Oldham
Safeguarding Adults Board

Oldham
Partnership

SAFEGUARDING ADULT REVIEW

OVERVIEW REPORT

CONCERNING

Steven

Independent Chair: David Hunter

Independent Author: Ged McManus

V0.4 January 2019

This report is the property of Oldham Safeguarding Adult Board (OSAB). It must not be distributed or published without the express permission of the Board's Chair. Prior to its publication it is marked Official Sensitive Government Security Classifications April 2014.

Contents

Introduction..3

Establishing the Safeguarding Adult Review..3

Terms of Reference..6

Background information 9

Notable events..10

Analysis of notable events 14

SAR Panel Learning...35

Conclusions 37

Recommendations...42

Appendix 1: Table of Notable Events...44

Appendix 2: Action Plan...58

1 Introduction

1.1 This Safeguarding Adult Review, hereinafter referred to as the Review, is about Steven 32 years of age. Steven had a long history of involvement with mental health professionals including statutory detention and a formal diagnosis of paranoid schizophrenia. Steven is his real name and is used in the report at the request of his mother and step-father.

1.2 In May 2016, Steven was found drunk in the street and arrested for breaching an anti-social behaviour order [ASBO] and was given a 12 month Conditional Discharge.

1.3 On 16 October 2016, Steven was found in an intoxicated state in Middleton. He was abusive to police officers which led to his arrest for breaching his ASBO. The following day he appeared at Greater Manchester Magistrates' Court and was sentenced to four months imprisonment for the October 2016 breach and the May 2016 incident relating to the Conditional Discharge. He went to HMP in Greater Manchester.

1.4 During his time in custody Steven was seen by mental health professionals who provided his care. He was generally uncooperative with most professionals while in custody and prior to his release date in January 2017, it was planned to complete a Mental Health Act assessment. That assessment concluded, on a split decision, that he did not meet the criteria for detention under Section 2[1] Mental Health Act 1983.

1.5 Steven was released from prison on 13 January 2017 to no fixed abode as he would not engage with Shelter. In the early hours of the following morning Steven was found on fire. He was admitted to hospital with significant burns and sadly died on 26 January 2017, in the Burns Unit of a Manchester hospital.

1.6 At an inquest in February 2018 HM Coroner concluded:
'The deceased took his own life whilst the balance of his mind was disturbed in part because the risk of his doing so was not recognised and appropriate precautions were not put in place to prevent his doing so'.

1.7 The review offers it condolences to Steven's family.

2 Establishing the Safeguarding Adult Review

2.1 Decision to Hold a Safeguarding Adult Review

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been

[1] Section 2 MHA provides a power to detain a person in hospital for assessment for up to 28 days.

meeting any of those needs) if-

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met

(2) Condition 1 is met if-

(a)the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if—

(a)the adult is still alive, and

(b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.1.1 Following Steven's death in January 2017, a Safeguarding Adult Review referral was completed in a timely manner by Greater Manchester Police. However, as Steven died in a different location to his latest residence there was some uncertainty about which area should take responsibility for the Safeguarding Adult Review. The referral was passed to Oldham Safeguarding Adult Board in June 2017 and on 16 June 2017 the Board's Independent Chair determined that the circumstances of Steven's death met the criteria for a Safeguarding Adult Review and that it would be conducted by the Oldham Safeguarding Adult Board. A further delay was incurred due to new processes being established by the board and challenges in commissioning an independent Chair for the review.

2.1.2 On 7 December 2017, David Hunter was appointed as the chair for the Review and was supported by Ged McManus who wrote the report. Neither has worked for any of the agencies contributing to the review and they were judged by the Chair of Oldham Safeguarding Adult Board to have the experience necessary to conduct an independent and thorough enquiry. The first meeting of the Safeguarding Adult Review panel took place on 12 January 2018.

2.2 Agencies contributing information to the review

Greater Manchester Police [GMP]

HMP

Greater Manchester Mental Health NHS Foundation Trust [GMMH NHS FT]

Shelter

Cheshire and Greater Manchester Community Rehabilitation Company [CGMCRC]

Clinical Commissioning Group Oldham

First Choice Homes Oldham [FCHO]

Pennine Care NHS Foundation Trust [PCFT]

National Probation Service [NPS]

Adult Social Care Oldham

Pennine Acute NHS Trust

Manchester University Hospitals NHS Foundation Trust

Her Majesty's Coroner for Manchester West

Prisons and Probation Ombudsman

2.3 Glossary of agencies involved in the review

Greater Manchester Mental Health NHS Foundation Trust [GMMH NHS FT]
GMMH NHS FT is the provider of mental health, substance misuse and offender personality disorder services in custodial settings [HMP]. All services are delivered in partnership with a number of different health providers and multiple agencies internally and externally.

The Mental Health Inreach Team (MHIT) bring together the skills, knowledge and experience of psychiatrists, psychiatric nurses, and a social care group worker, working in partnership with the healthcare staff of the prison inpatient unit and the discipline staff on the wings. Within the prison they provide the assessment and support people need to deal with the problems that can stem from mental ill health.

Pennine Care NHS Foundation Trust [PCFT]
Pennine Care Foundation Trust provides Specialist Mental Health provision across Bury, Rochdale, Oldham, Tameside & Stockport

HMP

HMP is a category B local Prison. It holds both sentenced and remand prisoners aged 18 and over from the local courts. The Prison is operated by Sodexo Justice Services under contract to HMPPS[2]. Sodexo provides all core services within the prison including primary healthcare. Secondary Mental Health is provided by Greater Manchester Mental Health NHS Foundation Trust [GMMH NHS FT].

Cheshire & Greater Manchester Community Rehabilitation Company, [CGMCRC]
Provider of probation services to low and medium risk offenders.

Shelter
A national charity providing advice, support and legal services to people struggling with poor housing and homelessness. Shelter is contracted by CGMCRC to provide housing advice to inmates at HMP Forrest Bank.

First Choice Homes Oldham [FCHO]
First Choice Homes Oldham is a not for profit housing association formed for the benefit of the community. Its charitable objects are to carry on for the benefit of the community:

- The business of providing and managing housing, including social housing, and providing assistance to help house people and associated facilities.
- Any other charitable object that can be carried out from time to time by a registered society registered as a provider of social housing with the Regulator.

3 Terms of Reference

3.1 General

The purpose of a Safeguarding Adult Review is neither to investigate nor to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- Review the effectiveness of procedures of both multi-agency and individual organisations;
- Inform and improve local inter-agency practice;
- Improve practice by acting on learning and developing best practice;
- Prepare or commission an overview which brings together and analyses the

[2] Her Majesty's Prison and Probation Service

findings of the various reports from agencies in order to make recommendations for future actions.

3.2 Specific Terms

1. What information did your agency have about the following that indicated Steven posed a risk of causing harm to himself or others?

   a. Substance misuse
   b. Mental health
   c. Self-neglect

2. What did your agency do with that information and did you complete a risk assessment, if so what risk assessment tool did you use?

3. What was the outcome of the risk assessment and who did your agency share it with?

4. What did your agency do to secure, or help secure, accommodation for Steven prior to his release from HMP on 12 January 2017?

5. What consideration did your agency give to Steven's financial circumstances and did he have a Care Act [Care and Support] assessment?

6. What medication did your agency prescribe or supply to Steven?

7. What mental capacity assessment[s] were completed by your agency, what assessment tool was used and what was the outcome?

8. Were there any opportunities missed by your agency to raise a safeguarding adult alert and request or hold a strategy meeting?

9. What consideration did your agency give to referring Steven to MAPPA? [Multi-Agency Public Protection Arrangements]

10. Did your agency have any resourcing issues when assessing or providing services to Steven?

11. What consideration did your agency give to diversity issues when dealing with Steven?

12. What has your agency learned from completing your review?

13. What outstanding or innovative practice did your agency identify?

3.3 Time period under review

3.3.1 From 1 January 2016 to 13 January 2017

3.4 Family Involvement

3.4.1 Steven's mother and step-father initially engaged with the review and later withdrew. In a meeting with the independent Chair of the review they raised the following issues. The family responded to a proposal to see the report and in January 2019 provided some feedback. Where applicable that feedback has been included in v0.4 of the report. The SAR Panel believes the agencies responses to the family's points were satisfactorily addressed.

1. Did Steven see a Catholic priest during his last imprisonment? If not why not?
   It is now known that Steven attended a catholic mass on several occasions and spoke to a chaplain on the prison wing informally.

2. Why wasn't he detained under Section 2 Mental Health Act on 12 January 2017 when it must have been obvious he was mentally unwell and needed compulsory help in a safe environment? Steven's family believe that the clinicians who undertook this assessment were not familiar with his history.
   [see 6.1.14]

3. Why was the venue for his mental health appointment changed on the day he was released and who changed it? [13 January 2017]
   [see 8.20]

4. Given that the family was unable to meet Steven at the prison gate why didn't some professional take him to his appointments? It must have been obvious that he would not attend by himself given is long history of not attending.
   [see 8.22]

5. There were basic errors in the information provided to the assessing clinicians about Steven's criminal convictions. For example, they had him convicted of an offence when he would have been 8 years old and one conviction was attributed to him two years before he was born. These errors did not instil confidence in family.

   It is unclear what documents Steven's family are referring to. A comparison of Steven's convictions recorded on the Police National Computer and convictions recorded in the TARA risk assessment completed by PCFT on 10 January 2017, shows that the TARA is largely accurate with only very minor errors or omissions. The errors referred to by Steven's family are not present in this document.

   Steven's family responded to the above point and provided a handwritten 13 page document from Oldham Council Commissioning Directorate titled, 'Approved Mental

Health Professional Report Form.' It was completed by a named Approved Mental Health Practitioner [AMHP] and dated 13.1.17. The last page of the document contains dates for 13 criminal offences and their outcomes. While the page does not specifically say they refer to Steven, the logic is they do as otherwise their presence in the document is incongruous. Given Steven's date of birth many of the dates attributed to offending cannot be accurate. Therefore on this point the family's view that, 'These errors did not instil confidence…' is founded on fact.

6. What investigations were done about Steven's reported remarks that he was going to kill people when he was released?
   [see 6.3.8]

7. What assessments were made of the risk he presented himself and others prior to his release in January 2017?
   [see 6.2.1 and 6.2.3]

4 Background information

4.1 Steven was the youngest of three sons. He was born in Oldham and from the age of about two years lived in Middleton where he was brought up and went to school. He was never in paid employment and relied on state entitlement for his income.

4.2 Steven's mother said that he could not cope too well with life because of his longstanding mental health problems and misuse of alcohol. When under the influence of alcohol, he was unpredictable and unreasonable. Steven knew that alcohol led to poor behaviour and his desire for drink overcame any concerns that consumption led to.

4.3 Greater Manchester Police had significant involvement with Steven. The first recorded contact was in 1998, when Steven was arrested for burglary of a house. He has 45 custody record entries recorded within Greater Manchester since digital custody records began in 2002. On the Police National Computer Steven has 30 convictions spanning 46 offences for offences against property, acquisitive crime, public order, drug offences, offences against the person and offences against the courts as well as Road Traffic Act offences.

4.4 Within the review period Steven was arrested and brought into police custody on 5 occasions. Each time his mental health presentation was concerning to the custody staff and he was seen by a police appointed healthcare practitioner.

4.5 Steven was first recorded as a missing person in 2006, with 21 recorded missing episodes. The overwhelming majority involve unsanctioned absences from hospitals after presenting with self-harming and leaving prior to treatment or leaving the ward after

being admitted under the mental health act.

4.6 Within the period under review Steven has been recorded as a missing person on four occasions; three of which relate to him going missing after being on accompanied leave whilst a Section 3 Mental Health Act 1983[3] was in place on the mental health ward at Royal Oldham Hospital. One missing instance relates to him failing to attend two appointments with his social worker following his discharge from hospital. On each occasion he was either located safe or was located in an intoxicated state and arrested.

4.7 Steven has had several formal mental health diagnoses including paranoid schizophrenia. The dates and details of the diagnoses appear in Section 5 of this report.

4.8 The review panel thought it was fair to say that Steven's behaviour was challenging, particularly when he was intoxicated.

5 Notable events

Set out in the following table is a sample of the notable events identified by the review panel. They are listed without commentary. The full list appears at Appendix 1. The analysis of the events appears in Section 6. Some of the events pre-date the beginning of the review period [1 January 2016] and are included to add context and aid understanding.

Date	Event
Pre 1 January 2016	
28.02.06	Diagnosis of paranoid schizophrenia.
24.03.14	Prison medical notes self-report his diagnosis as Paranoid Schizophrenia. Confirmed with his Care coordinator.
10.11.15	Sentenced to 18 weeks custody for Breach of Anti-Social Behaviour Order x 2. A Probation pre-sentence report recorded: It is also noted that a mental health assessment had been carried out prior to completion of the report. It is stated that this assessment concluded that Steven was not mentally ill and that issues linked to his cognition and presentation were a result of prolonged alcohol abuse/ withdrawal. This information was obtained by the report writer through discussion with the relevant mental health professionals. [The identity of the mental health professionals is unknown]. The report identified that Steven presented a medium risk of serious harm[4] [ROSH] to the public and a high risk of re-offending.

