Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr F and the provision of Mental Health Services, following a Homicide committed in December 2008

November 2010

Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Tel: 029 2092 8850
Fax: 029 2092 8877

www.hiw.org.uk

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Chapter 1: The Evidence

Summary of the Index Offence

1.1 On 20 December 2008 Mr F attacked his neighbour Mr U, delivering several blows to his head using a hammer. Sadly Mr U suffered fatal injuries and died instantly. Mr F was subsequently arrested later that day and on 12 June 2009 Merthyr Tydfil Crown Court ordered his indefinite detention under the Mental Health Act in a secure unit.

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 (see Annex B and G).

Brief History of Mr F

1.3 Mr F was born in 1947, and was brought up in the Merthyr Tydfil (Merthyr) area of South Wales. While relationships with his parents and older sister were described as being difficult, he lived at home until the age of 22.

1.4 Mr F's school record was unremarkable and he left secondary education with no qualifications, later attending college to study a pre-engineering course and securing an apprentice position with the Post Office.

1.5 By 1970 and at the age of twenty three it was apparent that Mr F was leading a very social lifestyle, which caused his family concern. His behaviour had allegedly become erratic and he was aggressive towards work colleagues. As a result Mr F sought advice from his GP, who diagnosed

depression and referred him to Mental Health Services. From 1970 onwards Mr F was receiving care for his mental health issues from his GP, Mental Health Services and Social Services.

1.6 Mr F married and fathered two sons, the first was born in 1972 and the youngest in 1974. He and his wife divorced in 1984.

1.7 Mr F came to the attention of the police on several occasions. The first incident was in 1971, during a short time living in London, when Mr F was allegedly involved in a disturbance at a hotel. Mr F was arrested and remanded in custody at HM Brixton for four weeks. A further incident occurred in 1979, when Mr F allegedly threw an object at a police car, and another in 1988 when Mr F was found by the police in a Merthyr street in a distressed state.

1.8 In 1979 Mr F moved to an area of Merthyr and lived there for a number of years. He did not enjoy living in this area. Mr F reported that he felt that his mental health deteriorated during his time in this area due to an incident when his house was broken into and also following several alleged altercations with youths and neighbours that lived nearby. He eventually moved to a maisonette in a different area of Merthyr in 1992.

1.9 Mr F also reportedly began experiencing difficulties with local youths when he was in this new area. He therefore moved to a local authority warden controlled complex in 2003; in the same area. It was when he moved to the complex that Mr F met Mr U who was a neighbour living across the road from him. Initially the neighbours got along and they helped each other with shopping and other chores; however their relationship gradually deteriorated as Mr F became agitated and began to perceive Mr U's behaviour as *'intrusive'*. It appears that in hindsight this altered perception was due to Mr F's deteriorating mental health.

Employment History

1.10 It is apparent that being in gainful employment was something that Mr F attached a great deal of importance to. He held several positions following his leaving school, however due to his illness and erratic behaviour he was unable to stay in one position for any sustained length of time.

1.11 During the period 1971 to 1988 it is unclear how many jobs Mr F held. Later, in 1996 Mr F became involved in a project being run by a mental health charity, initially as a service user then in 1997 he was formally employed as a Project Lead. Mr F held this position until 2002, when he was allegedly involved in a violent incident at work, which led to his dismissal.

1.12 From 2002 until 2008, Mr F had several work placements at various retail stores; these were arranged by the local authority social services. Records indicate that Mr F enjoyed these placements and that his mental health stabilised during these periods of employment.

Diagnosis, Care and Treatment by Mental Health Services and Social Care Services

Care and Treatment: 1970s and 1980s

1.13 Mr F had a long involvement with Mental Health Services in the Merthyr area. He first came to the attention of mental health services in 1970 at the age of twenty three when he was treated by his GP for depression. This was following periods of Mr F *'over socialising'* and becoming increasingly aggressive towards colleagues and family. Mr F at the time believed there were outside influences that led to his first *'breakdown'* which resulted in his referral by his GP to mental health services. These influences ranged from family issues to work life becoming increasingly stressful.

Hospital Admissions

1.14 Mr F moved to London in 1971, where his involvement in an incident with the police led him to be detained for a period in Brixton Prison. Following this event Mr F returned to South Wales later the same year and was referred to Whitchurch Hospital in Cardiff where (following a diagnosis of *'deep depression'*) he received a course of six Electro Convulsive Therapy (ECT) treatments.

1.15 It appears that following his discharge from Whitchurch Hospital (it was unclear from the records made available to us how long Mr F was a patient at Whitchurch) Mr F stopped taking his medication. By late 1971 Mr F had lost his job with the Post Office and his mental health had deteriorated. He was taking clomipramine (Anafranil*)* as prescribed by his GP.

1.16 From the information made available to us it would appear that Mr F lost contact with mental health services until 1979; the reason for this eight year gap is unclear. Mr F became re-engaged with mental health services in 1979 following a further incident with the police. Over the course of the next ten years Mr F engaged with and accessed mental health services in the Merthyr area intermittently.

1.17 Between 1979 and 1989 Mr F was admitted to hospital for treatment for his mental health issues on three occasions; two of these were voluntary admissions. The first admission took place on 2 December 1980; Mr F was admitted to hospital as he had suffered with severe depression for a period of eight weeks. He was diagnosed as having '*Bipolar Disorder*'. It is unclear whether Mr F was offered or received any follow-up or support following his discharge from hospital. It is clear however that following his discharge Mr F again disengaged with mental health services; this time for a period of three years.

1.18 Mr F's second admission to hospital took place in September 1988, this time he was admitted under Section 136 of the Mental Health Act (see Annex C) following an incident where he was found by the police in a distressed state, undressed, in the street and '*banging*' his head against a wall. Mr F was still under the care of mental health services at this time. On this occasion Mr F was diagnosed with '*mixed affective disorder'* and was hospitalised for a period of two weeks. It was clear that Mr F had been non-compliant with his medication during the period leading up to his admission. He responded well to treatment and was placed on lithium[1].

1.19 On 1 December 1989. Mr F voluntarily admitted himself to St Tydfil's hospital in Merthyr for a three week period where he was noted to be upset, lonely and to have thoughts of self harm. Records also indicated that Mr F was drinking alcohol to excess and that his non compliance with medication was contributing to his low mood. He was discharged from hospital on 21 December 1989 having been prescribed clomipramine and lithium. Upon his discharge he was referred to the Lithium Clinic so that his lithium levels could be regularly monitored.

Community and Outpatient Care

1.20 In addition to his hospital admissions during the late 1970s and 1980s Mr F accessed the jointly run health and social service day centre based at Gwaelodygarth, Merthyr on a few occasions as well as mental health outpatient services for assessment and treatment. Over this period he received a series of diagnoses:

- '*Long standing depression'* in 1979.
- '*Bipolar disorder'* in 1980.
- '*Manic depression in combination with personality disorder'* in 1984.
- '*Mixed affective disorder'* in 1988.

[1] Lithium is a drug that is used as a mood stabiliser in the treatment of depression and bipolar disorder. Once stabilised Lithium levels need to be checked approximately every three months.

1.21 During the 1970s and 1980s Mr F lost contact with mental health services frequently and we found little evidence of services making efforts to engage with him proactively. This was to be a consistent pattern for Mr F which continued throughout the next 20 years.

