Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr D and the provision of Mental Health Services, following the Homicide of Father Paul committed in March 2007 and the Ambulance reponse and care provided to Father Paul's family and local community

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PART 1

Report of a review in respect of Mr D and the provision of Mental Health Services, following the Homicide of Father Paul committed in March 2007

Chapter 1: The Evidence

Summary of the Index Offence

1.1 On 14 March 2007, outside the vicarage of St Fagan's Church in Trecynon, Aberdare, Father Paul Bennett (Father Paul) was repeatedly stabbed by Mr D, (who was known to him) sadly Father Paul died at the scene.

1.2 Mr D was still present at the scene, calmly sitting on a garden bench when the police arrived and was arrested. Mr D had scattered 10 CDs on the ground containing details of his plans and intentions. On 16 October 2007, Cardiff Crown Court ordered his indefinite detention in a secure hospital.

Background

1.3 In circumstances where a patient known to Mental Health Services is involved in a homicide, the Welsh Assembly Government may commission an independent external review of the case to ensure that any lessons that might be learnt are identified and acted upon. As of January 2007 these independent external reviews are conducted by Healthcare Inspectorate Wales.

1.4 In addition, in this case HIW was asked to review the response, care and treatment provided to Father Paul by the Welsh Ambulance Services NHS Trust (WAST) on the day of the incident and also, following concerns raised by Father Paul's widow, HIW extended its remit in respect of this review to examine the support that was offered to Father Paul's widow, her family and the wider community following the traumatic events surrounding Father Paul's death. Both of these matters are dealt with in part two of this report.

Brief History of Mr D

1.5 Mr D was born in Mountain Ash in 1983 and lived in many different locations and settings in South East and Mid Wales during his childhood and early adulthood. He was the middle child of three brothers. The early part of his life was spent in the Penrhiwceiber and Nant y Fedw areas. Mr D's parents' relationship ended when he was young and following the separation, his mother and the children stayed initially with his maternal grandmother until being allocated housing of their own. There are differing accounts but it would appear that as a child Mr D witnessed some violence in the home. From his birth, Mr D's mother had requested support from social services as she was struggling to cope with her three sons.

1.6 In 1994, when aged approximately 11 years old, Mr D, along with his brothers, were seen together by an educational psychologist due to their increasing involvement with petty crime and incidents of aggressive behaviour at school. Due to the mother struggling with her three sons, Mr D and his brothers lived with their father intermittently during 1994 before returning to live with their mother in February 1995.

1.7 In 1995, when aged 12 years old, Mr D and his family moved to Llandrindod Wells.

1.8 Mr D made his first court appearance in Llandrindod Wells in November 1996, aged 13, charged with using threatening words and behaviour. It was reported by the social worker involved with the family that six weeks prior to this time Mr D had presented himself to the police station stating that he had had enough at home and wanted to go into care.

1.9 Later in November 1996, arrangements were made by Powys Social Services for Mr D and his brothers to go and live with their father in Abercynon, due to their mother being unable to cope with the children. However Mr D and his brothers returned to live with their mother in Llandrindod after a period of time and in February 1997 Mr D was remanded

into the care of Powys Social Services. He lived for a while with foster carers in Newtown, Powys. This was the beginning of a period when Mr D resided in several different care settings.

1.10 In March 1997 Mr D was arrested in Cardiff, where he was residing with another set of foster carers, and in June 1997 he was made subject of a Supervision Order at Aberdare County Court. A subsequent Supervision Order was made at Llandrindod Wells Magistrates' Court in August 1997. In September 1997 Mr D was made subject to a 15 months Criminal Supervision Order at Llandrindod Wells Magistrates' Court having been charged with entering a domestic building as a trespasser.

1.11 In October 1997, following a disagreement with his mother, Mr D was once again placed with foster carers. Sometime between October 1997 and February 1998 Mr D moved back to live with his mother and the family relocated to Mountain Ash.

1.12 In February 1998 Mr D was once again living with his father and during this period his father withdrew Mr D from his school in the Cynon Valley due to him suffering verbal abuse and intimidation from other children. This was a decision supported by the school, education welfare, and social services. No alternative school was found for Mr D but he did receive some form of home tuition. Mr D is reported to have engaged fully with social services and youth justice workers, meeting all the requirements of the supervision order imposed in 1997.

1.13 It appears that over the next few months Mr D achieved a level of stability and was regularly seen by the Aberdare Youth Justice Team. It was reported by social workers involved in Mr D's case that he had shown an increased level of maturity and improved attitude.

1.14 Mr D moved back to live with his mother in January 1999, however, following referral from Mountain Ash Police, subsequent to his mother contacting them stating that her sons were smashing up her house and that she wanted them accommodated, Mr D returned to the care of his father in February 1999 at his mother's request. Later during the same month, Mr D presented to Mountain Ash Police station in a distressed state requesting admission to care. He remained in the Police station overnight. His mother indicated to the police that she wished to have Mr D home, but that she needed support. However, Mr D expressed concerns about returning home but he did eventually agree to return to live with his mother.

1.15 Mr D's mother and the children then moved to live in Porthcawl for a short time. In March 1999 Mr D presented to Life Line in Swansea, a UK led organisation involved with drug abuse, alcohol abuse, drug addiction and related disorders, stating that he had nowhere to go. Mr D's mother told Life Line that she could no longer cope with Mr D and as a consequence Mr D went to live with his maternal grandmother.

1.16 Mr D moved back to live with his mother in Abercynon sometime in the summer of 1999. In October 1999 Mr D was held in police custody following an incident where they were living relating to assaults involving weapons. This incident involved five boys who broke into Mr D's accommodation, one of whom Mr D allegedly stabbed with a small knife. Mr D was subsequently remanded to local authority care in Rhondda Cynon Taf. There were no charges brought against him in relation to this incident.

1.17 Sometime after, it appears that Mr D and his elder brother were sharing a bedsit in Aberdare for a period of time, before he moved into a house in Penrhiwceiber with his younger brother.

1.18 When Mr D left school he attended a carpentry course at a local college and Mr D joined the Territorial Army for a period. Mr D left college and took up various types of short-term employment, the longest of which was 6 months spent as a scaffolder.

1.19 Mr D and his younger brother were evicted from their property in Penrhiwceiber when Mr D was aged approximately 17 years old. Mr D lived at various locations in the Aberdare/Abercynon areas until moving back to live with his mother when he was 18 years old. Mr D appears to have resided with his mother for most of the next six years, in various locations around the Cynon Valley. This was interspersed with periods living with either of his two brothers, or his father.

1.20 It is difficult to precisely date the onset of Mr D's mental illness. He is quite certain, in retrospect, that he started hearing voices in 2004 however, initially, he did not disclose this to anyone. According to his mother, when he was aged 22 (in 2005), Mr D first told her that he believed he was God. So the onset of his illness might have been in 2004, but Mr D did not display any behavioural change or report any symptoms directly related to possible mental problems to others until 2005.

1.21 By 2005 Mr D, aged 22, was telling his mother that he was hearing voices from the Bible and was becoming preoccupied with religion. At this time his mother had become involved in religion and she says she was unsure whether Mr D may have been experiencing a spiritual conversion. She had also been disappointed by her earlier experiences of taking her older son to the GP and in retrospect feels that this was partly responsible for her not seeking medical help for Mr D. She arranged for the elders of her Church to visit Mr D and discuss his feelings; however nothing constructive came from this meeting at which Mr D was muddled and struggled to articulate his thoughts to the elders.

1.22 In January 2006, Mr D moved to live with his father in Abercynon for a brief period, before moving to live in Maerdy with his younger brother. He was forced to vacate the property in Maerdy due to an incident related to an alleged stabbing at the property and the police advised that it would be unsafe for him to return there. Mr D eventually moved to live with his mother in a flat in Aberdare in March 2006.

