Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr G and the provision of Mental Health Services, following a Homicide committed in May 2009

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Summary of the Index Offence

1.1 On 16 May 2009 Mr G attacked his mother Mrs H with a knife, inflicting a considerable number of injuries. Sadly, Mrs H died as a direct result of the wounds she received and Mr G was arrested that same day. It appears that Mr G had also taken an overdose of anti-psychotic medication beforehand.

1.2 On 5 October 2009 Swansea Crown Court found Mr G guilty of the manslaughter of Mrs H on the grounds of diminished responsibility and ordered his indefinite detention at a secure unit under the Mental Health Act.

Background

1.3 Mr G was born in 1961 and was brought up in the Solihull area of the West Midlands.

1.4 Mr G left school having attained three A' levels. He went on to obtain an honours degree in engineering and later, followed a course in computer programming.

1.5 After completing his higher education, Mr G gained a position as a trainee computer programmer. He became unemployed about six months before his first admission to a psychiatric hospital in 1985.

1.6 Following his release from hospital after his first admission in 1985, Mr G was initially employed maintaining a motor cycle track - a position which he took up following a scheme he became involved in whilst in hospital. He later became interested in gardening and was employed as a gardener until being made redundant a few years later. Mr G eventually set up his own business undertaking maintenance gardening for domestic clients.

1.7 Following his father's death Mr G continued to live with his mother and in the summer of 2007 they moved to Pembrokeshire. At this time Mr G's mother was a frail lady in her eighties with considerable healthcare concerns who wished to be closer to her daughter and son-in-law. When Mr G moved to Pembrokeshire, he was not in any employment and was claiming benefits.

1.8 It appears that Mr G found it difficult to form relationships. However he did have some friends through his interest in motorcycles and aero modelling and went on holidays and meetings related to aero modelling.

1.9 Mr G had no criminal offences recorded against him, although he had been known to the police prior to his admission to hospital in 1985 as he had become verbally abusive towards his family several times before his admission.

Care and Treatment

Contact with mental health services in the West Midlands

1.10 Mr G first became known to mental health services in 1985 when a referral was made by his GP. He was seen by a consultant psychiatrist and was noted to be showing symptoms of personality change; he was withdrawn, suspicious and depressed. He was subsequently diagnosed as having schizophrenia. His initial treatment involved rehabilitation and he was prescribed Stelazine[1].

1.11 Over the year following his initial diagnosis in 1985, Mr G was described as becoming progressively more stable. However, Mr G was detained under the Mental Health Act in November 1987; prior to his detention he was showing signs of being tense and perplexed. Records note that he had refused food and was having auditory hallucinations.

1.12 Mr G was discharged from hospital in January 1988 following an improvement in his mental health and periods of what were described as *'satisfactory'* home visits. Following his discharge from hospital Mr G was seen at outpatient clinics five times during 1988, on each occasion he was noted to be making progress and to be compliant with his medication of Haloperidol[2] and Procyclidine[3]. During this period he also attended a rehabilitation day unit three days per week.

1.13 Mr G was discharged from mental health services in January 1989 because he continued to remain well and compliant with his medication.

[1] Stelazine – this is a drug used in the treatment of psychoses (and anti-psychotic medication). It belongs to a class of drugs called the phenothiazines, which have been used since the 1950s and are sometimes referred to as *'typical antipsychotics'*.
[2] Haloperidol – this is another antipsychotic medication, belonging to the Butryphenone class. This is another *'typical antipsychotic'.*
[3] Procyclidine – this is a drug used to treat some of the movement side effects of the antipsychotic medications, particularly the muscle stiffness and tremors.

1.14 Mr G appears to have been compliant with medication thereafter and had regular contact with his local mental health service, albeit there was a gap in his clinical care records between 1989 and 1996 where no service contact appears to have been required since his medication was being prescribed and monitored by his GP.

1.15 There is no record of Mr G having been seen again by mental health services until October 1996. He was referred back to services at this time following an attempt to commit suicide. He had tried to gas himself by using a gas fire. He was seen at an outpatient clinic appointment, which his parents also attended. The mental health team's assessment, records that Mr G was feeling lonely although he was not presenting any symptoms of hallucinations or developing further potential for self harm.

1.16 Mr G was referred again to mental health services by his GP in January 1998, following a request by Mr G to have his medication reviewed. At the time of referral he was taking five mg of Haloperidol twice daily as well as Procyclidine. The GP noted that Mr G's condition worsened if he missed taking his medication.

1.17 Mr G was seen in March 1998 by a consultant psychiatrist at Birmingham & Solihull Mental Health NHS Trust, who agreed to lower his medication to five mg a day. He was seen on several occasions in the outpatient clinic, but over the next few months Mr G's behaviour seemed to deteriorate; he became more argumentative with his family and as a result of his behaviour lost his job as a gardener.

1.18 On 6 October 1998 he was seen again by the consultant psychiatrist in the outpatient clinic following a referral made by his GP which noted behavioural changes. This behavioural deterioration led to his hospital admission on 10 October 1998.

1.19 Mr G was brought to the hospital by the police who had been called to Mr G's home by his mother as he had become argumentative after drinking alcohol. Mr G had become worried that his mother was lying about him and accused her of moving his possessions around the house and hiding them. The day following his admission Mr G became argumentative and intimidating to hospital staff and was placed on Section 5(2) of the Mental Health Act; he was subsequently transferred on to Section 3 on 16 October 1998. He became progressively more psychotic and disturbed and could not be managed on the open ward and was transferred to the Psychiatric Intensive Care Unit (PICU) on the 29 October. During this admission Mr G was prescribed Amisulpiride, an alternative antipsychotic medication, but due to his deterioration, was put back on Haloperidol. On 24 December 1998 he was discharged from the ward back home on 15mg Haloperidol per day apparently despite his mother's wish not to have him home, and attempts by her and Mr G's social worker to seek alternative accommodation.

1.20 Following his discharge, Mr G was next seen in January 1999 by his consultant psychiatrist. He was compliant with medication and was receiving home visits from his social worker. In February 1999 Mr G received his first Care Programme Approach (CPA) review which was conducted by his consultant psychiatrist and his key worker. The notes of the meeting indicate that it was agreed that the safety of Mr G's family would be continually monitored. It was also agreed that Mr G was to stay at the family home.

1.21 From 1999 to 2003 Mr G was reviewed quarterly at outpatient appointments with his consultant psychiatrist. Throughout this period his notes indicate that he was compliant with medication. It appears that this compliance with medication had led to an improvement in his home life as his mental health had become more stable.

1.22 In 2003 an agreement was reached between the consultant psychiatrist and Mr G to reduce the level of Haloperidol to ten mg per day. On 15 July 2003 his consultant psychiatrist noted in a letter to Mr G's GP that Mr G "*feels a little better since we reduced his medication slightly. I note that when it was reduced below 10mg he started to become unwell and I don't think that there is any scope for reducing any further. I have explained this to him.*"

1.23 In August 2004 Mr G attempted to commit suicide by walking in front of a bus. Mr G sustained severe injuries including facial fractures that required maxillofacial surgery. He was in hospital for four months, which included a period of three months in the intensive care unit. He was treated with Haloperidol whilst in hospital but was not transferred to a psychiatric bed. However, he was reviewed by a psychiatric liaison registrar, who did not report any psychotic symptoms at the time of his review. During this consultation Mr G confirmed that on the morning of his suicide attempt he had awoken in a confused state and was in turmoil, unsure of his identity and of his sexuality. Mr G was also seen by mental health services on 10 December 2004.

1.24 Following his discharge from hospital Mr G saw his consultant psychiatrist at the outpatient clinic on 26 January 2005. He was taking 10mg of Haloperidol a day. At the consultation he recalled the incident with the bus and recounted the associated psychotic experiences to the psychiatrist. He denied changing his dose of Haloperidol or missing doses.

1.25 At this time he was also being seen by a Community Psychiatric Nurse (CPN). On 25 February 2005 Mr G was admitted to hospital informally following a referral by his CPN who reported that he was hallucinating and having strange thoughts. His Haloperidol was increased to 15mg and he was on this dose when he was discharged on 21 April 2005.

1.26 Mr G's mother and sister expressed concern about the paranoid thoughts and aggression Mr G had expressed towards his mother, during the periods of home leave that took place during his admission and also following his discharge. Mr G's mother also reported problems to the ward staff and told them that she was scared of her son as he had been verbally abusive towards her. His mother advised that he had accused her of moving things and called her a liar. She told staff that she did not want him to go home on further leave and it was agreed that he would stay on the ward and that his mother would visit him there. The staff also observed that Mr G was irritable whilst on the ward and that he had requested to be known by a different name and told them that he did not want to be treated '*as a child'.*

1.27 Following Mr G's discharge from hospital his CPN also noted his aggressive manner. On one visit made by the CPN, Mr G refused to speak with her and his mother and would only speak with his social worker on his own. His mother is recorded as stating that Mr G was still expressing some paranoid thoughts towards her.

1.28 In May 2005 Mr G's sister made a telephone call to the CPN expressing considerable concern about Mr G's behaviour – she detailed instances of when: Mr G told telephone callers that his mother wasn't in when she was; when he had simply put the telephone down on his mother's friends; when Mr G had taken his mother's address book and deleted all her contacts and was very rude to family members. His sister was recorded as being '*gravely concerned for her mother's welfare and safety*'.

