Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr I and the provision of Mental Health Services, following a Homicide committed in June 2009

November 2011

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Contents

Chapter 1: The Evidence

Summary of the Index Offence

1.1. On the evening of 6 June 2009 *Mr I* viciously attacked his mother at the family home in Tremorfa, Cardiff. *Mr I*'s mother suffered significant injury during this assault. Later the same evening *Mr I* went to visit an acquaintance, *Mr S*. During the visit *Mr I* attacked *Mr S* with a shard of glass inflicting considerable injuries. Sadly *Mr S* died instantly as a direct result of the wounds he received.

1.2. On 14 June 2010, *Mr I* was convicted at Cardiff Crown Court of the manslaughter of *Mr S* on the grounds of diminished responsibility and of grievous bodily harm with intent in relation to the attack on his mother. *Mr I* was sentenced, by means of a court order under sections 37/41 of the Mental Health Act 1983[1], to be detained at a high secure mental health unit indefinitely. Special restrictions were placed in relation to his discharge.

Mr I's Background

1.3 *Mr I* was born in 1971 and was brought up in the Tremorfa area of Cardiff. He was one of five siblings. His relationship with his family appears to have been good, although at the age of eight, *Mr I* was seen by an educational psychologist as he was suffering from over reactions and demonstrating aggressive behaviour. On one occasion he was expelled from school due to his involvement in a *'fight.'*

1.4 *Mr I* left school at the age of fifteen with no qualifications. After leaving school, *Mr I* sought employment and held various short term jobs mainly as a labourer on building sites around the Cardiff area.

[1] Sections 37/41 of the Mental Health Act 1983: An Admission to Hospital by Court Order with Restrictions. This is where the Crown Court decides that (on the advice of two doctors) an individual would benefit from going to a hospital to receive treatment for a serious mental health problem instead of going to prison. Section 37 deals with treatment of the mental health problem. Section 41 (often called a Restriction Order) means the Secretary of State decides when an individual can be given leave and when they can leave hospital.

1.5 As a result of a 16 year relationship *Mr I* fathered three children.

Mr I's Social and Criminal History

1.6 *Mr I* had a history of consuming alcohol and drugs (mainly amphetamines and cannabis) on a regular basis. He also attended Accident and Emergency (A&E) departments on several occasions due to his involvement in altercations. In 1998 he had a metal plate placed in the left side of his face following an attack. He was hospitalised in 2004 following a further assault wherein he sustained facial injuries.

1.7 From the age of sixteen until the homicide, *Mr I* is known to have been convicted of 65 offences and he served four prison sentences. He was first convicted in 1992 for a violence-related offence and was sentenced to three years in prison.

1.8 *Mr I*'s convictions related to:

- Offences against the person.
- Offences against property.
- Theft and kindred offences.
- Offences relating to court/prisons.
- Miscellaneous offences.

1.9 In 1999 *Mr I* received a three and a half year prison sentence for a domestic incident and in 2002 was given a 21 month sentence for a similar offence.

1.10 In 2004 *Mr I* and others forced their way into the home of an acquaintance and assaulted him as *Mr I* believed that the victim of the assault was having a relationship with his partner. Although it was never established, the victim alleged that the group had an axe in their possession when they entered the house. *Mr I* evaded police enquiries in relation to this incident by moving to the Swindon area where he met a *Ms T* with whom he formed a brief relationship and subsequently co-habited for a short period. It appears that *Mr I* started to experience delusions

during this time, believing *Ms T* to be using recording equipment hidden within a DVD player to *'spy'* on him. *Mr I* later said that he had *'acted up'* to this and had made several false comments regarding his sexuality and behaviour to what he believed to be a camera recording his actions.

1.11 *Mr I* returned to Cardiff after the break up of his relationship with *Ms T*. On his return he was arrested in relation to the incident that had occurred in 2004. In October 2005 he was convicted for aggravated burglary and assault occasioning actual bodily harm. *Mr I* was given a three year prison sentence and served eighteen months at HMP Channings Wood, Wiltshire, as he had given *Ms T*'s address as his current residence upon his arrest. On his release from prison on licence he was placed in a bail hostel in Wrexham, North Wales. The decision to relocate *Mr I* to North Wales was made due to there being a view that *Ms T* may pose a risk to *Mr I*.

1.12 Whilst in residence at the probation hostel in Wrexham, staff there became aware of *Mr I*'s paranoid delusions relating to the DVD player and made a referral to a local GP in February 2007.

1.13 Despite the decision to locate *Mr I* to Wrexham, he was harassed by *Ms T*; this included incidents of him being aggressively followed by *Ms T* and receiving a series of malicious phone calls and various threats. In an attempt to stop this, the Probation Service successfully applied for an injunction against *Ms T* preventing her from harassing *Mr I*.

1.14 As a result of this aggravation from *Ms T*, *Mr I* absconded after four weeks at the hostel, thereby breaking the terms of his probation licence. *Mr I* absconded to his home area of Tremorfa, Cardiff, where he stayed with parents and friends; this included a short stay with *Mr S*. It was during his stay with *Mr S* that the focus of *Mr I*'s delusions became more apparent and pronounced. *Mr I* accused *Mr S* and his own brother of writing the word *'nonce'* in indelible ink on his forehead and of gluing contact lenses to his eyes so that he could not see what they had written.

1.15 *Mr I* was eventually persuaded to give himself up to the police and on 13 May 2007 he was remanded and admitted to HMP Swansea to complete his sentence.

HMP Swansea

1.16 On 25 May 2007 *Mr I* was assessed by the prison mental health in-reach team[2] and they considered him to be *'floridly psychotic.'* The in-reach team referred *Mr I* to forensic services (provided by Caswell Clinic[3]) and he was seen by a consultant forensic psychiatrist from the Caswell Clinic on 29 May 2007.

1.17 The medical examination notes record that *Mr I* made constant reference to the term *'nonce'* being written on his forehead and to his belief that his former partner *Ms T* had contacted other inmates within the prison to spread rumours that *Mr I* was a *'paedophile'* in order to enact revenge on him. *Mr I* was subsequently prescribed antipsychotic and antidepressant medication.

1.18 *Mr I* was seen again by the same consultant forensic psychiatrist in late June 2007. He was still presenting as delusional and requested that he be taken to hospital to have the *'ultraviolet ink'* removed from his face as he believed that the word *'nonce'* was still there. Due to his continuing persecutory delusions *Mr I* was prescribed Olanzapine[4] at 10mgs daily and Amitriptyline[5].

1.19 By mid *July* 2007, *Mr I* had stopped taking his prescribed medication although he was still having persecutory delusions. He was also refusing input from Caswell Clinic and had stopped engaging with mental health staff at the prison, as he was adamant that he did not need treatment.

[2] Mental health in-reach services to HMP Swansea were provided by the former Swansea NHS Trust at the time of *Mr I's* detention there.
[3] Caswell Clinic is the Forensic Medium Secure Unit (MSU), providing a Forensic Mental Health service to sixteen unitary authorities across South Wales. When *Mr I* was detained there it was part of the former Bro Morgannwg NHS Trust.
[4] Olanzapine is an atypical antipsychotic drug.
[5] Amitriptyline is a tricyclic antidepressant drug.

Admission to the Caswell Clinic

1.20 On 16 October 2007, due to his continuing mental illness *Mr I* was transferred to Caswell Clinic's Penarth Ward[6], under sections 47/49 of the Mental Health Act 1983[7]. On his arrival, *Mr I* was dismissive and ignored staff, categorically denying that he had any mental illness. He also denied having any of the delusional beliefs that he had expressed in prison. However during his admission assessment he was noted as experiencing paranoid persecutory delusions relating to an incident that occurred when he was co-habiting with *Ms T* in Swindon and a further incident involving the word *'nonce'* being written on his forehead.

1.21 *Mr I* was prescribed antipsychotic and antidepressant medication and was made the subject of an intensive care plan. Staff considered *Mr I* to have had little insight to his illness during his time at the Caswell Clinic. He was uncooperative and distanced himself from the nursing team and other patients. On the few occasions that *Mr I* did engage with staff it was documented that he did not discuss any problems or issues. *Mr I* did not overtly portray or give signs of further deterioration of his mental illness, although it was recognised that this may have been due to his lack of interaction with staff.

1.22 On 25 December 2007, the provisions of section 49 of the Mental Health Act 1983 expired. *Mr I* received a letter from the Ministry of Justice confirming this and drawing his attention to the fact that he was eligible to apply for a Mental Health Tribunal Review[8].

[6] Penarth Ward is an Intensive Care Ward that provides care for patients requiring a high level of nursing care within a Medium Secure environment.
[7] Section 47 of the Mental Health Act 1983 allows the transfer of a convicted prisoner to a hospital for treatment of a mental illness. Section 49 provides for restrictions to be placed on offenders subject to section 47 where it appears necessary to protect the public from serious harm. Individuals subject to section 47 may continue to be detained in hospital for treatment after the expiry of their prison sentence.
[8] The Mental Health Review Tribunal for Wales (MHRT for Wales) is an independent judicial body. It hears applications and references for people subject to the Mental Health Act 1983.

