Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

An Independent Review of the Circumstances which led to a Homicide during 2020

CTMSB 07/2021

The Fatal Event

On 5 May 2020, Ann* approached her local supermarket carrying a kitchen knife. She struck a man on his head as he left the store. Ann entered the supermarket where a woman customer became the next victim. Ann stabbed the woman and threatened to kill her.

When Adult C sought to intervene, Ann attacked him. A woman shopper intervened by placing a crate between Adult C and Ann. He fell to the floor and the woman dragged him away from Ann to the rear of the store. Another woman shopper who tried to help Adult C was stabbed. Ann returned to Adult C and hit him with improvised weapons. He died from blunt force trauma to his head.

During the hours before these unprovoked and random attacks, Ann's parents believed that she was in a mental health crisis. They recalled pleading for help for their daughter who had been a mental health inpatient ten weeks previously.

At her trial, Ann pleaded guilty to the manslaughter of 88-year-old Adult C by reason of diminished responsibility. She admitted to the attempted murders of three others. Ann was assessed as being "profoundly mentally ill" with schizophrenia at the time of the offence. She had been hearing voices telling her that people were going to slit her throat and she had ceased to take her medication because of the side effects. Ann received a Hospital Order with Restrictions under s.37/41 of the Mental Health Act 1983. It is without a time limit. She is detained at a high secure hospital.

*"Ann" is the pseudonym suggested by her parents. Adult C was fatally attacked by Ann.

A Summary

This review was commissioned by Cwm Taf Morgannwg Safeguarding Board during February 2022. It resulted from a fatal event at a supermarket during May 2020, which led to a 29 year-old woman pleading guilty to manslaughter on the grounds of diminished responsibility. This review builds on the independent investigation commissioned by Cwm Taf Morgannwg University Health Board (CTMUHB) and a request from Welsh Government that the perspectives of those associated with the tragedy should be sought. The agencies which worked with Ann shared documentation with the reviewers. Ann's own account of the significant events in her life are largely absent from this documentation and although the reviewers were keen to seek her views, it was determined that Ann was not well enough to engage with this review. Her parents contributed their perspectives and recollections.

Ann's contact with mental health services began during 2016. However, documentation provided by CTMUHB, Rhondda Cynon Taf County Borough Council, Probation, South Wales Police and Welsh Ambulance Services NHS Trust, Barod and the Oasis Centre confirms that Ann became known to a range of services, most particularly when she lost the custody of her child, and commenced intimate relationships with violent men. Between 2014-2015, she was known to be a "high risk" victim of domestic violence. The experience of her parents was that their well-being was profoundly tied to that of their daughter's well-being. Ann heard voices;[1] she reported feeling suicidal; she did not adhere to her prescribed medication; and she was known to misuse drugs and alcohol. Two violent outbursts involving close relatives, among other events, resulted in losing custody of her child. Later, Ann had a period of imprisonment.

Looking back, there were a number of potentially derailing events in Ann's early life.[2] Her parents described her school life as being blighted by bullying. She experienced many violent incidents as a teenager, principally as a victim, and she experienced significant bereavements. Ann had three admissions to psychiatric hospitals between February 2019 and February 2020. Within this period, she was hospitalised for 190 days in total. The first hospital discharge took place when she was on leave from the ward. Since Ann did not attend a three-day follow up appointment she was discharged in her absence. This meant that the scope for negotiating ongoing care and treatment with Ann was compromised. Ann had a "one-off" appointment with a Community Mental Health Team worker and separately, a psychiatrist. After the second hospital discharge there was no community follow-up. The third hospital discharge occurred days before the Welsh Government suspended all non-urgent appointments due to the COVID 19 pandemic. Ann was not present during the final hospital discharge. She was at her parents' on home leave which she reported as going well. She was visited at home on a single occasion during March 2020. When Ann ceased to be a hospital patient, there was no planned community support in place for her, since her Care Coordinator was not appointed until after her hospital

[1] Clinicians and her relatives assumed that these were auditory hallucinations

[2] See for example, Finlay, S., Roth, C., Zimsen, T. Bridson, T.H., Sarnyai, Z. and McDermott, B. (2022) *Adverse childhood experiences and allostatic load: A systematic Review* Neuroscience Biobehavioural Review May;136:104605. doi: 10.1016/j.neubiorev.2022.104605. Epub 2022 Mar 9. PMID: 35278597 (accessed 23 October 2022)

discharge. Therefore, the onus was on Ann and/ or her parents to make contact with services. Ann's parents, Mr and Mrs P,[3] were frustrated that mental health services did not engage with the reach of her distressing life events. They believe that these began when she discovered that the man to whom she was engaged and the father of her child left her. Ann's subsequent relationships were violent and Ann increasingly relied on drugs and alcohol. Over time, the voices Ann could hear became menacing. They threatened her. She reported feeling unsafe on at least 15 occasions during her hospitalisations. Ann was last seen by professionals, a social worker and nurse, on 2 March 2020. The pandemic precluded routine appointments. Ann was living with her parents at that time and this was seen by some agencies as a protective factor in her support. The local authority and the Cwm Taf Morgannwg University Health Board developed different processes for dealing with risk concerning the cancellation of appointments which diminished their collaborative capacity. This was against the backdrop of considerations concerning the transmission of COVID 19.

In terms of learning, the review identified the following:

1. Uncertainty concerning Ann's mental health status. Although she was the subject of 35 multi-disciplinary team meetings as an inpatient, the perceptions of some nursing staff differed from those of the seven consultant psychiatrists responsible for her hospital treatment. There was no negotiated crisis plan setting out the resources, operating procedures and responsibilities at the point of hospital discharge. Ann did not benefit from the succession of referrals within the hospital and community.
2. There are questions concerning the effectiveness of CTMUHB's complaints handling procedures despite the Health Board's reported adherence to *Putting Things Right*. Ann's parents were troubled by many aspects of Ann's care. It is possible that there were occasions during Ann's hospitalisation when their views eclipsed those of their daughter and their challenges estranged them from mental health and other professionals.
3. Even before the pandemic, the warning signs concerning Ann's rapid deterioration were not recognised or were poorly processed. She did not benefit from inter-disciplinary working.
4. It is not clear that services were attentive and responsive to Ann's decision making over time. Her decision-making capacity was not questioned.
5. Assumptions concerning families' willingness and ability to continue to provide accommodation and support require regular interrogation. Families who are supporting relatives in mental distress over long periods of time develop skills and strengths. There are times when these may be overshadowed by the difficulties that the relatives they care for are facing.
6. Ann was separated from her family and friends by men who were aggressive. Agencies working with Ann state that they did all that they could despite her ambiguous cooperation. Assurance is required that the Multi Agency Risk Assessment Conference's will disrupt the coercive power of individuals wherever there are opportunities to do so.

[3] Also anonymised

7. It is possible that the reflections of the people whose lives were affected by the fatal event are interim. That is, traumatic memories differ in terms of durability and they may change over time. The victims[4] continue to negotiate the complex consequences of their experiences. The personal consequences are wide-ranging and span feelings of guilt, of fragility, the importance of protecting and/ or comforting close relatives and the challenges of resuming working lives.

There are seven recommendations:

	Recommendation
1	Ann's narration of significant events in her life and her aspirations are largely absent from the documentation available to this review. Although the interpretation of her parents and the professionals who worked with her as an inpatient are important, they are not Ann's own account. Although CTMUHB has policies and procedures concerning person-centred care and conflicts of interest, the review raises questions of whether and how they were invoked. • **CTMUHB should provide assurance to the Regional Safeguarding Board that its process of encouraging people with mental health challenges to contribute to the information gathering concerning their medical, psychiatric and family history is being reinforced and embedded in practice. This is to ensure that significant events in patients' lives and, separately, what matters to them are captured in their own words. Separately, CTMUHB should advise the Regional Safeguarding Board of the actions it is taking to ensure that conflicts of interest are disclosed – most particularly when staff are, or have been, closely related to a patient.**
2	Ann's serial "Did Not Attend" appointments resulted in her case being closed to the Domestic Violence service. When Ann was in hospital there were two occasions when she Did Not Attend outpatient appointments (because outpatients had not been informed that Ann was an inpatient) resulting in her discharge from outpatients, and subsequently from the Primary Care Mental Health Service; and when Ann did not attend a "3 day follow-up appointment" on a ward where she had been an inpatient, no further appointment was offered. • **A history of missed appointments is a risk marker. CTMUHB and other relevant services should provide the Regional Safeguarding Board with evidence of proactive engagement with patients with mental health problems lost to follow-up appointments to reduce the risks arising from their failed attendance.**
3	There was merit in some of Mr P 's challenges [Mr P is Ann's father] concerning Ann's inpatient and outpatient care and treatment. On many occasions he had sought to

[4] One person prefers to think of themselves as a "witness"

	bring Ann's deteriorating mental health to the attention of professionals. He was comforted by glimpses of her progress but conflict and distress resulted when these were repeatedly halted. Generally, however, as the volume and complexity of complaints escalate, there are challenges in closing cases at the same time as additional complaints are opened. This impacts significantly on the handling of complaints, on staff and on the service available to other complainants. • **Complaints provide valuable feedback to services. CTMUHB should provide the Regional Safeguarding Board with evidence of (i) how it "triages" and works with patients and families who use the complainants process frequently; (ii) how it works with complainants who self-identify as having language based difficulties such as dyslexia, using voicemail, printing on coloured paper and/ or screen-reading software such as Texthelp, for example; (iii) how it facilitates and uses feedback and complaints' feedback specifically, concerning mental health service patients and their relatives; and (iv) how it supports staff who report feeling distressed and/or intimidated by complainants.**
4	Granting and withholding leave of absence are subject to legal provisions. Assessment of inpatients' mental capacity to consent to their treatment, give instruction concerning information-sharing and related matters, such as leaving the ward, should be undertaken regularly. • **CTMUHB should advise the Regional Safeguarding Board of what has been done since the its internal review to ensure that (i) the provisions of the Mental Health Act (1983) as amended and the Mental Capacity Act (2005) are correctly enacted; (ii) the systems in place now ensure that informal patients receiving inpatient care, whose treatment falls outside the MHA, are not denied leave; and (iii) it is promoting learning networks and a rolling programme of inter-professional training concerning the MHA, the MCA and the interplay between them.**
5	The adequacy of hospital discharge planning has implications for the use of community services and future readmissions. • **CTMUHB should inform the Regional Safeguarding Board of the ways in which the Mental Health (Wales) Measure (2010) is enacted and how its activities and those of local authorities are being changed and improved. In addition, the outcome of an operational audit to ensure that the specific statutory and regulatory requirements are met should be shared with the Regional Safeguarding Board.**
6	On 5 May 2020, Ann's parents contacted mental health services. They knew that her mental health had declined and, as advised, they sought help during this crisis. Responses to their phone calls fell short of their expectations. Since Ann did not have a Care and Treatment Plan in place, she did not have a crisis plan.

	• **CTMUHB should provide evidence to the Regional Safeguarding Board of its effective engagement with patients and their families in crisis planning. This should include the preparation of a brief accessible guide, in relevant formats, for staff to read through with patients and their families. Its purpose is to enhance people's understanding of likely service responses during mental health crises.**
7	News and media reporting wields great influence, most particularly when it includes graphic accounts of tragedies and other eventualities. How these stories are reported is of keen interest to the individuals and families affected by the incidents. • **A whole systems approach - in which partnership is imperative - is required if all University Health Boards, local authorities and the police are to be alert to the impact of news and social media reporting concerning their post incident processes. For example, if there is to be a Root Cause Analysis, it should be made explicit that this is a confidential process, the content of which will not be shared with the public. The NHS Delivery Unit, with the assistance of Welsh Government, is well placed to initiate such work with the police, local authorities and individuals who have been affected by incidents, accidents and tragedies.**

What we did

There was a series of complementary strands to this review. These began with discussing:

(i) The Core Tasks within the Terms of Reference and the practicalities of fact-finding
(ii) the implications of a "modified Adult Practice Review"
(iii) the deliberations of the 1 February 2022 Review Panel.

Cwm Taf Morgannwg Safeguarding Board met on 1 February 2022, at which the appointment of review authors was discussed. Virtual Review Panel meetings were held on 1 April, 23 May, 4 July, 21 September, 12 and 26 October, 11 November 2022, and 9 January 2023. Since a 12-month timeframe could not trace back to times of past traumas and their potential impacts on a young woman's life, contact with Ann and her parents was negotiated. There were two person-to-person meetings with Ann's parents and an extended 'phone call. They told their story, outlining critical events in her life and the sense that they have made of these. They re-experienced emotions as they recalled particular times. They described personal, social, local and cultural contexts. Necessarily there are different "takes" on the events they described. What their recollections revealed of their experience is not consistently aligned with the same events documented by the professionals with whom they were in contact. We indicate in the review where some accounts differ markedly from those of the professionals concerned.

During July 2022, contact with Ann was deemed inappropriate by the clinical team responsible for her care and treatment at the high security hospital.

We read the independent investigation commissioned by Cwm Taf Morgannwg University Health Board (CTMUHB) and undertaken by colleagues at Cardiff and Vale University Health Board and Rhondda Cynon Taf County Borough Council (RCTCBC) concluded during January 2021, including its associated action plan. In addition to the summary reports and chronologies of the organisations represented, clarifications were sought from their authors. Their responses became available during March to September 2022. During June and August 2022, more detailed information was sought from CTMUHB and South Wales Police. These were answered by the Patient and Care Safety Unit and the Public Protection Department respectively. They were received during July and October 2022.

Although relatives of Ann featured in the documents reviewed, only the status of her parents is specified in this review. Others are referred to as "relatives" or "close relatives."

Letters were sent to Ann's parents and to the people who were harmed by the events of 5 May 2020, inviting them to share their reflections. The meetings with the people who were harmed spanned May-June 2022. A meeting with Healthcare Inspectorate Wales took place

during September 2022. This was in response to its review of discharge arrangements for adult patients from inpatient mental health services in CTMUHB.[5]

The narrative chronology is derived from each of the agencies' chronologies and provided an early picture of the main themes. Elements of this became the principal focus of the Review Panel's discussions. However, since records are mute evidence they have to be interpreted without the benefit of commentary concerning the conditions in which they were written and the anticipated readership.

The minutes and actions arising from each Panel meeting were confirmed at the following meeting.

Sections of the report were circulated to Panel members during August - November 2022.

Keeping track of all meetings and the key individuals who engaged provided a record of the significant information gathered, accountability and governance. Notes were taken during all meetings and the accuracy of these was checked out with the interviewees. The Review Panel Chair undertook person to person meetings with some of the people who had been harmed. They are not identified. Following all meetings with individuals associated with the tragedy, de-briefings were timetabled.

Contributors to the Review

Thanks are extended to all contributors to this review since its inception:

Chair and Director of Social Services, Merthyr Tydfil County Borough Council

Head of Nursing, Child and Adolescent Mental Health Services, Cwm Taf Morgannwg University Health Board

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[5] https://hiw.org.uk/local-review-discharge-arrangements-adult-patients-inpatient-mental-health-services-cwm-taf (accessed on 27 June 2022)

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Particular thanks are extended to the Safeguarding Board Business Unit for its professional and first class support. We are indebted to the Chair for assistance in interviewing victims, meeting with Healthcare Inspectorate Wales and surefooted guidance. Particular thanks go to Ann's parents, the victims and Adult C's family. They have contributed immeasurably and helped to guide the review to its conclusions.

The Narrative Chronology

The chronology of events provided by each agency was merged into a single chronology. Since it was difficult to understand Ann's experience of the mental health system, an explanation of Cwm Taf Morgannwg UHB's mental health services was provided as follows:

"The Local Primary Care Mental Health Support Service (LPMHSS) provides Mental Health interventions under Part 1 of the Mental Health Measure[6] (MHM), usually for mild-moderate mental disorders.

The Community Mental Health Team (CMHT) provides a mental health treatment and support service to individuals under Part 2 of the MHM. This will usually entail support from a multi-disciplinary team, including psychiatry, and will mean the service user has an identified Care Coordinator and care plan.

The Crisis Resolution Home Treatment Team, (CRHTT) provides an urgent mental health assessment for those at risk of hospitalisation and, when appropriate, provides intensive home treatment as an alternative to admission.

There are referral pathways between each service. In particular, LPMHSS and CMHT share a triage process wherein cases are discussed to ensure the correct pathway."

Although "the timeframe set for the review will be 12 months prior to the event [with agencies requested] to provide summary reports of significant involvement prior to this date," the narrative chronology adopts the identical timeline to that of the UHB's Root Cause Analysis (RCA).[7]

January 2019

21 January: Ann was living with her parents. She made a late night call to the Crisis Resolution Home Treatment Team (CRHTT) about feeling suicidal. She expressed views about her parents which were recorded as "delusional." Ann's mother also spoke. She explained that Ann had not been taking her anti-psychotic medication and that the removal of Ann's child four years previously had been a major "stressor" in her daughter's life. An assessment was offered in the early hours but this was declined since it entailed transporting Ann to a service. Advice was offered and an appointment for the following morning was accepted.

[6] Mental Health (Wales) Measure 2010

[7] This is an accepted method used and endorsed by health services in England and Wales in response to adverse events. It seeks to determine systemic causes and prevent the recurrence of identical or similar incidents recurring retrospectively. See Neal, L.A., Watson, D., Hicks, T., Porter, M. and Hill, D. (2004) Root cause analysis applied to the investigation of serious untoward incidents in mental health services *Psychiatric Bulletin* 28, 77-77. See Appendix for CTUHB's description of how the Root Cause Analysis is nested in its investigation processes

22 January: Ann's parents made three calls: they rang the Community Mental Health Team (CMHT); the Royal Glamorgan Hospital (RGH); and the CRHTT seeking a home visit. They explained that they had received "no help since previous discharge." They were offered a late afternoon appointment. This was declined by her parents.

[The CRHTT explained that it does "not undertake crisis assessments at home." It is solely funded to undertake hospital based assessments.]

28 January: Ann's father rang the Local Primary Care Mental Health Team (LPCMHT) "to raise concerns…about the lack of support." He recalled that when the father of Ann's child left her, she had spent over two years begging for help at RGH. When she told a CRHTT practitioner that she had been subjected to a relative's sexual assault, "she felt she had been turned away despite feeling suicidal." He added that she had been abused by a former partner; she had been admitted for an assessment in Cardiff; and that she had lost trust in the Consultant Psychiatrist. In a return call, Ann's father was asked to put the request in writing "to see if the doctor could be changed in primary care." Her father explained that he is dyslexic.

[The same psychiatrists may operate in primary care and secondary care. Ann was receiving psychiatry in primary care which is also known as "Shared Care."]

During **January 2019**, the fragmented nature of mental health services is captured. Ann was seen by CRHTT and CMHT practitioners. It is clear that the well-being of Ann's parents is inherently and profoundly tied to the well-being of their daughter and the availability of assistance to complement their own support.[8] Although the prevention of suicidal behaviour is a goal of inpatient and outpatient psychiatry, its risk was keenly felt by Ann's parents. They could not fathom why their daughter's circumstances did not constitute an emergency necessitating a home visit.

February 2019

14 February: Ann was brought to the RGH by the police having threatened to stab her father. She was assessed by CRHTT practitioners. Ann reported that her father was leaving messages for her; she felt that he wanted to rape her; she intended to kill him with a knife; and that she had not been taking her medication since December. Her notes stated that Ann had recently been discharged from the CMHT due to non-engagement. Ann was admitted informally and she agreed to re-start her medication. Her diagnosis was "delusional beliefs."