1.29 Mr G was seen on a monthly basis throughout 2005 by his social worker, a community recovery worker[4] and at the outpatient clinic. Discussions took place in relation to alternative accommodation for Mr G as he indicated a preference to move out of his mother's house because he felt that she treated him as a child. However, it does not appear that this matter was progressed as Mr G continued to live at his mother's house up until her death.

1.30 Mr G's mental state appears to have stabilised during the later part of 2005. He was seen by his consultant psychiatrist at the outpatient clinic on three occasions during 2006 and his mental state seems to have continued to be stable. During one of these consultations, on 15 March 2006, a risk assessment was undertaken. A record of the assessment included '*on relapse, there is a tension on occasion between Mr G and his mother with whom he lives. Mrs H has described Mr G as very rude towards her*. *Additionally Mr G can become quite suspicious of his mum when unwell, accusing her of taking things from him'*. Mr G was still taking 15mg Haloperidol daily.

1.31 Mr G was seen at the outpatient clinic on 31 January 2007 when a CPA review was undertaken by the consultant psychiatrist and his social worker. He was noted to be stable and it was recorded that he had no psychotic symptoms or thoughts. He was to continue on 15 mg of Haloperidol per day.

Transition to Pembrokeshire

1.32 Mr G was seen in July 2007 at the consultant psychiatrist's outpatient clinic at Birmingham and Solihull Mental Health NHS Trust. The notes of the consultation indicate that Mr G's mental state was stable and that he was compliant with his medication. The record of the consultation also confirmed that he was on standard CPA and that his care co-ordinator was the

[4] A community recovery worker supports the service user in their restoration of a good quality of life by working with the service user and in some cases their families and carers, to take effective measures in identifying early signs of relapse.

consultant psychiatrist. During this consultation Mr G told his consultant psychiatrist that he was planning to move to Wales with his mother. The consultant psychiatrist advised him to register with a GP locally which he did. His consultant psychiatrist wrote to his new GP on 12 September 2007 to inform her of Mr G's current medication requirements and the consequences of him failing to comply with medication. The consultant psychiatrist also indicated in a letter to the GP that he was enclosing a note of the outcome of his last outpatient consultation with Mr G. However Mr G's new GP told us that the outcome letter was not included with the letter from Mr G's consultant psychiatrist. No other documentation was sent by Birmingham and Solihull Mental Health NHS Trust at that time and there was no formal CPA handover.

1.33 Records from Mr G's GP in the West Midlands were sent to his new GP in Pembrokeshire in October 2007. Mr G was subsequently assessed by the Pembrokeshire GP practice on 18 February 2008 as part of an annual process that the practice undertook for patients that had mental illness. As a result of this assessment he was referred to the South Pembrokeshire Community Mental Health Team (CMHT). The GP's referral letter outlined Mr G's history of mental illness and emphasised the importance of his remaining on his current levels of medication. The GP also requested that Mr G receive support from a psychiatrist and a CPN.

Contact with mental health services in Pembrokeshire

1.34 Pembrokeshire CMHT discussed Mr G's case in March 2008 and a CPN from the Narberth *'patch'* CMHT was allocated to him. Notes were requested from Birmingham and Solihull Mental Health NHS Trust and we have been told that these were received shortly after 16 April 2008. However, there was no accompanying letter with the notes and there is no formal record of the actual date the CMHT received the file or where it was kept.

1.35 Mr G was first seen by a consultant psychiatrist in Pembrokeshire on 11 April 2008 at an outpatient appointment. Records indicate that Mr G was to stay on his current level of medication and carry on with the outpatient appointments so that he could be monitored for Tardive Dyskinesia[5].

1.36 Mr G was next seen on the 16 April 2008 by his CPN. This was the first visit made by a member of the CMHT since Mr G's relocation from the West Midlands. Notes suggest that Mr G's mental state was stable and that he was compliant with medication. On 18 April 2008 an initial assessment document was completed and on 23 April 2008 a risk profile was drawn up by the care co-ordinator. Monthly visits from the CPN and continued outpatient appointments with a psychiatrist were agreed with Mr G. It was also determined that Mr G should remain on his current level of medication; as suggested by the consultant psychiatrist. Following the initial home visit, a note was placed on the FACE[6] system outlining that Mr G was at risk of suicide due to his history of suicide and of risk of relapse although there was no current indication of risk. It appears that Mr G was discussed at a CMHT meeting on 17 April 2008. However it appears that, from the records we have seen of that meeting, the care co-ordinator was not present.

[5] Tardive Dyskinesia is characterised by repetitive, involuntary, purposeless movements, such as grimacing, tongue protrusion, lip smacking, puckering and pursing of the lips, and rapid eye blinking. Rapid movements of the extremities may also occur. Impaired movements of the fingers may also appear.

[6] FACE is the name of an integrated electronic suite of documentation for mental health services produced by FACE Recording & Measurement Systems Ltd. It is used by a number of NHS organizations for the capture and recording of information relating to patient contacts, assessments and CPA related documentation.

1.37 Mr G continued to be regularly reviewed by an associate psychiatrist at the CMHT during outpatient appointments in June and September 2008 and March 2009. Monthly visits were also made by his care co-ordinator (the CPN) throughout 2008, continuing into 2009.

1.38 In May 2008 a different CPN was allocated responsibility for the co-ordination of Mr G's care. It appears that this handover went well and without any problems. Mr G remained stable and compliant with his medication and monthly visits from his care co-ordinator continued. Notes of consultations between Mr G and the associate psychiatrist suggest that he had a small concern about unusual tongue movements (hence earlier reference to monitoring for Tardive Dyskinesia) although later notes suggested that he was satisfied that this was due to the surgery received in 2004. The associate psychiatrist also recorded that Mr G had mentioned that one of the indicators of Mr G relapsing was that he sometimes confused traffic noise with screaming or laughter.

1.39 On the 18 March 2009 the associate psychiatrist saw Mr G in her outpatient clinic. It appears that this was intended to be a CPA review meeting at which Mr G's care co-ordinator should also have been present. However, due to a miscommunication the care co-ordinator did not attend and so the CPA review was undertaken over two separate meetings – one involving the associate psychiatrist and Mr G on 18 March 2009 and another involving the care co-ordinator and Mr G on 1 May 2009. We could find no record of a discussion between the care co-ordinator and the associate psychiatrist in relation to this review and it appears that the review was completed by the care co-ordinator without input from the associate psychiatrist.

Initial deterioration in Mr G's mental health

1.40 On 8 May 2009, Mr G travelled with his mother to Cornwall for a family holiday. However, on 11 May 2009 he contacted his care co-ordinator by telephone as he was concerned that he was not feeling well and that the

'journey may be the cause'. Mr G also said that his sleep was disturbed and that he feared that he was having a relapse. Following a discussion with his team leader and the consultant psychiatrist, the care co-ordinator contacted Mr G by telephone later that day to advise him to increase his medication if feeling unwell.

1.41 Mr G and his mother began their journey home from Cornwall on 13 May 2009, stopping overnight on the way. They recommenced the journey on 14 May 2009 but became lost, apparently crossing the Severn Bridge several times. Mr G became increasingly agitated and upon nearing a retail complex near Swansea, parked the car and left Mrs H inside. Mr G telephoned a family member in Pembrokeshire for assistance. Subsequently the local police picked him up on a roundabout half a mile away in a confused and disoriented state. The police returned him to the car.

1.42 In the meantime family members from Pembrokeshire arrived and they drove Mr G and his mother home. At approximately 10:00pm that night Mrs H attempted to contact the care co-ordinator on his mobile phone but was unable to get an answer. She was also unable to leave a message since the only option provided was a facility to leave a text message - a function that was not available on Mrs H's telephone.

1.43 Mr G called the care co-ordinator at 5:19pm on 15 May.2009. The care co-ordinator's notes indicate that Mr G seemed *'cheerful'* considering the events of the previous day. He told the care co-ordinator it had been a *'horrendous'* journey back from holiday in Cornwall and described becoming lost and described an *'aberration'* in that he had become too frightened to drive and so he had left his mother in a car park near Swansea. Mr G confirmed that the police had picked him up on a nearby roundabout and had taken him back to his car.

1.44 The care co-ordinator also spoke with Mr G's mother during the same telephone call who indicated to him that there was more to the story than Mr G had highlighted and provided additional details, including that they had to be

collected from Swansea by family members. She told the care co-ordinator that in her view Mr G was not as good as he said he was; although there was nothing specific other than he was a bit irritable. The care co-ordinator arranged a home visit for 26 May 2009 and advised Mrs H that he would be on leave the following week but that he would pass the information on to another, named, colleague after the weekend. The care co-ordinator also advised Mrs H to contact Mr G's GP or to dial 999 if there was any further concern.

The day of the homicide - May 16 2009

1.45 At 2:49am on 16 May 2009 Mr G contacted the police to report that he believed that he may have raped someone whilst on holiday in Cornwall. The police attended his home at 11:00am and Mrs H informed them that Mr G had not been taking his medication and was hallucinating. On checking, the police found that no report had been made in Cornwall regarding a rape and so took no further action at that time.

1.46 At 10:25am Mrs H rang the social services out of hours telephone number and spoke to an Approved Mental Health Professional (AMHP) expressing concern that Mr G was relapsing. Neither Mr G nor his mother were known to social services. The AMHP therefore assured Mrs H that he would contact the on-duty Crisis Resolution Home Treatment (CRHT) team[7]. The AMHP contacted the team and was advised that they were all out on call and to call back later in the morning. The AMHP spoke with Mrs H again at 11:15am following a request for contact. The police who were still in attendance took the call and advised that Mr G was not in urgent need of hospitalisation. The AMHP told the police officer in attendance that he would contact the CRHT team to arrange a home visit to Mr G.