1.23 Despite *Mr I* exhibiting progressively more stable behaviour during this time at the Caswell Clinic he reacted aggressively to any intervention by staff and on 31 December 2007 accused staff of being part of a *'conspiracy'* with *Ms T* and of contacting her via the internet.

1.24 On 1 January 2008 *Mr I* was found collapsed in his bedroom by staff and was taken to the A&E department at the Princess of Wales Hospital, Bridgend. *Mr I* was treated in the Intensive Treatment Unit (ITU) as a consequence of him having deliberately taken an overdose of his prescribed antidepressant and antipsychotic medication. He was discharged back to Caswell Clinic on 2 January 2008.

1.25 On his return to the Caswell Clinic, *Mr I*'s physical health began to deteriorate and he was transferred back to the Princess of Wales Hospital on the same day as it was suspected that he was suffering from Neuroleptic Malignant Syndrome[9]. As a result *Mr I's* psychotic medication was stopped for a short period of time until he was started on a different antipsychotic, Risperidone.

1.26 On 5 January 2008 while at the Princess of Wales Hospital *Mr I* struck a member of staff in the face and a day later threatened another member of staff with violence as, due to his delusional state, he had thought they had called him a *'nonce.'*

1.27 Following these incidents *Mr I* was noted to have regretted his actions and to have been compliant with his medication. However in February 2008, *Mr I* was transferred to the Tenby Ward[10] at Caswell Clinic following an incident involving another patient.

[9] A rare but potentially life-threatening adverse reaction to neuroleptic or antipsychotic drugs.
[10] Tenby ward is a 14 bed male admission and assessment facility that also provides treatment for patients with a primary diagnosis of mental illness.

1.28 Initially *Mr I* settled on the Tenby Ward but he soon became increasingly frustrated at being detained at the Caswell Clinic as he no longer believed that there was a need for him to be there. He would on occasion display aggressive behaviour towards staff and became increasingly challenging. *Mr I's* family also felt that he no longer needed to be an in-patient at the Caswell Clinic.

1.29 On 15 February 2008, the Caswell Clinic received a letter from *Mr I*'s solicitor advising that he was making an application to the Mental Health Review Tribunal (MHRT) on *Mr I's behalf* as he felt that he should no longer be detained under section 47 the Mental Health Act and wished to be discharged from Caswell Clinic. Subsequently the MHRT confirmed that they would consider *Mr I*'s case on 23 April 2008.

MHRT Proceedings

1.30 In readiness for the MHRT a Care Programme Approach (CPA)[11] review was undertaken by the Caswell Clinic on 16 April 2008. The CPA meeting was attended by Caswell Clinic staff members and they were later joined by *Mr I*'s father. Apologies for their non-attendance were received from the Probation Service, Cardiff Low Secure Forensic Services (*Mr I* was deemed a resident of Cardiff) and South Wales Police.

1.31 The CPA review focused on the evaluation of *Mr I*'s care plan and his progression whilst detained at Caswell Clinic. The notes of this meeting state:

> *'There are clear issues of a delusionary nature that continue to trouble* Mr I*… His irrational and often times instantaneous inappropriate anger is generally misdirected and his potential for dealing with matters violently are significant.'*

[11] Care Programme Approach (CPA) is a system of delivering services to those with mental illness in England and Wales. The approach requires that health and social services assess need, provide a written care plan, allocate a care coordinator, and then regularly review the plan with key stakeholders.

1.32 In March 2008 the Caswell Clinic submitted a medical report on *Mr I* to the MHRT which stated:

> *'In our opinion* Mr I *needs further treatment in hospital in a psychiatric medium secure unit. The team needs more time to assess his mental state and assess the risk that he poses to himself and others as a result of his paranoid psychosis.'*

1.33 The report also recommended :

> *'… detaining* Mr I *for a further period of time under section 47/49 of the Mental Health Act due to the risk that he poses to himself and others. In our opinion due to the nature and degree of his mental state he warrants detention in a medium secure unit under the Mental Health Act 1983.'*

1.34 In addition to the medical report, a multi-disciplinary team at Caswell Clinic also prepared a *'HCR-20 – Violence risk asse*ssment[12]*'* for the MHRT. The summary of risk stated that:

> *'some of his* [Mr I's] *offences were extremely violent. He has major problems with alcohol and some of his violent behaviour was related to his alcohol abuse.'*

1.35 The HCR-20 also stated that:

> *'he* [Mr I] *is suffering from a delusional disorder and there is a possible risk to the people involved in that delusional system from* Mr I. Mr I *does not have any insight to his mental illness. He has breached his probation order in the past and was extremely resistant to engage with psychiatric services while he was in prison and during the initial part of his admission to Caswell Clinic.'*

[12] The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence. The HCR-20's results help mental health professionals determine best treatment and management strategies for potentially violent, mentally disordered individuals, including parolees, forensic mental health patients, and others.

1.36 Caswell Clinic also instigated a Multi Agency Public Protection Arrangement (MAPPA)[13] meeting to discuss *Mr I*'s pending tribunal hearing as he was categorised as being a *'Level 2'* offender[14].

1.37 The MAPPA meeting was held on 22 April 2008 and included representatives from the Caswell Clinic, the Probation Service, Cardiff Low Secure Forensic Services and South Wales Police. Discussions were focused on identifying appropriate arrangements for the ongoing care of *Mr I* if the MHRT agreed that he should no longer be detained under section 47 of the Mental Health Act. Those planning the arrangements were provided with relevant background information which made reference to the fact the *Mr I* presented some risk of violence to the public if under the influence of alcohol.

1.38 The Tribunal hearing convened on 23 April 2008 but was adjourned until 23 May 2008 as:

> '...*the Tribunal was unable to reach a final decision…as to the risks if* Mr I *were discharged and requires this further information to reach a decision as to whether the statutory criteria have been met and whether suitable accommodation and supervision is available in the event of discharge.'*

1.39 Following the adjournment of the Tribunal further MAPPA meetings took place on 6 and 15 May 2008. Both meetings were attended by representatives from the Caswell Clinic, the Probation Service, Cardiff Housing, Cardiff Low Secure Forensic Services and South Wales Police. Those present were made aware of the MHRT's reasons for adjourning and following discussion it was agreed that should the MHRT decide that *Mr I* should no longer be detained under section 47 he should be moved to Mandeville House[15], a probation hostel in Cardiff. The Probation Service

[13] Multi-Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the *'responsible authorities'* tasked with the management of registered sex offenders, violent and other types of sexual offenders and offenders who pose a serious risk of harm to the public. MAPPA involves all agencies involved in the development of risk plans and is coordinated by the responsible authorities (Police, Probation and prison Service).
[14] Level 2 applies to all offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and who are deemed to require active multi-agency risk management whilst they remain under Probation supervision.
[15] Mandeville House is a probation hostel in Cardiff managed by the probation service.

assumed responsibility for making the necessary arrangements with Mandeville House. If released from Caswell Clinic to Mandeville House *Mr I* would be subject to a licence[16]. Given the risks posed by *Mr I*'s historic use of alcohol and drugs additional conditions were to be placed on *Mr I*'s licence to ensure that he stayed drug and alcohol free while he was a resident at Mandeville House.

1.40 A further CPA and section 117[17] review was held on 16 May 2008; this was attended by representatives from the Caswell Clinic and Cardiff Low Secure Forensic Services. It was concluded at this meeting and recorded in the minutes of the meeting that:

> *'the team (Caswell) do not recommend that* Mr I *is discharged into the community at this stage.* Mr I *has not been able to address the issues that brought him to Caswell Clinic from prison and therefore is unlikely to be aware of the management of his illness.'*

1.41 The Caswell Clinic multi-disciplinary team did not consider *Mr I* to be ready to be discharged but as requested by the MHRT compiled a care plan in readiness for his possible discharge. The minutes of the CPA meeting also state:

> *'Caswell have a care plan for his discharge into the community which involves Mandeville House and then accommodation with Cardiff Housing Authority. Supervision will be provided by probation for a month period and supervision will be provided by Caswell Clinic and then the Low Secure Unit based at Whitchurch Hospital, Cardiff.'*

[16] If sentenced to more than 12 months in prison, individuals may be released early on licence. Being on licence means that the individual is still serving a prison sentence but they can live in the community instead of being in prison. Whilst on licence, there are rules that individuals must follow. How long these rules apply for depends on the length of the sentence. If the rules are broken, the individual has to go back to prison (be recalled).

[17] Section 117 of the Mental Health Act 1983 (MHA) provides free after-care services to people who have been detained under sections 3, 37, 45A, 47 or 48. The responsibility for providing after-care services rests with the patient's Health Body (if in Wales) and the local social services authority. However there is no compulsion for any individual to accept after-care.

