Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

The provision of mental health care and treatment provided to Mr M by Betsi Cadwaladr University Health Board (BCUHB), prior to committing a homicide in May 2011

November 2014

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Chapter One: Executive Summary

1.1 On 13 May 2011 Mrs H was shopping in an establishment known as Mas Articulos, Mejor Precios on Avenida Juan Carlos in the resort of Los Cristianos, Tenerife. Without warning Mr M approached Mrs H from behind before attacking her with a knife, inflicting significant injuries. Mrs H sadly died following the injuries she sustained.

1.2 On 22 February 2013 a court residing in Santa Cruz, Tenerife found Mr M guilty of murder and sentenced him to detention for psychiatric treatment in a psychiatric hospital in Seville, "*a closed prison psychiatric establishment*" for twenty years.

1.3 Mr M was first referred to Mental Health services provided by Betsi Cadwaladr University Health Board (BCUHB) in June 2010. Mr M had been visiting his aunt who resided in north Wales. Concerned with his strange behaviour, his aunt contacted the police who subsequently applied section 136[1] of the Mental Health Act (1983) on 29 June 2010, allowing for further assessment with mental health services to take place.

1.4 Mr M was subsequently admitted to Ysbyty Glan Clwyd Hospital's Ablett Psychiatric Unit[2] in Bodelwyddan. Over the next five months he was assessed, within the provisions of the Mental Health Act (1983), on three separate occasions at the Ablett Psychiatric Unit. The first two assessments resulted in admission.

[1] If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety. http://www.legislation.gov.uk/ukpga/1983/20/section/136

[2] Situated at Ysbyty Glan Clwyd Hospital in Bodelwyddan, at the time of Mr M's care the Ablett Psychiatric Unit had 44 beds covering the geographic areas of east Conwy, Denbighshire and west Flintshire. In its present state the Ablett Psychiatric Unit has 30 acute beds including 10 old age functional beds. These beds cover east Conwy and Denbighshire and exist alongside community and home treatment services.

1.5 Following Mr M's last period of admission between 12 September and 11 October 2010, he was discharged from mental health services in north Wales. While the precise date of departure is unclear, it is believed that soon after this discharge Mr M left the country for the island of Tenerife, Spain.

1.6 Clinical notes relating to Mr M's discharge on 11 October 2010 stated that "*Given the nature of this admission, Mr M is clearly troubled to some extent (to be willing to feign illness for accommodation)*". The diagnosis made at the second admission, and reason for discharge at that time, was that Mr M was malingering.

1.7 It is clear, with the benefit of hindsight, that by the time Mr M had tragically committed the murder of Mrs H on 13 May 2011, his mental health had deteriorated significantly. During court proceedings in Spain the coroner's report[3] made reference to his diagnosis being that of paranoid schizophrenia.

1.8 The circumstances surrounding Mr M's July and September 2010 admissions to the Ablett Psychiatric Unit would suggest that future admission into hospital may have been likely. While we are not aware of any occasion where Mr M made threats to members of the public, there were several occasions where he did make threats whilst receiving care at Ablett Psychiatric Unit. However, in assessing his risk, none of the health professionals or key workers who had engaged with him during his time in north Wales, ever considered Mr M as having the potential to seriously harm others.

1.9 Had Mr M been diagnosed with a serious mental illness during his time in north Wales there are many factors to consider in determining

[3] Information taken from Legal Medical Institute in Seville, Forensic Psychiatry Service, Regional Ministry of Justice and Public Administration, Government of Andalusia Coroner's Report.

whether any subsequent homicide could have been prevented. These include:

- The elapsed time between discharge from north Wales adult mental health services and the index offence: There was a period of approximately 7 months between the time Mr M was discharged in October 2010 and when the index offence took place in May 2011;
- The nature of any treatment prior to contact with north Wales mental health services: There was no previous history of treatment for mental disorder, therefore information unavailable to call upon with regard to Mr M's clinical and social management and potential risk;
- The nature of any treatment in Spain[3] prior to the index offence: Mr M was admitted to the Short Admission Unit from the Psychiatric Service of Nuestra Senora de la Candelaria Hospital in Tenerife, where he stayed from 18 January 2011 until 4 February 2011. Mr M was discharged with a diagnosis of delirious ideas disorder[3] for which he was treated. Information regarding the precise nature of the treatment Mr M received while in Spain is outside HIW's remit, therefore conclusions cannot be made regarding this; and
- Difficulty in care planning resulting from uncertainty around where Mr M would reside following discharge from hospital in north Wales.

1.10 Despite these factors, there were clear shortcomings relating to the care and treatment that was provided to Mr M during his time with north Wales mental health services. It is difficult to determine how these deficiencies may have directly influenced and led to the tragic events of May 2011. However we do believe that had the issues that we identify within the report been addressed, that the likelihood of such an incident occurring might have been significantly reduced.

Summary of Mr M's condition and care

1.11 Mr M had a normal upbringing, displaying no signs to his family of having any potential mental health issues or tendency towards violence. The family believed Mr M to have bright future prospects. Mr M is reported to have travelled extensively, spending periods of time residing in the Caribbean, Ibiza, Tenerife, Great Britain and Egypt.

1.12 Concerns were first raised about Mr M's mental state by his aunt on 29 June 2010, due to his acting very strangely and telling people that he was going to be famous. This resulted in Police applying Section 136 of the Mental Health Act 1983, with further assessment at Ablett Psychiatric Unit deeming it necessary to admit him under Section 2[4] of the Mental Health Act. Mr M left the unit on 17 July 2010 having spent just under three weeks as an inpatient. At this point Mr M had been diagnosed as hypomanic secondary to illicit substance use.

1.13 Mr M spent the subsequent weeks primarily living in a church annex in Flint before 12 September 2010 when he was observed by Police Officer 2 to be working at a local car wash. Given his previous involvement with Mr M's first admission, Police Officer 2 enquired as to Mr M's wellbeing. When Police Officer 2 enquired as to his wellbeing and whether he needed any help, Mr M replied by saying that he thought he needed help. Police Officer 2 took Mr M to the Ablett Psychiatric Unit and upon arrival was informed that they could not admit him as he had not been brought in formally on a section 136. Police Officer 2 subsequently took Mr M to Ysbyty Glan Clwyd Accident and Emergency (A&E) where he was seen by a Doctor. The Doctor proceeded to interview Mr M, deciding that further psychiatric assessment was required and arranged for his informal admission to the Ablett Psychiatric Unit. After spending 30 days at the Ablett

[4] Section 2 of the MHA 1983 – can be authorised for those persons suffering from a mental disorder of a nature or degree that warrants their detention in hospital for assessment (normally for 28 days) to decide whether compulsory admission is necessary under the MHA, in the interests of their own health or safety, or for the protection of others.

Psychiatric Unit, Mr M was discharged on 11 October 2010 having been assessed as having no serious mental illness. Mr M was given the diagnosis of 'malingering'[5].

1.14 On the evening of 11 October 2010, at 11pm Mr M was brought to the Carrog Ward, Llwyn y Groes Mental Health Unit by North Wales Police on section 136 for assessment. Mr M had been acting strangely outside a local supermarket in Queensferry. Following completion of the assessment, it was felt that he displayed no evidence of mental disorder. Instead it was concluded that he was presenting with religious delusions in order to secure accommodation, as he was homeless at the time. It was decided that as Mr M had been discharged from Ablett Psychiatric Unit earlier that day, there was no need to admit him for further admission and that the original plan should remain, that he attend a 7 day follow-up on 18 October 2010. This was Mr M's last known contact with mental health services in north Wales as he never attended the follow-up appointment.

1.15 There are a number of key points to note from Mr M's admissions to the Ablett Psychiatric Unit:

- He was an individual who appeared to lack insight into his condition.
- He regularly reported symptoms suggestive of a psychotic illness possibly complicated by substance misuse (i.e. dual diagnosis) or of a possible dual diagnosis.
- The eventual diagnosis of malingering precluded him from receiving a range of after care services and community based support, such as could be provided by the Community Mental Health Team.

[5] Malingerer (conscious simulation); includes persons feigning illness with obvious motivation.

1.16 It is clear from the evidence reviewed that several aspects associated with Mr M's care were not delivered to a sufficient standard, in turn influencing the formation of an appropriate diagnosis and satisfactory aftercare arrangements.

1.17 We identified that there was a consistent but limited number of key staff, with limited multi-disciplinary representation, who regularly attended ward rounds. This exposed consultant psychiatrists to a narrow breadth of information when forming clinical judgements regarding Mr M. Further there existed a local culture where a prejudiced view of Mr M was fostered by some staff. An example of such views included how he was deemed to be tactile as a result of being foreign; how he was deemed to be muttering gibberish as a consequence of talking his own language; and how his problems may be drug induced. As a result the review team were concerned as to the level to which some staff understood issues related to equality and diversity.

1.18 We found that there was limited engagement with the family of Mr M. Our review revealed that the engagement that did take place was not of a level that enabled an effective contribution towards establishing a diagnosis. Furthermore this was not of a level that could helpfully inform decisions about current or future care planning arrangements.

1.19 Given his brief time in north Wales and his foreign national status, constructing a background history would have proven difficult. However, in appreciating this difficulty the professionals responsible for Mr M's care and treatment should have ensured a level of engagement with the family that would have assisted in developing a greater understanding of his background and history.

1.20 Our review found that nursing, medical and other clinical notes were recorded in separate sections and were not kept together within patients' paper case record. A lack of integrated notes hampered

effective comparison, decision making and systematic monitoring and review of Mr M's clinical presentation and progress. Integration of clinical notes allows for more fully informed, multi-disciplinary assessment and care planning decisions to be made.

1.21 Alongside the issue of a lack of integrated notes, our review identified that paperwork, whether it be relating to Mental Health Act matters or clinical notes, did not always provide the necessary details. We found Section 136 paperwork was at times incomplete.

1.22 Clinical notes were lacking in detail regarding Mr M's medicine management. It was unclear to the review team as to the rationale behind the medication provided to Mr M, given that the opinion being formed was that Mr M did not have a serious mental illness. Furthermore, there was limited information regarding why Mr M was discharged with no medication, given that prior to the point of Mr M's discharge in October 2010, he was prescribed a high dose of Olanzapine[6].

1.23 Discharge arrangements following both of Mr M's admissions at the Ablett Psychiatric Unit were unsatisfactory. It was unclear as to whether adequate steps had been taken to ensure due regard was given to his wellbeing, for example, ensuring transportation to a safe place.

1.24 From evidence reviewed, there was confusion between the Community Mental Health Team (CMHT) and the Vulnerable Adults and Homelessness Team (VAHT) regarding the nature of the referral of Mr M to VAHT. As a result of no formal written referral being received by VAHT (from the CMHT), there was an initial confusion as to the nature of the support Mr M required and by whom. Despite this confusion, Mr M was seen by the VAHT in order to assess his needs. During the

[6] Antipsychotic preparation

interview, staff became concerned when he became agitated and expressed grandiose ideas. There appeared to be no protocol in place for escalating these concerns. Had these concerns been formally referred to the CMHT there may have been an opportunity for further intervention.

1.25 There was a lack of clarity regarding the status of a phone message made by a staff member at Ty Celyn CMHT to the VAHT team. The confusion lay in whether the phone message made and subsequent phone discussion constituted a formal referral of Mr M from the CMHT to the VAHT team. In spite of concerns observed and raised by the VAHT staff member, Mr M was only provided with information to support his attempts to find accommodation, rather than direct support to secure accommodation. This may have been influenced by Mr M not having any local connection with the Flintshire area, Mr M was also provided with an emergency food bag. There was no further contact between Mr M and the VAHT team.

1.26 Mr M's diagnosis of malingering, which was formulated during his second admission to the Ablett Psychiatric Unit, directly affected subsequent decisions regarding the follow-up and support that Mr M received following discharge. One such effect was that a care co-ordinator was not allocated. This led to Mr M being discharged from services in October 2010 with no support or care being provided, nor any planned, other than the 7 day follow-up meeting.

1.27 The feigning of a serious mental illness is both unusual and rare. We believe that too much emphasis was given to the perceived apparent gain in making a diagnosis, with less emphasis given to regularly reported signs and symptoms that were more suggestive of a psychotic illness or of a possible dual diagnosis. Mr M's diagnosis was not formulated in isolation and it was a decision made and agreed upon by several individuals. A diagnosis of Malingering needs to be supported

by a substantial evidence base. Our review of evidence suggested that this was not the case.

1.28 As a result of this review we have made a number of recommendations for the relevant services which are detailed below. These recommendations aim to ensure improvements within these services and assist with learning from this tragic incident.

Recommendations

1. Betsi Cadwaladr University Health Board to ensure that invitations to attend ward rounds (now known as MDT / Clinical Team meetings) are sent to a wider, multi-disciplinary group of individuals.

2. Betsi Cadwaladr University Health Board to provide an update regarding progress made by the Clinical Programme Group (CPG) in agreeing a standard for timely senior clinician reviews and physical examinations. Compliance with these agreed timescales should be monitored.

3. Betsi Cadwaladr University Health Board should ensure the families of patients are involved in the planning, development and delivery of the patient's care, treatment and discharge planning to the fullest extent possible.

4. Specifically in relation to mental health clinical records, Betsi Cadwaladr University Health Board should ensure that:

   a. Patient clinical records are fully integrated.
   b. Mental health clinical records are of a good standard reflecting professional guidelines for record keeping.
   c. Good practice standards in record keeping are audited, and forms part of a rolling programme of audit and training.

d. Consideration is given to the use of electronic case records as a means of supporting the integration of notes and increased access to them.

5. In relation to patient assessments, Betsi Cadwaladr University Health Board should ensure that:

a. Staff compliance with their standard for timely senior clinician reviews and physical examinations demonstrating continued compliance.
b. In line with their own guidance, all patients are subject to urine drug screening within 2 hours of admission.

6. In relation to training, Betsi Cadwaladr University Health Board should:

a. Provide substance misuse training for staff to ensure that patient care is not compromised on the grounds of potential and actual substance misuse problems.

7. Betsi Cadwaladr University Health Board should promote a more collaborative and evidence based clinical leadership model and support training initiatives for effective and collaborative multi-disciplinary teamwork.

8. Betsi Cadwaladr University Health Board should ensure systems are in place to support the development of clear and measurable standards of care and practice that are evidence based where possible and promote a culture of regular monitoring and clinical audit.

