require that the trust has robust risk management and assurance process which provide significant assurance to the Trust Board, and through them to our regulators.
Resource Implications	☐	

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favourably than any other?	☐	☒	☐
Are there any valid legal / regulatory reasons for discriminatory practice?	☐	☒	☐
If answered 'YES' to either question, please include a section in this report explaining why			

EXECUTIVE SUMMARY

1. On 26th April 2018 SU1, a service user known to Trust Assessment Services was arrested on suspicion of the murder of his mother and attempted murder of his grandmother's carer. He was arrested and after his detention in custody he was assessed under the mental health act and detained under section 2, admitted to Ashworth Hospital-High secure services.

2. The Trust has undertaken a Root Cause Analysis Review into the care and treatment provided to SU1 which after being agreed by the Board of Directors in January 2019 has had further amendments on the request of the Local Division and has been shared with NHS England, Liverpool CCG and the victims family as per the agreed procedures regarding the reporting and investigating of serious incidents.

3. The review found a series of Care and Service Delivery Problems, Contributory Factors and a Root Cause related to the incident which have led to a series of recommendations and an action plan that will be implemented by the Local Division and its completion monitored by Liverpool CCG.

4. The Judge in the criminal trial for SU1 requested that the report be shared in the public domain. The Trust sought legal advice and the opinion of H.M. Coroner; they both supported the view that the full report could be shared via the public board papers. H.M. Coroner has stated that he will be satisfied that the learning has been put in to the public domain once the public trust board meeting has occurred and therefore he is unlikely to hold an inquest into the death of SU1's Mother.

BACKGROUND

5. SU1 presented twice to Mersey Care NHS Foundation Trust Assessment services; Hospital Mental Health Liaison Team on 30/03/18 and Criminal Justice Mental Health Liaison Team on 26/04/18.

6. After his second assessment with Mersey Care Assessment Services Criminal Justice Liaison Team whilst in custody at St Anne St custody suite for an alleged common assault on 26/04/18, he is reported to have left custody with his mother, who had acted as his appropriate adult, after being cautioned and released. He left the police station with his mother and shortly after he is alleged to have murdered her by stabbing her with a knife. He is then alleged to have attended his grandmother's home address and attempted to murder his grandmother's carer by stabbing her. He was arrested at the scene and after his detention in custody he was assessed under the mental health act and detained under section 2, admitted to Ashworth Hospital-High secure services.

7. The review identified that in the panel's opinion the root cause of the incident was SU1s complex presentation which was not explored by the practitioners in depth. This lack of exploration may have been due to SU1s presentation as well as a lack of sufficient training in exploring psychopathology. This resulted in a delay in diagnosis and therefore untreated psychosis.

8. The Recommendations identified are:

    a. Front line staff to complete training and demonstrate competencies in assessment skills and recognising common mental health conditions
    b. Knowledge and understanding of Autism Spectrum Disorder to be improved through training
    c. To develop RiO system to remind staff to involve carers/relatives as part of the assessment and capture these discussions.
    d. For front line staff to be skilled in risk assessments and formulation
    e. To share learning with SU1's GP around importance of clear documentation and the referral pathway to single point of access.
    f. To review process of MDT discussions around A&E assessments.
    g. Develop Standard Operating Procedures for Core 24
    h. To raise the profile of risk of harm to self and others if families are not consulted as part of an assessment and if staff are not adequately trained.
    i. Review staffing levels in A&E to ensure the staffing levels can meet the demand

9. Agreed actions for learning include:

    a. An Oxford model event
    b. Feedback and reflective practice to both teams involved in the assessments
    c. The report should be shared via the police liaison officer to address specific issues and to consider changes and or improvements to future partnership working
    d. Share report with GP and share learning
    e. Teams from A&E and CJLT to demonstrate learning by engaging in training and changing practice

COMPLIANCE AGAINST THE CQC's DOMAINS – SAFE

10. This report has identified learning points regarding safeguarding and protection from abuse, managing risks, safe care and treatment and with particular focus on learning when things go wrong. The learning from this review aims to provide assurance of the Trusts Quality and Safety Framework and it's commitment to

using best practice, improvement science, digital technology and performance monitoring to reduce and prevent risks and harm.

COMPLIANCE AGAINS THE CQC's DOMAINS – EFFECTIVE

11. Learning points in relation to assessing needs and delivering evidence-based treatment, staff skills and knowledge and how staff, teams and services work together have been identified and will be addressed via the associated action plan.

COMPLIANCE AGAINS THE CQC's DOMAINS – WELL LED

12. The learning outcomes associated with this review are to provide clear oversight and effective processes to analyse and monitor safety performance concerns and drive improvement to prevent harm.

GAPS IN ASSURANCE / NEXT STEPS

13. The Board of Directors is asked to:

    a. Consider the report and accept its findings.
    b. Identify any further assurances required with regards to SU1's care and treatment.
    c. Agree for the Quality Assurance Committee to monitor completion of the action plan

SIDE BY SIDE WITH SERVICE USERS / CARERS / STAFF

14. The report itself documents service change and improvements. Those improvements will have service level co-produced implementation plans.

STEVE MORGAN
DIRECTOR OF PATIENT SAFETY
March 2019

Root Cause Analysis Investigation Report

Version 13: 13.12.2019

Incident Investigation Title:	Care and Treatment of SU1
Incident Date:	26/04/2018
Incident Number:	StEIS reference: **2018/10658** Incident reference: **WEB83098**
Author(s) and Job Titles:	Risk and Governance manager (Joint lead reviewer) Consultant Forensic Psychiatrist, Associate Medical Director (Joint lead reviewer) Clinical Psychologist, Asperger Team Service User/Carer Rep Mortality and Incident Practitioner Team Leader, Liverpool City Council
Investigation Report Date:	October 2018

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1. MAIN REPORT:

The panel wish to remind the readers of this review that this analysis has only been made after the panel members have had the opportunity to:

- Read a wealth of materials; much of which have become available after the serious incident, in the form of assessments undertaken at his current hospital.
- Spend considerable time and effort talking to staff and learn from their comments;
- Discuss the relevant issues amongst themselves and with a range of other experienced clinicians;
- Spend much time thinking about the possible areas of concern and coming to rational conclusions.
- The time to do these things in such depth is never routinely set aside due to service constraints.
- Moreover, the analysis is made with all the advantages and disadvantages that come with hindsight and this will inevitably alter the interpretation of events, and may lead to over interpretation, which needs to be borne in mind.
- Whilst a number of matters have been put forward as recommendations for consideration by the clinical team, the managerial team and the organisation as a whole, it must be noted that staff that assessed SU1 did so with the experience and skills they had. There were no formal recommendations made directly at individuals in the teams

2. EXECUTIVE SUMMARY (including incident Description and consequences)

Incident Description:	SU1 presented twice to Mersey Care NHS Foundation Trust Assessment services; Hospital Mental Health Liaison Team on 30/03/18 and Criminal Justice Mental Health Liaison Team on 26/04/18. After his second assessment with Mersey Care Assessment

	Services (Criminal Justice Liaison Team whilst in custody at St Anne St custody suite for an alleged common assault on 26/04/18, he is reported to have left custody with his mother, who had acted as his appropriate adult, after being cautioned and released. He left the police station with his mother and shortly after he is alleged to have murdered her by stabbing her with a knife. He is then alleged to have attended his grandmother's home address and attempted to murder his grandmother's carer by stabbing her. He was arrested at the scene and after his detention in custody he was assessed under the mental health act and detained under section 2, admitted to Ashworth Hospital-High secure services.
Incident date:	26th April 2018
Incident type:	Alleged Homicide
Specialty:	Adult Mental Health
Division	Local Division
Actual effect on patient:	Detained in Ashworth Hospital under the Mental Health Act
Actual Severity of Incident:	Death of service user's mother and serious harm to grandmother's carer
Level of Investigation	Level 2 investigation
Involvement and support of the patient and/or relatives	In accordance with Mersey Care Foundation Trust's "Open Policy" SDA13 the Trust have met with SU1's father and step-mum, aunty and uncle (victim's sister and her husband) to offer support during this difficult time and share the information gathered during the review process . They were given the opportunity to ask questions pertaining to SU1's care and treatment, which is embedded within the body of the report. The report has also been shared with SU1's father and step-mother after obtaining permission from SU1. The family accepted the views that were laid out in the report and were satisfied with the contents and scope of the report.
Detection of the incident	CJLT received a referral on the 26.04.18 following SU1 being arrested for a second time after being arrested for alleged homicide. Police called to an incident to a report of a female

	being assaulted. On police arrival a female was found with multiple stab wounds, the injured person was believed to be SU1's grandmother's carer. The carer has told police that SU1 had made off and then returned. Police arrived and arrested the male. On the way to police custody, officers have found another victim at a different location who was deceased; this is SU1's mother. SU1 has then been arrested for murder.
Care and Service delivery problems	• Lack of professional curiosity and competency based training with regard to assessing psychosis and risk. • The family were not given opportunity to corroborate history of presentation and symptoms • MCT Staff nor SU1's GP explored why SU1 had attacked brother and father. • Communication in relation to who was referring to the Asperger's Service and required follow up for SU1 by his GP. • Not identifying Psychosis and risks associated with this presentation during the first assessment at A&E leading to a delay in assessment and treatment by EIT and delay in treatment. • No evidence of a safeguarding referral being received from GP practice to care line. • GP had no specific training in Mental Health • Lack of specific psychopathology training for front line assessment practitioners • Generalised MHP job description for assessment teams • CJLT have no medical oversight and hence no medical input other than via the on-call system.
Contributory factors	**Patient Factors** • Complex presentation, first episode psychosis, although describing psychotic symptoms did not present in an overt manner. • Concomitant use of alcohol and drugs • A lack of observable or reported distress by SU1 at the time of assessments **Individual factors** • Lack of professional Curiosity i.e. staff assessing did not explore symptoms in depth

- GP assumed SU1 was awaiting SPA assessment
- Police minimised assault

  A&E Practitioner felt under pressure as she was the only practitioner on duty due to sickness
- Professional judgment clouded due to mention of Asperger's

Task Factors

- MCT staff and GP did not explore why SU1 had attacked his brother and step father
- Family not offered time to corroborate story at either assessment and with police via a statement

Communication Factors

- CJLT team was not aware of the risks associated with untreated psychosis therefore a MHA assessment was not requested.
- CJLT were not aware that SU1' s family intended to take him back to A&E for further assessment following release from custody due to concerns with his mental health and them being frightened of him.
- The plan following assessment was not clear, which led to SU1 not being referred anywhere.
- SU1's GP assumed a referral was made for SU1 to Mental Health Services due to unclear documentation received from the A&E Assessment Service.

Team and social factors

- It appears that a collective assumption was made by SU1' s GP, the police and A&E Staff with regard to SU1 appearing well dressed, being from 'a nice family and home', and this may have clouded their judgment in relation to his presentation and risk. A human factor related to unconscious bias.

Work environment/Conditions factors

- Staff who were interviewed informed us that allocated time for assessments is limited due to the volume of patients

attending A&E requiring assessment, however, staff can request extra support via on-call managers and also SPR on call

- Band 6 Practitioner required to work with the support of two Band 3's due to sickness, usual staffing levels consist of 2 x band 6 and 2 x band 3. There was only 1 band 6 on for the night duty due to sickness
- There were 3 assessments referred at 18:15, 19:45 and 20:15 on 30th March. All seen by the nightshift though at 21:20, 22:40 and 23:30 (1practitoner) –
- Time constraints for assessments due to demand

Organisational and strategic factors

- Mental Health Practitioner job description is generalised for all disciplines
- As psychosis was not initially deemed the primary diagnosis, NICE guidance was not followed in line with 1st episode of psychosis.
- As SU1 was under caution in police custody after the alleged section 39 assault, MHP's have to advise that anything said could be used as evidence. This can make it difficult to ask direct questions i.e. The stage of the proceedings has barriers into how questions can be asked
- Assessment Standard Operating Procedures are still under review.
- FME did not see SU1. The current model of care is that Custody Sergeant makes a decision with regard to whether someone is fit to release. If a MHA is needed the FME would have to authorize this but in this case at the time of assessment this was not deemed mentally unwell hence why FME did not assess SU1

Equipment & Resources

- Little/No Psychological or Senior Medical support for CJLT and A&E teams during overnight assessments and there is no follow up discussions during working hours within a MDT. There is however, access to medical expertise through the on-call system.
- Pathway for Asperger's is 6 weeks therefore SU1 would not have been seen rapidly at point of first assessment.

