Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# Report of a review in respect of:

## Mr L and the provision of Mental Health Services, following a Homicide committed in October 2012

September 2014

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## Chapter 1: Executive Summary

1.1 On the afternoon of 19 October 2012 in the Ely and Leckwith areas of Cardiff, Mr L carried out a series of attacks in his van on members of the public. Mr L also assaulted several people with a crook lock. In total, there were 21 individuals injured in the incident, one of which, Miss A, sadly died following the injuries she sustained.

1.2 On 6 June 2013, Mr L was convicted at Cardiff Crown Court for the manslaughter of Miss A on the grounds of diminished responsibility. Further to this offence, he was also convicted of seven offences of attempted murder, two offences of causing grievous bodily harm with intent, two offences of attempting to cause grievous bodily harm with intent, five offences of assault occasioning actual bodily harm, one offence of common assault and one offence of dangerous driving. Mr L was sentenced by means of a court order under section 37/41[1] of the Mental Health Act 1983 to be detained at a high secure mental health unit indefinitely.

1.3 Mr L was first referred to Mental Health Services in Cardiff following a visit to his GP Practice (Four Elms Medical Centre, Cardiff) in April 2003 and over the next 4 years he was admitted to hospital under sections of the Mental Health Act 1983 on four separate occasions, due to relapses in his condition. Throughout the period reviewed (2002-2012) there were repeated issues noted in relation to Mr L's non adherence with prescribed medication, which evidence suggests was the causal factor in the relapses Mr L experienced.

1.4 It is now clear that at the time that Mr L had tragically killed Miss A, and injured 20 other individuals, his mental health had deteriorated significantly. Records taken from Mr L's sentence hearing indicated that he appeared to be psychotic, experiencing persecutory delusions and auditory hallucinations at the time of the incident.

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

1.5 The history of Mr L's contact with mental health services indicated that a relapse of his condition was likely if he should stop his medication. His previous hospital admissions had been generally well managed and his general state had been adequately observed in a hospital ward whilst he was not taking his medication. His mental state and behaviour had responded well to prescribed medication and the effects of him stopping medication were already known. The circumstances prior to Mr L's 2003 and 2007 admissions would also suggest that any future admission(s) into hospital may have required a significant intervention.

1.6 In none of the previous instances of contact, with mental health services or during the care he subsequently received, were there ever any threats made to members of the public. Mr L had made a good recovery following his contact with mental health services between 2007-2011. Whilst evidence reviewed indicates that a relapse of his psychosis could have been predicted following cessation of medication, and was indeed recognised to be a risk by the clinical staff, the subsequent homicide could not have been predicted. Given the circumstances, it is difficult to see how the homicide could have been prevented by the Mental Health Services.

## Summary of Mr L's condition and care

1.7 Mr L had a stable upbringing in a very caring and supportive family environment and there were no behavioural problems noted during his childhood. Mr L achieved good grades at school and went on to study at university. It was during this time when Mr L first showed signs of his illness, which resulted in his studies ending early into his second year.

1.8 Concerns were first raised about Mr L's mental state by his parents in February 2002, which gradually worsened over the next year, eventually

resulting in his first admission to Whitchurch Hospital, Cardiff, in July 2003, under section 2[2] of the Mental Health Act.

1.9 The notes reviewed during this period clearly describe symptoms of psychosis in the absence of substance misuse. During his hospital admission, a medication regime was established which allowed Mr L to be successfully treated, discharged and followed up via Rawnsley Day Unit Services, part of the University Hospital of Wales. The key points to note during this first contact with Mental Health Services were the difficulties experienced in engaging with Mr L, his lack of insight into his condition and his reluctance to take his medication, especially during the periods he was acutely unwell.

1.10 Despite appropriate follow up care, Mr L's reluctance to engage hindered the efforts made by the health care professionals, with Mr L seeming to prefer contact at a distance via scheduled outpatient appointments, rather than regular visits to the Rawnsley Day Unit.

1.11 Discussions that have since taken place with Mr L have revealed that he was always concerned about the stigma he felt was attached to being a patient of mental health services, and his reluctance to engage with services and comply with a medication regime stemmed from this.

1.12 Mr L's second serious episode of mental ill health of note began in April 2007. Within a short period he had three separate admissions to hospital, all under the Mental Health Act. The first admission resulted in an unsuccessful early discharge, following which Mr L was quickly readmitted the next day. After this second admission the decision was made to detain Mr L under section 3[3] of the Mental Health Act, after his initial admission under section 2,

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[2] Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days

[3] Section 3 is similar to section 2; except the detention is for treatment and may be for a duration of up to 6 months, although this can be extended.

owing to his slow recovery, his limited insight into his condition, limited engagement and compliance with medication. However, soon after the decision to detain Mr L under section 3, he was discharged from the section by the Mental Health Review Tribunal. Once again, shortly after discharge, Mr L was readmitted following a public scene involving the Police in Usk. Again, this admission to hospital was under section 2 and he was subsequently detained under a section 3.

1.13 Mr L was successfully treated during this, his third admission of 2007, and had a controlled discharge which involved the Crisis Resolution and Home Treatment Team[4] (CRHTT).

1.14 The key points of note during this second episode were again that Mr L was an individual who lacked insight into his condition; was reluctant to engage with services during times when he was unwell and whose symptoms presented in a very public fashion when acutely ill. Due to this admission resulting in a longer period in hospital staff were able to observe that without treatment it became apparent Mr L was aloof and rejecting of intervention. Once again Mr L responded positively to his medication regime by making a good symptomatic, functional and social recovery. He was able to work and develop relationships. Nevertheless, the review team noted some concerns relating to the organisation of Mr L's discharges from hospital; highlighted in 2007 and his discharge from the Links Community Mental Health Team (CMHT) in Cardiff in October 2011.

1.15 It is clear from the evidence reviewed that Mr L's reluctance to comply with his medication regime was the causal factor in the episodes of deterioration in his mental health. We also know from our review that from

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[4] The CRHT Teams aim to act as 'gatekeepers' to mental health services, rapidly assessing individuals with acute mental health needs, providing immediate multidisciplinary community-based treatment 24 hours a day, 7 days a week; ensuring that services are provided in the least restrictive environment, as an alternative to inpatient care for a maximum of 8 weeks; remaining involved with the client until the crisis is resolved and the client linked to ongoing care; and being actively involved in discharge planning, facilitating early discharge if inpatient care has been necessary.

approximately October 2011 until the incident in October 2012, that it was likely that Mr L was not taking any of his medication.

1.16 Further to this our review identified that communication was poor between the Links CMHT and Four Elms Medical Centre (FEMC) in relation to Mr L's condition and admissions in 2007. There were occasions when GPs at FEMC, after seeing Mr L, had to remind the CMHT that he required follow up appointments.

1.17 The assessment and monitoring of the physical health of patients with psychoses is important. Our review revealed that the data recorded at the mental health reviews completed by FEMC for Mr L was variable in terms of being comprehensive.

1.18 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

### In relation to Cardiff and Vale University Health Board

1. Cardiff and Vale University Health Board should provide HIW with strong and clear assurances that actions identified from the Health Board's own internal review following this tragic incident have been implemented and completed.

2. In relation to discharge arrangements, Cardiff and Vale University Health Board should ensure that a robust review process exists for all patients following their discharge from secondary care services / settings. This process should include measures to ensure that:

a. A written contingency plan is developed setting out the action to be taken if an emergency/deterioration in a patient's condition occurs. This plan should be subsequently shared between the CMHT team, the patient's General Practice, the patient and the patient's carers (where appropriate).

3. In relation to communication, Cardiff and Vale University Health Board should:
   a. Review and consider the adequacy of communication and information sharing procedures between its Community Mental Health Teams, Crisis Resolution and Home Treatment Teams and GPs, and how these can be improved.

4. Specifically in relation to community-based mental health services, Cardiff and Vale University Health Board should:
   a. Undertake a review of the resources allocated to each of their CMHT's, ensuring that they are equitably, and adequately resourced taking into account the population and morbidity for each CMHT area[5].
   b. Since the incident the Links CMHT has implemented an Integrated Manager and new systems. Therefore, Cardiff and Vale University Health Board should provide clear and strong assurance to HIW that the new systems currently in place at the CMHT have addressed the concerns highlighted in this report. Specifically, these include:
      - Adopting an integrated and consistent team approach to patient care;
      - Ensuring that there is a clear management structure in place and clearly defined roles and responsibilities in place at the CMHT.

[5] Cardiff and Vale University Health Board should refer to a previous recommendation made in the Report of a Review in Respect of Ms A and the provision of Mental Health Services following a Homicide Committed in October 2005. Report Issued May 2008.

c. Ensure that all case loads are routinely reviewed and audited to ensure their manageability as per the guidance documents referenced in paragraphs 3.6 and 3.9 in order to identify where individual case loads are excessive. Appropriate action should then be taken to address any issues that emerge.

5. In relation to patient and carer engagement, Cardiff and Vale University Health Board should ensure that:
   a. Processes are in place to ensure that the views of relatives and/or carers of patients are taken into account when making decisions about their care.
   b. Where appropriate, families and/or carers of patients are fully informed about the decisions and plans in place for patient care, including effective communication of any subsequent discharge or contingency plans.

### In relation to Primary Care services

6. Cardiff and Vale University Health Board should assess the possibility of sharing the arrangement introduced by Four Elms Medical Clinic (FEMC) in relation to monitoring the collection of patient prescription medication from their selected pharmacy across the Health Board area; thus ensuring better medication compliance for all conditions.

### In relation to The Welsh Government

7. The Welsh Government should seek assurance that there are protocols in place between Health Boards and Primary Care for all patients with psychoses. The protocols should include arrangements for medication monitoring and routine physical health checks in accordance with existing guidance. They should be clear

about the respective responsibilities of primary and secondary care agencies.

8. The Welsh Government should consider the benefit of having named doctors at General Practices for patients with mental health conditions.

## Chapter 2: The Evidence

### Mr L's Family and Social history

2.1 Mr L was born in 1980, and at the time of the incident was 31 years old. Mr L is the eldest of three brothers. All reports suggest that Mr L was raised in a stable and supportive family environment. His parents tried to assist Mr L a great deal throughout his life, especially during the occasions when he was mentally unwell.

2.2 Mr L was raised in Roath, Cardiff and for the majority of his life lived with his parents and two brothers. However, during the year leading up to the index offence in 2012, Mr L had been living with his partner in Ely, Cardiff. Mr L's family described him as a quiet, kind person who is very loving and caring.

2.3 Mr L did not present with any early developmental problems and performed well at school. He achieved good grades in his G.C.S.E's and A-levels. After leaving school, Mr L went to the University of Glamorgan in Pontypridd to study Design and Technology. Mr L completed his first year in University, but discontinued his studies after two weeks of starting the second year due to becoming unwell. This may have been due to early signs of his subsequent mental disorder, but he did not seek help at this stage. Having left University, Mr L worked in a variety of jobs over the next three years including working in an electrical appliance store, a call centre and storage warehouse.

2.4 During 2006, Mr L began working for Her Majesty's Revenue and Customs (HMRC) where he remained an employee until October 2012.

## Mr L's Criminal History

2.5 With the exception of the index offence, Mr L's only previous known criminal activity occurred in 2007 when he was arrested on suspicion of intending to commit a robbery of a bank in Usk, Mid Wales. Mr L was not charged following his arrest. The circumstances of this incident are detailed later in this report.

## History of contact with Mental Health Services

### February 2002

2.6 On 1 February 2002 Mr L attended the Four Elms Medical Centre (FEMC), in the Roath area of Cardiff, with his mother and saw GP1 following concerns around his well being. GP1 recorded that *'Mr L was very anxious, depressed and also had concerns that people were talking about him in his previous job'*. Mr L stated that he was '*sleeping and eating OK and had no suicidal thoughts'*.

2.7 GP1 discussed potential medication options with Mr L and documented that medication would be considered should the issues he was experiencing continue, especially Mr L's obsessive thoughts regarding his body image.

