Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr N and the provision of Mental Health Services, following a Homicide committed in November 2014

March 2016

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

 WG28365 Digital ISBN 978-1-4734-6245-8

Contents

Chapter One: Executive Summary

1.1 On the evening of 5 November 2014 Ms J accompanied Mr N to his accommodation at the Sirhowy Arms Hotel, Argoed. In the early hours of 6 November 2014, Gwent Police received a telephone call from the owner of the hotel who reported that Mr N had attacked Ms J. Ms J suffered significant injuries and sadly died.

1.2 Shortly after his restraint and arrest by Gwent Police Mr N died. The circumstances surrounding his death are subject to ongoing Independent Police Complaints Commission (IPCC) investigation and Coroner inquest.

1.3 In February 2015 HIW was commissioned by the Welsh Government to undertake an independent external review into the care, medical history and events surrounding the homicide committed at the Sirhowy Arms Hotel, Argoed on 6 November 2014. The outcome of this review was to produce a publicly available report detailing relevant findings and setting our recommendations for improvement.

1.4 In taking this review forward HIW has considered the care provided to Mr N from health and social care services, reviewed decisions made in relation to the care he received and considered the effectiveness of multi-agency interfaces in the provision of care.

1.5 Mr N was the eldest of four brothers. His parents divorced when he was around 10 or 11 years of age and he remained living with his mother. He attended secondary school in Blackwood, Caerphilly until the age of 13 when he was expelled for fighting. Mr N subsequently resumed his schooling before leaving full time education at the age of 15.

1.6 From his adolescence Mr N was a prolific user of drugs. In August 1995 at the age of 15 he had contact with the Gwent Drug Misuse

Service and it was during contact with this service that he confirmed to staff that he had smoked cannabis from around 11 to 12 years of age. Throughout the remainder of his life he continued his relationship with drugs and other illicit substances, a relationship that was harmful and led to negative psychological and psychiatric effects.

1.7 Mr N was a prolific offender with a total of 26 convictions against 78 offences; 41 offences resulted in juvenile custodial sentences, followed by 14 offences resulting in custodial sentences in adult prison.

1.8 Mr N was first referred to mental health services in April 1997 when he had two informal admissions to Ty Sirhowy Acute Mental Health Inpatient Unit, provided by what is now the Aneurin Bevan University Health Board. The first admission on 16 April was a result of his presentation to police following his arrest and charge for burglary and attempted theft. This informal admission for assessment was on the basis that he remain drug free. However, two and a half hours later Mr N was discharged having found to be using cannabis.

1.9 Mr N's second informal admission occurred on 21 April 1997 at the request of his mother following a fight with his brother. Health records for this admission indicate no evidence of psychiatric illness and that Mr N was a heavy illicit drug user, with no intention on his part of giving up cannabis and amphetamines. Mr N was discharged the morning of 22 April when visited by his mother.

1.10 Mr N's first and only admission under the Mental Health Act (MHA) (1983) came in May 2004. He was initially admitted to Ty Sirhowy Mental Health Inpatient Unit on an informal basis for assessment following concerns raised by his partner. Questions were raised by clinical staff as to whether all the symptoms were drug induced or purely psychotic. Doubts were also raised regarding whether Mr N would stay and comply with treatment given the choice. Therefore on 11 June 2004 in order to better assess and observe his symptoms, a

decision was made by a Mental Health Review Tribunal (MHRT) to detain him under Section 2[1] of the MHA for assessment.

1.11 Mr N was discharged from Ty Sirhowy Mental Health Inpatient Unit on 5 July 2004 with a diagnosis of schizophrenia, having spent just over five weeks as an inpatient.

1.12 Following his discharge Mr N was the recipient of community care provided by a Caerphilly based Community Mental Health Team (CMHT). Over the next seven months Mr N met with a Community Psychiatric Nurse (CPN) and Psychiatrist, failing to attend one appointment in August with the Psychiatrist.

1.13 Mr N's contact with community care ended on 3 February 2005 when he was convicted of six offences and sentenced to five years imprisonment. Records are sparse regarding his whereabouts following this conviction; however, evidence indicates that he served time at HMP Channing Wood and HMP Dartmoor.

1.14 Mr N was remanded at HMP Cardiff on 8 December 2009 having been charged with burglary. Following a period on remand Mr N was released from HMP Cardiff on 22 December 2009.

1.15 Upon release Mr N was referred to the Caerphilly CMHT by the HMP Cardiff prison forensic mental health service and seen in January 2010. Mr N had multiple outpatient reviews with a CPN over the course of the year, however, it was decided to end the outpatient reviews in late 2010 as it was felt that Mr N was not presenting with any signs of psychotic illness.

1.16 From June 2011 to October 2014 Mr N spent over two and a half years of his life in prison. Whilst at both HMP Cardiff and Parc prisons Mr N

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

was the recipient of regular and well documented care from prison health services. A consistent approach was taken by health staff at both prisons in order to provide greater stability regarding his mental health.

1.17 Whilst at HMP Parc in July 2014, due to Mr N's intermittent compliance with medication, an absence of reported psychotic symptoms and Mr Ns overall presentation, a decision was made to stop Mr N's mental health medication and continue with regular monitoring to provide greater clarity regarding his diagnosis. During the period July 2014 to his release on 23 October 2014, Mr N functioned well, was employed as a prison barber and reported no ill effects.

1.18 As a result of having served his entire twenty seven month sentence in prison, Mr N was released from HMP Parc on 23 October 2014 without any statutory supervision. A discharge summary for Mr N's release from HMP Parc stated that upon his release no referral would be made to the CMHT in Caerphilly. This discharge summary was sent to Mr N's GP and Caerphilly CMHT for information. Mr N was in agreement that should any concerns arise with his mental health, he should go to his GP who would be able to make a referral to his local CMHT.

1.19 Following his release from prison, Mr N was deemed to be homeless therefore in need of accommodation. Mr N initially tried to gain accommodation in Newport to be near his father, however, he was unsuccessful as he could not prove an established connection to that area.

1.20 As a result, accommodation was secured for Mr N by Caerphilly County Borough Council, an area he had an established connection with, at the Sirhowy Arms Hotel. The Sirhowy Arms Hotel had been used by Caerphilly County Borough Council since 2008 as emergency bed and breakfast accommodation.

1.21 Once in the community, Wallich Homeless Charity staff, commissioned by the Council to provide help and advice to homeless and vulnerable people throughout the local area, met with Mr N to undertake an initial housing needs assessment. Following this initial assessment, Wallich staff attempted to further engage with Mr N but were unsuccessful.

1.22 Mr N spent fourteen days in the community before the serious and tragic incident of 6 November 2014. In the days leading up to the incident it was felt by those who had come into contact with Mr N that he was low in mood and pessimistic about his future but that he did not display any psychotic symptoms or signs of mental illness.

Our Conclusions

1.23 Despite his lack of inclination to engage with health services, Mr N did demonstrate a willingness to engage with a CPN on repeated occasions over periods of time in 2004 and 2010. During the last period of engagement with Mr N in 2010, the CPN formed the opinion that Mr N did not suffer from schizophrenia, instead believing Mr N to be suffering from a personality disorder. Unfortunately this opinion was never documented.

1.24 The period of time between late 2010 and October 2014 is dominated by Mr N serving various custodial sentences. As a result there is a scarcity of documented evidence for any care and treatment he received whilst in the community.

1.25 At a pre-release meeting prior to his release from HMP Parc into the community on 23 October 2014, Mr N presented as disinterested and unengaged when offered support with accommodation, employment or help addressing his substance misuse. Once back in the community Mr N, whilst not compelled to engage with this support, was aware that it was available to him. However, he remained disinterested and not willing to engage with the support available to him.

1.26 We found that there was a lack of a formal procedure in which Mental Health In-reach Teams (MHIRT) would be invited to a pre-release meeting at HMP Parc, and/or whether up-to-date information about an individual's mental health was shared with all meeting attendees. The sharing of such information in this case would have assisted with clarifying the reasoning behind Mr N's medication management, specifically the withdrawal of prescribed medication during his time at HMP Parc.

1.27 On 23 October 2014, having served his sentence fully, Mr N was released back into the community with no licence conditions having served his full sentence. He was released without medication and with the understanding that he could meet with his GP who would then arrange an appointment with the CMHT if required.

1.28 On 29 October 2014 Mr N went to South Street Surgery with the intention of obtaining a sick note. During this visit Mr N was asked about his mental health. He informed the GP that he had an appointment with his CPN and Psychiatrist at the CMHT. Mr N had no such appointments arranged. The GP concluded there were no concerns regarding Mr N's presentation and issued him with a MED3 doctor's note for a period of 4 weeks based upon his previous diagnosis of schizophrenia.

1.29 It is clear that Mr N proved a complex and challenging individual to supervise and support from a health perspective. Mr N demonstrated repeated poor compliance with various appointments and rarely complied with prescribed medication.

1.30 Contributory factors to the difficulty in engaging with Mr N included his frequent time in prison, his unstable accommodation arrangements, his reported feeling of being institutionalised and his erratic behaviour most often fuelled by his use of illicit substances.

1.31 During his time in both HMP Cardiff and HMP Parc prisons, Mr N was the recipient of regular and well documented care from prison health services. A consistent approach was taken by health staff at both prisons in order to provide greater stability and clinical knowledge regarding his mental health.