1.42 On 23 May 2008 the MHRT reconvened at Caswell Clinic and decided that:

> *'the patient SHALL BE DISCHARGED from liability to be detained with effect from 17 June 2008 at 12:00 noon … the tribunal is satisfied that the patient suffers from a mental health illness which has responded to the current treatment in its widest sense of the word. The illness is no longer of a nature or degree to warrant compulsory detention under the Mental Health Act.'*

1.43 It also appears that the Tribunal also gave some weight to the fact that *Mr I* was to be discharged to a probation hostel which offered 24-hour supervision and that he would receive daily input from a Community Psychiatric Nurse (CPN) from Cardiff Low Secure Services. *Mr I* was to be subject to Mandeville House's rules and overall supervision until his licence expired. There was confusion in relation to the date on which *Mr I's* licence and hence his prison sentence was due to expire. The Caswell Clinic was therefore unable to obtain a definitive discharge date before *Mr I* was moved to Mandeville House.

1.44 At a MAPPA meeting on 3 June 2008 it was confirmed that Cardiff Probation Service was now responsible for supervising *Mr I* and that he was to be offered weekly appointments at the Caswell Clinic. *Mr I* was to continue to be under the care of the Caswell Clinic for a further six months following his move. Mandeville House was to also be provided with a copy of *Mr I*'s care plan so that they were fully aware of the care treatment being provided.

Mr I's Period at Mandeville House

1.45 *Mr I* arrived at Mandeville House on 17 June. He was escorted there by his Caswell Clinic care co-ordinator[18] and his parents. Medication and CPA documentation were provided to the hostel. It is understood that on his arrival at the hostel the probation officer advised *Mr I* that there had been an error in the information provided to him in relation to the date on which his licence ended. *Mr I*

[18] The role of the care co-ordinator is fulfilled by the person who is best placed to oversee the care management of an individual and can be any discipline depending on capability and capacity. The care co-ordinator has the authority to coordinate the delivery of the care plan.

had been originally told that his licence was due to expire on 24 July 2008 but as he had absconded from the probation hostel in Wrexham his sentence had been extended. It was agreed that the correct date would be confirmed by the Probation Service at a later date. On 18 June *Mr I* registered with a local GP Practice. He saw his GP on 24 June 2008.

1.46 *Mr I* received his first visit from his Caswell Clinic care co-ordinator on 24 June 2008. *Mr I* was noted to be welcoming, although anxious to discuss issues such as further visits. *Mr I* told the co-ordinator that he was happy to be out of the Caswell Clinic and explained that he had spoken to Probation who had clarified that his licence was due to expire in September 2008 and not July 2008 as was first thought. The care co-ordinator explained that staff from the Caswell Clinic would be visiting him on a weekly basis for the next month and then a further CPA meeting would be held to review his care plan.

1.47 *Mr I*'s care co-ordinator and his CPN from Caswell met with him on 1 July 2008. It was recorded that *Mr I* appeared very welcoming, relaxed and in good spirits. He appeared to be genuinely pleased to meet with the Caswell members of staff. *Mr I* spoke of his desire to keep himself out of the criminal justice system and claimed that he was remaining abstinent from alcohol and illicit substances.

1.48 *Mr I's* Responsible Medical Officer (RMO) during his time at the Caswell Clinic visited him on 8 July. *Mr I* told the RMO that he felt very happy with his current situation and was content at Mandeville House. He was compliant with medication and did not describe any symptoms of mental illness. Staff from Caswell Clinic also spoke with the probation officer at Mandeville House who confirmed that *Mr I* was complying with the requirements of his licence and that there were no problems at that time.

1.49 *Mr I* was seen again on 15 July 2008 by his care co-ordinator and remained in good spirits. A further MAPPA meeting also took place on this day. It was confirmed at this meeting that responsibility for *Mr I*'s probation arrangements had been transferred to Cardiff Probation Services. It was also noted that it had been officially confirmed that *Mr I*'s licence would end on 24 September 2008.

1.50 On 16 July 2008 *Mr I* met with his probation officer who advised him that the condition of his licence restricting him from visiting the Tremorfa area of Cardiff was due to be lifted. *Mr I* was also told that a residential property had been identified for him in the Ely area of Cardiff and that he would move there when he was released from Mandeville House.

1.51 The following day (17 July 2008), *Mr I* left the hostel to attend his daughter's birthday, but by 11pm that night *Mr I* had failed to return. *Mr I* had absconded from the hostel breaching the terms and conditions of his licence. He was reported to the police as missing during the early hours of the 18 July 2008.

1.52 A CPA review *meeting* had been planned for 22 July 2008, however due to *Mr I* having absconded and subsequently recalled to prison, this meeting could not proceed as a CPA review (partly due to the fact that the patient must attend a CPA review). Instead a professionals' meeting was held between the care co-ordinator from the Caswell Clinic, the deputy manager at Mandeville House and the social work team manager from Cardiff Low Secure Services.

1.53 The notes of this meeting were recorded by the care co-ordinator and subsequently shared with the RMO (absent), Caswell Clinic CPN, probation officer (absent), the social work team manager from Cardiff Low Secure Services and Cardiff clinical nurse lead (absent) from Cardiff LHB step down services (from medium secure units to low secure units). The notes state that those present were surprised that *Mr I* had absconded as his licence was due to expire and the conditions of his licence in relation to his visiting the Tremorfa area of Cardiff had been lifted. It was also noted that Cardiff Low Secure Services acknowledged that they had a statutory duty on behalf of the local authority under section 117 of the Mental Health Act in respect of *Mr I* and advised that they would attend the next

MAPPA meeting to be held in readiness for *Mr I*'s possible discharge from prison. The notes of the meeting also state that those present anticipated that *Mr I* would be detained at HMP Parc in Bridgend.

Mr I's Time in HMP Parc

1.54 *Mr I* handed *himself* in at Canton Police Station in Cardiff on 19 July 2008 where he was remanded in custody. He was taken to HMP Parc on 21 July 2008 to serve the remainder of his sentence.

1.55 On arrival at HMP Parc *Mr I* underwent a routine medical assessment. *Mr I* advised staff that he had previously been a patient at the Caswell Clinic where he had been treated for paranoid delusions. *Mr I* confirmed that he was taking medication for his mental health issues but denied that he was suffering any current mental health issues. He signed a Primecare[19] consent form that allowed his information to be shared with third parties such as Health Trusts and his GP. On 22 July 2008 a fax was received from *Mr I*'s GP that confirmed that he was being prescribed Risperidone.

1.56 A referral was made for *Mr I* to attend the Registered Mental Health Nurse[20] (RMN) clinic in HMP Parc on 29 July 2008 but it appears that he did not attend. It is also recorded that he failed to collect his medication from the medicine hatch on 8 August 2008.

1.57 *Mr I* was eventually persuaded to attend an RMN clinic on 11 August 2008. The notes of this consultation record that *Mr I* was initially defensive as he was concerned that he may be readmitted to Caswell Clinic. *Mr I* confirmed that he had spent eight months at Caswell and had been treated for paranoid delusions and depression although *Mr I* denied that he was currently suffering from any of these issues. It was noted that *Mr I* was compliant with medication as he feared being

[19] Primecare is an independent commercial organisation providing primary healthcare services in the UK. They were contracted to run the healthcare wing at Parc Prison.
[20] RMN employed by Primecare.

sectioned again. At the consultation *Mr I* refused any further appointments or referrals to mental health. It was also recorded that there was *'no evidence of mental disorder present.'*

1.58 The prison RMN contacted the mental health in-reach team[21] to discuss *Mr I*'s care and making a referral to them. However, due to *Mr I* being unwilling to engage with mental health services this referral was not made by the RMN as the in-reach team would only accept referrals that the patient had consented to.

1.59 On 12 August 2008 *Mr I*'s RMO's office at Caswell Clinic faxed a copy of *Mr I*'s medical report to HMP Parc. However as *Mr I* was still refusing to engage with mental health services no further attempt was made to contact or refer *Mr I* to the Caswell Clinic at this time.

1.60 On 24 August 2008 *Mr I* was seen in his cell by the RMN as he had been refusing meals. The RMN recorded that there was no visible evidence of mental illness or deterioration and that *Mr I* was still refusing to engage with mental health services.

1.61 *Mr I*'s impending release, his historic mental condition whilst at Mandeville House and the fact that he would not be subject to any supervision as he had completed his sentence were discussed at two further MAPPA meetings held on 9 and 16 September 2008. However, no information relating to *Mr I*'s current mental health state was made available at the meeting. The MAPPA meetings were hosted by Cardiff Low Secure Services but neither the Caswell Clinic nor HMP Parc representatives were invited to attend or asked to contribute to them.

1.62 *Mr I* was invited to attend a RMN clinic at HMP Parc on 19 September 2008 so that he could be assessed prior to his release on 24 September 2008, but he did not attend. On 21 September 2008 *Mr I* again refused to consent to the prison RMN contacting the mental health in-reach team, Caswell Clinic or his GP to advise them

[21] Mental health in-reach services to HMP Parc were provided by the former Bro Morgannwg NHS Trust at the time of *Mr I's* detention there.

of his impending release from prison. *Mr I*'s medical notes record that prior to his release from prison he was still compliant with medication, but was still continuing to refuse any mental health input.

