Independent External Review into a Homicide at Prestatyn, Wales on 25th March 2003

Commissioned by Cardiff Local Health Board

Report Dated:

November 2004

ECRI
Weltech Centre
Ridgeway
Welwyn Garden City
Hertfordshire
AL7 2AA

EXECUTIVE SUMMARY

Introduction

ECRI, an independent health service research organisation and Collaborating Centre of the World Health Organisation, was appointed by the Cardiff Local Health Board on 27th January 2004 to investigate, report and make recommendations, where necessary, in respect of the care plan and the events leading up to a homicide incident in March 2003. The members of the Root Cause Analysis (RCA) Investigative Team were independent of the organisations affected by this incident.

The investigative Root Cause Analysis process was progressed in accordance with national and international best practice guidelines in this area.

Background

On 25th March 2003, PK, a Cardiff resident, killed BD, a retired accountant, by inflicting multiple fatal knife injuries on him at Frith Beach Festival Gardens, Prestatyn. He was initially readmitted on 30 March 2003 under Section 2 of the Mental Health Act, formally recalled by the Home Office on 31 March 2003 under Section 42(3) and redetained as a Section 37/41 patient. At his criminal trial in Chester Crown Court PK pleaded guilty to manslaughter on the grounds of diminished responsibility and was subsequently transferred to Ashworth Hospital, Liverpool.

At the time of the offence PK was under the care of the Community Forensic Psychiatric Team at Whitchurch Hospital, Cardiff and was living in independent accommodation. PK has a history of contact with mental health services since 1983. At the age of 26 he was diagnosed with paranoid schizophrenia.

The investigative team has reviewed evidence from a number of individuals and has read substantial documentation from all the relevant agencies involved.

All of those interviewed who have provided information have had the opportunity to amend and approve the information they have forwarded or described. In addition, all the agencies involved have replied to all questions put to them and have readily supplied all documentation requested.

Key Issues and Recommendations

A number of key operational and policy issues, have been identified from the review undertaken. In the main document the RCA team has made specific comments which help put the issues into context.

In order to improve public and patient safety in future, the investigative team makes recommendations for action and where appropriate has distinguished between action at a local level and broader lessons for the service. These are outlined below: -

Operational Issues Identified

1. Failure to meet specified conditions of discharge and Supervised Aftercare

RECOMMENDATIONS:

In terms of Supervision and Placement the RCA team recommends the following actions:-

Local level

a) That Bro Morgannwg NHS Trust and Cardiff and Vale NHS Trust give careful consideration to whether patients conditionally discharged into the community can be adequately managed in full-time independent living or whether they should remain in supervised hostel accommodation.

This is particularly the case where the required relapse indicators and missing person rules may be practically difficult to apply in the situation of fully independent living. Where patients are suitable for transfer to independent living, both Trusts should give careful consideration to determining how long these should remain in supervised settings before transfer and what continued day care facilities may be required as part of their aftercare.

b) That Health Commission Wales reviews its requirement in terms of medium secure provision and identifies bed shortages that exist.

Broader Learning

c) That Social Services Departments ensure adequate and appropriately staffed 24 hour supervised hostel accommodation is made available.

d) That NHS Trusts always formally bring difficulties in obtaining appropriate aftercare facilities to the attention of their commissioning authorities.

e) That where 24 hour supervised care is specified in the conditions of discharge and cannot be met, the matter should be brought to the attention of Local Health Boards/Health Commission Wales to ensure this requirement is properly applied.

f) That where patients need to be discharged into 24 hour supervised hostel accommodation, the length of time in supervised care is specified by Mental Health Review Tribunals (MHRTs) in the conditions of discharge and the discharge plan in advance.

g) That Local Health Boards and Health Commission monitor compliance with the conditions specified for discharge.

2. Failure to monitor Substance Misuse as a condition of discharge.

RECOMMENDATIONS:

The RCA team makes the following recommendations for consideration:-

Local Level

a) That Bro Morgannwg NHS Trust should ensure that protocols exist for screening to continue to occur once patients are transferred to the care of other Trusts.

The RCA Team understand that staff at Caswell Clinic have now introduced randomised drug screening when supervising patients in the community.

Broader Learning

b) That all patients discharged from secure care with a history of alcohol or drug abuse/misuse should be routinely, regularly and randomly tested for illicit drugs and alcohol use.

This could be applied with urine testing, hair testing and breathalysing. It should be considered and specified in the care plan.

There should be a low threshold for tolerance of substance mis-use in the community, where it has any impact on the risk of dangerousness and a clear management plan where substance misuse occurs, should be specified in the care plan.

That the care plans of patients who currently fall into this category should be reviewed by all NHS Trusts with this advice in mind.

3. Failure to inform the Home Office of the admission to Whitchurch Hospital on 19 April 2002.

RECOMMENDATIONS

The RCA Team makes the following recommendations:-

Local Level

a) That Bro Morgannwg NHS Trust, Cardiff and Vale NHS Trust, Cardiff and Bridgend Social Services Departments review their policies and procedures for both medical and social supervisors to ensure clarity and compliance with statutory reporting requirements.

Broader Learning

b) That all NHS Trusts and Social Services Departments ensure that a clear action plan for any problems occurring during the period of supervised care should be specified in advance and that all staff are fully conversant with it.

4. Failure to ensure medication compliance whilst in hospital.

RECOMMENDATION:

The RCA Team makes the following recommendation:-

Local Level

a) That Cardiff and Vale NHS Trust ensures there are robust mechanisms in place to monitor the compliance of conditionally discharged patients in taking oral medication.

5. Appropriate Crisis Management by the Community Mental Health Team, Cardiff & Vale NHS Trust on the 24 March 2003.

The RCA team felt that the Community Mental Health Team acted appropriately and therefore no action or recommendations are made in respect of the crisis management.

6. Failure to apply the agreed 12-hour missing rule as required by the Care Plan by the Community Mental Health Team (CMHT).

RECOMMENDATION

The RCA Team makes the following recommendations:-

Local Level

a) That Cardiff and Vale NHS Trust and Cardiff Social Services Department ensure that clear care and social services plans exist for all patients currently conditionally discharged and under supervision. In addition, all staff should be familiar with the contents and conditions identified within the clinical notes prior to communicating or taking any action relating to patients or relatives making contact to discuss clinical problems.

7. Lack of specific and measurable relapse indicators.

RECOMMENDATIONS

The RCA Team recommends that that the utilisation of the list of relapse indicators in terms of clinical management needs to be more clearly specified to avoid ambiguity. To achieve this the investigative team recommends:-

Local Level

a) That guidelines are produced by Bro Morgannwg and Cardiff and Vale NHS Trusts, detailing the way in which individual relapse indicators are translated into clinical actions. This will reduce the potential for human error. The RCA team considers it would be good practice when listing the relapse indicators to indicate the strength which each indicator should be considered as sign of relapse and to specify the action to be taken.

It is recognised that clinical judgement must be allowed to vary the action at the discretion of the practitioner.

b) That both of the aforementioned Trusts should review all relapse indicators presently in use with high-risk patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.

Policy Issues Identified

This RCA Team noted a number of wider Mental Health Act and policy issues for consideration nationally. These are commented on below.

5.0 Role of the Mental Health Review Tribunal (MHRT):

RECOMMENDATIONS

The RCA Team makes the following recommendations:-

a) That MHRTs (prior to Legislative amendment of any legislation) ensure that whenever they are made aware that problems associated with the conditions of a patient's discharge may arise, or have already arisen, these are addressed without delay.

b) That Health Authorities/Local Health Boards (prior to the amendment of any legislation) undertake an independent monitoring role to ensure compliance with the imposed conditions of discharge and ensure that a duty of care is being met to the patient themselves and the public.

9. Role of the Home Office:

RECOMMENDATIONS

The RCA team identified that the Home Office has a substantial role to play in management processes and emphasise the following:

a) Medical Supervisors have a statutory responsibility (Mental Health Act, Section 41 (6)) to comply with Home Office Mental Health Unit reporting requirements. Reports submitted should be comprehensive, timely and identify any issues of concern.

b) That supervising psychiatrists and social supervisors should fully cooperate with the Mental Health Unit of the Home Office in order to ensure that any risks are minimised as far as possible. The Home Secretary can only discharge his responsibilities properly if he has high quality and promptly delivered information to act upon.

c) That the Home Office Mental Health Unit should require all NHS Trusts to review relapse indicators presently in use with conditionally discharged patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.

CONCLUSION

The RCA Team identified a number of systems failures relating to the lead up to the homicide committed on 25 March 2003. The Team concluded that the event was difficult to predict because of the lack of specific and measurable relapse indicators. The 12-hour missing rule was an important part of PK's risk management plan. Although, the offence had already been committed, the failure to implement the 12-hour rule resulted in a situation where PK was effectively out of the area without the instruction to recall him being considered or put in place.

ACTION PLANNING

As part of the process all stakeholder organisations have been asked to confirm the accuracy of the chronology of events. Feedback received as of publication indicates an understanding of the issues and a willingness to learn and avoid reoccurrence of such tragic events.

The provision of mental health services to patients is a multiagency activity involving Mental Health Trusts, Local Authorities and government departments. The findings contained within this report require a multiagency response and in this regards it is anticipated that all relevant organisations and agencies will respond and work together to address the issues identified upon publication of this report.

It is hoped that this report further strengthens the action planning process in order to reduce the likelihood of re-occurrence of such an incident as far as possible. Each organisation has been asked produced detailed. Each organisation has been asked to produce detailed action plans to address the issues and recommendations in the report.

Acknowledgements

ECRI wishes to extend its deepest sympathy to those touched by this tragic event that initiated this review.

ECRI would also like to express its thanks to Cardiff Local Health Board, for their assistance and contribution during this process.

Finally, ECRI would also like to take the opportunity to thank all those who participated in and contributed to the review. Their input is appreciated and the contribution made will, we hope, result in lessons being learned.

Contents

1.0 Root Cause Analysis in Healthcare 14

2.0 Background 16

3.0 Tabulated Chronology of Events 20

4.0 Key Findings, Root Causes and Recommendations for Improving Safety 37

5.0 Action Planning 52

Appendix A – Root Cause Analysis and Patient Safety

Appendix B – Sources of Information Clinical

Appendix C - Person Contact List and Anonymisation Key

Appendix D – Example of Graded Relapse Indicators with Clinical Actions

Appendix E – The Role of the Home Office

Appendix F - NPSA Classification of Contributory Factors

1.0 Root Cause Analysis in Healthcare

This section of the report describes the background to the investigative methodology employed by the external investigators.

1.1 A crucial element of any patient safety incident is the ability to learn from the event and enhance the ability to deliver a safe and effective service to patients. Root cause analysis (RCA), is a retrospective systematic process of analysis of a patient safety incident. Its purpose is to identify what, how, and why a particular event occurred. The output from such an analysis is then used to identify those areas that require change and provide for recommendations and sustainable solutions, in order to minimise the chance of re-occurrence of the incident. The RCA process consists of six main activities:

- data gathering
- information mapping
- identifying problems
- analysing problems for contributory factors
- agreeing the root causes
- recommendations and reporting

1.2 The Government's Chief Medical Officer's report in England *"An Organisation with a Memory"* (2000) presents the results of findings by an expert group reviewing adverse incident management and the options for learning from such events. This and a subsequent publication entitled *'Building a Safer NHS for Patients'* (2000) identified significant opportunities and benefits that exist to reduce unintended harm to patients in NHS care. A further English Department of Health publication *'Doing Less Harm'* (2001) outlined the infrastructure and key requirements for NHS organisations to manage, learn and administer adverse incidents.

