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*Judgment: approved by the court for handing down (subject to editorial corrections and proofing prior to publication)**	*Delivered*: 13/12/2023

IN THE CORONERS COURT FOR NORTHERN IRELAND

CORONER MARIA DOUGAN

INQUESTS TOUCHING UPON THE DEATHS OF
LILLIAN MAJORIE CAWDERY
AND
MICHAEL JULIEN HOPE CAWDERY

Mr Steven McQuitty BL (instructed by Ms Sophie Laverty, Coroners Service for Northern Ireland); on behalf of the Coroner
Mr Thomas Fitzpatrick BL (instructed by Mr Patrick Mullarkey, O'Reilly Stewart Solicitors) for the Next of Kin
Mr Sean Smyth BL (instructed by Ms Sarah Loughran, Directorate of Legal Services) on behalf of the Belfast Health and Social Care Trust (BHSCT) and the Southern Health and Social Care Trust (SHSCT)
Ms Rachel Best BL (instructed by Mr Andrew Jackson, PSNI Legal Services) on behalf of the Police Service of Northern Ireland (PSNI)
Ms Ciara Ennis BL (instructed by Mr Patrick McMahon, Patrick McMahon Solicitors) on behalf of Mr Thomas Scott McEntee

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I want to thank, first and foremost, my own legal team for their support and dedication, throughout this inquest process, together with the staff from the Coroners Service for Northern Ireland. I also wish to thank the legal representatives acting on behalf of the Properly Interested Persons (PIPs) for their assistance and for the collaborative approach that has been adopted throughout.

I want to formally recognise the engagement and resilience of the extended Cawdery family. I admire their tenacity and determination in seeking answers about the loss of their loved ones. Michael and Majorie Cawdery, both aged 83 years old, were kind-hearted people, whose lives tragically ended, in the most unimaginable way. I am grateful for the respect that the Cawdery family have shown this inquest process and I offer my sincere condolences on the loss of Michael and Marjorie.

Introduction

[1] The inquests proceeded in Banbridge Courthouse from 12 June 2023 until 26 June 2023. During the 10-day inquests, I heard oral evidence from 40 witnesses,

and I considered a further 28 statements, together with voluminous reports, notes, and records, which were admitted pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ('1963 Rules'). It has not been possible to recite all the evidence in these findings, although all the evidence received by me has been considered in its totality, before arriving at these findings.

Summary of events

[2] Shortly after 12 noon on Friday 26 May 2017, Michael, and Majorie Cawdery (hereinafter referred to as 'the deceased') left their home at 42 Upper Ramone Park, Portadown, to do their grocery shopping in the local Tesco store. At approximately 12:25 hours, Mr Thomas Scott McEntee broke into the deceased's home. At 13:35 hours, the deceased returned home and entered their property. At approximately 15:15 hours, the son-in-law of the deceased, Mr Charles Little, observed Mr McEntee leave the deceased's home and drive off in their car. Mr Little and his wife Mrs Wendy Cawdery, daughter of the deceased, entered the home. They found the deceased lying on the floor, with extensive wounds, wrapped up in rugs. They both died from their injuries. Later that afternoon, Mr McEntee was arrested by PSNI in a field in Portadown. There is no dispute that the deceased died from the injuries inflicted by Mr McEntee. Mr McEntee was found guilty of their manslaughter, by reason of his diminished responsibility, upon his guilty pleas at Craigavon Crown Court on 23 May 2018. A High Court Judge sentenced Mr McEntee on 28 June 2018, to life imprisonment in respect of the manslaughter convictions, with a minimum tariff of ten years. The detailed sentencing judgment can be found at *R v McEntee* [2018] NICC 12.

Scope of the Inquest

[3] It was agreed by the Properly Interested Persons prior to the inquest commencing that proceedings would:

(1) consider the four basic factual questions, as required by Rule 15 of the 1963 Rules, concerning:

- Who the deceased was;
- When the deceased died;
- Where the deceased died;
- How the deceased died;

And to determine the cause of death in relation to each deceased.

(2) To examine whether any of the following caused or contributed to their deaths:

(i) The events of 22 May 2017

(a) The police interaction with Mr McEntee on that date; the decision making in terms of the use of powers available to police at that time; what powers were used and what powers were available; what protocols were applied; what training the officers had received in use of such powers and policies;

(b) The BHSCT staff decision making; care path determined for Mr McEntee; the continuity of care after he left the Mater Hospital and transferred to the SHSCT;

(c) What information was conveyed to Trust staff by police about Mr McEntee;

(d) Whether alternative decisions that might have been taken at that time would likely have altered the outcome.

(ii) The events of 24 May 2017

(a) The SHSCT staff decision making; care path determined for Mr McEntee; whether it was capable of implementation;

(b) Whether alternative decisions that might have been taken at that time would likely have altered the outcome.

(iii) The events of 26 May 2017

(a) The decision to refer Mr McEntee to Craigavon Area Hospital for admission, as opposed to Daisy Hill Hospital;

(b) The communication of information about Mr McEntee to staff at Craigavon Area Hospital;

(c) The police interaction with Mr McEntee on that date; the decision making in terms of the use of powers available to police at that time; what powers were used and what powers were available; the decision to refer Mr McEntee to Craigavon Area Hospital for admission as opposed to Daisy Hill Hospital; what training the officers had received in use of such powers and policies;

(d) The SHSCT staff decision making, care path determined for Mr McEntee; the care path options available to Trust staff; the policies or guidance relied upon;

(e) The response to Mr McEntee leaving the Emergency Department;

(f) Whether alternative decisions that might have been taken at that time would likely have altered the outcome.

(3) To ascertain what lessons have been learnt by the Trusts and by the PSNI as a result of these deaths and whether steps have been taken to implement changes to address that learning.

[4] It was further agreed that the inquest would consider events of 25 May 2017 when Mr McEntee was encountered by police in Warrenpoint.

[5] An inquest is a fact-finding exercise, it is not a criminal or civil trial. The correct standard of proof to be applied when considering any issue at inquest, is the civil standard, the balance of probabilities, and I must be satisfied that any act or omission caused or contributed in more than a minimal or negligible way to the death.

[6] I am satisfied that this inquest has addressed all the relevant issues and that, where possible, I have reached a finding in respect of the matters which come within the scope of this inquest.

[7] These findings are somewhat unique, in that they are largely focused on the actions of the person, Mr McEntee, who was found guilty of the deceased's manslaughter, by reason of his diminished responsibility, upon his guilty pleas, rather than the deceased themselves. However, as the scope of the inquest outlines, Michael and Marjorie Cawdery are at the core of these narrative findings.

Evidence

[8] These findings are divided into five incidents, each dealing with Mr McEntee's engagements and interactions with police officers from PSNI and staff from the BHSCT and SHSCT, over a five-day period, across four key dates, leading up to the deaths of the deceased, together with the incident leading to the deaths of the deceased.

- Incident One - 22 May 2017 (Belfast City Centre & Mater Hospital, Belfast)
- Incident Two - 24 May 2017 (Daisy Hill Hospital, Newry)
- Incident Three - 25 May 2017 (Warrenpoint)
- Incident Four - 26 May 2017 (Daisy Hill Hospital & Craigavon Area Hospital)
- Incident Five - 26 May 2017 (Upper Ramone Park, Portadown)

Background

[9] Dr Martina Molloy, Mr McEntee's GP, gave evidence to the inquest. She told the inquest that Mr McEntee joined the Practice on 13th November 2015, as he had moved back to Derry/Londonderry from Lurgan to live with a relative during that summer. At that time Mr McEntee was under psychiatry in Newry and had a keyworker.

[10] At his first appointment, Mr McEntee reported a past medical history of excess alcohol, which he had been off for 4 months; that he occasionally used illicit drugs and was on Diazepam for years; and that he was diagnosed with Emotionally Unstable Personality Disorder (EUPD).

[11] Dr Molloy explained that the practice's involvement with Mr McEntee was minimal. His medication was clarified, and he was receiving his prescriptions. She described how his medication consisted of a high dose antipsychotic, high doses of benzodiazepines and an antidepressant. This medication continued to be prescribed from November 2015 to his departure from Derry/Londonderry in May 2017.

[12] When it became clear that Mr McEntee was going to stay in Derry/Londonderry, in November 2015, his keyworker in Newry formally handed over responsibility to his GP. In February 2016, Dr Molloy referred Mr McEntee to the Primary Care Liaison Service, the local mental health service, in Derry/Londonderry, so he could be seen locally by a consultant psychiatrist.

[13] Mr McEntee was assessed by a member of the multidisciplinary team of the Primary Care Liaison Service in March and April 2016, and it was decided by that team member, a social worker, after discussion with a Consultant Psychiatrist, that he should stay on the same medication and that he should attend the Beacon Centre for a mindfulness course and SHIP service, a counselling service, which he availed of until April 2017. It was agreed with Mr McEntee that he no longer needed to be followed up by the Community Mental Health Team and Mr McEntee had no further contact with the Primary care Liaison Service. There was no change to his medication.

[14] Dr Molloy explained that Mr McEntee's recorded diagnosis of EUPD, according to the GP Practice, "would not be termed a serious mental illness", and accordingly he was not on their high-risk register. This is despite Mr McEntee being on a high dose of mood stabilisers, which a patient should not be on for long periods of time.

[15] When asked about the lack of review of Mr McEntee's medications, specifically, that there was no sufficient recognition of the importance of monitoring Mr McEntee's high dose mood stabilising medication, Dr Molloy stated that she sought advice from the consultant psychiatrist in April 2016, "the experts as such" and they stated that Mr McEntee should remain on the same medication. She stated

that, on that basis, they were content to continue with the same medication up to May 2017 when Mr McEntee left the area.

[16] Dr Molloy explained that now, the practice has a Pharmacist who reviews medications for all patients. After 13 – 14 months when medications must be reauthorised, the practice "would probably have reached out to him" and reviewed his medication. Dr Molloy explained that this 13–14-month review would be a governance arrangement in place in her practice to ensure medication reviews are carried out on a regular basis for illnesses like EUPD. She stated that "with the mostly unstable personality disorders, 13, 14 months would be reasonable." She stated that for psychiatric treatment, serious mental illnesses would be reviewed by the secondary care system which would be a consultant psychiatrist and they in turn inform the GP in relation to any changes to medication required.

[17] On 23 May 2017, Mr Joe McConville, a Community Psychiatric Nurse (CPN) from the Unscheduled Care Team in the Mater Hospital, telephoned the Practice to inform them that Mr McEntee had been assessed the previous day, 22 May 2017. Mr McEntee informed them that he was on Quetiapine 800mg but only took 400mg and flushed the rest down the toilet. The CPN informed the practice that Mr McEntee was now living in the SHSCT area, and that they were unable to set him up with Mental Health Services there, as he was still registered with the Practice in Derry/Londonderry. The CPN stated that Mr McEntee was advised that he should register with a GP practice in SHSCT area.

[18] Dr Molloy had no contact number for Mr McEntee, so she left a message with the Village Pharmacy, where he collected his weekly prescriptions on a Friday, to advise him to register with a GP nearer to where he was now living, following the advice from the CPN in the Mater Hospital and this was her last contact in relation to Mr McEntee.

Incident One: 22 May 2017, Belfast City Centre & Mater Hospital, Belfast

[19] Constable Neill Cully gave evidence to the inquest. On Monday 22 May 2017, he was on patrol with Constable Simpson. At approximately 08.45 hours, he was tasked to attend the area of Antrim Road, as Mr McEntee had called 999 alleging that he was being chased by persons from Londonderry. When Constable Cully arrived in the area, he could not locate Mr McEntee. He called him on his mobile telephone and advised Mr McEntee to attend Musgrave Police Station and he would meet there. Mr McEntee attended Musgrave and left before Constable Cully arrived. After advising him to return, Constable Cully spoke with Mr McEntee in an interview room.

[20] Mr McEntee told Constable Cully that, from a young age, he had been followed by people who were part of a "cult" and that he was followed on the bus from Newry. He stated that he needed to speak to a police officer who knew about cults, a "cults liaison officer." He refused to give any further information. His mobile phone rang and he spoke to his sister. He refused to give Constable Cully

her telephone number. Constable Cully conducted a search on the police computer system and telephoned his sister, Ms Donna McEntee.

[21] Constable Cully told the inquest that he felt Mr McEntee needed some kind of help, but that it did not need to be immediate care and control and for medical treatment, and therefore, he took the view that Article 130 of the Mental Health (Northern Ireland) Order 1986 ('the 1986 Order') did not need to be invoked.

[22] Article 130 of the 1986 Order provides as follows:

> "(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of Article 129.
>
> (2) A person removed to a place of safety under this Article may be detained there for a period not exceeding 48 hours for the purpose of enabling him to be examined by a medical practitioner and to be interviewed by an approved social worker and of making any necessary arrangements for his care or treatment.
>
> (3) Where a person is removed as aforesaid, it shall, where practicable, be the duty of the constable who has so removed him without delay to inform some responsible person residing with that person and the nearest relative of that person of that removal."

[23] Guidance on the use of the provision is set out in the 'Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986' ('GAIN Guidelines') (October 2011). This is a practical guideline for all agencies involved in mental health care, including all Health and Social Care Trusts, Northern Ireland Ambulance Service (NIAS) and PSNI. Specifically, the GAIN Guidelines set out the legal responsibilities of police officers when they come in contact with persons with a mental disorder. Relevant portions of the GAIN Guidelines, in relation to PSNI at an A&E Department state:

> "Where police convey a person to an A&E Department, it will be the responsibility of the relevant Trust to make the necessary arrangements for assessment under the MHO."
>
> "Police Officers bear legal responsibility for the health and safety of this person until a handover has taken place. During the 'handover' period the Trust staff should be

> able to co-ordinate their staff and obtain all relevant information from the police officer attending."
>
> "At the hospital premises, the doctor/medical staff are responsible for the assessment of the detainee and their physical and mental welfare."
>
> "Police may remain after the handover has taken place if they wish to consider an arrest once the mental health assessment has been completed or because the joint risk assessment has indicated the need for continual police presence due to a medium to high risk of violence or absconding or breach of the peace." (p380)

[24] The 'Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986 (October 2015) ('the Regional Interagency Protocol'), provides the framework for co-operation and joint working between PSNI; NIAS and Health and Social Care Trusts. Both the GAIN Guidelines and the Regional Interagency Protocol apply in this inquest. Between them, they lay out a list of agreed processes and responsibilities for agencies most likely to be involved in managing people in mental health crisis.

[25] Constable Cully told Ms McEntee that he suspected her brother had mental health issues but that he did not express any suicidal thoughts and that based on how he was presenting, Constable Cully was of the view that he did not suspect him to be a danger to anyone else. He asked Ms McEntee to attend Musgrave Station and collect her brother. She agreed to travel from Londonderry to collect him. Constable Cully was of the view that she could take him to his GP and get the treatment he required.

[26] In the meantime, Constable Cully spoke with Police CCTV operators and briefed them on Mr McEntee's description and informed them that the enquiry office would contact them if Mr McEntee left the station. He told Mr McEntee that his sister was on her way and that he should remain in the enquiry office until she arrived, and he agreed to this. Constable Cully also provided him with a "protect yourself" booklet. Constable Cully told the inquest that he did not believe he had the power to detain Mr McEntee, at that point, and that he did not believe it was for police to be staying with him as he had other duties to attend to and that he did not feel he required any further information from Ms McEntee in person. He stated that he was satisfied with the actions that he had taken based on the information available to him at that time.

[27] Approximately one hour later, a Constable Cusworth from Lisburn Road Station, telephoned Constable Cully and explained that he was with Mr McEntee and his sister in Belfast City Centre and he was enquiring about the content of Mr McEntee's interactions with him. Mr McEntee had left the enquiry office in Musgrave Street and Constable Cully explained that, unfortunately there was a

breakdown in communication between the enquiry office and the CCTV room. Constable Cully advised Constable Cusworth of the conversation and he replied that the same thing was being said to him. Constable Cusworth stated that Mr McEntee was not showing any signs of suicidal thoughts or danger to any other person. Constable Cusworth stated that he would leave Mr McEntee in the care of his sister.

[28] Constable Cully told the inquest that when he was based at Tennant Street Station, North Belfast, he dealt with members of the public who had mental health issues and he often invoked Article 130 of the 1986 Order, as well as taking people to hospital voluntarily on a weekly and sometimes daily basis.

[29] Constable Cully stated that he was not familiar with the Regional Interagency Protocol and could not recall any PSNI training in relation to it. He was, however, aware of a form titled 'Joint Risk Assessment to Determine the Need for Ongoing Police Involvement' ('the Risk Assessment'), which was Appendix 2 to the Regional Interagency Protocol, which determined the need for on-going police involvement in the hospital. He explained that this risk assessment form would be filled in by officers in consultation with the nurse in charge to determine whether ongoing police presence was necessary. PSNI training records provided to inquest, recorded that Constable Cully attended the course "Mental Health/Adult Safeguarding" in April 2017.

[30] In relation to the concept of 'Least Restrictive Option' (as outlined in paragraph 3.0 of the Regional Interagency Protocol), meaning where certain circumstances all apply, the police can hand over responsibility for the care and treatment to the relevant health care professional as soon as it is safe to do so, Constable Cully stated that he was aware of the concept through experience and speaking to more experienced officers. He stated that taking away someone's 'liberty' by applying Article 130 is "a last resort" and that trying to get people to hospital voluntarily would always be the preference.

[31] Constable Cully held the view that if someone were going to hospital voluntarily or under Article 130, the process and treatment would be the same. When it was put to him that there are, in fact important procedural differences; that under Article 130 a mental health assessment would be conducted by a doctor and an approved social worker rather than a doctor and psychiatric nurse; and that a nearest relative would be consulted as part of the process and the person can be detained for a period up to 48 hours; Constable Cully explained that he was not aware of those differences.

[32] Constable Jonathan Thompson gave evidence to the inquest. Constable Thompson told the inquest that, at approximately 13.00 hours on 22 May 2017, he was on duty with Constable Cusworth when they attended the Europa Bus Station due to a report that Mr McEntee's sister Ms Donna McEntee had concerns regarding her brother's mental health, specifically, that he was going to harm himself. The police serial recorded, "she reports her brother…has mental health issues…saying statements like 'they want me to cut myself' and 'people are poisoning my water'

and ...'following me in the woods' and he doesn't appear to be in the right state of mind."

[33] Constable Thompson spoke with Mr McEntee, and he told him that people were chasing him. He initially spoke about people from the travelling community who were chasing him over a disagreement about work. This quickly changed to him speaking about "demons" and "a cult" and that "this goes deep." He believed these people wanted to kill him. When asked if he had any thoughts of self-harm or suicide, Mr McEntee said he did not, and that he was running away in order to stay alive as the "demons" following him were trying to kill him. Constable Thompson explained that Mr McEntee was speaking to himself and Constable Cusworth, in a "flippant way", responding with short answers and giving the impression that there was nothing wrong with him. Constable Thompson stated that, in his view, Mr McEntee was paranoid and appeared not to trust anyone.

[34] Constable Thompson described how Sergeant Prendergast arrived at the scene and spoke with Ms McEntee. Constable Thompson stated that he the consulted with Sergeant Prendergast, who agreed that Mr McEntee needed to be taken to hospital for assessment. Constable Thompson told the inquest that there was no agreement between himself and Sergeant Prendergast that Mr McEntee needed to be detained under Article 130 of the 1986 Order.

[35] Constable Thompson stated that he asked Mr McEntee if he would attend hospital to be assessed and Mr McEntee replied that he would, but only if police escorted him as he believed the "cult" was watching him. Constable Thompson stated that as Mr McEntee was willing to attend hospital voluntarily with police, he did not need to use any power or force to detain him. He stated that, as Mr McEntee, appeared to be quite calm and comfortable when speaking to police, he believed that informing him that he was being detained may have escalated the situation and had an adverse effect. Constable Thompson told the inquest that, he did not deem it appropriate, to exercise his powers in respect of Article 130 of the 1986 Order.

[36] Constable Thompson explained that prior to this incident, he was very familiar with Article 130, and 'least restrictive option' and the risk assessment form, however, he was unfamiliar with the Regional Interagency Protocol which provided the guidance. Constable Thompson was asked about his knowledge of the GAIN Guidelines, which set out the legal responsibilities of police officers when they encounter persons with a mental disorder. Page 377 of the GAIN Guidelines state that:

> "If all elements of Article 130 MHO are present and the person is not arrested for an offence, they should always be detained under the MHO and taken to a place of safety."

Constable Thompson explained that he was not aware of the GAIN Guidelines and that, in fact, was the first time he had heard that statement. He went on to say that

he did not completely agree with the statement, as Mr McEntee was a person willing to go to the hospital voluntarily, and invoking Article 130 "unnecessarily may have an adverse impact and an adverse reaction." Constable Thompson stated that if "Mr McEntee hadn't been willing to go with us voluntarily, he would have been detained." He accepted that that statement was based on the premise that, a person agreeing to go voluntarily, was not going to change their mind. He stated that, even though the conditions for Article 130 are met, if consent is given, then, in his mind, Article 130 is "set to the side."

[37] During the journey to the Mater Hospital, Mr McEntee recited poetry, almost rapping, which he stated he had made up himself. These poems included lines about his faith, as well as the demons and cult that were watching and chasing him. They arrived at the Mater Hospital at 13:55 hours. As Constable Thompson sat with Mr McEntee in the waiting room, Mr McEntee continued to speak about the "demons" and the "cult." In Constable Thompson's view, he did not appear to be under the influence of alcohol or drugs. Constable Thompson told the inquest that, if during the waiting time, Mr McEntee stated he wanted to leave, then he would have invoked Article 130 and he accepted the comment, that, in fact, at that time, Mr McEntee was in a 'de facto' form of detention. He stated, "we were generally just minders just to make sure that he didn't run away or abscond." Whilst they were waiting for triage, Constable Thompson began completing the risk assessment form, inserting Ms McEntee's mobile number on it and the comment, "Thomas feels people are following him all over country wanting to cause him harm." There was a 'yes' inserted to the question, "does person's behaviour or history suggest a risk of absconding?" At 15:10 hours Constables Thompson and Cusworth were relieved by Constables Thompson and Gibson. Constable Thompson stated that he recalled briefing both constables about what Mr McEntee had been saying and he presumed he handed over the risk assessment form to the officers at that time.

[38] Constable Thompson told the inquest that he had no knowledge of the consequences or knock on effect for the type of mental health assessment of a police officer's decision to invoke Article 130. He accepted that, it was only after hearing the evidence of his colleague, Constable Cully, that he was aware there was a difference in how a person would be assessed in the Emergency Department whether brought under Article 130 or voluntarily. He professed that this information did not form part of his police training.

[39] It was put to Constable Thompson, that two experts in policing, Mr Peter Galbraith QPM instructed on my behalf, and Inspector Jonathan Owen QPM, instructed by the PSNI, produced reports for the inquest, and both agreed that:

> "The constituent elements of Article 130 were fully met at the Europa Bus Station and that Mr McEntee should have been detained in invoking Article 130, which would have initiated a process of formal mental health assessment at hospital" and "where the constituent elements of Article

> 130 are met, particularly with regard to the element of 'immediacy' of care or control, we are agreed that Article 130 should be invoked, without delay, and not put off to some later point. This is in keeping with guidance set out in the GAIN Guidelines. In our view, this overrides any necessity to consider the principles of 'least restrictive option' set out in the Regional Interagency Protocol." "In summary, we are agreed that there was a pressing need to invoke Article 130 following exchanges at the Europa Bus Station."

[40] Constable Thompson explained to the inquest, that, "with the benefit of what I know now and the difference in the guidelines and the difference in how Mr McEntee would have been treated, I would have invoked Article 130."

[41] Constable Thompson concluded by stating that, when he found out Mr McEntee was not detained by clinicians in the Mater Hospital, he was surprised as he explained, in his view "there was clearly something wrong."

[42] Constable Kyle Cusworth gave evidence to the inquest. He told the inquest that, on 22 May 2017, he attended the Europa Bus Station, along with Constable Thompson and spoke with Mr McEntee. He described how Mr McEntee appeared upset that his sister, had called the police and reported that he had mental health issues and was concerned about his well-being. He advised Constable Cusworth that he had been chased for a number of weeks by a group from the Travelling Community in relation to work he had carried for them and that was why he was trying to get away.

[43] Constable Cusworth then spoke with Ms McEntee, who was very upset, and she stated that her brother needed help as he had not been taking his medication and that he required a mental health assessment. She then left the area visibly upset and crying. Constable Cusworth stated she did not elaborate on what medication Mr McEntee was prescribed. Constable Cusworth then telephoned Constable Cully who had dealt with Mr McEntee earlier in the day, and he explained to Constable Cully that Mr McEntee was not exhibiting any signs of concern. Constable Cusworth reported that Constable Cully stated that he came to the same conclusion.

[44] Constable Cusworth returned to Mr McEntee, who then explained that the PSNI was infected and over run by demons, that he could see angels and intended to live in the woods, where he could be safe. He declared that people were part of an infection trying to exterminate him. Constable Cusworth told Mr McEntee that they would escort him to the Mater Hospital for him to be assessed by the mental health team, which he agreed to. Constable Cusworth stated that he could not recall any conversation amongst officers about Article 130, stating "I don't think it came up because there was no requirement for it to come up at that stage."

[45] During the journey, Mr McEntee further spoke about demons chasing him and he recited poetry. Whilst in the Mater Hospital, Constable Cusworth described

his behaviour as consistent, and he appeared to truly believe that there were also demons in the hospital. Constable Cusworth could not recall whether it was he or Constable Thompson that provided information to the Triage Nurse, Staff Nurse Osbourne. The triage form timed at 14.35 hours read, "*Presenting complaint, PSNI informed by family, Thomas behaving strangely. Very paranoid/delusions.*" On handover to Constables Thompson and Gibson, Constable Cusworth stated that he explained in detail, their dealings with Mr McEntee, and the thoughts he was having. He and Constable Thompson left the hospital at 15:15 hours.