Care and Treatment: 1990 - 2002

Hospital Admissions

1.22 During the 1990s Mr F was admitted to hospital on three further occasions. The first was a two week stay in St Tydfil's hospital which was on a voluntary basis. Mr F was admitted on 2 January 1990 and during this time he was diagnosed as having '*manic depression'*. His lithium levels were checked on admission and were found to be low.

1.23 His second admission took place on 25 May 1990 when Mr F once again admitted himself voluntarily. He remained an inpatient for six weeks. On this occasion he was assessed as being in the *'depressive stage of manic depression'*. Once again Mr F's lithium levels were found to be low upon admission.

1.24 On 29 September 1994 Mr F was admitted to St Tydfil's again. He was diagnosed as being in a *'depressive stage of manic depression'* with symptoms of social isolation, poor self care, withdrawal, anxiety and agitation. He was also noted to be drinking alcohol to excess which was evidenced by a liver test. Mr F was discharged after two weeks and was prescribed lithium and trazodone.

Community and Outpatient Care

1.25 Between 1990 and 1995, Mr F continued to be seen as an outpatient by mental health services. He was seen on at least thirteen occasions. Mr F's mental state was assessed as being stable at these outpatient appointments, although it was noted that he was not always compliant with his medication.

1.26 Despite Mr F having been known to mental heath services since 1971, until 1996 there was no evidence of a care plan having been put in place to help proactively manage his mental health issues. The plan was developed by Mr F's primary nurse who noted that his manic state was aggravated by alcohol and established that Mr F should receive a visit from his Community Psychiatric Nurse (CPN) once every six weeks. The CPN was attached to the newly established Community Mental Health Team (CMHT).

1.27 However, not long after the care plan was developed, Mr F once more disengaged with mental health services and due to his non attendance at outpatient appointments he was discharged from mental health services in December 1998. This period of disengagement with services coincides with Mr F's period of employment with the mental health charity (see earlier reference).

1.28 Between 1996 and September 2002 Mr F's only contact with mental health services was through the Lithium Clinic. Although he often did not attend his appointments, when he did his lithium levels were erratic.

Care and Treatment: 2002-2007

1.29 In September 2002, Mr F was re-referred by his GP to the CMHT as he was suffering from depressed mood and anxiety attacks (this was possibly due to him having lost his job with the mental health charity). Mr F was not seen by the team until January 2003 when he attended an outpatient appointment. The reason for the gap between September 2002 and January 2003 is unclear.

1.30 Mr F was next seen in June 2003. It is not clear who initiated this referral. However records indicate that a Social Worker had became involved in Mr F's care and was supporting Mr F to make an application to be re-housed in a warden controlled complex. It was noted that Mr F's lithium levels were high and therefore his lithium was decreased. It was noted in his care plan that Mr F's mood was low and that *'his lithium levels and mental state should be monitored'*. References to structuring meaningful activity for Mr F were also made.

1.31 It is unclear how it was intended that the care plan be enacted as Mr F was not seen again by mental health services until April 2004, when he attended an outpatient appointment. He was seen by the Clinical Assistant[2] and was reported to be tearful and low in mood. Mr F was offered admission to hospital for assessment but declined. Mr F's GP was notified and he was seen again by the Clinical Assistant in outpatients in October 2004. Mr F once again reported as being low in mood and referred to having fallen out with his neighbour, believed to be Mr U.

[2] A Clinical Assistant is an experienced and senior doctor working under the supervision of a consultant.

1.32 Mr F was admitted to St Tydfil's Hospital on 26 November 2004 for six weeks following an overdose of Prozac, aspirin and paracetamol. This was his last admission to hospital. Mr F reported that the main reason for his overdose was an alleged argument with his neighbour, again believed to be Mr U.

1.33 At this time Mr F displayed symptoms that included isolation, guilt, tearfulness, helplessness, hopelessness and anhedonia[3]. Records note that he was exhibiting paranoia towards his neighbour, however we found no evidence of a full risk assessment having been carried that assessed Mr F's risk to himself and others.

1.34 Nursing notes record that Mr F *'worries about Christmas'* and that he admitted drinking alcohol heavily. On 21 December 2004, Mr F left the ward without notifying staff and later in a telephone call told them that he had been drinking. Mr F returned to the ward and discharged himself on 4 January 2005. We found no evidence of a discharge plan or follow up arrangements being in place upon his discharge.

1.35 Mr F was not seen again by mental health services until June 2005 when a Care Programme Approach (CPA) review was undertaken by a consultant psychiatrist. It was noted that Mr F's mental state had stabilised and he was therefore subsequently referred back to the care of his GP for the remainder of 2005.

1.36 On 11 January 2006, Mr F was seen, following a GP referral, by his social worker who was part of the CMHT. Mr F was reported as being visibly upset and to have very negative views about himself. Mr F stated that he was leading a reclusive lifestyle, due to arguments with his neighbour, again believed to be Mr U.

[3] An inability to experience pleasurable emotions from normally pleasurable life events.

1.37 Mr F's lithium levels were checked on 12 January 2006 and the results indicated that Mr F was not fully compliant with his medication. Mr F did not attend six separate outpatients appointments made for him between February and October 2006.

1.38 In October 2006, Mr F attended an outpatient appointment with the Clinical Assistant. It was noted that Mr F was non compliant with medication and that he had apparently fallen out with one of his sons. Following assessment by the Clinical Assistant he was seen by the Consultant Psychiatrist in November 2006 when a CPA review was conducted in conjunction with his social worker. Mr F was on *'standard CPA'* as he was considered to be low risk. At this assessment it was noted that Mr F's mood was falling due to his non compliance with medication and his having lost his job.

1.39 In the following January (2007) Mr F's GP was notified that following his assessment in November 2006 Mr F had been diagnosed as suffering from *'occasional depression'* and that he was now complaint with lithium and coping at home.

1.40 In March 2007, Mr F's social worker closed his case at the CMHT as it was assessed that no further input from the CMHT was needed at that time. It is unclear from the records precisely why the decision was taken to close Mr F's case at the CMHT.

1.41 Mr F failed to attend outpatient appointments between May to September 2007. However, in November 2007, Mr F's GP was notified by the Clinical Assistant that Mr F was still depressed although he was compliant with medication and his mental state was stable. It is unclear as to what Mr F's status was in relation to the CMHT at this time and in particular whether his case was *'open'* or *'closed'*.

Care and Treatment during 2008

1.42 Mr F was next seen in outpatients in April 2008 by the Clinical Assistant. Notes made at the time indicate that Mr F was anxious although he did not present with symptoms of depression. Mr F was subsequently referred back to the CMHT although he did not attend appointments made for him in May, June or July 2008. As a result of his non attendance he was discharged again from outpatients.

1.43 Mr F did however attend a CMHT assessment on the 12 August 2008. This assessment, conducted by a social worker, recorded that Mr F was a sixty year old man with a history of bipolar affective disorder which was well maintained with lithium. He was also noted to be attending outpatient appointments regularly with both the Clinical Assistant and the Consultant Psychiatrist at the CMHT. This assessment does not tally with the evidence we have gathered which identifies Mr F as having missed several appointments in the preceding months and to him having irregular lithium levels.

