Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr J and the provision of Mental Health Services, following a Homicide committed in March 2010

September 2013

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Contents

Chapter 1 The Evidence

Summary of the Index Offence

1.1 Sometime between the 28 February and 2 March 2010, Mr J attacked Mrs A at her home in the Thornhill area of Cardiff. Mrs A sustained severe trauma injuries to her head and was also found with lacerations to her wrists. Sadly Mrs A died from her injuries. Mrs A was discovered by South Wales Police on 2 March 2010.

1.2 On 10 March 2011, Mr J was convicted at Cardiff Crown Court of the manslaughter of Mrs A on the grounds of diminished responsibility. Mr J was sentenced by means of a court order under section 48/49 of the Mental Health Act 1983 to be detained at a high secure mental health unit indefinitely.

Mr J's Background

1.3 Mr J was born in 1978 and spent his early years in the Stoke–on–Trent area, however he moved around the U.K. with his family due to his father's job. The family moved to South Wales when Mr J was approximately nine years old and resided in the Merthyr Tydfil and Pontypool areas.

1.4 Mr J is one of four siblings having two brothers and a sister. During his childhood, Mr J attended various schools before the family settled in the Pontypool area. He enjoyed school and studied for his GCSEs and A levels. Mr J was said to have had a strained relationship with his parents and left the family home at the age of 17.

1.5 Following school, Mr J gained employment and held several positions including working as a holiday representative in Italy and Spain. Mr J married in 2003, although the relationship broke down in 2005.

1.6 Following the breakdown of his marriage, Mr J moved to the Portsmouth area to seek employment, however he was unsuccessful and returned to South Wales in 2007. He subsequently moved in to live with his sister for approximately 18 months.

1.7 During this period he formed a relationship with a woman who was also living at his sister's home, however the relationship broke down. Following the breakdown of this relationship, Mr J was observed by his sister to be acting strangely with his mood becoming erratic. He had allegedly scribbled random messages around the home and had begun asking strange questions. He left his sister's home in October 2008.

1.8 After leaving his sister's home, Mr J became homeless and was allegedly living in a tent. However when his tent was found abandoned in the Ystradfellte area, the family became concerned for his welfare. Dyfed Powys Police were contacted and Mr J was reported as a missing person.

1.9 Police records state that on the 18 November 2008 Mr J was stopped and spoken to by officers from the Gwent Police force in the Abergavenny area; this was following a phone call from a member of the public who was concerned for Mr J's welfare. Following this contact the missing person Police National Computer (PNC) circulation was cancelled and Dyfed Powys Police were informed that Mr J had sought medical attention.

1.10 Following his period of living in a tent, Mr J gained employment and lived and worked at a hotel in the Pontypool area; however Mr J left the hotel following a disagreement with his employers. Mr J allegedly stole cash and cigarettes from the hotel in retaliation to the disagreement.

Mr J's Criminal History

1.11 In December 2008 Mr J was once again homeless, sleeping rough in the Usk area. As the weather began to get cold, Mr J relocated to a local farmer's barn. He

was discovered by the farmer who confronted Mr J and was subsequently attacked by Mr J with a hammer. Mr J escaped by stealing the farmer's vehicle.

1.12 Mr J was arrested by officers from the Gwent Police Force on the 11 February 2009 and subsequently charged and bailed to appear at Newport Magistrates Court on 18 February 2009 under Section 47 for assault occasioning bodily harm[1]and taking a vehicle without consent. He was also charged with burglary in respect of theft of cash and cigarettes from the hotel. Mr J had also been arrested by South Wales Police on the 7 February 2009 for allegedly slapping a resident of the hostel where he was residing in the face. Mr J admitted to the offence and he received a caution and was released the same day. The injured person confirmed to the police that they were content with their action.

1.13 Mr J was sentenced by Newport Magistrates Court on the 12 March 2009 for the charges relating to assault occasioning actual bodily harm, burglary and taking a vehicle without consent. Mr J was given a 16 week sentence suspended for 18 months, plus 18 months of supervision by the Probation Service with a specific requirement for him to engage in 10 treatment sessions with a mental health professional. Mr J was bailed to a privately run bail hostel[2] in the Cardiff area during the period prior to him being sentenced. He remained at the hostel following him being sentenced as a temporary arrangement.

1.14 Whilst residing at the bail hostel, Mr J was reported to have been sending *'disturbing'* emails to a spiritual medium that he had met at a spiritualist church. The medium was concerned for their own safety and that of Mr J due to the content of the emails. The emails sent by Mr J allegedly contained threats to commit suicide and he claimed to be *'the saviour of the Earth'*.

[1] Section 47 assault occasioning bodily harm is where an offence is committed when a person assaults another, thereby causing actual bodily harm (ABH). Bodily harm has its ordinary meaning and includes any hurt calculated to interfere with the health or comfort of the victim

[2] Mr J was residing at a Clear Springs facility that runs bail hostels on behalf of the Ministry of Justice.

1.15 No formal complaint was made to the Police by the Spiritualist Medium; however on the 17 April 2009 Police officers attended Mr J's residence and advised him of the need to use social media more responsibly in regards to contacting the medium or spiritualist church in the future.

Mr J's Contact with Probation

1.16 Following his appearance at the magistrate's court on 12 March 2009, Mr J was made subject to supervision by the Probation Service. On 27 March 2009 the Offender Manager reviewed Mr J's file. Initially the Probation Service had risk assessed Mr J as Tier 2[3] on the Offender Assessment System (OASys[4]) with regards to the risk he posed to the public. However, on review of the initial assessment of Mr J the Offender Manager escalated his status to a Tier 3 risk to the public (higher status) due to the seriousness of the index offence (the use of a weapon to cause injury), his mental health issues, and the fact that he was homeless.

1.17 Mr J attended his initial appointment with his Probation Officer on 19 March 2009 where the conditions of his supervision were explained to him. However, Mr J failed to attend any further appointments with his Probation Officer or respond to correspondence sent to him, and so Mr J was summonsed by the Probation Service to appear at Cardiff Magistrates Court on 20 April 2009. He failed to appear at Court and so an arrest warrant was issued to the court enforcement officers in line with court protocol, on 27 April 2009.

[3] Tiers are designated to probation clients based on their previous convictions, personal circumstances and age. There are four tiers. Tier 1 being low risk and Tier 4 being a higher risk to the public.

[4] OASys is designed to enable a properly trained and qualified individual, often a Probation Officer, to: assess how likely an offender is to be re-convicted, identify and classify offending-related needs, including basic personality characteristics and cognitive behavioural problems, assess risk of serious harm, risks to the individual and other risks, assist with management of risk of harm. Links the assessment to the supervision or sentence plan and indicate the need for further specialist assessments and measure change during the period of supervision/sentence.

1.18 There is little information available regarding Mr J's movements between March and May 2009 and there is no record of him being in receipt of health or social care services; however it is understood that Mr J was residing at the bail hostel to which he had been remanded back in February 2009. Records available highlighted that following a suicide attempted on the 2 May 2009, residents at the bail hostel made an emergency call to the ambulance service. Police were also alerted and using a PPD1[5] form made a referral to Protection of Vulnerable Adults. However, as Mr J had been conveyed to hospital and subsequently admitted to Whitchurch Hospital no further follow up was made by the Police.

Mr J's admission to Whitchurch Hospital

1.19 On 2 May 2009 Mr J was taken by ambulance to the Accident and Emergency Unit (A&E) at the University Hospital of Wales with a laceration to his wrist. He told A&E staff that he had cut his wrist in a deliberate attempt at suicide.

1.20 Mr J was assessed by the Mental Health Crisis Team based in the A&E department. During his assessment he stated that he thought that his lifestyle had become *'chaotic'* over the past 18 months and that he was able to communicate with three *'spirits'*. He also confirmed that he saw *'shimmers'* which he interpreted as being spirits. Mr J claimed to have attempted suicide on seven previous occasions over a two year period.

1.21 Mr J was assessed by the Crisis Team as requiring further mental health input and was escorted by a member of the Crisis Team to Whitchurch Hospital where he was admitted as an informal patient at 00:35 hours on 3 May 2009. The Crisis Team member escorting Mr J advised staff at Whitchurch Hospital that they should contact the Community Psychiatric Nurse working with the Probation Service and advise of his admission as he was subject to supervision by the Probation Service. The

[5] A PPD1 is a referral form used by police to refer an individual or group to Social Services in an event that they are assessed as vulnerable.

Community Psychiatric Nurse working with the Probation Service was alerted of Mr J's admission via the healthcare PARIS[6] system.