1.32 What is clear from his time in prison is that Mr N was inconsistent both in terms of his reported psychotic symptoms and his compliance with anti-psychotic medication. There were no reports of psychotic symptoms affecting Mr N's day to day functioning, with staff regarding him as a "*run of the mill prisoner*" and that did he not stand out. Healthcare records substantiate this, indicating that Mr N coped well within the prison environment, participating in leisure activities and holding several jobs.

1.33 Mr N's diagnosis of schizophrenia in 2004 was never re-evaluated, and indeed it is unclear, given his illicit drug misuse, whether this diagnosis can or should have been fully relied upon.

1.34 Schizophrenia is normally diagnosed when there is clear evidence of psychotic symptoms for a minimum of a month. Schizophrenia should not be diagnosed during states of drug intoxication or withdrawal. Drug induced psychotic disorders occur during or after substance use and symptoms can be very similar to schizophrenia, usually resolving within one month of being drug free. Schizophrenia will persist after one month unless treatment is provided.

1.35 The review team does not feel that a sufficient drug free period occurred during Mr N's admission assessment in 2004 for a diagnosis of schizophrenia to be confidently confirmed. The review team believes that it is more likely that he was experiencing drug induced psychotic episodes. Evidence indicates that Mr N's mental health improved if he remained drug free and that it deteriorated in line with his drug use.

1.36 No consideration appeared to have been given by health services to the rationale of prescribing Mr N medication given he demonstrated an unwillingness to comply. Mr N often denied psychotic symptoms and presented as functioning well whilst in prison, this was particularly the case during the last year of his detention.

1.37 With evidence indicating an absence of reported psychotic symptoms, history of substance misuse, intermittent compliance with medication and overall presentation, we believe that the decision to stop Mr N's medication in July 2014, and to continue regular monitoring to provide greater clarity regarding his diagnosis, was an appropriate one.

1.38 From the evidence reviewed, it is apparent that Mr N's return to his local area after his release from HMP Parc in 2014 would lead to a high risk of re-offending due to contact with criminal affiliates and access to drug dealers / users in the area. However, given Mr N was deemed homeless and the lack of available accommodation, the review team understand that there were pressures upon the local authority to find accommodation for Mr N. As such the decision was made to place Mr N at the Sirhowy Arms Hotel.

1.39 We were concerned to learn of the absence of risk information, such as an individual's prior offence, that was routinely shared by Caerphilly County Borough Council with the Sirhowy Arm Hotel or any owners of those providing accommodation. It was also unclear as to whether there was a well defined understanding of roles and responsibilities regarding the provision of health and social care between those providing accommodation and Caerphilly County Borough Council. Despite this we do not feel this to have been a significant factor in the incident that occurred on 6 November 2014.

1.40 Mr N was a complex individual, with clear evidence that he had drug induced psychotic episodes. However, despite his diagnosis of schizophrenia in 2004, there was insufficient evidence in recent years

of such an illness, more a vulnerability towards developing psychosis following drug consumption.

1.41 Between 2004 and the incident of November 2014, Mr N did not display typical schizophrenic symptoms. He did however require regular psychiatric support and monitoring over this time period. His history suggested that Mr N could be vulnerable outside of prison due to his continuing drug misuse, possible personality disorder and chaotic lifestyle. His use of illicit substances in a binge fashion was highly likely to continue, resulting in further psychotic episodes. HIW's review team therefore believe it is likely that Mr N required long-term psychiatric care and treatment.

1.42 It was generally felt that Mr N's presentation in the immediate days and weeks leading up to the incident of 6 November 2014, indicated he was low in mood, pessimistic about his future but without signs or symptoms of mental illness such as psychotic symptoms. The change in Mr N's behaviour at the Sirhowy Arms Hotel is likely to have been a result of his taking illicit and/or psychoactive substances and his severe reaction to this.

1.43 Despite this we believe it is difficult to see how the incident of 6 November 2014 could have been either predicted or prevented by health services.

1.44 Our review has not identified any significant root causes or factors that led to the unfortunate and tragic event of 6 November 2014. Whilst we did find areas for improvement relating to healthcare and support in the course of our review and these are highlighted by our recommendations, we do not believe that the presence of these issues contributed to this tragic incident.

1.45 As a result of this review we have made a number of recommendations for the relevant services which are detailed below. These

recommendations aim to ensure improvements within these services and assist with learning from this tragic event.

Recommendations

1. HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop a process whereby case formulation is routinely introduced and updated, as a prisoner moves from prison to prison and mental health care services. This supports and improves availability, continuity and sharing of information which helps clinicians understand and consider care and treatment planning programmes where appropriate, regarding longstanding and complex cases.

2. HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should ensure procedures are in place to check the rationale for prescribed medication, especially when an individual presents a history of non-compliance.

3. Welsh Government to review the provision and the availability of more structured interventions for individuals within the community that have both a personality disorder, mental health issues and substance misuse concerns.

4. Caerphilly County Borough Council should ensure that, where possible, a summary of risk is shared with managers of community accommodation with the permission of the individual being housed.

5. Caerphilly County Borough Council to take steps to ensure regular and appropriate communication with the managers of community accommodation to assist with awareness of roles, responsibilities and

any current or ongoing issues regarding individuals provided with accommodation.

6. Caerphilly County Borough Council should offer to provide training to the staff of establishments providing accommodation. Training would primarily relate to: illicit substances; prescribed medication needs; risk assessments; safeguarding issues relating to children and adults; mental health awareness; and break away/de-escalation techniques.

7. Stakeholders involved in prison discharge and aftercare planning such as local Community Mental Health Teams and Prison In-reach Mental Health Teams, should:

   a) ensure systems are in place to allow better sharing of healthcare information prior to discharge from prison. This would help ensure consistency and act as a protective measure against possible relapse in any mental health condition; and

   b) Prison In-reach Mental Health Teams and CMHTs to implement a voluntary follow-up appointment within one month of an individual's release from prison. The offer of such a follow-up appointment would help with consistency of care and help support any immediate care issues in an initial period of high risk.

8. Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop clear lines of accountability regarding the responsibility for attempting to engage with individuals who regularly do not attend appointments.

9. Stakeholders who have staff involved either directly or indirectly in, or with serious incidents, should have clear and confidential procedures in

place to offer them appropriate and timely psychological and trauma support services.

10. Stakeholders should ensure that support is provided, either directly or via signposting, to families affected by such incidents. Support should also include ongoing dialogue regarding investigation processes that enables the basis for mutual understanding and trust.

Chapter Two: The Evidence

Mr N's Family and Social History

2.1 Mr N was born in Newport, Wales on 3 December 1979, and at the time of the incident was 34 years of age. Mr N was the eldest of four brothers. His parents divorced when he was around 10 to 11 years of age and he remained living with his mother. He attended Primary school in Newport, and Secondary school in Blackwood, Caerphilly until the age of 13 when he was expelled for fighting. Mr N subsequently resumed his schooling before leaving at the age of 15.

2.2 Mr N had one significant personal relationship from 2003 until 2012. Mr N had one child as a result of this relationship and was a parent to his partners two other children.

Mr N's Criminal History

2.3 Mr N had a total of 26 convictions against 78 offences[2] against his person. 41 offences resulted in him serving juvenile custodial sentences, and 14 offences resulted in adult prison sentences. Some of these convictions included:

- One offence for assault occasioning actual bodily harm
- One offence for wounding with intent
- One offence for battery[3]
- Five offences against property
- Three offences relating to assaults upon police officers
- Three weapons related offences
- Fourteen offences relating to drugs
- Fifteen offences committed whilst on bail

[2] Police National Computer records
[3] See: http://www.cps.gov.uk/legal/l_to_o/offences_against_the_person/

2.4 The Police National Computer (PNC) highlighted Mr N as a prolific offender, with warning flags related to violence, weapons, escaper, mental health, drugs and offending on bail.

2.5 In October 1995, at the age of 15, Mr N received his first custodial sentence at a young offenders institution for a period of two years.

2.6 Most of Mr N's last two years of life was spent in both HMP Cardiff and Parc Prisons. On 4 February 2013 Mr N was sentenced to a 27 month custodial sentence on the charge of blackmail. Mr N was subsequently released on licence on 9 September 2013, spending 11 days in the community before he was arrested by police on 20 September 2013 for breaching his licence conditions[4]. Mr N returned to HMP Cardiff on 23 September 2013.

2.7 Mr N subsequently served his whole 27 month sentence in prison. This meant that on 23 October 2014 he was released without any statutory supervision. Mr N spent fourteen days in the community before the serious and tragic incident of 6 November 2014.

Mr N's history of contact with health services

2.8 Mr N voluntarily attended an initial appointment with Gwent Drug Misuse Service on 9 August 1995 when he was 15 years of age. This was a face to face appointment where Mr N advised a Support Worker that he had smoked cannabis from 11-12 years of age. Information indicates that Mr N had smoked cannabis on a daily basis for the three to four months prior to this appointment. However, Health records indicate that Mr N first used drugs at the age of 9, although it is not clear to what type of drug(s) this refers.

2.9 Mr N subsequently attended three further appointments with Gwent Drug Misuse Service on 21 August 1995, 5 September 1995 and 5

[4] The breach of licence condition related to an alleged burglary. This charge was subsequently discontinued by the Crown Prosecution Service (CPS) on 18th December 2013.

October 1995. These appointments ceased following his conviction for burglary and theft, upon which he was sentenced to a young offenders' institution.