[46] Constable Cusworth stated that, at that time, he was a probationary Constable and that he had used Article 129 and 130 of the 1986 Order before this incident. He explained that he did not recall much training on it, apart from an explanation of the legislation. Whilst he had never heard of the term 'least restrictive option' he stated that he was sure he heard a variation of it and his inclination was to work with someone rather than "drag them kicking and screaming." Constable Cusworth went on to say that he could not recall seeing the Regional Interagency Protocol or GAIN Guidelines before, but was aware of the risk assessment pro forma, which was an appendix to the Regional Interagency Protocol. He agreed with Constable Thompson, that, in his view, whilst someone agrees to go voluntarily, the option to invoke Article 130 "is still there" and can be utilised. Inspector Owen's comment of 'it is my opinion that the purpose of invoking powers such as Article 130 is not simply to place someone into the hands of the health service so that an assessment can be commenced. I believe that it also ensures that the assessment process is completed.' There are two different outcomes or assessments at hospital, based on whether Article 130 is invoked. Constable Cusworth told the inquest that, knowing that now, and on reflection, he would have considered the matter differently. He stated that, "at the time I didn't have that knowledge." When the comments of Inspector Owen and Mr Galbraith, in relation to the constituent elements of Article 130 being fully met at the Europa Bus Station, Constable Cusworth, replied, that on reflection and based on what he knows now, he would agree.

[47] Sergeant Philip Prendergast (now Chief Inspector Prendergast) gave evidence to the inquest. On 22 May 2017, he attended the Europa Bus Station to assist Constables Thompson and Cusworth. Sergeant Prendergast spoke with Ms McEntee. She outlined her fears and concerns in relation to her brother. She was very upset as she believed police were not going to help her brother and she then left the area.

[48] Sergeant Prendergast then spoke with Mr McEntee, whom he described as gaunt. Mr McEntee stated that he had been sleeping rough in Tullymore Forest and other areas and that he was on the run and needed to keep moving. Sergeant Prendergast explained that, at first, Mr McEntee seemed plausible, and he appeared very knowledgeable about legislation around mental health. He did, however, seem paranoid and stated that he had fallen out with a traveller family back in Derry, who were looking to harm him. Sergeant Prendergast became concerned at the content of the conversation as Mr McEntee believed that demons were chasing him and there was a conspiracy by the Church. He explained to the inquest that the "longer we

spent with him, I developed serious concerns around his mental health." Mr McEntee told Sergeant Prendergast that he had not taken his medication for a year and a half, as he did not need it, as he had stopped drinking. They discussed getting him to see his GP or going to the hospital, but Mr McEntee was adamant that he would not, as he was fine, and did not have any mental health or other problems.

[49] Sergeant Prendergast then discussed the matter with Constable Thompson and they both shared concerns for Mr McEntee's mental health and general welfare and they deemed that he needed some immediate care. Sergeant Prendergast told the inquest that, as Mr McEntee was unwilling to go with police, both he and Constable Thompson discussed and agreed the necessity for Constable Thompson to detain Mr McEntee under Article 130 of the 1986 Order, so that he could get immediate care. He explained in evidence that, at that "stage there was pretty much no other avenues open to us." He stated, "to me that was the decision that was required." Sergeant Prendergast told the inquest that Constable Thompson agreed that Article 130 would be used, as immediate care was required, "my honestly held belief was that's what was going to happen."

[50] At approximately 13.35 hours, Constable Thompson re-joined Mr McEntee and Constable Cusworth. Due to the conversation he just had with Constable Thompson, Sergeant Prendergast believed that Constable Thompson was detaining Mr McEntee under the 1986 Order as Mr McEntee accompanied the two constables to their patrol car. Sergeant Prendergast later learnt that Mr McEntee had not been detained under Article 130 and that he had gone voluntarily with the officers. He explained that he was surprised by this, because when he was speaking to Mr McEntee, he was definitely not agreeing to attend the hospital.

[51] When asked if he was aware of the distinction in terms of assessment process in hospital when Article 130 is invoked, and when it is not, Sergeant Prendergast replied that he was not aware of the distinction or what level of medical assessments take place, "in my understanding and operational experience to date, has always been, it's the same assessment, but I could be wrong." He told the inquest that, in fact, he was surprised that a different assessment is carried out, "it's actually news to me now", "I wasn't aware of that."

[52] Sergeant Prendergast told the inquest that he understood that when police take a person to hospital voluntarily, they remain with that person, under the Regional Interagency Protocol, which he was aware of at the time, until the hospital assumes responsibility and no longer requires police presence. When it was put, that Constables Thompson and Cusworth were unaware of the Regional Interagency Protocol but were aware of the risk assessment appendix, Sergeant Prendergast explained that he was not surprised by this, as the risk assessment would be used regularly by the officers.

[52] Sergeant Prendergast agreed with the comments of Inspector Owen and Mr Galbraith, that the constituent elements of Article 130 were fully met at the Europa Bus Station and that Mr McEntee should have been detained by invoking

Article 130. He went on to say, "there was clearly mental health issues being displayed and concerns around his mental health and his wellbeing." When asked, Sergeant Prendergast was unaware of the GAIN Guidelines, which state that, where elements are met, Article 130 should be invoked without delay and not put off to some later point. He stated that depriving someone of their liberty would be a last resort. He stated that police enactment of Article 130 is quite low in comparison to the level of calls that police attend which are mental health related. He stated, "over 40 per cent of our calls relate to vulnerability including mental health" while "17% of calls last year were crime related."

[53] Constable Hugh Gibson (now Detective Constable) gave evidence to the inquest. He explained that, at approximately 15.00 hours, on 22 May 2017, he and Constable Gavin Thompson relieved Constables Cusworth and Thompson from duties at the Mater Hospital. Constable Cusworth told him that Mr McEntee attended the Mater Hospital voluntarily for assessment, and that he had been talking about angels, demons, and spiritual matters. Constables Gibson and Thompson remained with Mr McEntee for approximately one hour, before he was triaged and during that time, he spoke at length about feeling that "God" had put a "special light" within him and he believed that "the devil and his demons" were trying to "extinguish" this light. He talked about having a special purpose and that the "devil" could use anyone to try and "put my light out." Constable Gibson described Mr McEntee's behaviour as disturbing.

[54] Mr McEntee then stated that he did not want to stay at the hospital any longer, he was getting frustrated at the length of time it was taking, and he said that since he was there voluntarily, he could leave. Constable Gibson told the inquest that he "very firmly" told Mr McEntee that because of what he disclosed, if he tried to leave the hospital, he would be restrained by police and detained under Article 130 of the 1986 Order. Constable Gibson described how he looks for the "path of least resistance, to keep somebody on side, to achieve the outcome, the outcome of him being assessed." In this case, he stated, "we followed the spirit of 130 without invoking 130 because we didn't need to."

[55] Constable Gibson explained that, before this incident, he had invoked Article 130. He stated that he was familiar with the risk assessment and may have heard of the Regional Interagency Protocol but could not be sure. He stated that, in his experience, there was no difference in the mental assessment that was conducted, whether Article 130 was invoked or not, both then and now.

[56] At approximately 16.00 hours, Mr McEntee was triaged without police being present. Constable Gibson informed the triage nurse, Staff Nurse Osbourne, that he had concerns for Mr McEntee's state of mind and that he believed he needed to be assessed and detained under the 1986 Order.

[57] Constable Gibson told the inquest that he was "very concerned" by Mr McEntee's behaviour and his concern "was that he would harm others." Whilst not contained in his witness statement, he explained that this view was formed by

the things he was saying and accessing information on his hand-held device, showing red flags, previous convictions, including burglaries with weapons. He stated that he was concerned that, if Mr McEntee was having some sort of breakdown or schizophrenic episode and had a propensity for violence in the past, he may harm someone. When asked, Constable Gibson stated that he could not recall the detail of his conversation but was of the view he would have told Staff Nurse Osbourne this information.

[58] Constable Gibson described, how, when waiting for the assessment, Mr McEntee recited a rap poem and the lyrics were quite dark and related to demonic forces/influences and his struggle against them. Constable Gibson stated that he was quite concerned at the content and asked Mr McEntee what he would do if the "devil" used someone else to "put his light out" and he replied that he would defend himself.

[59] Mr McEntee was assessed at approximately 18.30 hours by the Mental Health Team. Constable Gibson told the inquest that he spoke with the two clinicians, Dr Melissa King and CPN Mr Joe McConville, in private and relayed his concerns. Whilst not detailed in his statement, he believed that he relayed that Mr McEntee could seriously hurt persons and not feel responsible as he had perceived religious delusions, based on his interactions and information police held about past his criminal convictions and use of violence. Again, whilst not detailed in his witness statement, he also believed he told them that Mr McEntee had stopped taking his medication and that he had been sleeping rough. He also believed that he told Dr King and Mr McConville that he did not think Mr McEntee would present as violent to them but that they would remain outside the assessment room. Constable Gibson told the inquest that he did his best to convey the information about Mr McEntee's behaviour to the mental health team. Constable Gibson believed he informed them of his belief that Mr McEntee was a danger to himself and others. He told the inquest that his background prior to joining the police was working with homelessness people and working in probation hostels, and he had experience of persons with mental health problems and that he also expressed this to Dr King and Mr McConville, to "give weight" to his views. Constable Gibson recalled Mr McConville saying, "we'll see about that." Mr McEntee was then assessed in private for approximately 45 minutes.

[60] After the assessment Constable Gibson was told by the mental health team that Mr McEntee was not a danger to himself or others. Constable Gibson replied that he was surprised to hear this given his conversation with Mr McEntee. The mental health team stated that they were recommending that Mr McEntee link in with his GP to reduce the amount of medication he was using and that they were discharging him into his GP's care. The officers then transported Mr McEntee to Central Train Station as he said he was going home to his family.

[61] Constable Gibson was given the partially completed risk assessment at the police handover. The first box states, "circumstances of attendance (if under Article 130, medical assessment required)." The risk assessment states that it should be

completed by nurse in charge and police at emergency department to determine the need for on-going police involvement when the patient appears to be settled. The answer to the two questions "Has the person harmed/threatened to harm themselves?" and "Has the person assaulted/threatened to assault anyone?" was answered "No." Constable Gibson explained that he wrote the names of Dr Melissa King and Mr Joe McConville on the form as they did not agree to sign it. The explanation Constable Gibson recalls was that Mr McEntee was not under Article 130.

[62] Constable Gibson told the inquest that during their time in the Mater, he and Constable Thompson were receiving regular police control transmissions, querying progress in assessment and the length of time they would be staying. He responded advising that they were remaining because of their concerns.

[63] Constable Gavin Thompson gave evidence to the inquest. He described how, at the time, he was a probationary Constable. At arrival at the Mater, he and Constable Gibson were told by Constable Cusworth, that Mr McEntee had agreed to attend voluntarily to undergo a mental health assessment. He stated that Constable Cusworth told them that Mr McEntee had been saying things like "people are after me", "they are trying to get at me" and that he was generally showing signs of a mental health disorder. When asked about the details of the handover which Constable Gibson detailed in his evidence, and which Constable Thompson did not, Constable Thompson stated that, while Constable Cusworth may have relayed those details, he could not recall the detail and he may have missed them or forgot to record them in his witness statement.

[64] When Constable Thompson spoke to Mr McEntee, he stated that he appeared agitated and fidgety, and he recited poetry referring to demons and people in his head. He described this as disturbing and not normal behaviour for a person of sound mind. He explained that, at that time, there was nothing to suggest "that he would be a risk to anybody." He stated that, whilst he did not recall the detail Constable Gibson provided of devils, demons and extinguishing his light, Constable Thompson conceded that these things could have been said, he just did not record it in his statement.

[65] Constable Thompson recalled having the risk assessment document, as he inserted the name and telephone number of Ms McEntee at the top of the document. When asked whether, at the time, he was aware of the differences in hospital assessment if Article 130 was used and he stated that he was not. He stated that he could not remember whether he received additional training in relation to the use of Article 130 since 2017. He confirmed that his practice in using in Article 130 has not significantly altered since 2017.

[66] Mr McEntee told the officers that he was giving it another half hour and then he was leaving. Constable Thompson informed him, along with Constable Gibson, that if he did leave, he would be left with no option but to detain him under Article

130 of the 1986 Order. He stated that Mr McEntee saw this as a threat. Mr McEntee then returned inside and stated that he would then stay until he was assessed.

[67] Constable Thompson recalled Constable Gibson speaking to the Mental Health Team prior to assessment. Whilst he was not privy to the conversation, he stated that he could see no reason why Constable Gibson would not have told them the information that PSNI were aware of. He went on to say, that, it was in their, and Mr McEntee's best interests to disclose whatever they knew at the time. The assessment lasted 30-45 minutes and upon exiting the room, Mr McEntee commented, "You see, I told you I wasn't crazy." He recalled Constable Gibson going into the room and speaking to the Mental Health Team, but he did not know the content of that conversation. They then took Mr McEntee to Central Train Station.

[68] Staff Nurse Mark Osbourne gave evidence to the inquest. On 22 May 2017, he was working as a staff nurse in the Mater Hospital Emergency Department and allocated to triage. He triaged Mr McEntee with information provided by both him and the accompanying police officers. On the triage form or 'flimsy', under presenting complaint he recorded, "PSNI informed by family of Thomas behaving strangely. Very paranoid/delusions." Under medical history Staff Nurse Osbourne recorded "DSH, O.D's, Depression, Fluoxetine, Seroquel, Diazepam, Lyrica." He noted, "Staying in Warrenpoint with daughters Auntie for 2 weeks" and recorded the address.

[69] Staff Nurse Osbourne told the inquest that the information provided by Mr McEntee did not indicate that it was appropriate for a referral to the Mental Health Team and that there was nothing to cause him concern. He presented as calm and pleasant. Staff Nurse Osbourne explained that he then questioned the police officers, and they gave the information that his family were concerned about his behaviour and that he had talked about "the light and the good and the bad and people being after him."

[70] Staff Nurse Osbourne then began completing the "BHSCT Emergency Department Mental Health Assessment Form." The reasons for attending are noted to be "Paranoid delusions" and the question "is the person behaving bizarrely, acting extremely paranoid and responding to hallucinations" is ticked 'yes.' Except for the name of a family member, the rest of the form was not completed, as Staff Nurse Osbourne explained that it was not the responsibility of the triage nurse to do this, he stated that it would be the responsibility of the treating clinician to complete this.

[71] Once Staff Nurse Osbourne had triaged Mr McEntee, at 16. 27 hours, he then requested a mental health assessment through the 'One Point of Referral for Mental Health', which was based in Woodstock Lodge and provided a single point for all referrals for mental health assessments in the BHSCT. All referrals are then directed to the appropriate service, in this case, the Unscheduled Care Team, part of the mental health service, in the BHSCT. When a referral is made, an electronic pro

forma is completed by Woodstock staff and uploaded and this can be accessed by the Unscheduled Care Team. There is a one- hour target for assessments.

[72] The pro forma noted Mr McEntee's medications and "people were trying to poison him, and he had a light inside him which enabled him to know good and bad people – absconded from PSNI station before seen by anyone. Pts sister rang PSNI very concerned as acting paranoid past few days. PSNI picked him up at Europa Hotel and brought to Mater A&E. PSNI still with him, not under arrest." Staff Nurse Osbourne confirmed that that information was provided by him. He described how the mental health team would have access to the Emergency Department flimsy as well as this information, as they are left in a referral box in the Emergency Department.

[73] Staff Nurse Osbourne was adamant that no police officer advised that Mr McEntee needed to be "sectioned" meaning detained under the 1986 Order, or mentioned devils, demons, angels, or Mr McEntee's past criminal record or that there was concern he could harm others.

[74] Mr Joe McConville, Mental Health Nurse, in the Unscheduled Care Team, gave evidence to the inquest. He explained that he had been in mental health for 17 years. Mr McEntee was referred by the One Point of Referral. He stated that he was told where Mr McEntee was and given a brief synopsis of the referral information orally. He described how the written referral form is passed to their duty desk online. Mr McConville told the inquest that he could not recall seeing the written referral prior to the assessment, despite a time difference of two hours and 20 minutes. When asked, he stated that it can take up to an hour or maybe an hour and a half, before it comes through and he accepted "I'm saying that it must have been with us, but I don't ever remember actually seeing it." Mr McConville accepted that the information in that referral would have been relevant for his assessment.

[74] Mr McConville and Dr Melissa King, Foundation Year 2 Doctor, made their way to the Mater Emergency Department to assess Mr McEntee. He confirmed that the ED flimsy and Staff Nurse Osbourne's partially completed mental health assessment would have been available to them. He stated that it was responsibility of staff in the Emergency Department to complete this form fully, which was at odds with Staff Nurse Osbourne's evidence.

[75] Prior to assessment, Dr King contacted the WHSCT for some background on Mr McEntee and was informed he had a previous diagnosis of EUPD, which Mr McConville emphasised was a recognised mental illness. In relation to personal details, Mr McEntee gave the name and telephone number of Sonia Treanor as next of kin and stated that she was his sister. Ms Treanor was not his sister, but the sister of his long-term friend.

[76] The assessment began at 18.30 hours and finished at 19.25 hours, lasting a total of 55 minutes. The 'Belfast Trust Emergency Mental Health Assessment Proforma' was completed by Dr King during the assessment, with Mr McConville leading the assessment. Mr McConville described Mr McEntee as presenting as

bright and reactive with no formal thought disorder. He told them that he was staying in Warrenpoint with his sister (Sonia Treanor) and he had an issue with a neighbour's car being burnt out and that led to him being intimated. The contact with police being called to the Europa was recorded. When asked about his "inner light", Mr McEntee explained that he had been sober for 1 year and 11 months and that made him happy, which was his inner light. Mr McConville explained that he was very articulate in describing this.

[77] Mr McConville described Mr McEntee as euthymic, with no thoughts of life not worth living. He denied suicidal ideation, plan, or intent. Mr McConville recorded that there was no evidence of psychosis, and no evidence of expression of perceptual disturbance in modality. He denied any thought to harm others. He stated that there was no mention of archangels, cults, or religious delusions. He told them that he decided to take less of his antipsychotic drug and that the last time he took it, was the day before. As he was going to be staying in Newry or Warrenpoint Mr McConville told him to register with a GP in that area to get a new prescription.

[78] Mr McConville stated that Mr McEntee was on the highest does of antipsychotic medication he had seen for someone with EUPD and that he was aware withdrawing from antipsychotic medication can trigger a significant mental health reaction and he admitted that he did not think to ask Mr McEntee if he had any medication with him and if he didn't, what he would do. He accepted that it would have been relevant for his assessment.

[79] Mr McConville stated that he was concerned about where Mr McEntee would be staying that night. Towards the end of the assessment, Mr McEntee's mobile phone rang, and he handed Mr McConville the phone saying, "it is my sister." Mr McConville spoke with Sonia Trainor and asked for confirmation of identity. He could not recall whether he asked if she was his sister or simply next of kin. She replied 'yes.' He took the call in the room in the presence of Dr King and Mr McEntee and she confirmed that people were intimidating him but that he was more paranoid than he needed to be. She agreed that he could return to her home in Warrenpoint. This was recorded in the assessment proforma as collateral information. Mr McConville explained that there was no management plan in place when speaking to Ms Trainor. He stated that they would usually gather collateral information at the end of an assessment.

[80] Mr McConville confirmed that the conversation with Ms Trainor lasted, "about a minute, a minute and a half; it wasn't very long." Mr McConville accepted that he should have left the room to speak to her in private. When asked whether he thought such a short period of time was sufficient to gather collateral information, Mr McConville replied that he believed he asked the relevant questions, but with the benefit of hindsight, he accepted he should have asked more questions of her. Mr McConville conceded that he did not check who the person was that he was speaking to or confirm if she was the person that he had been staying with previously. When questioned, what efforts he made to get collateral information, he said "I made none because I obviously didn't make the phone call" referring to

Ms Trainor's call and he went on to say, "I didn't feel, at that point, there was any need to get anymore."

[81] In relation to the information Constable Gibson told the inquest that he provided to Mr McConville and Dr King before the assessment, Mr McConville refuted that they were ever told of demons or a cult or that Mr McEntee had presented a risk of violence based on his past criminal record. He stated that the conversation with Constable Gibson lasted "30 seconds." He stated that Constable Gibson told them "very, very little" when he asked how Mr McEntee had been and was there any information that he needed to share with them. He was of the view that whilst the police were a potentially significant source of collateral information, he explored the issues with Constable Gibson adequately. He stated that, if he were told the information that Constable Gibson stated he did, he would have taken that information very seriously and that it would have formed part of the assessment and in fact, he would have thought Mr McEntee was psychotic and he would have questioned everything he said. He also refuted Constable Gibson's evidence that he told him of his previous work with homeless and probation hostels and his experience of mental health issues.

[82] Mr McConville stated that in his 11 years working in the Unscheduled Care Team he never saw the risk assessment form before this inquest, and he refuted Constable Gibson's suggestion that he refused to sign it. Mr McConville described how he did not see any significance in the police staying with Mr McEntee in the Emergency Department whilst not using Article 130, as he said, it had occurred before and since. Mr McConville explained to the inquest that now, if a patient is with police, they ask to speak to the police first for information before going into the assessment, however, there is no pro forma for recording the information.

[83] A plan of management was drafted which included that Mr McEntee would stay with Ms Trainor, that a referral would be made to the SHCST in order to re-engage him with mental health services there and to inform his GP of the assessment. This plan was later added to and approved by the multi-disciplinary team.

[84] Mr McConville told the inquest that after the assessment, Constable Gibson did come back into the room, but he disagreed with his evidence that he expressed surprise at Mr McEntee being released.

[85] The following day, Mr McConville contacted the Mental Health Team at Daisy Hill Hospital in Newry and tried to link Mr McEntee into their services, however, he stated that he was told that Mr McEntee would have to register with a GP in the SHSCT and then be referred to their service. This information was inaccurate, as persons who reside in the SHSCT area are eligible for and should be able to receive psychiatric care from the Trust. Mr McConville stated that he did not know that at the time. He then telephoned Mr McEntee's GP in Derry and left a message on his presentation to their service and of his non-compliance with all his

prescribed medication. He left his contact details for the GP to get back to him which they did but according to the GP notes, got no response.

[85] Mr McConville explained to the inquest that there have been changes in the referral process to the Unscheduled Care Team, so now the Care Team triages calls, so they obtain all the information they require first hand.

[86] Mr McConville accepted that had all of the known information about Mr McEntee been collated then that would have informed the assessment and "put a different slant on it" and he would have been questioned on the information and Mr McEntee would been referred to acute care "because obviously it is very worrying all the things that he is alleged to have said."

[87] When the evidence of Dr Turner was put, that it is quite common for people who have psychosis to try and conceal their symptoms and have periods of lucidity, with symptoms not being apparent, Mr McConville agreed. He also agreed with the comment that, it was crucial to make every attempt to get as much collateral information as possible. He explained that throughout the assessment he was asking questions and watching for body language, for any indication that Mr McEntee was basically trying to hide anything or withhold anything. When asked if he thought his assessment was successful, he replied that, "at the time, yes, but with hindsight, no."

[88] Dr Melissa King, Specialty Doctor, gave evidence to the inquest. At the time of the above assessment on 22 May 2017, she was a Foundation Year 2 doctor, working a four-month rotation in psychiatry, within the BHSCT. Her primary job was based at Knockbracken Healthcare Park, and she was part of the Unscheduled Care Team.

[89] On 22 May 2017, she was on call for the Unscheduled Care Team alongside Mr McConville. At 18:00 hours, Mr McConville informed her that Mr McEntee had been referred for assessment. The referral was made by telephone to Mr McConville, who then gave her a briefing about the referral from Staff Nurse Osborne. Dr King confirmed that she did not read the referral form from the One Point Referral and relied on the information given to her by Mr McConville. She stated that she could "only assume" that Mr McConville had the referral. Dr King stated that she did read the ED flimsy prior to the assessment and that Staff Nurse Osbourne's notes would also have been contained in the flimsy.

[90] Dr King told the inquest that in the BHSCT, if a patient were deemed medically fit from triage, they could be referred directly to the mental health team without being seen by an ED doctor and without the BHSCT Emergency Department Mental Health Assessment Form being completed. Dr King stated that this should, in her view, be completed for each patient, as some important information could be missed at triage.

[91] Prior to the assessment Dr King contacted the Psychiatry Department in the WHSCT to collect information regarding Mr McEntee's past psychiatric history. She

was informed that Mr McEntee had a diagnosis of EUPD and that he had been discharged from the care of the Community Mental Health Team in Londonderry in March 2016. She was also informed that Mr McEntee had previously been engaging with the community addictions team based in the SHSCT.

[92] Mr McConville led the assessment whilst Dr King acted as a note-taker, completing the Belfast Trust Emergency Mental Health Assessment proforma.

[93] Mr McEntee was first asked by Mr McConville about his reason for presenting himself to the police. Mr McEntee said that he had been staying with a relative and had offered to complete some work for a neighbouring family. During this time, the neighbour's car was burnt out and following this, they began to intimidate Mr McEntee. Mr McEntee stated that these events had occurred over the two/three weeks prior to the 22 May 2017. Mr McEntee reported that on the day of the assessment, 22 May 2017, he had taken the bus to Belfast, with the aim of travelling to Altnagelvin Hospital for an appointment. Mr McEntee stated that he believed he was being followed on the bus and so instead of getting a connecting bus, he attended Musgrave Police Station and told the police that he was in danger and under threat. Mr McEntee stated that, after leaving the police station, he went to meet a relative at a bus station and the relative then phoned the police about him, as they were concerned that he had become paranoid.

[94] Mr McConville then asked Mr McEntee to explain what he meant about the "inner light" which he had discussed with the police. Mr McEntee stated that he had been sober from drugs and alcohol for one year and eleven months. Mr McEntee explained that his sobriety was his "inner light" and that he was happy again. Mr McEntee explained that other people were trying to bring him down and "snub the light out."

[95] Mr McEntee denied any thoughts that his life was not worth living or any suicidal ideation. Mr McEntee also denied any thoughts to harm himself or others.

[96] Mr McEntee confirmed that he had previously been in contact with the Community Addictions Team in the SHSCT and that he had a history of deliberate self-harm in the form of cutting and of intentional overdoses. Mr McEntee stated that he had had three/four previous admissions to the Bluestone Psychiatric Unit in Craigavon and two admissions to Gransha Psychiatric Hospital in Londonderry.

[97] Mr McConville asked Mr McEntee about his current medications. Mr McEntee said that he was allergic to Librium and that he got his medications supplied weekly. Mr McEntee stated that he had good medication compliance and that his current medications included Seroquel (generic name Quetiapine) 800mg (an antipsychotic medication), Duloxetine 120mg (an antidepressant medication), Pregabalin 600mg (a medication used for the treatment of neuropathic pain), Diazepam 15mg (a medication used in the treatment of anxiety) and Omeprazole (a medication used for symptoms of reflux or excess stomach acid production). Mr McEntee stated that he had reduced his Seroquel down to 400mg himself, without medical guidance.

[98] Mr McConville then asked Mr McEntee about his family history, personal history, and substance misuse. In relation to forensic history Mr McEntee stated that he had served two years in prison for armed robbery.