[7] At this time the duty CRHT team comprised a qualified Mental Health Nurse Practitioner and a Healthcare Assistant.

1.47 Shortly afterwards, the AMHP spoke with the CRHT team and advised them to visit Mr G as he was non-compliant with his medication. A CRHT practitioner telephoned Mrs H at around midday and spoke with both the police officer who was in attendance and Mrs H. It was agreed that a visit to assess Mr G would be made to the home at 1:30pm.

1.48 The AMHP also telephoned and spoke to Mr G's sister at around 12:30pm to provide support and to explain that once the CRHT had attended, they would contact the social services out of hours team to inform them of the situation and if required, a further visit for a mental health assessment would be arranged. Mr G's sister told the AMHP about Mr G's behaviour and background history, during similar circumstances in the past. Mr G's sister also told us that she had repeated this information to the CRHT practitioner over the telephone prior to his visit.

1.49 The CRHT team arrived at the family home at 1:30pm and the CRHT practitioner carried out a mental health assessment of Mr G; who insisted that Mrs H leave the room for the first part of the assessment. During this assessment Mr G admitted to the practitioner that he had not been fully compliant with his medication and that he was hallucinating and hearing voices.

1.50 Following the completion of the assessment family members and Mrs H joined Mr G and the CRHT team. The CRHT practitioner's assessment record notes that during discussions Mrs H and her daughter described Mr G as *'argumentative/aggressive, confused and unpredictable'* and *'not right'*. CRHT records state that the team left at around 2.45pm; Mr G having agreed to take his medication. Mr G's sister is recorded as saying that her mother had subsequently told her that she had seen Mr G take one of his pills at 4:00pm.

1.51 Mr G's sister contacted the AMHP at around 4.50pm concerned that Mr G was deteriorating and that the situation was escalating. She described Mr G as being verbally abusive and argumentative. She requested further input from the CRHT. The AMHP contacted the CRHT at around 5.10pm and

spoke with the team's healthcare assistant to relay the family's concerns. The AMHP also relayed the family's request that the CRHT contact family members in Cornwall to discuss the behaviour exhibited by Mr G whilst on holiday. The AMHP advised the CRHT healthcare assistant that the family were concerned about the rapid deterioration in Mr G's mental state and explained that Mr G has been hospitalised in the past when displaying similar signs.

1.52 By the time the call from the AMHP came through to the CRHT the CRHT practitioner had gone off duty (although he was still in the CRHT office writing up his notes) and the CRHT team leader had taken over. The CRHT team leader telephoned and spoke with Mrs H at around 5:30pm. When asked about the current situation, Mrs H described Mr G as being *'alright'* and that she was *'fine'*. The CRHT team leader confirmed that the team would visit the following day.

1.53 Immediately after speaking to Mrs H the CRHT team leader called Mr G's sister to offer a further assessment that evening. However, as she was told that it would not be possible for a doctor to attend, Mr G's sister felt that a there was no point in a further assessment taking place that evening. She told us that she feared that it would aggravate Mr G's condition without removing him from her mother's house and therefore she had reluctantly agreed to the CRHT team leader's proposal to defer this assessment pending further assessments by the CRHT and a doctor. It was confirmed that the CRHT team would visit again at 12:30pm the next day (Sunday) and that an assessment by a doctor would be made on the Monday. The CRHT team leader advised that if Mrs H was concerned she should call 999.

1.54 A further telephone call was made to the family home that evening, at around 8:30pm, by the CRHT's healthcare assistant to advise that the CRHT would visit at 12:30pm the next day. However there was no answer and so she left a message on the answer machine confirming the arrangement.

1.55 At 9:43pm another AMHP, who was now providing the out of hours cover, received a message from Mr G's sister to say that Mr G had allegedly killed Mrs H and that she was en route to her mother's home. According to an account made later by Mr G, this homicide took place between 7:30pm and 8:00pm. The police also contacted the AMHP at 10:13pm to advise of the situation and to confirm that Mr G was being taken to the local A&E department as he had allegedly taken an overdose of medication.

Management and Organisation of Services

Arrangements for the provision of mental health services in Wales

1.56 The National Health Service in Wales was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of NHS Trusts and Local Health Boards. The commissioning of primary and all secondary mental health services became the responsibility of Local Health Boards (LHBs). In 2008 and 2009 the provider of secondary services in the Pembrokeshire area was Hywel Dda NHS Trust and the commissioner of secondary services was Pembrokeshire Local Health Board. A further reorganisation took place in October 2009 with the amalgamation of the Hywel Dda NHS Trust and three LHBs (including Pembrokeshire LHB) to form Hywel Dda Local Health Board. The health service body providing mental health services at a secondary level in South Pembrokeshire at the time that this review was commissioned was Hywel Dda Local Health Board.

The South Pembrokeshire CMHT

1.57 There are two CMHTs in the Pembrokeshire area, comprising of South Pembrokeshire CMHT and North Pembrokeshire CMHT. The relevant CMHT for the purpose of this review was South Pembrokeshire CMHT. South Pembrokeshire CMHT is based at Pembroke Dock with a satellite office (known as a *'patch'*) located in Narberth. The North Pembrokeshire CMHT is based at Canolfan Bro Cerwyn in Haverfordwest. The consultant and associate psychiatrists are based at Canolfan Bro Cerwyn. It is at this site that the acute mental health beds for Pembrokeshire are located and patients' medical records are stored; there is also access to FACE from this site. Pembrokeshire County Council also provides social worker input into the CMHTs within the Pembrokeshire Council area. The CMHTs are multi disciplinary consisting of social workers, consultant psychiatrists, community psychiatric nurses, psychologists, community care workers, occupational therapists, healthcare assistants, and administrative staff. In 2007 the Wales Audit Office undertook a baseline review of adult mental health services in Wales, which highlighted that Pembrokeshire was one of the areas in Wales which had the lowest number of funded posts (CPNs, AMHPs (ASW) and other social work funded posts) at approximately 2.1 funded posts per 10,000 adult population.

1.58 The aim of the CMHT is to ensure that people with mental health needs receive timely, effective assessment, care and treatment in the most appropriate setting in accordance with their identified needs.

1.59 The CMHT offers advice and assessment to individuals referred to the team via a single point of access process. Individuals receive a comprehensive assessment of needs. Once an assessment has taken place, the individual's needs are discussed via a multi disciplinary meeting to provide a Care Programme Approach (CPA) that meets their needs.

1.60 The CMHT operates Monday to Friday during normal working hours. Provision for an out of hours service is provided through the social services emergency out of hours service (operating 24 hours a day) and the Pembrokeshire Crisis Resolution Home Treatment (CRHT) team which operates daily from 9.00am until midnight.

Crisis Resolution and Home Treatment (CRHT)

1.61 The Health Board's operational policy for the CRHT service is informed by Welsh Health Circular 2005 (048) – *'Policy Implementation Guidance on the development of Crisis Resolution / Home Treatment (CR/HT) services in Wales'* and the guidelines the Sainsbury Centre for Mental Health issued in 2001 in relation to developing Crisis Resolution Teams. The guiding principles are cited as:

- Crisis management, to the point of resolution.
- Engagement with users, families and carers.
- A holistic approach.
- Approach work with users strengths rather than *'illness'* model.
- Improvement and maintenance of mental health through psycho education.
- A collaborative approach.

1.62 The Health Board has set out its service objectives for the CRHT service to meet the needs of service users who are:

- Currently experiencing a crisis as a result of serious mental ill-health.
- Vulnerable or disabled to the extent that they need intensive or extended time for treatment and support.
- Likely to require inpatient treatment in the absence of intensive support.

1.63 It is also envisaged that these service users would be:

- Over the age 18 or over 16 years and not in full time education in accordance with the CAMHS policy.
- Would meet the criteria for adult mental health services regardless of an upper age limit.

1.64 And that the services provided to these users would involve:

- Providing a service which works closely with other mental health services, primary care and the voluntary sector.
- Acting as *'gatekeeper'* to acute inpatient beds and facilitate early discharge where possible.
- Providing a service which is an alternative to hospital, between the hours of 9.00am and midnight, seven days a week.

Guidance relating to mental health services in Wales

1.65 The National Assembly for Wales and the Welsh Assembly Government have issued guidance to health service bodies in a number of publications. Of particular relevance, in relation to this review are *'Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency (National Assembly for Wales 2001)', 'Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users, (Welsh Assembly Government 2003)'* and in relation to current expectations with regard to mental health *services 'Welsh Health Circular (2006) 053'* and *'Adult mental health services in primary healthcare settings in Wales (Welsh Assembly Government 2006)'*. *'Welsh Health Circular (2005) 048'* also refers specifically to *'Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CRHT) services in Wales'.* The National Leadership & Innovation Agency for Healthcare (NLIAH) also produced a report in 2009 reviewing the usage of the Care Programme Approach (CPA) in Wales. More recently, in July 2010 the Welsh Assembly Government has

issued interim policy implementation guidance on the delivery of the Care Programme Approach in Wales. At the same time it has also issued interim policy implementation guidance about the role of CMHTs in delivering community mental health services.

