Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr E and the provision of Mental Health Services, following a Homicide committed in August 2007

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Chapter 1: The Evidence

Summary of the index offence

1.1 On 4 August 2007 Mr E attacked Mr V, the victim who was known to him, with a knife stabbing him five times, twice in the chest and three times in the back. Sadly Mr V died of his wounds. Mr E was arrested and on 20 December 2007 the Court ordered his indefinite detention in a secure hospital.

Background

1.2 In circumstances where a patient known to Mental Health Services is involved in a homicide the Welsh Assembly Government may commission an independent external review of the case to ensure that any lessons that might be learnt are identified and acted upon. As of January 2007 these independent external reviews are conducted by Healthcare Inspectorate Wales.

Brief History of Mr E

1.3 Mr E was born in 1964, was brought up in Newport, Gwent and family relationships with his parents, sisters and brother were close. At the age of four years he had demonstrated some difficult behaviour including destructive impulses which caused his parents concern. However psychiatrists and paediatricians who saw him at that time considered him to be a ‘normal little boy’.

1.4 Mr E’s experience of early schooling was unremarkable but in his latter years at secondary school he found the work difficult and that led to him truanting.

1.5 On leaving school Mr E was placed on a Youth Training Scheme and subsequently he held a number of unskilled manual jobs, including that of a taxi driver. However Mr E had been unemployed for a considerable time prior to the homicide.

1.6 Mr E appeared to have been able to form social relationships. He had had male friends and occasional relationships with women including one which lasted for four years.

1.7 Mr E first met his victim, Mr V, when they were at school together. They had become friends and Mr V and Mr E had met each other's family and had meals with them. In 2001 Mr E moved into a flat adjacent to where Mr V was living. They continued to be friends and spent time in each other's flats. In late 2002 Mr E states that he reported a matter relating to Mr V to the police. From that point onwards Mr E was fearful that Mr V would know that it was he who had made the report and would retaliate against him.

1.8 Mr E moved out of his flat at first staying with an acquaintance, then briefly with his parents, before moving into a local authority hostel in July 2003. Mr E remained at the hostel until 13 August 2003 when he was admitted to the Royal Gwent Hospital. He had been found unconscious in his room at the hostel. He was discharged from hospital on 29 August 2003 and from that time until the homicide occurred Mr E lived at his parents' home.

1.9 During the time he was living in his own flat Mr E had been using drugs, mostly marijuana. He says he stopped using illicit drugs when he went to live with his parents.

1.10 From 2002 Mr E became increasingly socially isolated and throughout the period he was living with his parents and at the hostel Mr E had maintained his fearfulness that there were people who would attack him. As far as his family were aware that was associated with his belief, for which we could find no basis, that Mr V would retaliate for his having made the report to the police. Other factors had also led to the isolation Mr E sought for himself.

He reported to staff of psychiatric services that Mr V and his ex-landlord had evidence of behaviour on Mr E's part which Mr E regarded as shameful. Again we could find no evidence to substantiate that fear on Mr E's part. Mr E believed that Mr V and his landlord were placing that evidence on the internet and that it was becoming known across Newport. For that reason he did not want to go out.

1.11 The practical outcome was that Mr E isolated himself in his room at his parents' home, just as he had at the hostel, for over four years.

1.12 Mr E's deteriorating mental state placed severe strain upon his parents with whom he was living. Even within the house he would isolate himself in his room. He kept his windows screened and all curtains closed in the house. For some period of time he had convinced his parents that his fears were real and that they too were at risk from the people he feared.

1.13 During the weeks leading up to the homicide Mr E had shown a little more willingness to leave his room. He would go to the supermarket early in the morning before many people were about and would visit his sister's home in the company of his parents, as he had been doing on the day the homicide occurred.

Arrangements for delivery of mental health services in Gwent

Community Mental Health Teams (CMHT)

1.14 Within Gwent there were 12 multidisciplinary and multi-agency Community Mental Health Teams (CMHTs) run by the Gwent Healthcare NHS Trust and the Social Service departments of the five County Borough Councils. They provided mental health services for people between 16 and 64 years drawing upon the skills of both health and social services staff. Each team covers a specific geographical area.

1.15 Gwent Healthcare NHS Trust provided a variety of services which included inpatient treatment, outpatient clinics, group work (e.g. anxiety management, carer support, relaxation therapy etc.), day treatment, specialist psychological interventions (e.g. family therapy) and liaison psychiatry. There were specialist forensic and personality disorder services provided by the Trust.

1.16 Clinical staff, including Medical staff, Community Psychiatric Nurses, Community Occupational Therapists and Clinical Psychologists provided a range of other Community Services. A proportion of their work took place in patients' homes. The majority of the work involved clinic and group sessions at various locations within the catchment area, including Depot and Lithium clinics.

1.17 Mr E was receiving care and treatment from the Newport East CMHT which was based at the Goldtops Centre in Newport.

Guidance relating to Mental Health Services in Wales

1.18 The National Assembly for Wales and the Welsh Assembly Government have issued guidance to Health Service bodies in a number of publications. Of particular relevance, in relation to this review are 'Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency (National Assembly for Wales 2001)', 'Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users, (Welsh Assembly Government 2003)', 'Raising the Standard (Welsh Assembly Government 2005)', 'Policy Implementation Guidance on the Development of Crisis Resolution/Home Treatment Services in Wales (Welsh Health Circular (2005) 048' and in relation to current expectations with regard to mental health services 'Welsh Health Circular (2006) 053' and 'Adult mental health services in primary healthcare settings in Wales (Welsh Assembly Government 2006)'.

1.19 We set out in the annex relevant extracts from these documents, together with an outline of powers under the Mental Health Act, 1983.

Care and Treatment by Mental Health and Social Care Services

1.20 Mr E first came to the attention of mental health services when he was four years old when he was assessed as a result of concerns expressed by his parents about incidents of 'head banging' and damage to property. Paediatricians and psychiatrists who saw Mr E at that time did not believe these to be symptoms of a psychiatric problem and subsequently Mr E displayed no behaviour of concern until he began to struggle with work at school in his later secondary school years and began to truant. He formally left school at 16 years of age and had a history of employment until 2001 at which time his health problems were becoming evident.

1.21 The first referral of Mr E, as an adult, to specialist mental health services was in July 2002. His General Practitioner (GP) had referred him to the Community Mental Health Team (CMHT) with symptoms of depression, for which his GP had been treating him, which Mr E was said to have been suffering for eleven months. An earlier attempt to engage him in counselling, in February 2002, had not been followed up by Mr E.

1.22 At the beginning of August Mr E failed to attend an appointment which was offered to him by the CMHT. As a result on 13 August 2002 the CMHT discharged him, unseen and informed the GP about that. On 10 October 2002 the GP again made a referral to the Consultant Psychiatrist at the CMHT. An initial appointment was made for Mr E to attend the CMHT on 28 October 2002 and subsequently alternative appointments for 29 October, 2 December and 9 December 2002. None of these appointments were kept and again on 18 December the CMHT discharged Mr E and notified the GP.

1.23 In July 2003 Mr E went to live in a local authority hostel, as a first step to obtain his own accommodation away from Newport and what he perceived as the threats to him. On 12 August 2003 one of the staff at the hostel had a conversation with Mr E and, noting that he appeared depressed, suggested that he should make an appointment with his GP. Mr E's father had been keeping in regular telephone contact with his son. On 13 August 2003, after failing in efforts to contact Mr E for two days, Mr E's father went to visit him at the hostel. He could not get a response from Mr E's room and persuaded a member of staff to open the door where Mr E was found to be unconscious. Mr E was admitted to the intensive care unit at the Royal Gwent Hospital. He had injured himself in falling or as a result of body movements whilst unconscious. Doctors believed at that time that his condition resulted either from a drug overdose or a brain infection and it was later confirmed that he had suffered a drug overdose. During his period in hospital Mr E was assessed by a staff grade psychiatrist (1), who noted a history of depression going back some eight or nine years. He remained in hospital until 29 August 2003.