[99] Mr McConville then went on to formally assess Mr McEntee's mental state. He maintained good eye contact with and appeared to be bright and reactive during the assessment.

[101] Mr McEntee's speech was of normal rhythm and volume and his speech remained spontaneous and coherent. Mr McEntee did not appear to show evidence of having a formal thought disorder. Mr McEntee denied any active plan or intent to end his life. He denied any thought insertion, thought withdrawal, or thought broadcasting. Mr McEntee denied any delusional beliefs. When Mr McConville asked Mr McEntee for a second time regarding the "inner light", Mr McEntee stated this was his sobriety from drugs and alcohol and that he did not want people to take this from him. When asked by Mr McConville, Mr McEntee denied any auditory or visual hallucinations.

[102] Mr McConville then had a conversation with Mr McEntee's next of kin, Ms Trainor, in both their presence. She confirmed that the concerns for Mr McEntee's safety were real, following the incident with the neighbour's car. During the phone call, the next of kin had explained that they felt that Mr McEntee was being more paranoid than he needed to be, but that he could stay with them following the assessment. Dr King agreed that the phone call should have taken place outside the room, and she stated that normally that would be common, as collateral histories are taken at the end of assessments.

[103] Afterwards, both Dr King and Mr McConville formulated a management plan and Mr McConville advised Mr McEntee to register with a general practitioner in the area in which he was now staying, and they agreed that he should be referred to the SHSCT Community Mental Health team to follow up his current psychiatric medications and to advise him to register with a GP in the area in which he was staying.

[104] In relation to engagement with police officers, before the assessment, Dr King agreed with Mr McConville's evidence, that it was a very short interaction, when Constable Gibson mentioned paranoia and inner light, but there was no mention of angels and demons or poison. She explained that if he had, she would have documented that information on the proforma under "referral information" and that would have prompted further questioning of Mr McEntee and the next of kin. Dr King refuted Constable Gibson's evidence that they were told, by him, that Mr McEntee was a danger to himself, or others and she stated that if they were told that, they would have asked the police to stay during the assessment for their own safety as well as that of Mr McEntee's.

[105] In relation to engagement with police officers after the assessment, again Dr King agreed with Mr McConville's evidence, that no concerns were raised by Constable Gibson, as she explained they would have been taken very seriously and

potentially have led to a reassessment. Dr King could not recall Constable Gibson asking her and Mr McConville to sign the risk assessment form.

[106] When it was put to Dr King that, it was clear that, during the 22 May 2017 Mr McEntee presented very differently at times, at one time talking about angels and demons and other times, being calm, coherent, and plausible, she explained that she had no concerns during the assessment, and she was satisfied with the answers Mr McEntee provided. She went on to say, that there were no concerns, from her. Dr King accepted that, had she known all of the information that existed, in relation to Mr McEntee, the management of him, would have been different.

Incident two: 24 May 2017- Daisy Hill Hospital, Newry

[107] Mrs Ann Donnelly gave evidence to the inquest. On Wednesday 24 May 2017, she was employed as a receptionist in the Mental Health Department at Daisy Hill Hospital, Newry. Between 15:00 hours and 15:30 hours, Mr McEntee arrived at reception and told her colleague, Ms Marie Tierney, that he was there to collect his medication. She described him as being calm and polite. He explained that he had been advised by a psychiatrist in the Mater Hospital, that he should come there to be seen as he needed to get medication. He stated that he had been told by the Mater staff that they would contact the Mental Health Department in Newry to advise them that he would be calling.

[108] Ms Tierney telephoned the community team secretary to verify this information and it became apparent that no one in the Mental Health Department had been contacted about Mr McEntee. Ms Donnelly checked both computer systems (PAS and PARIS) and established that Mr McEntee was not currently known to the mental health services in the SHSCT. She then telephoned the Newry and Mourne Home Treatment Team office to ask if one of their staff could see Mr McEntee.

[109] At approximately 15:45 hours, she spoke to the Home Treatment Team leader, Mr Damian Carbery, and he advised that he would telephone her back to confirm when someone would be available to return to the Department. Mrs Donnelly spoke to Mr McEntee and asked if he was happy to wait and he confirmed that he was. He went to the shop inside the main hospital building and then returned to the waiting room. He went back to the shop short time later and then returned again. Mrs Donelly stated that it was quite rare for all the staff to be out at the one time. At approximately 16:30 hours, Mr McEntee asked how much longer it would be, and he was advised that they were trying to get an update. Mr McEntee went outside again. Mrs Donnelly spoke to Mr Carbery again and he explained that he had not been able to contact any of his team as they were out of range from mobile network and assured her that someone will be back to see Mr McEntee as soon as possible.

[110] By 17:00 hours, Mr McEntee had still not returned to the waiting area. Mrs Donnelly went outside to look for him. At approximately 17.10 hours, a member of the Home Treatment Team, Mr Richard Gardiner, arrived to see Mr McEntee and Mrs Donnelly explained that he had left.

[111] Mrs Donnelly told the inquest that there is now there is a protocol whereby a shift coordinator in the support and recovery team is based inside the Mental Health Department and can see a patient if they cannot be seen in a reasonable time by the Home Treatment Team.

[112] Mr Damian Carbery, Team Leader for Newry Home Treatment Team/Crisis Response Team gave evidence to the inquest. He described how the service provides a safe alternative for patients to hospital, and medical acute care at home. At approximately 15:45 hours on 24 May 2017, he received a telephone call from Mrs Donnelly advising him of Mr McEntee's self-presentation to the Mental Health Department. He advised Mrs Donnelly that he would attempt to contact staff to determine when they would be finished with their current clients and then contact her with an approximate time for assessment. Mr Carbery explained that he attempted, on a number of occasions, to contact staff, with no success, with the likely explanation that their mobiles were out of coverage. On that particular day, they were very busy and as Team Lead, he had to see patients, which would not have been the norm. They had a full complement of staff that day, six in total.

[113] Mr Carbery accepted that there was a flaw in the system as staff, who were points of contact, had to go to areas with no mobile coverage and therefore could not be contacted. He explained that a pager system is going to be introduced which would cover 99.9% of the area they cover, and this would significantly reduce any concerns. Also, as Mrs Donnelly explained, the policy has been updated so that if anyone self-presents and home treatment are unable to see someone within a reasonable period, the shift coordinator is called upon from the support and recovery team to see that patient and so now there will be a significantly less delay. Mr Carbery agreed that, in his opinion, non-compliance with long term medication by someone with a long-term history of mental illness and dislocation from an area are red flags that a mental health practitioner would be looking for.

[114] At 16:45 hours, Mr Carbery received another telephone call asking for an update. He eventually contacted Mr Gardiner, senior practitioner, who was returning to base from another assessment, and he agreed to assess Mr McEntee. At approximately 17:15 hours Mr Carbery was advised that Mr McEntee had left the building and that a brief search of the area was being conducted. Mr Carbery explained that he had previously cared for Mr McEntee as an inpatient and recognised that he may have become impatient waiting to be seen by the Home Treatment Team. Later, Mr Carbery made a record of the attendance by Mr McEntee in Daisy Hill for consistency of care.

[115] Mr Carbery explained that now, there is an Integrated Liaison Service, which assesses patients, face to face, who present to the Emergency Department in Craigavon Area Hospital and Daisy Hill Hospital.

[116] Dr Ursula Conroy, GP, gave evidence to the inquest. At the time, she was working as a Doctor in the Emergency Department of Daisy Hill Hospital. At 20:27 hours on 24 May 2017, Mr McEntee self-presented to the Emergency Department

and the triage nurse, Leanne Kennedy, noted that he reported having had thoughts of self-harm that day, but denied current suicidal ideation. He was recorded as a category 3 out of 5. Staff Nurse Kennedy completed the first part of the Mental Health Risk Assessment form.

[117] Dr Conroy assessed Mr McEntee at 22.10 hours. He informed her that he had been diagnosed with EUPD and was known to the Mental Health Team in Derry. He explained that he had been staying with his sister in Derry for a period and then left Derry due to some trouble two weeks previously. He stated that he was staying with his child's Aunt in Kilkeel for the past two weeks.

[118] Upon questioning by Dr Conroy, in relation to the mental state examination, Mr McEntee stated that his mental health had deteriorated suddenly that day. He told her that he was prescribed Seroquel (Quetiapine), Diazepam and Pregabalin and that he had not taken his medication for three days. He described his thoughts as being disordered and when questioned, he stated that he had thoughts of life not worth living throughout the day and that he had cut his wrists and neck with a blade. He stated that he had ongoing thoughts of life not worth living presently and that he was unable to distract himself from these thoughts. When questioned about current plans to harm himself, he stated that he may cut himself again. He stated that he felt he was unable to keep himself safe that night if discharged. He denied alcohol and illicit drug misuse.

[119] Dr Conroy's explained that, on examination, Mr McEntee was calm and cooperative. He did not appear to be responding to auditory or visual hallucinations and his speech was of normal rate and tone and his eye contact was appropriate. There were superficial lacerations on his forearms.

[120] Dr Conroy took the view, given the history, that Mr McEntee was at risk of further self-harm and decided that he warranted a mental health assessment by the on-call Mental Health Team, as he had expressed active suicidal ideation and thought disorder and had completed an act of self-harm earlier in the day. She contacted the on-call Home Treatment Team to refer Mr McEntee for assessment. Dr Conroy was clear in evidence that she was making a referral, not seeking advice. She spoke to Mr Jonathan Johns, Mental Health Nurse, and stated that she relayed the history and examination to him from reading off her notes recorded on the ED flimsy. Mr Johns stated that he would get some information on Mr McEntee's past psychiatric history and would get back to her. A short time later, Mr Johns informed her that he had spoken to the Mental Health Team in the WHSCT regarding Mr McEntee's past psychiatric history, and he told her that he had a history of multiple DNAs with psychiatric services, which was not correct, and had been assessed in the BHSCT a few days previously.

[121] Dr Conroy told the inquest that Mr Johns told her, that based on his history and his current presentation, he did not feel Mr McEntee warranted assessment by the Mental Health Team that night, as the thoughts of life not worth living were likely chronic, given his diagnosis of EUPD. Dr Conroy explained that Mr Johns

advised her to discharge Mr McEntee and that the Mental Health Team would contact him by telephone in the morning.

[122] Dr Conroy told the inquest that, at that time, she felt Mr Johns had more information than her after contacting the WHSCT and he had more expertise than her in mental health. She accepted that, she had Mr McEntee in front of her and had more information in relation to current presentation. She stated that she respected Mr Johns' plan as he had more experience and more information and she was a junior doctor, " I respected his decision from his specialist field and took his advice. I did not feel that needed to be challenged. I trusted what he was telling me." She had worked in the Emergency Department at that stage for 18 months and had made referrals to the Home Treatment Team before and she explained that they usually attended when a referral was made, so on this occasion "when they said they weren't going to assess him, I thought it must be for good reason." When it was put to Dr Conroy that an Independent Serious Adverse Incident Review (Level 3) ('the ISAI Review') conducted by the BHSCT and SHSCT, recorded that one senior clinician stated that 99% of people presenting in similar circumstances would be assessed, Dr Conroy agreed.

[123] Dr Conroy then informed Mr McEntee that the Mental Health Team did not feel he needed assessed that night and that they would contact him in the morning at his daughter's Aunt's house by telephone. Mr McEntee then informed her that he did not feel he could go back to that house and that he had nowhere else to stay. Dr Conroy stated that Mr McEntee mentioned that he did not have his mobile telephone. Dr Conroy explained that her customary practice would have been to advise a patient to contact the Emergency Department and leave a telephone number on which they could be reached, and she recalled saying this to Mr McEntee. She stated that she went back to Mr Johns and told him this.

[124] Dr Conroy then informed the nursing staff of his situation, and they contacted the emergency social worker to arrange emergency accommodation. Dr Conroy described how Mr McEntee waited calmly in the Department whilst emergency accommodation was being arranged. Accommodation was arranged in the Francis Court Hotel and Mr McEntee was discharged from the Department at 00:50 hours. When asked, why she did not go back and inform Mr Johns that part of the management plan had now changed, that instead of staying with a friend, Mr McEntee's position was that he had nowhere to go and was homeless, Dr Conroy replied that she did not feel that going back and telling Mr Johns' that information would have changed the outcome. When it was put that Mr McEntee openly stated that he was at risk of self-harm that night if on his own, and he was now sent off to stay in a hotel on his own and that that was important information that may have changed Mr Johns' opinion of an assessment, Dr Conroy replied, "yes, perhaps."

[125] Dr Conroy told the inquest that she was not aware she had to complete the Mental Health Risk Assessment form and that is why it was not completed. She had never seen the form before despite having made mental health referrals before this incident. She explained that it is a tool to help assess the level of risk in determining

whether a referral is required to the Home Treatment Team. It sets out various questions with tick boxes and at the bottom is a "outcome of risk assessment box" asking "what overall category of risk applies to this patient?" and the options are green, amber, or red meaning high risk. When asked what category Dr Conroy would have chosen for Mr McEntee, had she filled it in, she agreed he would have been medium risk. The consequences of the category are important as there is an action related to the level of risk, so for medium level "a mental health assessment is required before discharge can occur" and "referral to liaise with psychiatry team to be seen within approximately two hours." Dr Conroy agreed that when speaking to Mr Johns, she could have told him this information and that Mr McEntee needed to be assessed within two hours.

[126] Dr Conroy did not agree with Mr Johns statement that "Mr McEntee was reporting no active thoughts or plans to self-harm" as she recorded that he was. Also, she did not recall a management plan that a mental health assessment could be offered later in the evening or overnight, and she stated that "she could not recall any mention of that."

[127] It was put to Dr Conroy that Dr Trevor Turner, Consultant Psychiatrist, was instructed on my behalf and produced a report and that his opinion was that "this incident represented a missed opportunity to examine Mr McEntee's mental state in a more detailed fashion" and "to clarify the nature of his mental state" and "that, on balance, it was likely that additional medication or support would have been offered with consideration of an admission to hospital if details of his mental state warranted that. Further treatment would, on balance, have had the potential for affecting the outcome regarding the deaths of Mr and Mrs Cawdery." Dr Conroy agreed that "in hindsight and knowing all the details" the failure to conduct a mental health assessment did represent a missed opportunity.

[128] Mr Jonathan Johns, Registered Mental Health Nurse, and Senior Practitioner within the Home Treatment Crisis Service, in SHSCT, give evidence to the inquest. At 22:20 hours on 24 May 2017 he received a telephone call from Dr Conroy about Mr McEntee. Mr Johns recorded that Mr McEntee had attended the Emergency Department with self-inflicted superficial lacerations to his arms; was describing ongoing thoughts of self-harm and thoughts of life not worth living but had no specific plans to end his life; that he hadn't taken his medication in last number of days and that he was currently staying with a friend in Newry, but lives in Londonderry. Mr Johns recorded that Mr McEntee was known to mental health services in SHSCT and WHSCT and had attended the Mater Hospital recently.

[129] Mr Johns then contacted the WHSCT and spoke to Ms Kelly McGilloway. Mr Johns stated that he was told that Mr McEntee and he had a diagnosis of EUPD and substance misuse. He explained to the inquest that suicidal ideation can be a common symptom of a person with a depressive episode and who are emotionally unstable with EUPD. He also stated that he was told Mr McEntee had a history of poor engagement with services and that he had served a custodial sentence for armed robbery. Mr Johns told the inquest that he was told by WHSCT that

Mr McEntee had been discharged from Mental Health Services in the WHSCT for poor attendance. Mr Johns explained that the information passed to him, gave him the impression of Mr McEntee being, "a waste of space."

[130] Mr Johns told the inquest that he discussed the case with two colleagues in his office who were on night duty and that one had looked up Mr McEntee's PARIS notes and was able to tell Mr Johns his past psychiatric history in the SHSCT.

[131] Mr Johns stated that he then shared the information with Dr Conroy and discussed Mr McEntee's current presentation. Mr Johns stated that Dr Conroy advised that Mr McEntee was unable to give an address and telephone number for this friend in Newry. Mr Johns stated that, in his view, the thoughts of life not worth living were likely "chronic" given his diagnosis of EUPD, and that a management plan, according to Mr Johns was agreed between himself and Dr Conroy. He stated, "I was happy to put this management plan in place" and "keep the options open to see whether this could be managed." He explained that the key factor for him, was that Mr McEntee had no active suicide plan in place, and he felt that he could be managed by way of crisis telephone call or face-to face if it proved necessary. He was clear, that it was Dr Conroy who discharged Mr McEntee, which conflicted with Dr Conroy's evidence. Mr Johns stated that it was an unusual presentation, having been in Belfast days prior and then turning up in Daisy Hill.

[132] Mr Johns stated that the management plan was Mr McEntee could go to his friend's house and he was to contact the Emergency Department with details of the address where he was staying at and a telephone number on which he could be contacted on; that Dr Conroy would then pass the address and telephone number to the Home Treatment Crisis Response Team who would contact him by telephone to provide crisis intervention and arrange follow-up if needed; and finally if Mr McEntee current crisis could not be resolved by crisis phone intervention, then a face to face mental health assessment could be offered and arranged later in the evening/overnight as needed. He stated "It didn't come across to me, at the time, of a genuine mental health crisis, just with his past background and his current behaviour. So that's why we felt – I felt a crisis management plan to be put in place and let's take it from there."

[133] Mr Johns was of the view the management plan was agreed by Dr Conroy and at no time did she say she was not happy with it. Mr Johns told the inquest that had he been informed Mr McEntee had nowhere to stay that night, he stated that he would have been assessed. Mr Johns stated that he finished his shift at 01:00 hours and there had been no further contact from the Emergency Department.

[134] When asked, whether there was anything stopping him having a telephone conversation with Mr McEntee at that time, Mr Johns replied that, in hindsight, he could have spoken to him on the phone to get more of a history as to why he was presenting and what help he could benefit from their service.

[135] Mr Johns described how he had seen Mental Health Risk Assessment forms before, the form Dr Conroy did not complete, and that these forms would be provided when he attended the Emergency Department for an assessment.

[136] Mr Johns told the inquest that if he were told the information that was recorded by Dr Conroy in the ED flimsy, that Mr McEntee had expressed active suicidal ideation and thought disorder and had completed an act of self-harm earlier in the day, he would have "100%" have gone from Craigavon Area Hospital to Daisy Hill to assess Mr McEntee face to face. He stated that, if all the things recorded on the ED flimsy were told to him, "that would all be very concerning." Mr Johns stated that "I felt I made the right decision at the time." Mr Johns disagreed with Dr Conroy's evidence that she had made a referral for an assessment, whereas Mr Johns took the view that she was seeking advice. He stated, "if she had come to a conclusion this man needed to be seen, then she would not have agreed my management plan." Mr Johns explained that the SHSCT has since introduced a protocol whereby anyone that presents with self-harm must be seen face to face for an assessment.

[137] When it was put to Mr Johns that the ISAI Review, stated that, "the decision by the HTCR practitioner, who was a nurse, not to assess Mr McEntee, was a failing and compounded the difficulty Mr McEntee had experienced in accessing mental health services that day", he replied that "I'm obviously not going to say a failing on my part because what seems to be a failing was the fact that the Trust didn't have protocols in place that a person presenting with self-harm was to be seen face to face; it happened after this terrible tragedy."

[138] Mr Carbery told the inquest that, had he been provided with the information that Dr Conroy states she provided Mr Johns, he would have gone to Mr McEntee and assessed him on the basis that he had presented to the Emergency Department and that there was an expression of intent and that an inability to agree to any kind of safety plan. He explained that those factors were enough of a "red flag to go and assess anyone."

[139] Ms Kellie McGilloway, Crisis Service Manager in Grangewood Hospital in WHSCT, gave evidence to the inquest. On 24 May 2017, she was working on night duty as a Nurse Practitioner in Crisis Home Treatment Team. She took a call from Mr Johns who was seeking information in relation to Mr McEntee. She recalled sharing information about his care from EPEX computer system. She stated that, reading from the computer screen, this would have consisted of his diagnosis, therapeutic engagement and any history of self-harm or suicidal behaviour and any history of violence or aggression or substance misuse. She stated that the call was not documented on EPEX or his paper folder as he was not in the care of the WHSCT at the time. When asked whether she advised Mr Johns that Mr McEntee was discharged because he did not attend, Ms McGilloway replied that she did not and, in fact, advised that it was a "natural discharge and actual transition to the Community and Voluntary Team."

Incident three: Warrenpoint – 25th May 2017

[140] Constable Robert Stevenson gave evidence to the inquest. At approximately 18:10 hours on 25 May 2017, he was detailed to attend an incident of a drunk male making a nuisance of himself in Warrenpoint town centre. The police serial recorded, "caller reports there is a foreign national male making a nuisance of himself in the Square at moment. He appears to have a bottle of Buckfast sitting on one of the benches beside him and is quite drunk. He keeps approaching ladies in the street and is becoming bit of a pest.….Requests police have a word as some women feel vulnerable." A short time later another call was logged "caller reports that there is an intoxicated male causing a nuisance, caller stated that he is approaching customers and trying to get into people's cars." Constable Stevenson told the inquest that he was not aware of the detail of the calls.

[141] Upon arrival, he came across Mr McEntee, sitting on the footpath with his legs on the layby part of the road. Constable Stevenson described Mr McEntee as being very intoxicated and he had a bottle of Buckfast in his hand. He gave his address as Derry, although Constable Stevenson noted that he did not have a Derry accent. He checked his details on the police computer which brought up a different address and when asked, he agreed he lived there. Constable Stevenson asked him if he could get a train to Lurgan and then home from there and he agreed. He was then conveyed to Newry train station. During the short journey, Constable Stevenson described him as rambling about Free Derry and asking if they were "truly free." At the station he made his way to the terminal. Constable Stevenson remained in the police vehicle and observed Mr McEntee speaking to two ladies, as if he were trying to obtain a light from them for a cigarette in his hand. It later transpired that, in fact Mr McEntee, did not board the train and entered a private property nearby where he slept overnight.

[142] It was put to Constable Stevenson that both Inspector Owen and Mr Galbraith agreed, that once he became aware of his name and date of birth, he could have asked for further information from the control room, and that may have flagged up his interactions at the Europa Bus Station and the Mater Hospital, and Constable Stevenson agreed that it was possible. He agreed that information from NICHE, such as history of self-harm and violence towards police with alcohol, was useful information to have before speaking to him. Both Mr Galbraith and Inspector Owen went on to say that given the nature of the reports, necessitating police attendance to Warrenpoint, and given Mr McEntee had given incorrect address details, should have raised suspicion or "the professional curiosity of officers to ask more searching questions" and to conduct more detailed checks, via the control room. Constable Stevenson accepted that this was possible to have done so at the time.

Incident four: 26 May 2017 Daisy Hill Hospital & Craigavon Area Hospital

[143] Constable Paul O'Toole gave evidence to the inquest. At approximately 09:45 hours on Friday 26 May 2017, Constable O'Toole was travelling on the Camlough Road, Newry, with Constable Riddle on their way to attend court, when they were

made aware, by radio transmission, that a naked male, Mr McEntee, was observed walking in Bessbrook. As this was quite close to where they were, they were tasked to attend the call. On arrival, they were advised that he had made his way to the roundabout on Camlough Road. When they attended, Constable O'Toole described how they observed Mr McEntee, naked, with total disregard to being naked, walking very causally down the Camlough Road towards Newry town centre. They both alighted from their vehicle and as Mr McEntee saw them, he laughed, before running across the road in the direction of Daisy Hill Hospital. They caught up with him on Hospital Road, where they got out of their vehicle as he jumped over the wall and into a graveyard. At this point a female stated that she was the person who phoned the police and she give them his clothes which she had collected, together with a wallet which had his ID in it.

[144] Constable O'Toole explained that they then received a further radio transmission stating that Mr McEntee was outside Daisy Hill Hospital Mental Health Unit. When they arrived, they observed Mr McEntee running out of the hospital grounds onto Hospital Road being chased by police officers and security. Constable O'Toole stated that they parked at the lower exit on Hospital Road and Mr McEntee was running towards them.

[145] When they alighted from their vehicle, Mr McEntee stopped running and turned towards the chasing police officers and got into a fight stance, raising his fists. Constable O'Toole stated that he shouted at him, and he turned towards him and proceeded to walk towards him with his fists raised. Constable O'Toole told the inquest, that he considered his options at this stage, and believed that the use of his police issue baton would be ineffective as this would give him the opportunity to run past him. Due to the number of people around, he believed the use of CS spray would have caused more issues.

[146] Constable O'Toole stated that he took the view, that if he stood his ground, it would bring the problem to an immediate, safer end, as there were enough police officers to bring Mr McEntee to the ground. Constable O'Toole, described to the inquest, how Mr McEntee approached him in a fighting manner, his fists held high, just below the side of his head and he was bouncing on his toes. His eyes were fixed on Constable O'Toole and, as he got to within approximately two feet of him, Constable O'Toole believed Mr McEntee was about to strike out with his fists. At this time, Constable O'Toole observed a gap between his hands, and he seized an opportunity, and delivered two punches towards his upper chest, the first strike hit him on the chest and the second strike struck him around the side of the head. This made Mr McEntee drop his head and Constable O'Toole started to push his upper body to the ground. He explained that he used the minimum force needed to restrain Mr McEntee.

[147] At this time, Constable Riddle, came in behind and they both placed Mr McEntee on the ground in a controlled manner. Constable Riddle instructed Mr McEntee to place his hands behind his back and he complied with the instructions and handcuffs were applied to the rear. It was at this stage, Constable

O'Toole realised his hands were covered in blood, which he believed came from a wound on Mr McEntee's left arm. He then returned his police vehicle to clean his hands. He brought over Mr McEntee's clothes to other officers at the scene. He overheard a hospital staff member state that Mr McEntee was a mental health patient and that they knew him. Constable O'Toole declared that this had a "calming effect" on the situation, and he believed the hospital staff were going to deal with him.

[148] Constable O'Toole observed that Mr McEntee, now wrapped in a white hospital blanket, had slice marks around his lower neck and he was staring straight ahead, as if he were stuck looking at one point and he was silent. Constable O'Toole and Constable Riddle then left after being at the scene for approximately 10 minutes. Constable O'Toole explained that it was his belief, that Mr McEntee would be brought into the hospital, which was 100 yards away.