1.63 *Mr I* was released from HMP Parc on 24 September 2008. Upon his release he was no longer subject to any supervision by any statutory agency – although he was still subject to Section 117 after-care arrangements and the provisions of CPA. It is not known whether a medical assessment took place prior to his discharge as nothing had been documented within *Mr I*'s prison healthcare notes.

Post release from HMP Parc

1.64 Upon his release from HMP Parc, *Mr I* was technically homeless and therefore returned to live with his parents in Tremorfa, Cardiff. It is unclear as to whether *Mr I* continued to take his medication following his discharge from prison as he was not in contact with mental health services or his GP. Over time *Mr I* began spending longer periods of time alone in his bedroom. He also became agitated and was increasingly paranoid that there was a *'conspiracy'* against him and that he had writing on his face.

1.65 Between October and December 2008 the police were called to *Mr I*'s family home three times. The first call was made on 29 October 2008 when *Mr I* called them due to a disagreement with his brother; no action was taken on this occasion.

1.66 The police were again called on 23 November 2008 because *Mr I*'s parents had become concerned about the possible deterioration of his mental health and his father had found a hammer in his bedroom. Using the South Wales Police Vulnerable Person alert system the police who attended the call out made a referral to the Cardiff Public Protection Unit (CPPU) [22]. The CPPU in turn passed

[22] Cardiff Public Protection Unit is a Multi agency Public Protection Unit based with South Wales Police in Cardiff to assist in managing with high risk offenders who fall within the ambit of Multi-Agency Public Protection arrangements (MAPPA).

information about *Mr I* onto Cardiff Social Services' Contact and Assessment Team. Unfortunately this information was not shared with those individuals and teams that had attended the MAPPA meetings held to discuss *Mr I* and the risk he posed.

1.67 Referrals made to the CPPU are discussed at weekly meetings held at Cardiff Central Police Station. These meetings include participants from the Police, Probation Service, Health Boards (NHS Trusts pre 2009) and Housing; and discuss anybody who has been highlighted through the South Wales Police Vulnerable Person alert system, ongoing MAPPA cases and referrals, or anybody considered a high risk. It is unclear as to whether *Mr I* was discussed at this forum.

1.68 Police were again called to *Mr I*'s family home on 19 December 2008 by *Mr I*'s father who requested their attendance as *Mr I* was *'going berserk'* in his room. When the police arrived *Mr I* appeared calm and there were no real signs of him presenting a risk to himself or others. However, the police officers were sufficiently concerned to make a further referral to the CPPU. We found no evidence of this information being subsequently shared with Cardiff Social Services.

1.69 It appears that *Mr I* left the family home in March 2009 and for a period of six weeks lived in a tent within the grounds of Bute Park in Cardiff. *Mr I* alleges that he had to return to the family home when the police burnt his tent down. During this period, *Mr I* did not come to the attention of the homeless services operating in Cardiff.

1.70 *Mr I* became increasingly preoccupied with his delusion that he had writing on his face and would make regular references to its existence to both family and friends. It appears that on 24 May 2009 *Mr I* coerced *Mr S* to confess to him in writing that he had deliberately written the word *'nonce'* on his face. *Mr I* kept this confession in his possession and would periodically show it to family and friends.

Day of the Homicide – 6 June 2009

1.71 *Mr I* had become increasingly paranoid towards his mother and allegedly accused her of *'dying his hair silver and his eyebrows pink.'* This delusion resulted in *Mr I* shaving his eyebrows off.

1.72 On the day of the homicide, *Mr I* was alone with his mother in the kitchen of their family home when she apparently made a comment about his eyebrows. *Mr I* proceeded to viciously attack his mother leaving her with significant injuries.

1.73 Later that evening *Mr I* visited *Mr S* at his home. An argument ensued as a result of *Mr S* attempting, in *Mr I*'s view, to retract his previous written *'confession.'* *Mr I* picked up a shard of glass from a broken mirror and stabbed *Mr S* several times including a blow to his throat. *Mr S* sadly died of his injuries at the scene.

1.74 The following day on 7 June 2009, *Mr I* knocked on the door of a house in Tremorfa appearing dazed and upset claiming that he had assaulted somebody. The police were called and *Mr I* was taken to Fairwater Police station where he was detained.

Management and Organisation of Services

Arrangements for the Provision of Mental Health Services in Wales

1.75 The National Health Service (NHS) in Wales was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of NHS Trusts and Local Health Boards.

1.76 A further NHS Wales reorganisation took place in October 2009 which amalgamated the NHS Trusts and Local Health Boards into seven Health Boards. Abertawe Bro Morgannwg University Health Board replaced Swansea NHS Trust

and Bro Morgannwg NHS Trust and three LHBs (Swansea LHB, Neath Port Talbot LHB, and Bridgend LHB). Cardiff and Vale University Health Board replaced Cardiff and Vale NHS Trust, Cardiff LHB and the Vale of Glamorgan LHB.

1.77 At the time of *Mr I*'s involvement with mental health services the Caswell Clinic was run by the former Bro Morgannwg NHS Trust. Services in Cardiff at a secondary level were provided by Cardiff NHS Trust and primary care services were commissioned by Cardiff LHB.

Caswell Clinic

1.78 Caswell Clinic is the Forensic Medium Secure Unit (MSU) serving South Wales providing a Forensic Mental Health service to sixteen unitary authorities[23].

1.79 The Caswell Clinic is currently managed by Abertawe Bro Morgannwg University Health Board (and at the time of the events in question, the former Bro Morgannwg NHS Trust). The Social Work Team comprised four social workers and a social work manager and is based at Caswell Clinic; this team is managed by Bridgend County Borough Council on behalf of a liaison group which includes the sixteen local authorities. The Caswell Clinic has capacity for 64 beds located across five wards.

1.80 There are five clinical teams, each led by a consultant forensic psychiatrist, and comprising of a specialist registrar, senior house officer, primary nurses, community mental health nurse, social worker, occupational therapist and a psychologist.

[23] Blaenau Gwent, Bridgend, Caerphilly, Carmarthenshire, Ceredigion, Merthyr Tydfil, Monmouthshire, Neath/Port Talbot, Newport, Pembrokeshire, Powys, Rhondda Cynon Taff, Swansea, Torfaen and Vale of Glamorgan.

Mental Health Review Tribunal (MHRT)

1.81 Mental Health Review Tribunals are independent judicial bodies that operate under the provisions of the Mental Health Act 1983 and the Mental Health Review Tribunal Rules 1983. A Tribunal's main purpose is to review the case of a patient detained under the Mental Health Act 1983 and to direct the discharge of any patient for whom the statutory criteria for discharge have been satisfied. In some cases, the Tribunal also has the discretion to discharge a patient who does not meet the statutory criteria. In these cases the Tribunal have to make a balanced judgement on a number of serious issues such as the freedom of the individual, the protection of the public and the best interests of the patient.

Multi-Agency Public Protection Arrangements (MAPPA)

1.82 Multi-Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the *'responsible authorities'* tasked with the management of sex offenders, violent and other types of sexual offenders and other offenders who pose a serious risk of harm to the public. MAPPA *'responsible authorities'* include the National Probation Directorate, HM Prison Service and England and Wales Police Forces. MAPPA is co-ordinated and supported nationally by the Public Protection Unit which is located within the National Offender Management Service. MAPPA were introduced by the Criminal Justice and Courts Services Act 2000 and the Criminal Justice Act 2003.

HMP Parc

1.83 HMP and YOI Parc is a Category B local prison, housing approximately 1126 convicted male adults and young people both convicted and on remand[24]. HMP Parc opened in November 1997 and is the only private prison in Wales. It is currently managed by Group 4 Securicor on behalf of the Prison Service. Healthcare was provided by Primecare[25] when *Mr I* was at the prison.

1.84 The in-patient unit is staffed by registered nurses and provides for both the physical and mental health needs of those patients requiring a 24-hour nursing presence. Primary care surgeries and out-patient clinics are delivered by medical staff and registered nurses.

In-reach Services for HMP Parc

1.85 Secondary (in-reach) mental health services to HMP Parc at the time of *Mr I*'s case were provided by the former Bro Morgannwg NHS Trust (now Abertawe Bro Morgannwg University Health Board).

1.86 The initial service is provided by a consultant psychiatrist (three sessions) who will lead the team of two full-time CPN's and a part-time administrative support. There are also specialist sessions for psychology, occupational therapy, substance misuse and social work when required. The Caswell Clinic provides tertiary forensic psychiatric consultation and liaison. Referrals to the tertiary psychiatrists can be directed either through primary care or in-reach.

1.87 In-reach mental health services are managed via ABMU Health Board's Mental Health Directorate.

[24] The Prison Service provides secure accommodation for young people (formerly known as juvenile offenders) aged 17 who are on remand, 15 – 17 year old males and 17 year old females who have been given a custodial sentence. A young offender is someone who is aged between 18 and 20.
[25] Primecare is a provider of primary health care services in the UK. Their health care services are commissioned by many organisations including NHS trusts, police forces, prisons and other secure establishments, as well as commercial organisations.

