Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales

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

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Chapter 1: The Evidence

Summary of the index offence

1.1 On 3 October 2006, at a flat in Rhyl, Mr C stabbed a woman he had initially met in October 2005 whilst an in-patient at the Ablett Unit at Glan Clwyd Hospital, a mental health unit run by the former Conwy and Denbighshire NHS Trust. His victim sadly died of her injuries on 5 October 2006.

Background

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

Mr C's contact with Mental Health Services and Social Care Services, including Diagnoses, Care and Treatment

1.3 Mr C was born in May 1984. At that time his family was already known to the Local Authority Social Services staff and he became the subject of a care order only a few months after his birth. Mr C was cared for by his maternal grandmother and her husband until his grandmother's death when he was aged ten years old. During that period it was known that Mr C had difficulties; for example, he was assessed as having special educational needs, and there were reported incidents of fire setting and inappropriate behaviour.

1.4 Following his grandmother's death, Mr C was placed in a number of foster/residential homes where he presented challenging behaviour including aggressive and inappropriate sexual behaviour. During this period there was no referral to Child and Adolescent Mental Health Services (CAMHS). In his teenage years he came to the attention of the criminal justice system as a result of him

committing a number of offences. In October 2000, at the age of 16, Mr C was admitted to Glan Clwyd Hospital in North Wales following a heroin overdose and was subsequently referred to a Drug and Alcohol Team. In the same year he was made subject to a Supervision Order which it was the responsibility of the local Youth Offending Team to supervise. It was at this time that he was placed at a specialised care unit in Stoke on Trent and received a psychiatric assessment which noted that Mr C had been 'hearing voices' since December 1999 and had associated paranoid delusional beliefs. The adolescent forensic psychiatrist (psychiatrist 1) diagnosed a psychotic disorder.

1.5 At the beginning of 2001, Mr C had returned to Rhyl and on 15 March he was assessed by a consultant psychiatrist who diagnosed an underlying psychotic illness, possibly schizophreniform in nature and he was prescribed Olanzipine. It was intended that the local Community Mental Health Team (CMHT) would continue to review Mr C and see him again in two weeks, liasing with probation and social services as necessary.

1.6 On 1 April 2001 Mr C was admitted to the Ablett Unit as an informal patient. Whilst on the Unit two particular matters were noted by the Ablett Unit. Firstly he had 'befriended' a female patient who he attempted to take to his room and secondly, he was identified by police as a man who had been reported to them as carrying a knife. During assessment he disclosed allegations of having been sexually abused whilst a child, which resulted in child protection procedures being initiated, but these were not pursued by way of a full assessment. Clinical risk assessment scoresheets were completed which provided an assessment of the risk Mr C posed to staff and (damage to) property. The assessment of the level of risk posed by Mr C increased over the course of the first few days that he was in the Unit (On 2 April he was assessed as being of low risk, on 4 April he was considered to be of medium risk and on 5 April he was assessed as being of medium/high risk). During this period Mr C remained in contact with the Youth Offending Team, staff from which visited him twice during the course of April. Social Services child care staff also had contact with him with a view to planning a placement for him following discharge from hospital. Mr C was discharged from the Ablett Unit on 12 April 2001.

1.7 On 21 November 2001 Mr C appeared at Mold Crown Court where he was sentenced to three years detention at a Youth Offenders Institution (YOI). He was held at HMYOI Stoke Heath where he presented very difficult and challenging behaviour including self harm and attacking staff. During the course of that period of custody, Mr C was transferred to Ty Llywellyn Medium Secure Unit (MSU) in North Wales on 30 July 2002 under Section 47/49 of the Mental Health Act 1983. There he was diagnosed as suffering from an antisocial personality disorder (psychiatrist 2) with some traits of borderline personality disorder. Mr C was not assessed as having evidence of mental illness so was not considered suitable for continued treatment at Ty Llywellyn, at least in part because his behaviour was being exacerbated through contact with other patients in the MSU and the impact he had upon the capacity of the Unit to care for other patients, but primarily because of the severity of his behaviour and the inaccessibility of his problems.

1.8 Mr C was transferred back to HMYOI Stoke Heath on 29 August 2002. In March 2004 Mr C was granted early discharge on licence from the YOI and was placed at St David's, an independent residential facility in Carrog. He later moved into Ty Newydd probation hostel where he formed a relationship with a female resident, concerning which he was issued with a warning for inappropriate sexual behaviour in late August 2004. Earlier, in July 2004, an evaluation of Mr C's mental state had been undertaken for Denbighshire Local Health Board which assessed the risk posed by Mr C as level one; he was considered to be a risk to himself and others and was regarded as being a high risk when under the influence of drink or drugs. On 6 September 2004, following him throwing himself in front of traffic on the road outside of the hostel, Mr C was issued with a final warning by the probation hostel and on 16 September his licence was revoked and he was recalled to HMYOI Stoke Heath.

1.9 Mr C was again released on licence from HMYOI Stoke Heath on 3 December 2004. He was accommodated at Plas y Wern probation hostel in Ruabon, Denbighshire. The assessment conducted at his release concluded that he presented a risk of violence and would need a high level of support and a structured placement post release.

1.10 Early in 2005 concerns arose about Mr C's mental state and he was assessed by a consultant psychiatrist (psychiatrist 3) who on 10 January 2005 highlighted Mr C's need for a long term care plan and the involvement of several agencies in his care and treatment. On 23 January Mr C cut his wrists with a knife and later that month overdosed on prescribed medication. On 2 March 2005 Mr C did not return to the hostel by the time of curfew and was later found to have been drinking heavily. His licence was again revoked and he was returned to HMYOI Stoke Heath. The probation assessment completed at that stage refers to Mr C's mental health as being his biggest problem. The assessment refers to the view of a consultant psychiatrist (psychiatrist 2) at the Medium Secure Unit that Mr C did not suffer from a mental illness and the view of a consultant (psychiatrist 4) at the YOI who believed that Mr C suffered from mental disorder but demonstrated behaviour of a personality disorder.