[3] Section 3 is titled Admission for Treatment

[4] Medium Risk of Serious Harm:
There are identifiable indicators of ROSH. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse. Ministry of Justice Multi-Agency Public Protection Arrangements Guidance 2016.

Post 1 January 2016	
08.01.16	Steven was released on standard licence conditions to Cheshire and Greater Manchester Community Rehabilitation Company (CGMCRC) management. He failed to report to its Oldham office. Later that day he was detained under section 136 Mental Health Act 1983 and later discharged.
19.01.16	Offender Assessment System (OASys) by CGMCRC; low ROSH to the public.
16.02.16	CGMCRC: A fixed term recall i.e. 14 days to allow for accommodation issues to be addressed was requested. Arrested and retuned to HMP about a week later.
08.03.16	PCFT: Mental Health assessment; the decision was made to use least restrictive option and Steven was subsequently released from prison on standard licence to engage with the Community Mental Health Team [CMHT].
10.03.16	Sentenced to 4 weeks custody for breaching non-molestation order on his mother.
23.03.16	Steven released from HMP Liverpool and presented to FCHO as homeless. FCHO referred him to Adult Social Care as an urgent case.
05.04.16	Steven found by police at the side of M62 motorway. Taken by ambulance to A&E at Huddersfield Royal Infirmary.
13.04.16	Police Community Support Officer [PCSO] sees Steven in car park. He talked about being executed and being able to travel in time.
20.04.16	Steven was admitted to the mental health ward as an informal patient.
22.04.16	Steven was seen by Dr A, but refused to answer questions. He was placed on a Section 5(2) MHA[5] and a medical recommendation for Section 2 MHA was completed. Steven presented with delusional ideas and thought disorder.
25.04.16	PCFT: Detained under Section 2 MHA.
20.05.16	PCFT: Steven discharged from Parklands House [psychiatric facility]. Primary diagnosis, chronic social problems.
21.05.16	Steven appeared at Greater Manchester Magistrates' Court and received 12 month conditional discharge for the breach of Anti-Social Behaviour Order.
03.06.16	Detained in North Wales under Section 136 Mental Health Act and admitted to a mental health ward, Birch Hill Hospital Rochdale. Steven reported there were demons in his body which were telling him to commit suicide and harm himself. Detained to mental health ward under the Section 2 MH Act.
15.06.16	PCFT: Dr C diagnosed: Emotionally Unstable Personality Disorder. Steven was discharged from Birch Hill hospital.
16.06.16	GP: Received a letter from PCFT: discharged Primary diagnosis – Emotionally Unstable Personality Disorder, factitious disorder. [Factitious Disorder was previously called Munchausen's syndrome]

[5] Application in respect of patient already in hospital

01.07.16	CGMCRC: Steven sentenced 14 days imprisonment; HMP. Breach of non-molestation order
13.07.16	HMP: Steven presented as delusional, unkempt and Section papers were completed and he was detained under section 2 [Admission for assessment] of the Mental Health Act.
14.07.16	Steven transferred by ambulance from HMP Forrest Bank to mental health ward, Oldham. Next day assessed as having no capacity to consent to treatment.
08.08.16	Successful application made for Section 3 MH Act.
11.09.16	Ran away from staff while on escorted leave.
20.09.16	Ran away again from staff while on escorted leave.
25.09.16	Steven returned to mental health ward of his own accord. Not intoxicated.
29.09.16	Steven absconded from mental health ward.
06.10.16	PCFT: Care coordinator met with Steven on the ward. Steven had been drinking in the morning. Steven took his own discharge; reported missing next day.
16.10.16	GMP found Steven and arrested him for being abusively intoxicated. He was seen by police appointed health care practitioner and said he was under a voodoo curse, that this is a long term thought. He was deemed to have capacity. Sentenced to 4 months prison
17.10.16	HMP; mental health assessment denied self-harm thoughts.
25.10.16	Steven seen by Shelter resettlement worker
7.11.16	PCFT: A multi-disciplinary team meeting took place involving the care coordinator, a number of PCFT staff and Steven's probation officer. HMP Forrest Bank In Reach Team were invited but could not attend. Agreed actions were: 1. Establish where Steven wants to live. 2. Arrange and complete two mental capacity assessments regarding independent living and finances. 3. Identify the psychiatric consultant in the prison. 4. Obtain contact details for prison housing workers so that the care coordinator can liaise with them. 5. Arrange a Multi-Disciplinary Team [MDT] meeting at the prison in early December.
18.11.16	GP: Assessment letter from consultant forensic psychiatrist In Reach Mental Health Team. Diagnosis – paranoid schizophrenia and currently under the Care Programme Approach with a Community Psychiatric Nurse.
13.12.16	Confirmation HMP Resettlement Officer to attend multi-disciplinary team.
14.12.16	HMP: Professionals/Care Programme Approach meeting to discuss Steven's resettlement plans in the community and risk management following release from custody. Steven was seen by some attendees on the wing as he did not attend the meeting. Probation advised hostel a possibility. The following actions were agreed: 1. To arrange a mental capacity assessment for living independently

	and engagement with services, i.e. CMHT, housing and medication. 2. Refer to One Recovery Oldham s] before release [part of Addiction Dependency Solution.] 3. Email clinic letters to CGMCRC. 4. Make referral to Probation Service Approved Premises. 5. Discuss accommodation options with Steven.
23.12.16	Not a priority for Approved premises.
05.01.17	GP: Review letter from consultant forensic psychiatrist Mental Health Inreach Team. Consultant forensic psychiatrist states Steven remains psychotic and refusing to take his medication. Consultant forensic psychiatrist to discuss with Pennine Care about an admission to hospital under the Mental Health Act.
09.01.17	Steven refused to sign release plan. One Recovery Oldham contacted to arrange release appointment on 13.01.2017. A further entry on 09.01.17 records that One Recovery Oldham was informed of the possibility that Steven would be detained under the Mental Health Act on release form Forest Bank.
09.01.17	HMP: professionals/care programme approach meeting to discuss resettlement in the community and risk management following release from custody. A number of actions were agreed: • A Mental Health Act assessment was to take place prior to Steven's release from prison. • Obtain clarity on the reliability of the information that Steven had said he would harm children and people with them on his release. • Information to be sent to Psychiatric Intensive Care Unit [PICU] where bed has been arranged for Steven if he is deemed to be detainable. • Appointments with CMHT and homeless section to be offered if Steven is not detainable. • X to meet Steven, to complete a release plan and offer an appointment with One Recovery. • A&E departments to be contacted with Steven's clinical information in case he presents there if released.
09.01.17	HMP: Recovery worker went on the wing to give him his appointment as a backup plan for his release in the community as per plan from the professionals meeting in the morning. Steven reported that he would attend the meeting. Recovery worker noted a blood splash on the floor and discussed this with Prison Custody Officer on the wing neither party thought it warranted an Assessment Care in Custody Teamwork book being open.

	Third party information that he was saying the devil has told him to kill a child and any adult with them on his release from prison. This was not taken seriously by many professionals despite it being assessed as good quality intelligence.
11.01.16	Criminal Justice Mental Health Team, undertook Trust Approved Risk Assessment and sent copy to CGMCRC and MAPPA support. It was assessing: harm to self and suicide; harm to others and violence; Self-neglect; exploitation and vulnerability.
12.01.17	Outcome from mental health assessment not detainable under the Mental Health Act.
12.01.17	Shelter Team Manager telephoned HMP to attend healthcare to discuss homelessness appointment to be arranged for the next morning. Letter prepared for resettlement worker to give Steven on release. Approved mental health professional made appointment 10.30 for the next day with Steven's Care Co Coordinator.
13.01.17 0730 hours	HMP: approved mental health professional phoned to inform change of location for his appointment. It was changed to mental health outpatient clinic. HMP issued travel warrant. Case Manager spoke to Steven to advise that his brother was unable to pick him up. He was aware he had a travel warrant. Advised of appointment with community mental health team.
13.01.17	Released from HMP
14.01.17	Steven found alight by public in Collyhurst, Manchester

6 Analysis of notable events

6.1 What information did your agency have about the following that indicated Steven posed a risk of causing harm to himself or others:

a. **Substance misuse**
b. **Mental health**
c. **Self-neglect**

6.1.1 Cheshire and Greater Manchester Community Rehabilitation Company

6.1.2 Steven's offending management was allocated to Cheshire and Greater Manchester Community Rehabilitation Company [CGMCRC] on 11 November 2015 following his sentence to 18 weeks custody for the offences of Breach of ASBO X 2. Some information is therefore shortly prior to the start of the review period but it is included here because of its significance.

6.1.3 At the time his case was allocated to CGMCRC, Steven had a considerable offending history and information in the form of previous assessments dating back to 2009 were available. These assessments contained detail around Steven's previous substance

misuse, mental health and self-neglect. Historical information relating to treatment received and action taken in respect of Steven's mental health was also contained in those assessments, as was information linked to substance misuse and Steven's general well-being.

6.1.4 The records available to CGMCRC showed that Steven had a well-established pattern of erratic compliance and that there had been a number of different diagnoses over time in respect of his mental health. Significantly, it was recorded in the assessment completed at the end of Steven's previous sentence in March 2015 that he had previously doused himself in petrol and had threatened to kill himself.

6.1.5 Information included in the Pre-Sentence report which led to Steven's allocation to CGMCRC on 11 November 2015, was also available. This assessment identified that Steven presented as unwell and lacking in lucidity and had a previous diagnosis of schizophrenia and psychosis. It was also noted that a mental health assessment had been carried out prior to completion of the report and that this assessment concluded that Steven was not mentally ill and that issues linked to his cognition and presentation were a result of prolonged alcohol abuse or withdrawal. The panel heard that the NPS probation officer completing the pre-sentence report was likely to have done so under significant time pressure and would have been gathering information from a number of sources. The panel felt that this highlighted the importance of the clarity of language used in reports together with the need for an enhanced understanding of mental health diagnoses and the historic risk presented by a person who is being assessed. The BASIC Custody Screening, BCS and BCS Resettlement Plan completed by HMP at the time of Steven's reception into custody in November 2015 was also available. In this it was recorded that there were no current concerns regarding Steven's risk of self-harm.

6.1.6 Steven did not engage well with CGMCRC and was reluctant to disclose information about his substance misuse or mental health issues. As a result, the CGMCRC responsible officer sought information through discussion with other professionals. Throughout the review period, which included further periods in custody, Steven's risk of causing harm to others was assessed as low.

6.1.7 On 11 January 2017, CGMCRC was advised by the Community Mental Health Team that Steven had threatened to "kill a child and any adult with them" on his release. The CGMCRC responsible officer thought that the quality of the evidence was so poor that further action was not warranted and the risk was not reassessed. The handling of Steven's threat is examined later in the report. It should be noted that this information was shared by the Community Mental Health Team and not through the more formal prison intelligence system. Had the information been assessed and graded correctly at that time, as it was on 12 January 2017, then the CGMCRC responsible officer may have

taken a different view of it.

6.1.8 **Greater Manchester West Mental Health NHS Foundation Trust – Inreach Team. Secondary Mental Health Care provider at HMP**

6.1.9 The Inreach Team case manager allocated to Steven had known him during four periods of time he spent in HMP between 2014 and 2017.

6.1.10 Steven's first significant period at HMP during the timeframe of the review began on 1 March 2016. He presented as delusional, hostile and had deteriorated since he had last been in HMP. Arising from his presentation a mental health assessment was arranged with a view to Steven being detained under section 3 of the Mental Health Act on his release from prison on 8 March 2016. The assessment was completed and Steven was not deemed to be detainable by the assessment team. He was released the following day with an appointment to attend the Community Mental Health Team.

6.1.11 Steven was next at HMP on 1 July 2016 with a release date of 14 July 2016. [Trespass on railway]. He presented as delusional and The Assessment, Care in Custody and Teamwork (ACCT) [6] book was opened due to him expressing to staff that he was experiencing suicidal ideation. This process manages triggers and warning signs that an individual might express when they have thoughts of suicide and deliberate self-harm. It is a means whereby staff can work together to provide individual care to prisoners who are in crisis. A multi-disciplinary approach is taken and the individuals concerns are taken into consideration.

6.1.12 On 13 July 2016, was detained under section 2 of the Mental Health Act and transferred by ambulance to the mental health ward, Oldham.

6.1.13 On 17th October 2016, Steven again returned to HMP. Steven said that he had been drinking alcohol until he passed out and presented with a tremor associated with alcohol withdrawal. He was placed onto an appropriate alcohol detoxification regime.

