Trafford Strategic Safeguarding Partnership

Safeguarding Adults Review

'Mike'

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Introduction

1.1 Mike[1] was a White British male who died in his flat in the Trafford Council area of Greater Manchester in August 2023. He died from stab wounds which appeared to have been self-inflected. At the time of his death he was 35 years of age. Mike had struggled with his mental health for a number of years and first accessed private medical support for psychosis during his twenties but apparently did not become known to mental health services in Greater Manchester until 2020. He was admitted to hospital under the Mental Health Act in July 2020 and in November 2021 and was under the care of the Ramsgate House, Salford community mental health team (CMHT) for schizophrenia. Following his second Mental Health Act hospital admission he was supported by a care co-ordinator for several months. He was intermittently compliant with prescribed antipsychotic medication and also used alcohol to 'drown out' the auditory hallucinations he experienced. Following an earlier house move from the Salford City Council area to the Trafford Council area, Mike's Salford GP practice removed him from their list in July 2022 and the following month he registered with a GP practice in the Manchester City Council area. The Salford CMHT began the process of transferring his care to the Trafford North CMHT but before the transfer could be finalised, Mike left the UK for several months to visit family abroad and go travelling. Unable to complete the CMHT transfer, the Salford CMHT discharged him to the care of his Manchester GP in February 2023. His Manchester GP Practice saw Mike after his return to the UK the following month but did not refer him back to the CMHT as the GP Practice had received a second letter from Salford CMHT incorrectly stating that Mike's transfer to Trafford North CMHT had been completed. Mike obtained employment in Gibraltar in May 2023 but quickly became mentally unwell and was admitted to hospital under the Gibraltar Mental Health Act and after discharge the following month, he returned to the UK. Workplace related stress appeared to be a very significant issue for Mike. His flatmate became increasingly concerned about Mike's paranoia and suicidal ideation and sought help from a number of agencies including Greater Manchester Police (GMP), the North West Ambulance Service (NWAS), Greater Manchester Mental Health NHS Foundation Trust (GMMH) – the provider of the CMHTs in both Salford and Trafford - and Access Trafford during the 24 hour period prior to Mike's death but was unable to obtain support for him prior to Mike's death.

1.2 Trafford Strategic Safeguarding Partnership (TSSP) decided to commission a discretionary Safeguarding Adults Review (SAR), following a referral from GMP in August 2023. The TSSP has the discretion to undertake a SAR where it believes there would be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice. In particular, the TSSP felt that there may be

[1] *Mike is the name by which the man at the heart of this Safeguarding Adults Review was known by family and friends.

learning arising from the way in which partner agencies responded to Mike's flatmate's efforts to seek help for him in the period immediately prior to his death. The TSSP also expressed concern about the possible premature application of the principles of Right Care, Right Person[2]

1.3 Trafford Strategic Safeguarding Partnership commissioned David Mellor to conduct the SAR. He is a retired chief officer of police, a former Safeguarding Adults Board chair and has 12 year's experience of conducting SARs and other statutory reviews. He has no connection to services in Trafford. A SAR Panel of managers from the agencies which had been in contact with Mike was established to oversee the review. Membership of the SAR Panel and details of the process by which the SAR was conducted is shown in Appendix A.

1.4 An inquest is to be held in respect of Mike's death.

1.5 Trafford Strategic Safeguarding Partnership wishes to express its heartfelt condolences to Mike's family and friends.

Terms of Reference

2.1 The SAR has focussed primarily on the period from November 2021 when Mike was admitted to hospital under the Mental Health Act until his death in August 2023 although Mike's contact with agencies prior to November 2021 has been considered where relevant.

2.2 The SAR has explored the following key lines of enquiry:

- Explore the care and treatment Mike received whilst admitted to hospital under the Mental Health Act in the UK.
- Explore the arrangements for discharging Mike from his Mental Health Act hospital admission in the UK and providing mental health care and treatment in the community.
- Explore the complexities arising from Mike's admission to hospital under local Mental Health Act provisions in Gibraltar. In particular explore an apparent lack of connectivity between services in Gibraltar and the UK when Mike was discharged and returned to the UK and the lack of awareness of the care provided and any potential diagnosis during Mike's Gibraltar hospital admission.
- Explore how effectively cross border issues were addressed, in particular the arrangements for the transfer of Mike's care from Salford community mental health team to Trafford North community mental health team.

[2] Right Care, Right Person (RCRP) is an operational model developed by Humberside Police that changes the way the emergency services respond to calls involving concerns about mental health. It is in the process of being rolled out across the UK as part of ongoing work between police forces, health providers and Government. GMP was in the process of implementing RCPC at the time of writing this SAR report.

- Explore how complexities arising from Mike spending substantial periods outside the UK were addressed.

- Explore agency responses to any safeguarding adult concerns which arose in respect of Mike.

- Explore how partner agencies responded to third party reports that Mike may be actively suicidal.

- Explore whether partner agency responses to contacts made on behalf of Mike on the day he died followed agency policies and standard operating procedures and whether there were any contextual circumstances, such as the time and day on which the contacts were made, which impacted on their response.

- Explore if the principles of Right Care, Right Person (RCRP) were applied in this case. (The SAR has been advised that RCRP had not yet been implemented by Greater Manchester Police (GMP), but that RCRP principles may have been applied during the GMP response when Mike was presenting in crisis).

- Explore how practitioners addressed the interaction between Mike's mental health, alcohol consumption and periodic lack of concordance with prescribed medication.

- Explore the effectiveness of information sharing and multi-agency working to safeguard Mike.

- Explore the impact of the Covid-19 pandemic on Mike and on his access to services.

Chronology of key events

3.1 Mike was one of four siblings who was brought up by his parents in a country outside the UK although he completed his secondary school education in the UK. Mike's parents have contributed to this SAR and described their son as a kind and generous person who had a 'heart of gold'. He obtained his private pilot's licence in his late teens and a commercial pilot's licence three years later. Mike's parents feel that the stress which he began to increasingly experience in his various workplaces began with the anxiety caused by attempting to pilot planes during the night hours. His parents have advised the SAR that Mike first accessed private medical support for psychosis during his twenties but apparently did not become known to mental health services in Greater Manchester until 2020.

3.2 Mike's flatmate for the final two years of his life has contributed to the SAR and he also observed the anxiety Mike experienced in the workplace which was assuaged only marginally by the transition to home working arising from

the pandemic. His flatmate felt that Mike had very high expectations of himself and wanted to make his family proud but was reluctant to seek help from family, friends, employers or support services. Mike's parents observed that their son didn't like taking medication for any type of illness and much preferred alternative herbal remedies.

3.3 On 27th July 2020 Mike was detained under Section 136 of the Mental Health Act (MHA)[3] by GMP after members of the public reported that he was acting strangely by touching train tracks to check if they were 'live'. Mike was admitted under Section 2[4] of the MHA to the GMMH Meadowbrook Unit - which is an adult inpatient facility based in Salford Royal Hospital which accepts referrals from the community mental health teams (CMHT)[5] or via the GMMH Liaison team located at the Salford Royal Hospital. He was admitted from 27th July until 14th August 2020 and was diagnosed with 'unspecified non-organic psychosis'. He was initially discharged to the care of the Salford Home Based Treatment Team (HBTT) and transferred to the Ramsgate House, Salford CMHT on 11th September 2020 as a standard care patient.

3.4 Mike engaged with outpatient appointments (via telephone due to the restrictions introduced as a result of the pandemic) with Speciality Doctor 1 in November 2020, March 2021, April 2021 and July 2021. A further appointment scheduled for 8th November 2021 did not go ahead. Mike was initially prescribed Risperidone[6] 2mg twice a day (later increased to 2mg in the morning and 3mg at night) and Thiamine[7] 50mg four times a day and acne medication. Mike reported experiencing auditory hallucinations which were not commanding in nature but were derogatory. He was smoking cannabis and drinking alcohol but declined the offers of referrals to Achieve Recovery Services[8] on several occasions. His GP records indicate that Mike did not collect his medication after July 2021. (The SAR has been advised that GP practice 1 has no mechanism for checking that patients are ordering and collecting their medications, unless they are flagged as needing assistance to order and collect. These patients would be on a weekly blister pack delivered by the pharmacist. Mike was not flagged as needing a weekly blister pack).

[3] Section 136 MHA gives the Police the power to remove a person who appears to be suffering from a mental disorder and is in need of immediate care and control from a public place and take them to a place of safety for the purpose of an assessment of their health and wellbeing.

[4] Section 2 MHA allows for a person to be admitted to hospital for up to 28 days to assess whether they are suffering from a mental disorder, the type of mental disorder and/or how the person responds to treatment.

[5] Community mental health teams provide multi-disciplinary assessment, treatment and care of individuals with severe and enduring mental health problems. They provide a service to individuals from 16 years of age up to 70 years of age with a diagnosed functional mental health problem, unless the service users' needs would be best met by the Older Adults CMHT or vice versa.

[6] Risperidone is an antipsychotic medicine that helps with symptoms of some mental health conditions including schizophrenia and mania symptoms of bipolar disorder.

[7] Thiamine, also known as vitamin B1, helps to turn food into energy and to keep the nervous system healthy. Synthetic thiamine can be used to treat or prevent vitamin B1 deficiency.

[8] Achieve is a substance use treatment and recovery service provided by GMMH in the boroughs of Bury, Bolton, Salford and Trafford.

3.5 Shortly after 11am on 13th November 2021 a member of the public contacted GMP to report a naked male walking in a public park in the Trafford Council area. Officers attended and located Mike meditating under a tree. He spoke calmly but appeared confused. His appearance was described as 'dirty', he had no belongings with him and he said that he had deliberately locked himself out of his apartment and that he would figure out how to get back into his apartment in due course. The officers consulted the Greater Manchester Mental Health Tactical Advice Service (MHTAS)[9] who accessed Mike's mental health records and established that he had a diagnosis of non-organic psychosis and was open to the Cromwell House, Salford CMHT (actually Ramsgate House). Mike had failed to attend an outpatient appointment five days earlier and had declined a referral to Achieve Recovery Services for cannabis use. (After Mike had not attended the recent outpatient appointment, the CMHT had offered him the next available appointment and contacted his GP practice to enquire whether he was collecting his medication).

3.6 Mike was documented to have reluctantly agreed to speak to the MHTAS mental health professional and was said to be unable to see why the Police had been called, saying that he did not think there was anything wrong and claiming that his medical records were all 'lies'. He went on to say that there was nothing wrong with him, adding that he wasn't taking his antipsychotic medication. MHTAS advised officers that detention of Mike under Section 136 of the MHA would be appropriate due to obvious concerns for his mental state, suspected psychosis, risks presented on scene (refusing to put clothes on) and reluctance to engage. The officers detained Mike under Section 136 and took him to Trafford General Hospital for a Mental Health Act assessment. He was then transferred to Wythenshawe Hospital to complete the assessment following which was he was again admitted under Section 2 of the MHA to the GMMH Meadowbrook Unit. MHTAS notified GP Practice 1 and the officers submitted a 'medium' risk care plan. Mike was not discussed at the Daily Risk Management meeting or the care plan shared with partner agencies as he had been admitted to hospital under the MHA.

3.7 At the beginning of Mike's admission to the Meadowbrook Unit he was described as 'very unwell', reported to be paranoid of both staff and peers and was constantly asking to leave the ward. He said he did not feel safe on the ward and was given PRN medication[10]. Mike was suspected to have taken two butter knives from the servery but when a search was completed nothing

[9] The Greater Manchester Mental Health Tactical Advice Service (MHTAS) is a 24/7 service based within the Control Room at Greater Manchester Police Headquarters. The service is delivered in partnership with Pennine Care and Greater Manchester Mental Health NHS Foundation Trust (GMMH) and works with Greater Manchester Police (GMP) to support police officers and call handlers to deal with mental health issues more effectively. MHTAS do this by providing access to their team of registered mental health professionals, who will support police staff with decision-making and onward referrals to services through telephone and video conferencing. The service operates as a part of the Vulnerability Support Unit, which screen calls and offer specialist support to frontline officers or divert people from a police response to the appropriate health and social care services across Greater Manchester.

[10] Sometimes medication may be required to be given 'PRN' (Latin phrase for 'pro re nata') meaning 'when required'. This medication is usually prescribed to treat short term or intermittent medical conditions and is not to be taken regularly.

was found. A mental state assessment was completed which found that Mike 'lacked insight' and was reluctant to take medication which he said made him feel drowsy.

3.8 On 18th November 2021 Mike's paternal aunt (who resided in the UK) reported him as a missing person to GMP and on 20th November 2021 his flatmate also reported Mike missing to GMP. On both occasions GMP responded by confirming Mike's Section 2 MHA admission to the Meadowbrook Unit. The contact between Mike's paternal aunt and Mike appears to have led to his father contacting the ward on 19th November 2021, following which Mike agreed to accept medication for a time. He was prescribed Risperidone 5mg daily.

3.9 Also on 18th November 2021 GP practice 1 received a letter from Salford CMHT to advise that Mike had not attended his 8th November 2021 telephone appointment and requesting that the GP check when Mike last collected his risperidone prescription. The GP ascertained that Mike had not collected his medication since July 2021. By this time the GP practice had been notified of Mike's hospital admission. The GP checked that Mike was still an inpatient and informed the CMHT about the non-collection of medication.

3.10 Mike continued to wear hospital clothing for some time as no clothes had been brought in for him. It took some time for personal belongings including his mobile phone to be obtained. He was later allocated a peer mentor who shared concerns with staff that Mike was low in mood and presented a risk to self. He was offered the necessary paperwork to initiate an appeal against his Section 2 admission although there is no indication that an appeal was made. Mike again began declining medication. There was one incident involving Mike secreting medication. Intramuscular medicine[11] was discussed on several occasions should Mike continued to refuse medication, but it does not appear to have been administered at any stage. Mike was said to not like the thought of long-acting chemicals staying in his body. He sometimes neglected his personal hygiene. Mike had limited interaction with peers and could appear isolative. He responded to staff when spoken to or when he needed anything. On occasion, he was documented to be agitated, aggressive and abusive. Mike said that he meditated often.

3.11 It was decided to refer Mike for care co-ordination[12], having previously been provided with standard care although the standard care form was incorrectly

[11] Physical restraint may, on occasion, need to be used to administer rapid tranquillisation by intramuscular injection to an unwilling patient, where the patient may lawfully be treated without consent.

[12] Care co-ordinators help to co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time. They can support people to become more active in their own health and care and are skilled in assessing people's changing needs. Care co-ordinators are effective in bringing together multidisciplinary teams to support people's complex health and care needs. However, there has been a shift away from generic care co-ordination to meaningful intervention-based care and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care. The way forward is for a named key worker for all service users with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase

sent to the CMHT by ward staff. This mistake was recognised before Mike was discharged and the correct form was to be submitted.

3.12 Mike became slightly less guarded as his admission progressed and he attended a Psychology Therapy group on motivation and behavioural activation and participated well. He also attended a 'Hearing Voices' group when he showed insight into the impact of his substance misuse on his mental health. The ward maintained phone and email contact with Mike's father who was documented to feel that Mike remained unwell at the time the decision was made to discharge his son.

3.13 On 9th December 2021 Mike was discharged on the grounds that he did not meet the criteria for further detention under Section 3 MHA[13]. He was considered to have partial or fluctuating insight and was 'compliant with his medication apart from his night medication' and was said to feel calmer on his medication after his initial resistance. No care co-ordinator had been allocated at the point of discharge. GP practice 1 received a discharge summary and was advised that Mike had stopped taking Risperidone but had restarted this during his hospital admission and the dose had been increased to 5mg. On 16th December 2021 GP practice 1 phoned Mike who confirmed that he was taking his medication, and a repeat prescription was issued. A 7 day follow up was completed by Ramsgate House CMHT when Mike was documented to be in good spirits and compliant with medication.