[149] Constable O'Toole agreed that, at the time, there was no discussion or handover of the situation, amongst the police officers at the scene, about a plan or who was taking responsibility for Mr McEntee. When asked the question, who is responsible for a situation when all the officers are the same rank, Constable O'Toole explained that it is always the main car detailed for that area, in this case, Delta Hotel seven zero (DH70) (District Newtownhamilton). They effectively take the lead. That day, he was Delta Alpha seven zero (DA70) (District Ardmore Station). He explained that as more calls come in, the next car deals with that next call, which would be 71, and so on. Constables McDermott and Kenmuir were response team DH70. Constable O'Toole told the inquest that police officers were present on the scene and saw events unfolding and therefore was of the view that a formal handover was not necessary.

[150] When asked whether he gave any consideration to exercising any statutory powers of arrest or Article 130 of the 1986 Order, Constable O'Toole replied that, he did not, as there were hospital staff present and the situation "had calmed significantly" and "the priority was to try and get him seen to." He did not recall any discussion, at the scene, between police officers about what they were going to do, or in relation to invoking Article 130. In his 11 years of service, at that time, Constable O'Toole confirmed that he had used Article 130 before this day but explained that he was not aware of the consequences in relation to the mental health assessment and the involvement of an approved social worker and nearest relative, that followed when it was invoked. He recalled some training on Article 130 at Garnerville, and he could not recall why, from his training records, he did not attend a training course run in the District titled 'Mental Health from Crisis to Care' in April 2017.

[151] Constable O'Toole was directed to the Regional Interagency Protocol, and he could not recall whether he was aware of the Regional Interagency Protocol at the time, but is aware of it now, together with the Risk Assessment, which he said has "been drilled into us since." Principles of the 'least restrictive option' were put to Constable O'Toole, in particular, if any of the circumstances apply, police can hand

over responsibility to the relevant health care professional, as soon as it is safe to do so, and he was asked whether two nurses standing at the scene, was a handover envisaged by the Regional Interagency Protocol and he accepted that it was not. The four constituent elements of Article 130 of the 1986 Order were put to Constable O'Toole, and he accepted that all four were present when he restrained Mr McEntee on Hospital Road. Both Inspector Owen and Mr Galbraith agreed that once 'Mr McEntee was apprehended, subdued, and restrained with handcuffs at Hospital Road, Newry, adjacent to Daisy Hill Hospital, there was a necessity for officers to arrest or detain him at the earliest opportunity.' Despite agreeing that all four elements of Article 130 were present, Constable O'Toole disagreed with the experts, stating that the situation had calmed significantly, and mental health staff were present. He did agree with Mr Galbraith and Inspector Owen's comment that Article 130 would have been more appropriate than any other power, such as arrest for a public order offence, given how he was presenting.

[152] Inspector Owen and Mr Galbraith commented that, as the only agency present with powers to detain, Mr McEntee should have been removed without delay and taken to the closest place of safety available, which was Daisy Hill Hospital, a walking distance away. Constable O'Toole agreed, but was of the view, it would not have been necessary to invoke Article 130 to do that. Inspector Owen and Mr Galbraith commented, that if Mr McEntee was being restrained under common law powers, then that should have been for the shortest time possible, and Mr McEntee being restrained for around 35 minutes exceeded, in their view, the boundaries of what may be considered as reasonable, proportionate and potentially lawful. Constable O'Toole agreed that if someone is not arrested, but restrained, that action must be justified. Inspector Owen and Mr Galbraith took the view that 'Constables O'Toole, then Kenmuir and McDermott appear to have given no consideration to the application of police powers in respect of Mr McEntee following his apprehension and restraint.' Constable O'Toole agreed with this statement.

[153] When asked if the same situation arose again, in the same circumstances, would Constable O'Toole make the same decision again and he replied "yes", he would still do the same as he did in 2017, "I wouldn't do anything differently."

[154] Constable Mark Riddle gave evidence to the inquest. Constable Riddle described how, when they arrived at Daisy Hill hospital he observed Mr McEntee, calmly walk across the zebra crossing, which led to the steps from the hospital down to Hospital Road. Constable O'Toole shouted at him to stop but he looked and then walked on.

[155] Constable O'Toole and Constable Riddle then headed to the hospital exit where they observed Mr McEntee running towards them. They alighted from their vehicle and observed that Mr McEntee was making shapes with his arms and hands, that he was doing some sort of martial arts, when he was confronted by Constable O'Toole and Constable Riddle. Constable Riddle drew his CS spray but did not use it. Constable Riddle observed Constable O'Toole punching Mr McEntee in the head

area and then he was then taken to the ground. Constable Riddle placed handcuffs on Mr McEntee to the rear. At no time did Mr McEntee struggle.

[156] At this stage, other police officers had arrived and taken control of Mr McEntee. Constable Riddle explained that a number of hospital staff arrived and explained that they were aware of Mr McEntee and that he had mental health issues. Constable Riddle stated that, in his view, he "didn't appear to be in his right state of mind." Constable O'Toole handed over Mr McEntee's clothes and they left the scene. At no stage during Constable Riddle's interactions did Mr McEntee speak. He estimated that he and Constable O'Toole were at the scene for less than five minutes. He told the inquest that he thought Mr McEntee was going to be taken to Bluestone Psychiatric Unit, because of the presence of the two staff from the hospital. He agreed with Constable O'Toole's evidence that car DH70 was the main car at the scene. When asked, Constable Riddle stated that he did not know who was taking charge of the situation and he agreed that this was unsatisfactory.

[157] When asked whether he gave any consideration to using Article 130 of the 1986 Order, he replied, "To be perfectly honest with you, no, we didn't. It was probably one of the last things we was thinking about." He confirmed that he had used Article 130 before this and was aware of the different mental health assessment which flows when it is invoked. When asked how he knew this, he replied from his initial training in Garnerville, experience, and ongoing training. It was pointed out that there was no record of Constable Riddle having attended the 'Mental Health from Crisis to Care' training in April 2017, even though he told the inquest that he had attended district training as well as e-learning packages on Article 130. Constable Riddle confirmed that he had no awareness of the Regional Interagency Protocol but was aware of its Appendix 2 – the Risk Assessment. Constable Riddle agreed that all four constituent elements of Article 130 were present during his interaction with Mr McEntee. When it was put to him that both Inspector Owen and Mr Galbraith agreed that the elements, having been satisfied, police should not have hesitated to use Article 130 at the scene on 26 May 2017, Constable Riddle agreed.

[158] When Constable Riddle was asked if he came across a situation again, where there was someone in the state of distress, like Mr McEntee was, whether he would act any differently in terms of having a discussion with colleagues, querying the basis, on which they were holding Mr McEntee or whether Article 130 was going to be used, he replied that "I don't believe I would have done anything different, but, yes, I would agree that probably that statement should have been made, or that conversation should have been had."

[159] Constable Anthony McCartan gave evidence to the inquest. At approximately 09:52 hours on 26 May 2017, a Newtownhamilton callsign requested Constable McCartan and his colleague Constable Miller's assistance looking for a naked male on the Camlough Road. A further report was received confirming that he was at Daisy Hill Hospital.

[160] On arrival at Constable McCartan observed members of hospital staff running through public entrance. Constable McCartan immediately exited his vehicle and followed. He saw Mr McEntee standing in the middle of Hospital Road. He was completely naked and appeared uncooperative. He could see that several police officers had surrounded Mr McEntee. Constable McCartan made his way down towards him and there were four police officers present along with two staff from the hospital. He stated that he was not thinking about an arrest at that stage. Mr McEntee was restrained and under police control. Mr McEntee was taken off the road and detained on the footpath. Constable Johnson and Constable McGinn then arrived provided assistance.

[161] Constable McCartan told the inquest that Mr McEntee he did not respond to any questions whilst he was present. He remained silent and stared up into the sky. Constable McCartan attempted to engage with him by asking was he ok, however he did not reply. One of the hospital staff stated that he liked to be called "Jesus." He explained that, to his knowledge, the hospital staff did not cause any confusion in relation to roles and responsibilities. Constable McCartan took hold of Mr McEntee's left arm to prevent him from attempting to leave. Constable McCartan described him as not being co-operative, in that he would not walk back to the hospital. It was decided that an ambulance would be tasked to bring him around to the hospital. He stated, "otherwise we would have been dragging him up the road and we didn't feel that would be appropriate." Also, in his view it made more sense to get an ambulance down as it had more space, rather than the back of a police car which "was cramped." He stated that had he had known the ambulance would have taken 35 minutes, he was of the view Mr McEntee could have been walked up or carried up to the entrance of Daisy Hill.

[162] Mr McEntee was then lowered to the ground by Constable McCartan and a colleague, as they were aware they could be waiting a while for an ambulance. He was placed on the ground face up and some of his clothing was placed underneath his head for comfort. Constable McCartan remained at his side holding his left arm. During this time, Mr McEntee did not communicate with anyone. He continued to stare up into the sky.

[163] Constable McCartan told the inquest that he did not recall any discussion or planning amongst officers about who was taking responsibility or risk assessing the situation. The only plan, he was aware of, was to hold him until an ambulance arrived and then a decision would be made at that stage. He agreed with Constable O'Toole's evidence that car DH70 was the main call sign and the default position being that they were the responsible officers. He did state he did not know many people from Newtownhamilton Response Team and so he did not know which individual was responsible. After approximately 10 minutes, Constable McCartan left the scene.

[164] When asked what his belief was when leaving the scene, Constable McCartan replied that "I spent 10 years in the police and all of it was in response, my belief

would have been that he would have been taken to hospital to be seen by a mental health team."

[165] In relation to Article 130 of the 1986 Order, Constable McCartan explained that he had used it many times and that he was familiar with the consequences in terms of mental health assessment that flows from the invocation of Article 130. He attended the District course 'Mental Health from Crisis to Care' on 13 April 2017, which, he stated, "included references to the Regional Interagency Protocol and the Article 130 provision." He told the inquest that from April 2017 to when he left police in April 2019, he did not recall receiving any training in relation to mental health and the use of Article 130 and the interaction between police and clinicians. When asked whether the four constituent elements of Article 130 were met for the period in which he attended Mr McEntee, he agreed that they were.

[166] When it was put to him that Inspector Owen and Mr Galbraith agreed that once Mr McEntee had been apprehended, subdued, and restrained with handcuffs, there was a necessity for officers to arrest or detain him at the earliest opportunity, Constable McCartan accepted that statement and accepted that the most appropriate power that should have been exercised by police was Article 130, given Mr McEntee's presentation. When asked, if the same scenario arose, Constable McCartan stated that, with hindsight, it was appropriate that Article 130 was invoked.

[167] Constable Jack Gray gave evidence to the inquest. On 26 May 2017, he was in attendance, along with Constable Ross, at Daisy Hill Hospital. Whilst at the hospital he overheard a Newtownhamilton callsign receiving a report of a naked male. At approximately 10:00 hours, he saw Mr McEntee march across his path, along the corridor, followed by security staff. He thought that he was already a patient at the hospital. He then began to run along in the direction of the main entrance and Constable Gray proceeded to chase him. Constable Gray followed Mr McEntee where he grabbed hold of his right arm. Mr McEntee began to struggle, and he pulled away and left along Hospital Road. Constable Gray then noticed that his left hand was completely covered in blood from Mr McEntee's arm. Whilst backing away from Constable Gray, Mr McEntee began to form a pose with his body which Constable Gray described as a karate fighting stance, as he had his arms outstretched in front of his body, as if in preparation for a fight. Constable Gray continued to approach him and shouted at him to stay where he was. Constable Gray described how Mr McEntee showed no signs of listening to any of the things he was telling him.

[168] Constable Gray then noticed other officers had arrived on the scene and Mr McEntee then turned his attention to them whilst maintaining a fighting stance. He saw Constable O'Toole proceed to Mr McEntee at which point Mr McEntee attempted to challenge Constable O'Toole before Constable O'Toole placed his hands on him. Mr McEntee continued to resist and fight off Constable O'Toole and then he was taken to the ground and Constable Gray assisted by holding his right arm as handcuffs were applied. As Mr McEntee was under the control of the

Newtownhamilton officers, Constable Gray then returned to Daisy Hill Hospital. When Mr McEntee was asked his name, he replied "Jesus." He shared the view of Constable O'Toole and Constable Riddle, that Mr McEntee was a risk, not just to himself, but to others.

[169] Constable Gray told the inquest that he was aware of Article 130 prior to this and knew that there was a difference in mental health assessments when it is invoked. He recalled receiving training during his time in Garnerville and stated that there was also District training, although it was put to him that there was no record of him attending the course "From Crisis to Care" in 2017. He described that whilst he was not aware of the Regional Interagency Protocol, he was aware of the Risk Assessment. He stated that, in his view, the conditions were met for Article 130 to have been invoked and, in hindsight, it should have been, however, when asked, if the same situation arose again, he confirmed, that, in fact, he would not do anything differently.

[170] Mrs Julie Matchett, Team Leader with Psychiatry of Old Age Team in the SHSCT, gave evidence to the inquest. At approximately 09:50 hours on 26 May 2017, she was working in the Mental Health Department at Daisy Hill Hospital and overheard a member of staff say that there was a naked man outside the building. She looked out the window and saw Mr McEntee standing outside the Department. At one stage she noted that he had his arms stretched up in the air and appeared to be saying something which could not hear. Mrs Elizabeth Williamson, Team Leader with the Support Recovery Team, was also in the office and they both made their way down the stairs towards Mr McEntee. She explained that Mr McEntee was unknown to her, and someone informed them that he had presented to the Mental Health Department on the previous Wednesday and had left without being seen.

[171] Both Mrs Matchett and Mrs Williamson went to Mr McEntee, who was with several police officers. He was covered with a blanket, and she believed that there was a total of six officers with him at this time. Mrs Matchett told the inquest that she identified herself to Mr McEntee and explained that they were nurses and that they wanted to help him. She described how he was looking upwards towards the sky and that he did not make any direct eye contact, nor did he respond to any questions. He stated, "I am Jesus." He then began to try and sit down, and the officers assisted him to the ground, and he went into supine position. There was no verbal interaction from him. When he lay down, he closed his eyes and kept them closed.

[172] Mrs Matchett saw that he had two superficial scratches on the left side of his neck, they were not bleeding but appeared fresh, and she stated that there was a smell of alcohol from his breath. Mrs Matchett then knelt beside Mr McEntee and while on the ground he licked his lips and said, "someone is trying to kill me" or "somebody is trying to kill me." Mrs Williamson asked who was trying to kill him, but he did not respond. Mrs Matchett tried to reassure him that he was safe, and they wanted to help him. An ambulance was requested, and Mrs Matchett stated that she was with Mr McEntee for approximately 40 minutes before it arrived. When

the ambulance arrived Mr McEntee stood up and walked into the ambulance with no resistance and police officers accompanied him. In relation to which hospital he should go to, Mrs Matchett explained that if Mr McEntee were brought to the Emergency Department in Daisy Hill, he could have been assessed and if it were deemed suitable, he could then have been transferred to the Bluestone Psychiatric Unit at Craigavon Area Hospital. She stated that she had already left the scene when the decision as to which hospital was being made but stated, "I would have thought that he should have gone to Daisy Hill" because it was "the nearest place." She explained that if he were compliant, they could have walked him to the Emergency Department of Daisy Hill "but at one stage he wouldn't even stand" and so an ambulance was called.

[173] Mrs Matchett was of the view "the police were in charge of the situation; they had a man who was handcuffed and under their control" and that he was "going to hospital not of his own volition because he was handcuffed." She gave her view, "I don't believe that he was in any position to give informed consent to agree to anything. He was not co-operative with any questioning, he refused to answer any questions, he wouldn't make any direct eye contact, so I don't believe that he would have had the capacity to consent to going to hospital himself." She agreed that, over the course of the 40 minutes, waiting on the ambulance, Mr McEntee became more pliable and by the time the ambulance arrived, he was complying and walked into the ambulance, but that it was certainly not the case that he was complying for the entire 40 minutes. She stated that the arrival of the ambulance appeared to change his demeanour.

[174] When asked whether she thought the police officers had deferred to her and Mrs Williamson as nurses, Mrs Matchett replied that that was not her sense of the situation and that they were both present to support Mr McEntee. She disagreed that there was ever a handover from police at the side of the road to her and Mrs Williamson, "Mr McEntee would never have been my responsibility or Elizabeth Williamson's responsibility either. We were community staff"; "We were there to assist but we were not in a position, and we would not have been responsible for taking or accepting responsibility for his care." She concluded by stating that they had "no powers whatsoever" and they were there to try and assist and support.

[175] Mrs Elizabeth Williamson, Team Leader in the Support and Recovery Team in the Mental Health Department in Daisy Hill Hospital, gave evidence to the inquest. At approximately 10:00 hours on 26 May 2017, she was alerted to a naked male outside shouting that he was Jesus Christ and standing in a crucifixion stance with his arms and legs outstretched. Both she and Mrs Matchett made the decision to go and help, as "he gave the appearance of being disturbed." As she was leaving the building, one of the administration staff informed her that the man was called Thomas McEntee. She did not know him and had no professional dealings with him.

[176] Mrs Williamson saw him running towards Hospital Road, in between two parked cars, with one police officer at each end of the cars. He pushed past one of them onto the road, however he was stopped by another police officer and the officers then restrained him.

[177] Both Mrs Williamson and Mrs Matchett then proceeded to make their way to him and she heard one of the police officers say that they needed to get help from mental health. Mrs Williamson informed the police officers that they were from the relevant department. Police officers wrapped Mr McEntee in a blanket and put him to the ground on the footpath outside the hospital and she could see that he was handcuffed. She explained that she thought that they were going to arrest him or take him to hospital.

[178] Mr McEntee was not communicative, and she could see that he had superficial cuts to his necks and wrists. Mrs Williamson spoke to Mr McEntee by name, and he replied, "I'm not Thomas, I'm Jesus" and later "they are going to kill me." Following this, he remained silent refusing to communicate, and he fixed his eyes on the sky for a considerable length of time. Mrs Williamson stated, "I was just trying to reassure Mr McEntee that Julie and I were nurses, we were there to try and keep him safe, we were going to keep him safe and comfort him. At one stage I lifted his head and I knelt and put his head on my knee." She was of the view Mr McEntee "was very disturbed" and she agreed with the comment from the ISAI Review that his utterances, indicated a psychotic mental state at the time. She did not recall any conversation between police about any powers being used or what they were going to do with him.

[179] Mrs Williamson then contacted Mr Andrew Ruck, Bed Manager in Bluestone Psychiatric Unit, to advise them of the current situation to suggest that they might need a bed in the Psychiatric Intensive Care Unit given Mr McEntee's presentation. He confirmed that beds were available in Rosebrook. She could not recall whether she made the police officers aware of this.

[180] As it was apparent that Mr McEntee was not going to walk, Mrs Williamson told the police that she thought an ambulance should be called. They could address any physical issues and deal with the issue of transportation. She stated that, at no time, did any police officer disagree with this, given that the entrance to the hospital was 100 yards away. An ambulance arrived 35 minutes later to take Mr McEntee to be medically assessed in the Emergency Department, as he was un-cooperative, and he was not going to walk. During this time, one of the administration staff came down and Mrs Williamson asked if they could bring down Mr McEntee's notes, so that that information could be provided to the paramedics.

[181] When the ambulance arrived, Mrs Williamson stated that Mr McEntee got up "right away" and walked into the back of it, escorted by police. She then went into the back of the ambulance with Mr McEntee for a short time. She provided his details from his medical notes to the ambulance crew. The ambulance crew asked where Mr McEntee should be taken, either the Emergency Department in Craigavon

Area Hospital or Daisy Hill Hospital. Given Mr McEntee's presentation, Mrs Williamson explained that she made the decision for Mr McEntee to be transported to Craigavon Area Hospital for ease of transfer to Bluestone Psychiatric Unit, following his assessment and treatment in the Emergency Department. She stated that she thought "it was just a helpful thing to do" and "nobody challenged me on that." Also, she thought the ambulance came from Craigavon and "so my rationale was that they could take him back to Craigavon, so that they could be back in their place" and she still felt that it was an appropriate decision. When asked whether she could have considered advising the paramedics and police officers that the decision was not up to her, as he was under police control, and that she should leave to police, she replied that she "quite possibly" could have.

[182] Mrs Williamson agreed that she adopted the role of "good Samaritan" and had no official role to play in the 45 minutes that she was at the scene. She explained that, at no time, did she assert to police that she was in charge of Mr McEntee. She agreed that there was no one designated at the scene to take overall responsibility and in her view "the police were definitely in charge." When asked if she felt that her and Mrs Matchett's presence led to the police deferring to them, she stated "I think they left us to care for Mr McEntee", "I think they handed over that responsibility, because we were, I suppose, in effect offering mental health first aid to Mr McEntee", "but as regards anything else, no." Mrs Williamson was of the view that there was no handover from the police to her and Mrs Matchett. When asked whether, in her opinion, the four constituent elements of Article 130 were met, she agreed and when asked whether it was apparent to the police officers, she replied "I would have thought so."

[183] Constable Derry McDermott gave evidence to the inquest. At approximately 10:00 hours he and his colleague Constable Kenmuir received a report of Mr McEntee running naked. They had callsign DH70 that day. He agreed with Constables O'Toole and Riddle's evidence that they were the responding callsign. On the day, Constable McDermott was the observer and Constable Kenmuir was the driver. Constable McDermott agreed with Mr Galbraith's comment that, on the basis of the callsign position, Constable McDermott and Constable Kenmuir had "primary police responsibility for the incident once Mr McEntee had been apprehended and the situation then brought under control."

[184] When they arrived at Daisy Hill Hospital, Constable McDermott saw Mr McEntee being chased by police colleagues. Constable McDermott then made his way to Mr McEntee who had been caught and restrained at this stage. He was sitting handcuffed on the footpath. When Constable McDermott tried to speak to Mr McEntee, he just ignored him, staring in one direction the whole time, only on one occasion did he acknowledge Constable McDermott, saying that his name was not Thomas, it was Jesus.

[185] Constable McDermott did not witness Constable O'Toole's restraint of Mr McEntee and he confirmed he was not told why he required restraint and agreed that would have been useful information for him to know.

[186] Two staff from the hospital were present and Constable McDermott told the inquest that his impression was, that they were looking after Mr McEntee as he was one of their patients as they said, "he was one of ours." When he was told that Mrs Williamson, explained in evidence, that they were effectively providing 'mental health first aid' and telling him he was going to be safe, he agreed that that accorded with what he observed. He went on to say, "my perspective on it was that this guy needs medical help and he's getting it." When asked if their presence affected his view, he stated, "it changed my perspective", "it impacted me as in, I believed that he was being treated at this point. You know, okay, it's out in the street and it's the early part of treatment, but to me it's - he's now under their control and I'm here for a different reason. I'm here now to control that he doesn't abscond." He confirmed that he "took a step back", as he viewed Mr McEntee as being under Mrs Williamson's and Mrs Matchett's care. He stated that, if "they asked me to do something, I would have done it for them. If they needed him moved, I was leaving it to them at this point, because I didn't consider it to be a matter that I needed to be involving myself in." Constable McDermott agreed that the comment of the ISAI Review, that, police deferred to the mental health team whenever they arrived, was a fair summary of the situation. It was put to Constable McDermott that, it would not have been appropriate to defer at that stage, as there was no proper handover between police and medical staff and no risk assessment conducted and he did agree that the difference between him and Mrs Matchett and Mrs Williamson was, that, he had extensive powers available to him to deal with Mr McEntee and they had no powers.

[187] Constable McDermott explained that there was no discussion between him and Constable Kenmuir and the other police officers about, the circumstances of the restraint, the assault of Constable O'Toole, whether Mr McEntee was going to be arrested for public order offences or assaulting a police officer or whether he needed treatment before they left the scene. He stated that, it all happened so quickly, so he was not surprised there was no discussion about arrest or powers under Article 130 of the 1986 Order being exercised. His view was, "at this point I would have been leaving it to the hospital staff who were giving him medical care" and he thought he would be taken to Daisy Hill Hospital. When asked, whether at any stage, he considered, "what powers am I holding him under?", Constable McDermott replied, "It honestly never crossed my mind at the time."

[188] Constable McDermott was told an ambulance was on the way and they waited approximately 40 minutes it to arrive. During this time, Constable McDermott did not recall any discussion about where the ambulance would take Mr McEntee. He told the inquest that, an ambulance being called, "sort of made sense" as Mr McEntee was not co-operating. It was never suggested that Mr McEntee could be transported in the back of the police car. Constable McDermott described how, Mr McEntee would not move for them, but was showing no aggression towards them. Constable McDermott agreed that, as Mr McEntee was calm and under control, it was an opportunistic time, to consider what basis they are detaining him and whether Article 130 should be invoked, and he stated, "It

probably was a good moment to do that, but I didn't do it. I just thought he's being treated, there's no need to, it's not necessary to use any powers." He accepted that Mr McEntee was not receiving a full mental health assessment which might have resulted in him being detained under the 1986 Order.

[189] Constable McDermott conceded that "it never crossed his mind" to seek further information on Mr McEntee from police control. He accepted that it would have been incumbent upon him to seek information and a full handover from the police officers at the scene and police control. Constable McDermott accepted that he, as observer, was responsible for the care of Mr McEntee and that at no time did he exercise any of his police powers in respect of him, and that, in his view, the restraint for 35 minutes with handcuffs, was under a common law power. He accepted that he did not check to ascertain whether Mr McEntee was a risk to others from police control or ask his colleagues further information about the restraint.

[190] When the ambulance arrived, Constable McDermott stated that they were able to persuade Mr McEntee to walk unaided into the back of it and he then removed his handcuffs as he complained they were hurting him, and the ambulance crew needed to treat Mr McEntee. As Constable McDermott was taking off the handcuffs, he asked Mr McEntee if he was going to behave and he replied, "yes." Constable McDermott then stated that he overheard that Mr McEntee was to be taken to Craigavon Area Hospital. When asked whether he raised any objection to Craigavon, given that Daisy Hill was 100 yards away, he replied, "It made sense, because from my experience the mental health team are based in Craigavon."

[191] Constable McDermott asked the ambulance crews if they wanted one of the police officers to travel with them in the back of the ambulance, to which they replied no, but "could we follow behind until they got there." He stated that he was not aware what information the paramedics were told in relation to the incident but did agree that they would need to be properly informed before they could refuse an offer of additional support. He explained that police could accompany a person, whilst not under arrest, but if they posed a risk, but that he did not feel strongly about it as Mr McEntee was compliant. He stated that he was "taking advice from the paramedics" and he considered Mr McEntee to be a voluntary patient when he got into the back of the ambulance.

[192] When it was suggested that Mr McEntee fell into a category of a person who was behaving erratically, and perhaps could not be trusted, Constable McDermott replied that he was with him for 40 minutes and he was compliant, although it was pointed out that he was in handcuffs for that length time and lying on the ground. Constable McDermott stated, "whatever episode Mr McEntee had had, it was over, in my eyes, I didn't see him having any more" and added "my thought process at the time was, I'm not even sure that this was solely down to mental health. I mean, I wasn't sure if he had taken drugs, or if he had taken drink, but what I was sure was, he's being very compliant at that point."

