Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr K and the provision of Mental Health Services, following a Homicide committed in March 2011

March 2014

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Summary of the Index Offence

1.1 On 22 March 2011, Mr K attacked Mr Z whilst they both resided at a hostel in Claude Place, operated by Cardiff Mind. Mr Z sustained severe injuries and sadly died as a result of the wounds he received.

1.2 On 21 December 2011, Mr K was convicted at Cardiff Crown Court of the manslaughter of Mr Z on the grounds of diminished responsibility. Mr K was sentenced by means of a court order under section 37/41 of the Mental Health Act 1983[1] to be detained at a medium secure mental health unit indefinitely.

Mr K's Family and Social history

1.3 Mr K was born in 1984 and at the time of the incident was 27 years old. He had a history of periods of homelessness, alcohol and substance misuse.

1.4 Mr K was raised in Mountain Ash, part of Rhondda Cynon Taff; although during various periods he lived in Porthcawl, Pontypridd, Aberdare and Abercynon. Mr K also spent some time in Leicester where he was studying a university course in Physics.

1.5 Mr K is one of five biological siblings having three brothers and a sister, with Mr K being the youngest. He also has four step sisters. It was documented that Mr K's mother left the family home when he was very young, returning briefly for a period before leaving indefinitely when Mr K was seven years old. Despite this, Mr K maintained contact with his mother and had intermittent periods of time living with her since his mid- teens.

1.6 Mr K was raised by his father supported with the help of his paternal\grandmother who came to live with them following the death of her husband. Sadly after spending two years in the family home, when Mr K was approximately

[1] A section 37 is called a "hospital order". A section 41 is known as a "restriction order". A court makes the order but requires medical evidence from two doctors

eight or nine years old, his grandmother died. Mr K's stepmother moved into the family home shortly after and was heavily involved in the care of the children.

1.7 There were several reported incidents during his childhood of Mr K behaving strangely. He would climb onto buildings putting himself at risk and at times jump off. On one occasion, Mr K climbed onto the roof of a local swimming pool where he fell through the roof and fractured his skull. When Mr K was seventeen, he and a friend jumped off a bridge into a shallow river. Mr K escaped serious injury but was treated for shock. On another occasion, Mr K kicked in a shop window, injuring his leg in the process.

1.8 Mr K performed adequately at school and excelled particularly at Mathematics and Science. He made and kept many friends and enjoyed playing football. However, from an early age Mr K had problems with his feet (due to a variant of talipes[2]) and had to wear orthopaedic shoes for a time. It was reported that people would comment on Mr K's clothing and footwear in a derogatory fashion and make fun of him. Mr K was also a very small child and he was apparently bullied in both junior and comprehensive school.

1.9 It is believed that at the age of fourteen or fifteen Mr K left the family home and went to live with his mother. It was around this time that it is believed that he began drinking alcohol and using illegal substances. It was reported that his mother was not tolerant of Mr K's poor behaviour and as a result he only lived with her for a very short period of time. He subsequently moved to live with his biological sister. Mr K's use of drink and drugs led to him regularly getting into altercations, which often led to him being injured due to his small physical stature.

1.10 On leaving his sister's home, Mr K went to live with one of his brothers. He stayed with this brother for short periods in a number of properties over the years. On two occasions his brother went away and on his return he had found that he had been evicted and his property boarded up. It was reported that this was because Mr K had invited friends in to have parties which resulted in damage to the property, arguments with neighbours, and the police being called.

[2] Club foot is sometimes known as talipes. Club foot is a deformity of the foot and ankle that is present at birth (congenital). If it is treated early, the position and function of the foot can be greatly improved.

1.11 Mr K also spent periods living with various other family members. His moves between them were usually precipitated by Mr K's drinking, drug misuse and poor behaviour.

1.12 Mr K went on to live at 'Cynon Action for Single and Homeless' (The Old Bakery Housing Project)[3] in Aberdare.

Mr K's Criminal History

1.13 Mr K's first encounter with the Police was when he was sixteen years of age. In March 2000, he was arrested for being carried in a motor vehicle taken without consent. At this time it would appear that Mr K was living in the homeless accommodation referred to above 'Cynon Action for Single and Homeless' in Aberdare.

1.14 Between 2000 and 2011, prior to the index offence, Mr K had several convictions, namely theft, shoplifting and public order offences.

1.15 Between 2000 and 2003 Mr K was arrested eleven times. He was charged with the following offences:

- public Order
- theft
- shoplifting
- indecent assault on a female over sixteen years of age.

1.16 Five custody records indicate a high level of intoxication and violent behaviour whilst in police custody.

1.17 There were a further eight occurrence reports between 2003 and 2011 with alcohol being a key factor in these occurrences.

1.18 Where medical assessments were recorded, there were no disclosures of illness, medication or that he was suffering from a mental health illness, or had ever

[3] Cynon Action for Single and Homeless (The old Bakery Project) is temporary accommodation in Aberdare. This is now known as ADREF Ltd.

self harmed. Mr K had been offered a drug referral facility on an occasion when he was in police custody in January 2007.

1.19 It was recorded that Mr K had been fined and given community service on a number of occasions for being drunk and disorderly. It was also recorded that he spent time in Her Majesty's Prison (HMP) Leicester for a few weeks following non-payment of fines and not attending community service.

History of contact with Mental Health Services

September 2009

1.20 Mr K saw his General Practitioner, *GP 1* of Portway Surgery, Porthcawl on 28 September 2009, having recently registered with the Surgery (he had initially been seen as a temporary patient on 23 September 2009). He had attended the GP with one of his brothers who had encouraged him to make the appointment. It was recorded:

> *"He [Mr K] has moved from Leicester where he was studying physics although he has basically moved around a lot over the last few years and has actually had periods of being homeless. He is apparently having difficulty sleeping; he is speaking to himself and is low in confidence. He is not currently on any medications and he denied any previous illnesses in the past".*

1.21 Mr K's brother reported that their parents had split up when they were children and that things were "hard at home". Mr K explained that he had ended up living with his sister when he was fourteen years of age and then moved in to sheltered accommodation in Aberdare for two years. His brother reported that Mr K had changed a lot and was "no longer himself"; was more withdrawn and noticed that Mr K would avoid eye contact with him.

1.22 With regards to Mr K's drug and alcohol misuse, it was recorded that he was no longer smoking cannabis but smoking tobacco. He was drinking twelve cans of lager a week and smoking ten cigarettes a day. Mr K did report that he had

previously smoked cannabis although had not done so for a number of months. It was also recorded that he had a tendency of binge drinking but again had not done so for the last few months.

1.23 A 'mental health state examination'[4] noted that Mr K was slightly unkempt and engaged in no eye contact throughout the consultation and had a flat affect[5]. Mr K did report that he was hearing voices but could not describe who was speaking to him.

1.24 Bloods had been carried out on 24 September 2009 (following his first appointment as a temporary patient) and revealed a normal full blood count, glucose, thyroid function, Urea and Electrolytes (U&E)[6], Epidermal Growth Factor Receptor (EGFR)[7] and Liver Function Tests (LFT)[8] with a Gamma GT of 29.

1.25 At this appointment on 28 September 2009, Mr K stated he was depressed and was experiencing anxiety for the last four weeks.

1.26 Following GP 1's assessment Mr K was commenced on Effexor MR9 75 mgs once daily and an urgent psychiatric opinion was sought. Mr K was referred to Consultant Psychiatrist 1, at 'Mental Health Well Being and Out Patient Centre' at the Princess of Wales Hospital in Bridgend (Coity Clinic) on 30 September 2009.

October 2009

1.27 The Integrated Line Manager from Porthcawl Community Mental Health Team wrote to GP 1 on 12 October 2009 advising the GP 1 that they had received the

[4] The mental status examination or mental state examination, abbreviated MSE, is an important part of the clinical assessment process in psychiatric practice. It is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment.
[5] Flat affect: A severe reduction in emotional expressiveness. People with depression and schizophrenia often show flat affect. A person with schizophrenia may not show the signs of normal emotion, perhaps may speak in a monotonous voice, have diminished facial expressions, and appear extremely apathetic. Also known as blunted affect.
[6] U&E is a blood test and is often used as a screening test for patients who are generally unwell, to detect abnormalities of blood chemistry, including kidney failure and dehydration.
[7] EGFR is estimated Glomerular Filtration Rate, usually based on serum Creatinine level, age, sex, and race. Normal GFR is approximately 100mls/min/1.73m2.
[8] LFTs measure various chemicals in the blood made by the liver. An abnormal result indicates a problem with the liver, and may help to identify the cause. Further tests may be needed to clarify the cause of the liver problem.
[9] Effexor XR (venlafaxine hydrochloride) extended-release capsules is indicated for the treatment of major depressive disorder

referral and had discussed it in their Multi- Disciplinary Team meeting and agreed that a referral to the 'Mental Health Well Being and Out Patient Centre' for a Psychiatric Outpatient appointment would be the most appropriate course of action. All of Mr K's information was forwarded to the centre and *GP 1* would be informed of the outcome in due course.

November 2009

1.28 Mr K was subsequently assessed on 4 November 2009 by *Doctor 1*, Staff Grade to *Consultant Psychiatrist 1*. Mr K attended this appointment alone and it was recorded:

> *"He described his symptoms as not feeling focused, having lost weight, trying to do things and nothing seems to be working and that everything seemed to fall apart. He described a loss of interest in things and making excuses for not doing things. He is in the habit of sleeping most of the day and also complaining of feeling sluggish and drained".*

1.29 It was recorded that the symptoms appeared to have been present for the last four years along with a history of alcohol misuse. It was recorded:

> *"He said that he gets an urge to drink and when he starts drinking he cannot stop himself and usually ends up spending all his money. He has been drinking this much alcohol (five to eight cans of Budweiser two or three times per week) over the last four years. Mr K described his current alcohol intake as normal although commented that friends and family were concerned about his intake".*

1.30 On mental state examination undertaken by *Doctor 1*, Mr K was noted to be well dressed and well kempt. His eye contact was fleeting in nature but the rapport was spontaneous. He smelt of alcohol, appeared slightly drowsy and his speech appeared slurred. Initially Mr K denied having had any alcohol but later admitted to having a can of alcohol before arriving for the appointment. Mr K described his mood as feeling drained and sluggish. *Doctor 1* could not elicit any disorder of thought or perception and his cognition appeared 'grossly intact'. Mr K appeared to have poor insight into his condition as he did not see the increase in alcohol intake as a problem, rather that it was normal behaviour for him.