	Education & Training Factors • Lack of training in risk assessment for the teams interviewed(SDP3) • Lack of training around mental health assessments and psychosis and Asperger's • There are no clear identified competencies that define the roles that are undertaken in CJLT and A&E Liaison teams and hence do not direct the supervision and learning that is required. • There are no competencies around assessment of risk in psychosis(SDP4)
Root causes	After careful consideration of the facts and following discussion, the Review Panel's opinion is that the root cause of the incident was SU1s complex presentation with psychosis, which was not explored by the practitioners in depth. This lack of exploration may have been due to SU1s presentation as well as a lack of sufficient training among staff who undertook the assessments in exploring psychopathology. This resulted in a delay in diagnosis and therefore untreated psychosis, which ultimately may have led to the violent views formed by SU1 just prior to the death of his mother and assault of his grandmother's carer.
Recommendations	• Front line staff to complete training and demonstrate competencies in assessment skills and recognising common mental health conditions • Knowledge and understanding of Autism Spectrum Disorder to be improved through training • To develop RiO system to remind staff to involve carers/relatives as part of the assessment and capture these discussions. • For front line staff to be skilled in risk assessments and formulation • To share learning with SU1's GP around importance of clear documentation and the referral pathway to single point of access. • To review process of MDT discussions around A&E assessments. • Develop Standard Operating Procedures for Core 24 • To raise the profile of risk of harm to self and others if families are not consulted as part of an assessment and if staff are not adequately trained.

	• Review staffing levels across the three A&E teams to ensure the staffing levels can meet the demand
Arrangements for sharing learning	• Oxford model event • Feedback and reflective practice to both teams involved in the assessments followed by the wider assessment services • This report should be shared via the police liaison officer to address specific issues and to consider changes and or improvements to future partnership working. • Share report with GP and share learning • Teams from A&E and CJLT to demonstrate learning by engaging in training and changing practice.

3. BACKGROUND AND CONTEXT (much of the background has been accessed from information held by his current clinical team)

SU1 is a 21 year old male from Liverpool who is currently detained at Ashworth High Security Psychiatric Hospital, under dual detention, both Section 3 of the Mental Health Act and Section 35 of the Mental Health Act.

SU1 was admitted to Ashworth Hospital from St Anne's Police Station on 27 April 2018, after he was arrested for the murder of his mother and attempted murder of the carer of his grandmother. At the time of admission, it was noted that SU1 had been extremely unsettled and aggressive towards police officers whilst in custody.

SU1's father, and his late mother lived in London after they had met. When his mother became pregnant with SU1, she moved to Liverpool temporarily and stayed with her mother, wishing for SU1 to be born in Liverpool.

Reports from the family suggest that SU1 was born through a normal delivery with no known complications following birth. His mother was aged about 42 when SU1 was born and had no history of complications during the pregnancy. The pregnancy, which proceeded to full term, required delivery via forceps due to prolonged labour. SU1 was born at Fazakerley Hospital in Liverpool.

The family had some concerns that SU1 had developed an infection soon after his birth and although his late mother suspected meningitis, it appears that he was discharged from hospital following a 3-day admission with no complications. SU1 met all of his developmental mile stones and there does not appear to have been any major illness that SU1 suffered from early on in his life.

His father was unaware of any mental illnesses within the family although his knowledge of mental illness within the extended family is limited. The information that is available suggests that SU1's mother had been taking an antidepressant for many years, but it is not known what this was for or for how long.

Reading through records available to his current clinical team at Ashworth Hospital, of his childhood and upbringing, it appears that Mr SU1 had a very supportive environment in which he grew up in. There was no history of physical or sexual abuse. There is no history of offending behaviour prior to the current charges being brought against him. SU1 has been described as a '*happy, chatty child, full of beans, very confident, thoughtful and caring'. SU1* appeared to be interested in sport and played rugby from the ages of 5 to 12. It was at the age of about 9 that SU1' s parents separated and SU1 seems to have said, '*I'll have to get on with it',* which his father thought was strange for a 9 year old. It appears that SU1 then grew up spending some time with his father and some with his mother.

With regard to his education, SU1 attended primary school where it is noted there were no issues with his academic performance. SU1 was suspended for 3 days for bullying another pupil, but other than this incident there are no other incidents of note. Throughout his nursery and school years, he had multiple groups of friends. He made friends easily and it was noted that he gained friendships. He eventually achieved GCSE and BTEC qualifications.

SU1 had several jobs, following his education, and worked in sales for Hopsons for a couple of months in 2014. He then worked as a graphics designer and as a weekend manager for a shop in Birkenhead. He worked as a kitchen porter in France in 2015 and worked as a support technician doing data input. In 2017 he worked as a kitchen, an IT and used to work for as a steward at a local football club. The family noted that SU1's multiple jobs were something that they found unusual because there was little understanding of why this was happening. SU1 had also spoken about setting up his own technology company. He did so on the 25 April 2018.

It was noted from the history obtained from records that SU1 did not have any long term intimate relationships. It is possible that he had a girlfriend in France who he used to keep in touch with.

More recently, since the beginning of this year, it is noted that SU1 had visited Barcelona with a friend and his friend called SU1' s father stating that SU1 had been thinking of jumping off the 5th floor of a hotel balcony in Barcelona. The friend had told SU1's father that he had taken a cannabis cookie and, hence, the father formed the view that this might have been a drug induced episode of behaviour. When he returned from Barcelona, it was agreed that SU1 would live

with his father and his partner. It was noted that SU1 had become sullen and quiet, compared to his usual self. They also noted that SU1 had lost motivation and weight following his return. He had stopped cleaning up the house and commented that he was making enough money by buying and selling Bitcoins and football exchanges.

SU1 had applied for multiple jobs, and had accessed a 3 week training course in the hope that he would be able to work in the online fraud department of a bank at the end of the course. He then is reported to have met with a Lithuanian girl who also attended the course with him. During discussions with the bank, they asked SU1 if he had suffered from mental health problems and it appears this offended SU1. We are not clear what prompted these questions, but it appears to have offended SU1.

SU1 who was at this time in London (following his bank experience), appears to have called his father and stated that he was going to look for a job and that a girl was meeting him. However, later that night at 1am, SU1 called his father distressed that he had paid for a cheap hotel and that there was a strange man in bed when SU1 had gone to the room. It appears that SU1 was quiet distressed by this, but later gave a different story to his father stating that he had given all of his possessions away to a homeless person, as they had surrounded him. His mother then took him to the Royal Liverpool Hospital, when he returned from London the next day and told her his step-brother had put software on his phone. The next day his step-mother overheard SU1 talking to his friends on the phone stating '*I thought I was in a computer game, I thought I could see numbers and signs and that I had to get to the next point or I was going to die'.* Over the course of the next few days, the family noted that SU1 seemed far more distracted than usual. He was checking his phone constantly and spending most of his time in his room, surfing on his laptop. Over the course of the next few weeks, SU1 had been texting his father and this appeared to be strange as there was little in terms of coherence between these text messages. Examples of these are '*I have people issues with everyone apart from you…I have a portfolio of £14,000 invested monthly…I want to live in Canada, snow, it's basically water…I'd like to go to the mountains…it's normal to feel lost.'* (These are some of the text messages his father received).

On 25 April 2018, SU1's step-brother had called his mother, extremely distressed, stating that SU1 had tried to strangle him. SU1 had turned the music up and walked into his room, and got him in a headlock and it was only after he managed to get off the strangle hold after a struggle that he ran out of the room. His stepbrother left the house and went to his friend's house. His stepbrother has since the incident, commented that SU1 would often come into his room and sit quietly at the end of his bed and that he had also stated that the black towels in the bathroom had bad vibes and that they were evil.

Following the incident with his brother, his father asked SU1 what had happened and SU1 responded stating '*nothing'* and left the home to go and work at the football stadium. When he did return, following that he was asked by his father again about the incident and it is alleged that SU1 then grabbed his father and wrapped both his arms around his neck. He then proceeded to punch his father on his face and it was only when his stepbrother came in and asked him to stop that he did so. The family were clearly scared of what had happened and had locked their bedroom doors at night. The next morning he was taken to his GP and was told about the attack. The GP advised him techniques to deal with anger whilst at the GP surgery, SU1's father found a bread knife, wrapped in clothing, in SU1's bedroom. He then contacted the police as he was worried about the risks. SU1 was arrested by the police and taken into police custody. It was here that he had his second contact with Mersey Care NHS Trust, with the criminal justice liaison team on 26 April 2018 and referral was made to Asperger's Team and Early Intervention Team.

Following his assessment by the criminal justice liaison team and release from custody, it appears that SU1 then proceeded to go with his mother back to her house and it was here that the alleged offence took place, which resulted in the death of SU1s mother following which he attended the home of his grandmother, with the intention of informing her of what had happened and during this proceeded to stab the carer of the grandmother, as he had formed the view that the carer was '*manhandling'* his grandmother.

He was then arrested and taken into police custody, where he was assessed under the Mental Health Act and detained under Section 2 of the Mental Health Act and transferred to Ashworth Hospital. Sadly, his mother died from her injuries and the carer of his grandmother had serious injuries, stemming from what appears to be wounds as a result of stab injuries.

4. Mental Health Background

SU1 was not known to services, prior to his 2 contacts with Mersey Care NHS Trust. Following his first contact with Mersey Care on 30 March 2018, the Mental Health Practitioner had come to the conclusion that SU1 presented with features suggestive of Asperger's Syndrome. A letter was sent to his GP, detailing the assessment, however the plan was not clear and was misinterpreted by GP that a referral to Asperger's had been completed. There does not appear to be any contact with mental health services up until his next contact on the 26 April 2018, following what appears to be the assault on his step-brother and father.

What has become apparent is that SU1 had experienced a gradual deterioration of his mental health in the months prior to his alleged serious incident.

5. Recent Mental Health History

SU1 was admitted to Ashworth Hospital having been detained under section 2 of the Mental Health Act 1983. However, since then he is now detained under Section 3 of the Mental Health Act and concurrently under Section 35 of Mental Health Act (on the order of the courts for undertaking as assessment of his mental health condition to provision a report to help the court make a decision about likely mental health issues that might need to be considered in the case).

Following his admission to Ashworth Hospital, he had a (prescribed) drug free trial for the first 4 weeks, during which he was monitored and observed closely. His treating psychiatrist noted that SU1 had now been formally diagnosed with paranoid schizophrenia having had symptoms of the illness elicited and displayed during his admission at Ashworth Hospital.

His treating psychiatrist noted during interview for the purposes of this investigation that SU1 did not present with the obvious symptoms of psychosis during the first few interviews. His treating psychiatrist formed the view that SU1 did suffer from paranoid schizophrenia having explored psychopathology and symptomatology over many weeks and over extended periods of observation and monitoring.

Since the diagnosis has been made, SU1 has been commenced on antipsychotic medication in the form of Quetiapine. He was initially commenced on Clopixol (zuclopenthixol, 10 mgs), but developed side-effects to this medication and it was discontinued and was commenced Quetiapine, which he has been taking on a regular basis. It was noted that his mental state has improved significantly, but that he continues to lack insight into the seriousness of the offence that he was involved in.

6. Terms of Reference

6.1 Purpose

To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients

7. Key Objectives:

The purpose of the review is as follows: -

To develop a chronology of SU1's involvement with Mersey Care NHS Foundation Trust and mental health services in general.

To identify any gaps in service provision and/or policy and identify any contributory factors and why any gaps occurred using Trust Policies and procedures, NICE guidance and/or best practice guidance.

To consider the robustness of the assessments undertaken by the Hospital Mental Health Liaison Team and Criminal Justice Mental Health Liaison Team in March/April 2018.

Identify if risks were considered and managed, particularly in relation to the symptoms of potential psychosis.

To consider any specific issues or questions that the family of SU1 have, ensuring that answers to them are included in the final report, which will be shared with them, as part of the Trust's Duty of Candour process.

To raise immediate concerns with the services management team to ensure remedial action can be taken without undue delay.

To identify the root cause or influencing factors that contributed to the incident occurring

To identify where improvements in practice / systems could be made to prevent a similar incident occurring in the future.