1.44 The record of the assessment undertaken on 12 August 2008 notes that Mr F exhibited symptoms of social isolation, lack of structure and had occasional suicidal ideas but that Mr F had no plan to act on these. A risk assessment was also completed with Mr F deemed as *'demonstrating no risk of note'*. It is unclear whether this assessment related to Mr F's risk to himself or to others. Mr F admitted during the assessment that alcohol was a weakness of his but stated that his consumption was under control. The care plan developed following this assessment notes that Mr F should be referred

to the health-led day unit at Seymour Berry, Merthyr for introduction to the *'Men's Group'* and the *'Sunrise Group'*[4]. Mr F's name was added to the waiting list and it was noted that he would be contacted when a place became available for him. The notes also stated that Mr F no longer needed social worker input due to him being relatively well and because there was nothing more to be offered to him from a social work perspective.

1.45 On 14 August 2008 Mr F was seen again in outpatients by the Clinical Assistant. Mr F's mood was found to be euthymic and he was apparently compliant with medication. It was noted that his regime of lithium was on-going and that he was awaiting group intervention at the day unit.

1.46 Mr F contacted the CMHT by telephone on 3 October 2008 and explained to the Duty Officer that he was feeling low in mood and that he felt that he needed to be seen. Mr F explained to the Duty Officer that he had been *'referred to groups'* but that he had heard nothing regarding the appointments. Mr F was advised that he may benefit from a Crisis Assessment and the Duty Officer arranged for him to be seen by the Crisis Resolution Home Treatment team (CRHT) at 3pm in St Tydfil's hospital later that day. Mr F agreed to this and attended St Tydfil's Crisis Suite as arranged where a joint emergency assessment was conducted by a Senior House Officer (SHO) and a CRHT Practitioner. Following assessment Mr F was offered a period of home treatment, which he accepted along with a leaflet on depression. A risk assessment was completed, which identified a potential for self neglect; no other risk was noted.

1.47 The next day (4 October 2008) Mr F was seen at home by CRHT staff. He remained low in mood but notes indicate that he agreed to work towards rebuilding some structure to his daily routine. CRHT staff also noted that Mr F was a diet controlled diabetic and that he was not checking his bloods regularly. His blood levels were therefore checked and CRHT staff agreed to

[4] These groups run by the Seymour Berry Centre, cater for a variety of needs and are aimed at providing a sense of purpose and belonging. The services include anxiety management, relaxation, healthy living and relapse prevention.

help him learn how to use a glucometer to improve his confidence. Mr F was provided with CRHT telephone numbers and encouraged to contact the team anytime that he felt that he needed their support.

1.48 Mr F received a further home visit from the CRHT on the 5 October 2008 and it was noted that he showed signs of improvement; he reported that he had ventured out to the local shops. The need to have his lithium levels checked and to arrange day services was discussed with Mr F.

1.49 On 6 October 2008 CRHT staff undertook another home visit. It was recorded that Mr F had started to complete the Occupational Self Assessment that the CRHT had given him, but that he had found it difficult to concentrate and complete. It was also noted that Mr F was asking for hospital admission. The CRHT arranged an appointment for Mr F to be reviewed by the Consultant Psychiatrist on 13 October 2008 and Mr F agreed to attend St Tydfil's the next day to meet with the Occupational Therapist who would help him to complete the Occupational Self Assessment. His blood sugar levels were also checked.

1.50 The CRHT contacted the day unit at the Seymour Berry centre on 7 October 2008 to refer Mr F to their services, but the CRHT was informed that Mr F had already been placed on the list. The day unit agreed to prioritise his referral.

1.51 Mr F received a scheduled visit from CRHT Nursing Auxiliary Support staff on 8 October 2008. Mr F claimed that he had taken around four paracetamol tablets and told CRHT staff that he planned to take more. Mr F then allegedly threw a glass at the wall while the CRHT staff were present. CRHT staff called the CRHT office for advice and it was decided that the CRHT Nursing Auxiliary Support staff would transport Mr F to the crisis suite at St Tydfil’s Hospital.

1.52 During his interview with the CRHT Practitioner[5] at St Tydfil's, Mr F stated that his taking of paracetamol *was 'not a deliberate act of self-harm but a gesture'* in order to be admitted to hospital. Mr F confirmed that he did not want to go home and that he felt he could not cope living at his present address as he felt isolated and lonely. He stated once more that felt that he needed admission to hospital for *'respite'*. The CRHT Practitioner explained that it was not appropriate for Mr F to be admitted and Mr F proceeded to voice thoughts of *'possibly assaulting his neighbour'* and cited problems of *'excessive masturbation'* and *'being psychotic'.*

1.53 The CRHT Practitioner assessed Mr F's show of aggression in the presence of the CRHT Nursing Auxiliary Support staff and his subsequent claims during assessment to be a deliberate attempt to engineer an admission to hospital. Mr F was once again told by the CRHT Practitioner that he would not be admitted to hospital and he reluctantly agreed to be taken home and was supplied with night sedation medication for four nights. It was agreed that a home visit would be made by the CRHT the next morning. No doctor was involved in this decision making process as the CRHT Practitioner did not feel that to be necessary, neither was a full risk assessment undertaken upon Mr F's acceptance of *'Home Treatment'*.

[5] Usually an experienced Registered Mental Health Nurse (RMN).

1.54 The following day (9 October 2008) Mr F received a home visit from the CRHT. It was noted that he was now much calmer and that he was apologetic about his behaviour the previous day. Mr F stated that he had slept well having taken the medication provided. A referral to GOFAL[6] for home support was discussed, and Mr F agreed that this would be beneficial. He also stated that he was looking forward to attending the men's group at the day unit on 14 October. Later that same day Mr F received a further home visit from the CRHT and was noted to be much brighter. He advised that he was planning to attend a *'World Mental Health Day'* event at the local Labour Club the next day.

1.55 The CRHT spoke with Mr F by telephone on 10 October 2008 and he advised that he been at the *'World Mental Health Day'* event all afternoon and therefore did not feel that he needed a visit that evening. The CRHT agreed to telephone Mr F the next day to arrange their next visit.

1.56 Mr F was next seen by the Consultant Psychiatrist on 13 October 2008 at the CRHT unit. Mr F was again low in mood and the notes record that Mr F was once again seeking admission to hospital, which was discouraged.

1.57 On 14 October 2008 Mr F attended the men's support group at the Seymour Berry day unit. Although he arrived late, records indicate that Mr F settled into the group as he knew most of his peers. He was invited to attend the group again on 17 October 2008; however Mr F did not attend any further meetings of the group.

1.58 Mr F's next contact with the CRHT was by telephone on the 16 October 2008 when Mr F advised that he did not want a home visit over the weekend due to him having commitments.

[6] A charity that provides assistance for mental health service users with various aspects of daily life including applying for benefits, tenancy issues, health appointments, advocacy, daily living skills, accessing work and training, debt management and budgeting, crisis prevention, advice in accessing suitable housing, and liaison with other health professionals such as CPNs, CMHT, G.Ps and psychiatrists.

1.59 Telephone contact was again made by the CRHT on 20 October 2008 and a subsequent home visit was made later the same day. It was noted that Mr F had not left his home all weekend. On the same day Mr F received a letter from the CMHT informing him that due to his non-attendance at the Seymour Berry Men's Group on 17 October 2008, he would subsequently be discharged from CMHT services back into the care of his GP. The rationale for this decision is unclear.

