Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr H and the provision of Mental Health Services, following a Homicide committed in March 2009

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Summary of the index offence

1.1 On the evening of 24 March 2009 in Llanbradach, near Caerphilly, a 66-year-old woman was stabbed four times by 22-year-old Mr H. The victim was unknown to her attacker and sadly later died of her wounds. Mr H was arrested on the same day and on 4 May 2010 Cardiff Crown Court ordered his indefinite detention under the Mental Health Act 1983[1] in a high secure hospital.

Background

1.2 In circumstances where a patient known to mental health services[2] in Wales is involved in a homicide the Welsh Government may commission an independent external review of the case to ensure that any lessons that might be learnt are identified and acted upon. As of January 2007 these independent external reviews have been conducted by Healthcare Inspectorate Wales (HIW).

Social history of Mr H

1.3 Mr H was born in 1986 and was brought up in the Caerphilly area. He lived with his mother, father and younger brother, but had a difficult relationship with both his parents, particularly his mother, and as a result spent periods of time being cared for by his maternal grandparents and maternal aunts.

1.4 Mr H attended mainstream education where he could be disruptive and challenging to teachers; he was excluded from school at the age of seven for a period of time due to his intimidating behaviour towards other children. As a teenager played truant and fought with others.

[1] **Mental Health Act 1983** - Legislation in England and Wales that allows the compulsory detention of people in hospital for assessment and/or treatment for mental disorder. People are detained under the Mental Health Act in the interests of their own health or safety; or the safety of others.
[2] **Mental health services** - A combination of different mental health care professionals treating people with mental illness. Mental illness can impact on a wide range of health and social needs, such as housing, employment, relationships and physical well being.

1.5 Mr H was diagnosed with Asperger's Syndrome[3] in 2001 and had a Statement of Special Educational Needs (SEN)[4], receiving support from the school's SEN co-ordinator[5]. Mr H left school at 15, with no formal qualifications.

1.6 Following his leaving school Mr H did not enter employment. The only evidence we found relating to employment or training was Mr H undertaking a paper round while he was still at school and a car valeting placement as part of a training scheme where he lasted four weeks.

1.7 Mr H came to the attention of the police on several occasions, although there is no record of him ever having been convicted of any crimes prior to the index offence[6]. The police were also called to the family home several times after quarrels between Mr H and his parents, including an incident in August 2001 which resulted in him going to live with his grandmother.

Arrangements for the delivery of mental health services in Caerphilly

1.8 At the time of the index offence, mental health services in Caerphilly were the responsibility of Gwent Healthcare NHS Trust's Division of Community and Mental Health Services. This service was managed by a divisional general manager who reported directly to the chief executive. Five locality managers (who had responsibility for managing a range of services for both community and mental

[3] **Asperger's Syndrome -** A form of autism, which is a lifelong disability that affects how a person makes sense of the world, processes information and relates to other people. Autism is often described as a *'spectrum disorder'* because the condition affects people in many different ways and to varying degrees. People with Asperger's Syndrome are often of average, or above average, intelligence. They do not usually have the accompanying learning disabilities associated with autism, but they may have specific learning difficulties. These may include dyslexia and dyspraxia or other conditions such as attention deficit hyperactivity disorder (ADHD) and epilepsy.

[4] **Special Educational Needs (SEN) -** Learning difficulties or disabilities that make it harder for children to learn or access education than most children of the same age, and who may need extra or different help from that given to other children of the same age. A Statement of Special Educational Needs may be recorded by the local authority, setting out the individual child's needs and the help they should receive. It is reviewed annually to ensure that any extra support given continues to meet the child's needs.

[5] **Special Educational Needs Co-ordinator (SENCO) -** A member of staff in a school who is responsible for ensuring that the needs of pupils with special educational needs (SEN) are met appropriately.

[6] **Index offence -** The offence which the patient has been convicted of and which has lead to their current detention.

health in the five county borough areas of Gwent) answered to the general manager. Ward and team managers reported to senior nurses who were responsible to the locality managers.

1.9 The range of services provided by the Trust's Division of Community and Mental Health Services included community mental health services (for adults and older adults), which incorporated in-patient care, crisis resolution/ home treatment, first access, assertive outreach, early intervention, older adult day hospitals and general community teams. The Division also provided forensic psychiatry services, personality disorder services, substance misuse services, district nursing, community hospital, rehabilitation and continuing care. Community Mental Health services were provided by a range of clinical staff, including medical staff, community psychiatric nurses (CPNs)[7], occupational therapists (OTs)[8] and clinical psychologists[9].

1.10 An NHS Wales reorganisation took place in October 2009 which amalgamated the NHS Trusts and Local Health Boards into seven Health Boards[10]. Aneurin Bevan Health Board replaced Gwent NHS Trust and five LHBs (Caerphilly Teaching, Newport, Torfaen, Blaenau Gwent and Monmouthshire).

Child and Adolescent Mental Health Services (CAMHS)

1.11 Child and Adolescent Mental Health Services (CAMHS) support young people up to the end of Year 11 in school (age 16) or until their 18th birthday if still in full-time

[7] **Community psychiatric nurse (CPN) -** A registered nurse who is trained in mental health and works with people in the community. CPNs work as part of a team and may see people in a variety of settings such as at a GP surgery, in a clinic or health centre or in a client's own home. They work closely with GPs and other health professionals. They provide practical advice, ongoing support with problems, supervise medication, give injections and help with counselling. They also work out care plans with other members of the team, service users and carers.

[8] **Occupational therapist (OT) -** A professionally trained person who works in hospitals and various community settings to assess and treat people with physical and/or mental health problems through purposeful activity. They work as part of a team to identify problems caused by people's conditions and find ways of coping with these to encourage independence and a better quality of life.

[9] **Clinical psychologists -** work with people with any one of a wide range of psychological or mental health problems, including mental illness. They may work directly with individuals, families or groups, assessing their needs and providing appropriate interventions; or they may work indirectly, for example by providing support to parents, carers or other professionals. Assessment often involves the use of psychometric tests and direct observation of behaviour.

[10] **Health Boards -** responsible for delivering all healthcare services within a geographical area. They are responsible for planning, designing, developing and securing delivery of primary, community, secondary care services and specialist and tertiary services for their areas, to meet identified local needs within the national policy and standards framework set out by the Minister.

education who are experiencing mental health issues, delivered by a multi-disciplinary team (MDT)[11] offering assessment and a variety of therapies.

Community Mental Health Teams (CMHTs)

1.12 Within Gwent there are currently twelve Community Adult Mental Health Teams (CMHTs) provided jointly with the Social Services[12] departments of the five county borough councils and Aneurin Bevan Health Board (formerly Gwent Healthcare NHS Trust). Each team covers a specific geographical area. CMHTs provide mental health services for people between 16 and 65 years drawing on the skills of both health and Social Services staff. CMHT's are multi-disciplinary teams consisting of social workers, consultant psychiatrists, psychologists, CPNs, OTs, healthcare assistants, community care workers and administration staff.

1.13 The aim of the CMHT is to ensure that people with mental health needs receive timely, effective assessment, care and treatment in the most appropriate setting in accordance with their identified needs. The CMHT offers assessment to individuals referred to the team via a single point of access process. Individuals receive a comprehensive assessment of needs. Once an assessment has taken place, the individual's needs are discussed via a multi-disciplinary meeting to provide a Care Programme Approach (CPA)[13] to meet their needs.

Assertive Outreach Teams (AOTs)

1.14 Assertive Outreach Teams (AOTs) are specialist teams for mental health service users who have demonstrated a reluctance or inability to use other services.

[11] **Multi-disciplinary team (MDT) -** A team consisting of health and social service professionals and non-professionals, including doctors, nurses and therapists, working together to provide care and treatment for patients.

[12] **Social Services -** A term generally used to refer to local authority Social Services departments. These are responsible for non-medical welfare and care of adults and families in need. Social Services have a range of statutory duties and provide advice, assessments of individual need and interventions for eligible children and adults. They also arrange and provide services under community care for adults, children and families. They take a lead in safeguarding children and protecting vulnerable adults from harm.

[13] **Care Programme Approach (CPA) –** The system of delivering mental health services to people within secondary mental health services (such as those provided by Community Mental Health Teams). CPA. requires that health and Social Services assess individual need and risk, provide a written care plan, allocate a care co-ordinator, and regularly review the plan with stakeholders, including the individual. There are two levels within CPA – Enhanced and Standard – and the level an individual receives is indicated by the complexity of their needs.

AOTs work alongside CMHTs and receive referrals from them. Assertive Outreach recognises that a person's non-engagement with existing support services poses a risk of a deterioration in their mental health and therefore of being unable to live successfully in the community. AOTs aim to help service users to achieve the best possible quality of life and to maintain their ability to live within the community, maintaining contact and increasing their engagement and compliance with services. AOTs provide intensive, practical support and treatment and active engagement with service users, working alongside them to help them in aspects of their lives that they identify as difficult. AOTs include staff such as mental health nurses, occupational therapists, social workers, support workers, psychiatrists and psychologists.

1.15 In the Gwent area there are currently five Assertive Outreach Teams (AOTs), run jointly by Aneurin Bevan Health Board and the Social Services departments of the five county borough councils. In Caerphilly, Newport and Torfaen the AOTs have been fully established; the two AOTs in Blaenau Gwent and Monmouth are smaller, having been established from service re-design rather than dedicated funding.

Mr H's Diagnoses, Care and Treatment by Mental Health Services and Social Services

Children's Services: 1994 until 2003

1.16 Mr H first came to the attention of Social Services in **1994** when he was seven years of age**.** He was referred to an educational psychologist[14] by the school's head teacher, due to his disruptive and intimidating behaviour at school. Mr H was also referred to Child and Family Services (a department of the former Mid Glamorgan Social Services) at this time because his mother was having difficulty dealing with his behaviour. However, the family later cancelled appointments stating that they did not require them, and the case was closed by the social worker working for Child and Family Services.

[14] **Educational psychologist -** Educational psychologists tackle the problems encountered by young people in education, which may involve learning difficulties and social or emotional problems.

1.17 In **July 2000** when Mr H was thirteen years of age, his mother again contacted Caerphilly Social Services as she was finding Mr H's behaviour difficult to cope with. A social worker saw Mr H but decided no further action was necessary.

1.18 Mr H was referred by the general practitioner (GP)[15] to a consultant psychiatrist[16] at the Social and Communication Disorders Clinic[17] in **May 2001** aged 14. He was assessed as having a range of social and communication problems which indicated the possibility of Asperger's Syndrome. The consultant psychiatrist decided that further input was needed from a nurse, paediatrician[18] and speech and language therapist[19] in order to reach a definite diagnosis[20].

1.19 Subsequently, a community nurse[21] visited Mr H's home in **June 2001**. She reported back to the consultant psychiatrist that the family was in *'crisis.'* The community nurse made a referral to Caerphilly Social Services, although it is unclear whether this was followed up or not.

1.20 A further referral to Caerphilly Social Services was made by Mr H's family in **July 2001**. A social worker visited the family and considered the family to be coping well with Mr H's behaviour in general. The social worker reported that the family were attending family therapy[22] sessions in Cardiff and that Mr H was in the process of being assessed for a possible learning disability[23]. His case was once again closed by Caerphilly Social Services, on **17 July 2001**.

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[15] **General practitioner (GP) -** A family doctor.
[16] **Consultant psychiatrist** - A medically trained doctor who has gone on to train and specialise in treating mental disorders and can prescribe medication.
[17] **Social and Communication Disorders Clinic -** A clinic mainly for complex cases of suspected autism or Asperger's syndrome in children. The aims of the service are to determine the diagnosis (if any) and to make recommendations for treatment.
[18] **Paediatrician -** A doctor who provides specialist medical care to infants, children and adolescents.
[19] **Speech and language therapist -** Speech and Language Therapy is for both adults and children and young people with communication or swallowing difficulties. This may include difficulties producing and using speech, understanding and/ or using language, feeding, chewing or swallowing, a stammer or a voice problem.
[20] **Diagnosis -** Identifying a medical condition by its pattern of symptoms (and sometimes also its cause and course).
[21] **Community nurse -** A registered nurse who works with people in the community.
[22] **Family therapy -** A way of working with families when one or more family members are experiencing problems. It is based on the idea that the behaviour of people is influenced and maintained by the way in which they interact with others, particularly within strong social systems such as a family. By addressing the *'system'* – i.e., the family as a functioning unit – family therapy works to address and overcome the problems being experienced by the individual(s) within it.
[23] **Learning disabilities -** Delays in a person's intellectual and social development across a wide spectrum, ranging from those who live ordinary lives to those who access specialist learning disability services because of severe intellectual impairment and/ or behavioural problems.

1.21 Two days later on **19 July 2001**, Mr H was assessed for Asperger's Syndrome by a consultant community paediatrician[24]. She made a new referral to Caerphilly Social Services as in her opinion Mr H was *'clearly a child in need and possibly at risk of his own behaviour.'*

1.22 Later in **July 2001**, Mr H and his parents were seen by the Child and Adolescent Mental Health Services (CAMHS). The doctor noted Mr H's lack of empathy with other people and hazardous behaviour to himself and others. His mother told the doctor that Mr H had accused her of abusing him to a social worker and that she was now afraid that he would manipulate any form of discipline into an accusation of child abuse.

1.23 Three weeks later, in **August 2001**, the police were called to the family home after a row between Mr H and his mother. He was taken to his maternal grandmother's home a few doors away. A social worker visited Mr H's parents after the event and his case was passed to the Caerphilly Social Services Children with Disabilities Team[25].

1.24 In **September 2001** a social worker from the Children with Disabilities Team visited Mr H at his school, and also talked to the SEN co-ordinator. A second visit to the school was made a few days later and a third in early **October 2001**. During the social worker's visits Mr H stated he was unhappy about the health assessments he was going through as he felt there was nothing wrong with him and blamed his mother's attitude for his difficulties. The social worker suggested having a *'Child and Family Support Meeting'* with representatives from the NHS, the school, Social Services, Mr H and his parents, which was arranged for **20 November 2001**.

1.25 Prior to this meeting taking place, Mr H and his parents were reviewed again by CAMHS at outpatient clinic[26] appointments in **September and October 2001**.

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[24] **Consultant community paediatrician -** Consultant community paediatricians make asses, diagnose and manage children with developmental difficulties and disabilities and associated conditions.
[25] **Children with Disabilities Team -** A specialist team within a local authority department of children's Social Services which looks after the specific needs of children and young people with disabilities.
[26] **Outpatient clinic -** A service for patients who do not stay overnight in hospital

His parents explained that his behaviour deteriorated during school holidays, and also expressed confusion in relation to the roles of the different professionals who had become involved with their family. At the end of **October 2001** the CAMHS doctor wrote to the social worker, stating that he believed that *'*[Mr H's] *problems are really complex and are going to be difficult to manage. Also I have concerns that his behaviour will deteriorate in future and* [Mr H] *will get into trouble with the law.'* On **7 November 2001** the same doctor reiterated his concerns about Mr H's aggressive behaviour over the phone to the social worker and also followed the conversation up with a letter in which the consultant psychiatrist shared his *'worries that* [Mr H] *will end up committing an offence. By any means I do not think that medication on its own will be enough and I think interventions should be considered both at school and at home to make the situation safer and more pleasant for* [Mr H]*, his relatives and the professionals involved.'*

1.26 At the end of **October 2001** Mr H was seen by a speech and language therapist, as part of the assessments being undertaken to determine whether Mr H's had Asperger's Syndrome. The speech and language therapist stated that Mr H did not require speech and language therapy but would require support from the Advisory Teacher[27], as although he had a good understanding of language at a functional level, he had difficulties with expressive language and therefore understood things in a very literal way.

1.27 Mr H was reviewed again at the Social and Communication Disorders Clinic in **November 2001** and they felt that they had sufficient information to make a firm diagnosis of Asperger's Syndrome.

1.28 A Support and Plan meeting[28] took place on **20 November 2001** and was attended by Mr H's social worker, the CAMHS doctor, the school's SEN co-ordinator, Mr H and his parents. Following this meeting, the Social Services Children with

[27] **Advisory teacher -** An experienced teacher who is seconded from a classroom position, usually for two or three years, by the Local Education Authority (LEA). Advisory teachers are generally based in the LEA office, and travel around to different schools to work on specific projects, such as special educational needs (SEN).
[28] **Support and Plan meeting -** A meeting convened by Social Services when it is considered that the child and family may benefit from other services and a more co-ordinated approach from a range of agencies. The meeting includes the child, their family, and representatives from different services, to identify a multi-agency plan to meet their needs.

Disabilities Team decided to discharge[29] Mr H from Caerphilly Social Services as they felt he did not meet their eligibility criteria due to his level of independence; which they considered to be evidenced by the fact that he had a paper round. Social Services officially closed Mr H's case in **March 2002** when he was fifteen years of age.

1.29 A note of the Support and Plan meeting prepared by the Children with Disabilities Team was sent to the CAMHS doctor who contested the minutes, as they did not mention the comments and references that he and other professionals had made at the meeting in relation to the risk that they felt Mr H presented to others. The CAMHS doctor strongly disagreed with Mr H being discharged from Caerphilly Social Services as he felt Mr H did have a disability, he stated in his letter that his *'needs are great and he still represents a risk.'*

1.30 The CAMHS doctor wrote to Caerphilly Social Services again in **June 2002** asking them to reconsider their decision to close Mr H's case. However Caerphilly Social Services decided to uphold their decision as they still felt his level of ability was too high to meet their criteria for support from the Children with Disabilities Team. The CAMHS doctor wrote again in **July 2002** expressing his disappointment that *'the Disabilities Team does not consider children within the autistic spectrum to be disabled and requiring support.'* A social worker interviewed Mr H and his family again in **August 2002** but believed that CAMHS were better placed to support him.

1.31 Throughout this period, Mr H continued to be seen by the CAMHS doctor who started him on the antipsychotic drug Risperidone[30] in **December 2001**. Although Mr H's mother, grandmother and his school thought this had helped and noticed that his behaviour improved, Mr H did not perceive any benefit from it and regularly stopped taking it. He also increasingly failed to attend CAHMS appointments, which the CAMHS doctor believed was in part due to a lack of support from Caerphilly Social Services. As a result, in **August 2002** Mr H was discharged from CAMHS due to his lack of attendance and non-compliance with his medication.

[29] **Discharge -** The point at which a person formally leaves a service, often to take up another one. On discharge from hospital the MDT and the service user will develop a care plan for other services available in the community.
[30] **Risperidone -** Medication used to treat the hallucinations, delusions, and thought disturbances of schizophrenia and other psychoses.

1.32 In **November 2002** after significant problems with his behaviour, Mr H attended the CAMHS clinic again and was reviewed by the consultant in Child and Adolescent Psychiatry[31]. It was noted that there were considerable problems with his behaviour and that Mr H had been non compliant with his medication as he was unsure of any benefit, although his mother felt that there was improvement. The consultant advised that Mr H give Risperidone a proper trial by taking it in the morning and evening, and also asked for a community psychiatric nurse (CPN) to work with Mr H on anger management techniques.

1.33 In **February 2003** and again in **April 2003**, when Mr H was sixteen years of age, his mother made calls to Caerphilly Social Services about Mr H's aggressive behaviour, and referred to a violent outburst towards her which caused her to call the police. Social Services provided advice to Mrs H and closed the case.

1.34 In **May 2003** Mr H moved in with his maternal grandparents. Mr H was reviewed again by CAMHS in **July 2003**, and the consultant noted that Mr H had been non compliant with Risperidone but that his behaviour had become better after he had moved out of the family home and in with his grandparents. The consultant felt that although Mr H clearly exhibited Asperger's Syndrome traits, the degree of difficulty which he experienced was largely due to the family environment, so he discharged Mr H from CAMHS.

1.35 The following month, in **August 2003**, Mr H's grandmother called Caerphilly Social Services asking for support as she and her husband (who was suffering from cancer at this time) were having difficulty coping with Mr H's aggressive behaviour, which had worsened. The case was passed to the Children with Disabilities Team. A similar call was made the following day by Mr H's mother. The social worker from the Children with Disabilities Team called the family back, but as there was no answer and Mr H's family did not get back in touch, there was no further action taken by Caerphilly Social Services.

[31] **Consultant in Child and Adolescent Psychiatry –** A consultant psychiatrist who specialises in working with children and young people who have mental health problems. Psychiatrists work with a wide range of therapeutic techniques, including individual psychotherapy, behavioural therapy and family therapy. Where medication is prescribed for children, it will usually be as part of a much broader range of treatment.

1.36 In **September 2003** Mr H made a self referral to Caerphilly Social Services by visiting their offices. He explained that he was now homeless and so the Caerphilly Social Services Intake and Assessment Team[32] completed a homelessness assessment and faxed it to the Caerphilly Borough Council Homeless Unit[33]. Social Services then closed the case. A further referral was made by Mr H's mother in **December 2003**, a few days after Mr H turned seventeen years of age.

Health and Social Services in the Caerphilly Area: January 2004 to February 2006

1.37 Mr H was seen by the Caerphilly Community Learning Disabilities Team (CLDT)[34] on **19 January 2004** when he was seventeen years of age. The consultant psychiatrist who assessed him felt that Mr H had longstanding difficulties in relation to social interactions, particularly manifested in his relationship with his mother, but that these were more indicative of the family's problems. He did not believe Mr H to have a learning disability and therefore felt him to be inappropriate for the learning disabilities team.

1.38 In **January 2004** Mr H moved back in with his parents, but by the beginning of **February 2004** his mother once again felt unable to accommodate him due to his aggressive behaviour. She made a referral to Caerphilly Social Services.

