Healthcare Inspectorate Wales

Report of a review in respect of Mr B and the provision of Mental Health Services, following a Homicide committed in April 2006

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Chapter 1: The Evidence

Summary of the index offence

1.1 On 18 April 2006 between 22:00 and 22:30, in Bargoed Park, Bargoed, a 21-year-old man who was unknown to Mr B, was stabbed 38 times and died at the scene. Mr B was arrested on the 20 April 2006 and charged with murder. He was found guilty on the 3 November 2006 at Cardiff Crown Court and sentenced to life imprisonment with a recommendation that he should serve at least 20 years in prison.

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 B

1.3 Mr B was born and brought up in South Africa where he lived with his family until he was four years old when he returned to the United Kingdom with his mother and brother. At the age of approximately 13, the family moved from England to Wales. He left school at the age of 16 with 5 GCSE's but it was reported that he did not enjoy his experience there. He stated that he had no friends, nor has he maintained contact with anybody since he left.

1.4 Mr B entered a training scheme in computers until the age of 18 after which he worked for a loft insulation company. He left this job to become employed in the local supermarket where he worked for a period of approximately 10 years. Mr B ceased his employment at the supermarket in August 2004, reportedly due to stress, and remained unemployed until the date of the index offence.

1.5 Mr B got married at the age of 24, and his daughter was born in 1999.

1.6 The first record of Mr B having mental health problems was in October 2000 and he was treated initially by his GP. Mr B was referred to the Bryn Golau Community Mental Health Team (CMHT) as an urgent case by his GP in October 2003. He was seen by the medical team and reported to them that he had homicidal thoughts and that these had been present for approximately 5 years. Mr B said that he had been suffering from mood swings and anger over a period of 6 years, that he felt the antidepressant medication that he was taking was not working, and he had become more aggressive recently and was finding it harder to deal with his anger. Mr B reported that he had experienced homicidal thoughts in the past about a range of people - a former girlfriend, his former Assistant Manager at work, a neighbour who lived opposite to his house, and also towards his brother to whom he had loaned money.

1.7 The Police were called to a disturbance at Mr B's address on the 23 September 2003; Mr B had threatened to kill his brother's partner due to a disagreement over the money that his brother owed him. The Police resolved the issue at the scene and no further action was taken. This was the only reported contact that Mr B had had with Criminal Justice Services prior to the index offence.

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

1.8 Mr B's initial assessment at Bryn Golau CMHT on 8 October 2003 gave the team concern and so he was referred urgently to the Gwent Forensic Psychiatry Service (GFPS) for advice in relation to the level of risk he presented, to himself and others, and case management. Mr B was seen by the Clinical Forensic Psychologist from the GFPS on the 17 October 2003. It was felt, following Mr B's interview, that he posed a significant level of risk, and therefore a further joint assessment was arranged involving both the Clinical Forensic Psychologist and a Senior Nurse from the GFPS.

1.9 This second joint assessment was held on 31 October 2003 and at this interview Mr B presented features that suggested a risk of future violence, including mentioning the possibility of acting out scenarios which he had fantasised about. It was agreed that an immediate action plan should be drawn up and implemented, and a further appointment was made with the GFPS for the 19 December 2003 to begin psychological intervention. It was decided that Mr B should be treated as an individual who had a high risk of serious violence. The GFPS's belief was that Mr B's risk of becoming violent was not related to a serious mental illness, i.e. Mr B did not suffer from command hallucinations or delusions, but it was felt the risk he posed heightened when he was depressed. The advice given by the GFPS to the CMHT outlined the importance of monitoring Mr B's depression regularly and carefully over a prolonged period of time. As a result of the joint assessment Gwent Police were alerted of the GFPS's concerns in October 2003. Mr B was aware of this and had no objections stating that this made it much less likely that he would do anything and not get caught, and that he felt this would be a preventative factor against his acting upon his homicidal and violent thoughts. Following advice from the GFPS, Mr B was given a status of high-risk within the CMHT's risk log.

1.10 The Consultant Psychiatrist saw Mr B at Bryn Golau CMHT again in January 2004 and he referred Mr B to the local medium secure psychiatric

service, the Caswell Clinic, so that advice regarding the management of Mr B could be given. The CMHT's Consultant Psychiatrist requested a joint assessment and advised that a case conference should be considered.

1.11 In February 2004, Mr B cancelled an appointment with the GFPS's Clinical Forensic Psychologist at which point he was referred back to the CMHT. The CMHT contacted the GFPS again in March 2004 to raise concerns about Mr B's poor level of engagement with treatment. However when discussed with Mr B, he stated to the GFPS that he did not want any further contact with the Clinical Forensic Psychologist. It was agreed to arrange a Section 115 meeting (Crime and Disorder Act 1998) to share information surrounding Mr B's risk. However it is unclear from documentation whether such a meeting took place.

1.12 In April 2004, Mr B cancelled an appointment which had been offered by the Caswell Clinic. He also told the CMHT's Consultant Psychiatrist on 6 April 2004 that he did not wish any further involvement from the GFPS. Mr B was eventually seen by the Caswell Clinic in June 2004 by a Specialist Registrar in Forensic Psychiatry and, following assessment, it was felt that he continued to pose a significant risk of violence. The report provided by the Caswell Clinic to the CMHT stated that Mr B suffered from recurrent depressive illness, which at times could be severe with psychotic symptomatology.

1.13 It was felt that there was an acute affective mood disorder and that the intrusive thoughts were not present when Mr B was not depressed. The opinion expressed by the Specialist Registrar from Caswell Clinic was that Mr B required assertive management of his affective mood disorder, and that close monitoring of his mental health whilst in the community was needed. In addition he advised that further psychological assessments and interventions would be beneficial as would frequent visits from a Community Psychiatric nurse (CPN) in order to properly monitor Mr B's mental state. The report also noted that it would be of benefit to involve Mr B's family in relapse monitoring in order to ensure a more comprehensive risk assessment and management

package. It was suggested that if Mr B showed deterioration in his mental health, it would be advisable to react swiftly and if clinically indicated, to admit him to hospital for further assessment of his mental health and the risk to himself and to others.

1.14 The CMHT had reservations about the Caswell Clinic's recommendation is respect of regular CPN visits to Mr B's home because of concerns for the safety of the worker. They also had concerns about the appropriateness of the Caswell Clinic team's diagnosis. The Caswell Clinic team had suggested a diagnosis of depression, while, at that time, the CMHT's Consultant Psychiatrist believed Mr B to be suffering from a personality disorder. A referral for psychological intervention was never made to the CMHT Psychologist by the CMHT's Consultant Psychiatrist, neither was he involved in this case after Mr B's refusal to engage with the GFPS's Forensic Psychologist.

1.15 Mr B had quit his job by August 2004, but reported to the CMHT's Consultant Psychiatrist that his experience of homicidal thoughts had reduced. It was agreed that a second referral would be by the CMHT to the team at the Caswell Clinic for further consideration of the diagnosis, but no action was taken to arrange this referral. The Consultant Psychiatrist at the CMHT believed that the risk to the public had diminished to the extent that Mr B was to be taken off medium risk status according to CMHT's Multi Disciplinary Team's (MDT) notes for 25 August 2004. Mr B had initially been allocated as 'High Risk' status on the MDT risk register on 26 November 2003, changing to medium risk on 7 July 2004.

1.16 On 2 September 2004, Mr B's mother contacted the CMHT duty desk with concerns regarding her son's mental state and deteriorating mood, and he was reviewed by the CMHT's Staff Grade Psychiatrist on the same date. Mr B is reported to have stated at this appointment that his mood had deteriorated and that he had been having homicidal thoughts about seven different people that he knew, but did not have a relationship with, other than he may pass them in the street. He reported that he had not made any

attempt to approach them and stated that he did not carry any weapons. Mr B said he did not have any thoughts of harming his wife or his child. Mr B was offered admission to Ty Sirhowy (an inpatient unit in Blackwood, Gwent) at this point, but he declined citing the need to be at home to take his daughter to and from school. He did however agree to a further risk assessment being undertaken by the GFPS, and his antidepressant medication was increased.