1.24 From 29 August 2003 until the homicide in August 2007 Mr E lived with his parents (although his room at the hostel was not formally vacated until 28 October 2003). The staff grade psychiatrist (1) who had seen Mr E during his period of hospitalisation had provided a discharge letter to the GP and the Newport East CMHT. His assessment was that Mr E presented with features of depression and that he should be assessed by a community psychiatric nurse (CPN). On 3 September 2003 a CPN (1) from the Newport East CMHT conducted a domiciliary assessment of Mr E at his parent's home. In the course of that assessment a risk assessment was undertaken as a result of which Mr E was assessed as presenting a 'low' risk. It was during this assessment that Mr E first disclosed his delusional beliefs about Mr V and his landlord. Subsequently the CPN collaborated with a staff grade psychiatrist (2) at the CMHT to draw up a care plan. Mr E was clearly unwell and needed medication; he was delusional and it was concluded that Mr E was exhibiting symptoms of psychosis and medication should be commenced.

1.25 On 13 September and 15 September 2003 Mr E was seen at the CMHT by a CPN (1) and a staff grade psychiatrist (3). The CPN (1) had weekly contact with Mr E at first but then monthly until November 2003 when the CPN (1) took a break from work. At that point Mr E declined to accept contact from another CPN.

1.26 On 15 December 2003 Mr E was seen at the CMHT by a staff grade psychiatrist (3) who sought re-engagement by a CPN with Mr E. Mr E was seen again by that staff grade psychiatrist (3) on 22 December 2003 when it was noted that he was suffering a 'significant relapse'. Mr E was presenting low mood and fixed delusional beliefs with paranoid ideation which the psychiatrist believed to be consistent with a diagnosis of paranoid psychosis.

1.27 On 24 December 2003 a CPN (2) visited Mr E at his parent's home. Subsequently that CPN visited Mr E at his parents' home on 6 January and 11, 17 and 25 February 2004. His delusional beliefs continued. Scheduled visits to the CMHT were cancelled by Mr E on 19 January and 3 March 2004.

1.28 On 16 March 2004 a staff grade psychiatrist (2) and the CPN (2) conducted a domiciliary visit. The psychiatrist's diagnosis was depression with psychotic features within a background of pre-morbid social phobia.

1.29 On 26 March and 5, 13 April 2004 the CPN (2) visited Mr E at home. On 19 March the initial CPN (1) involved with Mr E resumed responsibility for contact with him. Further home visits were made on 28 April, 28 May and on 2 June 2004 the CPN (1) discussed a care plan with Mr E. Between 5 June and 29 June 2004 the CPN (1) explored options for a hospital admission in respect of Mr E, but it was believed there were no beds immediately available[1] and on 29 June 2004 at a point when it seemed a bed would be available Mr E was reluctant to be admitted to hospital.

[1] The Trust has pointed out that at the time there was a system in place which would have located an available bed. We report here what we were told in interviews.

1.30 On 2 July 2004 Mr E was assessed by a staff grade psychiatrist (1) at the CMHT and on 6 July the CPN (1) visited him at home. On 7 July Mr E was offered a bed at St Cadoc's Hospital which he declined.

1.31 Further home visits were made by the CPN (1) on 2 August and 1 September 2004. On 15 September 2004 Mr E's parents were seen by the CPN (1) and a carer's assessment was completed. Although Mr E's parents' comments in the assessment demonstrate their need for greater support we could find no evidence of that plan resulting in any action on the part of the CMHT. Mr E was seen at home again on 8 October but subsequently cancelled appointments on 19 October and 18 November. He was seen by the CPN (1) on 19 November and 30 November 2004 and his mental state had not changed. By that time Mr E was suggesting that he was wasting the CPN's time and that the CPN should no longer visit.

1.32 On 21 February 2005 Mr E kept an appointment with a locum consultant psychiatrist to whom he had been referred in November 2004 and with whom a previous appointment had had to be cancelled. The locum consultant psychiatrist diagnosed Mr E as suffering from psychotic depression.

1.33 On 8 April 2005 the CPN (1) made a home visit. The following month the CPN (1) was due to leave Newport East CMHT and Mr E refused to be transferred to another CPN. Mr E's GP was informed.

1.34 A staff grade psychiatrist (2) assessed Mr E at the CMHT on 16 August 2005. A diagnosis of persistent delusional disorder with secondary depressive disorder was made. Mr E remained isolated and very depressed. At that stage he admitted to suicidal ideation but denied any thoughts of harming others.

1.35 In August the possibility of further CPN contact was mooted and a CPN (3) had some initial contact with Mr E during September and October. Mr E did not feel he would benefit from seeing a CPN so he was discharged from

CPN contact on 21 October 2005. The staff grade psychiatrist (2) followed up Mr E again on 19 October when the impression was one of ongoing mono-symptomatic persistent delusional disorder in the context of secondary depressive illness. When Mr E was seen again by the staff grade psychiatrist (2) on 28 December the psychiatrist had no cause to change that view. At the meeting with the psychiatrist Mr E had become more amenable to the possibility of CPN involvement in his care and treatment.

1.36 On 25 January 2006 contact with a CPN (3) was resumed. There were a total of 26 home visits conducted by the CPN (3) during the course of 2006 until 2 October 2006 when Mr E telephoned the CMHT to thank the CPN (3) but to say he no longer wanted visits from her. Mr E subsequently cancelled two further appointments with the CPN (3) and was discharged from CPN contact on 10 November 2006.

1.37 On 24 January 2007 Mr E visited his GP who noted that he was due to see a staff grade psychiatrist at the CMHT. Mr E needed a formal referral letter to the psychiatrist and that was provided by the GP. Later that day a staff grade psychiatrist (2) saw Mr E and subsequently CPN (3) began to visit Mr E at home. The first visit was on 12 February 2007 and in the following five months the CPN (3) visited Mr E at home on a further 17 occasions the last occasion being 30 July 2007.

1.38 Mr E had his last outpatient appointment with a psychiatrist when he saw the staff grade psychiatrist (2) on 28 March 2007, who was going on maternity leave from April 2007. Responsibility for Mr E was not formally transferred or re-allocated to another psychiatrist, although the Trust has pointed out that responsibility for the care of Mr E would have automatically fallen to the Consultant Psychiatrist in post at the time.

1.39 We noted that there was no point during his contact with the CMHT, other than the apparently inconsequential carer's assessment undertaken in September 2004, when members of Mr E's family were engaged. In particular there was no social worker referral in relation to support for the family. Given

that Mr E was living with his parents, their knowledge of his circumstances, the level of their interaction with him, their concern about him and the resulting stress upon them, that was a failing.

1.40 On 6 August 2007 Mr E was arrested for the homicide of Mr V.

Diagnosis, care and treatment by mental health and social care services

1.41 Initially Mr E had been receiving treatment for a number of complaints from his GP. At the surgery his low mood had been identified and in July 2002 referrals to mental health services resulted from the GP's assessment that Mr E was subject to depression.

1.42 Mr E had his first substantive adult contact with psychiatric services when he was admitted to the Intensive Care Unit (ITU) at Royal Gwent Hospital on 13 August 2003.

1.43 Case notes show that on admission to ITU, although he was being investigated for neurological disorder, it was also thought that he may have taken a drug overdose. At this point it was not clear whether that might have been accidental or intentional. His presentation, once fully conscious, led to an assessment by liaison psychiatry staff and thereafter more substantial contact with the Newport East CMHT. The initial view was that Mr E displayed features of depression.

1.44 It was only after he had been discharged from hospital that toxicology results revealed that Mr E had indeed had a high, toxic level of the anti-depressant Dothiepin in his blood, a drug he had been prescribed for his depression. In the light of discussion with Mr E who had retrospectively constructed a view about the use of his medication, the Review Team believes that to have been the result of an accidental overdose resulting from a belief on Mr E's part that as the medication worked it would do so even quicker if he increased the number of tablets he took.