1.23 Mr D was by now engrossed with religion, the Bible and his belief that he was God. The flat was located near to the Church in Trecynon and overlooked the vicarage. According to Mr D's mother, Mr D reportedly started to visit the church regularly, on one recorded occasion leaving a note for Father Paul, the vicar of the parish. Mr D's mother told us that she subsequently visited Father Paul in order to voice her concerns regarding her son's religious beliefs and his mental state. She also stated that Father Paul had agreed to meet with Mr D for a discussion, which took place at the flat where Mr D was staying with his mother and that during this meeting Father Paul requested that Mr D stop dropping notes off at the vicarage and a discussion ensued about some aspects of the Bible during which Mr D was eager to point out to Father Paul his belief that Jesus had a temper and that the Bible's teachings were hypocritical. According to Mr D's mother, Father Paul agreed to see Mr D again; however when he again attempted to meet with him Mr D was allegedly told that Father Paul was unable to see him. Other than Mr D's mother, there was no other witness or evidence of these meetings or discussions taking place between Father Paul and Mr D.

1.24 In July 2006, Mr D slit his own throat outside the vicarage in Trecynon using a stanley knife causing a 9cm superficial laceration to the left side of his neck. He was taken to the A&E department of the Prince Charles Hospital in Merthyr Tydfil, but left the hospital of his own accord shortly after receiving medical treatment and walked home to Aberdare. From this point onwards there was a distinct change in Mr D's behaviour at home, with him spending most of his time on the computer, which he used to visit religious message board websites and chat rooms. Mr D was reportedly still attempting to visit Father Paul but he had apparently stopped mentioning voices.

1.25 Mr D was often living alone at the flat in Trecynon during June 2006 to March 2007. Whilst it was his mother's flat, for much of the time she was living with her partner at the time, intermittently returning to stay with Mr D in Trecynon.

1.26 In the months leading up to March 2007, Mr D's mother recalls that he was becoming more aggressive and violent towards her and that Mr D was seeing 'signs' emanating from the computer. Mr D had been banned from using several websites, by the website providers, due to the extreme views he was expressing on the message boards.

1.27 Mr D was arrested on 14 March 2007 following the murder of Father Paul in the grounds of St Fagan's Church, Trecynon, Aberdare.

Mr D's substance misuse history

1.28 Mr D had reportedly been misusing substances since approximately 1994 when aged 11 years old. He was a regular user of cannabis and also sniffed gas and aerosols. On March 12 2001, when Mr D was little over a month short of his 18th birthday, he was seen by Child and Adolescent Mental Health Services (CAMHS) in relation to his substance misuse. Mr D had been referred to CAMHS by Drug Aid, a voluntary organisation with which Mr D had had contact in relation to his drug usage and 'complex needs'. Mr D was not given a full assessment by the CAMHS nurse due to him arriving 25mins late for his appointment and not showing a willingness to comply with the assessment process. Mr D had attended the assessment expecting to be given a script for Diazepam; however he was told that this would not be the case.

1.29 It was established during the appointment that Mr D was using up to 50mgs of Diazepam daily, as well as significant daily doses of cannabis. Mr D appeared to be sedated throughout the interview but no signs of psychosis were observed. The detoxification process was explained to Mr D, which included significant engagement with agencies, and urine testing. It was

explained that any detox would be significantly faster than the six months that Mr D hoped for, at which point Mr D became increasingly agitated and upset. The courses of action open to Mr D were explained to him, including referral to other services, however Mr D "stormed out" of the appointment at this point.

1.30 As Mr D was nearly 18 years old it was felt that he should be referred to Adult Services and the CAMHS nurse contacted the Adult Substance Misuse Services to discuss further options for Mr D. However Mr D was not referred to this service since it was not possible to engage with him to assess his commitment to treatment and to discuss treatment options. Similarly, due to Mr D's unwillingness to co-operate with CAMHS and his failure to keep appointments, Drug Aid ended their involvement with Mr D on 13 March 2001.

Mr D's psychiatric and medical history until 2004

1.31 The first significant contact that Mr D had with any agency concerning difficult behaviour was the referral to the Local Authority Educational Psychologist in 1994 (see paragraph 1.5). However involvement with the psychologist ceased when the family moved to Llandrindod Wells in 1995.

1.32 On 12 August 2000, Mr D attended A&E at Prince Charles Hospital having been assaulted. He attended Prince Charles again on 21 September 2000, having been referred to the Consultant Physician by his GP for recurring blackouts which Mr D had been suffering from for nearly two years. There is reference to recreational cannabis use in relation to this referral.

1.33 Mr D attended a clinic at Prince Charles Hospital again on 21 December 2000 where reference was made to seizures as a child, and an Electroencephalography (EEG) was arranged, as well as an ECG and CT head scan. Mr D attended the follow up CT head scan on 8 March 2001 but an EEG was not undertaken.

1.34 In February 2001, Mr D was referred by his GP to Drug Aid, who subsequently arranged the referral to the CAMHS service outlined in paragraph 1.27. In April 2001 Mr D was removed from the GP list due to his threatening and abusive behaviour when he demanded Diazepam at the GP surgery.

1.35 On 19 April 2001 Mr D arrived at Prince Charles Hospital A&E via ambulance. He was complaining of having blackouts for the past 5 years. Mr D was noted as a known drug addict who took Diazepam on a regular basis, and used 'blow' and solvents. Mr D discharged himself from A&E. Mr D also had an appointment for a CT Head Scan scheduled for 19 April 2001; however he did not attend this appointment. A letter was sent to Mr D's GP advising of his non attendance for this appointment and reference was made to an EEG which had been undertaken prior to his planned follow up clinic appointment and reported as normal.

1.36 Mr D was brought to Prince Charles A&E on 29 May 2001 in police custody. Mr D had reportedly swallowed a substance whilst in custody. Mr D was examined; however he discharged himself against medical advice.

1.37 On 7 August 2001 Mr D was seen at A&E in Prince Charles Hospital suffering from a suspected overdose. Mr D was seen by a doctor who did not identify any significant problem and a referral was made to a physician. However, Mr D once again discharged himself before the physician could see him.

1.38 Mr D was seen in A&E Prince Charles Hospital on 16 March 2002, following an alleged assault. Mr D was seen by a doctor and from x-rays taken, no abnormalities were detected and Mr D was discharged. Mr D's next significant involvement with health services was on 20 March 2004, when he attended Prince Charles A&E having been pushed in front of a car. No significant injury was suffered and Mr D was discharged having had his wounds dressed and receiving paracetamol.

1.39 On 30 September 2004, Mr D attended A&E, Prince Charles Hospital following an incident when he was stabbed in the neck with a pair of scissors. This was related to an apparent disagreement over a computer game. Mr D was treated and discharged.

Mr D's psychiatric and medical history from 2005 onwards

1.40 Following Mr D's arrest after the alleged stabbing incident at their property in Maerdy in March 2006, Mr D was examined twice by Police Forensic Medical Examiner (FME) on separate occasions at Ton Pentre Police Station. Mr D had complained of suffering from stress, depression and blackouts and he admitted that he smoked cannabis and took Diazepam. The first FME noted that whilst Mr D expressed some odd ideas at assessment, he was otherwise calm, orientated and aware of his situation. The FME considered Mr D fit to be detained. Whilst Mr D's demeanour at the police station was variable, volatile and at times violent, again, at assessment, the second FME found Mr D to be calm, co-operative, compliant and fully cognisant of his situation. Mr D showed no symptoms to suggest that he was mentally disturbed or psychotic and his behaviour was therefore attributed to his drug use.

1.41 Forensic Medical Examiner arrangements are privately contracted between police and private medical practitioners; therefore there are no formal arrangements for the reporting that an assessment has taken place or the outcome of any assessment, to be made available to the patient's GP or any other NHS organisation. Therefore the outcomes of these assessments were unknown to the NHS.

1.42 On 9 July 2006, at 07:19, Mr D was taken to Prince Charles A&E suffering from a 9cm, self inflicted superficial laceration to the left side of his neck. Mr D had cut his own throat outside the vicarage in Trecynon. The police who attended the 999 call noted that Mr D was very quiet, calm and good natured and that he gave the paramedics no problems whatsoever. Mr D did present a letter to the police and paramedics which contained anti-

religious sentiment, leaving the paramedics believing that although they did not feel threatened, they felt that Mr D had a psychiatric problem. Mr D was reviewed by the A&E Senior House Officer (SHO) at 07:30. It was stated that Mr D had cut his neck as he wanted to kill himself, but could not proceed further due to the pain. Mr D was claiming that he wanted to stop governments of the world from going to nuclear war; he presented his letter to the A&E nurse and claimed that he was an incarnation of Jesus Christ.

