Healthcare Inspectorate Wales

Report of a review in respect of Ms A and the Provision of Mental Health Services, following a Homicide committed in October 2005

May 2008

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Chapter 1: The Evidence

Summary of the index offence

1.1. On 19 October 2005 at 12.20pm, in a shop in the City centre of Cardiff, a woman was stabbed and later died.

1.2. A shop video of events, supported by eyewitness accounts, shows Ms A going into the shop, getting a knife from a shelf display and removing it from its wrapping (using a cigarette lighter to burn away the plastic covering). The video gives the impression of Ms A going up to a woman intending to stab her, which she did not do. Ms A then goes out of camera shot, she comes back into shot, as does a third woman. The third woman is seen with a knife handle sticking out of her back. That woman had been stabbed and subsequently died.

1.3. Following these events, witnesses gave evidence to the effect that Ms A had acknowledged her responsibility for the homicide. Ms A was heard to have said, "I've just stabbed someone, call an ambulance", "Call the police, they need to arrest me", and later, addressing the arresting police officers, "I f*****g stabbed her, take me away", "I did it. It was premeditated." "I didn't know her. I picked her out. She was the second one. I bottled it on the first one."

1.4. Later in the police station Ms A said in interview, "I completely deny stabbing her". At Cardiff Crown Court on 27 October 2006 Ms A was found guilty of the offence of manslaughter on the grounds of diminished responsibility and was made subject to an order under the terms of sections 37 and 41 of the Mental Health Act 1983. She is currently receiving treatment at a Medium Secure Unit.

Background

1.5. 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 from these circumstances are identified and acted upon. As of January 2007 these independent external reviews are conducted by Healthcare Inspectorate Wales (HIW) (See Annex B and G).

Brief History of Ms A

1.6. Ms A was born in 1961 and brought up in Cardiff where she lived with her family until she was 15 years old. The family was not without difficulties.

1.7. By the time Ms A came into contact with mental health services at the age of 31, certain features of her life appeared to be well established. While caring for her children, her practical difficulties were compounded by cannabis abuse and reported misuse of alcohol. She found it difficult to maintain contact with mental health and social care services on her own initiative and she had some experience of the criminal justice system.

1.8. Ms A's contact with mental health services in Cardiff can be divided into two periods: 1992-1998, when she was given a diagnosis of schizophrenia and treated with anti-psychotics and followed up by services. And in 2003-2005 when she was given a diagnosis of borderline personality disorder and not given continued treatment or followed up.

1.9. Records show that the first consideration of a mental health problem in respect of Ms A was in June/July 1986. Her GP recorded that she experienced panic when people came to her house, accused her husband of having affairs and reported having intense feelings of jealousy. She was assessed on one occasion at the Psychiatric Outpatient Clinic in Cardiff on 8 July 1986. Her GP reported her having paranoid feelings of everyone conspiring against her. She was given Stelazine by her GP.

1.10. Ms A's first continuing contact with specialist mental health services was in 1992. After an initial diagnosis of depressive illness, this was subsequently changed to a more substantive diagnosis of a psychotic illness, paranoid schizophrenia. During the course of the following years a number of alternative diagnoses were put forward, including drug induced psychosis and borderline personality disorder. Throughout her contact with mental health services Ms A had presented in a variety of ways, which may account in part for the range of diagnoses offered. However, the HIW review team noted that there were occasions throughout the period of her contact when symptoms of psychosis were presented, consistent with the earlier diagnosis of psychosis in 1992.

1.11. At the end of 1998, towards the end of the first period of contact Ms A had with mental health services in Cardiff, she became homeless. By October 2000 she ceased to be in contact with Cardiff services and, following a short period of imprisonment, established herself in Gloucestershire where she obtained accommodation and received services from local mental health services. A second period of contact with mental health services in Cardiff began in September 2003 when Ms A was admitted for inpatient care at Whitchurch Hospital. For a while Ms A moved between Cardiff and Gloucestershire, but from the end of 2003 she seemed to have returned permanently to Cardiff, although she was homeless. During that period she was accommodated mainly in hostels in central Cardiff but there is some indication that she also experienced periods of street homelessness. In the period leading up to the index offence she was resident at Tresillian House, a hostel for the homeless operated by the Housing Department of Cardiff County Council. At that time an assessment of her situation showed that, in addition to being without appropriate accommodation, her cannabis abuse continued and she misused alcohol occasionally. That assessment also showed that, whilst Ms A recognised those drug and alcohol problems, she did not wish to take any steps to overcome them. It is also evident that the Local Authority had taken steps to re-house Ms A in more suitable accommodation but Ms A had been unable to respond positively to its efforts.

Diagnoses

1.12. The first record of Ms A having mental health problems was in June/July 1986. At that time she complained of feelings of panic when people came to the house, accused her husband of affairs and she was said to be suffering intense feelings of jealousy which grew into paranoid feelings of everyone conspiring against her. No formal diagnosis was on the record but she was prescribed Stelazine by her GP. In May 1992, Ms A was found to be suffering from auditory hallucinations, paranoid ideas and bulimia. After an initial diagnosis of depression, subsequent diagnoses of schizophrenia, schizoaffective disorder and depressive psychosis were made. It was noted that her depression seemed to be worse from 1989 onwards and Ms A was presented as being increasingly worn down and hopeless. In July 1992, following further assessment by the Pendine Community Mental Health Team (CMHT), a diagnosis of borderline personality disorder was put forward and, in August of that year, there was a further question of whether Ms A was suffering from a borderline personality disorder rather than a functional psychosis.

1.13. In July 1993, Ms A was experiencing strange phenomena and following further psychiatric assessment, schizophrenia was diagnosed. In October of that year Ms A was complaining of depression and intermittent auditory hallucinations. The diagnosis was unclear but the possibility of an affective psychosis, schizoaffective disorder or psychotic depression was considered. By 14 October 1993 Ms A had been admitted as a day patient to Whitchurch Hospital.

1.14. On 21 October 1993 Ms A appeared to be experiencing auditory hallucinations and she was urged to stay in hospital. Ms A did not agree to stay, as she was concerned about the care of her children at home. Subsequently, she accepted a depot neurolepetic injection and a few days later, when childcare had been arranged for her children, she was admitted again as an inpatient to Whitchurch Hospital. She was diagnosed as suffering from schizophrenia with depression and treated with Depixol from November

1993. A sick certificate issued in December 1993 referred to a diagnosis of psychotic disorder and the discharge summary completed in that month by Whitchurch Hospital gave a diagnosis of schizophrenia with depression, with further reference to an apparent personality problem with underlying aggression.

1.15. Following further contact with mental health services in Cardiff, Ms A was admitted again as an inpatient to Whitchurch Hospital in March 1994. Records indicated that staff felt Ms A's illness had previously been induced by drugs, but was now one of a depressive disorder. During this period of treatment Ms A was given Electro-Convulsive Therapy (ECT). In June 1994 a discharge summary offered a diagnosis of chronic schizophrenia complicated by heavy drug use. Ms A was referred to the community drug team. At that time Ms A was being treated with Depixol which continued into 1995. In February 1995 an out patient assessment suggested that Ms A was displaying no symptoms of psychosis, treatment with Depixol was to continue and Lofepramine was started. Ms A did not tolerate the latter and this treatment ceased in April 1995. In July 1995 Ms A was reviewed as an outpatient when she reported low moods and hearing derogatory voices. Prothiaden and Diazepam were commenced. In September 1995 Sertraline was prescribed, but it was unclear from the records whether Ms A ever started to take that medication. Depot medication continued until 5 March 1996 when Ms A refused medication. At that time she was complaining of hearing noises in her head and demonstrating paranoid ideation. Prothiaden was increased from 50mg to 75mg. Ms A's contact with Cardiff mental health services continued through the years into 1999.