1.3 Root Cause Analysis (RCA) has been adopted by the Welsh Assembly Government and National Patient Safety Agency as the preferred method of investigation and development of new safety procedures to reduce adverse incidents within the NHS.

1.4 RCA is conducted in a systematic manner according to guidelines adopted at both national and international levels.

Further information on Root Cause Analysis and Patient Safety is attached in Appendix A.

2.0 Background

PK – (Date of Birth 3rd March 1969)

On 25th March 2003 PK, a Cardiff resident, killed Brian Dodd, a retired accountant, by inflicting multiple fatal knife injuries on him at Frith Beach Festival Gardens, Prestatyn. Following this attack, PK stole a car from outside a newsagent in Ormeskirk, Lancashire after threatening the owner. He was arrested by police on the 28th March and was found to have two offensive weapons in his possession. Eyewitness accounts, CCTV footage and DNA evidence all linked PK with the attack.

He was recalled by the Home Office on 31st March 2003 and detained under Section 2 of the Mental Health Act.

At his criminal trial in Chester Crown Court PK pleaded guilty to manslaughter on the grounds of diminished responsibility and was subsequently transferred to Ashworth Hospital, Liverpool.

Mr Dodd and PK were not known to each other. Mr Dodd was 72 years old at time of his death.

PK has a history of contact with mental health services since 1983. At the age of 26 he was diagnosed with paranoid schizophrenia.

PK has an extensive past history of criminal behaviour, which at one time resulted in a custodial sentence in Dartmoor Prison. In 1996 he committed an unprovoked violent assault with a knife resulting in detention at Ashworth Maximum Security Psychiatric Hospital, Liverpool. In retrospect, the violent assault and his past criminal behaviour appeared to be directly related to florid psychotic symptoms. He was treated and transferred to the Caswell Clinic, a Medium Secure Unit, Bridgend in 1999.

At the time of the offence PK was under the care of the Community Forensic Psychiatric Team at Whitchurch Hospital, Cardiff, part of the Cardiff and Vale NHS Trust. He was living in independent accommodation.

Terms of Reference for the Independent External Review

On 25 October 2003 Cardiff Local Health Board was requested by the Director of Health and Social Care Department, Welsh Assembly Government, to commission an independent external review into the care management arrangements for PK and the events leading up to the Homicide. Following a tendering process, in January 2004, Cardiff Local Health Board commissioned ECRI, an independent health research organisation and Collaborating Centre of the World Health Organisation to undertake the review. The terms of reference were specified as: -

"To undertake a Root Cause Analysis…

- to consider the care provided to PK as far back as is necessary to learn from the events of 2003

- to review the decision-making processes in PK's care management, including:-

    - PK's detention at Ashworth High Security Hospital in 1996
    - transfer from Ashworth Hospital under the care of Caswell Clinic
    - conditional discharge from Caswell Clinic to community services provided by Cardiff and Vale NHS Trust
    - community care management arrangements thereafter up to the homicide incident in March 2003

- to identify any significant events/triggers that could have led to changes in behaviour and identify assessment of risk and action taken leading up to the incident in March 2003
- to take into consideration the care provided and events prior to PK's detention in 1996, to identify any significant factors

- to review and benchmark operational practices and protocols relating to the care management and monitoring of PK, that were in place throughout his care and that of current practices, against other providers of similar services

- to produce a comprehensive report, detailing the key findings and recommendations. (Subject to appropriate consents – it is expected that a report will be placed in the public domain)

- to work with organisations involved in developing an action plan to ensure that lessons are learnt from this case."

Investigative Team

The members of the Root Cause Analysis Investigative Team were independent of the organisations affected by this incident. The investigative team comprised of:

- RCA Investigative Administrator
- Chief Nurse (former member of the Mental Health Act Commissioner)
- Two Consultant General Adult Psychiatrist
- Consultant Forensic Psychiatrist
- Senior Psychiatric Social Worker
- Lay representative and Investigative Co-ordinator

The investigative team has reviewed evidence from individuals involved with the care of PK and has read substantial documentation from all the

relevant agencies involved. The full details of the documentation reviewed are itemised in Appendix 4 of the report.

All of those interviewed who provided information have had the opportunity to amend and approve the information they have forwarded or described. In addition, all the agencies involved have replied to all questions put to them and have readily supplied all documentation requested.

In practice with recognised Root Cause Analysis process, and in order to encourage an uninhibited contribution by all those involved, individuals are not identified by name.

3.0 Tabulated Chronology of Events

This section of the report provides a chronological review of the significant events entered within the clinical documentation reviewed in relation to the care of PK. A person contact list and anonomysed key is attached in Appendix C.

Date Of Event	Event & Symptoms	Source and Date of Source
1983	A psychiatric report indicated that PK first came into contact with the child and adolescent psychiatrist because of his 'anti-authoritarian attitude'.	Psychiatric report by CP3 – 24 July 2003
1983	A psychiatric report indicated that PK moved to Pencae School for children with behavioural problems.	Psychiatric report by CP7 – 9 Sept 2003
Pre 1993	A social work report indicated that PK claimed to have used steroids both orally and intramuscularly for bodybuilding following his rejection from the Army for physical problems. He also admitted to using illicit drugs including cannabis, amphetamine and occasional LSD.	Social Work Report by SW4 - 8 April 1999
18 Aug 1993	A psychiatric report indicated that PK was convicted of Driving without insurance, dangerous driving and aggravated vehicle taking.	Psychiatric report dated – 1 Oct 2003
11 Nov 1993	A psychiatric report indicated that PK was convicted of failing to surrender to bail.	Psychiatric report dated – 1 Oct 2003
17 June 1994	A psychiatric report indicated that PK was convicted of carrying a shortened shotgun, driving whilst disqualified, going equipped for theft, no insurance, failing to surrender to bail, taking a conveyance without authority, theft and possessing an offensive weapon. He was sentenced to 10 months imprisonment, but was released early.	Psychiatric report dated – 1 Oct 2003
26 Oct 1994	A psychiatric report indicated that PK was convicted of aggravated vehicle taking, driving whilst disqualified, making off without paying, going equipped for that and possessing an offensive weapon in a public place. He was sentenced to 18 months imprisonment at HMP Dartmoor.	Psychiatric report dated – 1 Oct 2003
1994	A social work report when PK was admitted indicated that during 1994 he felt extremely paranoid and that he routinely assured that he had access to an offensive/lethal weapon to intimidate those who may wish to attack him.	Social Work report by SW4 8 April 1999
1995	A social work report indicated that towards the end of his sentence mental illness appeared to develop. PK disclosed that he had been hearing voices for some 3 months prior to reporting them.	Social Work report by SW4 8 April 1999
23 Oct 1995	A psychiatric report indicated that PK was released from Dartmoor and moved back with his parents.	Psychiatric report dated – 1 Oct 2003
Oct 1995	A social work report indicated that PK's mother reported that she recalled him acting in increasingly bizarre ways including being paranoid that he was being followed and that "they" were photographing him.	Social Work report by SW4 8 April1999

Date Of Event	Event & Symptoms	Source and Date of Source
December 1995	A psychiatric report indicated that PK smashed the window of his neighbour's car with a Gurka knife. He later admitted that he had started carrying a Gurka knife because he believed that the people following him also had weapons and that he smashed his neighbour's car because he heard him meowing like a cat.	Psychiatric report dated – 1 Oct 2003
5 January 1996	A discharge report indicated that PK's first psychiatric admission to Whitchurch Hospital was voluntary following referral from his GP. The impression was "*a 26 year old man with poor impulse control leading to a forensic record, who presented with a history of auditory hallucinations but in whom there was no objective evidence of serious mental illness. There may be evidence of a post-traumatic stress reaction but this would be better managed as an outpatient."* He was discharged on 8 Jan 96.	Discharge summary 10 Jan 1996 by SHO to CP1
25 Jan 1996	CP2's letter indicated that on assessment, PK reported a 4-month history of depression following his release from Dartmoor prison. He was seen with a friend of 16 years standing who confirmed she had never seen him like this. Mental State examination revealed moderate depression and retardation. He was not hearing voices at this time and his previous auditory hallucinations were considered typical of depression. He admitted to paranoid feelings but there was no evidence of delusions. He was prescribed Cipramil 20mg daily.	Letter to GP1 from CP2 - 25 Jan 1996
10 Feb 1996	Inpatient psychiatric notes indicated that following referral from his GP for violent urges, PK was readmitted to hospital. He experienced urges to attack people and described auditory hallucinations. The GP had started him on Zuclopethixol 10mg bd, Cipramil 20mg od and Diazepam 5mg tds.	Inpatient psychiatric notes - 10 Feb 1996
11 Feb 1996	Inpatient psychiatric notes indicated that PK was refusing medication and denied any psychotic phenomenon. Later that day self-discharged against medical advice.	Inpatient psychiatric notes - 11 Feb 1996
12 Feb 1996	Inpatient psychiatric notes indicated that the GP phoned the ward saying PK requested readmission. PK was expressing intrusive thoughts telling him to harm people. He was spoken to on the phone when he said "satellite TV owes me money" and "I want to kill my mother and father, my mother puts things in my food". Following discussion with the Specialist Registrar on call it was felt that the picture was more of personality disorder with no mental illness. He was to be followed up in Outpatients.	Inpatient psychiatric notes - 12 Feb 1996
13 Feb 1996	A psychiatric report indicated that whilst in a public library PK grabbed a stranger by the throat and slashed the victims face with a cut-throat razor, leading to a 12cm laceration. He was remanded to HMP Cardiff where he spoke of believing he was being followed by MI5, voices telling him to stab people, Martians following him, thoughts being put into his mind via satellite, and headaches due to the microwave. He also said that Martians had given him the razor and that he felt it had been a cry for help because people were ignoring his complaints.	Psychiatric Report by CP7 – 9 Sept 2003

Date Of Event	Event & Symptoms	Source and Date of Source
8 May 1996	A psychiatric report stated: *"PK suffers from mental illness within the meaning of The Mental Health Act 1983, namely paranoid schizophrenia, which is characterised mainly by paranoid delusions, auditory hallucinations and thought insertion. The illness is of a nature and degree that requires treatment in a hospital setting.* *I do not think that PK can be safely treated in conditions of medium security. I therefore recommend his admission to Ashworth Hospital under section 48/49 of the Mental Health Act for urgent treatment.*	Psychiatric report - 8 May 1996
6 June 1996	A Court letter indicated that PK was transferred to Ashworth Maximum Security Hospital in Liverpool under section 48/49 of the Mental Health Act 1983.	Letter to CP4 from Officer of the Crown Court 6 June 1996
24 July 1996	A psychiatric report indicated that PK was convicted of wounding with intent and having an offensive weapon.	Psychiatric Report by CP7 – 9 Sept 2003
1 Oct 1996	A admission summary indicated the medication administered was Clopixol 100mg fortnightly, Droperidol 30 mg at night.	Admission summary by SGP1 1 Oct 1996
3 Oct 1996	A report of the multidisciplinary case conference, concluded: 1. The circumstances surrounding the index offence are directly related to PK's mental illness, namely paranoid schizophrenia. 2. Nature of behaviour in relation to the offences, which put others in danger, is most probably motivated by his mental illness. 3. PK did not suffer from mental handicap or psychopathic disorder. However further investigations were required to ascertain that he did not suffer from an underlying personality disorder. 4. Nature of offence, previous convictions of possessing a dangerous weapon and his attempt to abscond whist on remand indicate the level of dangerousness and the need for further detention in conditions of maximum security.	Report by CP4 – 16 Oct 1996
3 Sept 1997	A psychiatric report indicated that a urine sample taken whilst a patient at Ashworth revealed traces of cannabis.	Psychiatric Report by CP7 – 9 Sept 2003
10 Nov 1997	A nursing referral assessment form indicated inconsistency in medical care: PK had 3 RMO's between his admission and the date of the report. It was noted that this raised some concern as to the understanding of his mental health needs. Therefore a transfer to a medium secure unit to be delayed.	South Wales Forensic Psychiatric Service Nursing referral assessment form – 10 Nov 1997
17 Nov 1997	A report by CP6 indicated that PK maintained improvement over the previous 6 months, he was cooperative and no management problem. Some negative symptoms evident, but no evidence of positive psychotic symptoms. PK had gained good insight. Medication – Clopixol 400mg im every 3 weeks.	Annual report to the Home Office by CP6 – 17 Nov 1997
28 April 1998	A progress summary identified no current or recent symptoms of psychosis. Negative symptoms improved. Depot medication changed in January to Flupenthixol. No aggressive behaviour since admission to Ashworth. He attended a drug and alcohol awareness group with favourable reports. PK's presentation did not warrant his being detained in a special hospital.	Progress summary and risk assessment SGP1 – 28 April 1998