1.43 The SHO's plan was to refer Mr D to the Psychiatrist on call. A telephone call was made at 08:20 by the SHO and it was agreed that Mr D would be reviewed by the Mental Health Crisis Team at 09:00 when the service opened for the day. In the meantime, Mr D's wound was cleansed and treated. However, it is reported that Mr D walked out of the A&E department at 08:10 without informing anybody as he feared that he might be sectioned. At 08:20, Merthyr Police Station was contacted by A&E staff regarding Mr D's mental state and the police advised that they would come to the department. The SHO believed that Mr D was still in the A&E department, at the time he made the referral to mental health services.

1.44 The police arrived at the A&E department at 09:00 and Mr D's details were given. The staff nurse was extremely concerned about Mr D's mental state and conveyed this concern to the police. The staff nurse also contacted the Psychiatric Liaison Team when they started their shift at 09:00 to express her concern.

1.45 At 12:40 the police informed the A&E department that Mr D had been found safe at his mother's house in Aberdare. It is believed that Mr D had walked home from the A&E department of Prince Charles Hospital, Merthyr Tydfil. Police entered the flat and found Mr D with his mother present; Mr D was calm, compliant and very quiet. Police have powers under section 136 of the Mental Health Act (1983) to detain mentally disordered persons found in public places; on the basis of what they saw they did not believe it was

necessary to use them on this occasion[1]. Police had no concerns for Mr D's safety due to the fact that he was in his mother's company. On receipt of this information the Psychiatric Liaison Team were informed of the mother's address by the A&E staff nurse but as a result of knowing that he was safe at home, the level of concern at the Trust about Mr D reduced.

1.46 There is no evidence to confirm that any attempt was made by the Psychiatric Liaison Team to contact or visit Mr D following the incident on 9 July 2006. There is a diary note from that day which merely shows the name and date of birth of Mr D, no further action was seemingly taken in respect of Mr D and no mental health assessment was carried out. It would appear also that no further action was taken following the message from the police that Mr D was found safe at his mother's house.

1.47 Mr D visited the Minor Injuries Unit at Aberdare Hospital on 18 July 2006 in order to have his sutures removed, his wound was noted to have healed and he was discharged. The Minor Injuries Department would not have been aware from the information held on the A&E information system, that the patient had been referred to the Psychiatric Liaison Team. This was Mr D's last contact with health services prior to the incident on 14 March 2007.

1.48 It is clear that Mr D had experienced a disruptive upbringing which continued into his early adulthood. The family frequently moved location around the mid and south east Wales areas and Mr D himself was either sent to foster parents or lived with his father intermittently over periods of time. Drugs, crime and violence featured prominently in Mr D's childhood with several instances of note, including the violent murder of his maternal uncle on Mr D's 16th birthday.

[1] As Mr D was not in a public place at the time that the police saw him in July 2006, the police would not have been able to exercise their powers to detain under section 136 of the Act. Had the police found Mr D prior to his arrival at his mother's home then they could have used these powers to detain Mr D. In this instance, this option was not available to them.

Management and Organisation of Services

Arrangements for Provision of Mental Health Services in Wales

1.49 The Welsh Health Service was reorganised in 2003, this resulted in the abolition of Welsh Health Authorities and the establishment of Local Health Boards. The commissioning of primary and most secondary mental health services was the responsibility of Local Health Boards. In respect of Mr D, the responsible Board was the Rhondda Cynon Taf Local Health Board.

1.50 The health service body providing mental health services at a secondary level to the Abercynon area during the period covered by this review was the former North Glamorgan NHS Trust.

1.51 At primary level, general practitioners are responsible for providing services and initiating interventions from other parts of the health service. During the time covered by this review Mr D was registered with GP Practices based in Aberdare, Abercynon and Llandrindod Wells.

Guidance relating to Mental Health Services in Wales

1.52 The National Assembly for Wales and the Welsh Assembly Government have issued guidance to Health Service bodies in a number of publications. Of particular relevance, in relation to this review are ‘Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency (National Assembly for Wales 2001)’, ‘Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users, (Welsh Assembly Government 2003)’ and in relation to current expectations with regard to mental health services ‘Welsh Health Circular (2006) 053’, and ‘Adult mental health services in primary healthcare settings in Wales (Welsh Assembly Government 2006)’.

1.53 We set out in the annex, relevant extracts from these documents, together with an outline of powers under the Mental Health Act, 1983.

Chapter 2: The Findings

The Predictability of the Homicide Committed by Mr D

2.1 Throughout his childhood and early adult life Mr D led a nomadic, erratic existence which involved constant movement between his parent's care and various foster placements over a considerable period of time. The influence of Mr D's upbringing on his behaviour was considerable and the response of social services to his needs was episodic and inconsistent, with no long term planning due to Mr D's high level of mobility.

2.2 It is not possible to date precisely the onset of Mr D's serious mental disorder. By 2005 however, he was clearly experiencing auditory hallucinations and delusional thinking. However no symptoms or signs of a serious mental disorder were apparent to any health service that came in contact with Mr D prior to 2006. In retrospect, it appears that the only people, (until Mr D's self-harm incident in July 2006), who might have been aware that Mr D may have been suffering from mental illness, were his own mother and possibly the victim himself. At that time Mr D's mother misattributed his emerging religious delusions to a spiritual experience rather than symptoms of a mental illness.

2.3 The only documented instance of Mr D attending a health facility to seek help while mentally unwell was the A&E attendance in July 2006. Mr D told us that by 2006 he had already started thinking of killing other people as a result of his psychotic thinking. Mr D also told us that he cut his throat in an effort to stop himself from "killing many people". However he did not share this information with anyone at the A&E department. While his mental state was found to be abnormal by the A&E staff, who initiated a psychiatric referral for further assessment, there is no evidence to suggest that he had disclosed his violent intent to any staff member. The available records of this contact are scarce in respect of the information exchanged between the A&E staff and the Psychiatry Liaison Team.

2.4 While it is clear that some information was passed on, as evidenced by an entry of Mr D's name in the Liaison Teams documents, it is not clear whether details of Mr D's mental state, risks and the concern of A&E staff were communicated. It is also not clear what the Liaison Team had planned for Mr D's assessment and follow-up.

Risk

2.5 In retrospect it is clear that between 2006 and 2007, Mr D was at a serious risk of committing harm to the general public, to Father Paul in particular and to himself. This was directly because of the nature and severity of his mental illness. However Mr D had not been assessed by any psychiatric service which could have established that such a risk existed, nor were the services that had some engagement with Mr D aware that he had a mental health problem or was a danger to others. In hindsight, we have evidence that Mr D may have developed a psychotic disorder around 2004, but at no point had Mr D been seen by any psychiatric service that could have identified the disorder and initiated treatment and on the occasions when he was examined by the FME his behaviour was attributed to substance misuse.

2.6 There is a possibility that had Mr D received a full psychiatric assessment at this stage, a diagnosis of psychosis could have been made and appropriate treatment initiated. Had he received such treatment over a period of time and responded adequately, the risk of his committing an act of violence or homicide might have been reduced. However it is not possible to state in retrospect that this missed opportunity would have necessarily and by itself prevented the subsequent homicide.

2.7 We do believe that there were some shortfalls to the treatment that Mr D did or did not receive. The remainder of this report will concentrate on these areas.

Health Service Intervention

2.8 Mr D's first contact with mental health services was in May 1995, when he was seen, along with his mother and brothers by a CAMHS psychiatrist following referral from the Education Welfare Officer amid concerns about the brothers' behaviour. It appears that following this appointment, a series of key indicators were flagged up as indicating that Mr D was 'at serious risk'. These included:

- A history of cruelty to animals.
- Sexual assault on an underage girl by Mr D and others.
- Inconsistent accommodation.
- Poor school attendance.
- Children left on their own by mother.
- Use of physical control/punishment.