9. In relation to equality and diversity, Betsi Cadwaladr University Health Board should ensure that:

a. Equality and diversity training continues to be rolled out to all new staff and that all staff receive regular refresher training in these issues.

10. In relation to mandatory training and a system of recording training across the Ablett Psychiatric Unit, Betsi Cadwaladr University Health Board should ensure that:

a. Mandatory staff training regarding Mental Capacity Act (2005) and DoLS, is facilitated; and
b. A comprehensive system that is used by all wards should be introduced to ensure consistency across the Ablett Psychiatric Unit and to enable an effective overall audit of training at the unit.

11. In relation to improvements in section 136 staff practice, Betsi Cadwaladr University Health Board should ensure that:

a. Steps are taken to ensure that all staff involved with the application of section 136, complete relevant documentation so that it is comprehensive, legible and reflects requirements of the MHA and MHA 1983 Code of Practice.
b. Steps are taken to inform staff of the designated area, as specified within its own protocol, for carrying out section 136 assessments across their mental health services.
c. Ablett Psychiatric Unit staff ensure that they are clear about the protocol in place for discharge of individuals not deemed to require admission, and that this protocol is adhered to.

12. The health board to ensure that patients on medication and who then take their own leave against medical advice, are appropriately supported in their medication needs at the time of discharge.

13. The health board should ensure that where Consultant Psychiatrists or other clinicians seek to apply a diagnosis of malingering, that it is

supported by a clear and substantial evidence base relating to an individual patient.

14. The health board to provide an update regarding the development of a more systematic approach to clinical supervision and reflective practice groups, or forums for nursing staff.

15. The health board should ensure that risk assessment processes are clear and robust and through appropriate training that all staff possess the appropriate skills to deliver these processes.

16. The health board should ensure that patients who have unresolved diagnostic issues, and who are not registered with a General Practitioner, should receive proactive involvement from the CMHT.

17. In relation to a patient's discharge, Betsi Cadwaladr University Health Board should ensure that:

    a. Care Co-ordinators remain actively involved in a patient's discharge and after care and that all steps taken are detailed clearly within patient documentation.
    b. Ablett Psychiatric Unit staff involved with section 136's to ensure that they are clear of the protocol in place for discharge of individuals not deemed to require admission and that this protocol is adhered to.

18. Betsi Cadwaladr University Health Board and Flintshire County Council should consider implementing a joint protocol addressing how VAHT concerns about the behaviour of an individual discharged from a CMHT, could be escalated back to that CMHT for further consideration.

19. The health board should ensure that patients are aware of the right to access an Independent Mental Health Advocate (IMHA). This is in line

with the Mental Health Act (1983) and the Mental Health (Wales) Measure 2010 which expands the provision of an IMHA to all patients.

Chapter Two: The Evidence

Mr M's Family and Social History

2.1 Mr M was born in Ronse, Bulgaria on the 4 May 1983 and at the time of the incident was 28 years of age. He visited his aunt in Flint, however, it is unclear as to how or when exactly he arrived. When visiting his aunt she was concerned enough about his behaviour to phone the police on 29 June 2010.

Mr M's Criminal History

2.2 With the exception of the index offence. Mr M's only previous known criminal activity was when he was stopped by British Transport Police in Cumbria on 19 July 2010 for travelling on a train without a ticket.

Background to Betsi Cadwaladr University Health Board (BCUHB)

2.3 Betsi Cadwaladr University Health Board is an NHS Wales organisation in north Wales headquartered in Bangor. The Local Health Board (LHB) was created in October 2009 through the merger of the North Wales NHS Trust (previously North East Wales NHS Trust and Conwy & Denbighshire NHS Trust), the North West Wales NHS Trust, and the six LHBs of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham.

2.4 The total catchment area for healthcare services contains a population of approximately 692,000[7]. As the largest health organisation in Wales it provides a full range of primary, community, mental health and acute[8] hospital services across the six principal areas of north Wales (Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham) as well as some parts of mid Wales, Cheshire and Shropshire.

[7] Mid 2013 https://statswales.wales.gov.uk/v/fJA
[8] Where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community.

2.5 The board is responsible for the operation of three district general hospitals, 22 other acute and community hospitals, and a network of over 90 health centres, clinics, community health teams and mental health units. It co-ordinates the work of 121 GP practices and other NHS services provided by north Wales dentists, opticians and pharmacies.

2.6 As of March 2013 the health board employed 13,827 Full Time Equivalent (FTE) staff, with approximately 1,721 FTE staff involved in mental health[9]. There are around 90 medical, 790 FTE qualified nursing staff, 518 FTE health care assistants, 9 support workers and 150 technical FTE staff involved in mental health services. Within each local authority area, social workers and nurses work for integrated Community Mental Health Teams (CMHT) with shared health and social services management arrangements.

Background to Ablett Psychiatric Unit

2.7 Situated at Ysbyty Glan Clywd in Bodelwyddan, at the time of Mr M's care the Ablett Psychiatric Unit had 54 beds covering the geographic areas of east Conwy, Denbighshire and west Flintshire. West Flintshire being the area Mr M resided in at the time. The wards were mixed functional[10] adult and older persons.

2.8 At the time of Mr M's care a small home treatment team[11] linked to the Ablett Psychiatric Unit was responsible for covering the west Flintshire area. A home treatment team linked to the acute unit in Wrexham were responsible for covering the rest of the Flintshire area. The unit in

[9] Information obtained from Stats Wales - https://statswales.wales.gov.uk/v/dOM and BCUHB
[10] Functional disorders, a term not often used in psychiatry which refers to a group of mental disorders where there is no readily apparent brain disease (neurological disorder) and includes a group of psychoses such as schizophrenia and manic – depressive, or Bi Polar disorder and some depressive disorders and neuroses, such as anxiety, or other types of depressive disorders.
[11] Home Treatment Teams help avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes.

Wrexham had 44 adult acute care beds including 8 Psychiatric Intensive Care Unit (PICU).

History of contact with Mental Health Services

Admission One

June 2010

2.09 On 29 June 2010 as a result of his behaviour in terms of acting very strangely and telling people that he was going to be famous, Mr M's aunt contacted the police. Upon arrival at the home of the Aunt, Police Officer 2 subsequently decided to apply section 136 (rev.10/08) of the Mental Health Act (MHA) 1983, taking Mr M to the Ablett Psychiatric Unit, Ysbyty Glan Clwyd Hospital for assessment.

2.10 Upon arrival at the Unit an Adult Mental Health Care Programme Approach (CPA) Initial Assessment was undertaken by Senior House Officer (SHO1). Presenting problems were documented as:

"Bulgarian…Aunt in Flint…Known via Church – loss of weight. Prev used drugs. World travel. Arrived in UK morn (via Gatwick). V. Paranoid…watched in Caribbean. 'Power to save people…God building mansion'. Not known to Mental Health services in North Wales. No medication…mum – breakdown. Aunt (UK) has never known him to be unwell.

Reason for assessment: grandiosity to aunt – called police: s136 MHA. Known to police officer arresting via church – noted weight loss".

2.11 Following assessment, the decision was made by the Approved Mental Health Professional (AMHP 1), General Practitioner 1 and SHO 1 to detain Mr M under section 2 of the MHA. The rationale in support of the recommendation was stated as:

"presents in acute hypomanic state, agitated pressure of speech, grandiose ideas that he is the Messiah and has powers from God to save the world. Believes there are hidden cameras following him. No

insight and does not feel he needs to be in hospital. Needs further assessment in hospital".

2.12 Mr M was admitted to Dinas male ward[12], Ablett Psychiatric Unit on the evening of 29 June 2010 following a recommendation to section. Upon arrival on the Ward Mr M was recorded as being in an acute hypomanic state with grandiose ideas.

2.13 On the 30 June 2010 the nursing report and evaluation recorded that at 3:15pm Mr M:

"Attended ward discussion this afternoon, [Mr M was] very pleasant but pressure of speech evident, over talkative. Staff have tried to explain his rights on the section, does not appear able to understand at this time, to be revisited".

July 2010

2.14 On 1 July 2010 Consultant Psychiatrist 1 recorded Mr M's presentation within the clinical notes as "*slim built Bulgarian gentleman, well dressed and pleasant, good eye contact, co-operative and good rapport established, psychomotor agitation[13], speech loud and pressured, flight of ideas. Presented with grandiose ideas i.e. being Jesus the Messiah and God building him a mansion*".

2.15 Clinical Notes recorded several observations regarding how Mr M presented during this initial interview. These observations included:

"*There is an organised Mafia trying to kill me and others who believe*"

"*He believed that he died 6 weeks ago and that he now would live forever*"

[12] Acute Adult Psychiatric Ward
[13] Psychomotor agitation is a series of unintentional and purposeless motions that stem from mental tension and anxiety of an individual.

"*He feels very happy and on top of the world*"

"*He has a lot of energy and through the will of God, he is able to deal with the numerous ideas that come into his mind*"

"*He said that he is in 'Heaven' and did not believe that he is in Hospital. He said that the reason for this was because he eats 3 times a day and there are beautiful staff to talk to*"

"*No thoughts of harming himself or others*"

"*Claimed to have used crack cocaine, heroin, ecstasy and all sorts of illicit substances and that he has stopped using them after miracle 6 weeks ago this Sunday*"

2.16 Consultant Psychiatrist 1 believed Mr M demonstrated a lack of insight, stating that he didn't believe himself to be unwell or indeed in hospital. However, whilst stating this Mr M did agree to take the medication prescribed to him.

2.17 Mr M's initial presentation, as evidenced within the Nursing Report and Evaluation Notes stated that on the afternoon of 1 July 2010, Mr M attended the ward house meeting and discussion group and was recorded as "*being much more appropriate, [having] good concentration [with] no evidence of thought disorder or pressure of speech. Observations were reviewed to normal in view of [a] more settle[d] presentation*".

2.18 In the evening it was recorded that Mr M's speech was quite rapid, expressing grandiose thoughts, flight of ideas and was prescribed

Olanzapine[14]. Mr M subsequently passed another quiet night and was appropriate with staff.

2.19 On 2 July 2010 Staff Nurse 1 completed an In-patient Risk Management Plan. Information within the identified needs section recorded Mr M as "*on s2 MHA, presenting with pressure of speech, flight of ideas, paranoid delusions were evident on admission. Requires period of assessment*".

2.20 Within the Goals section it stated:

"*Mr M's mood to settle, behaviour to be appropriate. Able to make sensible future plans*".

2.21 The final section of the in-patient risk management plan details planned Interventions. This stated:

"*build therapeutic relationship monitor mood, diet, sleep pattern behaviour…Ascertain Mr M's future plans, currently unclear*".

2.22 On 5 July 2010 Consultant Psychiatrist 1 and Staff Nurse1 undertook a review of Mr M's wellbeing with staff reporting that he was settled on the ward, with no management problems and Urine Detection Screen (UDS) results proving negative for illicit drugs.

2.23 Nursing staff interviewed Mr M found him to be feeling better with thoughts racing. Mr M stated that he was on a mission to save the world and could show them how he would do this if provided with a fork, knife and bread. Mr M was found to have good eye contact and be co-operative. However, he also presented as being slightly agitated together with having pressured speech and a flight of ideas.

[14] Olanzapine is used to relieve the symptoms of schizophrenia and other similar mental health problems. Such symptoms include hearing, seeing, or sensing things that are not real, having mistaken beliefs, and feeling unusually suspicious.

2.24 On 8 July 2010 Staff Nurse1 recorded how they felt that Mr M's pressure of speech[15] had declined. The SHO1 also noted that Mr M had been friendly on the ward and was behaving appropriately. It was also recorded how he had discussed taking drugs and explained how this enabled him to compare right from wrong. SHO1 recorded how Mr M went on to explain how "*he was able to control his drug taking, feeling sad that some people are drug addicts*".

2.25 On 8 July 2010 Consultant Psychiatrist 2, Mr M's Responsible Clinician, recorded Mr M as saying:

"*In hospital because 'they' want to protect him from being killed outside. His mouth is 'golden' so people want to protect him – hospital protecting him*"

2.26 Consultant Psychiatrist 2's Clinical Notes for the ward round of 15 July 2010 stated:

"*Staff consistently reporting that outside of ward round, Mr M is well settled, lacking any pressure of speech, not at all irritable, entirely appropriate even after provoked by other patients. This raises questions as to nature of episode itself (? drugs ? malingering) and to need for him to stay in hospital. Remains on s2 but has shown no need for this to continue*"

2.27 Consultant Psychiatrist 2's Clinical Notes, regarding when he saw Mr M, observed him to be "*much more appropriate. Speech no longer rapid, has to bring up Jesus Christ himself as wanted to make point he is still unwell…no longer displays clear symptoms of hypomania*".

2.28 Subsequently within the Clinical Notes Consultant Psychiatrist 2 stated:

[15] Talking rapidly and almost non-stop. http://www.patient.co.uk/doctor/Mania-and-Hypomania.htm

"*Agreed following plan – discharge date set in two weeks, s2 to be rescinded today. Mr M can have leave as required to make enquiries about uni course. If he wishes to take early discharge ahead of scheduled date he can*"

"*Risk. Despite his objective hypomania in WR [ward round], this has not been seen since his admission by ward staff. Suggests a level of insight into his own actions which would be protective against him harming others/himself as being vulnerable. Low risk therefore evident*"

2.29 Mr M was discharged under section 23[16] of the MHA by Consultant Psychiatrist 2 on the morning of 15 July 2010. Within the evaluation section of the In-Patient Risk Management Plan, was the inclusion of details from Staff Nurse1 that Mr M had been discharged off section 2 and was to stay informally to allow him time to make future plans. The evaluation was further supported at Mr M's Risk Assessment and Management Review which noted:

"*Settled on the ward. Re-graded to informal 15-7-10. No management problem*"

2.30 On 16 July 2010 the Acute Care Ablett Psychiatric Unit Occupational Therapy Report put forward a plan for Mr M to attend occupational therapy and ward based activities in order to provide structure to his day. This started retrospectively on 7 July 2010 and was designated as ongoing.