1.60 The CRHT contacted Mr F once more on 21 October by telephone to discuss the group session at the Seymour Berry Unit. Mr F told staff that he had attended the session (although the CMHT had been informed that he had not), and that it had gone *'ok'*. He also told them that he had left the house for supplies. Mr F was again adamant that he did not require a home visit from the CRHT that day. Mr F was subsequently seen at home on 23 October 2008 by the CRHT and it was noted that he was low in mood and negative. He was provided with advice and support.

1.61 The CRHT attempted to contact Mr F three times by telephone on 24 October 2008 but got no response. A home visit was made by the CRHT later that day and Mr F appeared to be under the influence of alcohol. Mr F was reluctant for the CRHT worker to enter the house and it was agreed that CRHT staff would visit again the next day. Mr F contacted the CRHT the following day and advised the team that he did not require a home visit over the weekend although he did agree to a home visit on 27 October 2008.

1.62 Mr F was next seen at home on 27 October 2008 as arranged. Mr F stated that he had been at home all weekend and he was encouraged by the CRHT to continue attending the men's group (the fact that Mr F had only attended once was not known by the CRHT). Mr F was advised that his Home Treatment visits were to cease as he had become less reliant on them. It was explained that support could still be offered by telephone by the CRHT if he felt it was needed. His GP was also informed of this decision by letter.

1.63 Mr F contacted the CRHT on 30 October 2008 by telephone requesting a home visit. It was explained to Mr F that he had been discharged from Home Treatment although support could be offered over the telephone by the CRHT if he felt it was needed.

1.64 Mr F contacted the CRHT service once more on 6 November 2008 stating that he no longer felt motivated and that he was low in mood; notes indicate that Mr F was told during this conversation to contact a social worker at the CMHT himself (which he said he would do). The CRHT notes indicate that home treatment was no longer deemed to be beneficial for Mr F although it was unclear to the review team as to the reasoning for this.

1.65 Mr F's sister contacted the Clinical Assistant at the CMHT on 18 November 2008 expressing concerns regarding Mr F as he was feeling unwell. The Clinical Assistant subsequently visited Mr F at home and noted that Mr F was feeling depressed and lonely and that he was non-compliant with his medication. Mr F displayed no intention to self-harm neither were any feelings of aggression displayed. The decision was therefore taken by the Clinical Assistant to increase his anti-depression medication.

1.66 On 26 November 2008 Mr F contacted the CRHT again and reported feeling unwell. He stated that he was unable to cope and requested a home visit. The CRHT again advised Mr F that they were unable to provide a home visit and support was offered over the phone although Mr F apparently hung up the call.

1.67 Mr F was next seen at an outpatient clinic appointment by the Clinical Assistant on 11 December 2008 when it was noted that Mr F was still low in mood, although he was improving despite still having difficulties with daily routine.

1.68 On 18 December 2008, Mr F contacted the CMHT day-time Duty Team stating that he was feeling distressed and that he was having difficulty coping. Mr F was provided reassurance over the telephone by the Duty

Officer (who happened to be one of Mr F's previous social workers and therefore knew him) and it was suggested to Mr F that he should attend the CRHT for an assessment. Mr F agreed to contact the CRHT himself; however no call was ever received by the CRHT. This was the last contact Mr F had with services before committing the homicide of Mr U on 20 December 2008.

Arrangements for the Delivery of Mental Health Services in Merthyr

1.69 The Welsh Health Service was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of NHS Trusts and Local Health Boards. The commissioning of primary and most secondary mental health services was the responsibility of Local Health Boards. A further reorganisation took place in October 2009 with the amalgamation of the NHS Trusts and Local Health Boards.

1.70 The health service body providing mental health services at a community and secondary level in the Merthyr Tydfil area at the time of the index offence was the Cwm Taf Health Board.

Community Mental Health Team (CMHT)

1.71 The CMHT in the Merthyr Tydfil area is based at the Seymour Berry Day Unit. The team works within the wider provision of community mental health services of Cwm Taf Health Board and Merthyr Tydfil County Borough Council, who jointly provide the service. The CMHT is a multi disciplinary team consisting of Social Workers, Consultant Psychiatrists, Community Psychiatric Nurses (CPN), Community Care Workers, Occupational Therapists, Healthcare Assistants, and administration staff.

1.72 The aim of the team is to ensure that people with mental health needs receive timely, effective assessment, care and treatment in the most appropriate setting in accordance with their identified needs.

1.73 Individuals are accepted for assessment in line with the local authorities agreed eligibility criteria.

1.74 The team offer advice and assessment to individuals referred to the team via a single point of access process. Individuals receive a comprehensive assessment of needs. Once an assessment has taken place, the individual's needs are discussed via a multi disciplinary meeting to provide a CPA that meets their needs. Further support and assistance is provided through a comprehensive list of programmes offered by the day unit at Seymour Berry.

1.75 The CMHT operates Monday to Friday from 08:30 – 17:00, however out of hours services is provided through the Social Services Emergency service or St Tydfil's Hospital Crisis Team.

Crisis Resolution and Home Treatment (CRHT)

1.76 The CRHT within the Merthyr area was developed following the Welsh Assembly Government's policy for the Implementation Guidance on the Development of CRHT services in Wales (2005) and the Sainsbury Centre report for the *'Remodelling of Mental Health Services in Merthyr Tydfil and Cynon Valley'* (2004). The CRHT in Merthyr has two main components;

- Assessment of Individuals that have been referred from any source, such as Community Mental Health Services or GP.
- Following an Assessment of Individual needs, CRHT offer Home treatment, should this be appropriate.

1.77 The aim of the service is to provide, through the CPA, rapid multi-disciplinary community based treatment 24 hours a day, seven days a week, 365 days per year for people experiencing acute mental health crisis for whom home treatment would be appropriate.

1.78 For self referral on initial triage, assessments are conducted over the telephone. If it is felt that is appropriate the individual is invited to a full assessment at CRHT premises based at St Tydfil's hospital. The CRHT accepts individuals from the age of sixteen (provided that they are not in full time education) up to the age of sixty five.

Guidance relating to Mental Health Services in Wales

1.79 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*)' 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). *'Welsh Health Circular (2005) 048'* also refers specifically to *'Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CRHT) services in Wales.'* The National Leadership & Innovation Agency for Healthcare (NLIAH) also produced a report in 2009 reviewing the usage of the Care Programme Approach (CPA) in Wales.

Chapter 2: The Findings

The homicide committed by Mr F was not predictable

2.1 Having reviewed the evidence HIW believes that the particular incident which led to the death of Mr U was not predictable. However, there were deficiencies in the level of care that Mr F received. Healthcare Inspectorate Wales is of the view that had Mr F been properly assessed and had he received more proactive care there is always the possibility that the outcome for him and Mr U may have been different. Mr F made several references to his difficulties and concerns with his neighbour over the years preceding the homicide. In particular, on 8 October 2008 he told CRHT staff that he wanted to assault his neighbour but this conversation was never considered as part of a formal assessment and an assessment of his risk to others was never made.