2.9 The family was seen three times in May 1995 and on three occasions in June 1995, although two appointments were also missed over this period. The suggested course of action put forward by the psychiatrist was for the mother to implement a 'stars and rewards' scheme for her sons, in an attempt to direct their behaviour. It was also recommended by the psychiatrist that 'befriending be provided' to the brothers in order to support them and alleviate the situation. There does not appear to be any follow up to these suggested courses of action and it is unclear what the long term plan was in relation to Mr D and the care of the family as a whole. Later in 1995, the family relocated to Llandrindod Wells and therefore involvement with CAMHS appears to have ceased.

2.10 Mr D attended the A&E department of the Prince Charles Hospital a total of nine times over a period of 6 years between 2000 and 2006. Whilst there were not any singularly remarkable visits to A&E up to July 2006, there were a total of four attendances during 2000 and 2001, some of which (two overdoses) might have prompted concern. The A&E department at Prince Charles Hospital is used regularly by the local community as an alternative to a GP, with many regular attendees, therefore, as a result, Mr D's attendances

over a 6 year period do not set him apart as being a frequent visitor to the A&E department, however, no pattern or link seemed to have been made which may have prompted a referral, for example to substance misuse services. Mr D was assessed by two separate Forensic Medical Examiners at Ton Pentre Police Station in March 2006, but neither felt Mr D to be exhibiting signs of mental illness and his behaviour was attributed to the effects of substances used in conjunction with cannabis.

2.11 However the key issue in relation to Mr D's A&E visits relates to his attendance in July 2006, having slit his own throat outside St Fagan's Church, Trecynon.

2.12 We are satisfied that the SHO who first treated Mr D and the staff nurse involved with the incident dealt with the situation adequately and appropriately. It was clear to the SHO that Mr D was exhibiting behaviour that required further mental health assessment and he correctly called the acute psychiatric SHO on call at St Tydfil's Hospital in order to arrange for immediate assessment. However, given the time that the SHO made the call was 8:20am and the Psychiatric Liaison Team did not begin their shift until 9:00am, this 40minute delay meant that Mr D walked out before an assessment could be made. Subsequently the Psychiatric Liaison Team was updated by staff at A&E once they had been informed that Mr D had been found at his mother's flat.

2.13 Again, appropriately, given the level of concern that A&E staff had regarding Mr D, the police were called once it became apparent that Mr D had left the A&E department. There is documentation showing that the Psychiatric Liaison Team was notified of concerns in relation to Mr D at 9:00am but Mr D had since left the A&E department. It appears that once it became apparent that Mr D was safe at his mother's flat, no further action was taken by the Psychiatric Liaison Team to pursue an assessment themselves, contact the GP or alert the local mental health team about Mr D's attendance at A&E.

Communication

2.14 There is ambiguity regarding the level of concern that was communicated by the A&E department at Prince Charles Hospital to the Psychiatric Liaison Team regarding Mr D's mental state following his attendance in July 2006. The only record which the Psychiatric Liaison Team had was a diary entry detailing Mr D's name and date of birth. No further detail was present. We were unable to determine the precise content of this communication to the Psychiatric Liaison Team and the detail of this communication was not recalled by staff involved. We were told that had the appropriate level of concern been passed on to the Psychiatric Liaison Team then the liaison nurse could have made a unilateral decision about the next steps. Communication of referral details between A&E and the Psychiatric Liaison Team should have included written follow-up of the telephone referral with sufficient details to enable the Psychiatric Liaison Team to determine the best course of action. We were concerned about the communication process which was in place at the time of Mr D's July 2006 attendance at A&E. It was reported to us that a letter is automatically generated and sent to the GP following an attendance at A&E. We did not see any evidence of a letter addressed to Mr D's GP following the July 2006 A&E visit or any other of Mr D's other visits to A&E. We were informed by the Trust that whilst this system was technically possible, it was not being used at the time of the incident.

2.15 We believe that the standard of communication and record keeping in relation to the July 2006 A&E visit was well below an acceptable standard. An opportunity to assess Mr D's mental state was missed. This was the first occasion that any agency or service had flagged up concerns in relation to Mr D's mental state as an adult. We therefore believe that this was a key incident, one which led to Mr D's apparent mental illness being undiagnosed and untreated.

2.16 It has been noted that should this incident occur today and Mr D was to attend at A&E with similar presentation, a different course of action would be taken. The former North Glamorgan NHS Trust has developed a Crisis

Resolution Home Treatment Team (CRHT), which means that the Mental Health Service is able to offer 24-hour crisis assessment services, with staff able to visit A&E directly if requested.

2.17 Despite apparently first showing signs of being unwell when proclaiming to his mother that he was God in 2005, Mr D's mental state was not formally assessed on a single occasion prior to the offence in March 2007. The opportunities to carry out such an assessment were scarce; however, on the one occasion when Mr D's mental state was noted, no assessment was made.

2.18 It is now clear that Mr D's mental state played a key part in the homicide on March 14 2007, however, Mr D's mental state was not fully known to any medical services. The root causes for this were:

- Despite being indicated as being 'at serious risk' during the CAMHS appointments in 1995 and several risk factors being highlighted, there was a lack of follow up to any of the suggested courses of action.
- A lack of any long term plan following the CAMHS appointments in 1995.
- No checking of previous attendances to see if an emerging pattern was emanating from Mr D's visits to A&E over a period of 6 years, particularly in relation to the four attendances in 2000-2001, some of which may have been related to self harm.
- A 40 minute delay in relation to the Psychiatric Liaison Team being able to see Mr D following his A&E attendance in July 2006, resulting in Mr D walking out of the department before a formal mental health assessment could be carried out.
- No follow up attempt made by the Psychiatric Liaison Team to pursue assessment once Mr D was found to be back at his home in Trecynon and a lack of any attempt by the Psychiatric Liaison Team to alert community mental health teams or the GP of Mr D's situation.

- Ambiguity regarding the level of concern communicated by the A&E department to the Psychiatric Liaison Team, due to the lack of a detailed record being available.
- Poor communication between the A&E department and the GP, as an automatic letter was not generated and sent to the GP relating to Mr D's attendance at A&E in July 2006.

Local authority intervention

2.19 It appears that the services provided to Mr D and his family by the local authorities during his childhood were largely on an episodic and incident-focused basis. Mr D was part of a family presenting diverse and interconnected problems. Mr D's contact with social services finished in 2001, six years before the homicide and he was not known to adult social services.

2.20 The first contact with the local authority occurred in 1994 when Mid Glamorgan County Council Social Services became involved following a referral from the police.

2.21 There was some evidence of attempts by Mid Glamorgan County Council Social Services to take a more holistic approach and attempts appear to have been made by a social worker to work with Mr D's mother. It is clear however that Mr D's mother was struggling to contain her sons' behaviour at this point and this culminated in the family being evicted from their accommodation and relocating to Llandrindod Wells, part of Powys County Council.

2.22 Despite being allocated a social worker, Mid Glamorgan County Council Social Services' early involvement with Mr D and his family was largely reactive and there was no evidence of a comprehensive assessment having taken place. None of the alternative living arrangements provided by the local authority lasted for any length of time; they were largely short-term in nature.

2.23 The service received by Mr D was mainly as a result of his criminal activity as opposed to addressing his long term social care needs. The early family response by Mid Glamorgan County Council Social Services' Youth Offending Team appeared to stop short of providing a clear and long term solution as to how it should proceed to support Mr D and there was a focus on minimum intervention, following a 'befriend and advise' approach which was generally adopted at that time by Youth Offending Teams (YOTs).

2.24 When living in Llandrindod Wells, Mr D and his family had some involvement with Powys County Council Social Services, however, again there is no evidence of either a comprehensive assessment of Mr D or of the family being undertaken to identify problems, strengths or support needs. It is clear that there was a lack of long-term planning for Mr D's care.

2.25 The responses provided by Powys County Council to Mr D's needs were episodic and crisis driven with involvement being prompted by calls from other professionals, the police, neighbours or sometimes family members themselves, including Mr D's mother. Little work was done to support Mr D's mother to become a more effective parent although we were told she repeatedly asked for help.

2.26 We were informed that children's services were limited in Powys at that time and there was no Powys based youth justice service. The family would have received 'basic' generalist social work services in keeping with the Children Act emphasising the need to keep children out of care and with their families.