[193] Constable McDermott and Constable Kenmuir then followed the ambulance to Craigavon Area Hospital. On arrival, Constable McDermott approached the Emergency Medical Technician, who was in the back of the ambulance, Mr Morgan, and asked him if he was happy enough with Mr McEntee, who was now fully dressed, or did he want them to remain. Mr Morgan replied "no, no, it's okay, he has agreed not to run away." Constable McDermott then turned to Mr McEntee and asked him if he was happy enough, and he replied "yes, thank you." Constable McDermott then informed Constable Kenmuir about the conversation, and they then left. When the CCTV of this was shown at inquest, Constable McDermott agreed that it was a very quick conversation.

[194] When it was put, that setting aside Article 130, would it not have been good policing practice to accompany Mr McEntee, into the Emergency Department, he replied that, no, given the information that he had, he had no reason to think Mr McEntee was being non-compliant. When it was put to Constable McDermott, that, there were a number of serials logged commencing at 09:47 hours about Mr McEntee's actions on the Camlough Road, naked, with a backlog of traffic, to being restrained and handcuffed outside Daisy Hill Hospital at 10.04 hours, the ambulance arriving at 10.39 hours, Constable McDermott conceded that, he could have accessed this information from police control or on his mobile device. The serial logged at 10.57 hours read "This person is being conveyed by ambulance to Craigavon Hospital, and they request we escort them to that location. He is perfectly calm at present. He will be going to A&E in Craigavon to have an injury to hand, looked at, and then will ultimately be going to Bluestone Unit. If he is calm at that stage, we will be able to withdraw and leave him in a place of safety, will update in due course." Constable McDermott assumed that Mr McEntee would be brought to Bluestone Psychiatric Unit. When asked about the use of the specific term "place of safety" which is used in Article 130, Constable McDermott could not recall if he made this transmission, or his colleague Constable Kenmuir did. The next transmission at 11:44 hours recorded "Male has been left at Craigavon Area Hospital in the care of ambulance staff."

[195] When the comment from the ISAI Review was read "When Mr A no longer showed any physical resistance after being restrained and handcuffed by police officers outside the DHH this influenced the professionals' view of his level of risk. The assumption was that because he had settled and become compliant, he would remain so", Constable McDermott agreed. He accepted that now, his perception has changed, and that he should have accompanied Mr McEntee into Craigavon Area Hospital. Constable McDermott accepted that he should have got more information on Mr McEntee and handed that information over to the paramedics who would have, in turn, informed the staff in the Emergency Department in Craigavon Area Hospital.

[196] Constable McDermott told the inquest that had he have known the extent of force required to restrain Mr McEntee and his behaviour outside Daisy Hill, which would probably have changed his actions at Craigavon Area Hospital.

[197] Constable McDermott explained that during his time with Mr McEntee, he never thought it necessary to arrest him for a criminal offence nor did he think of using Article 130 as "130 is more to get him to the treatment and he was already getting that when I'm there." He described how he was not aware of the consequences for the type of mental health assessment of using Article 130. The training records for Constable McDermott showed that he had not completed the District wide 'From Crisis to Care' mental health training in 2017. He confirmed that in 2017, he was not aware of the Regional Interagency Protocol or Risk Assessment, but that he is now.

[198] When Constable McDermott was asked whether he now agreed that the four constituent elements of Article 130 were present during his time with Mr McEntee, he agreed that they were, and then when asked whether he accepted, that he should have used Article 130 for Mr McEntee on 26 May 2017, he replied "yes", although he maintained that the presence of the two hospital staff threw his thinking in that he was receiving treatment. Mr Galbraith and Inspector Owen's comment "We agree that at the moment Mr McEntee was apprehended, subdued and restrained with handcuffs at Hospital Road, Newry, adjacent to Daisy Hill Hospital, there was a necessity for officers to arrest or to detain him at the earliest opportunity", Constable McDermott accepted that comment. In relation to the comment "As the only agency present with powers to detain Mr McEntee, we agree that he should have been removed without delay, and taken to the closest place of safety available, which was Daisy Hill Hospital, a walking distance away. Given his obvious injuries this was the best place for initial care and further consideration of next steps regarding formal mental health assessment" Constable McDermott believed that he felt he did not have to intervene because Mr McEntee, in his eyes, was receiving treatment, when he arrived. In relation to Inspector Owen and Mr Galbraith' comment "In summary, based on the facts available we agree that officers present, and in particular Constables O'Toole, then Kenmuir and McDermott, appear to have given no consideration to the application of police powers in respect of Mr McEntee following his apprehension and restraint", he replied "I agree that the handover should have been better, and I would have changed how I would have perceived things." However, when asked the question "if there was anything about this scenario, if this was to occur again would you act any differently?" and Constable McDermott replied, "no" but later conceded that Article 130 should have been invoked and if it was, the nearest place of safety was Daisy Hill Hospital and he would have remained with Mr McEntee until a risk assessment was conducted and it was appropriate to hand him over to the medical staff and it was safe for the police to leave.

[199] Constable Alastair Kenmuir gave evidence to the inquest. On 26 May 2017, Constable Kenmuir was on patrol accompanied by Constable McDermott. Constable Kenmuir agreed with Constable McDermott's evidence that they were the primary callsign and, therefore, had responsibility to deal with the incident at Hospital Road. When they arrived at Hospital Road, they saw Mr McEntee in the middle of the road and a number of police officers trying to restrain him. Constable Kenmuir stopped

the police vehicle and got out to assist. He observed Constable O'Toole succeeding in catching, restraining, and handcuffing Mr McEntee. He confirmed he did not witness the fighting stance adopted by Mr McEntee towards Constable O'Toole, nor did he see Constable O'Toole punch Mr McEntee. As he approached, a passing ambulance driver give him a blanket which he used to help cover Mr McEntee up. Members of staff from the mental health Department of Daisy Hill Hospital came to talk to Mr McEntee. The staff asked Constable Kenmuir to task an ambulance, which he did through the police control room. The officer in the police control room then requested the ambulance. An audio clip of the call was played to the inquest and Constable Kenmuir confirmed that it was not his voice speaking and appeared to have been another officer at the scene, but he could not identify the voice. During the call, the assumption was that Mr McEntee was being taken to Daisy Hill and a query was raised by the ambulance operator as to why an ambulance was needed as the hospital was 100 yards away. Constable Kenmuir told the inquest that he "had to actively persuade him to task an ambulance because of the proximity to the hospital."

[200] Constable Kenmuir told the inquest that it was apparent to him, that there was a concern over Mr McEntee's mental state, at that time, and that in the car on the way to the scene, he did consider that this may be a situation where Article 130 was appropriate. He explained that he was glad to see the hospital staff, as he did think Mr McEntee had mental health problems. He stated that he did not have a lot of direct engagement with staff as they were engaging directly with Mr McEntee. He described how, like Constable McDermott, he formed a view that Mr McEntee was a patient of the mental health unit and that he was known to the staff. Constable Kenmuir explained that whilst he knew the staff had no powers to do anything about Mr McEntee on Hospital Road he stated, "I am also aware that 130 doesn't need to be invoked if the person's receiving treatment and that was my understanding, that he was there, he was getting attention." He confirmed that in his mind, Mrs Williamson and Mrs Matchett were providing treatment as "they were talking to him. He was engaging, very limitedly towards them, but at the same time, I believe that that's what they were doing." Constable Kenmuir admitted that, in his view, the staff were taking charge of Mr McEntee's care but that the police were in charge of the situation generally and there was no formal handover to the hospital staff.

[201] Constable McDermott and Constable Kenmuir along with the two staff of the Mental Health Department then waited for the ambulance with Mr McEntee. During this time, Mr McEntee lay silently on the ground. He was completely passive, and he had his eyes closed for most the time.

[202] When asked who had control over Mr McEntee until he left the scene in the ambulance, Constable Kenmuir replied "we would have physical control over him but, to be honest, in my mind, it was being guided by mental health staff as to what their best opinion on his and what the best outcome for him would be." When asked who had responsibility for Mr McEntee until he left the scene in the ambulance, Constable Kenmuir replied "ultimately the police." He stated that there was "a big

degree of deference" to the mental health staff. When it was suggested to Constable Kenmuir that that deference was not appropriate as the hospital staff had no legal powers and that, they were, in fact providing mental health first aid on the side of the road, Constable Kenmuir repeated that, he did not believe invoking Article 130 was necessary, as "I didn't perceive that any removal to a place of safety was necessary for him because, he was, in my mind, getting that treatment and so any removal wouldn't have been necessary so, therefore, any powers that I would have as a police officer weren't relevant in those particular circumstances." When it was put that "treatment" meant treatment at a higher level than at the side of the road, Constable Kenmuir stated that he did not know what the treatment was to look like "so I didn't know that wasn't what he would be receiving." He stated that he did know Mrs Williamson had telephoned Bluestone and "so all that in mind I, I was assuming at the time, rightly, but in hindsight perhaps not, but I was assuming then that I didn't need to invoke any powers because the pathway that would be invoked, if those powers were used was the same, but I understand that might not be the case now." Constable Kenmuir explained that he did not give any thought to what powers police were exercising at the time regarding the ongoing restraint of Mr McEntee.

[203] Constable Kenmuir admitted he did not have a conversation with Constable McDermott about what he saw in relation to the restraint of Mr McEntee by colleagues and conceded that he should have, nor was there any conversation with the other police officers about what transpired before they arrived and what should happen next before they left the scene. Constable Kenmuir stated that he did not consider contacting the police control room for more information on Mr McEntee.

[204] When the ambulance arrived, Mr McEntee got up and walked into the back of the ambulance, with Constable Kenmuir. He stayed with Mr McEntee while the paramedic dressed the wounds to his arms in the back of the ambulance. During this time one of the hospital staff was talking to the other paramedic and had a file containing information about Mr McEntee. Mr McEntee was calm and remained seated at the back of the ambulance. He did not speak apart from saying "I don't live there" when he overheard the paramedic and staff member talk about his addresses from the file.

[205] Constable Kenmuir stated that he overheard the conversation with Mrs Williamson and the paramedic about taking Mr McEntee to Craigavon and he stated, "that seemed perfectly sensible to me at the time." Constable McDermott then told him that they were to follow the ambulance to Craigavon. When asked, if he thought, why not get Mr McEntee to his feet, and take him to the Emergency Department in Daisy Hill, he replied, " to be honest, that's the obvious answer and not to put too fine a point on it, if there hadn't been mental health support there, that's what I believe I would have done, but I didn't want to sort of intrude to what I thought was happening." When asked whether he gave any thought to the fact that Mr McEntee was previously acting erratically, then became passive, and might start acting erratically again, Constable Kenmuir stated "I did and to be honest that's why I was content to follow the ambulance." When asked if it was not appropriate for an

officer to remain in the back of the ambulance, he stated that, for him it was about the 'least restrictive option' and sometimes "police can infame the situation" and they were "literally just right behind in case things had changed."

[206] Constable Kenmuir was asked about the information provided to the paramedics which was recorded on the Northern Ireland Ambulance Service Patient Report Form (PRF), "found running naked on Hospital Road." He accepted that was inaccurate as he was caught by police and that information along with "restrained by police" was relevant to the question of risk posed by Mr McEntee. Constable Kenmuir confirmed that if someone was arrested, police are required to accompany that person in the back of the ambulance.

[207] On arrival, they parked behind the ambulance and Constable McDermott exited vehicle to speak with the paramedic. Constable Kenmuir followed, and he saw Mr McEntee exit the ambulance fully dressed and Constable McDermott having a brief word with the paramedic. He then observed Mr McEntee and a paramedic walk into the hospital. The inquest viewed the CCTV of this interaction. Constable McDermott informed him that the paramedic did not require any further assistance and Constable Kenmuir then drove the vehicle back to the Newry area.

[208] Constable Kenmuir explained that he had invoked Article 130 before and since the deaths of the deceased. He stated that, he rarely went into hospital with a voluntary attender, because of resourcing and his callsign being required elsewhere. When asked whether all four constituent elements of Article 130 were satisfied during his time with Mr McEntee, he agreed that three were, but he did not agree that 'removal of that person to a place of safety' was necessary, "because of my belief that treatment was being initiated" and that he did not think that "removal to a place of safety would achieve anything more than was already being set in motion." He explained that at the time he was not aware of the mental health assessment process that follows from invoking Article 130. He recalled being trained on the definition of Article 130 and the dissemination of the Regional Interagency Protocol in 2015 with a flowchart printed and attached to the wall in Newtownhamilton police station. He stated that "whether it's satisfactory or not, a lot of training in the police just tends to be an email to everybody, you know, like, make yourself aware of this procedure." Records show that Constable Kenmuir did not attend the "From Crisis to Care" mental health training, in April/May 2017. When asked, Constable Kenmuir stated that, if faced with a similar scenario, he would take the same actions again and he would not use Article 130, "I wouldn't use Article 130 based on those circumstances if I was seeing it again, to be honest."

[209] The comments of Mr Galbraith and Inspector Owen were put to Constable Kenmuir, "We agree that at the moment Mr McEntee was apprehended, subdued and restrained with handcuffs at Hospital Road, Newry, adjacent to Daisy Hill hospital, there was a necessity for officers to arrest or detain him at the earliest opportunity" and he replied, "I didn't think of any powers at the time." He agreed with the comment "Whilst officers have potential powers by virtue of other legislation to rely upon, Article 130 was the most appropriate, given his presentation

and subsequent conduct as well as the valuable information provided by mental health staff" stating "that makes sense." He agreed with the statement "we agree that he should have been removed without delay and taken to the closest place of safety available, which was Daisy Hill hospital a walking distance away" which he said would have occurred if not for the presence of the hospital staff. Constable Kenmuir stated that he did not consider that Mr McEntee represented a risk to them or anyone during his time with him. When asked if he were told that Mr McEntee was in a martial arts stance against Constable O'Toole, would that change his thoughts in relation to risks posed to others, and he stated, "I would have liked to have known that, but I don't think ultimately it would have changed." He disagreed with the comment that he appeared to give no consideration to the application of police powers in respect of Mr McEntee following his apprehension and restraint, stating that he did consider it and did not think it was appropriate.

[210] Mr Andrew Ruck, Patient Flow and Bed Management Coordinator, in the SHSCT, gave evidence to the inquest, which was admitted by way of Rule 17. At 10:15 hours on 26th May 2017, he was contacted by Mrs Williamson to find out the bed availability in Bluestone Psychiatric Unit. She advised that she was dealing with an incident Newry with the PSNI and advised that given the situation, an admission to Rosebrook Psychiatric Intensive Care ward, may be required. Mr Ruck confirmed that there were beds available. At approximately 11:00 hours, Mrs Williamson contacted him again and gave the name of Mr McEntee and advised that he was being taken by ambulance to Craigavon Area Hospital. Mr Ruck then notified Bluestone Psychiatric Unit to advise them to expect a referral. By mid-afternoon, he had not been contacted to arrange an admission for Mr McEntee.

[211] Mr Patrick Rooney, Paramedic with the Northern Ireland Ambulance Service, gave evidence to the inquest. On Friday 26 May 2017, he was accompanied by Mr Ryan Morgan and based at Newry ambulance station. He was the driver and he explained that the attendant, in this case Mr Morgan, would deal with the patient. At approximately 10:11 hours, they received a call to attend Hospital Road. They travelled from the Portadown area and arrived at 10:36 hours. They observed Mr McEntee on the ground with a blanket over him and he was accompanied by two police officers and two females from the Mental Health Unit. Mr Rooney parked the ambulance, and Mr Morgan got out and spoke with the police. Mr Rooney opened the rear door of the ambulance and Mr McEntee was escorted into the back of the ambulance by his colleague and two police officers. He was handcuffed to the rear. In the back of the ambulance, a police officer removed the handcuffs for Mr McEntee's comfort. Mr Rooney explained that Mr McEntee was compliant whilst Mr Morgan assessed his condition.

[212] Mr Morgan stepped out of the ambulance and spoke to the two staff members to discuss the most appropriate place to take Mr McEntee. A decision was made to take Mr McEntee to Craigavon Area Hospital Mr Rooney was told this by Mr Morgan. Mr Rooney stated that "it wasn't controversial in the fact that it looked like that was going to be the ultimate destination, Bluestone." He agreed that legal responsibility lay with him and Mr Morgan and if they said he was going to Daisy

Hill, that would have been the decision. At one stage, Mr Rooney referred to Mr McEntee as Thomas and he replied that his name was "Jesus."

[213] Mr Rooney told the inquest that the information they knew, was what appeared on the screen in the ambulance, on which call details are recorded, that Mr McEntee walked naked from Bessbrook and was shouting at the mental health team outside the hospital; and was chased by police, and that it was the mental health team that requested the ambulance. Mr Rooney stated that they knew he was being restrained by police and whilst he did not know why "he was obviously naked so to me, that would have been an arrestable offence so I could have taken it that that was why he was detained."

[214] Mr Rooney drove the ambulance to Craigavon Area Hospital, and they were followed by Constables McDermott and Kenmuir. Mr Rooney explained that this does happen and was not a rare occurrence. His belief was that Mr McEntee was going to the hospital voluntarily but that there "was a risk that he may abscond." Mr Rooney stated that he did not know that police had to restrain Mr McEntee because he was posing a threat to officers and stated that that would have been information he would like to have known together with his history of violence.

[215] They arrived at 11:35 hours. By this stage Mr McEntee had changed into his clothes. Mr Rooney did not speak to the police officers at Craigavon as he went to retrieve a wheelchair. When he returned, the police officers had left. He stated that "my expectation was that they would have stayed until they would have got clarification from the department whether they required them." Mr McEntee was taken into the Emergency Department, and he was booked onto the system. He stated that he would, at least, have expected the police to wait outside.

[216] Mr Rooney told the inquest that he did not detect any signs that Mr McEntee was under the influence of alcohol or drugs. Mr Rooney explained that the PRF was completed by Mr Morgan and normally a copy is handed over to Emergency Department staff. Mr Rooney remained with Mr McEntee in the Emergency Department for approximately 25 minutes. Mr Morgan performed the handover with the hospital staff. At one point, Mr McEntee went outside for a cigarette and Mr Rooney stood outside with him. Mr Rooney and Mr Morgan were then told that they were free to go.

[217] Mr Ryan Morgan, Emergency Medical Technician with the Northern Ireland Ambulance Service, gave evidence to the inquest. At approximately 10:11 hours on 26th May 2017 he, and Mr Rooney received an emergency call through their medical data terminal (MFT) and were tasked to Hospital Road, Newry. They were advised that a person was queried to have psychiatric issues and that he was naked. They were also advised that the PSNI and mental health staff were with the person. When they arrived Mr McEntee two police officers were with Mr McEntee along with two mental health staff.

[218] Mr Morgan stated that he spoke initially to the mental health staff to find out his primary medical concerns. He stated that he would have been told that he had

been running naked in public around the hospital ground, and that he was known to mental health staff. He then he carried out a primary survey of Mr McEntee to rule out any life-threatening injuries. He had a laceration to his right forearm which was not bleeding but could have required stitches. He had superficial laceration to his left wrist and his neck area.

[219] Mr McEntee then walked into the back of the ambulance with police close by. Mr Morgan could not recall whether police offered any information prior to Mr McEntee going into the ambulance. He was of the view that Mr McEntee was handcuffed because he was naked in a public place and the handcuffs were to stop him from absconding. He stated that he wasn't made aware of any violent or aggressive behaviour towards police. He stated that whilst he did not confirm the position with police, they did not proactively tell him what had happened. The police officer removed the handcuffs for his comfort and so that his wounds could be addressed.

[220] Mr Rooney took a set of observations from Mr McEntee and Mr Morgan then exited the ambulance and spoke to the mental health team. He told the inquest that he "asked them in their opinion, was Mr McEntee likely to require inpatient treatment for his mental health?" He stated that Mrs Williamson replied "yes" and as a result of the discussion, it was decided that Mr McEntee would be taken by ambulance to Craigavon Area Hospital. He stated that Mrs Williamson "may have felt she made that decision." He stated he wasn't aware of her telephone call to Bluestone and that, in his "head, it was logical to be going to Craigavon, if he was going to require inpatient treatment for mental health." He stated, "we were all in agreement that he goes to Craigavon." Mr Morgan stated that the police had no input in this, "the police were passive to this." He agreed with Mr Rooney that ultimate authority as to where they would be going would rest with him and Mr Rooney.

[221] One of the hospital staff provided him with a set of medical notes at the scene and Mr Morgan took relevant information from them to complete the PRF. When asked what information the police provided, Mr Morgan replied, "I can't recall any information being provided." Mr Morgan told the inquest that he did not know the police had used force to restrain Mr McEntee as he posed a threat to them; he did not know about Mr McEntee's previous criminal behaviour, and he agreed that that information would have been relevant. When the police officer took the handcuffs off, Mr McEntee was asked if he was going to behave, "are you going to stay here and get treatment" and he agreed, and Mr Morgan believed he asked him "do you plan to abscond" and he replied "no." Mr Morgan stated that he was "happy that the patient was compliant at that point in time" and that he "perceived no threat or aggression or violence, so I was comfortable to be in the back with him on my own with him."

[222] Mr Morgan explained that had he been aware of the background from police, he would have said yes when Constable McDermott asked whether they wanted them to attend in the back of an ambulance, "If I had known he had threatened

police officers to the point where he needed that much physical restraint to him, I wouldn't have been happy travelling to hospital without a police presence", "I would have wanted them there for my own personal safety."

[223] Mr McEntee was then conveyed to Craigavon Area Hospital, leaving the scene at 10:52 hours and arriving at 11:35 hours. The police officers followed the ambulance. On arrival at Craigavon Area Hospital, Mr McEntee got dressed by himself in the back of the ambulance. Mr Morgan had a short conversation with Constable McDermott with him asking "are you happy enough?" Mr Morgan stated that that Mr McEntee was not going to run away, and Constable McDermott was content to leave the scene and Mr Morgan did not indicate anything to the contrary as Mr McEntee had been compliant and he did not feel under threat during the journey. He stated that ultimately it was a decision for the police but, for his part, he did not need them anymore.

[224] In the Emergency Department, Mr McEntee was booked on to the system and waited for ambulance triage. Staff Nurse Trimble triaged Mr McEntee along with Staff Nurse Skeath. Mr Morgan stated that there was a verbal handover to hospital staff approximately 25 minutes after arrival. He stated that the handover involved him summarising the information contained on the PRF and he stated that he would also have given them a copy of the PRF. Mr Morgan explained he advised that Mr McEntee's mental health issues, "lacerations/psychotic", were his chief complaint and that he consented to assessment, treatment, and conveyance. In relation to capacity, he ticked "no" as he stated, "I couldn't say that he had complete capacity." When Staff Nurse Trimble's evidence was put, that she stated that she was told by Mr Morgan that "the patient was found wandering in Newry naked" and that he was restrained by police to prevent further attempts at self-harm, Mr Morgan agreed that that was not the complete picture and inaccurate. When the ED flimsy, that Staff Nurse Trimble completed, was compared to the PRF, it was apparent there were important differences and that the ED flimsy did not have the details about being restrained by police, the use of handcuffs and the fact that police followed. The presenting complaint on the ED flimsy was "self-harm."

[225] Mr Morgan stated that he provided a verbal handover as well as a copy of the PRF and so he took the view that all the relevant information was provided to Staff Nurse Trimble. He did agree that she was not aware of the seriousness of what happened outside Daisy Hill, because he was not aware of the seriousness of what happened, he stated, "I couldn't hand over information I didn't have." He stated that had he have known the information himself, he would not have felt comfortable in the back of the ambulance alone and would have asked police to stay in the ambulance and in the Emergency Department. Mr Morgan did state that recording on the PRF, that an inpatient admission in Bluestone Psychiatric Unit was likely, would have been useful for the Emergency Department staff to know.

[226] Staff Nurse Lynsay Trimble (nee Booth) gave evidence to the inquest. She described how Mr McEntee was brought in to the Emergency Department on a wheelchair by paramedics. She attended Mr McEntee's ambulance triage with Staff

Nurse Skeath in minor's cubicle 12 at 11.51 hours. She described how, Mr McEntee presented with deliberate self-harm wounds to both his right and left arms, and she explained that, from the ambulance notes and verbal handover from the paramedics, she understood that he was found wandering in Newry and Hospital Road naked. She was told that the PSNI had restrained Mr McEntee from further attempts of self-harm when the ambulance service arrived. Once there was a handover from paramedics, they then left.

[227] Staff Nurse Trimble explained that she then filled in an ED triage flimsy from the information provided at handover. She prioritised him as a "2" meaning high risk of further self-harm. When asked about the PRF being handed over by Mr Morgan, Staff Nurse Trimble explained that the basis of the handover "is more on the verbal handover. We don't go straight for PRFs" and "you can refer to the likes of PRF at a later stage if needs be." She stated that she could not recall Mr Morgan handing over the PRF document but accepted that normal practice was to receive it from paramedics.

[228] Staff Nurse Trimble was asked about the differences in the information contained in the PRF and the information she recorded in the flimsy. She recorded that he was wandering naked on Hospital Road and restrained by police from further self-harm, and when asked where she got that information, she stated that Mr Morgan handed over the information. She agreed that that information was incorrect in material ways and would have perhaps portrayed a passive individual in need of assistance, whereas he walked naked from Bessbrook, was pursued by PSNI, and was eventually captured, and restrained as he presented a risk to police officers. She stated that it was "absolutely" something that would have been important for her to know. Staff Nurse Trimble confirmed that there was no police present with Mr McEntee in the Emergency Department and explained that she did not know they accompanied the ambulance to Craigavon Area Hospital. When it was put to her that the PRF stated "police followed for transfer", she replied that the PRF is not "our first point to look at", they look at the patient and rely on an oral handover and that is information which would normally be provided. She told the inquest that, in her experience, if police accompanied a voluntary patient, they usually came in to the Emergency Department to speak to the medical staff and "just as a precaution the police still stay in attendance in case things change."