6.1.14 Steven was largely uncooperative during this period at HMP. On many occasions he declined to attend appointments with professionals including a consultant psychiatrist. On 12 January 2017, a Mental Health Assessment Act was conducted at HMP. The Mental Health Act Assessment had access to Steven's risk assessment, a handover of his case and recent risk information that he had said to another prisoner that he was going to "kill a child and any adult with them" on his release from prison. Steven denied saying this when asked. The assessing team who were all present at the same time, attempted to

---

[6] The Safer Custody Programme. Management of Prisoners at risk of harm to self, to others and from others. www.justice.gov.uk/downloads/offenders/.../psi-64-2011-safer-custody.doc

find where the information had come from and when they were unable to find out the information was not taken seriously. Information was also known that during his recent periods living in the community Steven had been found sleeping at the side of a motorway and sitting on a railway line. In order to detain Steven under the Mental Health Act, the assessing team of two psychiatrists who both knew Steven and an Approved Mental Health Practitioner [AMHP] would have had to agree that detention under the act was necessary and proportionate. The two doctors would recommend that the patient be detained under the Mental Health Act and the AHMP would make the application. In this instance the community psychiatrist felt that detention was not required and the AHMP did not make an application for detention.

6.1.15 **Pennine Care NHS Foundation Trust**

6.1.16 Steven was known to PCFT from 2005 to 2017. Services were aware of his substance misuse, his fluctuating mental state and his self-neglect.

6.1.17 PCFT knew that Steven had a dependency on alcohol and from time to time utilised other substances such as cannabis. PCFT staff discussed Steven's dependence on alcohol with him on several occasions during his inpatient stays but did not make any referral to Drug and Alcohol services. It was thought it was better for Steven to refer himself as he would then be motivated to engage with the service. Steven often informed nursing staff that he would refer himself to Drug and Alcohol services once discharged from hospital but declined to engage in detox as an inpatient.

6.1.18 Steven's alcohol consumption was documented within his risk assessment, but he would often minimise his alcohol consumption. Staff, on Steven's admissions into hospital, could have supported him in addressing his alcohol misuse with a referral to Drug and Alcohol Services for intervention. Nursing staff on the ward could have offered education to Steven around the effects and use of drug and alcohol on his on his mental and physical health, given that Steven was in a supported environment. This would have given staff an opportunity to offer such an intervention as part of his care planning. Community services were in a difficult position to support Steven with drug and alcohol misuse due to his disengagement on discharge or release from prison as the Community Mental Health Team were often unaware of his whereabouts.

6.1.19 When allowed leave from the ward during his periods in hospital [section 17 Mental Health Act], Steven would often go missing. He would then return to the ward in an intoxicated state. Although his right to leave was sometimes removed, when reinstated he repeated his behaviour.

6.1.20 Steven had thirteen admissions to psychiatric inpatient units dating back to 2005. Eleven of these were informal admissions. During different admissions to hospital Steven

received several differing diagnoses, including paranoid schizophrenia [made by a Forensic Consultant Psychiatrist in 2015] emotionally unstable personality disorder (EUDP), Schizo-Affective Disorder, depression, anxiety and Chronic Social Problems. This variance in the diagnoses could have contributed to inconsistent and unclear treatment plans and made it difficult to have a consistent and clear treatment plan under the care programme approach [CPA].

6.1.21 On 20 April 2016, Steven was admitted to the mental health ward as an informal patient after attending an appointment with the Community Mental Health Team. He said that he had been sleeping rough and had attended the appointment to see if he could get some food. Steven displayed delusional beliefs and when asked if he felt like hurting himself or anyone else he replied, "if I had a firearm, I'd blow my head off". Whilst on the ward he was detained under Section 2 of the Mental Health Act as a result of his behavior. By 20 May 2016, Steven was well enough to be discharged from hospital and arrangements were made for him to attend at First Choice Homes homeless section, to obtain accommodation. However, he was arrested in a drunken state a few hours later by the police. The panel thought that a Care Act [Care and Support] assessment under section 9 of the Care Act 2014 should have been arranged whilst Steven was in hospital and that this was a missed opportunity to assess his needs.

6.1.22 On 3 June 2016, Steven was admitted to the mental health ward, Rochdale, following assessment under Section 136 of the Mental Health Act 1983 resulting in an application for detention under a section 2 of the Mental Health Act 1983. The inpatient nursing staff did not communicate with Oldham Community Mental Health Team as they were unaware Steven had a care coordinator in the Community Mental Health Team. [These services are all within PCFT.]

6.1.23 Whilst on the ward there was a delay in obtaining medical notes and nursing staff were unaware of a recent admission [two weeks earlier] Steven had to the mental health ward in Oldham. The nursing staff did have access to PCFT's IT system. However, as it was a new system to the nursing staff on the ward, they were unfamiliar with how to access relevant information. Not knowing the Community Mental Health Team were involved with Steven led to a failure in his care during his inpatient stay and upon his discharge. The SAR panel were assured that PCFT has addressed this issue and therefore a recommendation is not necessary.

6.1.24 Steven remained on one to one observations up to the day of his discharge due to him dismantling smoke alarms, but this was not viewed in the context of his deteriorating mental state despite nursing notes indicating he remained delusional. On 15 June 2016, Steven was discharged into to the community and was not deemed to be a risk to himself or others. He was discharged with no accommodation and a seven day follow up

appointment [in line with PCFT guidance] was requested by the ward staff to the Home Treatment Team in Oldham. There is no evidence that Steven attended this appointment. At the same time the Community Mental Health Team who had been trying to contact Steven since his last admission and discharge from the mental health ward, discharged him from their service. There was no connection or communication between the services which all belong to the same Trust. There is no evidence to show what was done to support Steven in trying to find accommodation. The panel thought that an assessment under section 9 of the Care Act 2014 should have been arranged whilst Steven was in hospital and that this was a missed opportunity to assess his needs.

6.1.25 On 13 July 2016, Steven was transferred to the mental health ward, Oldham from HMP having been detained under section 2 of the Mental Health Act. [This was later reassessed and transferred to section 3 MHA[7]]. He was deemed not to have capacity to consent to treatment and was uncooperative and aggressive to staff to the extent that a rapid tranquilisation procedure was used. During this stay in hospital Steven went missing from the ward on a number of occasions, at one point for five days. He was known to have used alcohol and suspected to have used cannabis. After a referral for care coordination on 30 August 2016, attempts were made to engage Steven in a Care Act assessment. However, he refused to engage in the assessment. Section 11 of the Care Act 2014 states;

Refusal of assessment

Where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment (and section 9(1) does not apply in the adult's case).

But the local authority may not rely on subsection (1) (and so must carry out a needs assessment) if—

(a) the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or

(b) the adult is experiencing, or is at risk of, abuse or neglect

The panel felt that there might have been an opportunity to complete a Care Act assessment earlier in this admission.

---

[7] At the point of being detained under section 3 MHA Steven met the criteria for the provision of Section 117 Aftercare. Section 117 of the Mental Health Act says that aftercare services are services which are intended to meet a need that arises from or relates to a person's mental health problem and reduce the risk of their mental health condition getting worse, and them having to go back to hospital. This covers things like healthcare, social care and supported accommodation.

Notwithstanding this considerable effort went into finding accommodation for him for his prospective discharge from hospital. However, nothing had been arranged when he appeared before a Mental Health Tribunal on 5 October 2016 and was discharged from detention under the Mental Health Act. Steven had debt issues from a previous tenancy and said that in any case he found living on his own isolating. A number of accommodation providers were approached but Steven's difficulties were felt to be too complex and the accommodation providers were unable to meet his needs. He agreed to stay as a voluntary patient pending accommodation being found but discharged himself from hospital the following day without waiting for this to be resolved.

6.1.26 It was known that Steven was persistently homeless following admissions into hospital or prison. There was substantive historical information on his alcohol and drug misuse which would have impacted on his ability to maintain his self-care and attend to his basic needs, and he had failed to attend GP appointments for physical health checks. Whilst PCFT were aware of Steven's self-neglect, due to his social circumstances and his significant use of alcohol and other substances, it was difficult to address this in the community due to Steven's poor engagement, homelessness and often unknown whereabouts.

6.1.27 **Greater Manchester Police**

6.1.28 Within the review period Steven was arrested and taken into custody on five occasions. Each time his mental health presentation was concerning to the custody staff and he was seen by a police appointed healthcare practitioner. The panel felt that formal mental capacity assessments should have been conducted given Steven's presentation.

6.1.29 On 8 January 2016, Steven called 999 claiming to have a head injury. He was located by police officers and did not have a physical injury. He was quoting verses from a bible whilst claiming to be an American soldier. The attending officers detained him under Section 136 Mental Health Act and he was taken to The Royal Oldham Hospital for assessment. In order for S.136 to be relevant the officers must have been satisfied that Steven was in imminent need of care or control and detaining him was in the best interests of Steven or for the protection of others. Steven was unfit to be assessed due to drunkenness and stayed overnight at the hospital where he was assessed the following morning by two qualified psychiatrists and an Approved Mental Health Practitioner. No evidence of a mental disorder was found and he was discharged. Attempts were made to assist Steven to arrange suitable housing and he was asked to wait at the hospital whilst that process was ongoing. However, he left before anything could be resolved.

6.1.30 On 24 February 2016, Steven was arrested on a warrant which recalled him to prison. The police custody officer was concerned about his mental health and caused him to be examined by a police appointed healthcare practitioner. He was found to be fit to be detained in police custody and was later transferred to prison.

6.1.31 On 13 April 2016, a PCSO came across Steven in car park. Steven presented as having paranoid delusions and was talking about being executed and having the ability to time travel. He was taken to hospital by ambulance and was later discharged following a referral to the Mental Health Liaison Team when he was considered not to be psychotic.

6.1.32 On 18 April 2016, Steven was arrested for trespassing on a railway and taken to a GMP custody facility. He was assessed by a police appointed healthcare practitioner and found to be fit for detention in police custody, specifically he did not have any intention to harm himself or others. The Community Mental Health Team was contacted and an appointment arranged for Steven to attend there on his release from custody.

6.1.33 On 20 May 2016, Steven was arrested for breach of ASBO by being drunk in a public place. Steven had paperwork showing that he was on leave from the mental health ward. The police appointed healthcare practitioner spoke to the mental health ward staff and ascertained that Steven was deemed to have full mental capacity and had chronic social issues rather than a mental health issue. He was charged and remanded in custody to appear in court the following day. An assessment of mental capacity under the mental Capacity Act 2005 should be decision and time specific. The panel discussed this in the context of the police being told that Steven 'was deemed to have full mental capacity' and concluded that the recording of the discussion between the two health care professionals would have been enhanced by reference to when and with regard to which specific decisions Steven's mental capacity had been assessed.

6.1.34 On 25 June 2016 Steven was arrested for failing to attend at court in answer to a summons for trespassing on the railway. During his initial booking in risk assessment he disclosed that he suffered from mental health issues but denied any suicidal ideation or self-harm. Steven was nonsensical during the booking in process and risk assessment. He denied alcohol or drug misuse. He was seen later by the police appointed health care practitioner who noted; "*Presents as bizarre in his thought process but when focussed able to engage and answer complex questions without difficulty. Presents as having full mental capacity and as not showing behaviour that will be a harm to himself or others. Discussed his imminent appointment [mental health] and states he will be happy to attend."*

6.1.35 On 13 October 2016, Steven was reported to the police as a missing person by his social worker. This was because he had failed to attend appointments and had not been seen since he left hospital on 6 October 2016. The social worker told the police that Steven had previously attempted to take his own life by jumping from a bridge. A missing from home report was taken and graded as medium risk.

6.1.36 Steven was located on 16 October 2016 in an intoxicated state and was arrested for being drunk and disorderly. Upon arrival at the custody facility Steven was very intoxicated, aggressive and violent, attempting to bang his head on the counter and making threats to assault staff. He was assessed by the police appointed healthcare practitioner. Steven appeared to have capacity but stated that he was under a voodoo curse and had been since he was a child. Steven was charged and remanded into custody to appear at court the following day. As the assessment of mental capacity is decision and time specific the panel were unclear on how Steven's mental capacity was assessed and thought that a formal mental capacity assessment would have been helpful. This is a learning point.

6.1.37 **Oldham Adult Social Care**

6.1.38 On 8 January 2016, Adult Social Care were involved when Steven was detained under section 136 Mental Health Act [paragraph 6.1.29 refers] When assessed later, no admission was required and a referral was passed to First Choice Homes.

6.1.39 Oldham Adult Social Care [Multi Agency Safeguarding Hub] received a referral from First Choice Homes on 1 April 2016, outlining concerns about Steven. He had been accommodated in a hotel as he was homeless but staff there had reported that he had caused damage to a windowsill [fire] that he was hearing voices telling him to hurt someone and that he was possessed by the devil. The information was emailed to mental health services and Adult Social Care closed the case.

6.1.40 **First Choice Homes Oldham**

6.1.41 First Choice Homes had contact with Steven when he was referred to them or presented to them as homeless. He was provided with temporary hotel/ bed and breakfast accommodation on two occasions, but other residents found him to be difficult and intimidating. In March 2016, he caused damage to a windowsill at a hotel by burning it with his lighter. This caused FCHO staff to make a referral to Adult Social Care on 23 March 2016 which was repeated on 31 March 2016 as it was apparently not received.

6.1.42 FCHO had sporadic involvement with Steven as he moved between the community, hospital and prison. Staff were aware of his alcohol misuse and liaised with other agencies in order to help him. In June 2016 FCHO recorded following a conversation with mental health professionals that Steven did not have mental health issues but that his issues were drug related. The panel thought that this was an example of a perception of Steven affecting his treatment and potentially the services he received. This is a learning point.