2.27 It appears that on the occasions that Mr D lived with foster carers his behaviour stabilised and even improved, including his school attendance. He appeared to respond well to consistent care and management. Similarly, upon returning to the Rhondda Cynon Taf area in 1998 Mr D is recorded as having engaged fully with social services and youth justice workers in a very enthusiastic manner, meeting the requirements of his supervision order. However, there appears to be have been no identification and analysis carried out of what was resulting in the improvements in Mr D's behaviour and there was no plan developed to build upon this improved engagement by Mr D. Mid Glamorgan County Council Social Services' involvement with Mr D was determined to a large extent by the criminal activities he was involved in and not so concerned with the wider family context.

2.28 It is important to note that at no point during Mr D's contact with either Mid Glamorgan County Council Social Services or Powys County Council were any serious mental health issues identified or noted.

Involvement with other agencies

2.29 Mr D's only other notable involvement with agencies was following a referral made by his then GP at the time to the Drug Aid voluntary organisation for his Diazepam dependency. Following his first appointment with Drug Aid, Mr D was referred to CAMHS in relation to his substance misuse. It was noted that there was concern about Mr D's level of distress, and his low self esteem, however, following Mr D's unwillingness to take part in the detoxification process offered following his CAMHS appointment, Drug Aid had no further contact with Mr D.

2.30 Mr D's late arrival at the CAMHS appointment and his subsequent refusal to engage during the meeting meant that he did not receive a full assessment from the CAMHS nurse. There was no evidence of any mental illness noted at any point during this appointment and given that Mr D was imminently due to turn 18, the only option available was to refer him to adult substance misuse services. This however does not appear to have been carried out and it is of concern that the case file relating to Mr D's involvement

with the CAMHS service is now missing. We did not therefore have the opportunity to examine any documentation related to this meeting with the CAMHS service. This is unfortunate, as it meant that we could not review the context in which any of the decisions regarding Mr D's care were made.

2.31 The root causes of the failures in relation to multi-agency involvement were:

- Mr D's family leading a nomadic existence during his childhood, which continued during his adulthood.
- Mr D's reluctance to engage with services, notably CAMHS and Drug Aid.
- The involvement of local authorities' children departments were predominantly reactive and short-term focused, failing to address the interaction and impact of ongoing complex problems in the wider family and their social environment.
- The failure of social services to engage assertively with the family and in particular Mr D, to provide long-term planning for the care and support of Mr D based on comprehensive assessment and analysis of risks, strengths and support needs.
- Little support offered by local authorities to Mr D's mother despite her requests.
- Apparent lack of analysis, during Mr D's periods of improved behaviour and school attendance, of the reasons for this and subsequent failure to use this to inform future planning for Mr D by relevant services.

Chapter 3: Recommendations

In view of the findings arising from this review we recommend that:

3.1 In relation to attendances at A&E, the Health Board should ensure that:

a) Patient records should be reviewed thoroughly at every attendance at A&E, in particular to highlight any developing concerns that may emerge in light of past attendances.
b) Communication between the A&E department, other departments and GPs is subject to formal arrangements, including immediate telephone contact when necessary, formal written reports and routine auditing.

3.2 In relation to community mental health services, the Health Board and Local Authorities:

c) Measures should be taken to ensure the correct logging of calls and that urgency is assessed effectively, followed up by an appropriate response.
d) The new arrangements in place, relating to out of hours access to mental health services, are subject to formal auditing arrangements by the Health Board.
e) Communication with other agencies is timely and effective and that any follow up is carried out fully and comprehensively.
f) All agencies need to meet together in order to discuss how to handle complicated cases and develop a comprehensive care pathway.

3.3 The Health Board and Local Authorities should ensure that:

g) Records are accurately documented and reviewed in order to aid with spotting any patterns which may emerge in relation to the risk assessment process.

h) Record management arrangements are robust and routinely audited and that records are kept secure at all times.

i) Joint working across agencies is effective and that responses are well coordinated.

3.4 In relation to risk management, the Health Board should ensure that:

j) Organisations issue a proportionate response in accordance to the assessed level of risk.

k) Organisations ensure that risk management processes are robust and that a long term view is taken in relation to risk management.

Chapter 4. Postscript

In November 2009, HIW received an updated action plan from the newly formed Cwm Taf Health Board reflecting progress that the organisation has made since August 2007 against the recommendations made in this report. A full copy of the action plan is available on the HIW website: www.hiw.org.uk

The action plan demonstrates that the Health Board has made progress in addressing the recommendations that we have made, these include:

- The implementation of regular liaison meetings between the Accident & Emergency Department and Mental Health Directorate.
- The development and implementation of more robust and documented referral systems for departments including Accident & Emergency when referring patients to mental health services, including psychiatric assessment services.
- The development of a 24 hour Crisis Resolution Home Team (CRHT) to help provide rapid and timely access to mental health services for those referred and identified as being in need.

PART 2

Review of ambulance response and care provided to Father Paul's family and local community

Chapter 1: Review of the response, care and treatment provided to Father Paul Bennett by the Welsh Ambulance Services NHS Trust following the incident on 14 March 2007

Summary of events

1.1 At approximately 14:46 on 14 March 2007, a call was received by the emergency services informing them of a man having been stabbed in the grounds of the vicarage at St Fagans Church, Trecynon. Police officers arrived at the scene and found Father Paul lying on a path between the vicarage and the church in Trecynon with multiple stab wounds. Mrs Georgina Bennett was present inside the vicarage; close by on a bench sat a man with bloodstained clothing. Father Paul's wife indicated that the man sat on the bench was responsible for the injuries to her husband. She explained to officers that she had been in the vicarage with her husband; he had gone outside and shortly after she heard cries. She went out and saw him being stabbed in the head and chest and made attempts to pull the assailant off him. She went back into the vicarage and phoned the emergency services.

The Ambulance Service's response to the incident

999 Call

1.2 The Welsh Ambulance Services NHS Trust (WAST) received an emergency call at 14:46 on 14 March 2007 and the tape recording of the 999 call made to emergency services begins with a distressed female, Mrs Georgina Bennett, requesting an ambulance to the vicarage at St Fagans Church. There is a short delay as there is some confusion regarding the precise location of the vicarage. Father Paul's wife makes it clear that the assailant is still present at the scene, armed with a knife. She also states that

her husband is unconscious and not breathing. The call taker asks the caller to go out and check her husband initially, prior to knowing that the assailant was at the scene and also once more after being informed that the assailant is present and still armed. Approximately 10 minutes following the incident, the police arrive and a police officer takes over the call informing the call taker that Father Paul is deceased, this is not questioned by the WAST caller and first aid advice is not given to the police over the phone.

Vehicle Response

1.3 An ambulance was mobilised at 14:49 and arrived at the vicarage at 15:03. At the time of the call there was a WAST, single-manned response vehicle located nearer to Trecynon than the ambulance which was dispatched from Merthyr ambulance station. However, in line with the Trust's 'Lone Worker' policy this single-manned vehicle was not dispatched as the alleged assailant was reported as still being at the scene and armed with a knife. The police had advised the ambulance service that they should not attend the scene until police officers had arrived and made the area safe. It may however have been appropriate to dispatch this rapid response vehicle, instructing the ambulance crew member to wait at a safe distance, or at a safe meeting point arranged with the police, as was the case with the double manned ambulance crew. The Lone Worker policy states that:

> "Other agencies, if required, such as the police, will be called and the Control Duty Manager will monitor their arrival"

and in line with this the police were contacted during the 999 call by members of the control team.

Clinical care at the scene

1.4 Upon the paramedic crew's arrival at the scene, they were informed by the police that Father Paul was deceased. Following examination of Father Paul they reported that he had sustained significant external injuries, including massive head injuries, significant blood loss and a large chest wound with the heart visibly punctured. Whilst the crew would not have been aware of the internal injuries that actually caused the victim's death, they felt that the external injures were of such a nature that they were incompatible with life. They concluded that resuscitation should not be attempted. Father Paul was pronounced 'life extinct' at the scene following confirmation by means of a heart tracing which showed there was no rhythm or electrical activity.