1.45 When discharged from hospital he returned to live with his parents. At this time he appears to have been in the 'grip' of an early psychotic illness. He has given a story of seeing cameras in the lamp-posts outside his parents' house. He described distinct experiences of people in the street laughing and talking about him, possibly pointing but these symptoms were not yet specific and relating to any particular individual. During this time he had the features of what could be described as delusional mood. There is an indication from his history, that these vague beliefs crystallised at the end of the second week that he was home after his discharge from hospital, possibly after he met Mr V in a local hardware store, and then they developed into a fully blown delusional belief that he had been secretly filmed on video by Mr V and the landlord. That belief system has since been unchanged and has been held with almost unchanging intensity throughout the course of Mr E's illness.

1.46 The diagnosis made by the clinical team at the CMHT was 'psychotic depression' followed by a more consistent diagnosis of 'persistent delusional disorder'. Subsequent to the homicide, the Caswell Clinic (the Medium Secure Unit in South Wales) has made a diagnosis of 'schizophrenia'.

1.47 Taking into account the course of a psychotic disorder, at the time of his admission to hospital ITU following the apparent overdose, the presence thereafter of ideas of reference, possible auditory hallucinations and the development of a fixed persecutory delusional belief, there is strong support for the diagnosis of schizophrenia. Clearly periods of disturbance of mood have been a feature throughout.

1.48 Mr E had been prescribed a number of different anti-depressants prior to his hospitalisation in 2003. Subsequent to the diagnosis of a psychotic element to his disorder, following his discharge from hospital, he was placed on anti-psychotic medication as well as anti-depressants. The use of anti-psychotic medication with the addition of anti-depressants to treat a disturbance of mood would be the typical medication prescribed as part of an overall treatment regime for schizophrenia, delusional disorder or, indeed, psychotic depression. However a key feature of Mr E's treatment was his

non-compliance with medication regimes. The medical records show many occasions upon which, concern was expressed about Mr E failing to take medication.

1.49 The CMHT supported the medication regime upon which Mr E had been placed by providing contact with a CPN. For example in the years 2006 and 2007 there were a total of 43 face to face contacts between Mr E and a CPN, the vast majority taking place at his home.

1.50 The three CPNs who had contact with Mr E encouraged compliance with his medication, supported his attendance for assessments at the CMHT, monitored his progress and assessed the risk he presented. They worked with him to minimise his preoccupation to the exclusion of all else with his delusional beliefs and encourage other interests and activities outside his home. The effectiveness of those approaches was again limited by the extent to which long term consistency was achievable, in part because there were periods of time when Mr E did not wish to have contact, but also because of the strength and consistency of the delusions he experienced and the limited monitoring of compliance with medication afforded through weekly or monthly visits.

Leadership, Management and Staffing of Mental Health Services provided to Mr E

1.51 Mental Health Services were provided to Mr E by GPs working in primary care and secondary care services provided by Gwent Healthcare NHS Trust.

Primary Care Services

1.52 Mr E had considerable face to face contact with his local GP surgery prior to August 2005, but very little between August 2005 and August 2007. Most of his visits related to physical ailments which received appropriate attention from GPs working at the Practice.

1.53 In the course of their contact with him, the attention of GPs had been brought to Mr E's state of mind, in particular from July 2001 when he appeared to be suffering from depression. Appropriate medication was provided and a referral was made to the CMHT. Throughout the remaining period until the homicide GPs continued to provide prescriptions for medication aimed at treating his mental illness. GPs played a central role in ensuring the re-referral of Mr E to the CMHT on two occasions when he had been discharged from CMHT services or had stopped contact with CPNs (October 2002 and January 2007).

1.54 Annual medication reviews were conducted by the GP Practice in relation to Mr E's drug regime. However those reviews did not include face to face discussion with Mr E. Liaison between primary and secondary care services took place by means of letter, which is reasonably standard practice between GP Practices and hospital doctors. There was no regular formal or informal face to face liaison between the GP Practice and the CMHT as sometimes takes place elsewhere at CPN level.

Secondary Care Services

1.55 Although there were occasions upon which in-patient care and treatment was explored for Mr E, other than the period of two weeks that he spent in intensive care as a result of the overdose in 2003, Mr E did not spend any period of time in a psychiatric hospital.

1.56 He was seen twice by a hospital based staff grade psychiatrist as part of the liaison service which visits the Royal Gwent Hospital when requested:

- Once whilst in the intensive care unit; it was that assessment which prompted the engagement of the CMHT with Mr E in August 2003.
- Again in July 2004 when the possibility of an in-patient bed was being explored.

1.57 The major part of Mr E's care and treatment rested with the Newport East CMHT.

1.58 From the point at which Mr E was first referred to the CMHT in July 2002 until the homicide occurred in August 2007, a number of factors relating to Newport East CMHT are relevant:

- Staffing.
- Workload.
- Organisation and Systems.
- Leadership and Management.

1.59 We comment upon each of these below.

Staffing

1.60 CMHTs were designed to bring together specialist mental health staff from the secondary care sector and social work staff trained in care of those suffering from mental health problems. Successful work with mental health patients in the community requires coordinated responses from both health services and social services.

1.61 There had been a number of changes to the CMHT staffing between 2002 and 2007 and either as a result of illness or delays in filling posts, for significant periods there was no substantive Consultant Psychiatrist in post to provide services within the team. A number of middle grade psychiatrists had held locum roles within the team and the one staff grade psychiatrist who was consistently in post throughout the period had two substantial periods of absence, once because of ill health and then because of maternity leave.

1.62 A key impact of this situation was that middle grade psychiatrists were for the most part unsupported by senior staff. Other than for one assessment conducted by a locum consultant psychiatrist, at no point was Mr E seen by a

substantive consultant psychiatrist. The attention of Gwent Healthcare NHS Trust had been drawn to this matter but we could find no evidence of a satisfactory response to these difficulties having been put in place until the appointment of the current substantive Consultant Psychiatrist in September 2005. We also noted that the Consultant Psychiatrist in post at the time of our Review was also the Clinical Director of Adult Psychiatry in the Trust. There was no cover for the time that his Clinical Director duties took him away from duties at the CMHT. We were told that that did have an impact upon his role at the CMHT, for example he was unable to attend all of the CMHT meetings.

Workload

1.63 Interviewees said that the CMHT workload throughout the period from 2002 to the time of our Review had been high. We were told that the Newport East CMHT was dealing with the most morbid and transient population in Gwent and that, at the time of our Review, the Team was managing 105 patients, subject to enhanced CPA.

1.64 Clinically, Mr E had not, on the surface, presented evidence of the extent of problems or, more importantly, the level of risk posed by many other patients being supervised by the CMHT. Therefore, he had not come to the attention of the Consultant Psychiatrist and he was not subject to the enhanced Care Programme Approach (CPA) (see below). Risk Assessments undertaken by the CMHT had not highlighted a concern.

Organisations and Systems

1.65 During the course of our Review it was apparent that there were deficiencies in respect of the organisation and systems of the Trust. These were evident in relation to:

- CPA – The Care Programme Approach[2] had been poorly developed within the CMHT. We found that in respect of Mr E he should have been subject to enhanced CPA but there was no evidence that he had been. That was one factor which made it less likely that his needs would come to the attention of a Consultant Psychiatrist or be discussed as part of multi- disciplinary team meetings (MDT).
- MDT – Multi-Disciplinary Team Meetings had not been well organised. Any member of the team was able to raise a case for discussion, but the only cases systematically brought before the MDT were new referrals. Records show that Mr E was discussed at the MDT only twice, both occasions being in 2004.
- Support and Supervision of Staff – Arrangements for the support and supervision of staff were not optimal. As far as the middle grade medical staff are concerned some of the difficulties are set out above. Routine supervision or the opportunity for consultation with Consultant Psychiatrists was not available. The team management arrangements meant that the supervision of other staff was rather ad hoc. There was some resentment among health service staff in relation to the Team Leader role being held by a member of Social Services staff. Limited management supervision and several lines of professional accountability and supervision have done little to forge a united Team or assist morale.
- Risk Assessment and Management – From 2002 until recent changes were introduced the arrangements for risk assessment and management in the Trust had been weak. The Trust had adopted a formal risk assessment system but training to use the system had been patchy (at the time of our fieldwork we met a number of staff who had received no training). At the time of our visit there was evidence of this having improved; a risk strategy was in place which included training for staff in how to conduct a

[2] See Annex G

clinical risk interview, clear pathways had been developed to assist staff to take appropriate steps following the identification of a risk (including a high risk pathway for those who said they might kill someone), auditable paperwork had been introduced and a clinical risk reference group established. But further work is necessary.