1.11 Mr C was finally released from custody on completion of his sentence on 5 September 2005. Discussions about where he might be accommodated on his release had been prompted by the local authority housing and social services department and shortly after release Mr C was living in a flat under the management of Cai Dai, a charitable organisation in Denbighshire working for the benefit of people with psychiatric problems. The discussion involved the Hafod CMHT in Rhyl, but it was the Tîm Dyffryn Clwyd CMHT which was responsible for him while at Cai Dai and that team considered it to be an unsuitable placement. On 13 September 2005 a Care Programme Approach (CPA) assessment was undertaken; the plan included referral for an opinion from a consultant psychiatrist, referral to the Serious Mental Illness (SMI) team in view of the risk Mr C presented and the provision of a support worker for seven hours a week. A risk assessment was conducted resulting in Mr C being assessed as presenting a level one risk.

1.12 In October 2005 Mr C was admitted to the Ablett Unit, part of the Conwy and Denbighshire NHS Trust, under Section 2 of the Mental Health Act 1983, having been found by police 'walking into the sea'. It was during this admission that Mr C first met Mrs Y.

1.13 On 2 November 2005 Mr C was assessed by two doctors in succession, but this was not a mental health act assessment. The doctors concluded that there was no evidence of psychosis and a diagnosis of personality disorder and antisocial personality disorder was suggested. Mr C was assessed as presenting a level two risk. On 7 November Mr C did not return to the hospital from leave and he was formally discharged in his absence on 9 November 2005.

1.14 In January 2006 the transfer of responsibility for Mr C from Tîm Dyffryn Clwyd CMHT to Tŷ Celyn CMHT, in Flintshire, was discussed, but on 2 February 2006 Mr C was formally discharged because he did not want to use the services of the CMHT.

1.15 On 13 April 2006 Mr C was again taken to A&E at Ysbyty Glan Clwyd because he had again been found 'walking into the sea'. He was seen by the duty psychiatrist (psychiatrist 5) who recorded paranoid tendency on the part of Mr C and an overt psychotic episode. Mr C was admitted to the Ablett Unit on 14 April. The in-patient care plan/Care Programme Approach (CPA) relating to this episode was found to be incomplete but information available includes Mr C's status as being of 'no fixed abode' and reference to his awaiting a court appearance for burglary and assault committed in the Rhyl area. On the 18 April Mr C left the unit and did not return, but he was re-admitted on 20 April 2006 after a further incident of 'walking into the sea'. He 'absconded' again on 23 April but was returned to Ablett Unit again on 24 April by Ambulance following another incident of 'walking into the sea'.

1.16 Mr C was discharged from the Ablett Unit on 27 April 2006 following an assessment by a consultant psychiatrist (psychiatrist 6) that Mr C did not suffer from a mental illness but had a personality problem. The assessment was that there was little that could be done for Mr C. He was referred to the duty person at Hafod CMHT.

1.17 On 3 August 2006 Mr C was again taken to A&E after an incident of 'walking into the sea'. He was discharged to his sister's address, the plan being to refer him to drug and alcohol services,

1.18 On 17 August 2006 Mr C was admitted to the Ablett Unit under Section 136 of the Mental Health Act 1983, following an incident of deliberate self-harm. The following day he was reported to be requesting that he should be detained under the Mental Health Act and the inappropriateness of doing so was explained to him. He was at that time assessed as a level two risk. On 19 August Mr C left the Ablett Unit without informing staff. He was at that stage an informal patient and was discharged in his absence. Staff at the Ablett Unit were aware that on 19 August Mr C had been arrested. He was in fact taken in by the police on a court warrant for non-attendance in respect of an offence of drink driving, but there appears to have been some miscommunication about the seriousness of that matter. The Trust told the review team that it believed that the charges were more serious and understood from the Probation Service that it was expected that Mr C would be remanded in custody or imprisoned. No fresh assessment of risk was undertaken at that time.

1.19 Mr C again attended A&E following an incident of self laceration on 8 September 2006. The discharge plan included follow-up by the CMHT and in response a Community Psychiatric Nurse (CPN) visited his accommodation on 10 and 11 September but got no response. Following a risk assessment on 29 September 2006 (when Mr C failed to attend a clinic appointment) the CPN at Hafod CMHT arranged for a multi-agency risk meeting to take place on 12 October 2006 to consider Mr C (i.e. nine days after he stabbed Mrs Y and seven days after her death).

1.20 Throughout the 12 month period from October 2005 to October 2006, Mr C was in regular contact with Mrs Y.

1.21 The index offence occurred on 3 October 2006.

Mr C and the Criminal Justice System

1.22 Mr C has a considerable history of criminal activity. It is not intended that this report should present the detail of his involvement with the criminal justice system; however, three matters are of relevance to this review:

1.23 Firstly, the review team noted that on many of the occasions upon which Mr C came to the attention of police or the Courts he was known to have had knives in his possession and on occasions these were found to have been used in the offences he committed.

1.24 Secondly, we noted an association between Mr C's anticipated Court appearances and his presentations at A&E or the Ablett Unit.

1.25 Thirdly, the Review Team noted the complex inter-relationship between the Criminal Justice System and Mental Health Services in the period immediately leading up to the index offence. That was notable in three ways:

- Mr C had a number of Court appearances, relating to burglary and assault charges, in the year before the index offence; however the Court was not persuaded that the risk he presented, in terms of further offending or the risk he posed to others, was so serious that bail should not be granted.
- On 21 September Mrs Y was admitted to the Ablett Unit and was said at that time to have suffered a 'broken' nose at the hands of Mr C and to be terrified that he would kill her. On 23 September it was clear that Mrs Y wanted to press charges against Mr C. Hospital records suggest that she was assisted to make a call to the police but a note in the record shows she was still awaiting a visit from the police on 24 September. However, there is no record within police systems of a complaint being made and there is no subsequent record of the matter being followed up by health service staff[1].

[1] With reference to paragraph 1.25 and 1.32; Since the completion of this review North Wales police have confirmed that they did receive a telephone call from Mrs Y and that this matter is now being further investigated.

- Following Mr C's arrest on 19 August 2006 Mental Health Service staff continued to be under the impression that he remained in custody. A reference in a psychiatric assessment form relating to use of the Beck Hopelessness Scale (BHS) dated 19 September refers to Mr C as being in police custody. That was not the case.

