INDEPENDENT EXTERNAL REVIEW

INTO THE HOMICIDE AND SUICIDE IN LLANGADOG ON 27th FEBRUARY 2003

COMMISSIONED BY
CARMARTHENSHIRE LOCAL HEALTH BOARD

Bwrdd Iechyd Lleol
Local Health Board
Sir Gaerfyrddin
Carmarthenshire

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1. ACKNOWLEDGEMENTS

1.1 Carmarthenshire Local Health Board would wish to extend its deepest sympathy to those involved in the tragic event that resulted in this review.

1.2 Carmarthenshire Local Health Board would wish to take the opportunity of thanking all those who contributed to and participated in this review. Their input is greatly appreciated, and the contributions made will result in lessons being learned in order to improve services in the future.

2. GLOSSARY OF TERMS

A&E	Accident & Emergency
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CT	Computerised Tomography
CXR	Chest X Ray
DNA	Did Not Attend
ECG	Electrocardiogram
EEG	Electroencephalogram
GP	General Practitioner
LHB	Local Health Board
MAPPA	Multi Agency Public Protection Arrangements
OREMS	Nursing Assessment Tool
OT	Occupational Therapy
PRISM	Mid & West Wales Alcohol and Drug Advisory Service
SHO	Senior House Officer
WWGH	West Wales General Hospital
(X)	Member of the Public

3. INTRODUCTION

3.1 The purpose of the independent external review is to examine, within the context of its terms of reference, the events leading up to this tragedy, and to draw conclusions and make recommendations for change that might prevent re-occurrences of this kind.

3.2 Whilst this tragedy could not have been predicted, the issues raised by this review have been present for some time and yet other tragedies did not occur.

3.3 The intention of the independent external review's recommendations is to improve services so that the risk of future such tragedies will be reduced.

3.4 That is not to say that such events can be eliminated entirely.

4. BACKGROUND

4.1 Summary of Relevant Clinical History

4.1.1 Mr William Davies, a 59-year-old farmer, was first referred to the mental health services of Pembrokeshire & Derwen NHS Trust in October 2002, when admitted via the accident and emergency (A&E) department, Carmarthenshire NHS Trust, from police custody following an attempted self-strangulation.

4.1.2 Mr Davies had earlier been taken into police custody following an incident with a shotgun, involving threats to Ms Caroline Evans, the landlady of a public house in Llangadog.

4.1.3 During this first admission to the trust, Mr Davies was treated with anti-depressant medication. He had had no previous contact with the psychiatric services before this event.

4.1.4 Following discharge from the acute psychiatric ward in November 2002, Mr Davies was engaged with a care plan in the community that included community psychiatric nursing input, medical out-patient monitoring, psychology counselling, input from the local alcohol advisory service (PRISM), and contact with his general practitioner.

4.1.5 Mr Davies had one further admission to the trust in January 2003, triggered by an increase in alcohol consumption and deterioration in mood. Community services continued again following Mr Davies' second discharge from the acute psychiatric ward.

4.1.6 Mr Davies began disengaging from the mental health services around 11th February 2003. From 13th February 2003, a change was noted in Mr Davies' behaviour and presentation which caused concern to the community mental health team (CMHT) at Clos Bran, Llangadog (outline of the composition and activity of the CMHT attached at Appendix 1). They decided to ensure that all future visits to Mr Davies' home would be made by more than one member of staff at a time.

4.1.7 Throughout the two week period leading up to the tragedy, three significant incidents were noted that were aggressive in nature, following which on 25th February 2003 the clinical psychologist advised the community mental health team to pursue a forensic assessment.

4.1.8 On 27th February 2003, Mr Davies shot and killed Ms Caroline Evans. Mr Davies then shot and killed himself.

4.1.9 Greater detail of the care journey and the immediate events leading up to the homicide and suicide are detailed in Chapter 5, Summary of Events, and in the Chronology of Key Events at Appendix 2.

4.2 Review Process

4.2.1 At the request of the Director of Health & Social Care, Welsh Assembly Government, Carmarthenshire Local Health Board commissioned a review into the care management arrangements for Mr Davies and the events leading up to the homicide and suicide.

4.2.2 A review panel was established, independent of the providers involved, and supported by external advisors approached through their relevant professional bodies:

- Mr Alan T Jenkins, Chairman (solicitor, part time member of judiciary)
- Prof. John Gunn (CBE, MD, FRCPsych., F.MED.SCI) - Royal College of Psychiatrists nominee
- Mr Frank Corr (RMN, RNMH, MA Health Law, DMS) - Royal College of Nursing nominee

4.2.3 Local advisors to the review process were:

- Mr Alan Brace - Carmarthenshire LHB (Executive representative)
- Dr Chris John – (MB, BS, FRCGP) Carmarthenshire LHB (GP representative)
- Mrs Jane Jeffs - Carmarthenshire LHB (Lay member representative)

4.3 Terms of Reference for the Independent External Review

4.3.1 The purpose and aim of the review is to consider the treatment and care provided to Mr Davies by the mental health services of Pembrokeshire & Derwen NHS Trust, and to examine all management reports on the incident requested by the review panel.

Function/Objectives of the Review

a. To examine the quality and scope of the assessments made of Mr Davies' health and social care needs from 24th October 2002 to 27th February 2003.
b. The nature of the risk assessment of potential harm to himself and others.
c. The medical and psychiatric history of Mr Davies
d. The social history including the nature of any court appearances and convictions.
e. The role of psychology in relation to Mr Davies' health needs.
f. The extent to which Mr Davies' care corresponded to statutory obligation, relative guidance from Welsh Assembly Government, and local operational policies:
    i. the extent to which Mr Davies' prescribed care plans were effectively drawn up, delivered and complied with by Mr Davies;
    ii. to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of Mr Davies;
    iii. to examine the adequacy of collaboration and communication between agencies involved in the care of Mr Davies, the provision of service to him and between the statutory agencies involved;
    iv. to examine and comment on the nature of any risk assessment and the management of identified risk presented by Mr Davies to himself or others.
g. To prepare a report with recommendations to Carmarthenshire Local Health Board and Welsh Assembly Government

4.3.2 The panel reviewed evidence from individuals involved in the care of Mr Davies, and read substantial documentation from all the relevant agencies involved. Full details of this documentation is provided in Appendix 3.

4.3.3 Panel meetings were convened on:

Independent External Review Panel

Meeting Dates

- 1st September 2003
- 8th to 10th September 2003
- 24th October 2003
- 12th January 2004
- 9th to 10th September 2004
- 28th January 2005
- 18th March 2005

4.3.4 The protracted nature of the panels meetings was due, in the main, to delays in establishing the inquest process into the deaths of Mr Davies and Ms Evans, and the consequent effect this had on the ability of the police to engage with the review process.

4.3.5 All individuals and agencies co-operating in this review responded to the questions put to them, and readily supplied all documentation requested. All those interviewed who provided information have had the opportunity to approve and, where appropriate, amend early drafts of this report.

4.3.6 In order to encourage an uninhibited contribution by all those involved, individuals are not identified by name. Those invited to make submissions before the panel included:

- Chairman, Pembrokeshire & Derwen NHS Trust;
- Acting Chief Executive, Pembrokeshire & Derwen NHS Trust;
- Director of Mental Health & Learning Disabilities, Pembrokeshire & Derwen NHS Trust;
- Operational staff from Pembrokeshire & Derwen NHS Trust involved in the care and treatment of Mr Davies – consultant psychiatrists, community psychiatric nurses, staff nurses, psychologists and support workers;
- General practitioners from Mr Davies' GP practice;
- Representatives of Dyfed Powys police;
- Representatives of PRISM (mid & west Wales alcohol and drug advisory service);
- Representatives of the crown prosecution service;

4.3.7 A full chronology of the involvement of Mr Davies with Pembrokeshire & Derwen NHS Trust and other agencies was identified from the following information:

- Information obtained from statements and interviews from staff directly involved with Mr Davies and the incident;
- Information obtained from mental health service team health records, medical records, care plans, risk assessments and correspondence;
- Statements from and interviews with external agencies involved in Mr Davies' care journey.

4.3.8 Information drawn from the above sources has been analysed in order to identify critical problems and general learning points within the key findings and recommendations.

5. SUMMARY OF EVENTS

5.1 First Admission
24th October 2002 to 20th November 2002

5.1.1 Mr Davies was admitted to the acute psychiatric ward of Pembrokeshire & Derwen NHS Trust on 24th October 2002 following a reported attempted suicide whilst in police custody. Mr Davies had tried to strangle himself with his jumper after being arrested by police following an argument in his local pub in Llangadog. He had been arrested because he had assaulted the landlady, Ms Evans, and was in possession of an unlicensed shotgun, with which he had threatened to kill her.

5.1.2 Mr Davies was uncommunicative on admission. He was regarded as suicidal and placed on 15 minute observations.

5.1.3 On 25th October 2002, the staff nurse on duty noted that Mr Davies claimed that he had had an "affair" with Ms Evans which had ended. He had wanted Ms Evans to kill him even though he asserted that the gun he was carrying was not loaded. Mr Davies also denied pointing the gun at her. He was understood to say that the landlady would not see her 28th birthday, and he would not see his 60th. Mr Davies continued to threaten suicide stating he would jump into a nearby river.

5.1.4 A physical and psychological assessment was undertaken as well as a social assessment on admission. Mr Davies was noted as being a 59 year-old farmer with low mood, and was later assessed as suffering from moderate to severe depression. Mr Davies had a 10 month history of excessive alcohol consumption, disturbed sleep and appetite, and also complained of headaches. Following initial assessment by the team, Mr Davies was commenced on anti-depressant medication.

5.1.5 During admission, Mr Davies disclosed that the sale of his prize herd of cattle in November 2001, and associated loss of role and community standing, caused him distress.

5.1.6 Mr Davies was interviewed by the police on 28th October 2002, and arrested and charged with two offences of possession of a shotgun with no certificate, and a threat to kill. Mr Davies was bailed to the acute psychiatric ward of Pembrokeshire & Derwen NHS Trust with the condition that he could drive through the village of Llangadog but not stop. He was to appear at Ammanford magistrate's court on 7th November 2002.

5.1.7 Whilst on the acute psychiatric ward, Mr Davies attended occupational therapy (OT) sessions, and was seen by the local alcohol advisory service (PRISM) on two occasions.

5.1.8 Mr Davies was also assessed by the psychology service who identified moderate anxiety, "normal depression" and a trait of perfectionism in his personality. Follow-up counselling was advised.

5.1.9 There were reports of fluctuations in Mr Davies' mood, usually reactive to media reports about the incident, court appearances or family issues.