To present a review document to the Local Division Validation Group and Director of Patient Safety, who will undertake the initial accuracy check and validation process prior to it going to the CCG/NHS England.

(NICE Guidance will be used throughout the review as the benchmark standard to assess the quality of the care provided)

8. Key Deliverables

Investigation report
Action plan
Implementation of actions

9. Scope (investigation start & end points):

As per Terms of Reference

10. Investigation type, process and methods used

Level 2 incident investigation

Gathering information via review of patient electronic records, interviewing staff involved within service user's treatment and care, review of patient electronic records, mandatory training matrix, Trust policies and procedures, reflective practice interviews with teams

Identify any care or service problems that may have attributed to the incident

Identify any contributing system factors/root causes via use of the Fishbone model

11. Arrangements for communication, monitoring, evaluation and action:

Report to be shared with individual staff concerned and relevant teams

Action plan to be monitored for completion with divisional governance arrangements

12. Investigation Commissioner

Director of Patient Safety, Mersey Care NHS Foundation Trust

13. Review Panel members: Roles, Qualifications, Departments

Risk and Governance manager (Joint lead reviewer)

Consultant Forensic Psychiatrist (Joint lead reviewer)

Clinical Psychologist, Asperger Team

Service User/Carer Rep

Mortality and Incident Practitioner

Team Leader, Liverpool City Council

14. Sources of information and evidence gathered

- Access to service user's records- Epex clinical case notes, care plan, risk assessments,
- Clinical records from Ashworth hospital-PACIS

- Time allocated to staff to undertake interview
- Access to training database
- Relevant trust policies/procedures
- Trust Policy SA03 Reporting, management and review of adverse incidents
- Trust Policy SA13 Being Open (including Duty of Candour)
- Trust Policy SD33 Supervision and reflective practice
- Trust Policy IT06 Health Records Policy and procedure
- ASS02 Operational Guidelines and Protocol for the Hospital Mental Health Liaison Team (HMHLT) 2017.
- Face to face interviews
    - MHP-A&E
    - MHP-CJLS
    - GP
    - A&E Consultant
    - Current responsible clinician at Ashworth Hospital

- https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/liaisonpsychiatry/plan/planstandards.aspx
- https://www.nice.org.uk/guidance/qs80 Psychosis and schizophrenia in adults
- https://www.nice.org.uk/Guidance/CG142 Autism spectrum disorder in adults: diagnosis and management
- Triangle of care document
- Datix form WEB83089
- Group nominal technique-CJLS
- Questioning-Team manager CJLS and Team manager A&E
- GP reflection
- Opinion from Independent GP at NHS England
- Interview from victims family and perpetrator family
- Team meeting minutes
- Supervision information
- Job descriptions/role outlines
- Duty rotas
- WTE and skill mix
- Standard operating procedures for teams involved
- Achieving better access to 24/7 Urgent and emergency care https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

15. Involvement of other organisations:

- GP practice

16. Stakeholders/audience:

- Commissioning officer
- CCG
- Coroner
- NHS England
- Trust Board

17. Level of investigation:

Level 2 RCA investigation

18. Involvement and support of patient and relatives (DUTY OF CANDOUR)

In accordance with Mersey Care Foundation Trust's "Being Open Policy SA13; the Trust have met with the perpetrator's father and step-mum, aunty and uncle (victims sister and her husband) to offer support during this difficult time and share the information gathered during the review process and given the opportunity to ask questions pertaining to SU1's care and treatment which have formed part of the report. The Director of Patient Safety has also met with SU1's grandmother's carer. SU1 has also been consulted with regard to sharing report with his family and he consented to this. In line with Duty of Candor and being open, the report has since been fed back to SU1s Father and Step mother.

19. Questions from SU1' s family

Crisis/A&E team. Do they have standard questions (early warning indicators) when they see someone and why was the decision made not to offer more support due to changes in behaviour?

Accident and Emergency Mental Health assessment teams use a prompt list to support their assessments, which also reflects the documentation used within an initial assessment. At the point of the initial assessment in A&E the practitioner believed that a referral to Asperger's team was the most appropriate at the time of the assessment. The assessment did not recognise the risks associated with psychosis as they were not florid in its presentation, however a referral to the Early Intervention Team for further assessment and evaluation should have been completed rather than just reference to considering a referral. A copy of this assessment has been included in the appendix

There is currently no routine medical oversight for assessments that take place overnight, unless the case is identified as complex, requiring the advice and guidance from senior clinicians who are available through the on-call system. There is no proactive review of cases on a regular basis to identify learning

points and improve care delivered. Although there is no immediate supervision for staff around complex cases; this would be picked up at a later date in individual staff member's regular supervision as per Trust Policy SD33 Supervision and reflective practice. All ward referrals get discussed within A&E with the lead consultant but currently the A&E assessments are not discussed as the current model of care is to only discuss service users on case loads, not one-off assessments.

Why were the family not offered the opportunity to give their story and history of events leading up to him presenting in A&E? The constant message was'' he's an adult he needs to take himself''

As both SU1's mother and father attended the first assessment, the practitioner made an assumption that if there was any other information that was pertinent then the family would have spoken out. The review team has identified that if the family where given additional time to discuss SU1's presentation, either prior to or after the interview, this could have potentially changed the decision around Asperger's diagnosis and would have given the practitioner more information to make a decision about further action.

The review panel noted that the family were not offered time or space to talk about SU1's presentation, which is contrary to what guidance would suggest practitioners do. However, the review panel noted that SU1's mother and father attended the assessment involving the Mental Health Practitioner from the A&E Liaison Team and it may well have been the view formed by the practitioner that there was nothing further to add to what SU1 had discussed/disclosed, given that this was done in the presence of his family members. Although this is not best practice, the practitioner who completed the assessment on 30th March 2108 noted that the parents had not raised any concerns during the interview process. It is clear that the parents did have issues that they wished to discuss but did not feel confident/comfortable to raise them in the presence of SU1.

It is important that practitioners understand that there might be, at times, conflict of interest when parents wish to talk about their child's mental health conditions in a separate environment. This is something that must form part of a psychiatric history.

Why did family not get a copy of follow up plan and how would they know actions have been followed through

It is not current practice to send a copy of the outcome of assessment to the service user or family. Although this is not offered the service user's family can request a copy of point of assessment, which if the service user agrees to can be shared with family.

Was the call made on the Wednesday by SU1's father to the crisis team recorded? Did the staff understand the concerns and were they aware of what had previously gone on? What is the escalation process around this process and was this discussed anywhere else?

There is an expectation that all contacts including phone calls with regard to service users should be recorded on the clinical notes system as per Policy IT06 Health Records Policy and procedure, however in this case the phone call was not recorded in the notes therefore the review team have been unable to establish what the staff had understood about concerns raised.

Why was there a delay of 6hrs in A&E at being seen by crisis team?

Issues where identified with regard to resources on 30th March 2018. Five assessments were completed in total during this time, three being during the morning shift and a further two during the late shift. A further three referrals were received at 18:15, 19:45 and 20:15 who were assessed during the night shift at 21:20, 22:40 and 23:30. Due to the referrals being received whilst the MHP's were carrying out assessments, this led to them being passed on to the night staff to pick up. There was also a referral received at 04:22 however the patient was discharged prior to being assessed. Due to one of the MHP's ringing in sick for the night shift at late notice, this shift was unable to be filled leaving one MHP to carry out all three assessments alone, which led to delays. The pressures on staffing at the time of the assessment of SU1 do not appear to have been escalated to senior managers.

Since the introduction of Core 24 (https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf) last October 2017 the targets from the commissioners is from the point of A&E staff referring someone to secondary care 1 hour to make initial contact and 4hrs to formally assess someone. This is monitored by the commissioners. It has been highlighted that the new Standard operating procedure is currently being developed.

Could the GP have done something differently?

The review panel did have the opportunity to speak with the GP that interviewed SU1 at the surgery. The GP stated that SU1 presented as being very settled and calm during the review. The GP noted that he did not explore why SU1 had been involved in the incident involving his step brother and his father. It appears that The GP had at the end of the assessment thought that SU1 may be suffering from a psychotic illness and following a second review, may then have considered referring him to the Single Point of Access team. The GP noted that

SU1 was rational during the interview and there was no evidence of overt psychotic symptoms. The GP has reflected on how he might have done his interview differently and wished that he had indeed asked SU1 about the reasons behind the assault of his step-brother.

With regard to whether anything else could have been done by the GP, we understand from the interview that it is not common practice for GP's to commence on antipsychotic medication. If there were significant concerns about an individual's mental health, a referral would have been initiated either to Single Point of Access, A&E or the police would have been involved. Neither of these appeared to be necessary following the assessment by the GP. At the time the GP did not form a view that SU1 was a risk to others and wanted to review him again after his leave. At this point the GP suggested the usual pathway for starting antipsychotics would be to refer to secondary care for stabilisation of mental health. Please refer to 34.11.

An opinion was sought from an independent GP regarding the care and treatment provided to SU1 by the GP and after reading the report he concluded that he did not believe there to be any issues regarding the GP care for the following reasons:

- The Review Panel formed the view that the presentation of SU1 was complex and very different to what was expected in somebody with an underlying florid psychosis." Therefore a 45min assessment suggests a great deal of professional curiosity and the fact that he considered a psychotic illness and was going to reassess implies a reasonable diagnostic acumen. It took the forensic psychiatrists 4 weeks of assessment to reach the formal diagnosis and the GP was on the right track early on.

- He disagrees with the criticism of the GP in the report that "… there appears to be a lack of professional curiosity ….. This appears to have been the case even when SU1 was taken to see his GP."

- He is of the opinion that overall the GP did not do anything different to anyone else in the same circumstances, he considered the diagnosis and wanted to reassess and pass to the mental health services. SU1 was anything but a florid presentation and not at risk to himself or others at that time.

What happened in the custody suite?

With regard to the police interventions following SU1' s arrest, the review team have sought clarification and access to the police records to understand what might have happened in terms of contact with Mersey Care and with the Police. Interviews with the staff from CJLT have led to an understanding of why a decision was made to discharge SU1 from police custody following an

assessment. There is a lack of clarity around why the police decided to discharge him from custody, however, in terms of his mental health, a member of the Criminal Justice Liaison Team who assessed SU1 had formed the view that he had symptoms of what appeared to be Asperger's Syndrome and of a psychotic illness. The practitioner had not formed the view that an urgent assessment for detention under the Mental Health Act was necessary given SU1's presentation during the interview. However, it was noted that there was no explanation of why SU1 had assaulted his stepbrother and his father and had this exploration taken place, maybe the practitioner would have formed a different view. The reviews noted that as SU1 was being seen under caution this can however hinder the line of questioning as direct questions around the offence cannot be asked.

The clinical review panel noted that even after the alleged incident and his admission to Ashworth Hospital, it had taken him a number of weeks of monitoring and exploration of symptomatology by experienced psychiatrists to come to the conclusion that he was indeed suffering from a psychotic illness. This is despite knowing the outcome of the alleged index offence.

Given that SU1 did not present with symptoms that would lead the practitioner from the Criminal Justice Liaison Team to conclude that he required immediate assessment and treatment, it is acceptable practice to make the referral with the view to this being picked up by the Early Intervention Team as soon as practicable.

See timeline and Appendix 1 for further detail

Why was SU1 released from **the police station into the care of his mother and not taken to a hospital as SU1'S father and stepmother had discussed with his mother?**

As addressed within the question above, the practitioner from the Criminal Justice Liaison Team had concluded that SU1' s presentation did not warrant immediate assessment and treatment compulsorily, given his settled behaviour during the assessment.

SU1 presented as being settled during the contacts he had with Mersey Care and the GP surgery. What has become apparent is that SU1 does present as being settled and unless exploration of his psychopathology is done in a manner that elicits symptomatology and risk, it can be difficult for clinicians to understand the risks he might present with.

Since his admission to Ashworth Hospital, SU1 has described outbursts of rage and anger, which makes him involve himself in violence. Given that he did not

present with these features when he was being assessed, it was not easy for clinical practitioners to come to the conclusion that he presented as a risk. There also appears to be some form of bias as practitioners both from Mersey Care and the GP who reviewed SU1, formed the view that he was not a risk of violence as he presented as being well kempt, articulate and settled. This may have led to the practitioners forming the view that he was not as risky as the family may have believed was the case. This may have also been a presentation that was understood to be driven by the use of cannabis that SU1 had previously noted. And given that there were no previous convictions, a formulation of risks becomes more difficult clinically on the basis history.