[229] In relation to the chief complaint recorded on the flimsy "self-harm", Staff Nurse Trimble was asked why she did not record "psychotic" which was on the PRF, and she replied that she did not recall the word "psychotic" being used during the oral handover. She stated that it was "a very brief handover." She also confirmed that she was not told that it was expected that Mr McEntee would go to the Bluestone Psychiatric Unit, which Mr Morgan accepted in evidence that he did not record on the PRF. Staff Nurse Trimble told the inquest that she could not recall reading the PRF document which Mr Morgan states he read from during the handover, as well as giving a copy to the triage nurses. She stated that she finished typing the flimsy and was then asked to cover in another department. She held the view that Mr Morgan should have given her more information during the oral

handover. She stated that "had we have known about the handcuffs, the level of restraint, the police attendance, the amount of police attendance and the force that was used, that would have been red flags to us to ask questions like where the police were now and why weren't they still there? But we had no information of any of that." She stated that, in light of this information, "the police should never have left."

[230] During Mr McEntee's assessment Staff Nurse Skeath recorded observations, while Staff Nurse Trimble gathered more information from Mr McEntee and recorded it on the computer. She stated that throughout the process Mr McEntee was compliant and forthcoming with all requests and questions. She stated that she had no worries at any stage with Mr McEntee. Whilst on Hospital Road he was saying his name was "Jesus Christ", he wasn't saying anything like that to Staff Nurse Trimble. She then left Staff Nurse Skeath alone in the triage room with Mr McEntee to complete the triage process.

[231] Staff Nurse Gemma Skeath gave evidence to the inquest. At approximately 11:51 hours on 26 May 2017, she was introduced to Mr McEntee who is brought in to the Emergency Department by Mr Morgan. Her role was to triage patients coming in from ambulances within 15 minutes. She remembered that particular day was exceptionally busy. She stated that she was told in the handover by Mr Morgan that Mr McEntee was found wandering on the Newry Road "but he's okay now" "he has lacerations on his arms, but he's okay." She stated that is all the information she recalled. She told the inquest that Mr Morgan was an Emergency Medical Technician and that, in fact, paramedics "give you a more detailed hand over because of their experience and their level of training." Staff Nurse Skeath explained that she was not given the PRF. She stated that sometimes they are left beside the computer, but that she was doing blood pressures and talking to Mr McEntee as well as listening to Mr Morgan, while Staff Nurse Trimble was typing. She agreed with Staff Nurse Trimble, that it was a very short handover. She went on to say "it was very blasé as in he came in and stated this is Mr McEntee, found wandering naked; however had lacerations on his arm but he's okay now. At no stage were police mentioned or the level of restraint mentioned to us." It was pointed out that Mr Morgan produced a detailed PRF with mentions of psychosis, restraint by police, previous episodes of self-harm, use of handcuffs, police transfer to hospital. When asked if any of that was recounted to her, Staff Nurse Skeath replied, "no." She agreed with Staff Nurse Trimble's evidence that when she triages a patient, she assesses the person in front of her and will take a verbal handover and read the PRF later. She stated that Mr McEntee absconded before she got a chance to read the PRF. She stated that she was under the same misunderstanding as Staff Nurse Trimble of the risks presented by Mr McEntee. The picture from her perspective was one of a risk of self-harm rather than dealing with a potentially psychotic, potentially highly erratic individual. She agreed that this misunderstanding was reinforced by Mr McEntee's presentation which was "someone presenting as someone who was normal."

[232] Staff Nurse Skeath then triaged Mr McEntee in cubicle 12, with Staff Nurse Trimble at 11:51 hours. She remembered asking him if he would stay and be reviewed by a doctor and he confirmed that he would. She noticed that he had lacerations to his neck and arms and the wound on his neck appeared old but the cuts to his arms were new and properly dressed. Staff Nurse Skeath asked Mr McEntee why he did the cuts and he replied, "for a number of reasons." In her opinion, he needed a mental health assessment. She agreed that with a patient like that, you cannot necessarily trust the accuracy and validity of what they are reporting, and she stated that "in hindsight I would read the PRF", "that is what I have learnt from this."

[233] Staff Nurse Skeath checked Mr McEntee's blood pressure and at this stage, she stated that she felt comfortable with him. He told her he had two beers, but she could not smell alcohol from him. At approximately 12.05 hours, Staff Nurse Trimble left the room and Staff Nurse Skeath applied a tourniquet to Mr McEntee's arm to take bloods. She put the needle in and at this stage, Mr McEntee he grabbed her hand and pulled the needle out. She told the inquest that, he was telling her in a firm tone, that she was not doing it right. Staff Nurse Skeath explained why she had to do this, but he got up and walked out. Staff Nurse Skeath stated that it was as though his personality had changed. She followed him calling his name, but he walked out through the exit doors across the car park in the direction of Bluestone Psychiatric Unit. She explained that she felt frightened by his change in demeanour. She immediately informed Ward Sister Loughran who did the absconding policy and police were subsequently informed. She stated that she did not have time to do the mental health assessment as he absconded. Staff Nurse Skeath stated that even if she knew all the relevant information about Mr McEntee, there was nothing she could have done differently, but she would have felt differently about the assessment.

[234] Clinical Sister Ciara Loughran gave evidence to the inquest. She explained that she was in charge of the Emergency Department in Craigavon Area Hospital on the morning of 26 May 2017. At approximately 12:05 hours, Staff Nurse Skeath informed her that Mr McEntee had absconded from ambulance triage. She reported that Mr McEntee had become aggressive whilst she had been attempting to take a blood sample from him and he ran out of the Emergency Department. Sister Loughran explained that she immediately activated the SHSCT absconding protocol, 'SHSCT Procedure of the Management of a Patient being Absent without Leave (Absconding) from an Acute or Non Acute Hospital Environment (October 2015). She stated that although he was a voluntary patient, it was appropriate to follow this policy "because of his self-harm and his alcohol on board." She followed the procedure and escalated the issue to Dr Mark Feenan (Associate Specialist in Emergency Medicine) and Dr Gareth Hampton (Consultant in Emergency Medicine), which was confirmed in the statements of both, which were admitted into evidence under Rule 17. Both agreed that Mr McEntee needed to be returned to the Emergency Department for further assessment to see "if the patient represents a significant risk of harm to himself or others."

[235] Sister Loughran immediately contacted the PSNI, and relayed information provided by Staff Nurse Skeath and that Mr McEntee needed to be brought back to the Emergency Department for further assessment. The police log records the call taking place at 12.40 hours. She explained that under the policy she could not go directly to the police without following the policy steps, "there have been times before where we have contacted the police straightaway and we have been too early. We have been told to go and complete the form and do your checks and ring us back." She believed that in total, the time taken was less than 30 minutes, although the call log would indicate that it was more like 35 minutes. She stated that, having to go through all the steps, she could not have contacted the police any sooner. When asked, Sister Loughran agreed that half an hour to deal with an urgent situation is too long, but there was nothing, under the SHSCT protocol that she could do to "short-circuit" it.

[236] Sister Loughran confirmed that the SHSCT's absconding procedure differs from regional guidance 'Regional Interagency Guidance on Dealing with Person who go missing from Emergency Departments (HSCB/PSNI 2016). It states: "If the decision is made to report a person as missing, all of the above must be completed or details recorded why any step was not completed prior to contacting the PSNI", in other words where a situation is urgent, police can be contacted immediately, without certain steps being taken. Sister Loughran agreed that flexibility, in the SHSCT policy, would be beneficial in an urgent situation and may the potential to speed up the process. The SHSCT stated that it operates its local procedure, which is in place today, as it includes additional safeguards in the process.

Incident Five - 26 May 2017 (Upper Ramone Park, Portadown)

[237] Mr Charles Little, son in law of the deceased, gave evidence to the inquest. Mr Little described how Michael Cawdery was a retired Veterinary Surgeon and Research Pharmacologist, who worked initially for the Colonial Governments of Kenya and Uganda and then for An Roinn Talmhaiochta. Majorie Cawdery was a Civil Servant in the Colonial Government of Uganda and then a Company Director and housewife.

[238] The deceased, both aged 83, lived at 42 Upper Ramone Park, Portadown and their daughter Wendy, her husband, Mr Little, and their family lived at number 42A. Both properties were adjacent to each other and shared a garden, courtyard, and road access.

[239] At 12:10 hours on 26 May 2017, Mr Little left his home to collect his wife from her work and then to go shopping.

[240] About 10 minutes later, at 12:20 hours, the deceased left by car to go for their weekly grocery shopping to Tesco's. Mr Little described to the inquest, how CCTV footage, showed Mr McEntee walking through the gateway, onto the property at 12:25 hours with the deceased returning to their property at 13:35 hours. CCTV footage showed Mr and Mrs Little returning at 15.15 hours.

[241] As Mr Little was sitting out in the courtyard with his dogs, Mr McEntee, walked round from behind number 42 carrying the deceased's car keys. Mr Little described how, Mr McEntee looked strange, and Mr Little asked him "if he was ok." He looked away and muttered something unintelligible.

[242] Mr McEntee then walked straight to the deceased's car and started the engine and revved the motor several times. The deceased had been having some problems with the car and Mr Little's initial assumption was that he was a mechanic. Suddenly the car shot forward and hit the side of the house and then reversed at high speed across the courtyard.

[243] Realising something was wrong, Mr Little shouted to his wife to call the police and ran to the front door of 42 to let the deceased know what was happening. As he did so, the car drove at him at high speed and then crashed through the closed gates and out onto the road at 15:35 hours.

[244] Mr Little went into number 42, in calling for the deceased. He described how the house seemed strange, as shopping was scattered in the kitchen and all the curtains drawn closed. He went to the living room doorway and looked in, then suddenly realised that he was looking down at a rolled-up rug with Michael Cawdery's feet sticking out from the end. Mr Little looked down the corridor and saw Marjorie Cawdery's feet sticking out from a another rolled-up rug in exactly the same position in another doorway.

[245] Mr Little ran out of the house and shouted to Mrs Little (nee Cawdery) to get an ambulance as her parents had been attacked. He then ran back into the house and unrolled the rugs turning both deceased onto their backs. Mr and Mrs Little attempted CPR and at approximately 15:45 hours PSNI officers and an ambulance crew arrived.

[246] Mr Little told the inquest that the deceased's lives were full of value and that they both had a desire to help people. They were very active despite, their years. Michael Cawdery continued to act as a peer reviewer for the British Medical Journal. Despite some health issues, Majorie Cawdery remained active and supported her husband and family. Mr Little explained that they were very close to their family and doted on their grandchildren. They had spent their lives helping others, particularly during their time in Africa.

[247] Mr Little told the inquest that that the family wish to know the truth of what happened and why decisions were made and why procedures and guidance were not followed or were followed when they should not have been. They needed to know what happened and why. He held the view that there was a lot of learning to be taken from the deceased's death. He stated that when "you've got somebody like Thomas McEntee who is living, what is effectively a chaotic lifestyle, and he's got serious mental health problems, and he's out there in the community and he's coming for help, he's on the highest levels of medication, people should take him seriously when he arrives at a medical facility looking for help."

[248] Constable Christopher Mowbray gave evidence to the inquest, which was admitted by way of Rule 17. At approximately 15:48 hours, on 26 May 2017, he arrived at 42 Upper Ramone Park, Portadown after responding to a report of a burglary with two possible casualties. On arrival, he was met by Mrs Wendy Cawdery and Mr Charles Little. He entered the property and observed a paramedic providing first aid to Michael Cawdery, who was lying on his back, on the floor between the doorway of the living room and hall. Constable Mowbray turned on his body worn camera and I viewed this footage. The paramedics advised that Michael and Majorie Cawdery were deceased, and their intention was to withdraw from the scene. Constable Mowbray then observed Marjorie Cawdery, lying on her back in a corridor that connected the bathroom/bedrooms to the hall. He observed blood marks on the walls of the hall that appeared smeared and a black handled kitchen knife, with its point embedded into the door frame of the hall.

[249] Constable Nick Beer gave evidence to the inquest, which was admitted by way of Rule 17. On the afternoon of Friday 26 May 2017 he, accompanied by Constable Crean, attended Craigavon Area Hospital to assist in trying to locate Mr McEntee. He checked the Emergency Department and the main reception area whilst Constable Crean conducted a foot patrol of the hospital grounds. At approximately 15:45 hours, Constable Beer received a radio transmission of an aggravated burglary in progress in Portadown where a vehicle had been stolen by a male whose description appeared similar to Mr McEntee. A further radio transmission stated that two persons have been found within the property deceased with probable knife wounds and that it would be treated as a double murder. A further radio transmission described a road traffic collision involving the deceased's stolen vehicle.

[250] At approximately 16:55 hours a radio transmission reported that a male, Mr McEntee, was self-harming in a field beside Springfields, Portadown. Constable Beer and Constable Crean attended and entered the field by climbing over a locked gate. Constable Beer observed Mr McEntee amongst approximately thirty cattle. Constable Beer described him as agitated, and he did not want police to approach him. A second callsign arrived in the field at this time and Constable Beer walked straight towards Mr McEntee and he raised his hands which were empty, at which point Constable Crean took hold of his left forearm and Constable Irvine took hold of his right forearm. Constable Crean applied handcuffs to the front and Constable Mooney searched Mr McEntee and found a metal kitchen knife, with approximately an 8 inch blade, which was located in his belt, a set of keys were located in the body warmer pocket and a cheque book in a pocket with the names of the deceased printed on it.

[251] Constable Crean then arrested Mr McEntee on suspicion of two counts of murder and cautioned him. As he was being escorted from the field, he was becoming more agitated and less compliant with police instructions. Constable Beer described how he repeatedly tried to take hold of Constable Beer's hand and squeeze it. Constable Crean attempted to put a forensics suit on Mr McEntee, and he deliberately frustrated all attempts to place the forensics suit on him. Constable

Crean attempted to place his hands into plastic evidence bags, but again he tried to frustrate any attempts to do this. In Banbridge Custody Suite, Constable Beer described how he stayed with Mr McEntee, and he made repeated references to him being a 'Demon' while staring directly at him for sustained periods of time.

[252] Constable Stephen Crean gave evidence to the inquest, which was admitted by way of Rule 17. He explained that when they attended Springfields, he could see Mr McEntee in a field surrounded by cows. At this time, there were four police officers in the field. Constable Crean could make out noises coming from Mr McEntee but was unable to distinguish what he was saying. He explained that it was initially thought that his name was Mark and so he stated, "is it okay Mark, we just need to talk to." Mr McEntee shouted back, "I am not fucking Mark" and "you won't come to me, you won't take me." He started to walk slowly backwards, and Constable Crean and Constable Irvine walked slowly towards him, and he was able to take hold of his left arm and wrist and put handcuffs on him. Constable Crean observed Constable Mooney remove a 6 inch to 8 inch silver knife from the waistband of his trousers. He then proceeded to give an incorrect name to the officers. Mr McEntee was observed to be wearing black denim jeans, black trainers, green beige T-shirt, and a sleeveless light blue fleece which Constable Crean noted were ill fitting and far too large to fit him. It later transpired this clothing belonged to Michael Cawdery.

[253] Constable Crean then cautioned Mr McEntee and arrested him. On the journey to Banbridge, Constable Crean described his behaviour as very erratic, and he was rambling about God. When Constable Crean closed the cell door in the custody suite, Mr McEntee was making low clicking noises and saying, "Go on kill yourself, take your gun and shoot yourself." He said this over and over again. When Constable Crean asked him if he were telling him to shoot himself, Mr McEntee replied to the effect, "Why would I do that, if I did that, it would make me criminally insane/mental."

[254] I received evidence from Dr Jonathan Morrow, Emergency Department Doctor; Ms Maria McCaffrey, Psychiatric Nurse, and Team Lead in Home Treatment Crisis Response Team; Dr Neil Anderson, GP Trainee, Psychiatry Placement; and Dr Edward Noble, Consultant Psychiatrist, which was admitted by way of Rule 17. They examined and assessed Mr McEntee on 26 and 27 May 2017 in Craigavon Area Hospital. Physical treatment was provided, and he was administered his medications, which he admitted he had not been taking. It was felt that, after mental health assessments, on three occasions, there was no obvious evidence of psychosis, thought disorder, mood disturbance or depressive illness. It was determined that Mr McEntee did not require any acute psychiatric input at that time, and he was discharged to police custody. It was only after a three-month assessment at the Shannon Clinic that a diagnosis of psychosis was firmly established.

[255] Dr Adrian East, Consultant Forensic Psychiatrist, produced a report at the request of Mr McEntee's solicitor, for the purposes of the criminal proceedings. Dr East diagnosed Mr McEntee with paranoid schizophrenia. He believed that there

was documented evidence of this paranoid schizophrenia, several days prior to the deaths of the deceased, and at the time of their deaths, Mr McEntee was suffering from paranoid schizophrenia. He stated, "the most striking aspect of this case is the breadth of supporting evidence. It is unusual to encounter so many corroborating sources to support the presence of a mental illness in the time leading up to an offence."

[256] A report compiled by Dr Christine Kennedy, Consultant Forensic Psychiatrist, on behalf of the Public Prosecution Service, concluded that, at the time of the offences, based on the comprehensive multisource information, it was her belief that, Mr McEntee was actively psychotic and suffering from a schizophrenic illness which was subsequently diagnosed by Dr East and was a diagnosis which she agreed with. She went on to say, "there is ample evidence of the presence of psychotic symptoms before, during and after the offences."

Pathology Evidence

[257] Professor Jack Crane, Locum Consultant Forensic Pathologist, and former State Pathologist for Northern Ireland, gave evidence to the inquest. He conducted autopsies on the deceased on 28 May 2017 and thereafter produced reports.

[258] Professor Crane told the inquest that Majorie Cawdery was reasonably healthy for her age. He explained that her death was due to the injuries sustained in an assault. He explained that there were three incisions on her scalp caused by a bladed weapon such as a knife. One of these, which was slightly ragged, was located above the right ear. The other two wounds, on the top of the scalp, were caused by the blade of the knife penetrating the scalp and then passing beneath it, before remerging as a second wound in front of it. Professor Crane also described how there was also a small incision just in front of the right ear which would appear to have been caused by the sharp pointed tip of a knife blade. He stated that the pointed tip of the blade had also gone through the lobule of the right ear and had punctured the skin of the neck behind it. There also appeared to be two superficial knife wounds at the inner corner of the right eye.

[259] Professor Crane described how there was a clean-cut stab wound across the back of Marjorie Cawdery's neck, which had penetrated the underlying neck muscles, but had not gone as far as the bony spine. It had been made by a sharp bladed weapon.

[260] There were two superficial incisions on the back of her right elbow and another on the back of her right hand, again consistent with having been made by a bladed weapon such as a knife, and possibly caused if her right her arm had been raised in a defensive-type gesture.

[261] Professor Crane stated that he also found a stab wound on the back of her left thigh just above the knee and another, in a closely similar position, on the back of her right knee. The injury to the back of the left side had penetrated deeply into the underlying soft tissues and had punctured the popliteal artery causing extensive

external bleeding. Professor Crane stated that it was principally the effects of blood loss from this thigh wound which were responsible for Majorie Cawdery's death, although blood loss from the other stab and incised wounds would have contributed to some extent to the fatal outcome.

[262] Professor Crane described how all the incised wounds and the stab wounds were consistent with having been made by a bladed weapon or weapons such as a knife or knives. Those wounds, which were slightly ragged, could have been caused by a knife with a serrated edge.

[263] Apart from the knife wounds, Marjorie Cawdery had also sustained some other injuries, including a little bruising on the under surface of the scalp, a small abrasion on the right side of the forehead, a couple of abrasions on the right shoulder, some blotchy bruising in the arms and in the back of the right hand and some bruising on the right side. None of these were serious, however, and some could have been due to blows or as a result of her falling or being pushed against furniture onto the floor.

[264] Professor Crane opined that Michael Cawdery died as a result of multiple injuries sustained in an assault.

[265] He explained that there was a complex pattern of injuries on MichaelCawdery's scalp, including two penetrating stab wounds, which had partially gone through the underlying skull. There were incisions, caused by a bladed weapon having been drawn across the skin, and areas of bruising and abrasion due to blows either from a blunt object or possibly due to kicks.

[266] On Michael Cawdery's face, the tip of a sharp bladed weapon, such as a knife, had been pushed into the inner corner of the right eye where it had penetrated the underlying bony eye socket. There were also incisions on Michael Cawdery's nose and extending downwards onto his chin from the left corner of his mouth. Other injuries on his face, including extensive bruising of the lining of the mouth, were due to blows, possibly kicks or stamps.

[267] Professor Crane described how there was an elliptical stab wound on the left side of his neck, just below the lower jaw, and although none of the major blood vessels in the neck were injured, the blade had gone through the back wall of the pharynx (throat). A further small stab wound on the back of the neck did no serious injury.

[268] Michael Cawdery had also been stabbed three times in the chest. One stab wound on the left side had gone through the chest wall and had punctured the left lung causing bleeding into the left chest cavity. The other two wounds, on the centre of the front of the chest had gone through the breastbone and one of these then punctured the front wall of the heart sac, although not the heart itself.

[269] Professor Crane stated that there was a further stab wound on the right side of the front of the upper abdomen and this had gone through the wall of the small bowel and its fatty attachment, causing bleeding into the abdominal cavity.

[270] Michael Cawdery had also been stabbed in the back. There was a fairly long stab wound across the centre of the back of the chest and this had gone into the underlying bony spine. There had been bleeding from the spinal fracture into the spinal canal and blood from here had tracked up the spinal canal and into the cranial cavity and around the hind part of the brain.

[271] There were a number of knife wounds to both Michael Cawdery's hands and to his right forearm and of these, two had penetrated completely through the left hand. Professor Crane stated that it seemed likely that these injuries were caused by Michael Cawdery raising his arms in a defensive gesture, probably to protect his face.

[272] Professor Crane explained that the stab wounds and incisions were of variable size and shape. They were consistent with having been caused by a bladed weapon or weapon such as a knife or knives. He stated that at least moderate force would have been required to inflict those ones which were penetrated the breastbone and spine.

[273] Professor Crane stated that the autopsy also revealed that the bony spine in the lower part of the neck had been fractured. The fracture was associated with bruising of the surrounding muscles indicating that it had occurred whilst he was still alive, although the mechanism of injury is unclear. He stated that it could have occurred if Michael Cawdery had fallen or been pushed to the floor or as a result of his neck been forcibly bent forwards or backwards.

[273] In summary, Professor Crane opined that Michael Cawdery had been stabbed and beaten and died as a result of his injuries, probably as a result of blood loss, spinal shock and bleeding over the brain surface. His death had not been immediate, however, and there was clear evidence, in the form of defence injuries to his hands, that he was still conscious when some of the injuries were inflicted.

Expert evidence

Dr Trevor Turner, Consultant Psychiatrist

[274] Dr Trevor Turner, Consultant Psychiatrist, was instructed on my behalf to comment on the care provided to Mr McEntee by the BHSCT and SHSCT. He produced a report and gave evidence to the inquest.

[275] In relation to Mr McEntee's assessment at the Mater Hospital on 22 May 2017 by Dr King and Mr McConville, Dr Turner noted that Mr McEntee was carefully examined and that the assessment, in his opinion, was consistent with good practice and reasonable in the circumstances and he did not consider that it represented a missed opportunity having regard to appropriate standards in a general hospital setting. Dr Turner explained that "appropriate information, background

information, is vital to carry out a mental state assessment" and that all information, "that corroborative evidence" within the knowledge of the police officers, including, paranoia, religious delusions, angels, and demons, should have been passed to the mental health team, if it wasn't, as it would have made a difference to the ultimate outcome of the assessment.

[276] In relation to Mr McEntee's medications, he explained that when Dr King and Mr McConville were told by Mr McEntee that he had halved his Quetiapine of his own volition, he stated, "notice should be taken of that because obviously if you half a dose of a strong antipsychotic, it is going to have an effect on your mental state." He agreed that collateral information should have been taken independently from Mr McEntee.

[277] In relation to Mr McEntee's attendance at the Mental Health Department of Daisy Hill Hospital on the afternoon of 24th May 2017, Dr Turner told the inquest that the way in which Mr McEntee was dealt with by staff, was consistent with good practice. However, Mr McEntee not being assessed represented a missed opportunity with regard to clarifying his mental state. He explained that further assessment may have established the nature of his underlying psychological state, and this could have represented a chance to offer treatment and further assessment. However, at the time of his presentation, Mr McEntee was not expressing any kind of physical or psychological disturbance.

[278] In relation to Mr McEntee's attendance at the Emergency Department in Daisy Hill Hospital on 24 May 2017, Dr Turner considered that this represented a missed opportunity to examine Mr McEntee's mental state in a more detailed fashion, given his background history and recent attendances. Dr Turner considered that, not to have carried out an appropriate psychiatric assessment, by the Home Treatment Team, represented a missed opportunity to clarify the nature of Mr McEntee's mental state. Dr Turner stated that he would have expected the Home Treatment Team to have carried out an examination of Mr McEntee, in terms of clarifying his mental state and any recent changes in his presentation as well as his use of medication, with clarification of his family's concerns. He stated "by and large, the doctor's opinion should have been taken on board and appropriate action taken", "the safe thing is coming to see someone, rather than not see someone." Dr Turner opined that given Mr McEntee's underlying reports of paranoid ideation, on balance, in his view, it was likely that additional medication or support would have been offered at this time, with consideration of an admission to hospital, if details of his mental state warranted that. He stated that further treatment would, on balance, have had a potential for affecting the outcome with regard to the deaths of the deceased.

[279] Dr Turner noted that there were attempts to contact Mr McEntee by telephone on 25 May 2017, and there had been no reply from either number. He stated that given Mr McEntee having attended twice at the Emergency Department in the previous 24 hours, he considered that good practice would have been to attempt to contact him personally by visiting the accommodation placement he had been given

and therefore he did not consider that the telephone attempts were sufficient in terms of good psychiatric practice. He stated that "personal contact is the vital thing in that regard" and "asking people to go and get a phone and phone you back is often too complication for patients who are in a mental state of confusion." Dr Turner could not state whether this represented a missed opportunity or whether this would have altered the outcome with regards to the deaths of the deceased, although he stated that a further mental state assessment would have enabled clarification of Mr McEntee's mental state.

[280] In relation to the events at Daisy Hill Hospital and Craigavon Area Hospital on 26 May 2017, Dr Turner stated that he believed the transfer to Craigavon was appropriate to enable ease of transfer to Bluestone Psychiatric Unit following assessment in the Emergency Department, although it was difficult to clarify the nature of information given to staff at Craigavon Area Hospital about Mr McEntee, and it appeared that limited information was provided.