1.22 Mr J was admitted to Ward East 2A (a mixed acute psychiatric ward) at Whitchurch Hospital. The medical records state that on arrival he appeared to be generally relaxed although he was edgy on occasions. The records also state that Mr J was able to converse with staff and his speech was at a normal rate, tone and volume with no evidence of any thought disorder, although his speech elevated when he talked of the three *'spirits'*. Mr J also disclosed that he saw *'spirits'* through shimmers that appeared to him.

1.23 Mr J divulged to ward staff that he was residing at a bail hostel but didn't like it there and felt the need to isolate himself in his room as he found it difficult to control his anger and frustration at other residents. A nurse noted in Mr J's records that:

> *'(Mr J) finds his feelings of aggression are particularly aimed at males & not females….find men disgusting, in general, not have good manners, not be sensitive like women [sic].'*

1.24 Mr J was observed over the following days and he was noted as being in a pleasant mood, approachable with good eye contact maintained. Although on times he was noted to be *'brittle'* and agitated. Mr J was observed on one occasion to be whispering to himself and pacing in the day area with no patients or staff around. When staff offered PRN[7] medication to help ease his agitation, he refused it.

1.25 Mr J was also observed as being sociable, particularly with a group of female patients. Mrs A (the victim of this homicide), was part of this group[8]. At this time, Mr J was showing no signs of any aggressive outbursts and interacted well within this group.

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[6] PARIS is an electronic assessment and care planning record available to service providers within the NHS.

[7] PRN is derived from the Latin phrase '*Pro re nata'* meaning *'as the circumstance arises'.* It is generally abbreviated to PRN in reference to dosage of prescribed medication that is not scheduled.

[8] Mr J and Mrs A first met during this period of Mr J's admission to Ward East 2A.

1.26 On 5 May 2009 staff on Ward East 2A attempted to contact Mr J's Probation Offender Manager to obtain his forensic history. A message was left with the Offender Manager, and on 6 May 2009 a Supervising Officer from the Probation Service contacted the ward and spoke to a staff grade nurse informing her that Mr J was in breach of his probation conditions and that a warrant for his arrest had been issued. The Supervising Officer informed the nurse of Mr J's potential risk of serious harm to others (due to the nature of the offence involving the farmer). At this point the Supervising Officer could have informed the police of Mr J's whereabouts so that they could have executed the arrest warrant. However as Mr J was receiving inpatient treatment and his whereabouts were known, the Supervising Officer requested that health staff contact the Probation Service again prior to Mr J's discharge so that supervision could resume and the warrant for his arrest activated.

1.27 An officer from South Wales Police contacted Ward East 2A on the 7 May 2009 to inform ward staff that Mr J had allegedly been sending further *'bizarre'* emails to a spiritual medium claiming that the voices heard by the medium were from him and not spirits. The police officer informed the staff nurse that he spoke to that Mr J had previously been warned about sending such emails, but had apparently continued to contact the medium via a social networking website as well as sending further messages to the medium's spiritualist church. The police officer advised that the police would contact the Ward again to ascertain when Mr J was to be discharged.

1.28 On the same day, Mr J was seen by his Responsible Clinician[9] (RC) for the first time. The delay in Mr J being seen by his RC was due to him initially being placed on the rota of a clinician who usually dealt with patients noted to have no fixed abode[10] (NFA). At the time of Mr J's admission the clinician responsible for this rota was on leave due to personal reasons and this resulted in some confusion and a delay in Mr J being allocated an RC.

[9] A Responsible Clinician is the Approved Clinician who has been given overall responsibility for a patient's case.
[10] Patients are placed on an NFA rota if they have no fixed address, residing in a hostel or are not registered with a GP.

1.29 Although the entry in Mr J's notes detailing the RC's assessment was made by the Senior House Officer (SHO)[11], it recorded that the RC's initial assessment noted that Mr J appeared to have *'psychotic symptoms'*. The assessment also stated that Mr J *'appears to have delusional beliefs'.* The RC requested a further forensic opinion[12].

1.30 Mr J continued to be observed by ward staff over the following days and appeared to be agitated; invading staff's personal space more than normal. However observations also noted that Mr J was interacting well with other patients, notably the group of female patients.

1.31 On the evening of Saturday 9 May 2009 Mr J became overly agitated and was observed to be slamming doors and pacing in his room. The situation escalated when Mr J become verbally abusive during an aggressive outburst aimed at another male patient. Unable to calm him, staff transferred Mr J to the Psychiatric Intensive Care Unit[13] (PICU) at Whitchurch Hospital. Mr J was risk assessed on 10 May 2009. This was the only risk assessment made available to the review team and hence appears to be the only risk assessment undertaken during Mr J's admission to Whitchurch Hospital. The risk assessment was completed by an experienced member of the nursing staff who assessed Mr J's risk as follows:

- Risk to others: SERIOUS APPARENT RISK.
- Risk to Child: LOW RISK.
- Risk of suicide: SERIOUS APPARENT RISK.
- Risk of deliberate self-harm: SIGNIFICANT RISK.

[11] SHO is a Junior Doctor.
[12] Forensic mental health is defined as an area of specialisation that involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led, or could lead, to offending.
[13] A Psychiatric Intensive Care Unit (PICU) is a type of psychiatric inpatient ward. On these wards staffing levels are higher than on a normal acute admission ward. PICUs are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk the patient poses to themselves or others.

- Risk of severe self neglect/serious accidental self-harm: SERIOUS APPARENT RISK.
- Risk of abuse by others: LOW RISK.
- Possible risk to staff members: SERIOUS APPARENT RISK.

1.32 Whilst on PICU Mr J was noted to be very aroused and agitated and at one point threatened to *'kill'* someone if he was not transferred back to Ward East 2A, as he felt that he *'was not like one of them.'* He was recorded as saying that if he was left on PICU he would *'not be held accountable for his actions'*. Mr J was informed that it was not possible for him to return to his previous ward due to his behaviour. He was informed that if he did not settle on PICU ward he would be placed under Section 5(2) of the Mental Health Act 1983[14] and transferred to the Low Secure Ward (West 3, an all male low secure ward). Mr J continued with his demands to be moved and was subsequently placed on section 5(2) by the on-call clinician on the 10 May 2009 (24 hours after being placed on PICU) and transferred to the Low Secure Ward, West 3.

1.33 Whilst on West 3 Mr J stated that he felt uncomfortable being on an all male ward and was frustrated at being moved to three wards over a 48 hour period. Although frustrated at this situation, Mr J appeared to be calm and settled. He was assessed again on the 11 May 2009 by his RC who noted that Mr J was rational and showed insight into his behaviour. Mr J was noted to have no delusional beliefs, although he still claimed to be hearing voices; advising that the voices were not commanding and neither was he influenced by them. The section 5(2) was revoked by his RC and Mr J was allowed to return to Ward East 2A on 12 May 2009.

1.34 On 12 May 2009 Mr J was assessed by a SHO on East 2A who recorded that he was over friendly and had been observed moving back and forth on a chair

[14] Section 5(2) is a doctor's holding power. It can only be used to detain in hospital a person who has agreed to informal (wilful) admission but then changed their mind and wishes to leave. It can be implemented following a (usually brief) assessment by the RC or their deputy, which, in effect, means any hospital doctor, including psychiatrists but also those based on medical or surgical wards. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the Section or detention under a Section 2 assessment order or Section 3 treatment order.

erratically. The record of the assessment notes that Mr J had pressured speech although he was coherent. Mr J spoke of spirits and the SHO recorded him as having a thought disorder and thought withdrawal. Mr J was assessed as having limited insight into his mental health and the clinician advised that the same management plan should be continued while he was on Ward East 2A for further assessment.

1.35 Over the following two days, Mr J was observed as being pleasant and appropriate in his interactions with other patients. He also took part in ward based activities and spent more time in communal areas. On the 14 May 2009 Mr J was assessed by a senior clinician from Low Secure Services[15] in response to the request made for a forensic opinion made on the 7 May 2009. The clinician who was a general psychiatrist and not a specialist forensic psychiatrist concurred with an earlier assessment made by Mr J's RC's in which he recorded that Mr J presented no signs of mental illness and that his delusional beliefs were part of his personality. Both the RC and Low Secure Services Clinician considered Mr J to have a personality disorder. The low secure clinician recommended that Mr J be discharged from Whitchurch, but noted that Mr J may benefit from psychology input.

1.36 Later the same day (14 May 2009), Mr J was discharged by an SHO (the same clinician who carried out the assessment of him on the 12 May 2009) on the advice of his RC and the low secure clinician. Mr J was discharged from Whitchurch with a diagnosis of personality disorder and no plans were put in place for him to be followed up by health services, partly due to Mr J refusing further input and the use of medication.