Date Of Event	Event & Symptoms	Source and Date of Source
16 Feb 1999	A hospital case summary indicated that-PK had transferred formally to Caswell Clinic – medium secure unit, initially on 6 months trial leave.	Ashworth Hospital Case Summary - 16 Feb 1999
12 April 1999	A case conference noted that CP3 had expressed an opinion that PK did not require conditions of a medium secure unit and felt that Whitchurch hospital should take over his care sooner rather than later. It was agreed however that PK required the assertive supervision and support that a Forensic Service could provide, but at low security level.	Caswell Clinic Case Conference 12 April 1999
10 Sept 1999	A Home Office email indicated that it had received an application for escorted leave. This letter was missing from the clinical notes.	Home Office Email 25 May 2004
5 Nov 1999	Home Office granted 12 escorted leaves. This letter was missing from the clinical notes.	Home Office Email 25 May 2004
23 Dec 1999	A nursing report indicated that during periods of leave PK was relaxed and appropriate. He showed no raised anxiety levels and his mental state appeared settled throughout. PK showed no violent or aggressive behaviour towards his escorts or public and was patient and appropriate. He posed no risk of absconding during the periods of leave and made no attempt to enter the area where his index offence occurred.	Nursing report on Escorted Community Paroles – 23 Dec 1999
14 Feb 2000	A letter authorised PK to be granted escorted day leave at the RMO's discretion, plus 6 accessional unescorted day leaves to the local area only to report back after 4pm	Letter to CP3 from the Home Office –14 Feb 2000
2 March 2000	A letter referred to local unescorted community paroles and– gave no cause for concern. Requested that PK be given unescorted community parole at the RMO's discretion to allow further progress in his rehabilitation.	Letter to Home Office Mental health Unit from CP3 – 2 March 2000
9 March 2000	A medical report stated: *"Since admission to the rehabilitation ward in the Caswell clinic his mental state has remained stable. He has occasionally smoked cannabis. This did not affect his mental state. He was co-operative in all respects. Administered his own oral medication. Mental State examination was normal with good insight. Medication Depixol 80 mgs every 3 weeks. Procyclidine 10 mgs daily. His acquisition and carriage of weapons was associated his mental illness. He suffers from Paranoid Schizophrenia. He has responded well to treatment and is compliant. Risk of violence is directly related to his mental state. Provided he takes regular medication there is less likelihood of relapse. PK and the clinical team feel that adequate markers of early relapse have been identified and with suitable monitoring any sign of early relapse should be appropriately addressed to prevent a relapse. Consumption of illicit substances will increase the risk of relapse. It is essential that when he is discharged into the community that his mental health is monitored closely. This would best involve continued support from Caswell Clinic with a gradual handover to local services. He should remain on a Section 41 Restriction Order thus allowing early recall should his mental health deteriorate in the community. He no longer requires detention in hospital. He should be discharged from the hospital order once the Tribunal is satisfied that the appropriate care package is in place."*	Medical report to MHRT by SPR1 –9 March 2000

Date Of Event	Event & Symptoms	Source and Date of Source
3 April 2000	The Home Office emailed a statement opposing discharge – *"The Home Secretary is pleased to note the progress PK has made. However discharge at the present time would be premature. PK has only just started a limited amount of unescorted leave to the local area and the Home Secretary would like to see testing on increasing periods of unescorted and overnight leave successfully completed before agreeing a discharge plan."*	Home Office Email – 27 Aug 2004
13 April 2000	A nursing report indicated that PK's mental state had been stable since admission to Caswell and he was compliant with medication of Depixol im 80mg 3 weekly. He showed good insight into his mental illness and had indicated symptoms of relapse. Recommended placement in a hostel environment with minimal supervised care.	Mental Health Review Tribunal Nursing Report – 13 April 2000
12 April 2000	The MRHT report indicated a History of alcohol and substance misuse and notes no history of use of drug or alcohol that is above the average of a man of his age. PK's previous substance misuse was recreational which became self-medication for an untreated mental illness. Since admission to Ashworth and the Caswell Clinic He continued to use cannabis on 3 occasions with no evidence of deterioration in mental health. The report states: *"Whilst there are no guarantees that PK will not use drugs again the monitoring via random urine testing and observation of his mental health will provide the safeguard required to allow community living."*	Report for MHRT –12 April 2000
13 April 2000	The Mental Health Review Tribunal stated "The patient SHALL be discharged from liability to be detained but the discharge is deferred until satisfactory arrangements have been made to meet the conditions set out below" 1. That the patient shall reside at HHA, Cardiff or similar 24 hour supervised accommodation. 2. That the patient shall accept medical supervision from the RMO CP3, or his successor to include monitoring for illicit substance abuse. 3. That the patient shall accept social supervision from SW4, Social Worker, or his successor.	Mental Health Review Tribunal - 13 April 2000
13 April 2000	A letter indicated that in April 2000 HHA provided 24 hour on site supervision with a manager and 4 full time care staff.	Letter from HHA dated 16 Jul 2004
5 May 2000	A letter from the Home office authorised that PK was to be granted occasional unescorted home leave at the RMO's discretion with a report back within 2 months.	Letter to CP3 from the Home Office – 5 May 2000
7 June 2000	A letter showed that the Home Office was informed that placement hoped for as stated in deferred conditional discharged, had fallen through. It was requested that PK be given occasional overnight leaves to his parents' address in order to allow him to reintegrate into his family before his discharge to an appropriate hostel.	Letter to Home Office from CP3- 7 June 2000
5 July 2000	A letter from the Home Office authorised PK to be granted 12 overnight leaves (not to be taken consecutively) to his parent's home.	Letter to CP3 from the Home Office – 5 July 2000

Date Of Event	Event & Symptoms	Source and Date of Source
5 July 2000	A letter to SW4 confirmed that UWHA were able to offer PK a residential place from 24 July 2000. The 24 hour on call service was to be provided from The Caswell Clinic and UWHA. The Clinical Team were of the view that this level of supervision was similar, but not the same, as that provided at HHA and that it met the need described in the multidisciplinary reports to the MHRT.	Letter to SW4 from UWHA – 5 July 2000 and Email from Chief Executive 25 Aug 2004
5 July 2000	A letter confirmed that UWHA was a 4 bed shared house. On site supervision was present between 6.00 am and 8.00 pm with an on call system out of hours.	Letter UWHA - dated 21 July 2004
24 July 2000	The care plan indicated the following: **Relapse Indicators Identified**: **Physical:** *Early:* Tense, anxious, and unable to relax. Describes a feeling that "things are not right, I'm not normal". *Middle:* Tense, anxious, parents describe eyes appear big. *Full:* Reduced appetite, believes food is being drugged, vomits every morning. **Psychological:** *Early:* Depression and paranoia, feeling of being followed or watched. *Middle:* Paranoia, auditory hallucinations. *Full:* Feels everyone is involved in a conspiracy, paranoid delusions, visual and auditory hallucinations. **Social/behavioural:** *Early:* Limits social contact. *Middle:* May contact family member for support, insomnia. *Full:* Previously carried weapons, stays up all night, checks the house. **Risk formulation**: Risk of violence to others in the context of paranoid delusional beliefs and auditory hallucinations when floridly psychotic. Previous history of illicit drug use, including steroids. Should he recommence use it may cause deterioration in his mental health. **Conditions of discharge**: Comply with the aftercare plans, submit to medical and social supervision, live where directed by care teams. **Actions to be taken if patient fails to attend for treatment**: Obtain information on last whereabouts from Hostel Staff – contact family. Unexplained absence – missing person after 12 hours: care team and police to be notified. **Accommodation**: 24-hour staffed supported accommodation.	Multidisciplinary care plan/Section 117 Aftercare package, Caswell Clinic notes

Date Of Event	Event & Symptoms	Source and Date of Source
24 July 2000	A letter from CP3 informed the Home Office that a placement at UWHA had become available and requesting that PK be granted overnight leave whilst the MHRT activates the deferred conditional discharge which was likely to take some time. The reason for the request was that a bed at the Caswell Clinic was needed urgently for a floridly mentally ill man who was currently on remand at Cardiff Prison.	Letter to Mental Health Unit, Home Office from CP3- 24 July 2000
25 July 2000	A letter indicated that PK was to be granted 4 weeks consecutive overnight leave to UWHA Projects, with a report back after 2 weeks.	Letter to CP3 from the Home Office – 25 July 2000
1 Aug 2000	A report to the MHRT stated: *"I can advise you that PK is now in a position to satisfy all of the conditions of discharge and would duly seek your approval for discharging PK from hospital. You will note that the address on the enclosed Aftercare plan is…… (UWHA). This is the address of the organisation called UWHA, which operates along the same lines as the previously anticipated accommodation in HHA. I am happy to say that PK has been granted four weeks unescorted community parole by the Home Office, which has facilitated his establishment at his new community address."*	Letter to MHRT Office for Wales from CP3 – 1 Aug 2000
1 Aug 2000	A letter indicated that the minimum acceptable level of supervision was staffing 24 hours a day. The MHRT was led to believe that UWHA was staffed 24 hours a day.	Letter from the MHRT for Wales dated 8 Jul 2004
8 Aug 2000	Confirmation was received, of the MHRT decision on 13 April 2000 to conditionally discharge PK.	Mental Health Review Tribunal decision – 8 Aug 2000
11 Aug 2000	A report showed that PK had received a conditional discharge subject to the following conditions:- That the patient should reside at ----------(UWHA) That the patient should accept medical supervision from the RMO CP3 or his successor to include monitoring for illicit substance abuse. That the patient accepted social supervision from SW4, Social Worker or his successor. PK was subsequently formally discharged from Hospital to reside at UWHA.	Conditional Discharge Report From the Home Office – 11 Aug 2000
11 Aug 2000	A report indicated that during the handover of care to the Forensic Community Team following discharge from Hospital, PK was to be jointly monitored, receiving weekly visits by members of the Caswell Clinic and Forensic Community Mental Health Team. PK's mental health remained stable and he felt settled into UWHA. Spending a lot of time at his mother's, but one or two days a week at the hostel.	Report on meeting with CPN at UWHA. 11 Aug 2000
1 Sept 2000	The notes of a meeting confirmed that at the meeting PK was reported to be looking forward to living independently. Advised to raise the issue of moving into independent accommodation in next review meeting.	Meeting with FCMHN, CMHN2 at UWHA – 1 Sept 2000