1.17 Mr B was seen again at the CMHT on 6 September 2004, his medication was continued and a follow-up appointment scheduled for two - three weeks' time. Mr B was then seen by the GFPS on the 10 September 2004, for assessment. Following this, it was agreed that joint working between the GFPS and the CMHT would be introduced. However, at a CMHT meeting held on the 15 September 2004, local CPN's said that they were not comfortable with visiting Mr B at home in view of the risk assessments. However, it was agreed at the GFPS MDT on 17 September 2004 to initiate joint working between the GFPS and the CMHT.

1.18 Mr B was reviewed by the Consultant Psychiatrist at Bryn Golau CMHT on 28 September where Mr B was described as being well at the present time. Following this meeting the Consultant Psychiatrist arranged a Section 115 (Crime and Disorder Act 1998) Multi Agency Information Sharing meeting for the end of October. This Section 115, organised by the CMHT, was held on 22 October 2004. Present at this meeting were representatives from Gwent Police, the CMHT, and the GFPS.

1.19 Mr B was seen at Bryn Golau CMHT on the 26 October 2004, where he again expressed his thoughts of harm towards his brother, although he said that the chances of anything occurring were remote, as he did not know where his brother lived. The Consultant Psychiatrist noted that he would like to arrange a further Section 115 meeting to discuss Mr B's problem, as he saw it, of "psychopathic personality disorder".

1.20 A second Section 115 meeting was held on the 3 November 2004. A plan was formulated following this second meeting to undertake an

assessment of Mr B at home. No one from social services was involved in either meeting although recommendations, which concerned social services staff and resources were made. These recommendations were not communicated to social services. It was planned that the CPN and Mental Health Social Worker should undertake the home assessment and any concerns for welfare of Mr B's child should be reported to the Child Care Team, Caerphilly Social Services. If a crisis occurred, it was agreed that Mr B was to be assessed immediately and, if appropriate, admitted to Ty Sirhowy (a 24-bedded unit for patients with acute mental health problems) in order to reduce and manage the risk. There is no evidence that the proposed assessment was either requested or took place prior to the events leading up to the incident in April 2006.

1.21 Following the Section 115 meeting held in November, the CMHT's Consultant Psychiatrist wrote to the Caswell Clinic on 9 November 2004 expressing his concern in relation to Mr B's diagnosis and requesting an appointment for Mr B at the Caswell Clinic. The CMHT continued to believe that Mr B suffered from psychopathic personality disorder with depressive features, but the Caswell Clinic in its assessment of June 2004, had felt Mr B had affective mood disorder with personality features being secondary.

1.22 On the 13 November 2004, a clinical information-sharing meeting was held between the GFPS's Forensic CPN and the CMHT's care co-ordinating CPN to discuss Mr B and agree a joint working process. Following this meeting home visits involving both the Forensic CPN and CMHT CPN commenced and Mr B was seen regularly, usually on a weekly basis over the next four months. Mr B engaged with services during this period of time, and reported that he felt that they were of some benefit to him.

1.23 In December 2004, the CMHT contacted Mr B's mother to voice concerns and to make arrangements for her to contact them if any disputes arose over the Christmas period, as Mr B's brother, with whom he had fallen out, was in the area.

1.24 Mr B was referred to an Anxiety Management Group and to an Occupational Therapist by the CMHT in January 2005, in order to increase his involvement with external activities as he had almost stopped any activities outside of his home. He attended all seven Anxiety Management sessions and it is reported that he related quite well to the other members of the group. He also started attending a Young Persons Group but stopped this after only one or two meetings. The MDT notes show that Mr B was removed from medium risk status during January 2005 as his wife had informed the CMHT of Mr B's improvement in mood and that the homicidal thoughts had receded.

1.25 In February 2005, Mr B was placed back on an 'on-going' risk table according to the MDT minutes. The MDT notes also document that an appointment for Mr B at the Caswell Clinic had been scheduled for 23February 2005, but there is no subsequent note as to whether or not this appointment was attended.

1.26 Mr B was first referred for input from Social Services mental health social workers in February 2005, when the CMHT care co-ordinating CPN asked for social work support to help Mr B complete a Disability Living Allowance application.

1.27 Mr B did not attend an appointment to see the Consultant Forensic Psychiatrist at the Caswell Clinic arranged for 16 March 2005. It is unclear who arranged this appointment, or whether this was the appointment which had been previously scheduled for 23 February 2005 as per the MDT notes. Mr B failed to attend the March appointment due to the Forensic CPN being on sick leave. The Caswell Clinic reportedly saw him on April 1 2005, however HIW did not see any records relating to this appointment.

1.28 Mr B had consistent input from the CPN's over the next 12-month period (up to April 2006) and a case conference was held on 11 May 2005, involving both the MDT and the GFPS at which it was noted that the Clinical Forensic Psychologist questioned the diagnosis made by the Caswell Clinic. As a result, the CMHT CPN was requested to make an appointment for Mr B

with the Caswell Clinic to clarify the diagnosis, however this referral was never made as the reported telephone call to the Caswell Clinic was not returned and this was not followed up by the CMHT.

1.29 It would appear that Mr B was first placed on an Enhanced Care Programme Approach (CPA), a framework used by secondary mental health providers for adults that require a complex care planning response, in May 2005. The notes from June 2005 also state that Mr B's mother contacted the CMHT with concerns about Mr B's mood.

1.30 In July 2005 there were concerns about Mr B's state following a conversation at an appointment with the CMHT's Staff Grade Psychiatrist. The Staff Grade Psychiatrist was asked to provide the GFPS with a report about the concerns. It is unclear what was the content of this report and what were the subsequent actions.

1.31 At the CPA meeting on 11 August, it was reported that there was no change in Mr B's state and that a Carer's Assessment meeting should take place. The mental health Social Worker met with Mr B's wife to undertake a Carer's Assessment in August 2005 at the request of the care co-ordinator. However the Social Work file was closed after Mr B's wife refused to carry on with the assessment after only one session at Bryn Golau. There is no indication as to whether the option of completing a Carers' Self-Assessment form was subsequently offered to Mr B's wife.

1.32 Mr B's CPN left the CMHT in September 2005 and it was agreed that GFPS would await contact from the CMHT to identify the newly allocated CMHT CPN. In October 2005, there had been a reported increase in Mr B's anger at an appointment with the CMHT's Consultant Psychiatrist, when Mr B demanded that he be given Diazepam. At a Care Programme Approach (CPA) meeting which was attended by Mr B and his wife, he claimed that he was not being given appropriate care and advice and said that if he committed a crime it would be the CMHT's fault. He also stated that he wanted a new

Psychiatrist as he refused to see the CMHT's Consultant Psychiatrist any more.

1.33 Regular visits were made to the CMHT CPN by Mr B over the next few months. On 5 January 2006 he was again assessed at the Caswell Clinic by the Consultant Forensic Psychiatrist, at the request of the CMHT, for a second opinion of the CMHT's diagnosis of psychopathic personality disorder with secondary depressive features. The assessment report was not received by the CMHT until the 10 March 2006. There is no explanation for the delay. Verbal feedback was given by the Caswell Clinic at the time to the CPN who accompanied Mr B to the assessment and the CPN's understanding of that feedback was that the risk presented by Mr B at the time of this assessment was minimal. However, the report, dated 30 January 2006, but received by the CMHT on 10 March 2006, recommended an urgent referral to a Psychologist for psychological treatment of Mr B's intrusive thoughts and cognitive therapy targeted at his low self-esteem. It also recommended assertive medical management of Mr B's symptoms and suggested that due to Mr B presenting high-risk behaviour, admission to hospital should be considered, on a compulsory basis if necessary[1], should symptoms recur to a significant extent. This assessment of Mr B as potentially high risk differed from the CPN's understanding of the verbal feedback, which was that Mr B presented as low risk. Recognising the difference of view with the CMHT over the primary diagnosis of Mr B, the Caswell Clinic stated in the report that it was happy to attend a Case Conference to discuss the issues. The CMHT did not appear to have taken this option up.