### April 2002

2.8 On 10 April 2002, Mr L's mother attended FEMC and saw GP2. GP2 recorded that:

> *'Mr L's Mother came to see me today, she is extremely worried about her son, who has worsened since the last visit and is now reluctant to leave the house. He feels people are talking about him and will not come to surgery. He has no obvious delusions and his mother does not think he is suicidal. As Mr L will not come to the surgery, I have arranged a house visit for tomorrow'.*

2.9 The following day, GP3 visited Mr L's house. However, Mr L refused to see the Doctor. It was agreed that GP3 would contact Mr L via telephone the following day. There was no evidence to suggest this took place.

## April 2003

2.10 On 4 April 2003, Mr L attended FEMC and saw GP4. Mr L again relayed concerns that he was worried that people were talking about him and was suffering from poor sleep. At the time Mr L was unwilling to talk to anyone else about these issues, but did agree to see GP4 again the following week.

2.11 On 10 April 2003, Mr L attended the FEMC again and saw GP4 who recorded that '*Mr L appeared down and talked about his concerns that people maybe talking about him'*. A mental state examination was undertaken and Mr L was noted to be '*displaying poor eye contact, to have both objectively and subjectively low mood and liable speech'*. There were no suicidal thoughts evident but Mr L continued to relay concerns that people were saying derogatory things about him.

2.12 Mr L was adamant that he did not want to take antidepressants or any other medication. However, he did agree that he needed help and agreed to attend the Links Community Mental Health Team (CMHT) in Cardiff to see a consultant psychiatrist.

2.13 Subsequently, GP4 sent a referral letter to the Links CMHT on 10 April 2003. In his letter GP4 stated that he had been approached by Mr L's mother on 4 April 2003, who had relayed her concerns about her son and stated that she was very worried that he may be depressed.

2.14 An outpatient appointment was scheduled for seven weeks later for Mr L on 16 June 2003 at the Links CMHT.

### May 2003

2.15 On 21 May 2003, Mr L's mother visited FEMC where she saw GP4 and raised further concerns that her son's condition was deteriorating. She stated that he had been unable to remain in work as he felt that colleagues were talking about him. She also felt that the scheduled Links CMHT appointment on 16 June 2003 may not be soon enough.

2.16 As a result of the concerns raised, GP4 contacted the Links CMHT to request that an earlier appointment was arranged.

### June 2003

2.17 A rearranged appointment was scheduled for Mr L on 6 June 2003 to see Consultant Psychiatrist 1 at the Links CMHT; but Mr L did not attend. Therefore, a Community Psychiatric Nurse (CPN1) went to visit Mr L at his home address to assess him. At this time it was noted that Mr L stated that he felt *'better than he had been'*, but that he said that he still felt '*stressed and paranoid that people were making derogatory comments about him*'. As a result he was not going out. There were no problems of substance misuse noted and Mr L was recorded as being of *'some'* risk of violence to self and to others. CPN1 also noted '*suicide risk could increase if left untreated'*. It was also noted that his parents felt that '*things were wrong and that their son needed help'*.

2.18 CPN1's conclusion summary stated that Mr L was *'depressed'* and that he had stated he wanted to *'sort things out, but not with medication'.* The action noted from CPN1's assessment was for an appointment to be scheduled with Consultant Psychiatrist 1 at the Links CMHT for an assessment. The appointment was scheduled for 10 June 2003 and CPN1 visited Mr L's home to accompany him. Once again Mr L refused to attend his appointment. Subsequently, CPN1 visited Mr L at home on 12 June 2003 and recorded that he was refusing medication and remained symptomatic.

2.19 On 18 June 2003, Mr L again failed to attend an appointment with Consultant Psychiatrist 1 at the Links CMHT. As a result, CPN1 visited Mr L at his home address and recorded that Mr L appeared *'better'* and it was agreed that CPN1 would visit him at home again in four weeks time.

## Mr L's first admission to Whitchurch Hospital

### July 2003

2.20 On 21 July 2003, Mr L's Mother visited FEMC and saw GP5 to express her concerns about her son. The consultation record completed by GP5 recorded that:

> *'Mr L is refusing medication. The CPN has requested we see him; he is becoming paranoid, accusing people next door of talking about him etc. They have called the Police and he is now extremely agitated and Mum feels he needs to be seen. I think he may need sectioning, so I suggest the Doctor who calls, speaks to Links about him'.*

2.21 As a result of this conversation, GP4 carried out a home visit later that day. GP4's consultation record of the visit stated there had been a '*great deterioration'* since GP4 last saw Mr L. Mr L was again expressing concerns that people were talking about him and making derogatory remarks. GP4 recorded that Mr L was unwilling to believe that his concerns may be delusions and was unwilling to take any medication or to go to Whitchurch Hospital to be assessed.

2.22 Due to Mr L's non cooperation, either with a voluntary assessment or with any medication, GP4 arranged for a home mental health assessment to be undertaken at Mr L's home.

2.23 Later that evening, GP4 and the Duty Consultant Psychiatrist visited Mr L's home address to complete the home assessment. However, before this assessment could be completed, Mr L jumped out of a first floor window to

escape. Mr L had later stated that he heard voices telling him not to return to his home. As a result, South Wales Police were contacted and subsequently apprehended Mr L at around midnight. Mr L was taken to Whitchurch hospital, Cardiff under section 136[6] of the mental Health Act (MHA), 1983.

2.24 Upon arrival at the hospital a section 136 assessment was completed by the Duty Consultant Psychiatrist and Senior House Officer 1 (SHO1)[7]. At this time it was documented:

> *'Mr L is a 22 year old male, single, presenting with increasing paranoid thoughts over the last two or three weeks with a history of psychotic illness. Mr L has not attended several appointments and had not been compliant with medication. There are no current thoughts of self harm or of harming others'*.

2.25 Following the assessment, the decision was made to detain Mr L under section 2 of the Mental Health Act. He was initially admitted to Ward East 3A (Psychiatric Intensive Care Unit, PICU), Whitchurch Hospital, Cardiff. Upon arrival on the ward Mr L was recorded as being '*distressed, anxious, and believed that people were laughing at him'*. Mr L also refused medication from staff.

2.26 Due to bed pressures on the PICU Ward Mr L was transferred to Ward East 5A on 23 July 2003, where he remained symptomatic. Mr L continued to display very little insight as to why he needed to be at the hospital or into his condition. During the initial period on the ward, Mr L was unwilling to take any medication, however, he did eventually agree to take medication and

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[6] This section allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital.

[7] A senior house officer (SHO) is a junior doctor undergoing training within a certain specialty. SHO's are supervised by consultants and registrars, who oversee their training and are their designated clinical (and in many cases educational) supervisors.

Sertraline[8] 50 mgs (an antidepressant) and Olanzapine[9] 20 mgs (an antipsychotic) were commenced. Mr L was encouraged by staff to participate in activities to try to distract him from his auditory hallucinations.

2.27 On 29 July 2003, Mr L's care plan was reviewed on the ward. It was agreed that there had been vast improvements noted over the nine days following Mr L's admission. There had also been slight improvements in Mr L's level of insight noted and he had been complying with medication. It was recorded that he had become a lot more settled and pleasant with improved mood. However, there were still occasions where he actively isolated himself.

2.28 Due to the improvements in Mr L's condition, it was agreed that section 17[10] day leave would be granted, with the day leave form authorised by Mr L's Consultant, Consultant Psychiatrist 1.

2.29 On 30 July 2003, Mr L's Mental Health Act Tribunal was held and the decision was taken to discharge him from section 2 and the ward with immediate effect. The discharge plan noted that Mr L was to attend the Rawnsley Day Unit services at The University Hospital of Wales, three times a week for psycho-education[11] and ongoing monitoring. On discharge from East 5A, Mr L was prescribed Olanzapine (10mg) and Sertraline (50mg).

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[8] Antidepressants like sertraline increase the amount of circulating serotonin available in the brain. This may help depression symptoms in some people.

[9] 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.

[10] This is the section of the Mental Health Act that allows for authorised periods of time away from the ward.

[11] Psycho education refers to the education offered to people with a mental health condition. Frequently psycho educational training involves individuals with schizophrenia, clinical depression, anxiety disorders, psychotic illnesses, eating disorders, and personality disorders, as well as patient training courses in the context of the treatment of physical illnesses.

## Community-based Care 2003-2007

### August 2003

2.30 Mr L began his community-based care in August 2003 at the Rawnsley Unit. An initial assessment was undertaken by the Deputy Day Services Manager (DDSM) of the Rawnsley Unit on 1 August 2003. During this assessment Mr L revealed that he had previously experienced paranoid thoughts that others were making derogatory comments about his appearance. It was noted that Mr L had previously suffered a psychotic episode and that he was a low risk to others. However, risks were noted in relation to the possibility of Mr L disengaging with the unit and non-adherence with medication.

2.31 Over the following week, Mr L attended the unit on a number of occasions. During discussions with staff Mr L stated that he no longer felt unwell and he felt his recent compulsory admission was unnecessary. It was also noted by staff that Mr L appeared to lack any insight into his illness and into the period leading up to his admission. Despite this, he agreed to continue to attend the unit and to take his medication. An assessment was undertaken by Consultant Psychiatrist 1 on 6 August 2003 who noted the *'psychotic thoughts from previous medication have improved'.*

2.32 On 11 August 2003, SHO2 sent a discharge summary to GP6 at FEMC. The letter detailed the circumstances of Mr L's section, his progress and subsequent discharge. It also detailed Mr L's current medication and plan for him to attend the Rawnsley Unit three times a week.

2.33 However, towards the latter end of August 2003, it was recorded that Mr L began to disengage with the unit, missing several appointments.

2.34 During a Multidisciplinary Team (MDT) meeting[12] on 29 August 2003 a plan was agreed to try to reengage with Mr L. Subsequently this plan was discussed with Mr L's mother who stated that she was relieved as she was concerned as her son was not leaving the house and was again expressing his concerns that people were talking about him.

2.35 Mr L was visited at home on two occasions in September 2003 by CPN1. It was noted that Mr L was reluctant to attend the Unit, and although feeling '*OK'* in himself, was lacking motivation, with no social activity undertaken. Mr L admitted that he was still experiencing paranoid thoughts and he agreed to attend the unit on 1 October 2003.

2.36 Mr L was assessed by Consultant Psychiatrist 2 on 1 October 2003, who recorded that:

> *'Mr L has not been going out. Denies any psychotic symptoms, however, has no insight into psychotic symptoms. Suspect that he is paranoid and avoiding going out as a consequence. Mr L is refusing to change his medication despite sleeping 12 hours a day and his mood being low. Mr L needs engaging and has agreed to attend the unit two hours a week'.*

2.37 Despite this agreement, Mr L did not attend the unit. He was not seen by staff until late October 2003. Following concerns voiced by Mr L's mother, a home visit was undertaken by a nursing assistant who noted that Mr L was not going out and that he became concerned and anxious when they visited a local café. The nursing assistant also recorded that Mr L's eye contact was poor. He again voiced concerns about others talking about him, and was unable to rationalise these thoughts. As a result of these concerns, the Deputy Day Services Manager in Rawnsley Unit made the recommendation that a case conference be arranged. Further to this a medication and care

[12] A multidisciplinary Team Meeting is a meeting of the group of professional from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

plan review was undertaken by Consultant Psychiatrist 2 on 22 October 2003. Mr L commenced on Quetiapine[13] 200mg twice a day (an antipsychotic) and Venlafaxine[14] 75mg daily (an antidepressant).

2.38 On the afternoon of 23 October 2003, Mr L met with the DDSM to discuss Mr L's ongoing issues. Mr L was noted as being frank and honest and admitted to the DDSM that he was frightened to venture out of his house, but denied hearing any voices. He stated that he was concerned that people were looking at him and making derogatory comments. Upon further discussion Mr L admitted that he was evaluating people's comments from their body language and eye contact. The DDSM noted that Mr L admitted that his mood was low which was effecting his motivation and that his anxiety levels may be causing him to misinterpret things. A new plan was agreed with Mr L to attend the unit three times a week and for a CPN to visit him at home on Wednesdays.

2.39 Mr L attended the unit on another two occasions that month. However his engagement with staff and the activities in which he took part were noted to be limited.

### November 2003

2.40 Mr L attended the unit on four occasions during the month and it was noted that he continued to be difficult to engage with and refused to participate in the majority of activities available. This is despite a Student Nurse being assigned to work with him. The Student Nurse also visited Mr L at home on seven occasions during the month. During discussions with staff Mr L admitted that he felt low and was still anxious about leaving his home. He reported that he was concerned about an article which talked about coded messages in the Bible; he said that this gave him strong feelings of *'déjà vu'*.