Chapter 2: The Findings

The Homicide Committed by Mr G

2.1 There is very little in Mr G's clinical history that suggests that others were of risk of harm from him. When unwell Mr G appears to have been of greatest risk of harm to himself.

2.2 That said, once Mr G started demonstrating signs of relapse, it could have been predicted that a significant psychotic episode would take place, although again there was no way for staff to predict the nature of any such episode or its tragic consequences.

2.3 Admission to hospital on the 16 May 2009 is likely to have prevented the homicide that occurred on that day. However, as he had agreed to increase his Haloperidol, agreed to continue to see the mental health services and was thought to be manageable at home, it was reasonable for the CRHT to offer treatment and supervision at home.

2.4 Given Mr G's presentation and seeming willingness to comply with his medication the CRHT were not in a position to section him under the Mental Health Act. HIW is therefore of the view that the CRHT team who saw Mr G on 16 May 2009 acted reasonably and followed a course of action that was not out of line with what other CPN practitioners might have done in the presenting circumstances and with the information they had at the time.

Services provided to Mr G were less than optimal

2.5 Although we have reached the conclusion that the tragic homicide committed by Mr G was not predictable, HIW does believe that the there were shortcomings in the care and treatment provided to Mr G during the entirety of his engagement with mental health services in Pembrokeshire. In particular,

we consider that Mr G's care pathway highlights issues of general concern in relation to the provision of mental health services by the Hywel Dda Health Board.

Arrangements for the transfer of Mr G's care from the West Midlands to Pembrokeshire

2.6 Mr G's last outpatient appointment with his consultant psychiatrist in the Birmingham and Solihull Mental Health NHS Trust took place on the 10 July 2007. Mr G advised her of his move to Pembrokeshire and she later sent a letter to Mr G's new Pembrokeshire based GP. She noted in her letter that Mr G was on five mg Haloperidol three times a day and that he would need to continue at this dose for the foreseeable future. All of the above information was contained within the documentation provided to South Pembrokeshire CMHT in April 2008 by Birmingham and Solihull Mental Health NHS Trust.

2.7 Mr G's consultant psychiatrist also emphasised the need for Mr G to continue on his current level of Haloperidol, warning that any reduction in the past had led to relapse and detention in hospital. The consultant psychiatrist also indicated that she was enclosing a copy of her letter which followed her last clinic consultation with Mr G. However the GP in Pembrokeshire has confirmed that there was no enclosure with the consultant psychiatrist's letter and this letter could not be found in Mr G's GP notes. This missing letter confirmed that Mr G was on standard CPA.

2.8 While the information detailed above was passed to Mr G's new GP and the CMHT, there was no CPA transfer from the consultant psychiatrist in Birmingham and Solihull Mental Health NHS Trust to the South Pembrokeshire CMHT. At the time Mr G moved to Wales he was on what is known in England as *'Standard CPA'* as opposed to *'Enhanced CPA'*. In England Standard CPA applies to people who are receiving care from one agency and who are able to self-manage their mental health problems and maintain contact with services. Enhanced CPA provides enhanced support for individuals with multiple care needs from a range of agencies, likely to be at higher risk and to disengage from services.[8]

2.9 The mental health team at Birmingham and Solihull Mental Health NHS Trust had an ongoing relationship with Mr G and were familiar with his illness and his admissions to hospital. HIW questions why a direct transfer of Mr G's care to the South Pembrokeshire CMHT was not actioned in this instance. Mr G had a long-term and severe mental health problem and had long-term contact with mental health services. His mental state was known to be unstable when his medication was reduced and this had resulted in admissions to hospital and several attempts to harm himself. His last admission to hospital had been only two years before his move to Wales. His social and vocational opportunities were limited and he was dependent on his immediate family. Given the severity, complexity and chronic nature of Mr G's problems we would consider it good practice to have made a referral directly to the South Pembrokeshire CMHT. A direct referral would have enhanced the communication between the two mental health providers and would have given an opportunity for the risk factors and complexity of the relapse factors to be clearly outlined.

2.10 At the time the consultant psychiatrist and the CPN from the South Pembrokeshire CMHT undertook an initial assessment of Mr G they had not seen his notes from the West Midlands. It is understood however that before the CPN completed his assessment he had had an opportunity to *'scan'*

[8] Refocusing the Care Programme Approach: policy and positive practice guidance. Department of Health Guidance 20 March 2008

Mr G's notes from the Birmingham and Solihull Mental Health NHS Trust to confirm the information he had already obtained from Mr G and his mother. There was no attempt on the part of the Pembrokeshire CMHT to contact Mr G's former consultant psychiatrist (his previous designated care co-ordinator) directly to obtain any additional information about Mr G's mental health including, for example, details of any relapse signatures.

2.11 We consider that the arrangements for the transfer of Mr G's care from Birmingham and Solihull Mental Health NHS Trust to South Pembrokeshire CMHT to be less than optimal. The major concerns in relation to this can be summarised as:

- No direct clinical contact between South Pembrokeshire CMHT and Birmingham and Solihull Mental Health NHS Trust following Mr G's relocation to Pembrokeshire.
- No direct referral or transfer of care between Birmingham and Solihull Mental Health NHS Trust and South Pembrokeshire CMHT.
- Insufficient information concerning Mr G's past history, risk and relapse factors provided by Birmingham and Solihull Mental Health NHS Trust to Mr G's GP in Pembrokeshire.

Pembrokeshire CMHT's initial assessment and early contact with Mr G

2.12 The evidence we have seen indicates that, at the time of Mr G's transfer to Pembrokeshire, staff within the CMHT were operating under considerable pressure in terms of balancing the time available to undertake thorough assessments of new patients against the potential to compromise the care provided to other patients. In view of these difficulties HIW does not consider Mr G's initial CPA assessment and the summary of his mental health history to be inappropriate, although more detail could have been provided within the assessment.

2.13 It is apparent that there was no multi-disciplinary assessment or discussion of Mr G during his early contact with the CMHT's Narberth patch team. In particular there is no evidence of the involvement of a social worker in the process although it is acknowledged that the patch team's social worker was absent from work because of long term sickness.

2.14 Mr G's GP also told HIW that she would have been willing to have more input into Mr G's mental healthcare but was not afforded the opportunity to do so. From the information we have seen, it is clear that it was not routine to invite GPs to participate in the CPA process or to attend Multi Disciplinary Team (MDT) meetings. Given the limitations of the CMHTs in terms of staffing and catchment area size (which will be referred to later in this report), greater liaison with primary care personnel would have been desirable.

2.15 Little regard appears to have been given to the clear carer roles which Mrs H fulfilled in relation to Mr G and vice versa. This is concerning in view of the fragility and age of Mrs H. The offering and undertaking a carer's assessment is a requirement and responsibility of all care co-ordinators. While we have been told that Mrs H did not wish to have a carer's assessment (this was not recorded on file), on balance we feel that as Mr G's primary carer and in view of her fragility, a more formal and comprehensive assessment of Mr G and his mother's social circumstances should have taken place.

2.16 It is our view that Mr G's mother should have been provided with the opportunity to have a greater input into the CMHT's assessment of Mr G's care and treatment needs. His care plan was primarily focused on pharmaceutical intervention rather than it being a holistic care plan involving carers, family and support networks.

2.17 A formal multi-disciplinary CPA meeting to discuss Mr G's care plan and risk assessment does not appear to have taken place. The care co-ordinator apparently prepared a care plan and risk assessment for discussion at a CMHT team meeting. However, the note of the meeting held

on 17 April 2008 at which the care of Mr G was discussed, does not make reference to his care plan nor does it appear that the care co-ordinator who prepared the care plan was present.

2.18 We are concerned that Mr G's initial care plan failed to demonstrate a consistent analysis of Mr G's past history and a lack of clear risk assessment based on clinical history taking. We feel that the approach taken led to poorly constructed relapse indicators and an inadequate crisis and contingency plan for dealing with an emergent relapse. The development, monitoring and regular updating of the plan should have been the responsibility of the whole multi-disciplinary team.

2.19 As referred to earlier we consider the Narberth patch team to have been operating under considerable pressure during the period between Mr G's transfer to Pembrokeshire and the tragic incident. It has been suggested by those interviewed that there was insufficient protected time for practitioners to undertake initial assessments and to develop summaries of patients' historical patient records.

2.20 It is worth noting that the associate psychiatrist who saw Mr G in her outpatient clinic in June 2008 identified one of Mr G's significant relapse signatures at this consultation. However this information does not appear to have found its way into Mr G's care plan nor was it used to inform crisis and contingency planning apparently because of difficulties staff experienced in copying or scanning letters and entering them onto the FACE system. The issue of information sharing will be considered in further detail later.

2.21 In our view the initial assessment process undertaken for Mr G was not robust and was not sufficiently thorough to reveal the needs and risks relating to Mr G and his family. The main contributory factors include:

- A lack of a rigorous initial assessment process including failure to hold a genuine multi-disciplinary meeting to discuss Mr G's case in detail, to clarify social, family and historical factors, to delineate a clear risk assessment and to develop a comprehensive care plan.
- Insufficient protected time and resource for staff at South Pembrokeshire CMHT to undertake a robust CPA Assessment particularly in light of a lack of formal transfer under CPA.
- Insufficient involvement of the GP in the initial assessment and subsequent care planning process.
- Insufficient regard or involvement of Mr G's mother in the care planning process.
- Insufficient capture, analysis and inclusion of social, familial and historical factors to inform assessment.
- Inadequate crisis and contingency planning.
- Difficulty inputting outpatient consultation letters into FACE.