1.37 South Wales Police were contacted by the ward manager to advise them of Mr J's discharge from Whitchurch as it was believed that a warrant was still out for his arrest. The police advised that they did not have possession of the warrant but

[15] Low Secure Services provide a comprehensive mental health service provision to offenders and others at risk of offending. They provide an inpatient, outpatient and community services which provide assessment and treatment, either directly or through supporting other professionals and agencies. These services provided by the former Cardiff and Vale NHS Trust and are based at Whitchurch Hospital.

were able to disclose that the courts in Pontypridd held it. The ward manager was also advised that the courts warrant officer[16] would inform the court of Mr J's discharge. Later the same day, a police officer called the ward asking about a separate matter in relation to the alleged harassment of a *'medium'* by Mr J. The police officer was advised of Mr J's discharge by a staff nurse.

1.38 The next day (15 May 2009) the Probation Supervising Officer was contacted by a staff member from Ward East 2A who left a message advising of Mr J's discharge from Whitchurch.

1.39 The Low Secure Clinician wrote to Mr J's RC on 28 May 2009 to formally advise of his opinion, which agreed with that of the RC. Both clinicians considered Mr J to portray *'transient psychotic symptoms in the setting primarily of a personality disorder'*. They considered that his *'long standing histories of hallucinatory voices were to arise from his personality and there was no evidence that would indicate schizophrenia'*. In this letter the Low Secure Clinician advises that Mr J may benefit from psychology input; and confirmed his agreement with the RC's view that outpatient management was the most appropriate way of caring for and treating Mr J. However, referral to a psychologist or arrangement of an outpatient appointment was never actioned, partly due to Mr J's reluctance to co-operate.

Mr J Post Discharge from Whitchurch Hospital

1.40 Following his discharge from Whitchurch Hospital, Mr J was once again homeless. He was asked by staff at Whitchurch Hospital to attend Marland House[17] on his discharge and register as homeless so that emergency accommodation could be arranged. Mr J attended Marland House as instructed however he was not eligible for the provision of temporary accommodation by Cardiff Council as he had no local connections and did not satisfy the criteria set in line with the Housing Act.

[16] Warrant officers are responsible for the recording of all warrants issued by the courts for execution on police computer systems. Warrants officers are responsible for executing bench warrants, breach warrants and the personal service of court documents such as summonses, adjournment notices and disqualified driver notices.
[17] Marland House is a housing advice centre ran by Cardiff Local Authority

Cardiff Council staff advised Mr J to attend Tresillian House, an emergency homeless centre, where he may be accommodated. However it appears that Mr J chose not to take this advice.

1.41 There is little information available in relation to Mr J's living arrangements following his discharge from Whitchurch Hospital in May 2009 to November 2009, as it appears that Mr J was not in receipt of services from Health or the Local Authority. However, Mr J claims to have been living rough in a tent on the outskirts of Cardiff. Mr J was allegedly intermittently in contact with Mrs A during this period, apparently visiting her occasionally at Whitchurch Hospital while she was still an inpatient. It is unclear as to how often Mr J visited Mrs A at Whitchurch Hospital and what the precise nature of their relationship was at this time.

1.42 In June 2009 Mr J changed his name by deed poll apparently in response to seeing the motion picture *Constantine*[18].

1.43 Mr J came to the attention of health services again on 24 November 2009 when he attended the A&E department at the University Hospital of Wales (UHW) claiming to have taken an overdose of Ibuprofen. Records confirm that when he attended A&E, he was clean and well groomed which was inconsistent with his claim to be living rough. Mr J told A&E staff that he had registered with Tresillian House but stated that he had not stayed there as he did not like the other residents. He commented that he felt that if he had stayed there he would have *'killed'* someone.

1.44 Following treatment for his overdose, Mr J was assessed by the Mental Health Crisis Team resident in the A&E Department. The Crisis Team accessed Mr J's medical record and ascertained that he had been discharged from Whitchurch Hospital in May 2009 with a diagnosis of personality disorder. Mr J was assessed by the Crisis Team as not having any psychotic symptoms although he had spoken about hearing and seeing *'spirits'*. It was recorded that during the assessment, Mr J had kept good eye contact, was fluid with speech and tone; had not presented as being agitated and had not been distracted (which is not synonymous of someone

[18] '*Constantine'* is an American Horror film released in 2005 by Warner Bros studios.

presenting with psychotic audio hallucinations). While not agitated initially, Mr J became aggressive when he was advised that he would not be admitted to hospital and threatened to commit suicide. The Crisis Team advised Mr J that there was no reason to admit him to hospital as he was not presenting psychotic symptoms. Both Crisis Team members in attendance were of the opinion that Mr J was seeking admission to hospital due to him not liking his living arrangements.

1.45 Mr J's behaviour deteriorated while he was being assessed and so the Crisis Team alerted the police. Coincidentally the police were already on route to UHW as Mr J had been reported as a missing person and Gwent police had been trying to locate him. Mr J denied that he had been a missing person, although he later admitted that he had sent a text message to a friend saying farewell. The Crisis Team were also aware that he was subject to supervision by the Probation Service as this information together with information in relation to Mr J's diagnosis of personality disorder had been noted on PARIS (following his admission into and discharge from Whitchurch Hospital).

1.46 The Crisis Team contacted the Probation Service who confirmed that a warrant for Mr J's arrest was still active. This information was relayed to the police in attendance. However the police officer confirmed that a record of the warrant was not available on the Police National Computer. The police records stated that:

> *'Police attended A&E on the 24 November 2009 as a result of a missing person circulation. The officers in attendance were informed by the member of the crisis team that probation had informed them that there was an arrest warrant for Mr J due to breach of conditions. Police response was that they checked and there was no record of a warrant outstanding for Mr J. No arrest was made.'*

1.47 It was not appropriate for the police to detain Mr J under Section 136[19] of the Mental Health Act, as he was already in a designated place of safety[20] (UHW) and two members of the crisis team had deemed him not to be appropriate for admission to hospital. Mr J left the hospital abruptly threatening to commit suicide and commenting that if he did it would be the fault of those who had assessed him.

Mr J's Time at the YMCA Hostel

1.48 Mr J made contact with the emergency bed co-ordinator based at Tresillian House on the 25 November 2009 and a bed was found for him at a YMCA hostel. On 30 November 2009, police became aware that Mr J was residing at the YMCA hostel through their local intelligence network.

1.49 Mr J was noted to have had difficulties settling in at the hostel and had several confrontations with other residents. He was noted to be verbally threatening to residents. On the 15 and 22 December 2009 his support worker at the YMCA contacted the mental health Crisis Team requesting input as she was concerned about Mr J's mental health as he was claiming to see *'spirits'* and to be able to see into the future; although he was not aggressive or showing any intent to self-harm. As Mr J was not in receipt of care and treatment from mental health services at that time the Crisis Team advised that Mr J should register with a local GP so that he could be referred to the local CMHT. The Crisis Team also advised that the YMCA should contact the police if Mr J became aggressive as well as the Probation Service as there was an outstanding warrant for his arrest.

[19] Section 136 is an order that allows a police officer to take a person whom they consider to be mentally disordered to a 'place of safety'. This only applies to a person found in a public place. Once subject to a Section 136 they assessed and, in some cases, a Section 2 assessment order or Section 3 treatment order can be implemented.

[20] A place of safety could be a hospital, police station or some other designated place. However, the most recent guidance states that a police station should only be used in exceptional circumstances, and all areas in Wales are working to ensure places of safety are available in appropriate settings, usually in a hospital. (http://www.mentalhealthWales.net/mhw/police.php

1.50 The support worker contacted the Probation Service on the 21 December 2009 and was advised that she should encourage Mr J to hand himself into the Courts. Mr J refused to hand himself in to the police but did hand himself in to authorities on the 18 January 2010.

Mr J Re-engaging with the Probation Service

1.51 There is ambiguity in relation to whom or which organisation Mr J surrendered himself, however, records confirm that he handed himself in on the 18 January 2010 and was seen at Magistrates Court on the same day. He was given conditional bail until the 25 January 2010 to reside at a local homeless centre (the YMCA hostel in which he resided at the time of his surrender). However the Court adjourned his case until 1 February 2010 to allow time for an up to date breach report to be provided by the Probation Service.

1.52 Mr J attended a meeting with the Probation Service on the 25 January 2010 so that a breach report could be written. This was his first meeting with Probation since his induction back in March 2009. Mr J raised concerns in relation to the arrest warrant, as he had been in contact with the police several times over the past nine months, but had been told that there was no warrant for his arrest. Mr J also told the Probation Officer that he had spent time as an inpatient at Whitchurch Hospital and that he had been discharged with a diagnosis of a personality disorder; he stated that Whitchurch could do nothing for him.