The Practitioner within CJLT was not aware that the plan was for SU1' s mother to take him straight to A&E following release from custody and reported that both SU1 and his mother stated they were happy with the plan for the referral to Early Intervention and Asperger's Team following the assessment. The Practitioner stated that SU1 and his mother had been leaving the building at the same time and his mother had thanked her for her time and again appeared happy with the plan. The practitioner has stated that his mother did not mention anything about taking SU1 to A&E.

Why was SU1 not offered any further support/medication/hospitalisation at any point after being seen on 4 different occasions clearly showing ''signs of psychotic symptoms'' as described by the family?

During both contacts with Mersey Care, the family had not voiced concerns in a way that led the practitioners to request urgent follow-up and neither did SU1's presentation at each contact portray this. The review team agreed that it was not unreasonable to conclude that cannabis use had impacted upon SU1's mental health. With regard to SU1's first offence, statements were not obtained from SU1's stepbrother or his father; therefore there was limited information available for use during the second assessment by the CJLT practitioner. The reasons for this are multifactorial as previously stated within the report.

22.0 Involvement and support provided for staff involved

Staff in CJLT where supported directly after the incident, over the weekend and during the following week through face-to-face support and over the phone. The Criminal Justice Liaison Team Practitioner also had supervision session on the Tuesday following the incident and was given some time off after that at her request. Staff members in the A&E department where also offered time to discuss the outcome of the incident, the 72hr review completed following said incident was sent to the A&E manager to share with the team.

23. FINDINGS

Detection of incident

CJLT received a referral on the 26.04.18 following SU1 being arrested for a second time for an alleged homicide. Police had been called to an incident to a report of a female being assaulted. On police arrival a female was found with multiple stab wounds, the injured person is believed to be the detained person's grandmother's carer. The carer had told police that the 'detained person' had made off and then returned. Police arrived and arrested the male for the alleged assault. On the way to police custody police have found another victim at a different location who is deceased, this is the detained person's mother. Detained person has been further arrested for murder

24. Notable practice

The review team noted that during the nominal group technique the CJLT was 'cohesive' and they had good support mechanisms for supporting each other despite the complexity and volume of assessments undertaken by the team.

Supervision in both teams by managers was undertaken and documented.

Care and Service Delivery Problems

SU1 had two contacts with Mersey Care NHS Trust prior to the alleged serious offence. During his first contact with the service at A&E within the Royal Liverpool University Hospital, the assessment, which was completed by the Mental Health Practitioner 1 was extensive in its content but did not conclude that there was sufficient evidence of a psychotic illness that was separate from a possible drug induced psychosis.

The extensive history documented describes multiple psychotic symptoms, which for an unknown reason were formulated as being as a result of Asperger's Syndrome and a possible drug induced psychosis. This may have stemmed from a suggestion from the family that going to see a specialist in Glasgow who had suggested that he may suffer from Asperger's. It appears that the practitioner then proceeded to find evidence to fit that particular diagnosis and discounted the psychotic symptoms that she had elicited. During the review in which Mental Health Practitioner 1 was interviewed, she notes that she attributed the psychotic symptoms to the use of cannabis, which SU1 had been extensively using prior to the assessment. Although this may have been a valid argument, it should have been the case that this particular practitioner considered the possibility of an underlying psychotic illness (separate from a

possible drug induced psychosis) and should have made the referral to the Early Intervention Service or an appropriate service such as community mental health team.

Mental Health Practitioner 1 formed the view that SU1' s presentation was primarily driven by his Asperger's and drug use and not of an underlying psychotic disorder on the basis that he did not seem particularly distressed during the review and his family members that had attended did not give her any information to suggest that his risks were significant. The family members; the review team understand, have formed the view that they were not asked for their opinion regarding SU1's presentation. It must be the case that practitioners as often as possible explore symptoms and history with the family, especially when they are readily available.

The A&E Liaison Team at the Royal Liverpool Hospital noted that they do not have formal training in terms of undertaking assessments of individuals that present to A&E. The particular practitioner that was involved in this assessment has extensive experience of undertaking mental health assessments, given that she had previously trained as an approved social worker. She spoke about how she received "*On the job training"*. She however relied on her knowledge and experience drawn from her training as an approved mental health social worker to undertake such assessments. She spoke about how she had supervision once every four to six weeks where she discussed five or six clinical cases. The manager checks her paperwork and checks that they are completed to a particular standard.

Mental Health Practitioner 1 noted that she has been working for many years in the A&E Liaison Team and that there have been no concerns about serious incidents or lack of expertise previously. There is evidence that her performance was being monitored through supervision with her line manager

Mental Health Practitioner 1, following the assessment concludes that Asperger's Syndrome is the primary problem and suggests a decision to refer to the Liverpool Asperger's Service. This referral was not completed or discussed with the GP and there is an assumption by the GP that this was done by the practitioner. The Review Panel can find no evidence from the information that has been made available to them to suggest that SU1 presented with a primary problem as a result of Autism Spectrum Disorder. Given that SU1 appears to have presented with what appears to be normal development, the diagnosis of Asperger's Syndrome should not have been considered. The primary issues should have been the presentation, which suggested a psychotic illness and the risks associated with it.

Mental Health Practitioner 1 sent the assessment to the GP. It appears that the GP then assumes that a specialist service has interviewed SU1 and uses some of this information to arrive at the conclusions he did at the review that was conducted at his GP surgery on 25th April 2018. This interview was after the incident in which SU1 attempts to strangle his step-brother.

The GP completes an assessment that lasts for about forty-five minutes and forms the view that there might be an underlying psychotic illness but that this could further clarified, given that he did not present with any obvious symptoms that would suggest risk to others, in the next appointment. The family have noted that they were not offered a second appointment, however, the GP has clarified via his emails that they have an open policy where patients can walk back into the clinic and that the family were informed about how to come back to the clinic if necessary. This may not clarify why the GP had noted that he would review SU1 again in a few weeks' time. There was no further appointment made.

The GP in his interviews with the panel noted that he had formed the view that SU1 did present with psychotic symptoms but did not present as a risk to himself or others and as such he did not see the need for referral to Single Point of Access, the police or to A&E.

The GP notes in his interview that he had considered the use of an antipsychotic. He puts this down in his reflective note but the review team have been unable to establish if this was documented in the case file with the GP. However, the family stated that there was no mention of antipsychotic use during the interview with SU1. The GP did note in his first interview with the panel that GP's do not usually prescribe antipsychotics and that they would only take individuals with a psychotic illness who had been stabilised by the Community Mental Health Team following a period of care and treatment under their service.

The GP noted that he had no specific training in mental health conditions other than his interest in it. He has undertaken further work in understanding the use of psychology recently but not in areas around psychiatry and risk.

Following SU1' s presentation to the GP, where he was noted to be quite settled and calm, SU1 is then reported to the police by his family, who then arrest him and take him to St. Anne's Custody Suite. It is here that he was assessed for the second time by Mersey Care via the Criminal Justice Liaison Team. Again this assessment is extensive by an Allied Health Professional, Occupational Therapist undertaking Mental Health Practitioner role. During this interview the Criminal Justice Liaison Team Practitioner documents psychotic symptoms but does not form the view that the psychotic symptoms are necessarily driving

significant risks. The plan is made to refer him to the Early Intervention Service. The assessment was thorough and did pick up on psychotic symptoms. She was of the view that the referral to Early Intervention Services was more important than the Asperger's Team referral as her view was that the psychosis was the primary problem.

With regard to why an explanation of the reason SU1 was brought to the police station was not explored, it became clearer during the interview that individuals who are arrested for certain crimes are well within their rights not to talk about the incident and staff who are exploring this have guidance suggesting that they should not ask direct questions that might incriminate the detainee. This may have prevented the Criminal Justice Liaison Team Practitioner from exploring the reasons why SU1 had been involved in the incident with his step-brother. However, when this was explored during the interviews with the practitioner, it was not immediately described as the reason for not exploring these issues. It appeared that SU1' s presentation which was fairly settled in manner, coherent conversations and his social circumstances that his family background and upbringing did not suggest an underlying serious psychotic illness or that there were risks of serious violence.

The practitioner from the Criminal Justice Liaison Team had formed the view that a referral to the Early Intervention Team would suffice in managing the risks that SU1 presented with. She had not formed the view that there were any immediate risks to the family or members of the public given the history that had been obtained.

What is apparent now is that the FME (forensic medical examiner) did not assess SU1 the first time he was arrested following the complaints by his father. The custody sergeant agreed that SU1 needed an appropriate adult. The FME agreed that as SU1 was staying overnight no immediate need to see SU1 re: fitness to release. The custody sergeant made the decision for MHP to assess SU1's mental health and it is noted that a referral be made back to the FME in the morning if needed. At the time of the assessment the Criminal Justice Liaison Team Practitioner did not feel the need to refer back to the FME as the role of the FME is from a medical perspective or they would see if a mental health act assessment was deemed appropriate as there were no acute signs of risk and a plan had been put in place to refer to Early intervention.

During SU1's arrest for the alleged offence he was brought back to St. Anne's Custody Suite where he was assessed by two psychiatrists and an approved Mental Health Practitioner. Even during this assessment it was not obvious that SU1 was psychotic and there were discussions regarding whether he met the criteria for detention under the Mental Health Act. He was detained following the eliciting of symptoms and the manner in which he presented. He was

eventually detained under Section 2 of the Mental Health Act 1983 and transferred to Ashworth Hospital given the serious nature of the offence.

During the investigation it became apparent that SU1 following his admission to Ashworth Hospital, was under observation constantly and it took the experienced team at Ashworth Hospital over four weeks to conclude that he was indeed suffering from a psychotic illness. The Review Panel interviewed the treating consultant forensic psychiatrist at Ashworth Hospital who stated that SU1 did not present with "*Straightforward paranoia or the frank common symptoms"*. The Review Panel are aware that it took an expert team of Mental Health Practitioners and a consultant forensic psychiatrist who knew what the incident was and what may have been driving that particular incident, over four weeks to diagnose SU1 with a paranoid psychosis and commence treatment. The Review Panel formed the view that the presentation of SU1 was complex and very different to what was expected in somebody with an underlying florid psychosis.

It became apparent that SU1' s rationale for committing the offence was a view that he had formed as a result of his underlying psychosis that his mother had been plotting against him by colluding with the lawyer at the police station. He also explained to his treating team that he had engaged in the acts against the carer of his grandmother because he believed that his grandmother, who he cared for dearly, was being manhandled by this carer. It appears from the conversations held with the clinical team that their view is that SU1's mental state at the material time was driven by a psychotic illness.

25. Service Delivery Problems

SU1 had two contacts with Mersey Care prior to the alleged index offence. His first contact with Mersey Care was on 30th March 2018, with the A&E Liaison Team based at the Royal Liverpool Hospital. This team has been in place for many years and was primarily staffed by senior mental health nurses. However, over the course of the last many years, the role has been expanded to allow occupational therapists and social workers to apply and become permanent mental health practitioners on this unit. The Review Panel are aware that this is the direction nationally; in terms of ensuring multidisciplinary teams undertake such assessments. This appears to have stemmed from the need for an increase in Mental Health Practitioners and the view that clinicians from other backgrounds bring varied experience and expertise to the team. Although the view of the division is that this was necessitated by national guidance.

It became clear to the Review Panel that these teams have regular clinical and managerial supervision but there is no formal process in place to ensure that they receive training in the complex assessments that they undertake. There is

no competency based checks to ensure that these practitioners are kept up-to-date in terms of their knowledge and skills.

Following the interviews with the team members and the Consultant Psychiatrist working within the A&E Liaison Team, it was apparent that they have approximately thirty staff within the team. They have approximately sixteen to eighteen Band 6 staff and the rest of the staff is support staff. The team consists of a team manager who has recently been changed and a consultant psychiatrist works alongside other practitioners. They do have admin support.