1.16. By October 2000 she ceased to be in contact with Cardiff services and, following a short period of imprisonment, established herself in Gloucestershire where she obtained accommodation and received services from local mental health services. In September 2003, following an admission to Whitchurch Hospital in Cardiff, Ms A was transferred to her local inpatient unit in Gloucestershire with a diagnosis of mental and behaviour disorder due to the use of cannabis. A discharge letter on 6 October 2003 referred to

reactive psychosis, drug induced psychosis. On 23 October at Whitchurch Hospital the assessing Doctor noted no psychotic features although Ms A was very paranoid. On 3 January 2004, Ms A was again admitted to Whitchurch Hospital at the request of her GP who reported that Ms A said people were trying to murder her; again she was diagnosed as having no psychotic features but being very paranoid. That view was confirmed at a Multi-Disciplinary Team (MDT) meeting at Whitchurch Hospital on 2 February 2004 when it was recorded that no psychosis had been demonstrated and that Ms A was to be discharged after a week. In September 2004, Ms A was taken to Whitchurch Hospital, was admitted and a diagnosis of borderline personality or alcohol/drug misuse was made. She was discharged on 20 September 2004. Other than an assessment by the Crisis Resolution Home Treatment Team (CRHTT) in April 2005, conducted as a result of an attendance by Ms A at A&E, Ms A had no further contact with mental health services.

1.17. Several things are striking about Ms A's presentation during the time she was in contact with mental health services:

- Ms A often presented with different features e.g. anxiety, depression, bingeing/vomiting, family and relationship problems, psychotic symptoms, bizarre or chaotic behaviour, hostility. Her 'bizarre' or chaotic behaviour also varied.

- There seems to have been difficulty in engaging Ms A with services – this was to some degree evident in the 1990s but became worse in the 2000s owing to her lack of fixed accommodation. There appears to have been considerable hostility at times, but also ambivalence on Ms A's part about engaging. She requested support when she felt that she needed it and appeared more responsive to services with a more 'open door' approach such as A&E, homeless people services, family centre.

- There was a background element of drug misuse. This seems to have been mainly cannabis (which seems consistent, especially in the

1990's). There was also periodic heavy alcohol use and possibly other drugs, but the evidence for multiple drug misuse is poor.

- She received two main diagnoses: schizophrenia (or related affective psychosis) and borderline personality disorder – these differ with her two periods of service contact in Cardiff.

1.18. In addition these further points arise from consideration of the records:

- The first record of any psychotic symptoms was in the GP notes of 8 July 1986, before she was first seen by mental health services later that month in an outpatient clinic (OPC). This first mental health services contact did not reveal any psychosis (but in retrospect her ideas of jealousy towards her husband may have been a symptom of psychosis). However, evidence of psychosis was picked up early in 1992/1993 during her first continuing contact with mental health services. Her presentation with psychotic symptoms varied over time, but several people did note the presence of psychosis in the 2000s.

- It is difficult to be certain about the risk factors that relate to homicide. She had two charges of assault leading to actual bodily harm, but neither strike as being precursors for more serious aggressive behaviour. We did note some reference to threats of violence towards others. However, most of her risk factors relate to non-deliberate self-harm and poor engagement with services (e.g. homeless, chaotic behaviour, periodic high alcohol use, poor parental background and abuse).

Care and Treatment by Mental Health Services and Social Care Services

In Cardiff 1992-1998

1.19. Ms A's first substantial contact with mental health services in Cardiff was in 1992. There followed a period of six years during which she was accessing a variety of mental health and social care services in the city.

1.20. Although there were a variety of diagnoses made during that time Ms A was predominantly viewed as suffering from a mental illness generally described as a psychotic disorder or as schizophrenia. From 1993 she was being actively treated for a psychotic illness at first for example through the use of Clopixol, and then Depixol. Stelazine was used in March 1996.

1.21. Ms A's contact with services was erratic and she found it difficult to maintain formal arrangements for contact. What stands out during this period is the extent to which the community psychiatric nurse and the social worker allocated to Ms A worked with her to overcome the difficulties presented by Ms A's failure to maintain formal contact. Work with Ms A included home visits to encourage her to keep CMHT appointments or to engage with her through less formal contact arrangements i.e. a women's group run by social services staff. It is clear that efforts were made to assist Ms A to retain her accommodation through ensuring that financial benefits were claimed and that a careful oversight was maintained of her management of the family home and the care of her children. Despite all the difficulties faced by Ms A it does appear that from 1992 until 1998 the treatment she received and the level of health and social care may have helped to ensure that a very problematic situation did not deteriorate still further. It was noted that this level of service came to an end when staff moved on; Social Services records available to the review team end at that point. At the end of 1998 Ms A's difficulties increased with the loss of her home. Between then and the end of 2000 there were only two further contacts recorded with the CMHT, both in September 1999 when Ms A was said to be very agitated and paranoid and was threatening to kill black men.

1.22. During much of this period Ms A's children were living with her. That may have been one factor leading to the level of services provided to her during that time. Given the circumstances of her life it would have been unusual if there had not been concern on the part of both child care and adult services. Social Services staff were concerned about the care of her children.

In Gloucestershire 2000-2003

1.23. The review team is grateful for the assistance of the Healthcare Commission in England for facilitating access to mental health services in Gloucestershire. HIW's powers only extend to English Trusts in cases where their services are commissioned by Welsh NHS bodies. In the absence of Ms A's consent for HIW to access her records in England, the review team had to rely upon the powers of Healthcare Commission in order to access the Ms A's records held by Gloucestershire Partnership NHS Trust. As a result of this co-operation the review team had access to both the Trust's records and those relating to the primary care received by Ms A during the period she was living in Gloucestershire. Access to these records was considered necessary in order for the review team to have an overview of the whole period of treatment and care received by Ms A to ensure that its findings and recommendations were properly informed.

1.24. Ms A had contact with health services in Gloucestershire and received mental health services both as an in-patient and an out-patient. Again her capacity to accept or follow-up help was intermittent but efforts to provide services for Ms A extended to two attempted home visits by the Consultant Psychiatrist of the CMHT. She had an inpatient admission in Gloucestershire between 17 September 2003 to 1 October 2003 following her transfer from the inpatient unit at Whitchurch Hospital Cardiff. She discharged herself from the inpatient unit and was offered follow-up but returned to Cardiff. There was only one formal diagnosis given and that was ICD-10 F12.12. (Mental and Behavioural Disorder linked to the use of cannabis). One of her GPs noted that she may be psychotic or may have a personality disorder. She was seen by the on-call psychiatrist in Cheltenham A&E Department on two occasions

and these encounters were recorded in lengthy letters. On the first of these occasions in February 2002 she was thought to be dishevelled and thought to be psychotic. The Senior House Officer (SHO) who saw her thought she may require admission but she left the A&E before this could be arranged. The SHO subsequently arranged that the consultant psychiatrist undertake a domiciliary visit. On the second occasion in June 2002 she was noted to be well kempt and the Staff Grade doctor noted the absence of any psychotic symptoms. She was treated with Olanzapine when she was an inpatient and during some of 2002 was given Stelazine by her GP. She was also given Temazepam by her GP in 2002 and 2003.

In Cardiff 2003-2005

1.25. Ms A's second period of contact with services in Cardiff began in September 2003 when Ms A was admitted to Whitchurch Hospital. She was transferred back to Gloucestershire a few days later, where a reactive (drug induced) psychosis was diagnosed. Ms A discharged herself from the hospital in Gloucestershire and toward end of October 2003 was admitted again to Whitchurch Hospital. Shortly thereafter she was discharged and between November and January 2004 she was living in a variety of accommodation, mainly in Cardiff.