5.1.10 Mr Davies was advised by his consultant psychiatrist to inform his wife of the "relationship" with Ms Evans but he failed to do so. Mr Davies' wife eventually found out herself during the court proceedings which put considerable strain on their relationship. This was exacerbated further when Ms Evans disclosed that she was pregnant and there was speculation that Mr Davies might be the father.

5.1.11 On the day of Mr Davies' court appearance on 7th November 2002, the main charge of threatening to kill Ms Evans was withdrawn by the crown prosecution service (CPS), and Mr Davies pleaded guilty to possession of a shotgun without a certificate, common assault and threatening words and behaviour. Magistrates adjourned the case to 26th November 2002 for preparation of pre-sentence reports. Sentencing was subsequently adjourned until 18th December 2002 for psychiatric assessment. Mr Davies was allowed to reside at home, but forbidden to stop in the village of Llangadog.

5.1.12 This decision by the crown prosecution service to withdraw the more serious charge generated a positive outlook in Mr Davies evidenced by his statement that although he had let family and friends down, he "could see light at the end of the tunnel".

5.1.13 Following a series of periods of leave from the ward, a discharge plan was formulated and Mr Davies was discharged on 20th November 2002 with community psychiatric nursing support and out-patient appointments, together with counselling from the psychology assistant and input from the local alcohol advisory service.

5.2 Intervening Period Between First and Second Admission 20th November 2002 to 1st January 2003

5.2.1 On Mr Davies' discharge, plans were made for visits from a community psychiatric nurse (who was also identified as Mr Davies' community key worker), and outpatient appointments with his consultant psychiatrist.

5.2.2 On 26th November 2002, police officers visited Ms Evans to offer advice and information. Ms Evans informed the police that her "relationship" with Mr Davies was purely platonic. She was offered the use of a panic button and was considering taking out an injunction against Mr Davies. Details of this visit and the issues discussed were not conveyed by the police to the community mental health team.

5.2.3 On 28th November 2002, the community psychiatric nurse first visited Mr Davies on his farm and continued to visit regularly to monitor his mental state. At this first visit Mr Davies informed the community psychiatric nurse that he felt low in mood following a report in the local newspaper raising issues about the original offence. This made him feel angry and he expressed regret that he had not committed suicide at the time. It was noted that discussions with Mr Davies were in front of his wife and son, which made exploring his feelings difficult. Mr Davies' wife was still very angry that her husband had "made a fool of himself in public".

5.2.4 Mr Davies' presentation was, in the main, stable during this period, with occasional fluctuations in mood, but he was reactive to local press reports about the incident and his forthcoming court appearance. Relationships with his wife continued to be strained.

5.2.5 The community psychiatric nurse conducted a risk assessment using the Trust's initial clinical risk assessment tool. This confirmed low mood, anger, suicidal ideation and stress regarding the impending court appearance on 18th December 2002.

5.2.6 The community psychiatric nurse's second visit took place on 3rd December 2002. Again it was noted that it was difficult to talk to Mr Davies with his wife in the kitchen. Mr Davies stated that his mood had improved but that he retired to bed early due to the strained relationship with his wife. There was anxiety related to the pending court appearance but an apparent eagerness to get on with his life.

5.2.7 A further visit took place on 11th December 2002, where again it was difficult to talk as Mr Davies' wife, daughter and grandchild were also present. Mr Davies stated that his sleep pattern was still disturbed. He described his mood as fair as he was apprehensive about his forthcoming court appearance.

5.2.8 During this period, Mr Davies was seen once in out-patients on 5th December 2002 by his consultant psychiatrist. Mr Davies expressed remorse for the events leading up to his initial contact with the mental health services. The consultant psychiatrist furnished a psychiatric report to Mr Davies' solicitor for use in the magistrate's court.

5.2.9 Mr Davies attended court on 18th December 2002 and was sentenced to undertake a 60 hour community punishment and two year community rehabilitation order. Mr Davies was content with the outcome, believing that he had been fairly treated.

5.2.10 A fifth visit was scheduled for 9th January 2003 by the community psychiatric nurse. Before this could take place, the community psychiatric nurse received a phone call whilst off duty on 1st January 2003, from a friend of Mr Davies to advise that Mr Davies was at their house, depressed and feeling suicidal and wanting to be re-admitted to the acute psychiatric ward.

5.2.11 The friend also advised of difficulties in accessing Mr Davies' general practitioner out of hours. The community psychiatric nurse arranged for admission to the acute psychiatric ward.

5.3 Second Admission
1st January 2003 to 13th January 2003

5.3.1 On admission, Mr Davies was low in mood with a two-week history of excessive alcohol consumption.

5.3.2 It was noted that Mr Davies had spent Christmas on his own as his wife was at their daughter's home. Mr Davies was further upset at a rumour which suggested he was willing to pay someone to kill Ms Evans. Mr Davies stated that he had no intention of self-harming but that he "just wanted to get better". Mr Davies explained that the reason for the change in his condition was that he had tried but failed to apologise to Ms Evans, leading to his recent excessive abuse of alcohol.

5.3.3 During this second period of admission, Mr Davies had little family contact. He was seen by the PRISM hospital link support worker, and agreed to follow-up support.

5.3.4 Mr Davies had his medication reviewed and by 8th January 2003 was requesting discharge. On 13th January 2003, following assessment by the medical team and the formulation of a care plan, Mr Davies was discharged from the acute psychiatric ward with nursing support and out-patient appointments, together with counselling from the psychologist's assistant and input from the local alcohol advisory service. Mr Davies was also provided with a helpline number for crisis calls.

5.4 Period Between Second Admission and Homicide/Suicide 14th January 2003 to 27th February 2003

5.4.1 Following his discharge, the community psychiatric nurse saw Mr Davies at home on 14th January 2003. Mr Davies displayed insight into his alcohol problems, agreeing to remain abstinent. His mood was reported as "back to normal", although the relationship with his wife remained strained. His community punishment and rehabilitation order was due to commence the following weekend.

5.4.2 Mr Davies was offered a weekly counselling appointment with the psychologist commencing on 27th January 2003 and was also offered an appointment to see a PRISM alcohol support worker on 5th February 2003.

5.4.3 On 23rd January 2003, Mr Davies was seen as an out-patient by his consultant psychiatrist, who subsequently reported concerns to the community mental health team regarding an outburst of aggression and "rigid" thinking by Mr Davies towards his son. The consultant psychiatrist did not see Mr Davies following this appointment due to annual leave.

5.4.4 The community psychiatric nurse's next visit was made on 28th January 2003. Mr Davies reported that although he went to the pub for a few hours each evening, he was abstaining from alcohol.

5.4.5 On 3rd February 2003, the police were informed that Mr Davies had followed (X), a member of the public, very closely in his car through the village of Llangadog. This information was not conveyed by the police to the community mental health team.

5.4.6 Mr Davies phoned to cancel his appointment with the PRISM alcohol support worker on the morning of 5th February 2003. A further appointment was arranged for 27th February 2003.

5.4.7 On 10th February 2003, Mr Davies kept his appointment with his psychology counsellor. A week's break was subsequently agreed due to the psychology counsellor's annual leave and a further appointment was made for 24th February 2003.

5.4.8 The community psychiatric nurse made another visit to Mr Davies on 11th February 2003. On this occasion, Mr Davies was not at home as he was undertaking his community punishment and rehabilitation order.

5.4.9 On 13th February 2003, at 22.30, Mr Davies' friend phoned the community nurse again off duty to advise that Mr Davies was sitting in his jeep, waiting outside a public house in Llangadog, threatening to "sort out" (X) whom he suspected of reporting him to the police which had led to Mr Davies' initial arrest in October 2002.

5.4.10 The community psychiatric nurse advised Mr Davies' friend to inform the on-call general practitioner, whilst the community psychiatric nurse made contact with the crisis intervention team. The community psychiatric nurse spoke to the staff nurse of the team who advised that due to Mr Davies' threatening history, two staff would need to respond, but there were insufficient numbers of staff available at that time. However, a member of the acute psychiatric inpatient ward team further advised that Mr Davies could be seen and assessed if taken to the A&E department at Carmarthenshire NHS Trust.

5.4.11 The community psychiatric nurse also made efforts to contact the on-call GP. Mr Davies' friend phoned again to advise that Mr Davies had moved on to waiting outside another public house in Llangadog.

5.4.12 Unable to speak to the GP on call, the community psychiatric nurse then contacted the police and informed them of Mr Davies' history. The police stated that they would deal with the incident. At 00.30 the police rang to inform the community psychiatric nurse that after satisfying themselves there was no further cause for concern, they had taken Mr Davies home.

5.4.13 The following day, although off duty, the community psychiatric nurse contacted the acting team leader of the community mental health team to advise of the previous night's incident.

5.4.14 The acting team leader, also a community psychiatric nurse, was asked to visit Mr Davies at home by the off duty community psychiatric nurse to assess his mental state. It was agreed that two people, the acting team leader and a support worker should visit. They were met by Mr Davies' wife who stated that the previous evening Mr Davies had gone out early as usual for a couple of drinks. Prior to this, he had received a telephone call informing him that his daughter had gone to America for a holiday. Mr Davies' wife had not told her husband this knowing it would upset him. Mr Davies reacted angrily on hearing this information. He proceeded to smash some crockery and then stormed out of the house.

5.4.15 Mr Davies' wife stated that Mr Davies was still angry and that he had cancelled his GP appointment for 10:00 that day.

5.4.16 When Mr Davies met with the acting team leader and support worker, he appeared hostile but denied any symptoms of depression other than poor sleep. He became more agitated and irritable and shouted that he was going to kill the person (X) who had ruined his life, not caring of the consequences as he could throw himself into the river. He then stormed out of the room.

5.4.17 The acting team leader did not believe from this first encounter with Mr Davies that he would act on his angry threat, and thought it best to leave him to calm down. This explicit threat to kill (X) was not reported to the police by the acting team leader or support worker. The acting team leader spoke with a GP from Mr Davies' practice on the phone, advising him that Mr Davies showed no signs of depression or psychosis, and that the phone call informing Mr Davies that his daughter had gone to America had triggered the previous night's incident. The GP, having seen Mr Davies on several occasions in the past few months, felt that his anger was more a police issue than a medical one.

5.4.18 The acting team leader did not discuss this event with the senior practitioner of the community mental health team, nor ask the senior practitioner who held line management responsibility for the CMHT, for advice or guidance, nor raise it at a formal supervision session between the two which was held on 17th February 2003.