On average the team receives between sixteen and seventeen referrals a day from the A&E, which are all assessed by the Mental Health Practitioners and between four and six referrals from the ward

The team have daily MDT meetings where a consultant is present and they will discuss ward referrals (as these remain on caseload for the duration of that particular individual's admission to the Royal Liverpool Hospital.) There is no system in place to retrospectively review the care and treatment plans for those that are assessed in A&E overnight as all service users are assessed and signposted or admitted as the case may be. This means that the consultant does not have oversight of the admissions or assessments that take place in A&E, in this specific team. Further, there is little medical oversight of the assessments that take place overnight by practitioners other than for them to be discussed with the manager during clinical supervision. Out of hours, the practitioners can call the on call psychiatry registrar, consultant or manager on call to discuss complex cases. In this case the practitioner did not identify this as a complex case from her assessment and therefore did not seek additional advice or support.

In terms of formal training to ensure that expertise is maintained, we were informed that they have lunchtime meetings where experts are invited in to offer support and expert advice. There is no formal mechanism in place to ensure that staff members maintain competencies and knowledge although some issues are managed by supervision and PACE. However there is national guidance available on what may be considered best practice developed by the Royal College of Psychiatrists based on best practice (PLAN) and this may be a useful method to develop competencies and skills.
https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/liaisonpsychiatry/plan/planstandards.aspx)

The training that the staff members within the A&E Liaison Team receives is mainly "on the job" training by observing other staff. There is no systematic manner in which training is imparted to these members. The understanding of

psychopathology is poor and this can lead to gaps in the quality of assessments which could eventually lead to cases of psychosis and other serious mental illnesses being missed.

26. Criminal Justice and Liaison Team

The Criminal Justice Liaison Team was invited to a discussion with the Review Panel. This was facilitated on 6th June 2018.

During the course of the review the panel found that the Criminal Justice Liaison Team functioned to a very high level. There was ample opportunity for clinical supervision and managerial supervision. However, there were members of staff that had no formal training in mental health; nevertheless they were performing at a level that was required for their current jobs. It was noted during the review that staff were well supported and were offered opportunities to train both on the job and to attend courses.

The team had a process in place to train and induct those new to the team by asking them to shadow more senior colleagues for a period of four weeks. They used the opportunity to discuss complex cases and share formulations.

The Review Panel formed the view that although the process in place to induct new members of staff into the team was robust, it did not make up for the lack of formal training and education in mental health for some of the practitioners regardless of their background. The Review Panel formed the view that this pattern of Allied Health professionals working within the service became a pattern after the service began advertising jobs for Mental Health Practitioners and anyone who had the necessary qualifications could apply and if appointable should be offered the job.

The Criminal Justice Liaison Team have a close knit group of staff that work well together. There used to be ample opportunities for staff to discuss issues, however, over the last few years given the fact that the Criminal Justice Team is now spread over multiple sites across the region, this has become more difficult. The team manager has considered using technology to allow teams to have the ability to communicate with each other far more often and quickly.

The FME did not see SU1. The current model of care is that and custody sergeant makes the decision with regard to whether someone is fit for release. If a MHA assessment is needed the FME would have to authorise this but in this case, at the time of assessment, this was not deemed appropriate hence FME did not assess SU1. This may change with the new model of care and assessment being developed by the CJLT.

It became clear during the review that there is no routine medical oversight of the assessments or a process to contact medical experts to discuss or review cases as the team, which commissioned as a nurse-led service are not contracted to have medical support other than using the on-call system. This has meant that the service is a nurse and allied health processionals' led service with medical support coming from FME, on call MCT psychiatrists or the RC of those individuals known to services. The team have acknowledged that having medical input would make understanding, sharing and learning from assessments more useful and safe for all involved and would then mean a more MDT approach to understanding risk.

27 CJLT Further Actions Taken

Training programme has been developed for all assessment Staff and has started. This includes formulation training, Mental health assessment training, Recognitions of symptoms of common, Mental health conditions, how to conduct an assessment, Mental capacity. There are currently 18 different topics identified. The training programme has been led by consult Psychiatrist for Assessment services.

- Formulation training has been completed and another cycle of training is being introduced to capture new staff on A&E and CJLS.

- Clinical Band 7 leads are in post in all A&E services and monthly reflective practice is taking place to discuss case profiling and complex cases led by a Psychologist

- Monthly audits of assessments take place on a random sample of cases. This will link into the clinical supervision process to check quality of documentation

- Away days held. This has been attended by all grades and professions of staff that included Social workers/AHPs and medical staff. Agenda and discussions have been focussed on how to conduct Assessments, identifying training needs, and escalation process when practitioners are working out of hours which includes discussion with on call clinical managers and also on-call SPR/Consultant

- All supervision for AHP to be completed by Clinical leads. Data quality and record keeping has been added to the discussion type options in the YourSupervision system for management supervision, clinical supervision and clinical & management supervision. Supervision data is monitored

through our governance processes and is discussed weekly in safety Huddle chaired by Deputy Chief operating officer

- AHPs to present case to Clinical Lead and /or consultant monthly.

- Formulation post graduate accredited course has been developed and AHP's are attending this. AHP involved in this case has completed this module. First course started September 2018. This is a way of training all our staff to deliver Psychological interventions Nurses and AHP's to deliver a range of NICE approved Psychological interventions. This will be monitored by CORE 24 managers who will ensure AHP will be prioritised for this course.

- Module being developed for Risk training within risk working groupSD10 Risk assessment Policy being updated (See progress in appendix 4)

- Staff have all been made aware of the findings and recommendation from the incident and have a chance to talk though any issues with managers in CJLS. Planned formal feedback session for A&E staff and report shared with the manager to discuss with team.

- A&E assessment teams undertake a handover at every shift change and discuss cases they have seen and any referrals which would include anything that might need escalation. As part of the daily bed management meeting all referrals are discussed for that 24hr period

- Within CJLS agreement has been made that if someone that anyone presenting with psychotic features and not open to a care team discuss with the on call SPR.

- Review of the education/training needs of all CORE 24 staff. AHP staff have been prioritised and additional support offered by clinical leads

28. A&E team

Staff will have an induction period of 1-2 weeks, dependent on their clinical experience and background. During this time they will shadow assessments and be supernumerary. New starters to Core 24 had a week's worth of induction in October 2017 however TC was a long standing member of the team so would not have had this induction.

The manager organises in-house training with other teams to enhance clinical knowledge. The Consultant Psychiatrist gives training to the team and they

have had speakers from other services, such as the perinatal team and the PD hub.

Staff do not have any specific training around Asperger's, the Asperger's Consultant was booked to come and give training to the team in May/June this year however cancelled for unknown reasons and this has not yet been rebooked.

Team meetings are held every 2 weeks and there was evidence within minutes around learning.

Staff escalate their concerns through the line management structure, out of hours will utilise bronze on call or medical staff on call. Staff can raise issues in team meetings and at reflective practice sessions.

The Mental Health Practitioner received supervision once during the time period, on 25.01.2018, her supervision was booked again for Sunday 25th March and Manager came from home to do this with her at 8pm however she had been moved to cover the Aintree team that night shift so was not available.

Staff can discuss complex cases with their colleagues, with the medic in the team, with the Team Manager or out of hours can use the on-call SPR or on call nurse managers. In this case this did not happen as the practitioner deemed it not to be a complex case.

29. Contributory Factors

All of these contributory factors are set out in the fishbone diagram that is attached and below.

30. Patient Factors

SU1's presentation to both A&E Liaison and Criminal Justice Liaison Team were complex. It was his first presentation of psychosis and there is little doubt in the minds of the Review Panel that first episode of psychosis can present with a clinical picture that is not obviously suggestive of underlying psychosis. SU1 presented on two occasions and on both times he presented as being settled with no overt evidence of distress and was coherent and amenable to suggestions that were being made. There is a history suggestive of alcohol and drug use and the clinicians formed the view that the presentation may be driven by drug use. This is not an uncommon presentation in young individuals who do take drugs. They can present with perplexity and some of the symptoms of psychosis. It is acceptable for clinicians to form the view that drug use may have driven the initial presentations to A&E at the Royal Liverpool Hospital.

31. Individual Factors of Clinicians

On both occasions that SU1 had contact with Mersey Care, there appears to be a lack of professional curiosity when the staff assessed symptoms. This appears to have been the case even when SU1 was taken to see his GP. Two of the clinicians who knew about the assault on SU1' s step-brother did not explore the reasons behind this. It is possible, had this been explored, a fundamental difference in the opinion of the clinicians may have been formed. It was also noted following the review that the police had appeared to down play the seriousness of the assault that SU1 was involved in with his step-brother by referring to the family background being one that is unlikely to be one that caused concerns. This may have directed the Criminal Justice Liaison Practitioner to believe that the assaults were not as serious.

It was also noted that during his first assessments, the A&E practitioner felt under pressure as she was the only practitioner on duty, due to sickness however she did not escalate these concerns or seek assistance from senior managers which she could have done. This may have contributed to the practitioner thinking around drug use leading to the presentation, and concluding on the possibility of Asperger's explaining the clinical presentation.

32. Task Factors

The Review Panel considered why the clinicians did not offer the family sufficient time to talk about the presentation of SU1 at home. During his first assessment at the Royal Liverpool Hospital, it appears that the family members were present during the interview and the clinician made the assumption that the family would have interjected if they thought there were issues that needed to be discussed. During the second assessment something similar happened with the mother of SU1 sat in with the practitioner during the review. Given that SU1 had spent much of his time with his father; it may explain why SU1' s mother did not know about his presentation. It may well be the case that the mother felt protective of SU1 and wished for him to have mental health support rather than have the police intervene at that time. In both cases the family did not express their explicit concerns about SU1. However, the clinician's did not explore this either. It is imperative as part of psychiatric examinations that corroborative history is obtained where possible.

33. Communication Factors

It was noted during the review that the forensic medical examiner did not see SU1 during his arrest and during the second contact with Mersey Care. The Criminal Justice Liaison Practitioner was not made explicitly aware of the

potential serious risks as the risks were minimised by the police and therefore did not conclude that there were sufficient risks to warrant a Mental Health Act Assessment. There was little understanding by the Criminal Justice Liaison Team that the family wished to take SU1 straight back to A&E if he were to be discharged by the police due to concerns the family had about his mental health.

34. Team & Social Factors

The GP, the two practitioners and the police came to the conclusion that SU1 presented as settled, was well dressed and kempt and had a supportive family. They probably were influenced (unconscious bias) by this presentation around what his diagnosis may be and the risks that he probably presented with.

35. Education & Training Factors

During the review it became clear that there was a lack of in-house training to undertake assessments, both in A&E and in the Criminal Justice Liaison Team. The training was delivered locally by teams and is not part of the development of these practitioners that is driven by the organisation. There is a lack of consistent training around mental health conditions especially around psychosis how identification should lead to plans put in place to manage these risks. There is no training around identifying autistic spectrum disorders and how to exclude them if necessary.

36. Equipment & Resources

It was noted that there was little psychology or routine medical support into the A and E assessment team and the Criminal Justice Liaison Team (who we understand now are not contracted to have medical input). Input from the Consultant Psychiatrist in the A&E Liaison Team was minimal in the assessments that were undertaken out of hours. Both teams knew that they had access to expert psychiatric advice if required via the Specialty psychiatry registrar (ST Higher trainee in psychiatry) on call or the consultant on call on both occasions but they were not used, simply because the practitioners did not identify psychosis as being a concern. Moreover, it is not normal practice to discuss issues with medical colleagues as there are none based with the CJLT team and over night for A and E teams.

37. Working Condition Factors

The time for assessments in the Criminal Justice Team was limited due to the custody time limit criteria and in the A&E assessments at the Royal there is

always pressure from referrals that have been received and the fact that on that particular night a member of staff had called in sick.

A reduction in the number of staff available meant that the lone assessor had to complete more than what would normally be her share of work during the night. Given that there are pressures to complete these assessments on time, it may have hampered the ability of the practitioner to function optimally.

38. Organisational & Strategic Factors

The Review Panel concluded that the Mental Health Practitioner job description is generalised for all disciplines, which essentially means that expert mental health skills may be lacking in some of those that are offered the job. Although practitioners from a non-nursing background appear to be working within scope there is an inability to demonstrate their competencies specifically to undertaking mental health assessments in the setting they are working in.

There is a lack of training for staff that undertakes front-facing assessments that is driven centrally by the organisation, which would ensure consistency and standardisation.

The Review Panel also noted that the clinicians were limited by the fact that SU1 presented to police custody having been charged with a Section 39 Assault. This would mean that direct questions around the alleged offence cannot be asked as it might incriminate the detainee. The charges also indicated a less serious offence that what was alleged to have been committed in the family home earlier.