1.53 Mr J's offender manager completed the updated breach report. Records also note that during discussions with the Offender Manager Mr J mentioned that he wanted to leave the country and live in Israel. Mr J also advised that he was able to communicate with spirits. The breach report stated that;

> *'Probation can see little compliance with the order if it remains in place and recommends revocation and activation of the suspended sentence so that Mr J can undergo psychiatric assessment whilst in custody.'*

1.54 On 1 February 2010 Mr J appeared in court. However the court adjourned for the pre-trial review until 15 February 2010 following a request from Mr J's solicitor that time be allowed for him to obtain evidence to support Mr J's claim that he was in hospital on the dates that he missed his appointments with Probation. It was later established that Mr J had missed the appointment with Probations Services and hence the arrest warrant had been issued prior to Mr J's admission to Whitchurch Hospital.

1.55 At the pre-trail review held on 15 February 2010, Mr J's solicitor asked for a further adjournment so that an up to date psychiatric report could be obtained. To allow time for the psychiatric assessment to take place the Court further adjourned the case until 8 March 2010.

1.56 After his appearance in court on 25 January 2010, Mr J attended a further three appointments with probation on 5, 9 and 16 February 2010. During these appointments it was noted that Mr J was making *'bizarre'* claims about being a spirit medium and being able to haunt people in their dreams. Mr J claimed that he would refuse any psychiatric intervention as he felt that he could deal with his issues himself. At this point the Probation Service were aware that Mr J's solicitor was arranging for him to undergo psychiatric assessment and so no contact with mental health services was made.

1.57 On 23 February 2010, Mr J attended what was to be his last appointment with Probation Services prior to the index offence. At this meeting, Mr J claimed to be uncomfortable at the YMCA hostel as he felt aggressive towards other residents. He requested that he be moved out of the hostel and allowed to live with a friend (Mrs A) who he claimed was a former nurse. The Probation Service agreed to explore this possibility due to the unrest that Mr J was causing amongst residents at the hostel.

1.58 The Probation Service contacted the Court and received confirmation that a conditional bail application could be made to vary the residence conditions of Mr J. However the courts advised that to do this Mr J must make an application through his solicitor. Mr J was also told that a change to his bail address could not be actioned until Mrs A had been spoken to and an assessment made of the suitability

of the residence and until a variation was approved he was required to reside at his current residence, the YMCA hostel.

1.59 The residence variation request was not actioned or approved by the courts as the Probation Service and Mr J's solicitor had been unable to contact the friend (Mrs A) to advise her of Mr J's forensic and mental health history and check with her whether given this she would still be willing to agree to Mr J living with her. The court adjourned this matter until 8 March 2010 to give Mr J's solicitor time to speak with Mrs A.

1.60 Mr J moved out of the YMCA hostel on the 23 February 2010 (the same day as his last appointment with the Probation Service). This was contrary to the Court's direction that he was to remain at the hostel until his application to vary his place of residence had been approved. Mr J gave the YMCA Hostel an address in the Thornhill area of Cardiff as his new place of residence. The Probation Service, unaware that Mr J had already moved in with Mrs A, made a further attempt to contact Mrs A on 1 March 2010 but did not receive a response. Records state that numerous phone calls were made to the address provided; however the phone number was constantly engaged. It is believed that by 1 March Mr J had already committed the murder of Mrs A.

Mrs A's Background

1.61 Mrs A was a 52 year old female with two adult children. She was a former nurse who had worked in the nephrology unit at Cardiff and Vale University Health Board and had played a key and successful role in the establishment of the home dialysis service for the area.

1.62 Mrs A had been known to mental health services since 1991, initially she had been admitted with depression following the breakdown of her marriage and received a course of ECT treatment[21].

[21] Electroconvulsive therapy (ECT) is a psychiatric treatment for depression in which seizures are electrically induced on an anesthetized patients for therapeutic effect.

1.63 Early in 2009, Mrs A was admitted to a crisis house following an attempt to self-harm whilst intoxicated. Following her discharge she was able to return to work. However, she found her return to work difficult and subsequently relapsed. Mrs A was admitted to an alcohol detox unit on the 28 April 2009 and was transferred the following day to Ward East 2A at Whitchurch Hospital.

1.64 Throughout 2009 and in the months leading up to her death, Mrs A had been hospitalised on several occasions due to her self-harming injuries following the consumption of alcohol. Mrs A's behaviour became more erratic; and her family became increasingly concerned for her welfare and about her friendship with Mr J.

Mr J's Relationship with Mrs A

1.65 As noted earlier Mr J first met Mrs A in May 2009 when they were both admitted to Ward East 2A in Whitchurch Hospital. Mrs A was already a patient on the ward when Mr J was admitted. During our discussions with staff it was widely acknowledged that Mrs A was part of the group of females that Mr J regularly sat and talked with. Throughout the period of Mr J's inpatient stay, Mr J and Mrs A were regularly seen together away from the group, however the relationship was observed by staff as being platonic and appropriate.

1.66 It is alleged that, Mr J and Mrs A were in regular contact following Mrs A's own discharge on the 22 June 2009. It was also rumoured by fellow patients that Mr J was allegedly living with Mrs A during part of this time. Our review of Mrs A's records highlighted that on 28 June 2009 she attended A&E following an attempt to self harm. Records note that Mrs A was brought in by a *'friend'* and Mr J's details are given as those of the next of kin. The next of kin record is signed by Mr J.

1.67 Mrs A was readmitted to Whitchurch on 22 July 2009. When allowed home leave on 6 October 2009 Mrs A had self-harmed and attended A&E. Mrs A was treated for her self-harm injuries and was transferred back to Ward East 2 A at Whitchurch Hospital and was later discharged on 19 October 2009. It is difficult to

determine precisely how much contact Mr J had with Mrs A between October 2009 and January 2010.

1.68 Mrs A was admitted to Llandough Hospital on 5 December 2009 after another episode involving alcohol and was subsequently transferred to Whitchurch on 8 December 2009 to receive treatment. Mrs A was discharged on 11 December 2009, but was readmitted to Whitchurch on 15 January 2010 following a further episode of self-harm. This was to be Mrs A's last admission to Whitchurch.

1.69 During the period of her admission to Whitchurch Hospital, Mrs A admitted to staff that she was looking forward to leaving hospital as a *'friend'* was moving in with her. Although rumoured by patients to be Mr J, staff had no firm evidence that it was him.

1.70 On the weekend prior to the index offence (20/21 February 2010), Mrs A was still an inpatient at Whitchurch hospital and Mr J attended the ward to visit her. They spent time together at the day centre with permission of the nursing staff. On 22 February 2010 it was reported that Mrs A was distressed following a conversation with her daughter. This was apparently due to Mrs A's daughter expressing concern over Mr J staying at Mrs A's house while she was at hospital. It was at this point that Mrs A revealed to staff that Mr J had stayed at her house during her admission to A&E in October 2009.

1.71 On the 26 February 2010 Mrs A was allowed home leave following a review with her consultant during which she was positive and upbeat and had asked to be discharged. Mrs A admitted to nursing staff and to her clinician that a *'friend'* was moving in with her. Mrs A was allowed home on the understanding that she attend a mood regulation group on the following Monday (1 March 2010) and returned to the ward on the Tuesday (2 March 2010).

1.72 Mrs A spoke with a family member on the morning of Sunday 28 February 2010 and had arranged to meet with them on the Monday morning. However on arrival at Mrs A's home on the Monday morning the family member could not get a response at the home or on the phone. Mrs A had also failed to attend the mood

regulation group at the hospital that day. Nursing staff on Ward East 2A attempted to contact her several times, but were unsuccessful.

1.73 Mrs A failed to return to Whitchurch Hospital on 2 March 2010 and staff became concerned for her welfare and attempted to contact her by telephone. Due to their increasing concern for Mrs A, hospital staff alerted the police on 2 March 2010 requesting that they carry out a welfare check. Sadly, Mrs A was found dead by police when they arrived at her home on the 2 March 2010.

Post Index Offence

1.74 Following the index offence Mr J absconded from the Cardiff area and travelled to Newtown in Powys. Whilst at Newtown, Mr J contacted the Probation Service to advise them that something bad had happened at Mrs A's address and to send the police to her address. Mr J subsequently handed himself in at Newtown police station on 3 March 2010 where he was arrested.