1.39 On **14 February 2004** Mr H presented at University Hospital Wales, Cardiff with an injury to his head. At this time Mr H was unable to return home and there was nowhere for him to live. Social Services spoke to his maternal aunt who explained that Mr H had admitted to her to having taken ten Ecstasy[35] tablets,

[32] **Intake and Assessment Team -** A team in a local authority's department of Social Services which considers new requests for assistance and helps to identify and assess an individual's current situation, issues and needs in order to determine the most effective means of helping the individual, including the appropriate team or service that will best meet their needs.
[33] **Homelessness Unit -** A local authority service which offers advice, support and practical help to homeless or inadequately housed people, or those in housing need. Many of its responsibilities are defined within housing legislation and guidance.
[34] **Community Learning Disabilities Team (CLDT) -** A multi-disciplinary team comprising of community nurses, social workers and support workers which offers services to adults with a learning disability.
[35] **Ecstasy -** An illegal drug classed as a hallucinogenic amphetamine.

antibiotics, paracetemol and alcohol, and to having cut his wrists. The family believed he was seriously depressed about going to live on his own.

1.40 A joint strategy meeting was held between the police and Caerphilly Social Services on **17 February 2004**, and a joint visit took place at which Mr H, his maternal grandparents and aunt were present. Social Services initiated proceedings under section 47 of the Children Act 1989[36]. On **15 March 2004**, children's Social Services Intake and Assessment Team initiated a transfer of Mr H to the adult Social Services Learning Disabilities Team. It was later decided at a meeting on **2 July 2004** that Mr H did not meet the eligibility criteria for support from the Learning Disabilities Team as he was viewed as having sufficient independent skills and his case was again closed by Caerphilly Social Services on **9 September 2004**.

1.41 Mr H moved into a new flat in Risca with the help of his wider family and then girlfriend in early **2004**. It was noted in Caerphilly Social Services files that at this time Mr H was using illicit drugs, mainly cannabis[37] and ecstasy, and that he had received some counselling for this.

1.42 On **5 October 2004** Mr H was found in his flat by neighbours having taken an overdose of Stemetil[38] which had been prescribed by his GP for nausea. Mr H advised that the overdose was in response to his hearing voices *('auditory hallucinations'[39])* commanding him to harm himself. When his urine was tested on his admission to hospital, it tested positive for cannabis. On **6 October 2004** Mr H was admitted informally[40] to Tŷ Sirhowy, a mental health in-patient unit part of the former Gwent NHS Trust, where he was prescribed antipsychotic medication.

[36] **Section 47 of the Children Act 1989 -** Places a duty on Local Authorities to make enquiries into the circumstances of children considered to be at risk of *'significant harm'* and, where these enquiries indicate the need, to undertake a full Investigation into the child's circumstances.
[37] **Cannabis -** Any of several mildly intoxicating hallucinogenic drugs, such as hashish or marijuana, prepared from various parts of the hemp plant.
[38] **Stemetil -** Anti-emetic medication used to treat nausea and vomiting.
[39] **Auditory hallucinations -** Hallucination of one or more talking voices, a symptom particularly associated with psychotic disorders such as schizophrenia, although many people not suffering from diagnosable mental illness may sometimes hear voices as well.
[40] **Informal admission** – People who voluntarily receive care and treatment from mental health services are known as **informal** patients.

1.43 On **9 October 2004** Mr H left the ward and was later found in a caravan by the police with a knife in his possession. He reported that he had run from the hospital in order to escape from the voices in his head, but he was not able to explain how he got hold of the knife. The following day steps were taken to safeguard Mr H by detaining him under the Mental Health Act. An assessment was undertaken by an Approved Social Worker[41], who decided that detaining Mr H was not the best course of action at that time.

1.44 Two days later, on **12 October 2004**, a second Mental Health Act assessment took place. Mr H was very distressed and agitated, had refused medication and again reported hearing voices. Although Mr H had informed staff that he was willing to stay in hospital, it was decided that, given the unpredictability of his current presentation and the significant risks to himself, such as self harm, should he leave the hospital, he should be detained at Tŷ Sirhowy under section 2[42] of the Mental Health Act.

1.45 A Mental Health Review Tribunal[43] took place on **1 November 2004**, which upheld his detention under Section 2 of the Mental Health Act. Later, on **9 November 2004**, it was decided that Mr H did not need to be detained under Section 3[44] of the Mental Health Act, and that he should remain in Tŷ Sirhowy on an informal (voluntary) basis.

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[41] **Approved Social Worker (ASW) -** A social worker who has received specialist training and who has been given responsibilities under the Mental Health Act 1983 to assess, when requested, whether a person needs to be detained in hospital. Since November 2008 this role has been replaced with that of the **Approved Mental Health Professional (AMHP) -** this is an experienced and qualified practitioner who is either a social worker, mental health nurse, an occupational therapist or a psychologist who has completed additional comprehensive and specialist training in order to be approved by the local authority under section 114, to fulfil designated functions under the Mental Health Act. Their functions include assessing whether a person needs to be compulsorily detained as part of their treatment ('sectioned') and making that application, founded upon two medical recommendations.

[42] **Section 2 of the Mental Health Act 1983** allows a patient to be admitted compulsorily to a psychiatric ward or hospital for assessment based on the recommendations of two doctors and an application by an AMHP. The purpose is to lawfully admit a patient for up to 28 days in order to assess, and if appropriate, treat their mental state, and if necessary detain them by converting this to section 3 (see definition below). This section cannot be renewed after the first 28 days have elapsed, although it may be used again on other occasions.

[43] **Mental Health Review Tribunal (MHRT) -** An independent panel of people who review the cases of patients detained under the Mental Health Act. A detained person can appeal against their detention to this panel. The Tribunal can discharge a detained patient from hospital or make other recommendations such as transfer to another hospital, and may reconvene and rehear a case if there is failure to comply with their recommendations. Tribunal hearings are normally held in private and take place in the hospital or community unit where the patient is detained.

[44] **Section 3 of the Mental Health Act 1983** allows a patient to be admitted to or detained in hospital for treatment based on the availability of appropriate medical treatment; the recommendations of two doctors and an application by the AMHP. The purpose of which is to lawfully admit a patient for up to six months in order to treat their mental condition. This section can be renewed for up to further six months and again yearly.

1.46 Mr H was discharged from Tŷ Sirhowy Hospital to his grandparents' home in **December 2004**, after trial periods of overnight leave there. He was prescribed Olanzapine[45] on discharge, and it was agreed that he would be reviewed in outpatient clinics thereafter. Following his discharge from Tŷ Sirhowy, Mr H was supported for a six month period by the Early Intervention Service[46], a service set up to work with people thought to be developing psychotic illnesses such as Schizophrenia[47]. The Early Intervention Service closed Mr H's case in **June 2005** when Mr H was eighteen years of age, as they felt that his diagnosis was more in line with Asperger's Syndrome. They were not aware that a diagnosis of Asperger's Syndrome had been confirmed in 2001.

1.47 A Carer's Assessment[48] was undertaken by the CMHT in **July 2005** at the request of Mr H's grandmother. As part of the assessment, a CPN and social worker completed a mental state examination[49] of Mr H and concluded that he was very unwell. They arranged for Mr H to be admitted informally to Tŷ Sirhowy three days later. Following this admission he was transferred to St Cadoc's Hospital for a long-term period of rehabilitation, due to his history of drug-induced psychosis[50]. At this point he was diagnosed as having mental and behavioural problems due to cannabis use.

1.48 Following his discharge in **October 2005**, Mr H moved to the Risca area and was transferred into the care of Risca CMHT. Mr H was supported by the CMHT's

[45] **Olanzapine –** An anti-psychotic drug used in the treatment of schizophrenia, bipolar disorder and acute psychosis.
[46] **Early Intervention Service -** A multi-disciplinary team which provides support and treatment in the community for young people with psychosis and their families. The aim is to reduce the period of untreated psychosis, which in turn, evidence shows, is likely to lessen future problems and improve the person's health and well being in the long term.
[47] **Schizophrenia -** A chronic mental health condition that causes a range of psychological symptoms including delusions (believing in things that are untrue) and hallucinations (hearing or seeing things that do not exist). Hallucinations and delusions are often referred to as psychotic symptoms, or symptoms of psychosis.
[48] **Carer's Assessment -** An assessment by Social Services which looks at a carer's situation to see if the carer is entitled to any services that could make caring easier for them. A **carer** is anyone who looks after relatives or friends who are frail, sick disabled or vulnerable for no pay.
[49] **Mental state examination -** An assessment of the individual's current state of mind. It assesses the range, quality, and depth of perception, thought processes, feelings, and psychomotor actions.
[50] **Psychosis -** Severe mental derangement involving the whole personality. These are severe mental disorders characterised by psychotic symptoms e.g. delusions, hallucinations and disorganised thinking. They are often divided into Functional Psychoses (mainly schizophrenia and manic depressive psychosis (or Bipolar affective disorder)) and Organic Psychoses (confusional states or delirium, dementias, drug induced psychosis).

Early Intervention Service until he moved to Scotland to be with his maternal grandparents

Motherwell Mental Health Services, Scotland: February 2006 – June 2007

1.49 Soon after moving to Scotland to join his grandparents, in **February 2006**, at nineteen years of age, Mr H presented at the Accident and Emergency Department of Wishaw General Hospital having taken an overdose of Diazepam[51], which he admitted to buying illicitly, and Quetiapine[52] (a prescribed antipsychotic medication). He also reported drinking alcohol to excess, taking Amphetamine-based drugs[53], and that he was hearing voices.

1.50 Mr H was seen for a second time in **February 2006** at Wishaw General Hospital in Scotland following an overdose of his prescribed anti psychotic medication, Quetiapine. Mr H reported suffering from frequent intrusive negative thoughts, which were also disrupting his sleep, and that he was using more medication to help him sleep. During this assessment he was described as being *'flat in his affect'* (presenting a lack of emotional expression), difficult to engage, having poor concentration and poor eye contact. He was admitted to the Medical Unit of Wishaw General Hospital for care and assessment.

1.51 Mr H's grandparents advised hospital staff of their concerns in relation to Mr H's difficult and aggressive behaviour and so when he was medically fit he was referred to the Psychiatric Ward[54] of Wishaw General Hospital, to which he was admitted on **2 March 2006**.

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[51] **Diazepam –** A prescription drug which affects chemicals in the brain that may become unbalanced and cause anxiety. Diazepam is used for the management of anxiety disorders or for the short-term relief of symptoms of anxiety. Diazepam may also be used to relieve agitation, shakiness, and hallucinations during alcohol withdrawal and relieve certain types of muscle spasms. It may also be used to treat seizures, insomnia, and other conditions as determined by your doctor.

[52] **Quetiapine -** A prescription drug used to treat symptoms of schizophrenia such as hearing, seeing or sensing things that are not real, mistaken beliefs and thoughts, and problems dealing with other people. It is also used to control the *'highs'* (excited moods) and *'lows'* (depressed moods) of bipolar disorder, and in addition to other treatment in depression.

[53] **Amphetamine -** A drug with a stimulant effect on the central nervous system that can be both physically and psychologically addictive when overused. The street term 'speed' refers to amphetamine-based drugs.

[54] **Psychiatric Ward -** A hospital ward providing in-patient and outpatient therapeutic services to patients with mental health issues.

1.52 On **13 March 2006**, Mr H walked out of Wishaw General Hospital and unknown to hospital staff and his family, he returned to Caerphilly by train. He presented himself at Caerphilly Police Station reporting feelings of depression[55] and following assessment by the Forensic Medical Examiner[56] was referred to Tŷ Sirhowy Hospital. The doctor who assessed him at Tŷ Sirhowy contacted Wishaw General Hospital to obtain details of his admission there and was told that Mr H was due to be discharged that day. It was decided that based on his presentation, he did not require admission to Tŷ Sirhowy. Mr H told the Tŷ Sirhowy doctor that he would make his own arrangements to travel back to Scotland.

1.53 Two days later, on **15 March 2006**, the police were called to Mr H's mother's house in the Caerphilly area, as she felt unable to cope with him, although he had not been violent or threatening. Subsequently, Mr H returned to live in Scotland.

1.54 On **20 June 2006** Mr H was re-admitted to Wishaw General Hospital following a review at the outpatient clinic. At this time there were concerns about his deteriorating mental health and an examination undertaken on his admission noted Mr H's poor self care and neglect, the absence of emotional expression, withdrawal from contact with others as well as poor eye contact and a degree of agitation and hostility. Mr H also appeared distracted and his thoughts appeared muddled. Mr H frequently left the ward without telling staff and had to be placed on constant observations.

1.55 The option to detain Mr H was considered in **July 2006** and an application was made for a Compulsory Treatment Order (CTO)[57] under the Mental Health (Care and Treatment Scotland) Act 2003[58]. However, as Mr H was accepting medication a CTO was not felt to be appropriate at that time.

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[55] **Depression -** One of the most common forms of mental health problem and can occur to people of all ages. Symptoms include feelings of despair, hopelessness and worthlessness, an inability to cope, sleep problems and sometimes thoughts of suicide.

[56] **Forensic Medical Examiner -** A doctor who examines and treats members of the police force for duty-related injuries and illnesses and gives first-aid treatment to civilians under arrest.

[57] **Compulsory Treatment Order -** A compulsory treatment order under the legislation for Scotland authorises the detention in hospital and/or treatment of a person for a period of six months. It has a built-in review mechanism, and only a Mental Health Tribunal may grant one.

[58] **Mental Health (Care and Treatment Scotland) Act 2003 -** An Act of the Scottish Parliament which applies to people with a mental disorder (including mental health problems, personality disorders and learning disabilities). The Act allows for people to be placed on different kinds of compulsory order according to their particular circumstances.

1.56 In **September 2006** Mr H was referred to the Rehabilitation Unit[59] at Wishaw General Hospital but attempted suicide by hanging himself on the ward. His medication was increased. Following this his mental state was recorded to have improved, although he continued to leave the ward.

1.57 On **1 November 2006**, Mr H walked out of the hospital and presented to a police station, having consumed alcohol. A referral was made to the Learning Disabilities Team.

1.58 Mr H was transferred to a Rehabilitation Unit on **21 November 2006** but was unsettled there and in early **December 2006** he was transferred back to the Psychiatric Ward at Wishaw General Hospital. He subsequently discharged himself against medical advice.

1.59 For the next four months Mr H regularly attended the Accident and Emergency (A&E)[60] department at Wishaw General Hospital complaining of hearing voices, experiencing feelings of loneliness and paranoia[61] and not taking his medication. On **14 February 2007** at twenty years of age, Mr H was again admitted to hospital after complaining of feeling depressed and suicidal. He later walked out of the ward but just prior to doing so he struck another patient without any provocation. After he left he refused to return and was discharged from the ward on **5 March 2007**. He continued to present himself to the A&E department throughout March, including more than once on the same day.

1.60 Mr H was reviewed by a staff grade psychiatrist on **3 April 2007**. His medication was altered and he was referred to the Mental Health Day Unit[62].

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[59] **Rehabilitation Unit -** Provides services mainly to patients who have undergone a period of acute hospital care and require further in-patient rehabilitation prior to discharge to enable them to maintain and lead as independent life as is possible for them.

[60] **Accident and Emergency (A&E) Departments -** Sometimes referred to as 'casualty' departments, A&E departments assess and treat people with serious injuries and those in need of emergency treatment.

[61] **Paranoia -** Experiencing persecutory or grandiose delusions. 'Paranoid ideation' is another term which covers delusions, but may also include the experience of suspicious ideas and beliefs that one is being harassed, persecuted, or treated unfairly.

[62] **Mental Health Day Unit -** Centre providing services to people with long-standing mental health problems, who are usually under the care of a Community Mental Health Team.

1.61 Throughout his period of care under mental health services in Scotland, Mr H was not given a firm psychiatric diagnosis and consultant psychiatrists felt that he may have had a degree of learning disability. Some attempt was made to obtain information from services in South East Wales but they were not made aware that a diagnosis of Asperger's Syndrome had already been made.

1.62 Mr H returned to live in South Wales in June 2007; as a result he was officially discharged by the mental health services in Scotland in **October 2007**.

Caerphilly Community Mental Health Team: June to August 2007

1.63 In **June 2007**, Mr H travelled down from Scotland to Wales by train taking four days to complete this journey. His parents refused to take him in, and he presented himself at Tŷ Sirhowy Hospital. When he attended the hospital he was noted to be extremely unkempt and generally uncommunicative. He was admitted to Tŷ Sirhowy and ward staff contacted Mr H's mental health team in Scotland to discuss whether he should be transferred back to Wishaw General Hospital. It was agreed that the MDT at Tŷ Sirhowy would make a decision about whether this was necessary in a few days time once they had assessed his mental state.

1.64 Several days later Mr H assaulted another patient on the ward at Tŷ Sirhowy without provocation. Ward staff contacted the police and explained to them that Mr H would not be allowed to stay on the ward due to the risk he posed to others and himself. Tŷ Sirhowy staff contacted the Psychiatric Intensive Care Unit (PICU)[63] at St Cadoc's Hospital who confirmed that a bed would be available for Mr H should he be assessed as needing to be detained under the Mental Health Act. The police removed Mr H from the ward for breach of the peace and took him to the police station where a Mental Health Assessment was undertaken. He was assessed as requiring detention under Section 2 of the Mental Health Act, and so Mr H was admitted to the PICU at St Cadoc's Hospital.

[63] **Psychiatric Intensive Care Unit (PICU) -** A locked ward in a hospital where some people detained under the Mental Health Act may be compulsorily detained. Patients are placed in PICU because they are assessed as being a risk to themselves or others on an open acute in-patient ward.

1.65 A week later (in early **July 2007**) Mr H was transferred from St Cadoc's Hospital back to Tŷ Sirhowy as his behaviour had settled. However, after returning to the ward he appeared agitated and to be openly responding to voices. He made threats to the patient he had previously assaulted, believed that other people on the ward were talking about him and absconded from the ward on two separate occasions. After 48 hours at Tŷ Sirhowy, he was transferred back to the PICU at St Cadoc's Hospital.

1.66 Mr H's Responsible Medical Officer (RMO)[64] at this time was Dr A, the CMHT's consultant psychiatrist. He felt that Mr H was suffering from hebephrenic[65] type of schizophrenia and was in need of continued detention under Section 2 of the Mental Health Act with a possibility of him being transferred to Section 3. In a report prepared for the Mental Health Review Tribunal, dated **11 July 2007**, Dr A stated that the need for Mr H's detention was *'due to his continued persecutory ideation'* (paranoia that he was being persecuted by others) and *'possible auditory hallucinations'* (hearing voices). He also stated that Mr H remained *'a risk to other people of violence'* and that there was a *'continuing risk of self neglect and non compliance with ongoing medication and engagement with the Mental Health Team.'*

1.67 Dr A referred in this report to Mr H's period of care under mental health services while in Scotland, including his many presentations at A&E *'either drug seeking or looking for admission complaining of psychotic symptoms or depressive symptoms.'* It also noted that Mr's H's mental health had deteriorated when he had been non-compliant with medication.

[64] **Responsible Medical Officer (RMO) -** The registered medical practitioner, generally a consultant psychiatrist, in charge of the patient's treatment (as defined in Section 34 of the Mental Health Act 1983 prior to November 2008). Since November 2008 this role has been replaced with that of the **Responsible Clinician (RC)** who is the approved clinician with overall responsibility for the patient's case (as defined in section 34 of the Mental Health Act 1983).

[65] **Hebephrenic schizophrenia -** A complex and chronic psychiatric disorder, often known as *'disorganised schizophrenia.'* It is characterised by illogical thought patterns and erratic speech (e.g. jumping abruptly from one topic to another when talking, responding to questions with answers which have little or no relevance to the question, or stopping suddenly while talking, as if the thought has abruptly left them), bizarre behaviour (for instance, wearing layer upon layer of clothing in the middle of summer, neglecting their personal grooming, having a very unkempt appearance, and lacking the motivation for simple tasks such as getting dressed or preparing a meal) and blunted or inappropriate emotional expression and response (e.g. appearing to have no emotions).

1.68 On **16 July 2007**, the Mental Health Review Tribunal decided that Mr H should not be discharged from his detention under the Mental Health Act. The following day Mr H was assessed and detained under Section 3 of the Mental Health Act. The Tŷ Sirhowy team decided that Mr H needed a structured management plan with clearly defined boundaries which could be better provided in a low secure unit[66]. A referral was made to Cygnet Hospital Kewstoke in Weston-Super-Mare, an independent sector mental health hospital with which Gwent Healthcare NHS Trust had a contract for providing low secure placements.

1.69 An associate registrar from Cygnet Hospital conducted an assessment of Mr H at PICU, St Cadoc's on **1 August 2007** and recommended that he be admitted to Cygnet Hospital for further assessment with a view to him being placed on the complex care ward[67].

1.70 The Continuing Healthcare Team[68] at the then Torfaen Local Health Board[69], which was responsible for commissioning independent hospital[70] placements for patients in the Gwent area, agreed the application for Mr H's transfer to Cygnet Hospital on **16 August 2007**. The confirmation letter clearly stated that as and when Mr H was ready to return to Caerphilly *'to a more appropriate community based*

[66] **Low secure units** - deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. Low secure units aim to provide a homely secure environment, through domestic levels of physical security such as a locked door, provided to impede (rather than completely prevent) those who wish to either escape or abscond. Low secure units rely more on staff observation and support rather than physical security arrangements, and have occupational and recreational opportunities and links with community facilities. Patients will usually be detained under the Mental Health Act requiring help, support and rehabilitation for several years.