1.34 Upon receipt of the Caswell Clinic's Consultant Forensic Psychiatrist's report in March 2006, an urgent referral was made by the CMHT to the GFPS's Clinical Forensic Psychologist. This was because Mr B had reported an increase in homicidal thoughts according to the CMHT CPN following visits during the period leading up to 10 March 2006. He was placed on the CMHT's medium risk register at this stage, discussions took place to change Mr B's

[1] See Annex H for the relevant section of the Mental Health Act 1983

medication regime, and the CMHT CPN informed Mr B's GP. A date was set for 8 May 2006 for an appointment with GFPS, over eight weeks after the request was made. It was also documented that Mr B was discussed on 15 March 2006 by the CMHT, and that Mr B's heightened risk was reported, at which point his medication was altered by the CMHT Consultant Psychiatrist. It appears that the CMHT failed to follow the advice from the Caswell Clinic's report, i.e. that Mr B should be admitted if he displayed any evidence of deterioration. He was not formally assessed for compulsory admission to hospital under the Mental Health Act, 1983 at any stage.

1.35 Mr B's intrusive thoughts are reported to have remained, but on the 12 April 2006 Mr B reported to the CMHT CPN that a short-term prescription of Diazepam was helping. Mr B visited his GP practice without appointment on the morning of the index offence, 18 April 2006, claiming that he had run out of his prescription. However, as a new prescription was not due, Diazepam was not given. Mr B then attended the surgery on the following morning, 19 April, to collect a prescription of Diazepam that had been arranged by the CPN following a telephone conversation between the GP and the CMHT.

1.36 Mr B was arrested on the 20 April 2006 on suspicion of the offence, which took place on the 18 April 2006.

Management and Organisation of Services

Arrangements for Provision of Mental Health Services in Wales

1.37 The Welsh Health Service was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of Local Health Boards. The commissioning of primary and most secondary mental health services is the responsibility of Local Health Boards. In respect of Mr B the responsible Board was the Caerphilly Local Health Board.

1.38 The health service body providing mental health services at a secondary level to the Bargoed area during the period covered by this review was Gwent Healthcare NHS Trust.

1.39 At primary level, general practitioners are responsible for providing services and initiating interventions from other parts of the health service. During the time covered by this review Mr B was registered with a GP Practice based in Bargoed.

Arrangements for delivery of mental health services in Gwent

Community Mental Health Teams (CMHT)

1.40 Within Gwent there are 11 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 provide 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.

1.41 Gwent Healthcare NHS Trust provides a variety of services which include 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.

1.42 A range of other Community Services are also provided by clinical staff, including Community Psychiatric Nurses, Community Occupational Therapists and Clinical Psychologists. A proportion of their work takes place in patient's homes, when necessary. The majority of the work involves clinic and group sessions at various locations within the catchment area, including Depot and Lithium clinics.

1.43 Mr B was receiving care and treatment from the Bryn Golau CMHT which is based at Aberbargoed Hospital, within the Caerphilly County Borough Council area.

Gwent Forensic Psychiatric Service

1.44 The Gwent Forensic Service was established approximately 10 years ago, and serves the whole of Gwent. The core of the service is the Ty Skirrid unit in Abergavenny. Ty Skirrid is a 12-bedded ward and forms part of the Gwent-wide forensic rehabilitation service. The ward caters for men and women who have a mental disorder and have offended or are at risk of offending and provides on-going psychiatric treatment. The unit is staffed on a 24-hour basis

1.45 The unit offers social and psychological intervention with an emphasis on community re-integration. Many of the clients have previously been in prison or secure accommodation. The unit also has access to local services who provide off site occupational therapy and adult education via the local college including a gardening project in Newport that clients attend on a daily basis.

1.46 Within the unit clients are actively taught and encouraged to develop daily living skills, e.g., clients are encouraged to make their own meals instead of being provided with hospital food.

1.47 There is also a pre-discharge facility adjacent to Ty Skirrid named Lindisfarne, which is a three-bedded unstaffed unit which provides unsupervised semi-independent living for clients prior to discharge.

1.48 The Forensic Service's community team comprises of one Forensic Psychologist, two Forensic Community Psychiatric Nurses (FCPN) and has medical cover from the Trust's Medical Director, and Consultant Psychiatrist based at one of the CMHTs and four sessions from a staff grade doctor.

1.49 The Forensic Service provides further expertise to CMHT's by way of consultation, advice and treatment of patients referred to it. The service

accepts referrals from prisons, secure units, CMHTs, probation and GP's amongst others.

Gwylfa Therapy Service (Personality Disorder)

1.50 The Gwylfa Therapy Service is a dedicated personality disorder service and was formed in February 2005. It is based at St Cadoc's in Caerleon. The Gwylfa Therapy Service offers consultation, support and advice to CMHT's and other in-house specialist mental health services. It also provides a clinical service for patients who cannot be managed at community level with a focus placed on borderline personality disorder.

1.51 A range of treatments are provided by the service including dialectical behaviour therapy, psychotherapy, cognitive behavioural therapy, and in some cases antidepressant medication. The service enables detailed assessments to be carried out in order to access treatment locally, or if necessary outside the County. The service comprises of a Consultant Clinical Psychologist, Consultant Nurse, Consultant Psychiatrist in Psychotherapy, and a Principal Clinical Psychologist.

Guidance relating to Mental Health Services in Wales

1.52 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).

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

Chapter 2: Findings and Recommendations

2.1 From the first time he presented himself at the CMHT, Mr B was assessed as posing a significant risk to himself and to others. The review team believe that it was clear that Mr B presented a high risk of potential violence, and that the possibility of him killing someone was apparent. It is also accepted however, that he was an unusual case, and that the historical risk factors usually associated with risk of violence were not present in this case. The timing and circumstances in which that risk became a reality could not have been identified precisely, and there had been no indication of a specific victim targeted by Mr B.

2.2 Once the risk posed by Mr B had been fully established, the CMHT took steps to inform the Police of the facts. However, in the absence of any offence having been committed by Mr B and the assessment by those involved in his care and treatment that he did not suffer from a mental condition or require further assessment which would justify action under the Mental Health Act, there were no legal powers under which he could have been detained.

2.3 The state to which Mr B's mental health may have played a part in the homicide is difficult to determine. Cardiff Crown Court, with the benefit of psychiatric reports, commented:

> *"I accept the medical evidence that you have suffered from a depressive illness for a number of years with homicidal fantasies but I am satisfied that illness had a very limited influence on your actions on the night you murdered DS. This is not a case in which the evidence justified a conclusion that there was an abnormality of mind which impaired your mental responsibility for the killing but only to a less than substantial extent. Your depressive illness was amenable to treatment and had been properly treated."*

2.4 Whilst it is impossible to predict whether a different approach to Mr B's treatment would have resulted in the risk of his committing an act of violence or homicide being reduced. HIW does believe that the services that were offered to Mr B during the course of his involvement with healthcare services had shortfalls. Whilst some aspects of care were good, for example there was regular intervention from the CPNs over a period of some 16 months right up to the date of the index offence. There were system failures in relation to issues surrounding the diagnosis of Mr B, and also concerning care management and multi-agency involvement. The remainder of this report concentrates on the ways in which we believe treatment and care might have been improved.

1. Diagnosis

2.5 From the start of his involvement with Mental Health Services, Mr B offered a complex, and sometimes confusing presentation, which understandably led different people associated with him to diverse conclusions. There had been a focus placed on the difference of opinion between the general adult psychiatrists and forensic psychiatrists about the psychiatric diagnosis of Mr B. However this did not appear to affect directly the interaction and care provided by members of the multidisciplinary team of the CMHT, in particular the CPN's, who had regular contact with him.

2.6 With the benefit of hindsight, we feel that the debate about the psychiatric diagnosis may have prevented a rational, more productive debate about the central symptoms and experiences with which Mr B presented and hence led to his high-risk status, namely the nature of his intrusive homicidal thoughts. The debate of diagnosis diverted attention because it was being used as the main determinant of responsibility for care. If Mr B was suffering mainly from depression, then the assumption was that he should and could be managed by the CMHT. If he was suffering predominantly from an antisocial personality disorder of a severe and dangerous nature, the assumption held by the CMHT was that this should be the responsibility of Forensic Services (The Caswell Clinic). This was not the view of the Forensic Service, however.

2.7 There was some evidence to suggest that at the time there was a poor level of understanding of personality disorder among all members of the CMHT. It was not clear what sub-type(s) of personality disorder(s) the team was diagnosing. There is evidence of discomfort by the CMHT at that time in accepting care of people with personality disorders as it was reported that appropriate skills had not been developed. We do not suggest that CMHTs should be the only resource in dealing with people with a predominant personality disorder, but knowledge and confidence in managing the personality disorder would enhance their confidence in managing patients who present with such difficulties.