1.31 Following *Doctor 1*'s assessment, he stated that *'Mr K suffers from alcohol dependence syndrome with a lack of insight into his condition'*. *Doctor 1* provided Mr K with psycho education[10] around this disorder and encouraged him to attend the 'West Glamorgan Council on Alcohol and Drug Abuse' and Addiction' (WGCADA)[11] to alter his behaviour. Mr K was advised to continue to take Venlafaxine (Effexor MR) in addition to Thiamine and Vitamin B Complex. Mr K was recommended for a follow up appointment in eight weeks time to assess the level of progress he had made and also to ensure if he had engaged with WGCADA. However, there was no evidence to suggest that Mr K was given a follow up appointment within the eight weeks of having seen *Doctor 1*.

1.32 A follow up outpatients' appointment was scheduled for 2 June 2010, but Mr K failed to attend and consequently he was referred back to his GP.

March 2010

1.33 On 12 March 2010, Mr K registered with Butetown Medical Practice` in Cardiff and was under the care of General Practitioner, *GP 2*. It was recorded that Mr K had gone to the Practice as he had knee problems. He had fallen out with his family and 'kicked his right knee in'. His knee was swollen so *GP 2* referred Mr K for an x-ray.

[10] Psycho education refers to the education offered to people with a mental health condition. Frequently psycho educational training involves individuals with schizophrenia, clinical depression, anxiety disorders, psychotic illnesses, eating disorders, and personality disorders, as well as patient training courses in the context of the treatment of physical illnesses. Family members are also included. A goal is for the consumer to understand and be better able to deal with the presented illness. Also, the patient's own strengths, resources and coping skills are reinforced, in order to understand that relapse is a part of their recovery, and contribute to their own health and wellness on a long-term basis. The theory is, with better knowledge the consumer has of their illness, the better the consumer can live with their condition.

[11] WCADA provides a range of treatment interventions for those affected by substance misuse. WCADA is one of the leading substance misuse treatment agencies in Wales providing Minnesota 12-Step Abstinence treatment and Harm Reduction services, including needle exchange and outreach, targeted to individual need. Other services provided include information, advice and treatment for young people, older and disabled people, family members and carers

April 2010

1.34 On 26 April 2010, Mr K had an x-ray which recorded that he had an avulsion fracture[12] of the lateral tibial plateau (fractured tibia). An orthopaedic referral was advised for further evaluation.

Mr K's period at Ty Gobaith, Salvation Army

1.35 Mr K registered with the Butetown Medical Practice in March 2010, however it is not until April/May 2010 that Mr K is recorded as moving into Ty Gobaith, a Salvation Army hostel in Butetown, Cardiff. It is not known when Mr K moved to Cardiff from Porthcawl or where he was living until moving into Ty Gobaith. Mr K was a resident at Ty Gobaith for a period of approximately four months.

1.36 Mr K accessed Ty Gobaith through 'direct access' and a basic needs assessment tool[13] was completed upon Mr K's admission which recorded that Mr K's main issues were alcohol misuse, cocaine misuse and ability to manage his money. There was no evidence to suggest that Mr K's previous mental health assessment by *Doctor 1* was shared with, or requested by staff at Ty Gobaith.

1.37 Mr K was allocated a key worker, *key worker 1* within three days of being at Ty Gobaith. Key worker 1 saw Mr K every week and completed a support plan every four weeks. Mr K's last support plan was carried out on 9 July 2010, which took over three weeks to complete.

1.38 The application form to reside at a Cardiff Mind hostel was completed on Mr K's behalf on 2 June 2010, it recorded:

> *'[Mr K] suffers with stress and anxiety particularly with crowds. [Mr K] was diagnosed with depression but doesn't feel this was an accurate diagnosis and doesn't take his medication'.*

[12] An avulsion fracture is a bone fracture which occurs when a fragment of bone tears away from the main mass of bone as a result of physical trauma
[13] The Basic Needs Assessment at Ty Gobaith is an assessment that looks at somebody's heath problems, GP details etc.

1.39 The application form also recorded that Mr K would benefit from support with:

- drinking and gambling which he [Mr K] does when stressed and anxious;
- staying on an even keel mentally and maintaining motivation;
- finding a job
- ensuring benefits stay up and running.

1.40 The application form stated that Mr K was currently living in a hostel [Ty Gobaith] and would benefit from more secure accommodation in a smaller project. *GP 2* from Butetown Medical Practice and Mr K's key worker contact details were recorded on the form so that they could be contacted to discuss Mr K and his support needs and complete professional assessment pro forma.

1.41 On 3 June 2010, Mr K had an appointment with *GP 2*. The records state that *GP 2* wrote to the trauma clinic for appropriate treatment as Mr K was still experiencing pain following surgery after his fractured tibia. *GP 2* wrote that the referral made by *GP 3* on 6 May would not be soon enough as Mr K was showing increasing pain in his knee. *GP 2* recorded that Mr K's mood was low.

1.42 Mr K was seen in the Trauma Clinic on 15 June 2010, where it was recorded that Mr K had sustained an injury to his right knee and went to see his GP where an x-ray was requested and showed a second fracture.

1.43 Upon examination, Mr K was still slightly tender over his lateral aspect of his knee joint but had a full range of movement. However, Mr K still got a lot of discomfort when he tried to walk. An MRI scan of Mr K's right knee was requested to decide his further management.

1.44 *GP 2* saw Mr K again on 24 June 2010 at the surgery. Staff at Ty Gobaith had brought Mr K for the appointment following concerns about his mental state. *GP 2* referred Mr K for an urgent psychiatric assessment at Hamadryad CMHT as *GP 2* thought Mr K was exhibiting negative features of a schizophrenic illness. *GP 2* recorded:

> *'I am concerned about this 26 year old man who has been living in Ty Gobaith for 2 or 3 months. He was brought to see me on 24/6/2010 by his keyworker. She [keyworker] is concerned that his mental health is deteriorating over the*

time that she has known him. He certainly seemed unwell compared to the other time I met him on 2/6/2010.

He [Mr K] is vacant, restless- fiddling with things, he cannot maintain a train of thought for long, he feels his eyes are wrong and keeps rubbing them. He denies hearing voices or seeing hallucinations. His mood varies. He also looks quite dishevelled.'

1.45 Following the GP's referral Mr K failed to attend an initial outpatient appointment with *Consultant Psychiatrist 2* at the Hamadryad Centre on 1 July 2010; however, Mr K was eventually seen on 8 July 2010. It was recorded at this appointment that he had been living at Ty Gobaith for a few months and was complaining of feeling restless all the time and described what he felt as "rage inside" with difficulty enjoying pastimes, such as attending the gym. It was recorded that Mr K wished to be able to enjoy life and felt that others were enjoying themselves. Mr K stated that he felt detached "like I am not really here".

1.46 The member of staff from Ty Gobaith who accompanied Mr K to the appointment reported concerns that Mr K had a tendency to isolate himself and at times appeared paranoid. There was one recent incident with a female at the Huggard Centre[14] when Mr K allegedly had exposed himself whilst he was out walking with her. It later proved impossible to ascertain whether this had any sexual motivation or whether this was merely social ineptitude.

1.47 *Consultant Psychiatrist 2* also noted:

'another noticeable feature is that he [Mr K] continually rubbed his eyes, in particular his right eye during the course of the consultation. He says that the eye feels uncomfortable and that this mannerism becomes more apparent when he is in peoples' company and he says he prefers to be alone'.

1.48 On mental state examination, *Consultant Psychiatrist 2* elicited no evidence of psychotic phenomena and his affect and mood appeared euthymic. It was recorded that he did have some *'somatic symptoms of depression'* and that the most likely diagnosis was that of depression however a primary psychotic disorder could not be ruled out.

[14] A Cardiff based charity that operates a day centre called the Huggard Centre.

1.49 Having apparently responded well to Venlafaxine 75mgs once daily in the past, Mr K was consequently prescribed 150mgs once daily. Arrangements were made for Mr K to be reviewed in six weeks time and he was referred for Community Psychiatric Nurse (CPN) input.

1.50 On 20 July 2010, a Multi disciplinary meeting was held where Mr K was discussed. In line with *Consultant Psychiatrist 2*'s recommendation it was agreed that Mr K should have CPN input and on 27 July 2010, *CPN 1* was allocated as Mr K's CPN.

1.51 On 4 August 2010, *CPN 1* was contacted by Mr K's key worker at Ty Gobaith (*key worker 1*) to inform that Mr K would not be able to keep his appointment scheduled for the following day (5 August) due to it clashing with another appointment. The key worker also stated that Mr K was in personal payment arrears and consequently would be moving from his accommodation at Ty Gobaith within the next day or so to Tresillian House[15]. Staff at Ty Gobaith had reported Mr K to be demanding in his behaviours but no violence was recorded. Mr K was on notice for not paying his rent whilst at Ty Gobaith and for inappropriate behaviour towards female residents. However, it is unclear whether this was intentional or due to intoxication.

1.52 On 5 August 2010, Mr K was seen by *GP 3* from the Butetown Medical Practice. *GP 3* found it difficult to engage with Mr K so again referred Mr K to see *Consultant Psychiatrist 2* at the Hamadryad CMHT. Consequently, an outpatient appointment was made for Mr K to see *Consultant Psychiatrist 2* on 19 August 2010. Mr K did not attend this appointment and therefore a further appointment was arranged.