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[13] Quetiapine is used to relieve the symptoms of schizophrenia, bipolar disorder, and other similar mental health problems.

[14] Antidepressants like venlafaxine increase the amount of circulating serotonin available in the brain. This may help depression symptoms in some people.

## December 2003

2.41 Mr L attended the unit on four occasions during the month and staff noted that he appeared to be in good spirits. Mr L informed staff that he had been taking his medication and felt a lot brighter in mood since being prescribed Venlafaxine. However, he continued to raise concerns that people were commenting on his physical appearance. Mr L stated that he was willing to engage with the unit after Christmas to explore his confidence issues as well as relapse prevention. On 19 December his Quetiapine was increased to 300mg twice a day.

## January 2004

2.42 On 22 January 2004, Mr L was contacted by the Rawnsley Unit to discuss the possibility of continuing at the unit and attending on a more regular basis. Mr L agreed to attend the unit on 26 January to discuss further. Whilst entering the unit for this appointment the concourse area was very busy and there were a group of people laughing which Mr L immediately took offence to and as he walked past the group, he spun around, made a pistol gesture with his hand and pointed it at the group.

2.43 During the subsequent discussion with staff Mr L initially refused to talk about the incident but later stated that *'it was the usual thing that happened, people talking about me'.* Mr L also stated that he no longer considered it necessary to continue taking medication, as he felt that it did not work, he didn't feel any better and he expressed concerns that he would end up back in hospital. However, he agreed to continue taking his medication until he was told otherwise by his consultant psychiatrist.

2.44 Mr L informed staff that he would not be attending the ward round scheduled for the following day, however, he reluctantly agreed when he was presented with the alternative option of being visited at home.

2.45 However, later the same day Mr L's mother contacted the unit to inform staff that his medication had run out which meant he had subsequently missed three doses. She also told staff that he was feeling unwell and would not be attending the ward round the following day. As a result of this conversation the DDSM met with Consultant Psychiatrist 2 to discuss Mr L's non engagement and the negative effect his current medication was having and his subsequent deterioration. It was agreed that a case conference and assessment of Mr L's current condition would take place on 4 February and Mr L's parents were advised to reduce his antipsychotic medication (Quetiapine) by 50 mgs in the period leading up to the meeting.

### February 2004

2.46 Consultant Psychiatrist 2 saw Mr L as scheduled on 4 February at the unit and Mr L's Mother was also present. Consultant Psychiatrist 2 concluded that Mr L was displaying some insight but was still unwell and preoccupied with his appearance. Therefore, the decision was made to stop the Quetiapine medication and to prescribe Risperidone[15] 4mgs (an antipsychotic) and Venlafaxine 225 mgs daily. Also, Consultant Psychiatrist 2 noted that she would be referring Mr L to see Consultant Clinical Psychologist 1 at the Links CMHT.

2.47 It was recorded that the new medication regime had a positive impact on Mr L although he still admitted to having down days, he was happy to engage with services as he felt it would be beneficial to him. It was noted in late February that Mr L was able to openly discuss the circumstances leading up to his admission under section 2 of the Mental Health Act, and displayed a considerable degree of insight into what happened to him. However, Mr L still admitted that he still had concerns about his appearance but was no

[15] Risperidone is used to relieve the symptoms of schizophrenia and some other mental health problems. Such symptoms include hearing, seeing or sensing things that are not real, having mistaken beliefs and unusual suspiciousness. It is also used to treat disruptive behaviour or agitation where this becomes a danger to self or to others. Risperidone works on the balance of chemical substances which act on the nervous system in your brain.

longer hearing derogatory comments or misinterpreting the mannerisms of others.

2.48 Despite the documented positive effect that the new medication regime had on Mr L, he continued to disengage with the unit. After numerous failed attempts from staff to try to encourage Mr L to re-engage, the decision was made to discharge Mr L from the Unit and back into the care of the Links CMHT. Mr L was in agreement with this decision.

2.49 A discharge summary letter was sent to Consultant Psychiatrist 2, GP4, CPN1 and Consultant Clinical Psychologist 1. The letter noted the improvements in Mr L's mental state and insight into his illness, and although there were still concerns about how he assessed his own appearance, Mr L was now able to recognise that he had been previously experiencing auditory hallucinations and paranoid ideas. However, the letter also detailed the problems experienced in engaging with Mr L at the Unit. It was recommended that Mr L continued with the current medication and that he should be followed up by the Links CMHT via either a CPN visit or an outpatient appointment.

2.50 Mr L attended appointments with Consultant Clinical Psychologist 1 on 9 and 23 March, who recorded that Mr L was insightful and acknowledged that he had been ill. He recorded that he wondered whether Mr L's conditions may have been Body Dysmorphic Disorder (BDD)[16]. Mr L stated he was currently quite socially active and hoped to get a job soon.

### April 2004

2.51 On 20 April 2004, Mr L attended an appointment with Consultant Clinical Psychologist 1 who documented that there were good signs of improvement. Also, Mr L stated that he had recently spent time in a call centre job, but had to leave as the computer screens were hurting his eyes.

[16] Sufferers of this disorder have an irrational preoccupation with a perceived body defect, either present in themselves or in others.

Mr L informed the Psychologist that he hoped to obtain a retail job and had interviews scheduled.

### May 2004

2.52 On 12 May 2004, Mr L was reviewed by Consultant Psychiatrist 2 who recorded that Mr L's *'mood is still low but a lot better'*. There were still occasional '*loud thoughts'* which occurred during stressful periods when he was tired and suffering from low mood. Mr L stated that he was unsure what he would like to do in the long term future but has an appointment with a career advisor scheduled.

### June 2004

2.53 Mr L was reviewed again by Consultant Psychiatrist 2 on 7 June 2004 who recorded that his mood was a little higher and that he was currently looking for work. However, Mr L admitted to not feeling back to his old self as he was still hearing occasional voices and still felt uneasy at nights. Mr L's Risperidone medication was increased to 6mg daily and Venlafaxine remained at 300mg daily.

### September 2004

2.54 On 29 September 2004, Mr L's mother contacted CPN2 to inform her that her son had obtained a full time job working in a storage warehouse which he was enjoying. Mr L's mother stated that his mood still remained a little low and felt that his current medication was making him quite sleepy and sluggish. However, she did feel Mr L was in the best condition he had been since becoming unwell.

2.55 Mr L's mother requested a review into whether his medication could be changed and CPN2 arranged an appointment with Consultant Psychiatrist 2 for 18 October 2004. Subsequently, Mr L was discharged from CPN involvement, CPN2 informed his mother that CPN input could be accessed if there were any issues in the future.

### December 2004

2.56 On 30 December 2004, GP7 completed Mr L's annual Mental Health Review at FEMC. Mr L's weight, BMI and blood pressure were recorded. A brief risk assessment was completed and Mr L noted as being *'well at present, working full time and still under the care of Links'* and a '*low suicide risk'.*

### February 2005

2.57 Consultant Psychiatrist 2 sent an update letter to GP7 at FEMC on 15 February 2005, in relation to Mr L's condition. The letter detailed that Mr L was reasonably stable on his current medication (Venlafaxine and Risperidone) and the medication doses would be reduced shortly. The Venlafaxine was to be reduced to 150 mg, and then subsequently stopped over the next 3 months, and Risperidone reduced to 4mg. Consultant Psychiatrist 2 noted that Mr L was not well controlled with Risperidone and was considering an alternative anti-psychotic.

### April 2005

2.58 On 5 April 2005, Mr L was reviewed by SHO3 at the Links CMHT. Mr L was recorded as being *'very cheerful with good eye contact'*. Mr L denied any suicidal thoughts; he admitted to still occasionally hearing voices but stated that he was able to get rid of them by listening to music. Mr L stated that he was enjoying his job, working 40 hours per week and was spending time over the weekends with his girlfriend.

2.59 SHO3 continued Mr L's Risperidone (4mgs) with his agreement and Venlafaxine was reduced by 37.5 mg with the aim of stopping the medication in a month's time, as there were no biological signs of depression/anxiety noticed. Mr L also stated that he wanted to stop his Venlafaxine medication as he did not feel that he was depressed. A further review was then scheduled for 10 May 2005.

### May 2005

2.60 On 31 May 2005, Mr L was reviewed by SHO3. Mr L was recorded as '*functioning very well and cooperative'* and noted to be '*communicative and cheerful'*. Mr L denied any self harm or suicidal thoughts, however, admitted to still experiencing voices on occasion, but stated that they did not bother him. Mr L stated that he was spending his free time with his girlfriend and that they were planning a trip to Ireland in July.

2.61 As there were no biological signs of depression or anxiety SHO3 made the decision to stop the Venlafaxine medication with immediate effect. Mr L also expressed concerns regarding his Risperidone medication but SHO3 noted that he explained that this medication needed to be gradually reduced. A further decision was made to review Mr L's condition and the Risperidone medication in a month's time. There is no evidence to suggest that this review took place.

### November 2005

2.62 On 14 November 2005, Mr L was reviewed again by SHO4, who recorded that Mr L was *'bright and in a good mood. His sleep, appetite and energy levels were ok'*. Mr L also informed SHO4 that he had recently left his job as a Sales Assistant as he found the role too stressful and he was now looking for something less stressful.

2.63 Mr L stated that he had not heard any voices since September 2005, there were no suicidal thoughts and that he was quite happy with his current medication (Risperidone 4mgs). The decision was made by SHO4 to continue with the current medication regime and to arrange a review in two months' time.

### January 2006

2.64 On 10 January 2006, Mr L was seen by SHO4 at the Links CMHT who recorded that he was in good spirits, was kempt, calm and well attired. It was noted that there had been no hallucinations, delusions or suicidal thoughts.

Mr L stated that he had been recently interviewed for a job at Her Majesty's Revenue and Customs (HMRC) and was expecting to commence work there shortly. Mr L did complain of some blurred vision, which SHO4 recorded may be drug induced. Therefore due to these complaints and the absence of any negative symptoms in Mr L's presentation, the decision was made by SHO4 to reduce the Risperidone medication to 3mgs on a trial basis to be reviewed in a month's time. Subsequently a letter was sent by SHO4 to FEMC to provide information on this decision. It was later recorded by Administrator 1 at FEMC, that a mental health review took place at the Links CMHT for Mr L. There was very limited information recorded on the FEMC system in relation to SHO4's review.

### February 2006

2.65 A follow up review was scheduled for 14 February 2006; however Mr L did not attend.

### May 2006

2.66 On 30 May 2006, Mr L was reviewed at the Links CMHT by SHO5. It was noted that Mr L was currently doing well on his new medication and there was no mood fluctuation or paranoid ideas. However, blurred vision was still an issue on occasion. Mr L stated that he was happy in his new job as it was less stressful than his previous job. Following his Mental State examination SHO5 recorded that:

> *'Mr L had good eye contact which was normal rate and coherent. His mood was objectively and subjectively euthymic with no abnormal ideas, thoughts or experiences. His cognition was in tact and he had good insight into his problems. There was no evidence of any psychotic mood disorder'.*

2.67 The decision was made to reduce Mr L's Risperidone to 2mgs and a follow up appointment was scheduled for two months time. A letter detailing this decision and review was sent to FEMC.

### September 2006

2.68 An outpatient appointment was scheduled for Mr L during September 2006, however he did not attend. The only contact Mr L had with health services for the next seven months was a visit to FEMC, which was in relation to a whiplash injury.

## Mr L's Second Admission to Whitchurch Hospital

### April 2007

2.69 By 13 April 2007, Mr L's parents were growing increasingly concerned that his condition had deteriorated and felt it was due to him reducing his medication without medical advice to do so. Mr L was complaining of headaches and seemed to be down in mood. Due to their concerns Mr L's mother arranged for a Links CMHT outpatient appointment for him; however, he again failed to attend.

2.70 Following this, Mr L's parents persuaded him to visit Whitchurch Hospital with them where he was assessed by staff. Due to Mr L refusing to be admitted to hospital, refusal of any medication and the risk of trying to abscond following the previous incident in 2003, he was subsequently detained under section 2 of the Mental Health Act, 1983. Mr L was noted by staff at the time to be '*thought disordered, had a pressure in his speech and lacked any insight that he was unwell'*. He initially refused all medication and became quite hostile. He was also angry at his parents for taking him to the hospital and stated that he did not want to see them again in the future.

