ACTION PLAN FOLLOWING THE REVIEW IN RESPECT OF MR D AND THE PROVISION OF MENTAL HEALTH SERVICES, FOLLOWING THE HOMICIDE OF FATHER PAUL COMMITTED IN MARCH 2007 AND THE AMBULANCE RESPONSE AND CARE PROVIDED TO THE VICTIM'S FAMILY AND COMMUNITY

Part 1 Actions for the Cwm Taf Local Health Board and Rhondda Cynon Taf County Borough Council

Part 2 Actions for the Welsh Ambulance Services NHS Trust

Cwm Taf Local Health Board and Rhondda Cynon Taf County Borough Council

Joint Action Plan in response to the HIW Review of the Homicide of Father Paul Bennett in March 2007.

Rec No.	HIW Recommendation	Response	Lead for Action	Timescales
1	In relation to attendances to Accident & Emergency, the Health Board should ensure that: • Patient records should be reviewed thoroughly at every attendance to A&E, in particular to highlight any patterns that may emerge in light of past attendances;	The A&E information system, provides the opportunity to review attendances to the department including presenting trends. The A&E department will develop criteria to inform the categories and prioritisation for record review arrangements. These already include all children attendances and will now also include patients attending with mental health issues either as a primary or secondary presentation to ensure appropriate actions are being taken.	Senior Nurse / Clinical Director	Implemented January 2010

Rec No.	HIW Recommendation	Response	Lead for Action	Timescales
	• Communication between the A&E department, other departments, and GPs, is subject to formal arrangements, including immediate telephone contact when necessary, formal written reports and routine auditing.	The Health Board will agree with GPs and formalise, appropriate discharge information requirements (including immediate telephone contact) which is subject to auditing. An A&E and Mental Health Pathway for the management of people who walkout of A&E prior to being seen has been developed. This affords A&E timely access to mental health advice and support in order to decide the level of immediate action and a secondary review of any further intervention required. This pathway is evolving and when fully established will provide a service that is seamless and appropriately reactive to any risks identified.	Medical Director Clinical Directors	March 2010 January 2010
2	In relation to community mental health services, the Health Board and Local Authorities: • Measures should be taken to ensure the correct logging of calls, and that the urgency is assessed effectively followed up by an appropriate response.	A review of the systems in place has led to the implementation of more robust arrangements, including the provision of supporting documentation to accompany referral information forwarded to mental health services. This has resulted in more informed decision making in respect of the response(s) required.		Implemented

Rec No.	HIW Recommendation	Response	Lead for Action	Timescales
	• The new arrangements in place relating to out of hours access to mental health services are subject to formal auditing arrangements by the Health Board.	The Health Board and Local Authority will ensure an Annual Audit of referrals, including out of hours access, is undertaken.	Clinical Director	January 2010
	• Communication with other agencies is timely and effective, and that any follow up is carried out fully and comprehensively.	The establishment of an A&E and Mental Health liaison meeting has been positive and has enabled productive discussion of any specific interface issues and joint review of any complex situations.	Heads of Nursing / Head of Mental Health	Completed
	• All agencies need to meet together in order to discuss how to handle complicated cases, and develop a comprehensive care pathway.	Multi agency groups have been established to take for example, audit processes and risk assessment forward. The care pathway for complex cases will be developed by these groups.	Director of Social Services Director of Primary, Community and Mental Health	Ongoing
3	The Health Board and Local Authorities should ensure that: • Records are accurately documented and reviewed in order to aid with spotting any patterns which may emerge in relation to the risk assessment process.	The Health Board and Local Authority continue to reinforce to staff the importance of maintaining accurate and comprehensive documentation, to inform any associated risk assessment processes. Examples are staff induction; team meetings.	Clinical Directors Director of Social Services	Ongoing