5.4.19 On 19th February 2003, the community psychiatric nurse visited Mr Davies at home. This was not an arranged visit but the community psychiatric nurse's first day back on duty. Mr Davies reported that he had not been sleeping well, that he had been thinking about (X) who he blamed for destroying his life. Mr Davies recalled that on 13th February 2003, he had passed a public house in Llangadog and had seen (X) in there.

5.4.20 As he spoke about (X) Mr Davies became irate and threw a cup, then a biscuit barrel, then a chair. He then told the community psychiatric nurse to leave. This was the last contact the community psychiatric nurse had with Mr Davies.

5.4.21 Believing that (X) was at risk from Mr Davies, the community psychiatric nurse informed the acting team leader of the community mental health team of these concerns, who in turn discussed the issue with Mr Davies' GP, who advised that as there was a potential risk to (X), the police should be informed. The community psychiatric nurse informed the police of these concerns who agreed to attend. Police advise that they were informed by the community pychiatric nurse that Mr Davies was not 'sectionable' in their view. Police officers attended and ascertained that there was no evidence that any offence had been committed or was about to be committed by Mr Davies. They asked Mr Davies if he required any medical attention, which he declined. Mr Davies was calm when the police left. An update of this visit was not conveyed by the police to the community mental health team. The acting team leader of the community mental health team did not report this incident to the senior practitioner, nor complete an incident report (IR1).

5.4.22 This event was further discussed in a ward round with the associate psychiatrist on 20th February 2003. Both the community psychiatric nurse and the acting team leader stated that visiting Mr Davies at home was too much of a threat and it was decided that no further lone visits should be made. An appointment was to be sent requesting Mr Davies to attend for an out-patients appointment at the surgery on 26th February 2003.

5.4.23 On 24th February 2003, Mr Davies did not attend his appointment with his psychology counsellor.

5.4.24 On 25th February 2003, events involving Mr Davies were discussed at the community mental health team meeting. The psychologist advised that a forensic psychiatry assessment should be considered. It was also agreed that Mr Davies' whole case be reviewed when his consultant psychiatrist returned from leave. A further risk appraisal was to be undertaken during the proposed meeting with the associate psychiatrist, and issues further discussed with Mr Davies during his counselling session scheduled for 3rd March 2003. The police were not informed of this review meeting, nor that a forensic assesment was being considered.

5.4.25 Mr Davies did not attend his out-patients appointment on 26th February 2003, and a further appointment was made for 5th March 2003.

5.4.26 On the evening of 27th February 2003, Mr Davies shot and killed both Ms Evans and himself.

6. KEY FINDINGS AND RECOMMENDATIONS

6.1 This section identifies those issues that the independent external review panel considers had a significant impact in terms of the care provided to Mr Davies, the services delivered, and also makes recommendations, where appropriate, for improving services.

6.2 These findings and recommendations are set out under headings relating to the terms of reference for this independent external review.

a **To examine the quality and scope of the assessments made of Mr Davies' health and social care needs from 24th October 2002 to 27th February 2003**

6.3 The panel identified weaknesses in the history-taking of Mr Davies. Mental health service staff appeared to take Mr Davies' history at face value and only from himself, with no attempt to corroborate with evidence from others.

6.4 When Mr Davies was first admitted into the mental health service, and a history was taken from him, it appears that his statement that he had had an "affair" with Ms Evans, and that she might or might not be carrying his baby, was accepted.

6.5 The community mental health team's subsequent dealings with Mr Davies appear to be based on the assumption that these facts were true. It was a mistake not to query the truth of these assertions. No consideration appears to have been given to the possibility that, in addition to his depression, Mr Davies might also have been harbouring jealous and even delusional ideas.

6.6 The consultant psychiatrist recorded that Mr Davies had "no ideas of harm to others" at the time of his admission, and the appraisal of the situation at the time was that Mr Davies realised he had a problem, but that he did not want to rectify it. He wanted to "die and put an end to everything". This provides the basis for the rest of the consultant psychiatrist's analysis. Later the consultant psychiatrist noted that Mr Davies described the affair with Ms Evans who gave his version of what is described as "an argument" without giving any content to that argument. The consultant psychiatrist further described how Mr Davies was diagnosed as suffering from a moderate to severe depressive episode. In summary, the consultant psychiatrist specifically stated that Mr Davies showed no evidence of underlying personality disorder or psychotic illness and stressed that the risk assessment in that summary was related to the time of the offence prior to admission, implying that it was not repeated at later stages.

6.7 Reviews of clinical risk assessment and management plans were not recorded at significant stages, such as when changes in Mr Davies' behaviour had been reported.

6.8 Recommendations

6.8.1 Patient history taking should include other sources of information particularly where there are public protection concerns, in order to ensure that an accurate assessment can be gained and appropriate interventions can subsequently be undertaken.

6.8.2 Reviews of clinical risk assessment and management plans should be repeated at significant stages in order to gain an on-going and up to date reflection of risk assessment.

b The nature of the risk assessment of potential harm to Mr Davies and others

6.9 Three risk assessments were recorded for Mr Davies on the Pembrokeshire and Derwen NHS Trust's risk assessment form. On each occasion Mr Davies was assessed as being at risk of self-harm but no further action by others, or management plan, was indicated or completed.

6.10 After Mr Davies attended court, there was a note that he was further stressed by the fact that his wife had discovered his affair with Ms Evans. None of these assessments included an evaluation of his risk to other people.

6.12 Whilst the hospital risk assessment form focuses on the individual characteristics of the patient concerned, in this case and in the panel's view, there was an unfortunate failure to evaluate the risk to others, and a failure to consider morbid jealousy, a dangerous psychotic disorder, as a diagnosis.

6.13 Clinical risk assessments should have been based on a detailed understanding of the patient's behaviour, thoughts, and stated intentions.

6.14 In the United States this type of risk assessment is now being called a "threat assessment", although acknowledging that this is not commonly incorporated into current assessment protocols in either a local or national context. Even if Mr Davies had refused to impart his aggressive thoughts and intentions to his carers, there was material available for the clinical team to assess him as posing a serious threat to others. For example, it was known that Mr Davies had borrowed a gun to threaten Ms Evans who had complained that he had threatened to kill her, and he was originally taken to court on that basis. Following his court case, Mr Davies continued to stalk Ms Evans and a member of the public (X), behaviour which can in itself be a criminal offence and which is also known to be highly dangerous.

6.15 A more accurate assessment would not necessarily have prevented the subsequent fatalities, but it might have led the clinical team to reconsider readmission to hospital.

6.16 Recommendations

6.16.1 Risk management plans, when completed, should be made available to all clinical staff, and plans to deal with each risk factor identified should be spelled out and linked to named individuals. These plans should be updated at each formal clinical assessment, i.e. ward round, team meeting, etc.

6.16.2 In any situation involving an actual or alleged sexual partnership which is going wrong, a diagnosis of morbid jealousy should always be considered.

6.16.3 Training programmes should be in place to teach clinical risk assessment techniques.

6.16.4 Consideration should be given to teaching and adopting more widely the concept of threat assessment rather than standard risk assessment as it is more clearly focused on the individual, whereas risks are largely statistical concepts.

6.16.5 Assessments of either kind should always lead to a plan for management*.

*** Footnote**

Action already taken by Pembrokeshire & Derwen NHS Trust includes the introduction of a screening assessment clinic protocol within the Llangadog community mental health team, which has resulted in a central point of referral being identified for all routine and urgent referrals, and all users receiving a standardised clinical assessment. Support and training has been provided by both senior management and the clinical psychology department. The clinical meeting has been restructured to accommodate feedback from the screening clinic.

c The medical and psychiatric history of Mr Davies

6.17 Mr Davies was not previously known to the mental health services prior to 24th October 2002, neither was there anything in the panel's opinion of immediate relevance in Mr Davies' previous medical history that would have had an impact on subsequent events.

6.18 There are no recommendations from the panel that can be made in regard to the medical and psychiatric history of Mr Davies.

d The social history including the nature of any court appearances and convictions

6.19 There was nothing particularly of note, in the panel's opinion, in Mr Davies' social history, nor did Mr Davies have any previous convictions or court appearances.

6.20 However, Mr Davies was noted to have poor impulse control and his alcohol consumption was thought to be a factor which would increase his risk to himself. Mr Davies was therefore instructed to abstain from alcohol and he was appropriately referred to the local alcohol advisory service for support.

6.21 There are no recommendations from the panel that can be made in regard to the social history of Mr Davies.

e The role of psychology in relation to Mr Davies' health needs

6.22 Leading up to the fatal incident, the panel noted inconsistencies in the perceptions of Mr Davies' presenting problems amongst professionals involved in his care.

6.23 Significantly, Mr Davies' general practitioner and the team leader of the community mental health team identified anger problems without any connection to Mr Davies' previous depression and behaviour, while the psychology counsellor did not note any anger problems.

6.24 Social issues were identified at key stages, which a trained social worker may have been able to provide input to, but no referral for a social assessment was made.

6.25 More latterly in Mr Davies' care, a forensic psychiatry assessment was suggested by the psychologist, which as a consultant to consultant responsibility, was agreed to be progressed when Mr Davies consultant psychiatrist returned from leave.

6.26 Recommendations

6.26.1 Views of individual professionals should be shared amongst all clinical staff, and articulated and reviewed at each formal clinical assessment, i.e. ward round, team meeting, etc.

6.26.2 Formal protocols for referrals for social assessments when significant social issues are raised, to be followed*.

6.26.3 Arrangements for accessing forensic psychiatry assessments/opinions in a timely manner, to be in place.

*** Footnote**

Implementation of the Care Programme Approach in Wales will address the formal protocols in place for social assessments.

f **The extent to which Mr Davies' care corresponded to statutory obligation, relative guidance from Welsh Assembly Government and local operational policies:**

i the extent to which Mr Davies' prescribed care plans were effectively drawn up, delivered and complied with by Mr Davies;

6.27 A disjointed approach to care planning within the mental health services was noted by the panel. There appeared to be a lack of integrated care management mechanisms in place, with care plans completed within the community mental health team making no reference to the wider involvement of other agencies such as PRISM or psychological counselling, although Mr Davies was referred to both.

6.28 The community psychiatric nurses' care plan detailed nursing input only, despite the community psychiatric nurse being Mr Davies' community key worker, demonstrating a lack of understanding of the role of a key worker in co-ordinating Mr Davies' care management.

6.29 Also at this time, there was a lack of a Care Programme Approach to providing a framework for care management in Wales.

6.30 Difficulties with record keeping were noted, particularly in regard to the rural nature of the service, leading to problems in integrating records.