1.75 On 4 March 2010 Mr J was assessed by a Consultant Psychiatrist from Low Secure Services while in custody at Cardiff Bay police station. The consultant noted Mr J as *'showing no signs of agitation or overt stress and displayed good eye contact throughout'* however the consultant was of the opinion that Mr J was *'floridly psychotic in that he described a fixed delusional system'* the record of the assessment also describes Mr J as *'markedly grandiose and described second and third person auditory hallucinations as well as visual hallucinations and somatic*[22] *hallucinations'.*

1.76 Mr J was remanded to HMP Cardiff and transferred to the health care facility where he was further assessed by a forensic psychiatrist on 8 March 2010. The Forensic Psychiatrist recommended that Mr J required an urgent transfer to at least a medium secure unit. The forensic psychiatrist contacted Ashworth Special

[22] Somatic hallucination is a hallucination involving the perception of a physical experience with the body.

Hospital[23] for an opinion on his risk issues and mental state and following their input Mr J was transferred to Ashworth Hospital under section 48/49 of the Mental Health Act on 11 May 2010. Mr J was later diagnosed as having paranoid schizophrenia by the forensic consultant based at Ashworth Hospital.

Management and Organisation of Services

Arrangements for the Provision of Mental Health Services in Wales

1.77 The National Health Service (NHS) in Wales was reorganised in 2003. This resulted in the abolition of Welsh Health Authorities and the establishment of NHS Trusts and Local Health Boards

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

1.79 At the time of Mr J's involvement with mental health services, Whitchurch Hospital and secondary care facility was run by the former Cardiff and Vale NHS Trust and primary care services were commissioned by Cardiff LHB.

Whitchurch Hospital

1.80 During 2009-2010 Whitchurch Hospital was a Psychiatric Hospital based in the Whitchurch area of Cardiff. Whitchurch Hospital services include General Adult Psychiatry, Elderly Psychiatry, Neuropsychiatry and Low Secure/Forensic psychiatry as well as Rehabilitation and Addiction services. Whitchurch Hospital is run by the Cardiff and Vale University Health Board.

[23] Ashworth Special Hospital is a high secure psychiatric hospital based in Merseyside, England. Ashworth Hospital is run by Mersey Care NHS Trust.

The Probation Service

1.81 The Probation Service in Wales are provided by the Wales Probation Trust which was formed on the 1 April 2010 following the merger of four previous Probation areas/Trusts in Wales. The Probation Trust works across 22 Local Authorities, seven Health Boards and four Police areas.

1.82 The Wales Probation Trust works with offenders aged 18 and over who have either been sentenced by the Courts to a community order, suspended sentence order or released on license from prison to serve the rest of their sentence in the community.

Chapter 2 Findings

Predictability of the Homicide Committed by Mr J

2.1 It is clear that by the time of the index offence, Mr J's mental health had deteriorated significantly to the extent that while in custody immediately following the homicide he was described as being *'floridly psychotic'*. Although he had spent time as an inpatient in Whitchurch Hospital during May 2009 Mr J had never previously been diagnosed as suffering from a mental illness.

2.2 Following a relatively short (12 days in total) and fragmented inpatient stay (due to him being cared for on three different wards) Mr J was diagnosed as having a personality disorder and discharged on 14 May 2009 with no future care or treatment arranged or planned by health services.

2.3 It was during his admission to Whitchurch Hospital in May 2009 that Mr J met Mrs A for the first time. There appears to be some ambiguity as to the precise nature of their relationship, however while some staff were unaware of any relationship, others were aware that Mr J and Mrs A had been interacting and meeting periodically post Mr J's discharge from Whitchurch.

2.4 A risk assessment carried out during Mr J's admission to Whitchurch indicated that he was at risk of self-harm, and presented a risk of harm to other patients or staff. Also Mr J had previously carried out a violent attack on a farmer on 9 December 2008, however it appears that Mr J's threats or acts of violence were directed toward males as indicated in his initial assessment on arrival at Whitchurch Hospital (see paragraph 1:23). There was no evidence to indicate that he was violent or threatening towards Mrs A or females in general, therefore we consider the homicide of Mrs A to have not been predictable.

2.5 We are of the opinion had there been a more assertive and less fragmented attempt by Health and Statutory services to gain a better understanding of the risks

that Mr J posed, it is possible that the homicide committed may have been preventable.

2.6 There was a lack of clarity as to the precise status of the arrest warrant issued on 27 April 2009. Notably a number of opportunities to action this warrant were missed during 2009. Specifically:

- Between the arrest warrant being granted on 27 April 2009 and his admission to Whitchurch Hospital on 2 May 2009, Mr J was residing at the bail hostel allocated to him, records clearly state that residents at the hostel contacted the ambulance service when Mr J had cut his wrist.
- Whilst admitted to Whitchurch Hospital between 2 May 2009 and 14 May 2009, the Probation Service was alerted to the fact that he was admitted as a patient on 5 May 2009 and was alerted on 15 May 2009 that Mr J had been discharged.
- Officers from South Wales police were in contact with Whitchurch hospital while Mr J was an inpatient. On 7 May 2009 an officer from South Wales police contacted Ward East 2A in regard to an email that Mr J had allegedly been sending to a medium and spiritualist church, records state that the officer was informed of the warrant for Mr J's arrest. Further, police were informed on 14 May 2009 that Mr J had been discharged that same day.
- Officers from South Wales police attended A&E on 24 November 2009 when Mr J was admitted due to an overdose. Members of the Crisis team told officers of the arrest warrant and confirmed this with the Probation Service; however the PNC had not shown an active arrest warrant for him.
- Records note that on 30 November 2009, South Wales Police were informed of Mr J's residential status at the YMCA hostel through the intelligence network.
- The YMCA support worker contacted the Probation Service on 21 December 2009 informing the Offender Manager of Mr J's residential status at the Hostel. Probation advised Mr J to hand himself into authorities, which he did on the 18 January 2010.

We have not been able to establish why the warrant was never actioned.

2.7 We are of the view that opportunities were missed by services to properly engage with Mr J at various points in time.

2.8 In attempting to identify the root causes that led to the tragic death of Mrs A between 28 February and 2 March 2010, the review team has considered the periods of engagement that Mr J had with statutory services. These are described in the following sections.

Mr J's Time at Whitchurch Hospital

2.9 Mr J had had no previous engagement with Mental Health Services until his admission to Whitchurch Hospital on Saturday 2 May 2009. He was admitted over a bank holiday weekend after being assessed in A&E by the Crisis Team following an attempted suicide. He spoke of his alleged ability to hear voices and of seeing *'spirits'*. Mr J also spoke of previous attempts at suicide and his feeling of being low. This caused concern and so he was admitted to Whitchurch Hospital as an informal patient. He was placed on a mixed acute ward, East 2A.

2.10 Initially on his admission to Whitchurch Hospital, there was ambiguity over who would be his Responsible Clinician (RC). This was due to it being a bank holiday weekend and the fact that Mr J was placed on the no fixed abode (NFA) rota. The clinician who was to take responsibility for Mr J however had taken leave due to personal reasons. This caused a delay of five days in Mr J being assessed by a RC.

2.11 Following his admission to Whitchurch Hospital, Mr J denied any further thoughts of suicide or having any mental health issues and was observed as being calm and appropriate. Mr J was initially assessed by the Senior House Officer on 2 May 2009 and his initial impression of Mr J was that he presented with psychotic symptoms and thought disorders.

2.12 Mr J was assessed by his RC for the first time on 7 May 2009, five days after his admission to hospital. He was seen during the RC's ward round and following his initial assessment he recorded that he considered Mr J presented with psychotic symptoms and appeared to have delusional beliefs. The RC subsequently requested a forensic opinion from the Health Board's Low Secure Service.

2.13 Over the course of a single weekend, Mr J was transferred to three separate wards. The first movement occurred on 9 May 2009 when Mr J became agitated and verbally aggressive following an argument with another patient. Mr J was transferred to the Psychiatric Intensive Care Unit (PICU). It was following his admission to PICU that Mr J received his first, and only, risk assessment. The risk assessment, completed by an experienced nurse, stated that Mr J was at risk of self-harm and a risk of harm to other patients and staff. The risk assessment stated that when challenged Mr J was uncomfortable and that he had made threats to harm people and on one occasion had threatened to *'kill'* someone if he were not moved.

2.14 We could find no evidence of how this risk assessment was used to inform or influence the care and management of Mr J during his time at Whitchurch. This risk assessment did not appear to have been fully evaluated and considered by clinicians, and significantly we found no evidence of a care plan ever having been developed for Mr J.

2.15 Whist on PICU Mr J became agitated and verbally aggressive and at one point made threats to "kill" someone if he was not moved back to his initial ward. Consequently he was placed on a Section 5(2) of the Mental Health Act and transferred again, this time to Ward West 3, an all male low secure unit.