Summary of relevant contact by Mrs Y with Mental Health Services and Social Care Services, including Diagnoses, Care and Treatment

1.26 Mrs Y had a long-term psychiatric illness of a recurring nature, resulting in inpatient treatment which was sometimes prolonged and sometimes involved her being detained under the Mental Health Act. She also had significant physical disability. These factors increased the degree of her vulnerability.

1.27 Mrs Y was a patient on the Ablett Unit in October 2005 when she first met Mr C who also became an in-patient in the Unit that month. It did not take many days before a relationship commenced between the two of them and before the end of the month there had been one occasion when Mr C had to be asked to leave Mrs Y's room by staff on the Unit.

1.28 Mrs Y was subject to assessments, including assessments of the risk she presented. Her contact with mental health services and in particular the Ablett Unit continued through 2005/06. The level of risk she presented varied from level one to level two, the risk presented being both of harm to herself and to others.

1.29 On 31 December 2005 whilst a patient on the Ablett Unit she claimed to have been wounded by another patient. (Note that Mr C was not a patient on Ablett Unit at that time and it is not clear to us whether or not this was a reference to Mr C).

1.30 Mrs Y's attitude to treatment was variable - at times she would actively seek help, on other occasions she would not comply with medication and would say that

she did not want any help with her health. Her domestic circumstances were difficult and at times she was homeless, sleeping in her car.

1.31 Following an informal admission to Ablett Unit on 2 August 2006 it was noted in hospital records that a young man involved with Mrs Y had been exploiting her vulnerabilities.

1.32 On her admission again to Ablett Unit on 21 September 2006 Mrs Y stated that she was frightened of Mr C and what he might do to her. She had a 'broken' nose at Mr C's hands and she was terrified Mr C would kill her. Nursing notes state that Mrs Y telephoned the police from the ward to report the incident and press charges. The record also states that on 23 September and 24 September Mrs Y was awaiting a visit from police in order to make a statement. There are no corresponding notes in police records. On the day of her admission (21 September 2006) the mental health team's plan was to discharge Mrs Y possibly on the following Monday but Mrs Y was told that it might be at the weekend because of the pressures on beds. It was noted that accommodation needed to be sorted out for her with possible alternatives of a women's refuge or a Bed and Breakfast being noted. The plan also made reference to a Protection of Vulnerable Adults referral, which would have been the responsibility of the Trust to make through its arrangements with Conwy Local Authority within whose area the Nant Y Glyn CMHT, based in Colwyn Bay, and responsible for Mrs Y's ongoing care, was located.

1.33 Mrs Y left the Ablett Unit on Monday 25 September 2006, with Mrs Y agreeing to be discharged to her ex-husband's address, where we were told by the Trust that it had been arranged that a Conwy Local Authority housing support officer would meet with her to discuss accommodation. No follow-up to the matter of a POVA referral was undertaken. No resolution of the matter of the attack upon Mrs Y by Mr C had been reached. A discharge letter to Mrs Y's GP referenced her vulnerability and a discharge Care Plan dated 26 September 2006 states that Mrs Y was of no fixed abode.

Risk Management in Respect of Mr C and Mrs Y

1.34 Both Mr C and Mrs Y were subject to the former Conwy and Denbighshire NHS Trust's arrangements for risk management during the course of their contact with mental health services.

1.35 During the period September 2005 to September 2006 formal risk assessments in respect of Mr C were recorded on 13 September, 26 and 27 October, 2 and 18 and 28 November 2005 and on 26 January, 14 and 22 April, 17 and 18 and 21 August, 29 September 2006. While the level of risk presented by Mr C varied between level 1 and level 2 it was clear that throughout his contact with mental health services he was viewed as being a risk both to himself and others. The risk presented by Mrs Y was assessed on 10 October, 10 and 30 November, 5 and 27 and 30 December 2005, 9 and 17 and 27 January, 19 March, 7 August 2006.

1.36 From the end of October 2005 it was known to staff on the Ablett Unit that a relationship had formed between Mr C and Mrs Y. Over the next 12 months, until the death of Mrs Y, there was considerable evidence of that relationship continuing and of the extent to which that relationship should have given rise to concern and the fact that latterly it involved violent episodes.

1.37 There was no evidence of this relationship being taken into account by mental health services staff when assessing the risks presented by either party individually or jointly. In particular there was no apparent understanding that from the point when this relationship was formed the risk Mr C presented to others was no longer just a general risk but one which might now have a particular focus upon Mrs Y.

1.38 Mrs Y was by any definition a vulnerable person. By 2 August 2006 it had been observed that Mrs Y's vulnerability was being exploited by Mr C. On 22 September 2006, whilst an inpatient on the Ablett Unit Mrs Y had agreed to be the subject of a POVA referral. No referral was made.

Multi Agency Arrangement for managing risk in relation to Mr C

1.39 National arrangements for managing those presenting a risk to the safety of the public were in place across Conwy and Denbighshire. These included Multi-Agency Public Protection Arrangements (MAPPA) and for those of a lower level of risk Multi- Agency Risk Assessment Conference (MARAC) meetings in operation. A summary of the arrangements is set out in Annex E**.**

1.40 Mr C was the subject of MARAC and MAPPA discussions. Following Mr C's release from HMYOI Stoke Heath particular arrangements for the close monitoring of him were in place, illustrating an awareness of the risks he posed and the capacity of the arrangements in place, at that time, to respond to those risks.

1.41 However, it is clear from the evidence we received that the MAPPA group was not appraised of the relationship between Mr C and Mrs Y. Trust arrangements for collating information for the Multi-Agency Public Protection Panel (MAPPP) had failed to ensure that the risk coordinator attending the MAPPP were provided with that information.

Management and Organisation of Services

Arrangements for Provision of Mental Health Services in Wales

1.42 The Welsh Health Service was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of Local Health Boards. The commissioning of primary and most secondary mental health services is the responsibility of Local Health Boards. In respect of Mr C at the time of the index offence the responsible Board was the Denbighshire Local Health Board.

1.43 The health service body providing mental health services at a secondary level to the Rhyl area during the period covered by this review was the former Conwy and Denbighshire NHS Trust. At a primary level, general practitioners are responsible for providing services and initiating interventions from other parts of the

health service. During the time covered by this review Mr C was registered with a GP Practice based in Prestatyn.