[67] **Complex care ward** - A hospital ward which is dedicated to patients with complicated needs, such as the treatment of more than one condition, elderly patients and patients who need the care of professionals in a number of different specialities, for example occupational therapists, physiotherapists, dieticians and pharmacists. These patients need special care to ensure they can go home safely and quickly.

[68] **Continuing Healthcare team** - A team responsible for assessing and case managing individuals who meet the criteria for Continuing Healthcare funding by the NHS. Continuing Healthcare is a package of care arranged and funded solely by the NHS where it has been assessed that the individual's primary need is a health need. The NHS is responsible for assessing, arranging and funding a wide range of services to meet the health care needs, both short and long term, of the population. In addition to periods of acute health care, some people need care over an extended period of time, as the result of disability, accident or illness to address and/or physical and mental health needs. These services are normally provided free of charge. The team assess patients to see if they are eligible for Continuing Healthcare and manage each application to ensure appropriate services are commissioned.

[69] **Torfaen Local Health Board (LHB)** - at this time was acting on behalf of all five LHBs in the Gwent area to coordinate and manage Continuing Healthcare. Since the NHS Wales reorganisation in October 2009, Aneurin Bevan Health Board has responsibility for Continuing Healthcare in the Gwent area.

[70] **Independent hospital** - A hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients themselves or, by insurers, or by the NHS (e.g. through Continuing Healthcare).

service, as his needs would have changed, the team would need to submit an application in view of these changes, the nature of community service provision, costs of the new service.'

1.71 When a detained patient is transferred to another hospital outside the management of the original hospital, it is necessary for the new detaining hospital to identify its own RMO who is responsible for the patient's care during their placement there. In circumstances where the patient is placed out-of-area in this way, a care co-ordinator from the home team (in Mr H's case, his local CMHT) remains actively involved in the patient's case and oversees the CPA process. This care co-ordinator role was allocated to a social worker from the CMHT, who was a part-time worker. Her supervisor, a senior social worker, represented the care co-ordinator at meetings when the care co-ordinator was not working. The CMHT consultant psychiatrist, Dr A, attended some of Mr H's CPA reviews and Mental Health Review Tribunals while Mr H was at Cygnet Hospital, which was good practice in order to plan for his eventual return to the Caerphilly area.

Cygnet Hospital: August 2007 to October 2008

1.72 Mr H was transferred to Cygnet Hospital [71]on **21 August 2007** where he was admitted to the Psychiatric Intensive Care Unit (PICU). Records show that he settled onto the ward and began to attend occupational therapy sessions.

1.73 In **October 2007** Mr H was granted escorted leave to see his grandfather in Scotland who was terminally ill. However the day prior to him travelling up to Scotland Mr H became agitated and aggressive both physically and verbally. The trip was postponed for a couple of weeks but again he became agitated and aggressive in the days leading up to the trip and so he was not escorted to Scotland. Mr H was noted to be very anxious about these visits and became quite distressed and threatening towards staff and the ward environment. At this time Mr H was

[71]Cygnet Hospital, among several other providers, was on this list, although this did not exclude other healthcare services being used by Gwent Healthcare NHS Trust according to individual patient need. Cygnet Hospital was the first of the secure units to engage with Gwent Healthcare NHS Trust in developing block booking contracts which resulted in reduced costs for individual placements. The Trust also continued to place individuals in other low secure units throughout this period.

described as showing lack of motivation, drive and enthusiasm to engage in any activities on the ward. He needed prompting to do almost anything for himself. Mr H's RMO at Cygnet Hospital, Dr B, considered that Mr H's behaviour was directly related to the stress associated with travelling to Scotland.

1.74 In **November 2007** Mr H was moved to the rehabilitation ward at Cygnet Hospital. During this time Mr H undertook activities such as swimming, going to the gym and playing pool with staff and fellow patients. A risk assessment dated **29 November 2007** recorded his risk of aggression to people as *'moderate (high when stressed).'*

1.75 A report dated **30 January 2008** prepared by Dr B noted that Mr H's medication had been changed, as he had become more withdrawn which compromised his ability to participate in rehabilitation activities. Dr B felt that Mr H's presentation was consistent with the diagnosis of hebephrenic schizophrenia that had been made by Dr A. However, Dr B did not agree that Mr H had Asperger's Syndrome as he felt his social and other skills were better developed than such a diagnosis would indicate.

1.76 In **February 2008** at twenty-one years of age, Mr H had his first period of unescorted leave under Section 17[72] of the Mental Health Act. He returned to the ward with cannabis and alcohol, and as a result all of his subsequent leave was cancelled. He was also required to complete a drug and alcohol awareness and relapse prevention programme. Dr B wrote an addendum to his psychiatric report for the Mental Health Review Tribunal in **March 2008** saying that this incident strongly reinforced his opinion that criteria for further detention were met in full.

1.77 At a review meeting on **2 April 2008** it was noted that Mr H's grandfather had died at the weekend. A decision was made to grant Mr H escorted leave to attend his grandfather's funeral. A risk assessment completed later in April 2008 recorded bereavement as an area of concern to be addressed. A named nurse was allocated

[72] **Section 17 of the Mental Health Act 1983** allows for detained patients to be granted Leave of Absence from the hospital in which they are detained.

to spend one-to-one time with Mr H to allow him to express his thoughts and feelings.

1.78 On **22 April 2008** Mr H was transferred from the rehabilitation ward to the PICU at Cygnet Hospital because of deterioration in his behaviour including having made threats to other patients, attacked a member of staff and set fire to a bin in his bedroom. He had also told staff that he wanted to commit suicide. Following his transfer to the PICU, Mr H was placed on continual observations and his location was checked by staff every five minutes due to the unpredictability of his behaviour.

1.79 On **24 April 2008** a Mental Health Review Tribunal was held to consider whether Mr H should continue to be detained under Section 3 of the Mental Health Act. The care co-ordinator from the CMHT was not able to attend and so another social worker attended on her behalf. The social worker's case notes recorded that the RMO from Cygnet Hospital (Dr B) told the Tribunal that Mr H *'had made little progress since his transfer to Cygnet Hospital and he was looking at transferring* [Mr H] *to another private hospital.'* This was named as a unit in Pontypridd run by Ludlow Street Healthcare, which caters for people with mental health and learning disabilities. The Tribunal decided to adjourn until 15 May 2008 as it required updated medical and social reports in order to make a decision. The Tribunal panel requested that Mr H's care co-ordinator and consultant psychiatrist from the CMHT (Dr A) attend the next meeting of the Tribunal. It also recommended that a Section 117 after-care meeting[73] should be held prior to the next Tribunal to make arrangements for Mr H's after-care[74] should he be discharged.

1.80 The Section 117 after-care meeting to plan Mr H's after-care under Section 117[75] of the Mental Health Act took place on **7 May 2008**, and was attended by Mr

[73] **Section 117 after-care meeting -** A multi-disciplinary team meeting to plan and agree the package of support to be provided for a patient following their discharge from hospital (see *'after-care'* and *'Section 117 of the Mental Health Act'* below).
[74] **After-care -** services which are provided to meet an assessed need arising from the patient's mental disorder and are aimed at reducing the likelihood of the patient being readmitted to hospital for treatment for that disorder. An after-care plan will be developed by the MDT with the service user prior to the patient's discharge, which will make clear what care and support will be provided.
[75] **Section 117 of the Mental Health Act 1983 -** Places a duty on local authorities and local health boards, in collaboration with non-statutory agencies, to provide after-care support services (which may include , include accommodation) for people who have been discharged from hospital having been detained for treatment under the Mental Health Act.

H's care co-ordinator from the CMHT. According to case notes, she *'informed the meeting that should* [Mr H] *be discharged his option would be to present at the homeless office.'* It was agreed by all present, including Dr B and the ward manager from Cygnet Hospital that *'this situation would be detrimental to* [Mr H] *as he is extremely vulnerable.'*

1.81 A Tribunal Report prepared by nursing staff from the PICU at Cygnet Hospital on **11 May 2008** recommended that Mr H should continue to be detained under the Mental Health Act. They stated that *'it is our professional opinion that* [Mr H] *would disengage with mental health services if not under section and could have poor concordance to all medication.* [Mr H's] *mental state would deteriorate and he would become a vulnerable young adult at the present time.'*

1.82 The Mental Health Review Tribunal reconvened on **15 May 2008**. Mr H's RMO was recorded as being another Cygnet Hospital consultant psychiatrist, Dr C (as Dr B was no longer working for Cygnet Hospital. Dr C temporarily covered RMO responsibilities for Mr H until a new (locum) consultant psychiatrist was appointed a few weeks later). Dr C told the Tribunal that he did not believe Mr H to be suffering from a mental illness, but from Asperger's Syndrome[76], and thus he felt Mr H ought to be transferred to a more appropriate setting to address his needs. The Tribunal was attended by the care co-ordinator's supervisor and by Dr A from the CMHT. Dr A told the Tribunal that it was his clinical opinion that Mr H had a mental illness (hebephrenic schizophrenia). The Tribunal's decision report stated that while *'there is no clear diagnosis and the evidence of mental illness is not the strongest,'* that *'on balance we conclude that he is suffering from a mental illness'* of a *'chronic and relapsing'* nature. It concluded that Mr H needed to continue to be detained under the Mental Health Act.

1.83 The Tribunal did however decide that Cygnet Hospital was *'an inappropriate setting'* and stated: *'we strongly believe that he should be transferred to his local unit with a minimum of delay so that proper arrangements can be made for his care in the community, if that is considered appropriate'* at a later stage. It also

[76] Cygnet Hospital Kewstoke had not been advised of Mr H's diagnosis of Asperger's Syndrome in November 2001

recommended that the transfer be carried out as early as possible and indicated that the tribunal panel would reconvene if the recommendation was not adhered to by 6 June 2008.

1.84 On **20 May 2008** a locum consultant psychiatrist at Cygnet Hospital, Dr D, took over RMO responsibility for Mr H.

1.85 On **21 May 2008** Mr H was discussed at the CMHT's weekly MDT meeting. According to records, Dr A made it clear that he *'would not be happy for* [Mr H] *to be returned to Tŷ Sirhowy, as was directed by the Tribunal.'* He was aware of the aggressive behaviour that Mr H had displayed while an in-patient at Tŷ Sirhowy previously, and believed that he needed to be placed in a low secure facility. Dr A felt that Tŷ Sirhowy could not offer the appropriate level of security to best meet Mr H's complex needs, and told the MDT that he would contact Mr H's RMO at Cygnet Hospital to discuss his concerns.

1.86 At around this time, Mr H's care co-ordinator made initial attempts to alert the Continuing Healthcare Team[77] at Torfaen Local Health Board to the fact that Mr H would require a placement elsewhere as he was due to be transferred from Cygnet Hospital. The issue was also brought to the attention of senior mental health managers at the then Gwent NHS Trust, through an email chain dated **29 May 2008**. It is evident from these emails that various low secure units were flagged as possible alternative placements where Mr H could be transferred. These included facilities in Ebbw Vale, Pontypridd and Bristol (all of which were part of the independent sector rather than the NHS). However, it does not appear that any attempts were made to secure a placement for Mr H at any of these facilities.

1.87 Mr H was transferred from the PICU to the Challenging Behaviours ward at Cygnet Hospital on **29 May 2008**.

[77] **Continuing Healthcare team -** A team responsible for assessing and case managing individuals who meet the criteria for continuing healthcare funding by the NHS. The team assess patients to see if they are eligible for funding and manage each application to ensure appropriate services are funded.

1.88 Dr A (the consultant psychiatrist at the CMHT) spoke to Dr D (Mr H's RMO at that time at Cygnet Hospital) at the beginning of June 2008. Records show that Dr A explained that he was *'unhappy with tribunal's recommendation'* and felt that Mr H should stay at Cygnet given that Mr H had recently absconded, brought cannabis back to the ward, been aggressive and had suggested that he wanted to hang himself. Dr D told him that he was *'happy with the current placement'* on the ward.

1.89 Between **June and September 2008** Mr H was both verbally and physically aggressive on the ward. Incidents included him threatening and assaulting staff and fellow patients and causing damage to the ward environment by punching and kicking doors and windows. He had to be restrained on numerous occasions. He also revealed ideas of self harm and expressed fears of being discharged with no place to live, no money and no job. Mr H said that he feared that he may go back on illicit drugs.

1.90 A nursing report dated **2 July 2008** stated that Mr H *'should remain on section 3 of the Mental Health Act to facilitate further assessment, treatment and improvement of his condition*. [Mr H] *continues to present a risk to others as he is easily provoked into becoming abusive/ aggressive due to current poor coping strategies. Risk to himself is also apparent as* [Mr H] *would neglect his self care and possibly be vulnerable to exploitation from others.'*

1.91 A follow up Mental Health Review Tribunal took place on **3 July 2008**, which upheld that Mr H should continue to be detained under Section 3 of the Mental Health Act. Mr H's care co-ordinator was unable to attend the Tribunal as she was on annual leave, but another social worker attended in her place. It was recorded in the case notes that a CPA/ Section 117 meeting was due to be held on 30 July 2008, and that *'the Tribunal have urged that this be used to plan for a move to a more suitable placement ASAP'* and strongly recommended that Dr A, the care co-ordinator and a nursing representative from his local CMHT attend.

1.92 On **29 July 2008**, a risk assessment undertaken by nursing staff at Cygnet Hospital recorded Mr H's risk of violence to others as *'significant.'* A nursing report

prepared the same day included a recommendation to *'strongly discourage the use of PRN*[78] *medication, taking into consideration the history of illicit substance misuse.'*

1.93 On **3 September 2008** Mr H was given a trial of unescorted leave to the hospital grounds. He walked straight out of the hospital entrance to the local shop and bought cans of beer. Subsequently Mr H was escorted by staff from the complex care ward for all leave (under Section 17 of the Mental Health Act): *'therapy leave; one hour three times a week escorted by staff in the grounds; one hour once a week in the locality escorted by staff; three hours once a week to the bank and to the town centre escorted by staff.'*

1.94 A note of a conversation held on **8 September 2008** between Mr H's care co-ordinator and nursing staff from the ward at Cygnet Hospital records that the nursing and ward staff at Cygnet Hospital felt that Mr H *'should remain with them in order to be given the best possible chance of rehabilitation.'*

1.95 At this time the care co-ordinator wished to apply for placements for Mr H at supported accommodation[79] for people with mental health issues, but felt unable to make any such referrals without a firm diagnosis from Mr H's consultant psychiatrist at Cygnet Hospital (Dr D). Records show that on **8 September 2008** and on **17 September 2008** she spoke to staff at Cygnet Hospital asking them to liaise with Mr H's doctor so that a formal diagnosis could be provided in writing to assist her.

1.96 On **24 September 2008** the care co-ordinator and her supervisor visited Cygnet Hospital and met with Mr H and also with Dr D. The Caerphilly Social Services case notes record that Dr D informed them that '*it was felt that during the last year there had been no evidence of mental illness in* [Mr H's] *presentation, there poses the question of why* [Mr H] *is still being detained at Kewstoke.'* The social workers were informed that Mr H's antipsychotic medication (Haloperidol) had been stopped. He reported feeling more agitated and had smashed windows the previous week.

[78] **PRN medication** - *'Pro re nata'* – medication to be taken *'as and when needed.'*
[79] **Supported accommodation -** An individual tenancy where you receive extra support from specialist staff, ranging from weekly visits to intensive 24 hour support. The accommodation and support is provided by organisations with expertise in supporting vulnerable people to improving life skills and opportunities.

1.97 On **25 September 2008**, the care co-ordinator was informed that the application made for supported accommodation for Mr H had been rejected due to Mr H's *'presenting volatile behaviour.'*

1.98 A Nursing Report prepared by the nursing staff at Cygnet Hospital on **28 September 2008** advised that *'the risks to himself and others would be extremely high if he were discharged into the community without an intense level of community support. The MDT have grave concerns that* [Mr H] *does not demonstrate the personal skills he would need to be able to live independently and the elevated risk of violence towards himself and others, plus the high risk of self neglect could lead to serious consequences for him.'*

1.99 Mr H's care co-ordinator produced a *Social Circumstances Report*[80] on **29 September 2008** which stated that, *'it has been extremely difficult to explore options in order to meet* [Mr H's] *needs, as to date there has been much confusion and deliberation with regards to a firm mental health diagnosis.'* It went on to say that finding accommodation for Mr H on his return to Caerphilly *'depends on a mental health diagnosis which is currently unclear.'* However, in the second line of that same report she states that *'Mr H has an established diagnosis on his last admission of Schizophrenic illness.'* The report points out that an application for supported accommodation had been unsuccessful *'as it was felt that he posed a high risk to other residents.'* As a result, the report clearly states that the only remaining option was that '*should* [Mr H] *be discharged he would present as homeless at the local Homelessness Unit. Should there not be housing available,* [Mr H] *would be placed upon the waiting list and homed temporarily within bed/breakfast accommodation.'* The report ends with the following statement: *'following discussions with* [Dr D] *and his nursing team it would seem that* [Mr H] *is not currently suffering from a mental illness. Therefore it is impossible to justify further detention on these grounds. However, there are concerns regarding risks due to* [Mr H's] *presenting behaviour.'*

[80] **Social Circumstances Report -** A report, usually prepared by a representative from Social Services, to provide information to a Mental Health Review Tribunal (MHRT) on a patient's social care needs.

1.100 On **30 September 2008**, Dr D produced a CPA Doctor's Report which stated Mr H's diagnosis as *'Asperger's Syndrome and Schizophrenia.'* Mr H's Haloperidol had recently been stopped, and on this date Dr D decided to also stop his Depakote[81]. As a way of weaning him off his medication gradually, Mr H was prescribed Olanzapine, with the intention of this being reduced or stopped a week later.

1.101 A Section 117 after-care meeting was held at Cygnet Hospital on **1 October 2008**, which was attended by consultant psychiatrists from both Cygnet Hospital (Dr D) and the CMHT (Dr A), as well as ward staff and the care co-ordinator. Social Services notes of the meeting record that Dr D felt that Mr H *'had not displayed any indication of mental disorder while detained'* but that Dr A *'disagreed with this and stated that he still stood by his original diagnosis'* of hebephrenic schizophrenia. It was agreed that for the purposes of the forthcoming Mental Health Review Tribunal due to take place the next day, it would be stated that Mr H was presenting with a mental illness of a *'nature'* but not a *'degree'*[82] which satisfied the criteria for detention under the Mental Health Act. The report of the Section 117 after-care meeting stated that Mr H was suffering from a mental disorder (hebephrenic schizophrenia), that he required treatment in hospital, and that he needed to be detained under the Mental Health Act to receive this treatment.

1.102 It was recorded in the report of this meeting that *'discharge from hospital is supported by the clinical team… only if a suitable package of after-care is in place.'* Social Services notes record that Mr H stated that *'should he return to Tŷ Sirhowy he would probably carry out unprovoked attacks on other patients as on previous occasions.'*

1.103 It is also recorded that the care co-ordinator informed the meeting that an application for supported accommodation for Mr H had been unsuccessful due to his

[81] **Depakote -** A type of medication known as a mood stabiliser used to treat the abnormal mood swings of people with psychiatric illness. People with illnesses such as bipolar affective disorder or manic depression suffer from abnormal mood swings, which range from episodes of abnormally high mood (mania or hypomania) to episodes of abnormally low mood (depression).

[82] If the person is suffering from a mental disorder of a ***'nature'*** or ***'degree'*** which makes it appropriate for them to receive medical treatment in hospital they are eligible to be detained for treatment under Section 3 of the Mental Health Act 1983.

'volatile behaviour.' She explained that if he were to be discharged, his only option would be to present as homeless, which *'would enable* [Mr H] *to be assessed and probably placed in temporary accommodation such as a bed and breakfast with a view to more suitable accommodation when it became available, such as a flat.'* The accommodation facilities section of the after-care plan[83] agreed by the MDT at the Section 117 after-care meeting records Mr H as being discharged to a *'Homeless persons B&B.'*

1.104 Following the Section 117 after-care meeting, Dr D produced an Update Report for the planned Mental Health Review Tribunal of **2 October 2008**, which states *'I do not believe that* [Mr H] *satisfies the criteria for detention, in terms of the degree of his illness. However, he still satisfies the criteria in terms of the nature of his illness.'* Dr D stated that he had no wish to discharge Mr H until he had received *'confirmation regarding a robust after-care package for him, including accommodation.'* The Tribunal was adjourned until 21 October 2008.

1.105 Case notes made on **2 October 2008** show that Dr D met with the care co-ordinator's supervisor from the CMHT and informed her that Mr H would be discharged (from detention under the Mental Health Act, and also from Cygnet Hospital) on 7 October 2008.

1.106 On **6 October 2008** the care co-ordinator telephoned the housing team from Caerphilly County Borough Council to make an appointment for Mr H as he was due to be discharged the following day. The housing officer was reluctant to provide an appointment for Mr H without having seen a risk assessment from Cygnet Hospital. Case notes record that the care co-ordinator told her that '*Cygnet would bring* [Mr H] *to the homeless office with or without an appointment, without her consent,'* so she agreed to make him an appointment.

1.107 Cygnet Hospital records note that on **7 October 2008** Mr H and the staff on the ward attempted to contact the Benefits Office several times in order to arrange Mr H's welfare payments upon his discharge, but the line was continuously engaged.