2.8 We believe that a formalised care plan should have been in place, involving both the CMHT and Gwent Forensic Services, which focused on addressing Mr B's intrusive thoughts and helping to manage the risk of him acting upon those thoughts. We feel that the debate surrounding the correct diagnosis for Mr B may have distracted from the need to directly tackle the key treatment need of treating Mr B's homicidal thoughts.

2.9 It is possible that mood changes may have had an impact on the frequency and intensity of Mr B's intrusive thoughts, and hence the logical conclusion is that his depression should be treated assertively. The team focused primarily on treating this depression with antidepressants, but psychological approaches, perhaps of a cognitive nature, which could have also helped, don't seem to have been used. For instance the Psychologist based within Bryn Golau CMHT itself had no involvement with Mr B at any point.

2.10 At times Mr B presented with symptoms of anxiety which were triggered by external influences, such as being alone in the house, walking in the streets, or joining a group of other parents, especially mothers whilst waiting for his daughter to come out of school. This may also have had an influence on the nature of his intrusive thoughts. Whilst it is accepted that the involvement of the GFPS's Clinical Forensic Psychologist was rejected by

Mr B. It is felt that the involvement of the Psychologist attached to the CMHT, could have provided an alternative source of treatment that may have been acceptable to Mr B; which was not explored by either team.

2.11 Mr B did attend an Anxiety Management group and also a single, or possibly two sessions of a Young Person's group. However there was no evidence of any kind of process for assessment or for the identification of treatment needs being undertaken prior to enrolment on these groups, nor was there any documentation detailing outcomes emanating from the conclusion of these sessions. Other psychological approaches were not attempted, and there does not appear to have been any constructive discussion regarding the planning of psychological interventions for Mr B both in terms of the groups themselves, and the potential influence of psychological interventions upon the dynamic risks presented by Mr B.

Medication

2.12 Prior to Mr B's referral to Bryn Golau he had already been taking an antidepressant (initially Reboxetine, later Citalopram, and finally Venlafaxine) as a result of depressive features diagnosed by his GP. These medications appeared to have been given for sufficient period of times and at therapeutic doses, but the benefit as far as mood stabilisation was disappointing. It is difficult from reading the GP notes to assess how a diagnosis of depression was arrived at, other than by accepting Mr B's statement that he was depressed, although it has been suggested that the notes do point to a psychiatric history having been taken. But the picture of depression does not appear to have been associated with other typical features of depression, such as sleep disturbances, appetite and weight loss. (Some of these symptoms were reported in the forensic assessments at the Caswell Clinic). There was however a history of overdose, as well as of anxiety, which sometimes can present diagnostic difficulties when present with depression.

2.13 After assessment by the CMHT, Mr B's Venlafaxine was increased. Although it is not clear whether this was because it was felt that there was a strong depressive component to Mr B's illness at the time, or whether it was considered that this may have an impact on his homicidal thoughts. In interviews with the CMHT Consultant Psychiatrist, it was stated that it was not felt that depression was a primary feature in the presentation. Therefore, prescribing a higher dose of the antidepressant does not have a robust rationale, and if anything, it could have the paradoxical effect of increasing the levels of anxiety or aggressive behaviour.

2.14 In the light of diagnostic considerations discussed above, it is worth noting that there are some reports that Venlafaxine can be effective with the symptoms of Obsessive Compulsive Disorder, although this medication is not licensed for this purpose. Therefore, it may have been of assistance in this case.

2.15 There are questions raised over how the decision was arrived at to introduce Carbamazepine, an anticonvulsant also licensed to be used as a mood stabiliser. According to the Consultant Psychiatrist at the CMHT, this was introduced as a result of a suggestion by Mr B's mother, who suffers from bipolar disorder. This seems to be an unconventional reason to give someone a mood stabiliser, and it may be unusual if this were the case to find that it was supported by the CMHT. Again we find no strong evidence to suggest that Mr B was presenting with a bipolar disorder, although if Mr B were to be suffering from a bipolar disorder the addition of Carbamazepine would be acceptable. According to literature reported by Wyeth Pharmaceuticals (manufacturers of Venlafaxine) plasma levels of Venlafaxine are not reduced when combined with Carbamazepine, although the plasma level of other compounds may be lowered by this medication.

2.16 In March 2006 the CMHT decided to change the antidepressant to Duloxetine, a similar class to Venlafaxine, and substitute the Carbamazepine with Semisodium Valproate. Manufacturers of Venlafaxine (Wyeth) recommend a gradual reduction (over 2 weeks at the doses Mr B was taking)

with a washout period between the two antidepressants, but the Maudsley (reference) guidelines accept that sometimes it is reasonable to introduce one antidepressant whilst tapering the other, although this might give rise to a Serotonin Syndrome and agitation. There is no data as to whether these drugs taken in combination can increase intrusive or obsessional ruminations. Irrespective of the different advice given by these two sources, we were not able to understand the rationale of introducing this different combination, as it was likely to have similar results to the previous combination, as the antidepressants were of the same class.

2.17 In relation to the issue that occurred on the 18 April 2006 when Mr B was unable to obtain his prescription of Diazepam from the GP until the following day when it was due as he had a weeks' supply provided on 13 April. We have been informed that this lack of medication over a 24-hour period would not have had any adverse effects upon Mr B.

2.18 Diagnosis of Mr B's condition often proved to be problematic and had an affect on the services he received. The root causes were:

- Mr B offered a complex and unusual presentation.
- There was a difference in opinion between clinical and forensic services (Caswell Clinic) regarding Mr B's diagnosis. This prevented the addressing of the central symptom of Mr B's intrusive homicidal thoughts.
- The CMHT were unclear over where management of Mr B's care lay, and their viewpoint conflicted with that of the Gwent Forensic Psychiatric Services.
- There was a poor understanding of personality disorder among members of the CMHT.
- A lack of a formalised care plan drawn up involving both the CMHT and Forensic Services.

- There was no involvement with the CMHT Psychologist and a lack of assessment of the possible psychological approaches available to Mr B.
- There were difficulties with implementing a rigid drug regime due to the uncertainties regarding Mr B's precise diagnosis.

2. Responsibility for care

2.19 A question which seemed to the review team to lay behind much of the debate concerning Mr B's diagnosis was which service should take overall responsibility for Mr B's care. Was it the responsibility of the CMHT or of the Forensic Services at Caswell Clinic? This was never resolved to the satisfaction of the CMHT, and caused some discomfort and confusion among front line workers. The Forensic Services at Caswell Clinic were very clear, however, that they were providing a consultancy service only.

2.20 Partly the problem arose, in our view, because at least within the CMHT, there was a lack of knowledge concerning the assessment, management and treatment of people with personality disorders, and specifically of the treatment and management of people who presented with anti-social traits. The staff of the CMHT, and in particular the CPNs, felt confused by the discrepancy of views between the senior clinicians of both the Forensic and Clinical services. This discrepancy of views was about the main diagnosis and, also it seemed, about the level of risk that Mr B was imposing. There appeared to be a lack of understanding of both static and dynamic risk within the CMHT, and the Forensic Services were not clear in their oral communication.

2.21 Gwent Healthcare Trust is distinctive for having a dedicated forensic service, and this is seen to be an area of good practice. The Gwent Forensic Psychiatry Service was established approximately 10 years ago and is a small unit comprising of one Psychologist, two Forensic CPNs, but with no full time Forensic Psychiatrist. The Gwent Service operates a small, dedicated

caseload, with which it works prior to handing care management responsibility back to the CMHT. Despite the small size of the Gwent Forensic Team, some CMHT staff report that they have close working relationships with this service, whilst others state that GFPS' staff are too busy and therefore they are reluctant to make demands on it. Whilst the GFPS appeared to offer an adequate assessment of Mr B initially, it did not provide a suggested plan of action. It was therefore difficult for HIW to ascertain how much support was given to the front line workers by the GFPS. There appears to be a need for a more direct process of consultation and supervision that would not leave front line workers feeling isolated, as we consider them to have felt.