39. Deduction

39.1 Root Causes

The Review Panel have met on multiple occasions and reviewed all of the information that is available to them. After careful consideration of the facts and following discussion, the Review Panel's opinion is that the root cause of the incident was SU1s complex presentation, which was not explored by the practitioners in depth. This lack of exploration may have been due to SU1s presentation as well as a lack of sufficient training in exploring psychopathology. This resulted in a delay in diagnosis and therefore untreated psychosis.

The untreated psychosis that SU1 presented with was not the usual or common presentation of psychosis. However, at no point during the contact that SU1 had with Mersey Care did he mention a risk of violence towards others. Although this may not have been explored explicitly in depth, there was no

suggestion from his presentation or information available to clinicians that he posed a risk to others. However, the clinicians that had contact with SU1 did not explore or make sufficient attempts to understand the possibility that SU1 was suffering from an untreated psychosis.

40. Lessons Learned

The Review Panel have discussed the various issues that have been identified that could help improve the care that is given to those that present with their first episode psychosis.

a) Clinicians who undertake front-facing assessments need to keep their knowledge updated with regard to the common presentations that individuals may present with to A&E and the Criminal Justice Liaison Team.
b) Individuals suffering from prodromal symptoms of schizophrenia or first episode psychosis may present with a varying degree of clinical presentations and clinicians need to be aware that any psychotic symptoms described should be fully explored using a pro-forma or tool if needed.
c) Clinicians need to be trained in the psychopathology that individuals with psychosis might present with and the implications of psychopathology on risk.
d) Clinicians who undertake assessments must consider speaking to the family, especially when incidents involve family members and this should become part of all assessments in the community.
e) When patients present with symptoms that are suggestive of psychosis, consideration must be given to discussing this with a senior member of staff within the team or a discussion with the on call registrar or consultant. Ideally there will be an identified doctor that works within the CJLT in the future.
f) Clinical supervision should include discussions around understanding and exploring psychopathology and risks.

41. Conclusions

The Review Panel concluded that the most likely cause for the serious incident was untreated psychosis. The reasons that SU1' s psychosis was untreated are multiple. His presentation on both occasions was not immediately suggestive of an underlying psychotic illness in that his presentation was settled; he was coherent, spontaneous and appeared to be amenable throughout. What was missed, which probably was due to SU1 not presenting with obvious psychotic symptoms were the risks that were associated with it.

The Review Panel also note that SU1' s psychotic symptoms were not easily elicited during the first four weeks of his admission to a specialised forensic unit

within Mersey Care. The senior clinicians who have expert training in undertaking assessments of individuals who present with significant risk took almost four weeks to confirm a diagnosis of psychosis and commence treatment. This probably is a reflection of the complexity of SU1' s presentation and the significant experience and expertise that may have been necessary to elicit the symptomatology during his first two contacts with Mersey Care.

50. Learning, feedback and changes to practice

Assessment Team

A training programme has been developed and commenced for all assessment staff. This includes formulation training, mental health assessment training, recognition of symptoms of common, mental health conditions, how to conduct an assessment, assessing mental capacity. There are currently 18 different topics identified. The training programme is being led by the Consultant Psychiatrist for Assessment services.

Formulation training has been completed and another cycle of training is being introduced to capture new staff on A&E and CJLS. Formulation training is aimed at enabling staff to bring together a vast array of information to create a cogent plan that recognises the multi- faceted needs of complex patients.

Clinical Band 7 have been in post since November 2018 in all A&E services and monthly reflective practice is taking place to discuss case profiling and complex cases led by a Psychologist. The clinical leads are separate from the band seven who manages the team , their focus is on developing clinical skills within the staff team , setting the clinical agenda and providing clinical supervision for all nursing and AHP staff.

Monthly audits of assessments take place on a random sample of cases. This will link into the clinical supervision process to check quality of documentation

Since the incident away days have been held. These have been attended by all grades and professions of staff that included Social workers/AHPs and medical staff. Agenda and discussions have been focussed on how to conduct Assessments, identifying training needs, and escalation process when practitioners are working out of hours which includes discussion with on call clinical managers and also on-call registrar/Consultant

All supervision for AHP is completed by Clinical leads. Data quality and record keeping has been added to the discussion options in the YourSupervision system for management supervision, clinical supervision and clinical & management supervision. Supervision data is monitored through the divisions governance processes and is discussed weekly in Divisional Safety Huddle chaired by the Deputy Chief operating officer.

All incidents and complaints occurring within these areas including data related to staffing levels, assessments delays etc. are analysed on a weekly huddle within the divisions safety huddle. Areas of concern are analysed, escalated where needed and necessary remedial actions put in place to enhance safety.

A dash board is now available for all core 24 activity managers and staff to review on a daily basis to ensure that any potential deficits are known and remedial actions put in place.

A new service manager is now responsible for all Core 24 activity, this person is a nurse by background and has vast experience of working in acute assessment services , he is leading the improvements to the service and setting and monitoring the standards to be adopted.

Shift leads at band six level are now in place to offer coordination and contemporaneous support and supervision to staff .

AHPs present clinical cases to their Clinical Lead and /or consultant on a monthly basis .

A formulation post graduate accredited course has been developed and AHP's are attending this. AHP involved in this case has completed this module. First course started September 2018. This is a way of training all our staff to deliver Psychological interventions. Nurses and AHP's to deliver a range of NICE approved Psychological interventions. This will be monitored by CORE 24 managers who will ensure AHP will be prioritised for this course.

Module being developed for Risk training within risk working group SD10 Risk assessment Policy being updated

Staff have all been made aware of the findings and recommendation from the incident and have a chance to talk though any issues with managers in CJLS. Further sessions are scheduled to allow further analysis and learning to take place.

A&E assessment teams undertake a handover at every shift change and discuss cases they have seen and any referrals which would include anything that might need escalation. As part of the daily bed management meeting all referrals are discussed for that 24hr period

Within CJLS agreement has been made that if someone that anyone presenting with psychotic features and not open to a care team discuss with the on call SPR.

A review of the MDT approach in CORE 24 is being undertaken.

Review of the education/training needs of all CORE 24 staff . AHP staff have been prioritised and additional support offered by clinical leads

To note there are only a small number of AHP across the division in the assessment teams which is enabling clinical leads to provide individual guidance and support.

Criminal Justice Team Learning

The review team have met with the CJLT on the 23.10.18 to discuss the report and learning from the investigation. Following reflection they outlined a number of changes they have already made to their practice as well as actions going forward which have been reflected in the action plan.

All of the team have now had formulation training facilitated by the Trusts transformational lead for psychological practice.

The practitioner who saw SU1 is currently doing post grad qualification in formulation that has been developed by the trust. This will provide enhanced skills in assessing our service users and improve the safety of our service users.

It was recognised that as CJLT are 'guests' in the custody environment this can be a challenge. The role of the practitioners is to support assessing if the perpetrator is fit for interview from a mental health point of view as opposed to doing a full assessment. If this would be needed the individual would then be signposted. In this case it was unusual the team had access to family. In current practice as the perpetrator/services users are interviewed in a separate area, unless they need an appropriate adult (That is not always family) practitioners would not have an opportunity to speak to families.

Introduction of a buddying system for service users is to be introduced to support decision making

An away day is scheduled for January and the learning from this case will be on the agenda and an update will be provide of any changes to practice that have been made in line with action plan.

Identified that having dedicated medical support to ask expert opinion on complex cases and people presenting with psychosis for the 1st time would be helpful. Also that as CJLS is a bespoke service that junior doctors with a special interest to do placements with team would be useful. Consideration should be given to EIT consultant having ring-in sessions to support the team. The team

suggested that there would be an expectation as part of the learning that if anyone presenting with psychotic symptoms a discussion would take place with the registrar on call.

Discussion took place around line of questioning when interviewing assessing and the team reflected this has made them think more about when assessing for psychotic symptoms that if these are described these should be explored in-depth (professional curiosity). They will now always consider the serious risks associated with psychosis and how to explore this when identified.

Currently the team are involved in a procurement process with Police commissioners and NHS England. If successful, the team will continue to provide Liaison and Diversion services in court and custody in partnership with physical health care provision, from April 2019. This will include a change in the way the service works with the police to a more integrated model with regards to decisions around fitness to be released and fitness to be interviewed and this may allow more questions around offences.

Action Plan Monitoring

Action Plan will be monitored through local division Governance procedures and also via Quality Assurance Committee

Arrangements for Shared Learning:

- Shared via a lessons learnt/share and learn session at a Quality event for all teams in the Division involved in case, Event for Criminal Justice has taken place and further discussion around changes to practice and learning to take place at their away day in January and planned event for Assessment team arranged.
- Shared to the Trust Patient Safety Team and will be presented to Board via Quality Assurance Committee
- Oxford model event planned for March 2019 to share learning across the trust.
- Learning from Review fed into risk assessment working group
- Share report with GP

Distribution List

- CCG
- NHS England
- Coroner

- Trust Patient Safety Lead
- Governance and Risk team for Local Division
- Team leader and team members involved.

Appendices

Appendix 1	Chronology
Appendix 2	Order of Events Taken from the notes by Criminal Justice Liaison Nurse
Appendix 3	Fishbone Diagram – Removed to allow for anonymisation – can be provided on request

Appendix 1

Chronology

DATE OF CONTACT	CONTACT WITH/Information from	ASSESSMENT STANDARD/Timeline	OUTCOME	REVIEW TEAM VIEWS
February 2018	SU1s Father and step mother	SU1 hadn't rang his father for about 3 weeks which was unusual so SU1'S father called him, SU1 admitted that he had lost his current full time job as he had missed the taxi to go in. In hindsight his work history had been erratic he did however still have a part time job working in a restaurant and he worked as a steward at a football stadium for all home matches.		
6th March 2018	SU1s Father and step mother	SU1 went on holiday to Barcelona at the beginning of March 2018 with his friend; at this time SU1's father and stepmother were in Tenerife on holiday. On the 6th March SU1 rang SU1's father and said he felt like jumping out of the hotel window and reported that he was on the 5th floor and he wasn't making sense. His step mother reported that it sounded like he had taken something and he admitted to taking a cannabis cookie. SU1's father then spoke to his friend and there where numerous phone calls as SU1's father tried to calm him down, asking them to get to the ground floor, get a coffee, and go for a walk.		Concerns re: mental state and harm to self
7th	SU1s Father	SU1 had asked his Father if he		Change of living

March 2018	and step mother	could go back and live with him and he returned from Barcelona and moved back to fathers home. They report that when he first moved back that he seemed a bit flat but they put it down to his social situation and acting like a teenager. He had started a training course with Barclays so was getting up regularly every day to attend the course. SU1 told his father that he had met a Lithuanian girl on the bus and wanted to go travelling with her. This was the first time something ''odd'' had happened. They think this girl existed and attended the course with him but have no evidence. SU1 also said that the bank had asked him odd questions about himself and if he had any mental illness which seemed to bother him.		arrangements. Concerns re: mental state
29th March 2018	SU1s Father and step mother	This was the last day of SU1s course with the bank. SU1 texted his dad to say he was at Lime Street. His dad thought he meant he was with mates having a drink. At 9pm SU1's father got a phone call from SU1s Mother to say SU1 was on a train on his way to London. SU1s father then rang him whilst he was still on the train, SU1 said he was going to stay in a B&B and had gone to London to find work. SU1's father tried to talk him in to coming back as it was bank holiday weekend and no one		Impulsive behaviour Concerns re safety, him being missing and disorientated. Out of character

		would be about. SU1 informed him that he had finished course and had not got the job. SU1 then phoned later, around 1:30am as he was wandering around London, by Earl's Court but didn't know exactly where he was. He had got a taxi form Euston station to a hostel and left his belongings in the room as there was a 'strange man 'in there. He was not making sense. SU1's father and stepmother where trying to use Google maps and get him to look for signs to identify where he was to book him in a nearby hotel. During this time he was also in contact with his mother and when his phone was still engaged by 2:00am SU1's father assumed that SU1 had found a room since he had been talking to his mother for at least ½ hour. However his mother had contacted the police and reported him missing as he was not answering his phone she had also put an appeal out and posted his picture on Facebook.		
30th March 2018 GOOD FRIDAY	SU1s Father and step mother	30.3.18 He returned to his mother's house of his own volition from London. He got off the train at Runcorn and got a taxi to his old address in Gambier Terrace where he used to live with his mother 10 years previously. He had told his mother that the numbers had		Bizarre behaviour Impulsive behaviour/disinhibited Concerns re: Bizarre thoughts and comments? Delusions

		been swapped round on the doors of all the houses. His mum initially rang 111 and was advised to take him to A&E mum and mums friend took SU1 to the Royal and SU1's father met them there around 5.00 pm. On the way SU1 was talking bizarrely about and had asked'' what dark secret are you and dad keeping from me?'' He talked as well about shop signs giving bad vibes and good vibes but dad never knew this until, mums friend mentioned it later. It came to light that SU1 had slept in Euston station and given all his belongings away, including his brand new iPhone 8. He had also withdrawn approx. £700 from his bank and it is unclear where this money has gone. They had arrived at the Royal approx. 4:00pm and waited 6 hours to be seen. In this period of waiting SU1's father describes SU1 as getting frustrated, erratic, inpatient and tearful. He was shouting and screaming which was out of character for him. He was also using offensive language and was confrontational. Whilst in the waiting area he recalls SU1s mother saying to SU1 ''do you remember smashing your phone when you thought someone was spying on you?''		Mood labile and incongruent? Communication issues between parents. Father unaware of pervious behaviours as had been living with mother
30th March 2018	SU1s Father and step mother	They were taken into a small room. It was unclear but SU1's father thought it was SU1s		Suggestion of Asperger's with no clear rationale?