1.5 WAST's 'Recognition of Life Extinct' (ROLE) / 'Do Not Attempt Resuscitation' (DNAR) policy states

> "In patients with cardio-pulmonary arrest, vigorous resuscitation attempts must be undertaken whenever there is a chance of survival, however remote."

1.6 The policy states that the following are unequivocally associated with death:

- Decapitation.
- Massive cranial and cerebral destruction.
- Hemicorporectomy.
- Decomposition.
- Incineration.
- Hypostasis.
- Rigor mortis.

1.7 None of the conditions above were present in the case of Father Paul. However, the policy also states that resuscitation can be discontinued when the following conditions are present:

- Submersion for more than 1 hr.
- A living will is present or in conditions where all the following are present:

    - Non-shockable rhythm
    - No bystander CPR.
    - More than 15 minutes since collapse.
    - The absence of any factors listed not compatible with life (as listed above).
    - Asystole for more than 30 seconds on the monitor.

1.8 The policy states that if none of these conditions are present, that resuscitation must always be initiated and continued to hospital.

1.9 From our review of records it is clear that as the heart tracing taken by the ambulance crew showed that there was no rhythm or electrical activity, that Father Paul had sustained severe injuries including massive head injuries, significant blood loss and a visible wound to his heart, as well as the fact that he had sustained his injuries more than 17 minutes earlier, a decision was taken not to resuscitate him. There is some ambiguity surrounding the lack of definition for the terminology ‘collapse’ and whether this refers to 15 minutes since Father Paul’s heart stopped beating, or since the initial attack; allied to the fact that the paramedics were at the scene 17 minutes after the incident. There also appears to be a contradiction in the WAST policy itself given that it is specified that

> “resuscitation attempts must be undertaken whenever there is a chance of survival, however remote”

Recommendations

1.10 In relation to the repeated requests for Mrs Bennett to check on her husband, given that the assailant was still present at the scene when Father Paul's wife made the 999 call, we believe that control room operator should apply the same standards of scene safety to callers as for ambulance personnel. The telephone scripts used by WAST should be reviewed and protocols put in place to ensure the safety of the caller and other members of the public at the scene, with particular attention given to the section asking the caller to check on Father Paul.

1.11 In relation to the initial delay in identifying the correct address during the 999 call, we believe that the value of installing appropriate software to assist with address identification in all WAST control should be examined to ensure delays with the identification of the location of incidents are minimised.

1.12 Prior to the arrival of the ambulance crew, first aid was not given to Father Paul. Bystander resuscitation should be encouraged for all calls where patients are unconscious and not breathing, unless the patient is unequivocally deceased as defined by the WAST ROLE/DNAR policy.

1.13 The WAST Lone Worker policy needs to be reviewed to ensure that patient care is not compromised by withholding solo resources. The use of meeting points and methods of liaising with the police in order to ensure the safety of the crew should be addressed.

1.14 WAST should work with the police to clarify the boundaries of police roles and responsibilities in relation to deciding that a patient is deceased and advising that resuscitation is not necessary.

1.15 WAST should work with the police to produce a clear set of guidelines for the police, similar to their own DNAR guidance for conditions unequivocally associated with death.

1.16 WAST staff, including control staff and ambulance crew should receive regular training in clinical, and operational policies which may be used infrequently, but in the most serious circumstances.

1.17 The WAST ROLE/DNAR policy states that resuscitation should not be undertaken in conditions where all five of the following are present:

i. Non-shockable rhythm.
ii. No bystander CPR.
iii. More than 15 minutes since collapse.
iv. The absence of any factors listed not compatible with life (as listed above).
v. Asystole for more than 30 seconds on the monitor.

1.18 This policy should be reviewed taking into account that a non-shockable rhythm could include an agonal rhythm or pulseless electrical activity where resuscitation would be appropriate. Consideration should be given to removing point i) from the list to avoid confusion as asystole, as covered in point v) is the only rhythm where DNAR should be considered. The policy itself is unclear as there appear to be contradictions in relation to ROLE/DNAR criteria and guidelines, with particular attention needed to be given to the definition of terminology.

Chronology of events on 14 March 2007

14:46:52	Call made by Mrs Bennett received at 999 Control Centre.
14:47	Initial confusion over precise location of incident.
14:48:17	Location correctly identified.
14:49:01	Paramedics dispatched. Ambulance was at Merthyr ambulance station at time and made its way immediately to Trecynon.
14:50	Police officers receive call over radio to attend incident at Trecynon.
14:52	Paramedics asked to stand down by police as assailant still present at scene armed with knife.
14:56	Police arrive at scene.
15:03	Paramedics arrive at scene.
15:06	Death Certified.

Chapter 2: Review of the care, support and counselling offered to Mrs Bennett, and with the wider community

Chronology of Mrs Bennett's care

2.1 Mrs Bennett was supported by a trained Police Family Liaison Officer within a few hours of the incident occurring on 14 March 2007. There had been initial delay on engagement as Mrs Bennett had to be treated as a 'forensic scene' because she was bloodstained.

2.2 The support of the Family Liaison Officer was available to Mrs Bennett initially and to her family later on the day of the incident and throughout the time leading up to the trial of Mr D. Mrs Bennett and her family were offered further support, facilitated by Victim Support.

2.3 Park Surgery was contacted on 16 March 2007 by the family of Father Paul with a request made for a home visit from their GP. The GP visited the family and spent some time with them. At that time the GP's assessment was that further primary care based bereavement counselling was the most helpful care which could be provided and the family were advised to contact the practice and the GP would call to see them as and when requested.

2.4 Victim Support had its first contact with Mrs Bennett by telephone on 22 March 2007 and an appointment was made for a home visit from two trained volunteers on 26 March 2007 and visits continued on a two-weekly basis. A second request for a home visit from the GP was made by Mrs Bennett, also on 26 March 2007 and the GP again visited and spent time with Mrs Bennett's family. The GP decided that the family and in particular, Mrs Bennett, required bereavement counselling above what the practice was able to offer. The GP made a referral by telephone to the Community Mental Health Team (CMHT) in Aberdare, rather than in writing, in order to press the urgency of

this need. However during this telephone discussion on 30 March 2007 the GP was informed that bereavement counselling was not the remit of the CMHT and that referral onward to CRUSE, a UK-wide bereavement service, would be the most appropriate course. The GP immediately telephoned CRUSE but Mrs Bennett declined their support as she felt that she needed more specialist support than the bereavement counselling that could be offered by CRUSE.

2.5 Shortly following this a friend of the family, the priest of a neighbouring parish, also contacted CRUSE directly, requesting that it engage with Mrs Bennett's family in order to offer specialist support. The CRUSE administrator based at Merthyr Tydfil, who is a trained counsellor, contacted Mrs Bennett to offer help and support, however Mrs Bennett again declined this offer. CRUSE sent leaflets to Mrs Bennett about the kind of help that their service could offer should she change her mind. CRUSE informed the vicar who had referred her that Mrs Bennett had refused their support, but reiterated through him that they were available to her, if and when she felt that she needed their support.

2.6 Following a home visit on 10 May 2007, the two Victim Support volunteers raised concerns with their manager about the family who they felt were struggling to cope. The volunteers visited the GP on behalf of Mrs Bennett and were informed that the family did not meet the criteria for counselling via the CMHT. The Victim Support Manager called the GP again on 11 May 2007 to express his concern about the welfare of the family and the GP undertook a home visit. The Victim Support Manager also contacted the CMHT directly with his concerns and they informed the manager that they had been expecting a referral from the GP, but would be prepared to accept a direct referral from Victim Support.

2.7 The GP visited the family on 14 May 2007 when he was informed that there had been no face to face contact with CRUSE and that the Church had provided a private psychologist who had visited once. The GP felt that the family were in crisis and that Mrs Bennett was exhibiting symptoms which required further investigation. The GP therefore contacted the Consultant Psychiatrist at the CMHT, directly and he agreed to conduct a home visit.

2.8 The Consultant Psychiatrist visited Mrs Bennett on the 15 of May 2007. Mrs Bennett was diagnosed as suffering from Post Traumatic Stress Disorder and prescribed medication. The Consultant Psychiatrist made a referral to the Psychology Services at Cwm Taf NHS Trust and Mrs Bennett was subsequently seen by a Consultant Psychologist for the first time on the 7 of June 2007. Appointments continued with the Consultant Psychologist approximately weekly until September 2008.