2.31 On 17 July 2010 Mr M discharged himself from the Ablett Psychiatric Unit against medical advice. Despite his self discharge, a Mental

[16] An order for discharge may be made in respect of a patient by hospital managers, the responsible clinician or by the nearest relative of the patient http://www.legislation.gov.uk/ukpga/1983/20/section/23

Health Inpatient Service Discharge Note signed off by Consultant Psychiatrist 2, stated that Mr M was discharged on 19 July 2010. The document stated that Mr M had "*no clear mental illness*" and that he took discharge against medical advice after the section 2 was rescinded. Mr M left the area and was subsequently confirmed as going to Carlisle when a Homeless Officer contacted Ablett Psychiatric Unit Deputy Nurse Manager 1 to say Mr M had arrived in Carlisle looking for housing. As a consequence of Mr M leaving the area, no follow-up appointment could be arranged. However, when Ablett Psychiatric Unit staff were informed that Mr M had arrived back at his Aunt's on 22 July 2010, arrangements were made for a seven day follow-up to take place on 29 July 2010.

2.32 The Ablett Psychiatric Unit Discharge Summary stated the following:

"*Diagnosis: Hypo manic episode ? secondary to illicit substance use.*
Legal status: Admitted under section 136 which was later changed to a section 2
Medication on discharge: Nil
Follow-up plan: Mr M left the Ablett unit against medical advice on 17 July 2010 and therefore no formal follow-up arrangements were made. Outpatient 7 day follow-up arranged for 29 July at 14:00hrs in Flint"

2.33 Consultant Psychiatrist 2's discharge summary provides details of Mr M's progress, a selection of information from this summary includes:

"*Mr M was with us for a short time. During this time the ward staff began to question his motives*"

"*It also became clear that he slept absolutely fine and questions were raised as to how somebody who was objectively this unwell could have managed to be on a flight all the way from the Caribbean to the UK without alerting the police*"

"*It was questioned as to whether he had other motives for being in hospital"*

"*He has been referred to the Vulnerable Adults Team and it has been explained that we are thinking that his presentation as mentally ill might be more goal orientated than genuine. This is based entirely on having had the ability to monitor him for a couple of weeks on the ward and noting that there were no consistency to these symptoms although as I have mentioned it is striking when you first see this gentleman how he does appear unwell*"

"*One must not take one off assessments to be definitive for the purpose of diagnosis, of course*"

2.34 In regards to Risk, the Discharge Summary stated:

"*As Mr M remained incredibly settled throughout it could be said that the risk he poses to himself or others appears to be low even if he is trying to give the impression that he is insight less about being manic. That said, he is a young man from a foreign country who is currently homeless and as such could be regarded as vulnerable in this respect*"

2.35 On 19th July 2010, as mentioned in 2.34, Deputy Nurse Manager 1 received a phone call from a Homeless Officer in Carlisle describing how Mr M had arrived looking for housing. Mr M presented with pressure of speech with the content being quite religious. Mr M was advised by the Housing Officer to seek help from psychiatric services. There is no record however of Mr M actively seeking help from psychiatric services.

2.36 On 29 July 2010 Mr M's seven day follow up meeting with the CMHT took place. It was noted that he appeared "*flat*", had poor eye contact and that his speech became pressured. He was recorded as saying that he felt worse since leaving hospital but denied any thoughts of self

harm or suicide. The outcome was that he should be referred to housing and discussed at the next team meeting.

2.37 On 29 July 2010 a member of staff from CMHT left a phone message with the Vulnerable Adults and Homelessness Team (VAHT) to inform them that Mr M's file was closed and he had been discharged.

2.38 On 30 July 2010 VAHT social worker 1 contacted Ty Celyn CMHT to discuss the referral of Mr M to VAHT. Social worker 1 expressed how he had concerns regarding Mr M, having interviewed him the previous day and witnessed him express grandiose ideas and agitation. CMHT social worker 2 informed social worker 1 that Mr M had been assessed and subsequently discharged. A discussion was also held as to whether a telephone call, deemed as an informal referral by VAHT, could be accepted, and the need for future referrals to be sent directly to the central duty team for formal allocation.

August 2010

2.39 During the period of August Mr M had been living in a church annex in Flint for approximately 4 - 5 weeks whilst looking for permanent accommodation. Mr M was asked to leave due to a combination of factors, firstly the church had been clear with him that it was only ever to be a short term solution as he looked for permanent accommodation; and secondly the church had grown increasingly concerned by his strange behaviour, such as becoming more verbally abusive and more grandiose in the ideas he expressed.

Admission Two

September 2010

2.40 On 12 September 2010 Mr M was observed to be working at a local car wash in the Flint area. Given his previous involvement with Mr M's first admission, Police Officer 2 enquired as to Mr M's wellbeing. In speaking to Mr M, Police Officer 2 observed that the conversation was

normal with no presentation of grandiose ideas. However, when Police Officer 2 asked Mr M if he wanted any help he replied by saying that yes, he thought he needed help.

2.41 Police Officer 2 then took Mr M to the Ablett Psychiatric Unit and upon arrival was told that they could not admit Mr M as he had not been brought in on a section 136. Police Officer 2 subsequently took Mr M to Ysbyty Glan Clwyd Accident and Emergency (A&E) where he was seen by a Doctor. The Doctor proceeded to question Mr M and decided following this that Mr M required further assessment and arranged for his informal admission to the Ablett Psychiatric Unit.

2.42 Admission paperwork for 12 September 2010 recorded that Mr M gave appropriate responses, only briefly mentioning his religious beliefs. Mr M was deemed to be co-operative and pleasant throughout his admission interview.

2.43 On 14 September 2010 nursing report and evaluation notes recorded that Mr M had a settled evening on the ward and on approach was pleasant with staff. However, he was observed to be talking to himself when staff passed his room during the early hours. Later that day, time was spent completing the Level 2 risk assessment by Consultant Psychiatrist 2 in which Mr M was deemed as appropriately focused with only a brief mention of 'higher powers'.

2.44 On 15 September 2010 ward notes recorded that Mr M had spent a settled evening on the ward mostly watching television. Mr M also took time to speak to the DHS[17] regarding an outstanding cheque. When told that he would not be receiving the cheque he was overheard stating "*I will have to murder someone to get deported back to Bulgaria*". When challenged about this statement, Mr M said that he was angry and that he would not harm anyone on the ward as they

[17] The review team believe this to be a reference to Department for Work and Pensions (DWP) despite being recorded within nursing report and evaluation notes as DHS

were just doing their job. As a result of pressure with bed numbers, Tegid Male ward was closed and Mr M was transferred to Tegid Elderly ward.

2.45 On the 16 September 2010 ward notes recorded that when Mr M was aware he was being observed by ward staff he appeared to be demonstrating illness. However, when observed discreetly Mr M showed no further signs of this. During the ward round Mr M stated that he was still hearing voices from priests and had religious views. He also stated that he was being bullied and was receiving racist comments on the ward so spent most of the day around Tegid Male ward.

2.46 On 17 September 2010 whilst on Tegid Elderly ward it was noted that Mr M was talking to himself in his native tongue when in public areas but not observed to be doing this whilst watching television alone. Mr M retired to bed at midnight but woke up at 2:15 am requesting night sedation.

2.47 On 18 September 2010 ward notes recorded that Mr M was proving to be very elusive, spending most of his time on the Dinas Male ward and in the corridors. He exhibited bizarre behaviour such as dancing and singing whilst pulling faces. However, when spoken to he was warm and appropriate, although communication was not always straight forward. He would continually ask what words meant throughout a conversation.

2.48 On 19 September 2010 Mr M accepted the offer of 1:1 time with the ward staff. Throughout the session, records show that Mr M moved backwards and forwards on his wheeled chair, describing his mood and feelings as "*normal"*. Mr M stated that he had been brought into hospital because he had "*no bed and no food*" and had no other plans other than "*to await death*". He appeared angry and upset at times but denied this stating "*I'm normal*". He also muttered angrily about religion

and politics stating how they had ruined his life. On one occasion, when asked about his family, he turned to his side and said "*she wants to know about your family*". Mr M stated that if he had the money he would go to Tenerife for the warm weather, but in spite of being homeless and having no money, he had no worries or problems, stating that "*I take my life as I always have for 27 years, I will just do everything*".

2.49 Later that day, Mr M was observed sitting in a chair talking to himself on a couple of occasions. He also entered the ward office in "*highly expressed emotion*" wanting to telephone the BBC regarding the Pope and Catholics on the television, repeatedly stating that "*they need to leave him alone. He has had enough*". Once he had left the office, he isolated himself in the lounge area on the ward, still talking with pressured speech.

2.50 Staff persuaded Mr M to take a walk with them around the hospital grounds. During this walk, Mr M explained that when he was in the Caribbean he was using "*crack*". He stated that he was being watched by the American and Australian Catholics who had put up a camera and microphone to watch him as "*they knew I was the Messiah*". Mr M went on to explain that he believed that they had convinced the FBI that he was a terrorist so that they could obtain their help in watching him, he knew this because whenever he did something wrong he did not get arrested or sent to prison. He stated that they could not touch him because of who he was. He went on to explain how he heard up to five voices, two of which he said were familiar and that he felt watched all of the time: "*I can't go to the toilet, I can't sleep. They are there all the time. They are getting on my nerves*". Mr M said that he was desperate to make them stop as he just wanted to feel alone. He then spent the rest of the evening in the lounge but was observed to be

muttering to himself. He also complained that he was unable to sleep and was subsequently prescribed Zopiclone[18].

2.51 On 20 September 2010 ward notes recorded that Mr M had been observed to be talking to himself in his native tongue on occasion but was polite and pleasant on interaction.

2.52 On 21 September 2010 ward notes recorded that Mr M was appropriate and warm throughout the day, although he was observed to be talking to himself on occasion. He was recorded as spending time with staff where his conversation consisted of a religious content and how he would laugh inappropriately throughout. He stated that he did not feel that he had a mental illness and did not require any medication. Furthermore he believed he was only there because he had no other accommodation.

2.53 During the night Mr M was very unsettled and at one point stood on his chair in the lounge area and preached about Jesus and his own beliefs about being a disciple. Upon request, Mr M got off the chair but continued to preach for a further 30 minutes, before finally going to his room.

2.54 On 22 September 2010 Mr M was very preoccupied by the paparazzi and his speech was pressured. He spoke out loud to 'Zion' (with who he was always in contact with 'through the Lord'). Mr M was observed to be loud in the lounge area throughout the evening and had to be asked to extinguish a cigarette when found smoking in the foyer. He later denied that he had been smoking.

2.55 On 23 September 2010 during Mr M's ward review it was recorded that he was still continuing to hear voices (over 100+) of which he was only

[18] Zopiclone is a medicine which is used to treat sleeping problems. http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Insomnia&medicine=zopiclone&preparation Zopiclone%203.75mg%20tablets

able to recognise some. Mr M stated that he recognised 5 voices that he understood, not by name but by their voices. He also stated that the voices "*know what I'm thinking. They engage with me in the spirit of the Lord. They are part of the people of Zion"*. Mr M did not remember a time when he wasn't like this, "*I hear them everywhere, even when I sleep"*. Mr M's care plan recorded that he was to continue with no medication and that a review by a consultant should be done as soon as possible. Records indicate that Mr M was seen by a consultant 4 days later on 27 September 2010.

2.56 During the evening whilst on the ward it was observed that Mr M was talking to himself on numerous occasions, and at times was very animated.

2.57 On 25 September 2010 ward notes recorded that when staff were around him Mr M had been shouting and talking to himself loudly. Nursing staff recorded "*none of us are convinced it is genuine as it only happens when staff are present""*. Throughout the evening Mr M got progressively worse, becoming verbally aggressive to staff when they asked him not to shout.

2.58 On the morning of 26 September 2010 ward notes record that Mr M telephoned his aunt and was overheard asking for money to pay for a flight to Tenerife. Later that afternoon, Mr M requested to see a doctor the following day as he wanted to be discharged with the intention of returning to Spain. Mr M continued to talk to himself in Bulgarian, however, this was seen as selective and only appeared to happen in the presence of staff. Mr M's behaviour was recorded as "*a little bizarre*" during the evening as he continued to talk to himself in Bulgarian.

2.59 On 27 September 2010 Mr M was seen by Consultant Psychiatrist 5 and an SHO (following Mr M's request the previous day to see a doctor). Consultant Psychiatrist 5 recorded that following a review of

the nursing notes the opinion regarding Mr M was mixed. Consultant Psychiatrist 5 recorded that there were a range of descriptions of bizarre behaviour and noted their views regarding diagnosis. The consultant recorded:

"*My view is that during a 30 minute conversation, he was mentally thought disordered. There was evidence of irritability. His mood…(illegible) elated. His thinking …(illegible) and had a grandiose….(illegible) religious content. He complained of hearing voices. His interaction was …(illegible) vague. He complained of being monitored by outside agency*".

2.60 Consultant Psychiatrist 5 recorded that Mr M's presentation during the interview was consistent with an acute episode of psychosis perhaps with a mood component. This was also reflected in nursing notes for the proceeding week which appeared consistent with psychosis. On conclusion, Consultant Psychiatrist 5 recorded that the idea of Mr M leaving hospital that day would more than likely result in detention on a section 136 within the day. Therefore, given the uncertainty about Mr M's diagnosis it was suggested that a period of assessment on a section 2 was needed.

2.61 The SHO recorded that Mr M wanted to leave and be deported. The SHO recorded that Mr M thought he was the Messiah, was listening to Zion (although did not elaborate who Zion was) who was reading his mind and that he thought he was being watched by cameras. Mr M also denied any admissions to other psychiatric units in the past.

2.62 At 11:20am on 27 September 2010 an application[19] was made under section 5(2) of the MHA for Mr M's formal admission to hospital with a view to an order for assessment. The reasons recorded were:

[19] Mental Health Act 1983 section 5(2) – Form HO12 – a legally required form, used to detail a report on a hospital in-patient considered to require an emergency holding order. This is used until an application for a section 2 is made and can only be completed by the registered

"*He present[s] as psychotic he wants to leave. In my view inpatient assessment is needed to meet his needs".*

2.63 Consultant Psychiatrist 5 completed the necessary medical recommendation[20] for admission for assessment, recording that*:*

"He [Mr M] presents with existence of acute psychosis on interview. On the ward his presentation is….. with acute psychosis. The diagnosis and treatment plan is …..In my view he requires inpatient …… which he declines'"

2.64 On the morning of the 28 September 2010 Mr M refused to take Olanzapine complaining that it made him feel sick. Mr M was then recorded as restless for most of the day with occasional aggressive behaviour. Prior to lunch Mr M broke the telephone by slamming it down and running out of the unit via the main entrance, later returning and appearing much calmer. Mr M was asked by the staff what was bothering him but he provided them with no details.