2.22 There appeared to be issues surrounding collaboration between the different professionals in discussing the diagnosis and care management of Mr B. The CMHT reported having difficulty arranging meetings with the Caswell Clinic. However staff at the Caswell Clinic say they have no recollection of a request for such meetings and state that it is their practice to offer such opportunities, and all agree that often this is the best way of coming to some form of consensus. Such a meeting could have facilitated discussion and clarification, with a view to giving a single message about treatment and management to the staff directly involved in Mr B's care.

2.23 There was an instance in May 2005 where following a case conference held by the CMHT; the decision was made to refer to the Caswell Clinic for clarification of diagnosis. However, this was never followed through. Nonetheless, as responsibility for care sat with the CMHT, more effort ought to have been made to follow up this referral. Similarly, the offer of a case conference that was made in the Caswell Clinic's report dated 30 January 2006 was never followed up.

2.24 We found, during the course of the review, that the service that was provided by the Caswell Clinic involved some delays, both in waiting for appointments and in forwarding reports back to the CMHT. There were also some delays in getting Mr B seen in the first instance which was out of the Caswell Clinic's control, as Mr B failed to be available for the first appointment

and his CPN was off sick when a second one was offered. The Caswell Clinic does respond to requests for advice from Community Psychiatric Services, however, there is no formal obligation upon the Caswell Clinic to offer consultations: the Clinic does not take formal responsibility for community cases nor are they resourced to do so. The Caswell Clinic staff told us that when it is informed that cases are urgent, in particular concerning people who are currently in hospital or detained, they are able to respond quickly.

2.25 There was an unexplained delay between the Caswell Clinic's report being compiled on 30 January 2006 and it being received by the CMHT on 10 March 2006. The CMHT CPN accompanying Mr B to the assessment in January understood that he was only of minimal-risk as a result of a reported verbal communication. This led to inevitable confusion and considerable uncertainties for the CPNs and medical staff at Bryn Golau. This was compounded by the eventual receipt of the report in March 2006, which included advice relating to case management and risk assessment of Mr B, following which Mr B was urgently re-referred to the GFPS for assessment. We believe that the delay in the written report getting to the CMHT was very unfortunate and that steps should be taken to ensure that every effort is made for reports to be communicated in a quick and efficient manner. This delay meant that Mr B was not seen by the GFPS prior to the date of the index offence, due to an excessive wait of over eight weeks until the next available appointment. It is however uncertain whether Mr B would have attended this appointment, or if this would have had any effect on the eventual outcome. Nonetheless we question why no appointment was offered sooner to a patient who was deemed as of high risk of violence to himself and to others.

2.26 We were informed that CMHT staff believe that the Caswell Clinic is often reluctant to accept responsibility for patients that have not committed offences, or who have not been admitted to hospital at some time, or appeared in Court. This creates a problem in the management of community patients that are deemed to present a high level of risk. The Caswell Clinic is a service commissioned by Health Commission Wales (HCW) and it provides Inpatient Medium Secure Services to individuals with severe mental ill-health

and who pose significant risk of serious harm to themselves or others, such that they require treatment in conditions of medium security. There remains an exclusion criteria for admissions into the Caswell Clinic for those patients with a primary diagnosis of personality disorder where this is associated with serious risk of sexual or violent offending. Such patients would be placed in specialist out of area services following a gate-keeping assessment by the Caswell Clinic, a role which the service undertakes for all South Wales patients requiring inpatient medium secure care. The service provides aftercare for patients discharged from the Clinic into the community, prior to the responsibility for their care being transferred to local mental health Services. The service also provides assessment and consultation to local Mental Health Services and agencies of the Criminal Justice System; it is not commissioned to provide secondary mental healthcare for patients in the community. We believe that the roles and responsibilities of services in the South Wales area ought to be clarified to community mental health services.It became apparent during the review that there was uncertainty over care management arrangements for difficult patients such as Mr B. We also note that the then newly created personality disorder service in Gwent, which might have had a more formal input to the case should the CMHT's diagnosis of personality disorder have been confirmed, was not approached by the CMHT in relation to Mr B. This service may have been able to offer an assessment and give advice in relation to patient management to the CMHT. Despite the service only being formed in February 2005, they were ready to accept referrals from the offset.

Supervision of staff members

2.27 We recognise that there is an expectation placed upon Consultant Psychiatrists to access their own requirement for supervision and support. However the Gwent Healthcare NHS Trust believes that no consultants work in isolation currently. There is no formalised structure in place for consultants to receive support other than that which they arrange for themselves, but consultants will often seek the advice of their colleagues within the region.

Similarly Forensic Psychologist supervision is provided by means of informal peer support, or group type supervision with another senior Psychologist.

2.28 Although not directly related to Mr B's circumstances (social work involvement with Mr B was very limited), we together with CSSIW, who supported this review, have concerns over the delivery of formal supervision to the social workers based within the CMHT. During the review, it became clear that there was some confusion surrounding the process of formal supervision, despite the local authority's Supervision Policy. Moreover we noted separate line management arrangements for the social services input to the CMHT which can obstruct the provision of a truly integrated service.

2.29 There was overall some confusion regarding the responsibility of Mr B's care. The root causes were:

- The CMHT were unclear over which service should take overall responsibility over Mr B's care. This was related to the lack of knowledge about treating personality disorder, and confusion over the conflicting diagnoses offered by both clinical and forensic services.
- There was not enough effort made by clinical and forensic services with regards to holding a meeting to discuss the diagnosis and care management of Mr B. This could have assisted with clearing up any confusion and provided an agreed way forward.
- An unfortunate delay in the CMHT receiving the Caswell Clinic's report dated 30 January 2006. This was compounded by the reported miscommunication regarding Mr B's risk status.
- The 8 week delay in an appointment being given by Gwent Forensic Psychiatric Services to see Mr B following the CMHT's request made on 10 March 2006. The homicide of DS occurred on 18th April 2006, prior to the appointment date of 8 May 2006.

Training Issues

Personality Disorder

2.30 We have found that knowledge and training in the assessment, diagnosis and management of personality disorders was lacking in the CMHT. At the time of Mr B's involvement with services, there was very little training concerning personality disorder in place for staff. HIW are aware that some attempts have been made to address this issue by using the expertise now available at the Gwylfa Therapy Service, which specialises in treatment of personality disorder. The Gwylfa Service offers consultation, support and advice to Community Mental Health Teams and other in-house specialist mental health services. They also provide a clinical service for highly disturbed patients who cannot be managed at community level. The service takes responsibility for the most difficult cases and also acts as an advisory service for the less complex cases. Referrals are accepted from both the GFPS and the CMHTs.

2.31 The Gwylfa Service was established in February 2005, some 14 months prior to the index offence. We are unclear as to the reasons why the CMHT did not refer Mr B to this service given that the CMHT believed that a diagnosis of personality disorder was predominant. This may have been because the service was in its infancy and had not been publicised enough, or because of a lack of agreement regarding diagnosis. We do not see why Mr B could not have been referred to the Gwylfa service that may have able to provide additional knowledge and expertise in the form of assessment and patient management advice should the diagnosis of personality disorder have been agreed.

2.32 There was also some confusion found in relation to the use of the language and concepts associated with personality disorder, such as "severe and dangerous personality disorder", "psychopathic disorder" "anti-social personality disorder" and "psychopathy", all of which are slightly different

concepts. The misunderstanding of some of these terms did not assist the liaison between services in this case.

2.33 It appears to us that there is a need for a more thorough, systematic approach to implementing personality disorder training within the region, primarily at CMHT level. Arrangements should be made to use available local expertise to provide both in-house training, and also external training on basic aspects of personality disorders to all staff involved with patients who are likely to have personality disordered aspects to their presentations. This training ought to be offered at a more intensive level to staff where a specific need is identified.

Therefore, in our view, the root causes were:

- A lack of training about personality disorder available to staff at the time of Mr B's involvement with services.
- No referral being made to the newly created Gwylfa Personality Disorder service for advice.

4. Risk Management

Risk Assessments

2.34 We found that there seems to be a subjective and variable approach to risk assessment, both by the CMHT and by GFPS. Given that the GFPS initially assessed Mr B as being of high-risk in October 2003, the CMHT were not advised of his assessment until 31 December 2003.