Admission One

April 1997

2.10 In the early hours of the morning on 16 April 1997 Mr N was arrested and charged with theft of a motorcycle and attempted burglary. Due to his presentation, Mr N was admitted informally[5] to Ty Sirhowy[6] Acute Mental Health Unit after he had been assessed at Blackwood Police Station at the request of the police. Mr N was admitted for assessment on the basis that he did not take any drugs. However, two and half hours after informal admission Mr N was found using cannabis and was subsequently discharged.

Admission Two

April 1997

2.11 On 21 April 1997 Mr N was again admitted to Ty Sirhowy this time at the request of his mother following a fight with his brother. Health records available to the review team do not indicate the specific reasons in regards to his mental health for his admission. However, health records do state that there was no evidence of psychiatric illness and that he was a heavy illicit drug user. Furthermore, that Mr N had no intention of giving up cannabis and amphetamines. Mr N was discharged the following morning when his mother visited him. No specific follow-up was deemed necessary.

[5] A person is admitted **informally** when they want to receive treatment in hospital and agree to their admission. Such people are referred to as "voluntary" or "informal" patients. Voluntary patients can of course discharge themselves and leave hospital at any time without the agreement of staff. See: http://www.mentalhealthwales.net/mhw/hospital.php

[6] Mental Health Inpatient Unit. Responsibility in 1997 of Gwent Healthcare NHS Trust

2.12 In June 1997 a psychiatric report[7] was produced which found two possible diagnoses compatible with Mr N's behaviour in accordance with International Classification of Disease[8] (ICD10) published by the World Health Organisation WHO. These were:

a) Mental and Behavioural disorder due to multiple drug use and use of other psycho-active substances (F19); and
b) Emotionally unstable personality disorder – Impulsive type (F60.30)

2.13 The report also mentions Mr N's self-reported drug use, especially cannabis and amphetamines and that Mr N did not recognize that his drug taking was a problem because "*he enjoys the buzz he gets out of them*".

2.14 In June 1997 Mr N was convicted of three separate offences totalling 10 months to be served at a young offender's institution.

2.15 On 22 December 1997 a letter from Gwent Probation Service was sent to his GP Practice in Bargoed raising concerns about his health, stating "…*it was apparent that* [Mr N] *is distressed and hearing voices and erratic thoughts, which is effecting his behaviour*". Gwent Probation Service requested for Mr N to be referred to the relevant agency for assessment.

2.16 On 25 August 1998 Mr N was referred to Ty Sirhowy following a recommendation from the Gwent Probation Services. It is unclear from the notes available to the review team as to whether there was any interaction between Mr N and health services between these dates. An

[7] Psychiatric report prepared at the request of Abertillery Youth Court was produced in relation to a variety of charges

[8] The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems, proving a picture of the general health situation of countries and populations. See: http://www.who.int/classifications/icd/en/

appointment was offered on 19 October 1998, however, Mr N failed to attend.

2.17 A medico-legal report[9] prepared in 1999 whilst Mr N was remanded at HMP Cardiff concluded that:

"*Mr [N] suffers from Substance Abuse Disorder of a variety of illicit drugs. Regrettably [Mr N] was not motivated to give up his illicit drug abuse*"

"*[Mr N's] personality structure is dominated by his tendency to get involved in anti-social behaviour. His behaviour is partly constitutional, and partly motivated by drug abuse. It is not possible at this stage to predict the evolution of this behaviour with increasing age*"

"*[Mr N's] experiences of hearing voices did not conform to the hallucinatory experiences of people with a mental illness. However, it is advisable for him to have a contact with a Community Psychiatric Nurse in the future to observe any changes to his alleged experiences*"

2.18 Evidence available to the review team does not indicate that contact with a Community Psychiatric Nurse occurred

2.19 On 19 April 2000 Mr N's mother contacted the Ty Sirhowy raising concerns about his mental wellbeing with regards to him hearing voices, responding to voices and hallucinations. Ty Sirhowy then offered Mr N an urgent outpatient appointment for 20 April 2000. However, Mr N failed to attend this appointment.

2.20 As far as evidence available to the review team indicates, Mr N did not have any further contact with health services until May 2004.

[9] Medicolegal report prepared for Hugh James Solicitors, provided by Aneurin Bevan University Health Board

Admission Three

May 2004

2.21 On 29 May 2004, Mr N was admitted on an informal basis to Ty Sirhowy Mental Health Inpatient Unit for observations. This followed concerns raised by Mr N and his partner that *"he didn't feel real, he had green creatures crawling out of his hands".* Mr N was referred to Ty Sirhowy by an out-of-hours GP and was subsequently assessed by an on-call Senior House Officer (SHO). The patient admission form records that Mr N presented as a *"24 year old gentleman presenting with symptoms of psychosis i.e. thought disorder, hallucinations. Query schizophrenia[10] or drug induced psychosis."*

2.22 Mr N was admitted onto the unit and observations commenced at Level one[11] to enable further assessment. Mr N was under the care of a Consultant Psychiatrist and '*PRN medication only*[12]' was directed.

2.23 Mr N stated that he had an *"illicit drug problem with heroin in the past and abuses amphetamines now"*. During interview Mr N *"reported to be responding to non-visible stimuli, continually turning head, adapting listening stance…He appeared agitated, suspicious and apprehensive. Partner described auditory, visual and tactile hallucinations of green creatures crawling over his body and hands. Displayed thought block, and apparent thought broadcasting."*

2.24 Observations of Mr N continued on a daily basis with detailed clinical records being made twice daily, both am and pm. On 30 May 2004 Mr

---

[10] See: http://www.who.int/mental_health/management/schizophrenia/en/

[11] Levels of observation vary in precise details per organisation, however, can be broadly defined as:

- Level One (General Observation): Minimal acceptable standard applied to all patients
- Level Two (Intermittent Observation): Patient's location checked at regular intervals as specified with patient notes
- Level Three (Constant Observation): Used for patients who present an immediate risk to themselves or others
- Level Four (Close Proximity Observation): Used for patients who present a high risk to themselves or others

[12] PRN "pro re nata" Latin for "as the thing is needed"

N spent time with a primary nurse, and it was noted that he was experiencing *"hallucinations both auditory, visual and tactile"*[13]. He was given Lorazepam[14] and Haloperidol[15] and these were reported to have a good effect.

2.25 On 31 May 2004 Mr N described that the haloperidol had been helping him to reduce the experience of auditory, visual and tactile hallucinations. Mr N reported that he wished to go home, however he was persuaded to remain on the ward. During the afternoon of 31 May 2004 Mr N experienced an oculogyric crisis[16], and was prescribed procyclidine[17]. Mr N stated that this had happened on two previous occasions, once as an inpatient and once when in prison. During the consultation, clinical notes record Mr N being distracted and his conversation was deluded[18]. PRN lorazepam was given and Mr N stated that he felt much more clear in his thinking.

2.26 Clinical records show that Mr N was *"quite agitated and suspicious. Requested medication for anxiety",* and he was prescribed PRN Olanzapine[19]. At 23:40 hours on 31 May 2004 Mr N was unable to be located following a ward search. Mr N had left the unit after climbing through a downstairs window in a TV room. A missing persons procedure was initiated and relevant personnel informed. Mr N's partner was contacted who advised staff that Mr N had gone to her

[13] An Hallucination is an experience involving the apparent perception of something not present and can be visual, auditory or tactile and is normally associated with psychosis or drug induced psychosis.
[14] Lorazepam is in a group of drugs called benzodiazepines (ben-zoe-dye-AZE-eh-peens). It affects chemicals in the brain that may become unbalanced and cause anxiety. Lorazepam is used to treat anxiety disorders
[15] Haloperidol is an antipsychotic medicine. It works by changing the actions of chemicals in the brain. It is used to treat schizophrenia. It is also used to control motor and speech tics in people with Tourette's syndrome.
[16] Involuntary contraction of the ocular muscles resulting in fixation of the eyes in an extreme (typically upward-looking) position, persisting for seconds to hours. See: http://www.oxforddictionaries.com/definition/english/oculogyric-crisis
[17] Procyclidine is used to relieve unwanted side-effects caused by antipsychotic medicines.
[18] A delusion is a belief or impression that is held despite being contradicted by reality, or rational argument and logic, typically a symptom of mental disorder.
[19] Olanzapine. Antipsychotic medication, used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.

house. Concerns were raised by Mr N's partner that he had left her house to return to the unit but that he *"appeared quite bizarre."*

2.27 At approximately 00:15hours on 1 June 2004 Mr N returned to the unit. Clinical notes record Mr N as *"quite suspicious and paranoid stating he had gone to check that partner was alone. Agreed to stay on the unit."* Mr N's partner raised concerns with staff at Ty Sirhowy that he may have smoked cannabis during this time and that his brother was visiting Mr N at the unit with the intention of supplying him with vodka and drugs: cannabis and heroin. Mr N was seen and assessed by medical staff who prescribed PRN Olanzapine and Procyclidine and observations at level two were initiated, being every 15 minutes. Mr N was risk assessed as a *"mod (moderate) risk of suicide because of hallucinations".*

2.28 At 07:00hours on 1 June 2004 Mr N became agitated and wished to leave the unit to go for a walk. Staff recorded that they felt unable to stop Mr N from leaving due to increasing levels of aggression. Mr N left the unit for approximately an hour. Mr N's partner again raised concerns with staff that Mr N's brother and friends would bring alcohol and illegal drugs (heroin) into the unit and it was agreed that only Mr N's father and his partner would be allowed to visit him.