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3.14 On 24th January 2022 Mike attended a telephone appointment with Speciality Doctor 1 and said that he continued to experience auditory hallucinations which were derogatory in manner, although he said that they had improved, were not constant and he reported being able to cope with these voices. He said he was sleeping well and taking his medication whilst acknowledging that he needed to pick up a new prescription. He was still smoking cannabis and drinking small amounts of alcohol.

3.15 On 18th February 2022 the pharmacy linked to GP practice 1 phoned Mike as he had not collected medication since the previous year. Mike advised the pharmacist that he had stopped taking medication for around a month but that he felt that he should start taking his medication again as he said that he was experiencing gradually increasing psychosis. The pharmacist noted that Mike had been due to be reviewed by Ramsgate House CMHT on 24th February 2022 but GP practice 1 had not yet received a clinic letter. The GP practice

resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.

[13] Section 3 of the MHA is commonly known as treatment order, it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met. These are that the person is suffering from mental disorder and that the mental disorder is of a nature or a degree which warrants their care and treatment in hospital and also that there is risk to their health, safety of the service user or risk to others. It also requires that the treatment cannot be given without the order being in place and that appropriate treatment must be available in the setting where it is applied.

made contact with Speciality Doctor 1 who advised that the plan was for Mike to continue with Risperidone.

3.16 On 21st February 2022 Mike was reviewed by his GP who documented that Mike was currently living in a flat with other people who were not all that supportive and who made derogatory comments about his appearance. The GP added that Mike became very distressed when other people were not aware of what he was going through. The GP documented that Mike did not feel safe in his own home. The GP noted that Mike appeared very agitated and thin. Mike did not feel that his medication helped and asked about Valium which the GP explained was not the best option. Mike said that he would prefer therapy so that he could not let the voices bother him. The GP documented that Mike was not suicidal although voices were saying that 'he would be better off dead looking like that' and noted that a friend of Mike had previously taken their own life. The GP planned to review Mike in one week and sought advice from Ramsgate House CMHT on how best to help Mike – about who the GP said he was worried. After speaking to the GP, a CMHT duty worker phoned Mike who said that he did not wish to discuss his mental health and would speak about this to his GP – with whom he said he had a positive relationship - the following week. The CMHT duty worker briefly raised Mike to 'red zone'[14] before reducing him to 'green zone' after further phone contact on 24th February 2022, when Mike said he had no suicidal thoughts and confirmed that he was safe.

3.17 On 28th February 2022 Mike was reviewed by his GP who documented that he was now taking his medication but still felt that they were not working. The GP noted that Mike seemed to be alone much of the time although his father and family had taken him out that day. Mike said that he was trying to hold down a delivery job and had an interview for another job which he was not confident about because of his employment history. Mike said that he sometimes had difficulty in taking instructions in. On the same date Mike was allocated a care co-ordinator who promptly made in-person contact with him (on 3rd March 2022) and completed a care plan, risk assessment (remained in 'green zone') and crisis plan. Mike said he was motivated to engage with the CMHT and was now taking his medication although he said he felt drowsy in the mornings which the care co-ordinator felt was likely to be a side effect of his medication and so advised him to take his night time dose of Risperidone slightly earlier. The care co-ordinator noted paranoia in that Mike reported believing people to be talking about him. He said that he was still experiencing auditory hallucinations although they were less intrusive than they had been in December 2021. He said that the voice could sometimes tell him to kill himself but that he had no plans to act on this. He also reported that he had been drinking large volumes of alcohol but had stopped doing so after a visit from his father and paternal aunt.

[14] Service users under Care Programme Approach (CPA) and have an allocated care coordinator should be rated 'red', 'amber' or 'green' depending on the level of risk. 'Red' zone should be contacted a minimum of 3 times per week, 'amber' - minimum fortnightly contact and 'green' - 4 weekly contact.

3.18 On 8th March 2022 Mike was reviewed by his GP by phone. He said he was taking his medication consistently and was 'engaging in therapy' at Ramsgate House, which he said he was finding helpful. He said that he had been much drowsier recently which the GP explained was likely to be secondary to medication but suggested blood tests to exclude any physical cause – with which Mike agreed. (The blood tests required no follow up action). A review appointment with his GP was arranged for 17th March 2022 which did not take place, possibly because Mike did not attend or cancelled. Mike's GP retired at the end of March 2022.

3.19 Mike continued to attend in-person appointments with his care co-ordinator during March 2022. On one occasion he reported recreational cocaine use which he said had increased his paranoia. He agreed to a referral to the Ramsgate House Community Engagement Recovery Team - who would aim to help him become involved in groups and volunteering in areas of interest to the patient – and was placed on a waiting list. The morning and night time doses of Risperidone were swapped so that he took the smaller of the two doses at night as Mike was concerned that he was sleeping for 12 hours at night which was not normal for him.

3.20 Mike continued to attend in-person appointments with his care co-ordinator during April 2022 and reported stopping his medication for a period because he felt better and then resuming his medication when he began experiencing auditory hallucinations. The option of a depot injection rather than oral medication was discussed – which Mike declined. Mike disclosed experiencing suicidal thoughts although he said he would not act upon them. He went on to say that he was worried about disclosing suicidal thoughts in case this resulted in a further hospital admission. His care co-ordinator encouraged him to be open and honest. Mike said that his father was planning to fly Mike and his siblings to Australia in November 2022 – which he said he was looking forward to.

3.21 During May 2022 Mike started a new job and cancelled in-person appointments with his care co-ordinator because of his new work schedule. His care co-ordinator maintained contact with Mike by phone. He said that work was going well but described it as intense and later reported being very busy with work and putting pressure on himself to meet deadlines, although he felt he could handle this. During June 2022, Mike said that he thought his work colleagues were talking about him when he went into the office which he said was making him feel paranoid. He also said he was thinking of moving out of his flat or asking his flatmate to leave as he believed he could hear him making derogatory comments about him. He later said that he had confronted his flatmate who had denied making derogatory comments about him and informed him that he believed it was his psychosis. Mike said he did not know what to believe. He also reported not taking his medication consistently and experiencing auditory hallucinations. He said he was struggling to sleep and so Zopiclone[15] was prescribed. By 14th June 2022, Mike's care co-ordinator felt that Mike was relapsing and becoming unwell and rezoned him to 'amber'-

[15] Zopiclone is a type of sleeping pill that can be taken for short-term treatment of severe insomnia.

which would result in weekly contact. He described the auditory hallucinations as 'tormenting' and disclosed drinking two bottle of wine each night. A referral to the Home Treatment Team (HTT)[16] was under consideration and his medication was changed to Flupentixol[17] tablets which Mike reported to be effective. Mike's referral to the Community Engagement Recovery Team was closed as he was in full time employment.

3.22 On 22nd June 2022 Mike's GP practice decided to remove him from the practice list from 6th July 2022. This decision appeared to have been triggered by noting in a letter from Ramsgate House CMHT that Mike's flat (address 1) was located in the Trafford Council area (GP practice 1 is located in the Salford Council area). It is understood that Mike had been living in address 1 – which is a short distance from the boundary of the Salford Council area - since 2021 and that GP practice 1 had first noted his change of address at the time he was admitted to hospital under the MHA in November 2021 but taken no action at that time. However, in June 2022 the GP practice sent an 'out of area' letter to Mike to advise him of his removal from GP practice 1 and advising him of his right to appeal the decision.

3.23 On 11th July 2022 Mike's care co-ordinator rezoned him to 'green' on the grounds that the Flupentixol was working well and his auditory hallucinations had stopped. Mike reported having fallen and hurt his jaw after drinking excessively.

3.24 On 14th July 2022 Ramsgate House CMHT wrote to GP practice 1 to update them on recent contact with Mike. It appears that the CMHT had become aware that Mike had been de-registered by GP practice 1 at that time and asked GP practice 1 to continue prescribing Mike's medication until he registered with a new GP practice.

3.25 Mike continued to engage with his care co-ordinator and Speciality Doctor 1 during July 2022. He continued to say that the medication was helpful and denied feeling paranoid or having thoughts of suicide or self-harm. He reported drinking two and a half bottles of wine each night but would not discuss why he was drinking and declined a referral to drug and alcohol services – as he had consistently done when offered such a referral previously.

3.26 On 4th August 2022 Mike spoke to his care co-ordinator by phone. The appointment had originally been in-person, but Mike requested that it be conducted by phone as he was busy with work. He said that he was not taking his medication consistently as he was forgetful at times and was again experiencing auditory hallucinations but denied thoughts of self-harm or suicide. His care co-ordinator advised Mike that once he had registered with a new GP practice, he would be transferred to the local CMHT.

[16] GMMH's Home Treatment Teams provide an alternative to inpatient care by offering short-term intensive community support by assertively engaging with service users in mental health crisis.

[17] Flupentixol is a first generation antipsychotic drug prescribed for schizophrenia and other psychoses.

3.27 Also on 4th August 2022 Mike registered with GP practice 2 in the Manchester City Council area (close to the border with Trafford Council) having been de-registered by GP practice 1 in the Salford City Council area on 6th July 2022. Mike completed an online physical activity questionnaire for GP practice 2 on 25th August 2022.

3.28 During August 2022 Mike reported not taking his medication as he had run out and been unable to collect a new prescription. He was said to recognise that his feelings of increased paranoia were due to not taking his medication. He also reported that his alcohol use had increased. At the beginning of September 2022 the CMHT advised Mike that now he had registered with a new GP, arrangements would be made to transfer him to a local CMHT, and he was said to have no objections to this.

3.29 On 28th September 2022 Speciality Doctor 1 wrote a 'transfer of care' letter in respect of Mike which was emailed to Trafford North CMHT (also provided by GMMH) – who confirmed receipt on the same date and advised that the letter had been passed to their duty team for screening. Mike's care co-ordinator twice emailed Trafford North CMHT asking for an update on the transfer of care before being informed on 12th October 2022 that Mike had been discussed at a Trafford CMHT MDT meeting on 11th October 2022 and that Mike's care co-ordinator would be invited to Trafford North CMHT's MDT team meeting on 25th October 2022 to 'present and review' Mike's needs.

3.30 On 13th October 2022 Mike's care co-ordinator reviewed him by phone. He said that he had not taken medication for the past 2 weeks and was experiencing psychosis, his mood was low and he believed colleagues in his office were talking negatively about him and so he was mainly working at home as a result. Mike became defensive when questioned about self-harm until the rationale for asking the question was given. He reluctantly said he had experiencing auditory hallucinations (command in nature), telling him to harm himself but had never acted upon them.Mike disclosed smoking cannabis all day and drinking 4 pints of alcohol at night. (This was Mike's last contact with Ramsgate House, Salford CMHT).

3.31 Also on 13th October 2022 GP practice 2 texted Mike to ask him to book an appointment for his annual mental health review. This review did not take place despite reminders being sent to Mike.

3.32 On 25th October 2022 Trafford North CMHT contacted Mike's care co-ordinator to cancel her attendance at the Trafford North CMHT MDT that day and re-arrange her attendance for the following week (1st November 2022). Mike's care co-ordinator was unavailable for the rearranged date but it was agreed that a community psychiatric nurse (CPN) from Ramsgate House, Salford CMHT could attend in her place although she would be available to answer any questions Trafford CMHT may have about Mike following the 1st November 2022 CMHT. The care co-ordinator also emailed a word document to the CPN attending in her place which contained concise information in relation to Mike's current presentation including medication non-compliance and psychotic symptoms. The progress note the care co-ordinator placed on

Mike's file was mistakenly entitled 'Transfer to Manchester Central MDT' which appears to the first of several occasions on which Trafford and Manchester Central CMHT became mixed up.

3.33 Following the 1st November 2022 Trafford North CMHT MDT team meeting, Trafford North requested the 'transfer of care' letter to be sent again and advised that Trafford North had arranged an outpatient appointment for Mike on 1st December 2022 and requested his Ramsgate House, Salford care co-ordinator to attend.

3.34 On 8th November 2022 Trafford North CMHT informed Mike's Salford care co-ordinator that the outpatients appointment on 1st December 2022 had been cancelled as there was 'no point' in going ahead until Mike had been allocated a care co-ordinator by Trafford North. Mike was stated to be on the care co-ordinator allocations list at Trafford North. Mike's care co-ordinator requested that Mike be prioritised for a care co-ordinator by Trafford North CMHT.

3.35 Mike's care co-ordinator was unable to contact Mike during November 2022. Phone calls went straight to voicemail and the care co-ordinator received no reply when she visited Mike's flat. She was unable to make phone contact with his father and on 25th November 2022 she requested GMP to carry out a welfare check. The care co-ordinator re-zoned Mike to 'red'. GMP later advised the CMHT to continue their efforts to contact Mike and if they continued to struggle to make contact with him, they should report him as a missing person. On 28th November 2022 the care co-ordinator visited Mike's flat and was able to speak to Mike's flatmate who said that Mike had been away in Australia for one and a half weeks and was due to return on 4th December 2022. The flatmate said that Mike had had a 'few bad days' prior to his departure and that he would message Mike to advise him that the CMHT were trying to get in touch with him. Mike was rezoned to 'green'.

3.36 On 29th November 2022 Trafford North CMHT contacted Mike's Salford care co-ordinator to request her to attend a Trafford North CMHT MDT to present Mike's case when he returned to the UK. The care co-ordinator replied that this had already been done and Trafford North replied to explain that due to staffing issues within their team, things had become a 'bit tangled' due to several people being involved and that an outpatient appointment would be booked once Mike returned to the UK and a care co-ordinator allocated once Mike had been accepted in outpatient clinic.

3.37 During the week commencing 5th December 2022 Mike's care co-ordinator started a new role within GMMH which meant that she was no longer a care co-ordinator. She contacted the patients on her caseload to inform them of this change and preparing handover documents for the incoming care co-ordinator (s) although the process of assigning a new care coordinator was not immediate.

3.38 On 13th December 2022 the care co-ordinator attempted to phone Mike but the call did not ring out and she was unable to leave a voicemail. On the same date she informed Trafford North CMHT that she had commenced a new role

and was therefore no longer care co-ordinating Mike. Trafford North CMHT advised Mike's (former) care co-ordinator that they would arrange an outpatient appointment for Mike once Ramsgate House, Salford CMHT had appointed a new care co-ordinator for him as they would need to attend the Trafford North outpatient appointment. Mike's (former) care co-ordinator responded by requesting Trafford North CMHT to book an outpatient appointment for Mike as either she or Mike's yet to be appointed new care co-ordinator would attend. Trafford North CMHT responded by stating that they were aware that the care co-ordinator had been unable to make contact with Mike since his (presumed) return from Australia and so they requested the care co-ordinator to make contact with Mike to ensure that he was willing to attend an outpatient appointment before it was booked.

3.39 On 15th December 2022 Mike's (former) care co-ordinator made an unannounced visit to his flat where she spoke to his flatmate who informed her that Mike had travelled to Malaysia and would not be returning to the UK until February 2023. After consulting a senior practitioner, the (former) care co-ordinator rezoned Mike to 'amber' so that he would be discussed weekly at MDT meetings and advised Trafford North CMHT which advised that an outpatient appointment would be booked for Mike once he returned to the UK.

2023

3.40 Mike continued to be discussed in Ramsgate House, Salford CMHT MDT meetings during January and February 2023. GP practice 2 unsuccessfully attempted to contact Mike by text and by phone to invite him to attend his annual mental health review. On 7th, 10th and 15th February 2023 Mike's (former) care co-ordinator phoned Mike and left messages on his voicemail asking him to contact Ramsgate House, Salford CMHT. She also visited his home address on 15th February 2023 and received no reply and a Salford CMHT duty worker visited on 21st February 2023 and was also unable to obtain a reply.

3.41 On 22nd February 2023 Mike was discussed at a Ramsgate House, Salford CMHT MDT meeting when it was agreed to discharge Mike to his GP due to numerous unsuccessful attempts to contact him. On the same date, his (former) care co-ordinator wrote to GP practice 2 to advise them that Mike had been travelling since November 2022 and was due back in the UK in February 2023 but the CMHT had been unable to contact him and so the CMHT was discharging him to his GP and had advised Mike to contact GP practice 2 so that a new referral could be made to Manchester North CMHT (Manchester North CMHT had been referred to in error). A copy of this letter should have been sent to Mike but this did not happen.