Guidance relating to Mental Health Services in Wales

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

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

Provision of Mental Health and Social Services in Conwy and Denbighshire

1.46 Mental Health Services within Conwy and Denbighshire were at the time of our review delivered via the Adult Mental Health and Social Care Partnership which was established in July 2005. Conwy and Denbighshire NHS Trust hosted the Partnership, which was overseen by a partnership Manager. Social Services formed part of the Partnership and linked into the Partnership Board at a senior level at monthly Partnership meetings. Budgets were held separately by each health and social care organisation with the Partnership Manager having overall responsibility for the total budget of approximately £9 million.

1.47 There were five CMHTs within the Partnership each having a single management structure in place. CMHT Managers had either a health or social services background and were ultimately responsible to the Partnership Manager, as was the Manager of the Ablett Unit, the Trust's in-patient facility. Social Services staff supporting mental health service users were seconded into the Trust but

continued to have access to local authority resources, for example housing. Social Services staff seconded in this way were drawn from both local authorities, for example, in relation to Mrs Y the relevant CMHT was Nant Y Glyn in Colwyn Bay to which Conwy Social Services staff were seconded.

1.48 The general view among those interviewed was that joint working and professional relationships within the CMHTs was well established and that they work well on a day to day basis. Managers were confident that the formal Partnership arrangement set up between Health and Social Services had in some instances strengthened informal arrangements that were already in place, in addition to establishing and formalising new structures and support systems. There was an acknowledgement by Managers that some teams were (perhaps understandably given the base from which they each started) in different places in relation to their development which had resulted in some variations as to how they operated, specifically in relation to service users gaining entry into the service. It was felt that the Partnership Manager having overall management responsibility (since August 2005) and the introduction of an integrated Care Pathway had gone some way to resolving this.

Chapter 2: Findings

The Predictability of the Homicide Committed by Mr C

2.1 The Review Team has considered very carefully the extent to which the homicide committed by Mr C might have been predicted and whether it might have been avoidable. It is clear to us that Mr C's behaviour through childhood, adolescence and adulthood gave sufficient cause to assess him as someone who presented a high level of risk to himself and to others. His predilection for knives and blades, the extent and nature of his offending behaviour, the actions he took which threatened his own life and his aggression towards others were all indicators of the potential for him to cause serious harm to himself and others. Until October 2005, other than the damage his actions might cause to himself, there was a general risk to the public. But from the point when he first began to form a relationship with Mrs Y the risk became both general and specific. Whilst Mr C continued to constitute a general risk to the public at large, a specific individual, Mrs Y, became the subject of particular risk of violence from him.

2.2 The Review Team has been careful to avoid the use of hindsight in reaching its conclusions about what it would be reasonable to expect the organisations working with Mr C and Mrs Y to have known or understood at the time when events occurred. However, we have reached the conclusion that while at the beginning of the relationship between Mr C and Mrs Y it may not have been immediately evident that a particular risk to Mrs Y had emerged, it should have been clear that this was so as the relationship continued. Certainly by the time of Mrs Y's inpatient care in September 2006 the risk posed to her by Mr C should have been self evident. But no organisation recognised that. As a result steps which might have been taken to protect Mrs Y were not progressed:

- There was no POVA referral,
- the knowledge of the relationship between Mr C and Mrs Y was not shared as part of the MAPPA,

- … a possible referral to the police of a serious assault upon Mrs Y by Mr C was not followed up,
- … Mrs Y was discharged from the Ablett Unit without the fullest consideration of arrangements for her re-integration into the community and the immediate risks of the situation she would face upon discharge.

2.3 While we cannot say that such steps would have guaranteed the prevention of her killing, had those steps been taken we assert that there would have been the possibility of actions being taken which would have rendered the homicide unlikely.

History and Symptoms

2.4 Mr C's case was an extremely difficult one. He presented at an early age with challenging behavioural problems, including those of a sexual and aggressive nature. In his early teens, these behavioural difficulties continued; he committed offences of arson and possession of a weapon. By the age of 16, a pattern of violent aggressive behaviour, use of bladed weapons and other criminal activity was established, together with the heavy use of alcohol.

2.5 He also presented with severe emotional disturbance. He described intense feelings of self loathing, and experienced severe, intense and usually brief periods of depression. He described longstanding suicidal and homicidal feelings which fluctuated in intensity, and on more than one occasion expressed the belief that he should be "locked up" to prevent him harming someone. He described persistent morbid ideation, which he self medicated with the heavy use of alcohol. He presented frequently to services with suicidal ideation, often expressed in a dramatic fashion, e.g. walking into the sea. We noted that there was an association between such events and Mr C's anticipated court appearances.

2.6 He also presented from time to time with auditory hallucinations. On one occasion this was thought to justify the diagnosis of a schizophreniform psychosis (2001). However on most of his presentations, these hallucinations were not

consistent with a diagnosis of psychosis, being fluctuating, transient, not ego-alien or bizarre in quality.

Problems in Engagement

2.7 His response to the provision of care in hospital was challenging and difficult if not impossible for services to manage. Mood swings tended to settle quickly and he could not be maintained in therapeutic contact. His behaviour on open wards posed a danger to staff and fellow patients. Even in the setting of a medium secure unit (Ty Llewellyn) it had not been possible to engage or manage him.

2.8 The Review Team assessed Mr C as posing severe challenges to general adult psychiatry services. We believe that he would have been difficult, if not impossible, to engage in any sustained therapeutic contact. Though he repeatedly sought containment, he rejected it almost as soon as it was offered.

Diagnosis

2.9 It was not the purpose of the Review Team to conduct an assessment of Mr C's mental health. However, on the basis of the records examined by the Review Team and the interviews it conducted, we believe that the diagnosis is one of severe personality disorder, of cluster 2 type, with antisocial and borderline/narcissistic features. Of people with such a disorder, the evidence suggests his condition to be towards the more severe end of the spectrum. The Review Team feels it unlikely that Mr C had a co-morbid psychotic illness. The evidence did not support this diagnosis, and could be explained on the basis of his severe personality disorder.