2.29 During the afternoon of 1 June 2004 Mr N complained of his *"inability to think clearly, thought block and poor concentration."* PRN medication was administered to Mr N for visual hallucination, *"green insects on skin".* It was noted that there was "*no inappropriate or aggressive behaviour*".

2.30 On 2 June 2004 a review of Mr N is recorded in the clinical notes, it states *"auditory hallucinations from behind him – sounds like his friends 'taking the piss'. Also visual hallucinations – thinks that objects being removed from vision. Initially quite agitated on ward, now feels calmer and able to control voices slightly better. Denies any drug use – only*

admits to taking ½ g amphetamine 3/52 ago. Known to have smoked joint of cannabis 1/7 ago and amphetamine 1/52 ago". Mr N was prescribed PRN Olanzapine and Chlorpromazine[20].

2.31 In the afternoon of 2 June 2004 Mr N was reported as acting *"vague and bizarre in content of conversation – unable to explain thoughts and feelings – stating he felt confused."* PRN medication was again given.

2.32 On the morning of 3 June 2004 Mr N requested PRN medication due to having further disturbed thoughts: *"Felt there were all crawly things on his face".* Clinical notes show Mr N's conversation in the afternoon of 3 June 2004 as being *"disjointed and bizarre. Appears paranoid and preoccupied and also appears to be experiencing auditory and visual hallucinations".* PRN medication was prescribed to Mr N at his request at 18:00hrs, however it is recorded that the medication had little effect.

2.33 Mr N requested to leave later that evening due to him not being able to handle smells on the unit and was persuaded by staff to remain until an on call SHO agreed to some further PRN medication. Mr N was later reviewed by medical staff and it was agreed for him to go on leave from the unit overnight until lunch time the following day. Olanzapine was prescribed prior to Mr N leaving the unit to stay with his partner.

2.34 Mr N returned to the unit lunchtime on 4 June 2004. Police attended the ward *"in connection with recent burglary on neighbouring house. Mr N was arrested at 14.00hrs and taken away to Blackwood custody unit for questioning"*. Mr N's mental state appeared stable at this stage and that his leave from the unit had gone well, *"with a reduction in symptoms".* Clinical notes record that three police officers attended the ward to search Mr N's belongings with regards to the burglary.

[20] Chlorpromazine. An antipsychotic medication used to treat certain mental or mood disorders.

2.35 Mr N was returned to the unit on 4 June 2004 by two police officers at approximately midnight. Staff at the unit were informed that Mr N had been charged and was on bail. Police informed the unit that "*he has been told that on no account must he go to his girlfriend's house and staff are to inform police and (his girlfriend) if he leaves the ward because she feels vulnerable/at risk"*. Police asked for more stringent observations to be placed upon Mr N. Clinical notes state Mr N was placed on Level three constant observations.

2.36 On the morning of 5 June 2004 clinical notes record that Mr N "*appeared disgruntled re constant obs*". The on-call SHO was contacted and agreed to come to the ward to review him. Mr N made a phone call and left the ward. A member of staff followed Mr N to a golf course in an attempt to persuade him to return. Mr N refused and threatened to take some drugs and take his own life; he then ran through the golf course to escape staff. The police were called due to the suicide risk.

2.37 The clinical notes record that the staff believed Mr N was a "*high serious suicide risk and police therefore agreed to look for him and pick him up on 136 MHA 1983*[21]". Mr N made contact with his family during the time he was absent from Ty Sirhowy. He was returned to the unit by his father where he stated that he had taken dihydrocodeine[22] and approximately £5 of heroin. It is recorded that his conversation was very disjointed and he was experiencing auditory and visual hallucinations and thought block. Mr N had "*very bizarre content of speech…also appeared unable to distinguish between reality and what was not real".*

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

[22] Dihydrocodeine. An opioid medicine used to treat moderate to severe types of pain.

2.38 Mr N was assessed by an SHO who noted *"No evidence of (illegible) hallucinations. Insight – No insight into mental illness. Thinks he is physically unwell. Plan – continue inpatient informally. Continue same medication. Level of obs II every 15 minutes".*

2.39 Clinical notes record that on 6 June 2004 Mr N continued to experience auditory hallucinations, in the form of a whisper. Mr N was prescribed PRN medication.

2.40 Mr N was reviewed by Doctor 1 on 7 June 2004. It was noted that he no longer had suicidal thoughts and his thoughts had improved as he was controlling them better. The level of observation dropped (from level two to level one) and Mr N was allowed to leave the unit with his brother for a few hours in the morning. Upon his return to the unit Mr N requested to leave the unit again with his brother to find a job. Clinical notes record that he was *"appropriate in conversation for the majority of discussion".*

2.41 Mr N left the unit with his brother at 16:30hours with an agreed return time of 22:00hours. He failed to return to the unit at the agreed time. SHO 1 was informed, however, it was concluded that nothing could be done as Mr N was an informal patient. Mr N's mother contacted the unit to advise that he was going between her house and his partners house and that he was *"behaving strangely and that he was abusive verbally towards her".* Mr N returned to the unit later that day and appeared *"highly delusional, paranoid and aroused. He denied substance abuse although staff noted dilated pupils and behaviour, traits bizarre."* PRN medication was prescribed by SHO 1, however it was recorded that it had little effect. Mr N became disruptive with other patients and staff had to intervene. The clinical records noted that Mr N was *"irritable, volatile and verbally hostile although some delusional ideas evident".*

2.42 On 8 June 2004 Mr N was seen by Psychiatrist 1 who recorded that Mr N *"feels people are playing games to read his mind. 3rd person*

derogatory hallucinations, running commentary, thought echo. Has some quite bizarre delusions regarding pictures in his mind and people controlling him…" Mr N remained on level two observations every 15 minutes and was prescribed and given Acuphase[23] at 15:30hours.

2.43 On the morning of 9 June 2004 Mr N walked out of the unit, acting in a confused manner. He was calmed down by staff and returned to the unit. Observations were continued at level two, every 15 minutes. At 15:10 hours Mr N approached staff presenting with stiffness in his jaw. Mr N had suffered a severe EPSE[24] Mr N was "*experiencing what appeared to be an acute dystonic reaction – unable to swallow and jaw disjointed, rigid trunk and neck*".

2.44 Mr N was seen by SHO 2 and procyclidine was prescribed to alleviate the effects of the medication. Clinical notes record that the plan for Mr N was *"avoid typical antipsychotic, monitor regularly…to be managed with quetiapine[25] for psychotic agitation".*

2.45 Information obtained from a Nursing Report[26] document records that Mr N requested to leave the ward on the morning of 10 June 2004 but was advised by staff to remain on the ward. Mr N was noted to be absent at 09:15 hours. He returned to the ward at 13.30 hours and agreed to stay, and he was placed under level three constant observations.

2.46 On 11 June 2004 documents indicate that Mr N's conversation appeared "*bizarre, talking about dead babies in his nose*". Subsequently Mr N was detained under section 2 of the Mental Health

[23] Acuphase. Injection for the initial treatment of acute psychoses including mania and exacerbation of chronic psychoses, particularly where a duration of effect of 2-3 days is desirable.
[24] EPSE. Extrapyramidal side-effect to an antipsychotic medication.
[25] Quetiapine. An atypical antipsychotic used to treat schizophrenia or bipolar disorder.
[26] Nursing Report in respect of Mr N dated 13 June 2004

Act (MHA) (1983) [27] for assessment[28]. The same day, Mr N applied to the Mental Health Tribunal to review his detention. At the mental health review tribunal on 18 June 2004 a decision was upheld to continue his detention for assessment under section 2 of the MHA (1983).

2.47 On 13 June 2004 the Nursing Report stated that Mr N *"presented as experiencing psychotic like symptoms stating that he was being 'controlled by his peers expressions and feelings"*.

2.48 Clinical records dated 14 June 2004 note that Mr N was *"psychotic, slightly agitated…abusing drugs…paranoid, preoccupied."* PRN Olanzapine was once more prescribed to Mr N.

2.49 A medical review of Mr N was carried out on 15 June 2004 and records him as being *"more insightful at the moment. He realised that there is something very wrong with him. Doesn't hear voices anymore but still believes people can read his thoughts and they are watching his eye. Admits to having bizarre delusions about his whole life from childhood. Obviously still not very well but willing to cooperate, happy to take tablets and remain on the ward for four weeks."*

2.50 On 15 June 2004 Mr N was granted 6 hours of Section 17[29] leave from the unit between 14.00 – 18.00 hours. A Section 17 Leave Form was signed by an Associate Specialist 1 for four hours to enable Mr N to spend time with his partner. Additional clinical notes record that following Section 17 leave on 15 June 2004 Mr N's behaviour was *"verbally threatening and abusive towards staff."*

---

[27] Section 2 of the MHA 1983 – can be authorised for those persons suffering from a mental disorder of a nature or degree that warrants their detention in hospital for assessment (normally 28 days) to decide whether compulsory admission is necessary under the MHA, in the interests of their own health or safety, or the protection of others.
[28] Following a decision made at a mental health tribunal that met on the 18 June 2004.
[29] Section 17 Leave. The responsible clinician may grant to any patient who is for the time being liable to be detained in a hospital under this Part of this Act leave to be absent from the hospital subject to such conditions (if any) as responsible clinician considers necessary in the interests of the patient or for the protection of other persons. See: http://www.legislation.gov.uk/ukpga/1983/20/section/17

2.51 Mr N had a further medical review undertaken by an SHO on 16 June 2004 where it was noted that he was *"slightly calmer today",* but that he was *"finding thoughts quite difficult to control at present".* Mr N's prescription for Olanzapine was increased.