3.42 Following his return to the UK, Mike's first contact with professionals took place on 12th March 2023 when he attended Longsight Police Station to report the theft of his motor vehicle from a nearby supermarket carpark. The enquiry counter officer contacted a GMP call handler to record the theft and shared concerns that Mike's. eyes were wide and bloodshot and that he 'did not seem 100%'. The following day GMP located the vehicle in Openshaw, where

Mike was attempting to start it. Mike informed GMP that his vehicle had never been stolen.

3.43 On 16th March 2023 GP practice 2 phoned Mike to arrange a physical health check on 21st March 2023 which he agreed to do. Mike attended the appointment on 21st March 2023 for an annual physical health review for individuals with mental illness. He was seen by a healthcare assistant. Mike said that he continued to experience auditory hallucinations, adding that he had stopped taking his medication in February 2023 as he didn't agree with his diagnosis. It is assumed that Mike will have had no access to his prescribed medication since he left the UK in November 2022. He said that he smoked 'weed' occasionally and after asking for details of Alcoholics Anonymous (AA) was advised that he could self-refer to Change Grow Live. Blood tests and sexually transmitted infections screening were completed at Mike's request. The healthcare assistant arranged for a GP phone call to Mike to discuss the fact that he had stopped taking his medication. A GP phoned Mike on 6th April 2023 and left a voicemail message which Mike did not respond to. GP practice 2 also texted Mike as a review was required in respect of an indicator of possible kidney damage following the blood tests. Mike did not respond and GP practice 2 had no further contact with Mike prior to his death. Neither the healthcare assistant nor the GP referred Mike to mental health services as requested in the Salford CMHT letter of 22nd February 2023 (Paragraph 3.41). The reason why GP practice 2 did not refer Mike back to mental health services appears to have been because the GP practice received a further letter from the Salford CMHT Speciality Doctor on 15th March 2023 which contradicted the 22nd February 2023 letter and incorrectly stated that Mike had been transferred to Trafford CMHT 'and accepted by them' and that he would be encouraged to book an appointment with his new CMHT when he returned to the UK.

3.44 During May 2023 Mike secured employment in Gibraltar and moved into an address located in the British Overseas Territory. On 13th May 2023 Mike was admitted to Gibraltar's hospital for patients with mental illness, initially on a voluntary basis, after presenting at A&E on 3 successive nights in distress. He was subsequently detained under Section 2 of the Gibraltar Mental Health Act – which is modelled on the UK MHA.

3.45 On or around 17th May 2023 Mike's (former) Ramsgate House, Salford CMHT care co-ordinator was contacted by consultant psychiatrist 1 from the Gibraltar hospital to seek more information about Mike and to identify a point of contact in the UK to assist in organising Mike's transfer back to the UK when he was ready for discharge from the Gibraltar hospital. Gibraltar consultant psychiatrist 1 was aware that Mike had been at a point of transition between CMHTs in the UK. Mike's (former) care co-ordinator confirmed that Mike had been discharged by Salford CMHT to his GP as he had been travelling and that she was hopeful that Trafford North CMHT would be able to support the referral of Mike to their team. The manager of Trafford North CMHT was copied into the (former) care co-ordinator's email correspondence with Gibraltar and she (the Trafford North CMHT Manager) provided consultant psychiatrist 1 with contact details for the Trafford home based treatment team

(HBTT) who would be able to support Mike once he returned to the UK. Additionally, it was agreed that a joint assessment of Mike by Salford and Trafford North CMHTs would take place. Gibraltar consultant psychiatrist 1 responded by emailing on 18th May 2023 to advise that he hoped to have a clearer view of discharge timescales the following week and would be back in touch with GMMH. Neither Salford nor Trafford North CMHT received any further contact from Gibraltar consultant psychiatrist 1, who it is understood was absent from work through sickness at the time of Mike's discharge.

3.46 On 5th June 2023 Mike was discharged from hospital in Gibraltar to the address at which he had been staying there. It is understood that he was to be supported by the Gibraltar mental health crisis response service[18] who were unable to contact Mike before he returned to the UK on 9th June 2023.

3.47 On Wednesday 16th August 2023 Mike phoned Manchester Mind's Welcome Team[19] and reported struggling with social anxiety and said that he was about to start a new job on 28th August 2023. He was referred to an in-person Manchester Mind Support Session and signposted to Able Futures[20] (with whom Mike did not make contact) and mindful meditations were sent to Mike to help with his anxiety.

3.48 On Friday 18th August 2023 Mike was phoned by a Manchester Mind Food for All administrator inviting him to attend a Mental Health Support Session on Monday 21st August 2023. Manchester Mind followed this up by emailing a Welcome Pack which includes information on where to go, what to expect and what happens at a Support Session.

Monday 21st August 2023

3.49 On Monday 21st August 2023 Mike did not attend the Manchester Mind Support Session.

Wednesday 23rd August 2023

[18] The Crisis Response Service operates 24 hours a day and offers rapid specialist support to people and families experiencing a mental health crisis. Anyone in need can dial 111 at any time. The 111 call centre will take information to establish the response that is needed, provide immediate support & advice and organise the response or any appointment needed. 111 will continue to monitor the situation and be available to provide support until the appropriate response is in place.

[19] Mind recognises that people struggling with their mental health can find this overwhelming and isolating and so their Welcome Team aims to make things easier by listening, helping the person to explore their options and helping them to access the right support. The Welcome Team phone line is open from 10am to 3pm Monday to Friday.

[20] Able Futures is a nationwide specialist partnership set up to provide the Access to Work Mental Health Support Service on behalf of the Department for Work and Pensions (DWP) and can provide up to nine months' advice and guidance from a mental health specialist to help the person learn coping mechanisms, build resilience, access therapy or work with their employer to make adjustments to help their mental health at work.

3.50 At 15:39 on 23rd August 2023, a Stretford Police Station enquiry counter officer reported a concern for Mike to a GMP call handler. The enquiry counter officer stated that Mike had visited the Station front desk twice to report being stalked and harassed by his neighbours - who he said he had never spoken to or met – and that he believed they were doing this in order to encourage him to kill himself. The enquiry counter officer added that Mike appeared to be really struggling with his mental health, appeared to be having 'a bit of a breakdown' and had isolated himself from everybody. Mike had declined to provide information about his mental health and left the Police Station as he feared he would be sectioned before later returning to the Station and apologising. During this second visit Mike provided his address details and said that there was 'no danger' of him taking his own life.

3.51 The GMP call handler graded the incident as a Grade 2[21] and sent the incident to NWAS at 15:49. The call handler asked the enquiry counter officer to advise Mike to return home. Although GMP had sent the incident to NWAS, they (GMP) also planned to attend.

3.52 As stated above, at 15:49 the GMP control room contacted NWAS to request an ambulance to be sent to Mike's home address as he had walked into a Police Station front desk a couple of times that day and 'was having a mental health crisis'. NWAS coded the call as Category 3[22]. An NWAS call handler called Mike back to attempt a further triage and Mike stated that he did not require any help with his mental health or require an ambulance. This incident was categorised as a mental health cancellation and was held for review by a clinician to allow for safety netting – which in the NWAS context means 'is it safe to accept the patient's cancellation?' - of those in mental health crisis – which had not been completed by the time NWAS received a second call from the GMP control room at 16:00 on the same day.

3.53 As stated above, at 16:00 the GMP control room contacted NWAS again to inform them that Mike had returned to the Police Station front desk for a second time and stated that he had previously cancelled the ambulance but had since changed his mind and now wanted to speak to the ambulance service. The NWAS call handler opened a new incident which was again coded as a Category 3 response. The NWAS call handler attempted to call Mike to complete a further triage but received no answer and so a voicemail was left. At 17:20 a mental health nurse within the NWAS emergency operation centre (EOC) attempted to call Mike but the call went to voicemail. At 17:30 the mental health nurse was able to phone Mike who denied thoughts of suicide although he admitted that he had had thoughts of this nature in the past. He had no thoughts to harm others. Mike reported he had not consumed any alcohol or drugs and had a history of schizophrenia but was not prescribed any medication. The mental health nurse asked whether Mike was open to mental health services and he replied that he was 'closed as they were unable to help him in the past'. Mike confirmed that he did not

[21] Grade 2 incidents require a Priority Response which is defined as attendance within the hour.

[22] Category three is for urgent calls. In some instances the person may be treated by ambulance staff in their own home. NWAS aim to respond to these within 120 minutes at least 9 out of 10 times (1).

want an ambulance and refused any further referral to mental health services or to a GP. He was provided with advice on action to take should his health worsen and encouraged to reach out for support at any time he felt he may need it. He was made aware that the mental health nurse would cancel the ambulance response.

3.54 At 18:07 GMP spoke to Mike by phone after visiting him at his flat and finding that he was not at home. Mike confirmed that he was safe and well but would not disclose his location. GMP closed the incident and planned to submit a care plan but there is no indication that a care plan was actually completed.

3.55 At 18:40 a GMMH mental health practitioner[23] contacted GMP to confirm that the ambulance had been cancelled for Mike. The mental health practitioner also advised that he had found the mental health services that Mike was under and was going to email them to follow this incident up. The GMP call handler documented that the GMMH mental health practitioner advised that mental health services may experience some difficulty in contacting Mike as 'he had recently moved'. The GMP call handler confirmed that the Police had earlier spoken to Mike by phone, when he confirmed that he was safe but would not disclose his location. GMP also confirmed that their incident log was now closed.

3.56 At 18:55 the GMMH mental health practitioner in the NWAS EOC contacted the GMMH 24/7 Mental Health Crisis Helpline for all ages and sent an email to the Trafford North CMHT manager who was on annual leave. Her out of office email advised that any urgent emails be sent to the CMHT team inbox or contact made with the CMHT by phone. It has not been possible to establish whether the GMMH mental health practitioner in the NWAS EOC followed the out of office email advice and sent the email to the CMHT team inbox or contacted the CMHT by phone, although there is no indication that they did so. The email to the Trafford North CMHT manager had a heading which identified Mike by his initials and his GMMH Paris electronic record number but there was no content in the body of the email to explain why the practitioner was sending the email.

Friday 25th August 2023

3.57 At 04:34 hrs on Friday 25th August 2023 Mike's flatmate phoned GMP via the 999 system to report that Mike had left their address with a medium sized kitchen knife, with which he intended to stab himself. The flatmate said that Mike had a diagnosis of schizophrenia and of psychosis and that Mike had told him not to ring emergency services as he was worried that he would be

[23] NWAS, GMMH and Pennine Care (who also provide mental health services in some Greater Manchester local authority areas) were running a pilot which involved GMMH and Pennine Care mental health practitioners working in the NWAS EOC to enable appropriately trained professionals to reach out to those who are suffering with mental ill health and provide support/liaison. The GMMH/Pennine Care staff also understand pathways open to those in mental health crisis and are able to access their own Trust's databases.

sectioned if emergency services became involved. The call handler created a Grade 1[24] incident and patrols were deployed to the area.

3.58 At 04:44 hrs officers located Mike not far from his apartment block although he initially made off from the police vehicle where he was being spoken to. At 04:47 hrs officers confirmed that they had detained Mike for a Section 1 search[25]. At 05:09 hrs officers informed the radio operator that the search of Mike and the surrounding area had been conducted and no knife had been found. The officers documented that Mike was not suicidal, that he did not want to speak to anyone, that he repeatedly said that he had done nothing wrong and that he just wanted to go home. Mike was then allowed to leave. A 'medium' risk care plan was completed which was reviewed by the GMP Adult Safeguarding Unit on 1st September 2023 by which time Mike had died. The adult welfare care plan was closed and the risk assessment increased to 'high' at that time.

3.59 At 09:55 Mike's flatmate rang the GMMH Trust Wide Helpline to express concern that Mike was feeling suicidal and to seek advice. The flatmate said that he was not with Mike as he (the flatmate) was ringing from his workplace and that Mike was likely to be in the flat they shared. The mental health practitioner who took the call from Mike's flatmate documented that the flatmate had phoned GMP 'a few days ago' as Mike was 'waving a knife around'. The police were incorrectly documented to have taken the knife off him and sent him home. The flatmate was advised to contact emergency services if Mike presented a risk to himself or to others so that a welfare check could be carried out. The flatmate was documented to have expressed some frustration on receiving this advice as he had previously contacted emergency services (GMP). The mental health practitioner noted that Mike did not appear to be under secondary mental health services at that time.

3.60 At 10:13 a Manchester Mind Food For All support worker phoned Mike to check-in with him as he had not attended the Manchester Mind Support Session on 21st August 2023 (Paragraph 3.49) and to invite him to attend the next scheduled Support Session. When asked about his mental health, Mike said that he was OK and confirmed that he was due to start a new job soon. Mike appeared reluctant to engage with Mind and implied that his father was keen for him to obtain support from Mind. During the call, Mike discussed hearing voices and he was asked about the content and tone of these voices. In their contribution to this SAR, Manchester Mind has advised that during this phone call of approximately 15 minutes duration, Mike gave no indication that he was approaching a crisis or that the voices were encouraging him to harm himself. After the call ended the Manchester Mind support worker emailed Mike information in relation to Hearing Voices Support groups in the community.

[24] Grade 1 incidents require an immediate response.

[25] Section 1 of the Police and Criminal Evidence Act (PACE) provides the police with a power to stop and search a person or vehicle where they have reasonable grounds to suspect that they will find prohibited items, including offensive weapons such as knives, stolen articles, equipment related to the commission of certain offences and fireworks.

3.61 At 12:58 on 25th August 2023 Mike's flatmate phoned GMP via the 999 system to report a concern for Mike. He explained that he had previously contacted GMP during the 'early hours' of that day after Mike left their address with a knife with the intention of killing himself. He went on to say that he had phoned Mike a few minutes ago (at around 12:45) and Mike had said that he wanted to end his life and did not see the point in carrying on. The flatmate explained that he was at work and that Mike was at home alone. The call handler carried out a THRIVE[26] risk assessment and assessed the incident as a 'medium' risk and at 13:08 hrs a Grade 2 incident was created and linked to the previous incident reported by Mike's flatmate at 04:34 on the same date (Paragraph 3.57).

3.62 At 13:09 the GMP call handler phoned NWAS to request an ambulance attend Mike's home address. GMP noted that NWAS had graded the call as Category 3 and that there was a 1 hour 30 minute 'wait time' (This is not the NWAS performance standard for Category 3 calls but NWAS gave GMP an estimated response time). NWAS documented that GMP had received a call from Mike's flatmate the 'previous night' after Mike had left the property they shared with a kitchen knife making threats to end his life. NWAS also documented that GMP had located Mike at that time and found no knife and that Mike said that he had no intent to end his life. GMP advised NWAS that Mike had schizophrenia, that his flatmate was concerned that he did not have capacity and had stated that he wanted to end his life but did not know how to do it. The NWAS call handler attempted to phone Mike to complete a triage but the call went through to voicemail. The NWAS call handler then phoned Mike's flatmate to complete the triage but this was not possible as the flatmate was not at the property with Mike. However, the flatmate identified himself as a mental health nurse and said that he was worried about Mike, who he said knew what to say to make people think he was OK and that 'the last thing Mike wanted' was to be detained under the MHA.

3.63 At 13:24 NWAS passed the incident into the Clinical Support Desk (CSD) for triage where a Clinical Navigator reviews all incidents entering the CSD to ensure appropriateness for telephone triage as well as identifying those which require a face-to-face response or obvious need for a higher response (not suitable for telephone triage).