2.65 At approximately 4:30pm a loud noise was heard by staff from one of the toilets. It transpired that Mr M had used his hand to hit the toilet door with force. His hand was examined by the duty doctor who noted swelling. Mr M appeared to be in a lot of pain so was prescribed analgesia and Lorazepam 1mg.

2.66 Mr M was assessed by Consultant Psychiatrist 3 who completed an application[21] under part 2 of the MHA for Mr M's admission to hospital for assessment. The reasons recorded as:

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medical practitioner, or approved clinician in charge of the treatment of the patient (or the nominated person in his/her absence).

[20] Mental Health Act 1983 section 2- Form HO4 – A legally required form to apply section 2 – medical recommendation for admission for assessment and outlines reasons why a patient should be legally detained and mist be completed by a section 12 approved medical practitioner and an approved mental health professional (AMHP) usually a social worker.

[21] Mental Health Act 1983 section 5(2) – report on hospital in-patient

"Mr M's behaviour has escalated throughout the day, he is screaming, disengaging with staff, trashed the phone and shouting and abusive".

2.67 Consultant Psychiatrist 3 recorded that a section 5(2) was in place and had been sent to the MHA co-ordinator. Mr M was recommended for section 2, PRN[22] Lorazepam and painkillers as per the SHO. A further recommendation was made for Mr M to be transferred to Brynmor, extra care ward. The reasons for the transfer being:

"*due to the risks posed of being on an open ward*".

"*Deterioration in his [Mr M] mental state. Responding loudly to his thoughts. Punched a door and damaged his hand, assessed and detained under section 2. Appears preoccupied with his thoughts causing him various levels of distress. He tends to respond to his thoughts in his native tongue."*

2.68 The goal was recorded as:

"To provide a safe environment for Mr M to assess his mental state to observe for signs of improvements which will allow for transfer to an open ward."

2.69 An application was made to hospital managers for the admission of Mr M under section 2 of the MHA. Following this application, an Approved Mental Health Professional Assessment report was completed by the AMHP2 and General Practitioner 1, approved under section 12(2) of the MHA.

2.70 As part of the assessment AMHP 2 spoke with Mr M's aunt, with details of this conversation recorded as follows:

[22] As required

"*he has told the local pastor that he is going to kill someone'*. *[AMHP 2] informed [Aunt] that today Mr M has possibly fractured his hand by banging on the walls/ doors, she said that he had done something similar at her house last week."*

2.71 AMHP 2's assessment also recorded that the recommending doctor, General Practitioner 1, had assessed Mr M twice previously, the most recent taking place on 28 September 2010. General Practitioner 1 did not agree that Mr M needed detention under section 2 as he had agreed he would stay in hospital. General Practitioner 1 felt that Mr M's symptoms may have been "*somewhat fake"*, although felt that Mr M had now significantly deteriorated and that the behaviours Mr M were now expressing were as a result of "*true psychosis"*.

2.72 Nursing staff reported that Mr M had become extremely agitated about leaving the hospital and as a result had injured his hand by thumping the walls/ doors. Consultant Psychiatrist 3 expressed the belief that this was due to psychosis and not bad temper.

2.73 During an interview with Mr M, AMHP 2 recorded that Mr M's recent history was unclear. During the interview, Mr M expressed that he was the son of God and talked about needing to get out of hospital to "*do his work"* i.e. as the son of God. Mr M did not accept that the thoughts he was having were delusional. Throughout the interview it was recorded that Mr M would turn to his side addressing his "*Zions*" entering into religious dialogue with those he appeared to believe were standing there.

2.74 It was felt that "*without a further period of assessment or treatment...then things were unlikely to change for him*". It was detailed how Mr M's current mental health problems needed to be investigated further and then treated appropriately. Furthermore, Mr M makes himself "*very vulnerable by his behaviour and his beliefs, particularly as*

he is homeless and would be wandering the streets". Mr M had previously shown aggressive behaviour, his aunt having seen this, therefore there was a possibility that others could be injured by such behaviour.

2.75 On 29 September 2010 the Mental Health Act Administrator sent Mr M's aunt a letter detailing that Mr M was now detained under section 2 of the MHA. Enclosed with the letter was a leaflet titled 'Your Nearest Relative' which outlines her rights in relation to the particular section of the Act under which Mr M was detained.

2.76 Later that day Mr M was recorded as having had a long period of what appeared to be responding to his thoughts, occurring in various parts of the ward, both in company of staff and when alone, and which appeared to be in his native tongue.

2.77 Ward notes go on to record that Mr M was initially quiet and settled on the ward, however, he became loud, shouting in his native tongue as the day went on. He then put a Christian radio channel on the television and described himself as an Evangelical High Priest.

2.78 During the ward round on 30 September 2010 Mr M was seen by the junior doctor. The junior doctor's clinical notes record that Mr M was on a locked ward (Brynmor) and was due for an operation on his hand the following day. His hand was still in plaster and his pain was controlled. He was recorded as quieter and less agitated, expressed little eye contact and some inappropriate laughter. However, Mr M still thought he was the Messiah, although for the first time he was willing to accept other explanations and that he might not be the Messiah. Mr M was recorded as now only hearing one woman's voice which was unclear. The junior doctor went on to detail that his impression of Mr M was that he was more settled and that there was a hint of insight. Mr M's Olanzapine medication was also increased to 20mg daily.

2.79 The ward notes also recorded that Mr M was compliant with his medication but talked to himself for the most part of the day.

October 2010

2.80 On 1 October 2010 Mr M had the operation on his hand, making a good recovery and returned to the ward where he slept. Mr M was recorded as continuing to speak "*gibberish*" in a foreign language and broken English and still maintained that he was the son of God.

2.81 On 3 October 2010 Mr M was recorded within the nursing report to have been residing in the longue area of the ward for most of the day listening to music. Occasionally Mr M spoke out loud to himself (to unseen stimulus). However, he engaged in appropriate conversation with the staff, profusely thanking them for returning his clothes from the laundry.

2.82 On 4 October 2010 the nursing notes record that Mr M was initially pleasant, but that by 10:00am he was shouting continually and would not listen to staff. He then threatened to pour boiling hot water over a female member of staff if the doctor did not come to see him.

2.83 Mr M was taken to an interview room where he continued to shout for a further 30 minutes. He stated that cameras were filming him and that he was the "*second coming*" which he believed had been confirmed by a Catholic Priest from the USA some 6 months previous. Consultant Psychiatrist 2 attended the interview and the discussion continued until nursing staff said they would Google the Catholic Priest on the Internet. Mr M was pleased that staff were willing to do this and requested an update on their findings. The nursing staff recorded "*it may be that he did this for effect and attention*".

2.84 In the evening Mr M was recorded as being more settled and apologised to staff for his earlier behaviour. However, nursing report

notes detail how he did have a couple of further verbal outbursts but these were not directed at anyone in particular.

2.85 Mr M had also been seen by Consultant Psychiatrist 2 during the ward round on 4 October 2010. Consultant Psychiatrist 2 recorded how Mr M had moved to Brynmor Ward and that the threats he had made to staff were purely to get attention. It was detailed how Mr M could be calmed down easily by talking calmly and clearly to him. Furthermore, Mr M, when attempting to cause harm, broke his own hand rather than targeting others.

2.86 On 5 October 2010 during protected 1:1 with a nurse, Mr M said that when he leaves the Ablett Psychiatric unit he was planning on travelling to Holland but was unable to disclose how he would fund this. Mr M was seen to talk to himself on occasion but not as loudly or for as long as the previous day. Mr M was prescribed Diazepam[23] to see if it had any effect, no benefit was evidenced.

2.87 During the evening Nursing Report notes detail how Mr M began shouting loudly in the courtyard and "*ripped up his passport*", demanding that the Police be called as well as the BBC. He then returned to the ward but was prevented from entering the kitchen whilst he was exhibiting this behaviour. Mr M stated that "*I don't need the kettle to hurt people, I can break you just like that*". He then walked away and continued to shout in the courtyard.

2.88 On 6 October 2010 Nursing Report notes record that Mr M had episodes of talking and shouting throughout the day but appeared to be able to control it. Staff did not attend to him during these episodes and the shouting eventually appeared to stop. It was recorded that "*he shouts in his native tongue but changes to English when in the*

[23] Diazepam is a medicine known as a benzodiazepine which is used in a number of conditions - an example is treatment of anxiety.
http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Anxiety&medicine=diazepam

company of staff". Late that evening, when outside having a cigarette Mr M jumped over the courtyard fence. Mr M was found and returned to the ward approximately half an hour later. When questioned on why he did this he stated "*well, the opportunity was there so I took it"*.

2.89 On 7 October 2010 Mr M was seen by Consultant Psychiatrist 2 during the ward round. Ward notes detail that he was interviewed at length, where he talked about being the son of God. He went on to say how he had been drawn to the UK to preach. Prior to this he stated that he had been a star timeshare salesman and was capable of speaking several languages. However, when Mr was presented with any evidence that brought doubt upon his assertions he would tilt his head to one side and state that he was talking to Zion. The ward notes go on to state that Mr M became more settled during his interview with Consultant Psychiatrist 2 and that he began to talk more rationally.

2.90 Consultant Psychiatrist 2 recorded that Mr M was still on section 2 and that "*they needed to work with Mr M towards an effective way to end it. The ward observations (which continued to split staff as to whether he was being genuine or not) were useful*".

2.91 Consultant Psychiatrist 2's ward round notes went on to state "*that they needed to find out from the Home Office how they could go about deporting Mr M as that might be the quickest way to achieve what they are so far failing to do, get a clear diagnosis with the benefit of, a corroborative history and allow for cultural factors to be stripped out*".

2.92 On conclusion, Consultant Psychiatrist 2 recorded:

"*Sustained grandiose ideation: With no collaborative history, cannot be certain as to how long this has gone on, but when discharged last time he did nothing more problematic than find a job at a local car wash and try [to] find accommodation.*

Irritability: This is extremely limited. He calms down quickly when asked. No-one feels threatened. I would suggest this is because he has not harmed anyone. Made threats only when he was later admitted, he wanted attention and ultimately because unwanted attention from the police i.e. potential custodial sentence does not serve his purpose- stops short of harming anyone because he wants our help.

Poorly defended and vague hallucinations: These seem frankly deceitful and certainly give evidence that he is malingering."

2.93 On 8 October 2010 Nursing Report notes detail how Mr M spent most of his morning in the lounge area hiding under a blanket. He was overheard muttering to himself in his native tongue. After lunch, Mr M became agitated and requested that he telephone the Bulgarian Embassy as "*he wanted out of here now"*. He "*ranted*" about the camera which had followed him for the last 6 months and wanted to call the BBC to report that the Pope and the Church had ruined his life. Mr M then demanded that he be let out as it was his human right. Staff attempted to explain his rights under the MHA but he shouted and swore at them saying that he wanted to kill himself. He was then offered PRN medication but declined stating "*he hadn't taken any of the previous Diazepam tablets instead saving them until he had 3, which he took that morning*". Mr M is then recorded as stating "*that they had not done anything*".

2.94 On 9 October 2010 Nursing Report notes record that Mr M spent a settled day washing his clothes. During the evening he began shouting at himself but soon settled.

2.95 On 10 October 2010 Mr M completed an appeal letter to the managers of Ablett Psychiatric Unit exercising his rights under the MHA to review his detention. Nursing Report notes also record that he became unsettled once he believed that Home Office immigration officials were

looking into his stay. This prompted Mr M to request a call to the Bulgarian Embassy, however, no further details were provided on this. Mr M calmed down by the evening and spent his time listening to music.

2.96 On 11 October 2010 Mr M was seen by the Consultant Psychiatrist 2 during the ward round. Ward round notes recorded that Mr M stated quite clearly that he had no interest in returning to Bulgaria because "*state support for the homeless is non-existent and the temperature can be very cold*". He went on to state that "*hospitals there were not particularly hospitable; he knew this as he had visited friends in the past*".

2.97 Ward round notes went on to state that Mr M insisted that he was allowed to leave as he wanted to go back to Flint to look for work at the local car wash for 2 weeks to enable him to gather enough "*money to go back to Tenerife and work as a PA or a timeshare salesman*".

2.98 On 11 October 2010 at 11:20am Mr M was discharged[24] having been assessed as having no serious mental illness and with the diagnosis of malingering. The discharge noted that in terms of risk that Mr M "*remains NFA [25] at present but states he intends to return to the Flint area to find work with a plan to accumulate money to go to Tenerife"*.

2.99 A seven day follow up appointment was given to Mr M for Monday 18 October 2010 at 1:30pm at Ty Celyn. He was also given the appointment letter for an appointment at the fracture clinic in November and a travel warrant to allow him to get to Rhyl. Mr M left the unit at approximately 12:30pm.

[24] 'Form HO 17: Mental Health Act 1983 Section 23- discharge by the responsible clinician or the hospital managers'
[25] No Fixed Abode (NFA) - Homeless

2.100 On the evening of 11 October 2010 Mr M was brought to the Carrog Ward, Llwyn y Groes Mental Health Unit[26] at 11pm by North Wales Police on section 136 for assessment as he was acting strangely outside Asda Supermarket, Queensferry. Mr M was talking about religion claiming he was the Messiah and the brother of Zion.

2.101 Consultant Psychiatrist 6 conducted the assessment at Llwyn y Groes Mental Health Unit, recording within relevant background history that he had been discharged from the Ablett Psychiatric unit that day following a period of admission, during which time he was placed on a section 5(2) followed by a section 2, in which the section 2 was re-graded to informal and he was discharged. He was also known to Consultant Psychiatrist 2 who felt that he displayed no evidence of mental illness and that instead he presented with religious delusions in order to get accommodation as he was homeless.

2.102 Within the Mental State Examination section of the assessment it was recorded that Mr M displayed poor eye contact but his rapport was okay. Although Bulgarian he spoke very good English and was able to focus on specific questions and gave appropriate answers. He also denied thoughts of self harm, suicide or harm to others and did not believe that he was unwell.

2.103 Clinical impression was recorded as: "*discharge from Ablett today. No evidence of mental illness. He says he wants somewhere to stay and some food. Some ? thought disorder but easy to direct back to topic of conversation*."