2.52 On 17 June 2004 a report produced by Psychiatrist *2* which makes reference to the first meeting on 15 June 2004 between Mr N and Psychiatrist 2 records "*During the interview he appeared more insightful. He realised there is something wrong with him. He didn't appear preoccupied or suspicious or responding to any sort of hallucinations, although on admission he admitted to tactile visual and auditory hallucinations, but obviously treatment has ameliorated his symptoms. He admitted to believing that people can read his thoughts and they are watching his eyes. He also had some bizarre delusion about going back from his infancy up until now and seeing changing colours when he closes his eyes."*

2.53 A Mental Health Review Tribunal[30] (MHRT) met on 18 June 2004 to decide upon an application dated 11 June 2004 regarding whether to detain Mr N for further assessment under Section 2 of the Mental Health Act. Part of the evidence assisting the tribunal in forming their decision was a report produced by Psychiatrist 2. Within this report the conclusion stated:

"*...his current presentation, the fact that he is changeable, demanding to leave the hospital, his early non compliance with management and treatment and also going out and taking drugs, I believe we need to keep him on Section 2 of the Mental Health Act. There are many unanswered questions as to whether all the symptoms are drug induced or are purely psychotic, because if we can keep him away*

[30] A Mental Health Review Tribunal (MHRT) is an independent quasi -judicial appeal process set up in 2008 in England and Wales and exists to safeguard the rights of persons detained or subject to the Mental Health Act.

from drugs long enough and observe his symptoms then we can tell. I do not believe he will stay and comply with treatment if he was given the choice". Section 2 of the MHA was therefore implemented from 11 June 2004 in order to undertake assessment.

2.54 Clinical notes dated 19 June 2004 show that Mr N experienced psychotic like symptoms when on daily leave for six hours on the 18 June 2004. However when observed on the ward by staff, Mr N did not appear to be distracted or preoccupied.

2.55 Mr N was granted further Section 17 leave from the ward on 20 June 2004 and presented as pleasant and settled prior to leaving with his partner. However, upon his return to the ward Mr N stated that his symptoms worsened.

2.56 On 21 June 2004 a fellow patient on the ward notified staff that Mr N had been seen with drugs on the ward and was overheard making arrangements to collect drugs. Despite this allegation, no risks were identified and Section 17 leave was agreed for Mr N to spend time with his partner overnight.

2.57 Mr N returned to the ward from his leave on 22 June 2004 and his mental state was noted as normal. The Police had arranged with staff to visit Mr N that afternoon to speak to him about an alleged offence. However, at approximately 18.00 hours Mr N left the ward and refused to return.

2.58 He returned approximately one hour later with a fellow patient. An empty bottle of vodka was later thrown from Mr N's room; he was breathalysed and a reading of .55 BAC[31] was produced on the

[31] Blood Alcohol Content (BAC)

alcometer[32]. Mr N initially denied that he had consumed any alcohol and he threatened to leave.

2.59 On 23 June 2004 Mr N's behaviour was noted to be *"bizarre, in the context of being outside body".* He was prescribed PRN medication and it was further noted that he *"presented as confused, stating he couldn't remember things that were previously said to him, also thinks people are talking through him".*

2.60 Mr N was visited on 24 June 2004 by a former patient of Ty Sirhowy. Records state that Mr N was overheard arranging for cannabis to be brought onto the ward. Consequently Mr N was denied leave from the ward until he was reviewed medically.

2.61 On 25 June 2004 Mr N was reviewed medically and granted overnight leave with his partner. Medication was prescribed prior to Mr N leaving the ward.

2.62 On 26 June 2004 Mr N returned to the ward at lunchtime following overnight leave. Mr N requested to take time off the ward but was informed in the afternoon that the Police and his solicitor were due to attend the ward for an interview. Mr N was later observed climbing out of a window in the conservatory. He was met by staff in the car park who encouraged him to return to the ward, however Mr N left by running towards the town centre.

2.63 Mr N returned later that day to the ward with his partner and presented as tearful, and worried about the police. Staff later observed Mr N in the smoking room, and due to suspicions regarding the cigarette containing cannabis, questioned Mr N who stated that it did not contain cannabis.

[32] An alco-meter estimates blood and alcohol content indirectly by measuring the amount of alcohol in an individual's breath.

2.64 On 28 June 2004 Mr N's partner visited him on the ward and informed staff that *Mr N had smoked cannabis the previous night. Mr N was reviewed by Psychiatrist 2* who cancelled all leave until he could be reviewed by Psychiatrist 1. Mr N was recorded as having *"no insight"* following this review.

2.65 On 29 June 2004 Psychiatrist 1 reviewed Mr N and recorded that he *"still had symptomology but settled with it on olanzapine".* Section 17 leave was granted to return to the ward on 1 July 2004. Clinical notes record that Mr N returned to the ward and was "*low in profile*".

2.66 On 2 July 2004 Mr N was medically reviewed and notes show that Mr N *"denies any symptoms now. Pleasant and chatty".* He was given leave over the weekend with his partner and returned to the unit on 4 July 2004.

2.67 On 5 July 2004 Mr N was discharged from Ty Sirhowy. He was allocated a Community Psychiatric Nurse[33] (CPN 1) and outpatient appointments at the local CMHT were arranged for every 3-4 weeks. Mr N was prescribed Olanzapine[34], Lorazepam and Chlorpromazine. The discharge summary signed by the Consultant Psychiatrist confirmed Mr N's diagnosis as schizophrenia[35] F20.9[36].

Community Care: July 2004 – December 2009

2.68 Following his discharge from Ty Sirhowy on 5 July 2004, Mr N was the recipient of community care provided by a Caerphilly based CMHT. The first set of clinical records post his discharge, dated 19 July 2004, note that CPN 1 had visited Mr N at home "*x3*" (three times). On the second visit it was recorded that Mr N had been beaten up at a friend's

[33] A community psychiatric nurse is a psychiatric nurse who is base within the community rather than a psychiatric hospital
[34] Omne Nocte. Latin: every night
[35] See: http://www.who.int/mental_health/management/schizophrenia/en/
[36] World Health Organisation (WHO) classification of Mental and Behavioural disorders includes the common varieties of schizophrenia, together with some less common varieties and closely related disorders. See: http://www.who.int/classifications/icd/en/GRNBOOK.pdf

house. At this point in time, Mr N only had access to a GP through Maindee[37] Police Station due to challenging behaviour toward a GP with whom he was previously registered.

2.69 On 22 July 2004 clinical notes detail that a family session was held between CPN 1, Mr N and his partner. Mr N was not taking his medication, Olanzapine, and it was recorded that he *"felt more psychotic when he was taking it, than he does now."* The clinical notes record Mr N stating "..*he now knows what it is when his head goes mad, and he can handle it. He described how he was able to look at himself from outside, that his brain was like a recorder re-running previous conversations…He felt that his eyes were alive, but his body was dead."*

2.70 Mr N's partner believed that his psychosis was returning, and that Mr N was: *"mumbling to himself, having imaginary conversations. This is worse when he has smoked blow. (girlfriend) fears if she stops him using blow, he will go on to heroin, which she can't cope with."* Mr N stated that he would not use illicit drugs. It was recorded that his vulnerability to psychosis was discussed and the protection his medication, Olanzapine, provides him. Mr N agreed to re-start his medication.

2.71 Mr N failed to attend a CMHT out-patient appointment with Psychiatrist 1 on 19 August 2004.

2.72 CPN 1 telephoned Mr N's home as arranged on 7 September 2004 and was advised that he had been arrested the previous day and remanded in HMP Cardiff. Notes record that Mr N had allegedly got into a fight and attacked a male with a baseball bat. CPN 1 recorded that he contacted HMP Cardiff to notify them of Mr N's mental health problems.

[37] Maindee is an inner-city area in the city of Newport, south Wales, approximately 18 miles to south of Blackwood.

2.73 CPN 1 recorded on 23 November 2004 that he had seen Mr N on 9 November 2004. No psychosis was noted. Mr N had been in court the previous day and had contacted CPN 1 seven times on the telephone stating that *"his head is gone…thoughts and voices are touching him, he can hear own thoughts like real conversations".* Psychiatrist 1 was contacted and agreed with Mr N's solicitor to assess him if an adjournment of the court case could be arranged.

2.74 A medical review of Mr N was carried out by a Consultant Psychiatrist on 1 December 2004. It was recorded that Mr N had started to take his prescribed medication, Olanzapine, within the last two weeks, however, prior to that had not taken it for two months. Prior to restarting his medication Mr N stated that he had begun to experience auditory hallucinations and felt anxious, although since restarting his medication he had not experienced any symptoms.

2.75 Psychiatrist 1 wrote a letter dated 17 December 2004 advising Mr N's solicitors that he was fit to attend Court and stand trial: *"When I saw him he was able to concentrate for approximately an hour without much difficulty. If it really is necessary, could I suggest a 10 to 15 minute break every hour in Court. You may find that this is not necessary as his anxieties may reduce once he is actually in the Court."*

2.76 On 24 December 2004 Mr N was contacted by CPN 1. Mr N confirmed that he had been using speed[38], which resulted in him *"having thoughts he didn't know where they had come from."* Mr N had taken Olanzapine for a few days and as a result felt better. It was noted that the court case was due to start on 10 January 2005.