2.2 We believe that there were gaps and flaws in the arrangements for the care and treatment of Mr F, in particular the absence of assertive management of his care and treatment, a lack of engagement with Mr F's family so that risk assessment could be better informed, system failures in relation to his care management and multi-agency involvement.

Services provided to Mr F were less than optimal

2.3 Although we have reached the conclusion that the tragic homicide committed by Mr F was unpredictable, HIW does believe that the services which were offered to Mr F over his long involvement with mental health services and in particular during the months leading to the index offence were less than optimal.

2.4 Mr F's involvement with mental health services tended to rotate on a cyclical basis and his wellbeing tended to fluctuate according to a regular pattern. Mr F would engage with services when he felt unwell, often these

periods of him feeling unwell occurred after he had decided to stop taking his medication. Mr F would then enter a stage of crisis leading to episodes where he would demand and plead to be admitted to hospital for treatment. Mr F would be admitted to hospital on an informal basis, spend some time receiving more intensive treatment before being discharged back into the community feeling better and able to cope once more.

2.5 Once back at home he tended to stop or reduce his medication and disengage with services again. Indeed missed appointments and failure to attend Lithium Clinics was a distinct feature of Mr F's involvement with mental health services. This pattern remained fairly constant over the long period of time that Mr F was involved with services with his relapses frequently linked to periods when he was not employed or involved in occupational activity.

Risk Assessment and Care Planning

Risk Assessment

2.6 Risk assessment and management was fundamentally flawed in respect of Mr F. We found the approach to risk assessment to be variable and subjective. Most concerning was that there was no regular risk assessment of Mr F and when such assessments were undertaken, the information on his alcohol consumption and episodes of violence, although known to health and social care staff seems to have gone ignored. Mr F's repeated comments about his relationship with his neighbour were never taken seriously.

2.7 During the course of our review we found no evidence of any attempt having been made by either health or social services to engage with Mr F's family, for the purposes of conducting a more detailed and thorough assessment of his problems, history, and behaviour at home. This we believe directly led to a deficit in the respective services' understanding of Mr F's history and the severe and continuing nature of Mr F's problems which in turn led to a perpetuation of the underestimation of risk that he posed.

2.8 We were frequently told, by the people that we spoke to, that Mr F came across as a congenial and relatively friendly man. But it is apparent that health and social care staff were aware of anecdotal information that provided a picture of a man who had severe mental health problems and who was a relatively heavy drinker. Mr F even reported to health staff that saw him over the many years of contact that he did feel that alcohol was a weakness, but this issue never appears to have been fully examined, considered as part of risk assessments or properly addressed.

2.9 Throughout his involvement with services, too much credence was given to Mr F's own analysis and description of events, for example his claims that his alcohol consumption levels were under control. As stated above the review team firmly take the view that Mr F's family should have been far more involved with Mr F's treatment and care, an exercise that would have assisted immeasurably with history-taking and would have aided the role of the family members in providing support or warnings that Mr F's mental health was deteriorating.

2.10 Information available in health and social care records would have also highlighted that Mr F had a pattern of disengaging with services and reengaging, when his mental health problems escalated again and that he was often non-compliant with medication. However, Mr F's history appears to have never been fully assessed or considered upon his re-contact with services.

2.11 We are also concerned that an assessment of the vulnerability of Mr F and the risk that others posed to him was never made. Our review highlighted that Mr F had become the focus for local youths while he lived in areas of Merthyr. While the CMHT appears to have been aware of these incidents we saw no evidence of discussions taking place regarding Mr F's possible status as a vulnerable adult.

2.12 Overall, it appears that the lack of any attempt by any of the services involved with Mr F to gain a full picture of his history and condition had a direct impact on the adequacy of any care plan or risk assessment which was subsequently carried out.

2.13 A particular concern directly relevant to the index offence is that on 8 October 2008, Mr F made a statement to the CRHT during an assessment that he wanted to assault his neighbour. Mr F's claim about his neighbour was dismissed by the CRHT worker as being an attempt by Mr F to gain admission to hospital, something which the CRHT worker believed was not required. However, this incident was never considered formally as part of a risk assessment as it was felt it was a one-off incident. This raises questions regarding the judgement of staff and their tolerance of risk.

Care Planning and Appropriateness of CPA Level

2.14 Taking into account the fact that Mr F had been known to, and engaged with services in the Merthyr area for nearly forty years, it was surprising that there was a lack of clear care planning. Whilst this did improve latterly, following Mr F being placed on standard CPA in 1996, it is clear that there had been a lack of a clear and constructive approach to engaging with Mr F throughout his involvement with mental health services and social care services.

2.15 There was a failure to make Mr F subject to enhanced CPA arrangements, and we take the view that this was a significant failure. Mr F was placed on standard CPA, primarily because he was not deemed by services to pose a risk either to himself or to others. As outlined above it is clear that had more rigorous attempts been made to gain a fuller history of Mr F and to better engage his family a different picture of Mr F's level of illness would have emerged supporting the fact that Mr F should have been placed on enhanced CPA.

2.16 Mental health services had a limited understanding and analysis of the risks that Mr F posed which resulted in inadequate levels of care, contingency planning and understanding of his relapse indicators. Had Mr F been subject to enhanced CPA his care would have been better co-ordinated and more assertive.

2.17 The fact that Mr F was placed on only standard CPA meant that he was deemed as being *'low priority'* despite his enduring mental illness.

2.18 In summary, we believe that the root causes identified in relation to risk assessment and care planning were:

- A lack of regular risk assessments being undertaken.
- A lack of full assessments being undertaken at the commencement of each episode of care.
- A lack of any attempt by health or social services to engage with Mr F's family to build a complete picture of his history and patterns of behaviour.
- A failure to take account of the *'historical'* information that was available in health and social care records concerning Mr F leading to the patterns of disengagement and escalation not being identified and considered.
- A failure to identify the particular risk emerging as Mr U had become a particular focus for Mr F.

- An over-reliance by health and social services on information provided directly by Mr F being taken at *'face-value'*, with no triangulation of this information with that held by services or with family.
- A lack of judgement in terms of what constitutes a risk, and a high tolerance of risk.

Carer's Assessments

2.19 While at the time of the homicide Mr F lived alone, one of his sons had lived with Mr F for many years following his parents divorce and it must have been stressful for a teenage boy to have to cope with living with a father who was mentally ill.

2.20 Mr F and his family had been known to children's and adult services over many years and this engagement was recalled as being helpful but sporadic by one of Mr F's sons - however the focus of the health and social care contact was on Mr F himself only.

2.21 If Mr F's son had been more assertively engaged with by children's services, then this may have led not only to a greater understanding of Mr F's illness, but more importantly to the son himself receiving the support that was so desperately needed during what must have been a hugely traumatic period. There appears to have been no transfer of information between children's and adult social services in relation to Mr F's son.

2.22 We believe that:

- There was a failure to engage with Mr F's son and to transfer information from children's social services to adult social services, in particular with regards to the son's status as a young carer. This led to invaluable information that could have been obtained from the son being missed. Had this information been obtained, it may have influenced future care planning and assessments by health and social services as well as providing support for Mr F's son.

Co-ordination/Integration of Services

2.23 Seamless and timely service provision is dependent upon good co-ordination between professionals and between agencies. What we saw in the case of Mr F was a lack of co-ordination and integration that led to less than optimal care and treatment being provided to him. We believe that the lack of coherence and collaboration between services compounded the crisis that Mr F found himself in during the weeks and months leading up to December 2008.