[281] It was explained to Dr Turner that there was an Emergency Department in Daisy Hill, but that Bluestone Psychiatric Unit was at the Craigavon site, and that the ISAI Review concluded, "Mr McEntee should have been taken to the Emergency Department at Daisy Hill Hospital as the nearest place of safety consistent with the regional guidance. This would have avoided him remaining in the undignified position of being handcuffed and covered only in a blanket in a public place for more than half an hour. He would have been triaged promptly before being seen by a doctor and his immediate needs would have been identified, including greater clarity on the need for referral to the Mental Health Team and admission to Bluestone. Medication might have been initiated by the Emergency Department in Daisy Hill Hospital." Dr Turner commented, "it doesn't matter which one he was in, it is the fact that someone should have been with him all the time so as not to let him escape. That is the key factor, really."

[282] In relation to the information that was passed from police officers to the paramedics and then to the staff in the Emergency Department in Craigavon Area Hospital, Dr Turner stated that it was vital that the information about Mr McEntee presenting as a danger to police and requiring three officers to restrain him, was vital information to have been passed on to the hospital staff as "that's very unusual behaviour and it is threatening behaviour and that should have been passed on. I am surprised that he wasn't detained under Section 136 on the spot." He stated "all aspects of a patient's behaviour and mental states should be passed on. The calm states and the non-calm states." He went to say "you've got to pass on all the facts. If you are bringing someone to a hospital, you've got to pass on all the facts of why they're bringing him to hospital. It is like saying he wasn't bleeding when he was bleeding."

[283] In relation to information exchange between the police and clinicians, Dr Turner stated, "I think it is a problem throughout the UK, which depending on police experience and training, sometimes they pass things on, sometimes they don't. It varies from area to area. In my area we had a very active process of training police

as to what was the problem, and we had very good police engagement and involvement. In some areas the police don't want to know and certainly want to drop people off. It is very variable, I am afraid, and I can't give a universal answer to that."

[284] Dr Turner stated in his report that given Mr McEntee's presentation he should have been monitored carefully by a Psychiatric Nurse such that he could be restrained from leaving the hospital. He stated that given his presentation he required both physical and psychological restraint, and on balance this would have prevented any further dangerous behaviour, for example, the deaths of the deceased. It was explained to Dr Turner that at Craigavon, Mr McEntee was a voluntary patient, he had not been detained under Article 130, the equivalent provision to Section 136 of the Mental Health Act 1983, and in the Emergency Department there were no psychiatric nurses or powers of restraint. Dr Turner replied, "Clearly if there was no section order, you have no power of restraint, but there is the practical common sense of knowing this guy was severely disturbed and required restraint with handcuffs by the police and therefore some sort of monitoring should have been continued. And I think that the law - although legal requirements are that he should have been detained under the Mental Health Act, the police practically deal with safety issues, and they should have been asked to consider continuing support him in the Emergency Department. That would have been the practical solution. But this consideration as to whether it was legal or not and the use of sectioning under the Mental Health Act, that seems to me what should have been done. I suppose looked at in the light of hindsight, he should have been detained under Section 136, in which case the police then would have stayed, I imagine. But they didn't stay because he wasn't being detained. That seems to me, I would have to defer to police expertise, but when you've got a man who required restraint and handcuffing, for them to be let free into a hospital department without any monitoring would seem to me, inappropriate."

Policing Experts

Mr Peter Galbraith QPM

Inspector Jonathan Owen QPM

[285] Mr Peter Galbraith QPM, retired Detective Chief Inspector in the Police Service of Northern Ireland, instructed on my behalf, produced detailed reports, and gave evidence to the inquest. Inspector Jonathan Owen QPM, from the Avon and Somerset Constabulary, instructed by the legal representatives acting on behalf of PSNI also produced detailed reports and gave evidence at inquest. Mr Galbraith and Inspector Owen met and discussed areas of agreement and disagreement and produced a joint memo which was put to witnesses during the course of oral evidence.

[286] In relation to the events on 22 May 2017, in Belfast City Centre and Musgrave Police Station, both Inspector Owen and Mr Galbraith agreed that Constable Cully and his colleague, were trying to do the right thing in terms of ensuring the

safeguarding of Mr McEntee, by safely re-uniting him with his sister. Unfortunately, they stated the good work of Constable Cully was undone when Mr McEntee was left alone in the Enquiry Office Reception area of Musgrave Street Police Station to await collection by his sister. After waiting for a period, Mr McEntee left the station unchallenged, despite the safeguards which the officer had put in place. They were of the view that Constable Cully should have remained with him until his sister arrived as this would have provided an opportunity to discuss Mr McEntee's situation with a close relative, and may have yielded further valuable information, possibly leading to a different course of action than had initially been considered. They both agreed that, on balance, Constable Cully had acted appropriately in seeking to deliver Mr McEntee safely into the custody of his sister. This was in keeping with guidance set out in the Regional Interagency Protocol and the principal 'the least restrictive option' – the least degree of control that an officer needs to place on a person.

[287] Prior to Constable Cully leaving Mr McEntee, Inspector Owen felt that Article 130, 'could' rather than 'should' have been applied, whilst Mr Galbraith felt that the bar for 'immediacy' was not fully met. They agreed that the course of action initially set by Constable Cully, would have been appropriate, had it been followed through to a safe conclusion between police and Ms McEntee.

[288] In relation to Article 130, Inspector Owen explained that "it's the one piece of legislation which differs from any other form of arrest or detention. A police officer cannot disapply Article 130. The only way that an Article 130 can be discharged is by an interview with a medical professional, medical practitioner who says, 'This person is not mentally disordered and doesn't need an assessment.' Or, if the assessment takes place and it's determined that there's no mental health condition. The officer is not allowed to make that decision. Any other form of arrest they could. But you cannot disapply if you're a police officer. And it doesn't matter how high ranking you are, the Sergeant can't tell you to, the Inspector can't tell you, it has to be a medical practitioner." He continued, "which is why they have to be taken to the place of safety. It's like a conveyor belt. Once you're on it, you can't get off."

[289] In relation to the second incident, at the Europa Bus Station, Belfast, Mr Galbraith, and Inspector Owen agreed that the constituent elements of Article 130 were fully met at the Europa Bus Station and that Mr McEntee should have been detained by invoking Article 130, which would then have initiated a process of formal mental health assessment at hospital. They explained that, in a situation, where the constituent elements of Article 130 are met, particularly with regard to the element of 'immediacy' of care or control, they agreed that Article 130 should be invoked, without delay, and not put off to some later point. Mr Galbraith and Inspector Owen stated that this is in keeping with the GAIN Guidelines, and, in their view, this overrides any necessity to consider the principles of 'least restrictive option' set out in the Regional Interagency Protocol.

[290] They agreed that that discussion and due consideration was given to potential options in respect of Mr McEntee. Following a discussion between Sergeant

Prendergast and Constable Thompson, they were in agreement regarding concerns for Mr McEntee's deteriorating mental health and believed that he should be assessed at hospital. Sergeant Prendergast felt that detention by virtue of Article 130 was appropriate, however, Constable Thompson, having considered the situation, and the apparent willingness of Mr McEntee to attend hospital, decided to be following a path of voluntary presentation, escorted by police, at Mr McEntee's request

[291] Inspector Owen and Mr Galbraith commented that "We do not have any confidence that operational officers would be aware of the nuances of the mental health assessment processes in place within health and social care, and therefore the knock-on impact of a decision to detain or present voluntarily." They agreed that there is likely to be much higher instances of presentations to hospital voluntarily, than there is by virtue of detentions under Article 130. This, they stated, in itself, underpins the importance of police officers understanding of mental health assessment processes, in order that appropriate considerations and decisions can be made, which best serve the person in crisis. They were further agreed that this approach was in keeping with the guidance set out in the Regional Interagency Protocol and that, in the circumstances, that guidance may have had undue weight on Constable Thompson's considerations and subsequent decision making on how to proceed.

[292] Both Inspector Owen and Mr Galbraith agreed that there was a thread running through Mr McEntee's encounters with police and medical staff, across the period of 22–26 May 2017. They explained that "he had the ability to mask his deteriorating mental health, and present an engaging communication style and persona, which we agree unduly influenced those with whom he came into contact with, to his advantage."

[293] In summary, they agreed that there was a pressing need to invoke Article 130 following exchanges at the Europa Bus Station. This would have been in Mr McEntee's best interests.

[294] In relation to the attendance at the Mater Hospital, Mr Galbraith and Inspector Owen agreed, that following Mr McEntee's voluntary presentation at the Mater Hospital, had he indicated that he was going to leave at any point, the police officers would most likely have acted to detain him under Article 130, as stated in evidence by Constables Gibson and Thompson. They agreed that this decision would have been focused on providing a duty of care to Mr McEntee, to ensure he received the mental health assessment that he so obviously required.

[295] At around 16:30 hours Mr McEntee told the officers that he would leave in half an hour if he had not been treated. He was informed that he would be detained if he attempted to leave and Mr Galbraith and Inspector Owen agreed, that from this point on, Mr McEntee could not reasonably be considered a 'volunteer', and any sense that Mr McEntee was presenting voluntarily ceased at that the point when he expressed his intention to leave and from then on there was a 'de facto' detention.

Inspector Owen commented, "if you're not prepared to leave the person there unsupervised, and police officers are going to remain. Why are they going to remain? But if you're in a situation where the police are going to be sat with them for six hours, and it could be constituted as de facto detention then the officers are better off, from a legal perspective, in using the power, the right assessment will happen, everybody is legally protected, including the person who's subject to the detention."

[296] In relation to the police attendance with Mr McEntee in Warrenpoint, both experts agreed that occurrence information, from the police control room, regarding Mr McEntee's engagement with police on the 22 May 2017, would have been available had a request for a check of occurrences on police systems been made by the officers present. They went onto say that given the nature of the reports necessitating police attendance to Warrenpoint and "given that Mr McEntee provided incorrect address details in the first instance, this should have raised suspicion or the professional curiosity of officers to ask more searching questions. Those suspicions may have led officers to conduct more detailed checks, via the control room, regarding Mr McEntee's background, which would have revealed not only details of the 22 May 2017, but other relevant information regarding his behaviour to inform their considerations and decision making."

[297] They believed that Mr McEntee's engaging communication style with police impacted on their decision-making process. They facilitated Mr McEntee with a lift to the railway station and one officer reported that he last sighted Mr McEntee talking to two women – they had initially been called to reports of him harassing women. The officers did not ensure he boarded the train, and he subsequently entered a private property nearby, where he slept overnight. In summary, they agreed that officers could, and indeed should, have done more to satisfy themselves regarding Mr McEntee's activity in Warrenpoint and his background.

[298] In relation to the events at Daisy Hill Hospital on 26 May 2017, Mr Galbraith and Inspector Owen agreed "that at the moment Mr McEntee was apprehended, subdued, and restrained with handcuffs at Hospital Road, Newry, adjacent to Daisy Hill Hospital, there was a necessity for officers to arrest or detain him, at the earliest opportunity." They opined that, "Whilst officers had potential powers by virtue of other legislation to rely upon, Article 130 was the most appropriate given Mr McEntee's presentation to police, his subsequent conduct as well as the valuable information provided by mental health staff." They explained that as PSNI were the only agency present with powers to detain Mr McEntee, "he should have been removed without delay, and taken to the closest place of safety available, which was Daisy Hill Hospital, a walking distance away. Given his obvious injuries, this was the best place for initial care and further consideration of next steps regarding formal mental health assessment." They stated that the most appropriate place of care, was the closest one, at Daisy Hill Hospital.

[299] Mr Galbraith and Inspector Owen commented that, as the clear actions of Mr McEntee, presented considerable risk to officers, the officers' actions, to

apprehend Mr McEntee, were proportionate, justified, and commensurate with the threat they were facing at the point of apprehension.

[230] As the 1986 Order does not contain a power of restraint, Mr Galbraith and Inspector Owen commented that, common law powers "should only have been for the shortest possible time until he could be formally detained under more appropriate legislation." Mr McEntee remained restrained in handcuffs for around 35 minutes and the experts commented, "In the absence of the application of formal police powers, we agree that the period of restraint exceeded the boundaries of what may be considered as reasonable, proportionate and potentially lawful."

[231] In summary, Mr Galbraith and Inspector Owen explained that, in their opinions, the "officers present, and in particular Constables O'Toole, then Kenmuir and McDermott, appear to have given no consideration to the application of police powers in respect of Mr McEntee following his apprehension and restraint." Mr Galbraith described this as a wrongly held belief, on the part of the officers, that mental health staff present had taken primacy over Mr McEntee, and that the police role became secondary and subordinate. In the same vein, Inspector Owen felt the officers did not proactively find out what their role was and proceed to do it. Mr Galbraith stated that there should always be 'whole of incident assessment' as "opposed to basing your decision making on one particular snapshot of time." He explained that police officers, using their decision making skills should operate the National Decision Making Model in their head and take into account everything that has happened from the start and not focusing purely on a particular element of time.

[232] Both experts agreed that the Regional Interagency Protocol, concept 'least restrictive option' "If the person found in a public place is willing to accept assistance, then the officer can offer/provide assistance without having to use any powers", may be misinterpreted by officers and that in the circumstances that existed, "police action to invoke Article 130 would override any requirement to consider the terms of 'Least Restrictive Option.'" Both did point out that there was no evidence to suggest that this guidance was even considered by officers at the time.

[232] Inspector Owen summarised, in his view, events on Hospital Road, "the Mental Health Team, were assuming that the police were dealing with it because he's in handcuffs and on the floor. The police thinking that the Mental Health Team were dealing with it because they are a Mental Health Team, but they're actually thinking that they're good Samaritans and then the ambulance turns up. But for the want of a conversation over a car bonnet in the 40 minutes amongst the professionals to say: What's happened here? What's happening now? What needs to happen now? And that does not appear to have taken place at all, to the point where, I actually believe that's more of an issue than whether powers were used or not. It was that lack of clarity as to what needed to happen, and who was responsible for what, was crucial and key for me."

[232] In relation to the incident at Daisy Hill Hospital, Inspector Owen commented, "you're not likely to see a more stark and obvious presentation necessitating Article 130."

[233] Both Mr Galbraith and Inspector Owen agreed that, at this time, "the absence of an initial proactive police response to invoke powers in respect of Mr McEntee, set the scene for what was to follow that day."

[234] Mr Galbraith and Inspector Owen commented on the use of the absence without leave protocol in Craigavon Area Hospital, which was used to alert the police that Mr McEntee had left the Emergency Department. They explained that Sister Loughran had to complete 'mandatory' enquiries, before notifying the police and they commented that they believed "that in the 30-40 minute period from leaving the hospital to it being reported to the police (during which time the Ward Sister completed the checks) the chronology suggests that Mr McEntee had already gained access to Mr and Mrs Cawdery's home."

[235] They agreed that whilst it would be entirely reasonable for the hospital to carry out checks, before notifying the police, there are situations where real and immediate risk to life exist from the moment the person leaves and so the implication that checks 'must' be carried out before the police are notified, could, in their opinion, "lead to adverse outcomes in the future." They agreed there needs to be more flexibility with the absconding policy and that this should include an agreed risk assessment matrix, together with clarity in relation to exceptions. Furthermore, they agreed that the reference to 'police demand' in paragraph 1.4 of the Regional Guidance, should be removed as they believed it was unhelpful commentary. They went on to say that patients at risk of absconding should be risk assessed on arrival and not after they have left. They went on to reference national guidance which would be of use for amending the present protocols or used a framework with which to re-design the local absconding procedure guidance.

[236] Mr Galbraith and Inspector Owen told the inquest that the documents flowing from the 1986 Order, the Regional Interagency Protocol and the Code of Practice are "out of date and require considerable reworking." They explained that the Code of Practice is out of step with the current Code for England and Wales and that, in its current form, there is little detail to assist police, particularly with regard to Articles 129 and 130.

[237] They stated that "there is an overarching issue in terms of synchronicity. Each document should accurately reflect the overarching legislation and the guidance for stakeholders should flow from that. The Protocol is supposed to flow from the GAIN Guidelines, The GAIN Guidelines is supposed to flow from the Code of Practice and the Legislation. In their current form they do not." They recommend a "rewrite" of the Protocol. They stated "The Protocol lacks balance and is weighted heavily toward cases in which Article 130 is invoked, with limited advice on voluntary presentations. This is particularly relevant given our belief that the number of cases presenting voluntarily to hospital greatly exceeds the number under

Article 130." They recommended considering the content of the Code for England and Wales, in tandem with the current GAIN Guidelines would be "a sound reference point" in developing a new Code of Practice for Northern Ireland. They agreed that the GAIN Guidelines need to be easily accessible by officers and that the Regional Interagency Protocol, in its current form, may be a source of confusion and misinterpretation.

[238] In summary, they agreed "that early consideration of a revised Code of Practice would provide the foundation to deliver a reworked Regional Agency Protocol and updated GAIN guidelines. This in turn, would clearly benefit police training and understanding in this key area."

[239] In relation to the Appendix 2, risk assessment document in the Regional Interagency Protocol, Mr Galbraith and Inspector Owen commented that there was nothing in the Protocol to explanation completion and that this required amendment, "if the Regional Protocol is re-examined following this inquest."

[240] Inspector Owen and Mr Galbraith concluded by explaining that the 'Flowchart' referred to in evidence, which is included within the GAIN Guidelines, lacks the information contained in the full GAIN Guidelines document and "lists questions which are currently potentially inaccurate and even misleading and that these need re-examination."

[241] Both agreed that a new programme of training for PSNI officers was required, as Mr Galbraith concluded, "training is a living process, it's constantly evolving and if there are lessons to be learnt from this case, which there will be, then that must be taken on board and incorporated into a programme of training, and I'm sure beyond Northern Ireland for that matter."

Conclusions on the evidence

[242] I find, on the balance of probabilities, that the death's of Michael and Majorie Cawdery on 26 May 2017, in their own home, were entirely preventable. Had adequate consideration been given by police officers in the Police Service of Northern Ireland to detaining Mr McEntee under Article 130 of the Mental Health (Northern Ireland) Order 1986, on two separate occasions, on 22 May 2017 and 26 May 2017, had Article 130 been invoked; had all the available information in relation to previous incidents been analysed and effectively communicated; and had mental health practitioners in BHSCT and SHSCT assessed Mr McEntee comprehensively and extensively, on two separate occasions, 22 May 2017 and 24 May 2017; I find, on the balance of probabilities, that Mr McEntee would not have been in the location of Upper Ramone Park, Portadown, on 26 May 2017, thereby preventing the deaths of the deceased.

[243] On all the evidence before me, there was a succession of omissions and missed opportunities, emanating from poor communication, a lack of informed, and effective decision making, on the part of police officers in PSNI, and staff in BHSCT and SHSCT, in their contact, care and treatment of Mr McEntee.

[244] These omissions and missed opportunities, whilst, analysed individually, may not be considered grave, the combination had devasting consequences.

[245] I find that, had these opportunities not been missed, the course of events would have been different and would have changed the outcome.

[246] Each of my findings, I detail below, I make on the balance of probabilities.

Incident One - 22 May 2017 (Belfast City Centre & Mater Hospital)

[247] I find that Constable Cully should have remained with Mr McEntee in the reception of Musgrave PSNI Station until his sister arrived from Londonderry. This would have had the potential to yield further information in relation to Mr McEntee's presentation and may have led to a different course of action.

[248] I find that, on 22 May 2017, outside the Europa Bus Station, the constituent elements of Article 130 of the Mental Health (Northern Ireland) Order 1986 were fully met and that Constable Thompson and Constable Cusworth should have invoked their powers under Article 130 and detained Mr McEntee and taken him to the Mater Hospital which would have initiated a process of formal mental health assessment. That process would have included an Approved Social Worker interviewing the nearest relative, who, I find, on balance, would have shared her serious concerns about the nature of the deterioration in Mr McEntee's mental health.

[249] I find that both Constable Thompson and Constable Cusworth had a lack of understanding and knowledge of Article 130, the Regional Interagency Protocol and principle of 'least restrictive option', and the nuances of the mental health assessment processes that follow invocation of Article 130. The importance of this knowledge is essential in order for appropriate considerations and decisions to be made, which best serve the person in crisis.

[250] I find that, at approximately 16.30 hours, at the Mater Hospital, when Mr McEntee expressed a desire to leave, and was told by Constable Gibson and Constable Thompson, that he would be detained, if he attempted to leave, he was no longer presenting as a voluntary patient, which he was, up to that point, and was therefore essentially 'de facto' detained.

[251] I find that the 'One Point of Referral' electronic referral form should have been considered by Mr McConville and Dr King before the mental health assessment commenced. I find that this would have led to probing questions in relation to the information contained therein, such as the paranoid references by Mr McEntee that 'people were trying to poison him', which were missed from their assessment.

[252] I find that the communication between police officers and hospital staff in the Mater Hospital was neither clear, comprehensive, nor unequivocal, as it should have been. I find that, when police officers accompany patients to hospital, there should be a full detailed and recorded handover.

[253] I find that Constable Gibson told Mr McConville and Dr King some information, but not all the detail that he claimed to have, during evidence. I find that he informed them of Mr McEntee's paranoia, delusions, references to demons and a light which enabled him to know good and bad people, but I find that he did not inform them, before the assessment, of Mr McEntee's past criminal history or highlight that he was a risk to himself and others. This is an example of why record keeping of handovers, on all sides, is essential.

[254] I find that it was unfortunate that Ms Trainor telephoned during the assessment, as this distracted Mr McConville from obtaining comprehensive, independent, collateral information after his assessment, thus leading to an important gap in collateral information.

[255] I find that Mr McConville should have taken separate detailed collateral information from Mr McEntee's next of kin in a telephone call, privately after that assessment. I find that one and a half minutes was an inadequate length of time to spend obtaining collateral information, which would affect decision making and outcomes. I find that the conversation not being in private, may have inhibited the information Ms Trainor felt she could provide in Mr McEntee's presence. I find that having received comprehensive collateral information, Mr McConville could have probed Mr McEntee further which may have affected the outcome and recommended possible further treatment rather than discharge.

[256] I find that Mr McEntee was unpredictable in his presentation, due to his underlying mental illness, and so presented to different people in different ways. That is why collateral information from all sources is essential and that includes PSNI officers accompanying patients to Emergency Departments. Therefore, I find that Mr McConville and Dr King should have been proactive in seeking detailed collateral information from Constables Gibson and Thompson, in relation to their experience of Mr McEntee, as they were with him for a period of four hours. This may have led Mr McConville to a different conclusion.

[257] I find that, after the assessment, Constable Gibson did speak to Mr McConville and Dr King, and voiced his surprise that Mr McEntee was being discharged. I find that Mr McConville was satisfied with his assessment, and he did not wish to question Constable Gibson any further on the matter.

[258] I find that Mr McConville and Dr King could have enquired further about Mr McEntee's medication supply and his access to his weekly prescription, given that he informed them that he was moving Trusts and GP practice, due to relocation.

[259] Had Mr McConville and Dr King considered all the information that was in existence when assessing Mr McEntee, I find that they would have been better informed about his paranoid thinking at the time, and I find that there was sufficient evidence for Mr McEntee to have been considered suitable for hospital admission at the time.

[260] I find that, following the Unscheduled Care Team's management plan, there were unsuccessful follow up actions with Mr McEntee's GP in Londonderry, and the SHSCT, which resulted in no tangible support for Mr McEntee once he left Belfast, and led to confusion later, in the Mental Health Department in Daisy Hill Hospital on 24 May 2017, and ultimately led to no continuity of care for Mr McEntee.

Incident Two - 24 May 2017 (Daisy Hill Hospital, Newry)

[261] I find that Mr Carbery acted appropriately in attempting to allocate a member of his team to attend Daisy Hill and assess Mr McEntee who self-presented. I find that they were unaware that Mr McEntee was following up on the intended referral from the Mater Hospital on 22 May 2017 which had not been successfully progressed. I find that the delay in a practitioner attending to assess Mr McEntee compounded his frustration at the lack of support and he vented this frustration by leaving before being seen.

[262] I find that, during Mr McEntee's attendance in the Emergency Department in Daisy Hill Hospital, on the evening of 24 May 2017, Dr Conroy should have completed the Mental Health Risk Assessment form, a tool to help assess the level of risk in determining whether a referral is required to the Home Treatment Team, which would have categorised Mr McEntee as medium risk and required a mental health assessment within 2 hours, meaning that he could not be discharged until a mental health assessment had been carried out. I find that, there should been better awareness and training of clinicians in Emergency Departments, of the referral mechanisms and processes to mental health services in the SHSCT, at that time.

[263] I find that after her examination and assessment of Mr McEntee, Dr Conroy made a referral to the on-call Home Treatment Crisis Response Team to refer Mr McEntee for a mental health assessment, rather than advice, as suggested by Mr Johns in evidence.

[264] I find that Dr Conroy relayed Mr McEntee's history and her examination, to Mr Johns from reading off her notes recorded on the Emergency Department flimsy, and this information included his thoughts of life not worth living which were ongoing, he attempted to cut wrists with blade, unable to keep himself safe that night and felt like he may cut himself again.

[265] I find that Mr Johns misinterpreted information that he obtained from the WHSCT, and this influenced his impression of Mr McEntee at that time.

[266] I find that Mr McEntee reached a threshold of need and risk, which required a face to face mental health assessment by Mr Johns from the Home Treatment Crisis Response Team, on the night of 24 May 2017. I find that, had an assessment been carried out, an accurate picture of Mr McEntee's mental state would have emerged; his medication would have been discussed and may have led to a prescription of medication and an assessment of risk formulated with appropriate safeguards put in place. All of which may have changed the outcome of events.

[267] I find that Mr Johns formulated the management plan which Dr Conroy implemented, and I find that, whilst Mr Johns was the senior mental health practitioner, Dr Conroy could have questioned his decision and management based on the information she had and the patient in front of her.

[268] I find that Dr Conroy should have informed Mr Johns that Mr McEntee was presenting as homeless. This important information had a direct impact on the management plan which could no longer be implemented as formulated. This additional information may have changed Mr John's decision to assess, as he stated in evidence.

[269] I find that the management plan, based on the premise that Mr McEntee would find a telephone and call the Emergency Department and leave a number on which he could be contacted by the Home Treatment Crisis Response Team, was flawed and unworkable and it demonstrated a lack of understanding and regard for Mr McEntee's needs at that time.

[270] I find that failure of the Home Treatment Crisis Response Team to conduct a mental health assessment of Mr McEntee, compounded the difficulty he was experiencing in accessing the mental health services at Daisy Hill that day and added to his frustration of not being taken seriously and in a way, alienating him from the services.

Incident Three - 25th May 2017 (Warrenpoint)

[271] I find that Constable Stevenson was informed by the police control room of the nature of the call requesting police attendance in Warrenpoint town centre.

[272] I find that Constable Stevenson should have sought more information on Mr McEntee from the control room regarding his background as well as his activity in Warrenpoint, which would have better informed his decision making to remove Mr McEntee from the area, due to the complaints and nature of the calls from the public.