Date Of Event	Event & Symptoms	Source and Date of Source
13 Oct 2000	The notes of a meeting confirmed that it was attended by members of the Caswell Clinic Team and Community Forensic Mental Health Team Relapse indicators and risk assessment vigorously reviewed. Change to previous care plan – Accommodation: 24-hour on-call supported accommodation.	Multidisciplinary care plan/section 117 after care plan – 13 Oct 2000
25 Oct 2000	A Home Office email confirmed the request for the Social Supervisor's report.	Home Office Email to ECRI – 17 Aug 2004
Nov 2000	PK completed re-housing application form supported by SW4, Social Supervisor.	Application form for Housing Association – Nov 2000
2 Nov 2000	A letter to PK from Rehousing Unit, Cardiff County Council, acknowledged PK's application for re-housing and requesting further information on the events of his criminal offence.	Letter to PK from Rehousing Unit, Cardiff County Council, 2 Nov 2000
3 Nov 2000	A report to the Home Office from SW4, Social Supervisor stated: "*UWHA should be seen as temporary accommodation fulfilling the task of assisting PK in developing the skills for moving on to permanent accommodation."* The report indicated no signs or symptoms of relapse since starting medication 5 years previous. Therefore the relapse indicators were speculative, based on the family's account of what they experience prior to the index offence. As the care team had never managed PK through a relapse it was concluded that there should be cautious monitoring of his mental state in the early days of his discharge and that relapse may show itself in ways that had not been anticipated. PK had settled well into the community in a supportive environment. PK was spending most of the time with his family who were very supportive. He had formed trusting and open relationships with the care staff at UWHA and was using their support and advice appropriately. Noted that PK had an extremely supportive family, both parents involved with him on a daily basis. The decision to place PK in supported accommodation, rather than at his mother's address – to give PK some independence and to share the responsibility of aftercare. Consideration of risk implicit in all areas of resettlement. There was clear delusional motivation for the index offence and since treatment began neither Ashworth nor Caswell Clinic reported any continued delusional beliefs or any other indication of risk to others.	Report to Home Office from SW4, Social Supervisor – 3 Nov 2000
6 Nov 2000	A Home Office email confirmed receipt of Social Supervisor's Report (SW4) re request on 25 Oct 2000	Home Office Email to ECRI – 17 Aug 2004
15 Nov 2000	A progress report from UWHA confirmed that after 3 months at the hostel PK was reported to be progressing well. The report also stated: "*Initially quiet, PK has now become communicative and interactive with both staff and clients. He has an excellent sense of humour and is easy going and friendly".*	Progress report from UWHA _ 15 Nov 2000

Date Of Event	Event & Symptoms	Source and Date of Source
7 Dec 2000	The letter of referral to the Disability Advisory Resource Team (for information purposes) indicated that PK had requested a series of overnight leaves to his parent's house over the Christmas period. The team were happy to grant this leave. PK had had a similar 4 night period of leave to his parent's house whilst they were on holiday.	Letter to The Home Office from SW4, Social Supervisor – 7 Dec 2000
29 Jan 2001	A Section 117 meeting was jointly attended by Caswell Clinic Team and Community Forensic Psychiatric Team. PK continued on three weekly depot of Depixol 80mg. Mental State stable. He was reported to be coping well with the transition from hospital to community.	Section 117 meeting report by CHMN1, Forensic Community Psychiatric Nurse – 29 Jan 2001
5 Feb 2001	The Home Office email requested the Social Supervisor's progress report addressed to SW4.	Home Office Email to ECRI17 Aug 2004
13 Feb 2001	The Home Office email requested the Social Supervisor's progress report addressed to SW4.	Home Office Email to ECRI– 17 Aug 2004
12 March 2001	The Home Office emailed a reminder for Social Supervisor's progress report addressed to SW4.	Home Office Email to ECRI– 17 Aug 2004
16 March 2001	The out patient review by CP3 noted that PK continued to do very well. Therefore requested that his care be formally handed over to CP1 in the Community Forensic Mental Health Team.	Out patient review by CP3 – 16 March 2001
21 March 2001	The Home Office email requested Medical Supervisor's progress report addressed to CP1.	Home Office Email to ECRI – 17 Aug 2004
4 April 2001	The letter stated: *" I am more than happy that we should take over the management of PK's case here in Cardiff and I will continue to see him in the outpatients department."*	Letter to CP3 from CP1 – 4 April 2001
9 April 2001	The Home Office requested, via email the Social Supervisor's progress report addressed to SW4.	Home Office Email to ECRI – 17 Aug 2004
26 April 2001	The Home Office emailed a reminder to Medical Supervisor (CP1) for Social Supervisor's (SW4) progress report.	Home Office Email to ECRI– 17 Aug 2004
30 April 2001	A report to the Home Secretary confirmed the Section 117 meeting was attended by members of The Caswell Clinic Team and Outpatient Forensic Mental Health Team: PK accepted by Cardiff Move-On and there was every prospect of a council flat in the near future. Care staff at the Hostel felt he was unsettled due to the unruliness of 2 new residents and that the placement was becoming hostile and counterproductive. Therefore it was agreed that it would be in PK's best interest to stay temporarily with his family. Psychiatric care were to be handed over to locally based forensic services at Whitchurch Hospital. Under the supervision of CP1. The aftercare plan stipulated 3 weekly visits from CPN to administer depot medication, and 3 weekly visits from social supervisor. Monthly outpatient visits with CP1.	Report to the Home Secretary from the Social Supervisor -1 June 2001
2 May 2001	A Home Office email confirmed receipt of the Medical Supervisor's (CP1) report as per request on 26 April 2001.	Home Office Email to ECRI – 17 Aug 2004
14 May 2001	A out patient review confirmed that PK remained in remission with no evidence of any delusions or hallucinations and his mood was stable. He remained on Depixol depot every 3 weeks, with prn procyclidine.	Out Patient review by CP1 – 14 May 2001

Date Of Event	Event & Symptoms	Source and Date of Source
25 May 2001	The Home Office requested via email the Social Supervisor's (SW4) progress report, expressing concern over delay in submitting of report addressed to SW4.	Home Office Email to ECRI– 17 Aug 2004
27 May 2001	A note of a social work visit confirmed that PK had moved into his own flat, within walking distance of his parents.	Social Work visit to Cardiff 25/26 June 2003
1 June 2001	The report to the Home Secretary from the Social Supervisor SW4 stated: *"There have been no signs or symptoms of relapse what so ever. PK has shown a remarkable response to fairly routine treatment through depot medication. He has excellent insight into its benefits and his need to continue. Risk assessment: PK and the aftercare team (including family) are well aware that there will always be the potential risk of harm to others should his mental state deteriorate to the point at which he is deluded and/or paranoid. It's probable that PK's previous convictions were also in response to psychotic phenomena. We therefore remain very confident that PK's approach to life is one of a fundamentally decent and law-abiding member of society and that his risk to himself and others results from the paranoid and deluded symptoms arising from untreated psychiatric illness."* Home Office informed of PK's temporary move to his family's house with a view of moving to independent accommodation as soon as possible.	Report to the Home Secretary from the Social Supervisor SW4 – 1 June 2001
1 June 2001	A letter from the MHRT indicated that once the MHRT has confirmed discharged it has no further official function. Any relaxation of the conditions would then be the responsibility of the Home Office.	Letter from the MHRT for Wales dated 8 Jul 2004
5 June 2001	The Home Office emailed confirmation of receipt of Social Supervisors report requested on 25 May 2001.	Home Office Email to ECRI – 17 Aug 2004
26 July 2001	An outpatient review confirmed that PK had continued to be reviewed on a monthly basis. Mood remained euthymic and no evidence of psychotic symptoms. Good complier with his after care plan. Making good progress at his new address.	Outpatient review by CP1 – 26 July 2001
3 Sept 2001	A letter to SW4 from Home Office Mental Health Unit indicated that in view of PK's change of address his residential condition on the discharge warrant to be amended. The relevant condition to be cancelled and replaced with the new address.	Letter to SW4 from Home Office Mental Health Unit – 3 Sept 2001

Date Of Event	Event & Symptoms	Source and Date of Source
10 Sept 2001	A report for Community case conference indicated that: Social Work Observations: PK had settled well in his flat. He has kept his appointments and complied with treatment. Community Psychiatric Nursing observations: PK had been visited on 3 weekly basis to administer depot and assess mental state. PK had always been welcoming, pleasant and appropriate. There was never any evidence of deterioration in his mental well-being. Occupational Therapist – These had not been involved as PK had been unwilling to be involved in activities. Medical comments: Regular reviews of mental state had been undertaken and shown no symptoms or signs of relapse. PK had attended outpatients and took medication regularly. Father's comments: Everything had been fine, no problems with care offered by the multidisciplinary team. Risk Assessment: A risk of violence to others in the context of psychotic illness was noted, although symptom free. Past use of illicit drugs caused deterioration in mental state. No longer used illicit drugs.	Report for Community case conference - 10 Sept 20
Dec 2001	A Medical report dated 1 Oct 2003 indicated that PK had become romantically involved with PT, whom subsequently would visit him regularly and on occasion stay over night. The Community Forensic Outpatient team were not aware of this relationship.	Medical report dated 1 Oct 2003 and Email from SW2 - 27 Aug 2004
21 Jan 2002	A Section 117 meeting had noted that all members of care team commented on PK's positive progress. The Section 117 meetings were planned every 6 months. No concerns over public safety.	Letter to Home Office from CP1 - 25 March 2002
20 March 2002	The Home Office requested, via email a progress report from Medical Supervisor addressed to CP1.	Home Office Email to ECRI– 17 Aug 2004
23 March 2002	The Home Office requested via email the Social Supervisor's progress report.	Home Office Email to ECRI– 17 Aug 2004
25 March 2002	A letter to the Home Office from CP1 confirmed that PK continued to attend outpatients approximately every 8 weeks. His mood remained stable and he showed no sign of psychotic symptoms. He continued to receive depot medication – Depixol 80mg every 3 weeks. He had a moderate alcohol intake and there was no evidence of illicit substance abuse. He showed no sign of being a danger to himself or others.	Letter to Home Office Mental Health Unit from CP1 – 25 March 2002
26 March 2002	The Home Office received, via email, the Medical Supervisor's report requested on 20 March 2002.	Home Office Email to ECRI – 17 Aug 2004

Date Of Event	Event & Symptoms	Source and Date of Source
19 April 2002	A discharge summary indicated that PK was admitted voluntarily to Whitchurch hospital after attending an assessment with his father. Father described PK's stress levels increasing and was concerned he would become aggressive. His father emphasised that he was behaving in a similar way before his prison sentence. No psychotic symptoms were elicited and he denied using any illicit drugs or drinking alcohol. After 3 days due to continuing agitation his depot was increased to depixol 80mg 2 weekly as well as Olanzapine 5mg daily. On numerous occasions he requested to be discharged but was always persuaded to remain informally. The Olanzapine was subsequently increased to 10mg daily. No evidence of overt psychotic features during his admission.	Discharge summary 19 June 2002
15 May 2002	The inpatient notes indicated that following a period of 8 days leave, when he stayed with close relatives, PK was discharged to outpatient follow up. PK and his family were happy with the decision. The Home Office was not informed of his admission.	Inpatient notes – 15 May 2002
21 May 2002	A letter from CP1 reported the out patient review: Olanzapine 7.5mg bd. Other medication included procyclidine 5mg qds and lorazepam 0.5mg bd prn. PK was making good progress and prodromal stage was subsiding.	Letter to GP from CP1 29 May 2002
23 May 2002	The Home Office, via email requested progress report from Social Supervisor addressed to SW3.	Home Office Email to ECRI – 17 Aug 2004
28 May 2002	The out patient notes stated that PK was much more relaxed with occasional irritability. Prodromal symptoms subsiding. For fortnightly review.	Out patient notes – 28 May 2002
11 Jun 2002	A letter to GP from CP1-12 reported no relapse signs or prodromal features. Olanzapine was altered to 5mg mane and 10mg nocte. He had stopped Lorazepam.	Letter to GP from CP1-12 June 2002
27 June 2002	The Home Office emailed a reminder to Social Supervisor by Home Office relating to a progress report addressed to SW3.	Home Office Email to ECRI – 17 Aug 2004
4 July 2002	The Home Office requested, via email, a progress report from Medical Supervisor addressed to CP1	Home Office Email to ECRI – 17 Aug 2004
9 July 2002	The Home Office received, via email a progress report from Medical Supervisor	Home Office Email to ECRI – 17 Aug 2004
9 July 2002	The out patient notes stated that PK was reasonably well. No evidence of psychosis. However reported being disturbed by noise, especially at night by children and cars in the street. Olanzapine changed to 10mg nocte.	Outpatient notes – 9 July 2002
1 Aug 2003	The Home Office requested, via email, the Social Supervisor's progress report addressed to SW3.	Home Office Email to ECRI– 17 Aug 2004
6 Aug 2002	A letter from CP1 regarding out patient review stated PK was going through a depressive spell with low mood, diurnal variation in mood, poor concentration, broken sleep pattern, lack of energy, a reduction in motivation and negative thoughts. No psychotic features evident. Diagnosed with post psychotic depression and started on Sertraline 50mg daily increasing to 100mg after 1 week. He remained on Olanzapine 10mg daily and depot depixol 80mg fortnightly.	Letter to GP from CP1- 7 Aug 2002