2.24 We feel that much of the problem was caused by ineffective formal systems that drove a focus on *'what the policy is'* and *'what we do'* rather than an approach that focused on the needs of Mr F. This, together with poorly developed arrangements for the transfer of care between the CMHT and CRHT in particular, led to unnecessary gaps in care.

2.25 It was unclear as to who was responsible for *'holding the ring'* in relation to Mr F's care and ensuring that it was properly co-ordinated. Also, it appears that no one was taking a long term view of Mr F's needs and as a result the care provided to Mr F was reactive and crisis driven.

2.26 In summary we consider the following weaknesses impacted on the quality and level of care provided to Mr F:

- The lack of a multi-disciplinary approach.
- Poor co-ordination of care.
- Inconsistencies in referral mechanisms.
- Poor communication and information sharing.
- Poor discharge arrangements.

These are explored in detail below.

Lack of a Multi-Disciplinary Approach

2.27 At the time of the homicide the CMHT was not operating as a coherent multi-disciplinary team, we found little evidence of any multi-disciplinary discussion ever being held in relation to Mr F. For example, when Mr F's case at the CMHT was closed in March 2007, there was no evidence of the individual who made the decision discussing it with anyone other than his/her line manager.

2.28 While we feel that the CRHT were generally responsive and supportive to Mr F's daily needs, once again, an opportunity was missed to put a multi-disciplinary approach in place. A number of different CRHT staff saw Mr F during October 2008 and the lack of an agreed multi-disciplinary plan meant that staff were just responding to Mr F's needs in an ad-hoc way.

2.29 The CRHT was at the time a relatively new service and while it provided Mr F with *'Home Treatment'* a key element of the intervention was not completed; namely a mapping of social and family networks and the activation of these to support the person in crisis. As this stage was not completed, when the CRHT withdrew its *'Home Treatment'* there were no back up plans in place to support Mr F.

2.30 At the time of our fieldwork there was a lack of senior medical input to the CRHT and this is an issue which we have raised with senior members of staff at the Health Board as a matter of concern. While it is acknowledged that this lack of medical input to this team did not have a material affect on the level of care provided to Mr F, as at the time of his engagement a consultant psychiatrist was attached to the CRHT, this is an issue that needs to be addressed urgently.

Poor Co-ordination of Care

2.31 There was much confusion as to who was responsible for the co-ordination of Mr F's care throughout his 40 year contact with services. In particular there was no-one allocated this role during Mr F's involvement with the CRHT and there was a lack of clarity over who was fulfilling this important role during the three months prior to the incident in December 2008.

2.32 In October 2008, Mr F had a total of 17 separate contacts with services, with 13 of them being face to face and four of them being telephone calls. This was clearly a sign of an individual in crisis and who was relapsing. As mentioned previously, Mr F historically would enter these periods of relapse and demand admission to hospital treatment - he had almost become accustomed to this routine. However in October and November 2008, due to the CRHT service now being in place, his requests for admission were denied, with home treatment being deemed to be the most effective way of providing care to Mr F. Had someone been effectively co-ordinating and overseeing Mr F's care they would have recognised this pattern and realised that assertive intervention was needed.

2.33 While *'Home Treatment'*, which is intended as an alternative to hospital admission and may have met Mr F's needs, he never received an adequate level of input from the CRHT as he was discharged after 24 days from the CRHT's care and no provision was made to ensure his care was picked up by the CMHT.

2.34 In effect, Mr F was possibly left feeling that no service was in control of his care, which may have contributed to Mr F's further relapse, allied to the fact that the Christmas period was known by services to be a stressful time for him.

2.35 The lack of clarity over who had this role of effectively overseeing Mr F's care appears to have contributed to his confusion as to which service he was to approach during his time of crisis during October to December 2008; this is supported by the fact that Mr F contacted various professionals during this period.

2.36 Mr F's last contact with services was on 18 December 2008, two days before the homicide of Mr U on 20 December 2008. Mr F was told to contact the CRHT - he never did.

Inconsistencies in Referral Mechanisms

2.37 We identified inconsistencies in the process of referral of care from the CMHT to the CRHT and back again. For example on one occasion when Mr F approached the CMHT in crisis they made an appointment for him with the CRHT. But on a later occasion, the CMHT merely provided Mr F with the CRHT's telephone number and he was told to contact the team himself.

Poor Communication and Information Sharing

2.38 We identified deficits in relation to the robustness of communication and information sharing between the services providing care and treatment to Mr F.

2.39 In particular there were problems in relation to the ability of the respective services to access the patient records for Mr F due to different case files, team diaries and duty books being used to record contact with clients. This directly impacted the ability of health or social services staff to gain an overall picture of an individual's needs, risks and involvement with agencies. An example of the impact of poor information sharing on decision making is the discharge of Mr F by the CRHT as they mistakenly believed that Mr F had engaged with the Day Unit at Seymour Berry. The CMHT had known that Mr F was not engaging with the Unit.

2.40 At the time of Mr F's involvement with the CRHT it did not have access to the local authority's SWIFT[7] electronic records system and the team was therefore unable to view this information or input any information onto the system themselves. While CMHT staff were able to view and input information onto SWIFT, they also entered information onto a separate *'duty incident book'* which could lead to discrepancies.

2.41 We were also told that across the Health Board, there exists a north/south divide in terms of access to the Health Board's own electronic records system, FACE. In the south, inpatient areas can log onto the FACE system from any site and see all the clinical activity that has occurred at individual patient level; however there is no access to this system within CMHTs. Access to SWIFT is also not available in the south. These arrangements are not mirrored in the north with the FACE system not being used; however the CRHT in the north does have access to the SWIFT system used by the local authority in that area.

2.42 We are aware that some improvements have been made since the incident but much more work is needed to ensure information is shared in a uniform and timely way.

[7] SWIFT is the name of an electronic Client Information System produced by Northgate Information Solutions, used by many UK Social Services departments.

Discharge Processes

2.43 It was unclear as to why, on 6 November 2008, the CRHT deemed *'home treatment'* to be no longer of benefit to Mr F. It was also unclear as to whether the CRHT formally transferred Mr F back to the care of the CMHT. What is clear is that the arrangements were insufficient and did not support seamless and timely care.

2.44 There were no discussions between the CRHT and CMHT regarding Mr F and so when Mr F contacted the CMHT as he had not got an adequate response from the CRHT, he was referred back to the CRHT.

2.45 We believe that shortfalls in relation to the co-ordination of Mr F's care arose due to:

- A lack of a multi-disciplinary approach to Mr F's care.
- There being no clear discharge process from the CRHT back to the CMHT.
- Confusion and a lack of clarity as to who held the role of *'Care Co-ordinator'.*
- Incomplete and poorly completed health records which lacked clear decision making trails.
- A lack of integrated patient records leading to difficulty in developing an overview of Mr F's care needs.