[83] **After-care plan –** A written plan setting out how after-care (within the meaning of Section 117 of the Mental Health Act) will be provided within the resources available

There is no evidence of this being further followed up by staff at Cygnet Hospital or of information being passed on to the care co-ordinator or the CMHT about the need to arrange Mr H's welfare benefits.

1.108 Mr H was not discharged on 7 October 2008 as had been planned. Instead, on **8 October 2008**, the ward manager at Cygnet Hospital spoke to the care co-ordinator and informed her that they wanted to discharge Mr H on 9 October, but that Dr D (his consultant psychiatrist) wanted to talk to Dr A (the CMHT's consultant psychiatrist) before he did so. The care co-ordinator asked Dr A to call Dr D. A note of the conversation recorded in Cygnet Hospital notes states that Dr A, *'has discussed with the care co-ordinator. He is happy that we discharge* [Mr H]. [Mr H] *shows no evidence of schizophrenia. While we acknowledge the risks to self, others and health and safety, we can't hold him on the section as* [Mr H] *shows no evidence of* [mental illness]. *To be discharged from the section tomorrow. Care package in place for* [Mr H] *as agreed at the CPA meeting. This is the best that can be provided – though there are concerns that this may not be enough. Recent Tribunal was adjourned but it is likely that he would be discharged when it reconvenes...* [Mr H has been] *seen, no evidence of mental illness, happy to be discharged tomorrow.'*

1.109 On **8 October 2008** the care co-ordinator telephoned the homelessness officer to arrange an appointment for Mr H on his discharge. The housing officer requested that someone from the CMHT attended the appointment. The care co-ordinator was not available on 9 October as she was a part time worker so she recorded in the case notes that her supervisor would attend instead. She then telephoned Mr H to let him know that Cygnet Hospital had arranged to transport him back to Caerphilly and that her supervisor would be waiting for him at the homelessness office.

1.110 A care plan was prepared by the CMHT on **8 October 2008**, although several sections are left blank and it is unsigned. The relapse indicators section states that Mr H had a risk of developing episodes of psychosis, that this was more likely to happen if he was experiencing stresses caused by drug and alcohol misuse, and recorded the early warning signs that things are not going well as *'violence and aggression.'*

1.111 On **9 October 2008**, Mr H was discharged from his detention, under Section 23 of the Mental Health Act which gives an RMO the power to discharge a patient. Mr H's RMO had since May 2008 been Dr D, a locum consultant psychiatrist. However, Dr D was on leave on 9 October, and so the Section 23 discharge documentation was signed by Dr C, a consultant psychiatrist employed by Cygnet Hospital, acting as Mr H's RMO in Dr D's absence.

1.112 Two members of staff from Cygnet Hospital drove Mr H to the Caerphilly homelessness office. They waited with him in their vehicle until his detention period officially expired at 1.30pm, and then left him in the foyer of the homelessness office with his belongings.

1.113 Later that day, Mr H was placed by the Caerphilly homelessness team in a bed and breakfast hostel for homeless people in Argoed.

1.114 A *Discharge Summary* prepared by a member of Dr D's clinical team at Cygnet Hospital on **15 October 2008** attributes Mr H's problems to his substance misuse and notes that he showed *'no evidence of mental illness.'*

Caerphilly Community Mental Health Team: October 2008 – January 2009

1.115 Following his discharge from Cygnet Hospital on Thursday 9 October 2008, there is no record of Mr H in CMHT case notes until the following Monday **13 October 2008**. The care co-ordinator spoke to Mr H on the telephone who told her that he had informed the benefits office of his change of address and would speak to her next week. The care co-ordinator also spoke to the homelessness team and arranged for Mr H's belongings to be collected from their office the following day.

1.116 The minutes of the CMHT weekly MDT meeting on **14 October 2008** and on **21 October 2008** contain no mention of Mr H.

1.117 On **20 October 2008**, a meeting was arranged under Section 115 of the Crime and Disorder Act 1998[84] to share information amongst agencies in relation to concerns about Mr H. Representatives of Social Services, the police and housing attended. Minutes of the meeting show that questions were raised about whether Mr H was *'likely to "pounce" on someone'* and the care co-ordinator and her supervisor explained that Mr H had a history of violent incidents including an unprovoked attack on a member of ward staff at Tŷ Sirhowy. The emergency housing officer is noted to have suggested that Mr H's placement in the bed and breakfast was therefore a risk. He agreed to arrange for a temporary flat for Mr H initially for a period of three to six months, and the police officer asked to be informed of where Mr H would be residing. The care co-ordinator's supervisor suggested at this meeting that it might be a good idea to refer Mr H to the Assertive Outreach Team[85], but the care co-ordinator explained that she had already tried and he had been turned down *'as they felt he did not meet the criteria.'*

1.118 Following his discharge from Cygnet Hospital on 9 October, Mr H was not seen by either health or Social Services until **22 October 2008** when his care co-ordinator visited him with a member of the Substance Misuse Team[86]. Mr H refused to engage in the assessment or in the work of the team and so his case was closed by the Substance Misuse Team.

1.119 Case notes made that same day (**22 October 2008**) show that the care co-ordinator spoke to the landlady of the homeless bed and breakfast hostel in Argoed who informed her that *'she has had to fix padlocks to her food stores as* [Mr H] *is stealing food on a regular basis'* and also that he *'had been found to have cannabis and amphetamines in his room and has been given a warning due to this.'* The care co-ordinator noted that she left a message for a colleague to visit Mr H as she was

[84] **Section 115 of the Crime and Disorder Act 1998 -** Gives power to disclose information to specified relevant authorities where the disclosure is necessary for the purposes of that Act.
[85] **Assertive Outreach Team (AOT) -** a multi-disciplinary team whose role it is to provide intensive support in the community for people with a serious mental health issue who are difficult to engage in other services.
[86] **Substance Misuse Team -** A local partnership which comprises the main agencies involved in tackling drugs and alcohol misuse. They operate in specific geographical areas and although membership can vary, it often includes the local authority, education service, Social Services, health authorities, police and housing services.

on leave the following week (we have not seen evidence to confirm if this visit took place).

1.120 On **28 October 2008** Mr H's landlady again contacted the senior social worker to report that Mr H along with another resident had broken into the washing machines at the hostel and stolen money out of them. She explained that Mr H had no money, and had *'sold off all his jewellery for money to buy drugs.'* The landlady was cooking Mr H lunch and evening meals and keeping a record of this, but had stopped doing this since he stole money. She was concerned that Mr H was becoming aggressive towards her, and was considering evicting him. The senior social worker spoke to the housing officer at Caerphilly County Borough Council who confirmed that the landlady '*had been made aware of the potential risks of violence posed by* [Mr H].*'* The senior social worker then contacted the police, who two days later confirmed that the landlady did not wish to make a complaint.

1.121 Minutes of the CMHT's MDT meeting on **4 November 2008** record that Mr H's placement at the bed and breakfast had *'broken down irrevocably due to his stealing and behaviour'* and that he was due to see the CMHT consultant psychiatrist at an outpatient appointment two days later. However, Mr H failed to attend the appointment that was due to take place on **6 November 2008**. The care co-ordinator attempted to visit him on **10 November 2008** but could not obtain an answer at the hostel.

1.122 On **12 November 2008** while the care co-ordinator was visiting Mr H the police arrived, having been called by the hostel landlady as there were *'a few people threatening* [Mr H] *for money.'* The care co-ordinator attempted to contact the benefits agency as Mr H was still not currently in receipt of his welfare benefits.

1.123 On **18 November 2008**, the Caerphilly County Borough Council Housing Team contacted the care co-ordinator to confirm that a flat would be available for Mr H to move into the following week. The next day, **19 November 2008**, the care co-ordinator submitted a referral for Mr H to be supported by the Caerphilly Assertive Outreach Team (AOT).

1.124 On **20 November 2008** Mr H was evicted from the homeless bed and breakfast hostel. It transpired that Mr H had received a large sum of money from his benefits back-pay, and had spent it on amphetamines. The landlady called the police and reported that Mr H had become violent, so the police escorted him from the premises. He was taken to a hotel in Newport.

1.125 There were no references to Mr H in MDT meeting minutes until **25 November 2008**. At this point one line recorded that Mr H had been evicted and stated *'we don't know where he is?'* Case notes recorded on **26 November 2008** suggest that the care co-ordinator thought that the police had not informed the CMHT that they had transported Mr H to a hotel in Newport on the night he was evicted. However, this was not the case, as the events surrounding his eviction are recorded on the same case note system on 21 November by the senior social worker.

1.126 On **1 December 2008** Mr H's case was accepted by the AOT for a one month assessment period.

1.127 Case notes record that Mr H was visited on **2 December 2008** by the care co-ordinator. Mr H was paying for the hotel in Newport himself, but was running out of money and would therefore be homeless within a few days. The care co-ordinator explained to him that because he had been evicted from the homeless hostel in Argoed, he would no longer be entitled to homelessness accommodation in Caerphilly. She advised him to present as homeless in Newport where support would be available to him.

1.128 The care co-ordinator followed this up with a letter of appeal to Caerphilly homelessness team, stating that unless Mr H was placed within the Caerphilly borough, Caerphilly AOT would not be able to take on his case as planned. Dr A (the CMHT consultant psychiatrist) also wrote a letter of support, dated **2 December 2008**, which stated, *'I am concerned about his mental health and the impact that homelessness will have on it. He has not been taking medication since leaving Cygnet Hospital, Kewstoke and has not attended appointments for review... It is most unfortunate that he was evicted from the* [homeless hostel in Argoed] *only a*

day or two before he was due to be given his own flat in Risca. While I understand that his actions had perhaps merited this course of action, I also feel that his illness and the absence of effective treatment would have been a significant factor in his deteriorating behaviour. The Assertive Outreach Team are now able to provide intensive support for [Mr H] *for an indefinite period if he can be found accommodation within* [Caerphilly] *borough... I am confident that he will be able to live in the community with an acceptable degree of stability and independence.'*

1.129 It appears from case notes made on **8 December 2008** that this appeal was turned down. The care co-ordinator spoke to a member of the AOT and agreed that they would write a second appeal letter together with Dr A at Mr H's out-patient appointment with him two days later.

1.130 On **9 December 2008** the care co-ordinator telephoned Mr H at the hotel in Newport and was told that he was not in his room and had not been seen. The only record of this incident recorded in the CMHT's MDT meeting minutes is *'where is he?'* The care co-ordinator faxed an alert to the Emergency Duty Team.

1.131 In the early hours of **10 December 2008**, the Out-of-Hours team at Gwent Healthcare NHS Trust received a call from the University Hospital of Wales (UHW), Cardiff. Mr H, now aged twenty-two years, had presented himself at A&E there, expressing paranoid thoughts and complaining of hearing voices telling him to commit suicide by jumping off a bridge. The Gwent duty doctor was happy to agree Mr H's transfer to Tŷ Sirhowy for assessment, it was also agreed that they would wait until an ambulance was available to transport him. At about 6.00am Mr H went missing for several hours (during which time UHW staff reported this to the police) before he was eventually found in the relatives' room in the hospital at 10.00am. He was brought back to A&E where staff tried to make him comfortable while he waited to be transported. They called the ambulance service several times to check when they would be ready to transport him, but the service was extremely busy. By 9.00pm it was finally confirmed that no ambulance would be available that night to complete patient transfers. UHW staff also contacted the police who at 10.30pm declined to take Mr H to Tŷ Sirhowy. A note in the clinical records made at 5.00am

the following morning showed that Mr H was still waiting in A&E for ambulance transfer. The note states *'unable to give adequate care as patient in corridor.'*

1.132 Mr H was eventually transported to Tŷ Sirhowy on **11 December 2008** where he was assessed by a doctor using CPA documentation. A risk assessment was undertaken and he was assessed as being at risk of violence, suicide and neglect. Mr H was admitted as an *'informal' patient.'* The staff nurse on the ward contacted Mr H's mother to explain where he was and that he had no personal belongings, so she agreed that she would try to bring him some that weekend.

1.133 During this period of in-patient stay at Tŷ Sirhowy, there were concerns that Mr H was abusing alcohol and drugs while on the ward. Mr H was placed back on anti-psychotic drugs which had been discontinued while he was at Cygnet Hospital.

1.134 On **17 December 2008**, Mr H's care co-ordinator met with Dr A, the Community Psychiatric Nurse (CPN) from the AOT, and a member of the Caerphilly Housing team to discuss Mr H's housing issues. It was decided that a new application for homeless accommodation would be made, but the housing officer suggested that they should consider finding private rental accommodation for Mr H if welfare benefits could be put in place to fund this. Records show that Dr A confirmed his diagnosis of schizophrenia and agreed that Mr H could remain in Tŷ Sirhowy *'as long as his behaviour allows this situation.'* However it was discussed that '*there is a significant risk that he will pose a serious management problem on the ward and may have to be discharged before alternatives have been put in place.'*

1.135 On **19 December 2008** a junior doctor at Tŷ Sirhowy met Mr H's parents, who explained that they would not be able to attend the CPA meeting the following week but wanted their concerns to be considered. They felt that Mr H was not capable of caring for himself but were unable to offer him accommodation as they did not feel equipped to manage him. His parents felt that he would benefit from supported accommodation which would provide him with a structured routine. The junior doctor left a message for an occupational therapist to contact the ward, to provide Mr H with support when living back in the community. He also made enquiries to a supported

accommodation organisation about their suitability criteria and it was felt that Mr H might be appropriate and the organisation agreed to send a referral pack.

1.136 On **25 December 2008** Mr H was collected by his father to go home for Christmas lunch for a few hours. He returned to Tŷ Sirhowy that evening and reported that it was *'the best meal he had ever had.'* He was recorded to generally appear settled that evening, although at one point he accused one of the nursing assistants on the ward of *'talking about him.'* Two days later on **27 December 2008** Mr H punched the same nursing assistant in the face, claiming that he had called him a name. This was recorded on the front page of his risk assessment documentation.

1.137 Throughout his in-patient stay at Tŷ Sirhowy from **December 2008** to **January 2009**, Mr H requested *'PRN'* medication on an almost daily basis for anxiety, and this was regularly prescribed to him. He regularly described hearing voices. He sometimes complained of an itching arm which he believed was a side effect of his anti-psychotic[87] medication, and frequently requested antihistamine for this. Mr H spent the majority of his time alone in his room sleeping and mostly did not want to engage in therapeutic activities. Generally he was described as fairly *'settled,'* but on occasion he was visibly agitated. It was planned that he would be monitored by the AOT on a daily basis following his discharge and that they would administer his prescribed medication.

1.138 On **6 January 2009** it was noted in MDT minutes that Mr H would be homeless when discharged from Tŷ Sirhowy. The following day a request was made for a placement for Mr H with the Caerphilly Homelessness Unit. Records made by ward staff state that Mr H was agitated and *'didn't want to leave.'* A risk assessment completed that day by a staff nurse at Tŷ Sirhowy recorded Mr H's *'risk of non-compliance with medication, risk of violence and aggression due to hallucinations and illicit substance misuse, risk of self neglect'* and referred to the incident on 27 December 2008 when he had attacked a male member of staff.

[87] **Anti-psychotic medication -** Medication normally prescribed to treat the symptoms of schizophrenia and in some cases manic depression.

1.139 The AOT had begun working with Mr H whilst he was on the ward in Tŷ Sirhowy in preparation for his discharge. Records show that at an MDT meeting held on **9 January 2009**, AOT staff questioned whether their team would be able to meet Mr H's needs as they felt that he needed seven-day-a-week input, and the AOT only operated five days a week. (This issue had also been recorded on the unmet needs section of a care plan dated 8 October 2008 which stated *'currently there is no weekend service with regards to AOT. This could be detrimental to* [Mr H's] *rehabilitation within the community.'*). We have seen no evidence of a risk management plan or any other document setting out how the risks associated with this unmet need would be mitigated.

1.140 A CPA review took place on the ward on **12 January 2009**, at which it was noted that Mr H had recently complained of hearing voices and that he felt that they were going *'to make him crack.'* He was recorded as being *'quite upset and worried'* about being discharged. The CPA assessment completed that day included a very brief risk assessment which stated that Mr H had *'attempted suicide by overdoses and hanging'* previously and that he was *'at risk of financial exploitation due to being vulnerable within the community.'* The plan recorded that he had been referred to the AOT *'in order to manage chaotic lifestyle.'* It is recorded in the clinical notes made at the CPA meeting that Mr H would need the AOT to give him his medication; however consideration does not appear to have been given to how Mr H's medication would be administered at weekends, when the AOT did not operate.

1.141 Mr H was discharged from Tŷ Sirhowy on **13 January 2009**. He was placed in temporary accommodation at a homeless bed and breakfast in Cwmtillery.

Caerphilly Assertive Outreach Team (AOT): January 2009 – March 2009

1.142 Following his discharge into the community on **13 January 2009**, the AOT supported Mr H with visits several times a week. This included taking him to local cafés, helping him to purchase a mobile phone, enabling him to visit his brother who lived nearby and taking him to a laundrette to help him clean his clothes. AOT staff

supplied his medication on their visits and supervised him taking it. However, on Fridays they left Mr H's weekend supply of medication with him to administer himself.

1.143 On **20 January 2009** the AOT's case notes record that Mr H was anxious and that he had told them that he wanted to be admitted to Tŷ Sirhowy as he was hearing voices. The AOT contacted a junior doctor at Tŷ Sirhowy who agreed to increase his medication (Risperidone and diazepam), but Mr H declined the offer of extra medication.

1.144 On **21 January 2009** AOT staff took Mr H to Tŷ Sirhowy as he was hearing voices that were telling him to harm himself. He saw the CMHT consultant psychiatrist (Dr A) who increased his medication.

1.145 On **24 January 2009** Mr H presented himself at A&E at Nevill Hall Hospital following an attempted overdose of prescribed medication. He explained that since leaving Tŷ Sirhowy he had been hearing voices. His account was that the previous day (**Friday 23 January**) he had tried to ignore them so he caught the bus into town, bought cigarettes and returned home. That evening he became unable to cope with the voices in his head and had tried to get rid of them by drinking a bottle of vodka and taking all the prescribed medication left with him by the AOT for the weekend. He had fallen asleep but the next day the voices were still present. Again, he tried to ignore them and caught the bus into town, but by 5pm he could not stand them any longer, and wanted to cut his wrists, so called an ambulance as he had no credit on his mobile phone to ring anyone else. The doctor who assessed him noted Mr H's high vodka usage. Mr H was transferred back to Tŷ Sirhowy and was admitted.

1.146 Mr H was discharged from Tŷ Sirhowy two days later on **26 January 2009**. Clinical notes dated **26 January 2009** record that Mr H told the junior doctor that day that he *'might overdose again.'* It was noted that the plan was for the AOT to *'extend their service'* and look for supported accommodation.

1.147 Following his discharge Mr H was placed back at the bed and breakfast in Cwmtillery, and received intensive support from the AOT on a daily basis (Mondays

to Fridays). He was visited by support workers, a social worker, an occupational therapist, a CPN and a consultant psychiatrist (Dr E).

1.148 Mr H's care plan and risk assessment was updated on **30 January 2009** to record *'moderate risk of suicide; when experiencing auditory hallucinations* [Mr H] *feels suicidal and has acted on those thoughts previously.'* The plan to reduce the risks of drug and alcohol misuse was stated as *'AOT will provide appropriate information, education and support, enabling* [Mr H] *to make rational choices about his drug use.'* The risk assessment stated that Mr H *'appears to be at low risk of violence/ aggression towards others; however in December 2008* [Mr H] *assaulted a male member of staff at Tŷ Sirhowy.'* The care plan recorded that the AOT would visit Mr H in pairs (as a precaution due to his violent incidents in the past) *'on a daily basis to administer oral medication, to reduce the risk of overdose'* but there does not appear to be any mention of support during weekends when the AOT did not operate.

1.149 On **30 January 2009** Mr H was reviewed by the AOT consultant psychiatrist, Dr E. He described ongoing voices telling him to harm himself and said that these were always present, but were quieter at the moment and he was now feeling able to resist them. Case notes of this appointment state *'daily dispensing of meds at present – review risks next week and remain at B+B.'*

1.150 On **11 February 2009** Mr H complained to the AOT staff that he was hearing voices telling him to kill himself. He described *'losing concentration'* and that the previous day he had wanted to hit people due to paranoia. He asked to be taken to Tŷ Sirhowy hospital but as he did not appear to be in distress or responding to voices, AOT staff explained that he should wait to be reviewed by Dr E at his appointment two days later.

1.151 At his appointment on **13 February 2009**, Dr E recorded that Mr H complained of having been hearing voices for five days, telling him to harm himself, but did not express suicidal ideas. Mr H said that the voices *'get him down'* but Dr E recorded that he was not *'objectively depressed.'* Mr H expressed a desire to change his medication to Quetiapine as this had *'suited him in the past'* and the

record shows that Dr E planned to review Mr H's previous clinical notes for his medication history.

1.152 On **20 February 2009**, Mr H again complained to AOT staff that he was hearing a lot of voices and asked to be dropped off at Tŷ Sirhowy. It was explained to him that this would not be appropriate as Dr E was currently reviewing his medication.

1.153 On **23 February 2009** Mr H was supported to move into a flat in Rhymney as he had been threatened by another resident at the temporary bed and breakfast in Cwmtillery. The AOT continued to visit him daily to administer his medication. At this time the AOT care plan recorded Mr H having problems managing his money and personal hygiene.