1.26. In January 2004 Ms A was again admitted to Whitchurch Hospital but within two weeks was again discharged. She was an in-patient at Whitchurch Hospital (and then subsequently transferred to the Rawnsley Unit at the University Hospital of Wales) between 14 February and 27 February 2004. During that stay at Whitchurch Hospital an anti-psychotic (Trifluoperazine) was used to alleviate mild agitation. Ms A was said to be paranoid and 'confused'. However no evidence of psychotic illness was identified while Ms A was hospitalised.

1.27. At that time a key feature was the growing strength of opinion that Ms A demonstrated no psychotic features. It is over this period that a diagnosis of

borderline personality disorder becomes the pre-dominant explanation of Ms A's presentation.

1.28. That was a crucial development because it was from that diagnosis that decisions were made that there was no mental health intervention which could or should be offered to Ms A.

1.29. In parallel, contact with social care services was limited. There was a single referral to a Social Worker at the CMHT during the January 2004 admission to Whitchurch Hospital but that referral was specifically focused upon Ms A's need for accommodation on discharge. Neither Health nor Social Services undertook a full assessment of Ms A's mental health and social care needs at that point.

1.30. In September 2004 Ms A was admitted to Whitchurch Hospital having been brought there by police. Within two days Ms A was discharged against medical advice with no planned follow up from the CMHT.

1.31. On 18 April 2005 Ms A presented at University Hospital Wales A&E in Cardiff. At that time she was referred to the on call psychiatrist and a CPN (Community Psychiatric Nurse) from the Crisis Resolution Home Treatment Team (CRHTT). She was then referred to the CMHT. On 25 April 2005 the referral was discussed at Sealock Multi-Disciplinary Team (MDT) which decided that Ms A had a personality disorder and was a substance misuser. It was decided that her recent presentation did not make her appropriate for involvement with the CMHT and no appointment was offered to her.

1.32. During this period of contact in Cardiff two services appeared to the HIW review team to offer continuing willingness to work with Ms A. The General Practitioner (GP), while being used only in a limited fashion by Ms A, did offer contact in a less structured, more helpful, way than other services. The GP had considerable experience of working with homeless people. Her arrangements for open surgeries rather than working through an appointment system and willingness to make visits to residents in hostels were a positive

response to the limited capacity of many homeless people to conform to more formal arrangements. The other service providing active intervention with Ms A was the Housing department of Cardiff County Council. Its staff at Tresillian House and elsewhere in the housing department took active steps to support Ms A, provide temporary accommodation and seek to resolve her accommodation problems.

Summary

1.33. Overall, the review team found evidence of two distinct periods during which Ms A had contact with mental health and social care services in Cardiff. The first period, 1992-1998 was characterised by a pre-dominant diagnosis of psychotic mental illness and high levels of engagement by health and social care services with Ms A. For a significant period further deterioration in Ms A's circumstances may have been averted.

1.34. The second period, 2003-2005 was characterised by a pre-dominant diagnosis of a borderline personality disorder, good engagement by housing services and potential for assistance from the GP to Ms A, but an absence of robust engagement by other services.

Management and Organisation of Services

Arrangements for Provision of Mental Health Services in Wales

1.35. In Wales the commissioning of primary and most secondary mental health services is the responsibility of Local Health Board. In respect of Ms A, the responsible Board was the Cardiff Local Health Board and its predecessor, Bro Taff Health Authority, prior to reorganisation in 2003.

1.36. The health service body providing mental health services at a secondary level in Cardiff in 2005 was the Cardiff and the Vale NHS Trust. Its mental health services are focused around in-patient facilities at its major site

at Whitchurch Hospital and smaller facilities at Llandough Hospital. It also operates 'jointly' with the Local Authority a number of Community Mental Health Teams. Initially Ms A was the responsibility of the Pendine CMHT (the first to be established in Cardiff) while latterly she fell within the remit of the Sealock CMHT.

1.37. At the primary care 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 Ms A had a number of GPs. In the period immediately prior to the index offence she was attending a Surgery in the Butetown area of Cardiff where the GP offered a particular service to those who were homeless, focused around the hostels located in that part of Cardiff.

Arrangements for Provision of Social Services and Housing Services in Cardiff

1.38. In 2005 the Local Authority, Cardiff County Council, provided both Social Services and Housing Services. These services had had contact with Ms A during the time she was receiving care from mental health services.

Provision of Services in Gloucestershire

1.39. From 2001 to 2003 Ms A spent periods of time in Cheltenham and Stroud. The Housing department of the Local Authority provided services. She was registered with two General Practices in Cheltenham and Stroud. Gloucestershire Partnership NHS Trust provided both inpatient and outpatient services for her during that period.

The Organisation and Management of the NHS and Social Services in Wales in respect of Mental Health Services.

1.40. At a strategic level there were a number of significant changes in the control and direction of public services between 1992 and 2005. These included:

- Reorganisation of Local Government in 1996,
- Reorganisation of the Welsh NHS Trust in 1998,
- Devolution of powers to the National Assembly for Wales in 1999, as a result of which the Assembly became responsible for the strategic direction and management of the NHS in Wales,
- Abolition of Welsh Health Authorities and the establishment of Local Health Boards in 2003.

1.41. Each change brought about shifts of responsibility for the delivery of services to the people of Wales. It is not possible to determine the extent to which that may have had a short term impact upon the delivery of services to Ms A although it might be anticipated that reorganisation of services could result in temporary constraints upon delivery of services.

1.42. 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, Adult mental health services in primary healthcare settings in Wales' (Welsh Assembly Government 2006).

We set out below relevant extracts from these documents:

'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 Problem 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 affective, 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".

1.43. 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:

- *More accessible,*
- *More responsive to provide help and support quickly,*
- *Enabled to seek out those who are difficult to engage,*
- *Capable of involving service users and carers in all aspects of planning,*
- *Effective in using care processes.*

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

enduring needs, often require help with other aspects of their lives such as housing, finance, employment, education and physical health needs.

This places demands on services that no one discipline or agency can meet alone and it's therefore necessary to have an integrated system of effective care co-ordination for all services to work together for the benefit of the service user''.

1.44. 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''.*

1.45. Standard seven of the National Service Framework sets 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''.

1.46. The Welsh Health Circular (2006) 053 provides some assistance in identifying how the interface between primary care and CMHTs should collaborate although it should be noted that this guidance post dates the incident which prompted this review. The Circular includes:

> *''In order to deliver effective care Primary Healthcare Teams (PHCTs) require prompt access to advice, assessment and intervention from specialist services. Each primary care practice will have access to a gateway worker to provide or facilitate access to this specialist input''.*

Local Management of Health and Social Services in Cardiff

1.47. At a more local level there were changes too. For example community mental health services saw the introduction of the first CMHT in Cardiff in May 1992. Ms A received services from that team during the first period of contact she had in Cardiff. During the second period of contact her local CMHT was the Sealock CMHT and since that contact ceased there has been further reorganisation of CMHTs in Cardiff.

1.48. Reorganisation of health services in Cardiff also included changes in overall responsibility for the provision of services. The responsibilities of former South Glamorgan Health Authority were transferred to Cardiff Community Healthcare Trust from 1 April 1995 until 1 April 1999. Between 1 April 1999 and 1 April 2000, Cardiff and District Community NHS Trust and University Hospital of Wales and Llandough Hospital NHS Trust were responsible for provision of services in Cardiff. From 1 April 2000 those responsibilities passed to the then, newly formed Cardiff and Vale NHS Trust.

1.49. During the course of our enquiries we heard of arrangements for a 'homelessness CPN' who took responsibility for links with the hostels in Cardiff and co-ordinating to an extent the use of services by homeless people. That role was withdrawn in 1999. There was comment among the people being interviewed about that having reduced the capacity of services to co-ordinate and integrate their services for the homeless.