Assertive Care and Treatment

2.46 We found little evidence to demonstrate that services had made any assertive attempt to engage with and treat Mr F over the many years he had contact with them. Evidence of this includes:

- The long term failure to follow up failed appointments.
- The failure to follow up on the matter of non compliance with medication more robustly. In this respect the guidance issued by NICE in relation to prescribing was not followed. Due to adverse side affects, Mr F's lithium levels should have been monitored every three months and his medication stopped if he failed to attend the monitoring clinic. Despite Mr F's erratic and sporadic attendance at the Lithium Clinic no assertive action was taken, with the checking of his Lithium levels inconsistent.
- The acceptance that Mr F would disengage with mental health services on a regular basis, stop taking his medication and then escalate to crisis again before contacting services.

Chapter 3: Summary Recommendations

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

Patient History and Assessment Process

3.1 Cwm Taf Health Board and Merthyr Tydfil Social Services should:

a) Re-evaluate the systems and processes it has in place for ensuring that patient history-taking is fit for purpose. Clear written guidance and training should be put in place to aid front line staff in compiling a complete patient history, using all available sources. History taking is an invaluable part of basic risk assessment and all staff need to be aware of how to take a history and of its importance in assessing risk. The guidance should also include information about how to deal with issues relating to confidentiality

b) Audit the use of carer's assessments, in conjunction with Merthyr Tydfil Social Services, to ensure that a full picture of the client's family arrangements are clear at an early stage during the care and treatment of the individual, whether they are subject to standard or enhanced CPA.

c) Review the approach taken in respect of conducting collaborative assessments between health and social services, with particular focus given to ensuring that an effective system of noting relapse indicators and contingency planning is implemented and audited.

d) Encourage carers, especially young carers, to engage and make contact with services including in transition planning when young people themselves become adults and move out of contact with children's services. This process needs to be audited and reviewed to ensure its efficiency.

Information Access and Sharing

3.2 Cwm Taf Health Board and Merthyr Tydfil Social Services should:

e) Review the arrangements currently in place for accessing patient records across their respective organisations with the aim of developing a single information sharing system across health and social services. In particular, work needs to be done urgently to ensure uniformity of access to electronic records across the whole of the health board area, as well as with the local authority.

f) Examine the possibility of implementing new IT systems that will support the ability to electronically scan documentation and also to provide the necessary support and training for any new IT system that is introduced.

Care Planning

3.3 In relation to CPA, Cwm Taf Health Board needs to:

g) Audit and review the CPA process currently in place and take steps to improve the implementation of CPA, having regard to the guidance issued by WAG in 2003[8] and the recommendations contained in NLIAH's review of CPA in Wales in 2009[9].

h) Ensure that all relevant staff are trained and have the appropriate skills required to improve the care delivered within the framework of CPA.

[8] Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users, (Welsh Assembly Government 2003).
[9] Review Of The Care Programme Approach In Wales 2009, (NLIAH 2009).

i) Produce clear guidance, in line with WAG policy, concerning the criteria for enhanced CPA and ensure that staff have a clear understanding of when enhanced CPA should be used.

j) Ensure that all relevant staff are adequately trained in risk assessment, with risk management being well integrated into the CPA process. This training should be audited to assess its impact.

k) Audit the discharge planning element of CPA, ensuring all decisions are documented accurately whether the patient is subject to standard, or enhanced level CPA.

Effectiveness of the Delivery Model

3.4 In relation to the function of the CMHT and CRHT, Cwm Taf Health Board needs to:

l) Review and audit the information sharing processes and arrangements in place between services within the organisation, with particular attention given to the interface between CMHTs, CRHTs, and with Primary Care Services, to ensure that patients are clear over which service they are under the care of.

m) Audit the arrangements for the MDT process within the CMHTs.

n) Ensure that medical support arrangements are put in place in relation to the CRHT.

o) Review the function and model of its CRHT, ensuring that the Home Treatment and Crisis Team staff are not split in their function.

p) Support more assertive engagement with patients around alcohol problems, utilising processes such as motivational interviewing training or standardised alcohol assessments. The Health Board should also remind staff to access and read patient notes before any new assessment.

q) Implement specific guidance and training to CRHT staff relating to conducting mental health state assessments.

r) Review and audit the processes in place for medication monitoring in primary care, in particular the processes used for the purposes of monitoring Lithium levels in mental health service users in line with National Patient Safety Agency (NPSA) guidelines[10].

[10] 'Safer lithium therapy' Patient Safety Alert; NPSA/2009/PSA005 (NPSA1 December 2009).

Annex A

Healthcare Inspectorate Wales Special Review of Care and Treatment Provided to Mr F

Scope of the Review

The review will:

- Consider the care provided to Mr F 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 20 December 2008*.
- Review the decisions made in relation to the care of Mr F.
- Identify any change or changes in Mr F's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 20 December 2008.
- Produce a report detailing relevant findings and setting out recommendations for improvement.
- Work with key stakeholders to develop an action plan(s) to ensure lessons are learnt from this case.

*As part of this exercise consideration will be given also to the personal history of Mr F.

2008 Chronology

Month	April	May	June	July
GP				
Outpatient Clinic	24/04/08: Mr F attended outpatient clinic appointment. Referred to CMHT.		12/06/08: DNA.	12/07/08: DNA.
CMHT		22/05/08: Did Not Attend (DNA) assessment appointment.		
CRHT				

The review team produced a timeline to assist its understanding of the interactions between events and services relating to Mr F. This 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.

August		October
	14/08/08: Seen by Clinical Assistant. Awaiting group intervention.	
12/08/08: Attended assessment appointment with Social Worker. Suggested care plan - introduction to mens' group at Seymour Berry day unit.		03/10/08: Mr F telephones CMHT feeling low in mood, spoke to duty officer. It was suggested to Mr F he may benefit from a crisis assessment and arranged for him to be seen by the CRHT at 3pm. Mr F agreed and attended St Tydfil's.
		03/10/08: Joint assessment by SHO and CRHT practitioner. Offered Mr F period of home treatment, which he accepted. No CPA coordinator noted. No notes of drug or alcohol intake. No notes identifying history.

October			
04/10/08: Home Visit. Mr F seen at home by CRHT staff. Provided crisis team telephone numbers and encouraged him to contact team anytime he needs support.	05/10/08: Home Visit. Mr F much improved. Discussed need to check lithium levels and arrange day service.	06/10/08: Home visit. Mr F started to complete occupational self assessment but found it difficult to concentrate and agreed to attend St Tydfil's the next day to meet with the Occupational Therapist to complete assessment. Checked blood sugar levels.	07/10/08: CRHT worker contacted day unit at Seymour Berry to refer but Mr F had already been placed on the list and the staff nurse there agreed to prioritise referral so that he can attend asap. Mr F telephoned the CRHT team to ask to be transported to his appointment at St Tydfils. Request was passed to the staff working home treatment that day.

October			
08/10/08: Home Visit. Mr F alleges overdose and throws glass at wall. Taken to St Tydfil's for assessment. Mr F stated he did not want to go home and that he had thoughts of *'assaulting his neighbour'* and wished to be admitted. Mr F told that it was not appropriate for him to be admitted and was taken home with night sedation for 4 nights and an agreement for a home visit the next morning.	09/10/08: Home Visit. Mr F much calmer. Apologetic about his behaviour the previous day. Second home visit on same day. Much brighter, planning on visiting the Labour Club for World Mental Health Day.	10/10/08: Telephone Contact. Mr F ok. Attended event at Labour Club and feels he does not need a visit that evening. Agreed to call next day to arrange visit.	13/10/08: Reviewed by CRHT consultant. Low in mood, anxious and fearful of the future. Mr F seeking admission to hospital but was discouraged. Arranged for bloods to be checked to inform future medication levels.