6.31 It was further noted by the panel that discharge summaries contained unhelpful jargon and difficult terminology when a narrative, free text approach would have been more helpful to intended recipients such as GPs.

6.32 Recommendations

6.32.1 A review of the summary of the joint care plan is required for the purpose of developing a Care Plan Approach*.

6.32.2 Training programmes to be put in place to teach care management and key worker roles.

6.32.3 The current system for integrating records should be reviewed with the objective of taking into account the rural nature of the service. Computerised patients notes with desk top machines at strategic points could prove particularly useful in addressing some of the technical problems in rural areas. If notes were updated locally, soon after each intervention, then all team members would be appraised of what was happening to patients at any given time.
Other key staff, such as GP's, could also be given access to patients' notes via a password.

6.32.4 Discharge information in discharge summaries should be enhanced by a narrative using simple words and language which can be understood by all intended recipients.

*** Footnote**
A Care Programme Approach is now in place in Wales.

ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of Mr Davies;

6.33 In any psychiatric treatment service the key resource is staff. Staffing should always be up to establishment level, with reviews to see if the establishment is sufficient, and if levels of seniority are appropriate.

6.34 Overall, the panel noted that there was a shortage of resources both in terms of permanent members of staff (albeit covered by temporary appointments), and the educational opportunities available to the health care team. Whilst it is acknowledged that it is difficult to recruit all grades of mental health professions, in Carmarthenshire there are vacancies for consultant psychiatrists, with recruitment from outside the area uncommon.

6.35 A new team leader to the community mental health team had only recently been appointed and was acting up into post covering sick leave at the time of the incident. Team work was poorly developed perhaps due to stretched senior management resources. There also appeared to be only limited administrative support for the team

6.36 As a result, and in the panel's opinion, workloads within the trust appeared high with consultant cover thinly spread. It is recognised that isolative working practices develop as a consequence of little or no available support. Awareness of what might constitute a need for tertiary referral may be low because of these deficiencies.

6.37 The panel further noted that access to forensic psychiatry resources in Pembrokeshire & Derwen NHS Trust is also very limited. There is one consultant within the trust who has a special interest in forensic psychiatry. Apart from that, the nearest service is in Bridgend, an hour or so away by car. Very few calls are made on the Bridgend forensic psychiatry service, and it is significant that a forensic psychiatry opinion was only considered at the end of Mr Davies' care management. Forensic opinions were not commonly requested as there would often be a significant delay in response.

6.38 Workload of the community mental health team, in the panel's opinion, appeared high and their level of experience insufficient. In addition, the community mental health team operates within a large geographical patch bringing with it a number of local rural problems, for example, staff working predominantly out of base, and regularly not returning to base either before or after their shift.

6.39 The panel found examples where the acting team leader did not onwardly report concerns and incidents from Mr Davies' community psychiatric nurse.

6.40 In the lead up to the tragedy, the acting team leader's assessment of Mr Davies' mental state was that he was not showing signs of depression or psychosis, but that he was angry, implying the cause to be domestic rather than psychiatric.

6.41 The acting team leader, along with other members of the community mental health team, did not equate Mr Davies' deterioration with a medical emergency that required extra resources and urgent further opinion. It would appear that they hoped they had sufficient time to confer with Mr Davies' consultant psychiatrist on return from annual leave. However, the community mental health team were aware of the increasing dangers as they took the decision not to allow staff to visit Mr Davies unaccompanied.

6.42 Cover for the consultant psychiatrist on leave was supplied by an associate psychiatrist, who would have had access to another consultant psychiatrist.

6.43 The panel noted that Mr Davies' community psychiatric nurse communicated well and the style adopted could be taken as an example of the informal approach which is useful in the management of psychiatric outpatients. The panel believes that the community psychiatric nurse's exemplary work in regard to this incident should be commended.

6.44 However, the panel also noted that the community psychiatric nurse, as key worker, should perhaps have taken a more proactive role in organising the team input.

6.45 A missing element in these events appears to be mental health education. The withdrawal by Mr Davies from mental health services, with thoughts of future management by others, in particular forensic psychiatry services, indicates that staff were alarmed and concerned for their own safety. They had insufficient experience and knowledge to be able to respond to the increasing dangerousness and to reduce it. Whilst the team worked closely with Mr Davies' GP, and repeatedly had contact with the police, communication through more informal channels may have signposted them in a more appropriate direction.

6.46 It is significant that the continuing professional training which occurs within the trust is largely local mental health employees teaching one another, with very few visiting teachers being sought, nor time out from trust-based activities undertaken to attend teaching conferences elsewhere.

6.47 Linkages could be strengthened with academia departments of psychiatry, nursing and psychology in a convenient university - either the University of Wales, Swansea, or University College, Cardiff, which has a growing section of forensic psychiatry.

6.48 An important technical adjunct which has been developed for long distances and rural areas is audio-visual communication using modern telephony and sometimes the internet. With appropriate equipment at selected sites it is possible to conduct teaching sessions, consultations and patient examinations at a distance. This will always be a useful adjunct to other forms of communication.

6.49 Recommendations

6.49.1 Efforts should be made to ensure staffing (to include medical, nursing, psychology, and occupational therapy) in the mental health field is up to establishment level and that the establishment level is sufficient. This could take the form of a brief research programme to evaluate the causes of any deficiencies.

6.49.2 A review of the working of the community mental health team should be undertaken to examine qualifications and leadership.

6.49.3 A review of local clinical leadership and supervision to ensure that this is properly being addressed.

6.49.4 A review of the capacity of local senior management to provide support and leadership for the mental health service teams.

6.49.5 Mid & West Wales should develop a low secure forensic psychiatry and forensic community service. A new post in forensic psychiatry dedicated to West Wales and linked to Bridgend for peer support should be considered.

6.49.6 For more effective communication, particularly in fraught and stressful situations, informal discussions with other knowledgeable staff should take place.

6.49.7 The medical on call cover system should be strengthened and formalised in order that there are clear cover arrangements and formal handover for staff on leave, including accessibility to all clinical notes. Staff off-duty or on leave should have cover which will embrace at some point in the chain a person of similar rank and position to the one on leave. No junior member of staff should ever have any doubt as to the means of contacting a senior member of staff.

6.49.8 Extra training for all staff in recognising and responding to psychiatric emergencies, especially learning when to increase resources to affect patient management.

6.49.9 Training programmes to be put in place to teach key worker and team leader roles.

6.49.10 The amount of training available to all professional staff should be increased with the main focus on general psychiatry (especially history taking and diagnostic skills) and psychiatric nursing. As a new dimension, forensic psychiatry training should also be included. Forensic psychiatry reviews and case presentations should take place on a regular basis with other service providers and disciplines as part of a local training scheme.

6.49.11 Mental health professional training should include experience of work outside the trust e.g. by attending courses elsewhere, by exchange schemes, and by frequent use of visiting speakers.

6.49.12 The panel notes that the Caswell unit at Bridgend now has audio-visual communication technology which could be linked to west Wales, which would assist in achieving some of the other recommendations made here and may even act as an interim partial solution to the staffing shortage.

iii to examine the adequacy of collaboration and communication between agencies involved in the care of Mr Davies, the provision of service to him and between the statutory agencies involved;

6.50 Mr Davies was admitted into the mental health services of Pembrokeshire & Derwen NHS Trust on 24th October 2002 from police custody. The information gained by the admitting doctor focused on the police advice that Mr Davies had tried to strangle himself with his jumper after being arrested. The fact that he had been arrested because he had assaulted Ms Evans, the landlady of a public house in Llangadog, and was in possession of an unlicensed shotgun, with which he used to threaten her life, appears not to have been stressed by the police.

6.51 From this point on, Mr Davies' management from the health service point of view was one of the management of a patient with suicidal propensities.

6.52 However, the case should also have been seen, from the beginning, as one of potential homicide, as it was threats to kill that took Mr Davies to the police in the first place.

6.53 In the panel's opinion, public protection was the responsibility of the police and the probation service as the two responsible authorities at the time of the incident (since joined by the prison service) with the health service contributing to and supporting this responsibility. It should thus be seen as a shared duty between these responsible authorities and the health service.

6.54 The view taken of Mr Davies on his admission quite possibly coloured the whole of his psychiatric care during the period under consideration. Mr Davies could have been seen as exhibiting both suicidal and homicidal propensities if a slightly different analysis of the admitting information had been undertaken.

6.55 A clearer picture of the events in the public house given by the police at the outset may have changed the whole course of the management of Mr Davies. There was a note made at the police station on 24th October 2002 to the effect that the police were reluctant to release Mr Davies in view of his risk of harming himself and others. A few days later, the police requested information about Mr Davies' discharge owing to the seriousness of events. Nevertheless a clinical note made a few hours later, after Mr Davies had been admitted to hospital, stated he had "ideas of self harm, no ideas to harm others".

6.56 The panel has previously noted that no easily available forensic psychiatry service existed in Carmarthenshire either then or now. An experienced forensic psychiatry opinion may have helped interpret this seemingly contradictory information.

6.57 The panel noted that Mr Davies was given a community punishment and rehabilitation order following his convictions. The panel believes that this would have involved some form of supervision from a probation officer. The panel did not find an assessment of Mr Davies from the probation service, nor evidence of liaison between the probation service and the mental health service. An exchange of information between probation and the mental health service would have been very helpful. MAPPA arrangements in place within Carmarthenshire should assist this process.

6.58 It is essential that there is a full exchange of information between the health care staff and the police when patients are passed from one to the other.

6.59 It is also essential that there is a full exchange of information between the other agencies involved in the care of mental health clients, and sufficient time allowed to act upon it. An example of this can be seen between the police and the crown prosecution service when the crown prosecution service dropped the charge of threat to kill preferred by the police, advising the police of this proposed action in writing, the day before Mr Davies' court appearance on 7th November, 2002.

6.60 With regard to the police involvement in Mr Davies' care, one of the tools used by them to assess his danger potential was a questionnaire known as Matrix 2000,the primary assessment tool utilised by police forces on a national basis*. The Matrix 2000 tool is in two parts - risk of sexual re-offending and risk of violent re-offending - and is designed to assess the risk of sex offenders and violent offenders re-offending. However, Mr Davies was not a sex offender, nor did he have a significant criminal history, and was therefore rated on this scale to be of low risk.

*** Footnote**

Current practice is that this information is also supplemented from Oasys Probation Assessments.

6.61 Risk assessment forms of this kind can be extremely misleading. They are based on the common observation that a high proportion of individuals with a significant criminal record are more likely than other people to re-offend in the same way. Unfortunately, such probabilistic questionnaires do not predict anything about an individual's future, they simply indicate which broad category of people a person falls into and, in this case, Mr Davies did not fall into the repetitively criminal/sex offender group.