Rec No.	HIW Recommendation	Response	Lead for Action	Timescales
	• Record management arrangements are robust and routinely audited and that records are kept secure at all times. • Joint working across agencies is effective and that responses are well coordinated.	The Health Board and Local Authority has taken action to ensure the importance of records management and compliance with information governance processes, which is continually reinforced with all staff. These arrangements are audited locally by both agencies and additional scrutiny is provided by the Regional Office of the Welsh Assembly Government. Established arrangements for the Care Programme Approach (CPA) are in place which are subject to audit and scrutiny. These arrangements are audited through an already established audit programme underpinning the delivery of the Care Programme Approach across Mental Health Services.	Board Secretary / Director of Social Services Director of Social Services / Director of Primary, Community and Mental Health	Audit January 2010 Ongoing
4	In relation to risk management, the Health Board should ensure that: • Organisations issue a proportionate response in accordance to the assessed level of risk. • Organisations ensure that risk management processes are robust and that a long term view is taken in relation to risk management.	The Health Board will continue its work with agency partners to ensure robust risk assessment processes inform case management. This does include long term planning and appropriate planning for individual's transition to adult services.	Director of Social Services Director of Primary, Community and Mental Health	Ongoing

Cwm Taf Local Health Board and Rhondda Cynon Taf County Borough Council

Joint Action Plan in response to the HIW Review of the care, support and counselling offered to Mrs Bennett, and the wider community, following the Homicide of Father Paul Bennett in March 2007.

Rec No.	HIW Recommendation	LHB Response	Lead for Action	Timescales
1	The Health Board should engage with health and social care providers to facilitate arrangements for a coordinated multi-agency response to serious incidents such as this homicide, to provide an appropriate and timely response to the needs of individuals and communities affected. That should include: • Identifying appropriate sources of help and support. • Establishing a system for engaging services, recognising the need to be pro-active in offering services. • Ensuring front line providers (e.g. GPs, A&E staff, social workers, community leaders) are aware of the arrangements, and how to mobilise them. • Ensuring links with police family liaison officers, victim support scheme and others so that they can provide access to the arrangements for those who need them.	The Health Board will collaborate with Health & Social Care Providers, to develop documented arrangements for establishing a coordinated, multi-agency response to serious incidents such as this homicide. To ensure the provision of an appropriate and timely response to the needs of the individuals and communities affected.	LHB Chief Executive Local Authority Director of Social Services	March 2010

Action Plan as at 23rd November 2009

Welsh Ambulance Services NHS Trust
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

The Welsh Ambulance Services NHS Trust Action Plan following the Health Inspectorate Wales' Review of ambulance response and care provided to the family and community following the homicide of Father Paul Bennett on 14th March 2007

No	HEALTH INSPECTORTATE WALES RECOMMENDATION	ACTION COMPLETED	FURTHER ACTION IDENTIFIED	EXECUTIVE LEAD	BY WHEN
1	In relation to the repeated requests for Mrs B to check on her husband, given that the assailant was still present at the scene when the victim's wife made the 999 call, we believe that control room operator should apply the same standards of scene safety to callers as for ambulance personnel. The telephone scripts used by The Trust should be reviewed and protocols put in place to ensure the safety of the caller and other members of the public at the scene, with particular attention given to the section asking the caller to check on the victim.	999 Control Room Call Takers are educated/trained to ensure the same standards of scene safety is given to callers as for ambulance personnel. AMPDS scripts and protocols have been reviewed to ensure the safety of the caller and other members of the public at the scene, with particular attention given to the section asking the caller to check on the victim. They are also subjected to regular audit to ensure compliance is being met. This requires a daily sampling of approximately 3% of calls.	The audit and review of AMPDS Scripts is the subject of an ongoing programme to ensure scripts and protocols meet the safety needs of callers and other members of the public at scene with particular attention given to the sections requiring the caller to check the victim.	Deputy CEO	Dec 2009

2	In relation to the initial delay in identifying the correct address during the 999 call, we believe that the value of installing appropriate software to assist with address identification in all Trust control should be examined to ensure delays with the identification of the location of incidents are minimized.	The Trusts ICT Department have introduced an improved Gazetteer address database which further assists in the rapid identification of the locations of 999 callers. Calling Line Identity (CLI) is also in place. CLI is a feature of modern telephone networks which carries the number of the caller into the 999 control where it appears on the computer screen. CLI identifies both landline and mobile numbers. Importantly the caller cannot withhold their number from this system in the way a caller can withhold their number when making personal calls. (CLI is also the system that allows the phone company to trace malicious or nuisance calls). The integration of CLI with BT's 'EISEC' system, and supported by the improved Gazetteer address database, means that when a 999 call is answered the Call Taker-can see on the computer screen the caller's number (landline or mobile) and the address of the landline or the map reference of the location of the mobile	WAST will continue to apply updates to the Gazetteer address database as they become available.	Director of ICT	Ongoing