2.71 Mr L was initially admitted to East 3A (Psychiatric Intensive Care Unit - PICU) where he refused to sign his Patient Rights Form and subsequently put small pieces of paper inside his ear. This resulted in Mr L being taken to the University Hospital of Wales to remove the foreign objects.

2.72 Over the next few days Mr L was noted to being settled on the ward but with no insight, however he agreed to accept medication. On 16 April 2007

Mr L was transferred from PICU to the Rawnsley Unit. Following discussions between staff and Mr L's parents it was revealed that he had recently been experiencing some problems which they felt may have contributed to his deterioration. These were a break up in his relationship with his girlfriend and events at work which had resulted in him being off on sick leave for the past week.

2.73 Mr L was assessed by the Crisis Resolution and Home Treatment Team (CRHTT) on 18 April 2007 for early discharge on 20 April 2007. It was agreed on 20 April that Mr L would be discharged from the Unit and would receive daily home visits from a member of the CRHTT to monitor his condition and compliance with medication.

2.74 Prior to his discharge Mr L drafted a statement of conditional discharge from the ward in which he agreed to the terms of discharge with Consultant Psychiatrist 2. In the letter Mr L stated:

> '*I have agreed with my Doctor that I am hereby released from Rawnsley Unit Acute Ward today (Friday 20 April 2007), on the understanding that I will continue to take Risperidone at the prescribed dose until told/advised otherwise. CPN's will visit me at home for a week or so and I will attend appointments with GP/doctor from time to time. I will be discharged from my section after a week from today if conditions are satisfied. Many thanks to those who assisted me'.*

2.75 On 21 and 22 April 2007, Mr L was on leave from the ward. He was visited by the CRHTT and stated that he was happy to be home was currently complying with his medication and would continue to do so. Mr L was noted to be well and talkative throughout the visits. He informed staff that he was eating and sleeping well and stated that he was happy to engage with the CRHTT.

2.76 However, on the morning of 23 April 2007, Mr L's Mother contacted the CRHTT to disclose her concerns that her son was not taking his medication as when she had recently questioned him; he became quite hostile and had accused her of not trusting him. Her concerns were magnified when she noticed that there were only a few tablets missing from his new supply of medication, Mr L stated that he had been taking tablets from his old supply. It was agreed that when Mr L was next visited at home by the CRHTT, his old medication would be removed to eliminate the risk of any confusion.

2.77 Mr L was again visited by CRHTT and at the time of the visit was outside tending to his car. Mr L stated that he was feeling a lot better since his stay in hospital. He was considering taking two or three weeks off work to recuperate as he was feeling a little stressed, and had plans to change his job in the near future to do something in auto mechanics.

2.78 On 25 April 2007, a CRHTT Staff Grade Psychiatrist 1 visited Mr L and his Mother at their home. Mr L stated that he was adhering to his medication regime and had noticed an improvement in himself as he was experiencing less anxiety and was able to come to terms with his recent split from his girlfriend. He also denied any suspicious or paranoid thoughts.

2.79 The Doctor did not observe any agitation, irritability or active psychotic symptoms but did note that Mr L was slightly anxious at the beginning of their discussion, however he settled down well. Mr L's Mother stated that she felt that he occasionally got agitated, especially in the evenings. However, she acknowledged that his condition had improved.

2.80 The Mental State Examination completed by the Doctor recorded that Mr L was appropriately dressed with relevant and coherent speech. His mood was *'OK'* but was observed to be slightly anxious. There were no major depressive or suicidal thoughts and he denied any paranoid ideas. Mr L was noted as having partial insight into his illness but was unable to directly link taking medication and his improvement in condition.

2.81 On 26 April 2007, Mr L was reviewed on the Rawnsley Unit by Consultant Psychiatrist 2 who noted that he was less agitated but remained unwell and had no insight into his illness. During their conversation, Mr L relayed concerns around the mental health of his parents as he reported that they were doing '*bizarre things'* and gave an example of his Mother moving magazines around his room and only vacuuming certain areas of his carpet. He also believed that his father was *'very distressed and he was alternately smiling in a trance'*. Consultant Psychiatrist 2 recorded that:

> *'When Mr L started talking about his parents it seemed clear that this was the centre of some of his delusional thinking. He became talkative when discussing their issues and moved from subject to subject without interruption. Mr L still does not understand the circumstances to his previous admission. He believes that he took his parents to be admitted for respite but the Doctor felt that it would be easier to admit him to enable him to relax from the anxiety his parents were causing him'*.

2.82 It was decided by Consultant Psychiatrist 2 that due to Mr L's engagement with CRHTT and the improvement in his condition he was to be discharged from section 2 to his parent's home with immediate effect and continue to be followed up by CRHTT. However, Consultant Psychiatrist 2 noted that if Mr L did not comply with his medication or if his delusional ideas become more apparent, he would require assessment under section 3 of the Mental Health Act.

### Mr L's third Admission to Whitchurch Hospital

2.83 The following day (27 April 2007), Mr L telephoned the CRHTT from outside his home and spoke to a member of the nursing team. He stated that he could not return to the house as his father was walking around threatening him with a knife. It was noted that during the conversation Mr L appeared to be very paranoid and psychotic.

2.84 Concurrently, Mr L's father was contacted by another member of the CRHTT. He stated that the family were struggling to cope with Mr L's current condition which he described as psychotic. He relayed concerns about his son's recent behaviour. He had been keeping flammable materials in his bedroom, sitting in his car with the door open obstructing the road and then refusing to move it when asked and also he recently threw away his brother's glucose monitor for his diabetes.

2.85 It was decided and agreed with Mr L's father that the CRHTT would visit Mr's home address and administer medication in order to reduce his symptoms. However, Mr L refused to have any contact and stated that the medication would not help to maintain his safety.

2.86 The CRHTT made arrangements with the duty doctor to prescribe as required medication (Haloperidol[17] 5mg and Lorazepam[18] 2mg). The Shift Co-ordinator and the Emergency Duty Team (EDT) were also notified of the situation in case a Mental Health Act Assessment was required, should Mr L refuse any medication. Whilst the process was being organised Mr L's Mother contacted the CRHTT to inform them that Mr L was still sat in his car on the drive and was refusing to return inside the house. Due to becoming increasingly concerned for her son's well being Mr L's Mother contacted South Wales Police at 23:00 to request that they attend the house to assist with the developing situation, until the CRHTT arrived.

2.87 The Police arrived at Mr L's home address and persuaded him to go back inside the house to wait for the CRHTT to arrive. The CRHTT arrived

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[17] Haloperidol is used to relieve the symptoms of schizophrenia and other problems which affect feelings and behaviour. These problems may make individuals hear, see or sense things that are not there, or believe things that are not true and/or feel unusually suspicious. Patients may be prescribed haloperidol to take for a short while to try to get such symptoms under control.

[18] Benzodiazepines like lorazepam are prescribed for short periods of time to ease symptoms of anxiety or sleeping difficulties caused by anxiety. Lorazepam works by affecting the way some chemicals in the brain (neurotransmitters) pass messages to brain cells - this has a calming effect. It also helps by relaxing tense muscles.

along with CPN3 and on arrival it was recorded that Mr L was '*clearly psychotic in presentation and there were signs of paranoid thoughts'*. He was also refusing to take any medication and had no level of insight. Mr L informed the staff present that he had been compliant with his medication, however his father stated that was not the case.

2.88 Staff attempted to administer the required medication; however Mr L refused. Due to Mr L refusing to go to hospital to be assessed and refusing to take any medication, the EDT team were contacted again by the CRHTT in order to facilitate a Mental Health Act Assessment at Mr L's home. However, due to another assessment the EDT were unable to attend for a further two hours. The CRHTT informed the police officers present and Mr L's parents became more concerned for theirs and their son's safety.

2.89 Consequently, the police officers present asked Mr L to speak with them outside the house, which he agreed to do. When they were outside Mr L was immediately restrained by the officers and removed under section 136 of the Mental Health Act. At 01:30hrs on 28 April 2007 Mr L was then taken to Whitchurch Hospital for further assessment.

2.90 Upon arrival at the Hospital Mr L was assessed by the Consultant on-call and an Approved Mental Health Professional. It was recorded that throughout Mr L's assessment he refused to discuss anything until he was seen by Consultant Psychiatrist 2. However, due to the information provided and his presentation, the Consultant on-call completed the first part of the medical recommendation for section 2 and Mr L was admitted to East 3A (PICU).

2.91 A risk assessment was completed upon admission to the hospital and it was recorded that Mr L was an absconding risk due to the incident prior to his previous sectioning in 2003. Mr L was also noted to being *'acutely unwell', 'thought disordered with very poor insight'* and it was recorded that there was

a *'history of non compliance with his medication'*. Mr L was also noted as being unsettled and was observed pacing the ward and his bedroom.

2.92 Mr L's parents informed staff that they were struggling to cope as they were extremely anxious about their son's well being. They felt that he needed to be admitted to hospital so that he could be under closer supervision, as he was so unpredictable. They were extremely distressed that their son had been discharged the previous day (26 April 2007), a decision which they felt was inappropriate given his current condition.

2.93 For the next few days it was recorded that Mr L was unsettled on the ward, was still refusing any medication and was observed responding to auditory hallucinations. Mr L was noted to be drinking copious amounts of water which caused him to vomit. He was subsequently seen by the duty doctor who advised him to reduce his water intake.

2.94 At this time it was recorded that Mr L began engaging with his solicitor as he wanted to appeal against his detention.

### May 2007

2.95 Due to Mr L's continuing refusal to take oral medication he was placed on Section 3 of the Mental Health Act on 1 May 2007. Following this, a depot antipsychotic medication (Depixol[19] 20 mgs) was administered.

2.96 For the next few days Mr L isolated himself in his room and his behaviour was noted to be '*challenging and disruptive*'. He continued to lack any insight into his illness and had a poor sleep pattern and there was some

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[19] Depixol injection contains the active ingredient flupentixol which 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.

Flupentixol works on the balance of chemical substances in your brain. Long-acting or 'depot' injections are used once your symptoms have been eased by taking tablets. The injection slowly releases flupentixol into your body and is given every 2-4 weeks. The main advantage of a depot injection is that you do not have to remember to take tablets every day.

religious thoughts voiced. As a result the decision was made to increase his depot medication to Depixol 40mg. The injection was scheduled to be given to Mr L on 8 May 2007. However, this was not received due to Mr L being discharged from section on the scheduled date.

2.97 On 7 May 2007, Mr L's parents submitted a letter to his ward addressed to The Mental Health Act Tribunal. The letter detailed their concerns that Mr L would be discharged from his section following the tribunal scheduled for the following day. They stated that they were worried that a discharge at this stage would be too early and would result in a repeat of the events which occurred prior to his admission on 27 April 2007. In the letter Mr L's parents request that it was not to be shared with their son.

2.98 On 8 May 2007, Mr L's Mental Health Act Tribunal was held and it was decided that Mr L would be discharged from hospital. The reasons for Mr L's discharged were detailed as:

> *'The Tribunal was satisfied that the patient had been suffering from a mental illness but was not satisfied that it remained a nature or degree which made it appropriate for him to be liable* ***[sic]*** *detained'*.

2.99 Mr L also gave evidence to the tribunal and it was noted by the Tribunal that:

> *'The patient gave evidence and displayed no evidence of thought disorder despite persistent challenging questions from the medical member of the tribunal. The patient at times was mildly inappropriate and does continue to hold false views regarding nursing staff but these do not justify a finding that he continues to suffer from a mental illness of a nature or degree which makes it appropriate for him to be liable* ***[sic]*** *detained. The tribunal does urge the patient to engage with the Mental Health Services to obtain appropriate care and treatment to secure his long term mental health'*.

2.100 The following day Mr L was discharged from hospital to his parent's home address. A discharge summary was sent to FEMC date 9 May 2007 which stated that Mr L was being discharged from section and the CRHTT and that the follow-up arrangements were *'To be arranged following discharge from the Rawnsley Unit'*. However, there was no contact between Mr L and any health service in the two months immediately after his discharge.