Findings

2.9 It is not unsurprising, nor is it unreasonable that the families of victims of tragic events such as these should have expectations regarding the type of services that should be provided to them. In Mrs Bennett's case, it appears that individually, people were proactive in engaging with her, Victim Support in particular; however it was not routine practice for health or social care agencies to directly approach victims in the aftermath of an incident such as this one and to offer support, unless they had been contacted directly by the person concerned or by other agencies. It would depend upon individual initiative whether an incident which had been picked up for instance, by reporting in local media, would prompt a direct response to offer counselling and support. Whilst Mrs Bennett did eventually receive an adequate level of input from the psychologist at Cwm Taf NHS Trust, it took some time for this service to be offered to her.

2.10 Mrs Bennett's GP did call CRUSE to see if this service could be used and the GP also attempted to engage the CMHT but only in relation to bereavement counselling, which could not be offered by the CMHT. The focus appears to have been on Mrs Bennett's bereavement and grief. There does not seem to have been any consideration or recognition of the fact that having witnessed the violent and traumatic attack on her husband, that she may have been suffering from Post Traumatic Stress or other psychological issues related to the shock of this experience. The CMHT was eventually engaged on 15 May 2007.

2.11 We consider that there was a short delay in identifying and engaging the appropriate services for Mrs Bennett because:

- The GP initially referred Mrs Bennett to the CMHT specifically for bereavement counselling leading to a delay of over two months between the indent occurring and Mrs Bennett being seen by the CMHT in relation to Post Traumatic Stress.
- The CMHT recommended to the GP that Mrs Bennett should be referred to CRUSE as bereavement counselling was not the remit of the CMHT.

Support to the wider community

2.12 Mrs Bennett had also raised with us the matter of arrangements to offer support to the wider community following serious and traumatic incidents such as the circumstances of Father Paul's death.

2.13 As far as formalised arrangements are concerned, the Health Board's arrangements for providing support and counselling services to individuals following a serious and traumatic incident are covered by its commissioning of a counselling and bereavement service provided by CRUSE.

2.14 There were no formalised health or social services arrangements in place to respond to traumatic incidents of this kind other than through self referral of those affected to health and social care professionals. However, CRUSE has told us that if requested, it would provide bereavement counselling and support for the wider community.

Recommendations

2.15 The Health Board should engage with health and social care providers to facilitate arrangements for a co-ordinated multi-agency response to serious incidents such as this homicide, to provide an appropriate and timely response to the needs of individuals and communities affected. That should include:

- Identifying appropriate sources of help and support.
- Establishing a system for engaging services, recognising the need to be pro-active in offering services.
- Ensuring that front line providers (e.g. GPs, A&E staff, social workers, community leaders) are aware of the arrangements, and how to mobilise them.
- Ensuring links with police family liaison officers, victim support scheme and others so they can provide access to the arrangements for those who need them.

Chapter 3: Postscript

In November 2009, the Welsh Ambulance Services NHS Trust (WAST) informed HIW that it had completed a review of the Lone Workers' Policy and is working in collaboration with the police under the auspices of the Joint Emergency Services Group (JESG) to ensure the safety of the public and crews.

HIW have been informed that WAST and the other Emergency Services in Wales now have an agreed Memorandum of Understanding in place ensuring a collaborative review of Serious Adverse Incidents following emergency responses.

In addition, the ROLE/DNR policy has been reviewed. The policy allows paramedics to Pronounce Life Extinct (PLE) in certain scenarios. The new policy aims to clarify the concerns raised within the report namely:

- Bystander CPR.
- Length of time from collapse to resuscitation.
- The absence of any factors listed as not compatible with life.
- Asystole for 30 seconds or more on the defibrillator monitor.

A copy of the WAST action plan reflecting progress that the organisation has made against the recommendations made in this report is available on the HIW website: www.hiw.org.uk

Annex A

Terms of Reference for the Review

The aim of the review was to:

- Consider the care provided to Mr D as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on 14 March 2007.[2]
- To review the decisions made in relation to the care of Mr D.
- To review the circumstances behind the referral or lack of referral of Mr D to mental health services.
- To produce a report detailing relevant findings and setting out recommendations for improvement.
- To work with key stakeholders to develop an action plan (s) to ensure that lessons are learnt from this case.
- Review the response, care and treatment provided to Father Paul by the Welsh Ambulance Services NHS Trust (WAST) on the day of the incident on 14 March 2007.
- Examine the support arrangements that were offered to Father Paul Bennett's widow, Mrs Georgina Bennett, her family, and the wider community immediately following the traumatic events surrounding the death of Father Paul.

[2] As part of this exercise consideration will be given also to the social history of GE.

Annex C

Review of Mental Health Services following homicides committed by people accessing Mental Health Services

In England and Wales there are approximately 52 homicides each year committed by people who are suffering from mental illness at the time of the offence. That amounts to 10% of murder and manslaughter cases dealt with in our courts. Of all perpetrators convicted of homicide each year, approximately 97 (18%) of them have had contact with mental health services during their lifetime.

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

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

Arrangements for reviews in Wales

Until 2007 independent external reviews into homicides by those experiencing mental health problems were commissioned by Local Health Boards. The investigations themselves were conducted by review teams brought together from third party health bodies or through commissioning from the private/independent sector.

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

Annex D

Arrangements for the review of Mr D and the provision of Mental Health Services, following the Homicide of Father Paul committed in March 2007 and the Ambulance response and care provided to the victim's family and community

Reviews and investigations by HIW draw upon the methods, techniques and skills which will be most efficient and effective according to the nature of the matter to be investigated, its extensiveness and any constraints of time or other resources. However HIW recognises the importance of structured investigations and is committed to the use of 'Root Cause Analysis' (RCA) to provide a formal structure for investigations, which may be adapted if circumstances make that appropriate. In taking forward this review HIW has ensured that the general principles which apply to investigation and upon which RCA provides guidance, have been followed and has made use of a number of the tools contained within RCA.

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

RCA brings together much of the best practice informing investigation processes. Through its use, the root causes for an undesired outcome can be identified and actions designed to prevent or reduce the likelihood of reoccurrence produced. Root cause analysis concerns itself with systems and reviews using the approach continue to 'drill down' through the perceived causes of an incident until originating, organisational factors have been identified or until data are exhausted.

Developed in the field of engineering, RCA helps professionals in a wide range of settings, who might otherwise be unfamiliar with investigation methods, to determine: what happened, how it happened and why it

happened. It is designed to encourage learning from past problems, failures and accidents and to eliminate or modify systems to prevent future occurrences of similar incidents. It provides a template for the non-professional investigator which ensures a systematic approach to investigation built upon good investigation practice and for those with more experience is a helpful checklist of necessary investigation steps and provides a 'tool box' of techniques which have proven success in uncovering root causes of events.

In the UK RCA has been adapted for use in NHS by National Patient Safety Agency (NPSA). In addition to developing RCA for use in the Health Service NPSA provides training for NHS staff in the use of RCA and is responsible for collating reports of incidents and providing national guidance and solutions in respect of problems identified from that work. The NPSA's work currently incorporates The National Clinical Assessment Service (NCAS); The National Research Ethics Service (NRES) - formerly COREC; The National Confidential Enquiry into Patient Outcome and Death (NCEPOD); The Confidential Enquiry into Maternal and Child Health (CEMACH); The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH); and NHS Estates (safety aspects of hospital design, cleanliness, and food).