Mr K's period at Tresillian House

1.53 Mr K left Ty Gobaith on 9 August 2010 and moved to Tresillian House. Staff at Tresillian House made an appointment for Mr K to go for an assessment with

[15] Tresillian House is accommodation for single homeless people aged 16 and over. Specifically cater for ex-offenders and people with alcohol, drug and mental health issues. Can accept people with care packages and couples

Cardiff Mind which was scheduled for Friday 20 August 2010. It was also recorded that Mr K was appointed a key worker, *key worker 2,* at Tresillian and they were due to meet on Thursday 19 August 2010.

1.54 On 19 August 2010, Mr K was visited by *key worker 2*. It was recorded that they had a long discussion and it was noted that Mr K had an appointment with the Hamadryad Centre that had been due that day but had been re-arranged to 8 September 2010. Mr K expressed that he didn't want to go to this appointment as he felt it was "pointless" because it wasn't helping him. *Key worker 2* discussed this matter with Mr K and also the issues around him not taking his medication and encouraged him to have another go at taking them. *Key worker 2* also explained to Mr K that his benefits and housing options may depend on him being in contact with Hamadryad, with this it is recorded that Mr K agreed to go to his upcoming appointment.

1.55 Mr K expressed to *key worker 2* that he felt that "there was a war going on in his head", which impacted on him making decisions and that he could not focus. Although Mr K stated that he felt that the thoughts were his own and not someone else's; he could not control them and found it difficult and upsetting.

1.56 Mr K stated that he found living at Tresillian House ok, but found it difficult to make and carry out plans. *Key worker 2* suggested that Mr K engage with activities at the Huggard Centre but Mr K stated that he found it difficult to be in that atmosphere. *Key worker 2* agreed to contact them to see if Mr K could go on a cinema trip. *Key worker 2* also recorded that he would talk to Cardiff Mind at Mr K's meeting regarding housing the following day (20 August) to see if Mr K could access activities there. Mr K had also received a date for an MRI scan on his knee scheduled for 24 September 2010. *Key worker 2* recorded that the radiology questionnaire that had been sent to fill out prior to the appointment had been completed and returned and an outreach van had been booked to take Mr K to the appointment. Key worker recorded that Mr K continually rubbed his eyes and held his head during the session, as if he was trying to block something out.

1.57 On 23 August 2010, *CPN 1* contacted Mr K's previous key worker, *key worker 1*, from Ty Gobaith as he had had no information on Mr K's whereabouts. The records state that on 9 August 2010 Ty Gobaith informed *CPN 1* that Mr K was now residing at Tresillian House.

1.58 On 30 August 2010 Mr K's key worker met with Mr K as arranged. Mr K was communicative for most of the session, although at times seemed to be distracted and occasionally lost track of the conversation. It was recorded that it appeared that Mr K first experienced mental health problems whilst studying Physics at Leicester University. Mr K was unclear at times about his mental health history, but it appeared that he was first prescribed antidepressants (Effexor MR) by his GP (*GP 1*), which he stopped taking because they made him feel sleepy. Mr K was subsequently prescribed Effexor but again stopped taking them as he felt they stopped having an effect on him. Key worker 2 explained to Mr K that it could take a while to get the dose of the medication correct and that he should continue to engage with the Hamadryad Centre to help him with this. Mr K was not keen to return there but agreed to go to his next appointment, which was scheduled for the 8 September 2010.

1.59 Mr K stated that in addition to his knee he was also experiencing pain with one of his feet but could not give any further details on this. He also stated that he would like to look into studying plumbing.

1.60 Mr K briefly spoke about what appeared to be some sort of domestic violence during his childhood. He talked about arguments in relation to daily tasks and chores that would end in physical violence. However, Mr K was uncomfortable talking about this subject in any depth and it was difficult to gauge what exactly might have happened. *Key worker 2* told Mr K that he could talk to them if he felt he needed to and also offered the opportunity for him to speak to someone independent.

1.61 From this session, *key worker 2* also spoke with Mr K about him not paying the agreed service charge the week before. Mr K stated that he needed to buy a new pair of trainers. Mr K was subsequently put onto self catering while he worked off the arrears and agreed to pay a sum of £30 when he was next paid.

1.62 Mr K had another session with *key worker 2* on 31 August 2010 where they discussed his upcoming appointments with Hamadryad and Cardiff Mind at length. Mr K was still agreeing to attend but became upset to the point of tears when discussing the need to "answer lots of difficult questions". *Key worker 2* reassured Mr K that he would support him and that everyone he was seeing would be acting to

support him and that the aim was to ensure he would feel better. Mr K also stated that he no longer wished to study plumbing; instead he wanted to study construction.

1.63 On 31 August 2010, *CPN 1* wrote to Mr K at Tresillian House stating that he had an appointment with him scheduled for 7 September 2010.

1.64 On 3 September, Mr K was seen by *key worker 2*. Mr K told him that he had walked to Barry (a town approximately 10miles south west of Cardiff) the day before to try to enrol onto a college course. However, when he got there, there were no courses that he wanted to do. *Key worker 2* did record that Mr K was walking with a limp but the details of this apparent visit to the college were hazy. *Key worker 2* discussed with Mr K whether it was an appropriate time to engage in work/study as he may struggle to manage a busier schedule. *Key worker 2* suggested that for the time being Mr K focused on working with agencies such as Hamadryad to try to improve the way he was feeling and to balance/clear his mind to allow him to be able to manage the extra study.

1.65 *Key worker 2* recorded that during their discussion Mr K changed the topic that he wanted to study on two occasions, firstly to electronics and then onto business studies. It was recorded by *key worker 2* that Mr K had difficulty in engaging with this issue. Mr K discussed having continual appointments that would disrupt his routine; however when *key worker 2* tried to explore this further, Mr K could not describe his routine, nor what he would be doing if he was not attending the scheduled appointments.

1.66 *Key worker 2* suggested that Mr K go to Glan Hafren College[16] to talk to them about enrolment. However, Mr K stated that he was too tired, needed a bath and had no money. *Key worker 2* told Mr K that he did not think these were good reasons for not going and that if he was struggling to mange this then he might have problems studying full time.

1.67 *Key worker 2* tried to talk to Mr K about his feelings and thought it useful that Mr K should focus on what he was feeling on the 'inside' rather than 'outside'. Mr K stated that he was still finding it hard to control his thoughts. Specifically, Mr K stated that he was constantly concerned over managing all his appointments especially his

[16] A tertiary college located in Cardiff.

benefits. *Key worker 2* spent some time defining to Mr K exactly what he needed to do with regard to this.

1.68 On 7 September 2010, *CPN 1* wrote to Mr K stating that he was sorry he missed him for their appointment that day. He re-arranged another date and was now due to see Mr K on 5 October 2010 at 10:30am.

1.69 On 8 September 2010, Mr K met with the Deputy Manager for Support Services from Cardiff Mind and the 'Initial Contact Assessment' form was completed. When asked to describe Mr K's mental health problems or emotional problems the form recorded:

> *'Going over things all day long, searching. Prefer to be with less people than living with before- where its busy/ hectic and causing stress and anxiety hence wanting to move. Wanting to take extra meds to feel better (has CPN).'*

1.70 The form also recorded under 'Alcohol Abuse' that:

> *'Don't think I [Mr K] have an issue with drinking. Some days I don't, others I do. Like to drink with other people, had one can this morning- not too much. Drink more when stressed/ anxious for interviews and things like that.'*

1.71 When asked about his current housing situation Mr K recorded:

> *'So busy in hostel and noisy- cannot relax, its stressing me out'.*

1.72 Mr K also recorded that he had ongoing problems with his knee and was waiting for an MRI scan.

1.73 A 'Mental Health Assessment' form was also completed where it recorded that Mr K was currently under the care of *Consultant Psychiatrist 2* from the Hamadryad CMHT and his last contact with him was in August 2010. The form recorded that he was diagnosed with depression, stress and anxiety. Mr K described his current mental health problems and recorded:

> *'I get stressed and anxiety when I have formal meetings, also in crowds. I need peace and quiet and the hostel is very noisy. I am trying to find out who*

I am. I like to get quiet time to myself. I sometimes need help to find medication which will help me and make me have a good nights sleep. My Psychiatrist is helping with this.'

1.74 Mr K also recorded that he had tried to commit suicide twice between 2005-2006, by overdosing on medication and jumping off a bridge.

1.75 Mr K also recorded that he had experienced depression, anxiety/ panic attacks, recurring disturbing thoughts, suspicions/ paranoia and self harm.

1.76 On 9 September 2010, an appointment was made for Mr K to see *Consultant Psychiatrist 2* at the Hamadryad Centre on 29 September due to Mr K failing to attend his appointment on 8 September 2010.

1.77 Mr K met with *key worker 2* on the 12 September 2010 where Mr K requested he go back on full board basis. The key worker decided that he could on the condition he paid £70 on the 21 September which he agreed to.

1.78 The key worker also recorded that he had completed the professional assessment pro forma (Common Risk Assessment) requested by Cardiff Mind and that he would follow up the referral on his return from annual leave. It was recorded that Mr K:

'can become frustrated and has problems controlling anger in situations, but no aggression directed towards staff or service users at Tresillian House or Ty Gobaith.'

1.79 *Key worker 2* also recorded that Mr K:

'Has sometimes found it difficult to engage with mental health services, but can do this with support', 'has previously stopped taking medication when felt has become ineffective' and 'there is some concern that [Mr K] may be easily led by others due to his problems with social situations'.

1.80 *Key worker 2* recorded no known risk to '*Risk of serious violence to others*', '*Risk of self neglect or accidental self harm*', '*Risk due to mental ill health'* and '*Risk*

due to alcohol or substance misuse'. *Key worker 2* also recorded that Mr K did not display any obvious signs of risk to self or others.