1.50. At the time of this Review, within the Local Authority Social Services Department there were discussions taking place concerning the configuration of services provided to the homeless and other vulnerable groups in Cardiff. Provision had been focused upon the Local Authority's 'City Centre Team'. The Local Authority had decided that there were alternative and more effective ways of delivering these services but we encountered some consternation, among a number of those we interviewed about the proposed changes. At the time of our review the matter was still under consideration and we were advised that any changes in the function of the City Centre Team would be made in consultation with stakeholders. The Local Authority anticipated that any changes introduced would lead to an improvement in services.

1.51. However the general direction of local changes in mental health and social care for people such as Ms A remained consistent. There was an intention to move services from large psychiatric hospitals into the community and to smaller in-patient units, which had been slowly progressing in Cardiff. The development of joint responsibility for mental health services between the NHS and the Local Authority had been promoted initially by the Department of Health in the UK and then by the National Assembly for Wales. In Cardiff, CMHTs were one way in which that joint responsibility was discharged. The integration of services for those with mental problems, drawing together the work of the public sector bodies with that of the voluntary sector was the third strand of change promoted by the National Assembly for Wales.

1.52. These broader directions for progress of mental health services were supported by a number of other initiatives, encouragement of the use of funding flexibilities to enable joint working, the introduction of unified assessment and the care programme approach to assessment and care of those suffering mental health problems.

Arrangements for delivery of mental health services in Cardiff

1.53. In Cardiff during the period of Ms A's contact with services the local management of services had developed but in many respects the directions of change outlined above had been slow to establish and a number of improvements remained to be completed at the time of this Review.

1.54. Within the Cardiff and Vale NHS Trust plans to replace the large Victorian asylum premises, housing the psychiatric hospital at Whitchurch, were being implemented. A new unit at Llandough Hospital had been opened recently but at the time of our Review it was still anticipated that it would be a further four years before all services delivered through Whitchurch Hospital would be relocated.

1.55. Joint responsibility for delivery of mental health services by the NHS and Local Authority in Cardiff had been accepted and in relation to CMHTs these were formally jointly provided services. However in the 2000s CMHTs had no single management structure, different professions reported through different lines of management and the nurse manager charged with co-ordinating the delivery of services had no direct authority to command and direct the whole Team's operations. The need for integrated management systems between the NHS and Local Authorities had been a priority for the then Health Authority no later than 2002[1]. But although in 2005 the Local Health Board (LHB) had set a target to introduce integrated CMHT management by February 2006[2], this had not been achieved. The concept of joint working was underdeveloped. It was made clear to us that relationships between Health Services and the Local Authority were not always positive at managerial and strategic levels.

1.56. There was evidence in the case of Ms A of a lack of meaningful integration of services, most clearly during the second period of contact with Ms A staff working in these services appeared to depend upon informal routes

[1] 'Mental Health Service Specification for Cardiff', Bro Taff Health Authority June 2002
[2] A report to LHB 18th May 2005

of collaboration based on goodwill. There was an absence of 'single points of access' to services, the failure of co-ordination of responses to Ms A's situation, the absence of a care programme approach and the lack of more direct pathways to health services from non-health referrers.

1.57. We examined the staffing levels at the CMHT, both in relation to health service and social work staff. We were told in interviews with staff that the resources available were appropriate and that the establishment of the CMHT provided sufficient staff to enable its workload to be managed well. In January/February 2004 the team had the following composition and served a population of 20,000:

Community Psychiatric Nurses (CPNs);

2 x G Grade
1x F grade
2 x E grade

Health Care Assistant 0.5 B grade

Occupational Therapist 0.5

Consultant Psychiatrist 1

Staff grade doctor 0.5

Social Workers 2 (of 4 covering Sealock and Riverside CMHTs)

Psychology – sessional input

1.58. We have considered this establishment in relation to guidelines suggested by the Sainsbury Centre for Mental Health (see Annex F). In the light of that work we believe that there is some under provision of staffing at the Sealock CMHT. Whilst the provision of some staffing may appear more or less adequate, consideration should be given to the high levels of deprivation in the area covered by the CMHT relative to other parts of Cardiff. Such higher levels of deprivation indicate high levels of morbidity and need for services. All staffing levels may need to be increased but, in particular, increases in the number and type of supporting staff in the CMHT needs to be considered.

1.59. Irrespective of the staffing establishment for the CMHT we noted that there had been difficulty in recruiting to some established posts. We heard that that had been the case during 2003-2005 in respect of psychiatrists, psychologists and social work staff. We were informed by the Trust that at the time of this review there were no difficulties in recruiting Psychiatrists and Psychologists.

Chapter 2: Findings

The Homicide committed by Ms A was not predictable

2.1. Having reviewed the evidence HIW believes that the incident, which occurred on 19 October 2005, could not have been predicted and that there were no indications, which suggested that, the homicide could have been prevented. We have noted the comments of the Court in arriving at its decision in relation to the index offence:

> *"No doubt there will be an enquiry into what had happened. All I can say is your case has presented great difficulty for professionals over many years and I do not think the finger of blame should lightly be pointed at anyone. I think it may well prove to be the case that it would have been very hard indeed for anyone to predict what eventually you chose to do on that particular day."*

2.2. We are persuaded that there is no evidence, which would lead us to a contrary view.

Services Provided to Ms A were less than optimal

2.3. Although we have reached the conclusion that the tragic manslaughter committed by Ms A was unpredictable. HIW does believe that the services that were offered to Ms A over the period leading to the index offence were less than optimal. It is impossible to say whether or not any different, more optimal, approach to Ms A's treatment and care over the longer term might have led to a different set of circumstances in which the homicide might not have occurred. The remainder of this report concentrates on the ways in which we believe treatment and care might have been improved.

Assessment

Diagnosis

2.4. The diagnosis upon which care and treatment was offered, and at times declined, to Ms A varied over the period she was in contact with mental health services. The review team takes the view that an accurate diagnosis of psychosis was made in 1992. It is also clear that a diagnosis of a psychosis has been accepted by the Court in respect of the index offence and is the basis of treatment Ms A is currently receiving at a medium secure unit. It seems likely that Ms A may also have suffered from a borderline personality disorder and at times one or other symptomatology was prominent, this made management of such a case more difficult rather than less and increased levels of need.

2.5. During the intervening period, from 1992-2005, other diagnoses were made. A key feature of this period was the focus upon untreatable borderline personality disorder which led to services becoming less available to Ms A. We take the view that management of individuals with complex needs, rather than simply the issue of treatability, is a matter that the Trust needs to consider carefully.

2.6. While it is clear to the review team that Ms A's presentation varied, we take the view that Ms A was very probably suffering from a chronic psychotic illness throughout the period of her contact with mental health services. We believe that the severity of the psychosis ebbed and flowed and that the symptoms were at some times clearer than at others. At points during her illness other co-morbid diagnoses may have been appropriate. The episodic nature of Ms A's contact with mental health services made it particularly important that a full assessment of her mental state should have been made each time. In particular, a risk assessment with a management plan should have been available following assessments for any individuals with such a long and complex pattern of service engagement. With such a multiplicity, all and any of which (psychosis, borderline personality disorder and substance

misuse) increase risks to the patient and to others as repeatedly highlighted in all the recent series of National Confidential Enquiries reports. From the records available to us that does not appear to have happened on each occasion, there is some evidence that during periods when she received treatment for psychosis Ms A appeared to respond positively to that treatment.

Fully Integrated Assessment

2.7. Detailed assessments of Ms A's mental health were important for the development of an appropriate diagnosis and the response of health services. However, the HIW review team's view is that more complete and comprehensive assessments of Ms A's circumstances and social needs, and the risks posed by her situation, were also required because of the intricate interaction of health and social factors in her life. While there are specific duties placed on social workers by legislation (particularly an Approved Social Worker, undertaking a mental health assessment) such integrated assessment is a particular responsibility of the whole community mental health team.