2.104 Following assessment, the management plan stated "*Discussed with Consultant on call – Consultant Psychiatrist 5: Discharge. Continue with plan for 7 day follow-up in Ty Celyn on 18 October. Seen with Duty*

[26] Queensferry is approximately 12 miles from the Carrog Ward, Llwyn y Groes Mental Health unit. The Ablett Psychiatric Unit, where Mr M was a patient previously is approximately 24 miles away from Queensferry.

Nurse and AMHP[3] *who were both in agreement with above plan*." Mr M never attended the follow-up appointment and is believed to have left for Tenerife a couple of weeks post discharge. Subsequently Mr M had no further communication with Mental Health Services in north Wales.

2.105 The terms of reference for this review limits HIW to investigate the care and support provided to Mr M during his time in north Wales. However, HIW's understanding is that prior to the index offence Mr M was admitted to the Short Admission Unit at the Psychiatric Service of Nuestra Senora de la Candelaria Hospital in Tenerife, where he stayed from 18 January 2011 until 4 February 2011. Mr M had been admitted by court order due to a deterioration of his mental health alongside behavioural disorder. Mr M was discharged after approximately two weeks with a diagnosis of delirious ideas disorder[27]. He was prescribed the treatment and contact with a social worker made.

2.106 On 13 May 2011 Mrs H was shopping at the establishment known as Mas Articulos, Mejor Precios on Avenida Juan Carlos in the resort of Los Cristianos, Tenerife. Without warning Mr M approached Mrs H from behind before suddenly attacking her with a knife, inflicting significant injuries. Mrs H sadly died from the injuries she sustained.

2.107 Healthcare Inspectorate Wales have undertaken this review in order to review the mental healthcare and treatment provided by Betsi Cadwaladr University Health Board during Mr M's time in north Wales.

[27] Information taken from Legal Medical Institute in Seville, Forensic Psychiatry Service, Regional Ministry of Justice and Public Administration, Government of Andalusia Coroner's Report.

Chapter Three: Findings

3.1 In investigating the care and support provided to Mr M during his time in north Wales, prior to committing a homicide in May 2011, the review team has considered the periods of engagement that Mr M had with statutory services. These findings are described within the following sections:

- Clinical Care
  - Ward Rounds
  - Clinical Leadership / Multi-Disciplinary Teamwork (MDT)
  - Engagement with the Family
  - Clinical Notes and Records
  - Physical Health Assessment

- Staff and Culture
  - Training

- Use of the Mental Health Act (MHA) 1983
  - Use of Mental Health Act for Mr M
  - Section 136

- Medication
  - Compliance with medication prescribed
  - Treatment response to medication prescribed
  - Medicine Management and Prescribing Rationale

- Diagnosis
  - Background
  - Definition of Diagnosis
  - Evidence for malingering diagnosis
  - Alternative Diagnosis
  - Risk Assessment
  - Diagnosis: Our View

- Discharge and After Care Planning
  - Medication ceased on discharge
  - Allocation of a Community Care Co-ordinator
  - Health of the Nation Outcome Scales (HoNOS)
  - Vulnerable Adults and Homeless Team (VAHT) / Community Mental Health Team (CMHT)
  - Communication

Clinical Care

Ward Rounds

3.2 During our fieldwork it was identified that the number of clinical staff participating in ward rounds was lower during the time of Mr M's care than current levels. The Ablett Psychiatric Unit was undergoing a significant period of change with the closure of Alyn ward, the forthcoming closure of Brynmor ward (extra care ward) and the development of a fully functioning Home Treatment Team. In addition, one ward was being changed to become a 10 bed functional elderly ward.

3.3 At the time of Mr M's care there was also a consistent but limited number of key staff, with limited multi-disciplinary representation, who regularly attended ward rounds[28] A Senior Nurse routinely attended ward rounds, contributing to discussions about patients. The Senior Nurse had a responsibility to ensure that clinical information relevant to a patient's presentation, their care and treatment, was shared with ward consultants and other team members attending the ward round. Furthermore, it was also crucial that they ensure the sharing of the views and opinions of other ward staff.

[28] Ward rounds are now called MDT / Clinical meetings, but for the purpose of this report as referring to a period of time in 2010 when Mr M received care, we will continue to use the term Ward Rounds.

3.4 Our fieldwork identified the apparent difficulties that arose for those staff outside this small, regular group of ward round attendees, in terms of them having confidence that their views and opinions were being conveyed to the relevant Consultant Psychiatrist and other members of the Multi Disciplinary Team (MDT). The review team heard of such difficulties during staff interviews, when it was explained how during morning clinical meetings staff would discuss Mr M and the suggestion of him 'acting' was raised. However, when a differing view was expressed by the nursing staff caring for him in terms of concerns that Mr M was actually clinically unwell, it was felt that these concerns were not listened to.

3.5 Ward rounds encompassing a small number of regular attendees, with limited multi-disciplinary representation of differing opinions, led to clinical judgements being made with incomplete information from the professional views and opinions of a small number of people. Collaborative, or alternative views relevant to a patient's presentation, their care, treatment and diagnosis, were not encouraged. Our fieldwork indicated the existence of a local ward environment that was not conducive to, and did not support, alternative views being expressed or challenged when appropriate.

3.6 Ward rounds conducted in this way could have exposed Consultant Psychiatrists to minimal feedback and narrowed the breadth of information made available to them regarding Mr M when forming clinical judgements.

Clinical Leadership / Multi-Disciplinary Teamwork (MDT)

3.7 At the time of Mr M's care, the ward MDT consisted of the deputy nurse manager, the ward Consultant and sometimes a Social Worker[29]. This small group regularly attended clinical ward rounds, shared information and made judgements and decisions about patient care.

[29] Both Consultant and Social Worker were part of the CMHT

3.8 At the time there were limited opportunities for Consultant Psychiatrists to participate in discussions about complex cases and other aspects of clinical working. The review team were informed that scheduled weekly training for Consultant Psychiatrists were in place. However, had more opportunities existed that promoted discussion about complex cases, a wider professional perspective and supportive environment would have been enabled.

Engagement with the Family

3.9 The review team found that there was limited evidence to suggest that engagement with the family of Mr M was at a level sufficient to develop a greater understanding of his background and history. Neither was engagement with the family to a level that enabled discussion and effective contribution towards establishing a diagnosis, or informed key decisions about current or future care planning arrangements, and their reviews.

3.10 Regarding Mr M's first admission there is a page of notes contained within the Nursing Report and Evaluation that provides limited detail about Mr M's background and family history. Within his Adult Mental Health CPA Initial Assessment dated 29 June 2010, there is only a cursory background family history depicted in the form of a diagram.

3.11 During his second admission, evidence suggests minimal engagement with the family of Mr M. Evidence from our fieldwork found prejudiced comments made concerning Mr M. Had liaison with the family been better, it could have helped with assessment of Mr M and possibly countered some of the prejudiced cultural views expressed by staff.

3.12 In constructing a background history for Mr M it is acknowledged that given both his status as a foreign national and brief time in north Wales, difficulties would have been encountered. However, given Mr M's short residence in Wales and lack of available medical history, family contact should have been more firmly established and

maintained. This is supported by Mental Health (Wales) Measure 2010 Code of Practice[30] which states that "*Patients and their carers should be involved in the planning, development and delivery of the patient's care and treatment to the fullest extent possible*."

Clinical Notes and Records

3.13 The review team identified poor quality and fragmented record keeping as significant areas of concern in relation to Mr M's case notes.

3.14 Following the narrative and care pathway for Mr M was very difficult, for example notes were in separate sections in the following way: Nursing Notes, Clinical Notes, Multi Disciplinary Team (MDT) Notes, Nursing Report and Evaluation Notes and In-Patient Clinical Care Pathway Notes. In addition, notes were not always kept together. Consequently much effort was required in determining the pathway of care planned and delivered to Mr M, highlighting the difficulties encountered by staff involved with Mr M's care at the time. This lack of integration of notes prevented a fully informed and multi-disciplinary assessment and care planning process, hampered effective comparison and decision making, hindered staff perceptions of the patient and adversely influenced effective and systematic monitoring and review of progress. An example of how difficult it was to follow the narrative of care given from clinical notes, was demonstrated by one staff member we interviewed informing us that they used a pen with different coloured ink in order to easily distinguish their own notes from that of other staff.

3.15 The lack of access to notes detailing a clear narrative of care placed an over reliance upon a handful of staff conducting ward rounds. This meant staff were forming opinions when not always fully aware of all prior nurse observations. Another example of this is that we were

[30] Mental Health (Wales) Measure 2010 Code of Practice http://www.assemblywales.org/bus-home/bus-business-fourth-assembly-laid-docs/gen-ld8880-e.pdf?langoption=3&ttl=GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20%28Wales%29%20Measure%202010

informed that a member of staff tended not to read nursing notes due to their not being integrated with Consultant notes, instead relying upon senior nurse feedback at ward rounds.

3.16 Use of integrated multi-disciplinary notes exposes a wider group of staff to the observations and judgements made by other members of a multi-disciplinary / multi-agency team. This contributes towards a more supportive and challenging environment encouraging wider professional opinion, greater objectivity, and a more fully informed and complete risk assessment process. Had this been the case during Mr M's care it could have influenced in a positive way Mr M's complex needs being better identified and managed.

3.17 Issues were identified with the quality and standard of the record keeping. The review team noted that several entries were made with no named individuals identified, signatures were sometimes absent when individuals were named, a number of note entries were undated and some note entries were illegible. The quality and integration of records at the time of Mr M's care was neither conducive nor supportive to effective care management or multi-disciplinary teamwork.

3.18 Issues relating to a lack of integrated notes and limited access to a breadth of nurse opinions regarding Mr M, could have been counteracted by effective monitoring and audit procedures. This is an area highlighted within the Mental Health (Wales) Measure 2010 Code of practice, specifically in terms of monitoring and review. Within chapter six of the Code of Practice it states the importance of monitoring and review:

"Monitoring and responding to [such] changes is fundamental to the delivery of effective care and treatment, and is also needed to ensure that reviews take place when required. In order to ensure that care and treatment provision remains optimal to the relevant patient's

*recovery, **regular monitoring** of the plan and the delivery of services is required"*.

The chapter goes on to say:

"*The review should consider any monitoring information which has been gathered **since** the care and treatment plan was first established, or since its revision at a previous review*."

3.19 It is important for staff to ensure that they apply the standards expected of them by their professional bodies.[31] [32] Following these standards ensures an improvement in accountability and the rationale behind patient care. Furthermore, it also supports effective clinical judgements and decisions, together with the identification of risks.

Physical Health Assessment

3.20 Physical Health Assessments for patients with mental illness is vitally important as mental and physical health concerns can be inter-related[33]. There is good evidence that '*people with all mental illnesses are at higher risk of physical ill health*[34].' Consideration and management of a patient's physical health concerns can contribute towards making a difference to a patient's appropriate care treatment and the overall wellbeing and recovery for that patient.

3.21 Before the Mental Health (Wales) Measure 2010 was in place, health board guidance stated that physical health assessments were to be undertaken within 24 hours of admission.

[31] Royal College of Psychiatrists – Good Psychiatric Practice http://www.google.co.uk/url?url=http://www.rcpsych.ac.uk/files/pdfversion/cr154.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=obb9U66-M5Xlatejgkg&ved=0CBQQFjAA&usg=AFQjCNEao-RTUNKe08eHWvhftri4T1C-IQ

[32] Nursing and Midwifery Council – Record Keeping Guidance for nurses and midwives http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf

[33] http://www.haringey.gov.uk/mental_health_needs_assessment_1_.pdf

[34] https://www.rcn.org.uk/__data/assets/pdf_file/0009/539892/2.2.1_Haddad.pdf

3.22 For Mr M's first admission there was a delay of 11 days[35] before he was physically examined. This was not noted for immediate follow-up by clinical staff. Upon his second admission Mr M was given a physical health assessment within 24 hours of that admission.

3.23 As part of Mr M's in-patient assessment (first admission), two days after admission a ward urine drug screen was undertaken on 1 July 2010 with a negative result confirmed on 5 July 2010. Health board guidance[36] stipulates that this screening should be undertaken within 2 hours of admission. However, it's not clear from the evidence available to the review team whether Mr M was subject to a second urine drug screen when admitted to the Ablett Psychiatric Unit for a second time.

3.24 The review team believe that the root causes of the issues highlighted within this section are:

- Limited multi-disciplinary team representation that regularly attended ward rounds and patient meetings.
- The existence of an environment where a very prejudiced view of Mr M was fostered based on misplaced cultural considerations and limited awareness.
- Limited opportunities for Consultant Psychiatrist or nursing staff to access clinical supervision or reflective practice groups with peers in order to promote discussion about clinical practice and individual patient care management.
- Limited evidence to suggest that engagement with the family of Mr M was of a level sufficient to develop a greater understanding of his background and history to inform decision making.
- The quality and lack of integration of clinical records hindering effective management of care in relation to Mr M.

[35] The Royal College of Psychiatrists recommends physical examination within 24 hours of admission.
[36] BCUHB Guidance: Acute Care – The first 7 days of admission

Recommendations

Ward Rounds

1. **Betsi Cadwaladr University Health Board to ensure that invitations to attend ward rounds (now known as MDT / Clinical Team meetings) are sent to a wider, multi-disciplinary group of individuals.**

2. **Betsi Cadwaladr University Health Board to provide an update regarding progress made by the Clinical Programme Group (CPG) in agreeing a standard for timely senior clinician reviews and physical examinations. Compliance with these agreed timescales should be monitored.**

Engagement with the family

3. **Betsi Cadwaladr University Health Board should ensure the families of patients are involved in the planning, development and delivery of the patient's care, treatment and discharge planning to the fullest extent possible.**

Clinical Records

4. **Specifically in relation to mental health clinical records, Betsi Cadwaladr University Health Board should ensure that:**

    a. **Patient clinical records are fully integrated.**
    b. **Mental health clinical records are of a good standard reflecting professional guidelines for record keeping.**
    c. **Good practice standards in record keeping are audited, and forms part of a rolling programme of audit and training.**
    d. **Consideration is given to the use of electronic case records as a means of supporting the integration of notes and increased access to them.**

Physical Health Assessment

5. In relation to patient assessments, Betsi Cadwaladr University Health Board should ensure that:

a. Staff compliance with their standard for timely senior clinician reviews and physical examinations demonstrating continued compliance.

b. In line with their own guidance, all patients are subject to urine drug screening within 2 hours of admission.

6. In relation to training, Betsi Cadwaladr University Health Board should:

a. Provide substance misuse training for staff to ensure that patient care is not compromised on the grounds of potential and actual substance misuse problems.