1.154 On **27 February 2009**, AOT case notes record that they had found evidence of Mr H having bought illicit drugs. Later, on **13 March 2009**, members of the AOT noted that Mr H was under the influence of street drugs and was noticeably paranoid; Mr H admitted to taking £30 worth of amphetamines the previous day. On both occasions AOT staff gave Mr H advice about the use of street drugs, and provided him with his weekend's supply of prescribed medication.

1.155 During his time in the Rhymney flat, Mr H reported to AOT staff that a neighbour and his associate had threatened him with physical violence, and that he was being exploited for money. There were further reports of threats from drug dealers, which were reported to the police by the AOT on **16 March 2009**. The police felt that Mr H was *'vulnerable' and 'targeted'* in this particular flat and felt that it was not safe for him to return to his flat. The AOT made a request to the housing association to re-house him, and were told that they would need to consider whether or not he would qualify for this. In the interim the AOT arranged for Mr H to stay the night with his brother.

1.156 An alternative placement was arranged the following day, and on **18 March 2009** the AOT assisted Mr H to move into his new accommodation in New Tredegar.

1.157 On **19 March 2009** the AOT spoke to Mr H's grandmother in Scotland who wished for Mr H and his brother to visit her in Scotland on 25 March 2009 for a week or so. The AOT's CPN discussed this with the senior nurse responsible for Adult Mental Health services in Caerphilly who agreed to the visit. The CPN noted that Mr H's brother had agreed to look after two weeks' supply of Mr H's medication when they made the trip, and that Mr H could stay with his brother the night before the trip to make travelling arrangements easier.

1.158 During a home visit on **20 March 2009** AOT staff noticed a change in Mr H's presentation, he was reported to have strange mouth movements and be repetitive in speech. Mr H admitted buying and taking amphetamines the previous day and not sleeping during the night. He was returned to his flat and given £20 of his money for the weekend.

1.159 Mr H was visited by the AOT's CPN and OT on **23 March 2009**, who recorded that he *'appeared mentally well, not complaining of any symptoms.'*

1.160 On **24 March 2009** members of the AOT called at Mr H's home to transfer him to his brother's flat where he would stay the night in preparation for an early journey to Scotland the following day. Mr H was waiting for the staff to arrive with his bag packed, and he was reported as being appropriately dressed and ready for his journey.

1.161 On the way to Mr H's brother's flat Mr H requested to stop at the bank to withdraw money and to go to Tesco's to purchase some cigarettes. On Mr H's return to the car, AOT staff noticed that he had purchased a half bottle of vodka. AOT staff advised Mr H not to drink alcohol that night as his grandmother was expecting him to be well behaved and he needed to be up early as his bus was leaving Cardiff at **07:30am** the following morning.

1.162 Mr H was taken to his brother's flat and AOT staff gave his medication to his brother to supervise. It is recorded that at this time Mr H was appropriate in mood and joined in conversations with AOT staff. He appeared to be looking forward to the trip and to seeing his grandmother. He did not complain of experiencing any

psychotic symptoms. Mr H was left at his brothers flat at approximately **12:00pm - 12.30pm**.

1.163 That evening, a 66 year-old woman was assaulted and stabbed four times on the street in Llanbradach, Caerphilly causing her death. Approximately 30 minutes later, Mr H who was in close proximity to the incident was approached by police and ran away. He was immediately apprehended and arrested.

Chapter 2: The Findings

The predictability of the homicide committed by Mr H

2.1 It is clear that Mr H had experienced problems since a young age. He struggled with relationships and experienced a range of complex problems including Asperger's Syndrome, Schizophrenia and drug and alcohol abuse. As he got older Mr H was on various occasions assessed as being a risk to others and to himself.

2.2 While we do not believe that the time and place of Mr H's attack on an innocent passer-by could have been predicted, there was a great deal of evidence which indicated that in a crisis, Mr H was likely to harm himself or others. He had attempted suicide in the past and had repeatedly admitted to having auditory hallucinations commanding him to self-harm, and as recently as late December 2008 he had assaulted a member of staff at Tŷ Sirhowy. It was entirely predictable from Mr H's presentation and history prior to the index offence that he would experience periods of crisis, and that his psychotic symptoms were compounded by his alcohol and drug misuse.

2.3 However, we firmly believe that the homicide may well have been preventable. Our review has highlighted many shortcomings in the care and treatment of Mr H and failings by various health and social care organisations over a number of years. This catalogue of failings includes issues of service provision and delivery, and the individual actions of particular clinicians and care providers.

2.4 Mr H and his family had struggled with his illness and behaviour since he was seven years of age. We believe that he should have received better support from statutory agencies when he was a child and that more notice should have been taken of his claims that there were wider family issues that needed to be addressed.

2.5 We are particularly concerned with regard to the circumstances surrounding Mr H's discharge from Cygnet Hospital. The rationale for his discharge is questionable and the fact that health and social care staff accepted that it was

appropriate for a vulnerable young man who had spent more than a year detained in hospital to be discharged to a Homelessness Office is indefensible. It is also indefensible that the CMHT failed to secure adequate accommodation for Mr H. Together the actions of Cygnet Hospital and the CMHT resulted in a vulnerable individual at high risk of harm to himself and violence to others being left homeless and unsupported.

2.6 The remainder of this report focuses on the ways in which we believe Mr H's care and treatment may have been improved.

Contact between Mr H and Children's Social Services

2.7 It is clear that from an early age, Mr H was experiencing a range of complex problems, some related to his Asperger's Syndrome (a diagnosis of which was confirmed in November 2001). As Mr H entered his teenage years his problems escalated and numerous referrals were made to Caerphilly Social Services by family members and healthcare professionals. On each occasion after only brief periods of involvement by Social Services Mr H's case was closed. In particular during the three and a half year period between July 2000 and December 2003, when Mr H was aged between 14 and 17, over 12 referrals were made. These included:

- July 2000: a referral was made by Mr H's mother; a social worker saw Mr H but decided that no further was action necessary;
- June 2001: a referral was made by a community nurse who assessed Mr H and was concerned that there were wider family issues;
- July 2001: a referral was made by Mr H's family. A social worker visited the family but closed his case reporting that the family was already attending therapy and that a learning disability assessment was underway;
- August 2001: a referral was made by the police after it was alleged that Mr H had struck his mother during a row. The referral was passed to the Children with Disabilities Team. Subsequently a social worker visited Mr

H three times at school during September and October, and held an MDT meeting with the school and CAMHS team in November 2001. Following this meeting, Caerphilly Social Services decided to discharge Mr H, and officially closed his case in March 2002;

- June 2002: a request was made by the CAMHS consultant for the Children with Disabilities Team to review their decision to close Mr H's case but they upheld their original decision;
- August 2002: a further request was made by the CAMHS consultant for Social Services to become involved in Mr H's case. As a result the decision to close Mr H's case was reviewed for a second time by a social worker who visited the family, but it was again decided that he was more suitable for CAMHS support rather than Social Services;
- February 2003: another referral was made by Mr H's mother;
- April 2003: a further referral was made by Mr H's mother. Social Services provided her with advice and closed the case;
- August 2003: two referrals were made by Mr H's grandmother and mother respectively. An attempt was made by a social worker to contact the family by telephone, when the family did not return the call the case was closed;
- September 2003: a self-referral was made by Mr H as he had become homeless. Social Services sent a fax to the Homelessness Unit and closed the case;
- December 2003: a referral was made by Mr H's mother.

2.8 We believe that Caerphilly Social Services missed numerous opportunities to actively engage with Mr H. The above list of referrals alone clearly points to a family in difficulty and in need of help and support. It appears that the consensus view within the Children with Disabilities Team of Caerphilly Social Services was that CAMHS was better placed to support Mr H. However, our review has highlighted that CAMHS had also asked Social Services to become involved on a number of occasions. Mr H's CAMHS consultant firmly believed that his case was complex and

that a greater level of social and family support was needed than could be provided by the CAMHS service alone.

2.9 Repeated pleas made by CAMHS to persuade the Children with Disabilities Team to take up Mr H's case were thwarted due to the eligibility criteria the team used, which did not identify Mr H as disabled enough to warrant support from their service. At one stage the evidence given to support the fact that Mr H did not meet the eligibility criteria was the fact that he had a paper round, as this was felt to demonstrate that Mr H had a sufficient level of independence.

2.10 We believe that as a result of the stringent eligibility criteria set by Caerphilly Social Services, Mr H and his family were not provided with the support they needed to help address and cope with the behavioural problems associated with his Asperger's Syndrome.

2.11 It is clear that the Children with Disabilities Team at Caerphilly Social Services did not regard Asperger's Syndrome as a disability, which our report on learning disability services published in December 2007 highlighted as a problem across many parts of Wales at that time[88].

2.12 It is concerning that Caerphilly Social Services' assessments of Mr H appeared to differ considerably with the opinions of other professionals who had contact with the family at similar times. For example, in July 2001, the social worker who visited the family considered them to be coping well with Mr H's behaviour, whereas the previous month a community nurse who had visited the Mr H's home described the family as being in *'crisis.'* Also in July 2001, a consultant community paediatrician described Mr H as being *'clearly a child in need and possibly at risk of his own behaviour.'* Similarly, the assessment of the CAMHS doctor that month was that Mr H displayed hazardous behaviour to himself and others and recorded that Mr H's mother was *'frightened to be alone in the house with* [Mr H] *and fears he may strike her.'*

[88] Healthcare Inspectorate Wales, *How well does the NHS in Wales Commission and Provide Specialist Learning Disability Services for Young People and Adults? Findings and Themes from the All Wales Review* (December 2007), p.20.

2.13 Likewise, in November 2001 Mr H's case was closed by the Children with Disabilities Team, despite having been told by CAMHS that they had '*concerns that his behaviour will deteriorate in future and* [Mr H] *will get into trouble with the law'* because of his complex behavioural problems. Similarly, their decision to discharge him in March 2002 was taken against the advice of CAMHS that his *'needs are great and he still represents a risk.'*

2.14 We believe that Caerphilly Social Services failed to give due regard to the views of other professionals and give them sufficient weight in making their decisions as to whether to provide Mr H with any support.

2.15 In February 2004, when Mr H was 16 years old Caerphilly Social Services did make a partial assessment of his needs and he was referred to the *'Children in Need'* services. At this time, the Children in Need services considered that had Mr H been younger or had he wanted their intervention, they may have been able to act in relation to Mr H's relationship with his mother, which was clearly fraught and Mr H had claimed from an early age that his problems were due to the way he was treated by his mother.

2.16 It is clear that Caerphilly Social Services were not, at this time, aware of the referral made to Mid Glamorgan Social Services by his school concerning Mr H when he was seven (this information does not appear to have been transferred to Caerphilly after local government re-organisation in 1996). The lack of awareness of the longstanding nature of Mr H's difficulties in school and within his family seems to have influenced Caerphilly Social Services' assessment of Mr H's needs when they became aware of him from July 2000 onwards. Opportunities were missed to provide the support needed to Mr H and his family and to work jointly with CAMHS.

2.17 In summary, throughout Mr H's childhood opportunities were missed by Caerphilly Social Services to provide him and his family with intervention and support despite assessments from numerous health professionals that the family were *'in crisis.'* This represented a denial of services for a child in need, and a lack of holistic thinking about the impact on the family. We find that these failings were due to:

- an assumption by Caerphilly Social Services staff that CAMHS was more suited to his needs, despite requests from CAMHS for Social Services support to complement their work;
- a lack of awareness of Mr H's earliest contacts with Social Services due to inadequate records transfer following service reorganisation;
- the eligibility criteria used by the Children with Disabilities Team which did not identify children with Asperger's Syndrome as being disabled;
- a failure by Caerphilly Social Services staff to heed the advice and professional views of CAMHS and other healthcare professionals about Mr H's level of need and risk to himself and others.

Care provided by Caerphilly Child and Adolescent Mental Health Services (CAMHS)

2.18 The care provided to Mr H by the Child and Adolescent Mental Health Service (CAMHS) throughout 2001 and 2002 was appropriate, and he was seen at regular outpatient appointments. During this period CAMHS started Mr H on medication, kept his GP informed of his progress via regular letters after each appointment, and also involved a CPN who met with his parents and grandmother to discuss their concerns about Mr H's behavioural problems. The CAMHS doctor made several attempts to secure social work support for Mr H writing repeatedly to the Children with Disabilities Team at Caerphilly Social Services to urge them to consider doing so, and highlighted his concerns about the risk he felt Mr H posed to himself and others, which we regard to have been good practice.

2.19 Mr H was discharged from CAMHS in August 2002 due to his lack of attendance, which the CAMHS doctor believed was in part due to a lack of support from Social Services. Had Caerphilly Social Services been prepared to work with Mr H and his family at this time, it is possible that he could have been supported to attend his appointments.

2.20 Nevertheless, Mr H re-engaged with CAMHS in November 2002 for a period which lasted until July 2003, at which point the consultant psychiatrist was satisfied that Mr H was settled living with his grandparents and having begun work experience. Unfortunately, this period of stability was short-lived for Mr H, who by October 2003 was homeless due to the fact that his grandparents had struggled to cope with his behaviour.

2.21 While we recognise that at the time of his discharge from CAMHS, Mr H was judged to have stabilised and therefore it was hoped that he would be unlikely to require adult services, we consider that Mr H should have been monitored by CAMHS for a longer period of time following his apparent stabilisation to ensure that he remained stable. Had this been the case CAMHS could have become actively involved in his transition to Adult Mental Health services. When Mr H was referred back to mental health services in January 2004, he was old enough to engage with adult services and so CAMHS was not contacted.

2.22 In summary we find that overall, the care provided to Mr H by CAMHS was good. However it was regrettable that his discharge by CAMHS in July 2003 meant that:

- Mr H was not monitored to ensure he remained stable;
- there was no transition process between CAMHS and Adult Mental Health Services.

Contact between Mr H and Caerphilly Adult Social Services, Community Mental Health Team (CMHT), Community Learning Disability Team (CLDT) and Early Intervention Service

2.23 Throughout 2004 and 2005, when Mr H was 17 to 18 years old, his relationship with services was disjointed, resulting in many referrals from and between services.

2.24 His age at this time contributed to difficulties in allocating Mr H to an appropriate service to meet his needs. Social Services work with children and young people up until the age of 18, whereas health services consider 16 year olds to be eligible for adult services. In Mr H's case, at 17 years old he was deemed to be old enough to be assessed by a consultant psychiatrist in Adult Mental Health rather than CAMHS, but at the same time children's Social Services were involved with Mr H (when they initiated proceedings under Section 47 of the Children Act 1989). However, he was referred in March 2004 from children's Social Services to the adult Social Services' Learning Disabilities Team. In both health and Social Services, transition arrangements appeared to have been weak and we found no evidence that Mr H's childhood records were considered.

2.25 It appeared that no service was equipped to provide support for his Asperger's Syndrome, and he fell between the *'two stools'* of services for learning disabilities and mental health. Two referrals to Caerphilly adult Social Services Learning Disability Team were made in January and July 2004, but on both occasions he was not taken on as a case, as he was not seen to meet the team's eligibility criteria, which did not provide support for Asperger's Syndrome.

2.26 In June 2005, after six months, the Early Intervention Service decided to cease providing Mr H with input as they considered that his diagnosis was more likely to be in line with Asperger's Syndrome than a psychotic illness. This points to a failure by the Early Intervention Service to examine his children's services records, which confirmed that he had been diagnosed with Asperger's Syndrome in 2001. Other adult services also later failed to fully review Mr H's children's services records, including the care co-ordinator at the CMHT. She was therefore unaware of the 2001 Asperger's Syndrome diagnosis and so was not in a position to pass this information on to other services including Cygnet Hospital Kewstoke or the Caerphilly AOT.

2.27 Furthermore, we consider the Early Intervention Service's decision to withdraw its support for Mr H to have been questionable given that the following month, in July 2005, he was readmitted to St Cadoc's Hospital for a long-term period

of rehabilitation because of his psychotic symptoms. At this point however, the Early Intervention Service agreed to work with Mr H again.

2.28 Risk assessments by both Health and Social Services during this period were inconsistent and inadequate, particularly in relation to Mr H's illegal drug use (recorded by Caerphilly Social Services in March 2004) and the risks he posed to himself and others (displayed on two occasions in October 2004 when he heard voices commanding him to harm himself). In October 2005 after three months of in-patient care, Mr H was discharged back into the community and full consideration does not appear to have been given to the risk factors associated with his drug use.

2.29 In summary we find that the Health and Social Services working with Mr H at this time failed to:

- provide adequate services to meet the needs of a young person with Asperger's Syndrome, and a co-occurring mental health issue;
- adequately or consistently consider risks of harm to himself or others, and risks associated with substance misuse.

The decision to discharge Mr H from Cygnet Hospital

2.30 We consider that the decision to discharge Mr H from Cygnet Hospital on 9 October 2008 and place him in bed and breakfast accommodation for homeless people was indefensible, in light of the available evidence. This finding is explained in detail in the paragraphs below.

2.31 It is important to clarify that the discharge of Mr H was signed off on 9 October by Dr C, a consultant psychiatrist employed by Cygnet Hospital, rather than Dr D, a locum consultant psychiatrist who had been Mr H's RMO at Cygnet Hospital since May 2008. (Dr C had been Mr H's RMO for a short period in May 2008, between Mr H's original RMO at Cygnet Hospital leaving and the appointment of Dr D as a locum consultant psychiatrist. During this period Dr C had attended the Mental Health Review Tribunal held on 15 May 2008 which had originally recommended that Mr H

should be transferred to another hospital closer to home; Dr C had told this Tribunal that he did not believe Mr H was suffering from a mental illness).

2.32 Mr H's discharge had been planned by Dr D in the days prior to his discharge. Our findings therefore question the rationale for Dr D's decision that Mr H should be discharged from his detention and from Cygnet Hospital. It should be noted however that our findings also apply to Dr C, who by formally signing off the discharge on 9 October must have accepted Dr D's rationale (which we find no evidence to support). References to *'the decision'* therefore apply to both Dr D and Dr C, unless otherwise stated.

2.33 Furthermore, we consider it to have been poor practice for Dr D, as Mr H's RMO, to have left it to another clinician to oversee the discharge of his patient.

2.34 The decision to discharge Mr H from Section 3 of the Mental Health Act did not take full and proper account of the recommendations made by Mental Health Review Tribunals in May and July 2008. While the Tribunal had recommended detention in a hospital closer to home, it concluded that Mr H met the statutory criteria for detention and should not be discharged. We found no evidence to support the clinical judgment of Dr D or Dr C that Mr H's mental state had improved in the period following these tribunals and prior to his discharge, to explain the difference of opinion with the Mental Health Review Tribunal.

2.35 The decision to discharge Mr H also contradicted the advice and conclusions that Dr D had set out in writing only days earlier:

- on 30 September 2008 (ten days prior to discharge) Dr D had stated in his CPA Doctor's Report that Mr H had *'Asperger's Syndrome and Schizophrenia.'*
- on 1 October 2008 (eight days prior to discharge), Dr D had been part of an MDT meeting which agreed that Mr H needed to be detained under the Mental Health Act to receive treatment in hospital for his hebephrenic schizophrenia;

- Dr D's Update Report prepared prior to the planned Mental Health Review Tribunal of 2 October 2008 (seven days prior to discharge) stated that Mr H satisfied the criteria for detention under the Mental Health Act due to the nature of his illness.

However, by 8 October, Dr D appeared to have changed his assessment and view in relation to Mr H and his continued detention under the Mental Health Act (recorded in Cygnet Hospital notes of his conversation with Dr A from the CMHT). We have seen no evidence to support or justify this change in view, and we consider it to be impossible for the nature of someone's illness to change within a week.

2.36 We also find it concerning that Mr H's problems were attributed to substance misuse, when other consultant psychiatrists who assessed Mr H were of the firm view that while the illicit drugs he used compounded his mental health issues, they did not cause them and have pointed to the fact that his symptoms of schizophrenia persisted even when he was free from illicit drugs.

2.37 At the beginning of October 2008 Dr D was in the process of reducing Mr H's psychotropic medication with a view to stopping it altogether. However, at the time of his discharge on 9 October Mr H was still being prescribed some antipsychotic medication. We believe that it was bad practice to discharge Mr H from hospital at a time when his medication was being changed. Discharging Mr H from hospital to a homeless hostel during this process was clinically unjustifiable and unsafe, as Mr H had a need for in-patient care to monitor his reaction to medication withdrawal (which would have increased his risk factors). It should have been possible for Mr H to have remained as an informal in-patient at hospital even if he was no longer detained under the Mental Health Act. We found no evidence to suggest that this course of action was considered as an option for Mr H, either by the MDT, Dr D or Dr C at Cygnet Hospital, or by the team from the CMHT (whose role and decision-making is assessed in the next section).

2.38 The decision to discharge Mr H did not take account of a full range of multi-disciplinary views, as would be good practice when discharging a patient from a section of the Mental Health Act. In particular, it is extremely concerning that the

decision disregarded a series of warnings from nursing staff (who had had intensive contact with Mr H) advising of the high risks associated with discharging Mr H to the community (as opposed to transferring him to another hospital). This included a nursing report on 11 May 2008 which predicted that Mr H *'would disengage with mental health services if not under section and could have poor concordance to all medication.* [Mr H's] *mental state would deteriorate and he would become a vulnerable young adult at the present time.'*

2.39 Likewise on 2 July 2008 a nursing report stated that Mr H *'continues to present a risk to others as he is easily provoked into becoming abusive/ aggressive due to current poor coping strategies. Risk to himself is also apparent as* [Mr H] *would neglect his self care and possibly be vulnerable to exploitation from others.'* This was also recorded in a risk assessment completed by nursing staff on 2 July 2008 which stated that Mr H posed a *'significant'* risk of violence to others.