2.8. Although the legislative expectations of social workers in CMHTs in Cardiff changed in the 1990s, 2000 and after 2004, there should always have been an expectation that an appropriate referral, would be followed by an assessment. Which should in turn have been followed by the development and implementation of a plan to meet the assessed needs which would then be monitored and reviewed.

2.9. The review team did not find a full social work assessment in the files, although we were told that such assessments had been undertaken during the period 1992-1998. The complex range of supports provided to Ms A and the children at that time suggest that an assessment had been undertaken and a plan put in place.

2.10. By the time of the social work intervention in the 2000s, the assessment of her social needs, undertaken by nursing staff on the ward, focused solely upon accommodation difficulties. An incentive for such a narrow referral focus is possibly created if the person is regarded as having a borderline personality disorder and a prompt discharge from hospital is sought. The CMHT policy was to give individuals with just housing and accommodation problems low priority. Its responsibility in these circumstances was to 'signpost' to other services. The HIW review team noted that by making a 'service' focussed referral, as happened in Ms A's case, rather than a request for a full assessment under a CPA or a unified assessment, access to more comprehensive services that might be required is blocked.

2.11. A request from the hostel where Ms A was living for her to be assessed by the CMHT prompted a CMHT policy driven response. The hostel was informed that any referral for assessment had to come from the individual's GP. As Ms A was reluctant to go to the GP this excluded her from a CMHT assessment. The review team noted that subsequent to the events which are the subject of this Report a draft protocol has been produced, and is being acted upon, introducing an additional route into CMHTs from nominated homelessness hostel managers. This is an interim arrangement pending a longer term strategy for mental health provision for homeless people.

2.12. We also noted that assessment procedures in place at homelessness hostels (we saw examples of those used both a Tressillian House and at the Salvation Army Hostel in Cardiff) provide further insights into the needs of the homeless. Integrated assessments should ensure that these insights are taken into account.

2.13. Access to assessment by the CMHT seemed to become increasingly linked to eligibility criteria. These criteria in turn are affected by the need to prioritise work, in particular for staff to prioritise mental health assessments for compulsory admission to psychiatric hospital and work for tribunals. Financial and staff pressures may also contribute to the team's management of requests for their involvement and their workloads. However the criteria for

access may in reality have the affect of reducing the opportunities to identify those in need of help from health and social care services.

2.14. At times the fact that Ms A is a woman seems to have been taken into account but not at other times. Her gender and history as a woman does not appear be taken in to account as part of overall assessments, which were made concerning her. It seems possible that the stereotyping of Ms A into female roles may have influenced the responses made by services; for example, she was seen either as a mother or as a verbally aggressive woman who had fallen out of society. To the extent that such stereotypes were present in organisational assessments, they may have limited the extent to which full consideration of Ms A and her particular circumstances was completed.

2.15. There does not seem to have been any consideration of the fact that Ms As aggressive behaviour might have been a useful survival technique for her, and other women who are street homeless, whilst also being destructive. No supportive or evidence based psychological intervention seemed to be offered to Ms A. Her lack of co-operation and aggressive behaviour appear to have limited the responses to her needs.

2.16. Opportunities to assess Ms A in the period 2002 – 2005 were missed or did not result in a full assessment. The root causes for that were:

- Ms A was difficult to engage,
- Ms A found it difficult to give a detailed account of her history,
- Health and social care organisations were not sufficiently inquisitive or motivated to seek information and that resulted in insufficient effort to collect information, including historical records relating to Ms A,
- Assessments that were made were ‘crisis focused’,
- Record keeping was variable and at times inadequate, and previous records were not accessed,

- The focus on Ms A's difficulties was narrowed to 'housing problems',
- The diagnosis of borderline personality disorder was incorrectly used to preclude further analysis and substance misuse was over emphasised in assessments,
- A 'deficit model' of assessment was predominant, focussing on problems and weaknesses rather than taking into account positives and strengths,
- There were limited services available for the management of people with borderline personality disorder.

Access and Engagement with Services

Access

2.17. The diagnosis of a borderline personality disorder appears to have had a major influence upon the ability of Ms A to access services during her second period in Cardiff. That diagnosis accounts for short and apparently unproductive periods of inpatient care and the decision by Sealock CMHT not to respond to the attempted referral of Ms A by offering an assessment or follow-up. The system for dealing with referrals by the CMHT results in some people not being seen because they are considered 'not suitable' for the type of services provided without a full assessment having been made. This occurred in the case of Ms A.

2.18. Irrespective of whether or not the review team is correct in believing that Ms A was suffering from an underlying psychotic illness, the question arises as to whether patients who are diagnosed as personality disordered should be excluded from Cardiff services. The review team takes the view, as iterated in strategy and guidance, that such a diagnosis in its self should not preclude mental health and social care services from a responsibility for providing services aimed at ameliorating or modifying the experiences and behaviour of people so diagnosed. And in particular that it should not lead to a situation where opportunities for reassessment of a person's mental state

are missed. While different views were expressed in this case about the preparedness of the CMHT to work with those experiencing personality disorders, the overwhelming conclusion of the review team was that there was a tendency to exclude people with borderline personality disorder from CMHTs.

2.19. The review team notes that there are emerging treatments available in relation to personality disorder. We were told of a pilot study in one Cardiff CMHT which had shown some promising results. We are also aware of a Personality Disorder Service, 'The Gwylfa Therapy Service' operating in Gwent, a neighbouring NHS Trust. As far as we have been able to ascertain during the period that Ms A was in contact with services, and at the time of this review, there were no dedicated or focused services available in Cardiff to assist patients experiencing personality disorder or staff working with them.

Engagement

2.20. Planned intervention with those suffering from mental health problems should be based upon a number of factors. The assessment of the risk they might pose to themselves or others is one of those factors. In the case Ms A the level of risk posed by her behaviours was assessed from time to time throughout the period of her contact with services and was taken into account in making decisions about the extent to which services might pursue engagement with her. However risk is not the only criterion upon which such decisions should be made. Among others might be the level of distress experienced by the patient/client, their family or others, the extent to which their standard of life might be improved through interventions, the alternative costs of attempting engagement and not pursuing it.

2.21. The review team accepts that a patient's willingness to engage with services is important and that, short of a situation in which the law permits treatment without the consent of the patient, services cannot be imposed upon patients. Ms A led what has been described as a chaotic lifestyle, certainly

her willingness or ability to maintain orderly, formal contact with services of any sort was variable.

2.22. However, the review team takes the view that people who are suffering from a mental health or social problem are often unable to engage with services in a formal, organised way as a result of their problems. That being so there is an obligation upon services to take responsibility for engagement with such people. We note that in the first period of Ms A's contact in Cardiff both health and social services staff did just that, with more extensive home visiting and use of informal settings, such as a women's group and the family centre. There was no planned outreach to Ms A in her second period in Cardiff.

2.23. While there is an eligibility dependant outreach service working out of the social care day service in Cardiff, there continues to be no outreach team either jointly or within the separate management lines of health and social care services in Cardiff for the homeless suffering from mental health problems. Had there been such, or an alternative way of trying to engage with the homeless and other groups who find it difficult to respond to more formal arrangement for provision of services. It might have offered additional opportunities to engage with Ms A on terms to which she may have been able to respond. However, aside from the question of whether or not an outreach team would provide one way to meet the needs of people such as Ms A the issue of engagement with such people is an issue the review team believes should be addressed as a matter of priority.