2.77 On 3 February 2005 Mr N was convicted of six offences and sentenced to 5 years imprisonment. The six offences were for "*Burglary and Theft*

[38] A class B drug amphetamine sulphate. A stimulant people take to keep them awake, energised and alert. See: http://www.talktofrank.com/drug/speed

– *Dwelling, Theft Act 1968 s.9(1) (b)*" and "*Wounding with intent to do grievous bodily harm offences against the person act 1861 s.18*".

2.78 Records regarding Mr N's whereabouts following February 2005 are sparse, however evidence[39] available to the review team indicates that he served time at HMP Channing Wood and HMP Dartmoor. A National Probation Service letter dated 21 August 2008 to CPN 1 stated: "*Whilst in prison, [Mr N] was felt to have mental health problems...looking at his probation assessment there is some suggestion that he may have been diagnosed as schizophrenic, linked to his drug use. He was released from Dartmoor on the 20 August 2008*..."

2.79 On 8 December 2009 Mr N was remanded at HMP Cardiff. Documentation for reception screening showed Mr N had been charged with burglary. He stated that he had been in HMP Dartmoor 17 months ago, that he had used cannabis within the last 12 months and that he had previously received medication for mental health problems in the form of Olanzapine.

2.80 A letter dated 18 December 2009 was sent to CPN 2 from Psychiatrist 4, both members of the HMP Cardiff In-reach Team. In this letter Psychiatrist 4 stated that he reviewed Mr N on 17 December 2009 whilst he was awaiting sentence for the charge of burglary. The letter states that Mr N "...*had a history of possible psychotic illness in the past and certainly he did receive a diagnosis of schizophrenia in April 2004...he has also been prescribed olanzapine previously. In interview he told us that he was currently not bad and that he was just 'getting on with it'. He gives no clear history of rank symptoms but he does appear to have an ongoing history of very strange intrusive experiences which he has difficulty describing...he describes them as 'premonitions' and he also gives a history of occasional paranoid ideation and other*

[39] Self reported to clinical staff by Mr N.

intrusive thoughts...Subsequent to this he has agreed to start a trial of antipsychotic medication in the form of quetiapine..."

2.81 Mr N was released from HMP Cardiff following a period on remand on 22 December 2009.

Community Care: 2010 onwards

2.82 On 14 January 2010 Mr N was referred to the Caerphilly CMHT by prison forensic services and was seen at home by CPN 1. Clinical notes stated: "*[h]as continued to have psychotic symptoms, believes he is changing colour, believes he can read peoples thoughts, can't sleep at night, felt better when prescribed something in prison, doesn't know what, but it also gave him akathisia*[40]*. Recent conviction for breaking into shop when he disappeared from family home, to sort his mind out. Hears derogatory voices, tries to ignore them. Feels people are against him. Girlfriend says he is ok when at home – it's under control*". The notes stated that Mr N was to start on Olanzapine 10mgs nocte[41].

2.83 On 18 January 2010 CPN 1 recorded that Mr N had received his prescription for Olanzapine and that Mr N reported symptoms of psychosis, specifically that: "*...he can't sleep, thinks he's changing colour 'sits there getting angry', can see something around people, can read people's minds, sees fluorescent see through images, hear talking at the back of my mind, derogatory content*". The notes state that Mr N had an appointment scheduled with the probation board[42] Doctor.

2.84 On 4 February 2010 CPN 1 saw Mr N at home who reported that Oanzapine is not too bad and he complained of a feeling that he had in his feet, like they're being tickled. CPN 1 questioned whether this was

[40]Akathisia is a movement disorder characterised by an inner feeling of restlessness and a compelling need to be in constant motion as well as actions such as rocking while standing or sitting, lifting the feet as if marching on the spot and crossing and uncrossing legs while sitting. See: http://www.medicinenet.com/script/main/art.asp?articlekey=33264

[41] Latin term meaning 'at night'.

[42] Notes are not clear in terms of stating the exact Board referred to, however, given the available evidence it is the review teams belief that it is the Probation Board

Akathisia before noting that Mr N reported: "*[t]he other things (i.e. psychotic symptoms) are just the same*".

2.85 On 22 February 2010 CPN 1 recorded that he received a call from a probation officer informing him that Mr N had split from his partner and was staying with his mother whilst he sought housing advice. CPN 1 spoke to Mr N's mother who reported that he was paranoid about his partner and that he had not been taking his medication as he reported that it didn't work.

2.86 On 4 March 2010 Mr N did not attend an appointment with CPN 1.

2.87 On 30 April 2010 CPN 1 attempted to contact Mr N on two occasions but without success. CPN 1 contacted Mr N's partner who alleged that Mr N had assaulted her and her daughter and that Mr N was subsequently not allowed access to her daughter. Mr N was offered a walk-in clinic appointment via his partner with CPN 1 and Psychiatrist 3 but did not attend, as a result the social worker was informed

2.88 Whilst it is not apparent from the evidence available to the review team when the domestic incident actually occurred, evidence does indicate that it was either on, or prior to 30 April 2010. Once the domestic incident was reported, arrangements were taken toward the scheduling of a child protection review conference and involvement of representation from multiple agencies, including that of a social worker.

2.89 On 11 May 2010, as a consequence of Mr N's alleged assault, the child protection conference was held and the children put on the protection register. Clinical notes that reference the child protection conference go on to state "*Mr N is seen urgently to sort medication. Out-patients arranged*."

2.90 On 13 May 2010 Mr N attended a walk in clinic with Psychiatrist 3 who recorded that Mr N was: "*experiencing hallucinations, thought isolation*

and withdrawal. Smoke cannabis daily...stopped olanzapine [of] own accord about Jan' 10. Prior to this was taking off and [on] since release from prison in Aug' 08...not keen to take medication. Denies any thoughts of self harm. Plan: Abilify[43] *10mg OD – f/u 2/52*."

2.91 On 25 May 2010 CPN 1 records within the clinical notes that Mr N "...*has not started taking abilify tablets as fears getting side effects of leg movement. Is not keen to take medication. [Girlfriend] not keen [for him] to take medication either, says she only had to get help for him once in 2004*."

2.92 On 7 June 2010 Mr N was invited to attend a care plan and review meeting with Gwent CMHT staff CPN 1 and Psychiatrist 2. Whilst the care plan is not clear in terms of whether Psychiatrist 2 attended, it is clear that CPN 1 was in attendance to conduct the review with Mr N. The review plan for this meeting states that "*since release from prison, no breakdown in mental health, but incident of assault against daughter. Had side effects from olanzapine, wont take abilify in case side effects return. Symptoms under control, childcare team involved*".

2.93 On 27 August 2010 the records state that CPN 1 was unable to contact Mr N. CPN 1 contacted Mr N's partner twice on the same day to try and see if Mr N was okay.

2.94 On 9 September 2010 CPN 1 notes that the "...*subgroup recommend deregistering"*[44] In terms of Mr N's mental health presentation, CPN 1 notes that he was *"…not getting many strange experiences, working through job centre to start painting and decorating business with friend. Advice re[garding] cannabis given*".

[43] An antipsychotic (Aripoprazole). See: http://www.drugs.com/abilify.html
[44] Deregistration. Relates to whether the Child Protection Review Conference decides the basis continuing to require a Child Protection Plan or not. Such a decision is based on the views of all agencies represented at the Review Conference

2.95 During our fieldwork CPN 1 stated that following multiple outpatient reviews it was decided that Mr N was not presenting with any signs of psychotic illness and was subsequently discharge from his case load. CPN 1 stated that he believed Mr N's principle mental health difficulty was personality disorder. CPN 1 stated that as he provided an early onset psychosis service and did not offer personality disorder treatment, he could not offer continuing support to Mr N in the community.

Prison Care – 2011 Onwards

2.96 In early June 2011 Mr N was convicted of obstructing powers of search for drugs under section 23 of the Misuse of Drugs Act 1971 and for assault of a police officer under section 89 (1) of the Police Act 1996. Mr N was remanded at HMP Cardiff and during his reception screen stated that he had previously received medication for mental health problems in the form of Olanzapine 25mg, which he last took one year ago. Evidence available to the review team indicates that the last instance of when Mr N received medication was in May 2010, receiving 10mg of Abilify at a walk in clinic.

2.97 On 23 September 2011 Mr N was released from HMP Cardiff back into the community. Information for this period, as provided by HMP Cardiff in-reach mental health team, specified that up until 17 August 2011 Mr N had completed four counselling sessions, however, details of the exact nature of these sessions was not given.

2.98 Following his release back into the community, information available to the review team was sparse prior to his being placed in custody at HMP Cardiff on 6 July 2012. Mr N's placement into custody related to offences that concerned an assault on a police officer and resisting or obstructing two other police officers. Mr N was subsequently convicted of these offences on 8 August 2012.

2.99 On 6 July 2012 Staff Nurse 1 at HMP Cardiff records that Mr N had: "*no thoughts of deliberate self harm or suicide, good eye contact and conversation. Known history of schizophrenia, states that he does not hear voices any more, also has flashbacks of pictures. States that he is coping okay at present, but due to a recent relationship breakdown feels he needs further mental health support from In-reach*". The record notes that Mr N had a history of benzodiazepine, amphetamine, methadone, cannabis and crack cocaine misuse and that he had used drugs in the last month. A referral to the mental health in-reach team and for a mental health assessment was also noted.

2.100 On 13 August 2012 Mr N failed to attend an appointment with the GP Locum. In fact throughout his time at both HMP Cardiff and subsequently HMP Parc (August 2012 to October 2014) Mr N failed to attend a further 27 appointments. These appointments were a combination of GP Clinic, In Possession (IP) medication[45] reviews, Physio, Dental, Triage Clinic and Standard Health Screening (SHS) appointments.