Ongoing engagement of Mental Health Services with Mr G

2.22 Shortly after Mr G's initial care plan and risk assessment was put in place, responsibility for his care co-ordination transferred to another CPN. The handover between the two CPNs appears to have taken place smoothly and we have no concerns about this process. Following his introduction to Mr G the second care co-ordinator visited him on approximately a monthly basis. We consider the approach adopted in these visits to be generally static, as opposed to dynamic. The approach to visits was low-key and relaxed. The same approach was adopted to risk review, monitoring and therapeutic care delivery.

2.23 We would question whether this predominantly *'social'* visiting approach led to a more complacent attitude at the time of the emergent relapse. We would also question whether it led to a wider service perception that Mr G was of a lower risk than he actually was and a lack of realisation by the services that the signatures of actual relapse were as serious as they were when they occurred.

2.24 During the course of this review we formed the view that the staff working out of the Narbeth patch appeared to be working largely in isolation with limited opportunity for peer contact. We are concerned about both the apparent informality of the arrangements for covering long term sickness and the small size of the Narberth patch team at the time and its lack of capacity to manage the loss of team members. We will say more about this later when we deal with management issues.

2.25 It appears to us that despite assurances from the Health Board there appears to have been a degree of disconnection between the Narberth patch practitioners and their medical colleagues (which was still in evidence at the time of our review). We note that the working patterns of the practitioners in the Narberth patch (two of the three practitioners were providing part-time input into the patch) meant that individuals were often unable to attend the regular CMHT meetings as occurred on set days at that time. This inevitably meant a further reduction in the opportunity for peer contact and discussion of professional issues with greater isolation from medical input.

2.26 We also consider that there was a failure to abide by the expectations of the CPA in terms of *'inter'* and *'intra'* agency involvement when formulating care plans and during the CPA review processes. It did not appear to have been a priority for professionals to hold multidisciplinary assessments. This is exemplified by the manner in which the first CPA review was undertaken – a first meeting between the associate psychiatrist and Mr G and a second one between Mr G and the CPN; no multidisciplinary discussion was recorded.

2.27 It is our view that the care and treatment provided to Mr G during the year leading up to the homicide was not sufficiently robust and that this generally reflects the way in which the local mental health services are organised and staffed in South Pembrokeshire. The nature of the involvement of mental health services with Mr G meant that opportunities were missed to ensure that appropriate contingency and crisis plans were drawn up to manage the risk posed by Mr G at times of relapse. The main causes of this in our view include:

- A lack of regular comprehensive assessment, including risk assessment.
- Inadequate care planning in particular the lack of a plan to deal with relapse and crisis.
- Failure to determine and review the outcomes of CPA planning
- Insufficient multi disciplinary working and review.
- *'Social'* visits; the focus of which was unclear and possibly too limited.
- An apparently informal instead of professional relationship with Mr G and his carer.
- Isolated clinical practice.
- Insufficient medical input into clinical assessment and decision making in the Narberth patch.

- Lack of consideration and assessment of the needs and expectations on an elderly carer.
- Lack of an outcome focused care plan to inform and direct the care co-ordinator's involvement.
- The lack of evaluation of the efficacy of the care plan as part of staff supervision processes.

Escalation – Involvement of mental health and social services in the days leading up to the homicide

2.28 Mr G and his mother travelled down to Cornwall on holiday on 8 May 2009 and whilst there, it appears Mr G started becoming unwell. He recognised he was becoming unwell and contacted his care co-ordinator by telephone on 11 May 2009. The care co-ordinator recognised this as a possible first sign of a relapse and felt it was appropriate to consider raising Mr G's dose of Haloperidol. He discussed this course of action with both his team leader and the consultant psychiatrist who agreed that the increase in dosage was appropriate. The care co-ordinator told us that Mr G had indicated his reluctance to increase his medication but said he would do so *'for now'*. The care co-ordinator asked Mr G to contact him upon his return from holiday. We are content that this course of action was reasonable although in view of the signs of relapse this would have been an appropriate opportunity to revisit the risk assessment and prepare a contingency plan.

2.29 Mr G and his mother returned from holiday on 14 May 2009 and as detailed in Chapter 1, their journey home had been *'horrendous'* with the local police and Mr G's family having to *'rescue'* him and his mother. Following their return home numerous contacts were made with mental health services on the days leading up to the homicide.

2.30 We were struck as we considered the events leading up to 16 May 2009 by the cumbersome and frustrating manner in which carers and family members had to contact various practitioners within the social and

healthcare teams. Furthermore, we consider the systems of communication available to enable liaison between team members to be inefficient.

2.31 While the evidence we have received suggests that Mrs H was provided with contact details for the CMHT main offices and that she and Mr G were also provided with the out of hours GP emergency telephone number; it appears that neither Mr G nor other family members were clear as to the correct process for obtaining assistance out of hours.

2.32 The family's initial contact with services on 16 May 2009 was with the out of hours AMHP who works for Pembrokeshire Social Services. The social service out of hours service is an emergency service which is not expected to provide the full range of day time services but is designed to respond to emergencies that cannot wait until day time working hours. The service is covered by one member of staff at a time and calls to the team come via the call centre in Haverfordwest which is where the AMHP was based at the time of the incident.

2.33 Mr G and his mother were not known to social services until the day of the incident and there was no information about any family member on the social services' *'Care First'*[9] computer system. Because of this Mr G's mental health history had to be relayed to the AMHP by Mrs H. He then had to contact the CRHT team to obtain further information about Mr G. Because the CRHT were not at their base in Bro Cerwyn, they were unable to provide the AMHP with additional information until they returned following a visit to another client.

2.34 On returning to Bro Cerwyn the CRHT contacted the AMHP practitioner but only provided him with limited information. We are of the view, given the information that was available, that the AMHP's decision making was appropriate. It was appropriate for him to ask the CRHT team to visit to assess Mr G and in particular to follow up the matter of Mr G's compliance

[9] *'Care First'* is Pembrokeshire Social Services' computerised client information management system

with medication. We are also content, that the information made available to the AMHP via CRHT, the family and the police (who had spent some time with Mr G and his mother) during the morning of 16 May 2009 did not suggest that the situation merited an assessment under the Mental Health Act.

2.35 The CRHT practitioner telephoned later and spoke separately to both Mr G's mother and sister. They both had to repeat information about Mr G's mental health history that they had earlier given to the AMHP. It was clear that they did not have access to notes of conversations held with Mr G's care co-ordinator on 15 May 2009 and as referred to earlier, there was no clear crisis plan in place to guide individuals who were unfamiliar with Mr G, as to how they should deal with his relapse.

2.36 Later on that day there was a shift change that meant that Mr G's family had to speak with a different member of the CRHT and explain the situation and Mr G's mental health history for a third time.

2.37 Mr G's family have also raised concerns about being unable to contact out of hours social services or the CRHT team directly. They found that a call-back was required. We are of the view that such call-backs are not always convenient or have the potential to be intrusive or compromising when there is a sensitive situation involving a fragile or deteriorating client. Whilst acknowledging that from a service user perspective an immediate response to a telephone call would be the best option, we accept that this is not always practical particularly when there is a small team. There is also an advantage to the call-back system in that by having a staffed telephone service the service user/carer will always have their call answered.

2.38 We consider that the processes for accessing emergency mental health assessment and care to have been inadequate and burdensome. The following root causes were identified:

- There was no crisis plan in place for the CRHT to follow and to inform Mr G and his carer(s).
- The social services AMHP did not have access to information held by the CRHT. (This is commented upon further in the section of this report headed information sharing).
- The social services AMHPs are not located within the same facility as the CRHT thereby diminishing their effectiveness and potentially creating a barrier to developing a closer working relationship between the two services.
- Mr G's family and carers had no information to enable them to contact the CRHT team direct.
- The processes in place to obtain support out of hours do not appear to have been communicated to Mrs H in a sufficiently clear way.
- There was inadequate resource in place to enable telephone support / reassurance to be provided to concerned patients or carers out of hours.
- There was an underestimation of the rate of Mr G's relapse and of the time taken for his mental state to improve with no direct re-assessment of the state of his mental health.
- There had been no contemporaneous recording of the information provided by Mr G and his mother on Friday
  15 May 2009 and no review of his care plan, contingency plan and risk assessment in light of the acknowledged developing relapse. In this respect there was insufficient facility for staff to access FACE thereby making the process of entering information both inefficient and burdensome.

CRHT's assessment of Mr G and Involvement with the family

2.39 We have heard evidence of a lack of clarity about procedure and policy in relation to the crisis response service which pre-dated the events of 16 May 2009. This includes inconsistent expectations of the role of support staff in the crisis team; high-level acute workloads; isolated working and a lack of team approach. .

2.40 We have been told that on this particular occasion, the lack of a bed was not an issue, as there was an acute bed available for Mr G on 16 May 2009. However, on 16 May 2009 there were competing demands on the CRHT stemming from a number of crisis situations that occurred on the day combined with the demands of covering a large geographical area. This appears to have led to a sense of *'flying by the seat of the pants'*. It should however be emphasised that we are not critical of the decision made by the CRHT practitioner and his colleague following their assessment of Mr G on 16 May 2009. While, as we have said earlier, admission to hospital is likely to have prevented the homicide that occurred on that day, Mr G had agreed to increase his Haloperidol, to continue to see the mental health services and was thought to be manageable at home, it was reasonable for the CRHT to offer treatment and supervision at home. HIW considers the CRHT team who saw Mr G on 16 May 2009 to have acted reasonably and to have followed a course of action that was not out of line with what other CRHT practitioners might have done in the presenting circumstances and with the information they had at the time.