Date Of Event	Event & Symptoms	Source and Date of Source
20 Aug 2002	The out patient review from the locum staff grade stated a marked improvement in mental state over previous 2 weeks. PK was more motivated, brighter, less withdrawn. No evidence of psychotic symptoms, irritability or anger. No concerns reported by father or CPN. Sertlaine 100mg continued.	Letter to GP from Locum staff grade psychiatrist – 21 Aug 2002
29 Aug 2002	The Home Office telephoned the Social Supervisor chasing the progress report.	Home Office Email to ECRI– 17 Aug 2004
17 Sept 2002	The outpatient review by CP1 noted PK's mood had improved considerably, he was more outgoing and less anxious despite still having some residual symptoms.	Letter to GP from CP1 20 Sept 2002
27 Sept 2002	The Home Office requested, via email the Social Supervisor's progress report addressed to SW3.	Home Office Email to ECRI– 17 Aug 2004
17 Oct 2002	The Home Office requested progress report from Medical Supervisor addressed to CP1	Home Office Email to ECRI– 17 Aug 2004
15 Nov 2002	An Email to ECRI stated that the Home Office had sent a letter to the Social Supervisor expressing concern over delay in submitting progress report addressed to SW3.	Home Office Email to ECRI– 17 Aug 2004
12 Nov 2002	A letter indicated that PK appeared to be well. Treatment – Sertraline 100mg daily, Olanzapine 10 mg daily and depixol 80mg every 2 weeks. 2 monthly reviews planned.	Letter to GP from Locum staff grade psychiatrist – 14 Nov 2002
18 Nov 2002	The Home Office emailed reminder to Medical Supervisor for progress report addressed to CP1	Home Office Email to ECRI– 17 Aug 2004
28 Nov 2002	The Home Office received Medical Supervisor's report	Home Office Email to ECRI – 17 Aug 2004
15 Jan 2003	The out patient notes stated that PK was displaying poor motivation and irritability, although mood and sleep were fine.	Outpatient notes – 15 Jan 2003
29 Jan 2003	A Home Office letter to Director of Social Services expressed concern over lack of Social Supervisor's progress report.	Home Office Email to ECRI– 17 Aug 2004
14 Feb 2003	PK received his depot medication by CPN2. PK looked well but was very concerned about the level of trouble caused by the children around the flat. There had been two cars burnt out overnight. Also reported children throwing stones and playing football around the flat.	CPN notes 14 Feb 2003
24 Feb 2003	A further Home Office letter to Director of Social Services expressed concern over lack of Social Supervisor's progress report.	Home Office Email to ECRI– 17 Aug 2004
1 March 2003	Social Supervisors report received by the Home Office	Home Office Email to ECRI – 17 Aug 2004

Date Of Event	Event & Symptoms	Source and Date of Source
1 March 2003	It was reported that CPN2 and SW2 visited regularly (every two weeks). The report also states: *" No signs that PK is a danger to himself or others and no suggestion that his mental health is deteriorating. PK lives near his parents, his flat is always well cared for and he offers a cup of tea to his visitors. PK rarely appears motivated but maintains his flat with the help of his close family. He is always dressed in clean clothing and his personal hygiene appears good".* *"PK owns a very friendly Rottweiler dog with his father. It spends the days with PK and he walks it with his father in the evening. Presence of the dog is probably helpful as it gives him a reason to leave the flat and gives him company."* *"PK's social activity is limited; he rarely leaves the flat and spends most of his time watching cable TV".* *"The flat is in a respectable area, however PK finds it noisy at night complaining of cars speeding, unofficial "car racing" activity and on one occasion a burnt out car near the house. The flat is on the edge of an estate, which has a reputation; therefore his reports are entirely possible. He applied for a transfer to a quieter area, although this is likely to take some time. However he is coping well and is not too distressed by the noise".*	Report to the Home Secretary from SW2, Social Supervisor – 1 March 2003
11 March 2003	A letter to GP from CP1-14 indicated that at an Outpatient review – PK's mental state had improved considerably despite occasional days of lethargy, and difficulty activating himself with poor concentration and being preoccupied. No evidence of exacerbation of his psychotic symptoms for some months, therefore Olanzapine was decreased to 5mg daily.	Letter to GP from CP1-14 March 2003
12 March 2003	The Home Office emailed a request for Medical Supervisor's progress report (later received on 28 Mar 2003) addressed to CP1.	Home Office Email to ECRI– 17 Aug 2004
14 March 2003	A psychiatric report indicated that the last date that PK's girlfriend reported seeing him. She stated that she felt he wasn't himself and that something was not right with him.	Psychiatric report dated – 1 Oct 2003
24 March 2003	A psychiatric report indicated that PK's father reported that he had visited PK on 24th March and had noticed that he had lost his appetite and that he was quiet and distant. These were familiar indications that PK was not well. His father told him to contact his nurse.	Psychiatric report dated – 1 Oct 2003

Date Of Event	Event & Symptoms	Source and Date of Source
24 March 2003	Hand written CPN notes stated CPN2 received a telephone call from PK at approximately 10.30-11.00am. PK informed him that his father had told him off and that he should be visited at home. As CPN2 was in the area he was able to see PK within the hour. PK was alone in his flat and he informed CPN2 that his father had told him off for not eating enough food and that his father and mother thought he was becoming unwell. PK was noted to be a bit quiet, but otherwise there was no cause for concern. PK asked for his medication to be reduced. PK phoned his father and at the request of CPN2 attended the flat. The issues that had raised concerns over PK's health were discussed, in particular PK's father's belief that he wasn't eating enough. CPN2 noted that PK was a big man who would often eat normally in his presence. It was decided that the best course of action would be for PK to attend at Whitchurch Hospital the following day for an appointment with CP1. CPN2 had no concerns relating to PK's mental health. He did not notice any change in his behaviour to what he was like normally on his visits.	Hand written CPN notes 24 March 2003 and statement by CPN2 10 April 2003
24 March 2003	A psychiatric report indicated that after his CPN had left PK went back to his father's house were he slept heavily on the couch, waking at around 5.45pm when he ate a sandwich and then returned home.	Psychiatric report dated – 1 Oct 2003
25 March 2003	Hand written CPN notes indicated that CPN2 had been involved in the running of the outpatient's clinic at Whitchurch Hospital on 25 March 2002. PK was due to attend for his appointment at 3.30pm. At approximately 3.45pm he received a telephone call on his mobile from PK's mother asking whether PK had arrived. She then informed CPN2 that when she had got up that morning she noticed PK was missing together with the family car and his dog. The information was passed to CP1. PK's mother was advised to bring him for assessment should he return unless she felt he was OK and had left due to temper. Then a home visit was to be arranged as soon as possible. Advised it would be up to her to report the car missing or if they were very worried about PK.	Hand written CPN notes 25 March 2003 and statement by CPN2 31 July 2003
25 March 2003	An email from SW2 confirmed CPN2 felt PK's mother was reluctant to inform the police, as she knew that PK did not have a driving licence, despite him having access to a spare set of keys left at his flat. The Forensic Community Team were not aware that PK had access to car keys or that he had been driving.	Ashworth Social Work visit to Cardiff 25/26 June 2003 and Email from SW2 – 27 Aug 2004

Date Of Event	Event & Symptoms	Source and Date of Source
25 March 2003	A psychiatric report indicated : **HOMICIDE OFFENCE:** On the morning of 25 March 2003 (actual time not specified) an elderly gentleman received at least 28 stab wounds to the head, neck and chest whilst walking his dog in Festival Gardens, Prestatyn. The victim died of his injuries. Several eyewitnesses reported seeing a man fitting PK's description walking his Rottweiller dog in Festival Gardens at that time. The Ford Mondeo was also seen in the car park. There was considerable forensic evidence linking PK to the offence.	Psychiatric report dated – 1 Oct 2003
26. March 2003	A report on nursing care and treatment of PK indicated that PK remained absent. The family had had no contact with him.	Report on nursing care and treatment of PK (not dated)
27 March 2003	A report on nursing care and treatment indicated that CPN2 telephoned the family. Again no contact from PK. CPN2 liaised with Clinical Nurse Management.	Report on nursing care and treatment of PK (not dated)
27 March 2003	A psychiatric report indicated that PK stole a car from outside the newsagents in Ormeskirk, Lancashire, after threatening the owner.	Psychiatric report dated – 1 Oct 2003
28 March 2003	Medical Supervisors report received by the Home Office The report on nursing care and treatment indicated that PK was discussed at Community Low Secure Multidisciplinary Team Meeting. Decision was made to inform the Home Office of PK's absence.	Home Office Email to ECRI – 17 Aug 2004 Report on nursing care and treatment of PK (not dated
28 March 2003	A Home Office email to ECRI confirmed telephone call from Medical Supervisor advising that PK has disappeared	Home Office Email to ECRI– 17 Aug 2004
28 March 2003	A psychiatric report indicated Police had arrested PK after the discovery of the stolen car in Gwent. He was found to be in possession of 2 offensive weapons and had a cut on his right hand. He was described by a police constable as "*scruffy, dishevelled with unkempt hair, unshaven and smelling strongly of alcohol"*.	Psychiatric report dated– 1 Oct 2003
28 March 2003 4.30pm	A summary of psychiatric assessment stated that following his arrest PK was initially mute. He was uncooperative and repeatedly belched loudly. He spoke in grunts and then short sentences but appeared calm. PK reported receiving messages from the TV over the last few months but denied any auditory hallucinations saying *"last time I admitted to that I ended up in Ashworth"*. He admitted that things had been unreal and confused over the previous few days. Admission to Whitchurch Hospital under a Section 2 of the Mental Health Act 1983 was arranged.	Summary of psychiatric assessment at Newport Police Station. Signature not legible - 28 March 2003
31 March 2003	An email from the Home Office confirmed a warrant was issued recalling PK to Ashworth Hospital	Home Office Email to ECRI– 17 Aug 2004