6.62 Christmas is a notoriously difficult time for people with alcohol problems, but PRISM, the local alcohol advisory service (funded through a joint agreement by the local authority, LHB, probation service and substance misuse action team), was closed for a two week period during Christmas 2002. This was at a time when Mr Davies needed support as he was on his own at home, his family celebrating Christmas elsewhere.

6.63 Access to a general practitioner out of hours proved difficult on a few occasions. Although the panel understands this difficulty was an irregular occurrence, and that it did not directly affect the care provided to Mr Davies, it did present difficulties to the community psychiatric nurse attempting to access GP support. There needs to be a clear understanding between general practice and the mental health services on access out of hours, and escalation arrangements in the event of problems. As responsibility for general medical services out of hours passed to local health boards in Wales in 2004, this will now be addressed by Carmarthenshire Local Health Board as part of the development of this service.

6.64 Recommendations

6.64.1 Robust liaison mechanisms should be established between the police and the mental health services to involve regular meetings with doctors and managers from both, in order that an appreciation of each others role and a full exchange of information when passing clients from one agency to another, can be gained*.

6.64.2 Multi-agency public protection arrangements (MAPPA) were in place at the time of the incident (with a mental health representative on the steering group) and continue to be in place in Carmarthenshire. In the panel's view, these should involve a consultant psychiatrist with forensic psychiatry experience or interest, and should follow the Royal College of Psychiatrists guidelines.

6.64.3 Scores on risk assessment scales should not be used in isolation for clinical or operational purposes, but only in the context of a full clinical evaluation in the case of psychiatric patients.

6.64.4 Funding arrangements should be put in place to ensure that PRISM is able to cover critical holiday periods such as Christmas.

6.64.5 Carmarthenshire Local Health Board and Pembrokeshire & Derwen NHS Trust to have clear protocols and guidelines in place for access to general medical services out of hours.

*** Footnote**

A Chief Inspector from Dyfed Powys Police Crime Reduction Department chairs the Dyfed Powys Criminal Justice/Mental Health Group which has representation from Pembrokeshire & Derwen NHS Trust, Carmarthenshire Local Health Board, the Crown Prosecution Service, Probation Service, Social Services and West Wales Action for Mental Health. Recognising the need for local perspective/liaison, it is intended that meetings with local representatives will be progressed as of June 2005.

iv to examine and comment on the nature of any risk assessment and the management of identified risk presented by Mr Davies to himself or others;

6.65 The panel found that public protection issues were not considered formally at any stage by the mental health services. The panel believes that there was a lack of understanding and training about public protection procedures within the mental health service, and a lack of liaison with both the police and probation sevice during Mr Davies' involvement with the mental health service. Whilst the community mental health team communicated on a number of occasions with the police, this did not result in the establishment of a formal arrangement such as MAPPA.

6.66 Potential risks to Ms Evans did not seem to have been explored to any great extent with Mr Davies, nor at ward round discussions. It is evident that Ms Evans was not the person deemed by the mental health service to be most at risk from Mr Davies but another person, (X), and perhaps to a lesser extent in the final days, members of the community mental health team as they witnessed Mr Davies' anger.

6.67 When risks to another person (X) were identified, the community psychiatric nurse took immediate and appropriate action to protect this member of the public and to try to get help to Mr Davies.

6.68 Significant incidents that occurred leading up to Mr Davies' death, although reported to the acting team leader of the community mental health team were not formally reported as incidents through the incident reporting (IR1) process. The internal management of serious incidents and difficult situations appeared common practice within the culture of the community mental health team.

6.69 In the community, most of the discussion with Mr Davies was conducted with other family members present which made exploring Mr Davies' feelings difficult. The community psychiatric nurse commented on this difficulty, but no action was taken to avoid the necessity.

6.70 There were also missed opportunities to speak with Mr Davies' friends, relatives, and visitors to the ward whilst Mr Davies was an in-patient.

6.71 Recommendations

6.71.1 Further training for mental health staff on public protection issues should be provided.

6.71.2 Formal training required on incident reporting processes.

6.71.3 When dealing with a patient in the community, efforts should be made by mental health staff to conduct some sessions without other family members present, in order to gain a more accurate assessment.

6.71.4 Opportunities should be taken by mental health staff to engage with patients' friends and relatives when visiting the ward in order to gain a more complete assessment.

g **To prepare a report with recommendations to Carmarthenshire Local Health Board and Welsh Assembly Government.**

6.72 This constitutes the report of the independent external review panel, with recommendations, to Carmarthenshire Local Health Board and Welsh Assembly Government.

6.73 The panel considers that the underlying causes of low resources in terms of staff numbers and appropriate skills, together with geographical isolation, played a key role in the deficiencies identified here. The panel further believes that these factors can be remedied with determination and imagination.

6.74 It is also important to recognise that if none of the deficiencies described here had been present, then the tragedy may still have occurred.

6.75 The staff, in spite of the deficiencies described above, seemed caring and enthusiastic at all stages. Morale appeared reasonably high before this tragic case, but this episode will have had a distinctly negative effect, and a lowering of morale will serve to damage the service further.

6.76 Recommendations

6.76.1 It is particularly important that the staff, who have been the focus of this investigation, should not be singled out for adverse action and blame.

6.76.2 Staff should be given support structures and advice to enable them to move on with confidence if the standards of mental health care in Carmarthenshire are not to fall.

7. CONCLUSION

7.1 The panel concludes that there is no evidence that this unfortunate tragedy, which has seriously affected a close knit neighbourhood and the whole of the mental health services of Pembrokeshire & Derwen NHS Trust, could have been prevented with certainty.

7.2 The panel are satisfied, within the limitations set out in this report, that the staff involved did their best to manage and treat Mr Davies, who presented some especially difficult problems.

7.3 Nevertheless this independent external review process has identified some important recommendations to be addressed, a summary of which is provided in Chapter 8 Summary of Recommendations.

7.4 Finally, the panel do not wish this report to become the focus for blaming individuals. The problems identified are much wider than any one individual, and blaming individuals would be unfair and would serve to damage mental health services within Carmarthenshire.

8. SUMMARY OF RECOMMENDATIONS

8.1 To examine the quality and scope of the assessments made of Mr Davies' health and social care needs from 24th October 2002 to 27th February 2003.

8.1.1 Patient history taking should include other sources of information particularly where there are public protection concerns, in order to ensure that an accurate assessment can be gained and appropriate interventions can subsequently be undertaken.

8.1.2 Reviews of clinical risk assessment and management plans should be repeated at significant stages in order to gain an on-going and up to date reflection of risk assessment.

8.2 The nature of the risk assessment of potential harm to Mr Davies and others.

8.2.1 Risk management plans, when completed, should be made available to all clinical staff, and plans to deal with each risk factor identified should be spelled out and linked to named individuals. These plans should be updated at each formal clinical assessment, i.e. ward round, team meeting, etc.

8.2.2 In any situation involving an actual or alleged sexual partnership which is going wrong, a diagnosis of morbid jealousy should always be considered.

8.2.3 Training programmes should be in place to teach clinical risk assessment techniques.

8.2.4 Consideration should be given to teaching and adopting more widely the concept of threat assessment rather than standard risk assessment as it is more clearly focused on the individual, whereas risks are largely statistical concepts.

8.2.5 Assessments of either kind should always lead to a plan for management.

8.3 The role of psychology in relation to Mr Davies' health needs.

8.3.1 Views of individual professionals should be shared amongst all clinical staff, and articulated and reviewed at each formal clinical assessment, i.e. ward round, team meeting, etc.

8.3.2 Formal protocols to be followed for referrals for social assessments when significant social issues are raised.

8.3.3 Arrangements for accessing forensic psychiatry assessments/opinions in a timely manner, to be in place.

8.4 The extent to which Mr Davies' care corresponded to statutory obligation, relative guidance from Welsh Assembly Government and local operational policies:

i the extent to which Mr Davies' prescribed care plans were effectively drawn up, delivered and complied with by Mr Davies;

8.4.1 A review of the summary of the joint care plan is required for the purpose of developing a Care Plan Approach.

8.4.2 Training programmes to be put in place to teach care management and key worker roles.

8.4.3 The current system for integrating records should be reviewed with the objective of taking into account the rural nature of the service. Computerised patients notes with desk top machines at strategic points could prove particularly useful in addressing some of the technical problems in rural areas. If notes were updated locally, soon after each intervention, then all team members would be appraised of what was happening to patients at any given time. Other key staff, such as GP's, could also be given access to patients' notes via a password.

8.4.4 Discharge information in discharge summaries should be enhanced by a narrative using simple words and language which can be understood by all intended recipients.

ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of Mr Davies.

8.4.5 Efforts should be made to ensure staffing (to include medical, nursing, psychology, and occupational therapy) in the mental health field is up to establishment level and that the establishment level is sufficient. This could take the form of a brief research programme to evaluate the causes of any deficiencies.

8.4.6 A review of the working of the community mental health team should be undertaken to examine qualifications and leadership.

8.4.7 A review of local clinical leadership and supervision to ensure that this is properly being addressed.

8.4.8 A review of the capacity of local senior management to provide support and leadership for the mental health service teams.

8.4.9 Mid & West Wales should develop a low secure forensic psychiatry and forensic community service. A new post in forensic psychiatry dedicated to West Wales and linked to Bridgend for peer support should be considered.

8.4.10 For more effective communication, particularly in fraught and stressful situations, informal discussions with other knowledgeable staff should take place.

8.4.11 The medical on call cover system should be strengthened and formalised in order that there are clear cover arrangements and formal handover for staff on leave, including accessibility to all clinical notes. Staff off-duty or on leave should have cover which will embrace at some point in the chain a person of similar rank and position to the one on leave. No junior member of staff should ever have any doubt as to the means of contacting a senior member of staff.

8.4.12 Extra training for all staff in recognising and responding to psychiatric emergencies, especially learning when to increase resources to affect patient management.

*** Footnote**

A Care Programme Approach is now in place in Wales.

8.4.13 Training programmes to be put in place to teach key worker and team leader roles.

8.4.14 The amount of training available to all professional staff should be increased with the main focus on general psychiatry (especially history taking and diagnostic skills) and psychiatric nursing. As a new dimension, forensic psychiatry training should also be included. Forensic psychiatry reviews and case presentations should take place on a regular basis with other service providers and disciplines as part of a local training scheme.