October				
				20/10/08: Letter to GP advising Mr F discharged from CMHT back to GP care.
14/10/08: Attended Seymour Berry Day Unit for Mens Group. Was given further apt for the 17 October.			17/10/08: Failed to attend Seymour Berry day unit.	
			17/10/08: Letter to CMHT file from Seymour Berry day unit advising Mr F did not attend.	20/10/08. Letter to Mr F stating as he had been failed to attend day unit and was being discharged form CMHT back to his GP.
	15/10/08: Blood tests completed by CRHT.	16/10/08: Telephone Contact:. Mr F explained, he was busy the next day and over the weekend. Agreed further contact on Monday.		20/10/08: Telephone Contact. Agreed to a visit that day. Home visit made, noted that Mr F not been out all weekend. Arranged to call next day to see how Seymour Berry group went.

October				
21/10/08: Telephone Contact. Mr F stated he had managed to attend the group at Seymour Berry. Discussed next home visit although he did not want a visit until Thursday.	22/10/08: CRHT contacted GOFAL to make referral.	23/10/08: Home Visit. Low in mood and feeling very negative.	24/10/08: Three telephone calls made - no response. Home visit made, answered door - was under influence of alcohol. Did not want CRHT worker to enter home. Agreed to call tomorrow to arrange visit.	25/10/08: Mr F telephoned CRHT to query time of next visit. He did not want visit over weekend. Agreed team would visit Monday.

October		November	
			18/11/08: Clinical Assistant received request from Mr F's sister for home visit to Mr F as unwell; visit made. Assessment: Mr F depressed, lonely and non compliant with meds. No intention of self harm. Did not want crisis team. No evidence of aggression, anti depressants increased and agreed to assessment at next Outpatient Appointment.
27/10/08: Home Visit. Stated he had been home all weekend. Encouraged to attend the Mens' Group. Explained his **case now closed** by CRHT. However he could call team for support if needed. Letter sent to GP explaining actions.	30/10/08: Mr F called CRHT requesting home visit. Explained he had been discharged for home treatment. Provided reassurance and support over the phone.	6/11/08: Mr F called CRHT as no longer motivated. Agreed for Mr F to contact Social Worker at CMHT. Notes state home treatment not deemed beneficial to Mr F at present.	

November	December		
	11/12/08: Seen by Clinical Assistant. Noted depressive symptoms improving although still having difficulty coping with daily routine.		
		18/12/08: Mr F calls CMHT. Spoke to Duty Officer. Mr F stated he was feeling distressed and difficult to cope. Reassurance given and suggestion Mr F attends CRHT. Mr F agreed to contact CRHT but contact never made.	**20/12/08: Index Offence Homicide of Mr U.**
26/11/2008: Mr F called CRHT requesting home visit, unable to cope and feels like trashing home. Advised team does not make home visits, tried to offer verbal support but Mr F hangs up the call.			

Annex C

The Mental Health Act, 1983

Section 136: Mentally disordered persons found in public places

(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 section 135 above.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an [approved mental health professional] and of making any necessary arrangements for his treatment or care.

[(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection].

Annex D

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 (CSSIW) in the review team.

Annex E

Arrangements for the Review of Mental Health Services in Respect of Mr F

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 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 Philip Timms	Consultant Psychiatrist
Mr John Murphy	Registered Mental Health Nurse
Dr Rob Hall	General Practitioner
Mrs J Phillipson	Social Services Inspector, CSSIW
Mrs F Ellard	Lay Reviewer, HIW Panel
Mr R Jones	Investigations Manager, HIW
Mr G Jones	Investigations Manager, HIW
Mr L Dyas	Assistant Investigations Manager, HIW
Mrs J Fellows	Investigations Co-ordinator, HIW

The information gathering phase of the review was conducted between January 2010 and May 2010. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the former Cwm Taf NHS Trust , Merthyr Tydfil County Borough Council, together with papers provided by the Local Health Board, and a GP. The Judge's comments made in determining the court disposal in the case were available. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officer. We were grateful to the police for their collaboration.

- Reading the case records maintained by Health Bodies and Local Authorities concerning Mr F.

- Reading interview notes and written statements provided by staff working with Mr F, 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.

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 forward by the review team. Peer reviewers provided each other with their own initial analysis of key issues. Following that, the review team met to undertake a thorough analysis, driving its consideration through key issues to root causes using a checklist derived from the RCA elements of the *'fishbone'* and utilising other techniques such as the *'five whys'*. The conclusion of that process was to determine the extent to which systems or processes might 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 recommendation.

Annex F

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) 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 and 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 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 systematic 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 and is the Local Supervising Authority for the statutory supervision of midwives.

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 G

Glossary

Anhedonia - An inability to experience pleasurable emotions from normally pleasurable life events.

Bi-Polar Disorder - A mental disorder characterized by episodes of mania and depression.

Care Programme Approach (CPA) - A system of delivering community services to those with mental illness. The approach requires that health and social services assess need, provide a written care plan, allocate a care co-ordinator, and regularly review the plan with stakeholders. There are two categories of CPA: 'Standard' and 'Enhanced' and these have been described in the Policy Guidance issued in 2003 (Welsh Assembly Government (2003) The Care Programme Approach for Mental Health Service Users – Mental Health Policy Guidance. Cardiff. NHS Wales).

Community Psychiatric Nurse (CPN) - A psychiatric nurse based in the community rather than a hospital.

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.

Crisis Resolution Home Treatment (CRHT) - A service for adults (aged 18 to 65) experiencing an acute mental health crisis which is available 24hours a day, seven days a week. This includes a rapid response following referral, intensive intervention and support in the early stages of the crisis and continuity throughout its management.

Detoxification / Detox - A treatment for addiction to drugs or alcohol intended to remove the physiological effects of the addictive substances.

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

Electroconvulsive Therapy (ECT) - Is a well-established, psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect.

Euthymic - Is a word used for indicating a normal non-depressed, reasonably positive mood.

General Practitioner (GP) - A family doctor.

Glucometer - A medical device for determining the approximate concentration of glucose in the blood. It is a key element of home blood glucose monitoring (HBGM) by people with diabetes mellitus or hypoglycaemia.

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

Local Health Boards (LHBs) - statutory bodies who were 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.

Mixed Affective Disorder - Is when people show features of both mania and depression at the same time. They are hyperactive while experiencing depressive mood.

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.

Mental Health Act 1983 - The Act which provides the legal framework within which Mental Health Services may be 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 provided health care services. Trusts employed a full range of healthcare professionals including doctors, nurses, dieticians, physiotherapists etc.

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.

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.

Psychiatrist - A physician who specialises in psychiatry.

Psychosis (psychotic illness) - Severe mental derangement involving the whole personality. 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).

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

Senior House Officer (SHO) - A doctor undergoing specialist training in the National Health Service. A doctor typically works as an SHO for 2-3 years, or occasionally longer, before becoming a registrar.

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.

Therapeutic Range - The range of doses of a drug that will produce beneficial results without side effects.

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.