- Record Systems – Record systems were poor. When the Consultant Psychiatrist joined the CMHT he could not, from the records available, identify how many cases the CMHT was dealing with. We found that CPA records were not good and there was still no system for highlighting when a CPA review was due and to alert managers when it had not been completed. Further, while the CMHT had identified the most serious cases which would be discussed on a rotational basis there were no systems in place for highlighting other cases which needed to be discussed with colleagues if work with patients such as Mr E was to be optimised.
- External liaison – there were no face to face liaison arrangements in place to link the CMHT to primary care services.

Leadership and Management

1.66 CMHTs provide a setting in which health and social services staff come together to provide seamless, integrated services to people with severe or enduring mental health problems. As well as opportunities that presents particular challenges as typically, in addition to the bringing together of two organisations, CMHTs also bring together a range of professional expertise.

1.67 In Newport East CMHT Social Workers, Doctors, CPNs and Psychologists each had their own professional supervision lines, which is not unusual. In terms of day to day management social workers, CPNs and Psychologists were managed by the CMHT Team Leader. However, that role was not well developed. The post holder, drawn from social services staff, also had a wider role within the social services department, carrying responsibility for all specialist mental health social workers within the local

authority. That meant there was no full time team leadership of the CMHT. It was clear to us that the team leader role within the team had been accorded little authority and the impression was one of a vacuum of management and leadership which at least in part, accounted for the lack of grip upon the organisational and systems issues commented upon above.

1.68 Medical leadership within CMHTs is usually provided by a Consultant Psychiatrist. Owing to illness and delays in making appointments Newport East CMHT had experienced an absence of consultant psychiatrist input for much of the time Mr E was receiving care and treatment. At the time of our Review the Clinical Director responsibilities were found to be reducing the amount of time the current Consultant Psychiatrist had available to provide leadership to the team.

Chapter 2: Findings

Predictability of the homicide

2.1 We do not consider that the homicide committed by Mr E was predictable. There had been no indication either from Mr E himself, or from health and social services' experience of him, that indicated a violent nature.

2.2 However, the nature of Mr E's symptoms was a significant warning of increased risk, either to himself or others, albeit perhaps not specifically of the tragic incident that did occur. Had Mr E been engaged more assertively in care and treatment, his history would have been different and that may have led to the likelihood of any homicide being averted. Although Mr E's beliefs relating to Mr V were known, and had been repeated regularly and remained unchanged over a long period of time, the seriousness of those beliefs do not appear to have been identified and linked to his mostly untreated psychosis. Had that link been made it may have prompted more assertive, probably inpatient, care and treatment.

2.3 There were flaws in the arrangements for the care and treatment of Mr E, in particular the absence of assertive management of his treatment and the failure to mobilise a wider range of intervention under an enhanced care programme approach. Support should have been offered to his parents as his main carers. We comment further upon these matters below.

Contact between Mr E and Mental Health Services

2.4 We found that initial attempts to obtain psychiatric assessment for Mr E had been diligently pursued by the Primary Care Practice. Those attempts had been thwarted as a result of Mr E's failure to attend appointments offered by the CMHT. However we question the policy in place at the CMHT at the time which meant that following failure to attend an initial offer of appointment a patient would be discharged. We believe that further exploration of the

importance of the referral with the GP practice would have been appropriate. Similarly in relation to the second referral from the GP we believe there was a case for the CMHT to have done more than offering appointments by letter and that a home visit might have been considered at that stage. It may be that had that taken place, Mr E would have been encouraged to receive treatment before the incident of the accidental overdose in 2003.

2.5 Once contact had been established with the CMHT, following the accidental overdose, it was sustained, with only short periods during which Mr E declined contact, up to the time when the homicide occurred. That contact focused upon encouraging Mr E to comply with medication, supporting him to engage in activities and developing techniques to minimise the impact of his delusional ideas. While it contained an element of monitoring compliance with medication, weekly or monthly contact could not provide the intensity of oversight which might now be provided by the Crisis Resolution or Home Treatment Team.

2.6 We are concerned about the absence of Consultant Psychiatrist input into the case of someone who, in retrospect, was a seriously ill patient. Setting aside the benefits of hindsight we believe systems should have been in place which would have brought Mr E to the attention of a more senior and experienced practitioner.

Diagnosis and Medication

2.7 Throughout the period that the CMHT worked with Mr E the diagnosis had consistently featured both psychosis and depression. Medication was prescribed to manage both aspects of his condition. After the homicide the diagnosis provided by the Caswell Clinic was one of schizophrenia. While a diagnosis of schizophrenia may not have led to any different medication, we believe that had a diagnosis of schizophrenia been made earlier it may have led to a more assertive approach to treatment, including admission to hospital, even if that had been against Mr E's wishes at the time.

2.8 We do not believe that diagnosis or medication decisions were inappropriate in Mr E's circumstances. However we take the view that Mr E's spasmodic non-compliance with medication was known to staff at the CMHT, and that his care and treatment might have been dealt with in a more assertive manner, on that basis alone.

CPA and Risk Assessment

2.9 CPA was poorly developed within the CMHT. There was a failure to make Mr E subject to enhanced CPA arrangements and we take the view that, that was a significant failure. It perhaps highlights a weakness of any structured system that, by dint of the fact that a patient is not placed on enhanced CPA there was then no formal failsafe mechanism through which he would be discussed by the whole CMHT including those with the most significant experience. Had Mr E been subject to enhanced CPA that should have prompted a greater measure of discussion amongst the team about his care and treatment. It might, for example, have led to the facts about his isolation for four years becoming known to the Consultant Psychiatrist whose experience may have led him to draw different conclusions about risk and the need for intervention in Mr E's case. It might also have led to more engagement with Mr E's parents by the CMHT.

- Risk Assessment arrangements were in place in the Trust and risk assessments were undertaken in respect of Mr E. However they were not reviewed with the frequency we would expect and documentation was not always completed.

Assertive Care and Treatment

2.10 We have noted the factors commented upon in this report which together have convinced us that there was a lack of sufficient assertiveness in the care and treatment of Mr E. Examples are:

- The early failure to follow up failed appointments.
- The fact that Mr E's family were not engaged in the arrangements for Mr E or offered social work support during what must have been a very difficult time for them. While we appreciate the necessity for appropriate patient confidentiality, we do not believe that would have precluded such engagement.
- The inability to follow up the matter of compliance with medication more robustly.
- The acceptance that from time to time Mr E would discontinue contact with CPNs, without apparently considering the need to ensure contact including the possibility of compulsory in-patient treatment under the Mental Health Act 1983.

Systems and Procedures in the CMHT

2.11 We are critical of record systems within the CMHT during the period Mr E was receiving care and treatment. It would appear that basic management data was not available to the extent that it was not even clear how many patients the Team was managing. There was no system for alerting staff to the need for CPA reviews, nor to inform managers whether those had been completed. While technological solutions to ensure good recording systems are helpful their absence should not be a bar to good practice.

2.12 MDT meetings considered new referrals and individual cases could be brought to the MDT by any member of staff but there was no procedure for the systematic consideration by the MDT of all cases receiving treatment. If that was precluded by the size of the team workload then there should have been stratification of cases by risk and need so that those needing priority could be formally identified and routinely reported upon at MDT meetings.