2.10 During our fieldwork there was a consistent view among those interviewed that people who present with personality disorder and complex needs, as did Mr C, not only have difficulty accessing services but, once they are in the system, the resources are not robust enough to provide the intensive support they require to manage their complex and difficult behaviour. This is clearly evidenced by events in relation to Mr C. This situation appears to be unchanged since the events

concerning Mr C and we believe that services will continue to struggle with similar individuals who are currently entering or presently in the service.

2.11 However, despite the considerable challenges presented by Mr C, and the severity of his case, the Review Team believes that there were significant failings in the approach of local services to diagnosis and risk management.

2.12 Though we agree the working diagnosis adopted by the health and social care teams involved in Mr C's case, i.e. that of a personality disorder, was superficially correct, there is no evidence of the teams having achieved a full understanding of Mr C, and his complex and varied presentation. The diagnosis of personality disorder appears to have resulted in an approach which saw some further assessments and occasional admissions as an in-patient. But some interviewees felt that there was nothing which could be done. The Review Team believes that while this was indeed an extremely difficult case, the difficulty was compounded by issues of engagement and treatment. Nevertheless a fuller understanding would have helped in the important areas of risk management and protection of the public.

2.13 This is best exemplified in the assessment of risk. For example at the time of his release from HMYOI Stoke Heath in September 2005, Mr C was considered to be a high risk to members of the public, with the risk of harm being imminent and the impact likely to be severe. However, the risk assessment noted in an assessment letter of November 2005, came to the conclusion that he was a "risk to himself, and a possible risk to others". The Review Team believes that this latter underestimation of the risks posed by Mr C occurred for the following reasons:

1. A failure to develop a comprehensive and detailed formulation of this complex case, at the time of taking over the case on his release from HMYOI Stoke Heath. The relevant information was available in health and social care records but was not accessed.

2. In relation to an assessment in November 2005, a failure to adequately take into account information relating to risk; this was available in the CPA documentation that constituted the referral.

3. Failure to take into account the particular risk developing as a result of the relationship between Mr C and Mrs Y.

2.14 Subsequent psychiatric opinions appear to have been based entirely upon this risk assessment, and led to a perpetuation of the underestimation of risk. We comment further about risk assessment below.

2.15 The Review Team noted that the sections of the Mental Health Act 1983 dealing with assessment and treatment appear not to have been used consistently. There appears to have been a reluctance to use these provisions, given the difficulty in managing Mr C in an open hospital environment. Indeed, when detained under the Mental Health Act in a medium secure unit in 2002, having been transferred from the YOI, it was not possible to contain him and the Responsible Medical Officer (RMO) at the time came to the conclusion that further detention in a medium secure unit was not appropriate.

2.16 However, given that Mr C was repeatedly presenting to general psychiatry services, we believe that a further forensic opinion should have been sought as problems continued to arise throughout 2005/06. Though this may well have come to the same conclusion as that made in 2002, clarification of the diagnosis and risk assessment through forensic opinion might possibly have clarified the respective roles of the mental health and criminal justice system in this case. We have noted the comments in the probation service documentation concerning the variety of psychiatric assessments and diagnostic uncertainty.

2.17 The root causes of the weaknesses in approaches to diagnosis in Mr C's case were:

- The lack of full assessments at the commencement of each episode of care.
- A failure to take into account all the information available about Mr C within the records held by health and social care agencies.
- The belief that there was nothing mental health services could do once a diagnosis of personality disorder had been made.
- The absence of specialist understanding and services for those diagnosed as suffering from a personality disorder.

Risk Management

2.18 Risk assessment and management was fundamentally flawed in respect of both Mr C and Mrs Y.

2.19 We believe that, at the time of Mr C's and Mrs Y's contact with mental health services risk assessment and risk management had not been integrated with the CPA. We received differing opinions as to when the Trust achieved integration of risk assessment with CPA. On the one hand we were told that the Trust took steps to ensure such integration in April 2007, on the other the Trust has informed us that CPA and risk assessment had been integrated in line with the Unified Assessment Process in April 2006. Whatever the formal position may be, no evidence was made available to the Review Team that assured us such integration had been achieved in Mr C and Mrs Y's cases.

2.20 There is nothing recorded to indicate that all the key stakeholders who had involvement with Mr C took part in a multi agency discussion at the time he re-entered services via Probation, having committed a very serious assault in January 2006. Therefore, the information on which any risk assessment was based at that time would have been incomplete, and significantly the information available to the MAPPA meetings was incomplete.

2.21 There is evidence to indicate that even where agencies were represented, the information known to individuals within those agencies was not brought to the table. For example, the MAPPA meeting of August 2006 was not appraised of the relationship between Mr C and Mrs Y and of the particular risks that relationship posed. This is particularly critical and significant in relation to the events resulting in Mrs Y's last admission to hospital in September 2006.

2.22 Mrs Y was clearly a vulnerable adult who was admitted to hospital as part of a process of crisis intervention because of her vulnerability. A lack of co-operation by Mrs Y in the risk assessment process was noted and we were told by the Trust that some discussion with her did include an option of staying at a women's aid centre and a plan for follow-up by a consultant two days after her discharge. However, the Review Team takes the view that Mrs Y was discharged from hospital without a sufficiently robust risk assessment, with no interim plan in place in relation to any required safeguards or the minimising of risk, but with there being sufficient concern to warrant a risk meeting being planned for 12 October 2006. That was sixteen days after her discharge and sadly nine days after she was killed. Robust risk management did not appear to be an integral part of planning, specifically in relation to a discharge plan as required under CPA.

2.23 The Review Team considered how Mrs Y's interests were protected given her vulnerability. Following her admission to hospital on 21 September 2006 there was a failure to refer Mrs Y via the POVA process to social services. She had clearly expressed her fear and belief to staff on the ward at the time of her admission that Mr C was "going to find her and kill her" and had agreed to a POVA referral being made on the 22 September 2006. There is no further reference to POVA in her notes and the review has established that this referral was never actioned.

2.24 It is reasonable to assume that had the POVA process been initiated the information gleaned may have impacted on the decision to discharge her. This may have provided Mrs Y with the protection (at least in the short term) she clearly needed and was requesting at that time. It would also have enabled all relevant parties to share information; specifically that Mr C had been released from police

custody back into the community at a time when Mrs Y had stated that she feared he would kill her. It would have provided an arena in which professionals could have jointly given her relationship with Mr C more considered thought in respect of what now was an escalating risk.