2.35 The GFPS, appropriately, informed Gwent Police of their concerns regarding Mr B following their second assessment on 31 October 2003. From the CMHT's MDT notes the level of risk posed by Mr B was assessed as high, medium, low, minimal, or non-existent at different times during Mr B's association with mental health services. However, there is no clarification as to what this actually meant in terms of risk of what, to who and under what

circumstances. This level of risk assessment depended on the person undertaking the assessment, the particular mood Mr B was in, or whether Mr B chose to disclose his homicidal thoughts. Despite this, we asked individuals about their views on the risk posed by Mr B during the period of their involvement in his care, all staff told us that they considered that he was always a high level of risk. This variability and lack of specificity of his risk classification could have given staff the false impression that at times Mr B was unlikely to act out his thoughts. Taking into account that there had been no assessment of the main triggers for Mr B's intrusive thoughts, and that this was not being directly addressed. HIW believes that staff did not know enough about Mr B's risk factors, and the function of his intrusive thoughts to be able to effectively gauge the level and context of the risk Mr B presented, and that it only took the addition of another precipitant or disinhibitor for him to act out on his ideas.

2.36 We consider the clinical risk assessment and management policy of Gwent Healthcare NHS Trust to have been inadequate. It was not possible to find a final version of this policy, and the policy available, whilst it did talk about risk assessment, gave little guidance with regards to management procedures. Staff interviewed did not appear to be aware of the contents of the Trust policy, and it certainly did not appear to either drive, or support practice.

2.37 Similarly, HIW questions the level to which the Care Programme Approach (CPA) was utilised. Mr B was placed on enhanced CPA and yet there does not appear to have been a formalised care plan used in respect of this. There was a lack of documentation indicating to what extent the enhanced CPA was being implemented. This is especially relevant in this case as the correct use of the enhanced CPA would have acted as a common thread to Mr B's multiple assessments and engagements with all aspects of the service. Although more effective usage of CPA may not have had a bearing on the sad outcome of this case, it should certainly have acted as a focal point for the co-ordinated planning of services provided to Mr B and enabled more effective assessment of risk.

2.38 The risk assessment tool being used by the Trust was inadequate. Since the tragic death of the victim the risk assessment tool has been changed to one named DICES[2], but none of the staff interviewed appeared confident in either it's use or utility. Risk assessment tools such as the HCR-20[3] or SVR-20[4] are generally seen to be the chosen tools for the prediction of risk of violence or sexual violence. The forensic teams stated that they are trained in such tools, and would use them in their current practice now. Tools such as the HCR-20 allow for the assessment of both dynamic and static risk factors. Static risk factors are those historical factors the presence of which are seen to increase the likelihood of violent behaviour. These factors are by nature unchangeable and based upon background information. Dynamic factors are those clinical and contextual factors that have been found in the literature to predict violent behaviour. These are factors that can change over time.

2.39 Given the lack of historical risk factors present in relation to Mr B in terms of forensic history. The completion of the HCR-20 would not have identified risk factors that were not known to the community team already. However it was the accurate assessment of the dynamic factors which might have assisted in the management and treatment of his case.

2.40 There was a lack of clear action planning following the initial assessment of Mr B at the Caswell Clinic in June 2004 where several actions were suggested, including regular CPN visits. However these visits were not implemented until November 2005. The Caswell Clinic's report also recommended the involvement of Mr B's wife and family in discussions surrounding relapse signatures, however this action does not appear to have been taken. We believe that a more sustained and continuous effort ought to have been made by the CMHT to engage Mr B's wife and family independent

[2] An evidence-based tool that assesses mental health risks. See Annex I.

[3] See Annex I for definition
[4] See Annex I for definition

of Mr B as they had been identified by the Caswell Clinic as key figures who could have aided with Mr B's relapse monitoring.

2.41 Calling a Section 115 meeting was good practice. Although we did not see documentation directly relating to it, we were informed by Gwent Police that there was a plan formulated at the Section 115 meetings held in October and November 2004. In respect of Mr B. Part of the plan was to recommend that a CPN and Mental Health Social Worker assess Mr B at home, and that Childcare Services at Caerphilly CBC Social Services should be informed of any risks to the child if necessary. However, there is no evidence that these actions ever took place. Social Services informed us that neither a social worker within the CMHT or from children's services had been invited to any Section 115 meetings relating to Mr B.

2.42 There was also some confusion about how the level of risk was communicated by the Caswell Clinic to the CMHT. At the time of the second assessment on 5 January 2006, the opinion offered verbally to the accompanying CMHT CPN was that Mr B was presenting with a minimum level of risk. During our interviews with the staff of the Caswell Clinic, it was explained that inevitably this assessment could only be applied to the context at the time, and that this was a changeable situation, which could alter very quickly depending on circumstances, for example the presence of disinhibitors and increase in other risk factors. This latter consideration was not communicated sufficiently clearly, leading the CMHT to believe that the forensic view was that he presented with a low level of risk. The issue with the delay in the Caswell Clinic's report from January 2006 reaching the CMHT further compounded the issue.

Information Sharing

2.43 There is mention within the patient notes that multi agency meetings were held in respect of Mr B. However we were not able to find written accounts of these meetings, or any necessary information and advice on care

pathways should different issues of concern arise, and who would be responsible to take action.

2.44 There appeared to be confusion surrounding the type of meetings that were held in respect of Mr B. The notes that were studied referred to Multi Agency Risk Assessment Group (MARAG) meetings being held, however it now appears that these were in fact Section 115 meetings, which relate to the Crime and Disorder Act 1998.

2.45 Section 115 meetings are held in order to share confidential information between agencies. There is no formal structure to these meetings and no formal arrangements for a chair of the meetings. However they are chaired predominantly by the Police.

2.46 We question why there was no Social Services involvement in any of the Section 115 meetings held in respect of Mr B, especially in light of the fact that Mr B had a young family. Social Services informed the review team that they were neither invited to, nor aware of, any of the information sharing meetings and would have expected a much more comprehensive involvement with the Section 115 process. Social Services only became aware of the need to become involved with care for Mr B's daughter when Gwent Police contacted them following the homicide. They had observed Mr B with his daughter at Bryn Golau during their brief involvement, but seen no cause for concern. As far as is known the CPN with care co-ordination responsibilities shared their view.

2.47 The GP Practice also informed us that they were not invited to any information sharing meetings, nor did they receive copies of any notes or minutes relating to such meetings regarding Mr B.

2.48 It appears to us that there are issues relating to the sharing of information between agencies, and a need for training to be provided in respect of the processes required to share information relating to care management, and of risk management. There do not appear to have been

any documented or circulated action plans formulated based upon information emanating from the Section 115 meetings that were held regarding Mr B, despite the apparent consensus over Mr B's high-risk status. We have viewed the notes relating to the Section 115 meetings held in October and November 2004 and they are informal in nature, hand-written, with little detail given as to decisions made, and no log of who attended the meetings. We believe that despite the informal nature of Section 115 meetings at the time of Mr B's involvement with mental health services, there should nonetheless have been clear and transparent documentation of any decisions that were made following these meetings, and a clear list of attendees provided.

2.49 It is noted that since 2006, a Section 115 Meeting protocol has been implemented by Gwent Police and there is now a formal pro-forma recording system in place for these meetings, containing detail relating to members present, and action plans emanating from the meetings. Gwent Healthcare NHS Trust informed us that it is currently developing a single protocol for Wales in respect of Section 115 meetings and that there isn't currently a policy in place for Section 115 meetings for the Trust.

The root causes of the issues relating to risk management were:

- There was a lack of an integrated approach to risk assessment across forensic and clinical services.
- Staff were inadequately trained to assess Mr B's risk factors and the function of Mr B's intrusive thoughts, therefore they were unable to effectively gauge the level of risk that Mr B presented.
- Gwent Healthcare NHS Trust had inadequate risk management policies which provided little guidance with regards to risk management procedures.
- There was a lack of implementation of the enhanced CPA that Mr B was placed. This meant that Mr B's care plan lacked a focal point for all services concerned.