1.88 Caswell Clinic provides a tertiary out-patient service to HMP Parc. The clinics are run within the prison by a consultant forensic psychiatrist. Referrals are made via the prison RMN. These clinics take place once a week under an arrangement with the Caswell Clinic.

Cardiff Social Service – the Links Team

1.89 The Links Centre is a community mental health centre which provides local services for people who are experiencing mental health problems to:

- Promote mental health.
- Prevent mental illness.
- Provide a local response for local people.

1.90 The Links team is a multi-disciplinary team consisting of consultant psychiatrists, Senior House Officer (SHO), staff grade psychiatrist, clinical nurse leader, CPNs, nursing assistant, occupational therapist, physiotherapist, psychologist, team administration manager, medical secretary and receptionist. The team also includes three full-time and four part-time social workers and a social work assistant.

1.91 Referrals are usually made by GPs, the Crisis Team, Whitchurch Hospital and Llanfair Unit (Cardiff Low Secure Services) as well as other health care professionals such as health visitors or prison liaison nurses.

Chapter 2: The Findings

The Predictability of the Homicide Committed by *Mr I*

2.1 The homicide of *Mr S* and the assault suffered by *Mr I*'s own mother were clearly deeply tragic events. In examining the circumstances that led up to these incidents, it has become clear to HIW that *Mr I* had a significant criminal history that involved violence.

2.2 *Mr I* was admitted to the Caswell Clinic from HMP Swansea in October 2007 as he was assessed by a consultant forensic psychiatrist as having a mental illness of a paranoid and/or delusional type. During the short time that *Mr I* was at the Caswell Clinic a firm diagnosis of his mental illness was difficult to determine due to *Mr I*'s lack of engagement and consistent denials of the existence of a mental illness. However, it is apparent to the review team and to those who have cared for *Mr I* following the homicide that he was suffering from a significant mental illness, which ultimately led to him attacking his own mother and committing the homicide of *Mr S*.

2.3 While the precise nature of the homicide and the attacks that took place on 6 June 2009 could not have been predicted, HIW firmly believes that it was predictable that a serious act of violence would be committed by *Mr I*. The HCR-20 risk assessment completed by the Caswell Clinic prior to the MHRT held in April 2008 indicated that *Mr I* posed a risk of committing acts of violence against others; his former partner *Ms T* was identified as being at specific risk. In addition, this assessment indicated that *Mr I* posed a risk of committing a serious act of violence whilst under the influence of drugs, alcohol or during periods of time without medication.

2.4 *Mr I*'s past behaviour included several acts of premeditated violence committed against individuals upon whom he had focused. *Mr I* had targeted delusions and fixations on certain individuals. The individuals at the centre of his delusions were not constant. However at various stages *Mr I*'s fixations focused upon his parents, his brother, his former partner and *Mr S*. It was clear to the review

team that *Mr I* had began to focus on *Mr S* and his own mother in the months leading up to the incidents; however due to him not being engaged with mental health services this fact was only known by family and friends.

2.5 In attempting to identify the root causes that led to the tragic events of 6 June 2009, the review team has considered the periods of engagement that *Mr I* had with several services over a two year period. We consider each of these periods in the sections below.

Mr I's Time at the Caswell Clinic

2.6 Apart from a brief period during his childhood when *Mr I* was seen by an educational psychologist, he had not had any engagement with mental health services until 2007 when HMP Swansea's mental health in-reach team referred him to the Caswell Clinic for assessment. The forensic psychiatrist who assessed *Mr I* diagnosed a serious mental illness and was sufficiently concerned about him to arrange his admission to the Caswell Clinic under the terms of sections 47/49 of the Mental Health Act. *Mr I* was admitted to Caswell Clinic on 16 October 2007.

2.7 It is clear that *Mr I* had begun to develop his mental illness some time prior to 2007. In particular it is known that he exhibited delusional beliefs relating to a DVD player during his time at Swindon in 2004; but *Mr I* appears to have largely managed to conceal the extent of his mental illness until 2007.

2.8 *Mr I* continued to deny that he was suffering any mental illnesses upon his admission to the Caswell Clinic; this claim appears to have been actively supported by his parents.

2.9 *Mr I* was difficult to engage with due to his guarded nature and the fact that he distanced himself from nursing staff and other patients hence it was difficult for staff to determine a clear diagnosis. Some of the staff we spoke to told us that they felt that *Mr I* had not portrayed any signs of deterioration of his mental illness during his

time at Caswell. Others felt that *Mr I* was a dangerous individual who posed a threat. Indeed *Mr I* attacked and threatened members of staff at the Caswell Clinic during his time there.

2.10 The review team consider the care plan developed by the Caswell Clinic to be appropriate given that it was understood that there would be the opportunity to engage with *Mr I* over a four to five year period of time. Caswell Clinic considered *Mr I's* mental illness was such that he would require a prolonged period in hospital so that he could be properly assessed and treated.

2.11 However, upon expiration of the section 49 element of the Mental Health Act on 25 December 2007, *Mr I* was able to apply for a Mental Health Tribunal Review (MHRT).

2.12 Appropriately, upon learning of the MHRT's decision to consider *Mr I*'s case, the Caswell Clinic arranged a CPA review for 16 April 2008, and initiated a MAPPA meeting which was held on 22 April 2008 to discuss the forthcoming Tribunal.

2.13 The Caswell Clinic also prepared a medical report which was submitted to the MHRT as evidence to support their recommendation that *Mr I* should not be discharged. The report stated that the recommendation that *Mr I* should not be discharged was based upon the risk that *Mr I* posed to himself and to others. It also stated that more time was needed to assess *Mr I*'s mental state given that he had been difficult to engage with since his admission six months earlier. The Caswell Clinic diagnosed *Mr I* as suffering from a paranoid psychotic illness or delusional disorder.

2.14 Despite the reports and risk assessments submitted by Caswell Clinic, the MHRT indicated on 23 April 2008 that they wanted information on the after-care arrangements that would be put in place if *Mr I* were to be released from detention. The Caswell Clinic therefore appropriately convened a further two MAPPA meetings in May 2008 which were attended by representatives of the Caswell Clinic, the

Probation Service, Cardiff Housing Services, Cardiff Forensic Service and South Wales Police. The focus of the discussions was on identifying suitable accommodation for *Mr I* if he were to be released from the Caswell Clinic.

2.15 In addition a further CPA and Section 117 review was held in May 2008. Whilst it was reiterated at this meeting that the Caswell Clinic team did not recommend that *Mr I* be discharged into the community, it was confirmed that an after-care plan had been developed. Supervision arrangements were also clearly set out with the involvement of the Probation Service, the Caswell Clinic and also Cardiff Forensic Services.

MHRT Decision

2.16 At the Tribunal hearing, held on 23 May 2008, the MHRT decided that *Mr I* was to be discharged on 17 June 2008. The Tribunal believed that *Mr I*'s illness was no longer of a nature or degree to warrant detention under the Mental Health Act. The MHRT was also satisfied with the arrangements that had been put in place should it recommend that *Mr I* be discharged.

2.17 The MHRT's decision to discharge *Mr I* came as a surprise to the Caswell Clinic team as the decision was contrary to their professional view that *Mr I*'s mental illness necessitated further treatment and that the risks he posed (as documented in the HCR-20 risk assessment) in particular to those at the centre of his delusions, was high. The Caswell Clinic team felt that they had only just begun to address *Mr I*'s mental health due to his lack of engagement, and that a long-term strategy was needed.

2.18 HIW offered the members of the MHRT the opportunity to discuss *Mr I*'s case and to explain the rationale for agreeing to his discharge despite the views of the clinical team working with him but they declined the opportunity.

2.19 *Mr I* was released from the Caswell Clinic on 17 June 2008 and escorted to Mandeville House.

2.20 HIW considers the care and treatment provided to *Mr I* by the Caswell Clinic while he was an inpatient there to have been appropriate. The review team felt that:

- The Caswell team had devised and, as far as they were able, implemented an appropriate care plan for *Mr I*. The team had also put a strategy in place to treat *Mr I* on a long term basis.
- *Mr I* was allocated an appropriate care co-ordinator and a Responsible Medical Officer.
- The CPA in place for *Mr I* was appropriate and properly addressed his needs.
- Detailed risk assessments had been carried out and appropriately shared and communicated.
- A robust case had been made by the Caswell team to the MHRT that recommended against *Mr I*'s discharge.
- Despite the unexpected MHRT decision to discharge *Mr I*, the Caswell team reacted quickly and appropriately in convening MAPPA, CPA and Section 117 meetings.
- The after-care arrangements put in place in readiness for *Mr I*'s discharge were reasonable and appropriate.

Mr I's Period at Mandeville House

2.21 HIW consider that the arrangements put in place in readiness for *Mr I's* discharge from the Caswell Clinic to have been appropriate.