Clinical Leadership / Multi-disciplinary teamwork

7. Betsi Cadwaladr University Health Board should promote a more collaborative and evidence based clinical leadership model and support training initiatives for effective and collaborative multi-disciplinary teamwork[37].

Standards of Care and Practice and Clinical Audit

8. Betsi Cadwaladr University Health Board should ensure systems are in place to support the development of clear and measurable standards of care and practice that are evidence based where possible and promote a culture of regular monitoring and clinical audit.

[37] West M, Eckert R, Steward K & Pasmore B. Developing collective leadership for health care. The King's Fund. May 2014.

Staff and Culture

3.25 It was evident both through our analysis of documentation and our fieldwork that at the time of Mr M's care the cultural awareness and understanding of cultural issues by staff was minimal.

3.26 There existed an environment where a very prejudiced view of Mr M was fostered based on misplaced cultural considerations and limited cultural awareness, alongside staff members' own individual perceived and ill-informed views regarding alleged drug use. This was highlighted during interviews with staff who informed us that several staff members believed Mr M to be street smart as a result of his background and dealings with the benefits office. In addition to this, during our interviews with staff we were told that senior nurses were highly influential and should they express any bias that this could unintentionally influence other members of staff. Several further examples of this environment we found during our analysis of documented evidence:

"*He was very tactile – hugging, as foreign types can be*."

"*On his first admission some staff didn't think he was ill and that he was a druggie – maybe his problems were drug induced*."

"*…muttering gibberish – his own language – not to anyone specifically*"

"*Still talking gibberish in foreign language and broken English*."

"*Given difficulties, need to find out about deporting Mr M from Home Office. This might be the quickest way to achieve what we are so far failing to do – get a clear diagnosis*."

"*Given his clear knowledge of 'the system' e.g. not being entitled to benefits*…"

3.27 Some staff highlighted a lack of understanding around equality and diversity. Our interviews with staff indicated a lack of cultural awareness on the unit at the time, consequently this resulted in some negative interpretations of Mr M's behaviour. Cultural stereotyping influenced some staff's individual and collective judgement. The review team were of the view that the culture that existed at the time, hampered consideration for obtaining interpreter services for Mr M when he lapsed into speaking Bulgarian. It should also be noted that during our fieldwork and evidence analysis, the majority of sources considered Mr M's command of the English language to be excellent. However, had more contact with his family been established, his overall language capabilities could have been better understood.

Training

3.28 Independent of this review, HIW undertook an unannounced mental health visit[38] to the Ablett Psychiatric Unit in June 2014. During that visit it was identified that staff training was recorded differently across all the wards, and that there was a lack of mandatory staff training in the following areas:

a. On Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training; and
b. The Mental Health Act (1983) and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.

3.29 It is important that mandatory staff training is undertaken in those areas identified during HIW's unannounced visit. This training will not only provide an understanding as to what the Mental Capacity Act and DoLS are, it can also ensure greater understanding of the key principles, principles of assessment and how best to record your

[38] HIW ensure that the interests of those who are, or may be, deprived of their liberty in healthcare settings are safeguarded by the ongoing monitoring of compliance with the Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. http://www.hiw.org.uk/mental-health-and-learning-difficulties

practice. It is also important that there be one system in place across the Ablett Psychiatric Unit, therefore ensuring consistency and mechanisms that allow for effective audit of training across the whole Unit.

3.30 The review team is in agreement with those findings identified by the unannounced mental health visit. These are supportive of our own findings that staff ensure they have the necessary knowledge and experience to ensure appropriate care management.

3.31 Given the relevance of the recommendations in relation to issues raised within this report, we have included the recommendations from the unannounced mental health visit within this report.

3.32 The review team believe that the root causes of the issues highlighted within this section are:

- Inadequate emphasis was given to objective opinion of Mr M's clinical presentation and progress and overreliance on subjective and biased perceptions and observations.

Recommendations

9. In relation to equality and diversity, Betsi Cadwaladr University Health Board should ensure that:

a. Equality and diversity training continues to be rolled out to all new staff and that all staff receive regular refresher training in these issues.

10. In relation to mandatory training and a system of recording training across the Ablett Psychiatric Unit, Betsi Cadwaladr University Health Board should ensure that:

a. **Mandatory staff training regarding Mental Capacity Act (2005) and DoLS, is facilitated; and**
b. **A comprehensive system that is used by all wards should be introduced to ensure consistency across the Ablett Psychiatric Unit and to enable an effective overall audit of training at the unit.**

Use of the Mental Health Act (MHA) 1983

Use of Mental Health Act for Mr M

3.33 The following presents a chronology of Mr M's history in relation to use of the mental health act:

First Presentation - First Admission		
Date	**Section**	**Comments**
29/06/10	s136	Brought to Ablett Psychiatric Unit by Police Officer 2.
29/06/10	s2	Assessed by approved mental health professional (AMHP1), section 12 Doctor (GP1) and Senior House Officer[39] (SHO1).
08/07/10	s2	Recommendation completed for section 2.
15/07/10	s23	Discharged from liability to be detained under section 2. Informal status.
17/07/10		Informal patient - took own discharge against medical advice.
Second Presentation - Second Admission		
12/09/10	Was taken to A&E. No use of section	Mr M arrived at Ysbyty Glan Clwyd A&E under police escort, telling staff he was the son of God and an immortal angel with special powers. Following assessment by Ablett Psychiatric Unit

[39] A Senior House Officer (SHO) is a doctor undergoing training within a certain speciality. SHO's are supervised by consultants who oversee their training and are their designated clinical (and in many cases educational) supervisors. SHO's are now referred to as Core Trainees (CT)

	136 applied.	Duty Doctor, Mr M was transferred to the Ablett Psychiatric Unit for informal admission.
27/09/10	s5(2)[40]	Recommendation for application to be made under section2 for Mr M's admission to hospital by Consultant Psychiatrist 5.
27/09/10	s2	Medical recommendation for admission for assessment by Consultant Psychiatrist 5.
28/09/10	s5(2)	Report on hospital in-patient by Consultant Psychiatrist 3 recommending admission to hospital under section 2
28/09/10	s2	Medical recommendation for admission for assessment by Consultant Psychiatrist 3
28/09/10	s2	Medical recommendation for admission for assessment by GP1
28/09/10	s2	Application by approved AMHP for admission for assessment by AMHP2.
11/10/10	s23	Discharge from section 2 by the responsible clinician Consultant Psychiatrist 2
11/10/10		Mr M was discharged.
Third Presentation		
11/10/10	s136	Brought in to Carrog ward, Llwyn Y Groes Mental Health Unit by Police1. Outcome of assessment was to discharge.

Section 136

3.34 Our analysis found that section 136 paperwork was not always fully complete, for example place of safety not being specified or the name of the police officer not clearly stated with signature omitted. Joint protocol guidance between North Wales Police, Welsh Ambulance and

[40] If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this part of the Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished. http://www.legislation.gov.uk/ukpga/1983/20/section/5

BCUHB states[41] "*As the detaining officer you MUST sign and date the form otherwise the detention will be unlawful'*." Additionally the guidance goes on to state "*it is essential that form MHA 136 is completed by the detaining officer with as much detail as possible including full circumstances leading up to the application of the 136*".

3.35 It was also not clear from our fieldwork as to whether staff were aware of the existence of a designated area for carrying out section 136 assessments. Guidance[42] at the time of Mr M's admission stated that there was a section 136 suite at the Ablett Psychiatric Unit, updated guidance states this as Area B of the Ablett Psychiatric Unit. However, on interviewing staff, it was not clear to the review team that they were fully aware of such a designated area and that they used whichever room or area was most convenient or available at the time. The provision of a designated area for carrying out section 136 assessments, allows for an individual to maintain both their privacy and dignity. Furthermore, it allows for appropriate assessment and support to be provided for up to 72 hours, while in a controlled environment.

3.36 The issue of procedures or protocols being in place for an individual brought in under section 136 only to be assessed, possibly not warranting admission and being discharged, was also raised during the review. The review team found that some staff interviewed appeared to have no clear understanding of the protocol in place regarding what should be in place should a person be discharged from section 136 to the community.

3.37 Section 6.1 of the health board's section 136 protocol in use during 2010 stated:

[41]Page 10 Section 136 Mental Health Act 1983 Protocol as amended by section 44 of the Mental Health Act 2007 – updated 2012
[42] Page 7 Section 136 Mental Health Act 1983 Protocol as amended by section 44 of the Mental Health Act 2007 – effective 2008 onwards

'*After a person has been detained under section 136 of the Mental Health Act 1983...and assessed but not admitted to hospital under section or as a voluntary patient they should be conveyed home or to the locality where they were originally picked up. All the agencies involved have joint responsibility but normally police will arrange for person to be taken to a police station and the psychiatric unit will arrange for persons to be taken Hospital'*.

3.38 Guidance contained within s136 Good Practice Guidance[43] states that:

"…*when a detained person has been assessed as not requiring admission to hospital…and detention under section 136 has therefore ended, the AMHP would normally take the lead role in:*

a. *Notifying the police of the end of the detention (where a police based place of safety has been used, or the police have remained during the assessment at a non-police based place of safety);*
b. *Making appropriate arrangements for the person to return safely to their community*."

3.39 Whilst the review team were informed that there was and continues to be a service in place for taxis to be provided, in the case of Mr M, following his discharge from both his first and second admission, there was no record or evidence of such a service being offered or provided. In terms of Mr M's third presentation to services, when under section 136 at 23:00hrs on 11 October 2010, following assessment he was deemed suitable for discharge from the section 136. It was then Police Officer 1 who offered Mr M transport to a safe location, not as good practice guidance states, that the AMHP will normally take the lead to arrange the safe return of the person to their community.

[43] Welsh Government - Sections 135 and 136 of the Mental Health Act 1983 – Good Practice Guidance

3.40 The review team believe that the root causes of the issues highlighted within this section are:

- Not clear from review team fieldwork that staff were aware of there being a designated area for carrying out section 136 assessments
- No clear understanding of any protocol in place regarding what should be in place once a person is discharged from section 136 to the community.

Recommendations

Section 136

11. In relation to improvements in section 136 staff practice, Betsi Cadwaladr University Health Board should ensure that:

a. Steps are taken to ensure that all staff involved with the application of section 136, complete relevant documentation so that it is comprehensive, legible and reflects requirements of the MHA and MHA 1983 Code of Practice.

b. Steps are taken to inform staff of the designated area, as specified within its own protocol, for carrying out section 136 assessments across their mental health services.

c. Ablett Psychiatric Unit staff ensure that they are clear about the protocol in place for discharge of individuals not deemed to require admission, and that this protocol is adhered to.

Medication

Compliance with medication prescribed

3.41 From the evidence available Mr M was compliant with the medication prescribed him. Only on one occasion, the 28 September 2010, did he refuse Olanzapine as he said "...*it made him feel sick*".

Treatment response to medication prescribed

3.42 On occasion reference was made regarding Mr M's positive response to medication but generally there was a lack of information indicating his response to the medication prescribed.

Medicine Management and Prescribing Rationale

3.43 The review team analysed documented evidence relating to the medication that was prescribed to Mr M. This evidence consisted primarily of clinical records, a prescription chart and the health board's own internal report. The review team found poor evidence to support the decision for stopping Mr M's antipsychotic medication at the time of discharge from hospital for both the first and second admissions. Olanzapine, an antipsychotic preparation, used to alleviate symptoms of psychosis, was stopped abruptly following both admissions with no other medication being dispensed to Mr M for the post-discharge period.

3.44 The opinion formed at the time was the Mr M's diagnosis was that of malingering and that this influenced the decision to discharge him without the appropriate medication treatment for his condition.

3.45 It was stated in the clinical case record that Olanzapine "...*has not had any effect on his stated beliefs. This will be stopped prior to discharge*" No effort was then made for gradual cessation of the Olanzapine to observe response to this reduction.

3.46 That the clinical team determined that there was limited response to the Olanzapine prescribed and in making the diagnosis of malingering, this removed the option of prescribing alternatives to Olanzapine or even to consider a higher dose of Olanzapine. Mr M's diagnosis of malingering played a large part in the making of these decisions.

3.47 The review team believe that the root causes of the issues highlighted within this section are:

- Clinical judgements made regarding Mr M's mental state on both inpatient admissions did not reflect information being collated by wider members of the ward clinical team.

Recommendations

Medicine Management Rationale

12. The health board to ensure that patients on medication and who then take their own leave against medical advice, are appropriately supported in their medication needs at the time of discharge.

Diagnosis

Background

3.48 An important aspect of this review into the provision of mental health care and treatment provided to Mr M by Betsi Cadwaladr University Health Board, is that of the diagnosis given to Mr M following his first and second admission, which was that of Malingering. Malingering can be defined as:

Malingerer (conscious simulation); includes persons feigning illness with obvious motivation.[44]'

3.49 Mr M was assigned three different diagnoses at varying times during his episodes of care with the health board, namely mania (including hypomania), malingering and mental disorder secondary to substance misuse.

3.50 Mr M's diagnosis in relation to his first admission[45] was that no clear mental illness was evident and that Mr M was only observed to present

[44] The International Classification of Diseases – version 10 (ICD10) – World Health Organisation (WHO) classification of mental behavioural disorders used in the UK. ICD1O Z76 – Persons encountering health services in other circumstances. Specific sub code Z76.5. The ICD10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (1992)

with symptoms suggestive of a manic illness at the time when he presented for admission and during ward rounds.

3.51 Clinical notes relating to Mr M's second admission at time of discharge stated that '*Given the nature of this admission, Mr M is clearly troubled to some extent (to be willing to feign illness for accommodation)*'. The diagnosis given for the second admission, and subsequent reason for discharge, was that Mr M was malingering.

3.52 Following discharge from section 2 Mr M left the Ablett Psychiatric Unit at approximately 12:30pm on 11 October 2010. At approximately 11:00pm the same day police applied a section 136 having picked Mr M up from outside a local Fire Station following reports from a local shop that he was behaving oddly. At approximately 11:30pm under section 136 police brought Mr M to the Llwyn y Groes Mental Health Unit's Carrog Ward as a place of safety.

3.53 Following assessment and acknowledgement of his discharge from the Ablett Psychiatric Unit earlier that day, the clinical impression formed was that Mr M displayed no evidence of mental illness. Mr M said he wanted somewhere to stay and some food. He was reported as displaying some thought disorder, but it was easy to direct him back to the topic of conversation. He was found not to warrant admission and discharged to the community with the plan for his 7 day follow up to take place on 18th October 2010.