3.64 At 13:44 a GMP District Sergeant closed the log relating to the 12:58 call from Mike's flatmate (Paragraph 3.61) updating it as follows:"Ambulance tasked and are best placed to deal with this incident as per the College of Policing APP on mental health (2), decision making concerning health care matters should be made by clinically trained professionals and not police officers. In general, when there is no reason to suspect that a crime has been, or is likely to be committed, responses to the needs of people with mental ill health and vulnerabilities should be provided by appropriately commissioned health and social care services. AP (Mike) is likely to receive best service if NWAS take

[26] The THRIVE (Threat, Harm, Risk, Investigation, Vulnerability and Engagement) model is used to assess the right initial police response to a call for service. It allows a judgement to be made of the relative risk posed by the call and is intended to place the individual needs of the victim at the centre of that decision.

primacy in this matter. We will attend if requested by the ambulance". GMP did not document whether they informed NWAS that they would not be attending unless requested by the ambulance service.

3.65 An (agency) GMMH mental health practitioner working in the NWAS EOC reviewed the incident and re-co-contacted the flatmate by phone in an effort to better understand Mike's needs. Before contacting him, the GMMH mental health practitioner established that Mike was known to GMMH but was not open to any GMMH services having been discharged due to non-engagement. The flatmate confirmed that he was not at home with Mike who he said had a history of schizophrenia and was 'threatening' to take his own life but did not have the capacity to do this. The reference to 'capacity' appears to relate to the 'means' to take his own life. The GMMH mental health practitioner discussed what the ambulance service would, and would not, be able to achieve should they attend Mike's address, given his flatmate's concern that Mike was unlikely to engage with the ambulance crew and may not allow them access to their flat. The GMMH mental health practitioner confirmed that ambulance service paramedics were not qualified to conduct MHA assessments and she gave the flatmate the phone numbers for the Trafford Approved Mental Health Professionals (AMHP)[27]. Both the in-hours and out of hours numbers were provided. The GMMH mental health practitioner advised that the ambulance crew would attempt to persuade Mike to 'attend' voluntarily should they be able to gain access to his flat and the flatmate was also advised to contact Mike's GP for assistance. (There is no indication that Mike's GP practice was contacted by the flatmate on 25th August 2023).

3.66 The GMMH mental health practitioner in the NWAS EOC unsuccessfully attempted to phone Mike on 3 occasions and left voicemail messages. Unable to complete a telephone triage, the GMMH mental health practitioner recommended that NWAS attend to conduct an in-person assessment and so the incident remained a Category 3 incident. She emailed a letter to Mike's GP practice – which the GP practice would not have seen until Tuesday 29th August 2023 given that Monday 28th August 2023 was a public holiday.

3.67 At 15:35 Mike's flatmate phoned Access Trafford[28]. In his contribution to the SAR, the flatmate said that he thought that when he rang the number given him for the Trafford AMHP service he was connected to Access Trafford. The SAR has been advised that if a person rings Access Trafford to request a Mental Health Act assessment, the details are obtained and passed to the AMHP Hub who would then make contact with the person requesting the assessment. The flatmate spoke to a customer service officer who documented that the flatmate was extremely concerned about Mike, who had schizophrenia and 'lots of suicidal thoughts' and had taken a kitchen knife out with him 'last night' and the Police had found him without the knife and

[27] Except for people who are dealt with through the courts, the involvement of an AMHP is necessary in order to make decisions about whether or not someone needs to be admitted to hospital under the MHA.
[28] Access Trafford is a call centre which receives phone calls and emails from members of the public who wish to make enquiries in relation to a number of Trafford Council services. It is open between 9am and 5pm from Monday to Friday.

brought him home. The flatmate requested an MHA assessment of Mike and that someone called him (the flatmate) urgently. He provided his mobile phone number.

3.68 The Access Trafford customer service officer had initially attempted to put the flatmate's call through to the Adult Safeguarding Hub but the line was busy and so she created a contact on the Adult Social Care client record system and at 15:39 the contact was assigned to a duty social worker requesting an urgent MHA assessment. The duty social worker – who was not an AMHP – had just returned to the Adult Safeguarding Hub from a home visit and read the information obtained by the customer service officer and identified that GMP were aware of the concerns in relation to Mike's mental health and had seen him 'the night before'. The usual course of action would have been to request the Police to complete a welfare check but the social worker noted that the Police were already aware of the concerns in relation to Mike's mental health and concluded that the right professionals were already dealing with Mike to enable him to access support around his mental health. The duty social worker planned to follow up with the Police and 'Mental Health Team' the next day to check whether there was any additional support required from Adult Social Care.

3.69 At 16:06 NWAS received a 999 call from Mike's flatmate who had returned home and found Mike in the bath having apparently stabbed himself. The first ambulance arrived at 16:13 and advanced life support was provided. An air ambulance also attended but Mike's death was diagnosed at 17:02. NWAS contacted GMP who later attended the scene. NWAS had been unable to respond to the 13:09 Category 3 call within expected timescales due to demand on resources.

3.70 At 16:10 Manchester Mind received an email which Mike's father had sent to the National Mind email address at 10:24 on the same day marked 'CRITICAL MY SON MICHAEL' which stated that he was worried about Mike who he said had 'descended into a very bad place again today'. Manchester Mind emailed Mike's father at 17:18 and confirmed that his son had been in contact with Manchester Mind but that that they could not disclose further information. They advised Mike's father that Mind are not a crisis service and signposted him to BlueSci[29] Trafford and the GMMH 24/7 Mental Health Crisis Helpline for all ages. Manchester Mind made a number of unsuccessful attempts to phone Mike over the following few weeks. (When Mike's parents read a late draft of this SAR report they advised that Mike's Greater Manchester based paternal aunt was on holiday abroad at the time Mike's mental health deteriorated in late August 2023).

[29] Since 2004 Blueski has provided a service to Trafford residents which involves working with users of the service and partners to provide a 'brokerage' approach that enables people to achieve their aspirations through a range of creative opportunities including; music and arts, volunteering opportunities, education and training related activities linked to mainstream life domains.

Views of Mike's parents and his flatmate.

4.1 Mike's parents spoke to the independent reviewer via video conferencing from their home in Malaysia. They described their son as a kind and generous man with a 'heart of gold' and a 'great personality'. They said he had lots of friends in Malaysia where he grew up and they both took great comfort from the tributes they heard from friends of Mike who attended his funeral in the UK and an informal memorial event they organised in Malaysia on Boxing Day 2023.

4.2 His parents said that Mike studied for his GCSEs and 'A' levels whilst attending boarding school in the UK. He obtained his private pilot's licence at the age of 18 or 19 after which he undertook training for a commercial pilot's licence, during which Mike became anxious about night flying and took a break in his training. They felt that their son's mental health struggles may have stemmed from the difficulties he encountered during commercial pilot training.

4.3 Mike's parents said that he moved on from this disappointment and qualified as a Building Information Modelling[30] draughtsman. He was employed in this field in Surrey for around three years before starting to 'jump around' jobs in the UK and elsewhere. His parents noticed that his employment generated stress for him and felt that this was because Mike's expectations of himself were unrealistic in that he felt that he should immediately become proficient in whatever role he had been appointed to. However, they became aware of other factors in the workplace which caused him stress after he left a job in Guildford. They said that he lacked trust in his co-workers and when he felt that they were talking negatively about him he found this 'shattering'. His parents said that he consulted a 'Harley Street Doctor' who prescribed medication for psychosis which they said he took until it ran out at which time he said that he felt better and didn't need to take the medication anymore. His parents said that they gave him advice on how to adjust to new jobs, but looking back they now feel that they were 'nagging' him to get a job without appreciating the severe impact employment could have on him. However, they added that they had frequent contact with Mike via facetime and he would invariably present as 'fine' during these calls.

4.4 They recalled that during the pandemic he worked in an Amazon warehouse and subsequently as a food delivery driver but was not happy and developed physical pain in his back. However, they felt that Mike had a 'remarkable recovery' in his life and employment when he secured employment with an engineering company in Leeds where he was able to work primarily from home, which his parents felt would be 'perfect' for him. His parents said that they were talking with him 3 times a week via facetime and he seemed very happy as he had money, friends, a job and was taking his medication.

[30] Building Information Modelling (BIM) is a process that encourages collaborative working between all the disciplines involved in design, construction, maintenance and use of buildings.

4.5 By the time of a family holiday in Australia in November 2022, his parents felt that Mike was 'not in a good place' in that he was not very sociable, wanted to be alone and had started to drink alcohol to get rid of the voices in his head. From Australia, they said he travelled to Thailand for several weeks where he spent time with Monks. His parents said that Mike was quite a spiritual person. Whilst in Thailand, they said that their son went into rehabilitation as he was drinking far too much and wanted to stop. They recall him saying that he 'needed fixing' around this time. His parents said that he was a 'different person' after the period in rehab and his father stayed with Mike after he returned to the UK in April 2023 and said that it was the best 3 weeks he had ever spent with Mike as an adult.

4.6 His parents said that what happened to him after securing employment in Gibraltar in May 2023 was a 'horror story'. They said that he was in a new place in a new job – 'new everything' – and that this triggered his anxiety levels massively. The hospital to which Mike was admitted under the Gibraltar MHA contacted the family and they got in touch with Mike. They felt that he 'seemed OK' during the last 2 weeks of his admission.

4.7 Mike's parents said they were largely unaware of their son's financial difficulties following his return to the UK from Gibraltar. They subsequently found out that he had sold the car given to him by his grandfather in order to pay his rent, including for the period he had been out of the UK. They said he only 'came clean' about this about 2 weeks before his death.

4.8 During the final two weeks of their son's life, his parents said he made a number of lengthy emotional phone calls to both parents in which he was 'questioning everything' including whether his parents had ever wanted him, why they treated him differently from his siblings. His parents advised the independent reviewer that they felt that they had given Mike a lot more attention than his siblings because they felt he needed it. They said that they involved his siblings in speaking with Mike during this period but he remained highly anxious. Then the phone calls stopped and their son stopped answering their calls. Mike's father got in touch with Mind in the UK who he said put his mind marginally at ease by confirming that he had been in touch with them. Mike's father said that he planned to fly to the UK to see Mike but was unable to obtain a seat on a flight and his parents were in Malaysia when they were contacted by GMP to advise them of their son's death on Saturday 26th August 2023.

4.9 Looking back they felt that Mike's diet (gluten intolerance), health including cirrhosis, lack of money and stress/anxiety were key factors which contributed to his death. His parents said that he didn't like taking medication for anything, preferring herbal remedies. They added that he was a 'great conspiracy theorist', implying that this was linked to his reluctance to take medication. They said that Mike worried about his general health and would ask "why had he got everything wrong with him?"

4.10 Mike's parents said that it was very difficult to obtain help for, or access information about, Mike from abroad and that neither GMMH nor GMP were contactable by phone from abroad.

4.11 Mike's flatmate has also contributed to this SAR. He said that he and Mike met during the first phase of the pandemic. Mike's flatmate is a mental health nurse and provided Mike with informal support during a psychotic episode which Mike was experiencing when they first met. The flatmate said that Mike gradually became well again and they stayed in touch. At that time Mike had his own place in the Salford City Council area and was doing well. Eventually they decided to share a flat together in the Trafford Council area.

4.12 The flatmate said that when Mike returned from Thailand in March 2023 he seemed quite well and had stopped drinking alcohol which the flatmate felt to be a positive development as he did not think that alcohol was good for Mike. He said that Mike was smoking 'a bit of weed' to relax him. He said that Mike then began drinking again – but not excessively. The flatmate felt that Mike's use of alcohol was part of a vicious cycle in which he would experience social anxiety, become mentally unwell, start hearing voices and then begin drinking alcohol to help him cope with the intrusiveness of the voices.

4.13 The flatmate felt that employment was a trigger for Mike's mental health issues as he struggled with social situations in the workplace and the move to remote working did not alleviate the problem as video conferencing meetings also caused him anxiety.

4.14 The flatmate said that Mike would get a lot of job offers when he was looking for employment and that he was 'really disappointed' when he had to leave his job in Gibraltar. The flatmate felt that Mike also felt a lot of shame when this job did not work out. After returning to the UK in June 2023 he said that Mike had two job offers and chose the higher paid job of the two but as his start date drew closer, the expectations associated with his new role began stressing him out. The flatmate said that he advised Mike to accept the job offer which involved less responsibility and less pay but Mike was reluctant to do this.

4.15 The flatmate went on to say that Mike put himself under pressure in going for demanding jobs with a good salary. He said that Mike had high expectations of himself and came from a successful family. He kept on trying to achieve success in employment and was motivated to make his family feel proud of him, particularly his father. However, the flatmate felt that because of the shame he felt about his mental ill health, he was reluctant to seek help from his employers. The flatmate felt that Mike was also reluctant to seek help from his family and would 'put on a front' which indicated that 'everything was alright'.

4.16 Following his return to the UK from Gibraltar, the flatmate said that Mike began using cocaine and crack cocaine although he stopped taking drugs completely during the final week of his life as he said he wanted to be 'clean'

and in the right frame of mind in anticipation of starting his new job on 29th August 2023.

4.17 The flatmate said that he went away on holiday for around a week in mid-August 2023 and that at that time Mike was OK apart from being 'short of cash' which he said was something which caused Mike to 'stress out'. He said that when he returned from holiday about 4 or 5 days before Mike's death, he could tell that he was 'not great' and was becoming really unwell. He said Mike had become very introverted and was not really engaging. The flatmate said that he sat with Mike to provide him with support.

4.18 The flatmate said that their tenancy in address was coming to an end at the time of Mike's death. He said that their landlord intended to increase their rent substantially and that he had tried to negotiate but the landlord 'wouldn't budge'. The flatmate said that he accepted that he and Mike faced eviction but thought that the matter would proceed through the Courts giving them more time to look for alternative accommodation. The flatmate said that his understanding of his and Mike's rights as tenants was mistaken and he eventually realised that they would have to give up the tenancy at address 1 earlier than anticipated. He added that at the time of Mike's death they had around 10 days to a fortnight before they would have had to have left.

4.19 The flatmate added that Mike had a lot of issues with paying the rent for address 1 and so he suggested that Mike obtain his own place. The flatmate planned to move into a studio flat and told Mike that he would stay with him there until he had sorted out his own accommodation. The flatmate said that he reassured Mike that 'he was not going to leave him stranded'.

4.20 When the flatmate returned home from work on Thursday 24th August 2023, he said that Mike told him that he was 'not good at all'. After going to bed, the flatmate said that Mike woke him up by banging on his (the flatmate's) bedroom wall and saying that he thought the flatmate was talking about him. The flatmate said that Mike had done this before. The flatmate said that he got out of bed and Mike began saying that he wanted to die and tried to remove a knife from the cutlery drawer which the flatmate initially managed to prevent him from doing. The flatmate said that Mike then managed to get hold of a large kitchen knife and he (the flatmate) took a step back into his bedroom in case Mike 'went for him'. Mike then said "I'm going to go out and do it' and left the apartment with the large kitchen knife. The flatmate then rang GMP and when the Police called him back to say that they had located Mike, he assumed that the Police would detain him under the MHA. He said he thought that there was no way the Police would 'let him go'.

4.21 The flatmate went on to say that to his surprise, Mike returned to the flat and woke him up and appeared upset that he had called the Police. He said he was 'baffled' by the Police decision not to detain him as he felt that Mike was psychotic and that anyone speaking to him would realise that he was 'not OK'. In the morning the flatmate said that he tried to persuade Mike to go with him to hospital adding that Mike got into the flatmate's car initially but then changed his mind. The flatmate went to work and initially maintained contact

with Mike by phone and mentioned one phone call which appeared to go well which reassured him to an extent. When Mike turned his phone off the flatmate's concerns increased which is when he contacted GMP to request a welfare check shortly before 1pm. He said he understood the Police to have agreed to carry out a welfare check and told them that they would need a fob to get through the outer door of the apartment block.

4.22 The flatmate said that he also spoke to the ambulance service who he told that Mike was unlikely to engage with them as he would not want to go to a psychiatric hospital. The flatmate said that the ambulance service said that they couldn't force Mike to engage with them and they then gave him the AMHP contact numbers. He said that he then rang Access Trafford – which he said he thought was the AMPH service - and was told that someone would get back to him but they never did.