Date Of Event	Event & Symptoms	Source and Date of Source
31 March 2003	A psychiatric report indicated that PK reported stopping his oral medication for some time before the offence. He presented as highly aroused, angry, irritable and spontaneously started talking about his psychotic symptoms. He had been experiencing a number of symptoms including auditory hallucinations, passivity experiences, thought broadcast and a number of paranoid delusions and delusions of reference. He also appeared low in mood and had slashed his face with a razor blade on the day before assessment. He was considered high risk requiring a higher level of secure care and medical staff recommended he receive acuphase.	Letter to CP1 from Consultant Forensic Psychiatrist - 31 March 2003
1 April 2003	A psychiatric report indicated that PK was recalled by the Home Office and transferred to Ashworth hospital.	Psychiatric report dated – 1 Oct 2003
25/26 June 2003	An email from SW2 confirmed the outcome of interview with PK's father: *PK seemed well on discharge from Whitchurch in May 2002*. Following his discharge from hospital in May 02 PK became increasingly stressed about the misbehaviour of his neighbours, which his father felt was the main pressure upon him at this time. There was a further problem when PK's application for extra benefit was declined. Following this his benefit was reduced. The Community Forensic Team were not informed of any problems with PK's benefits. He noticed that PK had become more withdrawn, less talkative and that sometimes when PK called to see him during the day, he would fall asleep, which was unlike him. PK denied any problems to his father. However his father advised him to see a doctor and therefore PK contacted his CPN, he was subsequently visited within the hour by his CPN. The CPN arranged for him to see his doctor the following day, but this was the day he went missing. PK's father did not contact the police until he received a parking ticket in respect of his car 2 days later.	Social work visit to Cardiff (from Ashworth) 2526 June 2003 and Email from SW2 – 27 Aug 2003
25/26 June 2003	An email from SW2 confirmed outcome of interview with PK's girlfriend: She noticed changes in PK for 3-4 months before the offence e.g., he would pace the room and be short with her often and behaved as if she had made insulting remarks to him, as if he was hearing voices. PK was also eating poorly and would often anxiously move the curtains to peer out of the window. She recalled incidents such as these prior to his previous violent offence. However the Community Forensic Team were not informed of this observed behaviour. She felt that PK was less willing to disclose his problems due to fear of readmission to Whitchurch Hospital, but also felt that PK had lacked support and especially questioned his reduction in medication just before the incident.	Social work visit to Cardiff (from Ashworth) 25/26 June 2003 and Email from SW2 – 27 Aug 2004

4.0 Key Findings, Root Causes and Recommendations for Improving Safety

This section identifies those issues that the review team considers had a significant impact in terms of the care provided to PK, the service delivered, and makes recommendations where appropriate for improving safety both at a local level and nationally.

Operational Issues Identified

A number of key operational and policy issues, have been identified from the review undertaken. In the main document the RCA team has made specific comments which help put the issues into context.

In order to improve public and patient safety in future, the investigative team makes recommendations for action and where appropriate has distinguished between action at a local level and broader lessons for the service. These are outlined below: -

4.1 Failure to meet specified conditions of discharge and Supervised Aftercare

PK was conditionally discharged from Caswell Clinic into United Welsh Housing Association (UWHA) on 11 August 2000. The Mental Health Review Tribunal (MHRT) for Wales has since stated (8th July 2004) that the minimum level of supervision expected for PK was: "….*residence in a hostel which is:*

- *Staffed 24 hours each day*
- *Staffed with sufficient experience in mental health issues to recognise signs of relapse*
- *Administered on the basis that the staff know where the patient is supposed to be 24 hours each day so as to eliminate the risk of prolonged unsupervised absence"*

The hostel originally identified, which could have met the MHRT conditions of discharge, was subsequently changed to another accommodation under United Welsh Housing Association (UWHA), where on-site supervision was limited to between the hours of 8.00 am to 6.00 pm and an on-call service at night.

Prior to PK's conditional discharge, the Home Office agreed to the Responsible Medical Officer's (RMO) request that PK be granted a period of overnight leave to allow the MHRT to activate the discharge and also because a bed was urgently needed at Caswell Clinic for another patient who was on remand in prison. Between July 2000 and May 2001 PK was approved 4 weeks leave, he was conditionally discharged in August 2000, his care formally handed to the Community Forensic Mental Health Team in March 2001 and he moved into his own flat on 27 May 2001.

COMMENT

In examining the discharge process, the RCA team made the following observations:

- The MHRT is an independent body with the power to discharge patients regardless of Home Office opposition. However, as hostel accommodation capable of providing 24-hour on-site supervised care was a condition of PK's discharge, then a hostel providing reduced periods of supervision should not have been utilised. Once a Tribunal has stipulated its conditions, the burden is passed to the Local Authority/Local Health Board to make the necessary arrangements.

- The reason for the placement with Hafod Housing Association (HHA) becoming unavailable is unknown, but if it was due to excessive demand, Bro Morgannwg NHS Trust should have informed the Commissioner, Bro Taf Health Authority (as it was then - now Cardiff Local Health Board) so it could have taken the appropriate action to seek alternative accommodation or, if none was available, bring the matter to the immediate attention of the MHRT. In the event that responsible authorities find it impossible to meet the discharge conditions imposed by MHRTs, they are advised to contact the Home Office so that consideration may be given as to whether the Home Secretary may wish to refer the case back to the MHRT under the powers conferred through Section 71(1), Mental Health Act.

- As pressure to transfer PK was the result of a shortage of medium secure beds, then this factor should be considered by the commissioning authority (Health Commission Wales).

RECOMMENDATIONS:

In terms of Supervision and Placement the RCA team recommends: -

Local Level

a) That Bro Morgannwg NHS Trust and Cardiff and Vale NHS Trust give careful consideration to whether patients conditionally discharged into the community can be adequately managed in full-time independent living or whether they should remain in supervised hostel accommodation. This is particularly the case where the required relapse indicators and missing person rules may be practically difficult to apply in the situation of fully independent living.

b) Where patients are suitable for transfer to independent living, both Trusts should give careful consideration to determining how long those should remain in supervised settings before transfer and what continued day care facilities may be required as part of their aftercare.

c) That Health Commission Wales reviews its requirement in terms of medium secure provision and identifies any bed shortages that may exist.

Broader Learning

d) That Social Services Departments ensure adequate and appropriately staffed 24 hour supervised hostel accommodation is made available.

e) That NHS Trusts always formally bring difficulties in obtaining appropriate aftercare facilities to the attention of their commissioning authorities.

f) That where 24 hour supervised care is specified in the conditions of discharge and cannot be met, the matter should be brought to the attention of Local Health Boards/Health Commission Wales to ensure this requirement is properly applied.

g) That where patients need to be discharged into 24 hour supervised hostel accommodation, the length of time in supervised care is specified by MHRTs in the conditions of discharge and the discharge plan in advance.

h) That Local Health Boards and Health Commission Wales be made responsible to monitor compliance with the conditions specified for

discharge.

4.2 Failure to monitor Substance Misuse as a condition of discharge.

On 12 April 2000 a report for the MHRT noted that PK's previous substance misuse was recreational, which became self-medication for an untreated mental illness. It was also noted that since admission to Ashworth and the Caswell Clinic he had used cannabis on 3 occasions, but with no evidence of deterioration of mental health. It was also noted that while there were no guarantees that PK would not use drugs again, the monitoring by random urine testing and observation of his mental health would provide a safeguard to allow community living.

This recommendation, regarding the monitoring of the misuse of cannabis or other substances (despite it being an MHRT condition of PK's discharge) was not incorporated into the multidisciplinary care plan dated 24 July 2000. There was a note, however, in the care plan that the recommencement of illicit drug use or steroids may cause a deterioration in PK's mental health, but there was no specific requirement for routine urinary drug testing or monitoring for alcohol misuse, which would have been a useful safeguard. Moreover, there is no evidence from the available records that urine drug monitoring or monitoring for alcohol abuse was ever performed after he was discharged into the community.

COMMENT:

The RCA team felt that it is possible that misuse of illicit drugs or alcohol may have been a contributory factor to his deterioration of mental state in the community. PK was noted to smell strongly of alcohol when he was arrested after the homicide.

RECOMMENDATIONS:

The RCA team makes the following recommendations for consideration:

Local Level

a) That Bro Morgannwg NHS Trust should ensure that protocols exist for screening to continue to occur once patients are transferred to the care of other Trusts.

   The RCA Team understands that staff at Caswell Clinic have now introduced randomised drug screening when supervising conditionally discharged patients in the community.

Broader Learning

b) That all patients discharged from secure care with a history of alcohol or drug abuse/misuse should be routinely, regularly and randomly tested for illicit drugs and alcohol use.

   This could be applied with urine testing, hair testing and breathalysing. It should be considered and specified in the care plan.

c) There should be a low threshold for tolerance of substance mis-use in the community, where it has any impact on the risk of dangerousness and a clear management plan where substance misuse occurs, should be specified in the care plan.

d) That the care plans of patients who currently fall into this category should be reviewed by all NHS Trusts with this advice in mind.

4.3 Failure to inform the Home Office of the admission to Whitchurch Hospital on 19 April 2002.

PK was admitted informally from 19 April 2002 to 15 May 2002. However, despite published Home Office guidance, neither the medical nor social supervisor informed the Home Office of this relapse and PK was therefore not considered for recall.

RECOMMENDATIONS

The RCA Team makes the following recommendations:

Local Level

a) That Cardiff and Vale NHS Trust and Cardiff Council review their policies and procedures for both medical and social supervisors to ensure clarity and compliance with reporting requirements.

Broader Learning

b) That all NHS Trusts and Social Services Departments ensure that a clear action plan for any problems occurring during the period of supervised care should be specified in advance and that all staff are fully conversant with it.

4.4 Failure to ensure medication compliance whilst in hospital.

Whilst an inpatient in Whitchurch Hospital, PK was prescribed oral medication. The RCA team felt that the use of oral medication to tide PK over a minor relapse was reasonable in order to ensure rapid effective action by the medication and limit side effects.

A gradual reduction in dose after the relapse would be reasonable and a higher maintenance dose of Depixol could have been substituted once it was firmly established a higher antipsychotic dose was required.

COMMENT:

The RCA Team considered this a reasonable clinical management judgement to make and one that would pass the Bolam Test (an established legal test relating to duty of care). It was noted, however, that there seemed to be no reliable system in place to monitor PK's subsequent compliance with taking oral medication

RECOMMENDATION:

The RCA Team makes the following recommendation:

Local Level

a) That Cardiff and Vale NHS Trust ensures there are robust mechanisms in place to monitor the compliance of conditionally discharged patients in taking oral medication.

4.5 Appropriate Crisis Management by the Community Mental Health Team, Cardiff & Vale NHS Trust on the 24 March 2003.

On 24 March 2003, the day before the homicide, PK was living in the community in a flat on his own. His CPN (CPN2), was called to the flat by PK. PK informed the CPN that his father had told him off.

The CPN was able to interview PK at his flat within 1 hour of receiving the call. Three symptoms were described: his father had become concerned because he was not eating enough food; his father and mother thought he was becoming unwell; and they had noted he was more quiet than usual.

PK himself had not complained of any subjective change in how he was feeling. His symptoms matched one or two of the less specific "full" and "early" relapse indicators (loss of appetite and

social withdrawal) and there were no declared psychotic symptoms. This placed CPN2 in a difficult situation; he had to make a clinical decision based on the evidence available at the time.

COMMENT:

The RCA team agreed that CPN2 acted appropriately, with a reasonable degree of caution, and arranged for PK to be assessed in the outpatient department the following afternoon. The CPN decision was based on the available information and with reference to the relapse indicators and the care plan.

4.6 Failure to apply the agreed 12-hour missing rule as required by the Care Plan by the Community Mental Health Team (CMHT).

On the 24 March 2003, on the day prior to the homicide, PK was last seen by his father, at his father's house, at 17.55. His parents noticed he was missing on the morning of the 25 March 2003 and that he had taken the family car. They contacted the CMHT at 15.45 to see if he had arrived for his outpatient appointment and then they informed the CMHT that he had gone missing with the car. **The parents were advised by the CMHT to inform the police themselves.**

COMMENT

The RCA team felt that the 12-hour missing rule was an important part of PK's risk management plan, and should have been acted upon entirely in accordance with the documented care plan.