2.101 On 26 September 2012 Mr N was discussed at the prison In-reach team meeting and a decision made that he would be added to the In-reach caseload of both CPN 2 and Psychiatrist 4.

2.102 On 27 September 2012 information was received that confirmed Mr N was closed[46] to both Ty Sirhowy and north Caerphilly CMHT.

2.103 Mr N failed to attend two previous appointments with CPN 2 who finally saw him on 16 November 2012. Mr N was recorded as appearing pre-occupied and agitated, stating: "*I need someone with similar experiences who I can spend some time talking through my problems and that is the reason I want to share my cell with another inmate...*"

[45] In-possession medication refers to prisoners who, following an In-possession medication risk assessment, are given responsibility for the storage and administration of their medication
[46] Closed/discharged due to a combination of missed appointments (a consequence of time in prison) and period of time since last contact.

However, Mr N was recorded as high risk and the decision made to have him remain in a single cell. This decision was based upon a previous record of Mr N "*…getting stressed out with having different cell mates all the time and some were winding me up*".

2.104 On 7 December 2012 CPN 2 saw Mr N who: "...*denied any psychotic symptoms and nil presented with any affective symptoms. Also denied any suicidal ideations*..."

2.105 Whilst in remand HMP Cardiff, Mr N appeared before the court on 4 February 2013 and was sentenced to a 27 month custodial sentence on the charge of Blackmail.

2.106 On 8 February 2013 Mr N was seen by CPN 3, a member of the prison In-reach mental health team. It was noted that: "...*he has not taking [sic] his olanzapine medication for the past few nights, as he was having side effects from this, pain in his legs, was finding it difficult to sleep due to this*".

2.107 On 11 February 2013 Mr N was transferred to HMP Parc and was seen by Mental Health Nurse 1 who recorded that Mr N had a previous diagnosis of schizophrenia/psychosis and that Mr N "*denied auditory hallucinations currently*".

2.108 Following an appointment with GP 1 on 4 March 2013 the patient notes stated: "...*has been on olanzapine since the age of 15 according to patient – he states that this is because of 'schizophrenia' – in my opinion a more likely diagnosis is one of drug induced psychosis*". It was also recorded that Mr N reported complaints about the side effects of Olanzapine and was therefore prescribed Quetiapine as an alternative by GP 1.

2.109 On 7 March 2013 GP 2 saw Mr N who described his symptoms when unwell, including: "...*my thoughts are not my own, every day I learned*

to block them out, believe I have peoples thoughts off them – have it all the time, every day – see them coming like pictures, drain me" Mr N was unable to give clear examples. Furthermore it was noted that Mr N had a previous diagnosis of schizophrenia but that this needed to be clarified with Ty Sirhowy and Aneurin Bevan Health Board medical records.

2.110 GP 2 recorded on 21 March 2013 that Mr N's diagnosis was probable schizophrenia but "*awaits information from Ty Sirhowy, Gwent*" as such information had yet to be provided since originally stated as required on 7 March 2013.

2.111 Records from 22 March 2013 indicated that further information was requested regarding Mr N's past involvement with psychiatric services. Records of the same day went on to state that: "*Has an OPA*[47] *letter from 2010 Has never been seen by* Psychiatrist 1 *as DNA'd appointments Last seen by* Psychiatrist 3 *2010*". The records also note that based on the information received from the original 7 March 2013 request, that Mr N reported to CPN 1 that he "...*always found medication and services to be unhelpful*".

2.112 On 26 March 2013 Mr N was seen by prison in-reach mental health team. Mr N requested to have prescribed medication in his possession. However, *Mental Health Nurse 2* noted that: "...*he has been non concordant for the past few days – wing staff tell me that they ask him daily to attend for medication – but he states he does not want it*..." *Mental Health Nurse 2* went on to state that they were unlikely to support in possession medication at that current time, and requested that Mr N "…*show some level of commitment regarding compliance*…" before the matter would be discussed again in the following weeks.

[47] Out Patients Appointment (OPA)

2.113 On 30 April 2013 Mr N was again seen by the prison in-reach mental health team. Clinical notes indicated that Mr N was pleasant on approach, made good eye contact and relayed that his mental health was settled, denying any FTD[48] or other psychotic presence.

2.114 On 30 May 2013 Mr N was seen by GP 2 and Doctor 2. It was noted that Mr N relayed symptoms such as: "...*used to have his thoughts blocked. Used to think game being played and felt skin being touched*". Mr N reported that outside prison he had been involved in cage-fighting and going to the gym. In regards his previous diagnosis the record stated: "*Previous diagnosis schizophrenia. Been on lots of medication – Olanzapine, Abilify, Quetiapine (600mg). Now on quetiapine 300mg but can't be bothered to stand in queue to get medication*".

2.115 Mr N was seen on 30 July 2013 by Mental Health Nurse 3. Mr N was due to be released on-licence[49] in 6 weeks time and the notes recorded that if his mental health deteriorated that a GP could refer him to the local CMHT services. The notes also state that Mr N denied any problems with visions and that he appeared to be functioning well.

2.116 In advance of his forthcoming release from prison on-licence Mr N was discussed on 2 September 2013 at a Domestic Abuse Conference Call (DACC)[50]. Separately the Multi Agency Risk Assessment Conferencing (MARAC)[51] notes indicate that a marker[52] was placed on the address of his partner and that Children's Services were updated regarding his release from HMP Parc.

[48] Formal Thought Disorder (FTD) - An acknowledged symptom of a psychotic disorder
[49] See: https://www.gov.uk/leaving-prison
[50] See: https://www.gwent.police.uk/advice-and-guidance/victims-of-crime/domestic-abuse/the-role-of-policing/daily-conference-calls/
[51] A local, multi-agency victim focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector organisations. See: https://www.gov.uk/guidance/domestic-violence-and-abuse
[52] A police marker can be placed on an address so police officers are aware to go to the home as quickly as possible if a call is made to the police for assistance

2.117 On 3 September 2013 additional licence conditions associated with the Prolific and other Priority Offender (PPO)[53] scheme were added, one of which was a drug testing requirement.[54]

2.118 On 10 September 2013 Mr N was released from HMP Parc and upon arrival at approved accommodation was intoxicated and refused entry by the accommodation owner. Alternative accommodation was sought and Mr N placed at a the Sirhowy Arms Hotel (where his brother also currently resided).

2.119 On 16 September 2013 Mr N attended a supervision appointment with his Offender Manager but did not appear to have taken his Quetiapine medication. Mr N stated that he had forgotten to pick up his medication on the previous Friday (13 September 2013) but that he had subsequently collected and taken his medication up until 15 September 2013. The Offender Manager noted: "...*there wouldn't have been enough medication for this to be the case if Mr N was taking the tablets as advised*".

2.120 Mr N's mother also attended the supervision appointment and explained that Mr N had not been taking his medication as he should have been. The Offender Manager subsequently agreed to chase further support for Mr N with his GP.

2.121 The Offender Manager contacted the north Caerphilly CMHT directly who confirmed that Mr N needed to be referred by his doctor (*GP*) to the CMHT for assessment. Furthermore the CMHT reported that Mr N was last seen by them in February 2011 but had failed to keep his appointments so his case was closed.

[53] The PPO scheme is a partnership between probation, police, local councils and other community organisations targeting these most prolific offenders. Prolific offenders are identified as having a long history of offending, with 30 or 40 convictions.
[54] This determined that as required by a probation officer, Mr N was to provide a sample of oral fluid / urine in order to test for specified Class A Drugs (for example heroin or cocaine).

2.122 On 19 September 2013 intelligence was received by probation services indicating that Mr N had breached his licence conditions in regards to making contact with his step-daughter and also his misuse of substances. Mr N also failed to attend a supervision appointment with the offender manager the same day.

2.123 On 20 September 2013 Mr N's family informed the Offender Manager that Mr N had not been taking his medication and been using amphetamine, mephedrone, benzodiazapine and drinking alcohol daily. Furthermore that he had been aggressive to immediate family members and had turned up to one family member's workplace in a chaotic state.

2.124 Due to him breaching the terms of his licence, Mr N was recalled to HMP Cardiff. At the point of recall on 23 September 2013 Mr N had in his possession 20 Quetiapine tablets from a prescription of 30 given on 13 September 2013. Had Mr N been taking his medication as prescribed he would have had 23 tablets left at the point of recall.

2.125 On 24 September 2013 HMP Cardiff Staff Nurse 1 noted, within the patient records, information regarding a mental health review. Within this information Staff Nurse 1 included reference to Mr N's self reported symptoms, in which he stated: "...*that it means seeing pictures and deja vu*[55]". It goes on to state that upon first impression: "...*it appears the issue may be personality based rather than major mental illness, as he didn't really understand medication or what symptoms he should be suffering to get schizophrenia diagnosis*".

2.126 On 4 October 2013 HMP Cardiff CPN 2 recorded that Mr N was unhappy at being recalled, furthermore that: "*I could do with a bit of help and support out there after having been released from Parc*

[55] Déjà vu from the French, meaning the phenomenon of having a strong sensation that an event or experience currently being experienced has already been experienced in the past.