4.23 He went on to say that he then decided to return home from work early only to find Mike in the bath having apparently stabbed himself.

4.24 On reflection, the flatmate said that even he as a mental health nurse found the whole system for accessing support for Mike to be confusing.

4.25 Mike's parents and his flatmate had the opportunity to read and comment on a late draft of the SAR report.

Analysis

Explore the care and treatment Mike received whilst admitted to hospital under the Mental Health Act in the UK and arrangements for discharge.

Explore the arrangements for discharging Mike from his Mental Health Act hospital admission in the UK and providing mental health care and treatment in the community.

5.1 The SAR has been advised that Mike was twice admitted to hospital under the Mental Health Act in the UK. The first admission was from 27th July until 14th August 2020 (Paragraph 3.3) and the second admission was from 13th November until 9th December 2021 (Paragraphs 3.5 – 3.13). Following the first discharge, Mike was supported by the Ramsgate House, Salford CMHT as a standard patient (Paragraph 3.3) but following the second admission, Mike was referred for care co-ordination by the same Salford CMHT (Paragraph 3.11).

5.2 During the early stages of Mike's second Mental Health Act admission, Mike was twice reported missing by a concerned relative and then by his flatmate to GMP (Paragraph 3.8) which raises the question of whether Mike's next of kin was notified of his admission sufficiently promptly. Mike appears to have given his father's details as next of kin when GMP detained him under Section 136 of the Mental Health Act, but it appears that his father may not have become aware of his son's admission until 19th November 2021 (Paragraph 3.8) – which was 6 days after Mike's admission. GMMH have advised the

SAR that the Trust's Policy is for the patient's 'carer' to be contacted by a staff member (with the patient's consent) to notify them of the admission, give the ward/unit contact details and invite them to the first MDT review – within 24 hours.

5.3 Contacting the patient's 'carer' was more complex in Mike's case as his parents lived abroad in a substantially different time zone. However, the fact that Mike's aunt – who lived in Greater Manchester – and his flatmate reported him missing to GMP 5 days after his admission, suggests that contact with Mike's 'carer' may have been delayed for some reason.

Recommendation 1

That Trafford Strategic Safeguarding Partnership obtains assurance from Greater Manchester Mental Health NHS Trust that Trust staff comply with the policy of notifying a patient's 'carer' within 24 hours of admission under the Mental Health Act.

5.4 The author of the individual management report (IMR) submitted by GMMH author questioned whether Mike should have been allocated an independent mental health advocate (IMHA)[31] as he had no family to support him on the ward (paternal aunt lived locally and brother lived in London but parents resided abroad). Mike was eligible for support from an IMHA as he had been detained under the Mental Health Act and should have been provided with information about the IMHA service by the hospital manager as soon as he became liable to be detained (3). It is not known why IMHA support was not accessed by Mike although it is noted that he was allocated a peer mentor (Paragraph 3.9). In the Care Quality Commission's (CQC) 2021/22 Annual Monitoring the Mental Health Act Report in 2021/22 (4), they expressed concern that patients were not being given enough advocacy support although in their most recent Annual Monitoring the Mental Health Act Report (2022/23) the CQC does not repeat this concern.

Recommendation 2

That Trafford Strategic Safeguarding Partnership obtains assurance from Greater Manchester Mental Health NHS Foundation Trust that people admitted to hospital under the Mental Health Act are supported to access independent mental health advocate (IMHA) support.

5.5 Mike was allocated a care co-ordinator on 28th February 2022. (Paragraph 3.13 and 3.17) This was approaching three months after his discharge from hospital. The care co-ordinator promptly made in-person contact with him (on 3rd March 2022) and completed a care plan, risk assessment and crisis plan. The delay in allocating a care co-ordinator meant that he or she was not available to be involved in planning Mike's discharge from hospital and that there was no care plan in place until the care co-ordinator completed this on 3rd March 2022. However, the SAR has been advised that there was a

[31] An IMHA is an independent advocate who is trained in the Mental Health Act 1983 and supports people to understand their rights under the Act and participate in decisions about their care and treatment.

management plan in place which the Speciality Doctor had created on 10th February 2022 and shared with Mike's GP which addressed medication, crisis pathways and outpatients appointment details.

5.6 The error made in referring Mike for standard care as opposed to care co-ordinator support prior to his Mental Health Act discharge (Paragraph 3.11) does not appear to have been a significant factor in the delay in allocating a car co-ordinator to Mike as the mistake had been recognised and rectified prior to his discharge taking place.

5.7 There was also a delay in Trafford North CMHT allocating a care co-ordinator to Mike which appears to have been a factor which delayed his transfer from Salford to the Trafford North CMHT (Paragraph 3.34). The question therefore arises as to whether there is a wider issue of a shortage of care co-ordinators which is delaying their allocation to patients. In 2023 the CQC inspected GMMH and one of the three core mental health services the CQC inspected was community mental health services for adults of working age. The CQC found that the Trust faced significant challenges recruiting and retaining care co-ordinators within their adult community mental health teams which meant that there were waiting lists, particularly for allocation to care co-ordinators. The CQC noted that these waiting lists were monitored with cases being prioritised and regular reviews taking place to assess risk (5).

5.8 Given that the issue of delays in allocating care co-ordinators has been highlighted by the CQC and the CQC has reported on the measures being taken to manage any risks associated with this situation, no recommendation is made to Trafford Strategic Safeguarding Partnership.

5.9 The SAR has been made aware that currently there is a shift away from generic care co-ordination to what is described as 'meaningful intervention-based care' which envisages a named key worker for all service users with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.

Explore the complexities arising from Mike's admission to hospital under local Mental Health Act provisions in Gibraltar. In particular explore an apparent lack of connectivity between services in Gibraltar and the UK when Mike was discharged and returned to the UK and the lack of awareness of the care provided and any potential diagnosis during Mike's Gibraltar hospital admission.

5.10 Mike secured employment in Gibraltar during May 2023 but within a short time he became mentally unwell and it is understood that he presented at a hospital emergency department on 2 or 3 occasions before being admitted to the Ocean View Hospital in Gibraltar on 13th May 2023 under the local Mental Health Act – which is similar to the equivalent UK legislation.

5.11 The Gibraltar consultant psychiatrist overseeing Mike's care made prompt contact with Salford CMHT following Mike's admission (Paragraph 3.45). Trafford North CMHT became involved in the discussions about Mike's discharge from hospital in Gibraltar and repatriation to the UK. The manager of Trafford North CMHT provided the Gibraltar consultant psychiatrist with contact details for the Trafford home based treatment team (HBTT) who would be able to support Mike once he returned to the UK. Additionally, it was agreed that a joint assessment of Mike by Salford and Trafford North CMHTs would take place. The Gibraltar consultant psychiatrist advised that he hoped to have a clearer view of discharge timescales for Mike by the following week and would be back in touch with Trafford North CMHT. At this stage the elements of a plan necessary to ensure that repatriation of Mike to UK mental health services were being put in place although it would have been helpful to inform GP Practice 2, given that Mike had been discharged from Salford CMHT to primary care in February 2023 (Paragraph 3.41).

5.12 However, the plan appears to have been undone by the Gibraltar consultant psychiatrist being absent from work through sickness at the time that decisions were taken in relation to Mike's discharge from hospital in Gibraltar and so a narrower, more parochial approach appears to have been taken to discharge planning for Mike. At the time of his discharge, Mike was to be supported by the Gibraltar mental health crisis service at the Gibraltar address in which Mike had been living at the time of his MHA admission (Paragraph 3.46). The mental health crisis team were unable to contact Mike and presumably discharged him from their care without apparently making further enquiry. It is understood that the population in Gibraltar is quite transient and so it is understood that it is not considered unusual for a patient to leave the Territory and move elsewhere.

5.13 The SAR has been advised that there is an ongoing investigation by Executives of the Ocean View Hospital in Gibraltar into the treatment, care and discharge of Mike. The SAR Panel member from GMMH attended a virtual meeting with Gibraltar colleagues but attempts to arrange a further meeting to ascertain what has been learned from their investigation has been unsuccessful.

5.14 However, it would not be appropriate to focus entirely on actions taken or omitted in Gibraltar. With the benefit of hindsight, it was unwise to rely so completely on Gibraltar to share information. Once discharged, it seemed very likely that he would return to the UK and be in need of support. When no further information about Mike was received from Gibraltar, neither Salford nor Trafford CMHT contacted Gibraltar to check on Mike's progress and whereabouts nor considered checking his Trafford home address. The fact that Mike had been discharged by Salford CMHT and that the intended transfer of Mike to Trafford North CMHT had not taken place meant that at that time he was no longer a patient of either CMHT and therefore his case was not subject to monitoring via MDT meetings. He had been discharged by Salford CMHT to primary care but GP Practice 2 were not informed about Mike's Gibraltar Mental Health Act admission.

5.15 GMMH have advised the SAR that they are reviewing their patient repatriation policy having found that the existing policy provides detailed guidance to professionals in relation to the repatriation of patients under the care of UK mental health services to their countries of origin as opposed to the repatriation of UK citizens from mental health services abroad back into the UK.

Recommendation 3

That Trafford Strategic Safeguarding Partnership requests Greater Manchester Mental Health NHS Foundation Trust to share their revised repatriation policy with the Partnership so that they (the Partnership) may scrutinise the revised policy to check the extent to which the policy could have enhanced arrangements for repatriating Mike from Gibraltar to the UK.

Recommendation 4

That Trafford Strategic Safeguarding Partnership write to the Gibraltar Health Authority to share the learning from this SAR with them and also to invite the Gibraltar Health Authority to reciprocate by sharing the outcome of their investigation with Trafford Strategic Safeguarding Partnership when complete.

Explore how effectively cross border issues were addressed, in particular the arrangements for the transfer of Mike's care from the Salford community mental health team to Trafford North community mental health team.

5.16 On 22nd June 2022 Mike's GP practice (GP practice 1) decided to remove him from the practice list from 6th July 2022 (Paragraph 3.22). This decision appeared to have been triggered by noting in a letter from Ramsgate House, Salford CMHT that Mike had moved to a flat located in the Trafford Council area, whereas GP practice 1 is located in the Salford Council area. It is understood that Mike had moved to the flat in the Trafford Council area – which is a short distance from the boundary of the Salford City Council area – in 2021 and that GP practice 1 had previously been aware of his change of address but had taken no action at that time.

5.17 It is not known how significant the retirement of Mike's GP in March 2022 was in the decision to remove Mike from the practice list of GP Practice 1. The GP had provided very effective continuity of care to Mike and Mike appeared to value the care provided by his GP, on one occasion stating that he preferred to discuss his mental health issues with the GP rather than the CMHT (Paragraph 3.16). As stated, Mike's GP had retired by the time the decision was taken to remove Mike from the list of GP practice 1 and this decision appeared to be entirely transactional and took little or no account of Mike's health and wellbeing at that time. He was not taking his medication consistently and his relationship with his flatmate and his work colleagues appeared to be adversely affected by his paranoia. His care co-ordinator re-zoned him to 'amber' as a result of concerns that Mike was relapsing and becoming unwell (Paragraph 3.21). A referral to the HTT was also under consideration. It would have been helpful for GP Practice 1 to have discussed

the proposal to remove Mike from the practice list with the care co-ordinator and considered delaying its implementation until his mental health was more stable. It is difficult to avoid the conclusion that it was not in his best interests for Mike to be removed from the list of GP practice 1 at that time.

5.18 The SAR has been advised that it is normal practice when a patient moves out of area for the GP practice to send a letter to the patient to allow them 4 weeks to appeal this decision. If there are any mental health concerns in relation to the patient, the patient's GP would be consulted. The author of the Primary Care IMR feels that there is learning from the SAR around the deregistering of vulnerable patients and consideration of whether the patient's care co-ordinator or key workers need to be made aware and whether they could help support the patient in registering with a new practice.

Recommendation 5

That Trafford Strategic Safeguarding Partnership writes to the Greater Manchester Integrated Care Partnership (ICP) to request the ICP draw attention to the consideration that all GP practice's across Greater Manchester take into account any risks and consult any other services the patient is in contact with before finalising a decision to remove a patient from the GP practice list because they reside out of the geographical area covered by that GP practice.

5.19 There are many areas of Greater Manchester where travelling a short distance can take you across the boundaries of several Greater Manchester local authorities. In Mike's case, the flat he moved to in the Trafford Council area was a short distance from the Manchester City and Salford City Council areas. The GP Practice to which he then transferred in August 2022 (GP practice 2) was not located in the Trafford Council area. GP practice 2 is actually situated in the Manchester City Council area close to the border of Trafford Council and a GP from GP practice 2 who attended the practitioner learning event arranged to inform this SAR commented that the position of the practice on the border of Manchester and Trafford sometimes led to confusion over which geographic secondary mental health service to refer patients to.

5.20 Given that transitions of any kind can carry risks for people who are vulnerable in some way, one wonders whether a more flexible approach could be adopted to the address at which people live, when they live close to the border of two local authority areas so that there is less emphasis on transferring people from one geographic service to another. In Mike's case he was removed from the list of a Salford GP practice because he had moved to Trafford but then was able to register with a Manchester GP practice.

5.21 Turning to the CMHT transfer, the SAR documents a very significant amount of time and effort expended in attempting to transfer Mike from the Salford CMHT to Trafford North CMHT between 28th September 2022 – when Salford CMHT Speciality Doctor 1 wrote a 'transfer of care' letter to North Trafford CMHT (Paragraph 3.29) and 15th December 2022 – when Trafford North CMHT advised that an outpatient appointment would be booked for Mike once he returned to the UK (Paragraph 3.39). The SAR has been advised that a

transfer between CMHTs cannot be completed until the receiving team has allocated a care co-ordinator to the person. As previously stated, Trafford North CMHT placed Mike on an allocations list for a care co-ordinator (Paragraph 3.34) which suggests that the previously referred to challenges in recruiting and retaining care co-ordinators may be delaying transfers of patients between CMHTs. However, the process by which Mike's Salford care co-ordinator attempted to transfer him to Trafford North CMHT appeared to become unnecessarily protracted. Trafford North CMHT requested the 'transfer of care' letter to be sent again (Paragraph 3.33) and also requested Mike's Salford care co-ordinator to attend a Trafford North CMHT to present Mike's case when this had already been done (Paragraph 3.36) and Trafford North later advised Salford CMHT that things had become a 'bit tangled' due to several people being involved (Paragraph 3.36). As both CMHTs are provided by GMMH, one would have thought that patient transfers would be fairly seamless, although it is accepted that Mike's departure from the UK for an uncertain period of time complicated matters.

5.22 Having been unable to complete the transfer of Mike to the Trafford North CMHT and because of the continuing uncertainty over when he was likely to return to the UK, Salford CMHT decided to discharge Mike to the care of GP practice 2 in February 2023 (Paragraph 3.41) but the letter sent to GP Practice 2 was not copied to Mike and it is unclear whether it was copied to Trafford North CMHT so that they could anticipate the future referral of Mike to Trafford North CMHT when Mike contacted GP Practice 2 again following his return to the UK. Additionally, some confusion over which CMHT Mike was to be transferred to had gradually crept in over time so that when Salford CMHT discharged Mike to GP Practice 2 in February 2023, the CMHT incorrectly advised GP practice 2 to refer him to Manchester North CMHT. GMMH records indicate that Mike may also have been incorrectly advised that he would be transferred to Manchester North CMHT.

5.23 The author of the GMMH IMR concluded that, on reflection Mike's case should have remained with the Salford CMHT until his return to the UK and the transfer of his care to Trafford North CMHT fully completed at that time. This is also the view of the SAR independent reviewer.