2.16 This movement across three wards during the period of a single weekend has led to us concluding that Mr J's care at Whitchurch was fragmented and we question how there could have been a full assessment of his mental health. The table below highlights the dates of his transfer across each ward:

Date	Ward
Saturday 2 May 2009	East 2A
Saturday 9 May 2009	PICU
Sunday 10 May 2009	West 3
Monday 11 May 2009	East 2A
Thursday 14 May 2009	Discharged

2.17 Mr J was assessed again on Monday 11 May 2009 by his RC. Records state that there had been no change in Mr J's mental state since the previous assessment undertaken on 7 May 2009. However the RC also stated in the same assessment that he felt that Mr J's current behaviour was not influenced by any psychopathology, that the voices were not commanding and that Mr J was not influenced by them. It is also stated that Mr J had no delusional beliefs. This assessment is very different to that carried out by the same RC on 7 May despite him having noted that there had been little change in Mr J's mental state.

2.18 A clinician from the Low Secure Service saw Mr J on 14 May 2009. This clinician spoke with nursing staff on ward East 2A who stated that since Mr J's return to the ward he had been appropriate, calm and interacting well with patients. The opinion of nursing staff was that he did not show symptoms of a mental illness. The clinician agreed with Mr J's RC's view that Mr J did not appear to have any psychotic illness or clear signs of distress. The clinician recommended that Mr J be discharged from hospital. The clinician formally documented his opinion in a letter sent to the RC on the 28 May 2009. Fourteen days after Mr J had been discharged.

2.19 Mr J was discharged from hospital on the 14 May 2009 by the Senior House Officer (clinician) on the advice and instruction of the RC, with no follow up arranged or medication. He was discharged to no fixed abode and was told to register as homeless. Mr J's diagnosis on discharge was that he had a personality disorder and not a treatable mental illness. While it was suggested that Mr J be offered psychology input to address his personality disorder, we found no evidence of this ever having been arranged.

2.20 An assumption was made by the RC that Mr J would be picked up by the criminal justice system due to the outstanding warrant for his arrest.

2.21 Staff at Whitchurch Hospital contacted the police on the day of Mr J's discharge to inform them that he was leaving, but the Probation Service were was not informed until 24hours later. The police advised that no arrest warrant was showing on the PNC; however they stated that a warrant was available at Pontypridd Court. Mr J was not arrested following his discharge.

2.22 In summary, Mr J's admission to Whitchurch hospital lasted 12 days and during this period he was moved across three separate wards. We believe that 12 days was not an adequate length of time to provide or give a considered view of Mr J's mental health. Due to Mr J moving across three different wards during the 12 days no single medical professional took an assertive overview of Mr J's care and treatment. There was no overarching care plan or CPA[24] put in place for Mr J and the mental health assessments undertaken were not robust. Only one risk assessment was undertaken during his stay and this highlighted him as being a significant risk to others, this does not appear to have influenced or informed subsequent decisions regarding Mr J's care.

2.23 We believe that had a greater effort been made to understand Mr J's mental health issues during his time at Whitchurch, a different diagnosis to that of *'personality disorder'* may have been made.

2.24 Overall HIW considers the care and treatment provided to Mr J while he was an inpatient to have been inadequate. Specifically:

- There was no evidence of Mr J being subject to or receiving a CPA whilst an inpatient.

[24] CPA or Care Programme Approach is a system of delivering community mental health services to individuals diagnosed with a mental illness. The approach requires that health and social services assess need, provided a written care plan and allocate a care co-ordinator. Then regularly review the plan with key stakeholders.

- Mr J was not risk assessed upon his admission to Whitchurch Hospital. Evidence suggests he was only risk assessed on his admission to the PICU.
- We found no evidence of the risk assessment undertaken influencing the care provided to Mr J during his time at Whitchurch or the decision to discharge him.
- We do not believe that adequate attempts were made to form a robust view of Mr J's mental health during his 12 day admission. His time at Whitchurch was fragmented with no overarching management plan for his care or treatment.
- The opinion provided by the consultant based in Low Secure Services was that of a general psychiatrist and not a forensic psychiatrist.
- The suggestion that Mr J may benefit from a psychological input was not followed up, partly as Mr J refused further input and the use of medication.
- The diagnosis of personality disorder effectively led to Mr J's discharge from Whitchurch with no further care, treatment or support planned by Mental Health Services. His condition was deemed to be untreatable.
- Whitchurch Hospital contacted the police, however health staff failed to contact the Probation Service as requested prior to his discharge. Neither did they include the Probation Service in the discharge process to ensure that Mr J was supervised on his release from hospital.
- Planning for Mr J's discharge was inadequate. There was no clear care plan or risk assessment in place. It appears that an assumption was made by health staff that the Probation Service or the police would *'pick up'* Mr J on discharge.

Mr J's Attendance at UHW in November 2009 and Further Contact with Health Services

2.25 Mr J's next contact with Health Services occurred when he attended the A&E department at the UHW on 24 November 2009 after allegedly taking an overdose of ibuprofen. He was assessed by the Crisis Team who had access to his mental health records which included information regarding his discharge from Whitchurch

Hospital six months earlier and his diagnosis of personality disorder. Mr J claimed to be living rough, but had presented as well groomed. It is clear that Mr J was still talking of his ability to speak with and see *'spirits'*; however notes indicate that his speech was fluent and tone was good; he was able to keep eye contact which is in contradiction to a person presenting with audio or visual hallucinations. Upon evaluation of all the information available to them the Crisis Team formed the opinion that Mr J may have been attempting to gain admission to hospital, and considered that an admission to hospital would not benefit Mr J.

2.26 Mr J's behaviour at A&E became irrational and quickly deteriorated once he was told that he would not be admitted and so the police were contacted. The police officers that attended A&E were unable to confirm at that point whether Mr J was subject to an arrest warrant, as no warrant was available on the Police National Computer (PNC), despite the Crisis Team having earlier confirmed with Probation Service that a warrant existed. As a consequence, Mr J was not arrested and left the A&E department apparently to no fixed abode.

2.27 After leaving A&E, Mr J contacted the emergency bed co-ordinator at Tresillian House and was offered an emergency bed at a YMCA hostel where he resided until 23 February 2010.

2.28 Mr J's behaviour deteriorated whilst he was residing at the YMCA hostel, which resulted in his Support Worker contacting the Crisis Team (the same team that had seen Mr J in November 2009 at UHW) on two separate occasions; the first on the 15 December 2009 and the second on the 21 December 2009. The Support Worker became increasingly concerned about Mr J's behaviour and his on-going claims that he was able to speak with and see *'spirits'.*

2.29 The Crisis Team advised the Support Worker that she should ensure that Mr J registered with a GP who would be able to refer him onto a Community Mental Health Team (CMHT) and to contact the Probation Service.

2.30 We believe that the decision to not admit Mr J taken by the Crisis Team that assessed Mr J at the A&E Department at UHW was broadly appropriate, in the

context of the information presented to them. '*However this was also the last main opportunity to reassess and re-diagnose Mr J's illness'*.

2.31 In relation to the contact made by the YMCA hostel to the Crisis Team in November, again the decisions taken were appropriate in the context that Mr J was not currently a patient of mental health services. The main issue to note however was that it was highly unlikely that Mr J would register with his GP in order to be referred to the CMHT. Predictably, this did not occur and as a consequence this was the last occasion that Mr J had any contact with Health Services prior to the index offence less than three months later.

2.32 In summary we believe that:

- Whilst the Crisis Team responded appropriately to Mr J's presentation at the A&E Department, based upon the information available to them, this opportunity to fully assess and possibly re-diagnose Mr J's illness was not taken.
- The ambiguity regarding the status of the warrant meant that Mr J was not apprehended at this point in time and was able to leave the A&E department with no care, support or supervision having been put in place by any statutory service.
- An opportunity to re-assess Mr J in December 2009 following the concerns raised by the Support Worker at the YMCA Hostel was not taken, partly due to the fact that Mr J was asked to register with a GP in order to gain a referral to the CMHT.

Mr J's Involvement with the Police and Probation Service

2.33 Mr J was arrested on 11 February 2009 and appeared at Newport Magistrates Court on the 18 February 2009 charged with assault occasioning actual bodily harm, taking a vehicle without consent and burglary. He was remanded to a private bail hostel based in the Cardiff area. On 12 March 2009 Mr J was sentenced and received an 18 month suspended sentence with 18 months supervision from the

Probation Service and a specified requirement that he engaged with mental health services.

2.34 Records indicate that he had no previous convictions and had not come to the attention of South Wales Police prior to 7 February 2009.