15 February: Ann was seen by a psychiatrist and prescribed anti-psychotic medication. A risk assessment identified (i) suicide and (ii) violence or harm to others. There was no reference to her history of drug and alcohol abuse. It was noted that Ann exhibited neither aggression nor hostility "as on previous occasions."

[8] See also Blom-Cooper L., Hally, H. and Murphy, E. (1995) *The Falling Shadow: One patient's mental health care 1978-1993* London: Duckworth; and Walker, J. (2022) My son. His mental health and I BASW: *Professional Social Work,* September 18-19

16 February: Observations of Ann were reduced from 15 minute checks to "general" ones, suggesting a reduction in risks arising from her mental health. Having reported "hearing a voice telling her someone would kill her if she stayed in hospital," she accepted PRN medication.[9]

17 February: Ann's risk assessment was completed adding "threats or intimidating behaviour." She was no longer deemed to be at risk of suicide.

Following a relative's telephone call, Ann stated that she did not wish information to be shared with her family. The caller had asserted that the family was withdrawing its support. Ann enquired if she could be killed in hospital. Hospital notes clarified that, in respect of Ann, its staff should "only speak to relatives face to face."

18 February: Ann "felt an intruder would be let in to kill her." She acknowledged that she was "struggling with voices" and confirmed that she wanted to engage with psychotherapy. A Multi-Disciplinary Team (MDT) review reported that Ann's drug screen was "positive for" prescribed tranquilizers. Her medication was adjusted.

19 February: Ann was reviewed by an admission doctor. She described the sexual messages she believed that her father was leaving for her before her admission. She attributed her anxiety to a belief that her violent ex-partner had disguised himself as a staff member. Ann admitted to taking cannabis every night "for years" but was inconsistent in her account of the quantity.

Ann met with a housing officer having stated that she did not wish to return to the family home.

20 February: Ann was reviewed by a psychiatrist who increased her anti-psychotic medication.

21 February: Ann refused her medication stating that she wanted to be alert "if someone tried to kill her." She was reassured and encouraged to take it.

22 February: a MDT [Multi-Disciplinary Team] review with a psychiatrist increased Ann's anti-psychotic medication. It appeared that she had not used cannabis for 30 days.

23 February: Ann believed that her violent ex-partner was on her ward and told staff that she was "scared."

24 February: Ann spent the morning in bed. Her mother visited and Ann consented to a discussion with staff. She expressed her hope that Ann's admission would be "longer" than her previous one. Staff confirmed that there were no plans for Ann to be discharged. Later, Ann explained that she "still felt as though someone was going to slit her throat."

25 February: At a senior psychiatry review it was noted that Ann was "still voicing delusions about her father wanting to have sex with her." Following a shouting exchange with a peer, Ann explained that she thought that she was "going to get her throat slashed." Since she

[9] This means Pro Re Nata – which refers to the administration of medication which is unscheduled/ taken as required

remained “unsettled” into the evening it was proposed that her medication should be administered at this time.

26 February: In view of Ann’s “paranoia in relation to her fellow patient” she was noted to be at “an increased risk of vulnerability.” Her mother visited and reported to staff that Ann discussed her own funeral and the messages she continues to receive from her father.

27 February: a MDT review with a specialty doctor noted that Ann was “not psychotic” an observation which did not align with that of some nurses, i.e. she was experiencing persecutory delusions most particularly at night. Ann was noted to be “irritable” when challenged about inconsistencies “in her story.” She was reassured by changes to the timing of her medication and requested PRN because she was fearful and unable to sleep.

28 February: a MDT review noted no change, i.e. Ann was still hearing voices – her ex-partner, parents, and her ex-partner’s new partner were telling her that they will kill her at night and she is “calmer in the day as a result.”

During **February 2019**, Ann was admitted to the RGH as an informal patient. She had not engaged with the CMHT and had ceased to take her anti-psychotic medication. Within three days she was no longer assessed as being at risk of suicide. However, her “voices” did not cease and her occasionally acrimonious relationship with her father was noted. Ann’s non-adherence to prescribed medication is familiar to mental health practitioners. Similarly, her poor attendance at appointments/ “failure to engage” brought into focus her poor self-management. Ann’s substance misuse – the deliberate dimming of her consciousness – was known to mental health practitioners prior to this period of hospitalisation.

March 2019

1 March: a MDT highlighted divided opinion concerning Ann’s diagnosis: psychosis or personality disorder.

April 2019

2 April: Ann attributed her morning sleeping-in pattern with poor night-time sleep.

3 April: the risk assessment was updated and referenced Ann being absent without leave during March.

4 April: Ann went out with her mother for lunch and then visited a relative.

5 April: She spent the morning in bed and later reported “increased voices.”

6 April: Ann required prompting to undertake hygiene routines.

7 April: Ann was visited by her mother.

8 April: Ann exhibited no distress. She asked about seeing the doctor with a view to going home.

9 April: Ann reported that "the only voice now is her mother crying." She requested overnight leave.

10 April: Ann left the ward for an hour and later sought information concerning family planning and STDs.

11 April: a MDT review by a GP trainee revealed that Ann recalled the reason for her admission and the content of her delusional thoughts. She noted that she no longer believed them. Ann added that she did not get on with her father. Ann met a psychotherapist and confirmed that she wanted her own home and wished to begin a catering course. Her "poor hygiene" was noted.

12 April: there was no evidence of distressing thoughts. Ann asked about her prospective discharge from hospital.

13 April: Ann's mother visited.

15 April: Ann spent time with her mother. She was noted to be "greatly improved."

16 April: Ann attended the Family Planning Group.

17 April: Ann requested overnight leave.

18 April: a MDT review with a psychiatrist and trainee GP considered the request for overnight leave with her parents. Ann sought help with her cannabis use and thoughts and stated that she would not smoke cannabis at home. She was noted to be "making goals…[and was] much more stable."

19 April: Ann was collected by her mother and advised not to use substances.

21 April: Ann had another overnight leave with her mother. She complained of a headache on return.

23 April: the psychiatrist was advised that Ann's father wanted to meet him. Ann reported back pain.

24 April: Ann spent time off the ward with a patient with whom she was in a relationship. Medication was administered for continuing pain.

25 April: Ann was on leave with her family. She returned with her mother to collect her belongings.

29 April: It was confirmed that Ann was to be discharged and her psychotherapeutic care (of two in-patient sessions) "transferred to CMHT." Ann's mother sought clarification concerning Ann's discharge status and stated that "leave is going well." She was told that Ann was expected back on **2 May** for a ward round.

During **April 2019**, it appeared that Ann had developed some insight into her delusions. She spent more time with her mother and appeared to seek "leave" from the ward as a prelude to being discharged. It is not known whether her family were involved in the decisions concerning her overnight leave or whether there were contingency plans/ persons to contact in the event of Ann experiencing a relapse. It does not appear that contact with Ann's father or involving her parents in MDT formulations/ discussions concerning the factors which led to Ann's distress was prioritised by clinicians. Ann did not benefit from psychotherapy in hospital because of the time required and the typically short duration of acute hospital stays.

May 2019

2 May: Ann's mother contacted the hospital to confirm that Ann was refusing to get up to return. At the MDT she was discharged in her absence. It was envisaged that the CMHT would "follow-up" a week later. It was agreed that her father would collect Ann's medication. Ann's "diagnosis/ formulation" was "delusional beliefs."

3 May: since Ann was not answering her mobile, a Community Psychiatric Nurse (CPN) contacted her mother with details of Ann's follow-up appointment.

5 May: documentation concerning Ann was forwarded from the hospital to the CMHT – even though the CMHT had not been asked to monitor Ann's medication or her symptoms. She was to receive a Shared Care Service "which was designed to manage patients who didn't require a multidisciplinary approach from a CMHT but were just needing to be seen by a psychiatrist for medication monitoring and who would only need to be seen once or twice a year."

9 May: the CPN made a home visit for post discharge follow up. Ann "engaged well" and had attended a college open day. Her mother was positive about her progress, i.e. "no voices since discharge" and Ann planned to remain with her.

Ann's experience as an informal, psychiatric inpatient ended during **May 2019**. Given her flashes of verbal hostility, her ambivalence about her parents' involvement in her support, the history of her suicidal thoughts, her fear that her life was in danger/ of having her throat slit and her medication non-adherence, it is remarkable that she was discharged in her absence. Ann had expressed fear that her life was in danger and she might have sought to defend herself from perceived harm. Perhaps there was an undocumented MDT. It is not clear what the promised "follow-up" entailed since the content of the discharge summary is not set out. However, "follow-up" within a week, by a CPN, does not align with not requiring "a multi-disciplinary approach from a CMHT…would only need to be seen once or twice a year" by a psychiatrist. Since the assessment of risk must be grounded in history, Ann's medication was not going to be supervised as it had been in hospital if she elected not to remain with her parents. It was not clear whether she was

believed to be at risk of violence in the family home. There appear to have been missed opportunities to engage with Ann's parents about their daughter's history, her previous response to prescribed medication and experience of its side effects, and what interventions they believed may be useful, for example. Aside from prescribed medication, it is not clear whether other interventions characterised Ann's experience as an informal patient.

June 2019

21 June: Ann "could not attend" an outpatient appointment due to tonsillitis.

This is the only record concerning Ann during June 2019.

Ann left hospital on 29 April 2019. There is no record of her having contact with any services during June or **July**.

August 2019

5 August: Ann's father telephoned the CMHT. He was frustrated that Ann had received no support since her discharge and stated that one of her psychiatrists "had done nothing for Ann." Although Ann could not attend an appointment on **21 June**, Ann's father believed that her next appointment was during December. He explained that he was recording the conversation for legal purposes. The records state that her appointment was **20 September**. Ann's father added that he intended suing the service "for taking away Ann's human rights." He was told that the CMHT nurse team leader would be informed of the conversation.

11 August: Ann's "diagnosis/ formulation" was "low mood secondary to previous psychosocial issues."

20 August: a letter was sent to Ann's father about his contact of **5 August**. This explained that since Ann's consent to share information was required, the CMHT had written to her to request this.

During **August 2019**, Ann's father contacted the CMHT to express his disbelief that three months after his daughter left hospital, there was no support for her. Although the Health Board states that it addressed the complaints which were triggered by Ann's circumstances, from her parents' perspective, the *Putting things right* procedure[10] did not work for them. A significant backdrop was Ann's consent to share information with her father which she later withdrew. It is unacceptable practice for post discharge follow-up from hospital to take three months. The family should have been involved in Ann's discharge and contributed to follow up planning.[11] At the relevant time there is no evidence that Ann did *not* wish them to be involved since she was discharged to their home in her absence. If the CMHT lead was informed of Ann's hospital discharge, the

[10] http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright (accessed 25 June 2022)
[11] See Section 1.5.1, NICE Guidance (2016) *Transition between inpatient mental health settings and community or care home settings*

outcome is not recorded. Minimally, a post-hospital discharge telephone call would have been helpful to demonstrate support and engagement with the family.

September 2019

5 September: Ann's father made an unannounced visit to the CMHT accompanied by a relative/ a witness to a prospective discussion with CMHT staff. He was appropriately advised that Ann had not given her consent for another relative to participate in discussions concerning her treatment.[12] The discussion concerned: Ann's "presumed capacity" which was explained by the CMHT; her father's assertion that the "root" of Ann's "illness" was her child's admission into care; an allegation of a sexual assault when Ann was in hospital[13] which her father associated with her return to substance misuse; denial of his request for a "family meeting"; and her abusive ex-partner had made Ann drug-dependent which is related to her "past trauma." Mr P had previously been asked to leave a crisis assessment due to him recording the meeting[14] and Ann was subsequently admitted to a Cardiff unit. He had asked whether Ann could be prescribed "a newer anti-psychotic."

20 September: Ann attended an outpatient appointment with her mother - five months after her hospital discharge. The psychiatrist had not met her previously. Her night time voices had returned. Her medication was discussed due to its Parkinsonian side-effects. Ann's mother believed that Ann was smoking cannabis but Ann denied this. It was reported that Ann had started some courses and that she wanted access to her child. Ann's "diagnosis/ formulation" was "psychotic illness."

During **September 2019**, Ann's parents were proactive in seeking help for their daughter. They attributed her mental deterioration to distressing life events and what they perceived as professionals' unwillingness to engage with her history of trauma. Given that Ann was plagued by her voices, the outcome of Ann's outpatient appointment is not clear in terms of her medication and/ or follow-up. Minimally a post hospital discharge telephone call would have been helpful in demonstrating support and engagement with the family. This is not evidenced.

October 2019

13 October: Ann went to CRHTT with her mother. She "appeared to be suffering" from movement disorders caused by anti-psychotic medication. It was planned that the on-call doctor would assess her. However, Ann's mother was talking to her husband and she handed her phone to a nurse. Ann's father said that he was recording the call and that he

[12] NHS patients are asked with whom they want information shared and this is recorded. There is nothing untoward about *not* sharing information with individuals who have not been cited

[13] There is no record of this

[14] The Health Board's (2012) *Mobile Phone and Media Communication Devices Policy* states that voice recording is "strictly not allowed within any area of the Health Board"

wanted his daughter to be admitted. Ann was admitted informally and was prescribed medication to alleviate the side-effects of her anti-psychotic medication. Although her "history of violence and aggression" was noted, she was not deemed to be a risk to others. Ann's "diagnosis/ formulation" was "Investigative Medicinal Product (IMP) induced parkinsonism."

14 October: Ann's father rang to ask if he could be included in a meeting with Ann's doctor. He was irritated when advised that her consent was required because she had given her consent previously. Subsequently, Ann signed a form confirming consent to her parents' involvement. During the meeting Ann's father stated the facts as he saw them: that Ann had been let down; she had not been provided with aftercare following her hospital discharge at the end of April; and she was taking antipsychotics without a diagnosis. His behaviour was experienced as intimidating and he was escorted from the ward.

Ann's medication was altered due to the side effects. She was prescribed PRN medication.

15 October: Ann had declined her night time medication. She was noted to be a "low risk to self or others." It was determined that her antipsychotic medication should cease. A drug screen tested positive for cannabis. At a meeting with a psychiatrist and senior nurses, Ann's father described the loss of Ann's child - the fact that she had no access to her child - and family bereavements. His recollection was "that she had attended RGH on 19 occasions and was turned away by CRHTT." She had assaulted a nurse "due to frustration and lack of perceived help. He apologised for his behaviour." It was agreed that Ann would be offered "talking therapies to address past trauma" and were advised that there was a 3-6 month waiting list. Ann's parents agreed to direct their questions to a named psychiatrist during office hours. The probation officer of another patient alerted the ward to a potential relationship between Ann and their client.

16 October: Ann's risk assessment was uploaded/ considered. It did not reference the risk behaviour displayed during her previous admission. Ann was largely monosyllabic during a review with a psychiatrist and nurse. She said that her medication was unhelpful, denied substance misuse (although she had tested positive for cannabis) and "had been paranoid about cameras in her bedroom and all around the ward." Ann recalled being bullied at school and struggling to concentrate at college. She described her harmful relationships, including her experience of being drugged and subjected to sexual assaults. She was referred for psychometric testing. Ann's mother visited. Ann's "diagnosis/ formulation" was "no evidence of psychosis."

18 October: Ann's father rang to request overnight leave for Ann. He stated that he believed Ann was "better without the medication." A MDT discussion determined that Ann was not a risk to herself or others and that there was "no evidence of psychotic symptoms." She went to her parents. She was prescribed PRN medication.

19 October: Although Ann was not answering her phone, her mother contacted the ward to confirm "all is well."

20 October: Ann's father rang the ward stating that Ann was "a new person…has got his daughter back." He arranged to return her during the evening. Ann's risk assessment was uploaded/ considered.

21 October: At a MDT review Ann was noted to be "blunted in affect" and described one of her voices. The psychiatrist and specialty doctor undertaking the review determined that there was "no evidence of formal psychiatric disorder from current admission noted." They acknowledged her history of "multiple traumas and substance misuse to self-medicate…potential for discharge with long term psychological input." The psychotherapist directed Ann to "apps, websites, mindfulness and stress control groups." In addition, she was given advice on accessing private therapy, for which her parents had indicated they would pay. The psychotherapist proposed a CMHT referral for care coordination; psychology to address trauma; community psychiatric nursing to monitor medication; health care assistance to assist with education; and a Primary Care Mental Health Service (PCMHS) referral to access courses and therapy. This information was shared with Ann's father who confirmed their willingness to pay for therapy and requested that the same nurse from the Home Treatment Team should be involved. At a review by a psychiatrist and nurse it was noted, "no serious mental illness identified" and acknowledged that a certain drug was to be avoided due to Ann's severe reaction. A three-day follow-up appointment was provided and Ann was given information about community support services. She was discharged and her discharge advice letter noted "HTT to be discussed with CMHT." Ann's "diagnosis/ formulation" was "no evidence of formal psychiatric disorder felt to be related to a history of multiple traumas and substance misuse to self-medicate."

23 October: a request for psychology at a Single Point of Entry (SPE) meeting could not be discussed without a psychologist present.

24 October: Ann did not attend the follow-up appointment on the ward. A letter was sent to her GP advising that no further appointment would be offered. The CMHT were not aware of the non-attendance.

28 October: a request for psychology at a Single Point of Entry (SPE) meeting could not be discussed without a psychologist present. CMHT requested Ann's assessment information. This was incomplete because Ann "was not on the ward for long enough." Contact was made with the psychotherapist who provided the relevant case note dates.

29 October: Ann's father contacted the ward to ask about a further follow-up appointment. He was advised that this was "unlikely due to the length of time since discharge." Ann's father became frustrated and discontinued the call.

30 October: Ann's father rang the ward and repeated his request for another appointment for Ann. He was advised that since she was "the best [her father] had seen her" a further appointment was not warranted, not least because Ann's care had transferred to the CMHT. Ann's father explained that "they are back in the same position with no support in the community." He was given the contact details of the CRHTT "to arrange reviews."

During **October 2019**, Ann was admitted to hospital from her parents' home and she returned there on discharge. She did not attend a single follow-up appointment and no questions were asked. Her parents were proactive in negotiating on Ann's behalf and the hospital acknowledged that Ann "would often allow" her father "to do the speaking on her behalf." Ann had reacted badly to a first generation antipsychotic drug and it does not appear that another drug or her long-standing self-medication was considered. Given that talking therapies had a 3-6 month waiting list, it is not known what support was offered in the interim. The documents suggest that when no follow-up was provided, the CMHT was not proactive. The ward did not refer Ann for care coordination (as proposed by the psychotherapist 21 October), the referral was for psychology input.

November 2019

6 November: South Wales Police made contact with Ann to establish whether she was having a relationship with, or was the potential victim of, a man she had met in hospital. Clare's Law disclosure was discussed with Ann.[15] He had convictions for violence. He had advised his probation officer that they had planned to get together post hospital discharge. There is no evidence that the hospital informed the police of Ann's prospective discharge in the light of probation's contact with the ward concerning this relationship on **15 October**.

7 November: Ann's father cancelled Ann's appointment with the drug and alcohol service because she was in hospital.

11 November: a request for psychology at a Single Point of Entry (SPE) meeting could not be discussed without a psychologist present (see also **23** and **28 October**). Although Ann had left the hospital on **18 October**, she had not been seen by any service since.

12 November: Ann was admitted to hospital in the early hours. Her mother accompanied her and attributed Ann's deterioration to her staying with a friend. Ann admitted to smoking cannabis and hearing voices threatening to kill her. She did not think that the cannabis was contributory but the absence of medication had had an impact. She stated that she would rather take her own life than allow her family to kill her. She reiterated her fear of others and her belief that her father would sexually assault her. Ann said that she felt safe on the ward. Her risk assessment was uploaded/ considered which cited her assault on NHS staff and violence directed at her father when unwell. Ann's "diagnosis/ formulation" was "?drug induced psychosis following illicit drug misuse."