		mother that might have suggested Asperger's. There was no opportunity to discuss concerns with the assessor and they were not asked what their concerns were. SU1's father reports that SU1 was able to hold it together and was monosybillic when answering the questions during the assessment. They were informed a letter would go back to GP to refer for Asperger's assessment but had not heard anything since re: follow up.		Difference in presentation in assessment than with the family Family not given appropriate opportunity to share there side of story/timeline
30th March 2018 GOOD FRIDAY	Adult Liaison Practitioner, Liverpool Liaison Team	Adult Liaison Practitioner, Liverpool Liaison Team assessed SU1 on 30th March 2018 and completed his assessment at 21:10. Her assessment was extensive and she notes "*Mum states he had a psychotic episode attempting to throw himself off a 5th floor balcony. He has been having mood swings, patient can be tearful, he is having visual hallucinations, he was reported as missing yesterday – he got a train to London. Having erratic behaviour, having panic attacks. He denies any episodes of feeling suicidal. Patient is strange in manner talking about politics. His mother states he is having delusions of grandeur …*" "*At some point he gave his mobile phone to a homeless person. He said that this filled him with relief as he felt that the phone had been hacked and he felt he was going to die".*	Plan – refer back to the GP and discuss a referral to the Asperger's Team.	x

		"He has however been behaving oddly at times over the past 3 weeks..." *"Viral meningitis when he was 4 months old".* *"Premorbid personality – when his mother described his outburst, his social difficulties, he appears to have some autistic traits. Mother's friend who works in the field has mentioned Asperger's previously but it has never been pursued"* Examination – thoughts. He says that his thoughts are quite clear at the moment although he does feel that through his mobile phone his identity has been compromised. He says that this is why he gave it to a homeless person. He said he found this freeing. Evidence of paranoid thoughts, no evidence of thought broadcasting, insertion, withdrawal or blocking. Some evidence of intrusive thoughts but he says he is generally of a positive nature and he is not perturbed by them. Hallucinations/Delusions/Altered Perceptions – no evidence of being distracted by external stimuli. Abuse – He feels he was emotionally abused by his parents because of the expectation they placed upon		

		him. He said this was made more uncomfortable because of his short attention span and his concentration issues. Diagnosis/Formulation/Summary/Initial Plan of Care This pleasant young man does not appear to have any significant mental health issues. However, his lack of empathy, his difficulty in coping with changes, his poor relationship with social situations appears to indicate this his difficulties are more in common with an Asperger diagnosis rather than an A-Typical mood disorder. Plan – refer back to the GP and discuss a referral to the Asperger's Team.		
31st March 2018	SU1s Father and step mother	His father left him to sleep as he was tired		
1st April 2018 EASTER SUNDAY	SU1s Father and step mother	SU1's mother took him to buy new clothes to replace the ones he had given away.		
2nd April	SU1s Father and step mother	There was a family outing to Chester. SU1 was notably quiet and preoccupied. He said ''my mum and Nan talk in code about me, they pretend to talk about neighbours, but they talk about me'' It is noted that he was close to his Nan and would often take her dog out for a walk.		Bizarre thoughts and conversation ?delusions
3rd April-10th April 2018	SU1s Father and step mother	SU1'S father took SU1 with him to work to help move furniture but again he appeared preoccupied and spent most of the time flicking through his		

		phone that he bought second hand in the week as a replacement.		
11th April 2018	SU1s Father and step mother	On SU1s 21st birthday they took him out for a meal but again he was very quiet and distant and not really engaging. He was staring though the window and appeared preoccupied.		Preoccupied
20th April 2018	SU1s Father and step mother	It was Step Brothers birthday and they want out for a meal. SU1 was supposed to work but had cancelled work so he could come to the meal. He again was preoccupied staring for long periods. He then left early and said his was going to a party with his friend. When they got back an hour later they noticed SU1 was at home upstairs in bed. He said his friend had decided not to go to the party.		Impulsive/preoccupied
21st April 2018	SU1s Father and step mother	SU1s left for work at 5pm and came back at 7pm and said he felt unwell with his stomach		Out of character
22nd April 2018	SU1s Father and step mother	SU1 went to movies with his friends.		
23rd April 2018	SU1s Father and step mother	SU1 spent most of the day in bed.		
24th April 2018	SU1s Father and step mother	Stepbrother rang SU1s stepmother at 1pm really upset and told her SU1 had tried to strangle him to the point of him not being able to breathe. Stepbrother was sat on his own bed when SU1 came in and stood staring at him. He then grabbed him around the neck and stepbrother had to fight him off him. SU1 then just wandered		Assault of step brother and father. Never been violent before. Change in behaviour. Incongruent Family frightened

		back into his own room. Stepbrother left the house as he was frightened and went to his friends as they were going to watch the match at Anfield later that evening. SU1's father was informed and he came home and stood near the front door and shouted SU1 as he was in his room. He came down and when he was asked what had gone on, he replied ''nothing'' and walked away. His stepbrother left the house as he was frightened at what he might do and rang him from his car at the end of the road he spoke to him for about 20 minutes. SU1 was unable to explain what had gone on and said he didn't have time to talk as he was going to work. SU1's father saw his friend pick him up. Stepbrother remained shaken up by the incident he arrived home from the match at about 11:00pm and again told stepmother and SU1's father what had happened. Normally SU1 would have been home by 11pm but he still wasn't home. He wasn't picking his phone up so they rang SU1s mother and at this point SU1 came through the door. SU1's father asked him to speak to his mum and he grabbed the phone and walked away into the hall. When he got off the phone he said ''it's all your fault'' and he grabbed SU1's father's arm and then tried to strangle him putting him in a head lock. SU1 dragged		of him and potential to harm. Poor sleep

		SU1's father into the kitchen and then pushed him against the fridge and punched him in the face and again held him in headlock. Stepbrother came downstairs and put his arm on SU1 and asked him to let go which he did and then he walked away to his bedroom. They did not think to ring police at this point they decided to let things calm down and deal with it in the morning. SU1's father then collected all the knives as he was concerned about the family's safety. Stepbrother went to bed with the bed up against the door, stepmother and SU1's father went to bed about midnight and locked their bedroom door. However 10 minutes later SU1 tried the handle of the door. He then knocked. The family report that SU1 would never usually just walk into their room he would always knock first so this was out of character. He then apologised and said he wanted to talk face to face and he was ''worried that stepmother had been caught up in it all'' They didn't open the door and he kept coming back saying he couldn't sleep and rambling about'' never fitting into school'', ''dad split me and stepbrother up'' He was insistent that his stepmother should open the door. He was crying at one point and this continued until 3am		
25th April	SU1s Father and step	When they got up in the morning he was awake sat on his bed		Mother seeking help from

2018	mother	looking like he hadn't slept. Stepmother took him to the GP. While waiting at the surgery mum rang him and following the phone call SU1 told stepmother that his mum wanted him to see one of her friends husband in Glasgow who was a psychiatrist for serial killers. He told her he didn't want to go but his mum had already booked train tickets to go and see her friend. SU1 saw GP with stepmother. SU1 told the GP about attacking stepbrother and his father, he told him about Barcelona and London. The GP pulled up the letter from crisis team when stepmother told him he had been seen by them. He talked about symptoms of Asperger's and stepmother informed him that SU1 was not experiencing these symptoms. The doctor then talked to him about different coping mechanisms like ''punching a pillow'' No medication or further support was offered at this point. GP just told SU1 he could contact him anytime but couldn't make him a further appointment. Meanwhile while SU1 was out of the house SU1's father searched SU1's room and found a large bread knife and a piece of metal (Car part) wrapped up in cloth. On return from GPs they took him out for breakfast and he appeared to be agitated. He said he was going to the Gym		professional friends- ''Psychiatrist for serial killers'' GP's advice with regards to dealing with anger Family questioned diagnosis of Asperger's Weapons found in house by father

		so SU1's father dropped him off at home and then dropped stepmother off at work and then he parked in a car park. SU1's father was supposed to be working from home but felt too frightened to go home. SU1's father then went back to the GP practice and there was a sign on the door saying closed for training. He could see staff in there looking at him as he was banging on the door but no one came. He then rang 111 and he was transferred to Bolton who couldn't offer any help other than'' ring the police''. He called the Crisis team. He tried to explain that he was concerned that SU1 was not well and needed to be seen and they told him they couldn't do anything and to ring the police. He rang Moss House and they also said to ring the police. SU1's father felt his last option was to contact the police. SU1's father and stepmother went to Admiral Street station at about 5:30pm and explained to the duty officer what had happened. He said he would send a car round at 7:00pm. SU1's father and stepmother waited at the end of the street for the police car to come. His stepbrother was out at work. stepmother escorted police in as SU1's father waited in the car at top of the road. SU1 told the police he took the knife and metal to his bedroom for protection. The police said they could remove SU1 and		Family seeking help and advice about SU1s mental state and were passed to different professionals with no clear ownership to help. Police preconceived ideas around home life. Seen as a domestic incident

		suggested taking him to another relative (mother). stepmother expressed concern about this due to there being 2 incidents and risks. The police said they would need to speak to SU1's father. One policeman took SU1 upstairs whilst the other took a statement from SU1's father. The police informed them that in order to make an arrest that SU1's father would need to press charges and SU1 would then be seen by a duty doctor in cells. SU1's father agreed to this, SU1 was arrested and taken into police custody. They came back at 10pm and took statements from both SU1's father and stepbrother. The police told the family that ''he appears sane to me, he comes from a lovely house and lovely family and it is likely to be seen as a domestic". In their experience it was likely he would be released that night as it was first offence and they couldn't charge him with possession of the knife as he hadn't done anything with it. SU1's father and stepmother were alarmed by this as they assumed that he would be sectioned that night. At approx. 11.30 pm they got a phone call from the police station to say they were keeping him the night as he hadn't been seen by doctor yet but he was settled and causing no problem.		
25th April	GP	SU1 attended surgery with his step mother because he had		