2.35 Mr J attended his initial induction appointment with the Probation Service on the 19 March 2009. He was assessed by his Offender Manager and was risk assessed as being a medium risk to the public or Tier 2 on their offender assessment system. However on 17 March 2009, following his initial induction appointment Mr J was re-graded to a Tier 3 risk to the public on the offender assessment system due to the fact that he had attacked someone with a hammer causing injury. It was also noted that he had mental health issues. According to the records available, at his initial induction appointment with his Offender Manager the conditions of his probation and specifically the requirement that he engage with a CPN were explained to him.

2.36 However, Mr J failed to attend any further appointments with the Probation Service and also failed to attend his appointment with the CPN. This effectively led to the Probation Service summoning Mr J to court to answer for the breach of his community sentence, and due to his non appearance in response to that summons the Court issuing a warrant for his arrest on 27 April 2009.

2.37 Until his admission to Whitchurch Hospital on 2 May 2009, Mr J was residing in the bail hostel he was remanded to. The Probation Service was alerted to the fact that Mr J had been admitted to Whitchurch Hospital on 6 May 2009, four days after his admission. The Probation Service's Case Manager requested that the hospital contact probation when Mr J was due to be discharged.

2.38 The Probation Service did not make any attempt to re-engage with Mr J whilst he was at Whitchurch.

2.39 Mr J was discharged from hospital on the 14 May 2009. The police were informed of his discharge; however there was a lack of clarity in relation to the status

of the arrest warrant at that time. Police did not have the warrant but were able to disclose that the court in Pontypridd did. The Probation Service was informed of Mr J's discharge from Whitchurch on 15 May.

2.40 In relation to the arrest warrant, we found no information to suggest that any agency made any attempts to clarify the whereabouts of Mr J between his discharge from Whitchurch in May 2009 and his attendance at the A&E department of the UHW in November 2009. However South Wales police records indicate that officers had tried to trace Mr J in relation to alleged harassment.

2.41 Subsequent to his attendance at UHW in November 2009, Mr J gained accommodation at a YMCA Hostel in Cardiff. Mr J's hostel Support Worker contacted the Probation Service on 21 December 2009 (following instruction to do so by the Crisis Team). The advice given by the Probation Service was that Mr J should be encouraged to hand himself in to police due to the breach of the conditions of his suspended sentence and the warrant which was out for his arrest.

2.42 Records also indicate that the police were aware that he was residing at the YMCA hostel. However while it is clear to HIW that both the Probation Service and police were aware of Mr J's residential status, Mr J was not arrested or contacted by the Probation Service until he handed himself in on the 18 January 2010. There is confusion over to whom Mr J handed himself as records only state that he *'handed himself in'* and appeared at magistrates court the same day. He was given conditional bail by the magistrate's court and remanded to the YMCA hostel where he was already a resident.

2.43 Mr J attended four sessions with his Probation Service's Offender Manager throughout January and February 2010. Records indicate that Mr J's behaviour continued to be erratic and that he was still claiming to hear and speak with *'spirits'*. His Offender Manager recorded following two separate appointments that Mr J was acting *'bizarrely'.*

2.44 On 1 February 2010 the Probation Service recommended at magistrate's court that Mr J's suspended sentence be reactivated so that Mr J could undergo

psychiatric assessment whilst in custody. This recommendation appears to have been overlooked as the court adjourned until 15 February to allow Mr J's solicitor to gain information regarding the date that Mr J had been admitted to hospital. The court made a further adjournment until 8 March 2010 to allow Mr J's solicitor to obtain a psychiatric report for Mr J. However before reappearing at court Mr J committed the homicide of Mrs A.

2.45 Although Mr J had exhibited strange behaviour during some of his appointments with his Offender Manager that raised concerns regarding his mental health state, as the Probation Service was aware that Mr J had been diagnosed as having a personality disorder and that a further psychiatric assessment was imminent, no action was taken to refer Mr J to mental health services for assessment. The Probation Service could have referred Mr J to the Community Psychiatric Nurse working for the Probation Service who would have been able to signpost Mr J to the appropriate health services had it been deemed appropriate.

2.46 Between his appearances at court on 25 January 2010 and attending what would be his last appointment with the Probation Service, Mr J had requested to vary his residence from the hostel to an address in the Thornhill area of Cardiff (Mrs A's home address). However to enable any further action, both probation and Mr J's solicitor had to contact the home owner (Mrs A) to clarify that she was aware of Mr J's criminal history and mental health issues and to establish whether she was happy for Mr J to move in with her. However Mr J moved out of the YMCA hostel on the 23 February 2010.

2.47 Whilst HIW's remit and powers to make recommendations merely extends to Health and Social Care providers, we feel that we must remark upon some of the interactions that Mr J had with both the police and the Probation Service. Specifically:

- There was a lack of clarity as to the status of Mr J's arrest warrant. On more than one occasion opportunities were missed to apprehend Mr J and bring him back under the supervision of the Probation Service or the courts. Most notably upon his discharge from Whitchurch Hospital in May

2009 and during Mr J's attendance at A&E in November 2009 and his subsequent stay at the YMCA Hostel.

- Both probation and police were aware of Mr J's whereabouts before his admission to Whitchurch Hospital, during his admission to hospital and again in December 2009 when the YMCA Hostel contacted the Probation Service.
- That the fact that the Probation Service were not notified of Mr J's discharge from Whitchurch Hospital until 24 hours after discharge may have resulted in another missed opportunity to engage with Mr J.
- The Probation Service did not refer Mr J to the Community Psychiatric Nurse as Mr J's solicitor was to arrange for him to undergo psychiatric assessment.
- There was ambiguity over how Mr J was able to leave the hostel and reside with Mrs A prior to the index offence as the court had not accepted the change of bail address at that point.

The Relationship between Mr J and Mrs A

2.48 Mr J first met Mrs A in May 2009 whilst they were inpatients on Ward East 2 at Whitchurch Hospital. Mr J and Mrs A were initially part of a group of patients who would gather and socialise regularly on the ward. On occasions Mr J and Mrs A had been observed by staff to be seen together holding conversation. It appears that the relationship between Mr J and Mrs A caused no concern to staff and they deemed their relationship during Mr J's period of admission to Whitchurch to be appropriate.

2.49 The relationship between Mr J and Mrs A continued after his discharge from Whitchurch Hospital on 14 May 2009; however it appears that nursing staff at Whitchurch Hospital and at the Community Mental Health Team caring for Mrs A were unaware of the nature of Mr J's and Mrs A's relationship. Most staff were not even aware that they were in contact with each other outside of the hospital.

2.50 Whilst fellow patients suggested to staff that Mr J may have been residing at Mrs A's home during her admission to Whitchurch (28 April 2009 to 22 June 2009) it

appears that these rumours were never recorded in Mrs A's medical notes. Similarly, while Mr J was noted in records as Mrs A's nominated next of kin following her attendance at the UHW A&E Department in June 2009, this was never queried as at that point in time Mr J had signed the record under the new name that he had changed to by deed poll in June 2009. Staff had known him by his previous name of KA which leads us to speculate that staff may not have recognised who he was at that point in time.

2.51 Mr J apparently kept in contact with Mrs A during the period July 2009 to January 2010 and would visit her home occasionally to walk her dog, meeting at neutral venues and attending Mrs A's Yoga Group.

2.52 Whilst an inpatient at Whitchurch Hospital, Mrs A would talk to nursing staff and Psychologist about a *'friend'* called John. However, nursing and clinical staff at Whitchurch hospital did not make the connection that the friend was Mr J, again possibly due to the fact that he had changed his name in June 2009 from his birth name of KA, which was the name he was known by during his admission to Whitchurch Hospital. None of this was ever recorded in Mrs A's medical notes.

2.53 Mr J visited Mrs A on Ward East 2A on the 21 February 2010 (the weekend before the index offence) and accompanied Mrs A to the day centre with the approval of nursing staff. It was reported that later, during the week leading up to the index offence, Mrs A had talked of a *'friend'* moving into her home and that she was looking forward to this. Nursing staff were not concerned by this news as they were of the opinion that this *'friend'* seemed to be there in a supportive role.

2.54 On 23 February 2010, Mr J applied to the court to vary his residence from the YMCA hostel to the residence of Mrs A in the Thornhill area in Cardiff. It is not clear whether this was actioned as the Probation Service and the solicitor failed to contact Mrs A to gain agreement to her having Mr J live with her. However it appears from the YMCA records that Mr J had physically moved out of the hostel on 23 February.