13 November: a psychiatrist reviewed Ann. Ann explained that cannabis dampened the voices in contrast with the minimal benefit she derived from antipsychotics. The psychiatrist proposed that her voices may be the result of negative or obsessive thoughts rather than a psychotic disorder and were exacerbated by cannabis. A relative contacted the ward stating

[15] Clare's Law allows an individual to request information from the police about their partner's history. In addition, it allows the police to disclose information about a person's history of domestic violence

that Ann was posting distressing material online. When spoken to, Ann said that she was worried “they” were going to slit her throat and that she could hear them.

14 November: Ann stayed in bed during the day. Her mother visited in the evening.

15 November: Although a nurse described Ann as “difficult to engage” she was later described as “brighter today.” Ann participated in a discussion about her substance misuse and agreed to a referral to a third sector drug and alcohol service. A risk and care management plan was uploaded/ considered. Ann’s mother visited in the evening. Ann’s “diagnosis/ formulation” was “?substance misuse.”

16 November: Ann remained in her nightwear all day.

17 November: Ann’s interactions with staff were described as “superficial.”

18 November: Ann remained in her room for most of the day. A psychiatrist determined that she exhibited “no evidence of psychotic symptoms…formal psychiatric disorder.” Records noted that Ann had “anxiety and depression” and that she wanted “support to address her cannabis use. She did “not see cocaine as an issue.” An appointment was made with the drug and alcohol service on **4 December**.

During the evening Ann told a nurse that the voice was telling her someone was going to slit her throat. She explained that she felt worse when she is not on medication and that cannabis helped her to relax. Ann’s mother and a close relative visited and agreed with Ann’s self-assessment of being “worse” when not taking medication.

19 November: Ann’s father contacted the ward requesting antidepressants for Ann. Notes from a psychiatrist’s review revealed: “usual” thoughts concerning voices and her throat being slit; no indication for antidepressants; and a trial of two antipsychotics was merited (one of which had previously resulted in a dystonic reaction). She was advised that she needed to be abstinent from drugs and alcohol before particular treatments could begin. The psychiatrist believed that Ann had a personality disorder and her “pseudo hallucinations” arose during discussions concerning her ex-partner.

Ann remained in bed for most of the day. She explained that she could hear the voices of her family outside her head saying they were going to slit her throat. She was verbally hostile towards her mother. Ann disagreed with the psychiatrist’s view that her voices are not real and that her poor sleep was rendering her “worse.” Ann’s father rang. He wanted an appointment to discuss Ann’s medication. Her “management plan and risk” were uploaded/ considered. She was asked to turn her music down during the night. She was prescribed PRN medication.

The father of Ann’s child received a text from Ann stating that her father would harm their child.

20 November: the psychiatrist stated that Ann was not depressed at the MDT review and that medication would not help. Nurses noted that Ann was “more argumentative.” She slept during the day and sang and danced in her room at night. It was noted that she was “not for HTT on discharge.” Her father rang requesting medication for Ann. He was unhappy

with the service and wanted the contact details of the Hospital Board's Chief Executive. When Mr P attended the ward he kept his phone on so that his wife could hear. The psychiatrist requested that he end the call and he was asked to leave. He stated that Ann could no longer stay in the home her parents rented to her. Records stated that Ann was "unkempt." She was prescribed PRN medication.

21 November: Ann slept until lunchtime and stated that she could not be bothered with personal hygiene. She was heard screaming during the afternoon but told the responding staff to "Fuck off." She told a nurse that people were coming to her room to kill her. She wanted to change rooms. The night staff noted that she was "paranoid and anxious." She was prescribed PRN medication.

22 November: ward notes state that Ann used £100 worth of crack cocaine at the weekend. She declined to speak to the specialty doctor since "no one believes" that she had voices "outside her head." Ann believed that if she told staff what the voices were saying they would "get pleasure from it" because of their involvement. She stated that she did not want information to be shared with her father.

23 November: Ann mostly remained in her room. She talked about the voices, the threat to slit her throat and her worry that her ex-partner would "come in the night." A relative rang the ward requesting that Ann's phone was removed from her. She had claimed online that her father was "a paedophile."

24 November: Ann remained isolated in her room. On request, Ann was given PRN to help her sleep. It had little effect on her skipping, singing and dancing during the early hours.

25 November: Ann's father contacted the hospital and was told that Ann had withdrawn her consent for information to be shared.

The police were informed by an ex-partner of Ann's about her social media posts which repeated claims about her father and stated that her ex-partner was going to slit her throat and burn her house down. The police contacted the CMHT and were advised that Ann was admitted "on an informal basis and that she had capacity"[16] to use social media. These were "crimed as malicious communications." It does not appear that the MCT review documented whether the social media posts were discussed with Ann. However, when a ward nurse advised her to remove the claims she "became hostile and swore at staff to leave her room." The police understood that the hospital "could not make her take [the posts] off Facebook" and that the ex-partner had not responded to the messages.

26 November: Ann refused to engage with a nurse and was inattentive to her personal hygiene. A relative rang to arrange a family meeting. Ann did not want her father to attend.

27 November: an MDT review noted that Ann's hygiene remained unattended and that she was "settled." She refused to meet the psychiatrist who proposed that since her father had refused to have her home "her presentation has changed…lack of engagement with staff is because she has not been put on medication." Ann declined to share the contact details of a

[16] It is not clear what Ann's presumed mental capacity related to

relative. It was believed that her behaviour was "more in keeping with a personality disorder." The psychiatrist was keen for Ann to transfer to the treatment ward "for other people to assess her." She became agitated during the evening – kicking doors, shouting and laughing at staff. She stated and then denied that she was hearing voices. She said of her father, "he's going to come into my room and slit my throat and if he does I'll bite his fucking nose off." Clinical notes confirmed that Ann's mental state was deteriorating. She declined PRN medication.

Ann's father phoned the drug and alcohol service concerning Ann's pending appointment. He confirmed that she remained in hospital. He explained that she had been a victim of domestic violence, having been violently beaten "numerous times." Her ex-partner had cut her off from her family; made her watch as he killed her pet; and drugged and sexually assaulted her. It was because of this relationship that Ann "lost all access to her child." The police recorded "numerous attempts" to contact Ann by phone, specifically to "provide suitable words of advice."

28 November: the psychiatrist at an MDT review stated that Ann's refusal to meet "was due to anger at not being given medication." The notes stated that her voices, "paranoid thoughts and agitation do not meet the criteria for psychosis." Ann was believed to be "an increasing risk to others." She was prescribed medication "to reduce the risk of assault." Ann complied with her medication but refused to move to the treatment ward. She agreed to have an electrocardiogram (ECG)[17] and hourly neurological observations.[18]Ann refused the observations during the night. Although the family meeting was cancelled because a relative could not attend, Ann's mother sought to re-arrange it, "if an independent doctor could be present." Her mother added that they had ceased to visit because Ann either ignored or shouted at them. Ann was "hostile and threatening" towards the nurses. Later, she told a nurse that she wanted to change rooms because she did not feel safe: "they will get me." She declined PRN and evening medication. Ann expressed fear about being "locked on ward"[19]she would not be able to escape if "they" entered. She appeared less fraught in the early hours. She did not sleep well.

30 November: Ann would not engage with staff and refused neurological observations. Her shouting appeared to respond to unknown stimuli. Advice was sought from the on call doctor. Her neurological observations had stopped and physical observations were taking place every four hours. It was noted that "Section 5 (2)[20]…not appropriate as she is not asking to leave." Ann accepted medication during the evening when she acknowledged that she continuously felt sick, was hearing voices say "horrible things" and yet "nobody believed her." She stared at peers and swore at one. Her dietary intake and hygiene remained wanting.

[17] A test to check the heart's rhythm and electrical activity
[18] Information concerning the function of the brain and spinal cord
[19] Her movements were restricted at the hospital which is not a secure estate
[20] This allows doctors to detain a person in hospital for up to 72 hours for the purpose of assessment to determine whether further detention is necessary

During **November 2019**, Ann was re-admitted to hospital. She was hearing voices that threatened to kill her and she had been smoking cannabis which she believed was more effective than prescribed medication. The extent to which this feedback and her suicidal ideation featured in her treatment plan is not specified. She feared being sexually assaulted and killed by her father and unspecified others and having her throat slit by an ex-partner. Ann posted claims online which were brought to the attention of the police. Notes arising from contact with the psychiatrist on 19 November appear to minimize Ann's symptoms and distress. Prescribing medication which caused distressing side effects was unlikely to advance her adherence to medication in the longer term. It is speculated that loud music obliterated her voices. She resisted a clinician's view that she experienced "pseudo-hallucinations"[21] and became anxious, occasionally argumentative, vulnerable to mood swings and inattentive to her personal hygiene – all of which are suggestive of deteriorating mental health. Ann was believed to be a "risk to others" towards the end of the month at a time when early signs of relapse were emerging. It is not known whether this risk was driven by Ann's self-reported thoughts and voices since Ann stated that no one believed their effect. Ann was not believed to meet the criteria for psychosis. "Long-term psychological input" had been recommended during **October** when two requests for psychology support were made. Another was made in **November** to no avail.

December 2019

1 December: Ann's Inpatient Management Plan (IMP) and risk plan were uploaded/ considered. She declined medication and her physical observations were reduced "due to no further fainting." During the night Ann "was more agitated and psychotic" and a duty doctor prescribed medication.

2 December: the psychiatrist at a MDT review noted that Ann had tested positive for cannabis; that she was "worse at night…[and] an increasing risk to others." Her medication was adjusted and another ECG was planned. Ann discussed her voices during the evening. She did not sleep.

3 December: Ann refused to meet with a doctor and Advanced Nurse Practitioner. She was "unkempt and malodorous" and agitated during the evening.

The father of Ann's child advised South Wales Police about Ann's text messages. These stated that Ann's father would harm their child who needed to be in a safe place. "He reported that she had had no contact with [their child] for the past six years." Although it was acknowledged that Mr P was unlikely to be a threat to their child, the father wanted to ensure that their child was safe.

[21] "…heterogeneous perceptual phenomena that are commonly experienced by people that are grieving or have lived through psychological trauma and patients with borderline personality disorder have the hallmarks of functional cognitive disorders…Patients with pseudohallucinations usually present to emergency departments or psychiatric clinics and their symptoms are often associated with emotional distress…the term is potentially pejorative and misleading to the public and clinicians…" Mustafa, F.A. (2020) *The Lancet,* 7

4 December: the police made contact with the hospital. The "…ward stated that Ann was severely unwell and her mental health is poor…[with] a history of obsession around men,[22] particularly her father…ward unaware that she had made contact with her ex-partner as she had obsessions around him." On the advice of nursing staff, no meeting with the police resulted, but information was shared with (i) children's services (see **25 November**) (ii) the CMHT on **5 December**.

Ann remained in her room for most of the day. She had an ECG. Her diet and hygiene were described as "poor." She told the night staff that she "would never hurt them." She was prescribed PRN medication.

5 December: Ann transferred to the treatment ward where her IMP and risk plan were uploaded/ considered. She was recorded as appearing "sullen." She was prescribed PRN medication.

6 December: Ann remained in her room for most of the day. She continued to neglect her hygiene and appeared "disheveled [but was] more animated and engaging." She slept poorly despite PRN medication.

7 December: Ann remained "isolated in room…poor diet and hygiene…good night's sleep with PRN."

9 December: Ann was unresponsive to prompts concerning her hygiene. During the evening she responded to hallucinations and told staff that the voices were telling her that "the staff are going to slit her throat during the night." PRN had "no effect." There is documented confusion concerning which psychiatrist had responsibility for Ann's treatment.

10 December: Ann was seen by an OT. Her room became partially filled with smoke due to damaging her mobile phone. Potential fire was not perceived as intentional. She was "unhappy with" social media. Ann was distressed "and paranoid" during the evening. She was prescribed PRN including a drug which had previously resulted in adverse side-effects (see **21 October**).

11 December: Ann spent most of the day in her room. No hallucinations were reported. She slept well with PRN medication.

12 December: Ann was "more stable…settled and pleasant" but sleepy during an OT assessment. Her mother visited.

13 December: Ann told a nurse that she did not feel safe and elaborated that she thought her father wanted to slit her throat. She explained that she was not showering "because there is a camera in there."

She was prescribed PRN medication.

14 December: Ann was noted to be "happy with room change" but was recorded as being "abrupt" with staff on one occasion. The night staff noted that she "seemed tormented by

[22] The origins of this statement are not known

something." She was responding to hallucinations in her room and subsequently became threatening when she was dissuaded from entering a male bedroom. She had threatened to hit staff if she could not have more than her prescribed PRN medication then "lunged…with fists raised when it was explained this was not possible." As she was taken to her room Ann attempted to kick staff. She wailed in her room saying that she wanted to kill her parents.

15 December: Ann mostly remained in her room apparently avoiding eye contact when having medication. Later, she apologised to the night staff who had been in duty. She "slept better."

16 December: "Diet better…hygiene remains poor." Ann told the night staff that the voices were still present.

17 December: the content of Ann's interactions was "disjointed. Psychotic in presentation with poor concentration." She told a nurse that she remained terrified of her father coming to slit her throat. She said that she wanted to live at her parent's cottage when she is discharged. She explained that not eating was intentional – "to make herself smaller so people don't pick on her." A CMHT referral was considered and Ann's Risk Formulation was uploaded/ considered, albeit one to which the MDT made no contribution.

18 December: "…settled…no distress."

19 December: the psychiatrist at an MDT review considered Ann's previous diagnosis of "poly-drug induced psychosis." A diagnosis of schizophrenia was posited following a detailed consideration of her history. Ann herself stated that she does not believe her voices are related to cannabis because she hears them when she in in hospital/ not using cannabis. She asserted that her father intended to rape her. Ann's medication was adjusted. She remained "unkempt" and was guarded with staff and said that her voices were "fine today." Her mother visited during the evening.

20 December: Ann declined OT but attended to her personal hygiene with assistance from staff. She slept well.

21 December: Ann was noted to be "sullen" during her mother's visit. She did not want to take her medication because it made her hungry and she did not want to put on weight. She swore at the staff offering PRN medication. She was heard to shout "I don't want to have babies." Later, Ann asserted that since she did not get on with her family she wanted a flat. She asked staff what she needed to do "to get into low secure" and asserted that she did not feel safe.

22 December: Ann was "edgy and distressed, seen and heard to be responding to voices. Still refusing medication." During the afternoon she became aggressive and hostile to staff and sought to attack a peer. She was described as "floridly psychotic…[and] tormented by voices." Nursing staff were troubled by Ann's "lack of compliance [and] distress." They believed that her detention was warranted. However, doctors disagreed: "there are no grounds to detain Ann."

South Wales Police received a call from the peer that Ann had sought to attack. This person alleged that a cup of tea was thrown over them, that Ann had threatened "to bite [their] nose off" and that she had woken people up with her screaming on **21 December**.

23 December: Ann spent the morning in bed. She was friendly towards a psychiatrist and nurse who discussed her medication. She recalled her hostility towards her peer and explained that "the voices told her [the peer] would do harm to her." Her medication was adjusted and she settled. She accepted PRN medication and slept well.

24 December: Ann's interactions were minimal. She complied with her medication and slept well.

25 December: Ann's mother spent most of the day with her. Ann accepted her medication but requested PRN because she believed that "someone would come in her room and slit her throat."

26 December: Ann was described as "superficial today…unkempt still." During her mother's visit she asked for her to be given the names of her medication so that she could "look them up" in terms of their side effects. Later, Ann told staff that she was feeling suicidal due to weight gain; that she intended to refuse medication; and that she did not feel that doctors were listening to her. She was given diet and exercise advice and agreed to see an exercise therapist and to be referred for advocacy.

27 December: Ann refused her medication and was "suspicious" with staff during the evening.

28 December: Ann continued to refuse her medication.

29 December: Ann declined her anti-psychotic medication but accepted medication to reduce her anxiety.

31 December: Ann attended an OT workshop. The level of her observations was reduced "in line with the reduction of risk behaviours." Ann became distressed after a visit from her mother. She talked to a nurse about her medication and weight. After the nurse shared information from the British National Formulary,[23] Ann accepted an anti-psychotic drug.

During **December 2019**, Ann remained in hospital and she continued to be plagued by threatening voices. Her expressed thoughts on 4 December suggest that she was entertaining the possibility of harming others. She was fearful for her personal safety, resolute in her belief that her throat would be slit, and aggressive towards staff and a peer. The alarm bells that rang among the nursing staff were not heard by doctors. Ann harbored thoughts of harming herself and others. When she attacked a peer she explained that she had done so because the voices told her that the peer was going to harm her. This suggests that those who Ann perceived as threatening were potentially at risk of assault. Ann was experiencing distressing psychotic symptoms which were unresponsive to prescribed medication. In addition, she had a reversed sleep pattern, she

[23] A reference book containing information and advice about prescribing and dispensing medications

sought isolation and was inattentive to her personal hygiene, her interactions with others were blunted or hostile and anxiety about weight gain triggered poor adherence to prescribed medication. Information suggests that the prescribed anti-psychotic medication was frequently supplemented with the effective use of the "as required" PRN prescription. A review of her regular prescription may have rendered Ann's treatment more proactive in limiting her distress rather than responding to it. If the MDT believed her symptoms were more trauma based (pseudo) it is not clear why the commencement of psychological intervention was not considered forAnn during her inpatient treatment. This would have assessed and considered her response to such intervention prior to her hospital discharge.

The Assessment of Risk during 2019

Ann was subject to the real-time management of risk for the duration of her stays in hospital. Risk "generally refers to the possibility of loss or costs when an outcome is uncertain, but in clinical and criminal justice settings, it means the chance of an adverse outcome."[24] However, "risk" also hinges on possible benefits as well as harms and it follows that assessments must also gather information about potential successes as well as potential failures.[25]

Although "risk assessment uploaded" is cited on six occasions, this downplays the clinical consideration of risk outcomes, their likelihood and the timeframes. For example, during:

- **February**, Ann's risk of suicide was revoked and she was perceived to be at an increased "risk of vulnerability"
- **March**, there were no changes made to her risk assessment
- **April**, her "risk and care plan" took account of the risk of Ann absenting herself from the hospital and changes to her medication
- **May**, her risk assessment and care and treatment plan were completed "for follow-on"
- **October**, Ann was rated as "no risk to others x2 …low risk to self or others…risk of substance misuse in the community…no suicidal or self-harm risk"
- **November**, Ann was "seen as an increasing risk to others [her assessment referenced changes to her medication] due to level of agitation and to reduce risk of assault
- **December**, Ann's risk assessments noted "an increasing risk to others due to recent hostility [and] the risk of taking [her] presentation at face value" was documented. Ann did not want to put on weight and the implication of her medication risk for weight gain was considered. Finally, a "reduction in risk behaviour" was noted.

[24] Blackburn, R. (2000) Risk Assessment and Prediction. In J. McGuire, T. Mason and A. O'Kane (eds.) *Behaviour, Crime and Legal Processes: A Guide for Forensic Practitioners.* Chichester: Wiley

[25] Carson, D. and Bain, A. (2008) *Professional Risk and Working with People: Decision-Making in Health, Social Care and Criminal Justice.* London: Jessica Kingsley Publishers

There are dangers in retrospectively considering risk, not least the temptation to consider selectively the factors which appear to anticipate the fatal event. Uncertainty has always been a dimension of risk. It could not be known whether the risk assessment was shaped by sufficiently reliable information or how likely or how serious Ann's threat to take her own life would be, for example. There were unsupervised periods of Ann's life - when she was subjected to domestic violence. During such times there was neither Health Board nor Local Authority monitoring of her substance misuse and its impact, her adherence to prescribed medication and/ or of signs that the Mental Health Act should be invoked.