## Mr L's Fourth Admission to Whitchurch Hospital

### July 2007

2.101 On 2 July 2007, Mr L's Mother contacted the Links CMHT to inform them that his mental health had deteriorated and he had left the family home the previous day, stating that he would contact them if he needed anything in the future. She was unaware of his whereabouts. Mr L had previously cancelled a CMHT appointment which was scheduled a few weeks earlier. Mr L's Mother was advised to contact the Police if she was concerned about her son's well being. Subsequently Mr L's mother contacted South Wales Police to report her son as a missing person.

2.102 Later the same day, staff working at a bank in Usk, Monmouthshire contacted Gwent Police as they were concerned about a man with a briefcase chained to his wrist and belt (Mr L), who had entered two banks and a post office in the area on numerous occasions and was acting suspiciously.

2.103 At the same time, Gwent Police Officers were investigating Mr L's vehicle which was unattended and parked on double yellow lines in Porthycarne Street, Usk. They found Mr L near the town square and stopped him. He was described by officers as being '*clearly agitated, aggressive and was visibly shaking'*. Mr L initially refused to provide any details and would not allow the officers to search him. However, the officers were able to persuade him to accompany them to his car where they could carry out a search of his vehicle.

2.104 Whilst the officers were searching his vehicle, Mr L placed the briefcase which had been chained to his wrist and belt on the front seat of his car. Subsequently, the officers searched the briefcase and found what appeared to be a Colt handgun (this was later revealed to be an imitation gas air weapon, which was loaded). Mr L also had a pair of latex gloves in his possession and a safe on the rear seat of his vehicle.

2.105 Mr L was arrested at 11:00am by the officers on suspicion of *'going equipped to commit a robbery'*. It was reported by the arresting officers that Mr L resisted arrest and as a result had to be forcefully arrested, which included the use of CS gas. Mr L was subsequently taken into custody, and it was recorded that it took three officers to restrain him. One of the officers sustained a cut to his mouth.

2.106 Once Mr L was in custody, the arresting officers were made aware of the previous concerns about Mr L, raised by the staff at the bank. During his time in police custody, Mr L was observed to have a '*strange presentation'*. Following this, numerous enquiries were made by officers including a visit to his parent's home address by a Detective Constable and six uniformed officers to search his bedroom. Mr L's parents informed the officers that their son had a history of mental health problems. Subsequently, Mr L was reviewed in police custody by a mental health professional and deemed unfit for interview. He was then immediately transferred to Ward East 3A (Psychiatric Intensive Care Unit) in Whitchurch Hospital and detained under section 2 of the Mental Health Act.

2.107 Mr L was admitted to the ward at 05:00hrs on 3 July 2007. On arrival he was handcuffed and was accompanied by two police officers, a social worker and a member of nursing staff. He was searched by the police prior to arriving on the ward and a lock knife was found on his person. This was later handed over to staff for safe keeping.

2.108 Staff noted that Mr L appeared to be in a lot of discomfort especially with his eyes when he arrived on the ward. When the handcuffs were removed Mr L was assisted to the bathroom area to wash his face. He was also provided with clean clothes.

2.109 A physical assessment was completed by the duty doctor and Mr L was offered PRN[20] medication, which he refused. It was noted by staff that his speech was bizarre in content and he was also speaking with an accent. Mr L was subsequently placed on 15 minute observations due to his behaviour and following his exposure to CS gas.

2.110 Later that afternoon (3 July 2007), it was documented by staff that Mr L was much more settled on the ward and was pleasant on interaction although on occasion had become suspicious. During conversation with staff he denied that any incident had occurred with the police the previous day and the reason he had been brought to the hospital was because his car did not have an MOT. Mr L informed staff that he did not want any information to be passed on to his family about his admission to hospital and he did not want to have any contact with anyone, including his parents.

2.111 On arrival to the ward Mr L was asked by staff to provide a urine sample for drug screening which he refused to do. Instead, he filled up the sample bottle with water and was adamant it was urine when he was challenged by staff.

2.112 On 4 July 2007, Mr L was reviewed by Consultant Psychiatrist 1 who recorded that:

> *'Mr L is currently on section 2. He was discharged by the tribunal 6 weeks previously after presenting with a sub acute psychotic episode with schizophreniform symptoms. He did not engage with services and*

[20] PRN is as and when needed medication

*was quite isolate and paranoid. He was arrested by police with a dangerous weapon. He has also spent excessive money'*.

2.113 On mental state examination Consultant Psychiatrist 1 recorded that:

*'Mr L's behaviour and presentation in the interview was normal. He tried to rationalise his behaviour and does not accept that he has any mental health problem. There is a marked paranoid process'.*

2.114 Consultant Psychiatrist 1's initial plan for Mr L was to continue with observations, to prescribe Amisulpride[21] (an antipsychotic) syrup 200mg twice a day and to see him again on 6 July 2007 to subsequently decide on a treatment plan.

2.115 For the next few days on the ward, Mr L continued to display no insight into his illness and refused any oral medication which meant that depot injections of Haloperidol 10mg and Lorazepam 2mg were administered on 7 July 2007. Mr L was observed to be subtly responding to unseen stimuli and was clearly displaying paranoid and psychotic delusions in relation to radiation and bombs. He also appeared to be fixated on his cleanliness as he was observed to be spending long periods in the bathroom area, washing his hands and brushing his teeth excessively and he refused to open doors or eat with bare hands.

2.116 It was recorded by staff that Mr L remained very guarded, was difficult to engage with and was isolating himself on occasions. The were occasions noted where Mr L had become quite intimidating and hostile with staff and he was only willing to discuss matters which concerned him, such as obtaining section 17 leave. Mr L's interactions with other patients were noted to be short and unsuccessful. He was observed on several occasions to be deliberately provoking other patients on the ward and made numerous accusations that other patients had threatened him.

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[21] Symptoms of schizophrenia include hearing, seeing, or sensing things that are not real, having mistaken beliefs, and feeling unusually suspicious. Amisulpride will help to ease these symptoms. It works on the balance of chemical substances your brain.

2.117 Mr L refused any contact with his family and refused to wear any of his own clothes which his parents had brought to the ward, stating that they were not his property. Instead, he wanted to borrow clothes from the ward.

2.118 On 10 July 2007, Mr L's parents submitted a letter to the Mental Health Tribunal (copied to Consultant Psychiatrist 1 and Ward Manager of East 3A). In the letter they firstly question the '*outrageous'* and *'disastrous'* decision to discharge their son on the 8 May 2007, firstly following the decision by his psychiatrist to increase his section from a 2 to a 3 due to his deteriorating mental health and also following receipt of their concerns prior to the Tribunal taking place.

2.119 The letter detailed the events which followed Mr L's discharge from hospital. These included a period of living rough in his car, running up a debt of £9000 in the two month period and buying numerous items including a 4 wheel drive vehicle. Mr L also had repeated confrontations with neighbours for frequently blocking off the street with his car and also they were made aware of an altercation with a work colleague. Mr L's parents stated that these issues were completely out of character for their son.

2.120 Their letter also made reference to the incident in Usk which resulted in their son's arrest and current admission. His parents stated that when they were visited by the police officers on the evening of 2 July 2007, they were informed that as their son had a replica gun on his person, should he have '*taken it a step further'* it could have resulted in him being shot by an armed response team.

2.121 Mr L's parents' letter requested that when their son appeals against his detention that the tribunal *'consider most carefully the consequences of releasing him before he has had any treatment. As he has constantly refused any prescribed medication for over the last six to nine months*'. The letter also

stated that '*they were worried that his next inevitable confrontation with the police may prove fatal'.*

2.122 The letter concluded with his parents stating that *'should their son be released without proper treatment again, they will have no alternative but to take civil action against all parties that they consider to be negligent in this matter'.*

2.123 Due to Mr L's ongoing non compliance with oral medication, it was decided on 10 July 2007 that a depot injection of Depixol 20mg a week would be prescribed. Mr L initially refused the injection as he stated that he did not need any medication. However, following further explanation from staff of the legal aspects of section 2 of the Mental Health Act, Mr L reluctantly complied and accepted the injection which was administered on the same day (10 July).

2.124 On 11 July 2007, Mr L was noted as being very demanding on the ward in relation to his section 17 leave. He asked to see the papers for his leave and stated that there were mistakes on the form. He therefore '*ripped it into pieces'* and handed it back to the staff member. It was noted that staff observed Mr L on several occasions deliberately provoking other patients on the ward. Later the same day he reported that he had been physically and verbally assaulted by a female patient. However, when questioned by staff Mr L stated that he did not wish to pursue the matter but wanted it to be acknowledged. Mr L made several complaints about staff and fellow patients during this period.

2.125 On 16 July 2007, the decision was made to increase Mr L's Depixol to 40 mg a week. On the same day Mr L was notified that his Mental Health Review Tribunal had been arranged for 20 July 2007. Subsequently Mr L informed staff that he did not consent to any of his family being notified of the scheduled tribunal.

2.126 On 17 July 2007, a nursing report was drafted by the Band 5 Nurse on Ward East 3A which concluded that:

> *'It is felt by the nursing staff involved in Mr L's care that he should remain as an in-patient in the hospital setting in order for a thorough assessment and treatment plan to be put in place for him. As Mr L poses a potential risk to himself and other people, it is felt that Mr L should remain as an in-patient until he develops more insight into his mental illness and agrees to comply with prescribed medication. Once insight and compliance with medication has acquired then it is felt that unescorted leave should be gradually introduced leading to support from the community team'.*

2.127 Later the same day, Mr L was transferred to the Rawnsley Unit and the care of Consultant Psychiatrist 2 due to bed pressures on East 3A. Following admission to the unit it was recorded that Mr L continued to lack any insight into his illness, needing to be in hospital or how his action prior to his current admission caused concern. There was minimum interaction with others and he was isolating himself in his room. However, there were no bizarre behaviours or any overt signs of psychosis; however, Mr L was noted as being '*guarded and suspicious'.*

2.128 On 20 July 2007, Mr L's Mental Health Act Tribunal was held and it was decided that he would not be discharged from section 2 of the Mental Health Act, 1983. The conclusion reached by the Tribunal was as follows:

> *'The Tribunal is satisfied that the patient is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period. The Tribunal is satisfied that the patient's detention as aforesaid is justified in the interest of his own health or safety or with a view to the protection of other persons'*.

2.129 The reasons for the Tribunal's decision were documented as:

*'This is Mr L's third section 2 admission since April 2007. The current admission arose following an incident where he was arrested near a bank in Usk and was found with a briefcase which contained an air pistol. Following his admission into hospital the nursing notes describe him as displaying delusional beliefs. Although, denying these beliefs, he was unable to offer a credible explanation for the events leading up to his admission or for the symptoms described in the nursing notes. Also Mr L has continued to be non compliant with medication and with services in the community, and confirmed during his Tribunal hearing that he would not be compliant either if he was discharged nor if he remained as an informal patient'.*

2.130 On 23 July 2007, Mr L was reviewed during the ward round. It was felt by Consultant Psychiatrist 2 that due to Mr L remaining unwell, his lack of insight and the ongoing issues with his non compliance with medication, his section was to be converted to a section 3.

2.131 Consequently, on 27 July 2007 Mr L was officially placed on section 3 of the Mental Health Act, 1983. Staff explained Mr L's rights to him which he appeared to understand. However, Mr L remained belligerent about the issue and stated that if he had to take his medication he would prefer to take it orally and would refuse any type of injection.

2.132 On 30 July 2007, Mr L was seen on the ward round by Consultant Psychiatrist 2. During this meeting Mr L agreed to take oral medication regularly and stated that the liquid Amisulpride was helping. He was started on liquid Amisulpride and further depot injections were stopped. Mr L was referred to the physiotherapist for exercise and it was agreed that if all went well he would be considered for unescorted leave.

### August 2007

2.133 Over the next 10 days on the unit, Mr L was recorded as being more settled and had agreed to take oral Amisulpride rather than the depot

injections. It was reported that there was no evidence of any psychotic symptoms or behavioural issues by staff during this period. Mr L had also been engaging with the ward activities and had begun communicating with his family again.