6.1.43 **HMP**

6.1.44 Steven had been an inmate at HMP on a number of occasions. The last of those began on 17 October 2016. Steven received a comprehensive initial assessment from Healthcare

staff on reception and was prescribed a detox regime for his identified alcohol dependence. He was also referred to the secondary mental health team [GMMH Mental Health Inreach Team]. Steven was also referred to and assessed by the prisons Integrated Substance Misuse and Recovery Services [ISMS] to address his substance misuse issues.

6.1.45 On 18 October 2016, Steven was assessed by a member of the HMP Recovery Team. At this assessment the Recovery Team completed harm reduction sessions with Steven including: overdose awareness; synthetic cannabinoids harm and reduction (NPS)[8] and, Hepatitis harm reduction. Steven was seen on a further 3 occasions by the recovery team prior to his release.

6.1.46 On 1 January 2017, Steven told a known person that he was going to be released on 13 January 2017 and "the devil had told him to kill all the children and their families". This information was given to a prison officer who subsequently submitted a Security Information Report containing the information on 12 January 2017 some eleven days later. Prior to that the information appears to have been shared informally with healthcare staff. There is evidence that healthcare staff knew about it from at least 9 January 2017 and the information was included in the TARA risk assessment of 10 January 2017. [see 6.2.3]

6.2 What did your agency do with that information and did you complete a risk assessment, if so what risk assessment tool did you use?

6.2.1 OASys[9] risk assessments were completed by CGMCRC on 19 January 2016, 17 February 2016 and 8 April 2016.

6.2.2 PCFT staff in both the inpatient and community settings regularly completed and reviewed Steven's risk using PCFT's Trust Approved Risk Assessment [TARA] tool in line with Trust policy. The identification and formulation of risk was shared amongst all agencies involved within Steven's care throughout.

The risk domains captured by the TARA risk assessment tool, are:

- harm to self and suicide
- harm to others and violence
- self-neglect
- exploitation and vulnerability

[8] New Psychoactive Substances

[9] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation service nationally from 2002 to measure the risks and needs of criminal offenders under their supervision.

All these domains are considered for both past and present risks, and the factors that increase or decrease the risk, in order to generate the risk formulation. The assessment also considers any safeguarding concerns to be highlighted and considered within the body of the assessment. The TARA provides a narrative summary of risk but does not have a facility to apply a grading e.g. low, medium or high risk.

6.2.3 On 10 January 2017, a risk assessment was recorded by Pennine Care NHS Foundation Trust using their Trust Approved Risk Assessment [TARA]. Steven's probation officer, care coordinator [PCFT] criminal justice mental health team, community drug and alcohol services and GMMHT Inreach Team were all involved in the assessment. This assessment provides a summary of Steven's history and risks posed by him to himself and others. It did not however include all of the information that was available in relation to the risks Steven posed to himself, examples not included are;

- It was recorded in the assessment completed at the end of a previous prison sentence in March 2015 that he had previously doused himself in petrol and had threatened to kill himself. [believed to relate to an incident in 2011]
- On 29 March 2016, Steven caused damage to a windowsill in his hotel room using a cigarette lighter.
- On admission to Parklands house on 20 April 2016 Steven said "if I had a firearm, I'd blow my head off".
- On 13 October 2016, when Steven was reported as a missing person police were told that he had previously tried to take his own life by jumping from a bridge.

This information was available to those completing or contributing to the risk assessment either through personal knowledge or access to their own agency records and its omission from the assessment is a learning point. The TARA risk assessment does not provide an opportunity to conclude what level of risk is posed, for example High, Medium or Low or a numerical scale. The panel thought that the risk assessment would be improved by having that facility.

6.3 What was the outcome of the risk assessment and who did your agency share it with?

6.3.1 The OASys risk assessments completed by CGMCRC assessed Steven as presenting a low risk of serious harm [10] to others and a high risk of reoffending. They noted that he presented a risk to himself through self-harm. The risk of self-harm is not graded as there is no facility within OASys to grade risk to self.

6.3.2 HMP had access to the OASys assessments and the information in them was shared verbally with other agencies including mental health.

---

[10] Low risk OASys definition is: Current evidence does not indicate likelihood of serious harm.

6.3.3 The Pennine Care NHS Foundation Trust TARA of 10 January 2017, was shared with the agencies who had been involved in its completion. It was also available to the two consultant psychiatrists and the approved mental health practitioner who examined Steven on 12 January 2017.

6.3.4 The risk assessment contained the information that Steven had been heard to say he would kill a child and any adult with them. Steven denied saying this when asked about it by healthcare staff and as they were unable to trace the source of the information it was considered to be unreliable and little weight was given to it.

6.3.5 Prisons in England and Wales process information and intelligence according to the National Intelligence Model[11] [NIM]. Intelligence [security information] reports are graded using a 5 x 5 system. This evaluates

1. The source of the intelligence [A-E]
2. The reliability of the intelligence [1-5]
3. How the intelligence should be managed and shared [1-5]

The most reliable intelligence is graded as A11 meaning that the source is always reliable, that the information is known to be true without reservation and that it can be shared with other law enforcement agencies.

6.3.6 The report detailing Steven's comments was graded as B21. This means that the source of the information is mostly reliable, that the information is known to the source but not to the person completing the report and that it can be shared with other law enforcement agencies.

6.3.7 An intrinsic part of the NIM system is that the source of the intelligence is never revealed. Therefore, when healthcare staff attempted to find the source of the information the system worked and they were unable to do so. In the experience of the chair and author a grade of B21 applied to an intelligence report provides a high level of confidence in relation to the intelligence it contains. The fact that healthcare staff could not find out the source of the information should not have affected how they used the intelligence. This is a learning point.

6.3.8 What may have affected what weight that was given to the information is that it had

[11] The National Intelligence Model [NIM] is a well-established and recognised model within policing that managers use for: Setting strategic direction. Making prioritised and defendable resourcing decisions. Allocating resources intelligently. Formulating tactical plans and tasking and coordinating resulting activity.

become known informally to healthcare staff at some time between 1 January 2017 and 9 January 2017. The Security Information Report containing the graded information was not submitted until 12 January 2017. Whilst this was in time for Steven's mental health assessment the fact that healthcare staff had previously tried to and been unable to find the source of the information may have affected how the information was regarded. The psychiatric team that assessed Steven on 12 January 2017, spoke to the prison officer who had reported the information and asked who had told him what Steven had said. The prison officer told them that he could not remember [while he may have forgotten, the SIR names the person giving the information]. The prison officer acted correctly in not revealing the source of the information but the assertion that he had forgotten the source of the information further downgraded the validity of it in the minds of the psychiatric team. It would have been more appropriate for the officer to say what the strength of the information was.

6.3.9 The information was also shared with Greater Manchester Police who recorded it on their intelligence system and CGMCRC. Steven's probation officer at CGMCRC considered that the information was of poor quality and did not warrant further action. [Ref para 6.1.7]

6.4 What did your agency do to secure, or help secure, accommodation for Steven prior to his release from HMP on 12 January 2017?

6.4.1 On 14 December 2016 a Care Programme Approach[12] meeting took place at HMP in relation to Steven's case. Steven was invited to but did not attend the meeting. Attendees were:

- Prison staff/offender supervisor
- Shelter
- CGMCRC
- Care coordinator, PCFT

The meeting focussed on Steven's mental health and accommodation and addressed the preparation for his safe release from prison.[13] It was discussed;

- That there would be a Mental Health Act assessment at the point of release to explore the possibility of Steven being detained under the Mental Health Act.

[12] The Care Programme Approach (CPA) is a package of care that may be used to plan mental health care. This factsheet explains what CPA is, when you should get and when it might stop. • The Care Programme Approach (CPA) is there to support your recovery from mental illness • CPA is a framework used to assess your needs. And make sure that you have support for your needs. • Community Mental Health Teams, Assertive Outreach Teams and Early Intervention Teams are likely to use CPA. • Your mental health services will have policies about who is able to get help under CPA. • Under CPA you will get a care coordinator who monitors your care and support. • Your care coordinator will review your plan regularly to see if your needs have changed. (source www.nhs.uk/conditions/social-care-and-support/care-programme-approach/

[13] Section 117 of the Mental Health Act says that aftercare services are services which are intended to meet a need that arises from or relates to a person's mental health problem, and reduce the risk of their mental health condition getting worse, and them having to go back to hospital. This covers things like healthcare, social care and supported accommodation.

- CGMCRC to ascertain if Steven could be accommodated in an approved premises. Reservations were expressed as to whether this would be possible.

6.4.2 Some of the meeting attendees went to see Steven on the prison wing as he had refused to attend the meeting. He refused to discuss anything about accommodation options or his mental health.

6.4.3 Following the meeting, enquiries were made to find Steven accommodation at National Probation Service Approved Premises. This was unsuccessful as he was assessed as presenting a low risk of serious harm to the public**.** Approved premises are normally reserved for those assessed as presenting a high risk of serious harm to the public. Although Steven had many problems, his low level anti-social behaviour and drunken offending did not present a high enough risk balanced against the needs of others of higher risk for him to be found accommodation in this way.

6.4.4 Shelter is contracted by CGMCRC to provide housing advice to inmates at HMP. Steven's case was allocated to a Shelter worker on 7 December 2016 and attempts were made to engage with Steven around his housing needs. The worker allocated Steven's case attempted to engage with him a number of times but was unsuccessful. Steven indicated that he would 'sort himself out'. On 12 January 2017, after a decision was made not to detain Steven under the Mental Health Act, he was given a letter to take to the homeless section of the area that he chose to go to on his release. Steven had previously said he would go to Oldham and therefore an appointment was made for him at First Choice Homes.

6.4.5 During previous periods when Steven was in hospital earlier in 2016, attempts were made to find suitable accommodation for him. A number of providers were unable to offer a placement due to his previous behaviour and complex needs.

6.5 What consideration did your agency give to Steven's financial circumstances and did he have a Care Act [Care and Support] assessment?

6.5.1 CGMCRC were aware of Steven's financial circumstances and on occasions gave him money for bus fares so that he could attend at emergency accommodation or other appointments. The focus of their work with him though was in liaising with mental health services. His financial situation was not given priority and his erratic attendance at appointments further exacerbated the challenges in supporting him.

6.5.2 During his time in hospital, Steven was given extensive assistance to contact the Job Centre plus helpline and support him at appointments. However, there were numerous obstacles as Steven failed the security questions and had no personal identification such as a passport, which complicated his claim for financial assistance. The benefits system is not easy to negotiate for someone with Steven's complexities and the attempts to do so

were largely unsuccessful.

6.5.3 The panel identified two periods of hospital admission during which it felt a Care Act assessment should have been conducted and was not. Please refer to paragraphs 6.1.21 and 6.1.25

6.5.4 During Steven's time in hospital from July to October 2016, there is evidence of a joint care and support assessment being completed and regularly reviewed within the Multi-Disciplinary Team ward round. The care coordinator, following discharge from hospital, would have continued to review and update the care and support assessment. However, because Steven discharged himself from hospital earlier than expected and the team were unaware of his whereabouts, they were unable to complete this.

6.5.5 Steven was unwilling to engage with the process whilst he was in prison and therefore a Care Act [Care and Support] assessment was not completed whilst he was in prison. On his release from prison on 13 January 2017 Steven had an appointment to attend at the Community Mental Health Team. His financial circumstances would have been addressed and a Care Act [Care and Support] assessment completed had he attended the appointment.

6.6 What medication did your agency prescribe or supply to Steven?

6.6.1 During Steven's hospital admissions in the timeframe of the review he was prescribed a number of antipsychotic, anxiolytics, benzodiazepines, mood stabilizing, analgesics and laxative medications as listed below.

Flupenthixol, Sertraline, Procyclidine, Promazine, Zopiclone, Lorazepam, Clonazepam, Paracetamol and Senna.
These medications and the doses were changed in accordance with the treatment plan and his presenting symptoms at the time whilst an inpatient.

6.6.2 Steven relied heavily upon PRN[14] medication predominantly Lorazepam for agitation and poor sleep. On the 17 May 2016, staff refused to give Steven PRN Lorazepam when he requested it as they felt his presentation was behavioural rather than a deterioration in his mental state. It was unclear if Steven was given or engaged in any education around his prescribed medications.

6.6.3 Upon arrival at HMP on 17 October 2016, initial health screening identified that Steven had been drinking heavily and he was prescribed a standard reducing alcohol

[14] Abbreviation meaning "when necessary" [from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed]

detoxification regime. This included: chlordiazepoxide 10mg, 24 tablets over 5 days, chlordiazepoxide 5mg, 16 tablets over 6 days, thiamine 100mg, 2 tablets twice daily for 28 days, and vitamin B compound tablets, 1 tablet twice daily for 28 days. Nursing staff monitored Steven's alcohol withdrawal daily and no concerns were raised during his detoxification.