January 2020

1 January: Ann refused anti-psychotic medication. It was believed that she was masking her symptoms. Later in the day she was heard singing in "an aggressive tone."

2 January: Ann was distressed, agitated and hostile. Since she threated to punch the psychiatrist, requiring a nurse to intervene, s.2 MHA[26] and rapid tranquilization resulted. Her history of dystonia[27] was considered. She was placed on a section 2 and accepted medication. Her parents visited.

3 January: Ann wanted to appeal her s.2. She accepted medication and agreed to an eating plan and to undertake activities. She showed some signs of dystonia when her parents visited and later accepted PRN medication.

4 January: Ann mostly spent the day in her room. She approached staff with her "head in the air and eyes rolling"[28] during the evening. She accepted medication. Her parents visited.

5 January: Ann's mother visited.

6 January: Ann reported having a "good" day in which her voices were better. It was noted that she may be masking or minimizing her symptoms.

7 January: Once again, Ann reported that her voices were not as bad and that the medication was helping to control the eye spasms. When her parents visited they questioned the prescribing of a particular drug, which in contrast, Ann believed was helpful. Her parents were invited to attend a ward round during the week.

8 January: Ann slept for most of the morning. Later, her parents visited and once again, questioned the administration of a particular drug. Ann became unsettled during the

[26] The purpose was documented as "for appropriate treatment with parenteral medication with a view to improve her mental state and reduce any risk to her and others' safety"

[27] Dystonia refers to uncontrolled and sometimes painful muscle movement (spasms). See https://www.nhs.uk/conditions/dystonia (accessed 1 August 2022)
It is possible that this refers to drug-induced movement disorders commonly associated with antipsychotic medication

[28] These are side effects of medication, commonly resulting from anti-psychotic medication. Given Ann's sensitivities, a regular prescription of anti-cholinergic medication to block or inhibit the side-effects or prescribing a modern, atypical antipsychotic would have constituted good practice. It is highly unlikely that a person experiencing such severe side-effects from prescribed medication would continue to take it

evening and reported that the voices were telling her that her throat would be slit in the night. She accepted PRN medication and asked staff not to enter her room during the night.

9 January: at the MDT review, which included CMHT managers and a pharmacist, Ann reported that she felt better and that her voices were fading. She declined anti-psychotic medication. Her father sought to raise concerns about Ann's previous mental health care and he was advised of the appropriate channels regarding these. He challenged the suitability of Ann's medication and proposed medication being trialled in America and Canada on the basis of legal advice. This was declined and Ann's medication was increased, that is, the one that resulted in the distressing side-effects. The ward round ended when her father became angry. It was determined that he was to be excluded from future ward rounds.[29]Ann accepted medication and a change in her demeanor was noted when her parents left.

10 January: Ann declined her night time medication having been out with her mother.

11 January: Ann's father was angry and accusatory towards staff because Ann had a facial rash. A doctor was contacted and medication prescribed. Ann requested her evening medication.

12 January: Ann was compliant with her medication and she attended to her personal hygiene.

13 January: Ann no longer wanted to appeal s.2. Her parents visited during the evening.

14 January: Ann went out with her parents. She accepted her medication on return.

15 January: Significant improvement was noted by nursing staff. Ann was not distressed and she reported that her voices had diminished. She met with an advocacy service and her father.

16 January: An MDT determined that Ann was settling well and her parents agreed. They were noted to be "overwhelmed by her progress." Although the medication's troubling side-effects were sporadically evident, Ann was discharged from s.2. She was able to have increased day and overnight-leave. A discharge meeting was planned for 30 January. She was to have "random urine drug screens."

18 January: Ann spent "leave" with her family.

19 January: Ann was physically unwell and spent most of the day in bed. She spent some time with her mother. Later she experienced difficulty sleeping due to her voices.

20 January: during overnight leave, Ann's mother contacted the ward to report that Ann was "on too high a dose…eyes are rolling and was stiff." She was advised that this would be discussed during the ward round of **23 January**.

21 January: eye rolling persisted. Ann's sleep was unsettled.

[29] It is not clear whether any consideration was given to ways of positively engaging with Ann's father, or even that his presentation arose from desperation concerning his daughter.

22 January: Ann was "compliant with medication." She reported that "there is no break" in her voices.

23 January: at the MDT review, Ann confirmed the persistence of her internal and external voices and stated that she could "manage them." A week's leave was arranged and her hospital discharge plan was discussed. Although a referral to psychology was discussed, the absence of the CMHT at the MDT was a procedural barrier.

28 January: Ann returned from leave prematurely due to "an increase in voices." She admitted to having had alcohol and cannabis. She was given PRN.

29 January: Ann remained in her room. She was distressed that her voices stated "staff are going to kill you."

30 January: at the MDT review, Ann confirmed the persistence of her voices wherever she was. Her mother expressed concern about "possible over sedation." A referral was sent to the CMHT. Later, Ann told a nurse that she thought "things got worse after smoking cannabis."

31 January: Ann reported that her "voices have reduced."

The constancy of Ann's voices characterised her hospital experience during **January 2020**. Ann reported that their presence appeared either in the foreground or background. When foregrounded, they were menacing and threatened her with a violent death. In addition, the side effects of her medication appeared unchanged. Ann's parents were frequent visitors and they were frustrated by witnessing the distressing consequences of her anti-psychotic medication, that is, either muscle contortions, eye rolling and/ or sleepiness.

February 2020

1 February: Ann was described as "settled." She was visited by her mother. Later, she approached staff with her "eyes in the air." PRN was administered.

2 February: Ann's mother visited.

3 February: Ann told staff that since she was fearful of needles she did not like the idea of depot injections.[30]

4 February: Ann reported that her voice was repeating the surname of her abusive ex - partner; that she was happy to return to live with her parents; and that because she could see the association between taking cannabis and her voices, she wished to discontinue smoking it. Later, following an altercation with a peer, Ann sought reassurance that she was safe on the ward.

[30] The injection of a long-acting drug for treatment maintenance. It permits less person to person contact and the less frequent administration of medication

5 February: Ann reiterated her wish to be discharged to her mother's home and assured staff that she would not take substances after being discharged from hospital.

6 February: Ann requested hospital discharge on **7 February**. She reiterated that she would not take substances. Overnight leave was planned with "further leave after ward round on return," plus a urine drug screen.

8 February: Ann returned, provided the urine drug screen and went on leave as planned. [On **13 February**, the result of the drug screen was "urine positive for cocaine but negative for cannabis."]

10 February: at the MDT, Ann's mother reported that leave had gone well. Ann was to be discharged on **17 February**. The case note states, "CMHT to provide support for stabilization and mindfulness work. Referral to psychology."[31]

13 February: Ann's risk assessment and treatment formulation was uploaded.

14 February: an outpatients' appointment was booked for Ann. It was documented by the ward that she was "for care coordinator 2 workers CPN and SW." [The next planned appointment for Ann to see a psychiatrist was approximately four months after being discharged.]

17 February: a referral to the relevant CMHT was recorded. It notes Ann's previous non-compliance and use of substances; the challenges of engaging with Ann's father; and the fact that "Ann and her family were not currently consenting" to depot.

19 February: Mr P made a complaint to South Wales Police concerning its investigation of Ann's domestic abuse by a violent ex-partner between 2015-2018. The complaint was not investigated because "no third party consent was supplied on behalf of Ann."

24 February: Ann contacted the ward to state that "leave had gone well" but she was not able to attend the MDT review "due to transport issues." Ann was discharged in her absence without a Care and Treatment Plan.[32] Her mother had undertaken to collect her medication. Correspondence to Ann's GP contained errors of fact, i.e. Ann's urine test was positive for cannabis; she was to receive "physiology" instead of psychology; and she was to receive mindfulness support – in the absence of a confirmatory CMHT assessment. The contingency plan was, "to contact crisis if any concerns or queries."

25 February: Ann was allocated to a social worker and a Community Psychiatric Nurse "for joint working."

26 February: Ann's social worker rang the family home to confirm a seven-day, follow-up appointment with her social worker and nurse. Mrs P stated that Ann would attend.

[31] It does not appear that Ann received any psychology input, despite referrals on 12 March and 23 October 2019 and 10 February 2020

[32]Ann was allocated a Care Coordinator/ social worker; the CMHT was involved in planning her community care and treatment needs after hospital discharge; or that Ann and her parents were credibly involved in the process

February 2020 was characterised by preparation for Ann's hospital discharge to her parents' home. Her voices had not been silenced and the disquiet of Ann's parents concerning her medication did not diminish. Her resolve not to take drugs was short-lived. Ann's hospital discharge took place in her absence with a crisis contingency plan, rather than a Care and Treatment Plan in place.

March 2020

2 March: Ann met the social worker and nurse. There was no contemporaneous case note concerning this meeting. The possibility of her moving to her own accommodation was discussed. This was the last and only occasion when Ann was seen by professionals after her hospital discharge. [A retrospective case note entry was made during the morning of **5 May**.]

13 March: the pandemic prompted the Welsh Government to suspend all non-urgent outpatient appointments. Since Ann had support from her parents, visits were deemed "not essential."

16 March: Ann's social worker rang to explain that visits were cancelled due to COVID 19. "Ann said she was ok." Mrs P reported that because Ann had been out on the night of **15 March**, she had not taken her medication. In addition, she expressed concern if Ann was to live independently, that is, without her mother to prompt and ensure that she was taking her medication. Mrs P was given the CMHT's phone number to ring "if she thought there was a deterioration." This placed the onus on Ann's parents to alert the service to her mental health deterioration.[33]

30 March: Seven days after the pandemic lockdown, Ann's social worker spoke to Mrs P. She confirmed that they had no current concerns and that they would make contact if concerns arose. The record stated "Family are aware of crisis number/ CMHT duty number. Family will ring if they have any concerns."

Ann was last seen on 2 **March 2020** and she was last spoken to, by phone, on 16 March. The Root Cause Analysis confirmed that the hospital discharge arrangements did not (i) explicitly reflect Ann's views or (ii) "acknowledge that her father was often the subject of her delusional thinking and associated fear of harm/threat." The pandemic precluded routine appointments and Ann's parents were advised that they could contact the CMHT or CRHTT. Ann's inconsistent adherence to taking prescribed medication without any supervisory oversight was identified by Mrs P as a challenge because of Ann's history. In addition, she had tested positive for non-prescription drugs before leaving hospital. It is

[33] It is not known whether the parents' expectations at the point of alerting were discussed with them. For example, they expected an immediate response to reflect their sense of urgency

not known whether this fact, in combination with returning to live with her parents, featured in her risk assessment.

April 2020

There are documented notes concerning a single day during April. On **6** April, Ann's social worker was informed that Mr P had been verbally aggressive to a Citizens' Advice Bureau worker when seeking clarity about Ann's benefits. The caution of CMHT professionals in engaging with Mr P was discussed. There was a history of difficult encounters which impacted on the confidence of staff and, with the appropriate consent, to involve them in discussions concerning Ann's care and treatment. Her occasionally fraught relationship with her father may have resulted in Ann withdrawing her consent to share information with him, or it may been associated with fluctuating mental capacity and/ or her mental health crises. On this occasion it does not appear that Mr P was asked what support he required to ensure that Ann received her welfare benefits. This may have opened up discussions concerning a carer's assessment, for example.

Information provided during July 2022 states that on 14 **April**, Ann's "diagnosis/ formulation" was "new diagnosis of schizophrenia, cannabis misuse."

5 May 2020

There are no documented notes for the beginning of May. Events of 5 May 2020 occupy seven of the 25 pages of the Safeguarding Review's chronology. Mr and Mrs P recall the day as follows:

I'd phoned at 8.30am on 5 May. Ann wasn't well. I phoned 999[34] *with Ann sitting next to me. I was thinking that perhaps the police could get help. I'd been in custody because of things that had been said, but my daughter wasn't well.*

I was begging them to come from the RGH. I said "she needs admitting." [Mr P also made calls to] *Ton Pentre's* [CMHT]*…social services mental health team explaining that my daughter is seriously ill at home. Then I phoned social services*[35] *and they said "there's a process we've got to go through." I wanted them – all of them to see that Ann was seriously ill. I phoned the seven times between 8.30am and 1.30pm - it was so immediately urgent."*[36] Mr P spoke to a Mental Health specialist at RGH and to a nurse. *"I was saying, please help us."* He believed that the police knew that Ann was "seriously ill." Mr P went to his wife's work place to discuss what they should do. He said that he *"was scared. I'd never seen her as ill as she was."*

[34] There is no police record of this call
[35] This may refer to the CMHT
[36] This number of calls is not supported in agencies' records

Beginning with the Crisis Resolution and Home Treatment Team's (CRHTT) record, Mr P rang on two occasions between **9.15 a.m.** and **10.00 a.m.** He requested a home visit because he believed that Ann "needs to be in hospital." He reported that she was in a relationship and it was noted that he "was not approving of this." It was confirmed that Ann was unaware of the call. Mr P was told that Ann's Care Coordinator would contact him. In Mr P's second call, he explained that he was outside his wife's work. He did not want to return home "for fear of an argument with Ann." He was told that the CRHHT were currently speaking to the Care Coordinator.

A CRHHT administrator emailed Ann's Care Coordinator/ social worker. "CRHTT…wishes [social worker] to ring Ann's father." The social worker emailed the CMHT lead nurse "to ask…what to do." The nurse asked the social worker whether they were "happy to ring" Mr P. The social worker asked if they should ring CRHTT before ringing Mr P. The nurse confirmed that this "would be useful."

Mrs P had added her voice to that of her husband. The social worker emailed[37] the psychiatrist stating that "both parents have rung expressing concern about Ann." The email set out the context: Ann had been "ok on discharge, living with her parents and taking her medication." However, "Over recent weeks she has begun going out and staying out, sometimes for up to two weeks at a time, therefore not taking her medication." In addition, since Ann had "begun a relationship with a heroin addict," her parents believed that she was "possibly taking cannabis again…Ann had been verbally aggressive this morning with her parents." She thought that her father wanted to rape her and "knife her." In addition, Ann had "been voicing bizarre thoughts on the internet" which were "vastly out of character." Ann's parents interpreted the combination of these behaviours as precursors to psychosis.

The social worker was unsuccessful in ringing Ann. The psychiatrist emailed the social worker and confirmed that Ann's notes had been reviewed and that she "provides a clear clinical impression of drug related mental behavioural disorder with psychotic phenomena rather than a primary psychosis, so risk of relapse would always be there…" The psychiatrist proposed that the team should (i) attempt to see her, via phone with the help of her parents or (ii) face to face and then consider (iii) CRHTT or (iv) informal admission. If these are not successful and her parents' concerns remain, "the team could plan a Mental Health Act Assessment." [38]

At **10.39 a.m.** Ann rang 999. She did not identify herself. She alleged that her father had attempted to attack her and wants to slit her throat. She did not want the police to attend stating that she would not answer the door if they did so. She had barricaded herself into house. Within minutes the police traced the call and identified Ann.

[37] It is possible that this reflects the virtual world which became many professionals' experience of working during the pandemic. It appears unduly time-intensive when a phone call may have been more appropriate
[38] This process should have been set out in a crisis plan

At **11.20 a.m.** the social worker phoned her manager to establish whether a visit was permitted.[39]

At **11.53 a.m.** the nurse was told that a response was awaited from the team's manager.

At **12.31 p.m.** the nurse was told that "a visit may take place," albeit with the caution that Ann had assaulted staff in the past.

At **13.11** the social worker received confirmation that they could visit. They were advised to let the psychiatrist know and "to consider contacting an Approved Mental Health Professional."[40]

At **13.18** the police spoke to Ann. She stated that she wanted a new address and a new identity. It was documented that Ann had mental health problems. The police officer spoke to a domestic violence service which undertook to contact Ann concerning a risk assessment and a potential move to a hostel. The officer noted that "Ann would be willing to go" to the hostel. She was told that the police had made contact with the "Live Fear Free" service which would be making direct contact with her.

At **13.19** the police enquired if anyone from the Mental Health Triage, which is based in the Police Control Room, could review Ann's history and make contact with the relevant officer.

At an unspecified time, the social worker rang Mr P and "discussed [the prospective] plan to visit and ascertain whether any of the family have COVID symptoms…[he confirmed that no one had. Mr P] was unsure if Ann was at the property…not answering the phone." The social worker requested the boyfriend's address and Mr P promised to ask a relative who was most likely to know. He confirmed that Ann had been using drugs.

At **13.46** the police established that Ann was being supported by the relevant Community Mental Health Team and sought to make contact with her social worker.

At **13.47** the police were alerted via a 999 call to a fight at the supermarket.

At **14.00**, the police log was updated. The social worker was known to be making their way to the address.

Some miscommunication was acknowledged in the documentation. The CMHT informed the social worker that the police had not attended Ann's home. Police contact had been via the phone. The social worker was advised to call 999 "if needed." Subsequently, the police informed the social worker and nurse not to attend Ann's address due to reports of an incident involving Ann.

At **14.04**, the police contacted the CMHT asking the social worker to ring back "urgently."

At **14.08**, the police informed the social worker that Ann had been arrested for murder.

[39] It is not clear whether this was due to Ann's history, COVID 19 or a combination of both
[40] This would suggest that a mental health assessment/ hospital admission was anticipated

The Known Impacts of 5 May 2020

In addition to Ann's family, five individuals and their families have experienced significant change and pain as a result of the tragedy. For them, there is a clear crossing over from before the event and after.

One relative expressed surprise that they had had no contact from the authors of the Health Board's independent Root Cause Analysis.[41] It took the intervention of an MP to explain that the report would not be published. This MP, Health Improvement Wales and a Welsh Government Minister confirmed the importance of engaging with and supporting the people involved and affected by the incident. This suggested to one relative that a Health Board was effectively allowed to "mark its own homework," even though the authors of the RCA were from another Health Board.

Since the Health Board's did not contact the victims or their families, its apparent incuriosity meant that it was unaware of their very specific questions, some of which arose during the trial. For example,

- What was the rationale for prescribing the specific medication for Ann when she was discharged from hospital? What do the prescribing records reveal? Could her non-compliance have been anticipated?

> Psychiatrists prescribe medications for patients with psychosis and schizophrenia. How they are taken, the frequency with which they should be taken and the duration of the drug treatment are subject to reviews. Different medications have different degrees of side effects such as sleepiness and weight gain. The NICE Guideline[42] states that (i) the choice of prescription should be made with the patient, taking into account the views of the patient, carers (if agreed), and considerations of side effects, for example; and (ii) recommends a combination of pharmacological treatment. The greater autonomy of newly hospital discharged patients may render them vulnerable to medication non-adherence. Substance misuse is similarly associated with non-adherence. It is commonplace for discussions concerning *how* medications should be taken to consider non-adherence.

- What contact did Ann and her family have with services in the days/ hours leading up to the tragedy? When did her parents call? Who responded and how quickly did they do so?