2.22 *Mr I* was taken to Mandeville on 17 June 2008 by his appointed care co-ordinator from the Caswell Clinic and a CPA pack was provided to the hostel staff on his admission. During his stay at Mandeville House *Mr I* was visited weekly by members of his Caswell Clinic care team, he was visited twice by his care co-ordinator, once by his CPN and once by his RMO.

2.23 While at Mandeville House *Mr I* registered with the local GP Practice on 18 June 2008. We were informed that *Mr I* turned up at the GP's surgery unaccompanied to see the GP for the first time on 24 June 2008. *Mr I* told the GP that he had recently been discharged from the Caswell Clinic and advised him of what medication he was prescribed. *Mr I* was subsequently prescribed Risperidone for 28 days on the basis of the information he provided. HIW is concerned that *Mr I* was not supported to register with a GP. This was *Mr I*'s only contact with any practice or GP prior to the homicide on 6 June 2009. The GP, who saw *Mr I* on 24 June 2008, did not have any information detailing *Mr I's* past medical history and medication either from the Caswell Clinic or Mandeville House.

2.24 The GP was unaware of *Mr I*'s past medical history especially in relation to risk. We were informed that since this case, practice has been changed; Mandeville House now provides a risk assessment to the GP with whom a resident registers and if the individual has a CPN, he/ she will attend with them when they register with a GP.

2.25 During the weekly engagements with staff from the Caswell Clinic, *Mr I* was reported to be happy to be out of the Caswell Clinic, and appeared relatively well. *Mr I* was refraining from drinking alcohol and taking drugs and was also apparently compliant with his medication. In addition staff at Mandeville house were happy with *Mr I* and he was causing no problems there. There appears to have been nothing to indicate that *Mr I* would abscond and break the terms of his licence as he did on 17 July 2008.

2.26 In relation to *Mr I*'s time at Mandeville House, HIW found that:

- The after-care arrangements put in place to support *Mr I* were adequate and the Caswell Clinic team provided weekly support to him as set out and agreed in his discharge plan.
- Procedures in relation to the registration of individuals recently discharged from a secure facility with the GP were not sufficiently robust during the period that *Mr I* was at Mandeville House.

- At the time of *Mr I's* registration in 2008, there were no regular meetings between GP practices and the mental health services in relation to patients on the Severe Mental Health register[26].

Mr I's Absconding from Mandeville House

2.27 The period of *Mr I's* absconsion from Mandeville House was relatively short. Effectively it lasted from the evening of 17 July 2008 to the morning of 19 July 2008 (meaning that *Mr I* was unlawfully living in the community during this period as his licence had been revoked). Precisely why *Mr I* chose to abscond is unclear, however he eventually turned himself in to the police where he was remanded in custody and taken to HMP Parc to serve the remainder of his sentence.

2.28 Up until the time that *Mr I* absconded from Mandeville House his after-care arrangements were clear and the various services and agencies appeared to be working well to ensure that they were implemented and delivered. Further, a plan was in place to gradually transfer *Mr I*'s care arrangements over to Cardiff low secure services and a property had been identified for him to move to following the completion of his sentence and his release from Mandeville House. However, *Mr I*'s absconsion from Mandeville House disrupted all of the arrangements that had been put in place. It was clear to the review team that there was a breakdown in communications between agencies at this point which contributed to Mr I not receiving the care, treatment and support that he needed and to *Mr I* going on to commit the index offence in June 2009.

2.29 Due to *Mr I* having absconded, the CPA review that had been arranged for 22 July 2008 was cancelled. Instead a professionals meeting involving members of staff from the Caswell Clinic (the care co-ordinator), Mandeville House deputy manager, and Cardiff Forensic Services (CPN and social work team manager) took place. It was clear from the notes of this meeting that those present were unaware of the fact that *Mr I* had handed himself in to the police on 19 July 2008 (three days earlier) as at this meeting it was noted that *'Mr I would probably be taken to HMP*

[26] A register of people with severe mental illness which is kept by the GP. Keeping people's name on this register will ensures that they are invited to the surgery every year for a health-check.

Parc when he was located.' As *Mr* I was a MAPPA case, information about his arrest, detention in custody and transfer to HMP Parc should have been shared with all agencies and individuals involved in his care. In particular his RMO should have been notified of his whereabouts and contacted for information about his mental health and treatment arrangements.

2.30 Further, while it had been agreed in earlier meetings that the Caswell Clinic team would retain after-care responsibility on behalf of health services for at least six months following *Mr I*'s discharge from the Caswell Clinic, it was confirmed by Cardiff Forensic Services at this meeting that section 117 after-care arrangements in respect of *Mr I* would be their responsibility from then on, unless there was a significant breakdown in *Mr I*'s mental health.

2.31 It was agreed at the meeting that *Mr I*'s RMO based at the Caswell Clinic would write to his/her counterpart in Cardiff Mental Health Services and formally request the transfer of *Mr I*'s care from Caswell to Cardiff.

2.32 While a note of this meeting was circulated to individuals from both Cardiff Forensic Services and the Caswell Clinic, including the RMO, a letter requesting the transfer of *Mr I*'s care to Cardiff was never sent. As a result *Mr I* remained under the care of the Caswell Clinic's RMO and care co-ordinator throughout his time at HMP Parc and upon his release from prison.

2.33 It was also agreed at the 22 July 2008 meeting that Cardiff would contact *Mr I*'s probation officer and arrange to be present at any MAPPA meetings convened in respect of the possible discharge of *Mr I* from the prison system. We are unclear as to whether this was ever actioned as subsequently Cardiff Forensic Services do not appear to have been invited to any MAPPA meetings.

2.34 In summary, HIW considers that:

- *Mr I*'s absconsion and subsequent recall to prison disrupted *Mr I*'s after-care arrangements and led to confusion as to who was responsible for *Mr I*'s care.
- Important information about *Mr I's* arrest and transfer to HMP Parc was not shared with those involved in his care and treatment.
- The CPA meeting arranged for 22 July 2008 should have gone ahead. As (*Mr I* by this time had handed himself in to the police and had been admitted to HMP Parc) had it done the issues highlighted in relation to the lack of formal handover to the Cardiff team may have been avoided.
- Not all the decisions taken at the meeting held on 22 July 2008 were actioned. As a consequence *Mr I* was never formally referred to Cardiff Forensic Services and therefore, the Caswell team remained identified as the provider of mental health after-care services during his time at HMP Parc, and upon his release.
- Following the meeting held on 22 July 2008 no effort was made to clarify which prison *Mr I* had been recalled to. Attempts should have been made to confirm *Mr I's* whereabouts and to liaise with the prison's mental health team.

Mr I at HMP Parc

2.35 *Mr I was* recalled to prison following his absconsion from Mandeville House and was admitted to HMP Parc on 21 July 2008.

2.36 It is apparent that *Mr I* told prison staff upon his arrival at HMP Parc that he had been previously detained at the Caswell Clinic. *Mr I* denied that he had any mental health problems at the time, however he did sign a consent form authorising the prison healthcare team to share his information with other organisations such as the trust, his GP, mental health in-reach services, and drug and alcohol services.

2.37 Given that *Mr I* volunteered the fact that he had been detained in the Caswell Clinic and had signed a consent form to allow the sharing of information, the review team believe that the prison healthcare team should have instigated contact with either the mental health in-reach team or the Caswell Clinic immediately upon his reception. We therefore believe that an opportunity to refer *Mr I* back to mental health services at the earliest opportunity was missed.

2.38 *Mr I* was finally persuaded to attend a RMN clinic in HMP Parc on 11 August 2008 after failing to attend previous appointments. Again *Mr I* volunteered information about his past detention at Caswell, however it was recorded that *Mr I* was not floridly psychotic at the time and that there was no evidence of a mental disorder present. *Mr I* also refused any further engagement with mental health services.

2.39 *Mr I*'s refusal to engage with mental health services proved to be a barrier that was not overcome by the healthcare team at HMP Parc.

2.40 While the RMN did attempt to refer *Mr I* to the mental health in-reach team on 11 August 2008, the RMN was told that due to *Mr I*'s refusal to sign a consent form, the in-reach team would not be able to accept the referral. The RMN did manage to obtain from the Caswell Clinic the report that had been prepared for the MHRT. It is unclear precisely how this report was obtained, but it was clearly faxed from the office of the RMO at the Caswell Clinic to the RMN in the prison healthcare team at HMP Parc on 12 August 2008.

2.41 The review team questions why no significant attempt was made to overcome the consent issue and take forward a referral to either the mental health in-reach team or the forensic service at Caswell. This is a particular concern given the fact that prison healthcare staff had sight of the report prepared by the Caswell team and so were aware of the risks posed by *Mr I*.

2.42 For the remainder of his time at HMP Parc, *Mr I* refused to engage with the RMN and steadfastly refused consent for the RMN to share information or notify his RMO or GP of his condition. We believe this was due to him fearing that he would be detained under the Mental Health Act again.