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

Professor S P Singh	Professor of Social and Community Psychiatry and Consultant Psychiatrist
Dr C Deakin	Medical Director, South Central Ambulance Service and Medical Director for the Hampshire & Isle of Wight Air Ambulance and honorary consultant to the London Air Ambulance

Mrs J Phillipson	Social Services Inspector, Care and Social Services Inspectorate Wales (CSSIW)
Mrs G Griffiths	Lay Reviewer, HIW Panel
Mr M Frost	Investigations Manager, HIW
Mr R Jones	Investigations Officer, HIW

The information gathering phase of the review was conducted between March 2008 and June 2009. It consisted of:

- Examination of documents relating to the organisation and delivery of services by the former North Glamorgan NHS Trust, Powys County Council and Rhondda Cynon Taf County Borough Council, together with papers provided by the Local Health Board and a GP. The Judge's comments made in determining the court disposal in the case were available. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officer. We were grateful to the police for their collaboration.
- Reading the case records maintained by Health Bodies and Local Authorities concerning Mr D.
- Reading interview notes and written statements provided by staff working with Mr D which were provided as part of the police or internal investigation processes;
- Interviewing key people particularly those with strategic responsibility for the delivery of services.

The information was processed using the proprietary software tool HIW has adopted for such tasks and by the HIW in-house investigation unit. In addition, all members of the review team read all the material generated by the review.

The analysis stage was taken forward by the review team. Peer reviewers provided each other with their own initial analysis of key issues. Following that the review team met to undertake a thorough analysis, driving its consideration through key issues to root causes using a checklist derived from the RCA elements of the ‘fishbone’ and utilising other techniques such as the ‘five whys’. The conclusion of that process was to determine the extent to which systems or processes might be put in place to prevent further occurrences and the nature of those systems or processes. The results of that stage are set out in this report as findings and recommendation.

Annex E

Healthcare Inspectorate Wales

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

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

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Assembly Government and healthcare providers, that services are safe and of good quality. Services are reviewed against a range of published standards, policies, guidance and regulations As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systemic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales, the Local Supervising Authority for the Statutory Supervision of Midwives and is responsible for monitoring approved nurse education programmes provided by higher education institutions in Wales.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

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

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

Annex F

Mental Health Act 1983

Section 5 of the Act contains the powers for a doctor or nurse to prevent someone who is otherwise a voluntary patient from leaving hospital:

"5.- (2) If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.

(4) If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in a hospital, it appears to a nurse of the prescribed class -

> (a) that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and
>
> (b) that it is not practicable to secure the immediate attendance of a practitioner or clinician for the purpose of furnishing a report under subsection (2) above, the nurse may record that fact in writing; and in that event the patient may be detained in the hospital for a period of six hours from the time when that fact is so recorded or until the earlier arrival at the place where the patient is detained of a practitioner or clinician having power to furnish a report under that subsection."

Section 136 of the Act relates to mentally disordered persons found in public places:

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

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

Annex G

Glossary

Agonal rhythm - An idioventricular rhythm, characterised by unusually wide and bizarre ventricular complexes, often seen in moribund patients.

Asystole - A state of no cardiac electrical activity, hence no contractions of the myocardium and no cardiac output or blood flow. Asystole is one of the conditions required for a medical practitioner to certify death.

Auditory Hallucinations - Hallucination of one or more talking voices. Particularly associated with psychotic disorders such as schizophrenia, although many people not suffering from diagnosable mental illness may sometimes hear voices as well

Community Mental Health Team (CMHT) – A multi-disciplinary team made up of psychiatrists, social workers, community psychiatric nurses, psychologists and therapists, providing assessment, treatment and care in the community, rather than in hospitals, for people with severe long-term mental health problems.

Computed Tomography (CT) - A medical imaging method employing tomography. Digital geometry processing is used to generate a three-dimensional image of the inside of an object from a large series of two-dimensional X-ray images taken around a single axis of rotation.

Consultant Psychiatrist - Is a physician who specialises in psychiatry and is certified in treating mental disorders.

Consultant Psychologist - The role of a psychologist is one who deals with patients suffering mental health problems in counselling or psychotherapy.

Criminal Justice System - The arrangements for management of crime the enforcement of laws and the administration of justice put in place by the Government; including the courts, police etc.

Crisis Resolution Home Treatment (CRHT) - A service for adults (aged 18 to 65) experiencing an acute mental health crisis which is available 24hours a day, seven days a week. This includes a rapid response following referral, intensive intervention and support in the early stages of the crisis and continuity throughout its management.

Detoxification / Detox - A treatment for addiction to drugs or alcohol intended to remove the physiological effects of the addictive substances.

Diagnosis - Identifying a medical condition by its pattern of symptoms (and sometimes also its cause and course).

Educational Psychologist - Educational psychologists tackle the problems encountered by young people in education, which may involve learning difficulties and social or emotional problems. They carry out a wide range of tasks with the aim of enhancing children's learning and enabling teachers to become more aware of the social factors affecting teaching and learning.

Electrocardiography (ECG) - The recording of the electrical activity of the heart over time via skin electrodes.

Electroencephalography (EEG) - The recording of electrical activity along the scalp produced by the firing of neurons within the brain.

Forensic Medical Examiners (FMEs) - A group of doctors working in the field of clinical forensic medicine. Most FMEs are GPs and work on a part-time basis. A significant few work as FMEs full-time. They are contracted by their local police force and in some cases by medical companies that hold a contract with a force. Service provision and requirement vary regionally and are subject to change.

General Practitioner (GP) - A medical practitioner who provides primary care and specialises in family medicine.

Index Offence – The offence which the patient has been convicted of and which has lead to its current detention.

Local Health Boards (LHB) - Statutory bodies who were responsible for implementing strategies to improve the health of the local population, securing and providing primary & community health care services and securing secondary care services.

Mental Disorders - These are psychological disorders usually classified under internationally recognised systems of classification such as DSM-IV and ICD and contain a range of diagnoses including psychoses, brain disorders and emotional or behavioural problems serious enough to require psychiatric intervention.

Mental Health Act 1983 - The Act which provides the legal framework within which Mental Health Services; may be provided without the consent of the patient.

National Confidential Enquiry - Project conducted under the auspices of the National Patient Safety Agency and other funders which examines all incidences of suicide and homicide by people in contact with mental health services in the UK.

National Health Service (NHS) Trust - A self-governing body within the NHS, which provided health care services. Trusts employed a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

National Service Framework - National standards of care published for a variety of conditions which are designed to improve the quality of care and reduce variations in standards of care.

Police Family Liaison Officer - Family Liaison Officers are police officers that are deployed to bereaved families during the investigation process and help with the exchange of information between the family and the senior police investigator. They will normally be the primary point of contact with the family in the immediate aftermath of an emergency. In the early aftermath of an incident the Family Liaison Officer may help to get support from other organisations.

Post Traumatic Stress Disorder (PTSD) - is an anxiety disorder that can develop after exposure to one or more traumatic events that threatened or caused great physical harm.

Primary Care - The first point of contact with health services. In the UK this is family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Psychiatrist - A physician who specialises in psychiatry.

Psychosis (psychotic illness) - Severe mental derangement involving the whole personality. These are severe mental disorders characterised by psychotic symptoms e.g. delusions, hallucinations and disorganised thinking, these disorders, historically and in common parlance, have been referred to as 'madness'. They are often divided into Functional Psychoses (mainly schizophrenia and manic depressive psychosis (or Bipolar affective disorder)) and Organic Psychoses (confusional states or delirium, dementias, drug induced psychosis).

Root Cause Analysis (RCA) - A systematic way of analysing problems to discover the ultimate reasons for it occurring.

Senior House Officer (SHO) - A doctor undergoing specialist training in the National Health Service. A doctor typically works as an SHO for 2-3 years, or occasionally longer, before becoming a registrar.

Social Services - A term generally used to refer to local authority, social services departments. These are responsible for non-medical welfare care of adults and families in need. Among other services it provides needs assessments for people and provides services under community care for adults, children and families.

Social Worker - A person professionally qualified and registered to deliver social work to individuals and their families in a variety of settings. Many social workers work for social services within local unitary authorities. Social workers promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising

theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Supervision Order - Supervision Orders were introduced under the Children and Young Persons Act 1969. The Crime and Disorder Act 1998 amended the Supervision Order. A Supervision Order can last up to three years. A range of conditions can be attached to a Supervision Order when the sentence is used for more serious offences.

Victim support - Victim Support is a government-funded voluntary organisation that can provide victims of crime with free confidential support, practical help and information.

Welsh Health Authorities - Predecessor organisations of local health boards and NHS Trusts which were responsible for the delivery of healthcare in Wales prior to 1 April 2003.