2.13 Arrangements for the supervision and support of staff within the CMHT were not adequate. With regard to Mr E's case middle grade psychiatrists were unsupported by Consultant level input and while there was some

discussion of the case between the CPNs involved in Mr E's care, the staff grade psychiatrists and the psychologist at the CMHT, there were only two occasions on which the case was discussed at a CMHT.

2.14 The post of Team Leader had not been properly developed. The authority that the role should carry was undermined by the attitudes of staff within the team towards the post and the post holder. Ideally we would have expected to see evidence of the Consultant Psychiatrist and the Team Leader working together to provide leadership to the team and to establish the systems, processes and procedures necessary for the efficient and effective management of the workload. Management supervision of the whole team should be focused on these roles. That does not preclude a role for professional supervision but the Trust needs to be clear about the differentiation of the role of professional supervisor and the management line.

Root Causes of the Deficiencies in the Services provided to Mr E

2.15 In summary we consider the following to be the root causes of the deficiencies of service we have identified in this report:

- Ineffective leadership and management systems operating within the CMHT.
- Poor implementation of CPA.
- Lack of an assertive approach to the care, treatment and monitoring of Mr E.
- Failure to recognise the needs of Mr E's carers and put in place support for them.

Chapter 3: Summary Recommendations

3.1 In view of the findings arising from this review we recommend that:

1. In relation to Leadership / Management Aneurin Bevan Health Board should, in collaboration with its Local Authority partners:

   a) Put in place systems to inform senior managers in both organisations about issues arising in relation to workload, team capacity, performance management.

   b) Take steps to improve the leadership and management resources within the CMHT, in particular when leaders within the CMHT are expected to undertake wider corporate roles.

   c) Ensure clarity about the requirement for high level leadership and management skills, not predicated upon a particular professional background, in the CMHT Team Leader role and take steps to ensure the post holder carries the appropriate authority to discharge the role effectively.

   d) Develop and implement an effective and robust caseload management supervision policy, consistent with development of the recovery model.

   e) Set out and implement a vision and strategy for seamless, integrated services to mental health service users.

   f) Ensure that policies and procedures, together with the introduction of resources such as the Home Treatment Teams, address the need for assertive care and treatment arrangements for patients when such are justified, including when appropriate at the referral stage of care.

2. Aneurin Bevan Health Board should take steps to improve the quality of planning for care and treatment using CPA in particular by:

    a) Taking steps to improve the implementation of CPA and establishing monitoring/auditing arrangements to monitor compliance.

    b) Providing staff training focused on developing the skills required to deliver and improve care within the framework of CPA, and take steps to ensure that in other training the relationship of CPA to successful practice is highlighted.

    c) Producing clear guidance, in line with WAG policy concerning the criteria for enhanced CPA, and ensuring that understanding of staff about when enhanced CPA should be used.

    d) Ensuring risk management is well integrated into CPA process.

3. In relation to Risk Assessment and Management Aneurin Bevan Health Board should make a clear decision about the tool to be used for this purpose, confirm an apparent decision to deploy the services of the Welsh Applied Risk Research Network (WARRN) and:

    a) Secure the resources necessary for implementation of the new system.

    b) Ensure the necessary training is put in place for all staff.

    c) Monitor the impact of training.

    d) Audit compliance with its arrangements for risk management.

4. Aneurin Bevan Health Board should:

    a) Develop clear written guidance for staff about dealing with patient's families, including how to draw them into appropriate and helpful collaboration with care and treatment of patients and how family members should be supported when their family member (the patient) may be placing them in difficult and stressful situations. The guidance should include information about how to deal with issues relating to confidentiality. The purpose of this guidance should be helping staff to have confidence in engaging with families assertively.

    b) Audit the use of carers' assessments, and the implementation of action plans derived from such assessments, to ensure they are conducted at an early stage in the care and treatment of patients, whether they are subject to standard or enhanced CPA.

5. Aneurin Bevan Health Board should review its arrangements for sharing information and active liaison between primary and secondary care services in relation to mental health patients. A specific responsibility should be identified within CMHTs for liaison with Primary Care, drawing upon experience elsewhere in Wales.

6. In order to maximise and encourage patients' compliance with medication regimes, Primary and Secondary Care services should ensure good communication and ensure that medication reviews are undertaken regularly, with patient involvement.

Chapter 4: Postscript

4.1 In October 2009 HIW received an updated action plan from the newly formed Aneurin Bevan Health Board reflecting progress that the organisation has made since August 2007 against the recommendations made in this report. A full copy of this action plan is available on the HIW website: www.hiw.org.uk

4.2 The action plan demonstrates that the Health Board has made significant progress in addressing the recommendations that we have made, these include:

- The implementation of monthly multi-disciplinary meetings involving senior clinicians.
- Provisions made for the improved management of Newport East CMHT including clarification of the Team Leader role and additional consultant.
- The implementation of a Locality CPA (Care Programme Approach) Board and a pan-Gwent CPA Board, with systems in place to identify service users requiring enhanced CPA.
- WARRN (Welsh Applied Risk Research Network) training now provided to all staff with 75% of staff having received this training.
- A newly agreed model for a First Access Service for Newport to improve liaison between secondary and primary care.

4.3 Whilst progress has been made in many areas, there is still work to be done in relation to the introduction of a robust caseload management system; the approval of a new service model for the Newport locality; and the development of specific guidance for staff about dealing with patients' families.

4.4 We have been assured by the Chief Executive of the new Aneurin Bevan Health Board that it will maintain and carry forward the progress demonstrated in the action plan, and will ensure that the changes made are fully embedded across the new organisation.

Annex A

Terms of Reference for the Review

The aim of the review was to:

- Consider the care provided to Mr E as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on 4 August 2007[3].
- To review the decisions made in relation to the care of Mr E.
- To identify any change or changes in Mr E's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 4 August 2007.
- To produce a report detailing relevant findings and setting out recommendations for improvement.
- To work with key stakeholders to develop an action plan (s) to ensure lessons are learnt from this case.

[3] As part of this exercise consideration was also given to the social history of Mr E.

Annex B

Review of Mental Health Services following homicides committed by people accessing Mental Health Services

In England and Wales there are approximately 52 homicides each year committed by people who were suffering from mental illness at the time of the offence. That amounts to 10% of murder and manslaughter cases dealt with in our courts. Of all perpetrators convicted of homicide each year, approximately 97 (18%) of them have had contact with mental health services during their lifetime.

It is of course a matter for the criminal justice system to ensure that investigation and adjudication is undertaken in respect of those homicides. However it is proper that each incident is also examined from the point of view of the services put in place to provide care and treatment to those who experience mental health problems. In Wales, the Welsh Assembly Government has expected an independent external review into every case of homicide committed by a person with a history of contact with mental health services.

The reports of the independent external reviews feed into the wider review process of all such homicides in the UK undertaken under the auspices of the NPSA and conducted by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

Arrangements for reviews in Wales

Until 2007 independent external reviews into homicides by those experiencing mental health problems were commissioned by Local Health Boards. The investigations themselves were conducted by review teams brought together from third party health bodies or through commissioning from the private/independent sector.

From January 2007 all independent external reviews in these cases are to be undertaken by Healthcare Inspectorate Wales. Where the services reviewed include social services, then arrangements are made to include Social Services Inspectors from Care and Social Services Inspectorate Wales in the review team.

Annex C

Arrangements for the review of Mental Health Services in respect of Mr E

Reviews and investigations by HIW draw upon the methods, techniques and skills which will be most efficient and effective according to the nature of the matter to be investigated, its extensiveness and any constraints of time or other resources. However HIW recognises the importance of structured investigations and is committed to the use of 'Root Cause Analysis' (RCA) to provide a formal structure for investigations, which may be adapted if circumstances make that appropriate. In taking forward this review HIW has ensured that the general principles which apply to investigation and upon which RCA provides guidance, have been followed and has made use of a number of the tools contained within RCA.

In its request to HIW to undertake this review the Welsh Assembly Government's Department of Health and Social Services indicated its support for an approach to the review which would make use of RCA.