8.4.15 Mental health professional training should include experience of work outside the trust e.g. by attending courses elsewhere, by exchange schemes, and by frequent use of visiting speakers.

8.4.16 The panel notes that the Caswell unit at Bridgend now has audio-visual communication technology which could be linked to west Wales, which would assist in achieving some of the other recommendations made here and may even act as an interim partial solution to the staffing shortage.

iii to examine the adequacy of collaboration and communication between agencies involved in the care of Mr Davies, the provision of service to him and between the statutory agencies involved;

8.4.17 Robust liaison mechanisms should be established between the police and the mental health services to involve regular meetings with doctors and managers from both, in order that an appreciation of each others role and a full exchange of information when passing clients from one agency to another, can be gained.

8.4.18 Multi-agency public protection arrangements (MAPPA) were in place at the time of the incident (with a mental health representative on the steering group) and continue to be in place in Carmarthenshire. In the panel's view, these should involve a consultant psychiatrist with forensic psychiatry experience or interest and should follow the Royal College of Psychiatrists guidelines.

8.4.19 Scores on risk assessment scales should not be used in isolation for clinical or operational purposes, but only in the context of a full clinical evaluation in the case of a psychiatric patient.

8.4.20 Funding arrangements should be put in place to ensure that PRISM is able to cover critical holiday periods such as Christmas.

8.4.21 Carmarthenshire Local Health Board and Pembrokeshire & Derwen NHS Trust to have clear protocols and guidelines in place for access to general medical services out of hours.

iv to examine and comment on the nature of any risk assessment and the management of identified risk presented by Mr Davies to himself or others;

8.4.22 Further training for mental health staff on public protection issues should be provided.

8.4.23 Formal training required on incident reporting processes.

8.4.24 When dealing with a patient in the community, efforts should be made by mental health staff to conduct some sessions without other family members present, in order to gain a more accurate assessment.

8.4.25 Opportunities should be taken by mental health staff to engage with patients' friends and relatives when visiting the ward in order to gain a more complete assessment.

8.5 To prepare a report with recommendations to Carmarthenshire Local Health Board and Welsh Assembly Government.

8.5.1 It is particularly important that the staff, who have been the focus of this investigation, should not be singled out for adverse action and blame.

8.5.2 Staff should be given support structures and advice to enable them to move on with confidence if the standards of mental health care in Carmarthenshire are not to fall.

APPENDIX 1

TOWY VALLEY COMMUNITY MENTAL HEALTH TEAM

Location
Based in Clos Bran in the village of Llangadog, originally viewed as a temporary base to support the development of providing a community based service to the population of north Carmarthenshire (11,871 adult population). The service is primarily based within a rural community and incorporates a number of villages within the localities of the market towns of Llandeilo and Llandovery.

The team at the time of the incident consisted of the following staff and activity undertaken between 1st September 2002 and 28th February 2003 (i.e. 6 months):

Posts (Funded establishment)	**Contacts**	**Individually Seen**
1.0 WTE Acting Team Leader	383	80
1.6 WTE Staff Nurses	402	84
1.2 WTE Support Workers	964	101
1.0 WTE Qualified OT	333	74
1 WTE Technical Instructor	593	44
Consultant Psychiatrist + Associate Psychiatrist	322	147
WTE Secretary 0.4 WTE Clerical Asst.		

N.B. The numbers of contacts identified relate to face to face or telephone contact.