1.81 A phone call was received by *CPN 1* from staff at Tresillian House on 20 September 2010. Staff had become increasingly concerned about Mr K who had become more aggressive and demanding in his behaviours. Consequently Mr K's allocated CPN, *CPN 1* arranged to see him and an appointment was made. On 23 September 2010, Mr K's CPN attended Tresillian House, however Mr K had just woken up and did not feel that he could manage the appointment. The CPN was informed that Mr K generally stayed up late reading his engineering books and then slept through the morning. It was recorded that Mr K had been demanding of late and staff found themselves agreeing to some of his demands, mainly at night, to keep the situation calm. No violence was reported. The CPN offered Mr K a further appointment on 29 September 2010 at 2:00pm.

1.82 Mr K's CPN eventually reviewed Mr K on 29 September 2010 (7 weeks after the first scheduled appointment for 5 August 2010) where he appeared heavily intoxicated with alcohol. Mr K's speech was slurred and he was difficult to follow but not aggressive. It was recorded that Mr K felt the main problem at the time was his rage and anger which appeared to be triggered when people had unrealistic expectations of him as he perceived it. Mr K gave an example, of staff asking him to do things and then "going on" at him when it was not done straight away. There was no evidence of psychotic symptoms, or any suicidal or homicidal ideation. Mr K informed *CPN 1* that he was going to be moving to a Cardiff Mind hostel soon and had mixed feelings about it. Mr K was advised that Cardiff Mind would arrange an anger management course for him but he expressed that he may not be able to cope with a group setting.

1.83 *CPN 1*'s impression of Mr K following his assessment was one of Mr K having alcohol dependency and anger issues. *CPN 1* felt that Mr K would no longer benefit from regular CPN support because there was little evidence of major mental illness and Mr K was consequently discharged from the CPN's caseload but remained under the care of *Consultant Psychiatrist 2* at Hamadryad CMHT, in the form of out-patients appointments. There was no evidence in the records stating that Mr K was seen by *Consultant Psychiatrist 2* for his scheduled appointment on 29 September 2010.

1.84 The following day (30 September 2010), Mr K was due to attend an appointment with Cardiff Mind. However, it is recorded that that he did not feel up to it, stating that he felt stressed as he had had little notice about the appointment.

1.85 Mr K appeared to be in some genuine distress, so the staff offered to re-arrange the appointment. Mr K's keyworker, *key worker 2*, explained that he would have to attend the next appointment and he would need to play his part in arranging his move on from Tresillian House. Mr K was offered further support in helping him make and carry out plans more effectively.

Mr K's period at a Cardiff Mind Hostel

1.86 Mr K moved into a Cardiff Mind supported accommodation hostel on Claude Place in the Roath area of Cardiff on 4 October 2010. Upon admission, Mr K was appointed a key worker, *key worker 3*, who was based at Claude Place offering support to the 5 tenants who lived there.

1.87 It was recorded in the Cardiff Mind log book that Mr K had financial difficulties from the time he moved into Claude place, borrowing money on his first day of his tenancy and soon after he fell behind with his rent. Mr K stated that he was no longer getting ESA[17] money from the DWP[18] but following enquiries made by staff, it was established that while Mr K had been banking the cheques, Mr K could not account for his money. Staff at Cardiff Mind recorded that Mr K showed poor engagement with the other tenants and made little co-operation with his support which resulted in a warning letter being issued to him for failing to comply with the scheme.

1.88 A multi disciplinary team meeting was held on 4 October 2010 at the Hamadryad CMHT, where Mr K was discussed. It was agreed that in line with *CPN 1*'s view, that CPN input should be withdrawn as it was felt that Mr K's main issue was his anger. Mr K was informed of this decision by letter.

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[17] Employment and Support Allowance (ESA)

[18] Department for Work and Pensions (DWP)

1.89 Mr K, accompanied by his Cardiff Mind Key worker (*key worker 3*) was reviewed by *Consultant Psychiatrist 2*, on the 5 October in the outpatient' clinic. Mr K told *Consultant Psychiatrist 2* that he had problems with anger management and expressed an interest in attending an anger management course that Cardiff Mind facilitated. Mr K also stated that he was overwhelmed by having to do his own laundry on top of everything else, yet when this was explored he could not state what he meant by 'everything else'.

1.90 *Key worker 3* told *Consultant Psychiatrist 2* that Cardiff Mind staff had reported that whenever Mr K was spoken to for any length of time he would have difficulty in concentrating on the thread of conversation and would often go off on a tangent.

1.91 The main problems recorded were that Mr K was getting stressed about things, his anger was building and that the venlafaxine had made no difference.

1.92 *Consultant Psychiatrist 2*'s opinion was that Mr K showed no signs of a serious mental illness and that his main problem was one of anger management difficulty. It was recorded that his Cardiff Mind key worker (*key worker 3*) was to enlist Mr K for a six week course in anger management. Mr K was consequently discharged from the clinic and from the care of *Consultant Psychiatrist 2*. *Consultant Psychiatrist 2* sent a letter to *GP 2* detailing that he has discharged Mr K, but would be happy to see him again should she feel it necessary.

1.93 Mr K had no further direct contact with Mental Health Services until the index offence.

1.94 On 12 October 2010, *GP 3* received a letter from the Consultant Orthopaedic Surgeon from Llandough Hospital, stating that the results of Mr K's right knee MRI scan had been reviewed and Mr K was placed directly on to the urgent in-patient waiting list for a right knee Anterior Cruciate Ligament (ACL) reconstruction, which the consultant planned to carry out in the next few months. The consultant also sent a copy of the letter to Mr K, however this was incorrectly addressed to The Salvation Army (Ty Gobaith).

1.95 On 13 October 2010, Mr K's key worker (*key worker 3*) helped Mr K to complete his 'moving in' forms including the Housing Benefit form. The key worker

also reminded Mr K that he had not paid any rent for the last two weeks. Mr K stated that he would receive payment the following week and would make payment then.

1.96 On 15 October 2010, Mr K had still not paid anything towards his rent as he was waiting on payment from the Department of Work and Pensions (DWP). Mr K told his key worker (*key worker 3*) that he had some concerns about the recent change of address and that he might not get his money because of it. The key worker supported Mr K in making a telephone call to DWP to sort it out.

1.97 The key worker also explained to Mr K the Individual Support Plan (ISP) process and tried to encourage Mr K to complete it. Mr K stated that he couldn't function at that time as he felt very anxious about his benefit claim.

1.98 The key worker spoke with Mr K about his short term goals. Mr K expressed that he wanted to study Chemistry and was exploring the different courses available.

1.99 On 19 October 2010, Mr K received payment from the DWP. He was also due to go and familiarise himself with the local area but instead chose to go and buy cigarettes and failed to return to the house.

1.100 Mr K returned later that day and smelt of alcohol. It was recorded by *key worker 3* that Mr K paid him £20.00 for rent. Mr K told him that he had bought a PlayStation video games console from cash converter as he wanted to do something that would stop him spending money on alcohol. They discussed how Mr K was going to manage to buy food over the next two weeks as he only had £55.00 left to support himself. Mr K intended to spend this on jeans and a coat as he didn't have any warm clothing.

1.101 On 25 October 2010, *key worker 3* spent two hours discussing three payment arrears on Mr K's ISP. It was recorded that the discussion was 'hard going' and 'it took a lot of back tracking and energy to cover the arrears'. A further meeting was arranged for Thursday 28 October 2010 to continue the discussion.

1.102 On 10 November 2010, Mr K was asked about his ESA payment by *key worker 3* as he was falling behind with his rent once more. Mr K told *key worker 3* that he had not received payment but agreed he would contact the ESA to find out why he hadn't been paid. Mr K used the office phone but stated that he couldn't get

through. His keyworker offered to ring them for Mr K which he accepted. When *key worker 3* rang it was found that the number was an automated answer machine that you had to press the corresponding telephone number button to access the service, this was something Mr K had not done. *Key worker 3* managed to get through to the ESA department and explained that he was acting on behalf of Mr K. *Key worker 3* was told that a cheque had been sent to Mr K on 29 October 2010 that was cashed on 2 November 2010 and that Mr K's next payment was due on 16 November. *Key worker 3* asked Mr K why he had denied receiving payment; Mr K stated that he had forgotten he had received the money. *Key worker 3* recorded that Mr K looked uncomfortable and started rubbing his face, that he looked away and became 'confused''. Mr K could not recall what he had spent the money on.

1.103 On 16 November 2010, *Key worker 3* rang Mr K's GP at Butetown Medical Practice to make an appointment for the following day as he needed to renew his medical certificate for the ESA. *Key worker 3* also made a further appointment with support staff for Mr K as he had a large debt with a bank that he was now being charged for. Mr K had already missed one other appointment that had been set up for him.

1.104 On 18 November, *key worker 3* and the Deputy Manager for Support Services at Cardiff Mind met with Mr K to finish the discussion around his ISP. Mr K was drinking and had to be asked to stop, it was clear that he was intoxicated. *Key worker 3* and the Deputy Manager for Support Services at Cardiff Mind managed to complete the ISP but not without difficulty as Mr K's eye contact was very poor. Throughout the meeting, Mr K was unable to concentrate and kept going off on tangents and losing the thread of the questions that were being asked of him.

1.105 On 1 December 2010, *key worker 3* met with Mr K over a coffee in the dining room. Mr K told him that he was expecting a cheque from the DWP and agreed to pay £40.00 rent that day to assist with clearing his debt. . Mr K told *key worker 3* that he was feeling well within himself, but had mentioned that *resident 1* (another resident of the hostel) had spoken to him regarding the TV and lights being left on in the living room.

1.106 That evening, it was recorded that Mr K had invited a friend into the house and *key worker 3* recorded that he had strong suspicions that Mr K and his friend

were smoking marijuana. *Key worker 3* also had to ask Mr K not to drink in the living room, he complied with this request.

1.107 On 1 January 2011, Mr K was admitted to the University Hospital of Wales (UHW) in Cardiff as he was vomiting blood. It was recorded that Mr K had been drinking steadily all that day which appeared to have caused him gastric problems. Mr K was discharged back to the hostel the following day.