Evidence for malingering diagnosis

3.54 Details taken from the clinical notes provide some indication of how the diagnosis of malingering was arrived at. Some of which include the following:

[45] First Admission: 29 June 2010 Second Admission:12 September 2010

”*Given difficulties, need to find out about deporting DD from Home Office. This might be the quickest way to achieve what we are so far failing to do – get a clear diagnosis. With the benefit of corroborative history and allowing for cultural factors to be stripped out. Failing any of this will give due consideration to discharge off s2/off ward at next ward round, given lack of anything suggesting risk or mental illness – rather risk related to some unspecified goal (“to get attention”).*”

”*No delusional elaboration of hallucinations...No observed emotional reaction to being persecuted...No outwardly detachment away from the mundane...interaction with other patients is flawless”*

”*Hallucinations – claims auditory hallucinations and visual hallucinations but content vague and occurrence is hardly characteristic of true auditory hallucinations*...”

”*No other psychotic symptoms evident*.”

”*Has been observed at length on two occasions in hospital. Felt to be malingering. Latest summary supports this*.”

”*Discussed medication. Mr M has been treated with 20mg Olanzapine. This has not had any effect on his stated beliefs*.”

”...*aware from his talk about his past that he is streetwise, capable of manipulation (talking of selling timeshares to unsuspecting tourists) and I have no doubt we are hearing of some fairly routine [illegible] talked up as mental illness*.”

”*Can speak calmly, rationally with no evidence what so ever of thought disorder or hallucinations*.”

”*He appears to be functioning too well for someone with such fluid symptomatology*.”

”*No evidence of mental illness*.”

Alternative Diagnosis

3.55 Mr M’s first admission diagnosis was that no clear mental illness was evident and that Mr M was only observed to be manic at the start of admission and during ward rounds but not between these times.

3.56 As already mentioned within earlier sections of this report, there were many entries in the clinical notes suggesting that Mr M was not mentally ill, only appearing to be so by manufacturing symptoms when he is aware of being observed by ward staff.

3.57 Parallel to those entries were those that described the opposite in terms of concerns regarding Mr M’s mental state. A selection of these are as follows:

”*He appeared angry and upset at times and yet claimed ’I’m normal’.*”

”*This afternoon whilst I was in another patient’s bedroom I looked out to see Mr M outside sitting on a chair talking. I left the patient’s bedroom returned back stood behind the door looking out and Mr M was still talking to himself*.”

”*Observed ‘muttering’ to himself (content not audible).*”

”*Mr M started shouting very loud to himself in Bulgarian on seeing me enter the lounge. When asked by staff not to shout Mr M became abusive towards myself and told me to ’get the f***ing police to deport me*’.”

”*Mr M’s behaviour was a little bizarre at times during the evening and continues to have conversations with himself in Bulgarian*.”

"*Reviewed by Consultant Psychiatrist 5 – flight of ideas, pressure of speech evident, appears to be expressing religious fervour. Believes he is being watched, very irritable*."

"*Later in the afternoon...staff heard a loud noise coming from one of the toilets. It turned out that it was Mr M, he had hit the toilet door really hard*[46]*"*

"Transferred to Brynmor (PICU[47]*) ward due to the risks posed of being on an open ward".*

"Some odd behaviour even when thinking he is not being watched."

"Mr M's behaviour has escalated...he smashed a telephone today, is loud, smashed his hand against a door, screamed and obviously damaged it."

"His presentation has definitely changed. He is at risk of harm to self and others and to property."

"Appears to have a psychotic illness and his risk to self and others and to property have increased considerably."

"...during a 30 minute conversation (with Consultant Psychiatrist 3) he was [illegible] disordered...evidence of irritability...elated...his presentation during the interview was consistent with an acute episode of psychosis...The nursing reports [illegible] would appear consistent with psychosis."

"...not straightforward to put him down as malingering given lack of consensus amongst staff."

[46] Injury sustained by Mr M was a fracture of the fifth metacarpal in the right hand
[47] Psychiatric Intensive Care Unit

3.58 Evidence, identified in the above extracts, highlighted to the review team that there was good evidence that Mr M could have been suffering from a psychotic illness. Alternative diagnoses to malingering could have been more carefully considered, namely that of an affective psychosis such as mania or schizophrenia or of a dual diagnosis (in this case psychosis combined with a co-morbid substance abuse problem).

3.59 Mania is a condition in which there is an elevation of mood with associated behaviours and thoughts. Schizophrenia is a condition, presenting with symptoms that can include hallucinations or delusions. Both conditions are normally long term mental disorders. Mr M is certainly recorded as showing manic symptoms in terms of elevated mood, irritability, being chaotic and was observed to be experiencing grandiose delusions (believed he was the son of God)[48] and auditory hallucinations.

Risk Assessment

3.60 Whilst there is evidence of some risk assessment being conducted, it was not systematic and was hampered by Mr M's second admission diagnosis of malingering. This was Mr M's first presentation to psychiatric services and he might have been considered an individual with first episode psychosis. This may possibly have been complicated by substance misuse, and therefore there was an unpredictability component to thinking about risk concerns and his prognosis.

3.61 In determining risk, undue emphasis was given to the diagnosis of malingering for each subsequent presentation to services following his first presentation in June 2010.

[48] Delusions - A delusion is a belief held with complete conviction, even though it is based on a mistaken, strange or unrealistic view. It may affect the way people behave. Delusions can begin suddenly or may develop over weeks or months.

3.62 ”*Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user*.[49]“ The enhancement of skills and systems for effective risk assessment need to be developed alongside objective clinical skills. There were indicators that Mr M suffered from a mental illness and could not be considered a low risk. It is unclear the relationship between his clinical presentation and how this related to the index offence he tragically committed some months later in May 2011, and whether this could have been foreseen.

Diagnosis: Our View

3.63 The patients diagnosis was fundamental in terms of clinical management, and actual decision that Mr M did not have a mental disorder and was in fact deemed to be malingering.

3.64 Feigning of a serious psychiatric illness is unusual and rare. Emphasis was given to the apparent gain in terms of making a decision as to the diagnosis. Less emphasis was given to regularly reported symptoms suggestive of psychotic illness or of a possible dual diagnosis[50].

3.65 Malingering is a rare diagnosis and when made needs to be supported by a substantial evidence base. In the case of Mr M this evidence was not apparent. Subsequent mis-diagnosis had a series of unfortunate consequences. The formation of this inappropriate diagnosis led to a less robust discharge plan to the community.

3.66 Mr M’s second admission diagnosis had an impact on the follow-up and support he received after discharge. As he was deemed not to be mentally ill he did not receive access to a range of treatment interventions and other mental health services. These services could

[49] Department of Health – Best Practice in Managing Risk
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf
[50] Dual Diagnosis (Drug abuse with other psychiatric conditions)
http://www.patient.co.uk/doctor/dual-diagnosis#

have included a range of CMHT members working together to provide the most appropriate care. Team members included nurses, social workers, psychologists, occupational therapists and psychiatrists. Mr M could also have benefited from being directed to other appropriate services that would have provided further information and advice to him and possibly his family. This advice could also have directed him towards other sources of support, such as those provided by the third sector[51], and helping them to access these services. The more appropriate diagnosis of psychosis may have led to a longer period of inpatient treatment with psychotic medication, and an increased likelihood of being discharged from hospital with appropriate medication for his condition.

3.67 It is important to note that no one individual acted in isolation in determining Mr M's diagnosis and that it was a decision made and agreed upon by several individuals. Although it must also be acknowledged that there was clearly a lack of consensus as to his diagnosis and at the time there was no system in place for escalating this issue for further discussion among a wider professional group. Additionally, it is clearly apparent that those staff spoken to who were involved directly with Mr M's care, were inexperienced and relied on a small, but influential group of individuals to convey their clinical decisions.

3.68 The review team believe that the root causes of the issues highlighted within this section are:

- Patient diagnosis was fundamental in terms of the clinical management, and actual decision, that Mr M did not have a mental disorder and was in fact deemed to be malingering.

[51] National Audit Office – Third sector definition
http://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/

- An inappropriate diagnosis was made due to a lack of an effective evidence base. For example, while there is evidence of some risk assessment being conducted, it was not systemic or evidence based and was in part hampered by Mr M's second admission diagnosis of malingering.

Recommendations

Evidence for Diagnosis

13. The health board should ensure that where Consultant Psychiatrists or other clinicians seek to apply a diagnosis of malingering, that it is supported by a clear and substantial evidence base relating to an individual patient.

14. The health board to provide an update regarding the development of a more systematic approach to clinical supervision and reflective practice groups, or forums for nursing staff.

Risk Assessment

15. The health board should ensure that risk assessment processes are clear and robust and through appropriate training that all staff possess the appropriate skills to deliver these processes.

Discharge and After Care Planning

3.69 During this review the review team identified concerns regarding the manner in which Mr M's discharge and after care was managed. These concerns have been broken down into various sections as described below.

Allocation of a Community Care Co-ordinator

3.70 Care Co-ordinators have a duty in partnership with patients to "*remain actively involved in the care and treatment of the relevant patient throughout the time that they remain in receipt of secondary mental*

health services, including during admission or ***discharge*** *from hospital"*[52].

3.71 Mr M was not allocated a care co-ordinator as he was not considered to meet the criteria for this, in that he did not have a Severe Mental Illness (SMI) and furthermore was not considered to have a mental disorder. A combination of Mr M's social circumstances, being homeless, the belief he wanted to travel to Tenerife and diagnostic uncertainty, all contributed to his not being considered for secondary mental health care and in turn being supported by CMHT staff and an allocated care co-ordinator.

3.72 The diagnosis of malingering deemed Mr M as not having a serious mental illness. As a result he was deemed not to require secondary mental health services, a care co-ordinator, ongoing care and treatment planning or after-care.

Health of the Nation Outcome Scales (HoNOS)

3.73 The Royal College of Psychiatrists states that "*HoNOS are 12 simple scales on which services users with severe mental illness are rated by clinical staff. These ratings are then stored and repeated, for example over the course of treatment, and then compared. If ratings show a difference, then that may indicate that a service user's health or social status has changed. The scales cover a wide range of health and social domains – psychiatric symptoms, physical health, functioning, relationships and housing"*[53].

3.74 When HoNOS ratings are made, the Royal College of Psychiatrists states that "*the minimum required is that a rating is made at the start of each episode of care and at the end*". Evidence available to the review

[52] Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (This had only just been made a legal requirement during Mr M's episode of treatment)
[53] Royal College of Psychiatrists - HoNOS Information http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/courses/honos/generalinformation/faq.aspx#scored

team showed that Mr M was subject to one assessment, although we were unable to determine when this assessment took place.

3.75 Mr M's HoNOS assessment gave him a rating of 4 out of a potential 48, with ratings relating to social functioning deemed unable to be rated. We acknowledge that, "*like all such ratings, HoNOS ratings are subjective and prone to some disagreement*."

3.76 Given the evidence seen by the review team, it is difficult to understand the HoNOS scores assigned. Two sections within the HoNOS assessment relating to behaviour and impairment, scored Mr M as having a minor problem. The other section relating to social functioning provided no score and was deemed as being unable to rate. The review team can only assume that this was a result of a lack of detailed information held regarding his family and personal circumstances. Low HoNOS scores relating to problems with associated hallucinations and delusions and other mental and behavioural problems, don't appear conducive with evidence documented within clinical records of Mr M's reported mental state.

Vulnerable Adults and Homeless Team (VAHT) / Community Mental Health Team (CMHT)

3.77 As mentioned within in the Diagnosis section of this report, Mr M was deemed not to have a serious mental illness and hence failed to meet eligibility criteria for secondary care services from the CMHT. Subsequently, post first admission Mr M was referred to Flintshire County Council's Vulnerable Adults and Homelessness Team (VAHT).

3.78 There was confusion between the CMHT and VAHT in terms of how Mr M was referred and as there was no written referral made to the VAHT, it is difficult to establish the facts and clarify the referral process or further actions to be taken.

3.79 Despite the confusion, Mr M was seen by the VAHT in order to assess his needs. During their interview staff became concerned when Mr M became agitated and expressed grandiose ideas. The concern was such that the person initially interviewing him requested another member of staff be present for the remainder of the interview. Staff were also concerned that he attended without a member of the Ty Celyn CMHT present.

3.80 A formal homeless application was not taken forward as it appeared to the VAHT that Mr M had no local connection in Flintshire. Mr M was subsequently provided with information to support his attempts to find accommodation and was also provided with an emergency food bag. There was subsequently no further contact between Mr M and the VAHT.

3.81 When the VAHT interviewed Mr M and became concerned as to his behaviour there appeared to be no protocol in place for escalating these concerns. Had these concerns been formally referred to the CMHT there existed the possibility of an opportunity for further intervention.

Communication

3.82 Effective communication is an important aspect of any successful management of a patient's care. Whilst acknowledging the impact diagnosis played in terms of after care for Mr M, there are also clear lessons to be learned in regards to how effective communication between the MDT, the CMHT and other services and agencies, could have better served Mr M.

3.83 Confusion and lack of clarity between the CMHT and VAHT in terms of who was supporting Mr M led to there being no formal written referral. A formal referral would have enabled all parties involved to identify

further information and health and social care needs, such as Mr M's connection to the local area.

3.84 As touched upon within the Clinical Care section of this report, communication between staff at the Ablett Psychiatric Unit and the family of Mr M in Flint, was not to a sufficient standard. Apart from those issues identified within the section titled Clinical Care, when the review team spoke to the family of Mr M, we were told that Mr M's family were not informed of his discharge from the ward.[54] The only communication they recalled receiving, was a letter chasing up Mr M's attendance at a seven day follow-up [55]meeting. Had communication with the family been more prevalent a better understanding of him could have been formed and appropriate after care arranged.

3.85 The review team believe that the root causes of the issues highlighted within this section are:

- Upon discharge from both his first and second admissions at the Ablett Psychiatric Unit, evidence showed that staff were unclear as to whether adequate steps had been taken to ensure Mr M's immediate wellbeing upon leaving the unit.
- Lack of rationale for discharging Mr M post second admission without any medication.
- No Care Co-ordinator allocated as Mr M was considered to not have a Severe Mental Illness (SMI) or a mental disorder.
- Confusion between the CMHT and VAHT in terms of how Mr M was referred, with no written referral made.