2.25 Initiation of the POVA process would also have provided the opportunity to consider other appropriate options in relation to Mrs Y's protection, for example those available in relation to domestic violence. There is no evidence that Mrs Y was appropriately advised or that any consideration was given to the escalating risk situation she found herself in. That was a serious omission. Staff, from an independent support service, commissioned by the CMHT, working with Mrs Y were also able to refer to POVA but did not do so. They had weekly contact with Mrs Y's CPN at that point and reported matters to him, but perhaps reasonably, deferred to him assuming he would do whatever was needed. The use of commissioned support services from the third sector is entirely appropriate but the terms of their work with service users and lines of accountability need to be very clear. In this instance it seems that POVA was not an integral part of all organisations' thinking in relation to the day-to-day work with vulnerable service users.

2.26 The root causes of the flaws in risk management in respect of Mr C and Mrs Y were:

- A failure to take into account the 'historical' information available in health and social care records concerning Mr C.
- A failure to identify the particular risk emerging as a result of Mr C's relationship with Mrs Y.
- Inadequate sharing of information between agencies and in particular through the MAPPA.
- Communication failures in respect of follow-up to the recorded notifications to police of Mrs Y's wish to report an assault upon herself.
- Non-implementation of the POVA procedures in respect of Mrs Y.
- Insufficient account being taken of the risks to Mrs Y at the point of her last discharge from hospital.

Information Sharing

2.27 In addition to the issues raised above in relation to risk management, communication difficulties were further compounded by the following root causes:

- A lack of integrated health and social care files and information technology systems.
- Incomplete and poorly completed health records which lacked clear decision-making audit trails.

Transition from Children to Adult Services

2.28 It was acknowledged by health and social care services that historically there were issues in relation to transition from services provided for children and adolescents to adult provision, which may have impacted on Mr C at the time. These mainly concerned a lack of resources, specifically that there was no dedicated manager for leaving care services within Social Services. In addition, joint working between the YOT and the Social Services Leaving Care Team was not as good as staff might have wished and it was very difficult to access CAMH services. The understanding of the Review Team is that these issues have now been resolved and that resources within the Children and Families Service have been much improved.

2.29 However, the current position with regard to formal protocols or understandings about the arrangements for transition between adolescent and adult services is unclear. In relation to that matter we have seen a document headed Denbighshire Transition Protocol, dated January 2006. We were told that it was considered to need further work and that a stakeholder event in October 2007 was undertaken from which a more detailed transition document has been produced. We have also seen a paper marked as 'work in progress' which addresses the transition from CAMHS to adult mental health services. That paper is undated and again it is unclear to us how far that work has progressed. It has been made clear to us that particular issues relating to young adults experiencing such mental health

problems as Mr C require commitment by CAMHS and adult mental health services to develop appropriate services which are accessible by this group of young people.

2.30 One of the current joint YOT Managers stated that there are now very good working relationships with the Looked After Children (LAC) team and probation service. In respect of young people with mental health issues the team has its own CAMHS practitioner who undertakes any assessments required and liases between their service and adult mental health services.

2.31 Mr C's transition from child and adolescent services to adult services was not optimal, the root cause was:

- The absence of sufficiently robust protocols in health and social care for the transition between children and adolescent services and those for adults.

Training and Development Issues

2.32 We note elsewhere in this report the extent to which the arrangements for the Protection of Vulnerable Adults applied to Mrs Y and have noted the failure to implement appropriate procedures. It was clear from discussions with those we interviewed that the development and implementation of POVA had lagged behind the similar arrangements for the protection of children. In particular, training had not been fully rolled out in all those organisations working with Mr C and Mrs Y and as a result the understanding of staff about their responsibilities was limited.

2.33 It was also clear to the Review Team that the training provided to staff in relation to CPA, in particular its relationship to risk assessment and management, had not been optimal.

2.34 The root causes of the weaknesses identified in training and development were:

- Failure to recognise the importance of the integration of CPA with Risk Assessment and Management in the context of training.
- Insufficient attention to the provision of POVA training.
- Inadequate follow-up of training in relation to CPA and Risk Assessment/Management to assess its impact.

Chapter 3: Summary Recommendations

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

… Mental health services should ensure that comprehensive assessments of patients are undertaken at appropriate intervals and in any case at the outset of each episode of care and treatment, such assessment should be based upon:

a. Teams ensuring they have all the necessary information about patients' backgrounds and previous incidents of care.
b. No assumptions being made about actions being taken by other organisations/agencies.
c. Checking the accuracy of assertions which may have been made about the patient or patient's circumstances.

… Training in the protection of vulnerable adults should be reviewed and provided as a priority for all mental health staff in Local Authority, Trust and Primary Care services to ensure that, in addition to awareness, it can be certain that POVA procedures are implemented and that current practice is consistent with the requirements of the POVA arrangements which have been adopted by the agencies across Conwy and Denbighshire.

… Intra-Agency Risk Assessment and Management procedures should be reinforced through further training which should emphasise:

a. The procedures to be followed.
b. The development of a culture which supports risk management, emphasising the importance of team work and addressing the view among some staff that risk assessments are currently 'tick box' exercises.
c. The availability of notes and history in relation to patients/clients.

d. The importance of giving due consideration to the implications of inter-relationships which might develop between patients/clients.
e. The importance of not making assumptions about what other agencies may or may not have done or what they know.
f. The sharing of information between individual teams and organisations.

… Inter-Agency Risk Management Arrangements should be reviewed and changes made to ensure that:

a. There is appropriate representation of agencies at meetings (such as MARAC and MAPPA) to ensure that information from those who have direct knowledge of the patient/service user is available when cases are being discussed.
b. All relevant information is made available to multi-agency decision-making meetings (for example, consideration should be given as to how clinical and other professional opinions can be provided, how relevant file data can be accessed and how factors which might change risks from being general to specific are brought to attention).
c. Systems are put in place to enable timely access to, and the sharing of, information.