2.134 As a result of Mr L's improvement in condition, it was agreed following a ward round on 3 August 2007 that he would be granted section 17[4] unescorted leave up to three to four times a day and staff discussed the possibility of overnight leave with Mr L's mother. Mr L was referred to the CRHTT for early discharge and was seen by a CRHTT Staff Grade Psychiatrist 1on the Rawnsley Unit. The staff reported that he was engaging well with the current treatment plan but that his mother was not keen to see him discharged at this stage. A CPA meeting[22] was scheduled for 9 August 2007. The CRHTT were invited to attend to allow them to assess his current condition to consider the possibility of early discharge.

2.135 Prior to the CRHTT assessment, a member of the team contacted Mr L's Mother to provide her with the opportunity to raise any concerns in relation to the possibility of him being discharged under the care of the CRHTT following the assessment. Mr L's Mother stated that her son's day leave visits had been going well, however she did believe that he was masking symptoms as he did not wish to be in hospital. She also relayed that during her conversations with her son, he had informed her that he was not ill nor has he ever been and that he did not need to be on any medication. She informed staff that she was concerned as her son had contacted the Police to see whether he could get his gun back from them.

2.136 Mr L's Mother was worried that should he continue to pursue his discharge via the Tribunal he may be able to find a plausible reason and be

[22] These review meetings are organised as necessary and usually take place at the CMHT. They are often attended by the Psychiatrist who is responsible the patient's medical treatment. This meeting is to ensure that the patient and those who are working with them are happy with the care plan and feel that it is relevant.

released. She thought that he would not engage with the CMHT if he was discharged. In closing Mr L's Mother stated that although she would like her son to be home, she felt that he would need to remain on section for at least another two months to ensure that he was compliant with medication in order to allow it to have some sort of therapeutic effect.

2.137 Following discussion with Mr L's Mother and the Ward Manager on Rawnsley Unit, the CRHTT decided that there needed to be more evidence of Mr L's engagement with staff, an improved mental state and further home leave with his family before the team would assess him for an early discharge. The team emphasised that Mr L's current belief that he did not suffer from a mental illness would make therapeutic engagement difficult. It was agreed that the CRHTT would contact the ward the following week to arrange a possible assessment.

2.138 For the next ten days Mr L's condition remained settled, there were no reports of obvious signs of psychosis and he was noted to be interacting well with staff and fellow patients. There were further periods of day leave, following which there were no concerns raised by Mr L's parents.

2.139 On 20 August 2007, Consultant Psychiatrist 2 reviewed Mr L during the ward round on Rawnsley unit and recorded that his condition had improved. Therefore, following discussion with Mr L and his Mother, a week's leave from the ward was agreed with the stipulation that the CRHTT would visit daily to administer medication.

2.140 On 21 August 2007 at 17:45 Mr L contacted the CRHTT to ask when they were going to be visiting him at home. However, the CRHTT had not received any notification or referral from the Rawnsley Unit. The CRHTT were unaware that Mr L had been discharged and unaware that one of the conditions of his discharge was the daily monitoring of Mr L by the CRHTT visiting. Subsequently the CRHTT contacted Mr L's mother to apologise for the miscommunication and informed her that a member of the team would

visit the following morning. Mr L's mother stated that no issues had arisen that day.

2.141 On 23 August 2007 a CPA/section 117[23] meeting was held on the ward. Consultant Psychiatrist 2, Mr L, his mother and a member of the CRHTT attended. Mr L stated that he was a little sedated and would prefer tablets (rather that liquid Amisulpride). He said that he was happy to take medication as long as it was necessary. The CRHTT agreed to visit daily and for the time being Mr L was to remain on Amisulpride liquid. However, on 28 August 2007 he was changed to Amisulpride tablets 200mg twice a day.

2.142 For the remainder of the week the CRHTT reported that during their home visits Mr L was noted to be pleasant and was observed to be taking his medication. In conversation with his parents it was reported that he was recovering well and there were no problems noted. However, following the home visit on 29 August 2007, the CRHTT staff member who visited Mr L, recorded that:

> *'Mr L remains very guarded about the important issues. His reluctance to engage on any meaningful level in regard to his illness, medication etc. is of great concern as he may well still be very unwell, but masking the symptoms'*.

2.143 On 30 August 2007, Consultant Psychiatrist 2 reviewed Mr L during the ward round at Rawnsley Unit and recorded that Mr L appeared a little better. Mr L stated that he had been taking his medication (now tablets) and now knows that he '*wasn't himself*' prior to his admission. He stated that he hoped to go back to work at HMRC within the next three weeks. The decision was made following the ward round for Mr L to remain on section 17 leave. An entry in the nursing notes on 31 August 2007 stated '*CPA meeting arranged for Thursday 6 September at 15:30. Social Worker 1 has been invited as*

[23] Section 117 of the Mental Health Act 1983 (MHA) places upon Health Authorities and Local Authorities a statutory duty to work together to provide after-care services for all patients who have been detained in hospital under a treatment section of the MHA (i.e. sections 3, 37, 47 and 48).

*have the CRHT (South). Mr L and his mother have been informed of the meeting, his mother has informed me that she may not be able to attend as she is working, but her husband will be able to come'*.

2.144 Subsequently, a CPA meeting was arranged for 6 September 2007 with the provisional plan to discharge Mr L from his section 3. However, following the arrangement of the CPA meeting the CRHTT requested that Mr L remain on section as they were concerned that he still lacked any insight and had informed that that he would stop taking his medication once he was discharged from section.

**September 2007**

2.145 On 2 September 2007, the CRHTT submitted a CPN referral to the Links CMHT in preparation for Mr L being discharged from CRHTT care into the care of the CMHT.

2.146 On 6 September 2007 Mr L's CPA review was undertaken on Rawnsley Unit. In attendance were Consultant Psychiatrist 2, CRHTT, Social Worker 1, Mr L and his father. Mr L stated that he was happy to continue taking his medication but asked for liquid medication as he felt that the tablets were giving him nightmares. Consultant Psychiatrist 2 agreed to this. Mr L also stated that he felt that he didn't need daily visits from the CRHTT and was happy with the suggestion to reduce the visits to every other day whilst arrangements were made to hand him over to the care of the Links CMHT.

2.147 During the review, the decision was made to discharge Mr L from section 3 and from the Rawnsley Unit. It was agreed that CRHTT would continue to visit him on alternate days whilst the Links CMHT handover was arranged and it was agreed that a section 117 aftercare meeting would be arranged for three months time. However, there was no evidence in the notes reviewed to suggest that this meeting took place. It was noted that a CPN referral to the Links CMHT was made by both the CRHTT and the Rawnsley

Unit with the aim of completing joint visits with the CRHTT and the CPN from the Links CMHT prior to Mr L being discharged from the CRHTT.

2.148 Subsequently, Mr L was discussed at the Links CMHT MDT meeting on the 11 September 2007. During the CRHTT feedback at the meeting it was noted that:

> *'Mr L was being seen every other day by the team and seemed to be doing OK. The CRHTT will be looking to discharge soon and it is noted that they will be referring for a CPN'*.

2.149 On 14 September 2007, the CRHTT forwarded a discharge summary letter to GP5 at FEMC. The letter provided a brief summary of the reason for the initial CRHTT referral and a summary of the treatment and intervention provided to Mr L including his current medication (Amisulpride 200mgs twice a day). The letter also stated that a CPN referral had been submitted to the Links CMHT for follow up and that an outpatient appointment was scheduled for Mr L at the Links CMHT on 26 September 2007. The CPN referral submitted was never actioned by the Links CMHT.

### Community-based Care 2007-2012

2.150 On 26 September 2007, Mr L was reviewed by Consultant Psychiatrist 1 in the Outpatient Clinic at the Links CMHT and he was recorded as being *'asymptomatic'*. Mr L was advised by Consultant Psychiatrist 1 to continue on Amisulpride medication and he would see him again in four weeks time. Subsequently, a letter was sent to FEMC on 10 October 2007 addressed to GP4 detailing this appointment.

### October 2007

2.151 On 23 October 2007 Mr L was reviewed by Consultant Psychiatrist 1 at the Links CMHT and is again recorded as being *'asymptomatic'.* Mr L was again advised to continue on Amisulpride 400mg daily and he would see him in another four weeks. A letter was sent to GP4 at FEMC to notify him of the appointment.

### December 2007

2.152 On 6 December 2007, it was recorded on the Paris Electronic Care Record that the Links CMHT Administration Manager assigned Consultant Psychiatrist 1 as Mr L's Care Co-ordinator[24].

### January 2008

2.153 On 10 January 2008, Mr L was reviewed by Consultant Psychiatrist 1 at the Links CMHT. It was recorded that Mr L was:

> *'asymptomatic after restarting his medication. He had better insight on the need of medication. He also gave a good account of his psychotic experiences'*.

2.154 Consultant Psychiatrist 1 advised for Mr L to continue on Amisulpride 200mg twice daily and scheduled another appointment for three months time. A letter detailing this information was sent to GP4 at FEMC.

### February 2008

2.155 Mr L visited FEMC on 7 February 2008 and saw GP7, who recorded that:

> *'Mr L was sectioned last year with psychotic type illness – he got better and returned to work in the Inland Revenue in October 2007. Has been fairly good until last few weeks as he was finding work stressful and felt he was not coping. Some paranoid feeling coming back with auditory mumbling when he was very stressed. Good insight into his situation'*.

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[24] A CPA care co-ordinator should be appointed to co-ordinate the assessment and planning process. The co-ordinator is usually a nurse, social worker or occupational therapist. The care co-ordinator should also make sure that the care plan is reviewed regularly. A formal review is made at least once a year. The review will consider whether CPA support is still needed.

2.156 As Mr L felt unable to work, GP7 issued him a Med 3[25] certificate for a two week period and asked Mr L to request a review appointment at the practice. GP7 noted that he would contact the Links CMHT to inform them of the concerns raised by Mr L. Mr L prescribed Amisulpride 100mg/per ml, 2ml (200mg twice daily) to be taken twice a day.

2.157 On 21 February 2008, Mr L visited FEMC and was reviewed by GP7, who recorded that:

> *'Mr L is coming to the conclusion that he isn't going to be able to go back to work to that particular job as it is too stressful. Mr L felt that he was stable while he wasn't working, he had good insight and knew who how to seek help if concerned. See in two weeks'.*

2.158 GP7 agreed to provide Mr L with a Med 3 certificate for another two weeks. Subsequently, over the next two months Mr L received a further three sickness certificates from FEMC due to stress related issues.

2.159 There was no contact with services until the 29 August 2008. Mr L was reviewed by GP8 at FEMC and the consultation record noted:

> *'Long history of paranoia – has not been seen by the Links CMHT since January – Mr L will make follow up appointment. Currently off work and thinks his job is exacerbating his condition – is requesting a letter to support a move to a less stressful position'.*

2.160 Later the same day, it was recorded that Mr L telephoned the surgery to notify them that he had been informed by the Links CMHT that he would be unable to get an appointment with the CMHT without being re-referred by his GP. As a result of this a referral was made on the same day by FEMC. Subsequently a CMHT appointment was scheduled for 21 October 2008.

2.161 Consultant Psychiatrist 1 saw Mr L on 21 October 2008, however there

[25] Med 3 certificate was a certificate issued by a doctor to confirm sickness absence from work. Med 3 certificates were replaced in April 2010.

was very little information provided in the notes documenting any discussions or judgements made during the meeting. However, following discussion with Consultant Psychiatrist 1 as part of our review, we were informed that Mr L asked for the Consultant's assistance in trying to reduce his hours in work. Following the meeting Consultant Psychiatrist 1 noted *'To write to employer'*. Subsequently on 27 October 2008, Consultant Psychiatrist 1 sent a letter to Mr L's employer, HMRC, providing a brief summary of Mr L's Mental Health issues. The letter stated that:

> *'he remains fragile and vulnerable to further relapse, however he is never a threat to anybody and is always a pleasant young man who is trying hard to lead a normal life as possible'.*

2.162 The letter continued:

> *'Mr L's emotional problems could be helped by changing his job if this is at all possible. He has difficulty in communicating with people for long periods and often becomes emotional and unable to concentrate'.*

2.163 On 20 November 2008, Mr L attended FEMC and saw GP8 who undertook a medication review. Mr L stated that he felt that he was improving and had recently seen Occupational Health at work with the view to being moved from phone contact with members of the public.

2.164 Mr L was subsequently moved from the Call Centre Team to the Administration Team within HMRC. There was no contact with the Links CMHT for the next 18 months.