[41] See Appendix by CTNUHB. A Root Cause Analysis commissioned by a Health Board is not undertaken with a view to publication. CTMUHB was not aware that certain investigative processes had ceased being commissioned

[42] National Institute for Healthcare and Excellence (2014) *Psychosis and Schizophrenia in Adults: Prevention and Management* at https://www.nice.org.uk/guidance/ng27 (accessed 16 October 2022)

In the days leading up to the tragedy, Ann and her family had no contact with services. During the morning of 5 May, Ann's parents were shocked and overwhelmed by Ann's presentation. They interpreted the distressing signs as their daughter having a mental breakdown. The Community Mental Health Team was contacted by the Crisis Team. Ann's social worker contacted Ann's father and attempted to contact Ann. In a further call to Ann's father he was told of the intended visit to Ann following consultation with the psychiatrist. Ann's parents' recollection of when they sounded the initial alarm does not align with the times identified in the documentation. They recalled the necessity of contacting the psychiatrist. They recall contacting the CRHTT, the police, the CMHT and the Hospital. Although the police have no record of contact from Ann's parents, they did receive a call from Ann alleging an attempted attack by her father. Mr P recalled making seven phone calls from 8.30 a.m. onwards.[43] The CRHTT case notes indicate that Mr P rang twice, at 9.15 a.m. and at 10.00 a.m. He was told that the CRHTT do not undertake home visits, and by the CMHT that "there's a process we've got to go through." It will be seen from the narrative chronology that the use of emails rather than phone calls meant that some time was lost. A social worker and nurse:

- requested whether they could undertake a home visit (permission for which was delayed because a manager was unavailable)
- contacted the CRHTT for information
- waited for a psychiatrist who did not know Ann [i.e. the senior clinician responsible for her treatment at the time] to read her case notes to provide advice
- gave consideration to Ann's previous assaults and the location of the prospective meeting
- spoke to Ann's father
- sought the address of the man with whom she was having a relationship in case Ann was not at her parents' address
- checked whether family members had tested positive for COVID 19, for example. (This question was routinely asked during the pandemic.)

Ann's parents were pushed to the brink and struggled to convey the significance of their daughter's behaviour. At 14.04, the social worker and nurse were on the way to see Ann. They received a call asking them to contact the police. The latter informed them of Ann's arrest.

How was the BBC able to access CTMUHB's review concerning [a former patient]? Was it leaked and/ or was "appropriate consent" secured?

CTMUHB does not share information concerning patients as a result of third party requests. CTMUHB's review concerning the former patient's death was shared

[43] It was not specified to whom each of these calls were made

with the coroner prior to the inquest. Inquests are the public face of the coroner's work and are typically subject to scrutiny and publicity. In general, the press may report whatever is said in court and this is a key source of the information reported by the BBC. Since this former patient was deceased, their family was involved in the investigation. It is possible that the family shared the review.

- Will this review draw on the evidence considered by the trial – not least because Ann's medication was considered in detail at her trial?

A review commissioned by a Regional Safeguarding Board does not have access to UK criminal trial transcripts, although these may be obtained at significant financial cost. A review is wholly dependent on the documented information which organisations are prepared to put into the public domain. This may be supplemented with information arising from an organisations' employees. Reviewers may invite the contributing organisations to ask the individuals who attended/ gave evidence at a trial to set out the information they prepared or recalled. Although they have no authority to insist that information is made available, reviewers may identify in their report the agencies which were less than forthcoming.

- Will HIW's review of mental health hospital discharges[44] be made public?

HIW advised that this will be a public document and was expected to be published during 2022.

- What does the promise of "communication and engagement" with victims look like for other families? Is there a typical experience?

A victim was informed by a MP that the Root Cause Analysis would not be shared since it was not commissioned for the public. During July 2021, they were informed by CTMUHB that "the Health Board is working in close liaison with Welsh Government to develop a communication and engagement plan…" There is no guidance in the *Putting Things Right* regulations concerning contact/ engagement with unrelated individuals who may be affected by an incident, unless it is within a healthcare facility. It would be a compassionate and considerate action on behalf of the UHB to assure itself that those affected by an incident resulting in harm

[44] https://www.hiw.org.uk/local-review-discharge-arrangements-adult-patients-inpatient-mental-health-services-cwm-taf (accessed 1 June 2022)

received support. The UHB understands that victim services were involved in this case. The UHB's Assistant Director of Communications has discussed how the UHB prepares a plan of engagement/ communication where a report is published which may impact on staff, patients and communities, as well as the UHB's reputation, in order to be prepared to support effectively. An example is the Independent Maternity Oversight Panel which ensures that the UHB has the right level of support in place for anyone who may be affected and who may require advice, information and support.

- How are formal responses to the victims of tragedies designed, most particularly those which ignore victims' experience?

There is a hierarchy of formal responses which begin with the police who are called to emergencies. They seek to save lives, make contact with other essential services, protect and preserve the scene of a potential crime and ensure the safety of people who were involved. During the investigation, individuals and families may be allocated a Family Liaison Officer or a Police Community Support Officer. In addition, public services may invoke their emergency plans, collaborate with the police and other relevant services and provide health and social care support. Generally, promises to learn from events are made to reduce the likelihood of such events recurring. This is anchored in the reviewing and investigation functions of Safeguarding Boards (s.135 of the Services and Well-being (Wales) Act 2014). In addition, Safeguarding Boards ask a "qualifying…body to supply specified information…A qualifying…body who decides not to comply with a request…must give the Safeguarding Board which made the request written reasons for the decision" (s.137).

- Why is it assumed that public, publicised and celebratory events for heroic actions are welcomed by victims' families?

Acknowledging bravery is an established post-incident process. The police always consult with nominees, paying particular attention to their privacy. The impulsive actions undertaken by Adult C and others on 5 May command attention because the events were highly situational: they were shopping and when the assaults began they put themselves in harm's way. It is the public's interpretation, and that of the media, that elevates actions to the status of heroic. Their behaviour spoke of a willingness to take risks on behalf of others and the act of awarding medals or certificates acknowledge actions that many of us do not take. The practice of institutions acknowledging outstanding, altruistic actions is infrequently questioned. Arguably the possibility that not all victims or victims' families would wish to be recipients of public awards is infrequently considered. It follows that

contact with victims and/ or their families to consider their thoughts and feelings prior to proposing an award is critical.

- Did COVID 19 and/ or the resulting staff shortages impact on Ann's support when she was discharged from hospital?

In part, yes. Ann had a single meeting with a social worker and nurse on 2 March 2020. The Welsh Government suspended all non-urgent outpatient appointments on 13 March. It was assumed that because Ann was living with her parents that they would assume a supervisory role and that her accommodation was stable. However, the documentation confirms that her parents had frequently sought the emergency assistance of services on behalf of Ann. Mr and Mrs P were given the numbers of the CRHTT and the CMHT's duty number "if they have any concerns." It does not appear that they were advised what to expect in the event of a mental health crisis. Although the CMHT is "not a blue light service," (that is, not an emergency service), Mr and Mrs P expected a response which acknowledged their growing sense of urgency. The Root Cause Analysis states that Ann's Care Coordinator did not know that Ann was likely to stop taking her medication and resume using other substances. A social care manager believes that Ann's care would have been different if it were not for COVID 19. In contrast, a healthcare professional stated that "nothing" could have prevented the tragedy. A healthcare manager noted that Ann was not detainable and she "had the ability to make an informed decision in relation to taking medication." In the absence of a mental capacity assessment, this claim may not be verified. However, it is possible that Ann was assumed to have the mental capacity to make decisions concerning her prescribed medication.

- Why wasn't Ann visited by a Mental Health Nurse?

Ann met with a social worker and mental health nurse on 2 March 2002 and on 5 May, a social worker and mental health nurse were to meet her.

- Why weren't Ann's previous attacks considered? Why couldn't agencies consider the whole picture? How could she be released without oversight and support? Wasn't anyone looking out for her?

Forecasting violent behaviour is difficult since uncertainty prevails. When considering the hospital discharge of a person with a mental health disorder, multi-disciplinary teams are alert to two possibilities: discharging a patient who will

commit a violent act or denying freedom to a patient who will not commit a violent act. Although Ann had received a prison sentence for a single, violent act at a time of acute mental distress, she was known to the police as a victim of violence who had mental health challenges. The transition from acute mental health services to community support is acknowledged to be a vulnerable period in the pathway.[45] Ann was discharged from hospital to live with her parents. A single meeting with a social worker/ Care Coordinator and mental health nurse occurred prior to the pandemic's lockdown.

- Why wasn't there a safeguarding panel meeting to discuss Ann?

Ann was known to Mental Health services, her GP and the CMHT. She had been an inpatient as recently as February 2020. The police investigation was the initial priority and this drew on clinical information. The police are accustomed to working in parallel with safeguarding practitioners. The Regional Safeguarding Board received a referral from Cwm Taf Morgannwg University Health Board to undertake an Adult Practice Review during May 2020. Since neither Ann nor her victims were adults at risk as determined by the statutory guidance,[46] a Mental Health Homicide Review (MHHR) was proposed. These have ceased to be undertaken in Wales,[47] and an external, Root Cause Analysis was commissioned by the Health Board, which was concluded on 21 January 2021. The Welsh Government identified gaps in the RCA - the voices of the victims and their families and separately - multi-agency working. It asked the Regional Safeguarding Board to oversee a review, that is, *not* an Adult Practice Review.

- Why did the police refer itself to the Independent Office for Police Conduct (IOPC)?

South Wales Police made a discretionary referral to the IOPC under S.12 of the Police Reform Act 2002.[48] On receipt of the referral, the IOPC made the

[45] Tyler, N., Wright, N. and Waring, J. (2019) Interventions to improve discharge from acute adult mental health inpatient care to community: systematic review and narrative synthesis *BMC Health Services Research* 19

[46] Welsh Government (2016) Social Services and Well-Being (Wales) Act 2014: Working Together to Safeguard People Volume 3

[47] Wales' Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews and Offensive Weapon Homicide Reviews are soon to be subsumed by the Single Unified Safeguarding Review

[48] Paragraph 7.3 of the IOPC's *Statutory Guidance on the Police Complaints System* states: "If a death or serious injury occurs following direct or indirect contact with a person serving with the police, and the person who died, or was seriously injured, was not under arrest or otherwise in the custody of a person serving with the police at the time, the appropriate authority will need to assess whether there is any indication that the contact may have caused or contributed to the death or serious injury. For example, through action, or inaction. If there is such an indication, this meets the definition of a DSI matter."

determination that the event did not meet the criteria of a "Death or Serious Incident" referral because neither the death of Adult C or the serious injuries suffered by other victims resulted from police contact. Since there was no causal link between the death and serious injuries and the actions of South Wales Police the IOPC carried out no investigation. South Wales Police found that "there was no behaviour that would justify misconduct proceedings."

- Will the action plans arising from potential recommendations be RAG rated?[49]

Yes. This practice is familiar across children and adult safeguarding and Health Boards. Typically, there are up to five recommendations and the organisations cited in these are tasked by the Safeguarding Board to give consideration to action planning. Although this is not a conventional Adult Practice Review, recommendations are anticipated and RAG rated action planning is likely to result.

Adult C's family were devastated by his death. His wife has dementia and he was her principal carer. She was admitted to a care home as a direct consequence of his death. They had endured their only child's death, after which, Adult C had been hugely supportive to his son-in-law and grandchildren.

Another victim reflected on whether she would have helped if Adult C had not intervened. Two people wondered if his life might have been saved had more people had come forward to help overpower Ann. One reported having "lost faith in people" and asked, "If I was in trouble would anyone come to my aid?"

One person recalled telling Ann to stop because she was "hurting people." For this person, "the trauma has been massive…a huge impact." They declined to tell close relatives about the incident for 12 months. This person had told Adult C they would "protect him" and he had thanked them. They have since experienced "mental hurt."

Two victims said of their experience and religious faith, "My faith is important to me and I feel the sanctity of life is precious." The other person noted, "If he hadn't helped he may be alive…I felt so guilty. I attend church and Reverend is very supportive…"

One person recalled feeling guilty at being angry at Adult C for being at the supermarket. He had been shopping elsewhere and had only called in for items he had not been able to get earlier. Their anger arose from the bleak consequences for his wife and family.

The experience of people who were terrified by witnessing the assault prompted a question about how they have managed since. Did their responses make them feel guilty? How can it be known that people are equipped to overcome this tragic event without proactive contact?

[49] Red-Amber-Green ratings are a coding scheme. The colours are shorthand for indicating what is going well or what is in trouble.

Three victims received counselling after the event and one had hypnotherapy for post-traumatic stress disorder. Although they returned to work, one became ill shortly afterwards and took sick leave, another realised that "a break from work" was necessary and the third welcomed retirement. Reading about criminal law and psychology and talking to others has been important in understanding the court process and what happened has been helpful for one person. Another was prescribed sleeping tablets stating "I couldn't sleep for months."

It was acknowledged that Ann's medication should have been monitored, but anger at the outcome of her actions characterised the experience of two victims, neither of whom wanted her to be released. One woman does not go out as much as she used to and has become wary about where and at what time she walks her dog. Another victim is a family carer and is plagued by thoughts of what might have happened had a very young relative been present. "I will never be the same again."

One person returned to the supermarket with "a very supportive Police Community Support Officer." Another reported that they "will never go back to that area again."

Learning Identified

Since crises have many faces they call for specific responses. The focus of the crisis at the supermarket required urgent action and three customers, not previously known to each other, took decisive action. Their experience and questions can and should be used to sharpen the thinking of those responsible for dealing with the crisis landscape.

Perhaps these people's reflections and recollections two years after the event are interim. That is, traumatic memories differ in terms of durability and they may change over time. However, it is clear that the victims of 5 May 2020 still have many unanswered questions. Learning is most effective when learners are actively involved and when the learning takes place in the context in which knowledge is likely to be used. They questioned the wisdom of media announcements concerning a "robust" reviewing process without engaging with the victims and advising them of the review and its implications. They want to understand how the Root Cause Analysis review fits into the learning processes of mental health services and safeguarding services – for the family, the individual professionals, their teams and their organisations. Although the police could set out what to expect of the criminal trial and provide Family Liaison support, information concerning the purpose and scope of a Root Cause Analysis; and the intention of Healthcare Inspectorate Wales to review of safe hospital discharges[50] was not shared with them. Families should not have to ask a Member of Parliament or Member of the Senedd to explain that the RCA contains confidential information and that without "appropriate consent," the content may not be shared. It should be possible to provide (i) an explanation concerning different reviewing processes (ii) answers to pressing questions and (iii) some preliminary, emergent general findings.

[50] https://hiw.org.uk/local-review-discharge-arrangements-adult-patients-inpatient-mental-health-services-cwm-taf (accessed 24 July 2022)

Although these people and their families continue to negotiate the complex consequences of this tragic event, the personal consequences are wide-ranging and span feelings of guilt, of fragility, the importance of protecting and/ or comforting close relatives and the challenges of resuming working lives. Since their own mental health challenges are acknowledged, and counselling is valued to different degrees, it appears remarkable that there is no proactive learning from victims. An empathic comprehension appears to be a component of the close and supportive bond that has developed between the three women victims. Careful attention to how people construct their understanding of traumatic events is crucial to identifying how their appraisals promote short and long term adaptation. Services must demonstrate their readiness to involve victims in processes of learning how best to support them, most particularly when information concerning mental health tragedies feature in the media.

Context and Beginnings

When people develop symptoms of distress and come to the attention of mental health services, a history of early trauma is implicated. When the line between struggling with trauma is crossed and the traumatised person goes on to harm others, their history features in considerations concerning the possible causes. Ann's history is no exception.

This review has identified eight potentially derailing themes in Ann's life. Although these are described within the following sections as though they are discreet, they are connected. The timeline for this review is the 12-month period before the fatal events of 5 May 2020. However, any credible risk assessment must involve consideration of:

- early manifestations of Ann's mental health challenges;
- the efforts of Ann's parents to bring Ann's deteriorating mental health to the attention of services;
- Ann's compliance with and responses to prescribed medication and their side effects; and
- whether there were previous acts or indicators of dangerousness which preceded 5 May 2020.

Bullying

Ann's family recalled that bullying blighted Ann's early school life. When Ann was hospitalised during 2019, she referred to being bullied at school. Her parents removed her from "two or three schools" to address the fact and extent of bullying. Although it is not known whether the power relationships Ann experienced were played out by groups of children or by the force of single personalities, her family recognised that the bullying she experienced was repeated, deliberate and harmful.

Bullying is generally hidden from supervising adults. When it is noticed it is challenging to bring it to a halt due to the reluctance of children and young people to speak out. There are typically gender differences in bullying behaviour. That is, girls are more likely to be subjected to physically indirect means such as humiliation, name calling, having belongings taken and being separated from friends via hurtful rumours, for example.[51] The potential consequences for the victims of bullying include depression and interpersonal difficulties.

Despite the protective interventions of Ann's family, it was recalled that "Ann lost interest in school because of the way she was treated…she was a caring, loving and thoughtful child…wouldn't harm anyone…she wore her heart on her sleeve. We had no problems with her." Ann's family wanted her "to feel safe and thought that a new school would be a new start…she was very soft and very pretty. That's why she had the trouble." Perhaps this impacted on Ann's capacity to make and maintain close and "best" friendships in school?

[51] Menesini, E. and Salmivalli, C. (2017) Bullying in Schools: the state of knowledge and effective interventions, *Psychology, Health and Medicine* 22 (1) 240-253

In parallel, problems became apparent in Ann's relationships with some relatives. The family believe that strong feelings of jealousy – the sense of a real or perceived threat to important relationships – were harmful to Ann. However, Ann did not seek to distance herself from these turbulent relationships, even when the rest of her family were clear that they were damaging. Her parents shared family photographs of their daughter before she became unwell. They explained that "In school, everyone wanted to date her." However, her family recalled that in early adulthood, she was not supported by respectful or mutually affectionate friendships. "There were people that Ann thought were friends." Those that she met through some relatives resulted in her eventually being "pushed out."

Significant Losses

Ann's family acknowledge the impact of significant bereavements in her life as a young adult. She had been close to an uncle with whom she had a "strong" and supportive relationship. His unexpected death was followed within a few months by that of her paternal grandparents. Ann lost three people with whom she had profoundly important attachments, one of whom, a social worker, had been a potent influence and role model.

Another bleak period commenced when Ann became pregnant in her late teens. At this crucial time, she discovered that the man to whom she was engaged and the father of her child was in a relationship with someone else. He remained the friend of a close relative's husband. Ann's life changed fundamentally. She was no longer with the man with whom she believed she had a shared future and she was to become a lone parent. The relationship with her child's father did not modulate into affection. Ann's parents question whether she recovered from the shock of this experience since they believe that her post-natal depression was followed by a succession of traumas which included estrangement from relatives.

Although Ann was a loving mother, her family recall that they became increasingly troubled by changes to her lifestyle, the company she kept and substance use. During 2012, mother and child came to the attention of social services. Ann was reluctant to engage with support services, including Sure Start,[52] most particularly when attention turned to her child's health and development.

During 2013, the police were called to the address of a close relative who alleged that a verbal altercation had resulted in Ann becoming violent. Ann was arrested and her child was looked after by Mrs P. It was noted that "All parties involved in the incident have refused to cooperate with any police investigation." However, information provided to the police by others indicated that Ann's child required a place of safety. The child was taken to foster carers. Within six months, a Residence Order[53] was granted to the child's biological father. A Contact Order was agreed for Ann and her parents which was to be supervised by the child's paternal family. The family believe that Ann's continued relationship with a violent partner,

[52] Sure Start provided help and advice on child and family health, parenting, money management, training and employment. It targeted the parents of pre-school children to support their learning and social development
[53] A Residence Order – also known as Child Arrangement Order - establishes where a child will live

not her child's father, who was drug dependent, resulted in the loss of all access to her child. There were occasions when "he beat her senseless."

Violence

Ann's contact with the police between 2004 and 2019, typically hinged on violent incidents, allegations of violence or the threat of violence. That is, out of 60 incidents, Ann was recorded as the alleged victim or witness in 49. She was the alleged perpetrator in the remaining 11 incidents.