Incident Four - 26 May 2017 (Daisy Hill Hospital & Craigavon Area Hospital)

[273] I find that as the clear actions of Mr McEntee, presented considerable risk to police officers, the actions of Constable O'Toole and Constable Riddle, to apprehend Mr McEntee, were proportionate, justified, and commensurate with the threat they were facing from Mr McEntee at the point of apprehension.

[274] I find that the moment Mr McEntee was apprehended, subdued, and restrained with handcuffs at Hospital Road, Newry, police officers, in particular, Constable O'Toole, Riddle, McCartan, McDermott or Kenmuir, should have detained him under Article 130 of the 1986 Order. Whilst there were other police powers available, Article 130 was the most appropriate given Mr McEntee's presentation.

[275] I find that the police officers present at the scene on Hospital Road, in particular Constables O'Toole, McDermott and Kenmuir, gave no consideration to the application of police powers in respect of Mr McEntee following his apprehension and restraint.

[276] I find that Constables O'Toole and Riddle should have provided a detailed handover of Mr McEntee's behaviour which led to the restraint, to their colleagues, who arrived on the scene and they should have started a discussion about who was in charge and which officer was taking responsibility for the situation, before leaving the scene.

[277] I find that Constable McDermott and Constable Kenmuir, as lead callsign, and the officers ultimately in charge of Mr McEntee, should have proactively ascertained all relevant information from their colleagues in relation to risk and next steps before they left the scene.

[278] I find, that with all the officers at the scene on Hospital Road, there was an emphasis on voluntarism and avoiding applying Article 130 due to a lack of understanding and knowledge of the provision, Regional Interagency Protocol and GAIN Guidelines. I find that an unintended consequence of this, was a general perception that underestimated Mr McEntee's risks and needs and I find that they should have adopted a cautious approach as there had been such recent unpredictability and volatility.

[279] I find that PSNI officers were in charge of the situation at all times, and mistakenly deferred to the well meaning mental health nurses, Mrs Matchett and Mrs Williamson, who had no powers.

[280] I find that, at this time, as demonstrated by his disturbed behaviours, Mr McEntee remained volatile and a risk to the public and Constable McDermott and Constable Kenmuir were falsely reassured, and they mistook his silence as compliance and co-operation. I find that there should have been a 'whole of incident assessment', as Constables McDermott and Kenmuir were basing their decision making on one particular snapshot of time. I find that at no time was Mr McEntee co-operative during his time on Hospital Road.

[281] I find that Mrs Williamson, whilst well intentioned, supportive, and acting instinctively, appeared to take the lead role, by default, and should have made it clear to police she had no powers and was simply acting as a good Samaritan.

[282] I find that Mrs Williamson, whilst well meaning, should not have made the decision to take Mr McEntee to Craigavon Area Hospital. I find that she was under a mistaken belief that the ambulance came from Craigavon, when in fact it came from Newry, and she knew the protocol that assessment in an Emergency Department had to take place first before any mental health assessment and that Emergency Department should have been the nearest place of safety, the Emergency Department, in Daisy Hill Hospital, 100 yards away.

[283] I find that there was a lack of pragmatic, decisive and rational decision making amongst police officers on the footpath on Hospital Road, in considering their response to the conditions and circumstances and what they were intending to achieve.

[284] I find that Constable McDermott and Constable Kenmuir as lead callsign, were ultimately responsible for Mr McEntee and I find that, once their colleagues left the scene, they should have taken decisive action and invoked their powers under Article 130 of the 1986 Order. I find their belief that two members of hospital staff, providing comfort to Mr McEntee whilst he was lying on a footpath, by the side of the road, was treatment for mental health issues, unsatisfactory.

[285] I find that Constables McDermott and Kenmuir should have obtained further information on Mr McEntee from police control during the 35 minutes spent waiting on an ambulance. This information on Mr McEntee may have assisted their decision making.

[286] I find that had Article 130 of the 1986 Order been invoked by any officers at the scene, Mr McEntee would have been taken to the Emergency Department in Daisy Hill Hospital and a discussion would have taken place with Emergency Department staff about ongoing risks to mitigate the risk of absconding; and a formal assessment under the 1986 Order would have taken place.

[287] I find that both Constable McDermott and Constable Kenmuir should have considered walking Mr McEntee to the Emergency Department of Daisy Hill Hospital, which was 100 yards away, or considered using the police vehicle to transport him.

[288] I find that Constables McDermott and Kenmuir failed to provide a proper detailed handover to the paramedics, in relation to the risk posed by Mr McEntee to others. This subsequently affected the adequacy of the handover to the staff in the Emergency Department.

[289] I find that, Mr McEntee should have been taken to the Emergency Department at Daisy Hill Hospital, as the nearest place of safety, 100 yards away. He would have been triaged promptly before being seen by a doctor and his immediate needs would have been identified as well as clarity on the need for a referral to the mental health team and admission to Bluestone Psychiatric Unit.

[290] I find that, as a minimum, Constables McDermott and Kenmuir should have accompanied Mr McEntee into the Emergency Department in Craigavon Area Hospital and remained with him, until he was triaged, and relevant information handed over to the hospital staff and he was risk assessed.

[291] I find that Mr Rooney and Mr Morgan should have sought information from Constables McDermott and Kenmuir at the scene, as they had responsibility for and control of Mr McEntee.

[292] I find that Mr Morgan gave a copy of the Patient Report Form to Staff Nurse Trimble and Staff Nurse Skeath in the Emergency Department and provided a short oral summary of the contents. However, I find that, Mr Morgan was falsely reassured by Mr McEntee's calm presentation, so that his handover, lacked essential details, and was somewhat diluted from the information contained in the Patient Report Form, such as the level of restraint required by police, use of handcuffs, and police accompanying the ambulance to Craigavon Area Hospital, that the plan was to admit him to Bluestone Psychiatric Unit. I find that he provided reassurance to hospital staff that, "he was okay", and therefore the hospital staff were unaware of the risk of further volatile and disturbed behaviour on the part of Mr McEntee. This highlights the importance of ensuring an effective handover process that covers all relevant information, particularly across interfaces of care, where gaps in information and misunderstandings can concur, which can have serious consequences.

[293] I find that Staff Nurse Skeath and Staff Nurse Trimble should have read the Patient Report Form so that they were equipped with all information rather than relying on a brief handover from Mr Morgan and information from a potentially inaccurate historian, Mr McEntee. The Patient Report Form contained detailed information which would have assisted the hospital staff in their assessment of Mr McEntee, in relation to the detail "psychotic" and the fact that the ambulance was "followed by police in transfer." This had the potential to lead to further questioning of Mr Morgan.

[294] I find that Sister Loughran activated the SHSCT absconding policy with due diligence. However, I find that the 'stepped process', required by the policy, which took 35 minutes, prevented an earlier alert to police, and I find that consideration, on a multi-agency basis, should be given to allowing greater flexibility, in processes to deal with those absconding from Emergency Departments who are at risk of harm.

Incident five – 26 May 2017 (Upper Ramone Park, Portadown)

[295] I find that, between 12.25 hours, and 15.15 hours on 26 May 2017, Mr McEntee made his way from the nearby Craigavon Area Hospital, broke into the deceased's home, and was disturbed by the deceased on their return home. I find that the deceased died from their injuries. Mr McEntee was found guilty of their manslaughter, by reason of his diminished responsibility, upon his guilty pleas.

General conclusions on the evidence

[296] I find that police officers on two occasions, 22 and 26 May 2017, relied on the principle of 'least restrictive option' and voluntarism to guide their decision making around the use Article 130 of the 1986 order. This highlighted the difficulty that police officers can be faced with, when making judgment calls in a fast moving, unpredictable situation. Therefore, I find all police officers in Northern Ireland, not just Student officers, or Probationary officers, but all officers, particularly those in response policing, require more training on these themes to equip them as first responders to people in crisis situations that need help and support.

[297] On 26 May 2017, Mrs Williamson stated that she was not aware of Article 130 of the 1986 Order, and this highlighted the need for training on the 1986 Order to relevant healthcare staff, not just those in Emergency Departments, but others who do not have regular dealings with the Order should have some knowledge base.

[298] I find that there is a responsibility on individual police officers to avail of training offered by PSNI, as well as a responsibility for PSNI to offer it. It is a joint responsibility. I find that there was a failure by some police officers to take personal responsibility and all reasonable steps to ensure that they attended mental health training courses. I find that there needs to be a new, extensive package of training on mental health, as recommended by Inspector Owen and Mr Galbraith, offered to all police officers in Northern Ireland.

[299] It is clear from the oral evidence I have heard that officers were and still are very reticent to use their powers under Article 130 of the 1986 Order, to take people to a place of safety, and that appears to be based on a lack of understanding of the power and the requirement to apply it, when the constituent elements of Article 130 are in existence. The lack of understanding and the lack of rational decision making was clearly borne out by the officers in giving evidence, some of whom stated that they would do exactly the same should they be faced with the same set of circumstances.

[300] I find that there should be greater training for staff across various grades and levels in the Emergency Department in all Trusts who come into direct contact with people presenting with a range of mental health needs. Lack of awareness of policies and procedures can leave staff vulnerable and susceptible to making incorrect decisions and can detrimentally affect the quality of care. As the Emergency Department is the first point of entry and when some individual's mental health needs are at their greatest, I find that staff need greater training and development to equip them in dealing with increasing numbers of complex presentations, such as Mr McEntee's, as well as training in triage, mental health assessments, risk assessments, the necessity for collateral information, referral processes to other Trusts and processes in filling in forms such Mental health Assessment forms.

[301] I find that, as suggested by Mr Galbraith and Inspector Owen, the two documents flowing from the 1986 Order, the Code of Practice (1992) and the Regional Interagency Protocol are out of date and require considerable reworking, in collaboration with key stakeholders. The Code of Practice has not been updated since inception, and there is little detail to assist officers, particularly with regard to Articles 129 and 130. The Regional Interagency Protocol has since been updated, with a revised version produced in 2019, however, there is little substantive change to the document, and it still provides limited advice on voluntary presentations, which is particularly relevant, given the number of cases presenting voluntarily exceeds the number under Article 130. Furthermore, the advice on Article 130 lacks clarity and could, in its current form, be a source of confusion and misinterpretation for police officers, as demonstrated in evidence.

[302] Whilst a revised Appendix 2 to the Regional Interagency Protocol has been developed and designed to record a greater level of key information to assist a joint risk assessment process, I find that there is no supporting guidance in the Regional Interagency Protocol, provided regarding completion of the document, to explain how or when to complete it, and therefore a review and re-draft of the Regional Interagency Protocol should include clear instruction.

[303] The GAIN Guidelines should form the best source of advice for police officers. The specificity of what police are expected to do when utilising their powers under the 1986 Order can only be found in the GAIN Guidelines. However, from evidence, officers were not aware of its existence and there is clearly an issue with regard to training and accessibility for officers of both the GAIN Guidelines and the Regional Interagency Protocol. These changes would clearly benefit police training and understanding in this vital area.

[304] I find that the Flowchart document regarding the 'Police Use of Place of Safety Powers under Article 130(1) and (2)' included at the end of the GAIN Guidelines lacks the information, nuances and subtlety of the full GAIN Guidelines, and the questions contained therein are potentially inaccurate and both should be re-examined and re-drafted, in order to assist officers in their response to people in mental health crisis.

[305] I find that a holistic review of the Code of Practice, Regional Interagency Protocol and GAIN Guidelines is required to ensure clarity, and consistency in application, together with multi-agency training, to reflect the emerging challenges in our society.

[306] I find that, the Regional document 'Regional Interagency Guidance on Dealing with Persons who go missing from Emergency Departments', developed on an interagency basis, stipulates that certain checks 'must' be carried before police are notified and this could lead to adverse outcomes. I find that there needs to be more flexibility which may encourage Trusts to adopt the Regional policy, rather adopting their own, resulting in a more consistent approach. Equally, I find that PSNI has a responsibility to demonstrate flexibility in responding to absconding alerts from Emergency Departments in relation to those at risk of harm.

[307] This inquest has highlighted the absolute necessity of clear, effective, robust, collaborative, multi-agency working, across all interfaces in dealing with mental health in Northern Ireland. This can be improved by way of interface meetings, meaningful engagement, and shared learning, which could only serve to build, enhance, and maintain positive relationships among those agencies involved in mental health care.

Cause of death

[308] A post-mortem was performed on Michael Cawdery, and it records, and I find that death was due to:

1(a) Shock, haemorrhage, and subarachnoid haemorrhage

Due to

(b) stab wounds, incised wounds, and blunt force trauma

[309] A post mortem was performed on Majorie Cawdery, and it records, and I find that death was due to:

1(a) Haemorrhage

Due to

(b) stab wounds and incised wounds of scalp, neck, and limbs

Postscript

[310] The above findings should be placed in the following context. As the scope of the inquest outlined, I heard evidence to ascertain what lessons have been learnt by the BHSCT and SHSCT and by the PSNI, as a result of the deaths of the deceased and whether steps have been taken to implement changes to address that learning.

[311] I heard evidence from Dr Pat McMahon, Consultant Psychiatrist, and former Associate Medical Director for Mental Health and Disability in SHSCT. He told the inquest about learning and changes in services in SHSCT following the Level 3 Independent SAI Review (ISAI Review), which identified a number of missed opportunities and failings of care.

[312] Dr McMahon explained to the inquest that the erroneous information passed to Mr McConville, about eligibility for psychiatric care in the SHSCT, should not happen again, as processes have changed and these changes have been communicated to all frontline staff to ensure that if someone is referred to any part of Mental Health Services in the SHSCT, this referral will be directed to a Central Booking Service who will carry out the initial triage and ensure the person receives the timeliest and most appropriate care. If it is an emergency, the referral will be forwarded to the Home Treatment Crisis Response Service. If a patient does not have a GP in the SHSCT area arrangements can be made with a local GP (temporary registration) or arrangements with their currently registered GP to ensure that any medication they may require can be accessed (for example by prescriptions being forwarded to a local pharmacy). He stated that "the Trust is confident to say the changes in practice are now embedded and refusal to accept referral should not happen again."

[313] In relation to Mr McEntee's attendance at the Mental Health Department at Daisy Hill Hospital on 24 May 2017, Dr McMahon explained, as outlined in evidence, that now if a person self presents, a call is made to the relevant Home Treatment Crisis Response Team. If the Home Treatment Crisis Response Team are

unable to respond immediately, another Practitioner, either the Duty Practitioner or Team Lead in the facility, will attend to provide the assessment, and determine the individuals care needs and arrange for their ongoing care.

[314] In relation to the failure to conduct a face to face assessment with Mr McEntee on the evening of 24 May 2017, the arrangement that was in place has now changed, so that the Integrated Liaison Service (ILS) now provide a 24/7 service to both hospital sites. Referrals are made by the Emergency Department team once they have identified the need for mental health input. Dr McMahon stated that seventy percent of patients are seen within the two hour target time.

[315] Dr McMahon told the inquest that on the morning of 26 May 2017, there was clear confusion with regards to who was taking the lead with decision making and what responsibility each agency had in the onward care of Mr McEntee. He stated that a significant number of mental health staff are not required to have detailed training on the implementation of all aspects of the 1986 Order and there is no agreed multi-agency training. The SHSCT has since ensured that ED staff receive training on mental health legislation pertinent to their area of work. He explained that attempts at developing multi-agency training have not been successful, as other agencies have indicated that they would have challenges within their limited resources to free staff to allow the training (currently not deemed mandatory).

[316] Dr McMahon agreed with Inspector Owen, that currently there are inconsistencies and differences, in the advice in the Trust's source documents - the GAIN guidelines and the Regional Interagency Protocol. He explained that the GAIN Guidance and the Regional Interagency Protocol provide different instructions and advice on processes and that the Regional Interagency Protocol more accurately describes what is happening in practice. Dr McMahon explained that Trusts rigidly followed the GAIN Guidelines, rather than the Regional Interagency Protocol, on the use of the 1986 Order, and that by doing so, there is a real risk, in his view, of patients coming to physical harm/death or being unlawfully detained for long periods.

[317] Dr McMahon explained the SHSCT has made changes to practices. If the police attend the ED with a patient, they are asked at the point of triage, if the patient is under Article 130, under PACE arrest or voluntary. This is now embedded in the SHSCT mental health risk assessment which was introduced as part of the learning and is used in all attendances at the ED.

[318] Dr McMahon told the inquest that he identified additional challenges that were not directly referenced in the ISAI Review, where change is still required in SHSCT, which he outlined in detail in his statement. He explained that while the Emergency Department in Craigavon Area Hospital has a dedicated mental health cubical, no such facility is available in Daisy Hill Hospital, and with the intense pressures in ED the area is often utilised for acutely ill patients, and this is an issue which needs addressed.

[319] Dr McMahon told the inquest that the issue of interagency working and use of Article 130 remains challenging. He suggested that it would be helpful for clinicians if the use of Article 130 by officers required formal documentation which would assist any subsequent assessment and may address the issue of dilution in communications. He stated that the Regulation and Quality Improvement Authority (RQIA), as regulators would have the authority to make such changes. Dr McMahon also suggested that the Appendix 2 Risk Assessment should be completed for all patients attending the ED who are accompanied by police in order to demonstrate active decision making and risk management.

[320] Dr McMahon stated, it was his belief, that, even with the changes made to date, within the SHSCT, that the decisions made by the agencies on the morning of 26 May 2017 could be repeated. He explained that the reason he believed this is because SHSCT staff and other agencies continue to follow the current GAIN Guidelines and Regional Interagency Protocol.

[321] Dr McMahon concurred with the opinions of Inspector Owen and Mr Galbraith, that the Code of Practice, GAIN Guidelines and Regional Interagency Protocol need revised and that they need to provide very clear and consistent advice and instruction. Also, any such changes would only become effective, in his opinion, if adequate and appropriate training follows, and such training would need to be multi-agency and multi-disciplinary. He stated that there would need to be a mandatory component to this training.

[322] Dr McMahon explained that there has been a draft revision of the Regional Interagency Protocol (December 2022) which will include conveyancing under the Mental Capacity (NI) Act 2016. He stated that, regionally all Trusts, would need to ensure that any learning regarding discrepancies between the GAIN Guidelines on the use of the 1986 Order and the Regional Interagency Protocol have been addressed, before it comes into force.

[323] Dr McMahon told the inquest that there was an update of the 'Regional Interagency Guidance on Dealing with Persons who go missing from Emergency Departments', in November 2017, and that, in his view, the measures are now, in essence, what was happening in the SHSCT in 2017 and that based on this current guidance, if a similar situation arose, that it would likely take a similar time to complete the checks before police would be contacted.

[324] I heard evidence from Ms Martina McCafferty, Social Care Lead, Strategic Planning and Performance Group (SPPG), Department of Health. She explained that, following the ISAI Review, a Regional Action Plan (2021-22) was developed to address the recommendations, and that this action plan has continued to be reviewed (Action Plan 2022-23).

[325] The Regional Action Plan 2022-23 incorporated all the recommendations from the 2021-22 Action Plan reflected under 6 key themes: Standardisation of Mental Health Services; Standardisation of Crisis Response Home Treatment and Mental Health Liaison Services; Multiagency and joint working relationships; Robust clinical

and care governance systems; Workforce planning training and development and Effective arrangements for engagement of people and families. It was agreed that SPPG and PHA have responsibility of overseeing the regional implementation of the Regional Action Plan.

[326] Ms McCafferty outlined, in detail, how, various strategies and policies were incorporated, and key strategic drivers supported the work taken forward in relation to the above themes. These were the DoH Mental Health Strategy (2021-2031), which is currently in year two; DoH report 'From silos to systems'; 'You in Mind Regional Mental Health Care Pathway' and 'A regional mental health crisis service for Northern Ireland' – policy paper and implementation plan (August 2021 & November 2021). She explained that the themes were being progressed and that work was continuing and monitored using a 'RAG Rating system.'

[327] When asked if there was one particular aspect of the ISAI recommendations which required particular attention, Ms McCafferty replied that "I think the issue in relation to family engagement is very clear and very evident. It is something that I know the review, the RQIA review, has also noted. That is a particular area that we would welcome an updated process in relation to."

[328] I heard evidence from Assistant Chief Constable Wendy Middleton, Police Scotland. She was formerly Chief Superintendent in PSNI and from 2018 she took forward the first SAI recommendations on behalf of PSNI, which were declared a Tier 1 Critical Incident as per PSNI Service Policy and managed by the relevant District, the District of Newry, Mourne and Down (NMD). She later represented the PSNI in the Level 3 ISAI Review process. ACC Middleton explained that, following discussions, it was agreed that no misconduct appeared to have been conducted on the part of any officer and that the PSNI's lead on Mental Health at the time, Inspector Mark Cavanagh, would support learning from the case.

[329] ACC Middleton explained that it was the collective view, that there was an increase in both the volume and complexity of mental health cases that PSNI were having to deal with, and more support was needed for frontline officers to deliver the most appropriate response. She explained that, since 2017, a number of developments have been implemented to support officers with the increasing demand in mental health calls and to ensure that the most appropriate service is provided. In June 2017, a process called THRIVE was introduced in the Contact Management Centres (CMC) in the PSNI. This was in process, rather than as a result of the death of the deceased. She explained that this standardised the approach and ensured that PSNI had a framework to help assess Threat, Harm, Risk, Investigative opportunities, Vulnerability and Engagement thus ensuring a better service to callers and members of the community.

[330] ACC Middleton described how a new IT system was introduced into CMS which is one of the most advanced and integrated systems in the police. This ensures that information relating to an individual is in one place, flags are identified, and this can be readily accessed by the responding officer. She did explain that "it is

reliant on that two-way communication between the contact management centre and the responding officer."

[331] In July 2018, the Multi Agency Triage Team (MATT) was commenced. This provided a mobile response team of PSNI, NIAS and mental health professionals, and was a crisis de-escalation service for those experiencing an acute mental health crisis and who are in contact with emergency services. It was located in Lisburn, Castlereagh, North Down, Ards and Belfast. However, NIAS has since pulled out, due to resource issues post COVID-19 and further funding is sought for a roll out. An evaluation showed that Article 130 interventions decreased, and outcomes improved for those in crisis.

[332] ACC Middleton told the inquest that a new training module has been developed, with the assistance of the Cawdery family, for all Student Officers who enter the PSNI, "who make up 60% of response policing in the PSNI." Stage 2 of the Probationer Development Programme has also been amended to reflect developments. This training module does not apply to current officers.

[333] ACC Middleton explained that the College of Policing have also published a comprehensive training programme in relation to Acute Behavioural Disturbance (ABD) and the response required from police. ACC Middleton also took forward a workshop, before she left PSNI in February 2023, to develop a Mental Health Strategy, to provide a foundation on which to agree a corporate position and to develop further training. A new Mental Health Lead has been appointed and is taking still forward that Strategy.

[334] Following the ISAI Review, ACC Middleton held a number of meetings with the SHSCT and agreed, in the spirit of continued joint working, there was a need to clarify roles and responsibilities, consider joint training, and to examine whether existing protocols were sufficient, including how missing persons are dealt with. These topics were taken forward and actions are still being progressed.

[335] ACC Middleton concluded, "this is very much about, let's take this one step at a time. If the protocol needs to be reviewed, which I would be supportive of, I have no difficulty in that, I do think that we learn every time, something happens, because our ultimate goal is to protect life, that is why we join the organisation, it is what we're there for. So we will - and the PSNI, certainly up until I left, and I have no reason to suspect otherwise now, we are always about, how do we make sure that things don't happen, how do we improve things, how do we skill and equip our officers at the front end. That is really vital. I hope that by doing what we have done to date, we have made some inroads there."

[336] I heard evidence from Sergeant Steven Kirkwood, from the Northern Ireland Police College in Garnerville. His role involves overseeing the delivery and development of the lesson titled 'Adult Safeguarding and Mental Health.' He explained that in 2017 Mental Health was taught to student officers within a half day lesson titled, 'Adult Safeguarding and Mental Health.' The main learning outcomes were that students should be able to understand the 1986 Order definitions and how

to provide the initial response to an adult with a mental health illness; to understand the police role on the use of the 1986 Order in relation to the GAIN Guidelines; to understand the legislation in relation to use of police powers to remove a person to safety. Operational practical days for student officers incorporate policing scenarios with mental health elements.

[337] Sergeant Kirkwood explained that since November 2020, probationary officers, Stage 2, now undergo training in mental health in the police college, by way of online lesson. The material within the online training package includes; introductions from Naomi Long and Professor Siobhan O'Neill (NI Mental Health Champion) on highlighting the importance of police and how they deal with people in mental health crisis; an input focusing on early intervention and how to communicate and de-escalate people in mental health crisis; communication techniques; identifying common mental health conditions and how they may appear, pathways available to get support for people experiencing mental health crisis; completing risk assessments with hospital staff when police arrive at the Emergency Department, and covering key points of Article 129 and Article 130 and associated procedures. The lesson has now been developed and rolled out in the Student Officer Development Program. Sergeant Kirkwood explained that there is now a training programme run by the University of Ulster which has taken on some of the responsibilities for mental health training within probation.

[338] Sergeant Kirkwood explained that Districts were responsible for delivering training course for current officers, however, he was unaware of training that may have been provided by individual districts in regard to mental health in 2017. From evidence, there appears to be a dearth of training for non-student or probationary PSNI officers. 'Mental Health & Policing: From Crisis to Care' was offered to Districts D and E in 2017, but training records show that the majority of officers, who gave evidence to the inquest, did not attend this or indeed similar training.

[339] Sergeant Kirkwood stated that in the last number of months, the Police College, has taken responsibility for District training, although what this would mean, had yet to be established. He stated, "We are yet to see how that eventually looks from a practitioner level anyway, but essentially I think the idea behind that is to centralise and have a better understanding of what is trained out and a better record of what is being trained out wider, so that there is a consistent approach more so than an individual District approach."

[340] Can the relatives of the deceased be satisfied that lessons have been learnt from their deaths? I commend the large body of work that has been taken forward by PSNI and the Health and Social Care Trusts, to date. The litmus test for lessons learnt, is, what would PSNI officers and Trust staff, do now, when faced with the same situation? Sitting here today, on the written and oral evidence before me, I cannot be satisfied, and as acknowledged by some witnesses to the inquest, that, some of the failings, which have been identified, would not occur again. More needs to be done.

[341] My hope is that the tragic loss of Michael and Marjorie Cawdery continues to serve as a catalyst for collective and sustained change, in the recognition and treatment of people in mental health crisis, thus ensuring that no family endures the pain that the Cawdery family carries.