RCA brings together much of the best practice informing investigation processes. Through its use, the root causes for an undesired outcome can be identified and actions designed to prevent or reduce the likelihood of reoccurrence produced. Root cause analysis concerns itself with systems and reviews using the approach to continue to 'drill down' through the perceived causes of an incident until originating organisational factors have been identified or until data are exhausted. Developed in the field of engineering, RCA helps professionals in a wide range of settings, who might otherwise be unfamiliar with investigation methods, to determine: what happened, how it happened and why it happened. It is designed to encourage learning from past problems, failures and accidents and to eliminate or modify systems to prevent future occurrences of similar incidents. It provides a template for the non-professional investigator which ensures a

systematic approach to investigation built upon good investigation practice and for those with more experience is a helpful checklist of necessary investigation steps and provides a ‘tool box’ of techniques which have proven success in uncovering root causes of events.

In the UK, RCA has been adapted for use in NHS by National Patient Safety Agency (NPSA). In addition to developing RCA for use in the Health Service NPSA provides training for NHS staff in the use of RCA and is responsible for collating reports of incidents and providing national guidance and solutions in respect of problems identified from that work. The NPSA’s work currently incorporates: The National Clinical Assessment Service (NCAS); The National Research Ethics Service (NRES) - formerly COREC; The National Confidential Enquiry into Patient Outcome and Death (NCEPOD); The Confidential Enquiry into Maternal and Child Health (CEMACH); The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH); and NHS Estates (safety aspects of hospital design, cleanliness, and food).

This investigation commenced with the identification of the type of expertise which would be necessary to undertake the review. A review team was established which provided the range of skills and knowledge required. The team consisted of:

Dr D Roy	Consultant Psychiatrist
Dr R Hall	GP
Mr D Furze	Mental Health Nurse
Ms G Griffiths	Lay Reviewer, HIW panel
Mr M Frost	Investigations Manager, HIW
Mr R Jones	Investigations Officer, HIW
Ms J Fellows	Investigations Coordinator, HIW

In addition, Mrs J Lewis, Social Services Inspector, Care and Social Services Inspectorate Wales (CSSIW) review documentation and provided advice.

The information gathering phase of the review was conducted between 11 and 14 November 2008. It consisted of:

- Examination of documents relating to the organisation and delivery of services by Gwent Healthcare NHS Trust together with papers provided by the Local Health Board, and a GP Practice.
- Reading the case records maintained by Health Bodies and Local Authorities concerning Mr E.
- Reading interview notes and written statements provided by staff working with Mr E which were provided as part of the police or internal investigation processes.
- Interviewing key people particularly those with strategic responsibility for the delivery of services within health and social services, but also extending to Mr E and his family and Gwent Police Service.

The information was processed by the HIW in-house investigation unit. In addition, all members of the review team read all the material generated by the review.

The analysis stage was taken further forward by the review team in a series of de-briefing meeting during the fieldwork phase. The conclusion of that process was to determine the extent to which systems or processes may be put in place to prevent further occurrences and the nature of those systems or processes. The results of that stage are set out in this report as findings and recommendations.

Annex D

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- Making a significant contribution to improving the safety and quality of healthcare services in Wales.
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee.
- Strengthening the voice of patients and the public in the way health services are reviewed.
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Assembly Government and healthcare providers that services are safe and of good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systemic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales, the Local Supervising Authority for the Statutory Supervision of Midwives and is responsible for monitoring approved nurse education programmes provided by higher education institutions in Wales.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003.
- Care Standards Act 2000 and associated regulations.
- Mental Health Act 1983 and the Mental Health Act 2007.
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001.
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Annex E

Guidance relating to Mental Health Services in Wales

Adult Mental Health Services for Wales states:

> *"The vision of the strategy requires a broadening of the concept of mental health, away from a purely illness and disease approach to one that makes the links between good mental health, poor mental health and the quality of life of individuals and communities. The response to the mental health needs of people in Wales can no longer revolve solely around the notion of services. Links must be made between the individual and the wider environment-addressing the social and economic determinants of poor health".*
>
> *"The Advisory Group report identified the need for mental health services to be considered in the widest possible sense. Housing and employment are vital components of a mental health services that aims to improve the social inclusion of people with mental illness. Mental health services need to adopt a holistic approach and services should be designed to fit the needs of users and their carers. Users should not have to fit in with what services provide. Positive, imaginative health promotion must be a major plank in any attempt to improve services".*

The terms used in this strategy are summarised here:

- *"Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the development of concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental, family or illness factors. Mental Health Problems describes a very broad range of emotional or behaviour difficulties that may cause*

concern or distress. They are relatively common, may or may not be transient but encompass mental disorders, which are more severe and/or persistent".

- *"Mental Disorders are those problems that meet the requirements of ICD 10, an internationally recognised classification system for disorder. The distinction between a problem and a disorder is not exact but turns on the severity, persistence, effects and combination of features found".*

- *"In a small proportion of cases of mental disorders, the term mental illness might be used. Usually, it is reserved for the most severe cases. For example, more severe cases of depression illness, psychotic disorders and severe cases of Anorexia Nervosa could be described in this way".*

Successful implementation of the strategy will depend on:

- *"Timely and appropriate assessments for all patients and for those with complex needs, the provision of formal written care plans that will be subject to regular review".*

This document is designed to provide a framework for mental health services that have the following aims:

- *"To ensure close co-operation between social services, health authorities and voluntary and private sectors in order to commission effective, comprehensive and co-ordinated mental health services".*

- *"To assess the medical, psychological and social needs of service users and carers at an appropriate time and with reviews at regular intervals".*

- *"To protect users, carers and the public from avoidable harm while respecting the rights of users and their carers".*

"The 1989 strategy stated that the severely mentally ill are a priority for secondary mental health services. Mental health services also have an important role in providing and supporting primary care in helping them to treat other mental illness. Some effective treatments, such as formal psychotherapies, are not available in primary care. Primary care also needs help with difficult or chronic cases and in the management of uncommon conditions. When resources are scarce, there is a tendency for mental health services to provide a ''psychosis only'' service. We believe this trend acts against the interests of all users, can reduce psychological treatment skills and would provide an unsatisfactory service for primary care. The policy that 80% of the workload of a mental health service should be with the severely mentally ill captures the sense of priority but guards against the possibility if too narrow a focus. Definition of severe mental illness in this context should take into account not only diagnosis but also the level of distress and disability that the individual is experiencing".

Mental Health Policy Guidance: The care programme approach for mental health service users, commenting upon the value of the care programme approach (CPA), states that:

"Services therefore need to be:

- *Effective in using care processes".*

Evidence and experience has shown the benefits of providing well co-ordinated care to those suffering with mental health problems. Mental health service users, particularly those with more complex and

enduring needs, often require help with other aspects of their lives such as housing, finance, employment, education and physical health needs. This places demands on services that no one discipline or agency can meet alone and it's therefore necessary to have an integrated system of effective care co-ordination for all services to work together for the benefit of the service user".

The care programme approach recognises two levels, the standard level and the enhanced level. The enhanced care programme approach should be used for those who present with all or some of the following:

- *"Multiple care needs, including housing, employment etc, requiring interagency co-ordination.*
- *Willing to co-operate with one professional or agency, but have multiple care needs.*
- *May be in contact with a number of agencies (including the criminal justice system).*
- *Likely to require more frequent and intensive interventions.*
- *More likely to have mental health problems co-existing with other problems such as substance misuse.*
- *More likely to be at risk of harming themselves or others.*
- *More likely to disengage with services".*

Standard seven of the National Service Framework set a target of achieving full introduction of CPA across Wales by December 2004, although it was hoped that sufficient progress would be made for the target to be met by December 2003. The National Service Framework also recognised that,

''authorities will need to ensure a fully integrated approach to the CPA and the health and social services Unified Approach to Assessing and Managing Care''.

Annex F

The Mental Health Act, 1983

Part II, section 2 of the act sets out the grounds upon which an application may be made for a patient to be admitted to a hospital and detained there for up to 28 days for the purposes of assessment:

2 (1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with sub-sections (2) and (3) below.