… The new Trust should put in place arrangements for informing the police of serious incidents involving patients, particularly in respect of those patients who may need help to take forward their wish to inform police of offences which they allege to have been committed against them. Those arrangements should include:

a. A protocol with police about how such matters should be reported and followed up to ensure appropriate actions are taken.
b. Ensuring that a police ‘incident number’, ‘crime number’ or other suitable reference is obtained and recorded to confirm the report has been registered.

c. Instructions to staff about the arrangements.

… Health and Social Care Agencies should review their existing arrangements for ensuring good internal communications and jointly review information sharing protocols between themselves and other agencies such as police and probation, to ensure that information bearing upon risk is shared and joint work in the interests of patients/service users is facilitated.

… Agencies should ensure that strategic priorities such as the implementation of Unified Assessment, CPA and POVA are owned and implemented not only at a strategic level but also at an operational level.

… The new Trust should establish a group of senior clinicians and managers to review the implementation of the Care Programme Approach, to ensure the following:-

a. Especially in complex cases, that thorough assessments are completed, which draw upon all available information within the Health Service and that held by partner agencies.

b. That such assessments include a detailed formulation, diagnostic assessment and risk management plan.

c. That assessments are regularly updated.

d. That assessments are communicated effectively across all teams and services that might be involved in the care of the individual.

… In respect of CPA, health service agencies should ensure that:

a. Staff have received appropriate training
b. That in mental health services CPA addresses transitions, in particular from in-patient to out-patient/community care and treatment.
c. That where CPA identifies actions to be taken, those are actioned and checked for completion, in particular if they are prerequisites for further actions such as discharge of a patient. The appointment of a care coordinator and the proper discharge of that role is a key factor in ensuring any care plans are implemented.
d. That CPA involves all the relevant parties and links to the unified assessment process.

… Clear protocols for the sharing of information between voluntary agencies and statutory services should be developed; these should be clear about who should take any action required in respect of risk, POVA and child protection procedures.

… Serious consideration should be given by the professionals concerned to appropriateness before moving patients between teams for administrative or clinical convenience in the interests of integrated, seamless, and co-ordinated services which deliver continuity to the patient.

… The Tŷ Llywellyn Medium Secure Unit should take the lead in discussions with Trusts and LHBs to identify protocols for referral and re-referral of patients, linked to the seriousness and persistence of the problems they present.

… In reviewing all-Wales arrangements for care, treatment and management of those suffering from mental health problems, the needs of those suffering from personality disorders should be addressed.

Annex A

Terms of Reference for the Review

The aim of the review was to:

- Consider the care provided to Mr C as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on 2 October 2006[2] and to the extent that relevant factors exist to consider the care and treatment of Mrs Y.

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

- To identify any change or changes in Mr C's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 2 October 2006.

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

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

[2] As part of this exercise consideration will be given also to the social history of Mr C.

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 may commission an independent external review will into cases of homicide committed by a person with a history of contact with mental health services.

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

Arrangements for reviews in Wales

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

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

Annex C

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

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

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

RCA brings together much of the best practice informing investigation processes. Through its use the root causes for an undesired outcome can be identified and actions designed to prevent or reduce the likelihood of reoccurrence produced. Root cause analysis concerns itself with systems and reviews using the approach continue to 'drill down' through the perceived causes of an incident until originating organisational factors have been identified or until data are exhausted.

Developed in the field of engineering, RCA helps professionals in a wide range of settings, who might otherwise be unfamiliar with investigation methods, to determine: what happened, how it happened and why it happened. It is designed to encourage learning from past problems, failures and accidents and to eliminate or modify systems to prevent future occurrences of similar incidents. It provides a template for the non-professional investigator which ensures a systematic approach to investigation built upon good investigation practice and for those with more experience is a helpful checklist of necessary investigation steps and provides a

'tool box' of techniques which have proven success in uncovering root causes of events.

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

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

Dr Suresh Joseph
Mr John Rospopa
Mrs S Whitson
Mrs Ann Jenkins
Mr M Frost
Mr R Jones
Ms C Fahey

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

… examination of documents relating to the organisation and delivery of services by the LHB, Trust and Local Authority. The Review team also had access to the police records relating to the case;

- reading the case records maintained by Health Bodies and Local Authorities concerning Mr C;
- reading interview notes and written statements provided by staff working with Mr C 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;
- developing and checking a timeline;
- a meeting during which senior staff of bodies involved with Mrs Y and Mr C checked the timeline and used some RCA techniques to examine further the issues lying behind the sad outcome of this case.

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

The analysis stage was taken forward by the review team. 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.

It should be noted that, while agencies such as the Police and the Probation Service extended their assistance to the Review by way of providing access to documentation and allowing the Review Team to interview relevant staff, the remit of this Review does not extend to those bodies.

Annex D

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) was established on 1 April 2004 by the National Assembly for Wales to discharge the functions conferred on the Assembly under Chapter 4 of Part 2 of 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 Assembly Government.

HIW's core responsibility is to undertake reviews and investigations into the provision of NHS funded care either by or for Welsh NHS bodies 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, HIW 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 Assembly Government receive useful, accessible and relevant information about the quality and safety of Welsh NHS funded care and;
- developing more effective and co-ordinated approaches to the review and regulation of the NHS in Wales.

On 1 April 2006, the responsibility for the regulation of independent healthcare under the Care Standards Act 2000 transferred to HIW from the Care Standards Inspectorate for Wales. 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.

In addition 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 and Midwifery Council (NMC) to conduct annual monitoring of higher education institutions in Wales which offers approved NMC programmes.

Annex E

Multi Agency Arrangements for the Management of Risk

MAPPA (Multi Agency Public Protection Arrangements) place a duty on the police and the National Probation Service to assess and manage risks posed by offenders in every community in England and Wales. In the most serious cases MAPPA can recommend increased police monitoring, special steps to protect victims and the use of closely supervised accommodation.

The MAPPA meetings are split into three categories:
Category 1: Sex Offenders
Category 2: Violent and other offenders
Category 3: Other offenders

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

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

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

For an individual to be subject to a MAPPA assessment, he/she needs to have had a conviction of 12 months or more in relation to an offence which shows that that person is capable of causing serious harm to the public.