[54] During an interview with Mr M's aunt she conveyed that the family were under the impression that the reason Mr M was no longer at Ablett Psychiatric Unit was because he escaped.
[55] 7 Day follow-up meeting scheduled for the 18 October 2010

Recommendations

16. **The health board should ensure that patients who have unresolved diagnostic issues, and who are not registered with a General Practitioner, should receive proactive involvement from the CMHT.**

17. **In relation to a patient's discharge, Betsi Cadwaladr University Health Board should ensure that:**

    a. **Care Co-ordinators remain actively involved in a patient's discharge and after care and that all steps taken are detailed clearly within patient documentation.**
    b. **Ablett Psychiatric Unit staff involved with section 136's to ensure that they are clear of the protocol in place for discharge of individuals not deemed to require admission and that this protocol is adhered to.**

18. **Betsi Cadwaladr University Health Board and Flintshire County Council should consider implementing a joint protocol addressing how VAHT concerns about the behaviour of an individual discharged from a CMHT, could be escalated back to that CMHT for further consideration.**

19. **The health board should ensure that patients are aware of the right to access an Independent Mental Health Advocate (IMHA). This is in line with the Mental Health Act (1983) and the Mental Health (Wales) Measure 2010 which expands the provision of an IMHA to all patients.**

Chapter Four: Recommendations

CLINICAL CARE

Ward Rounds

1. Betsi Cadwaladr University Health Board to ensure that invitations to attend ward rounds (now known as MDT / Clinical Team meetings) are sent to a wider, multi-disciplinary group of individuals.

2. Betsi Cadwaladr University Health Board to provide an update regarding progress made by the Clinical Programme Group (CPG) in agreeing a standard for timely senior clinician reviews and physical examinations. Compliance with these agreed timescales should be monitored.

Engagement with the family

3. Betsi Cadwaladr University Health Board should ensure the families of patients are involved in the planning, development and delivery of the patient's care, treatment and discharge planning to the fullest extent possible.

Clinical Records

4. Specifically in relation to mental health clinical records, Betsi Cadwaladr University Health Board should ensure that:

   a. Patient clinical records are fully integrated.
   b. Mental health clinical records are of a good standard reflecting professional guidelines for record keeping.
   c. Good practice standards in record keeping are audited, and forms part of a rolling programme of audit and training.
   d. Consideration is given to the use of electronic case records as a means of supporting the integration of notes and increased access to them.

Physical Health Assessment

5. In relation to patient assessments, Betsi Cadwaladr University Health Board should ensure that:

   a. Staff compliance with their standard for timely senior clinician reviews and physical examinations demonstrating continued compliance.
   b. In line with their own guidance, all patients are subject to urine drug screening within 2 hours of admission.

6. In relation to training, Betsi Cadwaladr University Health Board should:

   a. Provide substance misuse training for staff to ensure that patient care is not compromised on the grounds of potential and actual substance misuse problems.

Clinical Leadership / Multi-disciplinary teamwork

7. Betsi Cadwaladr University Health Board should promote a more collaborative and evidence based clinical leadership model and support training initiatives for effective and collaborative multi-disciplinary teamwork.

Standards of Care and Practice and Clinical Audit

8. Betsi Cadwaladr University Health Board should ensure systems are in place to support the development of clear and measurable standards of care and practice that are evidence based where possible and promote a culture of regular monitoring and clinical audit.

STAFF AND CULTURE

9. In relation to equality and diversity, Betsi Cadwaladr University Health Board should ensure that:

a. Equality and diversity training continues to be rolled out to all new staff and that all staff receive regular refresher training in these issues.

10. In relation to mandatory training and a system of recording training across the Ablett Psychiatric Unit, Betsi Cadwaladr University Health Board should ensure that:

a. Mandatory staff training regarding Mental Capacity Act (2005) and DoLS, is facilitated; and
b. A comprehensive system that is used by all wards should be introduced to ensure consistency across the Ablett Psychiatric Unit and to enable an effective overall audit of training at the unit.

USE OF THE MENTAL HEALTH ACT (MHA) 1983

Section 136

11. In relation to improvements in section 136 staff practice, Betsi Cadwaladr University Health Board should ensure that:

a. Steps are taken to ensure that all staff involved with the application of section 136, complete relevant documentation so that it is comprehensive, legible and reflects requirements of the MHA and MHA 1983 Code of Practice.
b. Steps are taken to inform staff of the designated area, as specified within its own protocol, for carrying out section 136 assessments across their mental health services.
c. Ablett Psychiatric Unit staff ensure that they are clear about the protocol in place for discharge of individuals not deemed to require admission and that this protocol is adhered to.

MEDICATION

Medicine Management Rationale

12. The health board to ensure that patients on medication and who then take their own leave against medical advice, are appropriately supported in their medication needs at the time of discharge.

DIAGNOSIS

Evidence for Diagnosis

13. The health board should ensure that where Consultant Psychiatrists or other clinicians seek to apply a diagnosis of malingering, that it is supported by a clear and substantial evidence base relating to an individual patient.

14. The health board to provide an update regarding the development of a more systematic approach to clinical supervision and reflective practice groups, or forums for nursing staff.

Risk Assessment

15. The health board should ensure that risk assessment processes are clear and robust and through appropriate training that all staff possess the appropriate skills to deliver these processes.

DISCHARGE AND AFTER CARE PLANNING

16. The health board should ensure that patients who have unresolved diagnostic issues, and who are not registered with a General Practitioner, should receive proactive involvement from the CMHT.

17. In relation to a patient's discharge, Betsi Cadwaladr University Health Board should ensure that:

    a. Care Co-ordinators remain actively involved in a patient's discharge and after care and that all steps taken are detailed clearly within patient documentation.
    b. Ablett Psychiatric Unit staff involved with section 136's to ensure that they are clear of the protocol in place for discharge of

individuals not deemed to require admission and that this protocol is adhered to.

18. Betsi Cadwaladr University Health Board and Flintshire County Council should consider implementing a joint protocol addressing how VAHT concerns about the behaviour of an individual discharged from a CMHT, could be escalated back to that CMHT for further consideration.

19. The health board should ensure that patients are aware of the right to access an Independent Mental Health Advocate (IMHA). This is in line with the Mental Health Act (1983) and the Mental Health (Wales) Measure 2010 which expands the provision of an IMHA to all patients.

Annex A: Background regarding the use of the Mental Health Act (MHA) 1983

The Mental Health Act sets out a legal framework that establishes when an individual can be admitted, detained and treated in hospital. An individual may be detained if they are thought to have:

i. A mental illness which needs assessment or treatment which is
ii. Sufficiently serious that it is necessary for
    a. Your health or safety, or
    b. For the protection of other people,
iii. And you need to be in hospital to have the assessment and treatment. And
iv. You are unable or unwilling to agree to admission.[56]

Following concerns from both Police and family it was agreed on several occasions by doctors and Approved Mental Health Professionals, that Mr M warranted further assessment or treatment for a potential mental illness.

Place of Safety

On three separate occasions Mr M was determined by either family or police to need assessment for potential mental illness. In line with a joint protocol between the health board, North Wales Police and Welsh Ambulance, and given the area Mr M was located within, he was taken to the appropriate place of safety[57] on each occasion.

In regards to mentally disordered persons found in public places, section 136 of the Mental Health Act 1983[58] states:

[56] Royal College of Psychiatrists – Being sectioned (in England and Wales) http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/beingsectionedengland.aspx
[57] For both his first and second admissions Mr M was taken to Ablett Psychiatric Unit, Ysbyty Glan Clwyd Hospital. For the third occasion he was determined as in need for further assessment he was taken to the Carrog Ward, Llwyn Y Groes, Wrexhan Maelor Hospital
[58] Section 136 – Mentally disordered persons found in public places http://www.legislation.gov.uk/ukpga/1983/20/section/136

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care of control, the constable may, if he thinks it necessary to do so in the interests of that person of for the protection of other persons, remove that person to a **place of safety** within the meaning of section 135[59] above.

A place of safety within the context of section 136[60] means:

a. Residential accommodation provided by a local social services authority under Part 3 of the National Assistance Act 1948;
b. A hospital (including independent hospital);
c. A police station[61];
d. A care home for mentally disordered persons; and
e. Any other suitable place where the occupier is willing temporarily to receive the patient.

Roles and Responsibilities of staff at place of safety

Section 136 of the Mental Health Act 1983 states:

(2) A person removed to a place of safety under this section may be detained for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment of care.

[59] Within section 135 “place of safety” means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948…, a hospital as defined by this act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier is willing temporarily to receive the patient.
[60] Sections 135 and 136 of the Mental Health Act 1983 Good Practice Guidance
[61] It is recommended that a police station be used as a place of safety only as a last resort

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

Annex B: List of medication prescribed, dose and for how long

List of medication prescribed, dose and for how long

The following presents a chronology of Mr M's prescribed medication and dosage:

First Admission: 29 June 2010 – 17 July 2010

Date	Medication	Dose
1 July 2010	Zopiclone[62]	3*75mg
	Olanzapine[63]	5mg nocte
3 July 2010	Olanzapine	Dose increased 10mg
8 July 2010	Olanzapine	Dose increased 15mg
	Diazepam[64] PRM	If agitation worsens
17 July 2010	Olanzapine stopped	

17 July 2010: Self discharge – no medication

Second Admission: 12 September 2010 – 11 October 2010

Date	Medication	Dose
12 September 2010	Zopiclone	7.5mg prn
12 September 2010	Lorazepam[65]	1mg up to qds prn for agitation
19 September 2010	Zopiclone	
22 September 2010	Zopiclone	1 tablet
23 September 2010	No Medication	

[62] Zopiclone is a medicine which is used to treat sleeping problems. http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Insomnia&medicine=zopiclone&preparation Zopiclone%203.75mg%20tablets

[63] Olanzapine is used to relieve the symptoms of schizophrenia and other similar mental health problems. Such symptoms include hearing, seeing, or sensing things that are not real, having mistaken beliefs, and feeling unusually suspicious. http://www.patient.co.uk/medicine/olanzapine

[64] Lorazepam is a benzodiazepine prescribed for short periods of time to ease symptoms of anxiety, or sleeping difficulties caused by anxiety.

	Zopiclone	7.5mg
27 September 2010	Olanzapine	10mg
	PRN Lorazepam	
28 September 2010	Lorazepam	1mg
	Paracetemol[66] and diclofenac[67]	
29 September 2010	Lorazepam	2mg
30 September 2010	Olanzapine	Increased to 20mg
1 October	Morphine[68]	10mg
	Cefuroxime[69]	1g
4 October 2010	Diazepam	2mg tds prn
5 October 2010	Diazepam	
7 October 2010	Olanzapine	Continued at present
	Diazepam	2mg
8 October 2010	Diazepam	3 tablets

11 October 2010: Discharged – no medication

[66] Paracetamol is a painkilling medicine available over-the-counter without a prescription. http://www.nhs.uk/Conditions/Painkillers-paracetamol/Pages/Introduction.aspx

[67] Anti-inflammatory painkiller. http://www.patient.co.uk/medicine/diclofenac-for-pain-and-inflammation

[68] Morphine is a medicine which is used in relieving post-operative pain and relieving severe pain. http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Pain%20(severe)&medicine=morphine

[69] Cefuroxime is a broad-spectrum antibiotic, which means that it is active against a wide variety of bacteria. http://www.patient.co.uk/medicine/cefuroxime-for-infection-britacef-zinacef-zinnat

Annex C: Index of wards in place at the time of Mr M's care

Ward Name	Ward Type	Bed Numbers
Brynmor Ward	Extra Care Ward	4
Alyn Ward	Open Acute Ward	10
Dinas Male Ward	Open Acute Ward	10
Dinas Female Ward	Open Acute Ward	10
Tegid Male Ward	Open Acute Ward	10
Tegid Female Ward	Open Acute Ward	10

Annex D: Terms of Reference

HEALTHCARE INSPECTORATE WALES (HIW):

REVIEW OF THE PROVISION OF MENTAL HEALTH CARE AND TREATMENT PROVIDED TO MR M BY BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB), PRIOR TO COMMITTING A HOMICIDE IN MAY 2011.

HIW is to undertake an independent review of a homicide carried out by a former mental health patient of Betsi Cadwaladr University Health Board (BCUHB) in Los Cristianos, Tenerife on the 13 May 2011.

The review will investigate the care and support provided to Mr M during his time in north Wales, prior to attacking Mrs H in May 2011.

In taking this review forward HIW will:

- Consider the care provided to Mr M as far back as his first contact with health and social care services in north Wales to provide an understanding and background to the fatal incident that occurred on the 13 May 2011.

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

- Identify any change or changes in Mr M's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred 13 May 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[70].

- Consider any other matters that may be relevant to the purposes of the review

[70] As part of this exercise consideration will be given also to the personal history of Mr M.

Annex E: Arrangements for the Review

Approach

Reviews and investigations by HIW draw upon methods, techniques and skills which will be most efficient and effective according to the nature of the matter to be investigated, its depth and any constraints upon 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 deem appropriate. In taking forward this review HIW has ensured that the general principles which apply to an investigation and upon which RCA provides guidance, have been followed.

The Review Team

The review began in June 2013. A review team was constructed to include relevant expertise. The members of the team were:

Dr Eleanor Cole	Consultant Psychiatrist – South London and Maudsley NHS Foundation Trust
Jane MacKenzie	Master of Social Science (MSc) Quality Management in Healthcare. Registered Mental Health Nurse (RMN), Registered Nurse (General) (RNG) and a member of HIW Inspection and Investigation teams in Mental Health Services across Wales
Freyja Ellard	HIW Lay Reviewer. An assessor for police recruitment and promotion and has been part of a number of HIW homicide investigation review teams.

Rhys Jones	Head of Investigation
Christopher Bristow	Investigations Manager
Ian Dillon	Investigations Manager
Lauren Bridgeman	Assistant Investigations Officer
Lianne Willetts	Investigations Assistant

The review consisted of three stages:

a. Collection and analysis of documents
b. Interviews with key members of staff including senior management, nursing staff, ward managers AMHP's, Consultant's, social workers and police officers.
c. Identification of findings, formulation of recommendations and completion of this report

Annex F: 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, carer, relative or employee;
- Strengthening the voice of patients and the public in the way health services are reviewed; and
- 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 HW 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 on 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 Nursery 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.