(2) An application for admission for assessment may be made in respect of a patient on the grounds that:

(a) He is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period.

(b) He ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

Part II, section 3 (2) of the Act sets out the grounds upon which an application may be made for a patient to be admitted to a hospital and detained there for treatment:

> *"An application for admission for treatment may be made in respect of a patient on the grounds that:*
>
> *(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*
> *(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and*
> (c) *it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section"*.

These two sections provide a test against which any decision to seek the admission to hospital of Mr E against his wishes would have had to be determined.

Annex G

Chronology

TYPE OF ACTIVITY	1964	2002						
	9 June	February	July	August		October		
CMHT / INPATIENT				Letter sent offering appointment [01.08.02]	Discharge letter sent to GP - DNA [13.08.02]		CPN #2 writes to Mr E offering appointment for 28.10.02 [21.10.02]	Apointment rearranged for 29..10.02
DOCTORS / CPNs		DNA - Failed to respond to request for counselling - DISCHARGED [26.02.02]		CPN #1		DOC #1	CPN #2	
GP		DNA - Failed to respond to request for counselling - DISCHARGED [26.02.02]	Referral to CMHT - Mr E suffering from depression for 11months [25.07.02]		Discharge letter sent to GP - DNA [13.08.02]	Referral letter sent to DOC #1 [10.10.02]		
ACCOMODATION	Mr E Born in Newport	16 Summerhill Avenue, Newport						

The review team produced a timeline to assist its understanding of the interactions between events and services relating to Mr E. This summary timeline is provided to supplement the evidence contained in the body of the report and demonstrate one way in which information available to the review team has been analysed.

2002					2003			
November	**December**				**July**	**August**		
Appointment re-arranged for 02.12.02 as Mr E could not attend [04.11.02]	DNA [02.12.02]	Letter to Mr E offering appointment for 09.12.02	DNA [09.12.02]				Mr E admitted to RGH due to suspected overdose [13.08.03]	
							DOC #2 assesses Mr E at RGH - Letter to DOC #1 and GP outlining outcome of assessment [28.08.03]	DOC #3
				Mr E discharged to GP due to DNA at CMHT [18.12.02]				
					Mr E moves to live in hostel [3 Clifton Place]	Mr E conversation with caretaker - says is depressed - he is advised to make apt with GP [12.08.03]		

2003								
September		**October**		**November**		**December**		
Domiciliary assessment by CPN #2 - Risk Assessment suicide indicator - low score [03.09.03]	Mr E seen in outpatients by DOC #4 and CPN #2 [13.09.03 & 15.09.03]			Letter to Mr E rearranging apt for 15.12.03 [06.11.03]	CPN #2 notes: Mr E no longer wants CPN input - discharged [07.11.03]	Mr E seen by DOC #4 in clinic - DOC requests CPN input [15.12.03]	Mr E re-registered onto CPN caseload (CPN #3) [18.12.03]	Mr E seen by DOC #4 - "Significant relapse" [22.12.03]
DOC #4							CPN #3	
		Letters from DOC #4 to GP - no change in Mr E's mental state [07.10.03 & 17.10.03]			Mr E discharged by CPN #2 [07.11.03]			
		16 Summerhill Avenue	64 Stockton Close					

2003	2004							
	January		February	March				April
CPN #3 sees Mr E at home [24.12.03]	CPN #3 sees Mr E at home [06.01.04]	Mr E due in clinic - cancelled as ill, rearranged for 03.03.04 [19.01.04]	Mr E seen at home by CPN #3 [11.02.04, 17.02.04, 25.02.04]	Mr E called CPN #3 asking not to be picked up for outpatient apt [03.03.04]	Mr E DNA appointment with DOC #3	Domiciliary visit: DOC #3 and CPN #3 [16.03.04]	CPN #3 case discussion with senior Psychologist [19.03.04]	Mr E seen at home by CPN #3 [26.03.04, 05.04.04, 13.04.04]
				DOC #3				

2004								
			May		June			
	Mr E discussed at MDT - care plan discussed with DOC #3 [22.04.04]	Mr E seen at home by CPN #2 [28.04.04]	Home visit cancelled by Mr E [05.05.04] - Mr E spoken to on phone [11.05.04]	Mr E seen at home by CPN #2 [28.05.04]	CPN #2 discussed careplan with Mr E - discussed Mr E at clinical supervision [02.06.04, 05.06.04]	Letter to DOC #2 with update and current plan (discussed at MDT) - Query admission to hospital [23.06.04]	Mr E seen at home [25.06.04]	CPN #2 called Augustus Ward - No beds, possibly one available tomorrow [28.06.04]
Mr E re-registered onto CPN #2's caseload [19.04.04]						DOC #2		

2004								
	July			**August**	**September**			
Mr E discussed at ward round - no bed. Later telephoned Mr E informing of available bed but Mr E reluctant to	Outpatient appointment with DOC #2 - assessment [02.07.04]	Mr E seen at home by CPN #2 [06.07.04]	Mr E contacted - offered bed at St Cadocs - Mr E declined [07.07.04]	Mr E seen at home for standard care plan meeting - decrease CPN visits [02.08.04]	Mr E seen at home by CPN #2 - mental state unchanged. Refer to psychologist and contact MIND and parents	MIND contacted and letter sent to parents re:carer's assmessment [03.09.04]	Carer's Assessment completed with parents - CPN #2 [15.09.04]	Home visit cancelled
	Letter from DOC #2 to GP re:assessment on 02.07.04							

2004								2005
October			**November**				**December**	**January**
Mr E seen at home CPN #2 [08.10.04]	Mr E's mother cancels appointment for Mr E [19.10.04]		DNA - appointment arranged for 18.11.04 [09.11.04]	Mr E cancels home visit [18.11.04]	Mr E seen at home by CPN #2 - Mr E felt he was wasting CPN's time [19.11.04]	Mr E seen at home - mental state unchanged - Mr E suggests no more CPN visits - letter sent to GP [30.11.04]	DOC #5 arranges appointment for 14.01.05 [07.12.04]	CPN #2 collects Mr E for appointment bu clinic cancelled [14.01.05]
		DOC #5						
	Letter to GP informing of completion of carer's assessment [13.10.04]					Mr E seen at home - mental state unchanged - Mr E suggests no more CPN visits - letter sent to GP [30.11.04]		

2005								
February	**March**	**April**	**May**	**August**	**September**	**October**		**December**
Outpatient appointment with DOC #5 - mental state unchanged [21.02.05]		Mr E seen at home - mental state unchanged - non-compliant with meds, refused to have DOC #5 and parents at CPA	Letter to GP & DOC #3 - Mr E not compliant with meds. Mr E unsure about future CPN input [06.05.05]		Letter to GP & DOC #3 - low mood and reluctant to have CPN support [26.09.05]	Mr E feels no benefit from CPN input - Discharged [21.10.05]	Letter to GP from DOC #3 outlining diagnosis [25.10.05]	Letter to GP from DOC #3 - Mr E telephones complaining about new meds [06.12.05]
			DOC #3	CPN #4				
	Letter to GP updating following DOC #5's appointment [22.03.05]		Letter to GP & DOC #3 - Mr E not compliant with meds. Mr E unsure about future CPN input [06.05.05]			Mr E discharged by CPN #4 [21.10.05]	Letter to GP from DOC #3 outlining diagnosis [25.10.05]	

2006								
January		**February**		**March**	**April**	**May**	**June**	
Letter to GP from DOC #3 - Mr E seen at outpatients apt at his request - CPN input re-initiated [05.01.06]	Mr E seen at home - agrees to weekly CPN #4 visits [25.01.06]	Mr E seen at home CPN #4 - agrees to focus on reducing anxiety and stress [01.02.06]	Mr E seen at home by CPN #4 [06.02.06, 20.02.06, 28.02.06]	Mr E seen at home by CPN #4 [07.03.06, 14.03.06, 22.03.06, 28.03.06]	Mr E seen at home by CPN #4 [04.04.06, 21.04.06]	Mr E seen at home by CPN #4 [02.05.06, 09.05.06, 16.05.06]	Mr E seen at home by CPN #4 [02.06.06, 09.06.06]	Mr E cancels home visit [14.06.06]
Letter to GP from DOC #3 - Mr E seen at outpatients apt at his request - CPN input re-initiated [05.01.06]								