APPENDIX 2

CHRONOLOGY OF KEY EVENTS

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
23rd October 2002 **Information from police statement taken from Miss Evans** Mr Davies arrived in public house in Llangadog at 19.00, consumed 5 to 6 pints of beer by 22.30. Appeared unhappy, said to Ms Evans "I won't see 60 and you won't see 28". At 23.15, Mr Davies left the pub, then re-appeared and said to Ms Evans "I'll have you, I'll blast your brains out, we'll go together". Mr Davies slapped Ms Evans across the cheek. Ms Evans defended herself, pushed Mr Davies outside, bolting the door behind him. Ms Evans let other customers out including (X) who then phoned back to say Mr Davies was still outside. Ms Evans let the last customer out and saw Mr Davies standing outside with a gun. Ms Evans pulled the gun out of Mr Davies' grasp, closed and bolted the door, and locked the gun away. After a few minutes, Ms Evans phoned the police. When they arrived, she received a phone call from Mr Davies sounding irrational and excitable saying "Go and phone the police, go on". He also threatened to commit suicide. Ms Evans handed the phone to the police.		
24th October 2002 Police subsequently attend at Mr Davies' farm at 01.30, and observe Mr Davies walking towards the road. Police arrest Mr Davies on suspicion of threat to kill. Mr Davies hands in five gun cartridges and is taken into custody.	**Information from A&E Record** Mr Davies admitted to A&E, Carmarthenshire NHS Trust, at 20.42, after attempted strangulation in police cell whilst in police custody. Mr Davies uncommunicative – history taken from accompanying police officer. From A&E, Mr Davies referred to	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
Information from custody record Mr Davies arrested at 01.30 and taken to Carmarthen police station on basis of threat to kill, and possession of a firearm in a public place. **Person in Custody** **Record of Examination taken at 04.30 and 14.10 by Police Force Medical Examiner** Reason for Call-Out – Mr Davies drunk, diabetic, suicidal state. Confirmation that Mr Davies is fit to be detained. Confirmation at 14.10 that Mr Davies is fit to be interviewed. **Result of Examination of Prisoner** 15 minute checks. Police reluctant to release Mr Davies in view of risk of harm to self and others. Requires mental health assessment. At approximately 20.00, whilst in police custody, Mr Davies attempts self-strangulation. Mr Davies subsequently taken to A&E, Carmarthenshire NHS Trust	in-patient psychiatry. Seen at 22.40 by senior house officer (SHO) – Mr Davies low in mood, disturbed sleep, on and off headache for past year. Excessive drinking for about 10 months. Mr Davies had binge drink previous night, argued with Ms Evans, landlady of public house in Llangadog, got hold of gun (empty), wanting her to kill him. No recollection of what argument was about. Mr Davies arrested by police as supposedly threatened Ms Evans. Attempted strangulation with jumper at approximately 20.00. Mr Davies said he wanted to kill himself – still suicidal. Admitted to acute psychiatric ward, Pembrokeshire & Derwen NHS Trust. **Information taken from admission note – 23.30** Mr Davies - no eye contact, low, terrible mood, depressed. Ideas of self-harm, no ideas to harm others. Realises he has a problem but does not want to rectify it – " wants to die and put an end to everything".	
25th October 2002	**Information from initial assessment** Physical, psychological and social assessment taken, with attendant summary of risks – Mr Davies a 59 year old farmer with low mood and suicidal ideation.	
26th October 2002	**Information from history sheet** To continue same observation levels. EEG, CT, ECG & CXR requests sent. To invite family to attend next ward round. To consider antidepressant medication dependent on Mr Davies' mental state.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
27th October 2002	**Evaluation & Patient Response to Care taken at 20.20**	
28th October 2002 Mr Davies interviewed at 21.00 at Carmarthen police station. Mr Davies in the custody of the mental health service at the time and accompanied by a staff nurse from acute psychiatric ward. Mr Davies arrested and charged with two offences – possession of shotgun with no certificate, and threat to kill. Bailed to acute psychiatric ward – condition of bail – could drive through the village of Llangadog but not stop, recognising the police's view of the seriousness of the incident. Police request ward to advise them when Mr Davies is to be discharged. Mr Davies to appear at Ammanford magistrates court on 7th November, 2002. Finger prints and DNA sample taken. Mr Davies returned to the acute psychiatric ward.	**Evaluation & Patient Response to Care Taken at 19.50**	
29th October 2002	**Evaluation & Patient Response to Care taken at 02.00 (when Mr Davies brought back to acute psychiatric ward from police station).** **Evaluation & Patient Response to Care taken at 13.00** HAD Scale completed- 10 for depression (borderline), 14 for anxiety (significant). Beck's completed – scored 34 (severe depression). Mr Davies seen by PRISM hospital link worker - appears more settled, less anxious, more comfortable within hospital environment, and better since discontinuation of alcohol.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
	Evaluation & Patient Response to Care taken at 18.20. Mr Davies seen by consultant psychiatrist who arranges for psychology referral and physiological investigations – CXR, ECG, bloods, EEG, CT scan. Personal history also taken.	
30th October 2002	**Evaluation & Patient Response to Care taken at 10.00.** Mr Davies to receive full physical investigations. Drug regime commenced and observation levels lowered. Mr Davies to be referred to counselling to discuss previous traumatic experiences. Consultant psychiatrist requests named nurse to discuss with Mr Davies issues in relation to affair, and to advise him to share same with family before facts are made public in court.	
31st October 2002	**Evaluation & Patient Response to Care taken at 12.35** Mr Davies complaining of not being able to sleep - prescribed medication if required. EEG report – normal with no evidence of any latent cerebral lesion. Psychology/psychotherapy referral made.	
1st November 2002	**Evaluation & Patient Response to Care taken at 11.45.** OREMs completed by student.	
3rd November 2002	**Evaluation & Patient Response to Care taken at 12.30.** Mr Davies settled on ward and interacting well.	
4th November 2002	**Evaluation & Patient Response to Care taken.** Mr Davies reviewed - observation levels reduced.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
5th November 2002	**Evaluation & Patient Response to Care taken at 09.00.** Mr Davies states he is "flat in mood in the mornings but mood lifts during the day". Mr Davies advised to share with wife details of his "affair", but he "does not know what to do". Mr Davies sees PRISM hospital link worker to discuss level of future support. Mr Davies states his preference is to await the outcome of his court appearance before accepting appointments from a PRISM alcohol support worker in the community.	
6th November 2002 CPS amend the charges faced by Mr Davies in the "Narey" Court the following day, advising the Police of their proposed action in writing.	**Evaluation & Patient Response to Care taken at 10.30.** Mr Davies attends ward round and states feelings of anxiousness regarding court appearance next day. Advised to contact his solicitor. Plan – drug regime to remain same, awaiting appointments for EEG and CT scan. **Evaluation & Patient Response to Care taken at 18.30.** Mr Davies seen by his solicitor. Mr Davies still not told wife of "affair" - unsure how to broach the subject, and worried about wife's response.	
7th November 2002 Mr Davies attends court – allegation of threat to kill withdrawn. Two new charges of common assault and threatening words and behaviour laid. Mr Davies pleads guilty to three charges – possession of shotgun with no certificate, common assault and threatening words and behaviour. Magistrates adjourn case to 26th November, 2002, for preparation of pre-sentencing and psychiatric reports. Mr Davies can reside at home, but cannot stop in the village of Llangadog, and is not allowed to speak to prosecution witnesses.	**Evaluation & Patient Response to Care taken at 18.00.** Mr Davies discusses leave arrangements with the consultant psychiatrist. Suggestion made that Mr Davies has a few hours home first before an overnight stay. Mr Davies is in agreement to this plan. Following court appearance, Mr Davies is relieved. Denies feeling suicidal, sees "light at the end of the tunnel".	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
8th November 2002	**Evaluation & Patient Response to Care taken at 13.15.** Mr Davies withdrawn and isolative for long periods in morning. Low and flat in affect due to reading report in local newspaper of charges against him. Feels shame and needs reassurance to regain positive outlook.	
10th November 2002	**Evaluation & Patient Response to Care taken.** Mr Davies shows no obvious signs of low mood.	
11th November 2002	**Evaluation & Patient Response to Care taken at 07.30.** Mr Davies advises that his wife has found out about his "affair" with Ms Evans.	
12th November 2002	**Evaluation & Patient Response to Care taken at 12.30.** Mr Davies granted leave from ward in care of his brother in law.	
13th November 2002	**Evaluation & Patient Response to Care taken at 09.45.** Mr Davies and daughter attend ward round. Referral arranged to psychology for assessment. Mr Davies due for weekend leave (wife will be at daughters). Drug regime reviewed. Mr Davies requests discharge. CPN input to be arranged. Risk assessments to be undertaken.	
14th November 2002	**Evaluation & Patient Response to Care taken at 12.40.** Mr Davies on day leave with daughter – to return for medication at 6.30pm.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
15th November 2002	**Evaluation & Patient Response to Care taken at 11.40.** Mr Davies on weekend leave until 18th November, 2002. Has been given free phone number to contact ward if mood deteriorates. Has agreed not to take alcohol whilst on leave as he suffers from poor impulse control following alcohol consumption. Initial clinical risk assessment undertaken to include psychiatric, behavioural and vulnerable indicators.	
16th November 2002		Mr Davies spends weekend at home working on farm.
17th November 2002		Mr Davies found out Ms Evans is pregnant. Mr Davies states he thinks he could be the father
18th November 2002	**Evaluation & Patient Response to Care taken at 14.30.** Mr Davies returns from leave. ECG undertaken.	
19th November 2002	**Psychology assessment taken by assistant psychologist** Mr Davies given a comprehensive cognitive-behavioural interview, and two psychometric measures. Mr Davies considerably anxious causing sleep interference. Psychometric Measures – HADS – anxiety = 9/21 (moderate; depression = 2/21 (normal). Young Schema Questionnaire – Short Form (YSQ-S1) – Unrelenting Standards = 5/5; Emotional Deprivation = 3/5; Self Sacrifice = 3/5; Emotional Inhibition = 3/5; Entitlement = 3/5. Young Schema Questionnaire indicates Mr Davies has perfectionist traits/lack of emotional closeness to others, a sense of putting others needs before own, difficulty in discussing	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
	feelings openly and the idea that he is entitled to more of life's benefits than other people. Conclusion – Mr Davies shows no obvious signs of serious mental illness, but is exhibiting an understandably anxious reaction to a regrettable and traumatic episode for which he shows remorse. Generally, Mr Davies' mood is reasonable, appearing quite rational, not thought-disordered, nor evidence of obsessive thoughts. Mr Davies explicitly states no intent to kill himself at present, nor to harm others. Mr Davies may benefit from referral to counselling.	
20th November 2002	**Evaluation & Patient Response to Care taken at 10.00.** Mr Davies attends ward round where discharge arrangements are discussed – Mr Davies content with arrangements. Discharge care plan – Mr Davies provided with freefone number. CPN to visit. Outpatients appointment arranged with consultant psychiatrist in 2 to 3 weeks time. Psychology follow-up to be arranged. Copy of risk assessment to be sent to CMHT and GP. Still awaiting CT scan. **13.30** Mr Davies discharged. Care plan reviewed and sent to GP and CPN. Discharge summary prepared for GP Discharge mental state – well-settled, mood euthymic, no ideas of self-harm or suicide, no idea of harming others. Motivated to abstain from alcohol. Well-oriented. Good insight (ICD10 Code F32.1 moderate episode of depression, F10 alcohol abuse). Discharged on anti-depressants. Discharge care plan – out-patient follow-up, CPN, psychology appointment for counselling, relapse/risk management plan undertaken.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
26th November 2002 Sentencing at Ammanford magistrate's court adjourned until 18th December, 2002, for psychiatric assessment. Police officers visit Ms Evans who states that the relationship with Mr Davies was platonic. Ms Evans considering taking out an injunction against Mr Davies. Ms Evans offered a panic button which again she will consider.	Psychological report provided to consultant psychiatrist from assistant psychologist, countersigned by clinical psychologist, stating that Mr Davies is exhibiting an understandably anxious reaction to his recent traumatic circumstances rather than a major mental illness. Mr Davies to be referred for counselling with regard to these non-pathological feelings of anxiety.	
27th November 2002 A police officer reports to two other police officers covering the Llangadog area that Mr Davies had stated he was in love with Ms Evans, indicating more research into the alleged affair is required. Two visit Ms Evans who states that there had been no "affair".		
28th November 2002	CPNs first attendance at Mr Davies' farm. Talking in depth is difficult in front of Mr Davies' wife and son sitting in the adjacent kitchen. CPN uses the Pembrokeshire & Derwen NHS Trust's initial clinical risk assessment tool which shows Mr Davies' mood is low. Tool also identifies Mr Davies is stressed regarding the impending court case. No evidence of psychosis. Evidence of depression and that Mr Davies is a potential risk to himself.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
3rd December 2002	CPNs second visit. Again difficult to talk as Mr Davies' wife is in the kitchen. Mr Davies eager to get court case over in order to get on with his life.	
5th December 2002	**Information from out-patient appointment with consultant psychiatrist at 14.45 in Llandovery.** Mr Davies' mood now stable, concentration improved, appetite and sleep good. Mr Davies denies any suicidal thoughts. Plan – continue drug regime, and appointments with CPN. Arrange for further out-patient appointment in 4 weeks time.	
9th December 2002	**Psychiatric Report by Consultant Psychiatrist prepared for Mr Davies' Solicitor.** States "belief that Mr Davies was acting out of character when the incident which led to his admission occurred, and that his actions were influenced by his mental state at the time and by his excessive alcohol consumption. Mr Davies has now received treatment for his depression and is recovering well, with alcohol consumption negligible". Consultant psychiatrist does not believe that "Mr Davies presents a risk to himself or others at present, and would hope that with ongoing treatment and insight into his mental health problems, any further episodes of depression could be diagnosed and treated early".	
11th December 2002	CPNs third visit. Again finds it difficult to talk as Mr Davies' wife, daughter and grandchild also present.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
18th December 2002 Mr Davies in court for sentencing – receives 60 hours community punishment and rehabilitation order.	CPNs fourth visit. Mr Davies in good spirits – felt he has been treated fairly by the court and content with community service terms. As Mr Davies displays no significant risk to himself or others, the next CPN visit is scheduled for 09.30 on 9th January 2003.	
Intervening Period Between 1st and 2nd In-Patient Episode		Mr Davies sees Miss Evans to apologise but she "does not want to know". Relations difficult with wife. Mr Davies on own over Christmas. Not sleeping, tearful all day/night, poor appetite, loss of interest, concentration poor, drinking heavily, occasional suicidal thoughts but no active plans/ attempts. Story has been reported in press again – Mr Davies worried about the rumour that he may be planning to kill Ms Evans.
1st January 2003	CPN receives phone call whilst off duty from family friend of Mr Davies to advise he is suicidal and depressed and wants to return to the acute psychiatric ward. No answer from GP on-call service so CPN arranges for Mr Davies to be admitted. Mental state examination taken on admission – no suicidal ideas at present, no thoughts of harming others. Patient's appraisal of illness – "depressed".	
2nd January 2003	**Evaluation & Patient Response to Care taken at 16.30.** Mr Davies expresses no ideas of self-harm or suicide.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
3rd January 2003	Mr Davies reviewed on ward. Observation levels decreased, drug medication reviewed.	
5th January 2003	**Evaluation & Patient Response to Care taken.** Mr Davies appears flat in mood.	
7th January 2003	**Evaluation & Patient Response to Care taken.** 2 DF assessments carried out by Mr Davies with results in the moderate to high region. Mr Davies seen by PRISM hospital link worker – agreed further support when discharged home.	
8th January 2003	**Evaluation & Patient Response to Care taken.** Mr Davies discussed in ward round with consultant psychiatrist. Mr Davies states that he is beginning to feel better with no suicidal thoughts. Plan to increase antidepressant medication. To discuss discharge for early/middle following week.	
10th January 2003	Mr Davies reviewed on ward – no ideas of worthlessness or hopelessness. Hopes to be discharged following week.	
13th January 2003	Mr Davies discharged from acute psychiatric ward - am. Follow-up plans – out-patients in 2 weeks time. CPN to call and support, also PRISM alcohol support worker. Discharge summary psychiatric service, prepared for GP	
14th January 2003	CPN visits Mr Davies – mood that day has reverted to normal. Community punishment and rehabilitation order to commence following weekend.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
19th January 2003		Mr Davies commences community punishment and rehabilitation order at Dinefwr Park, Llandeilo.
23rd January 2003	Mr Davies seen in out-patients by consultant psychiatrist. Mr Davies reports outburst at son for spending too long at mart when needed on the farm. Concern about this outburst is reported to the CMHT team leader who is asked to bring it to the attention of the CMHT clinical meeting. The consultant psychiatrist does not see Mr Davies again due to annual leave.	
26th January 2003		Mr Davies undertakes community punishment and rehabilitation order at Dinefwr Park, Llandeilo. Mr Davies tells a friend that he feels hard done by over this and blames Ms Evans.
27th January 2003	Mr Davies has appointment with counsellor in psychology department. Goal is to work on rebuilding social skills and integration back into the community. Contracted to meet for 6 sessions, with a view to reviewing work to date and Mr Davies' needs on the 6th session.	
28th January 2003	CPN visits Mr Davies. Mr Davies' wife again present.	
30th January 2003		(X) warned by employer that Mr Davies is "after (X)" and that (X) needs to "watch out when entering Llangadog". (X) recollects mentioning this matter to a police officer at Llandeilo police station.