2018		attacked his step brother the day before and parents were concerned why it had happened. He presented with an open manner if a little reserved. He was able to give a reasonable history of the events. SU1 stated he became really angry and went through to his step brother's room and put his hands around his step brother's neck. His brother was able to break free; SU1 could not give an account as to why he had done this but stated he was remorseful. After some prompts from his step mother SU1 talked about how he had recently moved back to his father and step mother's house to try and help him structure his day so he could apply for work He stated he was under pressure form his father to find work and they quite often argued. SU1 stated that he had previously been living with his mum and had left at his dad's suggestion not because there was a problem with their relationship. He discussed the experience in London and described what sounded like a psychotic episode. He had attended the Mental health team 10 days earlier and there was a suggestion that his presentation was as a result of a combination of cannabis and alcohol. GP described SU1s presentation on this occasion was similar to what was described in the initial assessment completed by A&E practitioner. SU1 stated he had		

		stopped drinking alcohol and smoking cannabis since his trip to London. SU1 reported reasonable sleep, concentration and appetite but was fairly irritable. He denied any auditory hallucinations and did not describe any ideas of reference or paranoid thinking. Some suggestions to structure SU1' s day and the importance of keeping occupied where discussed along with how to access help in an emergency.		
25th April 2018	Criminal Justice Liaison Nurse at 22:15	Criminal Justice Liaison Nurse notes that SU1 was brought to St. Anne Street police custody due to complaint made by his father and step-brother that they were the victims of domestic violence. In her notes she mentions that SU1 was given a thorough psychiatric examination on 30th March by a doctor (this is not the case as he was assessed by a liaison practitioner). Risks were highlighted to the FME. Possible drug induced psychosis. Risk of suicide, risk of further assaulting behaviour towards family. Fitness for release due to previous suicidal ideation. Declared wanted to jump from a fifth floor balcony. Risks have increased since 30th March assessment at A&E. A full mental state examination to assess need for hospital admission and fitness for		SU1 was not assessed by a doctor in RLUH it was by an AHP. Was not seen by FME

		release consecutively. To ascertain whether assaulting behaviour is behavioural or as a result of deterioration in mental state or drug induced psychosis.		
25th April 2018	Criminal Justice Liaison Nurse at 22:40	"*?? Custody officer agreed the need for appropriate adult, mum is currently being contacted. A decision that SU1 will be staying overnight. No current immediate need for FME to assess fitness for release. Custody sergeant agreed that his detention will be overnight in CJLT, staff can assess him further in the morning".*		
26th April 2018 08:45	Criminal Justice Liaison Nurse Assessment	"*SU1 is in St. Anne Street police custody suite where he has been arrested for Section 39 assault into two. Circumstances are regarding altercation between the detained person, father and brother, dad spoken to and he reported an altercation yesterday between SU1 and brother and day before with the father – both making complaints. SU1 was asleep when I first went to see him this morning but awake and alert when I spoke to him".* Mental state examination appearance. Dressed in smart casual clothing, well kempt. Psychomotor behaviour – no abnormal movements or gestures. Mood and affect – SU1 was slightly flat in presentation. He was open with responses and did not appear to be fearful or suspicious. No observed signs	AA for interview. See drugs work and custody. Refer to Asperger's team. Refer to Early Intervention Service.	The Criminal Justice Liaison Practitioner (she is a qualified OT and not a nurse) comes to the conclusion that SU1 was suffering from Asperger's and possibly SD. She does raise concerns about the psychotic symptoms and possible thought extraction and paranoid thoughts that he experienced about developmental technologies. She then decides to refer to the Early Intervention Service, possibly because she did not think there

		of anxiety. Speech largely monotone, normal in rate and volume. Appropriate in content although need to ask clear questions and explain the content of questions to elicit appropriate answer. Cognition/Memory. No problems with memory or concentration. Some issues regarding cognition. SU1 demonstrates difficulty with emotional awareness. He struggles to understand the context of social situation and conversation. He may agree with things he has misunderstood and then ask for further clarity. Thought Perception. SU1 said that he is paranoid about certain people. His dad's girlfriend and his mum. He said they project their insecurities about him onto him and he does not know why they do this and it makes him feel like everything is his fault. SU1 said that he has the surname of the man his mum was married to before his dad. He feels his father may not be his biological father but when he asks anyone about this they deny or just don't explain. SU1 said he is aware that his parents are possibly worried about him; he thinks his past behaviour may have given them cause for concern. He said he has behaved maybe badly in the past due to not understanding		were any risks. The issues I have identified include the fact that the incident which led to his arrest was not explored i.e., the assault that the family reported into the police for, his thoughts were not explored at length regarding any thoughts around the incident and what led to the incident. The concern is also about multiple psychotic symptoms that have been identified in the practitioner's assessment have not led to a formulation of an acute psychotic disorder which should have been picked up by a practitioner of such experience.

		things. SU1 said that when he "ran away" to London recently, he felt that his phone was hacked so he gave it away. He said he thinks that someone may be hacking his phone or tracking him. He cannot explain why or who this may be. He thought he may be attacked by someone who is controlling his phone. He also thought that maybe someone was trying to protect him and they can understand his thoughts better than he can. SU1 talked about artificial intelligence. He told me about the film which he thought may be linked to him. He feels that maybe the consciousness can be uploaded to a robot. That they have a stream of data from you and you wouldn't know it is uploaded. Risk to Self. SU1 denies any thoughts or history of self harm. He said he has had thoughts about killing himself in the past but not now. He said there is no need for it – it would be a last resort. Do unto others, denies any thoughts of harming others. SU1 was arrested for 2x assault on his dad and his brother. Following conversation with SU1's mother she mentioned that the dad had told her a knife was involved at some point in the assault. This was not mentioned in the complaint or interview – police sergeant informed. Drugs and Alcohol. SU1 said he		

		was smoking a lot of cannabis – sometimes daily but he stopped this three months ago and has smoked it once with a friend since then. He would like to talk to the drugs team in custody for information about the effects of cannabis. He said when he was eighteen years he drank because he thought he should but didn't enjoy it and doesn't drink now. He denied other drugs although he said he tried some things once, (ketamine, cocaine, ?? LSD). SU1 said he had a "mental breakdown" a few weeks ago when he went to London. He talked about a girl he was talking to on Facebook for three years and meeting up with her recently. He thinks she may be unwell and said he didn't know what she was talking about a lot of the time. Impression. Some of SU1's thoughts could be understood in the context of possible ASD/Asperger's Syndrome. He does not understand the social or wider context of things that happen in his life and in his past so he believes that some people might have a better understanding of his thoughts like his parents. However, he discusses possible thought extraction and some paranoid thoughts about people close to him and about developmental technologies.		

		Plan. AA for interview. See drugs work and custody. Refer to Asperger's team. Refer to Early Intervention Service.		
26th April 2018 12pm	Clinical note by Criminal Justice Liaison Practitioner (wrongly identified as Criminal Justice Liaison Nurse)	Assessment "*Spoke with mother, shared that I am intending to refer SU1 to the Liverpool Asperger's Team and to the Early Intervention in Psychosis Team and gain some basic clinical reasoning for this. She was relieved that this was happening. She said SU1 saw the GP a couple of days ago and he recommended that SU1 "go to the gym more". During a conversation mother said that the dad had reported that there was a knife involved in the incident with the dad and brother. This was not mentioned in police information. Informed police sergeant 2440 about mention of knife by mother".* Review teams' views. It appears that the Criminal Justice Practitioner made attempts to speak to the mother but not necessarily to corroborate some of the information that was obtained. It appears that the plan which had been decided following the assessment was being shared with the mother having obtained appropriate permission from SU1		
26th April	Clinical note by Criminal	Approached by custody sergeant in St. Anne's Custody		

2018 20:30	Justice Liaison Nurse 1	Suite along with police officer from VPU informing me that SU1 who had been assessed earlier by my colleague had been re-arrested in relation to murder/attempted murder.		
26th April 2018 20:50	Clinical Justice Liaison Nurse 1	"*I was advised by my colleague, that SU1 was under arrest on suspicion of murder/attempted murder. I have completed a Datix to reflect this given recent assessment by CJL Datix WEB83098.*		
26th April 2018 21:45	Criminal Justice Liaison Nurse 1	"*I have contacted bronze on call for Local Services to update regarding situation. Bronze on call informed me that she has escalated the incident to silver on call. Informed by bronze on call that silver on call has contacted the communication team. CJL team mangers informed of incident*".		
26th April 2018	Father and step mother	The family had spoken to mother and informed her that he probably would not be sectioned and she had agreed following release she would pick him up from the police cells. The police suggested he was likely to get let off with a caution. They had discussions about taking him straight to A&E on his release if he was not sectioned as their concerns still remained about his mental health which she agreed to do. In the interim SU1's father had tried to speak to GP that morning and he was not available as he only worked Monday-Wednesday. He was able to speak to another Doctor. SU1's father said he was begging her to help and do		

		something and again he was told there was nothing they can do. The family kept the house locked all day due to concerns that SU1's father was the target and SU1 might just show up. There was a phone call from mother informing them of outcome of assessment and there would be a referral to Early Intervention Team and Asperger's Team. They were informed mother was in the assessment as an appropriate adult as he wasn't fit to answer questions the last they heard from mother she was in a taxi taking him to A&E.		
26th April 2018	GP Account	SU1's Father attended surgery and saw one of GPs colleagues. SU1s father stated he was worried as after the consultation with GP yesterday SU1 had attempted to strangle him and was behaving extremely agitated trying to get into the bedroom. His father had called 999 and the police had arrested him but he was concerned that they might release SU1 and that he had found breadknife in SU1s room. He confirmed that he did inform the police of the findings and his fears and he was concerned that the police did not take his fears seriously. SU1s father was advised to speak to the police again and discussed how to access the mental health team again. Advised father that she would contact social services via Careline to discuss concerns.		There is no evidence to collaborate that Careline was informed in the social care/trust systems

		Careline was informed and said police would fax through relevant details when SU1 was released		
27th April 2018 08:00	Criminal Justice Liaison Nurse 1	"*Spoke with Inspector and updated him with a plan to assess SU1' s mental health and arrange Mental Health Act assessment with a view to admission, his details and events appeared to indicate that SU1 is mentally unwell and requires admission under Mental Health Act. Inspector happy with this plan. There is a possibility of SU1 transfer by police to Copy Lane Custody Suite due to separate police investigation and I await an update on this*".		
27th April 2018 09:04	Criminal Justice Liaison Nurse 1	"*Call made to Scott Clinic MSU Referral Team, A&E Practitioner advising that we require an MSU assessment of SU1 in custody due to risk and nature of offence. Received call back advising that Dr is the on call psychiatrist and he will come and assess SU1.*		
27th April 2018 11:30	Criminal Justice Liaison Nurse 2	Professionals meeting with Detective Inspector with regard to SU1 and the plan for him going forward.	Team from Scott Clinic and AMHP to see in custody and consider detention. If not, detain to be seen by FME fitted for interview	

			and dealt with appropriately. If remanded CJLT to send MH alert to prison.	
27th April 2018 14:20	Criminal Justice Liaison Nurse 1	"*Mental health team consisting of AMHP, Section 12 and Forensic Psychiatrist attended SAS Custody Suite and completed MHA assessment. Clear evidence of psychosis present, thought disorder, persecutory ideation, problems processing information and articulating experiences. After assessment MHA team agree that SU1 should be detained under Section 2 for a period of assessment. Discussed medium and high secure and a decision was made collaboratively that SU1 should be admitted initially to high secure due to volatility, nature of offence, behaviour after initial arrest in custody and media interest, with the view to step down potentially to Scott Clinic.* *It appears that he was admitted to Ashworth Hospital after discussion with on call Psychiatrist, the Chair of the Admissions Panel.*		
27th April 2018	GP account	SU1 was taken to A&E following allegedly assaulting a police officer. It was noted he was aggressive at the scene and had tachycardia and a small bruise to the right side of his head.		

		When he was assessed he was noted to be calm and alert		

Appendix 2

Order of Events Taken from the notes by Criminal Justice Liaison Nurse

1. No previous contact with police by SU1 or his family. He was reported missing by his family on 30th March 2018.

2. Arrested for Section 39 Assault x 2 on 25th April 2018 in the evening, not seen by CJLT but referred to the FME. FME did not see and referred back to CJLT.

3. Seen by CJLT 24th April 2018, psychotic symptoms are suspected to be ASD. Plan to refer to CJLT to EIT and Asperger's Team.

4. Mum acted as appropriate adult for interview. Discussion of concerns with CJLT.

5. Given an adult caution for Section 39 Assault into two, his brother and father did not give statements but SU1 made admissions in interview.

6. Left police custody at around 16:00 hours with mum.

7. Was observed arriving home by witnesses around teatime

8. Shortly after this he was at his grandmother's house with her and a carer from Mersey Care (name not given due to confidentiality).

9. No concern about his presentation, he was acting normally.

10. With note he then stabbed the carer approximately twelve times. She is in hospital with serious injuries, likely to need surgery later today.

11. Carer then phoned 999 and her employers. The employers phoned SU1's grandmother's next of kind. His uncle attended.

12. SU1 reportedly returned to his grandmother's address shortly after this.

13. His mother was then found deceased in her address she shares with SU1. It has been described as a "*Manic act of violence"*.

14. When booked into custody his demeanour was calm and nonchalant about the events today.

15. As below was aggressive was first in custody.