2.43 It was clear from our discussions with prison healthcare staff and our examination of records that at the time of *Mr I*'s detention at HMP Parc, prison healthcare provision was disordered and disorganised, with severe demands being placed on healthcare staff, the RMNs in particular. This situation has since been addressed.

2.44 We were told that if prisoners failed to attend RMN clinics, there was little time to arrange to follow this up. Similarly care plans or care pathways were not used during the time that *Mr I* was at HMP Parc. Similarly the review team considered the clinical supervision arrangements in place at HMP Parc for RMNs to be inadequate; this matter is still to be addressed.

2.45 Similarly we were told that the referral process to the mental health in-reach team at the time of *Mr I*'s involvement was unsatisfactory with the RMNs having little involvement in referrals and the discussion of these cases. We were also told that the RMNs would not be routinely informed of the outcome of assessments undertaken by the team.

2.46 It is clear that at the time of *Mr I*'s detention at HMP Parc, mental health in-reach services and the RMNs at HMP Parc were not working as a team. Arrangements for mental health in-reach services have been changed with the in-reach team now being physically co-located at HMP Parc; it is hoped that this will improve the relationships between the RMNs at Parc and the in-reach team.

2.47 We were also told that the RMNs at HMP Parc are not trained in the CPA and have little or no working knowledge of the processes. In *Mr I*'s case therefore, the RMNs would not have been aware that *Mr I* was subject to CPA and the fact that he had a care co-ordinator and RMO. Responsibility for liaison with the care co-ordinator would have fallen to the in-reach team had they accepted *Mr I*'s referral.

2.48 All prisoners should receive a medical examination prior to their discharge[27]. This involves an assessment by a clinician and the consent of the prisoner is obtained to pass on their information to third parties for follow-up care. Unfortunately *Mr I* did not receive a discharge examination[28] and clearly a further opportunity was missed to alert services (*Mr I*'s GP in Cardiff) to the fact that *Mr I* was being released into the community[29]. We were informed that at the time that *Mr I* was in HMP Parc, discharge screening clinics were rarely held.

2.49 In summary therefore, reflecting upon *Mr I*'s time at HMP Parc we found that:

- An early opportunity was missed to refer *Mr I* to the mental health in-reach team or forensic services at Caswell.
- The matter of consent proved to be a barrier to prison staff referring *Mr I* to mental health in-reach services or the Caswell Clinic.
- There was a failure by Caswell Clinic and HMP Parc to act on the information passed between services.
- There was no discharge screening summary carried out prior to *Mr I*'s release on 24 September 2008.
- There was a culture of under-recording of information within medical notes at HMP Parc at the time of *Mr I*'s detention.
- There was a lack of formalised clinical supervision arrangements available to RMNs at HMP Parc.
- There is no formal CPA training carried out for RMNs at HMP Parc.
- The referral process to mental health in-reach services and the Caswell Clinic was unclear at the time of *Mr I*'s detention. We note the recent developments of co-locating the mental health in-reach team at HMP Parc, which will hopefully improve these problems.

[27] PSI 53/2010 – Prisoner Discharge Guidance.
[28] PSO 3050 – Continuity of Healthcare for Prisoners.
[29] Prison Mental Health Pathway for Wales (2006).

Loss of Contact with the Caswell Team

2.50 As highlighted earlier in the report, the recall of *Mr I* to HMP Parc on 21 July 2008 led to confusion in relation to the after-care arrangements that were in place in respect of *Mr I*.

2.51 At the time of *Mr I*'s recall to HMP Parc, he remained the responsibility of the Caswell Clinic as per the CPA and section 117 after-care arrangements. A change to these arrangements had never been formally confirmed.

2.52 However we were informed that *Mr I*'s RMO had been completely unaware of the fact that *Mr I* was detained at HMP Parc and that his whereabouts were unknown to the Caswell Clinic. We were advised by the RMO that he would have gone to see *Mr I* irrespective of there being a referral had he known that *Mr I* was in HMP Parc. However, records indicate that the RMO's office faxed the MHRT report to HMP Parc on 12 August 2008. While there exists some ambiguity regarding the precise circumstances of this fax and any accompanying communication, clearly at some level staff at the Caswell Clinic were aware that *Mr I* was detained at HMP Parc. It was explained to us that normally the author of an MHRT report would release the records to the prison themselves, but it appears that in this case it did not happen.

2.53 Further, the review team was advised that had the Caswell team known about *Mr I*'s release in September 2008 they would have resumed their section 117 after-care arrangements. Usually in circumstances such as *Mr I*'s there would be discussions about the transfer of his care to low secure services in Cardiff.

2.54 HIW considers that following *Mr I*'s recall to prison there was:

- A lack of any concerted attempt by the Caswell team to identify which prison *Mr I* had been recalled to.
- Ambiguity regarding communications between HMP Parc and the Caswell Clinic in terms of who was privy to the information and precisely what information was shared.

- A failure by the Caswell team to fulfil their duty of care in respect of *Mr I*.
- A failure by the RMO to make sufficient efforts to find out which prison *Mr I* had been taken to, so that he could fulfil his duty of care.

The MAPPA Process

2.55 The MAPPA process in relation to *Mr I* was first instigated by the Caswell Clinic in April 2008 following a referral by the care co-ordinator. The referral was made as the MHRT was to consider *Mr I's* application for release from detention and *Mr I* was a *'level 2'* offender. The category of *'level 2'* applies to all offenders who have received a custodial sentence of twelve months or more in prison for a sexual or violent offence and whilst they remain under probation supervision. Legislation requires agencies to conduct a formal risk assessment of each offender and to allocate them to a tier of multi-agency management.

2.56 MAPPA meetings were held until *Mr I*'s recall to prison on 21 July 2008. They were well attended by all relevant agencies. *Mr I* was discussed at a total of five separate MAPPA meetings held between 22 April 2008 and15 July 2008.

2.57 Following his recall to prison on 21 July 2008, *Mr I* was referred to under the *'matters arising'* heading as part of a MAPPA meeting on 22 July 2008. Those attending were informed that *Mr I* was now back in prison although it is unclear as to whether the group were informed which prison. Significantly, there was no representative from the Caswell Clinic at this MAPPA meeting as they had not been invited.

2.58 No further meetings were held in respect of *Mr I* until September, when two MAPPA meetings were held (on 9 September 2008 and 16 September 2008); in advance of *Mr I*'s release from prison on 24 September 2008. No new concerns were raised at these meetings. Caswell Clinic and HMP Parc were not invited to these meetings.

2.59 The absence of representatives from Caswell Clinic and HMP Parc meant that the most up-to-date information that MAPPA had in relation to *Mr I*'s mental health was that provided to the 22 July 2008 MAPPA meeting where it was noted that *Mr I* was mentally *'well.'* Given that *Mr I* was to be released from licence on 24 September 2008, it appears to be a significant error not to have invited either the Caswell Clinic or HMP Parc to attend the September MAPPA meetings or for information not to have been requested from them that would have established *Mr I*'s mental health position prior to his release.

2.60 HIW considers this omission to invite HMP Parc and the Caswell Clinic to the September 2008 MAPPA meetings to be the key factor that resulted in *Mr I* being released from HMP Parc on 24 September 2008 with no plans for his ongoing support from mental health services in place.

2.61 In relation to the MAPPA process HIW considers there to have been:

- A clear omission to invite representatives from either the Caswell Clinic, or HMP Parc to the September 2008 MAPPA meetings.
- The September 2008 MAPPA meetings were held without there being any up to date or current information regarding *Mr I*'s mental health and wellbeing being available to the group.
- Health representatives from the Cardiff area present at the MAPPA meetings held on 9 September (whilst not previously involved with *Mr I's* care) did not alert other services to the fact that *Mr I* was to be released imminently.
- The Forensic Service Team Manager who stated at the meeting dated 22 July 2008 that he/she would attend any MAPPA meetings held in relation to *Mr I* in the future was not invited to any future meetings.

Mr I Post-discharge from HMP Parc

2.62 *Mr I* was discharged from HMP Parc on 24 September 2008, under no restrictions or supervisory arrangements. *Mr I* was free to reside where he wished, with nobody overseeing his care and wellbeing, and under no medical supervision whatsoever. *Mr I* having been discharged as homeless returned to Tremorfa to stay with his parents. His parents had previously been identified as being at risk from *Mr I* by the Caswell Clinic.

2.63 The arrangements for his after-care that had operated well during his brief time at Mandeville House were no longer in place, and the safety nets that should have safeguarded and mitigated the risk that *Mr I* posed to himself and others were rendered powerless by a series of failings. These included as highlighted above a lack of:

- Assertive attempts to identify which prison *Mr I* had been recalled to.
- Communication between agencies and organisations at key points.
- Any individual or service assertively taking control of and overseeing *Mr I*'s care and wellbeing.
- Up-to-date and relevant information being made available to inform the MAPPA meetings held in September 2008.

2.64 While back living in the community and left to his own devices, *Mr I*'s mental health spiralled out of control to the extent that his own family were forced to summon the assistance of the police to the family home on two separate occasions.