Annex F

Guidance relating to Mental Health Services in Wales

'Adult Mental Health Services for Wales dated September 2001' states:

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

… Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the development of concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental, family or illness factors. Mental Health Problems describes a very broad range of emotional or behaviour difficulties that may cause concern or distress. They are relatively common, may or may not be transient but encompass mental disorders, which are more severe and/or persistent.

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

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

'' Successful implementation of the strategy will depend on:

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

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

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

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

… To protect users, carers and the public from avoidable harm while respecting the rights of users and their carers''.

''The 1989 strategy stated that the severely mentally ill are a priority for secondary mental health services. Mental health services also have an important role in providing and supporting primary care in helping them to treat other mental illness. Some effective treatments, such as formal psychotherapies, are not available in primary care. Primary care also needs help with difficult or chronic cases and in the management of uncommon

conditions. When resources are scarce, there is a tendency for mental health services to provide a ‘’psychosis only’’ service. We believe this trend acts against the interests of all users, can reduce psychological treatment skills and would provide an unsatisfactory service for primary care. The policy that 80% of the workload of a mental health service should be with the severely mentally ill captures the sense of priority but guards against the possibility if too narrow a focus. Definition of severe mental illness in this context should take into account not only diagnosis but also the level of distress and disability that the individual is experiencing. “

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

‘’Services therefore need to be:

… Effective in using care processes.

Evidence and experience has shown the benefits of providing well co-ordinated care to those suffering with mental health problem. Mental health service users, particularly those with more complex and enduring needs, often require help with other aspects of their lives such as housing, finance, employment, education and physical health needs.

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

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

… ‘’ Multiple care needs, including housing, employment etc, requiring interagency co-ordination,

… Willing to co-operate with one professional or agency, but have multiple care needs,

- … Maybe in contact with a number of agencies (including the criminal justice system),
- … Likely to require more frequent and intensive interventions,
- … More likely to have mental health problems co-existing with other problems such as substance misuse,
- … More likely to be at risk of harming themselves or others,
- … More likely to disengage with services''.

Standard seven of the National Service Framework set a target of achieving full introduction of CPA across Wales by December 2004 although it was hoped that sufficient progress would be made for the target to be met by December 2003. The National Service Framework also recognised that ''authorities will need to ensure a fully integrated approach to the CPA and the health and social services Unified Approach to Assessing and Managing Care''.

Annex G

The Mental Health Act 1983

Section 2(2) of the Act sets out the grounds for admission for assessment:

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

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

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

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

"An application for admission for treatment may be made in respect of a patient on the grounds that –

(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and

(c) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section."

Section 47 of the Act relates to the removal to hospital of persons service sentences of imprisonment, etc:

“47. - (1) If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners -

(a) that the said person is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; and

(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that 'such treatment is likely to alleviate or prevent a deterioration of his condition;

the Secretary of State may, if he is of the opinion having regard to the public interest and all the circumstances that it is expedient so to do, by warrant direct that that person be removed to and detained in such hospital *[not being a mental nursing home*] as may be specified in the direction; and a direction under this section shall be known as "a transfer direction".

(2) A transfer direction shall cease to have effect at the expiration of the period of 14 days beginning with the date on which it is given unless within that period the person with respect to whom it was given has been received into the hospital specified in the direction.

(3) A transfer direction with respect to any person shall have the same effect as a hospital order made in his case.

(4) A transfer direction shall specify the form or forms of mental disorder referred to in paragraph (a) of subsection (1) above from which, upon the reports taken into account under that subsection, the patient is found by the Secretary of State to be suffering; and no such direction shall be given unless the patient is described in each of those reports as suffering from the same form of disorder, whether or not he is also described in either of them as suffering from another form.

(5) References in this Part of this Act to a person serving a sentence of imprisonment include references -

(a) to a person detained in pursuance of any sentence or prder for detention made by a court in criminal proceedings (other than an order under any enactment to which section 46 above applies);
(b) to a person committed to custody under section 115(3) of the Magistrates' Courts Act 1980 (which relates to persons who fail to comply with an order to enter into recognisances to keep the peace or be of good behaviour); and
(c) to a person committed by a court to a prison or other institution to which the Prison Act 1952 applies in default of payment of any sum adjudged to be paid on his conviction."

Section 49 of the Act relates to the restriction on discharge of prisoners removed to hospital:

"49.-(1) Where a transfer direction is given in respect of any person, the Secretary of State, if he thinks fit, may by warrant further direct that that person shall be subject to the special restrictions set out in section 41 above; and where the Secretary of State gives a transfer direction in respect of any such person as is described in paragraph (a) and (b) of section 48(2) above, he shall also give a direction under this section applying those restrictions to him.

(2) A direction under this section shall have the same effect as a restriction order made under 41 above and shall be known as "a restriction direction".

(3) While a person is subject to a restriction direction the responsible medical officer shall at such intervals (not exceeding one year) as the Secretary of State may direct examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require."

Section 136 of the Act relates to mentally disordered persons found in public places:

"136.- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the

interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

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

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).

Beck Hopelessness Scale (BHS) - a 20-item self-report inventory developed by Dr. Aaron T. Beck that was designed to measure three major aspects of hopelessness; feelings about the future, loss of motivation, and expectations. The test is designed for adults, age 17-80.

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.

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).

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.

Protection of Vulnerable Adults (POVA) – a scheme, as set out in the Care Standard Act 2000, that was introduced in 2004. At the heart of the scheme is the POVA list. Through referrals to, and checks against the list, care workers who have harmed a vulnerable adult, or placed a vulnerable adult at risk of harm, (whether or not in the course of their employment) will be banned from working in a care position with vulnerable adults.

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.

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.

Supervision Order - A Supervision Order can last up to three years. A range of conditions can be attached to a Supervision Order when the sentence is used for more serious offences. These are called 'specified activities' and can last for up to 90 days. A young person receiving a Supervision Order is also required to take part in activities set by the Youth Offending Team (YOT), which could include repairing the harm done by their offence either to the victim or the community and programmes to address their offending behaviour, such as anger management.

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.

Youth Offending Team (YOT) - There is a YOT in every local authority in England and Wales. They are made up of representatives from the police, Probation Service, social services, health, education, drugs and alcohol misuse and housing officers. Each YOT is managed by a YOT manager who is responsible for co-ordinating the work of the youth justice services