REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Ministry of Justice
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	INVESTIGATION and INQUEST On 1st November 2016 I commenced an investigation into the death of Philip Vernon Owen .The investigation concluded on the 22nd August 2019 and the conclusion was one of **Unlawful Killing**. The medical cause of death was **1a) Stab wound to the neck.**
4	CIRCUMSTANCES OF THE DEATH On 30th October 2016 at [redacted] Phillip Vernon Owen was killed by a stab wound to the neck by an individual. At the time of Phillip Owen's death, the individual had been and was involved with a number of state agencies. Subsequent to Philip Owen's death, the individual was diagnosed with a severe and enduring mental illness, namely Schizoaffective Disorder - Manic Type. The individual had been known to mental health services (GMMH) for a number of years. In 2013 the individual was diagnosed with Schizophrenia that was likely to be due to a functional psychiatric illness. In early 2014 the individual was referred to the Early Intervention Team (EIT).In 2014 there was a detention under the mental health act during which the primary diagnosis was Paranoid Schizophrenia. He was subsequently an inpatient on 5 further occasions – the time ranging from 4 weeks to 1 week. The last admission before Philip

Owen's death was on 24th June 2016 until 11th July 2016.The diagnosis recorded in discharge summaries reflected a view that drug use was driving the psychosis.

The diagnosis of a drug-induced psychosis was confirmed by the community psychiatrist. The electronic system was not amended. The individual ceased to use antipsychotics in the community and this was accepted by the EIT.

On 23rd September 2016 an incident involving the individual's brother was reported to the EIT. On 27th September 2016 the individual went to his mother's home address and assaulted her by strangulation. The individual was subsequently arrested, interviewed and charged with a S.39 assault on his mother. He appeared at court on 30th September 2016 and was remanded in custody to HMP Manchester. On 29th September 2016 a meeting discussed possible discharge of the individual from EIT but no clear decision was taken.

On 3rd October 2016 whilst in HMP Manchester, the individual took steps to take his own life. He was moved to the hospital wing. An assessment by a psychiatrist on 10th October 2016 concluded that there was an active psychotic illness, possibly drug-induced. Medicine for psychosis was prescribed. On 11th October 2016 there was a further attempt by the individual to take his life.

On 13th October 2016 the individual was sentenced by the court to 10 days custody for the assault on his mother. He was due to be released on that day. The unusual step was taken to hold back his release to 14th October 2016 by HMP, due to concerns about the risks of an unplanned release on 13th October 2016. On 14th October 2016 the EIT discharged the individual from their service. They failed to follow their own discharge process and failed to put an effective plan in place to manage the individual.

On 14th October 2016 the AMHP and care co-ordinator were made aware verbally that the prison consultant psychiatrist felt a Mental Health Act assessment was required. No written documentation was sent through in relation to that. The Mental Health Act assessment did not take place because the AMHP and care co-ordinator agreed without seeing the individual that one was not required. There was a failure to fully assess the risks of not carrying out such an assessment. In the period between the individual's release and the death of Phillip Owen, he was not assessed by Mental Health services. There was a failure to have an effective risk assessment in place within Mental Health services after his discharge from their team. On 19th October 2016 a MARAC meeting agreed a multi-agency meeting was required and

	would take place after the return from annual leave of the care co-ordinator. On 23rd October 2016 a further incident was reported to Mental Health services and Greater Manchester Police involving the individual's grandmother. The probation officer assigned to the individual was unsuccessful in attempts to meet with him. She conducted a risk assessment and identified the risk he posed to the public and his family as high. A telephone call was made to the probation service on 28th October 2016 by the individual's father expressing concerns regarding the individual's mental health. This was not passed on to the Mental Health services to action despite the individual being identified as high risk. On 30th October 2016 Philip Owen was found dead in his flat. The individual was subsequently arrested on 2nd November 2016 whilst awaiting Mental Health assessment. It is likely that the aggregation of the failures, created the circumstances whereby the killing could take place.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – The Inquest heard evidence from the Prison and Probation Service that, as was demonstrated in this case, there are significant challenges that are difficult to mitigate to ensure a safe release from custody where a very short custodial sentence is imposed which means an individual who is a high risk offender is eligible for immediate release. This is compounded where as in this case there is no significant licence period that the Probation Service can supervise; There was a lack of clarity as to how effectively these risks had been communicated to those involved in sentencing and what if any guidance existed support them in taking steps to minimise the risks to the public; It was unclear how much information was shared with the court regarding the level of risk by the Prosecution or the Probation Service and what

	expectations were or guidance to those assisting a sentencing court in the discharge of their duty.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th November 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [redacted] on behalf of the family 2) Greater Manchester Police 3) Trafford Council 4) Greater Manchester Mental Health 5) Prison and Probation Service, who may find it useful or of interest. I have also sent a copy of my report to the Sentencing Council, who may find it useful. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Alison Mutch OBE** **HM Senior Coroner** **02.10.2019**