6.6.4 As he was already known to the Mental Health Inreach Team an appointment was quickly made with the prison's visiting consultant forensic psychiatrist [Doctor A]. Steven refused to attend this and a further appointment and as a result was visited in his cell on 29 November 2016 by the visiting consultant forensic psychiatrist. Steven was adamant that he would not take any anti-psychotic medication and said, 'you lot sent me to hospital last time". Doctor A formed the view that Steven had a clear diagnosis of Paranoid Schizophrenia and believed that a further period of treatment may be required on release from prison in January 2017.

6.7 What mental capacity assessment[s] were completed by your agency, what assessment tool was used and what was the outcome?

6.7.1 On 20 May 2016 and 25 June 2016, whilst in police custody, Steven was seen by a police appointed healthcare practitioner. On both occasions he was assessed as having full mental capacity to make his own decisions. There is however no evidence of a formal mental capacity assessment being conducted.

6.7.2 After his admission to hospital from prison on 14 July 2016, an assessment under The Capacity to Consent to Treatment Record [The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2012] was completed. These records ascertained if Steven understood the proposed treatment and asked for his views regarding the treatment and his options. Steven was deemed not to have the capacity to consent to treatment.

6.7.3 There was only one recorded capacity assessment completed in accordance with the Mental Capacity Act 2005, whilst Steven was in hospital. This was when he discharged himself on 6 October 2016 the day after a mental health tribunal had released him from detention under the Mental Health Act. He was seen by an advanced nurse practitioner on discharge who recorded that Steven had the capacity to make unwise decisions in relation to homelessness and drink and drugs. The lack of capacity assessments may have been as a result of staff's understanding and application of The Mental Capacity Act 2005 principles which they felt did not require them to complete a mental capacity assessment.

Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be

able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

6.7.4 At a multi-disciplinary team meeting on 7 November 2016 an action was agreed to ask that GMMH NHS FT staff in the prison Mental Health Inreach Team to complete decision specific capacity assessments around accommodation and finances. This was recorded in the minutes of the meeting. GMMH NHS FT staff had been invited but were unable to attend. The assessments had not been completed by the time of a Care Plan Approach meeting held at HMP on 14 December 2016. The panel discussed the importance of clearly recorded and allocated actions together with a timely process to notify those not present at a meeting when actions have been allocated to them.

6.7.5 The meeting on 14 December 2016, agreed that decision specific capacity assessments would be completed in relation to accommodation and engagement with services prior to Steven's scheduled release from prison on 13 January 2017. Minutes of the meeting record that GMMH NHS FT staff at the meeting agreed to ensure that this was done within 'the next few days'. The purpose of the assessments was to contribute to the formulation of his care plan and ongoing aftercare arrangements in accordance with section 117 Mental Health Act. There is no evidence that these assessments were completed.

6.8 Were there any opportunities missed by your agency to raise a safeguarding adult alert and request or hold a strategy meeting?

6.8.1 There is evidence of opportunities missed by PCFT to support Steven. For example, on Thursday the 24 March 2016, PCFT staff were alerted to Steven being apparently

mentally unwell whilst residing at a hotel following his release from prison. Concerns were raised by a housing officer at First Choice Homes who also made a referral to Adult Social Care. The PCFT duty officer discussed the concerns raised by the housing officer with their team manager and rather than offering an immediate duty visit, offered an appointment for Tuesday 29 March 2016, five days later. It is believed this was due to it being Easter Bank Holiday Weekend. [Good Friday was 25 March 2016 and Easter Monday 28 March 2016]. The panel thought that PCFT staff should have gone to see Steven and explored other options, for example deploying the Home Treatment Team or a referral to Oldham Emergency Duty Team.

6.8.2 This decision resulted in a significant delay in Steven receiving appropriate treatment and care and the opportunity to complete a full, comprehensive, holistic risk assessment and assessment of his mental health was missed. The panel thought that staff should have considered raising an adult safeguarding concern. It is of note however that First Choice Homes had already done so. This appears not to have been received by Adult Social Care but when it was sent again on Thursday 31 March 2016, Adult Social Care's response was to email the information to PCFT and close the case. The panel thought that this was a missed opportunity to assess Steven's needs. This is a learning point.

6.8.3 On 29 March 2016, Steven attended the mental health outpatient clinic and was seen by PCFT staff. There was clear evidence of deterioration in Steven's mental state, but the focus of the appointment was on his homeless status and lack of finances. PCFT staff liaised with First Choice Homes but there was no immediate solution found. Steven agreed to a follow up appointment on 7 April 2016 and left saying he was going to see his probation officer [he did not do so]. There is no clear rationale as to why PCFT staff did not consider an assessment under the Mental Health Act 1983, an informal admission to the inpatient services or a safeguarding alert.

6.8.4 Following his release from prison on 23 March 2016, Steven attended appointments with CGMCRC on eight occasions up to May 2016. This was unusual and against his normal pattern of failure to attend appointments. During this period a deterioration in Steven's mental and physical health was noted and it was known that he was not taking medication. Whilst there was some liaison with mental health services a safeguarding adult alert may have provided the opportunity to hold a strategy meeting and precipitate a multi-agency approach to Steven's issues. This has to be balanced against the likelihood of Steven consenting to or cooperating with the referral, but it does not seem that a referral was considered.

6.8.5 Following the decision on 12 January 2017 not to detain Steven under the Mental Health Act it was clear that he was to be released on 13 January 2017 with no accommodation and little money. [Steven was given the standard release grant of £48 in cash] Steven was given an appointment to attend at PCFT and a travel ticket, with a plan that staff

there would then help him to attend other appointments, for example at First Choice Homes. A referral to Adult Social Care could have been considered by any agency involved. The panel noted that as Steven was known to mental health services the outcome of a referral on 23 March 2016 and 31 March 2016 was that information was sent to PCFT. It is likely that the outcome of a referral on 12 January 2017 would have been the same. The panel felt there was no overall risk picture for when Steven was not detained under the Mental Health Act. There was a failure to recognise persistent and escalating risks and lack of curiosity about the meaning of his behaviour.

6.9 What consideration did your agency give to referring Steven to MAPPA? [Multi-Agency Public Protection Arrangements]

6.9.1 The MAPPA [Multi-Agency Public Protection Arrangements] is a national framework to assess and manage the risk posed by serious and violent offenders. The MAPPA cannot address the risks posed by all potential offenders and its focus is convicted violent and sexual offenders living in, or returning to, the community. In order to qualify for management under the MAPP Arrangements an offender must fall into one of three categories being:

- i) A registered sexual offender
- ii) A violent or other (not registered) sexual offender who receives a custodial term of 12 months or more, or
- iii) Other dangerous offender i.e. a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.

6.9.2 On the basis of the convictions for which he was in prison, Steven was correctly allocated to CGMCRC. These offences were not themselves MAPPA eligible offences although Steven was a MAPPA eligible offender on the basis of his previous convictions. Active consideration was not given Steven's MAPPA eligibility and a referral was not contemplated by his probation officer. Although Steven was MAPPA eligible on the basis of his previous convictions the panel heard from a Senior Probation Officer [National Probation Service] that even if referred to MAPPA there is a high degree of likelihood that his case would have been screened out due to the high volume of other higher risk cases to be considered.

6.9.3 On 11 January 2017, CGMCRC were contacted by PCFT and told of the information received to the effect that Steven had threatened to kill a child, and any adult that child might be with, on his release from custody. Steven's responsible officer was of the view that the information received was of such poor quality that it was not possible to reassess the risks posed by Steven on the basis of it. The responsible officer thought that despite this information there was no credible evidence that Steven was capable of causing

serious harm to himself or others and that multi-agency working, beyond the liaison which was already in place, was not required. The panel discussed this and thought that it was a dismissive and overly optimistic view given Steven's history of disengagement from services. That needs to be balanced against the reality that even if Steven's risk had been escalated it would have been extremely challenging to call a MAPPA meeting before Steven's release from prison.

6.10 **Did your agency have any resourcing issues when assessing or providing services to Steven?**

6.10.1 It is clear that Steven required an assertive outreach approach in order to have the best chance of engaging and supporting him. PCFT do not have a separate assertive outreach team, and this function is imbedded within its Community Mental Health Team. The panel heard that the level of support required for an assertive outreach approach is difficult to maintain within the CMHT provision.

6.11 **What consideration did your agency give to diversity issues when dealing with Steven?**

6.11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

6.11.2 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol

addiction is not, therefore, covered by the Act.

6.11.3 It should be noted that although addiction to alcohol nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014[care and support] assessment is completed.

When determining eligibility under the Care Act, local authorities must consider the following three conditions.

Condition 1

The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

This includes if the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

Condition 2

As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section 'Eligibility outcomes for adults with care and support needs'.

Condition 3

As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

6.11.4 The panel felt that despite the complications of his various diagnoses over time, Steven's mental health was such that it had a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities. Most of his contact with services came about as a result of his mental health. There is no evidence of any negative bias in the provision of services to Steven because of his mental health. Indeed, the opposite is the case. Steven was provided with many services and offered others that he declined.

6.12 What has your agency learned from completing your review?

6.12.1 PCFT

- The importance of a shared patient record to ensure effective communication between PCFT services regarding patient care.
- The need for services within PCFT to be aware of each other's involvement. This would enable sharing information, developing a fuller picture of the patient taking into account the perspectives of colleagues from other services.
- The importance of timely incident reporting to support risk assessment and decision making.

- To ensure practice standards are of a high quality and are understood and adopted by staff. This will support the delivery of 'safe' and 'effective' patient care.
- The importance of identifying and acting upon patient vulnerability where mental capacity is deemed to be present.
- The need to review the TARA risk assessment.

6.12.2 **CGMCRC**

- There is a lack of clear guidance within the organisation around adult safeguarding. As a result of research completed in line with this review it has been established that Adult Safeguarding Practice Guidance has been created but is currently in draft form only. This now needs to be finalised and disseminated to staff.
- There is a lack of understanding amongst staff of the principles which underpin adult safeguarding. There is insufficient knowledge of the relevant legislation and the action should be taken in the event of adult safeguarding concerns.
- Although TTG [Through The Gate] procedures and guidance are well developed, these are not used effectively within CGMCRC. The effective use of TTG procedures needs to be embedded into standard practice.

6.12.3 **GMMH NHS FT:**

- The Trust acknowledges as professionals we must practice 'Professional Curiosity', which is the capacity and communication skill to explore and understand what is happening and why. Rather than making assumptions or accepting things at face value.
- It's also equally important for decisions around capacity to be fully documented in a person's records, which will evidence how professionals have demonstrated a person has capacity to make decisions unless it's established the person lacks capacity.
- The Trust recognises the important role of service co-ordination, communication and accountability and the difficulties of establishing a shared ownership and approach to the challenges of engagement and of balancing autonomy with a duty of care.

6.13 **What outstanding or innovative practice did your agency identify?**

The review did not identify any outstanding or innovative practice. However, the panel recognised that many practitioners worked hard and with compassion in an attempt to support Steven.

7 **SAR Panel Learning**

Each learning point it preceded by a contextual narrative.

7.1 **Narrative**

Steven's case was challenging for the professionals involved. His repeated failure to attend appointments and conform to societal norms meant that he disappeared from the view of services only to re-emerge when he was arrested or otherwise in crisis.

Learning

The use of standard processes [for example letters and appointments] which anticipate service user cooperation is not successful in all cases. Other options for example assertive outreach need to be employed with some individuals who are hard to keep engaged in services.

7.2 **Narrative**

Steven was assessed on one occasion to have mental capacity and assumed to have capacity on other occasions. Professionals did not recognise his self-neglect and were not equipped to deal with his risky behaviour.

Learning

Professionals would benefit from a framework for working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services.

7.3 **Narrative**

Steven's mental health diagnosis changed over time and was sometimes unclear to professionals. Perceptions of Steven which were not always supported by a diagnosis sometimes affected the services he was offered.

Learning

The working diagnosis [the latest diagnosis] together with historical information should be clearly identified and used to inform risk assessments and care plans.

7.4 **Narrative**

Steven's mental capacity was questioned on many occasions, but the panel has seen evidence of only one formal mental capacity assessment.

Learning

The completion of formal decision and time specific mental capacity assessments can help to formulate risk assessments and care plans and assists in the provision of appropriate services.

7.5 **Narrative**

When information was received by staff at HMP that Steven may pose a risk to others on

his release the information was not formally recorded or graded promptly and was shared informally with healthcare staff. This led to misunderstandings about the quality of the intelligence which were not resolved.

Learning

Prompt recording, grading and formal sharing of intelligence is necessary in order to ensure that professionals have the right information to inform decision making. Healthcare staff need to understand what intelligence gradings mean and be able to apply that knowledge to their risk assessments.

7.6 **Narrative**

Multi-disciplinary Team and Care Programme Approach meetings took place in relation to Steven. These generated actions which were not agreed or communicated and were not acted upon.

Learning

Actions from such meeting need to be agreed by all present and be Specific, Measurable, Achievable, Realistic, Time bound [SMART]. A process needs to be in place to notify professionals not present at meetings that they have been allocated an action prior to the minutes being available.