2.24. We note that in Ms A's case there were two positive exceptions to our comments above. We note that the Local Authority housing staff had made particular efforts, primarily through Tressillian House to resolve Ms A's accommodation problem and to provide assistance to her. We also note the particular efforts of the GP at the Butetown Health Centre to provide services which are more easily accessible to the homeless and others in a very deprived area. The model of accessibility she endeavours to provide to those unable to respond to expectations of being organised or responsive to formal

arrangements clearly places huge demands upon her surgery and upon her personally. In cases such as Ms A's the extent to which such services are supported by mental health services at a secondary level is questionable. In summary Ms A's access to services was subject to a number of constraints and filters and engagement with her was not sustained. The root causes of that were:

- Ms A had a chaotic approach to services but she would attempt to access services and some of those which were more flexible or determined to seek engagement with her appeared to have some success maintaining contact with her,
- The diagnosis of borderline personality disorder and perception that it was untreatable led to exclusion from services, rather than leading to a conclusion that a needs based management plan be implemented,
- Routes into services were not simple or short enough, while referral to any service should have the effect of 'opening doors', in the case of Ms A referral did not have that effect,
- Arrangements for contact between housing and health services had diminished with the removal of the CPN providing a link to hostels in Cardiff,
- Limited assessment of Ms A, and the apparent absence of services to mobilise as a result of assessments,
- Lack of co-ordination of services for Ms A,
- Services not being set up to readily engage with people presenting as Ms A did,
- Inadequate mechanisms for follow-up of formal and informal information received about a patient.

Coordination/Integration of Services

2.25. There were a number of ways in which the matter of provision of co-ordinated or integrated services arose in the review team's analysis of the circumstances of Ms A situation. These included:

- Integration of mental health services provided on an in-patient basis with those provided by the same Trust in the community;
- Interaction of CMHTs and CRHTs
- The arrangements for joint services provided by health and social care services in relation to the CMHT;
- Co-ordination between health, social services and housing.

2.26. In relation to each of these, we believe there were failures in the case of contact with Ms A. Which have implications for future work, not only with others in a similar situation to her, but more widely in respect of the public's legitimate expectations of the way services will be provided for them when they access health and social care.

2.27. In relation to the delivery of mental health services within the Trust we were struck by the failure of the common structure (the medical staff of the CMHT are the same staff who provide in-patient treatment at Whitchurch and Llandough Hospitals) to result in properly integrated services for patients. The key factors were the absence of historical perspective in conducting assessments of Ms A. This linked to the difficulties in bringing records together for the purpose of assessment and review and most significantly the absence of planning for on-going care at points when responsibility for Ms A might have been transferred from one form of service delivery to another. We found few care plans in the records and where we did find them they did not include plans for transition back into the community.

2.28. We heard that the way in which the CMHT and CRHT interact is not always consistent or productive. Between 9.00am and 5.00pm Monday to

Friday the CMHTs are expected to first assess whether admission to hospital is needed following a crisis referral, prior to MRHT assessing whether or not home treatment is appropriate in order to avoid admission. That will undoubtedly impact upon the ability of CMHTs to focus upon their core activities. It appeared also to be the case that there had on occasions been a tendency for referrers to find that each team would fail to provide a necessary service by reference to the other teams responsibility to provide it, leaving referrers in a position of stalemate.

2.29. As far as the joint responsibility for CMHTs we found that the arrangements in place depended heavily upon front line staff recognising a commonality of interest and making efforts to ensure the system worked. The fact that there is no overall manager of each CMHT with authority over all its staff, the extent to which the structure does nothing to ensure that professional silos are removed and some evidence of an insufficient will to work jointly at a strategic level as organisations, rather than as concerned individuals, was of particular concern. We were told that good relationships existed between health and social services, although in the course of our enquiries some comments were made which suggested that was not a universally held view. Senior managers in both organisations need to take responsibility for ensuring that good relationships result in common strategies, protocols and the will to provide well coordinated and, where it is in the best interests of patients/clients, integrated, services.

2.30. Seamless service provision is dependent upon good co-ordination between professionals and between agencies. What we saw in the case of Ms A was a situation that led to less than optimal services being provided to her. This was due to ineffective formal systems, a focus upon ‘what the policy is’ and ‘what we do’ and failure to focus upon the patient/service users needs. Best practice would have provided a more responsive approach to concerns raised by staff at Tresillian House. Rather than identifying her lack of permanent accommodation as the only problem preventing discharge from in-patient care, a more thorough assessment of need would have been

undertaken to which a co-ordinated approach to provision of services in the community might have been devised.

2.31. In summary Ms A received only limited services during the second period of her contact in Cardiff. This was the result of barriers to access to services and less than optimal efforts to engage with her. The extent to which services in Cardiff were co-ordinated and integrated had an influence upon that. The root causes were:

- Ms A did not fit comfortably into health and social services criteria and so was not seen as having priority needs,
- There were no dedicated services in Cardiff for those suffering from personality disorders and the arrangements for managing dual diagnosis (whether mental illness and personality disorder, or mental illness and substance misuse or indeed all three - i.e. triple diagnosis) were not implemented,
- Services operated an approach characterised as “if people do not show a willingness to work with us then we do not have the time to work with them” rather than using an outreach ethos for those assessed as having severe and complex enduring mental health needs,
- Ms A’s contact with services was fractured.
- There was no co-ordinated response from, or short of that liaison between, mental health services, social services and housing services for people who are homeless.
- The CMHT operated a system of determining whether a referral should be followed up based upon limited historical knowledge not validated to access to records rather than through conducting an appropriate assessment of those referred to its service.

Resources

2.32. The CMHT appeared to have a broadly appropriate establishment and at the time of our review staff were content that resources were adequate (See paragraph 1.56). However in taking forward decisions about the future of CMHT staffing the guidance we have examined, suggests that further thought might be given to the number of mental health workers and the provision of a broader range of support staff and services that constitute the multi-professional mix of the CMHT.

Chapter 3: Summary Recommendations

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

1. The Welsh Assembly Government should ensure that commissioners and providers of mental health services in Wales examine the current provisions for the care and treatment of those suffering from a personality disorder and that commissioners put in place relevant services where there are currently none provided (Related Healthcare Standard[3] 2).

2. Cardiff and Vale NHS Trust and Cardiff County Council Social Services and Housing Departments should ensure that integrated and co-ordinated services are provided for those experiencing mental health problems of whatever severity or duration, including for homeless people experiencing such problems. In particular:

   (a) the matter of management arrangements for effective joint working within CMHTs should be addressed,
   (b) pathways for patients/clients need to be established which will provide seamless services irrespective of the point of entry to the services (those pathways should identify how people may access services, the arrangements to ensure comprehensive assessment, the treatment and care to be mobilised, arrangements for smooth transfer from one service to another, the way in which exit from the system will be managed and provisional arrangements should return to care and treatment become necessary) (Related Healthcare Standard 12).

[3] 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.

3. Cardiff and Vale NHS Trust and Cardiff County Council Social Services Department should ensure that:

   (a) patient/client records are available at short notice to professionals who need them to inform assessments,
   (b) that required standards of recording are explicit and that staff are trained to complete records to those standards,
   (c) the adequacy of records and their availability are monitored,
   (d) staff are fully trained in the assessment of risk, understand the need for more detailed risk management plans and are able to utilise specialist tools in making assessments in those cases displaying severe and complex needs (related Healthcare Standard 25, 26, 27).

4. Cardiff and Vale NHS Trust and Cardiff County Council Social Services and Housing Departments should ensure that the Care Programme Approach and the related Unified Assessment Process is properly used:

   (a) in respect of all those for whom it is prescribed within the Welsh Assembly Government Guidelines,
   (b) through full assessments of patients/clients and addressing matters of co-ordination of all services to which the patient should have access in respect of the needs they present, and
   (c) the Welsh Assembly Government should encourage the negotiating bodies in respect of GP contracts to reach an early agreement for the contribution of GPs to the full assessment process (related Healthcare Standard 2, 7, 8, 12, 22, 24).

5. Cardiff and Vale NHS Trust and Cardiff County Council should:

   (a) develop structures, systems and procedures which will require, encourage and support active engagement of those health and social care services with patients/clients who may have difficulties in complying with rigid, formal arrangements for contact, including people who are homeless,

(b) encourage and support an organisational culture in which health and social care staff take responsibility for engaging appropriately with people who need services but may be unable or unwilling to do so without help to recognise a service's relevance or value to them (related Healthcare Standard 1, 2, 4, 5, 6, 7, 8, 12).