2.41 The family told us that they felt that opportunities were missed to obtain information from them about Mr G's behaviour and previous history of relapse. They felt that they were *'spurned'* by the CRHT when they tried to present additional information over and above the information presented by Mr G himself. A particular example cited was the manner in which the team refused to engage with a family member who approached them as they left following their meeting with Mr G. We can see no compelling reason why the CRHT seemed unwilling to engage with family members outside of Mr G's presence.

We would suggest that receiving (as opposed to imparting) information is not a breach of patient confidentiality. In fact we consider that it would have been entirely acceptable for their concerns to have been listened to and taken account of given the family's experience of in dealing with Mr G's illness over 25 years.

2.42 That said, even with the benefit of hindsight, we do not consider that such information would have had a material impact on the decision not to admit Mr G.

Information sharing, records management and communication

2.43 The use of mobile telephones as a means of communication with patients and their carers is a concern. We have heard from staff that clients were provided with practitioners' individual mobile telephone numbers which were only supposed to be used during working hours. We have no doubt that these practitioners were simply trying to be helpful in providing their mobile telephone numbers. However this was not the method by which the CMHT envisaged that contact would be made with care co-ordinators. There could be a number of pitfalls associated with leaving a message in an urgent situation such as leave or sickness meaning messages would not be picked up.

2.44 It is also important to mention at this point the difficulties that have been highlighted to us, in relation to working with FACE as currently implemented by the Health Board. These matters have already been highlighted in this report and were repeatedly raised by those interviewed during the review. Concerns about record management and information sharing is one of the most pervasive issues we have encountered during the course of this review and indeed in previous homicide reviews HIW has undertaken.

2.45 The Board's internal report of its review of the incident identified a concern about the storage of Mr G's historical record, from Birmingham, in the Narberth patch office instead of being returned to the medical records office in Haverfordwest. We have learned during the course of our review that it was not uncommon for records to be kept in the patch office because of the practical difficulties in accessing client records, for example, in terms of return journey time to Canolfan Bro Cerwyn. It would seem a sensible course of action to ensure that all patient records could be accessed centrally by all those requiring access. However we also appreciate that making a 20 mile round journey every time a patient record needs to be consulted is inefficient and as suggested by staff, has the potential to impact on time that could otherwise be devoted to patient care. It is also noteworthy that at the time of this incident the Health Board did not have a formal policy in place in relation to the storage of such records although we have been told that one has subsequently been introduced.

2.46 Health Board staff have told us that it is not technically possible at present to scan historical records such as Mr G's Birmingham and Solihull Mental Health NHS Trust records into the FACE system which would enable access to all professionals requiring that access. We have also heard that staff are not given sufficient protected time to prepare detailed mental health summaries. Consequently it seems that as long as this situation persists there will be the potential for deficiencies in the manner in which historical information is made available to all professionals.

2.47 Nevertheless, in terms of root cause, HIW is of the view that the fact that Mr G's historical records from Birmingham and Solihull Mental Health NHS Trust were stored in the Narberth patch office is of peripheral consequence to the outcome of this case and can be considered somewhat of a red herring. We consider that the copious historical records should have been adequately summarised. They could also have been used as a basis to prepare a comprehensive risk assessment including an appropriately

constructed relapse indicator analysis to draw up a crisis and contingency plan to deal with emergent relapses. If this had happened then we consider the storage location for the historical record to be immaterial.

2.48 Equally, if the Health Board had the capacity to enable historical records to be scanned into the patient record held on FACE again this would have meant that the location of the paper records would have been irrelevant and the whole of the record would have been available to all professionals with access to FACE.

2.49 Another difficulty with the information sharing systems as currently operated by the Trust in that having received a telephone call out of hours, it appears that the only means the care co-ordinator would have had for updating the FACE record with information, would have been to turn around and go back to the nearest office with a terminal for accessing FACE.

2.50 We are of the view that, on balance, this is what he should have done since this would have ensured that the telephone contact was properly recorded and a plan of action clearly set out on FACE. However, we also recognise that by not having a readily accessible system for updating FACE the Board was not providing its practitioners with a reasonable level of support to enable them to undertake their duties efficiently and without undue pressure being placed on its staff.

2.51 It is also relevant to highlight that not all professionals who could potentially become involved in providing patient care have the ability to access FACE. Whilst social services staff, that are members of a CMHT, have access to FACE out of hours social services staff such as the AMHP do not. Social services staff has access to their electronic client record management system called *'Care First'*. Regrettably, FACE and Care First do not communicate functionally with one another. GPs do not have access to FACE either although the Health Board has said that such access has been offered in the past.

2.52 Staff have also told us that as a tool to manage information and to assist in implementing CPA, FACE is too complex. We have also received complaints that FACE is also unsuitable as a tool to assist staff to draw up appropriate care plans which can be shared with patients. It is also complained that as a tool to assist in preparing risk assessments FACE is too reliant on *'tick boxes'* and has insufficient opportunity or encouragement to include narrative comment.

2.53 In addition to concerns about the system itself, staff have also expressed concern about the unreliability of the connection (via telephone link) between the patch office and the main CMHT office. We have also heard concerns about the difficulties experienced in having to return to base to input any information onto the system via a suitable terminal and that there is no facility to update information remotely.

2.54 It is clear to us that the FACE information management system as currently implemented and resourced within the Pembrokeshire CMHT does not adequately support mental health service delivery. This conclusion is also reflective of a wider concern expressed by NLIAH[10] who commented that '*The current information management arrangements do not effectively support the delivery of care. IT systems do not support the client/professional interface and are seen by practitioners as cumbersome and bureaucratic*'. The contributory causes of the inadequacies identified in the sharing of information seen in this case, in our view, are numerous and include (in no particular order):

- An inability or lack of capacity to scan historical information onto the system.
- A lack of a full summary of Mr G's clinical case history.
- A difficulty in transferring outpatient letters onto FACE.
- A concern about fitness for purpose in terms of outlining care plans and risk assessments for the CPA.

[10] Review of the Care Programme Approach in Wales 2009 – National Leadership and Innovation Agency for Healthcare (NLIAH)

- Inability of the system to communicate with the local authority's electronic case management system.
- Inability to access FACE remotely.
- Instability of the system when operated in satellite offices.
- Inability to access FACE by staff such as out of hours social services practitioners.

Management and governance issues

2.55 During the course of this review, we have identified a number of concerns in relation to the management and governance processes operating within Hywel Dda Health Board's mental health services which we consider contributed significantly to many of the shortcomings that have been identified above.

Resources and staffing levels – sustainability of small teams

2.56 Having analysed the information provided by the Health Board in relation to staffing levels within the mental health service teams in Pembrokeshire and the corresponding population base, it is our view that the South Pembrokeshire CMHT and the Narberth patch teams were understaffed in 2009 and that this was still the case at the time of our review. The Narberth patch team in May 2009 comprised of: one full time team leader; one CPN and one occupational therapist, both of whom worked within the patch for three days a week each and a full time social worker who had been on long term sick for a considerable period, prior to the homicide. The recommended staffing level in our view should be set at 5.0 WTE[11] for a team covering the size of the population within the Narberth patch area. We also consider that the team size, configuration and operation should take account of the dispersed nature of the population in this geographical area.

[11] Estimates derived from - Boardman, J. & Parsonage, M. (2007). Delivering the Government's Mental Health Policies. Services, staffing and costs. London: Sainsbury Centre for Mental Health.

2.57 The medical input into the CMHT is low and remains so (as of July 2010) since the consultant psychiatrist was covering both her own community responsibility as well as covering a consultant vacancy for the inpatient service. In addition, the associate psychiatrist is based for the majority of her time in Haverfordwest.

2.58 CMHTs cannot meet the comprehensive needs of service users and their families unless teams are sufficiently resourced. Teams that work in isolation, have insufficient skills, lack professional challenge and support cannot deliver integrated community services. Furthermore, teams need to create an ethos of assessment and care which delivers a quality service which is comprehensively evidence based and takes into consideration the views of the patients it treats.

2.59 At the time of the homicide the CRHT team does not appear to have been understaffed. However there were only two members of staff on duty during out of hours, covering the whole of Pembrokeshire. This issue has since been addressed and additional out of hours staff have now been recruited.

Culture of pragmatic solutions / making do

2.60 We have seen evidence that resource constraints have led to courses of action being taken which do not necessarily conform to the Health Board's own CPA policy.

2.61 Every patient on CPA (whether standard or advanced) in Wales should have a care co-ordinator. It is understood that a concern was raised with management about how the Narberth patch would comply with this requirements should a member of the team be absent (either through leave or illness). There is very little scope to appoint another care co-ordinator within the patch because all members of staff are already at full case load capacity.

2.62 We were told, that following discussions with management it was agreed that in the absence of a member of the team, individual practitioners would only deputise as care co-ordinators for those patients on enhanced CPA. This course of action would mean leaving those patients on standard CPA without a designated care co-ordinator, in contravention of the Health Board's own CPA policy; this is not acceptable.