7.7 **Narrative**

When the mental health assessment of Steven which took place on 12 January 2017 concluded that he was not detainable under the Mental Health Act he was released from prison the following day with a series of appointments to attend. Steven's history should have made it obvious that there was a low chance of him attending them.

Learning

Where a mental health assessment is planned to consider detention under the Mental Health Act immediately prior to a person's release from prison, a contingency plan should be developed to manage the release and engagement with services in the event that a decision not to detain under the Mental Health Act is made.

8 Conclusions

8.1 In coming to conclusions, the panel have taken into account the conclusions of the inquest and two separate independent reviews which have previously taken place into the circumstances surrounding Steven's death.

8.2 The coroner's verdict as recorded in Steven's death certificate was:
"The deceased took his own life whilst the balance of his mind was disturbed in part because the risk of his doing so was not recognised and appropriate precautions were not

put in place to prevent his doing so".

8.3

The Prisons and Probation Ombudsman report concluded:

*Steven had complex mental health needs and received a good deal of attention from the mental health team at HMP who managed him well. They attempted to secure his admission to hospital under the Mental Health Act following his release. However, at a formal assessment it was decided that he was not detainable.

While in custody there was no suggestion that *Steven was at risk of suicide or self-harm, and no monitoring was deemed necessary. I am satisfied that staff at HMP did all they could to manage his risk appropriately and that they made appropriate plans and preparation for his release.

8.4 The Prisons and Probation Ombudsman commissioned an independent clinical review of the care that Steven received whilst in HMP which concluded:

In conclusion I believe that overall the care that Steven received from healthcare staff at HMP was at least equivalent to the care he would have received in the community. Steven's mental health care was well managed by the Mental Health Inreach Team; in particular Nurse 1 appears to have provided a high standard of care. There was recognition that Steven's schizophrenia required assertive management due to his lack of insight, the negative symptoms of his psychotic illness and the likelihood that he would disengage from services.

I do have concerns that there was a missed opportunity to provide Steven with a further period of assessment and treatment. In my opinion from a review of *Steven's healthcare records there was adequate evidence that *Steven had a past history of a treatable mental illness and that his health was at risk on release from prison without appropriate care and treatment, Dr B and Nurse 1 supported this view at interview, however this opinion was not supported by Dr A, Consultant Psychiatrist and AMHP 1.

8.5 Steven spent much of 2016, in hospital or in prison. In the brief spells that he spent outside either institution his behaviour was chaotic and to non-professionals he presented as having bizarre behaviour which caused them to think that he was mentally ill.

8.6 Despite his behaviour, Steven was at times assessed as not being ill but instead suffering from social problems. He was assessed to be fit for detention by healthcare practitioners

whilst in police custody. Psychiatrists did not agree on a single diagnosis and during 2016, Steven was diagnosed as suffering from chronic social problems, EUPD, [emotionally unstable personality disorder] factitious disorder and schizophrenia. This illustrates how complex Steven's case was to manage. The following table summarises his various diagnoses in 2016.

8.7

Dates	Hospital/reason for Stay	Diagnosis
20.4.16. - 20.5.16	Mental Health Ward, Oldham. Informal then S2 Mental Health Act	Chronic Social problems
3.6.16.-15.6.16.	Mental Health Ward, Rochdale. S2 Mental Health Act	Emotionally Unstable Personality Disorder, Factitious disorder
14.7.16.-6.10.16	Mental Health Ward, Oldham. S2/S3 Mental Health Act	Schizophrenia

8.8 Steven had been in hospital and prison many times. There is evidence that he knew how to manipulate the rules of the system. For example, when on escorted leave from hospital he told staff that he knew they couldn't use force to detain him and then went missing. Steven was also familiar at least to some extent with his rights within the law and applied to a mental health review tribunal on two occasions in 2016 to be discharged from detention in hospital. On the second occasion he was successful.

8.9 When he was asked why he took anti-psychotic drugs in hospital but not in the community or prison he said it was because he knew he had to take them in hospital, but he thought they did not help him.

8.10 Steven had been in HMP on a number of occasions. Staff from the Mental Health Inreach Team were familiar with him and tried hard to develop a relationship. When he was due for release on 8 March 2013, he was assessed under the Mental Health Act and found not to be detainable. He was released from prison and within two days had been arrested and sentenced to a further four weeks in prison for breach of a none molestation order.

8.11 On 14 July 2016, when Steven was next due to be released from HMP, he was assessed and detained under section 2 of the Mental Health Act. He was taken to the mental health ward where he was subsequently detained under section 3 of the Mental Health Act until 5 October 2016, when he was successful in being discharged from his detention at a mental health tribunal.

8.12 Extensive attempts to find suitable housing for him had been unsuccessful and on 5 October 2016 he agreed to stay at the mental health ward until something could be found. However, Steven discharged himself from the mental health ward on 6 October 2016. On 7 October 2016, a specialist provider confirmed that they had suitable supported accommodation available for Steven subject to a planned assessment with him on 10 October 2016. Steven did not attend planned appointments and was reported to the police as a missing person by his care coordinator.

8.13 Steven was arrested in a drunken condition on 16 October 2016 and sentenced to four months in prison the following day. There was a delay in his care coordinator being notified of this but by 21 October 2016 the care coordinator was notified and communication established between the care coordinator [PCFT] and the prison Inreach Team [GMMHNFT].

8.14 On 7 November 2016, a Multi-Disciplinary Team took place at PCFT to discuss Steven's case. The HMP Inreach Team were invited but were unable to attend. An action from the meeting was for the prison Inreach Team to conduct mental capacity assessments for Steven in relation to independent living and finances. A similar action was recorded in the Care Programme Approach meeting that took place at the prison on 14 December 2016. There is no evidence that these assessments took place or were attempted. The completion of these assessments would have helped to assess Steven's ability to make informed decisions about looking after himself. The panel noted that there were a number of other occasions throughout the timeframe of the review when mental capacity assessments should have been conducted and were not.

8.15 During a number of interactions with the Inreach Team and Shelter staff in December 2016 and January 2017, Steven made it clear that he would not cooperate with their efforts to help him regarding housing and other matters. He said he would "sort himself out". Steven was reluctant to engage with staff and was guarded in what he said. On one occasion when visited in his cell he simply pulled a blanket over his head ending the conversation. He often declined to attend medical appointments and refused to shower or change his clothes.

8.16 Whilst Shelter staff attempted to engage with Steven, the availability of supported accommodation which had been confirmed on 7 October 2016, does not appear to have been followed up. This accommodation was subject to an assessment which did not take place after Steven left hospital unexpectedly, but it may have been possible to arrange for the assessment to take place whilst Steven was in prison.

8.17 As the time for Steven's release from HMP neared in January 2017, a decision was made by the visiting consultant psychiatrist [doctor B] to conduct a mental health assessment at the time of his release with a view to detaining him in hospital under section 2 of the Mental Health Act. Arrangements were made for Dr A, the consultant community psychiatrist who had been responsible for Steven's treatment in the mental health ward to attend at the prison together with an Approved Mental Health Practitioner. Both assessing psychiatrists were therefore familiar with Steven and his presenting issues.

8.18 Dr A did not agree that Steven needed to be detained and was supported by the AMHP. Dr A thought that the main risk present was Steven's vulnerability through his vagrant lifestyle [self-neglect]. Little weight was given to any risk to others as there was no corroboration of the information regarding Steven's comments to another prisoner. Dr B thought that Steven would benefit from a period of treatment and that there was a risk of deterioration if Steven was not on treatment and continued to drink heavily. Steven's history of self-neglect, risky behaviour and suicidal ideation was taken into account in the assessment. At the point of the assessment Steven did not present a risk to himself other than through self-neglect. The assessment concluded that Steven was not detainable under Section 2 or section 3 of the Mental Health Act.

8.19 Information that Steven had said that "the devil had told him to kill all of the children and their families", was given little weight because the mental health Inreach Team could not corroborate it. This appears to have happened because the information became known to medical staff before it was formally assessed and given a grading. Once it was formally reported and assessed on 12 January 2017, the information should have been given due consideration according to the formal assessment of the information as 'B21'. [para 6.3.5 et al]. The panel considered this point and thought that if greater weight had been given to this information then Steven would have been more likely to be detained under the Mental Health Act.

8.20 Once the decision was made at around 5 PM 12 January 2017, not to detain Steven under the Mental Health Act there was little time left to put other things in place. Steven was to be released the following morning with appointments to attend at the CMHT, housing and probation. The location of his CMHT appointment was changed by a PCFT manager to ensure that Steven could be provided with appropriate assessment and treatment if necessary. It was planned that once Steven attended the CMHT appointment someone from that team would accompany him and assist him with his other appointments.

8.21 On 13 January 2017, nurse 1 from the mental health Inreach Team attended at prison reception to see Steven as he was being released. He had hoped that his brother would pick him up, but this was not possible as his brother was starting a new job. The nurse made sure that Steven had enough money to get to his appointments and that he knew how to get there. Steven left and was not seen again until he was found on fire in the

early hours of the following morning. The police investigation showed that he had bought petrol, poured it on himself and set himself on fire.

8.22 It may have been possible for a professional known to Steven to have taken him to his first appointment. The panel thought that this could have been a professional from a number of agencies including CGMCRC and CMHT. It would also have been possible to order a taxi to take him to his first appointment. These options were not considered. The panel also reflected that even if Steven had been offered a lift or a taxi to his CMHT appointment he was under no obligation to take it. Given his relative lack of engagement with workers in prison and his history of failing to attend appointments the plan for him to attend of his own volition had a relatively low chance of success.

8.23 The panel discussed whether a transfer from prison to hospital under section 47 Mental Health Act could have taken place. The panel were told that this is a lengthy process. As Steven was on a normal prison wing and was not presenting as a risk to self and or others that warranted a Mental Health Act assessment being arranged, a transfer under section 47[15] would not have been appropriate. There is however no record of it being considered. It appeared to the panel that too much reliance was placed on him being sectioned a few days before release.

9 Recommendations

9.1 That Oldham Safeguarding Adult Board should seek assurance from its partners that appropriate assertive outreach capacity is in place to deal with adults who have capacity but put themselves at risk by making unwise choices.

9.2 That Oldham Safeguarding Adult Board should consider developing a framework for working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services.

9.3 That Oldham Safeguarding Adult Board should seek assurance from its constituent partners that a patients working mental health diagnosis [the latest diagnosis] is clearly identified and used to inform risk assessments and care plans.

9.4 That Oldham Safeguarding Adult Board should consider a multi-agency audit of the use of mental capacity assessments and develop an action plan informed by the results.

9.5 That HMP and GMMH NHS FT should provide assurance to Oldham Safeguarding Adult Board that workforce development has taken place in relation to the recording, grading

[15] 47Removal to hospital of persons serving sentences of imprisonment, etc. www.legislation.gov.uk/ukpga/1983/20/section/47

and sharing of intelligence.

9.6 That Oldham Safeguarding Adult Board should arrange for the learning from this review in relation to the need for actions from MDT and CPA meetings to be SMART to be shared with its partners and to ensure that processes are in place so that professionals who are not present at meetings, and have been allocated actions, are notified without delay.

9.7 That GMMH NHS FT ensures where a mental health assessment is planned to consider detention under the Mental Health Act immediately prior to a person's release from prison, Multi-Disciplinary Team meetings and Care Programme Approach meetings should develop a contingency plan to manage the release and engagement with services in the event that a decision not to detain under the Mental Health Act is made.

Appendix 1: Table of Notable Events

Date	Event
Pre 1 January 2016	
28.02.06	Diagnosis of paranoid schizophrenia.
29.12.13	Sentenced to 15 months in custody; assault occasioning actual bodily harm.
24.03.14	Prison medical notes self-report his diagnosis as Paranoid Schizophrenia. Confirmed with his Care coordinator.
10.11.15	Sentenced to 18 weeks custody for Breach of Anti-Social Behaviour Order x 2. A Probation pre-sentence report recorded: It is also noted that a mental health assessment had been carried out prior to completion of the report. It is stated that this assessment concluded that Steven was not mentally ill and that issues linked to his cognition and presentation were a result of prolonged alcohol abuse/ withdrawal. This information was obtained by the report writer through discussion with the relevant mental health professionals. The report identified that Steven presents a medium risk of serious harm[16] [ROSH] to the public and a high risk of re-offending.
27.11.15	Steven was in HMP and assessed by a Consultant Forensic Psychiatrist who noted that he remained delusional and lacked insight into his mental health issues. He was due to be released from prison on 8 January 2016.
Post 1 January 2016	
08.01.16	Steven was released on standard licence conditions to Cheshire and Greater Manchester Community Rehabilitation Company (CGMCRC) management. He failed to report to its Oldham office that day.
08.01.16	Steven is in Oldham Town Centre and calls the police via 999 saying he has a head injury. Upon arrival Steven is located in possession of a bible and is quoting passages whilst saying he was an American soldier. He was detained under Section 136 Mental Health Act 1983 and taken for assessment at the Royal Oldham Hospital. A referral sent to Adult Social Care.

[16] Medium risk of Serious Harm:
There are identifiable indicators of ROSH. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse. Ministry of Justice Multi-Agency Public Protection Arrangements Guidance 2016.