5.24 In a previous SAR (SAR Johnnie) (6) completed by this independent reviewer for Manchester Safeguarding Partnership, a long term resident of Trafford was placed just over the border in a residential care home in the Manchester City Council area where he died just over a year later. In that case Trafford CMHT committed a significant amount of effort in seeking to transfer Johnnie to one of the Manchester CMHTs which was arguably a key factor in a range of issues which adversely affected Johnnie's life in the residential care home not receiving the attention they merited. It is not known how frequently people are transferred between CMHTs in Greater Manchester but this case, and the SAR Johnnie case suggests that decisions to transfer a case between CMHTs should be carefully thought through, the case should not be transferred until it is safe to do so, and the needs of the patient should be uppermost in the minds of those involved in decisions over case transfer.

5.25 Mike was registered with GP practice 2 in Manchester for 12 months until his death. GP practice struggled to engage with Mike from the outset. He completed an online physical activity questionnaire (Paragraph 3.27) but the GP practice was unable to complete Mike's annual mental health review (Paragraph 3.31). GP practice 2 has reviewed it's policy for registering new patients and noted that the policy does not include offering new patients a face-to-face appointment nor does it include a process for identifying a new patient's vulnerabilities or risks, although the GP practice did code Mike as having a 'mental health diagnosis'.

Recommendation 6

That Trafford Strategic Safeguarding Partnership write to the Greater Manchester Integrated Care Partnership to highlight the importance of all Greater Manchester GP practices having a process in place to identify vulnerabilities or risks affecting new patients, and where such vulnerabilities or risks are present, to prioritise an in-person consultation with the new patient.

5.26 Following his return to the UK, Mike attended an annual physical health review for patients with a mental illness at GP practice 2 in March 2023 (Paragraph 3.43). The author of the Manchester Primary Care IMR observed that there appears to be a lack of professional curiosity at this appointment to enquire why Mike felt his mental health diagnosis was incorrect. However, the health care assistant who saw Mike sent a task via the patient record system to refer onto a GP from the practice to follow up with Mike as they did not assess the risk as requiring an immediate review. Unfortunately, Mike did not engage with the follow-up contact and message left by the GP. The GP practice did not refer Mike back to mental health services because they had been incorrectly advised by Salford CMHT that Mike had been transferred to Trafford CMHT. The transfer had not been completed and Mike had not been advised that he had been discharged from Salford CMHT.

Explore how complexities arising from Mike spending substantial periods outside the UK were addressed.

5.27 Mike had advised his care co-ordinator that he would be going on holiday in November 2022 during a much earlier appointment but does not appear to have subsequently reminded his care co-ordinator of his impending departure. It is unclear whether Mike had initially planned to leave the UK for such an extended period (November 2022 to February 2023). The author of the GMMH IMR felt that once Mike had reportedly left the UK, there should have been more robust efforts to contact his family to establish his whereabouts and inform them that he was no longer receiving mental health treatment. Whilst there is evidence that such contact was attempted the Salford CMHT did not manage to speak to Mike's father – who as stated lived abroad – and there were no contact details for his UK based brother on the Trust's electronic patient system. The Trust's policy for managing situations where patients do not attend appointments advises staff to adopt a safeguarding perspective when someone unexpectedly does not attend a planned appointment. Particularly when Mike's absence on the previously mentioned

holiday abroad began to extend into a lengthy absence from the UK, this safeguarding perspective should have been applied and more persistent attempts made to contact Mike's family.

5.28 It is worthy of note that when Mike returned to the UK in March 2023 and again returned to the UK from Gibraltar in June 2023 there is no indication that he contacted statutory mental health services. Mike did not appear to be in sympathy with the services provided by statutory mental health services although his Salford CMHT care co-ordinator appeared to have established a constructive relationship with him and supported him to engage with the service and improve his compliance with medication for a time. His family have advised the SAR that Mike didn't like taking medication for anything and preferred herbal remedies. He seemed to be slightly more accepting of therapy as opposed to medication. It seems possible that Mike may have perceived his extended absence from the UK as an opportunity to achieve some kind of break from statutory mental health services. This was the impression gained when he saw the healthcare assistant at GP practice 2 in March 2023 when he said that he had stopped taking his medication as he disagreed with his diagnosis. When he did turn to mental health services in August 2023 when anxious about a new job he was due to start in the near future, he chose to approach Mind, a mental health charity rather than statutory mental health services.

Explore agency responses to any safeguarding adult concerns which arose in respect of Mike.

5.29 No safeguarding referrals were made or considered in respect of Mike. He was admitted to hospital under the UK and Gibraltar Mental Health Acts on three occasions and so would have been considered to have been in a place of safety at those times. When Mike was assessed by Salford CMHT to be at increased risk during the period when they supported him in the community, they applied the GMMH zoning policy to increase or decrease the level of contact they had with Mike.

5.30 The author of the GMP IMR noted missed opportunities to safeguard Mike during Police contact with Mike in March 2023 (Paragraph 3.42) – when the enquiry counter officer noted that Mike's eyes were wide and bloodshot and that he 'did not seem 100%' - and on 23rd August 2023 (Paragraph 3.50) – when the enquiry counter officer noted that Mike appeared to be really struggling with his mental health, appeared to be having 'a bit of a breakdown' and had isolated himself from everybody.

5.31 In respect of the March 2023. incident, the GMP IMR author concluded that further information could have been obtained from the enquiry counter officer about their concerns in relation to Mike's presentation. This may have been a missed opportunity for the submission of a care plan. GMP response officers record safeguarding adult concerns on a care plan which are then tasked to a District Safeguarding Team or the MASH for enhanced risk assessment and onward referral to partner agencies. Any immediate safeguarding actions are expected to be undertaken at the incident by the response officer.

5.32 In respect of the 23rd August 2023 incident the response officer did not see Mike face to face but spoke to him by phone as Mike declined to disclose his location (Paragraph 3.54). On this occasion the officer informed the radio operator that he intended to submit a CAP but did not do so. Information had been shared with NWAS on this occasion, who advised GMP that they had located the mental health service that Mike was under which may have been a factor in the officer not submitting a CAP.

5.33 On Friday 25th August 2023 the Access Trafford customer service officer created a record which was promptly assigned to the duty social worker (Paragraph 3.68). This will be discussed in more detail in the section of the report which analyses agency response to Mike's flatmate's efforts to obtain help for Mike on 25th August 2023.

Explore how partner agencies responded to third party reports that Mike may be actively suicidal.

Mike's contact with agencies on Wednesday 23rd August 2023

5.34 Professionals who came into contact with Mike on Wednesday 23rd August 2023 became concerned that he may present a risk of suicide or self-harm. However, he told the Stretford Police station enquiry officer that there was 'no danger' of him taking his own life (Paragraph 3.50) and later denied thoughts of suicide although he admitted that he had had thoughts of this nature in the past, when phoned by the mental health nurse from the NWAS EOC (Paragraph 3.53). However, he also told the station enquiry officer that his neighbours were stalking and harassing him to encourage him to kill himself.

5.35 Mike was seen in-person only by the station enquiry officer – who noted that Mike appeared to be really struggling with his mental health, appeared to be having 'a bit of a breakdown' and had isolated himself from everybody (Paragraph 3.50). When GMP attempted to visit Mike at his home, Mike was elsewhere and declined to divulge his whereabouts. The possibility that Mike may have been careful about what he disclosed to professionals because he feared he could be admitted to hospital under the MHA, could have been given more weight.

5.36 Additionally, there could have been a stronger emphasis on follow-up. As stated in Paragraph 5.32, GMP planned to submit a care plan but there is no indication that a care plan was actually completed. This prevented the care plan being triaged by the District Safeguarding Team or the MASH for enhanced risk assessment and onward referral to partner agencies. However, as stated GMP were made aware by NWAS that the mental health service Mike was under had been located. The GMMH mental health practitioner in the NWAS EOC appeared to have concluded that Mike was under the care of the Trafford North CMHT – although as the SAR has established Mike had been discharged by Salford CMHT to Manchester GP practice 2 in February 2023 and was therefore not under the care of any CMHT at that time. The GMMH mental health practitioner in the NWAS EOC sent an email to the

Trafford North CMHT manager who was on annual leave. (Paragraph 3.56). The CMHT manager's out of office email advised that any urgent emails be sent to the CMHT team inbox or contact made with the CMHT by phone. As previously stated, it has not been possible to establish whether the GMMH mental health practitioner in the NWAS EOC followed the out of office email advice and sent the email to the CMHT team inbox or contacted the CMHT by phone, although there is no indication that they did so. The email to the Trafford North CMHT manager had a heading which identified Mike by his initials and his GMMH Paris electronic record number but there was no content in the body of the email to explain why the practitioner was sending the email. Therefore this appears to have been a missed opportunity to alert the Trafford North CMHT to Mike's presentation on 23rd August 2023. Although Mike was not under the care of the Trafford North CMHT, they were aware of his Mental Health Act admission in Gibraltar and had provisionally planned that their HTT would support him on his return to the UK. At the very least a more complete email from the NWAS EOC GMMH practitioner to the Trafford North CMHT would have alerted them to the fact that Mike had returned to the UK and did not appear to be mentally well. Potentially this could have led to the activation of the previously agreed plan for Mike to be offered support by the Trafford HBTT and for a joint assessment of Mike by Salford and Trafford CMHTs.

5.37 GMMH has advised the SAR that any contact with a CMHT from outside agencies should be sent to the generic email for daily follow up by Duty and not sent to an individual worker. In this case the email was sent to an individual worker by a GMMH mental health professional who was deployed to an outside agency.

Single Agency recommendation

That Greater Manchester Mental Health NHS Foundation Trust remind practitioners employed by GMMH but deployed to outside agencies as part of partnership working arrangements to always comply with the policy of sending emails to the generic CMHT email address.

Mike and his flatmate's contact with agencies on Friday 25th August 2023

5.38 GMP officers quickly located Mike following his flatmate's 999 call at 04:34 on Friday 25th August 2023 and decided that they did not have grounds to detain Mike under Section 136 of the MHA. Not finding the kitchen knife which his flatmate reported that Mike had armed himself with on leaving their apartment – either in Mike's possession or nearby - appeared to be a significant factor in the Police decision. The SAR has been advised that Mike appeared calm and rational when spoke to by the officers. However, they recognised his vulnerabilities and submitted a care plan which was tasked to the District Safeguarding Team for triage, but this had not been completed prior to Mike's death.

5.39 There is no indication that the Greater Manchester Mental Health Tactical Advice Service (MHTAS) were consulted on this occasion. MHTAS were able

to provide invaluable support to GMP decision making to detain Mike under the Mental Health Act in November 2021 (Paragraph 3.5 and 3.6). The SAR has been advised that MHTAS can be contacted by frontline Police Officers and Police radio operators to request support in relation to incidents involving mental health issues. Had MHTAS been contacted after officers responded to Mike's flatmate's call during the early hours of Friday 25th August 2023, they would have been able to check GMMH systems and may have been able to establish that Mike had not apparently been taking medication for many months and possibly have become aware that Mike had been admitted to hospital in Gibraltar under local Mental Health Act provisions. However, other professionals who attempted to establish Mike's status in terms of secondary mental health care on 25th August 2023 struggled to piece together information to enable them to determine whether he was still under the care of a CMHT. The SAR notes that a review of MHTAS capacity and demand carried out in 2023 found that demand on the service often exceeded capacity.

5.40 Mike's flatmate has advised the SAR that he was 'baffled' by the Police decision not to detain Mike. In his professional judgement he felt that Mike was experiencing psychosis and would have struggled to present as mentally well, although his flatmate acknowledged that Mike was strongly motivated to avoid being admitted to hospital under the Mental Health Act and would make every effort to present himself to professionals in a manner which reduced the likelihood of a hospital admission.

5.41 Later on the morning of Friday 25th August 2023, Mike's flatmate tried to encourage him to let him take him to hospital. When Mike declined, the flatmate went to work and tried to maintain contact with Mike by phone. Over the course of the day, the flatmate made substantial efforts to obtain support for Mike, particularly from around 12.45pm on that day when Mike began no longer answering his phone calls.

5.42 The approach adopted by the GMMH Trust Wide Helpline (Paragraph 3.59) and the approach expected of Access Trafford - but not followed by Access Trafford on this occasion (Paragraph 3.68) - was to advise the flatmate to call the Police and request a welfare check or in the case of Access Trafford to contact the Police directly to request a welfare check.

5.43 However, when the flatmate contacted GMP to request a welfare check on Mike, the Police subsequently decided that the ambulance service were best placed to deal with the incident and closed the incident (Paragraph 3.64). The District Sergeant took the view that 'decision making concerning health care matters should be made by clinically trained professionals and not police officers'. This is a reasonable view. However, without wishing to 'second guess' the decision of a busy professional who took a decision in good faith, it is worth pointing out that there are potentially a number of dilemmas arising from the view that 'decision making concerning health care matters should be made by clinically trained professionals and not police officers':

- The policy of several agencies at that time (GMMH Trust Wide Helpline and Access Trafford) was that the Police should be requested to carry out a welfare check in relation to an actively suicidal person.

- The ambulance service does not have a power of entry should Mike not have engaged. There was good reason to believe that Mike may not engage with the ambulance service on the basis of how he had presented two days earlier on 23rd August 2023.

- The ambulance service would not be able to treat Mike or take him to hospital for treatment without his consent – assuming he was deemed to have capacity to make decisions in relation to his care and treatment.

- As with Police Officers, NWAS paramedics are not trained mental health professionals.

- The ambulance service has been experiencing significant problems in meeting targets for responding to calls since the pandemic and so assuming that NWAS would have been able to provide a timely response was what might be described as a 'load bearing' assumption.

5.44 The GMP IMR concludes that whilst the District Sergeant was correct to take the view that a clinically trained professional, in the form of the ambulance service, would have been the best placed service to deal with this kind of incident, GMP has concluded that given that the ambulance service had estimated that they would not be attending for at least 1 hours and 30 minutes and given the call during the early hours of the same morning that Mike had taken a knife out of his flat to harm himself, GMP would have been best placed to attend this incident.

5.45 Mike's flatmate became increasingly concerned about Mike's welfare as the day wore on and as well as contacting GMP, he also had a substantial conversation with a GMMH mental health practitioner in the NWAS EOC who gave the flatmate the phone numbers for the Trafford Approved Mental Health Professionals (AMHP). Both the in-hours and out of hours numbers were provided. The in-hours number was the number for Access Trafford.

5.46 At 15:35 Mike's flatmate phoned Access Trafford. In his contribution to the SAR, the flatmate said that when he rang the number he thought had been to given him as the Trafford AMHP service he was connected to Access Trafford. As stated in Paragraph 3.68 the Access Trafford customer service officer initially attempted to put the flatmate's call through to the Adult Safeguarding Hub but the line was busy and so she created a contact on Adult Social Care client record system which was promptly assigned to a social worker for an urgent MHA assessment. The duty social worker read the information obtained by the customer service officer – that Mike's flatmate was extremely concerned about Mike, who had schizophrenia and 'lots of suicidal thoughts' and had taken a kitchen knife out with him 'last night' and the Police had found him without the knife and brought him home. The flatmate had requested a Mental Health Act assessment of Mike and that

someone called him (the flatmate) urgently. He provided his mobile phone number. The social worker appeared to be reassured by the fact that GMP were aware of the concerns in relation to Mike's mental health and had seen him 'the night before'. As stated, the usual course of action at that time would have been to request the Police to complete a welfare check but the social worker noted that the Police were already aware of the concerns in relation to Mike's mental health and concluded that the right professionals were already dealing with Mike to enable him to access support around his mental health. The duty social worker planned to follow up with the Police and 'Mental Health Team' the next day to check whether there was any additional support required from Adult Social Care. The flatmate's request for a Mental Health Act assessment does not appear to have been further considered and there is no indication that Access Trafford or the social worker made further contact with Mike's flatmate that afternoon.

5.47 As previously stated the SAR has been advised that if a person rings Access Trafford to request a Mental Health Act assessment, the details are obtained and passed to the AMHP Hub who would then make contact with the person requesting the assessment (Paragraph 3.67). The SAR has also been advised that the primary pathway to request an urgent MHA assessment for professionals is via the CMHT's Single Point of Access, where referrals are screened and triaged by duty workers and can be discussed with CMHT senior staff for case and risk management and prioritised.