2.40 A nursing report written on 28 September 2008 advised that *'the risks to himself and others would be extremely high if he were discharged into the community without an intense level of community support… the elevated risk of violence towards himself and others, plus the high risk of self neglect could lead to serious consequences for him.'* These risks were based on the level of violence that Mr H had regularly displayed while detained at Cygnet Hospital, including during the time leading up to his discharge. For example, it was documented that on 17 September 2008 he *'forcibly kicked the office door,' 'kicked out the glass panel in the office'* and *'punched two glass panels on the kitchen door.'* The following day Mr H *'kicked the door frame out of the wall.'* On 21 September he *'punched out the observation window in his bedroom door'* and two days later was *'verbally aggressive and hostile to* [a] *patient and threatened him with physical violence…* [Mr H] *with anger threw a knife to another patient.'*

2.41 Finally, a risk assessment prepared by Cygnet Hospital on 8 October 2008, the day prior to Mr H's discharge, stated that Mr H was *'at significant risk of violence towards others.'* It is a significant failing that these risk assessments do not appear to have informed the decision to discharge Mr H from hospital to homelessness in the community. While we accept that an individual can not and should not be

subject to detention under the Mental Health Act for longer than necessary and that being violent is not a reason on its own for detention, we believe that such matters should have been carefully considered in line with CPA guidance. It was clear that arrangements for Mr H's discharge were not satisfactory and his risk of violence should have more fully been taken into account.

2.42 We consider it to have been bad practice to discharge Mr H (who was recognised as a vulnerable patient with complex needs) in the full knowledge that he would be made homeless as a result. It was absolutely clear that there was no accommodation available other than a bed and breakfast for homeless people, which had been recorded in both the care co-ordinator's *Social Circumstances Report* of 29 September 2008 and in the report of the Section 117 after-care meeting on 1 October 2008. Dr D had stated at the Section 117 meeting on 1 October 2008 that he would only discharge Mr H once an adequate care package was in place. However, he spoke to Dr A from the CMHT on 8 October 2008 and was told that the care package that had been agreed at the CPA meeting on 1 October was in place; this care package had recorded Mr H's accommodation as a *'homeless B&B.'*

2.43 There was clearly no doubt that Mr H was going to be housed temporarily in a homeless hostel, which we consider to have been entirely inadequate and at odds with a supported recovery. The inadequacy of this arrangement appears to have been recognised by Dr D on the day prior to Mr H's discharge, when it was recorded in the notes of his conversation with Dr A that *'there are concerns that this may not be enough.'* This recognition that Mr H's after-care package was entirely inappropriate given the high risks associated with Mr H's placement in the community did not however appear to have informed or changed the planned action for the following day. We therefore conclude that Mr H's RMOs at Cygnet Hospital (both Dr D and Dr C) failed in their duty of care to him.

2.44 We find no evidence to support the assertion that it was likely that Mr H would be discharged when the Tribunal reconvened. It is our firm view that, had the Mental Health Review Tribunal reconvened as had been planned (on 21 October 2008) it would have found the proposed discharge arrangements unsatisfactory. The Tribunal had consistently maintained that Mr H needed to be detained in hospital; we

found no evidence that the nature of his mental illness had changed and the after-care package of a homeless bed and breakfast hostel was clearly unsuitable to meet his complex mental health needs.

2.45 Evidence shows that nursing staff felt strongly that Mr H should have remained in Cygnet Hospital in order to be given the best possible chance of rehabilitation. We were told that a placement on Cygnet Hospital's complex care ward is usually for 12 to 18 months, in order to provide a structured environment and continuity of care while dealing holistically with complex problems including drug use. Mr H had been transferred to the complex care ward in May 2008; therefore his period of five months on the ward was very short compared to the service that Cygnet Hospital usually offers to patients. It is disappointing that the decision to discharge Mr H therefore did not take account of a full range of multi-disciplinary views including those of the nursing staff. Mr H was not afforded the opportunities that a prolonged and stable period of support on this ward could have provided.

2.46 In summary, we believe that the decision to discharge Mr H from Cygnet Hospital and place him in bed and breakfast accommodation for homeless people was indefensible as it:

- did not take full and proper account of the recommendations of the Mental Health Review Tribunal;
- failed to provide evidence to support the assertion that Mr H no longer suffered from a mental illness of a nature or degree to warrant detention;
- contradicted Dr D's own views which he had put in writing only days earlier;
- demonstrated bad practice in discharging a patient at a time when his medication had been and was being changed;
- did not take account of a full range of multi-disciplinary views, and ignored the opinion of the nursing staff;
- did not take account of risk assessments which highlighted his high risk of harm to himself and others;
- demonstrated bad practice by discharging a vulnerable patient with complex needs, in the full knowledge that he would be made homeless;

- did not offer Mr H the same opportunities afforded to other patients for a prolonged and stable period of rehabilitation on an informal basis.

The CMHT's failure to find a suitable placement for Mr H in readiness for his discharge from Cygnet Hospital

2.47 Under Section 117 of the Mental Health Act, Caerphilly County Borough Council and the then Caerphilly Local Health Board have a duty to provide after-care for those patients for whom it applies. The LHB had entered into arrangements with Gwent Healthcare NHS Trust to fulfil these duties on its behalf, in this case through the provision of a CMHT in Caerphilly. We find that in the case of Mr H, all these statutory agencies failed to meet their duties in this respect. Our evidence to support this finding is set out below.

2.48 Despite there having been more than five months between the Mental Health Review Tribunal held on 24 April 2008 and Mr H's eventual discharge from Cygnet Hospital on 9 October 2008, the CMHT failed to find Mr H an alternative low secure hospital placement. The CMHT therefore failed to take full and proper account of the explicit recommendation of the Mental Health Review Tribunal.

2.49 It is documented on several occasions that between the Tribunal held in May 2008 and Mr H's discharge in October that the CMHT's consultant psychiatrist (Dr A) refused to transfer Mr H back to Tŷ Sirhowy at this time as he claimed it was not suitable for his complex needs and violent behaviour. He maintained that Mr H required a low secure hospital setting (a level of security which could not be provided at Tŷ Sirhowy). While there are no NHS low secure hospital facilities in the Gwent area, there are various low secure independent sector facilities within the vicinity, and an alternative independent hospital placement in Pontypridd was suggested at the original Tribunal in April 2008. However, neither this nor any other hospital placement was ever followed up as an option by the CMHT. We are concerned that the lack of a contract between Gwent Healthcare NHS Trust and another low secure hospital facility that was suggested in April was documented as being a factor which may have prevented the right placement for Mr H being pursued.

2.50 Mr H's care co-ordinator wrote to the Continuing Healthcare Team at Torfaen Local Health Board alerting them to the need to find a low secure hospital placement in an independent healthcare setting. However, it was not the Continuing Healthcare Team's responsibility to locate a placement, merely to authorise the funding for one once it had been agreed by the CMHT. It was the CMHT's role to source this placement. We believe that the CMHT did not understand the process of, or the different responsibilities involved in, securing an independent hospital placement.

2.51 The Continuing Healthcare Team brought the issue of finding a low secure hospital placement for Mr H in the independent sector to the attention of senior managers at Gwent Healthcare NHS Trust and Caerphilly Social Services. Senior managers agreed that they needed to make sure they discharged their duties under the Mental Health Act but no further action was taken to follow up the matter with the care co-ordinator or her supervisor and the care co-ordinator did not pursue any further hospital placements. We believe that this was due to a lack of clear leadership within the CMHT, and a lack of an effective multi-disciplinary approach. Social Services and health staff within the CMHT reported to separate managers. This arrangement failed to provide leadership to staff or take accountability for decision-making. As a result, the issue about finding Mr H a new hospital placement was allowed to lie dormant and unresolved.

2.52 It should have been possible for the care co-ordinator to draw on more support from the consultant psychiatrist at Caerphilly CMHT (Dr A), who maintained his firm opinion that Mr H had hebephrenic schizophrenia. However, it was made clear to us in interview that Dr A did not see it as his role to become involved in applications for alternative hospital placements; rather, his involvement seems to have been confined to refusing to readmit Mr H to Tŷ Sirhowy because of the *'management problems'* he would have posed to ward staff, due to his history of violence and risk of self-harm. This points to a lack of clarity within the CMHT regarding responsibilities for and clinical input into applications for Continuing Healthcare. These duties lay with Caerphilly LHB but the health board had entered into arrangements with Gwent Healthcare NHS Trust to fulfil the duties on its behalf

through the CMHT; however, Caerphilly LHB does not appear to have monitored how these duties were being carried out.

2.53 Clearly, the focus of the CMHT's efforts should have been on finding a hospital placement, in line with the recommendation of the Mental Health Review Tribunal, rather than accommodation in the community. Nevertheless, specialist supported accommodation for people with mental health issues would certainly have been preferable to a homeless hostel.

2.54 Case notes and tribunal reports as late as September 2008 cited a lack of clear diagnosis as a barrier preventing Mr H's care co-ordinator from making applications for supported accommodation for him. While there was obviously disagreement about Mr H's mental health diagnosis between his clinicians at Cygnet Hospital and Gwent Healthcare NHS Trust, the Tribunal in May 2008 had clearly stated that it deemed Mr H to have a mental illness. We also note that between December 2007 and July 2008, six clinical update reports were produced by Cygnet clinicians and sent to the care co-ordinator, which all stated Mr H's *'differential diagnosis'* as *'paranoid schizophrenia.'* This should have been enough evidence for the care co-ordinator to use in applying for supported accommodation placements or Mr H, and it is regrettable that this was not pursued more assertively and at an earlier stage. We largely attribute this shortcoming to a lack of advice and guidance for the care co-ordinator. It would appear that no-one at the time spotted the contradiction contained in her *Social Circumstances Report* which complained that there was a lack of diagnosis yet on the same document recorded Mr H's diagnosis as schizophrenia. The supervisory, advisory and quality assurance functions of management and leadership was wanting.

2.55 The care co-ordinator did make one application for supported accommodation for Mr H before the option of homeless accommodation was accepted. This was unsuccessful as Mr H was deemed to pose *'too high* [a] *risk to other residents'* because of his violence on the ward at Cygnet Hospital. At this point, we would have expected the care co-ordinator to have undertaken a risk assessment, which would in our view have indicated that Mr H needed secure hospital treatment, in line with the Tribunal's recommendation. The failure to do so raises questions about the

status of risk assessments in the CMHT, their judgements and tolerance of risk, and inadequate documentation of risks. In particular, Mr H being deemed as too high risk for supported accommodation should have alerted the care co-ordinator and her supervisor to the fact that it would therefore be unsuitable to place him in the unsupported environment of a homeless hostel.

2.56 We were told that further applications for supported accommodation were not made as there is a huge deficiency of supported accommodation in Caerphilly (only eight beds), and a lack of dedicated provision of mental health housing. Accommodation for single people is also scarce. We acknowledge that these factors contributed to the failure of services to find an alternative for Mr H other than homeless accommodation. Nevertheless, Caerphilly County Borough Council and Caerphilly LHB (which had entered into arrangements with Gwent Healthcare NHS Trust and Caerphilly CMHT) had statutory responsibilities under Section 117 of the Mental Health Act to ensure that adequate after-care was provided to Mr H. A deficiency of accommodation should have meant that *'best endeavours'* were made to explore other options to meet Mr H's needs as a vulnerable, high risk individual with complex care requirements.

Acceptance of homeless accommodation

2.57 We are extremely concerned that the CMHT accepted homeless accommodation as an appropriate placement for Mr H on his discharge from Cygnet Hospital. It is particularly concerning that the CMHT had referred to homelessness as the most likely option at the very start of May 2008, and that despite a recognition that this would be *'detrimental to* [Mr H] *as he is extremely vulnerable,'* the CMHT did not make greater efforts to prevent this from happening. This represents a significant failure in its duty of care to Mr H.

2.58 The CMHT neglected to notice the warnings raised by nursing staff from Cygnet Hospital in numerous documents. Several nursing reports, including one written only ten days prior to his discharge, referred to the high risk that, if discharged to the community at that time, Mr H would deteriorate, be vulnerable to

exploitation, become suicidal and become violent to others. Nursing staff repeated these concerns verbally to social workers from the CMHT, evidence of which was recorded in CMHT case notes. Furthermore, Mr H himself told the care co-ordinator and her supervisor that he was likely to pose a risk of violence to others. These risks did not appear to factor highly enough on the CMHT's radar and they were not escalated to senior management.

2.59 Dr A and the care co-ordinator were both present at the Section 117 after-care meeting held on 1 October 2008 to plan Mr H's after-care, which recorded the plan for his accommodation as being a *'Homeless persons' B & B'.* We do not believe that the after-care plan that was drawn up at this meeting should have been signed off, as homeless accommodation should never have been a part of the equation for Mr H's after-care. A bed and breakfast hostel for homeless people was entirely inadequate and inappropriate for Mr H, given his clinical history, presentation, risk of violence, self neglect, alcohol and substance misuse issues, which all demonstrated a need for intensive support which could not possibly be provided in that setting. Given that the care co-ordinator and Dr A were both fully aware of Mr H's complex needs, their acceptance of a homeless hostel as the planned after-care accommodation demonstrated neither good practice nor a duty of care.

2.60 Dr A was aware that when Mr H had last lived on his own in the community (when he had lived in Scotland in 2007), he had not coped well and had regularly presented at A&E, *'drug seeking or looking for admission'* (as Dr A had documented in his Tribunal report in July 2007). It is regrettable that Dr A did not appear to take into consideration Mr H's known pattern of behaviour when he was involved in planning his after-care. Had Dr A raised concerns about this, he could have used this information to ensure that the CMHT put in place a care plan which would have addressed the risks associated with Mr H falling back into this pattern of behaviour. Sadly this was not the case, and once back in Caerphilly Mr H quickly returned to this cycle of presenting at A&E complaining of hearing voices and overdosing on prescribed medication.

2.61 We believe that Dr A should not have agreed with Dr D during their telephone conversation on 8 October that he was *'happy'* (according to Cygnet Hospital notes) for Mr H to be discharged the following day in the full knowledge that he would be homeless, and in the full knowledge of his high risk of violence. No action was taken at this stage by Dr A to prevent Mr H from being placed in a homeless hostel. While we understand why Dr A would not have been keen to readmit Mr H to Tŷ Sirhowy (including evidence in case notes from 1 October 2008 that Mr H confirmed to his care co-ordinator that *'should he return to Tŷ Sirhowy he would probably carry out unprovoked attacks on other patients as on previous occasions'*), Mr H's own admission/ acceptance of his violent behaviour should clearly have demonstrated that he would pose a high risk of violence in the community, where he would be unsupervised. We cannot understand how health and social care professionals could have considered it acceptable to place someone in a homeless hostel who was a high risk of harming other patients on a ward.

2.62 It is unclear whether or not Mr H's experience, of being discharged from a long period of detention under the Mental Health Act and sent from hospital to the office of the Homelessness Team, was an isolated incident. While it may not be common, it does appear to have been an event that was accepted by significant numbers of those we interviewed (both health and social care professionals) as being unfortunate but nevertheless a sometimes unavoidable scenario. This poses questions as to whether this view is part of a wider cultural issue within these organisations (a question which is beyond the remit of this review to investigate). It may go some way towards explaining why the homelessness route was suggested by the care co-ordinator so soon after being told that Mr H could be discharged (in April 2008).

2.63 Caerphilly County Borough Council, as a local authority, has a duty under Section 117 of the Mental Health Act in relation to planning and providing after-care for those patients to whom it applies when discharged from detention. We find that systems within the housing department of Caerphilly County Borough Council potentially prevent the local authority from meeting its Section 117 responsibilities fully. These inadequacies are outlined below.

2.64 We were told that it was not possible to plan to meet accommodation needs in advance of Mr H's discharge because the housing department at Caerphilly County Borough Council was unwilling to allocate permanent housing to a vulnerable individual while they are still an in-patient. The process is set up to provide a short term placement at a bed and breakfast hostel when an individual is first registered as homeless, until a flat can be found for a temporary stay of up to six months. It is Caerphilly housing department's policy that an appointment cannot be made in advance of a patient leaving hospital, and a hostel must be allocated to the service user on the day that they leave hospital, as it is only then that they are able to register as homeless. In Mr H's case, an appointment was made at the homeless office for the day of his discharge, but this appears to have been due to the uncompromising statement (recorded in the care co-ordinator's case notes in a conversation with a member of the homelessness team) that Cygnet Hospital staff would be arriving with Mr H at their office *'with or without an appointment, without* [the housing officer's] *consent.'* We believe that as well as subverting the local authority's duties under Section 117 of the Mental Health Act, this policy must also be very unsettling for individuals with a mental health issue. It is not conducive to planning and supporting a good recovery and return to the community; this practice should not continue.

2.65 Furthermore, we consider that the process of allocating homeless accommodation to people with mental health issues is unsatisfactory. For mental illness to be counted as a priority it has to be severe and to have at least resulted in a hospital admission; some of those we interviewed thought that an individual also needed to have been detained under the Mental Health Act, whereas others did not indicate this. There is clearly confusion among the CMHT about the criteria used by Caerphilly County Borough Council's housing team to identify who is considered to be homeless and to have priority needs.

2.66 These issues have been examined in greater depth across Wales by the Wales Audit Office in its review of housing services for adults with mental health needs (November 2010). This found that across Wales, *'services for all homeless people with mental health needs had not improved and, despite the provisions of the Homelessness (Suitability of Accommodation) (Wales) Order 2006, problems still*

remained in respect of temporary accommodation, risk management, discharge from institutions and services for people with a dual diagnosis."[89]

2.67 In summary, we find that the failure of Caerphilly CMHT to fulfil the recommendation of the Mental Health Review Tribunal to find Mr H an alternative low secure hospital placement was due to:

- the refusal by Dr A to accept a transfer of Mr H to Tŷ Sirhowy from Cygnet Hospital;
- a lack of low secure NHS hospital facilities in the Gwent area;
- a lack of clarity within the CMHT about lines of responsibility for independent sector hospital placements; and
- a lack of effective multi-disciplinary leadership of the CMHT.

2.68 We find that the failure of Caerphilly County Borough Council and Caerphilly LHB (which had entered into arrangements with Gwent Healthcare NHS Trust and the CMHT) to fulfil its duties under Section 117 of the Mental Health Act to provide Mr H with suitable after-care accommodation, was due to the CMHT's:

- lack of supervision, advice, quality assurance and managerial support for the care co-ordinator;
- failure to undertake effective risk assessments, symptomatic of fundamental flaws in the approach to risk assessment in the CMHT and a lack of importance placed on the use of risk assessments;
- failure to pay due consideration to risks identified by nursing staff;
- failure to escalate concerns or utilise the MDT mechanism to identify solutions;
- acceptance that homelessness was a viable option for a vulnerable patient released from detention under the Mental Health Act;
- after-care planning based on available services rather than identified need; and

[89] Wales Audit Office, *Housing services for adults with mental health needs* (November 2010), p.9.

- unsatisfactory processes within the Housing Department at Caerphilly County Borough Council which prevented the allocation of tenancies to homeless people with mental health issues prior to discharge from hospital, particularly for those persons, such as Mr H, for whom the Council has duties in relation to Section 117 of the Mental Health Act.

On-going care by the CMHT

2.69 Following his discharge from Cygnet Hospital, Mr H's care and progress should have been closely monitored by the CMHT, particularly in light of his complex needs and unsatisfactory discharge and accommodation arrangements. We would have expected the CMHT to have seen him as a high risk case which required a *'textbook'* response; however, we find that this was not the case.

2.70 Although the care co-ordinator did initiate a meeting with the police and housing officer under Section 115 of the Crime and Disorder Act (which took place on 20 October), the minutes of this meeting do not contain any action points or refer to an action plan. It is concerning that although a question was raised at this meeting about whether Mr H was *'likely to "pounce" on someone,'* and it was recognised that Mr H's placement at the homeless hostel was a *'risk,'* we found no evidence of any risk assessment or risk management plan having been completed by the CMHT following this meeting, or at any point following Mr H's return to the community in Caerphilly following his discharge from Cygnet Hospital.

2.71 We were told that as neither Mr H's care co-ordinator nor her supervisor had been trained in the CMHT's new risk assessment tool, a risk assessment was not carried out at this point. We are concerned that a change in risk assessment tools and delays in staff receiving necessary training should not be used as an excuse to avoid completing a risk assessment. It would have been preferable for either the care co-ordinator or her supervisor to record an assessment of Mr H's risks using a different risk assessment tool until they had been adequately trained to undertake a new risk assessment using the correct tool, rather than do no risk assessment at all.

2.72 It is concerning that Mr H was not seen in person by anyone from the CMHT for nearly a fortnight following his return to Caerphilly from Cygnet Hospital. His possessions were not given to him for several days after his discharge. He did not have any money as Cygnet Hospital had failed to inform Caerphilly CMHT that his benefit payments had not been arranged, an issue which Cygnet Hospital should have planned earlier, with their belated attempts to do so having been unsuccessful. Mr H told his care co-ordinator that he thought that his benefits had been sorted out, but the care co-ordinator did not check to confirm this. However, the outcome of this confusion was that Mr H was left without money for food and bare essentials for several weeks. Although his landlady at the homeless hostel arranged with Mr H that she would cook meals for him until he could repay her, she stopped doing so when he stole money from the hostel's laundry facilities; a sequence of events which led to Mr H being evicted. We believe that Mr H's care plan should have been far more structured with far greater engagement from the CMHT in the days and weeks following discharge. Had this been the case, Mr H's welfare would have been more closely monitored, his behavioural risks should have been better managed in recognition of the impact of stress on his mental state, and his eviction could potentially have been prevented.