- The risk assessment tool that was used by the CMHT was not adequate in terms of assessing the dynamic factors, which would have assisted with the management and treatment of Mr B.
- There was a lack of concerted effort by the CMHT to engage Mr B's family and wife in the risk assessment process, and using them for the purposes of relapse monitoring.
- Action plans were never developed or put in place, both following the initial assessment by the Caswell Clinic in June 2004, and also emanating from the Section 115 Crime and Disorder Act 1998 meetings held in respect of Mr B.
- Both Social Services, and the GP were not invited to the Section 115 meetings held in October and November 2004.
- The communication of the risk levels presented by Mr B was inconsistent between services, in particular at the time of Mr B's second assessment at the Caswell Clinic in January 2006.

5. Integration of Social Services within the CMHT

2.50 HIW and CSSIW were made aware of some of the issues about the integration of Social Workers within the CMHT from discussions with Social Services staff and managers, and with Gwent Healthcare Trust management. The arrangements for providing liaison and support to the social workers has changed over the past three years. The Social Services Team Manager oversees the social work input to the three CMHTs in Caerphilly County Borough Council (CCBC). A Senior Social Work Practitioner is based within each team. Prior to 2005, part of this individual's role was the allocation of work to the CMHT Social Workers, and also to provide formal supervision to the Social Work staff based at the CMHT. This appears to have worked well. Since restructuring in 2005 the role of the Senior Social Work Practitioner became wholly practice focused, with work allocation being shared between the Social Services Mental Health Team Manager and the newly created Senior Social Worker, neither of whom are based within Bryn Golau. This has

had an impact on both the speed of allocation of work and also the formal supervision arrangements offered to Social Work staff.

2.51 Currently the CMHT is operating as two separate organisations running in parallel to one another with two different management structures in place. There are separate information technology systems and separate filing systems in place within the CMHT. Access to social work is not decided within the MDT (Multi Disiciplinary Team) setting and the Team Leader employed by Gwent Healthcare NHS Trust at the CMHT cannot command or direct social worker resources. The allocation of referrals for social work input is made directly to the Social Services Mental Health Team Manager or to the Senior Social Worker who log the referral on the CCBC electronic information (SWIFT) system. The work is then allocated formally to a social worker in the CMHT. From a health clinical perspective the impression is that this referral system leads to delays, however Social Services contend that this system means that data collection is more robust and enables hotspots to be identified quicker. It also ensures that the overall workload can be managed, and inequalities in workload identified.

2.52 There is acknowledgement from Social Services that the change in the Senior Social Work Practitioner's role has not been beneficial to CMHTs. Whilst it was reported that relationships within the CMHT are good on a personal level, Social Services recognise that the biggest challenge facing the CMHTs is to move to more integrated working. Managers acknowledge that there is a lot of work to be done to achieve parity with health, both from a strategic perspective, and on a more basic level of CMHT staff fully understanding the Social Worker's role.

2.53 Our view is that the problems relating to the integration, management and joint working with Social Services within the CMHTs need to be addressed. Communication is one aspect that appears to be lacking, both within the Trust, between the Trust and Social Services, and with other agencies. Managers from both agencies have changed or taken on different, over the period of time in question and this may have placed the CMHT under

pressure, however the onus is on all sides to work together to resolve any issues in a formalised manner. Most changes within the CMHT, including social work input have been in response to the Gwent Healthcare NHS Trust's modernising agenda, rather than any specific, agreed improvement plan.

The root causes of the problems were:

- There was a lack of understanding within the CMHT of the social worker's role.
- A lack of integration between clinical and social services meaning that the referral process and case management was not as effective as it could have been.

Chapter 3: Summary Recommendations

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

1. Gwent Healthcare NHS Trust and Caerphilly County Borough Council Social Services should ensure that provisions are made to implement a thorough, intensive, and ongoing training programme for its Mental Health staff in relation to personality disorder. All staff should receive a basic level of training, with higher levels of training offered to those staff members, including senior clinicians, that require it. Any programme needs to be supported and monitored for its effectiveness on an ongoing basis. *(Related Healthcare Standards[5]: 2, 11, 12, 22, 23)*

2. Gwent Healthcare NHS Trust and Caerphilly County Borough Council Social Services should have jointly agreed risk management procedures as part of unified assessment and CPA processes in respect of both the policies and the training offered. In particular:

    a) CMHT Staff should be fully trained in the assessment of risk, should understand the need for more detailed and specific risk management plans and be able to utilise, or refer for the use of specialist tools in making assessments in cases that display severe and complex needs.
    b) Multi-disciplinary arrangements for assessing risk need to be reviewed to ensure that all agencies are measuring and understanding risk using the same parameters and language, and that all risks identified have a corresponding management and treatment plan.

[5] Healthcare Standards have been established by the Welsh Assembly Government with the intention of improving patient experience and improve the quality of services delivered by healthcare organisations. See 'Healthcare Standards for Wales; Making the Connections Designed For Life' May 2005.

c) Procedures should recognise the value of drawing information from families of patients and third parties, and of involving them appropriately in the monitoring and management of risk.
d) The Trust's Clinical Risk Assessment and Management policy should be subject to regular audit to ensure that it is being correctly implemented and guides practice.
e) The Trust and Caerphilly County Borough Council Social Services' procedures should address the need to ensure that they fully involve partners of the Criminal Justice System where that is appropriate for the assessment and management of risk.
(Related Healthcare Standards: 2, 4, 16, 22, 23, 24, 25, 27)

3. All agencies involved with information sharing processes must ensure that the system used is robust and that actions emanating from meetings, such as Section 115 meetings, are documented and that all the relevant agencies are invited to and are involved in the process. In particular:

a) Training should be provided to educate staff as to the processes available to them in respect of sharing information between agencies.
b) A clear single protocol relating to Section 115 meetings (and other meetings, for example Section 117 Mental Health Act 1983, and MAPPA meetings) should be published and circulated to all relevant agencies.
(Related Healthcare Standards: 22, 24, 25, 26, 27)

4. Gwent Healthcare NHS Trust and Caerphilly County Borough Council Social Services should ensure that integrated and co-ordinated services are provided for those experiencing mental health problems of whatever severity or duration. In particular:

a) Effective management of CMHT MDTs including joint working arrangements within the CMHT should be reviewed and addressed.

b) Communication links between agencies and partners need to be more robust and consistent, in particular, in relation to healthcare organisations in cases where there is disagreement surrounding care management, or diagnosis.

c) Clients should be assertively managed by all services involved using carefully designed and managed care plans which need to be jointly formulated between services, focusing on key risks, how to manage these risks, and having clear decision pathways documented.

d) Supervision and support at all levels, both within Gwent Healthcare NHS Trust and Caerphilly County Borough Council Social Services needs to be reviewed to ensure its effectiveness, and monitored on a regular basis.

e) Steps should be taken to ensure that delays in providing appointments for patients are minimised, and in the case of those at the highest risk, eliminated.

f) Systems should be put in place to ensure that reports and other documentation are provided in a timely fashion.
(Related Healthcare Standards: 11, 12, 24, 25)

5 Gwent Healthcare NHS Trust and Caerphilly LHB should ensure that arrangements are in place for good communication with primary, secondary and tertiary care services to ensure that information is passed on in a timely and accurate fashion.
(Related Healthcare Standard: 12)

3.2 For ease of reference Annex D cross references these recommendations with the root causes identified in the course of the review and the broad areas of concern set out in this report.

Annex A

Terms of Reference for the Review

The aim of the review was to:

- Consider the care provided to Mr B 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 18 April 2006[6].

- To review the decisions made in relation to the care of Mr B.

- To identify any change or changes in Mr B's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 18 April 2006.

- 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.