During 2004, (when Ann was 14) she came to the attention of the police having been the subject of an unprovoked assault by a woman known to her. Following an investigation, the Crown Prosecution Service advised no further action, possibly due to the assailant's mental health status. The circumstances which led to the violence are not known. Neither is it known whether Ann's lifestyle exposed her to high risk times, places and/ or people.

During 2007, Ann was the victim of a robbery. Two women, one of whom was known to Ann, used force to steal her handbag. It is not known whether Ann's victimization was linked to her lifestyle or what the implications of the theft meant in terms of developing supportive friendships with other women.

Ann made a complaint of assault against her father (during 2008) and against another male relative (during 2012). The outcomes were that no proceedings were taken and, with reference to the male relative, it was established that the reported assault had been a verbal altercation. During 2015, Ann alleged that a relative had sexually assaulted her. Although he was arrested, no action resulted "due to no evidence to link him to the allegation." Separately, Ann alleged that her father was violent; that he had assaulted her (during 2015); and that he was watching her, having installed cameras in her home. On this occasion, Ann told officers that she was bi-polar. The police were aware that Ann had left a message on her parents' phone stating her intention to report false allegations against her father; separately, she reported that her father was attacking her (during 2016); and that her parents had threatened her and also threatened to burn her home (during 2017). Also during 2017, Ann alleged that her neighbour had assaulted her and, separately, Ann assaulted staff members at the mental health service, an attending police officer and her mother. This resulted in imprisonment of 16 weeks.

There is fragmentary evidence that Ann witnessed and was victimized by violence in the family home. The willingness of families to open-up to scrutiny may result in penalties for any disclosures, whether or not the witness or victim wishes this. This accounts for the hesitancy with which victims decline to press charges, for example. Domestic violence is one of the gravest problems faced by women, violating the most basic human rights. It is regrettable that no serious enquiries resulted from Ann's claims that her father was:

"…abusive towards her…physically and emotionally abusive towards her mother as she was growing up…he was very controlling towards her throughout her life." Ann told a professional that he "strangled her when she was a child" although she could recall no

specific details. In addition, she recalled her father "rubbing dog faeces in her face because she accidently brought it in on her shoe."

On three occasions, Ann's father was arrested and then released without charge. Mr and Mrs P assert that that during a period of hospitalisation in 2019, the police noted that Ann's delusions included being sexually assaulted by her father and having her throat slit by her ex-partner, who was not the father of her child.

During 2012, Ann became associated with violent behaviour herself. During 2013, a close relative reported Ann for assaulting her and two children, one of whom was Ann's child. Ann was arrested and bailed. This significant incident led to the removal of her child. The following year she pleaded guilty to common assault. She was arrested and charged during 2015 for assaulting a woman and, during 2017, there were two reports of Ann assaulting a woman.

Domestic Violence

Intimate partner violence is a matter of great personal significance in which rape and control are especially traumatic. Domestic violence concerns private violence which may be deferred. Typically, it concerns ongoing patterns of behaviour rather than isolated incidents. During 2014, Ann was noted to be a "high risk victim" of such behaviour. During the final three months of 2014, Ann was the subject of a Multi-Agency Risk Assessment Conference (MARAC),[54] two "High Risk Public Protection Notifications" (PPNs) were received[55] by the police Public Protection Unit and an Independent Domestic Violence Advisor (IDVA) was allocated. The IDVA rang Ann on four occasions before she was sent an "unable to contact" letter. Within three weeks a further High Risk PPN was received and the IDVA resumed attempts to contact Ann. At the third attempt, Ann stated that she was safe, attending college and being supported by family and friends. She declined help.

It was during 2014, that Ann's violent ex-partner entered her home and "made her watch him kill her pet rabbit." She reported that he had prevented her from seeing her family and friends. Ann described occasions when he kept her prisoner in her home because he did not want her to have any other relationships. Ann rang her father to collect her on an occasion when she had been assaulted and she began to stay with her parents regularly to protect herself. The ex-partner said that if Ann stayed with her parents he would burn their house down. Ann described herself as "extremely petrified" of him.

During 2015, there were five High Risk PPNs and a Medium Risk PPN – three within a three month timeframe. Ann did not engage with the IDVA on the first occasion and an "Unable to contact letter" was sent to her. On the second occasion, Ann answered the call and she was

[54] This considers how victims who are at high risk of serious harm may be helped. See, for example, https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf (accessed 13 June 2022)

[55] https://www.south-wales.police.uk/SysSiteAssets/media/downloads/south-wales/about-us/policies-and-procedures/english/adults-at-risk---english.pdf (accessed 14 June 2022)

told about the supports which were available to her. Ann declined help and explained that she had returned to live with her parents. However, she did express an interest in attending the Freedom Programme[56] - which she subsequently declined - and was given a contact number in the event of her ex-partner's prosecution. On the third occasion, Ann did not respond to telephone contact from the IDVA and an "Unable to contact letter" was sent. On the fourth occasion, Ann did not engage. It was alleged to the police that Ann had returned to live with her ex-partner. As enquiries were made about Ann's living arrangements, a fifth High Risk PPN was received. It emerged that Ann was in hospital. She told officers that she wanted her ex-partner to be prosecuted. She confirmed that she wanted help in the form of court support, housing and "some group work" with Women's Aid. The Medium Risk PPN identified a close relative. The IDVA could not contact Ann by phone and because her address was unknown, an "Unable to contact letter" could not be sent. Ann's contact with the service for people experiencing domestic violence was limited. Since it is "victim-led" it could not require her to accept its support, its courses or advice.

The legal remedies available to Ann were the arrest of her partner and restraining orders. Her ex-partner breached his restraining order on two occasions. As a result of his violence, Ann attended A&E on at least one occasion. Her parents assert that Ann had a miscarriage as a result of being physically assaulted by one partner.

Despite the chronic discord which involved repeated assaults, Ann declined to press charges. This is as familiar as the under-reporting of domestic violence. It is possible that Ann placed her faith in short term reconciliation and/ or was fearful of violent retribution. The restraining order was subsequently amended so that the couple could meet but he could not go to Ann's home. Ann was the subject of a MARAC during 2015. From her parents' perspective, the MARAC process did not reduce Ann's victimisation since she was assaulted by her ex-partner the following year when he reported a relative of Ann's to the police. In addition, it was alleged that the ex-partner made silent calls to Ann. When conveyed by ambulance to A&E for an "anxiety related medical presentation" (during 2016) the crew undertook a Domestic Abuse Enquiry. "Nil disclosure" was recorded.

South Wales Police noted of Ann that "there are issues with regards to the male persons in her life both family members and males whom she has had intimate relationships." During 2008, Ann informed the police of an argument between her parents which resulted in her mother being injured. When Ann intervened she stated that her father had hit and punched her. Neither Ann nor her mother would "pursue a complaint." During 2015, two days after Ann's father had alleged that her violent ex-partner was making silent calls to her, Ann alleged that her father was "being violent." He could be heard shouting during the call. Officers supported Ann to retrieve her property from her parents' home. Four months later, Ann alleged that her father had "assaulted her and threw her over a sofa." As a professional observed: "It seems clear that Ann did struggle to manage her life circumstances and struggled in particular with a lack of stable accommodation exacerbated by her family relationships. It appeared that Ann was in need of a range of support across her life areas

[56] https://www.freedomprogramme.co.uk/ (accessed 14 June 2022)

not only for her experience as a victim of domestic abuse albeit that on occasions, support was often refused."

Mr and Mrs P assert that allegations of domestic violence within their home are untrue. They remain hurt that this "false information" was instrumental in the removal of Ann's child. They assert also that allegations concerning domestic violence had been retracted by the police.

Mental Health Diagnoses and Challenges

Beginning with the ways in which mental health services perceived Ann's presentations, several diagnostic "pointers" were revealed. It was the psychiatrists' determinations which prevailed, even though there was a high turnover of psychiatrists and there were occasions when some nurses disagreed with them. As a result, there was uncertainty concerning Ann's mental health status which pre-dated 2019. Ann's parents were not perceived as having credible experiential knowledge concerning their daughter's presentation. Ann was distressed by the unpleasant consequences of medication side-effects and yet the same medication appeared to be the principal outcome of her diagnoses. Arguably this contributed to Ann's poor adherence to taking her medication and her ongoing psychosis.

Mr and Mrs P are convinced that Ann's mental health deterioration was triggered by her child being taken into care.

Multi-Disciplinary Team Meetings should be a crucial vehicle to discussing diagnoses and challenging the tendency to medicalize trauma; involving community-based professionals who will be involved in a person's post-hospitalisation life; exploring treatment options, the implications of treatment and patients' treatment acceptance capacity; and auditing "home leave" and "leave of absence" for voluntary and involuntary patients.

Ann self-referred to the Crisis Team during 2016. She reported that she was hearing voices and felt suicidal. In a Local Primary Mental Health Support Service assessment, she discussed difficult family relationships and negative thoughts. Ann was referred to an Emotional Coping Skills course. In subsequent contact with the Crisis Team, she explained that the voices remained and that she had been sexually assaulted by a relative 12 months previously. This relative was also known to mental health services. Ann was taking anti-depressant medication and it was proposed that the dosage should increase. The GP questioned whether Ann had a bi-polar disorder.

Ann's parents were increasingly concerned about their daughter's mental state. Although Ann was encouraged to attend a Valleys Steps course[57] she did not do so. During 2017, she had contacted the Crisis Assessment service because her parents had wanted her to return home. She described poor sleep, poor concentration and a poor diet. Within a few months, Ann made allegations about a neighbour. The police attended and she threatened to self-harm if they left. Ann wanted to move to another locality and since neither the police nor

[57] https://valleyssteps.org/ (accessed 14 June 2022)

the Crisis service could effect this, she confirmed that she had no intention of self-harming. A psychiatric assessment during 2017 described Ann's belief that people could read her mind through a bugging device in her ear.

Following a statement that she wished to take her own life, her parents called for an ambulance. Ann was extremely agitated when she attended the Crisis Assessment service stating that she "needed something taken out of her ear" – which her family believe referred to "voices." When Ann assaulted the Crisis Resolution and Home Treatment (CRHT) practitioner, Health Care Assistants, her mother and attending police, a MHA assessment was refused and Ann was arrested.

Ann's parents contacted CRHT shortly after Ann was released from prison. She was "unwell …brandishing a knife" and had "barricaded herself in the bathroom." CRHT advised the police to contact the Emergency Duty Team (EDT). Police records note that Ann did leave the bathroom to talk to officers and she became calm. Her father was noted to be "happy for Ann to remain at the address in his care."

Ann was later recalled to prison by probation. During the same month, Ann "self-presented at RGH for crisis assessment." Her family's escalating frustration meant that no assessment resulted. However, within 24 hours, Ann was admitted for assessment[58] having been removed by the police to a place of safety.[59]Ann was discharged from the Mental Health Unit after 41 days "with outpatient follow-up" plus CMHT follow-up. Days later, Ann was returned to the hospital by the police. She was "under the influence of substances, possibly amphetamines."

At the end of the year, Ann met with professionals supporting people living in abusive circumstances. Specifically, she requested help with housing having moved to a B&B when she was asked to leave her parents' home. She recalled that her parents were intolerant of her sleeping throughout the day. At the Local Primary Mental Health Service (LPMHS) she recalled with disbelief that she had struggles with auditory and visual hallucinations and that she had wrecked her accommodation. Although she continued to find the voices distressing, the anti-psychotic medication she was taking was helping. Her aspirations included more independence, more time with her parents, training/ work opportunities in care work and accessing a gym. Ann wanted to know for how long she would be required to take her medication and was advised to return to the hospital to check this out. In addition, she was directed to Citizens' Advice for assistance with her debts. Ann did not return to the hospital.

During 2018, at another appointment with professionals at the LPMHS, Ann reported that her medication had ceased to work because the voices persisted, although not when she is with her family. She explained that she wanted sleeping tablets because was taking cannabis to aid her sleeping. She added that she lacked energy but was shopping impulsively and that she was scared of gaining weight. In terms of aspirations, she decided that she wanted to

[58] S.2 MHA 1983 allows compulsory admission for assessment or assessment followed by treatment. It can last for up to 28 days

[59] S.136 MHA 1983 – if a person appears to have a mental disorder, the police may take the person to, or keep a person at, a place of safety

work in retail and she wanted “a clear diagnosis.” Ann explained that she was having some problems with probation because she was offered morning appointments. Due to her poor sleeping attendance at these was difficult. Although Ann confirmed that she favoured written correspondence over telephone contact, she Did Not Attend[60] two appointments and it was determined that he case should be closed. A letter informed Ann that she was discharged from the Mental Health Unit and that she could request a future assessment. The letter included information about contacting professionals.

Ann sought another assessment later in the year because she was hearing voices, she felt suicidal and was using amphetamines as well as anti-psychotic medication used to treat bi-polar disorder and schizophrenia. Although she requested another Out Patient Appointment, this was not offered “due to drug induced psychosis and poor engagement with OPD” (Out Patient Department). Five weeks later, Ann made further contact with the CRHT and explained that she had stopped taking her medication because of gaining weight. She was advised to contact her GP. The GP referred her to the LPMHS for a medication review. Ann cancelled the resulting appointment because she was unwell. A subsequent CRHT assessment recorded auditory hallucinations and “reduced medication.” She was referred to LPMHS and advised to attend a Drug and Alcohol Single Point of Assessment (DASPA) walk-in clinic.

At the beginning of 2019, Ann’s parents contacted the CMHT because their daughter was “in crisis.” They sought an assessment at their home but were offered an appointment at the hospital. Within two months, Ann was a hospital in-patient. She is known to have sent a text to her ex-partner stating that she was going to die. A few days later she was Absent Without Leave from the hospital.

Feeling unsafe

There were at least 15 occasions when Ann reported feeling unsafe during her stays in hospital during 2019. Although being on a ward with a locked entrance door and having previously been imprisoned, Ann did not appear consoled by these different conditions of confinement. Ann told hospital staff that she feared her throat would be slit and this was primarily associated with her feeling unsafe. She believed that her ex-partner - or less frequently, her father - would be the potential perpetrator. Ann wanted medication to help her to sleep and to silence the menacing voices as a means of dealing with their threats. In contrast, there were occasions when Ann wanted to remain alert during nighttime so that she would be alert and ready for her attackers. It is possible that the plaguing presence of her auditory hallucinations recalled the threat of an especially violent ex-partner who, according to her father, threatened to “slit” her throat as he beat her “black and blue.” Ann’s voices accompanied her when she left hospital.

[60] In learning disability services, there is encouragement to substitute “Did Not Attend” (DNA) notices with “Was Not Brought” (WNB) notices. Since there were occasions when Ann was without money and food and she was not staying with her parents, she was unlikely to prioritise attending hospital appointments

Instability and Poverty

During 2014, Ann had returned to live with her parents. They were distressed by the very tangible impacts of her violent relationship. However, within a few months, it appeared that she had returned to live/ be with her violent ex-partner. Ann specifically requested help with housing having moved to a B&B when she was asked to leave her parents' home. She recalled that her parents were intolerant of her sleeping throughout the day. Ann was found to be living with a woman friend on a temporary basis during 2015. She was sleeping on the sofa of another woman friend in anticipation of remaining in the Rhondda. During 2016, she had moved into allocated property and her door had been kicked in. She explained at the "Drop In"/ the Domestic Violence service that she had no food or furniture and had no money on her phone. A food parcel and the delivery of free paint and carpet tiles were arranged. Similarly, contact was made with a charity providing furniture. Separately, it was noted that Ann was to attend the benefits agency.

One of Ann's violent ex-partners was exploitative. Her debts and problems with financial management featured in her contact with service providers. Ann's mental capacity in decision-making in this context is not known.

The Risk of Recurrence - yet no resetting of services' responses

Ann's transition to becoming a lone parent was critical. She became peripherally known to children's services because she declined to participate in Sure Start. Later, her enthusiasm to begin vocational courses and secure employment appeared short lived and were subject to change. The years 2014 and 2015 were especially bleak because Ann experienced unrelenting domestic violence. She was allocated an IDVA on eight occasions, that is, the service response was constant even though her engagement was limited. Ann's reliance on alcohol and cannabis became conspicuous once she ceased to have responsibility for her child. One of her ex-partners was known to deal drugs. She had advised her probation officer during 2017 that she wanted medication to deal with the "constant" voices. However, it was difficult to gauge the influence of substances since testing was not routine and she gave professionals conflicting accounts of the quantities she was using. This became problematic when Ann was prescribed anti-psychotic medication and she declined to cease drinking/ using drugs. A proactive approach of engagement by services to understand Ann's non-adherence to prescribed medication and poor attendance at outpatient clinics was not addressed by proactive support. Similarly, the fact that she did not attend follow-up appointments with probation and other services suggests that she may have benefitted from different types of reminders and support, most particularly when she left her parents' home.

Since the best predictor of future behaviour is a person's past behaviour, Ann did not benefit from the focused prevention efforts of professionals tasked with keeping her safe from violent partners. There is no mental capacity assessment evidence concerning her contact with violent partners. The outcome was that she remained within their orbit and relied on substance use. The trauma of domestic violence is known to lead to severe mental

health problems which can manifest as substance abuse, which increases the risk of becoming drawn into the criminal justice system.[61] When Ann removed herself from the supervision of her parents she ceased to take prescribed medication and her mental health deteriorated. The cycle of her mental distress predated the 12 month timeframe of the Root Cause Analysis. In the period before she was hospitalised, and during the intervals when she was, she received no purposeful care or treatment.

[61] Safelives (2018) Insights IDVA England and Wales Dataset 2017-18 Adult Independent Domestic Abuse Services; Bennett, L. and O'Brien, P. (2007) Effects of coordinated services for drug-abusing women who are the victims of intimate partner violence, *Violence Against Women* 13, 4, 395-411

Additional Learning Identified

Since we have had no person to person contacts with the healthcare, social care and third sector practitioners, or the attending police officers, it would be presumptuous to set out what it is that they and/ or their teams and organisations have learned.

Necessarily there is a great deal to learn from the events leading up to 5 May 2020, and in this section, topics are identified which have exercised the reviewing process. A principal caveat merits restating: this review has relied on documents which the contributing organisations shared. Where these draw on the Root Cause Analysis' interviews with professionals and on professionals' notes, the latter are likely to be fragmentary and the former undertaken against a backdrop of distress and sadness.

Responding to Challenges and Complaints

Ann's parents were troubled by many aspects of her care. They were distressed by her harmful relationships and the lethal combination of substance misuse and mental disorder. It is not clear that their questions and challenges were effectively addressed. Mr & Mrs P stated that they raised several complaints with the Health Board about Ann's care and treatment but they never received any written response. It is possible that there were occasions during Ann's hospitalisation when their views eclipsed those of Ann and their challenges even estranged them from mental health and other professionals. Tensions between families and professionals are not unusual. Parents know their children better than anyone else. They understand the needs of their family, the beliefs and behaviours that matter to them and by which they live. In contrast, professionals' knowledge, skills and experience are nested within a context of services and services' priorities. It is not clear that Ann's parents' challenges and questions about her medication, for example, were addressed and answered in ways that were experienced as helpful. It is not clear that their expectations of mental health services were known. Typically, parents do not expect to be supporting an adult child with serious mental health challenges or find themselves acting as *de facto* Care Coordinators. Ann's life immersed them in the unfamiliar worlds of mental health legislation, psychiatry, hearing voices, threats of suicide, the criminal justice system and public protection.