		telephone.			
3	Prior to the arrival of the ambulance crew, first aid was not given to the victim. Bystander resuscitation should be encouraged for all calls where patients are unconscious and not breathing, unless the patient is unequivocally deceased as defined by the Trust ROLE/DNAR policy.	The training for all call handlers ensures that first aid instructions are provided to bystanders/families. This is reinforced to call handlers as part of regular ongoing training.	In light of the report from HIW, the Trust will further review the efficacy of the systems in place.	Deputy CEO	Ongoing
4	The Trusts Lone Worker policy needs to be reviewed to ensure that patient care is not compromised by withholding solo resources. The use of meeting points and methods of liaising with the police in order to ensure the safety of the crew should be addressed.	The Trusts Lone Workers policy was recently reviewed (2007-08) in line with the Trusts Rapid Response Vehicle (RRV) policy. A set of guidelines were developed describing appropriate dispatch processes, including the use of rendezvous points when scene safety was considered to be an issue.	A further review of RRV policy is currently underway following a risk assessment of the existing policy. Once again the issues of dispatch and rendezvous and stand off procedures are being considered in the light of recent experience. In light of the HIW report the Trust will re-review the Lone Worker policy.	Deputy CEO	Ongoing Feb 2009
5	The Trust should work with the police to clarify the boundaries of police roles and responsibilities in relation to deciding that a patient is deceased and advising that	The relationship with emergency services has been further developed and built upon through participation in the Joint Emergency Services Group (JESG). Relationships and	Continued participation in JESG.	Deputy CEO	Ongoing

	resuscitation is not necessary.	partnership working through the JESG arrangements facilitate the scoping of responsibilities including standardisation of resuscitation techniques. There is also a Memorandum of Understanding (2009) agreed between all the emergency services which ensures all serious adverse incidents following an emergency response to an incident are reviewed.			
6	The Trust should work with the police to produce a clear set of guidelines for the police, similar to their own DNAR guidance for conditions unequivocally associated with death.	The Trust has clear mechanisms/forums in place under the auspice of JESG to ensure effective communication between all the emergency services.	In light of the HIW Report the Trust will use the mechanisms of JESG to ensure the following; a) The Trust will always ask the police at scene to initiate CPR unless the officer at scene reports presence of one or more of the ROLE Criteria (JRCALC 2006). If there is any doubt whether CPR should be initiated, the police will be advised by the call handler to undertake CPR. b) The Trust is bound by JRCALC, but will work with the police to develop and agree a format that ensures	Deputy CEO / Clinical Director	Ongoing

			officers are provided with clear guidance and understanding of the ROLE criteria. c) The Trust will review the scripts within the AMPDS system to ensure they are tailored to the above requirements.		
7	The Trust staff, including control staff and ambulance crew should receive regular training in clinical, and operational policies which may be used infrequently, but in the most serious circumstances.	Training now occurs within the Control teams every week through the provision of protected time. The Trust complies with the requirements of the AMPDs audits for calls and takes action where required.	Education/training within the Control Rooms will continue within protected time.	Deputy CEO	Ongoing
8	The Trusts ROLE/DNAR policy states that resuscitation should not be undertaken in conditions where all five of the following are present: i. Non-shockable rhythm. ii. No bystander CPR. iii. >15 mins since collapse. iv. The absence of any factors listed not compatible with life (as listed above). v. Asystole for > 30 seconds on the monitor.	August 2008 the Trusts ROLE Policy was superseded by the JRCALC Clinical Practice Guidelines (2006) version of ROLE. The non-shockable rhythm is not included in the JRCALC list of exclusions for resuscitation. Through Clinical Governance and Operational Directives, The Trust regularly reinforces the importance of patient clinical record keeping supporting all decisions.	The Trust continues to comply with JRCALC Guidelines. This is monitored via Audit and Continuous Professional Development (CPD). The Trust will continue to ensure that all paramedics are trained to comply with JRCALC (2006).	Clinical Director / Director of HR & OD	Ongoing

	This policy should be reviewed taking into account that a non-shockable rhythm could include an agonal rhythm or pulseless electrical activity where resuscitation would be appropriate. Consideration should be given to removing point i) from the list to avoid confusion as asystole, as covered in point v) is the only rhythm where DNAR should be considered. The policy itself is unclear as there appear to be contradictions in relation to ROLE/DNAR criteria and guidelines, with particular attention needed to be given to the definition of terminology.				