2.73 The CMHT failed to put in place an adequate contingency plan, as required under CPA. This should have detailed the arrangements to be used at short notice to prevent Mr H's escalation into a crisis, for example in circumstances where the care co-ordinator is not available. Given that the CMHT had allocated Mr H's case to a part-time worker as his care co-ordinator, they should have ensured that there were formal arrangements in place to deal with situations in her absence. Had this been the case, Mr H could have been seen earlier by a member of the CMHT, enabling his financial situation to have come to light and been resolved sooner and potentially preventing the ensuing sequence of events.

2.74 Neither did the CMHT produce an effective crisis plan, also required under CPA. Crisis plans should specify the actions to be taken in a crisis, for example when factors place the service user and/ or others at risk (e.g. becoming homeless), or in response to known relapse indicators based upon previous experience (such as self-harming, alcohol and substance misuse, or experiencing auditory

hallucinations). Had a crisis plan been in place, it should have been initiated on several occasions following Mr H's return to Caerphilly from Cygnet Hospital and appropriate, timely action been taken. Notably a crisis plan could have drawn on knowledge of Mr H's pattern of behaviour while in Scotland, which Dr A had documented in his Tribunal report of July 2007. It is regrettable that this was overlooked.

2.75 The closest example of a crisis or contingency plan that we could find was an unsigned care plan produced by the CMHT on 8 October 2008. The relapse indicators section states that Mr H had a risk of developing episodes of psychosis, that this was more likely to happen if he was experiencing stresses caused by drug and alcohol misuse, and recorded the early warning signs that things are not going well as *'violence and aggression.'* We are concerned that this was clearly inadequate as the focus was on the effects of a crisis rather than the causes and prevention strategies.

2.76 We do not believe that management within the CMHT provided adequate supervision and support to the care co-ordinator, or responded appropriately when concerns about Mr H's wellbeing and whereabouts were raised. This led to very stressful situations for Mr H, including a period when he moved around South Wales seeking help from in-patient units, and self-harming. It appears that there was a breakdown in communication between the care co-ordinator and her supervisor, which impinged on the care Mr H was provided at key points. This included Mr H not being visited by anyone from the CMHT for nearly two weeks following his eviction and placement in a hotel in Newport. There was also a lack of input into Mr H's case from a CPN, which could have provided a more comprehensive ongoing mental health assessment. Had this been the case, Mr H's needs could have been met more holistically. We find that the CMHT failed to fully embrace the multi-disciplinary approach.

2.77 The CMHT's MDT did not take responsibility for scrutinising risk in relation to Mr H. References to Mr H in the minutes of the CMHT's weekly MDT meetings are very patchy; for example, he was not mentioned in minutes in the two weeks following his discharge from Cygnet Hospital. When Mr H is recorded as having

been mentioned in MDT meetings, it does not appear that there was any real discussion about his care and progress and no actions were recorded. In particular, it is of serious concern that, following Mr H's eviction and placement in a hotel in Newport in November 2008, minutes of the MDT only include one line about Mr H which states *'evicted from* [homeless B&B] – *we don't know where he is.'* The MDT did not, according to the minutes, adequately follow this up in subsequent meetings; he was not mentioned again for a fortnight, when the only statement next to Mr H's name is *'where is he?'* Given Mr H's vulnerability, complex mental health needs and known history of drug abuse, self harm and violence, the CMHT should have taken much more assertive steps to follow this up.

2.78 Mr H's eviction on 20 November 2008 in turn led to a sequence of events which left Mr H vulnerable and in danger of becoming unsupported by all agencies. Although a flat had been allocated for Mr H, which he was due to move in to a few days after this eviction, due to this incident Caerphilly homeless team deemed him no longer eligible for accommodation. The police had transported Mr H on the night of his eviction to a hotel in Newport, but as this was in a different local authority area it would have meant he could no longer receive support from the Caerphilly AOT as had been planned. The inflexibility of Caerphilly County Borough Council's housing department, even in light of an appeal supported by a consultant psychiatrist who explained the detrimental impact that homelessness would have on Mr H's mental health, potentially amounts to the local authority failing to meet its duties under Section 117 of the Mental Health Act. The uncertainty and instability that this caused Mr H, resulted in a crisis when he presented at A&E in Cardiff, describing hearing voices commanding him to jump off a bridge. This sequence of events poses significant questions about Caerphilly housing department's understanding and consideration of mental health needs when prioritising homeless accommodation, and their understanding of their legal duties under Section 117 of the Mental Health Act.

2.79 At this point, Dr A provided some support to the care co-ordinator by writing a letter on 2 December backing a new application for homeless accommodation for Mr H. However, we consider this to have been a missed opportunity for Dr A to have reconsidered admitting Mr H to Tŷ Sirhowy. While Dr A had clearly expressed a

view while Mr H was an in-patient at Cygnet Hospital that Tŷ Sirhowy could not comprehensively meet Mr H's complex needs or the level of security he felt he required; in his 2 December letter, Dr A stated that Mr H's *'illness and the absence of effective treatment would have been a significant factor in his deteriorating behaviour.'* Had Mr H been admitted at this point to Tŷ Sirhowy, it might have avoided the crisis situation a week later when Mr H became suicidal, unable to cope with voices in his head which were commanding him to jump off a bridge.

2.80 Following this event, Mr H was admitted to Tŷ Sirhowy when an out-of-hours duty doctor received a request to transfer him there from UHW in Cardiff where he had presented at A&E. It is concerning that Dr A maintained that if Mr H posed *'a serious management problem on the ward'* he would *'have to be discharged before alternatives had been put in place.'* It appears that Dr A was willing for Mr H to be discharged from hospital again without a more robust care package being put in place, if he posed difficulties for staff while at Tŷ Sirhowy.

2.81 Although Mr H was risk assessed on arrival at Tŷ Sirhowy in December 2008, he was deemed to be at low risk of violence. We are concerned that due consideration was not given to previous risk assessments or Mr H's known history of violence both at Cygnet Hospital and when he had previously been an in-patient in Tŷ Sirhowy in 2007; Mr H was later that month violent towards a member of staff.

2.82 The nursing report of 29 July 2008 prepared by Cygnet Hospital nursing staff which *'strongly discouraged the use of PRN medication, taking into consideration the history of illicit substance misuse'* clearly did not get picked up by anyone from the CMHT or fed into a risk management plan. It does not appear that concerns that Mr H was abusing illegal drugs and alcohol while on the ward prompted any remedial action, which should have been documented in a risk management plan. No one at Tŷ Sirhowy appears to have undertaken a risk assessment of the appropriateness of prescribing Mr H PRN medication and certainly, it does not appear that this was ever connected with his substance misuse issues.

2.83 Mr H was again discharged to the Caerphilly Homelessness Team on 13 January 2009, at which point his care was transferred to the AOT despite their

concerns that they could not offer a seven-day-a-week service. As mentioned previously, it is highly regrettable that the CMHT did not take account of Mr A's known history while in Scotland in 2007 of frequently presenting to A&E having overdosed on prescribed medication, expressing suicidal thoughts, auditory hallucinations or asking to be admitted to hospital. The opportunity to ensure that a crisis, risk management or care plan that addressed how to prevent a repeat of this pattern of behaviour was therefore missed.

2.84 Throughout January 2009, although Mr H was now under the care of the AOT, Dr A had several opportunities to reconsider options for caring for Mr H as an in-patient. He saw Mr H on 21 January 2009 when he disclosed hearing voices telling him to harm himself and Dr A reviewed his medication and increased his dose, and sent Mr H home with a prescription for the increased dose of his medication. Mr H's care plan at this time was for his medication to be administered by the AOT during weekdays but left with his weekend supply of medication to administer himself throughout weekends; this was despite Mr H being known to have attempted to overdose on prescribed medication in the past. Three days later, on 24 January 2009, Tŷ Sirhowy had to admit Mr H after he was transferred there from Nevill Hall Hospital, where he had presented himself at A&E saying he had overdosed on his prescribed medication as he could not cope with the voices in his head. This should have triggered a review of Mr H's care plan as it pointed to the fact that Mr H was struggling to cope in the community. However, instead, Mr H was discharged again two days later on 26 January 2009. Again on 20 February 2009 Mr H was turned away from Tŷ Sirhowy without having been given any treatment.

2.85 We believe that, given all the evidence of Mr H's vulnerability, complex needs and risk of self-harm, it was inappropriate for Mr H to have been discharged from Tŷ Sirhowy on 13 and 26 January 2009. Opportunities were missed on 21 January and 20 February 2009 to reconsider whether it was suitable for Mr H to remain in the community. By this point it was clear that Mr H was not coping well in the homeless accommodation in which he had been placed since leaving Cygnet Hospital in October 2008. In this period he had absconded from his homeless hostel, been evicted for stealing money (his welfare benefits not having been organised prior to being discharged from Cygnet Hospital), been placed in a hotel, and been

readmitted to hospital after presenting at A&E with suicidal thoughts. It would have been more appropriate to have considered options for in-patient care, either informally or under the Mental Health Act. If this had happened, services would have had the opportunity to reconsider the option of a long-term period of rehabilitation for Mr H.

2.86 An opportunity to consider using the Protection of Vulnerable Adults (PoVA)[90] process at this point was missed. The many moves in a short space of time and the vulnerability Mr H experienced at accommodation which was frequently to us described as *'undesirable'* at best, would have been very unsettling. Mr H was threatened and exploited by neighbours and was also known to be using illicit street drugs again. The CMHT was also aware that for a period of time Mr H had been without money for food and bare essentials. At interview it was apparent that PoVA was not regarded as a suitable option for a case such as Mr H by the social workers within the CMHT. We are concerned that adult protection procedures and the opportunity they could have presented to review Mr H's circumstances in a multi-agency setting were therefore not well understood within specialist teams.

2.87 In summary, in the period October 2008 to March 2009 the CMHT failed to:

- undertake or implement effective risk assessments, risk management plans, crisis plans and contingency plans (as required under CPA), or take account of previous risk assessments;
- fully consider and fulfil their statutory duties under Section 117 of the Mental Health Act, or remind other parties of this;
- ensure that Mr H had money, possessions and food in the weeks following his discharge to a homeless hostel;
- put in place formal arrangements to closely monitor Mr H's care and progress and provide sufficient support, including a robust care plan;

[90] **Protection of Vulnerable Adults (PoVA) –** adult protection procedures which give Social Services the responsibility for receiving referrals about and co-ordinating investigations into circumstances where a vulnerable adult has been abused or neglected, including through financial exploitation. The procedures are based on the National Assembly for Wales' publication, in July 2000, *In Safe Hands: Implementing Adult Protection Procedures in Wales* - guidance issued under Section 7 of the Local Authority Social Services Act 1970. Supplementary guidance to *In Safe Hands* was subsequently issued on financial abuse, in 2003 and in 2009.

- provide general and clinical supervision, support or leadership to the team and the care co-ordinator;
- embrace the role of the MDT in the provision of care to patients with complex needs;
- take responsibility for the scrutiny of risk;
- take assertive steps to follow up concerns that Mr H had gone missing;
- reconsider the options of in-patient care, either under the Mental Health Act or informally, for a long term period of rehabilitation;
- learn lessons from the consequences of Mr H's previous unsatisfactory discharge;
- assertively explore options for supported accommodation; and
- consider using the Protection of Vulnerable Adults (PoVA) process.

The role of the Assertive Outreach Team

2.88 Given that Mr H had displayed episodes of aggressive behaviour on a number of occasions prior to his discharge from Cygnet Hospital, and that Dr A had insisted that his needs were too great to be met within Tŷ Sirhowy and he warranted a low secure mental health in-patient facility, it was not appropriate that the AOT was expected to deal with the level of risk of violence and aggression posed by Mr H, and we strongly believe that Mr H should not have been placed under their care.

2.89 That said, we believe that AOT staff were aware that there was little other support being made available to Mr H, and were admirable in wanting to provide him with good care. Despite the instability in Mr H's housing while under the AOT (which was beyond their control), we consider it to have in many ways been Mr H's most stable period of care. He was receiving support five days a week from a multi-disciplinary team, was not violent during this period, and was seen to be making positive progress. HIW considers that individual members of the AOT acted professionally and to the best of their abilities and did all they could, given the resources made available to them.

2.90 At the time of Mr H's involvement with the AOT, the team was suffering from a lack of team leader. While management support was provided by the team leader of the CMHT in the north of the borough, the lack of a dedicated team leader meant there was no one within the AOT with the authority to feel able to suggest a different referral option and to reinforce that the AOT service was not set up to work with patients in such a vulnerable and chaotic position.

2.91 Despite the lack of dedicated team leader, individual members of the AOT did attempt to get this view heard and raised it at meetings with the CMHT on several occasions. Evidence shows that the AOT had originally turned down the CMHT care co-ordinator's request to transfer Mr H to their service in October 2008, on the grounds that he *'did not meet their criteria'* (recorded in minutes of the Section 115 meeting on 20 October 2008). Although they agreed to accept him for a one month trial period on 1 December 2008, during this month Mr H was readmitted to Tŷ Sirhowy and there was re-started on anti-psychotic medication which had previously been stopped on his discharge from Cygnet Hospital. Therefore, at an MDT meeting on 9 January 2009, AOT staff raised concerns about whether it would still be appropriate for Mr H to be placed under their care, as they only operated five days a week and believed he would require seven day a week care. However, it appears that the AOT's concerns were disregarded at this point by the CMHT (which at this point was still responsible for Mr H's care).

2.92 From this point onwards, it would appear that the AOT became resigned to the fact that little further support would be forthcoming from the CMHT and little attempt was made to make any formal referrals to Tŷ Sirhowy to readmit Mr H as an in-patient. Mr H therefore presented himself on repeated occasions to various A&E departments, which should have triggered a more thorough reconsideration of his care plan in the community. Findings have been made with reference to the clinical decision-making rationale in the previous section; however we also find that the AOT, who should have been the first line in assessing Mr H's risk in this period, could have made a formal referral to Tŷ Sirhowy.

2.93 The CMHT management team should have recognised that the AOT could not fully provide Mr H with the care he needed. In particular, the lack of weekend

cover clearly posed an issue in terms of the administration of Mr H's antipsychotic medication, but no consideration appears to have been given to how this would be managed. It was however recorded in a CMHT care plan on 8 October 2008 that the AOT's lack of weekend service would have been *'detrimental to* [Mr H's] *rehabilitation within the community.'* By the time of his discharge from Tŷ Sirhowy on 13 January 2009, this appears to have been forgotten by the CMHT. Had the implications of this been considered by the MDT at this point and a plan to mitigate the risks associated with this put in place, it might have prevented later situations when Mr H overdosed on his weekend's supply of medication on several occasions.

2.94 We are also concerned that Mr H's attempted overdoses on his weekend medication during his time under the care of the AOT did not trigger a change of plan with regards to his medicines management. We consider that, under CPA, this should have been recorded as an unmet need.[91]

2.95 The care that the AOT was able to offer Mr H was more limited than his needs required, due to inadequate resources which prevented the provision of a seven day a week service. We were informed that funding for the service in Caerphilly borough has historically lagged behind the other four local authority areas now under the collective remit of the Aneurin Bevan Health Board, despite it being one of the more deprived areas of Wales.

2.96 The CMHT failed to hand over a full set of records relating to Mr H when they transferred his care to the AOT. As a result, that team did not have access to all his previous risk assessments. The AOT's care co-ordinator completed a risk assessment on 30 January 2009, three days after his discharge from Tŷ Sirhowy, but at this time was still waiting for the CMHT to transfer his records and so conducted the risk assessment on the basis of Mr H's presentation and ward notes from his most recent in-patient admission at Tŷ Sirhowy. The AOT's care co-ordinator had not been trained in the new risk assessment tool that the AOT had recently adopted,

[91] Welsh Assembly Government, *Mental Health Policy Guidance: The Care Programme Approach* (February 2003), p.12. Current guidance on planning for unmet needs is available in Welsh Assembly Government, *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance* (July 2010), p.21.

but undertook a risk assessment using the old tool, with which she was comfortable. We regard this as having been far better practice than to have not done one at all.

2.97 The AOT's risk assessment did not deem Mr H's risk of violence to others to be high. However, we believe this was due to the fact that the AOT had not been given all the information available about his history, such as his regular displays of aggression while under Section 3 of the Mental Health Act at Cygnet Hospital, as well as more recently having been violent on the ward at Tŷ Sirhowy. Had the AOT had access to all the information available in Mr H's full health and social care records, it would have been possible for them to make a more informed assessment of his risks of harm to himself and others, and the risks associated with his substance misuse issues. Despite their limited information, leading to their risk assessment of a low risk of violence, the AOT took the appropriate precaution of staff visiting him in pairs. AOT staff working with Mr H at the time did not feel intimidated or threatened by him, and he was not violent while under the care of the AOT, prior to committing the index offence.

2.98 The AOT's January 2009 risk assessment, while it mentions cannabis use, plays down Mr H's amphetamine use, which was not considered a high risk. We find as above that this was due to the failure of the CMHT to handover all information about Mr H, which would have given them greater understanding of his long history of substance misuse, and the potential risks associated with it. We are informed that since this time, the AOT has changed its policy and would now ensure that it had received a full set of clinical and social care notes prior to commencing working with any new client.

2.99 Throughout the AOT's involvement with Mr H in early 2009, they became aware of his illicit drug use, particularly amphetamines, and this was recorded in their notes. However, there is no evidence of a risk assessment being updated or a risk management plan having been created to manage this and the increased risks of violence and self harm associated with drug use in people with a co-occurring substance misuse and mental health problem. Welsh Government guidance makes

clear that *'this client group has an increased risk of suicide and/or homicide'*[92] and that proper assessment of substance misuse is required under the Care Programme Approach. We find that this was inadequate.

2.100 We have concerns in relation to the CMHT and the AOT's tolerance of risk and failures to escalate concerns about known triggers (such as increased substance misuse) that might result in Mr H experiencing a crisis period or psychotic episode. As has been highlighted earlier, a crisis plan should have been put in place (by either the CMHT or the AOT) which identified relapse indicators and planned an appropriate response. In particular, the CMHT should have heeded previous risk assessments (including those completed by nursing staff at Cygnet Hospital during his detention there and by the care co-ordinator shortly prior to his discharge from Cygnet Hospital). Both had noted the increased risks associated with Mr H's known problems with alcohol and substance misuse. If the CMHT had made this information available to the AOT it would have been possible for them to consider this in planning how to deal with these trigger factors.

2.101 In particular, it is questionable whether the AOT's response to finding evidence that Mr H was using drugs in the days prior to his trip to Scotland (e.g. recorded on 20 March 2009) was adequate. At this point the AOT might have reconsidered whether a long journey to Scotland, which had in the past triggered increased anxiety for Mr H (for example when he was at Cygnet Hospital), was still appropriate at that time. Similarly, more consideration could have been given to the potential increase to Mr H's stress levels (a known risk factor) given that he had moved into new accommodation less than a week prior to the trip. However, the AOT's CPN did discuss with the supervisor whether it was acceptable for Mr H to visit his grandmother. On balance, we acknowledge that the decision to support him to spend time with a close relative who he had not seen for a considerable period of time could be considered appropriate.

2.102 On the day of the index offence, AOT staff were put in an extremely difficult situation when they found that Mr H had bought a half bottle of vodka, as they did not

[92] Welsh Assembly Government, *Service Framework to meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem* (September 2007), p.1

have the powers to remove items from him. We find that, given this scenario, AOT staff acted professionally and did all they could, by advising Mr H not to drink the vodka, reminding him that he needed to be well-behaved for his grandmother and ensuring that he was settled before leaving him with his brother.

2.103 In summary, care provided to Mr H by the AOT on the whole was good, but there were systemic flaws in the service's management arrangements and in the AOT's approach to risk assessment:

- a lack of team leader, resulting in a lack of managerial support or responsibility;
- a lack of funding to ensure the service was available seven days a week;
- a lack of training for all staff in current risk assessment tools; and
- a failure to give consideration to the Welsh Government '*Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem*.'

2.104 Overall, we find that the AOT was put in an untenable position by Caerphilly CMHT, which failed to:

- give due regard to the concerns raised by the AOT that they could not fully meet Mr H's needs (in particular, in relation to the management of his medication at weekends);
- recognise that placing him under the care of the AOT was inappropriate given Mr H's high risk of harm to himself and others; and
- hand over a full set of clinical and social care records, including risk assessments, to the AOT.

Chapter 3: Recommendations

In view of the findings arising from this review we make the following recommendations.

Integration, transition and information-sharing between services

3.1 Aneurin Bevan Health Board Adolescent Mental Health Services (CAMHS) and Caerphilly County Borough Council Social Services must enhance arrangements for working together effectively, and ensure that there is a clear, shared understanding of each others roles[93].

3.2 Aneurin Bevan Health Board and Caerphilly County Borough Council must work together to strengthen processes for transition from children's to adults' services, to include mechanisms for forward planning and multi-agency consideration of needs, identifying clear roles and responsibilities with a period of overlap where possible[94].

3.3 Aneurin Bevan Health Board and Caerphilly County Borough Council must put in place measures to ensure that:

- current information sharing arrangements between services exist;
- individuals' health and social care records are made available in a timely manner on transfer to a different service;
- on allocation of a new case, care co-ordinators are required to thoroughly review all previous health and social care records relating to the individual; and
- all available information relating to diagnosis and risk management is taken into consideration when care planning.