Split supervision - management and clinical

2.63 Another concern that we hold relates to the split between management and clinical supervision of staff, leading to a disconnection between the two processes. Management supervision is mandatory and is normally undertaken by direct line managers. Clinical supervision however is voluntary, not mandatory, for individuals but is recommended to be made available to all practitioners. We have also been told that any clinical supervision that staff receive, depends on whether they actively seek it as opposed to it being offered. Even when staff have both clinical and management supervision in place there does not appear to be a mechanism, formal or otherwise, for one to feed into another. We do not consider such arrangements to be good practice.

2.64 Much of the work undertaken by the CMHT is undertaken in isolation and there is restricted contact between practitioners and their peers. This leads to limited opportunities for discussion. Coupled with the rather variable involvement of clinical supervision we are led to conclude that staff do not necessarily have an appropriate overview of what constitutes good clinical practice and that there is insufficient opportunity to gain from the experience of others. We are also concerned that this could impact on the assessment and management of risk in the context of everyday clinical practice and that there should be a more proactive approach to the challenging of clinical decisions.

Use of learning – translation into practice

2.65 We consider that some of the lessons that should have been learnt as a result of this incident do not appear to have resulted in changes in practice or resource; despite some of the concerns that we have raised in this report, being highlighted in an earlier, internal review undertaken by the Board.

2.66 It is clear to us that there are at a number of shortcomings in relation to IT, communication and geographical isolation that have yet to be resolved. We are also concerned that opportunities to debate and learn from what happened in relation to this tragic incident, as part of a positive approach to improve both practice and management, were not arranged for all relevant health and social services staff.

CHAPTER 3

Summary Recommendations

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

1. On a strategic level Hywel Dda Health Board and Pembrokeshire County Council Board should jointly:

    - Enhance arrangements for joint working at a strategic and joint planning level between mental health services and social services for example, to look at issues such as the size of patches, staffing levels and cover, the roles, relationships and *'fit'* between the different mental health services provided by the two services.
    - Embed quality risk assessment and risk management, crisis and contingency planning processes in developing and implementing the care plan in conjunction with the carer and significant others in the service user's life.[12] The contingency and crisis plans should be easy to access for both health and social services staff on a 24 hour basis.
    - Embed within their practice and policies the ethos that '*accurate risk assessment relies upon a high quality history taking, sharing of information between individuals and services and locating relevant past information which may indicate areas of current and future risk'*.
    - Undertake a project with carers and mental health users' organisations, with a view to increasing the uptake and usefulness of carers' assessments.

[12] Delivering the care programme approach in Wales Interim Policy Implementation Guidance Welsh Assembly Government July 2010

- Make sure that the services review their CPA policies, to ensure conformity with the interim policy guidelines recently issued by the Welsh Assembly Government (see footnote 12 above) and to implement the recommendations of the 2009 Review of the Care Program Approach in Wales[13].

2. In relation to CPA, Hywel Dda Health Board and where appropriate, due to an involvement in the co-ordination and provision of care, Pembrokeshire County Council need to ensure:

   - Improved clinical team meeting structures to allow for improved review of new patients and clinical discussion of people with continued contact.
   - That the philosophy and guiding principles of the CPA are implemented consistently and that the approach is to be holistic, incorporating both clinical and social models of care which assesses and addresses medical, social and family circumstances and needs. This needs to be embedded in practice through training, supervision, documentation and the use of appropriate quality assurance processes to include all practitioners including doctors, care co-ordinators and supervisors.
   - That when carers' assessments are offered to a patient's family member(s), they are advised that by being identified as a carer they can be included in crisis and contingency planning.
   - That active consideration is given to providing GPs with greater opportunities to be included in the care/treatment of serious mentally ill patients.
   - That crisis teams be required to take in to account the views and supporting evidence provided by family & carers.

[13] Review of the Care Program Approach in Wales 2009 National Learning and Innovation Agency for Healthcare

3. In relation to FACE, Hywel Dda Health Board needs to ensure that:

    - A thorough evaluation and review of the fitness for purpose of FACE system and thorough training of all staff in its use is undertaken.
    - Historical paper patient notes should be incorporated into the FACE record in the form of thorough summaries and that care co-ordinators are given sufficient protected time to complete such summaries. However HIW recognises that if the mental health service from which the patient had been transferred from had engaged with the CPA transfer process when they became aware of Mr G's imminent relocation out of their area, the necessity for the actions recommended above would have diminished. For that reason this report will be drawn to the attention of the relevant departments in the Welsh Assembly Government and their counterparts in the department of health for them to take the matter forward as appropriate.
    - That consideration is given to the incorporation of a *'front page'* which, alongside the usual details of diagnosis, medication etc. should include triggers and relapse signs, contingency/crisis plans and include details of any vulnerable adults or children living at the same address.
    - That FACE be made available to both social services staff and if appropriate, GPs.

4. In relation to the function of the CMHT and CRHT, Hywel Dda Health Board and, where appropriate, Pembrokeshire County Council should:

    - Review the availability and implementation of clinical and managerial supervision to ensure that staff are appropriately supported.
    - Look to improve staffing levels in both teams.

- Ensure that there are formal arrangements in place to cover long term absences of staff.
- Clarify and develop guidance on the respective roles and responsibilities for co-ordinating a response to crises that involve the contribution of both the out of hours service and the CRHT. Specifically they should review and identify the circumstances and indicators to establish when a joint visit involving both CRHT and the out of hours practitioner should be considered and undertaken.
- Review the delivery of services within the Narberth patch and South Pembrokeshire CMHT to ensure that these reflect the demands of the geographical area.

Annex A

Terms of Reference

The review will:

- Consider the care provided to Mr G as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on 16 May 2009*.

- Review the decisions made in relation to the care of Mr G.

- Identify any change or changes in Mr G's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 16 May 2009.

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

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

* As part of this exercise consideration will be given also to the personal history of Mr G.

2009 Chronology

Date	May			
CMHT		11/05/09: Mr G contacts CMHT whilst on holiday in Cornwall. Reports not feeling well despite taking medication. Mr G mentions that *'journey may be a cause'* and reports that sleep is disturbed, worried about relapse. Care co-ordinator returns call and advises to increase medication following advice from his Team Leader and Mr G's Consultant.		
CRHT				
SOCIAL	08/05/09: Mr G departs on family holiday to Cornwall.		13/05/09: Begins journey home with overnight stop on the way.	14/05/2009: Journey home takes over ten hours. Mr G became confused and lost whilst driving home. He stops at a retail park near Swansea and abandons the car. Mrs H was left locked in the car. Mr G was found by police on a roundabout near Swansea in a confused state. Family return Mr G and Mrs H back home.

The review team produced a timeline to assist its understanding of the interactions between events and services relating to Mr F. This timeline is provided to supplement the evidence contained in the body of the report and demonstrate one way in which information available to the review team has been analysed.

May		
14/05/09: (10:10pm) Mrs H and daughter attempt to contact the care co-ordinator but no answer and there is only a facility to leave a text message	15/05/09: (5:20pm) Mr G contacts his CPN by telephone . The CPN's assessment of Mr G states, '*appears to be appropriate and cheerful considering ordeal day before'* . Home visit confirmed for 26/05/09. Advised that alternative CPN would get this information but as it is after 5pm would feed back on Monday. The Care Co-oordinator also spoke with Mrs H and advised her to contact the GP or ring 999 if concerned.	
		16/05/09: (02:49am) Mr G contacts police and reports he thinks he may have *'raped'* someone in Cornwall following disturbed sleep.

May		
16/05/09: (10:25am) Mrs H contacts the social services out of hours AMHP. Mrs H told the AMHP that his CPN had advised Mr G to increase medication but there was no signs of improvement. Mrs H expressed concern that Mr G was *'going 'downhill'* . The AMHP attempts to contact CRHT Team for more information but as they were out on a visit, called Mrs H back to advise her that he would attempt to contact them again later.	16/05/09: (11:00am) Police attend Mr G's home following his call. Mrs H advised police that Mr G had disclosed that he had not taken medication and was hallucinating. Police take no further action due to no evidence of a rape being reported in Cornwall.	16/05/09: (11:15am) The AMHP receives message to contact Mr G's sister. Inadvertently calls Mrs H and speaks to the police who are still in attendance. Police advise him that Mr G does not appear to be in need of urgent hospitalisation. The AMHP advises CRHT to visit Mr G to persuade him to comply.

May			
16/05/09: (11:20) The AMHP contacts the CRHT who agree to contact Mrs H and offers to visit if necessary.	16/05/09: (12:00PM) The CRHT practitioner makes contact with Mrs H by telephone. The CRHT practitioner also speak to Mr G. CRHT plan visit for 1:30pm.	16/05/09: (12:15pm) Police request return call from CRHT.	
			16/05/09 (12:30pm) The AMHP telephoned Mr G's sister who provides background information over the phone. He was advised that Mr G and Mrs H live in an isolated spot; AMHP discloses this to CRHT. The AMHP advised Mr G's sister that the CRHT Team would contact him following their visit should a full mental health assessment be required.

May			
16/05/09: (time unknown) The CRHT practitioner speaks with Mr G's sister. She repeats the information she provided to the AMHP.	16/05/09: (1:30pm) CRHT home assessment. Mr G was seen alone then with family. Family described Mr G as being aggressive, unpredictable and confused. FACE records determine that Mr G experiencing mental deterioration. Mr G admits non-compliance with medication and experiencing auditory hallucinations.		
		16/5/09 (4:00pm) Mrs H informs her daughter that she witnessed Mr G taking medication and that he is still becoming more agumentative and abusive towards Mrs H.	16/05/09 (4:55pm) AMHP returns call to Mr G's sister after receiving message to call her. Mr G's sister expressed concern that situation was escalating. Mr G was becoming argumentative and verbally abusive to Mrs H. She requests further input by CRHT. The AMHP passes on information to CRHT.