1.108 On 6 January 2011, Mr K came to the office and explained to *key worker 3* that he had run out of money and asked if he could reclaim £20.00 from the rent payment he had made a couple of days previous. Mr K had paid £50.00 on 29 December and a further £55.00 on 31 December 2010 after winning a bet. *Key worker 3* discussed with Mr K about his hospital admission due to excessive drinking and smoking and that the doctors had advised that he abstain from both. Mr K stated that he had no money to buy alcohol and that he needed the money to buy food. *Key worker 3* explained that he couldn't sanction giving Mr K money if he would go and buy alcohol or gamble it away. Mr K insisted the money was for food. *Key worker 3* escalated this to Deputy Manager for Support Services at Cardiff Mind who agreed that Mr K could have £20.00 to buy food only.

1.109 On 12 January 2011, *key worker 3* had a face to face discussion with Mr K. *Key worker 3* discussed an argument that had taken place the previous evening between Mr K and another female resident, *resident 1*, at Claude Place. Mr K stated that he was trying to "make things up with resident 1" as he didn't like ill feeling.

1.110 *Key worker 3* asked Mr K not to be rude to *resident 1* and try not to engage in conversation or contact with her unless *resident 1* indicated that she wanted this to happen.

1.111 *Key worker 3* also had an in depth discussion with Mr K about his mental health. Mr K disclosed that he felt that his mind was working too quickly and that he couldn't make sense of the world as it moved slower than he was thinking. Mr K stated that people thought he was "abnormal as a kid" but at the time did not realise that people thought differently to him and only started to notice this when he got older.

1.112 *Key worker 3* asked Mr K if he would commit to medication if it was prescribed to him. Mr K stated that "he would give it a go". *Key worker 3* suggested that he make an appointment with Mr K's GP that week and that he would go with Mr K and if necessary to assist Mr K to explain to the GP what Mr K had told him. Mr K agreed to this and told the key worker that he just "wanted to slow things down so that he could understand how other people think". An appointment was therefore made with the General Practitioner, *GP 4* for 4 February 2010 to discuss Mr K's mental health.

1.113 Mr K attended Llandough Hospital for a meeting with staff to discuss his knee operation scheduled to take place in February. During the discussion Mr K raised concerns about his sexual health as he had had unprotected sex in the past. Mr K was worried that he may have contacted HIV and could pass it on to others if he was to cut himself in the house or during the operation.

1.114 On 18 January 2011, Mr K completed a GP health questionnaire for Albany Surgery in Cardiff. On the form he denied taking any regular medication and answered 'yes' to having a disability, stating he had a bad knee. He did disclose that he had depression but was being supported by Cardiff Mind.

1.115 A letter from the Department of Orthopaedic Surgery at Llandough Hospital was also received by *GP 3* at the Butetown Practice on 18 January 2011. The letter stated that Mr K was reviewed in the pre-admission clinic that day and was scheduled for a right ACL reconstruction on 10 February 2011. Mr K had been told in great depth of the risks and benefits of the surgery and they had obtained his written consent for the surgery. However, a discharge letter from the Cardiff and Vale University Hospital stated that Mr K had been admitted for his right knee ACL operation on 27 January 2011, and was discharged the following day. There is no evidence as to why his operation was brought forward.

1.116 On 4 February 2011 there was a fire at the hostel which, according to Mr K, was caused when he got up in the early hours to make himself some toast. He stated that there must have been oil left on the grill pan which caught alight. This sounded the smoke alarm and subsequently woke one of the tenants, *resident 1*, who called the fire brigade and an ambulance.

1.117 Mr K also had a further altercation with *resident 1* that day (4 Feb) whereby she accused him of not answering the door or letting her know when someone telephoned for her. This frustrated Mr K and he threw his crutches at her which resulted in *resident 1* phoning the police, reporting she felt threatened by him. This prompted a meeting with the Project Manager at Cardiff Mind who warned Mr K that if he continued not to engage with his support then he would be in breach of his tenancy; however it would appear that Mr K continued not to engage.

1.118 Later that same day (4 Feb), Mr K, accompanied by his key worker, was seen by the GP, *GP 4*. Following this appointment, *GP 4* referred Mr K to LINKS CMHT in Cardiff due to concerns regarding certain aspects of his behaviour. *GP 4* recorded that he along with Mr K's key worker (*key worker 3*) were worried that Mr K was developing 'more overt psychiatric illness' and therefore requested an assessment due to Mr K being low in mood. *GP 4*'s referral letter stated:

> *'Since he [Mr K] has moved into the Cardiff Mind house his carers have become increasingly concerned about certain aspects of his behaviour. I have met Mr K on two occasions and on both occasions he has appeared very withdrawn and been unable to give a clear history. He appears to avoid eye contact and in our latest consultation was expressing some paranoid ideations regarding him not liking other people's thoughts and also thinking that people were aware of his thoughts. Both his careworkers and myself are concerned that he may be developing more overt psychiatric illness and would be grateful for your assessment as to whether or not you feel this is the case.*
>
> *I was unaware of his previous alcohol misuse the second time I saw Mr K but he has not been under the influence of alcohol on the two occasions that I have met him'.*

1.119 *GP 4* also stated that he had prescribed Mr K a small amount of Diazepam, however was aware that he had misused Diazepam in the past and would look to withdraw it in his next consultation with him and look to replace it with other medication.

1.120 On 14 February 2011, the LINKS CMHT wrote to Mr K following the referral made by *GP 4* on the 4 February 2011. The letter informed Mr K that he would need to contact them should he wish to make an appointment. The letter stated:

> *'As you are aware your General Practitioner has referred you to the Links Centre with a view to us helping you with your current problems. This appointment is an initial assessment which may last up to one hour and you will be seen by a member of our medical team……If I do not hear from you within two weeks from the date of this letter, I will assume that you no longer wish to access our service and will inform your GP accordingly.'*

1.121 Mr K did not make contact with the Links CMHT to make this appointment.

1.122 During a GP appointment with *GP 4* on 18 February Mr K stated that he had trouble sleeping and was short tempered and aggressive with the other tenants residing at Claude Place. Mr K was subsequently prescribed an antidepressant which was to be taken at night due to it causing drowsiness. *GP 4* recorded that Mr K was intoxicated during the appointment. *GP 4* also received a letter from the Department of Physiotherapy at the Cardiff Royal Infirmary stating that Mr K failed to make contact with them to arrange an appointment following their letter. Therefore, they were discharging Mr K back to *GP 4*'s care.

1.123 On 3 March 2011, Mr K was seen by *key worker 3*. Mr K showed signs of being able to budget and was on top if his laundry. Mr K stated that he would make a concerted effort to engage in social activities, however he explained that it depended on what day they were scheduled for. Mr K expressed that he wanted to attend the next anger management course that Cardiff Mind were running and that he felt a lot better since commencing the antidepressant medication. It was also recorded that Mr K was due to start having physio on his knee following his operation.

1.124 On 7 March 2011, Mr K ran out of his antidepressant medication and told a member of staff, Cardiff Mind *support worker 1*, that he needed to take them because without them he would start to feel down and would get into trouble and end up fighting. Mr K also stated that he had run out of money and was due to pay bills. This would leave him with no money after his next pay.

1.125 Later that day (7 March 2011), Mr K saw *GP 4*, where it was recorded that he was brighter in mood and was feeling better but agreed to continue with his antidepressant medication.

1.126 On 8 March 2011, Mr K was prescribed a months supply of the antidepressants following his appointment with his GP. Mr K had been paid some money so he paid his rent and it was recorded that he had a drink for "Dutch courage" before going out to do some shopping. Mr K then went to the Claude Pub with Mr Z (the eventual victim) and on their return it was noted that Mr K was bleeding from his forehead and ear. Mr K stated that he was attacked by Mr Y (an acquaintance of Mr Z) but later stated that he in fact had thrown the first punch as he had felt threatened.

1.127 On 14 March it is recorded that Mr K spent most of the day with Mr Z in his room watching television and listening to music. On the same day *GP 4* received a letter from the Department of Orthopaedic Surgery at Llandough Hospital, Cardiff stating that Mr K had failed to attend his physiotherapy appointment after his operation on his knee and therefore would not be offering Mr K a further appointment but would be happy to review him upon re-referral.

1.128 On 15 March 2011 Mr K showed Cardiff Mind *support worker 1* a letter stating that his ESA had been stopped. The Deputy Manager for Support Services at Cardiff Mind later spoke with Mr K regarding complaints from *resident 1* that Mr K was knocking her door at night which Mr K denied.

1.129 On 17 March 2011, Mr K's progress was reviewed by *key worker 3*. Mr K expressed his concerns about his ESA being stopped but showed no willingness to tackle the problem and has continually failed to attend appointments with Cardiff Mind advice personnel. Mr K stated that he felt tired all day as he was not sleeping at night and it was recorded that Mr K appeared confused regarding when he should be taking his medication. It was also noted that Mr K was spending a considerable amount of time with Mr Z, usually drinking. Later that day, it is recorded that Cardiff Mind *support worker 1* mediated between Mr K and *resident 1* so that they could clear the air between them.

1.130 On 18 March 2011, *GP 4* received a letter from *Consultant Psychiatrist 2* summarising his assessment of Mr K on 8 July 2010. *Consultant Psychiatrist 2* stated:

> *'I remember seeing him [Mr K] before when he was staying in the Huggard Centre and enclose an assessment letter from July 2010. Certainly at that point I thought he was depressed, however, a primary psychotic disorder could not be excluded'.*

1.131 On 21 March 2011, Mr K stated that he hadn't had any money for at least two weeks and was feeling very low in mood. He stated that he frequently felt angry and was afraid to go out in case he got himself into trouble. Mr K was encouraged to take action with regards to his ESA but again continued to show reluctance and unwillingness. Mr K was told that he "must" do something about his financial arrangements the following day.

1.132 On 22 March 2011, Cardiff Mind *support worker 1* met with Mr K and contacted the DWP on his behalf to resolve his ESA situation. Mr K was told that he must attend the Job Centre the following morning so that he could apply for a crisis loan.