5.48 Mike's flatmate decided to return home only to find Mike in the bath having apparently stabbed himself, contacted NWAS – who attended very promptly but were unable to save Mike. Everyone involved in this SAR's hearts go out to Mike's flatmate who made every possible effort to obtain support for Mike. Given that he contacted so many agencies on 25th August 2023 - but to no avail – it is incumbent on all partner agencies involved to reflect on their response to Mike's flatmate to identify whether there were missed opportunities and whether any changes need to be made to single and multi-agency policies and procedures.

5.49 It is important to acknowledge that decisions taken previously hampered the ability of partner agencies to respond to the escalating concerns about Mike on 23rd and 25th August 2023. In particular the Salford CMHT decision to discharge Mike to GP Practice 2 rather than holding his case until her returned to the UK and transferring him to Trafford North CMHT at that time – which meant that professionals attempting to find out whether Mike was in contact with mental health services on 23rd and 25th August 2023 struggled to obtain a clear picture – and the lack of contact between Gibraltar mental health services and Trafford North CMHT to arrange for Mike's repatriation to UK mental health services. The Salford CMHT discharge decision and the breakdown of the plan to repatriate him from Gibraltar to UK mental health services left Mike disconnected from appropriate support as his mental health deteriorated. It also seems clear that Mike wished to avoid contact with mental health services and appeared to have actively steered clear of statutory mental health services since November 2022.

5.50 The principal advice Mike's flatmate received on 25th August 2023 was that he should contact the Police and request them to conduct a welfare check. However, this approach did not yield the results the flatmate expected. GMP had not detained Mike under Section 136 of the Mental Health Act as the flatmate had anticipated when he contacted them during the early hours of that day and GMP passed his call to the ambulance service when he again requested a Police welfare check later in the day. And when the flatmate was contacted by the ambulance service and the constraints the ambulance service may face if they attended discussed with him – such as being denied access or Mike declining hospital attendance assuming there were no doubts about his capacity to make such a decision – the flatmate appears to have decided to contact the AMHP service to request a Mental Health Act assessment. Instead of getting through to the AMHP service his call was answered by Access Trafford who should have responded to his concerns by contacting the Police for a welfare check but did not do so, although they did refer the contact to the Adult Safeguarding Hub as expected. The social worker in the Adult Safeguarding Hub did not apparently appreciate the urgency of the request for support made by the flatmate to the customer service officer. Calling the flat mate back on the mobile phone number he had left may well have helped the social worker to fully grasp the circumstances and would have helped her to understand that although the Police had been involved with Mike that day, they were no longer involved. The social worker may have anticipated that the customer service officer has contacted GMP for a welfare check in accordance with policy. It would have been advisable to check that this had been done.

5.51 Turning to the changes needed to single and multi-agency policy and practice, Access Trafford have advised the SAR that their policy at the time was for the response to all calls taken where the person is actively suicidal to be that Access Trafford advise the caller that they have a duty of care to contact GMP for a welfare visit and make that call before sending the contact to the Adult Safeguarding Hub to respond. The SAR has been advised that Access Trafford customer service officers have been reminded of the policy, revisited e-learning training on suicide and the manager has requested additional training for customer service officer on communicating with people who may be actively suicidal.

5.52 The SAR has recently been advised that the process for responding to people who are presenting suicidal has been clarified as follows:

Step 1: Caller on Adult Social Care line presenting suicidal (immediate risk around taking their own life/immediate risk to others).

Step 2: Access Trafford advisor then opens the conversation and goes over what the resident has just said. Explaining we have a duty of care and the next steps. They can also advise the caller that they can also present at the A&E department of the local hospital requesting urgent mental health assessment.

Step 3: Advisor takes as much detail as possible from the caller, such as current location, telephone number, is anyone with them etc.

Step 4: Access Trafford Advisor calls through to 999 and requests Police assistance stating that there is a 'real and immediate risk to life or risk of serious harm' whereby they have been made aware that a Trafford resident is actively suicidal and plans to complete suicide (high risk situation where there are Article 2 Rights to life situation). The request is for priority response from GMP in line with Section 17 Police and Criminal Evidence Act (PACE)[32] and RCRP principles. Access Trafford Call handler will pass on the information to the GMP call handler. The resident is handed over to the 999 call handler and Access Trafford are given a call log to provide evidence that a priority Police response is undertaken.

Step 5: The Advisor raises an urgent contact record on Liquid Logic (the Council's electronic case records system) for the resident, explaining the actions taken and this is then assigned to the area team the vulnerable adult resides in. This is also followed up by an email to the area team.

The SAR has also been advised that If caller has no immediate plans to take their own life, then their call is redirected to the GMMH 24/7 Mental Health Crisis Helpline for all ages so that the person or the person can access tailored advice and support around their current mental health crisis.

5.53 This policy clarification appears to be consistent with the Right Care, Right Person policy which will be discussed later in this report. The SAR has also been advised that since 30th April 2024 there is an option on NHS 111 (press option 2) - for Greater Manchester footprint only – to access a service which aims to mitigate risks and explore solutions with the caller. The telephone number 111 (press option 2) is designed to be simple and memorable for a caller experiencing mental health issues. This service has the facility to transfer calls to the GMMH 24/7 Mental Health Crisis Helpline for all ages.

Recommendation 7

That Trafford Strategic Safeguarding Partnership seeks assurance in relation to the robustness of the whole system for responding to people who are presenting as suicidal or people who are seeking help on behalf of someone presenting as suicidal. In particular the Safeguarding Partnership should obtain assurance that

- *the clarified 5 Step Process followed by Access Trafford in responding to people presenting as suicidal is working effectively,*
- *there is a shared system wide understanding of what constitutes an immediate risk, which would therefore require a Grade 1 response by GMP,*
- *and there is a shared system wide understanding of the process by which a Mental Health Act assessment may be requested.*

5.54 Returning to the flatmate's request for Mike to be assessed under the Mental Health Act which was not actioned by Access Trafford, the 'nearest relative' has the right to request mental health services to carry out an assessment

[32] Section 17 gives the Police the power to enter premises without a warrant in order to save life and limb or prevent serious damage to property.

under Section 26 of the MHA. There is no indication that Mike's flatmate made such a request as a 'nearest relative', although the SAR has been advised that although he was not a relative of Mike, he could have made such a request as he had lived with Mike for a fairly substantial period of time This independent reviewer has completed several SARs in which family members have become very concerned about the mental health of a loved one but have been unsure of how to get help for them. In particular the independent reviewer has found that families in such circumstances have generally been unaware of their right to request a Mental Health Act assessment as a 'nearest relative'.

Recommendation 8

That Trafford Strategic Safeguarding Partnership ensures that information about the rights of a 'nearest relative' to request a Mental Health Act assessment is accessible to members of the public who may need this information and that relevant professionals have an awareness of this right so that they can provide appropriate advice to members of the public.

5.55 The SAR has also been advised of further work undertaken to improve Trafford's 'front door' approach to responding to people presenting with suicidal ideation. A group of colleagues from relevant partner agencies has met on several occasions to share suicide prevention training materials, information about staff supervision available via Greater Manchester resilience hub, clarification about referral routes to crisis support across Trafford and ensuring the Trafford Council website includes up to date information and appropriate signposting to support. This information is being brought together into Trafford Suicide Response guidance for professionals across all partnership sectors in Trafford. An initial draft has been produced, and when finalised this will be proactively disseminated.

Recommendation 9

That Trafford Strategic Safeguarding Partnership shares the SAR report with the multi-agency group reviewing Trafford's 'front door' approach to responding to people presenting with suicidal ideation, so that the learning from the SAR informs the draft Trafford Suicide Response guidance.

5.56 On 25th August 2023 no professional managed to communicate directly with Mike, other than GMP when responding to his flatmate's call that he had left their flat with a knife and later in the day when he was phoned by Mind. Mike contacted Mind on 16th August 2023 and was referred to a Support Session which he did not attend. The SAR has been advised that Mind do not routinely ask people at the first point of contact whether they are being supported by statutory services. This question would only have been asked if Mike had accessed some - but not all Mind services. Mind phoned Mike during the morning of 25th August 2023 to invite him to the next scheduled Support Session (Paragraph 3.60). When asked about his mental health, Mike said that he was OK and gave no indication that he was approaching a crisis or that the voices were encouraging him to harm himself.

5.57 As previously stated there were opportunities to explore issues affecting Mike's mental health two days earlier (23rd August 2023) if Mike had been prepared to discuss them. His flatmate has advised the SAR that an important priority for Mike was doing or saying anything which could put him at risk of being admitted under the Mental Health Act. Had any professional been able to encourage Mike to discuss his feelings openly, they may have become aware of the constellation of anxieties affecting Mike in relation to his financial worries which had recently led him to sell his car, his growing anxieties about the job he had accepted and the fears that he might struggle in this role and the impending termination of his tenancy and the uncertainty over where he might live thereafter.

5.58 Mind was also contacted by Mike's father on the day his son died (Paragraph 3.70). It is noted that the email his father sent National Mind at 10:24 that morning was marked 'CRITICAL MY SON MICHAEL' but was not passed to Manchester Mind until 16:10 that day. Manchester Mind have been asked whether the email could have been sent to them more promptly given the heading and the subject and advised that each local Mind is an independent charity, and although they form part of wider Mind network, local Mind organisations are not governed by them. In those circumstances there do not appear to be standards for issues such as speed of communication between National Mind and local Mind organisations. Had Manchester Mind received the email earlier in the day they would have been able to ring or attempt to ring Mike and would have had the awareness that his family was very worried about him – which they lacked when they spoke to Mike by phone at 10:13 the same day. In their contribution to this SAR, Mind have reflected on whether there could have been any benefit in them calling the GMMH Trust Wide Crisis line themselves to report a concern raised in this way given that the person contacting them (Mike's father) was not resident in the UK.

5.59 Over 23rd and 25th August 2023 professionals had only very limited opportunity to consider whether Mike had mental capacity to decline support such as his decision to decline the ambulance attendance on 23rd August 2023. There are some brief references to 'capacity' in the records of agency contact with Mike's flatmate, but the meaning of these brief references were ambiguous and appeared to relate to Mike's capacity to access the means to take his own life. However, when Mike's flatmate read extracts from a late draft of this SAR report, he stated that when he discussed Mike's capacity with professionals on 25th August 2023, he was referring to Mike's mental capacity to make decisions about the support he needed. The flatmate added that in his view Mike lacked capacity to make such decisions due to what he considered to be Mike's 'psychotic' state.

Explore whether partner agency responses to contacts made on behalf of Mike on the day he died followed agency policies and standard operating procedures and whether there were any contextual circumstances, such as the time and day on which the contacts were made, which impacted on their response.

5.60 One potential contextual issue was that the efforts of Mike's flatmate to obtain support for Mike took place on a Friday (and a Friday before a public holiday weekend) and so at around 5pm on that day most services would transition to out of hours provision. However, Mike was found deceased or dying by his flatmate shortly after 4pm on Friday 25th August 2023 and so out of hours services did not became involved. Mike's flatmate had apparently been given both the in-hours and out of hours Trafford AMHP contact numbers as a precaution.

5.61 Another key contextual issue was the demand which services were managing on Friday 25th August 2023, particularly NWAS who were unable to respond within target timescales to the Grade 3 incident created following Mike's flatmate's call to GMP just before 1pm – and which was passed to NWAS shortly thereafter. The challenges faced by the ambulance service in achieving expected response times to incidents has been well documented and is a multi-factorial and multi-agency UK wide challenge which fundamentally involves hospital trusts being unable to free up beds with safe discharge of those who no longer have medical need to be in hospital. The SAR has been advised that in the autumn of 2023 NWAS secured additional funds in order to recruit additional staff and procure additional ambulance vehicles in an attempt to minimise response delays.

Explore if the principles of Right Care, Right Person (RCRP) were applied in this case. (The SAR has been advised that RCRP had not yet been implemented by Greater Manchester Police (GMP) but that RCRP principles may have been applied during the GMP response when Mike was presenting in crisis.

5.62 In common with police forces across England and Wales, GMP is in the process of implementing the Right Care Right Person RCRP) approach which aims to identify when calls require a police response and when a different agency would be better placed to assist. GMP has advised the SAR that RCRP will not stop the police attending mental health incidents where there is a real and immediate threat to life, a risk of serious harm, a child is at risk, or where a crime or potential crime is involved. Of the 51,000 mental health concern for welfare calls GMP currently receives each year, 88% are not classed as emergencies – and these are the calls they wish to signpost to other agencies where they can.

5.63 RCRP had not yet been implemented at the time of Mike's death, but it was thought that RCRP principles may have been applied during the GMP response when Mike was presenting in crisis, specifically the decision taken by the District Sergeant to close the log without completing the Police welfare check on Mike requested by his flatmate (Paragraph 3.64).

5.64 As previously stated, the GMP IMR concluded that best practice would have been to create the incident reported to the Police by Mike's flatmate at 12:58 on 25th August 2023 as Grade 1 – Immediate Response. The GMP IMR author agreed with the District Sergeant's view that a clinically trained professional, in the form of the ambulance service, would have been the best placed service to deal with this kind of incident. However, as the ambulance

service would not be attending for at least 1hr and 30 minutes, given the recent calls made to police in relation to the fact that Mike had taken a knife out of the address with which to harm himself, the police would have been best placed to attend this incident.

5.65 It is worthy of note that the District Sergeant did not reference the RCPC principles the rationale she documented for not completing the welfare check. She did however, reference the College of Policing App on mental health which includes a section entitled 'Responses by the most appropriate agency'. This section of guidance makes no mention of RCPC and adopts quite a nuanced approach to the issue. It states that 'in general, when there is no reason to suspect that a crime has been, or is likely to be committed, responses to the needs of people with mental ill health and vulnerabilities should be provided by appropriately commissioned health and social care services'. Having set out this 'general' principle, the guidance goes on to provide examples of when the Police have a duty to respond, including the duty to protect the Article 2 right to life when the Police know, or ought to know of real and immediate risk to a person's life from an act or acts of violence; to exercise powers when confronted by people experiencing mental disorder; or to use reasonable efforts to find and escort to a place of safety a person attempting to take their own life. The guidance does not provide the strongest of justification for the District Sergeant based on what was known at the time so it seems possible that RCRP principles may have influenced her decision.

5.65 Many SAR Panel members felt that the approach documented by the District Sergeant appeared to be consistent with the principles of RCRP, which though not yet implemented as GMP policy at that time, had been trialled in the Humberside Police area and was planned to be implemented across the police forces of England and Wales. Additionally, several SAR Panel members expressed concern about the lack of clarity in relation to how RCRP will work in practice and whether the implications for how partner agencies will respond to the calls which GMP will no longer attend had been fully thought through.

5.66 It is accepted that these wider RCPC concerns are outside the scope of this SAR, but that Trafford Strategic Safeguarding Partnership will wish to seek assurance that clear communication will be shared about how RCRP will operate in future and to ensure that clear pathways are established. As stated the guidance provided to customer service officers in Access Trafford of the action to take in response to callers who are presenting as suicidal has been clarified in the light of the learning arising from this SAR and also takes account of RCRP.

Recommendation 10

That Trafford Strategic Safeguarding Partnership should seek assurance from its partner agencies that clear communication will be shared about how RCRP will operate in future and ensuring that clear pathways are established.

Explore how practitioners addressed the interaction between Mike's mental health, alcohol consumption and periodic lack of concordance with prescribed medication.