Moreover, notwithstanding the offence had already been committed, the CMHT's failure to notify the police or the Home Office (until three days later) was a significant failing resulting in a

situation where PK was effectively out of the area whilst presenting a serious risk to public safety and without instructions to recall him being considered or put in place.

Home Office guidance states *"A conditionally discharged patient may leave the approved address and break off contact with both supervisors. In such cases the social supervisor should report the fact to the Home Office immediately and then make every reasonable effort to locate the patient, contacting his colleagues in other areas if he has reason to believe that the patient may have gone to a particular place in a different locality.*

The Home Office may decide simply to wait until the patient's whereabouts are known. If necessary, however, the Home Secretary will issue a warrant for the recall of the patient, thus providing the police with the powers to bring the patient into custody".

The RCA team found no evidence that the above action took place or that social supervisors followed Home Office guidance. This matter is considered to be a significant system failure.

RECOMMENDATION

The RCA team recommends the following action:-

Local Level

a) That Cardiff and Vale NHS Trust and Cardiff Social Services Department ensure that clear care and social services plans exist for all patients currently conditionally discharged and under supervision. In addition, all staff should be familiar with the contents and conditions identified within the clinical notes prior to

communicating or taking any action relating to patients or relatives making contact to discuss clinical problems.

4.7 Lack of specific and measurable relapse indicators.

The relapse indicators had been carefully identified by the Caswell clinical team with reference to PK, his parents and the views of the clinical team themselves. However, it was recognised that they were "speculative". The Cardiff and Vale NHS Trust Community Mental Health Team had the opportunity to review and amend the care plan. Although PK displayed no psychotic symptoms, his change in appetite and his parent's non-specific concerns about him appearing unwell and quieter in effect proved to be reliable indicators of his relapse.

COMMENT

The RCA team considered that the actions expected of the care team, consequent on the relapse indicators, were themselves ambiguous and therefore subject to individual interpretation.

It has been concluded that it was likely that in the clinical setting more emphasis would have been placed on a patient's development of psychotic symptoms, which, unlike many other psychiatric patients experiencing a deterioration in mental state, did not present prior to the homicide in this case. It is possible that PK's relapse management in the community would have proved difficult, particularly so where consideration of recall arrangements may have been required.

RECOMMENDATIONS

The RCA Team recommends that the utilisation of the list of relapse indicators in terms of clinical management needs to be more clearly specified to avoid ambiguity. To achieve this the investigative team recommends:-

Local Level

a) That guidelines are produced by Bro Morgannwg and Cardiff and Vale NHS Trusts for detailing the way in which individual relapse indicators are translated into clinical actions. This will reduce the potential for human error. The RCA team consider it would be good practice when listing the relapse indicators to indicate the strength each indicator should be considered as a sign of relapse and to specify the action to be taken. It is recognised that clinical judgement must be allowed to vary the action at the discretion of the practitioner.

   An example has been produced at Appendix D to illustrate this idea, but it is anticipated that this will be subject to review and development by the Trust's own expert team with reference to the appropriate research and existing guidelines.

b) That both of the aforementioned Trusts should review all relapse indicators presently in use with high-risk patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.

Policy Issues Identified

The RCA Team noted a number of wider Mental Health Act and policy issues for consideration nationally. These are commented on below: -

4.8 Role of the Mental Health Review Tribunal (MHRT).

Under the present regulatory framework, a Tribunal does not have the power to police the work of the authorities required to make arrangements to ensure the prompt implementation of its decisions or to even set a time limit. It can, however, exercise its powers to ensure that problems are addressed at an early date if it is made aware that they exist, or may occur. It can, for example, under Rule 15 of the MHRT Rules 1983, call for reports and even summon witnesses such as Directors of Social Services Departments or Chairmen of NHS Local Health Boards[1].

COMMENT

Essentially, MHRTs are not currently responsible for providing any independent monitoring or authority over the clinical teams' subsequent actions after discharge. However, this could change with new legislation coming into force in the future.

The absence of this capability allows for partial compliance where Trusts find difficulty in meeting all the conditions in full.

RECOMMENDATIONS

The RCA Team makes the following recommendations:-

a) That MHRTs (prior to any Legislative amendment) exercise their powers to ensure that problems are addressed at an early date when they are made aware that they exist, or may occur.

[1] Jones R, *Mental Health Act Manual*, 7th Ed, Sweet & Maxwell 2001, p. 332.

b) That Local Health Boards (prior to the amendment of any legislation) undertake an independent monitoring role to ensure compliance with the imposed conditions of discharge and ensure that a duty of care is met to the patient and the public.

4.9 Role of the Home Office:

The role of the Home Office is described in Appendix E.

COMMENT

The RCA Team found it difficult to understand how PK could essentially transfer from conditions of medium security to independent living within a total period of only 9 months. It notes that the Home Office originally opposed PK's discharge but from information received subsequently understands that, in view of PK's successful periods of trial leave, it would have been unlikely to continue to oppose discharge when it eventually occurred. Given PK's offending history, the seriousness of the offence leading to him being detained in Ashworth Hospital, the inadequate hostel supervision and the relatively short period of time PK spent in the community, it felt his transition to independent living was not only completed too quickly but also without sufficient time based evidence of successful rehabilitation, in particular when considering the seriousness of the previous offence committed.

Furthermore, the medical and social supervision reports were not submitted on time resulting in the Home Office frequently chasing them from the supervisors and even having to take the unusual step of writing to the Director of Social Services on two occasions.

It is apparent that the Home Office is very reliant on the accuracy, timeliness and completeness of information provided by the clinical teams.

RECOMMENDATIONS

The RCA team identified that the Home Office has a substantial role to play in such management processes and would emphasise the following:-

a) That Medical Supervisors have a statutory responsibility (Mental Health Act, Section 41 (6)) to comply with Home Office Mental Health Unit reporting requirements. Reports submitted should be comprehensive, timely and identify any issues of concern.

b) That the Home Secretary is responsible for the management of conditionally discharged patients within the community. Supervising psychiatrists and social supervisors should fully cooperate with the Mental Health Unit of the Home Office in order to ensure that any risks are minimised as far as possible.

c) It is further recommended that the Home Office Mental Health Unit should require all NHS Trusts to review relapse indicators presently in use with conditionally discharged patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.

CONCLUSION

The RCA Team identified a number of systems failures relating to the lead up to the homicide committed on 25 March 2003. The Team concluded that the event was difficult to predict because of the lack of specific and measurable relapse indicators. The 12-hour missing rule was an important part of PK's risk management plan. Although, the offence had already been committed, the failure to implement the 12-hour rule resulted in a situation where PK was effectively out of the area without the instruction to recall him being considered or put in place.

5.0 Action Planning

As part of the process all stakeholder organisations have been asked to confirm the accuracy of the chronology of events. Feedback received as of publication indicates an understanding of the issues and a willingness to learn and avoid reoccurrence of such tragic events.

The provision of mental health services to patients is a multiagency activity involving Mental Health Trusts, Local Authorities and government departments. The findings contained within this report require a multiagency response and in this regard it is anticipated that all relevant organisations and agencies will respond and work together to address the issues identified upon publication of this report.

It is hoped that this report further strengthens the action planning process in order to reduce the likelihood of re-occurrence of such an incident as far as possible. Each organisation has been asked to produce detailed action plans to address the issues and recommendations in the report.

Root Cause Analysis and Patient Safety — Appendix A

Root Cause Analysis (RCA) is a methodology that enables you to ask the questions "How" and "Why" in a structured and objective way to reveal all the influencing and causal factors that have led to a patient safety incident. The aim is to learn how to prevent similar incidents happening again and to maximise learning.

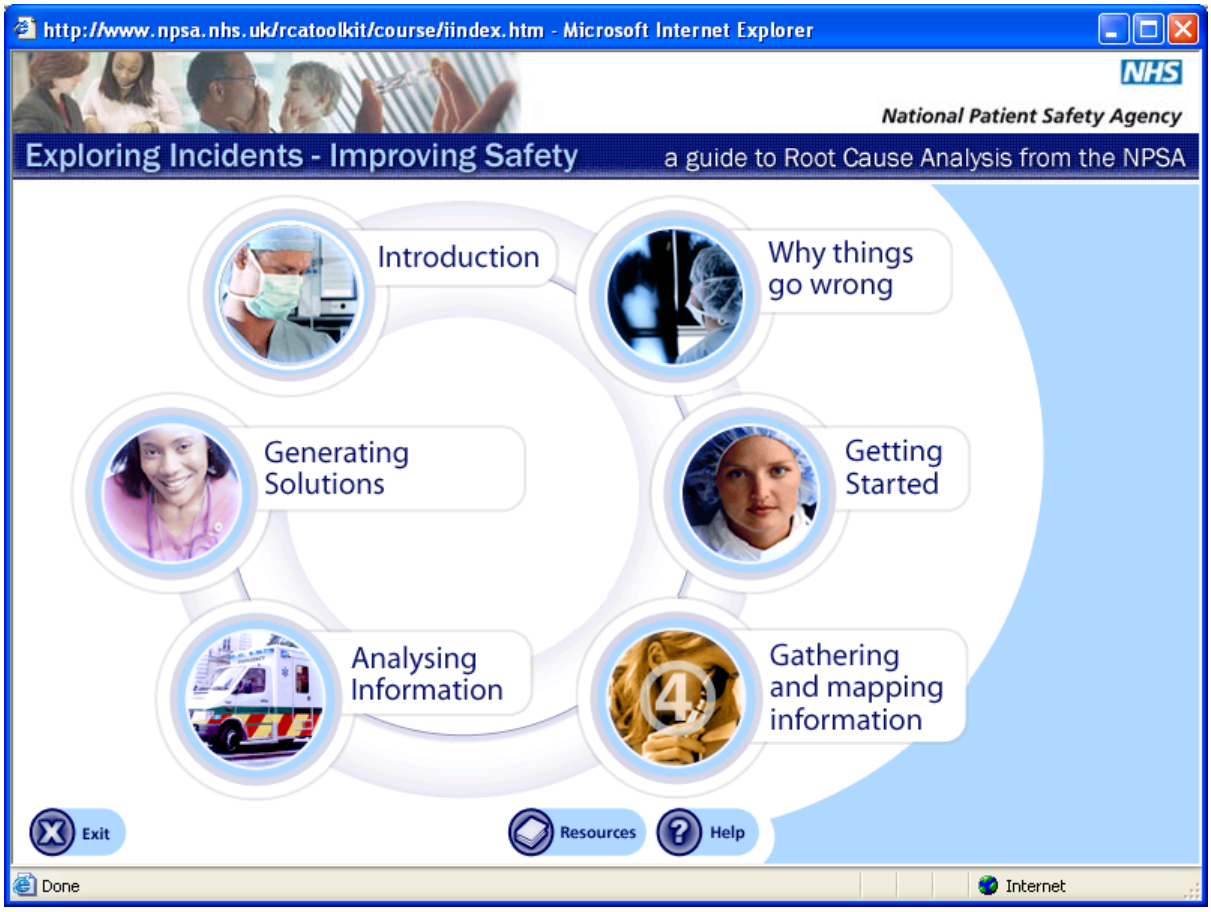
The process for undertaking an RCA enables a structured systematic approach to investigating incidents, which supports analysis of systems, rather than focusing on individuals. This approach will also support the identification of effective solutions to problems. It involves all levels of staff in identifying both causes and solutions, promoting a positive attitude to the management of incidents and moving towards a fair and learning culture.