There are questions concerning the effectiveness of CTMUHB's complaint handling procedures, including its investigation capability and its means of "Putting Things Right" in a way that is transparent, fair and proportionate. If individuals or families do not believe that their complaints have been addressed, they require time to i) set out the steps that have been taken ii) establish the sequence of events, from their perspective, and iii) discuss possible future options/ actions. There is a compelling case for organisations to adopt a "no wrong door" policy for complaints.[62] This means that if a complaint is outwith the scope of

[62] See House of Commons House of Lords Joint Committee on Human Rights *Protecting Human Rights in Care Settings* Fourth Report of Session 2022-23, 13 July 2022, HC 216

the CTMUHB, for example, it must be directed to the appropriate organisation within an agreed timeframe.

Crisis

A crisis is an abrupt event that runs the risk of escalating in intensity. In this case, the warnings signs were not recognised or were poorly processed. Ann's parents had detected a sense of threat when they turned to services for help. Their pleas required quick decision-making. Inaction and/ or incorrect decisions are likely to result in undesirable consequences and organisations may discover that their emergency responses are insufficient for the task in hand. Neither Ann nor her parents contributed to crisis planning within a Care and Treatment Plan and the Mental Health Measure. Ann was discharged on two occasions in her absence. During 2020, the crisis of the pandemic entered the frame. Even before the pandemic, interagency working was not evidenced for Ann. She did not benefit from either clear referral pathways or patient pathways. It was up to CTMUHB's mental health services to determine how its non-consensual interventions were to operate; and now, whether the service provided by the "crisis response home treatment team" should involve visiting people at home during mental health crises.

Mental Capacity

Ann does not appear to have benefitted from mental capacity assessments. This makes it difficult to establish how attentive and responsive services were to her decision-making over time. It is not clear from the documentation that Ann had the capacity to make key treatment decisions; whether her potential lack of capacity to make certain decisions was understated; or whether there were any realms in which her decision-making capacity was evidence based. The onus is on CTMUHB's mental health services to demonstrate that its professionals are supporting people's legal capacity in their day to day practice.

Perspectives over time

The downside of working apart from the experience of family caregivers is that it cannot be known how the timing of caring during their life course changes over time. Their perspective did not inform the care that Ann received or risk assessments. An understanding of a family's caring "career" offers clues or "markers" concerning the kind of assistance that is most likely to be of assistance at particular points in time. Assumptions concerning a family's willingness and ability to care require regular interrogation. For example, although hospital discharge is a stressful time, what happened on previous occasions when, post discharge, the family noticed that particular behaviours were difficult to make sense of and/ or live with? What fuelled their realization that something was going wrong? Was any practical help, support or respite made available and, if so, to what effect? The security of prolonged and separate working is a barrier to working with families who are supporting relatives in mental distress over long periods of time.

Intimate, controlling relationships

Ann appeared to seek the company of men who sought to dominate her and provided her with drugs. Perhaps these men made her feel special initially, but their aggression erupted

quickly. Since they separated Ann from her family and friends and she conceded authority to them, she could not defend herself. Agencies working with Ann state that they did all that they could despite her apparent ambivalence. Multi Agency Risk Assessment Conference interventions might have allowed Ann space to access victim support during the times when she was frightened. In addition, when Ann oscillated between (i) stating that she was "extremely petrified" of one partner and (ii) refusing to cooperate with efforts to prosecute him, perhaps a mental capacity assessment was indicated; changing her locks and ensuring that her windows were secure may have helped her to feel safe; plus, the use of "stop and search" powers; and perhaps facilitating Ann's engagement with women who had endured similar bleak experiences may have been helpful.

There are victims of domestic violence who present as uncooperative and even hostile. The task for all professionals is to convince such individuals that they will be tenacious in offering help. Against the backdrop of Article 2 of the Human Rights Act 1998, resources must follow risk because when people are fearful their decision-making is compromised. While specialist support provision is victim-led and there may be reluctance to appear coercive in seeking to protect victims of domestic violence, disruption can and does progress to the police making daily checks on a person's safety, for example, even though the person may have been assessed as having the capacity to challenge such intrusion. Some MARACs have developed a repertoire of interventions which do not hinge on either victim's mental capacity or willingness to work with those services which want to ensure their safety.[63]

[63] During 2022/23, South Wales Police delivered the Domestic Abuse Matters training package. The objective of the training is to improve the response of front line officers in engaging with victims over time and encouraging them to allow services to help them

The Core Tasks of the Terms of Reference

The review's "Core Tasks" were discussed during Panel Meetings. There were familiar challenges in terms of people's availability to meet and in clarifying and securing information within the review's timeframe of March - August 2022. During July 2022, it was determined by Ann's current clinicians that meeting her was inadvisable. This renders the review compromised since being listened to and giving value to what we say is a basic human need. It is a curiosity that so little may be gleaned from the documentation about what mattered to Ann. She allowed and then disallowed her father to speak on her behalf. This results in a grave problem for mental health and other services given the complex father-daughter relationship and Mr P's desire to protect her from possessive, harmful and violent intimate relationships.

The Significant Events in Ann's Life

In "Context and Beginnings" the facts of Ann's bullying are set out. Since her parents were unable to prevent bullying by school-peers, they moved her to different schools. They understood the importance of protecting her, and in doing so, underscored the knowledge that a young child needs help when they are under assault from peers. Ann's parents attributed her subsequent disinterest in schooling to her experience of serial bullying. Although Ann did have childhood friendships, her late teen and adult friendships do not appear to have offered trustworthy companionship. This prompted her parents to assert that Ann was unable to distinguish "real" friendships from potentially exploitative ones. Closer to home, some of Ann's own relatives behaved in ways that were hurtful. Ann desired friendships and yet their actions sometimes closed off this possibility.

Ann experienced three family bereavements within a short timeframe. In the loss of these relationships, Ann lost significant nurturing figures in her life. Ann's parents believe that it was the loss of Ann's relationship with her child's father that resulted in overwhelming her resources. They believe that her resulting post-natal depression was grief-related. Despite this personal calamity, Ann made a home for her child with her parents' support. Her focus was on nurturing and family photographs attest to the pleasure she derived from being the mother of an infant.

Ann's life stalled incrementally in ways that were isolating. Ann was a victim of violence as a teenager and she feared violence. She began a relationship with a violent man who was drug dependent, placing herself and her young child in peril. Ultimately, her lifestyle and the places in which she spent her time with her young child brought her to the attention of the police and children's services. Ann assaulted a relative and two young children, including her own child, which triggered the removal of her child during 2012. There are conflicting accounts of this event. She alleged that she was sexually assaulted by a relative. Later, her violence resulted in a prison sentence. Ann informed one service about episodic abusive behaviour in her family home as she was growing up. She made a complaint of assault against her father during 2008. The police responded to an incident reported during 2012. This hinged on her father's disapproval of her relationships.

Ann's accommodation became unstable and she became susceptible to poverty. She told staff at a drop-in service that "she slept with people so they would give her a place to stay."

Ann's parents were profoundly affected by the accumulation of challenges in Ann's life. They were proactive in assisting her materially; they accommodated her until the stress of doing so became so great it was unmanageable; they encouraged her to break off associations with certain individuals and with an alcohol and drug using social group; they sought to intervene when the extreme behaviour of a relative taxed the quality of their relationship; they fought for her to retain the custody of their grandchild; and when Ann's highly distressed behaviour, including the intrusion of her voices and suicidal intentions rendered her visible to mental health and other services, her father's pleadings on their daughter's behalf were experienced as aggressive. Ann ceased to have any contact with her child during 2015.

Families have a great deal to contribute to a patient's care. The basis on which care and treatment will proceed is generally set out during the process of obtaining consent from a patient and family. As treatment proceeds, the interest of the patient, the family and confidentiality is made explicit, most particularly if the family is envisaged as part of the care team in the community. Some families struggle to cope with the consequential stress arising from community-based treatment. They need help to deal with a patient's challenges when they impinge significantly on their lives, whether in their homes or in treatment settings.

During March 2019, the mother of her ex-partner was working where Ann was receiving inpatient care. That is, Ann was in contact with the grandmother of her child. Her parents believe that such contact should not have occurred because it resulted in her distress and it would not have arisen had Ann not been in hospital. In addition, and at the same time, her ex-partner's partner, her sister and his aunt were employed at the hospital.

It cannot be known if this account of significant events and circumstances tallies with Ann's own understanding of her history and the risks and conflicts to which she was exposed. It is certain that the losses of her relationship with the father of her child, and then her child, upended her life and overwhelmed her personal resources.

Ann's Experience of Domestic Abuse and Alleged Sexual Violence

Between October 2014 and August 2015, the police received seven "High Risk" notifications concerning her violent partner. During this period his threatening behaviour extended to members of Ann's family and he pleaded guilty to two breaches of a restraining order. Ann intermittently accepted the assistance of an Independent Domestic Violence Advisor.

This seriously troubled relationship was hugely disruptive. It was associated with Ann's use of cannabis, her association with other drug users, the loss of her child, financial instability, extreme weight loss, and fractured relations with her parents and other relatives. The extent of her violent partner's brutality, threats of aggression and decision-making on her behalf were unlikely to have been rare events. He threatened to slit her throat. It appears that Ann struggled to make the transition from being his victim because she declined, then

accepted and then declined the help offered by services. Her violent partner was jealous of her relationships. Mr P recalled an occasion when this man "beat her senseless…black and blue…" because she had returned the greeting of a casual acquaintance. On another occasion, "he bit her until his teeth met." He went on to stalk her. This was not her only violent and abusive partner. Services' documented accounts of events in Ann's life reveal a general course of events that happened over and over again, and in addition, her ambiguous engagement with potentially helpful services. Ann joined her ex-partner in subverting his prosecution. This allowed him to identify as a man who could control Ann and rely on her for support. It is regrettable that her contact with a women's refuge was brief. She was insufficiently exposed to other women's explicit rejection of violence in their lives. Ann may have benefitted from being in the company of women who think of themselves as having rights because the courts treated them as if they do.

During December 2015, Ann reported that a relative who had mental health problems had sexually assaulted her. She could not recall the details because she believed she had been drugged by this man. Although no prosecution resulted, it appears that this event and Ann's experience of domestic violence predisposed her to subsequent trauma. This account is dissimilar from police records.

Ann's Substance Use and Involvement with Specialist Services

There is a well-established link between cannabis and psychosis and it is accepted that cannabis triggers the onset or relapse of schizophrenia in predisposed people.[64] Its use is more prevalent and frequent among people with mental health conditions.[65] Ann advised hospital staff that she began smoking cannabis when she was 18 and it coincided with her hearing voices. The frequency of Ann's use of cannabis cannot be gleaned from the documents provided. The reasons that lead to her cannabis use may also have impacted on the consequences. For example, if it was novelty seeking and/ or psycho-social coping, she would have been exposed to risks. It appears that Ann was a long-term cannabis user and it is likely that she became dependent. The symptoms of such dependency include depression, sleep difficulties and restlessness.[66]

Reference to the Root Cause Analysis reveals that during **February 2019**, hospital staff believed that Ann's cannabis use was linked to her psychotic presentation. She admitted to using £10.00 worth of cannabis a night for years, and then contradicted this quantity of use. During **April 2019**, Ann advised hospital staff that she understood the link between cannabis

[64] Rey, J.M. and Tennant, C.C. (2002) Cannabis and Mental Health. *British Medical Journal* 325 (7374) 1183-1184

[65] Rup, J., Freeman, T., Perlman, C. and Hammond, D. (2021) Cannabis and mental health: prevalence of use and modes of cannabis administration by mental health status *Addictive Behaviours* http://cannabisproject.ca/wp-content/uploads/2017/09/Rup-et-al.-2021-Cannabis-and-mental-health.pdf (accessed 5 August 2022)

[66] Andersson, M.M., Hibell, B., Beck, F., Choquet, M., Kokkevi, A., Fotiou, A., et al. (2007) Alcohol and Drug Use Among European 17-18 Year Old Students. Data from the ESPAD Project: Swedish Council for Information on Alcohol and Other Drugs (CAN), The Pompidou Group at the Council of Europe.

and her thoughts and wanted help to address this. She was signposted to walk-in services. Before going on leave to her parents, Ann said that she would not smoke cannabis. On her return she denied that she had had any. At an outpatients' appointment during **September 2019**, Ann's mother stated that she believed Ann was smoking cannabis, which she denied, and was confirmed by subsequent drug-screen test. At an admission to hospital in the early hours of **November 2019**, Ann admitted to smoking cannabis, hearing voices and favoured taking her own life, rather than "allowing her family to kill her." She appeared to understand that she was experiencing the impact of *not* taking her prescribed medication. Later, it was explained to her that the voices were exacerbated by cannabis. She was referred to Barod for substance reduction techniques. She was offered a **December 2019**, appointment which was cancelled because she remained in hospital. (Her case was closed due to non-attendance.) Ann reported that "cannabis just helps her relax." During **January 2020**, Ann returned from leave and admitted to having had cannabis and alcohol. Later, she told a nurse that she thought "things got worse after smoking cannabis." In **February 2020**, Ann confirmed that she could see the correlation between cannabis use and voices. Once again, she stated that she did not wish to continue smoking it. Later in the month Ann tested positive for cocaine. This followed home leave. In the discharge advice letter to her GP, this was misinterpreted as "positive for cannabis." It added, "…advised patient to abstain from cannabis use. Patient declined input to help with this…" The final reference to cannabis occurred on **5 May** when Ann's father was "pleading" for help. He explained that, *inter alia,* she was in a relationship with a heroin addict and was using cannabis.

The Root Cause Analysis determined that Ann had frequent drug screens but the results of these were not always documented. The hospital discharge following her final stay (**February 2020**) took place in her absence. Her views on accessing Barod are not known.

During hospital admissions staff discussed with Ann her use of cannabis. During November 2019 and February 2020. It is documented that Ann did "not see" crack cocaine "as an issue" and that drug screening confirmed substance use as an endemic feature of her life. The approach was to encourage her to take prescribed medication and discontinue taking cannabis, cocaine and alcohol. However, Ann favoured using cannabis and cocaine and feared the principal side effects of prescribed medication, that is, weight gain, eye-rolling and muscle stiffness.

The extent to which relevant history was taken into account by professionals

Some sense of Ann's experience of her life may be gathered from the information submitted by the agencies to which she became known. These edited perceptions were produced after meetings with her and represent a reality. For example, during 2016-17, Adult Services knew that Ann's parents contacted mental health services on their daughter's behalf because she was in crisis and they wanted help for her. Ann was hearing voices and seeing dead relatives; her mental distress had its origins in bullying, losing her child, violent relationships and sexual assaults; and she wanted contact with her child. Ann herself reported being "flabbergasted that it got to this." She was struggling with auditory and

visual hallucinations and expressed remorse that on one occasion she had wrecked her flat. She wanted to be independent and her debts required attention. Additional goals included employment in care work and getting fit. She believed that her prescribed medication was helping to manage her symptoms. A few weeks later, this was no longer the case. Ann was using cannabis to help her sleep, she believed that she had an eating disorder, wondered whether she had Lupus,[67] wondered about working in retail and expressed frustration that she did not have a clear diagnosis.

Ann had frequent contact with the police from 2012 onwards. It was attuned to her mental health challenges, her troubled relationships with some men in her family and the men with whom she had intimate and violent relationships.

The Root Cause Analysis revealed that during February 2020, two community based professionals who were to work with Ann did not know of her "history" of non-adherence to prescribed medication. One of these professionals was Ann's Care Coordinator who had not met her prior to leaving hospital.

It does not appear that Ann's traumas were ever the focus of clinical attention. As the Root Cause Analysis notes "…there is limited evidence of discussions around her exact feeling about this traumatic event." Similarly, Ann's use of non-prescribed drugs and alcohol were known, repetitive behaviours which came into conflict with her personal needs and those of others in her life. There were no documented attempts to instill either no indulgence or moderate indulgence which engaged with the origins and circumstances of Ann's dependencies.

Inter-Agency Working

"…Shared Care is a service offered to people who are not deemed to warrant secondary mental health services, meaning they would not have a community care and treatment plan (CTP) or the right to self-refer to the service in the following 3 years. People who are open to Shared Care would see a psychiatrist in the same building as if they were seeing them as a CMHT patient, but would not be on the CMHT case load." (Root Cause Analysis)

Ann had 35 Multi-Disciplinary Team reviews during periods of hospitalisation – 29 in 2019 and six during 2020. Although this implies multi-professional or multi-disciplinary working with an emphasis on teamwork, the perceptions of the nursing staff differed from those of the psychiatrists and doctors in the critical domain of risk. The attention to MDT reviews at the hospital contrasts starkly with reviewing practice in the community. There is no evidence of Care and Treatment Planning, reviewing or purposeful contact with Ann and her parents. If there is a

(i) hospital to community pathway
(ii) primary care to secondary care pathway,

[67] A long term condition that cause joint pain, skin rashes and tiredness

neither can be discerned from the narrative chronology.

Ann experienced a succession of onward referrals and contingent arrangements for single issues, some of which were to in-hospital professionals. Without a post-hospital discharge Care and Treatment Plan, there was no negotiated crisis plan setting out the resource, the operating procedures and responsibilities. The lack of preparation became a complicated problem for the family to manage. The following examples convey the limitations of referral processes in the absence of indispensable planning. It is not merely that the outcomes are undocumented but repeat referrals from the hospital to community services are suggestive of flaws in the pathway:

September 2016: Ann was referred for an "emotional coping skills course."

December 2016: "would accept a referral into the CMHT…advised to see GP and re-contact crisis if mental state deteriorates; advised for GP to increase [medication] and new pathways details given…the decision was made not to carry out a Care and Treatment assessment as Ann more settled and signposting information given…gave information on Valley Steps[68]…advised that Ann returns to GP for meds increase; GP referred to CMHT for second opinion…"

January 2017: "crisis assessment…advised to return to GP…Valley Steps details shared."

February 2019: Ann was referred to (in hospital) therapy "for self-esteem work."

March 2019: Ann was referred to psychology; the Multi-Agency Safeguarding Hub received a Police Protection Notice, "screened it and sent it to the CMHT."

April 2019: Ann was "signposted" to walk-in services.

October 2019: referred to (in hospital) psychotherapist "for psychometric testing;" it was proposed that "a CMHT referral would provide care coordination, psychology to address trauma, a CPN to monitor medication and a Health Care Assistant to help with education and occupation;" referral to psychology [The Root Cause Analysis revealed that "The CMHTs do not regularly attend the ward rounds on the admission ward and again this makes the referral process harder."]

November 2019: The Root Cause Analysis confirmed that a psychologist need to be present to receive a referral. In addition, "…the psychologist wanted an update to see if she still requires input, as due to the length of waiting list there might be other services that were more useful;" Ann was referred to Barod concerning her substance use.

December 2019: referral to Gofal (a specialist mental health care provider); "Ann agreed…a referral to advocacy…needs referral for exercise therapy."

January 2020: Single Point of Entry referral; psychology referral; CMHT referral.

February 2020: referral to Merthyr Tydfil/ RCT area; psychology referral.

[68] https://cwmtafmorgannwg.wales/services/valleys-steps/ (accessed 5 August 2022)

There is no clarity concerning the coordination of Ann's mental health care during 2019-2020. It is not known who was accountable for ensuring that Ann received the in-hospital and community services to which she was referred. It is not clear why the absence of a professional at a MDT meeting was a barrier to accessing psychological support. In addition, there is no documented evidence of addressing such vexing organisation and ethical matters as:

- discontinuities arising from recruitment challenges in psychiatry (Ann was treated by seven psychiatrists between 2019-2020)
- inequalities between the decision-making of professionals and that of Ann's father
- prescribing a drug with distressing side effects
- Ann's history and limited motivation to discontinue taking non-prescribed drugs.