1.133 Later that day at 21.55 hours, South Wales Police received a call from 9 Claude Place, Cardiff stating that a male body had been discovered. On attendance, Mr Z was discovered to be deceased and Mr K made comments at the scene that implicated him in Mr Z's murder. Mr K was observed to have blood on his clothing and police reports stated that Mr K informed them that his friend (Mr Z) had asked him (Mr K):

> *"three times in total to kill him. Some people need to kill themselves. He provoked me to do it saying he didn't want to live anymore".*

Mr Z's Background

1.134 Mr Z was a 54 year old man with a history of psychosis, alcohol misuse and self harm. He was a long standing client of mental health services with several

inpatient admissions and was considered to be an individual who was at risk of being exploited by others. He moved into the Cardiff Mind hostel at Claude Place on 16 June 2010 following concerns about him being vulnerable to exploitation at his previous Cardiff Mind address elsewhere within Cardiff.

1.135 Throughout his time residing at the Cardiff Mind hostel at Claude Place Mr Z had continued input from his CPN (from the Links CMHT), a social worker, and also spent time being treated for alcohol detox. On occasions during his time residing there Mr Z had been behaving in a threatening behaviour towards fellow residents at Claude Place and Cardiff Mind support workers. One such matter was referred to the Police and Mr Z was warned that his behaviour could lead to him being evicted from Claude Place. Mr Z showed remorse about the incident and committed to abstinence in future.

1.136 Mr Z's usage of alcohol continued to be an issue however during his time at Claude Place leading to fellow residents becoming conscious of his behaviour. Mr Z had also complained to his CPN of experiencing visual hallucinations and this was noted as being an idiosyncratic indication of deterioration in his mental state.

1.137 In March 2011, a Protection of Vulnerable Adult (PoVA) referral was made by Cardiff Mind in relation to Mr Z due to him apparently having been assaulted by Mr Y. Despite the referral Mr Z was noted to be in good spirits and continued to avoid further contact with Mr Y. Mr Z alleged that Mr Y had attacked Mr K at the Pub and that Mr K had responded by assaulting Mr Y. Mr Z was advised by Cardiff Mind to report the matter to the Police, however, Mr Z was considered to have the capacity to choose not to report the assault to the Police.

Mr K's Relationship with Mr Z

1.138 It was through their residence at Claude Place that Mr Z and Mr K met and became acquainted. Mr Z was already a resident when Mr K was moved in. Throughout the time that Mr K resided there, Mr K and Mr Z were regularly seen together. The relationship was observed as being platonic. From the evidence reviewed, there was no suggestion that the relationship between Mr K and Mr Z was not appropriate. In fact the records stated that there was more concern regarding Mr

Z's relationship with Mr Y, whereas Mr Z's relationship with Mr K was actually regarded as positive.

1.139 Despite this view being held, on 22 March 2011 Mr Z was tragically murdered by his fellow resident, Mr K.

Post Index Offence

1.140 Following the index offence, Mr K was arrested in the connection with the alleged murder of Mr Z. He was taken to Cardiff Bay Police Station and was then transferred to Caswell Clinic[19].

1.141 The Police were not allowed to question Mr K until late June 2011 because he was deemed to be too severely ill to be questioned. Mr K was diagnosed with Schizophrenia and given treatment shortly after his initial assessment by clinicians at the Caswell Clinic.

[19] The Caswell Clinic provides specialist healthcare services for people from South Wales with mental health problems who are offenders or have a potential to offend.

Management and Organisation of Services

Arrangements for the provision of Mental Health Services in Wales

1.142 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.

1.143 A further NHS Wales reorganisation took place in October 2009 which amalgamated the NHS Trusts and Local Health Boards into seven Health Boards. Cardiff and Vale University Health Board replaced Cardiff and Vale NHS Trust, Cardiff LHB and the Vale of Glamorgan LHB.

The Links CMHT

1.144 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.

1.145 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.

1.146 Referrals are usually made by GPs, the crisis team, Whitchurch Hospital and Llanfair Unit (part of general adult mental health services) as well as other health care professionals such as health visitors or prison liaison nurses.

The Hamadryad CMHT

1.147 The Hamadryad CMHT covers the areas of Grangetown, Butetown, Riverside, Canton, Pontcanna and Upper Grangetown in Cardiff.

1.148 The team is a multi-disciplinary team made up of psychiatrists, social workers, community psychiatric nurses, psychologists and therapists, providing assessment, treatment and care in the community, rather than in hospitals, for people with severe long-term mental health problems.

Cardiff Mind

1.149 Applications and referrals to Cardiff Mind supported accommodation can be made by individuals or agencies on behalf of individuals providing they complete and sign the Cardiff Mind application form. The application form can be handed in, sent via post, faxed or emailed to Cardiff Mind.

1.150 Prior to accepting a service user into supported accommodation, an initial assessment interview will be carried out in order to:

- check information gathered to date
- focus on any complex issues and/ or risks presented by the service user
- ascertain that risks and needs can be managed within supported accommodation.

1.151 The supported accommodation service works in partnership with Housing Associations and Cardiff City Council, to provide 26 bed spaces in shared houses and flats. The accommodation is provided with support between 9:00am and 7:00pm with 24 hour emergency cover.

1.152 A referral may be rejected should the service user fail to meet the eligibility criteria and particularly if the risk presented by any of the individuals concerned cannot be adequately managed within the project.

Chapter 2: Findings

Predictability of the Homicide Committed by Mr K

2.1 It is now clear, with the benefit of hindsight, that by the time that Mr K had tragically committed the murder of Mr Z his mental health had deteriorated significantly (Mr K has been diagnosed as suffering from Schizophrenia). In attempting to asses whether the homicide of Mr Z was predictable a number of factors must be taken into consideration.

2.2 Mr K had a chaotic upbringing and historically suffered periods of prolonged alcohol and substance misuse, it was also apparent that he occasionally had had problems in controlling his own anger. He had been involved in numerous altercations over many years, most of which appeared to be self-inflicted. Mr K himself had talked about his own rage, episodes of becoming violent, and an example of this became apparent only a matter of days prior to the death of Mr Z when Mr K had allegedly assaulted Mr Y, apparently in the act of defending Mr Z.

2.3 Although Mr K was quite guarded in talking about his experiences to the mental health professionals with whom he had contact (Mr K did not wish to speak to the review team for instance), detailed analysis of the case records showed that Mr K had reported symptoms of psychosis from 2009 onwards. We know that these symptoms, though apparent in hindsight, did not result in Mr K being acquired as a patient with psychosis within the three mental health services he was referred to. Mr K also had significant substance misuse problems which may have obscured the clinical picture and prevented a clear diagnosis being made. We also don't know whether Mr K was continually ill from 2009 to the time of the offence, or just experienced episodes of psychosis.

2.4 Mr K meanwhile had never been considered to have the potential to commit a homicide by any of the health professionals or key workers who had engaged with him over the years. A common theme noted by those who had contact with him however was of Mr K's potential to commit an act of violence. This potential for violence nonetheless was never related as being a risk to any specific individual.

2.5 Mr Z himself had been noted as a potentially vulnerable individual, also prone to episodes of anger and erratic behaviour, primarily due to his alcohol use. The PoVA referral made by Cardiff Mind in March 2011 was an example of Mr Z's vulnerability causing him to be a victim of apparent violence. It was not therefore surprising that Mr Z could, or would become a victim of violence, either by his own self harm or perpetrated by others.

2.6 It is clear that Mr K and Mr Z were two very vulnerable people who had been housed together in a low-support facility. Both had severe alcohol problems and made regular recourse to the local pub. One (Mr Z) was very well-known to psychiatric services and received a high level of support, including a PoVA meeting being held in the month that he died. One (Mr K) was undiagnosed and not in meaningful contact with mental health services.

2.7 With the benefit of hindsight it is clear that an incident would not have occurred had Mr K not been accepted and allocated to be housed alongside Mr Z by Cardiff Mind. However, despite the risk of violence that Mr K posed, we do not believe that it was predictable that Mr K would commit an act of murder. In particular it was not predictable that Mr K would murder Mr Z, with whom he was noted to have an excellent relationship.

2.8 We are of the opinion however that had Mr K's psychosis been diagnosed earlier and importantly, had Mr K complied with any subsequent treatment, that the homicide of Mr Z was preventable.

2.9 In taking this view we consider there to have been failings and deficiencies in a number of aspects of Mr K's engagement with services. Specifically:

- deficiency in the referral process when Mr K required access to mental health services
- opportunities were missed by mental health services to diagnose a serious mental illness
- difficulties in engagement with an individual who had led a nomadic life and had spent periods of time living in temporary residential settings
- there were weaknesses in communication and information sharing between those services and agencies/organisations that had contact with Mr K leading

to important information that could have influenced Mr K's care and treatment being missed

- weaknesses in the assessment of risks, in particular with regards to the allocation of suitable residence for individuals such as Mr Z and Mr K

2.10 In attempting to identify the root causes that led to the tragic death of Mr Z on 22 March 2011, the review team has considered the periods of engagement that Mr K had with statutory services. These findings are described in the following sections.

Engagement with mental health services

The referral process for a patient who is suspected of having a psychotic illness

2.11 Between 2009 and 2011 Mr K was referred to mental health services three times by three different GPs. All three GPs raised a similar question in that they each suspected that Mr K man may have schizophrenia and/or a psychotic illness.

2.12 A diagnosis of possible schizophrenia is seen as a serious and urgent medical problem by GPs. The diagnosis needs to be made as quickly as possible and treatment not delayed.