2.55 As previously noted, there appears to have been a lack of clarity and knowledge regarding the precise nature of Mr J's and Mrs A's relationship. While

there were rumours that Mr J and Mrs A had continued to be in contact post his discharge from Whitchurch in May 2009 and that he was periodically living at Mrs A's address, none of this information or intelligence was ever recorded or noted in Mrs A's medical record. On the few occasions that Mrs A was questioned regarding the status of her relationship with Mr J she merely stated that it was purely a platonic relationship.

2.56 Staff advised that had they concerns about Mr J and Mrs A's relationship during their time as inpatients at Whitchurch then appropriate measures would have been taken to separate them and manage the situation. However, once Mr J was discharged he was no longer considered to have a mental illness and was not a patient of Mental Health Services. Mrs A meanwhile was considered to have capacity to make her own decisions; although it was felt that Mrs A's vulnerability increased during periods of her being unwell, this was not to the extent that there was any concern raised about Mrs A's safety and apparent friendship with Mr J.

2.57 We are concerned that there appears to be a 24 hour delay in raising the alarm that Mrs A had not attended the Emotional Regulation Group at the Crisis recovery unit on Monday 1 March and had not returned to the ward on Tuesday 2 March. There is evidence that on previous home leave Mrs A was vulnerable to alcohol and self-harm and had previously refused to return to the ward. However when Mrs A failed to attend the mood group on 1 March 2010, staff attempted to contact Mrs A by telephone without reply, however they did not action a welfare check until 2 March 2010.

2.58 In conclusion, we are of the view that:

- There was nothing more the nursing staff could have done whilst Mr J and Mrs A were inpatients as their relationship was deemed to be appropriate at that time as both patients had capacity.
- There is a possibility that the change of name to Mr J may have caused confusion, which led to nursing and clinical staff not making the connection that Mrs A's *'friend'* was in fact Mr J.

- There was ambiguity regarding the regularity and nature of Mr J's contact and relationship with Mrs A. While it appears that some staff were broadly aware of a relationship, none of this information was ever recorded in Mrs A's medical notes and therefore was never considered as part of her risk assessment or incorporated into her care planning arrangements.
- Whilst it was felt by some nursing staff and clinicians who had cared for Mrs A that during episodes of being unwell Mrs A may have been vulnerable, this concern was not of a sufficient level to prompt any action, either in isolation or in the context of an apparent relationship with Mr J.
- Given that Mr J was no longer a patient of Mental Health Services and had been diagnosed as not having a treatable mental illness, together with the fact that Mrs A was deemed capable to make her own decisions, it remains that had staff been fully aware of the extent of the relationship between Mr J and Mrs A, it is unclear precisely what action health staff could have been taken regarding the relationship
- It was concerning that health care staff did not raise the alarm about Mrs A's whereabouts on 1 March 2010 for 24 hours having only attempted to contact Mrs A by telephone. We query whether the previous risks regarding Mrs A's history of self-harm should have resulted in quicker, more assertive action from health staff.

Chapter 3 Recommendations

Communication

3.1 Cardiff and Vale University Health Board must review their existing arrangements for ensuring good internal communications and jointly review information sharing protocols between themselves and other agencies such as police and the Probation Service, to ensure that information regarding the discharge of a patient subject to arrest warrant or probation supervision is shared and joint work in the release of a patient from hospital.

3.2 All statutory services to review their information sharing process in relation to individuals admitted to a mental health unit who are subject to an arrest warrant.

Cardiff and Vale University Health Board

3.3 Cardiff and Vale University Health Board should ensure that risk assessments are always embedded into the care plan process and used to fully inform the care treatment plan and management of a patient[25].

3.4 The movement of patients between wards should be reviewed by the Health Board to ensure that these movements are appropriate, integrated, seamless and that co-ordinated care is always provided to patients.

3.5 Cardiff and Vale University Health Board should ensure that provisions are made to implement a thorough, intensive and on-going training programme for its Mental Health staff in relation to personality disorder. All staff should receive a basic level of training, with higher levels of training offered to those staff members, including senior clinicians that require it.

[25] Cardiff and Vale University Health Board should refer to previous recommendation made in the Report of a Review in Respect of Ms A and the provision of Mental Health Services following a Homicide Committed in October 2005. Report Issued May 2008, Chapter 3, Paragraph 2 (b), Paragraph 3 (d).

3.6 Cardiff and Vale University Health Board's Mental Health Services should give consideration to their process for assessing the appropriateness of relationships between patients.

3.7 The Health Board's Mental Health Services should ensure that when a forensic opinion is sought, arrangements are put in place to ensure a timely response is provided by a forensically trained psychiatrist.

3.8 The Health Board should review its provision of services for patients diagnosed with personality disorder in line with NICE[26] guidance; people diagnosed with personality disorder should not be excluded from any health or social care services because of their diagnosis.

3.9 The Health Board should ensure that welfare checks for patients on home leave and have not returned to the ward by the expected time and date are carried out with urgency according to the level of risk presented by the patient.

Arrangements for the Probation Service and Police

3.10 The Probation Service should consider its arrangements in providing staff with adequate mental health training.

3.11 The Probation Service should consider reviewing their process of referring clients who appear to have mental health issues to health services.

3.12 Both services should give consideration to reviewing their processes in regards to the status of an arrest warrant. In particular they should ensure clarity over the status of the warrant and jointly share information.

[26] See: http://www.nice.org.uk/nicemedia/pdf/CG78NICEGuideline.pdf.

Welsh Government

3.13 In reviewing all-Wales arrangements for care, treatment and management of those suffering from mental health problems, the needs of those suffering from personality disorders should be addressed[27]. Welsh Government should refer to the recommendation made in the report in Respect of Ms A and the Provision of Mental Health Services following a Homicide Committed in October 2005, report published in May 2008 and note the similar issues that appear in this case.

3.14 In view of the issues arising in this case, Welsh Government should review access to Mental Health Services for individuals deemed homeless or have no fixed abode, with particular attention given to those not willing to register with a GP.

[27] Welsh Government should refer to recommendations made in previous reports; Report in Respect of Ms A and the Provision of Mental Health Services following a Homicide Committed in October 2005, report released May 2008, Chapter 3, Paragraph 1; Report in Respect of Mr C and the Provision of Mental Health Services following a Homicide Committed in October 2006, report released in October 2008, Chapter 3, Recommendation 14.

Appendix A

Review Terms of Reference

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

In taking this review forward HIW will:

- Consider the care provided to Mr J 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 between 28 February 2010 and 2 March 2010.
- Consider the care provided to Mrs A as far back as her first contact with Mr J whilst under the care of Health and Social Services to gain an understanding of the relationship between Mr J and Mrs A leading to the fatal incident.
- Review the decisions made in relation to the care of Mr J.
- Review the decisions made in relation to the care of Mrs A and the subsequent relationship with Mr J.
- Identify any change or changes in Mr J's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred between 28 February and 2 March 2010.
- Produce a publicly-available report detailing relevant findings and setting out recommendations for improvement.
- Work with key stakeholders to develop an action plan(s) to ensure lessons are learnt from this case[28].

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

Appendix B

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

In England and Wales there are approximately 57 homicides each year committed by people who were 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 10% of them have had contact with mental health services in the 12 months prior to the offence[29]

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

The reports of the independent external reviews feed into the wider review process of all such homicides in the UK 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 independent sector.

[29] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2011.

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

Appendix C

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

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

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

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. RCA has been adapted for use in the NHS by National Patient Safety Agency (NPSA).

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

Dr Jane Mounty – Consultant Psychiatrist
Mr John Murphy – Psychiatric Liaison Nurse
Mrs Ann Jenkins – Lay Reviewer
Mr Rhys Jones – Head of Investigations
Mr Leigh Dyas – Assistant Investigations Manager

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

- Examination of documents relating to the organisation and delivery of services by the Cardiff and Vale University Health Board and the Probation Service. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officers. We are grateful to the police for their collaboration.
- Reading the case records maintained by the Health Board, the Probation Service and Local Authorities concerning Mr J
- Reading interview notes and written statements provided by staff working with Mr J and Mrs A which was provided as part of the police or internal investigation processes.
- Interviewing key people particularly those with strategic responsibility for the delivery of services.

The information was processed by the HIW in-house investigation unit. In addition, all members of the review team read all the material generated by the review. The analysis stage was taken forward by the review team. Peer reviewers provided their own initial analysis of key issues. Following that the review team met to undertake a thorough analysis, driving its consideration through key issues to root causes using those techniques developed from the RCA elements drawn up by the National Patient Safety Agency. The conclusion of that process was to determine the extent to which systems or processes might be put in place to prevent further occurrences and the nature of those systems or processes. The results are set out in this report as findings and recommendation.

Appendix D

The Roles and Responsibilities of Healthcare Inspectorate Wales

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

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

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

Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

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

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

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

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