5.67 Salford CMHT regularly encouraged Mike to refer himself to GMMH's Achieve Recovery Service in respect of his alcohol consumption, but he always declined the offer of this support. There is no documented exploration of Mike's reasons for declining support but it is possible that he often saw alcohol consumption as a method of 'drowning out' his auditory hallucinations. Given his reluctance to engage with statutory mental health services, the fact that Achieve was part of GMMH may have been a factor which deterred him from engaging with Achieve. However, he was offered a referral to Change Grow Live (CGL) – the Achieve equivalent in the Manchester City Council area when he saw the health care assistant at GP practice 2 in March 2022 but did not self-refer to that service – which is not provided by a mental health trust. However there was a missed opportunity for GP practice 2 to complete the referral to CGL on Mike's behalf which is the recommended referral guidance by CGL to Primary Care so that if the patient does not engage with the service, CGL will inform the referrer (the GP) so that further follow up can take place. During that consultation Mike seemed open to contact with Alcoholics Anonymous.

Explore the effectiveness of information sharing and multi-agency working to safeguard Mike.

5.68 This key line of enquiry has been explored earlier in this analysis, particularly in Paragraphs 5.34 to 5.59.

Support for people who experience workplace stress and anxiety.

5.68 This key line of enquiry has emerged during the course of the completion of this SAR. Mike's parents felt that their son's mental health struggled stemmed from the difficulties he encountered during his ultimately unsuccessful attempts to qualify as a commercial pilot (Paragraph 4.2). His flatmate felt that employment was a trigger for Mike's mental health issues as he struggled with social situations in the workplace (Paragraph 4.13) and that Mike experienced disappointment and shame when jobs didn't work out for him. The flatmate also felt that Mike put himself under pressure by applying for demanding jobs with a good salary (Paragraph 4.15) but was reluctant to seek help from his employers when he began to experience workplace stress.

5.69 GMMH have advised the SAR that securing and maintaining employment was seen as a protective factor although his care co-ordinator encouraged him to be open and honest about his mental health with his employer. GMMH also advise that whilst they do not have a specific tool to assess workplace related stress, the clinical risk assessment should consider workplace stressors as part of the holistic assessment and incorporate these into care planning. GMMH state that it would not be routine practice to liaise with a patient's employer unless this had been sought by Mike or the need arose over concerns relating to the patient's work with adults at risk or children.

5.70 Mike was qualified as a Building Information Modelling draughtsman and worked in this field and others for a range of employers in the UK and abroad. It is not known whether he sought support in respect of workplace stress from his employers. Some organisations have employee assistance programmes (EAPs) which offer free advice and counselling. Others have internal support systems such as mentoring or buddy systems. Mike was signposted to Able Futures by Mind although he did not make contact with them.

5.71 Working conditions and environment can have a huge impact on mental health, and, equally, someone's mental health can significantly affect performing well in their job (7). 1 in 6.8 people experience mental health problems in the workplace in the UK (14.7%). (8) The World Health Organisation (WHO) states that people living with mental health conditions have a right to participate in work fully and fairly. The UN Convention on the Rights of Persons with Disabilities provides an international agreement for promoting the rights of people with disabilities (including psychosocial disabilities), including at work. The WHO recommends three interventions to support people with mental health conditions gain, sustain and participate in work:

- Reasonable accommodations at work adapt working environments to the capacities, needs and preferences of a worker with a mental health condition. They may include giving individual workers flexible working hours, extra time to complete tasks, modified assignments to reduce stress, time off for health appointments or regular supportive meetings with supervisors.
- Return-to-work programmes combine work-directed care (like reasonable accommodations or phased re-entry to work) with ongoing clinical care to support workers in meaningfully returning to work after an absence associated with mental health conditions, while also reducing mental health symptoms.
- Supported employment initiatives help people with severe mental health conditions to get into paid work and maintain their time on work through continue to provide mental health and vocational support. (9)

5.72 Mike could have benefitted from the type of adaptations to his working environment envisaged by the WHO and return-to-work support after any mental health related absence. He appears to have been quite reluctant to disclose the impact of workplace stressors on his mental health so Mike may have benefitted from a ‘mental health aware’ workplace where managers and co-workers were able to identify signs of mental health in colleagues and sensitively offer help and support.

5.73 It is difficult to make a specific recommendation in relation to workplace related mental health. The SAR has become aware of an organisation called Mental Health at Work which provides ‘customised and innovative programmes which make a difference to working lives in organisations’. There could be benefit in some kind of initiative which brings together mental health providers, employers and organisations such as Mental Health at Work to share experiences and expertise. However, focussing on the responsibilities of the Safeguarding Partnership, there would be benefit in sharing the learning from this SAR with those responsible for the Trafford Suicide

Prevention Strategy 2022-2025 so that further consideration may be given to developing strategies to support people who experience mental health problems in the workplace.

Recommendation 11

That Trafford Strategic Safeguarding Partnership shared the learning from this SAR with those responsible for the Trafford Suicide Prevention Strategy 2022-2025 so that further consideration may be given to developing strategies to support people who experience mental health problems in the workplace.

Explore the impact of the Covid-19 pandemic on Mike and on Mike's access to services.

5.74 Mike was first detained under the Mental Health Act during July 2020, shortly after the restrictions introduced during the first Covid-19 lockdown had eased. It is not known how the first lockdown affected Mike's mental health and wellbeing. By the time he was admitted to hospital under the Mental Health Act for a second time in November 2021 restrictions on members of the public had been eased considerably although the self-isolation requirements relating to the Omicron variant was having a significant impact on staffing levels across a range of employment sector. Agencies continued to operate in accordance with the exceptional delivery models implemented at the outset of the pandemic.

5.75 It is noted that a great deal of contact with Mike by the CMHT was by telephone. The pandemic brought a shift away from in-person contact to telephone and video conferencing which appears to have been maintained post pandemic to a degree. The GMMH IMR suggested that hybrid working arrangements may also be a factor in the continuing emphasis on telephone contact with patients. GMMH advise that their current policy is to determine the type of contact they have with patients through assessments including the assessment of risk factors. Working from home became the norm for many professions during the pandemic. This appeared to offer the prospect of some relief from the workplace stress Mike experienced although his flatmate felt that the move to remote working did not alleviate the problem as video conferencing meetings also caused him anxiety (Paragraph 4.13).

Good practice

- The ongoing pilot scheme under which mental health practitioners from GMMH and Pennine Care work in the NWAS Emergency Operations Centre.

- The Salford GP provided excellent continuity of care to Mike, who appeared to really value the care he received from the GP.

- The role played by the Greater Manchester Mental Health Tactical Advice Service (MTAS) in advising the officers dealing with the incident which led to Mike being detained under the Mental Health Act in November 2021.

- Once appointed, the Salford CMHT care co-ordinator engaged effectively with Mike. Mike was listened to and his medication changed when he reported that his previous medication made him feel drowsy.

List of Multi-agency Recommendations

Recommendation 1

That Trafford Strategic Safeguarding Partnership obtains assurance from Greater Manchester Mental Health NHS Trust that Trust staff comply with the policy of notifying a patient's 'carer' within 24 hours of admission under the Mental Health Act.

Recommendation 2

That Trafford Strategic Safeguarding Partnership obtains assurance from Greater Manchester Mental Health NHS Foundation Trust that people admitted to hospital under the Mental Health Act are supported to access independent mental health advocate (IMHA) support.

Recommendation 3

That Trafford Strategic Safeguarding Partnership requests Greater Manchester Mental Health NHS Foundation Trust to share their revised repatriation policy with the Partnership so that they (the Partnership) may scrutinise the revised policy to check the extent to which the policy could have enhanced arrangements for repatriating Mike from Gibraltar to the UK.

Recommendation 4

That Trafford Strategic Safeguarding Partnership write to the Gibraltar Health Authority to share the learning from this SAR with them and also to invite the Gibraltar Health Authority to reciprocate by sharing the outcome of their investigation with Trafford Strategic Safeguarding Partnership when complete.

Recommendation 5

That Trafford Strategic Safeguarding Partnership writes to the Greater Manchester Integrated Care Partnership (ICP) to request the ICP draw attention to the consideration that all GP practice's across Greater Manchester take into account any risks and consult any other services the patient is in contact with before finalising a decision to remove a patient from the GP practice list because they reside out of the geographical area covered by that GP practice.

Recommendation 6

That Trafford Strategic Safeguarding Partnership writes to the Greater Manchester Integrated Care Partnership to highlight the importance of all Greater Manchester GP practices having a process in place to identify vulnerabilities or risks affecting new patients, and where such vulnerabilities or risks are present, to prioritise an in-person consultation with the new patient.

Recommendation 7

That Trafford Strategic Safeguarding Partnership seeks assurance in relation to the robustness of the whole system for responding to people who are presenting as suicidal or people who are seeking help on behalf of someone presenting as suicidal. In particular the Safeguarding Partnership should obtain assurance that:

- *the clarified 5 Step Process followed by Access Trafford in responding to people presenting as suicidal is working effectively,*
- *there is a shared system wide understanding of what constitutes an immediate risk, which would therefore require a Grade 1 response by GMP,*
- *and there is a shared system wide understanding of the process by which a Mental Health Act assessment may be requested.*

Recommendation 8

That Trafford Strategic Safeguarding Partnership ensures that information about the rights of a 'nearest relative' to request a Mental Health Act assessment is accessible to members of the public who may need this information and that relevant professionals have an awareness of this right so that they can provide appropriate advice to members of the public.

Recommendation 9

That Trafford Strategic Safeguarding Partnership shares the SAR report with the multi-agency group reviewing Trafford's 'front door' approach to responding to people presenting with suicidal ideation, so that the learning from the SAR informs the draft Trafford Suicide Response guidance.

Recommendation 10

That Trafford Strategic Safeguarding Partnership should seek assurance from its partner agencies that clear communication will be shared about how RCRP will operate in future and ensuring that clear pathways are established.

Recommendation 11

That Trafford Strategic Safeguarding Partnership shared the learning from this SAR with those responsible for the Trafford Suicide Prevention Strategy 2022-2025 so that further consideration may be given to developing strategies to support people who experience mental health problems in the workplace.

SAR Single Agency recommendation

That Greater Manchester Mental Health NHS Foundation Trust remind practitioners employed by GMMH but deployed to outside agencies as part of partnership working arrangements to always comply with the policy of sending emails to the generic CMHT email address.

Single Agency Recommendations:

GMMH:

- The Salford Standard Operating Policy for the CMHT to be updated with directions of the management of service users who are detained abroad. This will include remotely attending ward rounds and discharge planning meetings and liaising with the partner agency for safe repatriation.

- Robust follow up with families and correct associations and contact details recorded on Paris.

- Transfer processes – Standard Operating Procedure to be updated on the management if Transfers out of the team, robust procedures to follow to manage and hold out of area transfers.

- Transfers in and out of the team to be added to the Multi-Disciplinary Sheet for the MDT meetings.

- Transfer processes to be reviewed in both Trafford and Salford CMHT's.

- Risk Training has been undertaken with the staff teams in Salford facilitated by the Co-occurring Conditions Practitioners (Previously known as Dual Diagnosis Practitioners) in relation to managing service users who use substances, alcohol and are taking prescribed medication and the risks and inclusive of non-concordance.

- External investigation taking place at the Ocean Views Hospital into the treatment, care, communication with external agencies and discharge planning and discharge. Initial meeting with Consultants at the Ocean View Hospital due at the beginning of April 2024.

Salford GP (GP practice 1)

- Practice will take as learning the need to consider whether Care-Coordinators need to be made aware if a patient is being removed from their list to help support them to register with a new GP.

Manchester GP (GP practice 2)

- Review of Primary Care 'did not attend/was not brought' policy for adults to ensure incorporates risks for individuals with diagnosed mental health issues who disengage from services / non-responsive to various forms of communication from the Practice / non-concordant with medication.

- GP Practices to review their new patient registration policy/process to clarify when patients should be invited in for a new patient face to face appointment.

- GP Practices to review escalation process for all clinical staff (including health care assistants) to understand risk when patients disclose stopping mental health medication or displaying behaviour which could suggest mental health deterioration or relapse. The process to include responsibility of adding appropriate flags and codes to the patients records.

- GP Practices to review their policy on offering and completing referrals to substance misuse services – this is to cover situations where the patient may need more assertive outreach and referrals completing on their behalf.

NWAS

- This is not able to be understood clearly until the RCRP pathways have been agreed with all parties and GMP. In addition, robust understanding and monitoring of the agreed pathways must be in place to ensure the approach is working as expected.

- If the current pilot trial with NWAS, GMMH and Pennine Care continues and is commissioned the benefits should be mutually understood by all parties with communications undertaken to ensure all parties feel the approach is giving the best outcomes to meet the patient's needs.

Mind

- Roll out additional training in relation to suicide risk assessment / hearing voice risk assessment.

Adult Social Care

- Recommendation1: Access Trafford Manager has identified a learning and development need within the Access Trafford Team in relation to talking with people that are suicidal. Training is to be offered via the Trafford Council Learning and Development Team.
  Actions All Access Trafford staff to undertake e-learning re suicide awareness Access Trafford staff responding to ASC contacts are to complete a suicide prevention training course.

- Recommendation 2: The Strategic Lead for Mental Health is overseeing a number of actions designed to create more of an appropriate "front door" route for contacts that are made with the department for individuals struggling with mental health and suicidal ideation. Governance arrangements in place are that these actions are overseen by the Trafford Suicide Prevention Board. Neighbourhood model redesign to incorporate "front door" changes including links with Mental Health Services Automated telephone system response with guidance for callers reporting suicide ideation.

GMP

- No recommendations

References:

(1) Retrieved from https://www.nwas.nhs.uk/about/performance/999-standards/

(2) Retrieved from https://www.college.police.uk/app/mental-health/introduction-and-strategic-considerations

(3) Retrieved from https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF

(4) Retrieved from https://www.cqc.org.uk/publications/monitoring-mental-health-act

(5) Retrieved from https://www.cqc.org.uk/provider/RXV

(6) Retrieved from https://www.traffordsafeguardingpartnership.org.uk/Learning-and-development/Resource-bank/7-Minute-Briefings/7-Minute-Briefing-Distressed-Behaviour.aspx

(7) Retrieved from https://www.mentalhealth.org.uk/explore-mental-health/statistics/mental-health-work-statistics

(8) Retrieved from gov.uk/government/uploads/system/uploads/attachment_data/file/212266/hwwb-mental-health-and-work.pdf

(9) Retrieved from (https://www.who.int/news-room/fact-sheets/detail/mental-health-at-work)

Appendix A

Process by which safeguarding adults review (SAR) conducted.

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Membership of the SAR Panel:

Morgan Adams, Safeguarding Support Officer, Trafford Strategic Safeguarding Partnership.
Georgina Cartridge, Designated Practitioner for Adult Safeguarding, Greater Manchester Integrated Care Partnership.
Ciaran Cusack, Principal Social Worker, Trafford Adult Social Care.
Emma Hooper, Board Manager, Trafford Strategic Safeguarding Partnership
Catherine Hough, Named Nurse Safeguarding Children, Children in Care and Adult Strategic, Manchester NHS Foundation Trust.
Anne-Marie Lord, Safeguarding Adult Lead Greater Manchester Mental Health NHS Foundation Trust.
Clare Makin, Quality Assurance Officer, Trafford Strategic Safeguarding Partnership
David Mellor - Independent Reviewer
Vicky Tait, Detective Constable, GMP Serious Case Review Team.
Jane Whittaker, Safeguarding Practitioner, North West Ambulance service NHS Foundation Trust.

Chronologies which described and analysed relevant contacts with Mike were completed by the following agencies:

- Greater Manchester Integrated Care Partnership (Salford and Manchester)
- Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester Police
- Manchester NHS Foundation Trust
- North West Ambulance Service NHS Foundation Trust

- Trafford Council Adult Social Care
- Manchester MIND also shared information with the SAR.

The chronologies were analysed and issues were identified to explore with practitioners at a learning event facilitated by the lead reviewer.

Mike's parents and his flatmate have contributed to this SAR. At the time of writing Mike's parents and his flatmate were to be provided with the opportunity to read and comment on a late draft of the SAR report.

The independent reviewer developed draft reports which reflected the chronologies, the contributions of practitioners who attended the learning events and the views of SAR Panel members.

The report was further developed into a final version and will be presented to Trafford Strategic Safeguarding Partnership.