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
2nd February 2003		Mr Davies undertakes community punishment and rehabilitation order at Dinefwr Park, Llandeilo. Mr Davies is reported as getting more and more annoyed, with aggression building in him.
3rd February 2003 Police informed of Mr Davies' following of (X).	At psychology counselling session, Mr Davies reports he is upset following an argument with his son. Explore basic anxiety and anger management techniques i.e. breathing techniques, stress balls, list of supportive people to phone, taking time out, walking, etc. Mr Davies agrees to experiment at home to see what suits best. Mr Davies has had no further thoughts of harming himself or others.	At approximately 18.00, (X) drives through Llangadog and notices Mr Davies sat in his jeep outside public house in Llangadog. Mr Davies pulls out and follows (X) very closely, so close (X) cannot see his number plate. Mr Davies continues to follow (X) for about 5 miles. (X) drives to employer's farm. Mr Davies follows all the way before driving away. Concerned about Mr Davies' behaviour, (X) informs a police officer at Llandeilo police station.
4th February 2003		At around 18.00, (X) drives through Llangadog and notices Mr Davies again sat in his jeep outside public house in Llangadog. Mr Davies pulls out after (X) and follows for a short distance through Llangadog but is delayed by traffic and (X) gets away.

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
5th February 2003	Mr Davies telephones to cancel PRISM appointment. New appointment arranged for 27th February, 2003.	
9th February 2003		Mr Davies undertakes community punishment and rehabilitation order in Dinefwr Park, Llandeilo. Afterwards, Mr Davies goes to a pub in Llangadog in working clothes, annoyed, saying "Look at the state of me, all because of that ***** down there".
10th February 2003	Mr Davies attends psychology counselling session. States he suffers no thoughts or feeling of self-harm. Mr Davies and psychology counsellor agree one week break as psychology counsellor on leave. To meet again on 24th February 2003. Mr Davies informed he can phone counselling service or Teilo ward etc if further support needed.	
11th February 2003	CPN visits but Mr Davies not at home due to undertaking his community punishment and rehabilitation order.	
13th February 2003 At 22.56, three police officers attend at incident in Llangadog. Mr Davies states he is looking for (X). Police advise Mr Davies to go home otherwise he will be arrested for breaching the peace. Mr Davies is escorted home and the police speak to Ms Evans and (X).	Whilst off duty, the CPN receives a phone call at 22.30 from family friend of Mr Davies to advise that Mr Davies is sitting in his jeep outside the public house in Llangadog waiting "to sort out" (X), whom Mr Davies suspects of reporting him to the police in relation to the shotgun incident in November 2002. The CPN advises the family friend to contact the on-call GP service to establish if a Llandeilo GP is on call. The CPN attempts to arrange for members of the crisis intervention team to attend, but they advise	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
	that due to staff shortages they are unable to respond to the incident. They suggest the CPN contacts the crisis team based on a ward in St David's hospital. On discussing the case with the staff nurse on this ward, and considering the previous incident involving a shotgun, two people are required to respond and this is not possible at that time. However Mr Davies could be assessed in A&E, Carmarthenshire NHS Trust. The CPN phones the GP answering service asking them to arrange for a GP to make contact as a matter of urgency. Mr Davies now sitting in his jeep outside another public house in Llangadog, waiting for (X). The CPN, concerned as to the consequences of a confrontation between Mr Davies and (X) and unable to wait any longer for the GP, telephones Llandovery police station where the call is diverted to police headquarters. The CPN advises them of Mr Davies' history and the present cause for concern. Also advises that if need be, Mr Davies can be assessed by the crisis intervention team at A&E, Carmarthenshire NHS Trust. Police advise that they will deal with the incident. CPN is later contacted by the police at approximately 00.30 to state Mr Davies has been returned home. CPN informs the crisis intervention team of the police action	Mr Davies receives a phone call informing him that his daughter is in America. Mr Davies is very angry as he's concerned for her welfare, smashes crockery, shouts and storms out of the house. Mr Davies passes a public house in Llangadog, becomes angry at seeing (X) sitting there as he blames (X) for reporting him to the police with regards to the original shotgun incident. Mr Davies states his intention to "sort (X) out one way or another".

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
14th February 2003	CPN contacts acting team leader, CMHT, to advise of previous nights incident. Acting team leader is asked to visit Mr Davies at home that day to assess any change in mental condition. Agreed that two people should visit. Mr Davies is hostile, but denies any symptoms of depression other than poor sleep pattern. Mr Davies then becomes more agitated and irritable saying "I'm going to kill (X) who's ruined my life". Acting team leader returns to CMHT and contacts GP from Mr Davies' practice to discuss. Agrees that this was more of a police issue than a medical issue. This explicit threat to kill (X) was not rported to the police.	Mr Davies cancels his GP appointment (10.00)
16th February 2003		Mr Davies undertakes community punish-ment and rehabilit-ation order in Dinefwr Park, Llandeilo.
17th February 2003	Acting team leader formal supervision meeting with senior practitioner. Mr Davies' case / incident not discussed.	
18th February 2003		Mr Davies completes community punishment element of his community and rehabilitation order. Mr Davies pays account at the local farmer's co-operative saying "I don't want to owe anyone anything when they take me away in a box".
19th February 2003 Police are informed by the CPN of threat to (X).	CPN attends at Mr Davies' home (not formal appointment). Whilst talking about (X), Mr Davies becomes irate and loses his temper, swearing at the CPN and ordering the CPN out of his house.	

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
Police attend and Mr Davies states that he had lost his temper with the CPN. Police ask Mr Davies if he requires medical attention, which Mr Davies declines. Police leave when Mr Davies is calm.	CPN returns to CMHT, surprised by the suddenness and ferocity of Mr Davies' temper, and believing him to pose a significant risk to the safety of (X). CPN informs the police of the incident who state that they will attend.	
20th February 2003	Incident discussed at ward round and decision taken that no further lone visits to be made to Mr Davies' home. Out-patients appointment to be sent for 26th February, 2003 at Llandeilo surgery. CPN also asked to be present.	
23rd February 2003		Ms Evans receives threat from Mr Davies that she only has 11 weeks to live (Ms Evans also receives silent phone calls from kiosk in Bethlehem, Llandeilo)
24th February 2003	Mr Davies DNA with psychology counsellor.	
25th February 2003 Police informed by person or persons unknown, of Mr Davies' threatening behaviour towards (X).	Mr Davies discussed at CMHT meeting. Confirmed no home visits and no lone meetings with Mr Davies (Mr Davies to be seen in GP surgery or CMHT). Clinical psychologist suggests a forensic assessment be considered. In view of fact that Mr Davies has attained non-clinical scores on psychometrics, and is rational in his appraisals, he should be referred or followed up with a forensic assessment. Key worker to initiate. On consultant psychiatrists return from annual leave, a review of Mr Davies' package of care and risk assessment to be undertaken. Above issues to be discussed with psychology counsellor on 3rd March 2003 in next supervision meeting. Advised to suspend current work until in receipt of more information regarding outcome of forensic opinion.	Mr Davies confronts (X) in a public house in Llangadog, grabbing (X) and trying to push (X) off a bar stool. Others in the bar restrain Mr Davies and he leaves. (X) does not report this incident to the police but others do.

Police Activity/Court Action	Hospital/CMHT/Medical Interventions	Community/Local Knowledge
26th February 2003	Out-patient appointment at 14.00 with associate psychiatrist and CPN at Llandeilo surgery. Mr Davies DNA. Arrangements made for further appointment for Mr Davies to attend on 5th March 2003. Mr Davies' case to be reviewed in CMHT meeting with consultant psychiatrist on 4th March 2004.	Mr Davies found by a neighbour to be very aggressive, ranting and raving and clenching his fists, saying "If you see that *****, tell her I'll slit her throat". Mr Davies complaining of headaches but refusing to see a doctor. Mr Davies also states he has stopped taking his medication. Mr Davies and a neighbour prepare a bonfire for following day. Mr Davies wants to light it there and then but the neighbour says to wait until the next day. Mr Davies states "perhaps we won't be here tomorrow".
27th February 2003	PRISM appointment with alcohol support worker. Mr Davies DNA.	Mr Davies takes shotgun without permission from a neighbour – shoots and kills Ms Evans, then kills himself.

APPENDIX 3

DOCUMENTATION REVIEWED BY PANEL MEMBERS

Internal sources – Pembrokeshire & Derwen NHS Trust

- Report of the Serious Incident Review into the Care of Mr Davies
- Summary of Care Journey – Mr Davies
- CMHT Operational Policy
- Psychiatrists Report
- Nursing Report
- Psychology Report
- MDT Notes
- Statement from Key Personnel
- Transcripts from Interviews
- Trusts Briefing Note for External Review Team regarding the Internal Serious Incident Investigation Process
- Map setting out commissioning arrangements for secondary care
- Teilo Ward – Protocol for answering 0800 Helpline
- Clinical Risk Policy
- Policy for Multi-Disciplinary Working
- Clinical Supervision Policy
- Observation Policy
- Policy for Prescribing, Administration and Control of Drugs
- Policy to help prevent violence towards staff
- Guidelines on working with people who self-harm
- Procedure for the management of incidents in the workplace
- Sainsbury Centre for Mental Health – A Summary and Final Report on the Practice Development and Training Initiative for Mental Health Practitioners and Team Leaders across Pembrokeshire & Derwen NHS Trust
- Serious Incident Review – WD. Report on the Management of Clos Bran CMHT
- Clos Bran CMHT – Training/Supervision Record, August 2003
- Admission Protocol Mental Health & Learning Disabilities Division
- Operational Policy Teilo Ward
- Trust Report to NPSA Implementation Project Board (Wales) on Pilot Project – May 2002
- Summary and Final Report on the Practice Development & Training Initiative for Mental Health Practitioners and Team Leaders across the Trust – the Sainsbury Centre for Mental Health

External Sources

- Case Reviews – A Guide to Procedure – Dyfed Powys Health Authority
- Health Commission Wales – Revenue Allocations describing list of services responsible for
- WAG Mental Health Policy Implementation Guide
- WAG Planning & Commissioning NHS Services Guidance (draft)
- Dyfed Magistrates Court – Mental Health Assessment Scheme
- "Safety First" Five year Report of the National Confidential Inquiry into suicide and homicide by people with mental illness 2001
- "Alarm" Protocol for the investigation and analysis of clinical incidents
- Extract from NPSA Root Cause Analysis Toolkit on ALARM Local Protocol for Assessing and Managing Risk Dyfed Powys Police/Local Authorities
- Adult Mental Health Services – A National Service Framework for Wales
- GP Medical Record (electronic)
- A&E Record of Mr Davies – Carmarthenshire NHS Trust
- Custody Record of Mr Davies – Dyfed Powys Police

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