2.65 Sadly, even on these occasions, it seems that opportunities were missed to bring *Mr I* back into the system and under the supervision of services. The police were sufficiently concerned following their visits to the family home to complete and send a referral form (PPD1) to Cardiff Public Protection Unit on two separate occasions.

2.66 The referrals would have been sent to the Contact and Assessment Team at Cardiff Social Services. This team should have then identified if mental health issues were identified and if so send a notification to the local Community Mental Health Team or low secure unit.

2.67 On receipt of the referral, the Contact and Assessment Team checked the Carefirst[30] system to see if *Mr I* was already involved with a team. *Mr I* was not on the Carefirst system and so the Contact and Assessment Team decided to send the form to the Links team. The Links team checked the Carefirst and also the PARIS[31] health records system (to which some senior members of the team have access). *Mr I* was not known to either system.

2.68 The information recorded on the PPD1 form said that:

> *'*Mr I *has recently been released from a mental health hospital, as he suffers with mental illness. He is now living with his elderly parents. They are increasingly becoming concerned about his behaviour. He is locking himself in his room and refusing to come out. On this occasion, he was upset* [sic] *and causing problems but did not commit any criminal offences. He did not display any worrying* [sic] *behaviour in front of officers, but his parents are very worried about him.'*

2.69 Given the detail, HIW would have expected the Links team to have triggered a sequence of events that may have culminated in *Mr I* being brought under the supervision of statutory services. However, the police referral did not trigger any response from Cardiff Social Services.

2.70 In addition to the above, we were informed that PPD1 referrals were discussed at weekly meetings held at Cardiff Central Police Station (PPU Screening Meeting). It is unclear whether *Mr I*'s PPD1 form was ever discussed at this forum, which would have included attendance from Police, Probation and Housing Services.

[30] Electronic case management system used by Cardiff Social Services.
[31] Electronic Records used by former Cardiff and Vale NHS Trust.

2.71 The contact with the police on 19 December 2008 was the last known contact that *Mr I* had with any agency or service before he committed the savage and brutal attack on his own mother and killed his acquaintance *Mr S* on 6 July 2009. However, we believe that the police officers who attended the call to his parents' home acted appropriately and made the necessary referral to Cardiff's Public Protection Unit.

2.72 We believe that following *Mr I* coming to the attention of the police:

- There was a lack of an assertive effort made by the Links team to follow up the PPD1 forms that were sent to them in November and December 2008.
- There was a lack of robust arrangements in place for the handling of the PPD1 forms by Cardiff Social Services. We note that these arrangements have since been strengthened.

Chapter 3: Recommendations

Communication

3.1 All agencies and individuals involved in the care and support of an individual subject to a licence should be made aware at the earliest opportunity of the expiry date of a licence.

3.2 Processes for ensuring that all agencies and individuals involved in the care, treatment and support of an individual who absconds should be kept up to date. All agencies should ensure that they are informed of an individual's arrest and the prison to which they are returned to.

In Relation to HMP Parc

3.3 With regards to HMP Parc and consent issues being a potential barrier to making a referral to health and social care agencies, HIW believes that a clear protocol should be put in place whereby consent can be overridden when appropriate. This should also be made clear on the consent forms to remind staff and patient of the possibility that consent to share records with other agencies, for example GPs, NHS providers or social care agencies may not be necessary when an individual is considered to lack capacity or insight in relation to their mental health issues. Where necessary, staff should be trained in relation to consent issues so that they are clear in relation to implementing this guidance[32, 33].

3.4 HMP Parc should review its compliment of Registered Mental Health Nurses (RMNs) and ensure that levels are appropriate to enable timely and appropriate screening assessments to taking place at the prison mental health clinics.

[32] PSI 2002/25 – The Protection and use of Confidential Health Information in Prisons – Section 5.
[33] PSO 3500 – Chapter 7 Release/Discharge – Paragraph 7.6.

3.5 HMP Parc should ensure that staff are trained in the CPA arrangements for Wales and aware of the forthcoming legal duties under the Mental Health (Wales) Measure 2010.

3.6 HMP Parc Healthcare Services should ensure that medical note-taking processes are robust. This practice should be reinforced in order to ensure that all stages of care pathways are fully documented.

3.7 As per the Prison Mental Health Pathway[34] guidance and PSO 3500[35], HMP Parc should ensure that robust and effective multi-disciplinary discharge planning processes are in place. Consideration given to the CPA status of the prisoner. A copy of the CPA plan should be given to the prisoner upon release and transfer of care agreed with the care co-ordinator. Where relevant the prisoner should also receive a copy of their Section 117 after-care plan.

Arrangements between HMP Parc and In-Reach Services

3.8 In line with the Prison Mental Health Pathway[36], HMP Parc healthcare services and the Abertawe Bro Morgannwg University Health Board in-reach service should ensure that relevant prison nurses attend clinical and MDT meetings in order to strengthen relationships.

3.9 The protocols in place should be reviewed to ensure appropriate referrals are made to the in-reach team. We note this may be strengthened by the in-reach team now being located at HMP Parc.

[34] Prison Mental Health Pathway for Wales (2006)
[35] PSO 3500 – Chapter 7 Release/Discharge – Paragraph 7.6
[36] As per Prison Mental Health Pathway for Wales (2006)

Arrangements between HMP Parc and Caswell Clinic

3.10 Arrangements should be put in place[37] to ensure more robust and formalised communication arrangements between the Caswell Clinic and HMP Parc. Prison healthcare staff should advise the Caswell Clinic of any new prisoner that is under the care of a Responsible Clinician based at the Caswell Clinic.

In Relation to the Caswell Clinic

3.11 The Caswell Clinic should formalise the weekly meetings held to discuss patients, including those currently in the community or in prison, for whom the Caswell Clinic still formally retains section 117 after-care responsibility, on behalf of mental health services. Actions should be appropriately recorded and communicated to the relevant prison. A senior member of HMP Parc healthcare staff and a prison in-reach team member should attend this meeting.

In Relation to MAPPA and its Members

3.12 When it is felt appropriate and necessary to convene a MAPPA meeting the agencies responsible for the arrangements must ensure that every effort is made to identify and ensure that the appropriate parties are invited to the meeting. If those invited cannot attend, they should be included on any relevant circulation list to ensure that the most up-to-date and relevant information is made available for the MAPPA meeting.

In Relation to Cardiff Social Services

3.13 The processes in relation to the completion and review of PPD1 forms should be strengthened. Audit arrangements should be put in place to ensure their appropriate completion and escalation. In addition the function and intention of the forms should be clarified to all relevant stakeholders.

[37] In line the with Prison Mental Health Pathway for Wales (2006).

3.14 The Caswell Clinic and Cardiff Social Services should review and strengthen their processes for the completion of carers' assessments and ensure that the need to undertake a carers' assessment is emphasised as part of the CPA process.

In Relation to Cardiff and Vale University Health Board

3.15 Cardiff and Vale Health Board should review the arrangements that it has in place for sharing information across its mental health teams and services and with other agencies.

Annex A

Review Terms of Reference

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

The review will:

- Consider the care provided to *Mr I* 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 6 June 2009.
- Review the decisions made in relation to the care of *Mr I*.
- Identify any change or changes in *Mr I*'s behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred on 6 June 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 57 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 10% of them have had contact with mental health services in the 12 months prior to the offence[38].

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.

[38] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2011.

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 I*

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 John Murphy	Community Psychiatric Nurse
Mr Martin Kershaw	Social Work Team Leader
Mr Howard Teague	Regional Social Services Inspector, CSSIW
Dr Rob Hall	GP
Mrs Freyja Ellard	Lay Reviewer, HIW Panel
Mr Geraint Jones	Investigation Manager, HIW
Mr Rhys Jones	Investigation Manager, HIW
Mr Leigh Dyas	Assistant Investigation Manager, HIW

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

- Examination of documents relating to the organisation and delivery of services by the former Bro Morgannwg NHS Trust; Cardiff NHS Trust, Cardiff Social Services, The Probation Service, and HMP Parc. 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 are grateful to the police for their collaboration.
- Reading the case records maintained by Health Bodies and Local Authorities concerning *Mr I*.

- Reading interview notes and written statements provided by staff working with *Mr I* 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 National Patient Safety Agency. 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 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

References

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2011.

Welsh Government: Prison Mental Health Pathway for Wales (2006).

Welsh Government Health Services For Prisoners; Performance & Quality Indicators & Self-Assessment Process 2009-2010; Guidance.

Prison Service Order (PSO) 3500 – Continuity of Healthcare for Prisoners.

Prison Service Instruction (PSI) 53/2010 – Discharge.

Prison Health Performance and Quality Indicators, DoH 2008.
Her Majesty's Inspectorate of Prisons: EXPECTATIONS - Criteria for assessing the conditions in prisons and the treatment of prisoners (2008).
Guidelines for Information Management: Information Sharing Pathway; OHCS.

Prison Service Instruction (PSI) 25/2002 The Protection and Use of Confidential Health Information in Prisons and Inter-agency Information Sharing.