08.01.16	Steven was assessed by qualified staff from Pennine Care NHS Foundation Trust and discharged from Section 136 and further enquiries were made regarding housing.
09.01.16	The out of hours duty officer from First Choice Housing Oldham (FCHO) received a telephone call from the Council's emergency duty team. Steven was found a place at the Wilton Grange, a local private accommodation supplier.
12.01.16	CGMCRC: recall to prison for breaching his licence rejected for now; give him a chance to report. Low risk of causing serious harm to public.
19.01.16	Offender Assessment System (OASys) by CGMCRC; low ROSH to the public.
27.01.16	Steven turned up at his mother address in Warrington in breach of a non-molestation order. He requested money having recently come out of prison.
16.02.16	CGMCRC: A fixed term recall i.e. 14 days to allow for accommodation issues to be addressed is requested.
24.02.16	Steven is arrested on revocation of prison licence and transported to a police custody office.
25.02.16	Steven given to GEO Amey for transport to HMP.
01.03.16	HMP: Steven was remanded back into custody and he presented as delusional, hostile and had deteriorated since he had last been in HMP. He had been non-compliant with his medication in the community. He had been remanded due to licence recall and anti-social behaviour in the community. He self-reported that he had been homeless.
07.03.16	PCFT: HMP Mental Health Inreach Team (MHIT) requested a Mental Health Act assessment.
08.03.16	PCFT: Mental Health assessment; the decision was made to use least restrictive option and Steven was subsequently released from prison to engage with the Community Mental Health Team [CMHT].
08.03.16	CGMCRC: Steven released on standard licence from HMP Forrest Bank. Fails to attend probation office. [This is the 2nd time within the review period]
10.03.16	CGMCRC: Steven in Runcorn Magistrates' Court for Breach of Non-

	Molestation Order. On release from custody he walked to his mother's home. Sentenced to 4 weeks custody
23.03.16	Steven released from HMP to a hotel, standard licence conditions; told to report to Oldham probation office.
23.03.16	FCHO: Steven presented to homeless to duty officer. Released from HMP today and has nowhere to stay - referred by Probation. Accommodated in a hotel overnight and assessment booked for 9.00 am 24.03.16
24.03.16	FCHO: Steven presented as homeless. Hotel accommodation provided. Telephone call from the hotel Steven behaving erratically.
24.03.16	FCHO: referred Steven to Adult Social Care [ASC]; case urgent.
29.03.16	FCHO: Returned to First Place [FCHO Offices] following the bank holiday weekend at the hotel who will not have him back because he smoked in the room and caused some fire damage to window sill by burning it with his lighter. FCHO arranged a taxi to get him to the mental health clinic [Oldham Community Mental Health team] for his 2pm appointment. Phoned the mental health clinic who confirmed that he had arrived.
31.03.16	ASC received a referral from FCHO [a re-referral of the 23.03.16.]
05.04.16	GP received a Letter from mental health liaison team, at Calderdale Royal Hospital [West Yorkshire]. Steven found by police at the side of the motorway, asleep after stating he had been walking a long time. Taken by ambulance to A&E at Huddersfield Royal Infirmary and referred to mental health liaison. Steven was later discharged.
05.04.16	FCHO: Returned a call to Housing Solutions Kirklees [West Yorkshire] who raised concerns for Steven's welfare as he was found sleeping at the side of the M62 motorway in Kirklees. Explained what was happening with regards to Steven and his housing situation. They will keep him for one night and advised him to return to the mental health clinic tomorrow.
06.04.16	CGMCRC: Steven's licence period ends. He is now subject to Post Sentence Supervision. He is subject to conditions akin to those in his licence. It is however no longer possible to recall Steven to custody for a failure to comply. In the event of any such failure, enforcement action should be taken. It is possible to seek a 14-day custodial term on an application to enforce.
08.04.16	OASys by CGMCRC; low ROSH to public.

13.04.16	Steven is located by a Police Community Support Officer [PCSO] on the car park of an NHS building where school nurses, health visitors and safeguarding teams are based. Steven was showing signs of mental health crisis; talking about being executed and being able to travel in time. North West Ambulance Service [NWAS] attend and Steven is handed over to their care.
18.04.16	Steven arrested for trespassing on a railway. Seen by health care practitioner in custody, assessed by a police appointed medical practitioner. Enquiries are made with Mental Health services but he is not subjected to a full mental health assessment in custody. Steven is afforded the services of an appropriate adult in custody. He is released after being dealt with by way of summons with an appointment to attend at mental health services at 14:30 the following day.
20.04.16	Steven was admitted to mental health ward as an informal patient.
22.04.16	PCFT: Steven was seen by Dr A, but refused to answer questions. He was placed on a Section 5(2) MHA[17] and a medical recommendation for Section 2 MHA was completed. Steven presented with delusional ideas and thought disorder. Steven had left the ward on 22 April 2016 and returned 8 hours later, reasoning irrational, not agreeing to stay as informal patient.
23.04.16	PCFT: Referral for MHA assessment made to EDT following detention under Section 5(2). Steven did not agree to remain on the ward for assessment, therefore Section 5(2) was implemented. Referred to daytime Approved Mental Health Practitioner (AMHP) to complete.
25.04.16	PCFT: Detained under Section 2 MHA.
25.04.16	FCHO: Received a call from staff memeber on the mental health ward, requesting a letter confirming homeless officer as he has no proof of ID for credit union account. Letter sent to staff member confirming his homeless officer details.
27.04.16	Section 17 MHA leave[18]: up to three hours to sort out benefits
20.05.16	PCFT: Steven discharged from mental health ward. Primary diagnosis, chronic social problems.
20.05.16	Steven arrested for breaching his anti-social behaviour order after

[17] Application in respect of patient already in hospital
[18] Leave of Absence from Hospital

	being found intoxicated in a public place. Custody staff record that Steven has apparent mental health issues and has paperwork from the mental health ward. The mental health ward were spoken to by the police appointed healthcare practitioner and there is a record to say that Steven is deemed to have full mental capacity and has chronic social issues rather than a mental health issue. He was not interviewed; he was charged and remanded to appear in court the following day.
21.05.16	Steven appeared at Greater Manchester Magistrates' Court and received 12 month conditional discharge for the breach of Anti-Social Behaviour Order.
03.06.16	PCFT: Detained in North Wales under Section 136 Mental Health Act and admitted to mental health ward, Rochdale. Steven reported there were demons in his body which were telling him to commit suicide and harm himself. Detained on mental health ward, Section 2 MH Act.
15.06.16	PCFT: Dr C diagnoses Emotionally Unstable Personality Disorder. Steven is discharged from mental health ward.
16.06.16	GP: Received a letter from PCFT: discharged Primary diagnosis – Emotionally Unstable Personality Disorder, factitious disorder. [Factitious Disorder was previously called Munchausen's syndrome]
16.06.16	CGMCRC: Steven failed to report and his whereabouts were unknown. He was in breach of the terms of his post sentence supervision and, in line with his no fixed abode status, an application seeking a warrant for Steven's arrest was submitted to the Court.
22.06.16	FCHO: Steven seen lying on the floor at the back of First Place - spoken to by staff member. He said he will be coming into 'Housing' later today. The Police appear to have moved Steven on from the back of First Place.
25.06.16	Steven arrested for failing to appear warrant relating to the railway trespass offence. Seen by police appointed medical practitioner who comments that he presents as bizarre although can focus and can answer complex questions. Assessed to have mental capacity and says he is willing to attend at his pre-planned mental health appointment.
27.06.16	Steven handed to GEO Amey for transportation to prison.
01.07.16	CGMCRC: Steven sentenced 14 days imprisonment. Breach of none molestation order

01.07.16	He arrived HMP.
13.07.16	HMP: Steven presented as delusional, unkempt and Section papers were completed and he was detained under section 2 [Admission for assessment] of the Mental Health Act.
14.07.16	PCFT: Mental Health Act assessment conducted at HMP. Detained under Section 2 Mental Health Act.
14.07.16	Steven transferred by ambulance from HMP to the mental health ward, Oldham.
15.07.15	PCFT: Steven deemed not to have capacity to consent to treatment.
25.07.16	PCFT: Staff report over the last week that Steven has been disinhibited in behaviour and on occasions has been aggressive which has resulted in the use of the rapid tranquilisation procedure. Generally poor engagement. Paranoid and guarded, refusing to discuss issues around alcohol use. Does not want to remain in hospital.
29.07.16	CGMCRC case officer attended the mental health ward for the ward round where Steven is detained.
03.08.16	PCFT: Dr A informed Steven that he will be making an application for detention under Section 3 of the Mental Health Act. [Admission for treatment] Assessment arranged for 05.08.2016.
04.08.16	Steven reported missing from the mental health ward after leaving the site during 30 minute period of permitted leave. He is treated as a medium risk missing person.
07.08.16 0400	Steven returns to the mental health ward having been found by security staff. Greater Manchester Police are not informed of his return until 18:45 hours. He is visited and tells officers he has been visiting his grandmother.
08.08.16	PCFT: Application made for Section 3 MH Act.
31.08.16	PCFT: Steven served non-molestation order by court officer.
25.08.19	PCFT: Steven suspected of using cannabis brought in by visitor.
11.09.16	Greater Manchester Police and PCFT: Steven was on escorted leave when he ran away from staff. Medium risk missing. He was located at 11:00 hours in Tesco, Middleton. The Missing From Home record makes reference to Steven having fallen and banged his head so he

	was conveyed to Royal Oldham Hospital and handed back into the care of staff.
20.09.16	Greater Manchester Police and PCFT: Steven is reported missing after running away from staff whilst on escorted leave. Informed staff he did not believe he should be detained. Police and mother informed.
22.09.16	Steven located at his Grandmother's address.
23.09.16	PCFT: Police contacted ward and requested ward staff to obtain mental health warrant [Section 135 [2] Mental Health Act] as Steven was in grandmothers address and not willing to return with Police. Steven remains absent without leave.
25.09.16 1100	PCFT: Call from mother who expressed concerns that Steven was still off the ward, not having medication, would be using alcohol and may have gone to the address of a friend with drug connections.
25.09.16 1600	PCFT: Steven returned to the mental health ward of his own accord. Not intoxicated.
28.09.16	PCFT: Steven was supported by Occupational Therapist to meet Threshold Housing to complete assessment. Following assessment, Steven did not meet criteria and Threshold Housing. [Threshold is a housing, advice and support charity with operations across the Greater Manchester area.]
29.09.16	CGMCRC: Steven absconded from Oldham hospital.
30.09.16	CGMCRC: Steven has been picked up and returned to custody at HMP.
04.10.16	PCFT: Edward House completed assessment of Stevens needs and he did not meet their criteria. [Edward House is a community based residential service providing 24 hour support for individuals with enduring mental health needs, located in a pleasant residential area of Oldham.]
04.10.16	PCFT: Care coordinator contacted Birchwood 24 hour Rehabilitation Placement. They were unable to say whether they had vacancies. Birchwood are unable to offer an assessment until November. Birchwood highlighted that any alcohol or substance misuse needs would exclude Steven from their criteria. Therefore, following the above discussion a referral to Birchwood was not appropriate.
05.10.16	PCFT: Care coordinator attended Mental Health Tribunal for Steven and he was discharged from his section. Steven agreed to stay as informal patient until accommodation has been identified. Moreover, it was highlighted and agreed that if Steven goes absent without

	leave he will be discharged. Steven agreed that he will need to present as homeless if discharged. Section 117 Mental Health Act 1983 Aftercare will continue. **117 After-care.** (1)This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under section 37 above, or transferred to a hospital in pursuance of **[F1**a hospital direction made under section 45A above or**]** a transfer direction made under section 47 or 48 above, and then cease to be detained and **[F2**(whether or not immediately after so ceasing)**]** leave hospital. (2)It shall be the duty of the **[F3**clinical commissioning group or**]** **F4**... **[F5**Local Health Board**]** and of the local social services authority to provide **[F6**or arrange for the provision of**]**, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the **[F7**clinical commissioning group or**]F4**... **[F5**Local Health Board**]** and the local social services authority are satisfied that the person concerned is no longer in need of such services **[F8**; but they shall not be so satisfied in the case of a **[F9**community patient while he remains such a patient.**]** **.]**
06.10.16	PCFT: Care coordinator met with Steven on the ward. Steven had been drinking in the morning. Care coordinator confirmed that Care Tech [A company providing accommodation and social care support to adults] is completing an assessment with Steven on 10/10/2016 at 13.00 at the mental health clinic. [Oldham CMHT] Steven agreed to stay on the ward until Monday 10/10/2016. The plan is for Steven to be discharged from the ward on 10/10/2016. Steven took his own discharge and left the ward.
7.10.16	Care Tech confirmed they have supported accommodation available for Steven subject to the planned assessment on 10/10/2016.
13.10.16	Steven was reported missing to Greater Manchester Police by social Worker care coordinator after he had failed to attend 2 appointments in the past 7 days and was known to be of no fixed abode. The log is initially dealt with as a concern.
14.10.16	Greater Manchester police recorded Steven as missing from home.
16.10.16	Steven located by Greater Manchester Police intoxicated state in Middleton. He was abusive to the officers and arrested. He is noted to be particularly lewd to female officers and displays erratic behaviour whilst in custody. He is seen by police appointed health care practitioner and said he was under a voodoo curse, that this is a long

	term thought, consistent with previous interactions. He was deemed to have capacity and was charged breach of anti-social behaviour order and drunk and disorderly. He was remanded to Greater Manchester Magistrates' Court 17/10/16.
17.10.16	PCFT: care coordinator arranged a multi-disciplinary team (07.11.2016 at 11.30) to discuss future care needs and support under Section 117 Aftercare arrangement.
17.10.16	Steven appeared at court and received 4 months imprisonment for the order breach and Breach of conditional discharge relating to the offence on 20.05.16.
17.10.16 1841 hrs	Arrived HMP. Reception processes including mental health assessment. Denied any thoughts to harm himself. Alcohol withdrawal- medication prescribed. RGN HMP physical observations 19th to 23rd October 2016 due to alcohol withdrawal.
21.10.16	HMP: referral to In Reach Secondary Mental Health.
22.10.16	HMP: Invitation to attend Care Programme Approach[19] meeting.
25.10.16	Steven seen by Shelter resettlement worker, completed the BCST2, [Basic Custody Screen Tool] as per the Shelter contract with Purple Futures and produced an initial resettlement plan.
7.11.16	PCFT: A multi-disciplinary team meeting took place involving the care coordinator, a number of PCFT staff and Steven's probation officer. HMP in reach team were invited but could not attend. Agreed actions were: 6. Establish where Steven wants to live. 7. Arrange and complete two mental capacity assessments regarding independent living and finances. 8. Identify the psychiatric consultant in the prison. 9. Obtain contact details for prison housing workers so that the care coordinator can liaise with them. 10. Arrange an MDT meeting at the prison in early December.
18.11.16	GP: Assessment letter from Consultant Forensic psychiatrist in reach mental health team.