During the course of this review it became apparent that the local authority and the Health Board had separately developed different processes for dealing with crises during the pandemic. Although autonomy is highly prized within organisations' cultures, it appears remarkable that at such a critical time, mental health services' collaborative capacity was diminished. Ann's mother was asked to contact the CRHTT or the CMHT if she had any concerns about Ann. However, the context of this critical time resulted in (i) Ann's distressed parents having to identify the relevant service and specialists as the pace of events in their lives accelerated in a single morning and (ii) front line practitioners having to defer to their respective managers. The local authority's Single Point of Access (SPA) provides information, advice and assistance. Ann had been referred via RCT's SPA during December 2016.

Individually Focused Decision Making

The patterns of behaviour associated with domestic violence were played out in Ann's life. She became isolated from her family, health and social care services when her exploitative partner became her self-appointed gate-keeper. Ann's parents could not detain her at home or prevent her from resuming relationships with her violent partner. Under the control of this man, her ability to think independently and make decisions were compromised. One means of regulating her behaviour involved supplying her with cannabis and cocaine. It is not clear that Ann defined the physical harms she sustained from violent partners as crimes and rights violations.

During December 2019, Ann stated that she did "not feel listened to by the doctors." On occasions during her hospital stays she had said of her parents, "they want to control me." Ann's father was listened to by professionals but little account was taken of him. This is exemplified by an exchange during November 2019, when a professional acknowledged "trying to appease [Mr P] to try and make the family feel supported." He knew the impact of his angry outbursts because he did apologise (during October 2019). The importance of the role of Ann's nearest relative under the Mental Health Act 1983 appears to have been downplayed. Neither individually focused nor family focused decision-making is evidenced. Services might have extended their own effectiveness by working in partnership with the

family. Ann's parents had strengths which were overshadowed by the challenges that their daughter was confronting. The result was a prescriptive and directive model of mental health service delivery which made recommendations and referrals for prescribed treatments. Ann and her parents were not perceived as active collaborators or participants in the intervention and treatment processes. There were occasions when professionals reported feeling intimidated and uncertain how to work effectively with the family.

During November 2019, it is documented that Ann "finds in depth conversation difficult; family think information is being missed." Had creating and maintaining a family partnership been prioritized then the likelihood of professional recommendations and support which were consistent with the well-being of Ann and her parents would have been increased. When their strengths were overshadowed they might have been marshalled at another time and advocacy services provided. Ann did not benefit from the provision of an independent mental health advocate (IMHA, s.130E Mental Health Act 1983). Paragraph 13 of the Welsh Government's *Delivering the Mental Health Advocacy Service in Wales: Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Providers* (2011) states:

"The Welsh Government is committed to working with services to ensure that advocacy is available for individuals at times when their mental health and usual support mechanisms may be breaking down, leaving them vulnerable when key decisions about treatment and support may need to be made."

In addition, paragraph 83 states:

"In providing support to qualifying compulsory and informal patients, the IMHA will:

a. ensure that the voice of the patient is heard, by supporting the patient to articulate their views and to engage with the multidisciplinary team;

b. help patients to access information, and to understand better what is currently happening and what is being planned, and to understand better the options available to them;

c. support patients in exploring options, making better-informed decisions and in engaging with the development of their care plans;

d. support the patient to ensure that they are valued for who they are;

e. support the patient to counteract any actual or potential discrimination."

The Root Cause Analysis confirmed that (i) decision-making concerning home leave was inconsistent when Ann was an informal patient; (ii) the assumption that Ann had mental capacity concerning, *inter alia,* her use of social media, should have been assessed; (iii) there was no full appreciation of the risk factors in Ann's life, specifically including the risk of relapse; and (iv) there was a paucity of multi-disciplinary care planning. For example, what would constitute a crisis in Ann's post-hospital discharge life? It does not appear that warning signs of "deterioration" were ever explored with Ann or her parents.

The Statutory Duties of Agencies

The Social Services and Well-being (Wales) Act 2014, provides a framework for people's care and support, with a focus on the well-being of those needing support and their carers. The SSW-b Act has an explicit, people-centred approach, giving them a voice and real control; it supports people to achieve well-being; it promotes (i) the use of preventative approaches and (ii) collaboration. Ann's voice was absent before and after her admissions to hospital.

Section 24 (1) of the SSW-b Act states:

"Where it appears to the local authority that a carer may have needs for support, the authority must assess –

(a) Whether the carer does have needs for support (or is likely to do so in the future) and
(b) If the carer does, what those needs are (or are likely to be in the future)."

Adult Safeguarding had brief contact concerning Ann during August 2015. Mr P had made contact due to concerns about Ann. There was further administrative knowledge of Ann during March 2019, when a Police Protection Notice was received by the Multi-Agency Safeguarding Hub. It was screened and sent to the CMHT. Section 126 "(1) defines an "adult at risk" as an adult who –

(a) Is experiencing or is at risk of abuse or neglect,
(b) Has needs for care and support (whether or not the authority is meeting any of those needs), and
(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

The Mental Health Act (1983) (as amended) provides a framework for the treatment of people with a mental disorder when they are unable or unwilling to consent to that treatment. The MHA is principally concerned with the admission of people to hospital for assessment and treatment of their mental disorder.

Under the Mental Health (Wales) Measure it is a legal requirement for Local Health Boards and local authorities to work together to expand and strengthen mental health services at a primary care level. Under the MHM all adults accepted into secondary mental health services must have a dedicated Care Coordinator and receive a care and treatment plan which is proportionate to clinical need.

The Mental Capacity Act 2005, applies to those who lack capacity. Section 2 (1) of the MCA states:

"For the purposes of this Act, a person lacks the capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain."

The prevalence of mental incapacity in those detained under the MHA is high but not invariable.[69] It is documented that Ann's mental capacity was discussed with her father on a single occasion during September 2019. It is not stated what this related to. Arguably mental capacity and best interests' assessments should be a core part of inpatient psychiatric assessment given the tendency to overestimate patients' mental capacity.[70]

The Obstacles to Enacting Statutory Duties

When Ann's father phoned Adult Social Care during 2016, it was confirmed that following a crisis, Ann had been seen by a RGH psychiatrist who recommended seeing her GP concerning medication. Although "There was no further action required from the Crisis Team," it was noted that the GP could "refer her to Mental Health primary care if required." He was told that Ann "would need to agree to an assessment and be accepting of help." It was proposed that domestic abuse services might be more appropriate than the CMHT. Three days later Ann's father advised that she "was better and no longer needed assessment." When Ann met with social workers at the beginning of 2018, a provisional Care and Treatment Plan was prepared. She did not attend three further appointments and her case was closed. As a professional noted, "Given Ann's history of repeat crisis assessments, detention under s.2 and the treatment she was receiving for psychosis, it is surprising that more assertive attempts were not made to contact her and other agencies…"

Ann had been subject to one partner's control and brutality and her parents were frustrated that he manipulated her into declining to press charges. She was fearful and dependent. Ann reported her father to the police on two occasions during 2015. At the end of 2017, Ann reported her father on two occasions: she thought he was watching her and had placed cameras in her home; and subsequently, when her father was returning her to hospital because she had tried to commit suicide. Yet Ann did require physical separation and intensive intervention in order to recover. Ann's parents were hugely frustrated that professionals' perceptions of Ann's mental health contrasted so starkly with their own. Living with them represented periods of temporary stability for Ann. However, they were torn when she declined to follow through on the police prosecution of her violent and intimidating partner; when she ceased to have contact with her child; when she continued to associate with friends who used drugs and alcohol; when she ceased to take her prescribed medication; when the side-effects of her prescribed medication had shocking side-effects which were distressing to Ann and distressing to observe; and when she resumed taking cannabis. They were so familiar with these features of her life that they could not fathom the foregrounding of domestic violence services over mental health services, for example. Their efforts to help Ann to protect herself from a continuing destructive path appeared rigid, authoritarian and even controlling. This impacted on the responses of mental health services and the police – both of which received complaints. If

[69] Owen, G.S., Richardson, G., David, A.S., Szmukler, G., Hayward, P. and Hotopf, M (2009) Mental Capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *British Medical Journal* 337 (7660) 40-42, July 5

[70] Lepping, P. (2011) Editorial: Overestimating Patients' Capacity. *The British Journal of Psychiatry* 199, 355-356

there is a single refrain that encapsulates the position of Ann's parents, it is, "We were begging for help."

Ann's anti-social behaviour, disputes with neighbours, allegations of sexual assault, of harassment and of physical assaults, her provocative use of social media, and a burglary rendered her visible to the police. Although "agencies made every effort to engage with Ann to support a prosecution" against a violent partner, on one occasion she asked the police to leave because they were harassing her. Allegations made against her father resulted in his arrest. He was released without being charged. On one occasion the police invoked the MHA (s.136) to transport Ann to hospital where she was detained under s.2. A month later, she reported that her voices told her to kill her father. She had ceased to take her medication. At the beginning of 2018, the police accompanied Ann to hospital because she threatened to kill her father. In retrospect, the police could not understand why Ann was discharged to her parents' home. It noted, "It is not clear how much information, if any, was shared when Ann was discharged or what the plans were for her…[she] was prescribed medication but…would stop taking the medication without advice…"

It does not appear that mental health services ever sought feedback concerning how their services were experienced. Although there was acknowledgement of Ann's experience of trauma, of being in an intimate and violent relationship, homeless, and using substances for example, it appears that primacy was accorded to medication and onward referrals. Ann herself believed that she had a bi-polar disorder. The diagnosis on which her inpatient treatment was based was not stable. A diagnosis of schizophrenia was made during December 2019.

There were two occasions when Ann was absent from the process of being discharged from hospital – 2 May 2019 and 24 February 2020. It follows that there was no proper hospital discharge planning or risk assessment. Critically, indicators of Ann's potential deterioration, including signs which would give rise to a crisis, were not explored.

Finally, the dissatisfaction experienced by Mr P in the wake of his complaints impacted on his communications and resulted in escalating frustration. Its impact extended to Ann.

Conclusions and Recommendations

Ann's parents reflected: *"If only she'd got the help she needed…In all of this, no one helped us as parents…* [On 5 May 2020] *we'd never seen her as ill as she was."*

Within the partial prehistory of 5 May, it is possible that there were many behind-the-scene efforts to assist Ann as she faced distressing times and disruptive conflicts in her life. Efforts to improve the MARAC process and ongoing work on the action plan which resulted from the Root Cause Analysis signal professional commitment to learning from Ann's life. When she became known to services, she had several interconnected and synchronous problems. That is, Ann was a single parent, a social housing renter, occasionally homeless, economically inactive and dependent on means-tested benefits. Although her parents addressed the bullying she experienced in different schools, they could not influence her peer relationships as a young adult. Perhaps her engagement to the father of her child recovered her sense that she could enjoy a friendship, a romantic partnership and the prospect of a committed relationship. The discord that resulted from her partner ending the relationship before the birth of their child was hugely destabilizing. This bleak backdrop was compounded when a relationship with a dominating and violent man resulted in conflict with her own family and the family of her child. The removal of her child was associated with an unsafe lifestyle which included keeping company with people who used drugs, a reluctance to engage with services, including those for her child, unsafe, intimate relationships and a contested, violent "altercation" with a relative.

The tragic events of 5 May 2020 may be considered as an abrupt and brutal audit when every weakness in terms of supporting Ann and her parents was exposed. Plans are operational tools. Without prior planning effort – ensuring that a family know when to raise the alarm in the knowledge that organisations' procedures can be relied upon to act effectively – the limitations of pre-event interventions are brought to the foreground and subjected to critical examination.

Recommendations

	Recommendation
1	Ann's narration of significant events in her life and her aspirations are largely absent from the documentation available to this review. Although the interpretation of her parents and the professionals who worked with her as an inpatient are important, they are not Ann's own account. Although CTMUHB has policies and procedures concerning person-centred care and conflicts of interest, the review raises questions of whether and how they were invoked. • **CTMUHB should provide assurance to the Regional Safeguarding Board that its process of encouraging people with mental health challenges to contribute to the information gathering concerning their medical, psychiatric and family history is being reinforced and embedded in practice. This is to ensure that significant events in patients' lives and, separately, what matters**

	to them are captured in their own words. Separately, CTMUHB should advise the Regional Safeguarding Board of the actions it is taking to ensure that conflicts of interest are disclosed – most particularly when staff are, or have been, closely related to a patient.
2	Ann's serial "Did Not Attend" appointments resulted in her case being closed to the Domestic Violence service. When Ann was in hospital there were two occasions when she Did Not Attend outpatient appointments (because outpatients had not been informed that Ann was an inpatient) resulting in her discharge from outpatients, and subsequently from the Primary Care Mental Health Service; and when Ann did not attend a "3 day follow-up appointment" on a ward where she had been an inpatient, no further appointment was offered. • **A history of missed appointments is a risk marker. CTMUHB and other relevant services should provide the Regional Safeguarding Board with evidence of proactive engagement with patients with mental health problems lost to follow-up appointments to reduce the risks arising from their failed attendance.**
3	There was merit in some of Mr P 's challenges [Mr P is Ann's father] concerning Ann's inpatient and outpatient care and treatment. On many occasions he had sought to bring Ann's deteriorating mental health to the attention of professionals. He was comforted by glimpses of her progress but conflict and distress resulted when these were repeatedly halted. Generally, however, as the volume and complexity of complaints escalate, there are challenges in closing cases at the same time as additional complaints are opened. This impacts significantly on the handling of complaints, on staff and on the service available to other complainants. • **Complaints provide valuable feedback to services. CTMUHB should provide the Regional Safeguarding Board with evidence of (i) how it "triages" and works with patients and families who use the complainants process frequently; (ii) how it works with complainants who self-identify as having language based difficulties such as dyslexia, using voicemail, printing on colored paper and/ or screen-reading software such as Texthelp, for example; (iii) how it facilitates and uses feedback and complaints' feedback specifically, concerning mental health service patients and their relatives; and (iv) how it supports staff who report feeling distressed and/or intimidated by complainants.**
4	Granting and withholding leave of absence are subject to legal provisions. Assessment of inpatients' mental capacity to consent to their treatment, give instruction concerning information-sharing and related matters, such as leaving the ward, should be undertaken regularly. • **CTMUHB should advise the Regional Safeguarding Board of what has been done since the its internal review to ensure that (i) the provisions of the Mental Health Act (1983) as amended and the Mental Capacity Act (2005) are**

	correctly enacted; (ii) the systems in place now ensure that informal patients receiving inpatient care, whose treatment falls outside the MHA, are not denied leave; and (iii) it is promoting learning networks and a rolling programme of inter-professional training concerning the MHA, the MCA and the interplay between them.
5	The adequacy of hospital discharge planning has implications for the use of community services and future readmissions. • **CTMUHB should inform the Regional Safeguarding Board of the ways in which the Mental Health (Wales) Measure (2010) is enacted and how its activities and those of local authorities are being changed and improved. In addition, the outcome of an operational audit to ensure that the specific statutory and regulatory requirements are met should be shared with the Regional Safeguarding Board.**
6	On 5 May 2020, Ann's parents contacted mental health services. They knew that her mental health had declined and, as advised, they sought help during this crisis. Responses to their phone calls fell short of their expectations. Since Ann did not have a Care and Treatment Plan in place, she did not have a crisis plan. • **CTMUHB should provide evidence to the Regional Safeguarding Board of its effective engagement with patients and their families in crisis planning. This should include the preparation of a brief accessible guide, in relevant formats, for staff to read through with patients and their families. Its purpose is to enhance people's understanding of likely service responses during mental health crises.**
7	News and media reporting wields great influence, most particularly when it includes graphic accounts of tragedies and other eventualities. How these stories are reported is of keen interest to the individuals and families affected by the incidents. • **A whole systems approach - in which partnership is imperative - is required if all University Health Boards, local authorities and the police are to be alert to the impact of news and social media reporting concerning their post incident processes. For example, if there is to be a Root Cause Analysis, it should be made explicit that this is a confidential process, the content of which will not be shared with the public. The NHS Delivery Unit, with the assistance of Welsh Government, is well placed to initiate such work with the police, local authorities and individuals who have been affected by incidents, accidents and tragedies.**

Statement by Reviewer(s)			
REVIEWER 1	**Margaret Flynn**	**REVIEWER 2**	**Kath Hart**
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: - ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review: - ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Margaret Flynn	**Name** *(Print)*	Kath Hart
Date	13/02/2023	**Date**	13/02/2023

Chair of Review Panel
(Signature)

Name *(Print)*
Lisa Curtis Jones

Date 13/02/2023

Appendix

The Context of CTMUHB's Root Cause Analysis

"The Welsh Government's "Putting Things Right" guidance sets out how NHS bodies should effectively handle concerns according to the requirements of the NHS (concerns, complaints and redress arrangements) Regulations Wales (2011). The regulations may be accessed at http://www.wales.nhs.uk/sites3/page.cfm?orgid=932&pid=50738. The guidance provides a single structure for the consistent, fair and transparent management of all concerns ensuring that the person affected and/or their representative, is engaged and included according to the "Being Open" ethos.

A patient safety incident is "any unintended or unexpected incident which could have, or did, lead to harm for one or more people whilst in receipt of NHS-funded healthcare." A rapid review meeting, should be held within 72-hours of a serious or notifiable incident being identified to ensure the discussion and investigation process is commenced in a timely manner. A family liaison is formally identified at this meeting and a plan of contact is made with the aim of engagement in the investigation process and an opportunity to pose questions to the investigators as well as updates on progress. There is no guidance in the regulations around contact/engagement with other unrelated individuals who themselves may be affected by the incident, unless it was within a healthcare facility i.e. another patient. It would be a compassionate and considerate action on behalf of the health board to assure itself that those affected by the incident that caused harm were in receipt of support and the UHB understands that victim services were involved.

Where an incident is deemed to have caused harm (there is a nationally agreed five categories of harm, from no harm through to death), a proportionate level of investigation is agreed (investigation levels are between 1 for a **no/low harm review** to level 4 an **independent investigation** where the incident would be in the public interest for example a mental health homicide). In this case it was expected that an external mental health Homicide Review would be commissioned by Welsh Government, however when this option was not available, a level 4 independent investigation was commissioned to provide assurance on integrity and objectivity. The investigator and team are all independent of the organisation/ service where the incident occurred. A link for any patient and representative should be maintained by the UHB, as well as the independent investigators who will involve them in the process and seek their views and questions. The patient/family must be kept up-to-date with the progress of the investigation and given ample opportunity to comment and ask questions about the investigation.

The Root Cause Analysis (RCA) is an evidence-based, structured investigation process that utilises tools and techniques to identify the true (root) cause of an incident, by understanding what, why and how health systems failed from a determined point in time (usually no more than 12 months) up to the time of the incident. In this case it would not include a review or involvement with the victims of the incident. It provides the basis for evidence of how to 'put things right' in terms of immediate making safe, action planning, identifying any breach of duty, redress and any qualifying liability in relation to health care provision. RCAs will be shared with the index individual and their representatives - with consent from the individual. This is normally done in whichever way the patient/representative chooses,

including a face to face meeting with the clinical/management/executive team. For serious (now notifiable) incidents that have met the threshold for external notification to Welsh Government (now the NHS Delivery Unit), a notification and summary of completion is submitted for external approval. RCAs are confidential to the patient/representative and will only be disclosed externally when there is a lawful requirement to do so such as to the coroner and the police, for example. Individuals/representatives in receipt of the investigation are free to disclose this to whomever they choose."