2.165 On 10 December 2009, GP8 from FEMC sent a letter to Consultant Psychiatrist 1 to ask why Mr L has not been reviewed by the CMHT recently and requested that the issue is investigated.

2.166 Mr L visited FEMC on 23 December 2009 and was seen by GP9 who recorded that:

'*Mr L is not having any current follow up by Links Centre. He is keeping well and currently working part time. Had previously been stressed and depressed, but much improved currently and is taking his medication regularly. He will come back for reviews here'*.

2.167 On 15 January 2010, Mr L's mental health review was carried out at FEMC by GP8. During the review Mr L relayed concerns in relation to viral warts following which he was examined by GP8, reassured and provided with advice on treatment. Mr L's condition in relation to his mental health was noted to have improved and he was deemed to be '*low risk of suicide*'.

2.168 Mr L was reviewed by Consultant Psychiatrist 1 in the Outpatient Clinic at the Links CMHT on 6 May 2010. He was noted as being *'well, asymptomatic and in the stages of recover'.* Consultant Psychiatrist 1 advised Mr L to '*continue on Amisulpride 150mg twice a day and attempt to reduce the dose to 100mg twice a day in six months time'*. Consultant Psychiatrist 1 noted that he would see Mr L again in six months time.

2.169 Consultant Psychiatrist 1 reviewed Mr L again on 2 December 2010 during the Outpatient Clinic at the Links CMHT and recorded that '*Mr L is very well. Continues to be in remission and is doing three A levels with plans to study Medicine'*. There were no drug changes and it was agreed that Consultant Psychiatrist 1 would see Mr L again in six months time.

2.170 On 27 April 2011, Mr L was again reviewed by Consultant Psychiatrist 1 during Outpatient Clinic at the Links CMHT who documented that:

*'Mr L has been well for sometime. He is studying and working 12 hours a week. He has applied for an increase in hours, but this request was declined. He is quite happy to continue with the medication unchanged for a while'.*

2.171 Mr L's annual Mental Health Review was completed on 2 June 2011 by GP8 at FEMC. GP8 recorded that Mr L was '*feeling well'* and was working 12

hours per week at HMRC. Mr L was also thinking about getting his own flat. His weight was recorded as 88kg, height 188cm and B.M.I at 24.9. GP8 noted that Mr L's next mental health review was scheduled to take place 2 June 2012. However, this was to be Mr L's last contact with FEMC until the index offence

2.172 On 18 October 2011, Mr L was reviewed for what was to be the final time by Consultant Psychiatrist 1 at the Outpatient Clinic at the Links CMHT, who documented:

> *'Mr L is well and in the phase of recovery. He is working full time and taking Amisulpride 150mgs daily. I advised him to continue on the same dose for another year and gradually start to cut down by 50mgs every two months until he stops. I have not given him another appointment but quite happy to see him again in the future'.*

2.173 There was no further contact between Mr L and the Links CMHT until the index offence.

2.174 As part of the HIW review, members of the review team met with Mr L at Ashworth Hospital[26]. During discussion with the review team, Mr L said that approximately 10 months prior to the index offence; he stopped taking his prescribed medication completely.

[26] Secure hospitals are high-security hospitals that are used to treat people who are being held under the Mental Health Act, and who are thought to pose a significant danger to the public. There are three secure hospitals in England and Wales (Ashworth, Rampton and Broadmoor).

## Post Index Offence

2.175 Following the index offence, Mr L was arrested and taken to the segregation wing of HMP Cardiff on an ACCT[27] due to the nature of the offence. Mr L initially informed the officers questioning him that he knew the faces of the victims he had targeted as he recognised them as people he had seen locally who had been "gaslighting"[28] him. He stated that this was the reason he targeted them. It was later revealed that Mr L told the officers this as he did not want them to know that his hallucinations and auditory voices had caused him to carry out the offence, as this would indicate that he was mentally ill.

2.176 Following his arrest and charge, Mr L was subsequently transferred to HMP Long Lartin, Worcestershire on 23 October 2012, where he remained on remand for the next three months. During his time at the prison, Mr L refused any contact with his family, refused to take any medication and only agreed to eat bread and water. This resulted in him loosing approximately 4 stone in weight within three months. His rationale for this behaviour was that he felt that this was what *'normal prisoners ate'* and he wanted to be treated like a normal prisoner, not someone with a mental illness.

2.177 Whilst detained in custody, Mr L displayed a number of behavioural risks such as his refusal of all medication, his decision to restrict his consumption of food and fluid and the risk he posed of absconding. As a result of this behaviour and the nature of the index offence, it was agreed that Mr L could not be safely managed in the conditions of medium security. Therefore, a referral was made for an assessment by a Consultant Forensic Psychiatrist from Ashworth Hospital, Liverpool.

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[27] ACCT is a prisoner-centred flexible care-planning system which is designed to reduce the risk of suicide and self-harm

[28] Gaslighting is a form of mental abuse in which false information is presented with the intent of making victims doubt their own memory, perception and sanity.

2.178 Subsequently, on 3 January 2013 a forensic assessment was undertaken, and the decision was made for Mr L to be transferred to Ashworth Hospital on 24 January 2013. Following which, medication was commenced and his mental state settled.

## Chapter 3: The Findings

3.1 In attempting to identify the root causes that led to the tragic death of Miss A, on 19 October 2012, the review team has considered the periods of engagement that Mr L had with statutory services. These findings are described in the following sections:

- Discharge Arrangements
- Systems in place at FEMC to review Mr L's mental health care
- Monitoring medication compliance

### Discharge Arrangements[29]

3.2 There were concerns raised during this review in relation to the manner in which Mr L's discharges from hospital were managed.

3.3 The discharge arrangements following Mr L's admission in 2003 were appropriate. He was followed up at the Rawnsley Unit and seen by a CPN and Psychiatrist in the Links CMHT Outpatient Clinic. It was during this period that we learned of Mr L's reluctance to engage closely with services. He was however appropriately treated and followed up by the services. His contact with services ended due to the issue of his lack of engagement.

3.4 The discharge arrangements in relation to the 2007 admissions were less well organised and did not follow an accepted pathway of care, which would be expected for someone with Mr L's history of relapse and illness. Mr L had an early discharge in April 2007 and rapidly relapsed. However, the services responded quickly and readmitted him to hospital. His second discharge in May 2007 followed a decision by a Mental Health Act Tribunal. There was no attempt to follow him up and there was a period of two months where the Links CMHT did not have any contact with Mr L. Contact with

[29] The Mental Health (Wales) Measure came into force within 2012 and some of the issues highlighted within the following section would be covered by the measure. See: http://wales.gov.uk/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en

services was only reinitiated following a public incident in Usk, which resulted in Mr L being readmitted to Whitchurch Hospital under section.

3.5 His third and final discharge in September 2007 was inadequate. Given the nature of Mr L's psychosis, his risk of relapse, his history of repeated admissions and reluctance to engage with services, it would have been accepted practice to place him on the Care Programme Approach (CPA)[30] and to allocate a care co-ordinator. Prior to his discharge, two separate referrals were submitted to the Links CMHT (by the ward and the CRHTT) for CPN involvement. However, the decision was taken by the Links CMHT to follow-up Mr L via outpatient appointments with the Consultant, rather than allocate a CPN. It would be expected that Mr L would have been followed up by an appointed Care Co-ordinator (usually a CPN or Social Worker). This would be regarded as standard practice as part of the Care Programme Approach.

3.6 The decision taken by the Links CMHT to appoint a Consultant Psychiatrist as a Care Coordinator would not be considered standard practice in these circumstances. While attending the outpatient appointments with the consultant, Mr L received satisfactory follow up care. However, it is important to note that the consultant psychiatrist had a case load at times of over 300 patients, and thus contact during these appointments was often brief. Although there are no set case load amounts for consultants, having 300 people for whom one is responsible for could be regarded as excessive[31].

3.7 A possible benefit to Mr L of having had an assigned Care Coordinator at this time is that this may have assisted in building a better relationship between Mr L and the services available to him. A Care Coordinator would

[30] The Care Programme Approach (CPA) is the system that is used to organise many people's care from secondary mental health services

[31] Good practice for consultants can be found via: Royal College of Psychiatrists (2012) Safe Patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists.

have been better placed to monitor Mr L's compliance with medication and would also have been best placed to provide additional information with regards to Mr L's mental health and ability to maintain contact with his family.

3.8 It would be reasonably expected that under the circumstances Mr L would have been treated under CPA and assigned a Care Coordinator. This would have offered an opportunity to improve Mr L's engagement with services. It would also have allowed for closer supervision of his mental state and for earlier identification of deterioration in his condition. However, none of these conditions could have guaranteed to be successful in the longer term and there would be no guarantee that the assignment of a Care Coordinator would have prevented the homicide.

3.9 Further to the issues outlined above in relation to the Links CMHT, the review has found a number of organisational and systematic shortcomings which could have contributed lack of care of Mr L at the time, such as:

- It was reported that staff within the Links CMHT worked in one of two ways, either adopting an integrated team approach to patient care or by working in isolation. There was no consistent unified approach adopted by the Links CMHT.
- There was no overall manager at the Links CMHT at the time which meant no one had overall responsibility for the teams and it was reported that there was a clear lack of leadership at the time.
- Excessive case loads were reported by staff, with CPN case loads being as high as 30-40 patients and Consultants between 200-300 plus. The case load of the Consultant responsible for Mr L's outpatient appointments from 2007-2011 was at times in excess of 300 patients. Whilst we were told the case loads imposed on staff had been escalated to the Medical Director within the Health Board, we were unable to clarify how, when and if this had been communicated. As

detailed in the Department of Health's (1999) paper in relation to effective care in mental health services[32]:

- *'Good case load management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that staff in care coordinator roles are maintaining caseloads of suitable sizes with individuals who have active needs and that support and clinical supervision is provided'*.

- There were reports of inconsistent working practices in a number of areas. Additionally there was a lack of unified systems in place, for example, when managing new referrals and their allocation to members of the Links CMHT.
- There was no consistent approach used within the Links CMHT to deal with the allocation of new patient referrals. It was difficult to establish who attended referral meetings on a regular basis as there were no attendance lists available. There was both informality and inconsistency in approach. Again, there were reports of poor coordination between separate professional groups (Social Workers, CPN, Consultants and Administration etc.).
- It was reported that MDT meetings did not have the desired purpose and rarely would referrals be discussed or allocated to the appropriate teams. These meetings often had 20-30 members of staff and were unstructured.
- Concerns were also raised by staff during our review regarding the resource allocation for the CMHT sector areas. It was felt that the resource provision was not equitable given the population and morbidity in the area of Cardiff covered by the Links CMHT. Similar concerns around staffing levels at CMHT's were raised in a previous HIW Homicide report (Mrs A), which was published in May 2008.

[32] DH1999: 23 – Department of Health (1999) Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach: a policy booklet. London: DoH

3.10 Mr L was discharged from the Links CMHT by the Consultant Psychiatrist in October 2011. At this point Mr L was told to continue on the same medication dosage for the next year with the instruction to gradually reduce the dosage every two months until it had stopped completely. Mr L's medical notes had evidence that there was a risk of relapse when he was not on regular medication. However, there was no contingency plan developed in case of a relapse, nor was there a plan for the follow up and monitoring of the gradual reduction in medication.

3.11 There was no discharge summary or contingency plan completed for Mr L's final discharge in October 2011. It is noted that the Health Board criticised this in their own internal inquiry. Again, given Mr L's past history and the circumstances around his previous admissions, a discharge summary and contingency plan should have been circulated to the CMHT, FEMC and Mr L's family.

### Systems in place at Four Elms Medical Centre (FEMC) to review Mr L's mental health care

3.12 Mr L was first referred to the Links CMHT in early 2003 following of a visit by his mother to FEMC where concerns were raised in relation to his mental health. However, Mr L was reluctant to engage with the CMHT and did not attend the two appointments that were scheduled for him to see the Consultant.

3.13 Following another visit by Mr L's mother to FEMC in July 2003, to relay further concerns about her son's well being, arrangements were made by GP's at the practice for a home visit and subsequent mental health assessment to be carried out. This led to Mr L's first admission under section to Whitchurch Hospital. The review has found the FEMC acted accordingly in these circumstances.