2.13 On the first two occasions that Mr K was referred, 30 September 2009 and 24 June 2010, Mr K was seen promptly by a psychiatrist. The third occasion was less timely. In February 2011 the GP referred Mr K to the Links CMHT stating:

> *'Since he [Mr K] has moved into the Cardiff Mind house his carers have become increasingly concerned about certain aspects of his behaviour. I have met Mr K on two occasions and on both occasions he has appeared very withdrawn and been unable to give a clear history. He appears to avoid eye contact and in our latest consultation was expressing some paranoid ideations regarding him not liking other people's thoughts and also thinking that people were aware of his thoughts. Both his careworkers and myself are concerned that he may be developing more overt psychiatric illness and would be grateful for your assessment as to whether or not you feel this is the case.*

I was unaware of his previous alcohol misuse the second time I saw Mr K but he has not been under the influence of alcohol on the two occasions that I have met him'.

2.14 As a response to this GP referral, Links CMHT sent an 'opt in letter' to Mr K as opposed to being directly offered an appointment. Mr K chose not to contact the Links CMHT in order to make this appointment. *Consultant Psychiatrist 2*, the psychiatrist of the Hamadryad CMHT who had previously seen Mr K in the summer of 2010, also saw this referral on the health records computer system. *Consultant Psychiatrist 2* made his assessment letter of 8July 2010 known to the Links CMHT, but it does not appear that they responded by offering Mr K an earlier appointment.

2.15 The mental health service in Bridgend in 2009, and the Hamadryad CMHT in 2010 both responded promptly to the GP letters and suspected diagnosis.

2.16 However the Links CMHT response to the third GP referral in February 2011 was less responsive. The Links CMHT did not change the way in which they dealt with Mr K even though *Consultant Psychiatrist 2* had highlighted his letter to the CMHT. The Links CMHT was content to allow Mr K to wait 8 weeks from referral to being seen (February to early April). Tragically Mr K was to commit the murder of Mr Z in March 2011.

2.17 We consider there to have been deficiencies in the referral process. Namely:

- While the referral letter sent by the GP to the Links CMHT was appropriately marked as routine (and not 'urgent'), the decision to send Mr K an 'opt in' letter meant that Mr K elected not to contact Links CMHT himself to make an appointment. We believe this to be in part down to a lack of scrutiny on the part of the CMHT in scrutinising GP referrals and a weakness of the MDT[20] process within the Links CMHT at that time
- Mr K's historical lack of engagement with services meant that whilst offering an appointment to him may not have resulted him in choosing to attend, it was even less likely that Mr K would proactively follow-up, making an

[20] Multi Disciplinary Team – a team consisting of various mental health professionals, typically may include Mental Health Nurses, Psychiatrists, Social Workers.

appointment himself. We note that the Links CMHT may not have had knowledge of Mr K's historic lack of engagement with services

- There was a delay in the Links CMHT response to the GP's referral that ultimately led to the last opportunity to engage Mr K with mental health services prior to the homicide of Mr Z being lost.

Missed opportunities to diagnose a serious mental illness

2.18 After his arrest on 22 March 2011, Mr K was deemed to be so ill that the Police were not given permission to question him about his offence for three months, which suggests how unwell Mr K had become by the time of the index offence.

2.19 On the first occasion that Mr K was seen by a psychiatrist (*Doctor 1*) in November 2009 it was noted that 'Mr K suffers from alcohol dependence syndrome with a lack of insight into his condition'. The psychiatrist who saw Mr K did not have the benefit of the attendance of Mr K's family in his assessment, unlike the referring GP who had the benefit of Mr K's brother being present at assessment. This psychiatrist however did not refer Mr K for follow up by community mental health services. *Doctor 1* prescribed venlafaxine and asked Mr K to return in 8 weeks. This assessment did not involve the wider CMHT and Mr K was not given the opportunity to see a Community Psychiatric Nurse (CPN). This was the first missed opportunity to engage with Mr K and make a diagnosis. Unfortunately Mr K never returned and was not seen again by services in Bridgend.

2.20 In June 2010 Mr K was referred for the second time by a GP who was very experienced in dealing with the problems of the homeless. The referral letter written by this GP was very clear stating:

> *'I am concerned about this 26 year old man who has been living in Ty Gobaith for 2 or 3 months. He was brought to see me on 24/6/2010 by his keyworker. She [keyworker] is concerned that his mental health is deteriorating over the time that she has known him. He certainly seemed unwell compared to the other time I met him on 2/6/2010.*
>
> *He [Mr K] is vacant, restless- fiddling with things, he cannot maintain a train of thought for long, he feels his eyes are wrong and keeps rubbing them. He*

denies hearing voices or seeing hallucinations. His mood varies. He also looks quite dishevelled'.

2.21 Mr K was seen promptly by the Hamadryad CMHT, even though he failed to attend the first appointment. The Consultant Psychiatrist (*Consultant Psychiatrist 2*) undertook a careful and reasonable assessment and came to an initial view that Mr K's main problem was 'that of depression however a primary psychotic disorder could not be ruled out'. The Consultant Psychiatrist prescribed anti-depressant medication; referred Mr K to the CMHT and the multi-disciplinary team allocated Mr K to a CPN (*CPN 1*) two weeks later.

2.22 Engaging with Mr K was to prove problematic for the CPN due to Mr K frequently not attending or cancelling appointments. The CPN tried to see Mr K on several occasions before finally seeing Mr K and completing an assessment on 29 September 2010, some seven weeks after the first attempt. The CPN only saw Mr K once and at a subsequent multidisciplinary team meeting on 4 October 2010 said that he felt Mr K would not benefit from further CPN involvement and Mr K was therefore discharged. The CPN's view was that Mr K did not have any major mental illness and that his main issues were alcohol dependency and anger issues.

2.23 Mr K did see the Consultant Psychiatrist (*Consultant Psychiatrist 2*) on 5 October 2010. The Consultant Psychiatrist's opinion was that Mr K showed no signs of a serious mental illness and that his main problem was one of anger management difficulty. This was the last time that the Hamadryad CMHT saw or engaged with Mr K.

2.24 Whilst it was clear that Mr K was difficult to engage with, guarded in talking about his experiences, and would frequently not attend appointments, it is also clear that this was part of his pattern of behaviour. We feel that despite the prolonged and valiant efforts of the CPN to engage with Mr K, and the fact that Mr K was seen on more than one occasion by the Consultant Psychiatrist, an opportunity was missed to thoroughly assess Mr K and review him regularly.

2.25 Further to this we found little or no evidence of any consistent or structured engagement or sharing of information between the Ty Gobaith and Tresillian House and the Hamadryad CMHT. This may have led to important information that may

have influenced the Consultant Psychiatrist or the CPN's assessment of Mr K being missed.

2.26 Mr K again agreed to see a GP about his mental health problems in February 2011 following concerns being raised by staff at the Cardiff Mind hostel in Claude Place. On 4 February 2011, the GP referred Mr K to the Links CMHT, again suspecting a serious mental health problem. The response from Links CMHT was not swift but went through a process of asking Mr K to confirm he required an appointment. *Consultant Psychiatrist 2* also alerted the Links CMHT to his previous involvement with Mr K.

2.27 As stated in the previous section, this mechanism for obtaining an appointment with the Links CMHT mental health team did not operate effectively and as a consequence a further opportunity to engage Mr K with mental health services was missed.

2.28 Mr K first presented with symptoms indicative of a serious mental health problem in September 2009. Sadly it took until March 2011 for a diagnosis of psychosis to be made, by which time the murder of Mr Z had tragically been committed.

2.29 The root causes in relation to missed opportunities were:

- The assessment undertaken by the psychiatrist in 2009, despite the detailed referral letter provided by the GP, concluded that Mr K's primary issue was alcohol dependency. This lead to Mr K not being referred for further mental health service input with no follow up planned
- Mr K's guarded nature, in particular when seen by mental health professionals, meant that it was difficult to make a clear and definitive diagnosis of his mental illness. However, key information held by keyworkers at both Ty Gobaith and Tresillian House regarding Mr K's symptoms was not systematically shared with the Hamadryad CMHT. This information may have provided insight into Mr K's wellbeing that could have influenced assessments or decisions over Mr K's care and treatment, or indeed his diagnosis
- Whilst it is clear that the CPN unfailingly attempted to see Mr K on numerous occasions following referral by the Consultant Psychiatrist, had the key information held by Ty Gobaith and Tresillian House been shared, the CPN

may have sought to maintain engagement with Mr K over a longer period in order to gain a more complete picture of Mr K's mental wellbeing

- The decision taken by the Links CMHT not to directly offer an appointment to Mr K ultimately led to the last opportunity of engaging with him and possibly diagnosing a serious mental illness, being lost

Communication, Information Sharing and Assessments

Mental health services for the homeless in Cardiff

2.30 A theme that emerged during this review was of the difficulties that were apparent in engaging with peripatetic individuals, such as Mr K, often living in temporary accommodation or within hostels run by the voluntary sector. We were told by many of the individuals whom we spoke to from Cardiff Mind, Ty Gobaith and Tresillian House that they missed the input that they felt was missing from the CPN attached to the CHMTs who used to visit them regularly and see patients in their own home. This CPN role had the task of linking the homeless services with those of the CMHTs and was looked upon as an excellent resource for the homeless in Cardiff. We were told that the CPN who performed this role had left the service and had not been replaced.

2.31 Staff at the homeless hostels in particular said their clients found it more and more difficult to engage with the Hamadryad CMHT. The clients were expected to go to the Hamadryad Centre as opposed to being visited at their own home (although in this case the CPN made several efforts to visit Mr K at Tresillian House). When the linked CPN was in post, this individual saw the clients in their own homes/flats. As a regular visitor to the hostels, the CPN was well known and respected. This attendance also allowed key workers to pass on and share information to the CPN about clients who were resident there.

2.32 In Mr K's case, the key workers had vital information and intelligence about his mental state which was apparently not passed to the CMHT or any mental health professionals. As stated in the previous section, this process of information sharing between agencies and organisations dealing with homeless service users, or those in temporary accommodation on a daily basis needs to be strengthened ensuring that

key information that may influence the care and treatment of those known to mental health services is shared routinely. This responsibility lies with both the NHS mental health services and the hostels and voluntary organisations, and not merely with one organisation.