May		
	16/05/09: (5:30pm) The CRHT Team Leader calls Mrs H. She answers and advises that Mr G was *'alright'*. The CRHT advised her that they would call again tomorrow.	16/5/09 (5:40pm) The CRHT Team Leader calls Mr G's sister. The Team Leader offers to visit that evening. Mr G's sister reluctantly declines the offer to avoid aggravating Mr G further. The Team Leader gave assurance that a visit from the team would take place the next day at 12:30pm. The Team Leader also advised that there was no doctor available that evening, although a doctor would be able to assess Mr G on Monday. The Team Leader advised that if Mrs H feels threatened she should call 999.
16/05/09: (5:18PM) Telephone call received by CRHT from AMHP regarding call from Mr G's sister. The AMHP requests that the CRHT contacts a family member in Cornwall for information on Mr G's recent behaviour, whilst on holiday. He also informed the CRHT of the family's concerns over Mr G's rapid deterioration and advises that Mr G has been hospitalised in the past when presenting this behaviour. The AMHP advise Mr G's sister that he had requested a further call from CRHT.		

May				
16/05/09: It appears from later interviews with Mr G that he had attacked Mrs H sometime between 7.30pm and 8.00pm				
	16/05/2009: (8:30pm) The CRHT's Healthcare Assistance rang Mrs H's house to advise her and Mr G that the CRHT would visit at 12:30pm the next day. However, as the phone was unanswered a message was left on the answering machine.			
		16/05/09: (9:43pm) The AMHP receives a message from Mr G's sister advising that he had apparently killed Mrs H. The AMHP calls 999 but was advised that the police were already at the scene.	16/05/09: (10:13pm) Police contact the AMHP and advises that Mr G was being taken to A& E department of the local hospital since Mr G had reportedly taken overdose of medication.	16/05/09: (10:15pm) AMHP calls CRHT to advise that Mr G had killed Mrs H.

Annex C

Review of Mental Health Services following Homicides Committed by People Accessing Mental Health Services

In England and Wales there are approximately 52 homicides each year committed by people who were suffering from mental illness at the time of the offence. That amounts to 10% of murder and manslaughter cases dealt with in our courts. Of all perpetrators convicted of homicide each year, approximately 97 (18%) of them have had contact with mental health services during their lifetime.

It is of course a matter for the criminal justice system to ensure that investigation and adjudication is undertaken in respect of those homicides. However it is proper that each incident is also examined from the point of view of the services put in place to provide care and treatment to those who experience mental health problems. In Wales the Welsh Assembly Government has expected an independent external review into every case of homicide committed by a person with a history of contact with mental health services.

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

Arrangements for Reviews in Wales

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

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

Annex D

Arrangements for the Review of Mental Health Services in Respect of Mr G

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

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

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

Developed in the field of engineering, RCA helps professionals in a wide range of settings, who might otherwise be unfamiliar with investigation methods, to determine: what happened, how it happened and why it happened. It is designed to encourage learning from past problems, failures and accidents and to eliminate or modify systems to prevent future

occurrences of similar incidents. It provides a template for the non-professional investigator which ensures a systematic approach to investigation built upon good investigation practice and for those with more experience is a helpful checklist of necessary investigation steps and provides a *'tool box'* of techniques which have proven success in uncovering root causes of events.

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

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

Dr Jed Boardman	Consultant Psychiatrist
Mr Graham Williams	Registered Mental Health Nurse
Mrs J Phillipson	Social Services Inspector, CSSIW
Mrs J Hepworth	Lay Reviewer, HIW Panel
Dr G Jones	Investigations Manager, HIW
Mr R Jones	Investigations Manager, HIW
Mr L Dyas	Assistant Investigations Manager, HIW
Mrs J Fellows	Investigations Co-ordinator, HIW

The information gathering phase of the review was conducted between March 2010 and July 2010. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the former Hywel Dda NHS Trust; Pembrokeshire County Council, and Birmingham and Solihull NHS Mental Health Trust, and Mr G's GP. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officer. We were grateful to the police for their collaboration.
- Reading the case records maintained by Health Bodies and Local Authorities concerning Mr G.
- Reading interview notes and written statements provided by staff working with Mr G which were provided as part of the police or internal investigation processes.
- Interviewing key people particularly those with strategic responsibility for the delivery of services.

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

The analysis stage was taken forward by the review team. Peer reviewers provided their own initial analysis of key issues. Following that the review team met to undertake a thorough analysis, driving its consideration through key issues to root causes using those techniques developed from the RCA elements drawn up by the NPSA. The conclusion of that process was to determine the extent to which systems or processes might be put in place to prevent further occurrences and the nature of those systems or processes. The results of that stage are set out in this report as findings and recommendation.

Annex E

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- Making a significant contribution to improving the safety and quality of healthcare services in Wales.
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative and employee.
- Strengthening the voice of patients and the public in the way health services are reviewed.
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Assembly Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003.
- Care Standards Act 2000 and associated regulations.
- Mental Health Act 1983 and the Mental Health Act 2007.
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001.
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Annex F

Glossary

Approved Mental Health Professional (AMHP) – Is a professional such as a Social Worker, Mental Health Nurse, Occupational Therapist or Psychologist who has completed additional comprehensive and specialist training in order to be approved by the Local Authority and to fulfil designated functions under the Mental Health Act. Their functions can include helping to assess whether a person needs to be compulsorily detained as part of their treatment (sectioned).

Care Co-ordinator – Is the individual responsible for ensuring a care and treatment plan is developed and delivered and where necessary reviewed and revised. They are also responsible for co-ordinating the care which is delivered (both by themselves and others) and for keeping in touch with the service user.

Care Programme Approach (CPA) – A system of delivering community services to those with mental illness. The approach requires that health and social services assess need, provide a written care plan, allocate a care co-ordinator and regularly review the plan with stakeholders. There are two categories of CPA: *'Standard'* and *'Enhanced'* and these have been described in the Policy Guidance issued in 2003 (Welsh Assembly Government (2003) The Care Programme Approach for Mental Health Service Users – Mental Health Policy Guidance. Cardiff. NHS Wales).

Community Mental Health Teams (CMHTs) – Are at the heart of secondary care services. CMHTs receive referrals, mainly from primary care; undertake screening assessments and where allocation within the team is appropriate a range of more specialist assessments and interventions.

Community Psychiatric Nurse (CPN) – A psychiatric nurse based in the community rather than a hospital.

Crisis Resolution Home Treatment (CRHT) – A service for adults (aged 18 to 65) experiencing an acute mental health crisis which is available 24 hours a day, seven days a week. This includes a rapid response following referral, intensive intervention and support in the early stages of the crisis and continuity throughout its management.

Diagnosis – Identifying a medical condition by its pattern of symptoms (and sometimes also its cause and course).

General Practitioner (GP) – A family doctor.

Index Offence – The offence which the patient has been convicted of and which has lead to its current detention.

Local Health Boards (LHB) – Statutory bodies who were responsible for implementing strategies to improve the health of the local population, securing and providing primary & community health care services and securing secondary care services.

Mental Illness – These are psychological disorders usually classified under internationally recognised systems of classification such as DSM-IV and ICD and contain a range of diagnoses including psychoses, brain disorders and emotional or behavioural problems serious enough to require psychiatric intervention.

Mental Health Act 1983 – The Act which provides the legal framework within which Mental Health Services maybe provided without the consent of the patient.

National Health Service (NHS) Trust – A self-governing body within the NHS, which provided health care services. Trusts employed a full range of healthcare professionals including doctors, nurses, dieticians, physiotherapists etc.

National Service Framework – National standards of care published for a variety of conditions which are designed to improve the quality of care and reduce variations in standards of care.

Primary Care – The first point of contact with health services. In the UK this is family health services provided by GPs, dentists, pharmacists, opticians and others such as community nurses, physiotherapists and some social workers.

Psychiatrist – A physician who specialises in psychiatry.

Psychosis (psychotic illness) – Severe mental derangement involving the whole personality. These are severe mental disorders characterised by psychotic symptoms e.g. delusions, hallucinations and disorganised thinking. These disorders, historically and in common parlance, have been referred to as *'madness'*. They are often divided into Functional Psychoses (mainly schizophrenia and manic depressive psychosis (or Bipolar affective disorder)) and Organic Psychoses (confusional states or delirium, dementias, drug induced psychosis).

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

Schizophrenia – A chronic mental health condition that causes a range of psychological symptoms including delusions – believing in things that are untrue, and hallucinations – hearing or seeing things that do not exist. Hallucinations and delusions are often referred to as psychotic symptoms, or symptoms of psychosis.

Social Services – A term generally used to refer to local authority, social services departments. These are responsible for non-medical welfare care of adults and families in need. Among other services it provides needs assessments for people and provides services under community care for adults, children and families.

Social Worker – A person professionally qualified and registered to deliver social work to individuals and their families in a variety of settings. Many social workers work for social services within local unitary authorities. Social workers promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Therapeutic Range – The range of doses of a drug that will produce beneficial results without side effects.

Welsh Health Authorities – Predecessor organisations of Local Health Boards and NHS Trusts which were responsible for the delivery of healthcare in Wales prior to 1 April 2003.