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

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 B

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 L Fagin	Consultant Psychiatrist
Mr M Thornton	Primary Care Liaison Coordinator, Community Psychiatric Nurse
Mrs K Bailey	Chartered Forensic Psychologist
Mrs J Lewis	Social Services Inspector, Care and Social Services Inspectorate Wales (CSSIW)
Mr M Thomas	Lay Reviewer, HIW panel
Mr M Frost	Investigations manager, HIW
Mr R Jones	Investigations Officer, HIW
Ms C Fahey	Investigations Coordinator, HIW

The information gathering phase of the review was conducted between March 2007 and June 2007. It consisted of:

- examination of documents relating to the organisation and delivery of services by Gwent Healthcare NHS Trust and Caerphilly 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 and the review team also had access to the police records relating to the case;
- reading the case records maintained by Health Bodies and Local Authorities concerning Mr B;
- reading interview notes and written statements provided by staff working with Mr B 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 using the proprietary software tool HIW has adopted for such tasks and 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 D

RCA Table

Areas of Concern	Root Causes Identified	Recommendations
Diagnosis	• Mr B offered a complex and unusual presentation.	1
	• There was a difference in opinion between clinical and forensic services (Caswell Clinic) regarding Mr B's diagnosis. This prevented the addressing of the central symptom of Mr B's intrusive homicidal thoughts. 2, 4, 5	2, 4, 5
	• The CMHT were unclear over where management of Mr B's care lay, and their viewpoint conflicted with that of the Gwent Forensic Psychiatric Services.	2, 4
	• There was a poor understanding of personality disorder among members of the CMHT.	1
	• A lack of a formalised care plan drawn up involving both the CMHT and Forensic Services.	2, 4
	• There was no involvement with the CMHT Psychologist and a lack of assessment of the possible psychological approaches available to Mr B.	1, 2, 4
	• There were difficulties with implementing a rigid drug regime due to the uncertainties regarding Mr B's precise diagnosis.	1
Responsibility for Care	• The CMHT were unclear over which service should take overall responsibility over Mr B's care. This was related to the lack of knowledge about treating personality disorder, and confusion over the conflicting diagnoses offered by both clinical and forensic services.	1, 4
	• There was not enough effort made by clinical and forensic services with regards to holding a meeting to discuss the diagnosis and care management of Mr B. This could have assisted with clearing up any confusion and provided an agreed way forward.	4, 5

	• An unfortunate delay in the CMHT receiving the Caswell Clinic's report dated 30th January 2006. This was compounded by the reported miscommunication regarding Mr B's risk status.	4, 5
	• The 8 week delay in an appointment being given by Gwent Forensic Psychiatric Services to see Mr B following the CMHT's request made on 10th March 2006. The homicide of DS occurred on 18th April 2006, prior to the appointment date of 8th May 2006.	4, 5
Training Issues	• A lack of training about personality disorder available to staff at the time of Mr B's involvement with services.	1
	• No referral being made to the newly created Gwylfa Personality Disorder service for advice.	1, 4
Risk Management	• There was a lack of an integrated approach to risk assessment across forensic and clinical services.	2, 4
	• Staff were inadequately trained to assess Mr B's risk factors and the function of Mr B's intrusive thoughts, therefore they were unable to effectively gauge the level of risk that Mr B presented.	1, 2, 4
	• Gwent Healthcare NHS Trust had inadequate risk management policies which provided little guidance with regards to risk management procedures.	2
	• There was a lack of implementation of the enhanced CPA that Mr B was placed. This meant that Mr B's care plan lacked a focal point for all services concerned.	2, 4
	• The risk assessment tool that was used by the CMHT was not adequate in terms of assessing the dynamic factors, which would have assisted with the management and treatment of Mr B.	2, 4
	• There was a lack of concerted effort by the CMHT to engage Mr B's family and wife in the risk assessment process, and using them for the purposes of relapse monitoring.	2
	• Action plans were never developed or put in place, both following the initial assessment by the Caswell Clinic in June 2004, and also emanating from the Section 115 Crime and Disorder Act 1998 meetings held in respect of Mr B.	3, 4

	• Both Social Services, and the GP were not invited to the Section 115 meetings held in October and November 2004.	2, 3, 4
	• The communication of the risk levels presented by Mr B was inconsistent between services, in particular at the time of Mr B's second assessment at the Caswell Clinic in January 2006.	4, 5
Integration of Social Services within the CMHT	• There was a lack of understanding within the CMHT of the social worker's role. • A lack of integration between clinical and social services meaning that the referral process and case management was not as effective as it could have been.	4

Annex E

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) was established on 1 April 2004 by the National Assembly for Wales to discharge the responsibilities specified for the Assembly in the Health and Social care (Community Health and Standards) Act 2003. HIW was established as a Unit within the National Assembly with a formal independence provided through delegations made under the 2003 Act to the Chief Executive of HIW. In June 2007 functions that were formerly exercisable by the National Assembly for Wales were transferred under the Government of Wales Act 2006 to the Welsh Assembly Government and HIW is now a unit within the Government.

HIW's core responsibility is to undertake reviews and investigations into the provision of NHS funded care by or for Welsh NHS organisations, in order to provide independent assurance about, and to support the continuous improvement in, the quality and safety of Welsh NHS funded care. In doing so, HIW must play particular regard to:

- the availability of and access to healthcare;
- the quality and effectiveness of healthcare;
- the management of healthcare and the economy and efficiency of its provision;
- the information provided to the public and patients about healthcare and;
- the rights and welfare of children.

The frameworks of Clinical Governance and Healthcare Standards set by the Welsh Assembly Government are central to the way in which HIW assesses Welsh NHS organisations and Welsh NHS funded care.

In this respect, Healthcare Inspectorate Wales is committed to:

- strengthening the voice of patients and the public in the way health services are reviewed;
- working with others to improve services across sectors and agencies;
- working with other regulators/inspectorates to ensure that the public, NHS organisations and the Assembly receive useful, accessible and relevant information about the quality and safety of Welsh NHS funded care and;
- developing more effective and coordinated approaches to the review and regulation of the NHS in Wales.

On 1 April 2006, the responsibility for the regulation of independent healthcare transferred to HIW from the Care Standards Inspectorate for Wales (CSIW) under the remit of the Care Standards Act 2000. Independent healthcare settings include acute hospitals, mental health establishments, dental anaesthesia settings, hospices, private medical practices, and clinics where prescribed techniques include class 3b and 4 lasers.

On 1 April 2006, following the abolition of Health Professions Wales, HIW assumed responsibility for the statutory supervision of midwives and also entered an agreement with the Nursing & Midwifery Council (NMC) to conduct annual monitoring of higher education institutions in Wales which offer approved NMC programmes.

Annex F

Multi Agency Arrangements for the Management of Risk

The MARAG (Multi Agency Risk Assessment Group) that was mentioned within the records actually refers to MAPPA (Multi Agency Public Protection Arrangements). This body places a duty on the police and the National Probation Service to assess and manage risks posed by offenders in every community in England and Wales. In the most serious cases MAPPA can recommend increased police monitoring, special steps to protect victims and the use of closely supervised accommodation.

The MAPPA meetings are split into three categories:

Category 1: Sex Offenders
Category 2: Violent and other offenders
Category 3: Other offenders

The MAPPA operates at three separate levels within each of the above categories depending upon the severity of risk relating to the individual concerned.

Level 1: Ordinary risk management by one agency.
Level 2: Local inter-agency risk management. This is where more than one agency is required to implement a risk management plan.
Level 3: MAPPA - Critical Few. This is where a robust multi agency plan is required and the involvement of senior managers is required to
manage any risk assessment. this level of MAPPA is for the very high
risk offenders who pose a significant risk within the community.

In addition to the above each offender is also classified as being, Low, Medium , High or Very High risk depending on risk assessments conducted by both the police and the probation service.

For an individual to be discussed at MAPPA meetings he/she needs to have had a conviction of 12 months or more in relation to an offence which shows that they are capable of causing serious harm to the public. Due to this criteria Mr B would never have come under MAPPA's jurisdiction.

Annex G

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 problem. 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,*
- *Maybe 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 H

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; and
(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 B against his wishes would have had to be determined.

Annex I

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. Also referred to as **Psychopathic Personality Disorder**.

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).

DICES - An evidence-based tool which assesses mental health risks;
• Describe risk
• Investigate possible options
• Choose an option
• Explain why chosen option
• Share with others involved

General Practitioner (GP) - A family doctor.

HCR-20 - an empirically based guide to risk assessment instrument, which aligns risk markers into past, present, and future. The HCR-20 was designed to provide empirically based structured clinical guidance in relation to the assessment and management of individuals who are potentially violent.

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 contained within part II of the MHA.

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 examines 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 – See **Anti-social Personality Disorder** above.

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).

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 provide 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.

SVR-20 - A 20-item checklist of risk factors for sexual violence that were identified by a review of the literature on sex offenders. The checklist was developed to improve the accuracy of assessments for the risk of future sexual violence.

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.