6. A review of the staffing made available to the CMHTs within Cardiff and Vale NHS Trust should be undertaken. In particular the number of medical, nursing and social work staff and the provision of a broader range of support staff and services should be considered. The guidelines referred to in Annex E may be helpful in taking this forward (related Healthcare Standard 22).

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 Ms A as far back as her first contact with mental health services to provide an understanding and background to the fatal incident that occurred on 19 October 2005;

- Review the decisions made in relation to the care of Ms A;

- Identify any change or changes in Ms A's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 19 October 2005;

- Produce a report detailing relevant findings and setting out recommendations for improvement.

- Work with key stakeholders to develop an action plan(s) to ensure lessons are learnt from this case.

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 to be undertaken 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 National Patient Safety Agency (NPSA) and conducted by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

Arrangements for reviews in Wales

Until 2007 Local Health Boards commissioned independent external reviews into homicides by those experiencing mental health problems. 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.

Annex C

Arrangements for the review of Mental Health Services in respect of Ms A

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 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 J Boardman	Consultant Psychiatrist
Mr M Thornton	Primary Care Liaison Coordinator, Community Psychiatric Nurse
Ms J Phillipson	Social Services Inspector, Care and Social Services Inspectorate Wales (CSSIW)
Mr M Frost	Investigations manager, HIW
Mr R Jones	Investigations Officer, HIW
Ms C Fahey	Investigations Coordinator, HIW

Further advice was taken from Ms J Lewis of CSSIW, Social Services Inspector of CSSIW in respect of social work elements of the review.

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 Cardiff and the Vale NHS Trust and Cardiff County 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 Ms A;
- reading interview notes and written statements provided by staff working with Ms A 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.

This report addresses information gathered in the evidence chapter one.

As a further element within the information gathering process, which also contributed to sorting and analysis processes, was a meeting, attended by members of the review team and key personnel from relevant health, social services and housing bodies. At that meeting information was subject to group techniques to agree emerging key issues and begin the process of identifying 'root causes'. That group process:

- assisted with the confirmation and development of a ‘timeline’ [placed inside the front cover of this report]. Which had been initiated by the review team;
- using techniques such a ‘brainstorming’ and the ‘fish bone exercise’ to inform the review team’s analysis of the issues together with some of the root causes which might need to be addressed.

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
Assessment	• Ms A was difficult to engage,	2,5
	• Ms A found it difficult to give a detailed account of her history,	3
	• Health and Social Care organisations were not sufficiently inquisitive or motivated to seek information and that resulted in insufficient effort to collect information, including historical records relating to Ms A,	3,4,5
	• Assessment that were made were 'crisis focused',	2,3,4
	• Record keeping was inadequate, and previous records were not accessed,	3
	• The focus on Ms A's difficulties was narrowed to 'housing problems',	2,3,4
	• The diagnosis of borderline personality disorder precluded further analysis and substance misuse was over emphasised in assessments,	2,3,4
	• A 'deficit model' of assessment was predominant,	2,3,4

	• There were limited services available for the management of people with bipolar affective disorder.	1,6
Access and Engagement with services	• Ms A had a chaotic approach to services but she would attempt to access services and some of those which were more flexible or determined to seek engagement with her appeared to have some success maintaining contact with her,	5
	• The diagnosis of borderline personality disorder led to exclusion from services,	1,2,6
	• Routes into services were not simple or short enough, while referral to any service should have the effect of 'opening doors', in the case of Ms A referral did not have that effect,	4
	• Arrangements for contact between housing and health services had diminished with the removal of the CPN providing a link to hostels in Cardiff,	2,4
	• Limited assessment of Ms A, and the apparent absence of services to mobilise as a result of assessments,	2,4
	• Lack of co-ordination of services for Ms A,	2
	• Services not being set up to readily engage with people presenting as Ms A did,	2,4,5,6
	• Inadequate mechanisms for follow-up of formal and informal information received about a patient.	2

Coordination/Integration of services	• Ms A did not fit health and social services criteria,	2
	• There were no services in Cardiff for those suffering from personality disorders and the arrangements for managing dual diagnosis were not implemented,	1,6
	• Services operated an approach characterised as “if people do not show a willingness to work with us then we do not have the time to work with them”	2
	• Ms A’s contact with services was fractured.	2,5
	• There was no co-ordinated response from, or short of that liaison between, mental health services, social services and housing services for people who are homeless.	2,4
	• The CMHT operated a system of determining whether a referral should be followed up rather than assessing those who were first referred to their service.	2,3

Annex E

Projection of Human Resources for CMHT's derived from a Report by the Sainsbury Centre for Mental Health

The review team considered a report by the Sainsbury Centre for Mental Health on the staffing needs and costings of adult mental health services in England (Boardman, J. & Parsonage, M. (2007) *Delivering the Government's Mental Health Policies*. London:SCMH).

Chapter 4 of that report provides a basis for estimating the staffing required to operate generic CMHTs. The review team believes this gives helpful guidance for determining appropriate resources for CMHTs in Wales, although the caveats set out below should be noted in other parts of the UK, including Cardiff.

Application of the guidance to the Sealock CMHT

The population base for the SCMH report was based on population estimates for 2010 were used in the calculations for services and staffing as this is the year by which the NSF-MH standards are to be implemented in England. These estimates were based on the official census projections for 2010 (Government Actuary's Department, 2006). The projected total population for England in 2010 is 51,715,000, including 34,262,000 people (66.25%) aged 16–65 years. These figures represent the underlying population base used in our analysis. For ease of presentation the detailed service specifications for each NSF-MH standard described in the report relate to a hypothetical catchment area with a total population of 250,000. It is assumed that this hypothetical locality is representative of England in all relevant respects, including demographic structure. From the figures given in the official census projections, the local population of 250,000 will therefore include 165,625 adults of working age in 2010.

It is acknowledged that socio-demographic characteristics and other determinants of the need for mental health care vary greatly across the country and so the findings of this study will need adjustment if they are to be used in a local context. The Sealock CMHT covers a particularly deprived area of Cardiff and thus is likely to have more morbidity and demand than the 'average'. These average figures given below will require adjustment if applied to the Sealock catchment area.

Sealock CMHT

In January/February 2004 the team had the following composition:

CPNS

2 x G Grade

1x F grade

2 x E grade

0.5 B grade Health Care Assistant

0.5 Occupational Therapist

1 Consultant Psychiatrist

0.5 Staff grade doctor

2 Social Workers

Psychology – sessional input

The adult population served was 20,000.

The table below shows the number of workers suggested by the SCMH report (see box 9 above) adjusted for a 20,000 catchment area and compared to the actual for the Sealock team

	Team size from 20,000 average population – from SCMH report	Sealock Team Size 2004
Professionally affiliated staff		
CPNs	4.32 (all G grades)	5 (mixed grades)
Social Workers	2.6	2

Occupational therapists	0.92	0.5
Team Leader	1	1
Clinical Psychologist	1	0
Pharmacist	0.25	0
DUAL diagnosis worker	0.54	0
Learning Difficulties worker	0.54	0
Employment Lead	0.54	0
Consultant	1	1
Other medical staff	1.1	0.5
Non-professionally affiliated staff		
Pharmacy technician	0.24	0
Psychology Assistant	0.54	0
Employment Specialist	0.54	0
BME support Worker	0.54	0
Generic support workers	1.1	0

The team appears to be understaffed for Social Workers, Occupational Therapists and other medical staff, but adequately staffed for CPNs (although they may have too many junior grades) and for the consultant psychiatrist and team leader. They did not have a clinical psychologist or specialist workers, that may be important for their catchment area (e.g. BME worker). However they were lacking sufficient numbers of staff able to act as support workers.