2006							2007	
July	**August**	**September**	**October**		**November**	**December**	**January**	
Mr E seen at home by CPN #4 [04.07.06, 12.07.06, 17.07.06]	Mr E seen at home by CPN #4 [02.08.06, 09.08.06, 21.08.06, 23.08.06]	Mr E seen at home by CPN #4 [08.09.06, 15.09.06, 22.09.06]	Mr E calls CPN thanking for input - no longer wants visits [02.10.06]	Mr E discussed in supervision - agreed to contact to arrange CPA discharge meeting [23.10.06]	Letter to GP - Mr E cancelled last two apts so discharged [10.11.06]		Referral to CMHT from GP [21.07.07]	Mr E seen by DOC #3 [24.01.07]
					Letter to GP - Mr E cancelled last two apts so discharged [10.11.06]	Letter to Mr E to complete Mental Health Form (DES) [15.12.06]	Referral to CMHT from GP [21.07.07]	Mental Practice Mental Illness Report (DES) [24.01.07

2007								
February			**March**		**April**		**May**	
Letter sent to Mr E offering home visit on 12.02.07 [01.02.07]	Mr E seen at home by CPN #4 [12.02.07, 19.02.07, 26.02.07]	Post script entry by CPN #4 on risk assessment form from 27.04.05 [19.02.07]	Mr E seen at home by CPN #4 [05.03.07, 12.03.07, 20.03.07, 26.03.07]	Outpatient apt with DOC #3 [28.03.07]		Mr E seen at home by CPN #4 [30.04.07]	Mr E seen at home by CPN #4 [08.05.07]	Mr E seen at home by CPN #4 - angry when first arrived [15.05.07]
					DOC #3 on maternity leave			

2007							
	June			**July**			**August**
Mr E seen at home by CPN #4 [21.05.07, 29.05.07]	Mr E seen at home by CPN #4 - paranoid thoughts [04.06.07]	Mr E seen at home by CPN #4 - anxious - parents away [11.06.07]	Appointment cancelled due to illness [18.06.07]	Mr E seen at home by CPN #4 - unsure if wants continued CPN input [02.07.07]	Mr E discussed in supervision with senior psychologist [03.07.07]	Mr E seen at home by CPN #4 - reasonable spirits [09.07.07, 16.07.07, 30.07.07]	Mr E arrested following index offence [06.08.07]
	Annual Medication Review by practice - patient not seen [05.06.07]						

Annex H

Glossary

Affective Mood Disorder - A mental disorder not caused by detectable organic abnormalities of the brain and in which a major disturbance of emotions is predominant.

Approved Social Worker - An ‘approved social worker’ is a social worker who has received specialist training and who has been given responsibilities under the Mental Health Act 1983 to assess, when requested, whether a person needs to be detained in hospital.

Anti-social Personality Disorder - A personality disorder marked by a lack of ethical or moral development. Common behaviour seen in people with this disorder includes crimes against society, aggressiveness, inability to feel remorse, untruthfulness and insincerity, unreliability, and failure to follow any life plan.

Care Programme Approach (CPA) - The CPA provides a framework for care co-ordination for service users in specialist mental health services. The main elements are the allocation of a care co-ordinator, a written care plan which is reviewed regularly with the service user (and sometimes the carer) and the professionals and agencies involved.

Cognitive Therapy - A method of treating psychiatric disorders that focuses on revising a person's thinking, perceptions, attitudes and beliefs

Command Hallucination - A type of auditory hallucination in which the person hears voices ordering him or her to perform a specific act.

Community Mental Health Team (CMHT) - A multi-disciplinary team made up of psychiatrists, social workers, community psychiatric nurses, psychologists and therapists, providing assessment, treatment and care in the community, rather than in hospitals, for people with severe long-term mental health problems.

Community Psychiatric Nurse (CPN) - A nurse who works in the community seeing patients with psychiatric problems both at home and in clinics.

Criminal Justice System - The arrangements for management of crime the enforcement of laws and the administration of justice put in place by the Government; including the courts, police etc.

Depressive Illness - A generic term denoting a number of more specific illnesses characterised by exceptional sadness over a prolonged period, the length and depth of which are well beyond the limits of normality. This mood change is accompanied by other features such as loss of interest and pleasure, loss of energy, difficulty concentrating, worthlessness and guilt, weight loss and disruptive sleep patterns.

Diagnosis - Identifying a medical condition by its pattern of symptoms (and sometimes also its cause and course).

General Practitioner (GP) - A family doctor.

Index Offence - The offence which the patient has been convicted of and which has lead to its current detention.

Local Health Boards (LHB) - Statutory bodies responsible for implementing strategies to improve the health of the local population, securing and providing primary & community health care services and securing secondary care services.

Medium Secure Unit - These are part of the Forensic Psychiatric Services and provide locked in-patient care and treatment for patients detained under civil powers or those contained within Part II of the Mental Health Act.

Mental Disorders - These are psychological disorders usually classified under internationally recognised systems of classification such as DSM-IV and ICD and contain a range of diagnoses including psychoses, brain disorders and emotional or behavioural problems serious enough to require psychiatric intervention.

Multi-Disciplinary Team (MDT) - A team consisting of health and social service professions and non-professionals, including doctors, nurses and therapists, working together to provide care and treatment for patients.

Mental Health Act 1983 - The Act which provides the legal framework within which Mental Health Services maybe provided without the consent of the patient.

National Confidential Enquiry - Project conducted under the auspices of the National Patient Safety Agency and other funders which examine all incidences of suicide and homicide by people in contact with mental health services in the UK.

National Health Service (NHS) Trust - A self-governing body within the NHS, which provides health care services. Trusts employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc. Acute trusts provide medical and surgical services usually in hospital(s). Community trusts provide local health services, usually in the community, e.g. district nurses, chiropodists etc. Combined trusts provide both community and acute trust services under one management.

National Service Framework - National standards of care published for a variety of conditions which are designed to improve the quality of care and reduce variations in standards of care.

Occupational Therapist - A professionally trained person who uses purposeful activity and meaningful occupation to help people with health problems. In mental health they play a key role in helping people overcome problems and gain confidence in themselves.

Primary Care - The first point of contact with health services. In the UK this is family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Psychopathic Personality Disorder - A personality disorder, similar to anti-social personality disorder, characterised by a lack of empathy.

Psychosis (psychotic illness) - These are severe mental disorders characterised by psychotic symptoms e.g. delusions, hallucinations and disorganised thinking. These disorders, historically and in common parlance, have been referred to as 'madness'. They are often divided into *Functional Psychoses* (mainly schizophrenia and manic depressive psychosis (or Bipolar affective disorder)) and *Organic Psychoses* (confusional states or delirium, dementias, drug induced psychosis).

Psychotherapies - Psychological methods for treating mental disorders and psychological problems.

Root Cause Analysis (RCA) - A systematic way of analysing problems to discover the ultimate reasons for it occurring.

Social Services - A term generally used to refer to local authority, social services departments. These are responsible for non-medical welfare care of adults and families in need. Among other services it provides needs assessments for people and provides services under community care for adults, children and families.

Social Worker - A person professionally qualified and registered to deliver social work to individuals and their families in a variety of settings. Many social workers work for social services within local unitary authorities. Social workers promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Unified Assessment and Care management - An assessment process which ensures that health and social services take a holistic approach to assessing and managing an individual's care in whichever setting their needs are presented. It avoids duplication of information. It aims to make eligibility criteria fairer and to standardise them across Wales.

Welsh Health Authorities - Predecessor organisations of local health boards and NHS Trusts which were responsible for the delivery of healthcare in Wales prior to 1 April 2003.