3.14 Despite FEMC being instrumental in Mr L's first section in 2003, the notes reviewed have highlighted that there was very limited information

communicated to FEMC from the Links CMHT in relation to the subsequent admissions which occurred in 2007. There is no evidence to suggest that the practice were fully aware of the extent and severity of Mr L's mental health history, especially in relation to Mr L's first and third admissions during the period of April to September 2007. FEMC were provided with no information about the circumstances of Mr L's admissions nor were they made aware of any subsequent discharge, contingency or crisis plans.

3.15 The review has also noted a number of other issues:

- There are no named Doctors for patients at FEMC. Patients can and do see any doctor. This is not unusual in general practice. There was no single doctor with overall responsibility for Mr L and throughout the notes reviewed we identified nine different GPs had seen Mr L in relation to his mental health over a nine and a half year period. The FEMC internal review and our discussions with staff noted that Mr L could not be remembered specifically by any Doctor at the practice, including the GP who undertook three of Mr L's mental health reviews and was the lead for mental health at the practice. However, we were informed that Mr L's family were well known to the partners in the practice.

- The system used for incoming patient correspondence resulted in letters in relation to Mr L not necessarily going to the same doctor. An example of this was provided during our discussion with GP8, who carried out Mr L's final three mental health reviews at FEMC, we were informed that GP8 had not seen any correspondence from Links in relation to Mr L, including the final letter sent from Consultant Psychiatrist 1 in October 2011. Again, in a busy practice, this is not unusual. The letters however were in Mr L's electronic records and could have been accessed by any doctor who saw Mr L.

3.16 Between 2003 and 2012 there were various sources of guidance for GPs and CMHT's detailing how patients with schizophrenia should be monitored and how their physical health should be assessed. This guidance included:

- NICE guidelines on schizophrenia – 2002. This was updated in 2009 and published in 2014[33].
- Guidance on the mental health indicators in Quality and Outcomes Framework of the new GP contact – April 2004[34] onwards; and
- British National Formulary (BNF) – Guidance on the monitoring of patients taking anti-psychotic medication – September 2011[35] onwards.

3.17 Initially the NICE guidelines stated that the physical health checks should include checks on smoking, alcohol, drugs, blood pressure, weight, body mass index (BMI), diabetes and cholesterol levels. The NICE guidelines are now more prescriptive on what should be included in the physical health check and the frequency of this check.

3.18 The NICE guidelines on *Psychosis and schizophrenia in adults: Treatment and Management* published in February 2014 includes a full section on monitoring patients with schizophrenia and monitoring their mental health.

3.19 During Mr L's illness from 2003 to 2012 there were no discussions between the Links CMHT and FEMC to determine who should perform these physical checks and the frequency of these checks.

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[33] Nice guidelines on Psychosis and Schizophrenia in Adults: Treatment and Management – February 2014 - http://www.nice.org.uk/Guidance/CG178

[34] Latest guidance is Quality and Outcomes Framework Guidance for the GMS Contract Wales 2014/15 – Published June 2014 http://bma.org.uk/media/files/pdfs/practical%20advice%20at%20work/contracts/gps/qofguidancegmscontractwales201415_v7.pdf

[35] http://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421-antipsychotic-drugs

3.20 FEMC took part in the Quality and Outcomes Framework (QOF)[36] from April 2004 and Mr L had mental health reviews which included a review of his medication, review of his physical health and a review of the coordination of his care. These reviews were scheduled to take place every 15 months and Mr L had five mental health reviews from 2004 to 2012. The data entered at these reviews was variable in terms of being comprehensive and Mr L only ever had one series of blood tests during this time which was in April 2005.

3.21 Although the review does not consider these issues to be contributing factors to the incident that occurred, there are clearly opportunities for FEMC to learn and improve following the issues identified in our review.

### Monitoring medication compliance

3.22 Throughout Mr L's mental health history, compliance with medication was repeatedly documented as an issue. We cannot therefore be sure that Mr L was ever fully compliant with his prescribed medication. What can be deduced however is that Mr L's relapses coincided with periods when we know he was not taking his medication.

3.23 Mr L's medication was collected from his local Pharmacy. We were informed that if there were concerns around compliance with medication, the Links CMHT would monitor these patients by asking them to collect their medication directly from the CMHT building. This arrangement was never put in place for Mr L's medication and there is no evidence to suggest this option

[36] QOF was introduced in 2004 as part of the General Medical Services Contract, the QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. NICE's role focuses on the clinical and public health domains in the QOF, which include a number of areas such as coronary heart disease and hypertension.

The QOF gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas, for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of the practice list size and prevalence. The results are published annually. From: http://www.nice.org.uk/aboutnice/qof/

was ever considered, which suggests that staff did not feel there was a risk of non compliance. This is despite the documented history of issues with Mr L's non compliance with his medication. Should such an arrangement have been put in place for Mr L it would have allowed for increased monitoring of his condition, and provided some assurances of his compliance with his medication regime.

3.24 Evidence provided by FEMC from their internal inquiry shows that not all prescriptions were ordered from 2004 to 2012. There were particular deficiencies noted in the periods leading up to Mr L's relapses in 2007 and 2012. The information below details the prescriptions issued for Mr L from 2006 onwards:

- 2006 – 2 out 12 expected prescriptions issued
- 2007 - 0 out of 12 expected prescription issued
- 2008 – 7 out of 12 expected prescription issued
- 2009 – 7 out of 12 expected prescription issued
- 2010 – 5 out of 12 expected prescription issued
- 2011 – 5 out of 12 expected prescription issued
- 2012 – 3 out of 12 expected prescription issued

3.25 The evidence above shows when the prescription was issued. However, at the time there were no existing systems to establish whether the prescription was collected by the patient or dispensed by the chemist. Additionally, there is no way of knowing for certain whether Mr L was routinely taking his medication and at what frequency.

3.26 It is important to note that this is a problem for most practices and applies to all patients taking any medication prescribed by their doctors and not specifically to patients taking medication for mental health problems. During our review, we were informed that since the index offence, FEMC has implemented an arrangement with some participating local pharmacies where they are informed should a patient fail to collect a prescription or if there is an

irregularity in the patient collecting their medication. This is very good practice and a very rare method of ensuring compliance.

3.27 From the information gathered during our review it can be deduced that Mr L's non compliance with medication was a causal factor in the index offence. Even with stricter monitoring and control arrangements, medical professionals could never have ensured that Mr L was fully compliant with his medication regime whilst he was in the community. Due to Mr L's guarded nature when it came to his illness, even if a CPN had been assigned to him, there was no guarantee that his non compliance with medication would have been identified.

## Recommendations

### In relation to Cardiff and Vale University Health Board

1. Cardiff and Vale University Health Board should provide HIW with strong and clear assurances that actions identified from the Health Board's own internal review following this tragic incident have been implemented and completed.

2. In relation to discharge arrangements, Cardiff and Vale University Health Board should ensure that a robust review process exists for all patients following their discharge from secondary care services / settings. This process should include measures to ensure that:
    a. A written contingency plan is developed setting out the action to be taken if an emergency/deterioration in a patient's condition occurs. This plan should be subsequently shared between the CMHT team, the patient's General Practice, the patient and the patient's carers (where appropriate).

3. In relation to communication, Cardiff and Vale University Health Board should:
    a. Review and consider the adequacy of communication and information sharing procedures between its Community Mental Health Teams, Crisis Resolution and Home Treatment Teams and GPs, and how these can be improved.

4. Specifically in relation to community-based mental health services, Cardiff and Vale University Health Board should:
    a. Undertake a review of the resources allocated to each of their CMHT's, ensuring that they are equitably, and adequately

resourced taking into account the population and morbidity for each CMHT area[37].

b. Since the incident the Links CMHT has implemented an Integrated Manager and new systems. Therefore, Cardiff and Vale University Health Board should provide clear and strong assurance to HIW that the new systems currently in place at the CMHT have addressed the concerns highlighted in this report. Specifically, these include:
    - Adopting an integrated and consistent team approach to patient care;
    - Ensuring that there is a clear management structure in place and clearly defined roles and responsibilities in place at the CMHT.

c. Ensure that all case loads are routinely reviewed and audited to ensure their manageability as per the guidance documents referenced in paragraphs 3.6 and 3.9 in order to identify where individual case loads are excessive. Appropriate action should then be taken to address any issues that emerge.

5. In relation to patient and carer engagement, Cardiff and Vale University Health Board should ensure that:
    a. Processes are in place to ensure that the views of relatives and/or carers of patients are taken into account when making decisions about their care.
    b. Where appropriate, families and/or carers of patients are fully informed about the decisions and plans in place for patient care, including effective communication of any subsequent discharge or contingency plans.

[37] Cardiff and Vale University Health Board should refer to a previous recommendation made in the Report of a Review in Respect of Ms A and the provision of Mental Health Services following a Homicide Committed in October 2005. Report Issued May 2008.

### In relation to Primary Care services

6. Cardiff and Vale University Health Board should assess the possibility of sharing the arrangement introduced by Four Elms Medical Centre (FEMC) in relation to monitoring the collection of patient prescription medication from their selected pharmacy across the Health Board area; thus ensuring better medication compliance for all conditions.

### In relation to The Welsh Government

7. The Welsh Government should seek assurance that there are protocols in place between Health Boards and Primary Care for all patients with psychoses. The protocols should include arrangements for medication monitoring and routine physical health checks in accordance with existing guidance. They should be clear about the respective responsibilities of primary and secondary care agencies.

8. The Welsh Government should consider the benefit of having named doctors at General Practices for patients with mental health conditions.

## Annex A

## Review Terms of Reference

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

Healthcare Inspectorate Wales (HIW) is to undertake an independent review of a homicide carried out by a mental health service user in the Cardiff area on the 19 October 2012.

The review will investigate the care and support provided to Mr L in the period prior to October 2012.

In taking this review forward HIW will:

- Consider the care provided to Mr L as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on the 19 October 2012.
- Review the decisions made in relation to the care of Mr L.
- Identify any change or changes in Mr L's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred 19 October 2012.
- 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.

**Methodology and timescale for the review**

The review will be managed by HIW and consist of:

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

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

The review will commence in the summer of 2013 and the final report will be published in the summer of 2014.

## Annex B

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

The annual report produced by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report[38] notes that between 2002-2012 the Inquiry was notified of 265 homicide convictions, an average of 24 a year. There were 276 victims, an average of 25 per year.

During 2002-2012, 26 people convicted of homicide, 10% of the total sample, were confirmed as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 2 per year, ranging between 1 and 5 annually.

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

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

## Arrangements for Reviews in Wales

From January 2007 all independent external reviews in these cases are to be undertaken by Healthcare Inspectorate Wales. Where the services reviewed include Social services, then arrangements are made to include social

[38] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2014

services inspectors from Care and Social Services Inspectorate Wales (CSSIW) in the review team.

## Annex C

## Arrangements for the Review of Mental Health Services in respect of Mr L

Reviews and investigations by HIW draw upon the methods, techniques and skills which will be most efficient and effective according to the nature of the matter to be investigated, its extensiveness and any constraints of time or other resources.

However HIW recognises the importance of structured investigations and is committed to the use of 'Root Cause Analysis' (RCA) to provide a formal structure for investigations, which may be adapted if circumstances make that appropriate. In taking forward this review HIW has ensured that the general principles which apply to investigation and upon which RCA provides guidance, have been followed and has made use of a number of the tools contained within RCA.

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

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

Dr Jed Boardman – Consultant Psychiatrist
Dr Rob Hall – General Practitioner
Mr John Murphy- Mental Health Nurse
Mrs Ann Jenkins – Lay Reviewer
Mr Ian Dillon – Investigations Manager
Miss Lisa Bresner – Assistant Investigations Manager

Mrs Lianne Willetts- Investigations Officer

The information gathering phase of the review was conducted between July 2013 and March 2014. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the Cardiff and Vale University Health Board. Although we have no authority to require information from the police, the review team also had access to the information in relation to their involvement with Mr L. We are grateful to the police for their collaboration.

- Reading the case records maintained by the Health Board, the Links CMHT, and Local Authorities concerning Mr L

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

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

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

## Annex D

## The Roles and Responsibilities of Healthcare Inspectorate Wales

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

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

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality.

Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary,

HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the

Welsh Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

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

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