[19] CPA is a package of care that is used by secondary mental health services. www.nhs.uk/conditions/social-care-and-support/care-programme-approach/

	Diagnosis – paranoid schizophrenia and currently under the Care Programme Approach with a Community Psychiatric Nurse.
22.11.16	HMP: referral to Shelter
29.11.16	HMP: Steven seen in psychiatric clinic. In reach team visited and conducted the consultation on the wing as Steven declined to attend health care for the appointment.
07.12.16	Shelter: Case was allocated to start the pre-release planning. All offenders within 12 weeks of release must have their resettlement plan reviewed. The resettlement worker checks on any interventions that may be required in readiness for the offender's release. An intervention is simply a required action or task that has been identified to prepare the prisoner for release and effective resettlement into the community.
12.12.16	HMP: Multi-disciplinary team updated Care Co Coordinator. Steven's mental state described his poor self-care. Assessed by visiting consultant forensic and in reach colleague registered mental health nurse; refusing medication, denying any psychotic symptoms, lacking insight into his mental illness. Further assessment from In Reach and visiting forensic consultant suggesting that a possibility of him being assessed for hospital transfer if no further improvement. [At this time his diagnosis was paranoid schizophrenia last made on 18.11.2016]
13.12.16	HMP: Confirmation for HMP Resettlement Officer to attend multi-disciplinary team and allocated to Steven's case.
14.12.16	HMP: Professionals/Care Programme Approach meeting to discuss Steven's resettlement plans in the community and risk management following release from custody. Steven was seen by some attendees on the wing as he did not attend the meeting. Probation advised hostel a possibility. The following actions were agreed: 6. To arrange a mental capacity assessment for living independently and engagement with services, i.e. CMHT, housing and medication. 7. Refer to One recovery before release. 8. Email clinic letters to CGMCRC. 9. Make referral to Probation Service Approved premises. 10. Discuss accommodation options with Steven.
20.12.16	HMP: E-mail from care coordinator stating that they have not received a clinic letter yet and that Care Manager will update once Steven has been seen in clinic.

23.12.16	Probation IMR: Discussion by CGMCRC offender manager with approved premises allocations officer within National Probation Service Central Admissions Unit. Enquiry made for approved premise residency. Advised by allocations that Steven was not assessed as suitable for admission on release from custody due to his posing a low risk of serious harm. Eligibility prioritisation given to those who are assessed as high and whilst consideration may be given to complexity of risks the current wait time for a bed was advised at being eight weeks and that it would take longer than this to obtain a bed.
05.01.17	GP: Review letter from Consultant forensic psychiatrist in reach mental health team. Consultant forensic psychiatrist states Steven remains psychotic and refusing to take his medication. Consultant forensic psychiatrist to discuss with Pennine Care about an admission to hospital under the Mental Health Act.
06.01.17	HMP: Steven seen on the wing for assessment as he refused to attend his appointment [to see psychiatrist] on the healthcare wing. Referred for mental health act assessment on release. He continued his refusal to see psychiatrist.
09.01.17	HMP: Steven seen re completion of release plan, he refused to sign the release plan or recomplete overdose awareness. One Recovery Oldham [part of Addiction Dependency Solutions] contacted to arrange release appointment on 13.01.2017. Also attended a multidisciplinary care programme approach meeting involving Greater Manchester Mental Health NHS Foundation Trust, Criminal Justice mental health team and Steven's Care co-ordinator. A further entry on 09.01.17 records that One Recovery Oldham was informed of the possibility that Steven would be detained under the mental health act on release from HMP.
09.01.17	HMP: professionals/care programme approach meeting to discuss resettlement in the community and risk management following release from custody. A number of actions were agreed: • A Mental health Act assessment was to take place prior to Steven's release from prison. • Obtain clarity on the reliability of the information that Steven had said he would harm children and people with them on his release.

	• Information to be sent to PICU where bed has been arranged for Steven if he is deemed to be detainable. • Appointments with CMHT and homeless section to be offered if Steven is not detainable. • X to meet Steven, do a release plan and offer an appointment with One Recovery. • A&E departments to be contacted with Steven's clinical information in case he presents there if released.
09.01.17	HMP: Recovery worker went on the wing to give him his appointment as a backup plan for his release in the community as per plan from the professionals meeting in the morning. Steven reported that he would attend the meeting. Recovery worker noted a blood splash on the floor and discussed this with Prison Custody Officer on the wing neither party thought it warranted an Assessment Care in Custody Teamwork book being open. Third party information that prisoners were reporting that he was saying the devil has told him to kill a child and any adult with them on his release from prison.
10.01.17 Sunday	HMP: In Reach visiting psychiatrist to organise and complete Section 2 Mental Health Act.
11.01.17	CGMCRC: Steven's CGMCRC case officer contacted by Oldham community mental health team who report that HMP mental health in reach team have reported that Steven has threatened to kill a child and any adult with them on release. It is noted that the source of the information is not cited. CGMCRC case officer records that the poor quality/ unidentified source of the information is such that a reliable reassessment of the risks posed by Steven cannot be completed. Oldham community mental health team report that they have been asked to consider referral of case to MAPPA Support Unit in the National Probation Service. CGMCRC case officer advises that on the current risk assessment Steven is not eligible for referral. CGMCRC case officer discusses the case with a manager. It is agreed that the information received was of such poor quality that action could not be taken on the basis of it. The case is not suitable for a referral under MAPPA. Liaison with the National Probation Service/approved premises. It is confirmed that Steven was not eligible for a bed due to low ROSH assessment.

11.01.16.	CGMCRC: Information about the threats that Steven had made to harm members of the public on his release from prison was shared with Greater Manchester Police. This was input to the police intelligence system.
11.01.16	PCFT: Criminal Justice mental Health Team, undertook Trust Approved Risk Assessment and sent copy to CGMCRC and MAPPA support. It was assessing: harm to self and suicide; harm to others and violence; self-neglect; exploitation and vulnerability
12.01.17	HMP: E-Mail sent to clarify Third Party Information sent to HMP Security Manager Wing Senior Prisoners officers In Reach Team Manager to confirm what had been reported. Security Information. Report has been submitted advising that the information required for mental health act assessment and marked as urgent.
12.01.17 0946 hours	HMP: Mental Health Act assessment approved mental health professional, Consultant Forensic Psychiatrist Consultant Psychiatrist Case Manager E Mail sent A.M. prior to assessment to clarify third party reporting of risk towards others to HMP Management. The Security Information Report regarding the threats that Steven was alleged to have made was submitted on the day of his assessment. Advised that hospital bed had been sought. Advised if he deemed detainable under the mental health act then approved mental health professional, could return tomorrow and we would be able to keep Steven in HMP until all processes have been completed to transfer him safely to hospital. Discussed third party information to be confirmed that Steven had apparently disclosed about risk towards others. Mental health assessment team and Care Manager spoke to a prisoner officer on the day but still unclear information about third party information. Psychiatric Intensive Care Unit bed identified. Assessment conducted on the wing due to Steven not wanting to come over to healthcare. Outcome from mental health assessment not detainable under MHA.
12.01.17 1515 hours	HMP: Shelter Team Manager telephoned HMP to attend healthcare to discuss homelessness appointment to be arranged for the morning.

	Shelter telephoned 'out of hours' options team to update of the case but nil answer. Letter prepared for resettlement worker to give on day of release prior to him leaving the prison. Already given release letter and part 7 letter [Housing Act 1996 Homelessness and Threatened Homelessness] handed over to Steven. Next of kin contacted by approved mental health professional. His Mother informed us that his brother would be unable to pick him up due to starting a new job. Approved mental health professional made appointment 10.30 for the next day at the mental health clinic with his Care Co Coordinator.
13.01.17 0730 hours	HMP: approved mental health professional phoned to inform change of location for his appointment. It was changed to a different mental health clinic. Team Admin In Reach contacted HMP Reception to pass on this information. HMP issued travel warrant. Case Manager spoke to Steven to advise that his brother was unable to pick him up. He was aware he had a travel warrant. Advised of appointment with community mental health team.
13.01.2017	Released HMP Forrest Bank
14.01.17 0315	Steven found alight by public in Collyhurst, Manchester

Appendix 2: Action Plan

No	Recommendation	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
1	That Oldham Safeguarding Adult Board should seek assurance from its partners that appropriate assertive outreach capacity is in place to deal with adults who have capacity but put themselves at risk by making unwise choices.	The development of a multi-agency forum to discuss adults who are or may be at high risk – involving a representative from thriving communities, early help and action together.	Operational Subgroup		01/12/19	
2	That Oldham Safeguarding Adult Board should consider developing a framework for working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services.	Development of a multi-agency self-neglect policy and a Risk Management protocol. Once in place, this will require regular review and audit. Self-Neglect multi-agency training available for	Operational Subgroup Workforce		01/07/19 01/09/19 01/01/20	

		professionals.	development subgroup.			
3	That Oldham Safeguarding Adult Board should seek assurance from its constituent partners that a patients working mental health diagnosis [the latest diagnosis] is clearly identified and used to inform risk assessments and care plans.	Increase mental health representation into MASH, RAID/CMHT to attend/have regular input into cluster meetings, 7 minute briefing to be developed.	Operational subgroup		01/09/19 01/09/19 01/06/19	
4	That Oldham Safeguarding Adult Board should consider a multi-agency audit of the use of mental capacity assessments and develop an action plan informed by the results.	Multi-agency audit examining how the principles of the MCA are embedded in practice, Multi-agency training – comprising of information about the legislation and practical sessions demonstrating how to apply the legislation into practice,	Quality assurance and audit Subgroup Work force development subgroup.		01/09/19 01/09/19	

5	That HMP should provide assurance to Oldham Safeguarding Adult Board that workforce development has taken place in relation to the recording, grading and sharing of intelligence.	HMP have recently undergone an independent Security audit with a rating of moderate. Intelligence was part of the audit baselines and found to be compliant. Security analysts have also received additional guidance on Information dissemination by the Regional intelligence Unit (RIU).	HMP	Complete	Complete	Complete
6	That Oldham Safeguarding Adult Board should arrange for the learning from this review in relation to the need for actions from MDT and CPA meetings to be SMART to be shared with its partners and to ensure that processes are in place so that professionals who are not present at meetings, and have been allocated actions, are notified without delay.	CPA policy is in place, ensure this is circulated to all relevant staff teams, Training is mandatory for all health and social care staff for CPA plus, Internal audit to assess compliance	PCFT		Ongoing	

		and share good practice.				
7	GMMH NHS FT ensures where a mental health assessment is planned to consider detention under the Mental Health Act in the week before a person's release from prison, the Mental Health Inreach Team (MHIT) should coordinate a contingency plan involving other agencies in the event the criteria for detention isn't met.	MHIT to review their Standard Operating Procedures (SOP) to consider inclusion of an appendices i.e. flowchart to support staff around the co-ordination of Mental Health Act assessments and any contingency planning for mentally disordered prisoners who require additional support on release from detention. A 7 Minute Briefing Learning Event will be arranged. Target audience: MHIT	GMMH NHS FT	On final approval and publication of the SAR report the Trust will: 1. Support the design of a flowchart 2. Commence the design and delivery of the 7 Minute Briefing	End of Q2 2019-20	TBC