Other people may be involved as members of the team gathering and exploring information about an incident. The people who were actually involved in the incident may also be part of the process, for example, by being interviewed. It is also important to consider how patients and their families may be involved in the process. There has been extensive work and research into why such incidents happen and into the background to incidents in healthcare generally. The RCA process consists of six main activities:

- data gathering
- information mapping
- identifying issues
- analysing problems for contributory factors
- agreeing the root causes
- recommendations and reporting

The team should now have identified the fundamental issues or root causes, which need to be addressed. It is important that the lessons learned from the RCA are used to improve patient safety. The Multi-Professional team considers the recommendations and the wider implications of actually putting recommendations in place. These may involve considering cost implications, impact on other parts of the organisation and ensuring that action plans are part of the overall risk management programme on the organisation.

The specific processes involved in Root Cause Analysis can be found on the National Patient Safety web site: www.npsa.nhs.uk



Sources of Information Appendix B

This section of the report describes the background documentation reviewed, interviews conducted and relevant literature studied within the context of the clinical care delivered to PK.

1. Bro Morgannwg NHS Trust, Caswell Clinic - inpatient records.

2. Bro Morgannwg NHS Trust, Caswell Clinic - outpatient records.

3. Ashworth Hospital, Liverpool – inpatient notes

4. Home Office E.mail Correspondence – 4th May, 10th May, 25th May, 25th August, 26th August, 7th September and 6th October 2004 and meeting 28th September 2004

5. Whitchurch Hospital, Cardiff & Vale NHS Trust, – inpatient and outpatient notes

6. Whitchurch Community Forensic Mental Health Team, Cardiff & Vale NHS Trust – Community Psychiatric Nurse (CPN) notes

7. Cardiff Move-On – file notes

8. Interviews conducted on 15th April 2004 and 5th May 2004, with:

    Consultant Forensic Psychiatrist, (CP3)

    Consultant Psychiatrist (CP1)

    Social Work Manager (SW4)

    Community Psychiatric Nurse (CPN2)

    Senior Social Worker (SW2)

    Mrs PK (patient's mother)

    Mrs D (victim's wife)

9. Mental Health Review Tribunal Medical report by SPR1, dated 9 March 2000

10. Reply to questions by Mental Health Review Tribunal, dated 28 June 2004

11. E-mail Correspondence with Director of Integrated Commissioning, Cardiff Local Health Board, 9th August 2004

12. Letter from the Mental Health Review Tribunal for Wales, dated 8 July 2004

13. Letter from United Welsh Housing, dated 21 July 2004

14. Letter from Hafod Care Association Ltd, dated 16 July 2004.

15. Letters from Cardiff and Vale NHS Trust, dated 20 and 5 August

16. Letters from Bro Morgannwg NHS Trust, dated 25 & 26 August 2004

17. Letter from Forensic Community Team, Cardiff & Vale NHS Trust, undated (received August 2004)

18. Letter from Social Services, Bridgend County Borough Council, dated, 25 August 2004-09-07

19. Email from Cardiff County Council, dated 27 August 2004

20. Jones R, *Mental Health Act Manual*, 7th Ed, Sweet & Maxwell 2001, p. 332.

21. Baxter R, *The Mentally Disordered Offender in Hospital: The Role of the Home Office,* in *The Mentally Disordered Offender,* Ed Herbst K, Gunn J, Butterworth-Heinemann, 1991, p. 143.

22. Letter from Mental Health Tribunal for Wales, dated 8 September *Notes for the Guidance of Social Supervisors, Supervision and After-Care of Conditionally Discharged Restricted Patients* Home Office, Department of Health, Welsh Office, 1997

23. *"Conditionally Discharged Patients"* Internal Memorandum, Mental Health Unit, Home Office, 20th July 2004

24. 'Brief Risk Assessment' and FACE Risk Assessment Tools, Cardiff and Vale NHS Trust

Contact List and Anonymisation Key — Appendix C

This section of the report defines the personnel and organisations involved in the care of PK.

Department or Affiliation	Designation	Key
Index Family	Index patient	PK
Adult Inpatient Team (Whitchurch Hospital) & Community Forensic Mental Health Team, Cardiff & Vale NHS Trust	Consultant Psychiatrist	CP1
Adult Inpatient Team (Whitchurch Hospital) Cardiff & Vale NHS Trust	Consultant Psychiatrist	CP2
Social Worker (Community Forensic Mental Health Team), Cardiff Social Services Department	Principal Social Services Officer	SW1
Social Worker (Community Forensic Mental Health Team), Cardiff Social Services	Senior Social Worker	SW2
Social Worker (Community Forensic Mental Health Team), Cardiff Social Services	Senior Social Worker	SW3
Community Psychiatric Nurse (Community Forensic Mental Health Team), Cardiff & Vale NHS Trust	Community Psychiatric Nurse	CPN1
Community Psychiatric Nurse (Community Forensic Mental Health Team), Cardiff & Vale NHS Trust	Community Psychiatric Nurse	CPN2
Community Psychiatric Nurse (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Forensic Community Mental Health Nurse	CMHN1
Community Psychiatric Nurse (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Forensic Community Mental Health Nurse	CMHN2
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Consultant Forensic Psychiatrist	CP3

Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Specialist Registrar	SPR1
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Social Work Manager	SW4
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Primary nurse	PN1
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Primary nurse	PN1
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Occupational Therapist	OT1
Adult Inpatient Team (Caswell Clinic Medium Secure Inpatient Unit), Bro Morgannwg NHS Trust	Clinical Psychologist	CLP1
Adult Inpatient Team (Ashworth Special Hospital), Mersey Care NHS Trust	RMO 1, Consultant Psychiatrist	CP4
Adult Inpatient Team (Ashworth Special Hospital) Mersey Care NHS Trust	RMO 2, Consultant Psychiatrist	CP5
Adult Inpatient Team (Ashworth Special Hospital), Mersey Care NHS Trust	RMO 3, Consultant psychiatrist	CP6
Adult Inpatient Team (Ashworth Special Hospital), Mersey Care NHS Trust	RMO 4, Consultant Psychiatrist	CP7
Adult Inpatient Team (Ashworth Special Hospital), Mersey Care NHS Trust	Staff Grade Psychiatrist	SGP1
Adult Inpatient Team (Ashworth Special Hospital), Mersey Care NHS Trust	Senior Social Worker	SW5
United Welsh Housing Association		UWHA
Hafod Housing Association		HHA
Primary Care	GP	GP1

Example of Graded Relapse Indicators with Clinical Actions — Appendix D

This section of the report proposes some exemplar relapse indicators for the purposes of illustration.

Behaviour	Indicator Strength	Action
Physical violence or sexually inappropriate contact or collecting or possessing weapons	Zero Tolerance	Immediate consultation with RMO regarding recall or MHA assessment.
Verbally aggressive behaviour or increasing non-compliance with requests or absence from place of residence after a pre-determined period or sexually inappropriate remarks or behaviour	Very Strong	Multi disciplinary Team (MDT) clinical review to be called. The speed of response to be determined by clinical judgement.
Psychotic symptoms (e.g. hallucinations or delusions) or discontinuation of medication	Strong	Urgent Review of mental state by clinical team
Persistent sleep disturbance or stopping work or alcohol abuse or drug abuse	Moderate	Increase monitoring of mental state. Clinical review within 2 weeks
A few nights of poor sleep or disturbed concentration.	Low	Increased vigilance by staff for the development of other signs.

Role of the Home Office — Appendix E

The following paragraphs were provided by the Home Office to ECRI on 30 September 2004 outlining the role of the Home Office under the Mental Health Act.

'Section 41 of the Mental Health Act assigns certain responsibilities to the Home Secretary in the management of offenders who receive a hospital order with restrictions, when the court takes the view that this is necessary for the protection of the public from serious harm.

Once a restricted patient has been conditionally discharged, the Act gives the Home Secretary the following powers:

- to recall conditionally discharged restricted patients to hospital (s42(3));
- to vary the conditions of discharge (s73(5); and
- to stipulate the contents and frequency of reports from supervisors (s41(6)).

Recall

The power of recall provides for return to hospital of any restricted patient who poses a risk to others as a result of his disorder, which cannot be safely managed in the community.

Variation of conditions

The power to vary conditions reflects the need to manage a patient's progress dynamically. Effective treatment and progression in the community could well result in the relaxation of conditions.

Similarly changes in circumstances such as a new address could result in variation of conditions where appropriate.

Non-compliance/unachieved conditions

The Home Office can address failure to put in place or to comply with the conditions of discharge in several ways. Failure to comply does not in itself justify recall. Advice or warning by supervisors may suffice to achieve compliance. Amending conditions may enable a patient to remain in the community when conditions of discharge cannot be put in place. When non-compliance amounts to behaviour which may put others at serious risk, recall will be the option, provided there is evidence of mental disorder.

Enforcement/monitoring of conditions and risk

The Mental Health Unit of the Home Office discharges the Home Secretary's responsibility for protection of the public from conditionally discharged restricted patients by assessing risk on the basis of reports from supervisors. It does not have an explicitly investigative role to check compliance with the terms of their discharge; it depends on the reports of the professionals who are responsible for supervision to reflect the facts of the situation accurately as a basis for case management.

Guidance to social and psychiatric supervisors was issued in 1987 and updated in 1997 and 2003 respectively. It is also available via the Home Office website at www.homeoffice.gov.uk/inside/org/dob/direct/mhu/docs.html.

The supervising professionals have a responsibility to ensure patients' compliance with conditions on a day to day basis. When this is not possible, for whatever reason, they are required to inform the Home Office so that recall can be considered.

When they consider that the patient's conditions should be varied (for example, because accommodation arrangements have broken down or because they consider the patient has made progress and requires less intrusive supervision) they are required to inform the Home Office so that variation can be considered.

By stipulating the submission of (normally) quarterly reports from both medical and social supervisors, covering given issues, the Home Office should be able to maintain an awareness of the individual patient's mental condition and the level of risk posed to others. When circumstances merit it, the Home Office will request reports with greater or lesser frequency and may request reports to cover specific aspects of a patient's behaviour in the community (eg drug or alcohol consumption).

The Home Office advises supervisors to take a proactive approach to this; guidance calls for specific notification between the regular reports if necessary. It is clear that a report should be provided if there is any material change in the patient's circumstances, non-compliance with conditions or other cause for concern, for example, any admission to hospital'.

NPSA Classification of Contributory Factors Appendix F

This section identifies those positive and negative factors identified within the report and classifies them according to the key features involved in the provision of healthcare.

	Positive Factors	Negative Factors
Communication:	Documented communication between team members.	Lack of provision of information relating to social supervision to the Home Office.
Education & Training:		No evidence of Cardiff & Vale NHS Trust community staff receiving specific training in the management of conditionally discharged patients with very complex mental health needs.
Equipment/ **Medical Records:**		Documents missing from clinical notes (E.g. Home Office requests for information and letters to the Home Office)
Individual:	Prompt response by CPN2 when asked to visit PK. Prompt offer of outpatient appointment following father's concerns about PK.	
Organisational:	Cross Trust/agency co-operation. Home Office diligent requests for information from Medical and Social Supervisors	Possible shortage of medium secure beds. Possible shortage of hostel supervision placements.
Patient:		Possible poor compliance with taking oral medication prior to index offence. Speed of transition from medium secure environment to independent living.

Task (Policy):		Lack of specificity of Relapse Indicators and Consequent Actions. Exclusion of Substance Misuse screening as a relapse indicator. Failure to adequately monitor compliance with oral medication. Failure to audit whether conditions of discharge were met. No requirement for MHRT to specify length of time that conditions should apply.
Team		Lack of provision of 24 hour supervised care as specified in Conditions of Discharge.