Access to information within mental health services

2.33 Whilst we believe that processes for sharing information between mental health services and other organisations needs to be improved, we also believe that the ability to access information within mental health services also needs strengthening.

2.34 It was not clear to us what information had been, or could be accessed or shared between CMHTs in South Wales about previous referrals and assessments. Whilst the CMHTs in Cardiff share the same IT system – Paris, it was unclear to us whether services in Cardiff had access to the referral made in Bridgend in 2009 (part of a neighbouring Health Board – the then ABM University NHS Trust[21]). This information, had it been available to the Hamadryad CMHT in 2010 may have provided information that could have influenced any subsequent assessment of Mr K's mental health. However, it also seems that the previous information noted by the Hamadryad CMHT in 2010 was not used by the Links CMHT when it came to assessing Mr K's referral or offering him a prompt appointment in February 2011.

The Cardiff Mind admission process

2.35 We believe that this case highlights deficiencies in the admission process to Cardiff Mind premises. This in part, is due to the lack of information sharing arrangements noted in the previous section, but also in part due to the lack of rigour and thoroughness attached to Cardiff Mind's assessment process.

2.36 It is clear that Cardiff Mind, or indeed any similar voluntary organisation that operates hostels, needs to make every effort possible to ensure that the client mix at its hostels is appropriate and takes fully into consideration the risks associated with

[21] In October 2009, Abertawe Bro Morgannwg University Health Board was created when ABM University NHS Trust formally merged with the Local Health Boards of Swansea, Neath Port Talbot and Bridgend.

housing individuals who may be of a risk to themselves, to others, or vulnerable, within the same building.

2.37 We were told that in their experience Cardiff Mind felt that they did not routinely receive information from the CMHTs in Cardiff about those individuals who they were either considering to house, or who were already resident at their hostels. In particular we were told that Cardiff Mind were not routinely invited to any Care Programme Approach (CPA) meetings held to discuss current mental health service users residing at their properties.

2.38 We were also told however of the pressure that is sometimes apparent to fill vacant beds at the hostels, and the financial implications of operating at less than full capacity. This may, on occasion, lead to the potential of an inappropriate placement of a resident at a hostel, in particular if little is known about the individual's background. Ultimately this has the possibility of individuals being housed together who have very different support needs.

2.39 Staff at Cardiff Mind were very critical of the information they had received about Mr K prior to his move to Claude Street. We asked the question if this was a good placement in view of Mr K's known mental health problems. Staff at Cardiff Mind told the review team that in their experience information flowed in one direction – from Cardiff Mind to the CMHT. We were informed that they rarely received full information about a potential client from a CMHT.

2.40 We were told for instance that if a client was on CPA[22] and the CPA review was due, Cardiff Mind may be asked for information by the CMHT but seldom were they asked to be present at the CPA review. Cardiff Mind would not receive the result of a CPA review.

2.41 Whilst it does not appear that information was shared by the Hamadryad CHMT prior to Mr K's placement at Claude Street, we also are not clear whether Cardiff Mind made any specific request to access and receive this information during

[22] Care Programme Approach – CPA - Anyone experiencing mental health problems is entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that's regularly reviewed by that professional.

its own assessment of Mr K's application and any subsequent decision over where he should reside.

2.42 Having taken the decision to house Mr K at Claude Street, it is clear that staff at Cardiff Mind made assiduous attempts to get Mr K in contact with services once it became apparent that Mr K wasn't well. However, it is clear in hindsight that the decision by Cardiff Mind to offer residency to Mr K at their hostel in Claude Place was, in part, a contributory factor to the tragic events on 22 March 2011. We believe that a key factor that undermined this decision and increased the risk of an adverse event occurring was the lack of information that Cardiff Mind had regarding Mr K's background that may have led to the decision being taken to provide residency at an alternative hostel.

2.43 We believe that the root causes of the issues highlighted within this section are:

- the lack of any systematised process or approach in place to facilitate the sharing of vital information between those services and organisations that current, or potential mental health service users are engaged with, led to vital information about Mr K's symptoms not being shared with the CMHTs
- the lack of clarity regarding the access that mental health services had to information about Mr K's previous involvement with mental health services, either in other Health Board areas, or within the same Health Board, and how this information, if it was accessed or provided, influenced any decisions regarding care and treatment
- the allocation of Mr K by Cardiff Mind to its hostel in Claude Place was inappropriate. This was due in part to a lack of information available to Cardiff Mind about Mr K's previous engagement with mental health services, but also symptomatic of the lack of any process for the routine sharing of information between mental health services and Cardiff Mind.

Chapter 3: Recommendations

Cardiff and Vale University Health Board

1. The Health Board should review the referral process for individuals attempting to access mental health services ensuring that:

    a. Clarity is gained regarding the urgency level attached to each referral with clear guidance issued to both primary care and the community teams.

    b. The process of MDT referral meetings at each of its CMHT's is reviewed and audited, ensuring that the level of urgency attached to GP referrals correlates to the content of any referral.

    c. In line with Welsh Government guidance[23], individuals who are referred to CMHT's are offered an appointment within the allotted timeframe.

    d. Assertive attempts are made with those individuals who are difficult to engage with, who are homeless, or reside in temporary or hostel accommodation.

2. The Health Board, in conjunction with Welsh Government, should review the ability of its mental health professionals to access information about previous mental health referrals or engagement with services. Each assessment of a service user should have full access of any previous periods of engagement to ensure that any decision regarding any care and treatment is fully informed.

3. The Health Board should review what arrangements it has in place in order to reduce the Duration of Untreated Psychosis (DUP)[24]. DUP can be reduced by the

[23] The role of community mental health teams in delivering community mental health services, July 2010, Welsh Government (http://wales.gov.uk/topics/health/publications/health/guidance/mentalhealth/?lang=en)

[24] Psychosis and schizophrenia in adults: treatment and management: NICE guideline, Draft for consultation, August 2013: www.nice.org.uk/nicemedia/live/13569/64925/64925.pdf

effective use of early intervention teams and by mental health promotion campaigns[25].

Cardiff and Vale University Health Board and Cardiff County Council

4. The Health Board and Local Authority should review the adequacy of the arrangements currently in place to provide psychiatric services for homeless, vulnerable people. This review should consider arrangements that are in place in other areas of the UK.

Health, Local Authority and Voluntary Organisations: Communication and Information Sharing

5. In respect of service responses to homeless people, arrangements for the consistent sharing of information between mental health services and voluntary organisations, or local authority run accommodation, should be significantly strengthened. These arrangements should give consideration to:

    a. Improve liaison and the flows of information between respective organisations, in particular including keyworkers from voluntary organisations at any case review, or CPA meetings being held to discuss care and treatment of service users.

    b. Improvement of the links between the CMHTs and the homeless/temporary accommodation residences within Cardiff, including where possible regular input from mental health professionals.

    c. For individuals who are difficult to engage with, making appointments to see them at their home, minimising the possibility of appointments being missed, cancelled, or not attended. This should be done with appropriate risk assessments having been considered.

[25] http://www.jcpmh.info/commissioning-tools/cases-for-change/severe-problems/what-works/early-intervention/

6. Cardiff Mind should fully review its assessment and allocation processes, ensuring that key information relating to risk and to previous involvement with mental health services is fully taken into consideration when assessing where they may seek to reside clients. This review should include consideration of:

    a. The information required to make a fully informed assessment and being proactive in attempting to access that information.

    b. Ensuring that clients are always appropriately homed, taking full consideration of the risks of housing individuals together who have very different support needs.

Annex A

Review Terms of Reference

HEALTHCARE INSPECTORATE WALES SPECIAL REVIEW OF THE CARE AND TREATMENT PROVIDED TO Mr K

Healthcare Inspectorate Wales (HIW) is to undertake an independent review of a homicide carried out by a mental health service user in the Cardiff area on the 22 March 2011.

The review will investigate the care and support provided to Mr K and Mr Z prior to Mr K attacking Mr Z whilst residing at a MIND hostel in Cardiff.

In taking this review forward HIW will:

- Consider the care provided to Mr K 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 the 22 March 2011.

- Consider the care provided to Mr Z as far back as his first contact with Mr K whilst under the care of Health and Social Services to gain an understanding of the relationship between Mr K and Mr Z leading to the fatal incident.

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

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

- Identify any change or changes in Mr K's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred 22 March 2011.

- 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[26].

[26] As part of this exercise consideration will be given also to the personal history of Mr K and Mr Z.

Methodology and timescale for the review

The review will be managed by HIW and consist of:

- Document and data review;
- Interviews with staff involved in the care of Mr K;
- Benchmarking operational practices and protocols relating to the care management and monitoring of Mr K.

Mr K did not wish to be interviewed for the purposes of this review.

HIW will establish a small review team which will have the necessary expertise.

Annex B

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

The annual report produced by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report[27] notes that homicide by mental health patients has fallen substantially since 2006, with the most recent confirmed years (2009/2010) being the lowest since data began to be collected. During 2001-2010 an average of 74 patients were convicted of homicide in the UK, which rises to 115 when symptoms of mental illness is added. These figures appear to be falling.

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 conducted by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

Arrangements for Reviews in Wales

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.

[27] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013

Annex C

Arrangements for the Review of Mental Health Services in respect of Mr K

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.

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 Frank Holloway – Consultant Psychiatrist
Dr Rob Hall – General Practitioner
Mr Martin Thornton- Mental Health Nurse
Mrs Freya Ellard – Lay Reviewer
Mr Rhys Jones – Head of Investigations
Miss Lisa Bresner – Assistant Investigations Manager
Mrs Lianne Willetts- Investigations Officer

The information gathering phase of the review was conducted between April 2012 and January 2013. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the Cardiff and Vale University Health Board. 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 officers. We are grateful to the police for their collaboration

- Reading the case records maintained by the Health Board, Cardiff Mind, and Local Authorities concerning Mr K

- Reading interview notes and written statements provided by staff working with Mr K and Mr Z which was 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. 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.