However, when considering the projected staffing for the Sealock CMHT, the following should be taken into consideration:

1. The SCMH guidance was developed in an English context, consistent with the Department of Health's policies and guidance for mental health services in England.
2. Whilst the details of mental health policy will differ between England and Wales it is unlikely that the levels of morbidity will differ. As the

staffing levels for the CMHTs in the SCMH report were based on levels of morbidity in the population, it is likely that these and the projected staffing levels can be applied in Wales.

3. The projected CMHT staffing levels are based on a local area with 'average' levels of morbidity. As such these will need adjustment for areas with higher morbidity levels. A useful indicator of morbidity levels in a defined geographical area is the level of social deprivation in that area (higher levels of deprivation indicating higher levels of morbidity). In Wales the 'Welsh Index of Multiple Deprivation' is used as a measure of social deprivation and for resource allocation. It is known that the catchment area of the Sealock CMHT has higher than average levels of social deprivation (particular Butetown). This means that the projected staffing levels seen in the above table must be considered as underestimates and that the staffing levels required to effectively serve the catchment area are higher that shown.

In the view of the above consideration it is likely that:

a. The numbers of professional staff should be increased to levels greater that those indicated in column 2 of the table.
b. The range of professional staff working in the team should be reviewed to reflect the specific needs of the population (for example Dual worker, BME worker, Learning Difficulties Worker, Employment lead).
c. A broader range and number of non-professionally affiliated staff working in the team should be considered, along the lines of those suggested in the table.

Annex F

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 G

List of Drugs Prescribed for Ms A and their Use

Diazepam	Anxiolytic (reducing anxiety)
Prozac	Anti depressive
Clopixol	Depot Anti psychotic
Depixol	Depot Anti psychotic
Lofepramine	Anti depressive
Prothiaden	Anti depressive
Sertraline	Anti depressive
Temazepam	Hypnotic (‘sleeping tablet’)
Trifluoperazine (Stelazine)	Oral Anti psychotic

Annex H

Glossary

Accident and Emergency (A&E) - A hospital department which provides emergency treatment and initial treatment for both injuries and illnesses.

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-psychotics – They are drugs which act on the brain used to treat psychotic symptoms. They are sometimes known as major tranquillisers as they may also sedate and calm the user. Sometimes called 'neuroleptic' drugs.

Auditory Hallucinations – The experience of hearing voices or other sounds which cannot be heard by others, as there is no external source of the auditory experience. They are usually a result of a mental (psychotic) illness, and can be experienced in certain physical illnesses (such as in fever due to infection).

Borderline Personality Disorder - a severe personality dysfunction in which there is a pervasive pattern of instability of personal relationships, self-image, and affects and make impulsivity that is often present from childhood.

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 that is reviewed regularly with the service user (and sometimes the carer) and the professionals and agencies involved.

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.

Crisis Resolution Home Treatment Team (CRHTT) – A mental health team which is responsible for providing care and treatment in the community in response to emergencies and providing an alternative to hospital admission.

Depot Neurolepetic Injection – These are anti-psychotic medications, which are given, in a specially prepared injection into the muscle. The way in which the injection is prepared allows slow release and gradual absorption so that the active agent can act for much longer periods than is possible with standard intra-muscular injections.

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).

Drug Induced Psychosis – A psychosis developed as a result of injection of specific substances. These may be illegal drugs (e.g. heroin, cocaine, cannabis, LSD) or prescribed medications (e.g. steroids, anticonvulsants) or toxic substances (e.g. insecticides, fuel, paint).

Electro-Convulsive Therapy (ECT) - Medical treatment for involving the induction of a seizure in a patient by passing electricity through the brain. Less commonly used today and now mainly for people with severe depression.

General Practitioner (GP) - A family doctor.

Health Care Assistant – Support worker in a clinical area, who works under supervision of a registered practitioner who is accountable for the support worker's standards and activities.

Healthcare Commission - The independent inspection body for both the NHS and independent healthcare in England. It also has some residual responsibilities for review of healthcare in Wales.

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.

Paranoid – This term is usually used to mean the experiencing of persecutory or grandiose delusions. An associated term, **Paranoid Ideation** may also be used to cover delusions, but may also include the experience of suspicious ideas and beliefs falling short of delusions that one is being harassed, persecuted, or treated unfairly.

Paranoid Schizophrenia - A descriptive subcategory of schizophrenia in which the predominant symptoms are delusions and hallucinations. .

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.

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.

Reactive Psychosis – A psychosis occurring as a result of an external stimulus arising in the patient’s environment.

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

Sainsbury Centre for Mental Health – A national charity working to improve the quality of life for people with mental health problems. The centre carries out research, policy work and analysis to improve practice and influence policy in mental health as well as public services.

Schizoaffective Disorder - A psychotic disorder in which the features of both schizophrenia and symptoms of a mood disorder are present.

Schizophrenia – A mental disorder and syndrome with a range of features including delusions and hallucinations, disorganised thinking, changes in emotions, loss of drive and motivation and disturbance of behaviour. For many, but not all, people with schizophrenia it is a long-term disorder.

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.

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.

Annex I: Summary Timeline

Type of Activity	2002					2003			2004	2004					2005				
	February	June	July	September	November	March	September	October		January	February	April	September	November	April	June	July	September	October
In Patient Activity							Admitted to Whitchurch via A&E, transferred to Cheltenham after 5 days	Discharged from Cheltenham	Admitted to Whitchurch		5th Discharged, readmitted on 14th, 27th Discharged (Cardiff)		18th Admitted at Whitchurch, 20th Discharged against medical advice		Admitted to hospital, in Swansea after accident, requiring skin graft. Discharged 13th				
Diagnosis	Psychotic episode	No evidence of psychosis overdose of Tremazipam		Reported taking Stelazine	Continuing Stelazine, prescribed Tremazipam			Drug induced psychosis prescribed Olanzapane	Paranoid, no psychotic features		No Psychosis demonstrated no regular medication, 16th commenced Trifluoperazine	Anxiety disorder prescribed Diazepam	Borderline personality disorder, 22nd on severe mental illness register in Cheltenham		Personality disorder, substance misuse				
Out Patient Activity																			
CMHT	In Cheltenham ingestion of bleach, bizarre behaviour etc							Son phones, advised Ms A should be regisitered by GP, could arrange assessment if required							Referred following an assessment at A&E, no appointment offered				
GP			Newly allocated GP						Referral to Whitchurch for assessment			Consultation in Cheltenham		Registered with new GP in Cardiff					
Risk Assesment							Risk of suicide deliberate self harm, violence to others				Self harm, no risk of serious violence to others Trifluoperazine		High risk, deliberate selfharm, violent to others		Low risk, deliberate self harm, violence				
Social Services										Referral from hospital re-accommodation	Contacted re-accommodation								
Housing							Said to be living in Cardiff				Understood to be returning to Cheltenham				Residing Tresillian House, 20th request made to CMHT advised to contact GP as case closed, Ms A refuses appointment with GP	Verbally abusive to staff	Notice to quit Tresillian House extended to 15/08	Remains at Tresillian House	Refuse to move to more permanent accommodation offered, notice to quit on 14/10 withdrawn
Socio Economic																			
Criminal Justice													Presented at police station claiming her sons held hostage by their wives						
Public Services Arrangement					Abolition of Health Authorities				Restructure of Social Services, staffing said to be difficult with nearly 50% vacancies										18/10 Index Offence

The review team produced detailed timelines to assist its understanding of the complex interactions between events and services relating to Ms A.
This summary and partial timeline contains limited details (for example it does not contain specific dates which were in the detailed timeline) and is provided to supplement the evidence contained in the body of the report and demonstrate one way in which information available to the review team has been analysed.