[93] National Assembly for Wales, *Everybody's Business: All Wales Child and Adolescent Mental Health Services Strategy Document* (September 2001), p.10
[94] Welsh Assembly Government, *The Role of Community Mental Health Teams in Delivering Community Mental Health Services: Interim Policy Implementation Guidance and Standards* (July 2010), p.11.

Continuing Healthcare placements

3.4 Aneurin Bevan Health Board must ensure that Continuing Healthcare placements are made following full and due consideration of the appropriateness of the placement for the patient and that robust mechanisms are in place to monitor the clinical performance, quality and safety of care provided in such facilities.

3.5 Aneurin Bevan Health Board must ensure that it sets out a clear pathway for allocating and funding Continuing Healthcare placements and that all parties involved understand their roles and responsibilities.

After-care planning

3.6 Aneurin Bevan Health Board, Caerphilly County Borough Council and third parties such as Cygnet Hospital must put in place rigorous procedures to ensure that meetings to plan after-care under Section 117 of the Mental Health Act are held in a timely manner and attended by a multi-disciplinary team, using best endeavours to agree an appropriate package of support. A system must be developed to ensure that after-care plans are agreed and signed off by the patient's RMO, care co-ordinator and third party contractor and where agreement between the three cannot be reached there must be a suitable escalation arrangement.

3.7 Aneurin Bevan Health Board, Caerphilly County Borough Council and third parties such as Cygnet Hospital must ensure that after-care planning is systematically undertaken at the start of a patient's detention under the Mental Health Act, in order to plan for a safe and supported discharge.

3.8 Aneurin Bevan Health Board, Caerphilly County Borough Council and third parties such as Cygnet Hospital must ensure that, prior to discharge a multi-disciplinary team agrees after-care, CPA and risk management plans which detail the arrangements for:

- accommodation which adequately meets the needs of the patient, where accommodation is required as part of the after-care package;
- how medication is to be monitored and supervised if appropriate;
- mitigating a full range of risk factors including substance misuse and harm to the patient and others; and
- transport, supervision and care for the day of discharge[95].

3.9 Aneurin Bevan Health Board and Caerphilly County Borough Council must put in place a mechanism to ensure that after-care plans are timely, consistent, high quality and appropriate to meet the needs of the individual. Aneurin Bevan Health Board, Caerphilly County Borough Council and Cygnet Hospital should each conduct an audit of relevant patients currently detained under the Mental Health Act to assess the quality, timeliness and consistency of after-care plans.

3.10 Aneurin Bevan Health Board and Caerphilly County Borough Council must put in place measures to ensure that their after-care responsibilities for providing adequate accommodation and housing under Section 117 of the Mental Health Act are not discharged through the homelessness route.

3.11 In order to assure itself that it fully meets its Section 117 responsibilities, Caerphilly County Borough Council must revise its housing policies and processes to ensure that suitable, good quality housing is provided to people with mental health issues, particularly those due to be discharged from hospital. Systems should be put in place to enable suitable accommodation to be arranged prior to a patient's discharge from hospital.

3.12 Aneurin Bevan Health Board and Caerphilly County Borough Council must ensure that Mental Health Review Tribunal recommendations are promptly acted upon and that there is clarity about who is accountable for owning such actions. A clear escalation process must be in place.

[95] Welsh Assembly Government, *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance* (July 2010), pp.27 - 30

Risk Management

3.13 Aneurin Bevan Health Board and Caerphilly County Borough Council must assure themselves that risk management is embedded in the culture of all mental health services, ensuring that:

- all staff recognise that accurate risk assessment relies fundamentally on high quality history-taking and review of all previous information (including risk assessments)[96];
- all individuals' risk assessments and risk management plans are up-to-date, of high quality, with appropriate levels of risk tolerance, and are regularly reviewed;
- due regard is given to national guidance and evidence about common risk factors, including those for patients with complex needs (e.g. co-occurring substance misuse and mental health problems) and for scenarios known to be high risk (e.g. discharge from hospital);
- risk management is planned and scrutinised effectively at multi-disciplinary team meetings; and
- Contingency Plans and Crisis Plans are prepared for all patients under CPA, in accordance with Welsh Government Mental Health Policy Guidance[97]. Plans must be reviewed at multi-disciplinary team meetings when implemented in crisis or contingency scenarios, particularly when actions involve a multi-disciplinary response.

3.14 Aneurin Bevan Health Board and Caerphilly County Borough Council must ensure that Carers' Assessments are used consistently and recognise the impact of patient risk factors on carers' needs as well as those of the patient.

[96] Welsh Assembly Government, *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance* (July 2010), p.14
[97] Welsh Assembly Government, *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance* (July 2010), p.21

Service provision

3.15 Aneurin Bevan Health Board and Caerphilly County Borough Council must ensure that services' eligibility criteria do not exclude patients with complex needs. Eligibility criteria must be flexible, with the core emphasis focused on individuals' needs.

3.16 Aneurin Bevan Health Board and Caerphilly County Borough Council must ensure that the needs of children and young people with Asperger's Syndrome, and those with a co-occurring mental health issue, are met comprehensively[98].

3.17 Aneurin Bevan Health Board and Caerphilly County Borough Council must develop a range of community responses to people with complex needs, to include Crisis Resolution/ Home Treatment alongside Assertive Outreach.

3.18 Aneurin Bevan Health Board must ensure that a comprehensive range of local in-patient mental health services is available to all patients.

3.19 The Mental Health Programme Board for Wales must ensure that there is sufficient NHS low secure provision in Wales.

3.20 Aneurin Bevan Health Board and Caerphilly County Borough Council should ensure that the Caerphilly Assertive Outreach Team is adequately resourced to provide a service seven days a week where needed.

Leadership

3.21 Aneurin Bevan Health Board and Caerphilly County Borough Council must ensure that community mental health services, including CMHTs and AOTs:

- are managed effectively and equipped with strong leadership; and
- effective managerial supervision and support mechanisms are in place.

[98] Welsh Assembly Government, *Autistic Spectrum Disorder Strategic Action Plan for Wales* (2008), p.17

3.22 Aneurin Bevan Health Board and Caerphilly County Borough Council must strengthen multi-disciplinary team systems to support and ensure effective care planning and decision-making, including escalation arrangements.

3.23 Aneurin Bevan Health Board and Cygnet Hospital must undertake a thorough review of the rationale for the clinical decisions made at the time of Mr H's discharge from Cygnet Hospital and his subsequent care by the CMHT and non-admission to Tŷ Sirhowy.

Aneurin Bevan Health Board & Caerphilly County Borough Council

Addendum in response to HIW's report of a review in respect of: Mr H and the provision of Mental Health Services, following a Homicide committed in March 2009

Adult Mental Health Services

Introduction

The Healthcare Inspectorate Wales report has identified a number of major concerns regarding the care afforded to Mr H. The concerns are associated with the care he received across a range of Children's and Adult services provided by the Aneurin Bevan Health Board (ABHB) and the Caerphilly County Borough Council (CCBC). Sadly, the findings describe systemic difficulties throughout the organisations that were involved in providing his care.

Many of the findings relate directly to the months leading up to this tragic event and they describe the difficulties in service provision at that time. As a direct result of the initial investigation into this incident and as a consequence of the lessons learnt from other incident investigations, both CCBC and ABHB have introduced changes in service provision. The following details some of the key changes that have now been put in place. They have been categorised in the same themes that were outlined in the recommendations section of the HIW report. The themes are:

1. Integration, transition and information-sharing between services.
2. Effectively managing out of area placements in the independent sector.
3. The importance of effective aftercare planning.
4. The importance of effective risk management.
5. The importance of effective leadership.
6. Maintaining service development.

Overview

There have across agencies and services been a number of specific changes and initiatives to improve the experience of people going through Mental Health services such as:

- the introduction of Crisis Resolution Home Treatment Team in Caerphilly;
- real momentum in the integration of health and social care services;
- better communication and information sharing across agencies;
- better implementation of assessment and care planning through the Care Programme Approach (CPA); and
- higher profile within the Health Board with a Vice Chair and Director with a specific role at Board level for Mental Health Services.

1. Integration, Transition and Information-Sharing between Services

To date the development of integrated Mental Health (MH) services in Gwent has largely consisted of attempts over the last ten years to co-locate frontline health and social care teams. It should be acknowledged that these efforts have undoubtedly helped to improve both partnership working and communication in these teams. Additionally, some teams have attempted to further progress the integrated agenda by introducing such changes as a single case note system and/or integrated referral meetings. However, the incremental introduction of such changes has only helped to achieve the presence of an inconsistent service model across all five localities with a varying degree of integrated working at a team level but with no strategic sign up at a senior level across Gwent.

In recent months discussions have been held with a number of senior MH managers who have had experience in developing integrated MH services in Gwent. These discussions have helped to identify a number of difficulties, many of which were features of the service at the time of the incident. These difficulties include the following:-

- the absence of a strategic plan identifying the key stages to fully integrated services;
- being unable to develop a single line management structure;
- challenges in developing the appropriate culture amongst the staff;
- concerns for staff around role expectation and role erosion;
- conflicting financial priorities; and
- different perspectives on service models.

With the above in mind ABHB along with all of its Local Authority partners have now prioritised the development of a fully integrated Health and Social Care service across Gwent and South Powys. To enable this to materialise a Partnership Board has now been operational since August 2010. This Board has representatives at Executive/Director level from ABHB and all Local Authority Partners. The Board has assumed responsibility for overseeing the development of a fully integrated Health and Social Care service. To facilitate this it has been agreed that new Mental Health and Learning Disabilities Strategies for Gwent will be developed. There will full consultation on the development of the strategies which will be directed and informed by people who use the services. Currently there are three delivery groups, operational since November 2010, leading this development work. The three groups have been tasked with designing the relevant part of the strategy specific to their service area. These three service areas are:

- Older Adult MH services;
- Adult MH services; and
- Learning Disabilities services.

It is intended that the strategies will be developed by the summer of this year.

In addition to this ABHB and its local authority partners are currently developing an implementation strategy for the Mental Health Measure which will achieve a greater degree of integrated working across primary and secondary care services and in doing so improve access to care and treatment.

2. Continuing Healthcare Placements

Since the incident there has been further restructuring within the health service and with the creation of ABHB the Mental Health and Learning Disabilities Division was created. Within former Trust structures Mental Health services were merged with Community services. This reorganisation has also resulted in the return of the Mental Health element of Continuing Healthcare (CHC) to the Division who now assume the responsibility for its management. Since this time the following has been introduced:

- peer review panels that consider the requirements of all individuals requiring placement through CHC;
- increased forensic resource that has helped to coordinate the care of individuals in the private sector;
- all patients in out of county placements have identified care coordinators;
- increased step-down rehabilitation facilities for patients returning from low secure units;
- the development of a repatriation pathway; and
- a developed list of preferred providers who have been subjected to the European tending process.

ABHB believes that if all of the above had been in situ then a more robust management of Mr H's care pathway would have been achieved.

3 and 4 Aftercare Planning and Risk Management

Since this incident the Mental Health service along with its Local Authority partners has introduced an integrated Care Programme Approach (CPA) Board. Its purpose is to ensure all teams meet the standards of CPA and to consider the results of audits that identify best practice and address poor performance. This in itself will improve aftercare arrangements and the audits undertaken to date indicate an improvement in performance. In addition to this, the Welsh Government (WG) has introduced targets around the delivery of CPA. The Delivery and Support Unit (DSU)

and National Leadership and Innovation Agency for Health (NLIAH) have, and continue to undertake independent audits which confirm the results of local audits. Finally the DSU has undertaken a pilot study within Caerphilly which involved project groups improving CPA arrangements within the Borough, the results of this work is being fed into the CPA Board and any improvements that result will be introduced across the whole of Gwent.

Some of the criticism in the report related to the inconsistent approach to Risk Assessment and its management. Since this time ABHB and the Local Authorities have implemented the WARRN Risk Assessment process and to date 90% of staff are trained in its use. The WARRN Risk Assessment process is evidence based training pack and risk assessment process, which has been recommended for use by the WG. All staff within the Forensic Service have now been trained in the HCR20 Risk Assessment process. This is a more sophisticated Risk Assessment tool used in specific cases.

Further to the above, a risk pathway specifically addressing the needs of high risk patients has been developed. The pathway describes the actions and management practitioners should take when managing patients who present with high risk and complex needs. To complement this, a Risk Reference Panel has also been introduced. This panel meets on a monthly basis and consists of a team of experts in the field of Risk Management. This enables practitioners to present any individual they may have concerns about. They can then receive expert advice, guidance and supervision.

Finally, Community Mental Health Teams (CMHT's) have been provided with clear direction and a protocol designed to improve their discussion and management of risk. This includes a revised CMHT format, the development of a draft caseload management policy and caseload management tools incorporated within the policy. This tool is currently being piloted. This is to enable transparency of caseloads and support to the caseload holders managing complex high risk patients.

5. Service Provision and Leadership

It is envisaged that a number of service developments described in Section 1 i.e. Integration and Information Sharing, will have an impact on improving the leadership within the teams. In addition to this, all Team Leader Job Descriptions are currently being reviewed to ensure that they reflect the requirements of an integrated effective leader in a modernised Mental Health service. This will ensure that the leaders of the teams manage the services effectively and also help to enable the respective organisations to consistently highlight and share good practice and manage poor performance where it exists.

6. Service Developments

In addition to all of the above ABHB and its Local Authority partners have recently introduced a number of other service developments. Most important of which has been the introduction of Crisis Resolution Home Treatment Teams (CRHT's) across Gwent. The CRHT was not in place in Caerphilly at the time of the incident and the new Health Board approved the introduction and investment required to support the implementation of the CRHT. Furthermore steps have also been taken to address the management issues that were highlighted within the report. An integrated Team Manager, specifically for the Assertive Outreach Team (AOT) in Caerphilly County Borough, has been recruited and has been in post now for six months. It is envisaged that in the future any post across Gwent that becomes vacant will be considered as an opportunity to further introduce integrated Health and Social Care leadership.

Child and Adolescent Mental Health Services

Introduction

The Healthcare Inspectorate Wales report highlighted a number of concerns about the way in which Caerphilly County Borough Council's (CCBC) Children's Services and the Child and Adolescent Mental Health Service (CAMHS), worked with Mr H

when he was a child and young person. Whilst the report recognises some good practice from the CAMHS it also highlights a number of areas where the authors believe that agencies could have acted differently in Mr H's best interests. The report questions the way in which the systems that were operating at the time created exclusive rather than inclusive support structures. It is important that agencies learn the lessons from such reviews and demonstrate this by implementing any necessary changes in a timely and effective way. However, in the case of Mr H his involvement with these services occurred some seven to ten years ago. Since this period both services have made important changes to the way in which they operate and have sought to develop effective and close working relationships. Given the years that have passed since Mr H presented to these services as an adolescent, it is important to highlight some of the key changes that have taken place in the interim. The following details some of the important changes that have already been implemented that address the recommendations of the HIW review. They have been categorised against the individual recommendation:

Integration, Transition and Information-Sharing between Services

The CCBC Social Services have worked closely with the CAMHS to strengthen partnership and create an accessible range of services for children and their families. CAMHS provide advice and support to Children's' Services staff via the Consultant Child Psychiatrist who offers regular consultation/surgery time to staff who are able discuss individual cases on a one to one basis.

Since 2003 a joint Social Services, Education and CAHMS Core Group has met monthly. This Core Group has developed to ensure that there is an effective model for the delivery of a range of services for children and young people with mental health problems, where multi-agency consideration is required.

Membership of the panel includes the Consultant Child Psychiatrist, a Children's Services and Education Service Manager, Clinical Psychologists, Consultant Community Paediatrician and a Senior Educational Psychologist.

These meetings identify, develop, deliver and monitor multiagency care plans for children with needs such as Autistic Spectrum Disorders (ASD) and mental health issues. The meeting provides the opportunity for any agency to raise concerns about the interventions/non intervention of partners and to have this resolved. The meeting also provides a forum for agencies to discuss their roles and responsibilities around individual cases.

The meeting feeds directly into a Health, Children's Services and Education Heads of Service Meeting which provides oversight of the work of the CAHMS Core Group and can resolve issues in the very small number of cases where professionals are not in agreement. Importantly each Head of Service has agreed that where there are disagreements no family will be without a service while issues are resolved.

CCBC has identified the importance of transition for children with disabilities and has strengthened the links between Children's Services and Adult Services through the Transitional Operational Group (TOG), which was established in 2005. The TOG ensures that the Social Services Directorate has clear policies and procedures for the support and care of vulnerable young people as they move from children's services to adult Services. This group meets on a monthly basis and has ensured that young people from the Leaving Care Team, Children's Services Teams and Children with Disabilities Team who need support as they become adults receive an appropriate package of support from adult services. This does include a period of overlap work between the services.

Through the work of the TOG a need has been identified for a joint team to help young people and their families with transition. Eighteen years of age is seen as an artificial point in time and it would be more beneficial for young people with complex needs who do not easily fit into existing criteria to be supported through a much longer transition process. As a result there has been significant progress in scoping the establishment of a 14–25 year old team that will look at vulnerable young people with complex needs and how best their needs are met along their journey from adolescent to adulthood.

The multi agency CAHMS Core Group also provides a mechanism to identify at an early stage those young people whose vulnerability and complex needs indicate that forward planning to assist their transition to adulthood will be necessary. This ensures that the progress of the multi agency planning process is monitored on a regular basis.

Service Provision and Leadership

In 2006-07 Children's Services in Caerphilly restructured their operational teams and created three teams with responsibility for assessing children in need. Alongside the geographical changes there were also changes to the way families received assessments and in particular ensured that many more children and young people received a Core Assessment. A Core Assessment is an in-depth multi agency assessment of need and leads on from the Initial Assessment. If the subject of this Homicide Review had come to the attention of CCBC Children's Services after 2006-07 it is likely that he would have received a Core Assessment which would have ensured a more holistic approach to his needs. The recent Inspections into Children's Services in Caerphilly County Borough Council, namely the Safeguarding Inspection published in October 2009 and the Safeguarding Inspection published in September 2010 both highlight the very real improvements achieved in this area.

More recently the Local Authority has completed a strategic review of services to Children with Disabilities and their families. This has recommended a significant redesign of services to Children with Disabilities to ensure that services are more widely accessible and are based upon need rather than strict eligibility criteria. The implementation plan has made significant progress and has established clear steps to complete this redesign that has already included consultation with parents and staff.

The Strategic Review recommended that a specialist service should be created for children with diagnosed Autistic Spectrum Disorders (ASD) within the Children with Disabilities Team. This means that all such children and young people will be open

to a social worker in this team and have full access to the wide range of services available.

Children's Services in CCBC have been leading an ASD partnership planning forum that has mapped existing services and promoted the development of expertise within the Authority and strengthened links with our Health and Education partners.

Since involvement in this case the Local Authority has developed specialist provision at Trinity Fields School which now provides a range of ASD support services especially to families who need support with their teenage children – the services provided are bespoke, and using a person centred approach, reflect an individuals needs, wishes and aspirations. The aim of the services is to provide valuable respite for families and siblings of children and young people referred, provide support to children and young people with complex needs and allow them to enjoy appropriate activities during their time at the school.

Also over the last year local agencies in Caerphilly have created a dedicated Integrated Service for Children with Complex Needs (ISCAN). This model provides a simple non-bureaucratic process for an early holistic multi agency assessment of a child's needs. Professionals who may be involved include those from Health, Social Services, Education and the Voluntary Sector.

Conclusion

This addendum has been compiled following consultation and subsequent agreement from Healthcare Inspectorate Wales (HIW) and it has been developed jointly by senior managers from ABHB and CCBC.

Annex A

Review Terms of Reference

Healthcare Inspectorate Wales Special Review of the Care and Treatment Provided to Mr H

The review will:

- consider the care provided to Mr H as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on 24 March 2009;
- review the decisions made in relation to the care of Mr H;
- identify any change or changes in Mr H's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 24 March 2009;
- produce a publicly-available report detailing relevant findings and setting out recommendations for improvement;
- work with key stakeholders to develop an action plan(s) to ensure lessons are learnt from this case.

Annex B

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

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

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

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

Arrangements for Reviews in Wales

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

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

Annex C

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

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

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

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

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

experience is a helpful checklist of necessary investigation steps and provides a *'tool box'* of techniques which have proven success in uncovering root causes of events. RCA has been adapted for use in the NHS by National Patient Safety Agency (NPSA).

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

- Dr Anil Kumar — Consultant Psychiatrist
- Mr Martin Thornton — Community Psychiatric Nurse
- Mrs Jill Lewis — Regional Social Services Inspector, CSSIW
- Mrs Val Jones — Lay Reviewer, HIW Panel
- Ms Charlie Thomas — Investigation Manager, HIW
- Miss Tracey Jenkins — Assistant Investigation Manager, HIW

The information gathering phase of the review was conducted between September 2010 and March 2011. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the former Gwent Healthcare NHS Trust; Caerphilly County Borough Council's Department of Social Services, Cygnet Hospital, and Wishaw General Hospital, Motherwell, Scotland. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officer. We were grateful to the police for their collaboration.
- Reading the case records maintained by Health Bodies and Local Authorities concerning Mr H.
- Reading interview notes and written statements provided by staff working with Mr H which were provided as part of the police or internal investigation processes.

- Interviewing key people particularly those with strategic responsibility for the delivery of services.

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

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

Annex D

The Roles and Responsibilities of Healthcare Inspectorate Wales

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

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

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

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

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

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

Annex E

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