Prison...I wasn't referred to com[munity] MH team and I needed their help too after having problems with my partner and being made homeless". Mr N stated that he felt Quetiapine was better than Olanzapine. When CPN 2 questioned him about his substance misuse, Mr N insisted that he had stopped taking drugs about a year ago and had no intention of restarting. However, concerns were raised by the Offender Manager to CPN 2 that Mr N failed to attend drug testing appointments in the community thus breaching licence conditions. Mr N also reported to CPN 2 that he doesn't always disclose psychotic symptoms to staff for fear of being sectioned under the Mental Health Act as it had happened before. Mr N reported that he told staff everything was fine when it may not have been, using the gym and being a cage-fighter to release his stress and anger.

2.127 On 11 October 2013 Mr N was seen by Psychiatrist 4, a member of the prison In-reach mental health team. Psychiatrist 4 recorded Mr N as having no evident symptoms and "*taking Quetiapine, but [Mr N] requests follow-up*" as he was keep to accept help. This follow-up referred to Mr N's local CMHT as he was scheduled for release from HMP Cardiff on 17 October 2013.

2.128 On 17 October 2013 Mr N was released from HMP Cardiff and immediately rearrested at the gate of the prison for charges that related to burglary.

2.129 On 1 November 2013 Mr N was seen by CPN 2, a member of the prison In-reach mental health team. Mr N reported feeling aggrieved with Offender Supervisor 1, believed they had set him up to fail before he was due to be released from prison, this belief stemmed from his view Offender Supervisor 1 had put too many restrictions on him.[56] Mr

[56] Mr N stated these restrictions as being "…I could not go to my father in Newport, I had plans to join his business and stay with him, so right from the start [Offender Supervisor 1] didn't support my plans"

N also reported feeling bored in his cell and requested a job to keep occupied.

2.130 Aneurin Bevan University Health Board (ABUHB) records noted that North Caerphilly CMHT CPN 4 contacted Mr N's mother in response to the referral made 11 October 2013 but was informed that Mr N had been returned to prison. No further action was taken by North Caerphilly CMHT regarding this referral.

2.131 On 2 December 2013 CPN 2 saw Mr N in his cell and recorded that he appeared flat in mood which was appropriate to his circumstances but no psychotic symptoms were reported.

2.132 On 6 December 2013 Mr N was released from HMP Cardiff on the charges relating to his arrest on 17 October 2013 for burglary. Mr N was immediately rearrested at the prison gate for charges that related to conspiracy to commit burglary.

2.133 On 18 December 2013 during a prison visit by Offender Supervisor 1, Mr N confirmed that he had stopped taking his medication as "*he wanted something in his personality to change*".

2.134 CPN 2 and Team Manager 1 (TM 1) saw Mr N on 18 December 2013. TM 1 expressed concerns that Mr N was: "...*not taking his px'd*[57] *Neuroleptic meds".* Mr N had apparently had a fight with other inmates although Mr N denied this, furthermore Mr N reported his belief that staff were singling him out.

2.135 Mr N was seen by GP 4 on 29 January 2014 and noted that he had stopped taking his medication a month prior to their meeting, reported that he felt well, not depressed, with no self harming thoughts and was alert. GP 4 noted no evidence of a thought disorder. The records stated

[57] Prescribed

that Mr N had a history of substance misuse and had been using on the wing, "...*has been snorting subutex*[58]*...using it for the last two months or so*". Mr N stated to the doctor that "...*he did dabble with it [in the past] but this time feels he is using a lot more*". The notes continued, stating: "*15 years ago he did have an injection habit of mainly amphetamine – but he did kick the habit, never overdosed. All Opiate misuse has been inside prison, didn't use outside prison though while he was out*".

2.136 The records made by GP 4 noted his previous diagnosis by Psychiatrist 1 whilst at Ty Sirhowy and that a request had been put in: "...*to chase this*". Mr N had at this point stopped taking Quetiapine as: "*doesn't get any symptoms at the moment – not had any symptoms for the last month. Usual symptoms are impulsive thoughts which lead to reckless behaviour, and he tends to feel quite paranoid. Denies that this is anything to do with drug induced psychosis but that is a primary diagnosis from psychiatrists. Doesn't want to take anything for it at the moment though*".

2.137 A mental health SHS was completed on 4 February 2014 where Mr N stated he had no mental health problems. It was noted that Mr N had not taken his Quetiapine for some time. He had been seen by his GP on 29 January 2014 and Mr N had indicated that he did not want to take medication at the moment.

2.138 On 11 February 2014 Mental Health Nurse 4 recorded within the patient record that whilst Mr N had previously stated (29 January 2014) that he did not want medication, Mr N subsequently during this appointment he expressed concerns with not having his medication.

[58] Subutex is used to treat opioid dependence. See: http://www.drugs.com/cdi/subutex.html

2.139 Mr N was seen by HMP Parc Psychiatrist 5 on 26 February 2014 and although Mr N reported feeling stressed, he reported no re-emergence of psychotic symptoms.

2.140 Mr N did not attend his In-reach mental health team appointment on 26 March 2014 with Psychiatrist 5 nor his In Possession (IP) Medication appointment on the same day. Mr N's Quetiapine medication was ended as the course had finished.

2.141 On 15 April 2014 Mr N was seen by Mental Health Nurse 2 it was recorded that Mr N: "...*was pleasant and appropriate on approach, full range of facial expressions and good rapport easily established. Mr N told [Mental Health Nurse 2] that his mental health has settled somewhat, and stated that he was not experiencing any adverse effects from recommencing prescribed antipsychotic medication*". Mr N was told about a 'voice hearing' group and despite him saying that he would join the group, he did not attend.

2.142 Mr N did not attend his original In-reach mental health team appointment with Psychiatrist 5 on 21 May 2014, instead he was seen later that morning at a rescheduled appointment. Mr N reported no auditory hallucinations but did state that he was feeling paranoid. As a result his Quetiapine prescription was increased[59]. It was also noted that there was a need to be sure that Mr N was not abusing illicit substances given apparent sedated manner during this appointment. Mr N stated that this was a result of sleeping before the appointment.

2.143 On 16 June 2014 an email from Offender Supervisor 2 to Integrated Offender Manager 1 stated that Mr N had "…*been placed on report for damaging prison property[60], being absent from his cell and regurgitating his medication or using other meds*".

[59] Increased from Quetiapine 300mg modified release tablets to 400mg. See Annex B
[60] Pulled a notice board off a wall

2.144 On 17 June 2014 Mr N was seen by HMP Parc Mental Health Nurse 3 and reported feeling stressed and angry as a result of losing his job[61]. Mr N stated that he lost his job as a result of supplying drugs which he denied. The record indicated that he completed anger management courses in the past, however, when Mental Health Nurse 3 offered to find out if any new courses were being run by HMP Parc for him to attend, he declined the offer.

2.145 Mr N was seen by Mental Health Nurse 3 on 1 July 2014. Mr N said that he believed his medication had been doing nothing for him and it was noted that he did not present with any concerning behaviour, that he was relaxed and had good eye contact. Mr N was noted as having started a new job taking apart old computers.

2.146 On 16 July 2014 Mr N was seen by Psychiatrist 5. Mr N had apparently not been taking his medication for a few days and had reportedly been missing doses for some time. Psychiatrist 5 noted a range of positive behaviours: "...*he denied hearing any voices and did not report any strong paranoid thoughts and in fact is functioning quite well*". Mr N requested a longer drug free period.

2.147 The patient record from 5 August 2014 indicates that following discontinuation of his medication, Mr N met with Mental Health Nurse *3* and reported no psychotic symptoms.

2.148 Mental Health Nurse 3 saw Mr N on 26 August 2014 and noted that there were no concerns in relation to visual hallucinations or unusual thoughts.

[61] Evidence available to the review team does not clearly identify the job this refers to. At varying points of his time in prison Mr N was employed in the Amenities Room, Wing Cleaner and Barber.

2.149 On 27 August 2014 Mr N reported to an Offender Manager that he felt that he needed medication. This information contradicted the information he had shared with the prison in-reach team.

2.150 On the same day a pre-release sentence planning meeting took place with Offender Management Services. Discussions were held regarding suitable accommodation for Mr N upon release.

2.151 Mr N was seen by Mental Health Nurse 3 on 19 September 2014 and it was noted that no concerns were evident. Mr N had been without medication for a substantial period and that there had been no reported ill effects.

2.152 On 26 September 2014 Mr N was seen by Mental Health Nurse 3 and Psychiatrist 5 who noted that there were no signs of psychosis. The record noted that the CMHT had not been involved with Mr N since 2010 and that he was currently evidencing a 'high level of functioning' as evidenced by his employment as a prison barber. Mr N was told that following his forthcoming release on 23 October 2014 he could meet with his GP who could then arrange an appointment with the CMHT if required.

2.153 On 3 October 2014 discussions between an Offender Manager and a probation Team Manager were held to discuss accommodation arrangements for Mr N.

2.154 The Offender Assessment System (OASys)[62] records from 10 October 2014 stated that the Termination Supervision Plan was completed and that an Offender Manager had identified that Mr N was not at all motivated to change his behaviour. It was noted that very little work to address his behaviour had been completed with Mr N over the course

[62] OASys is a risk and needs assessment tool developed jointly by the Prison and Probation Services. OASys identifies and classifies offending related needs, such as a lack of accommodation and substance misuse. OASys is also used to assess risk offenders pose to themselves and others.

of his sentence given his limited time in the community and refusal to engage with prison interventions.

2.155 On 16 October 2014 Offender Supervisor 2 and Integrated Offender Manager 1 met and discussed Mr N's release arrangements. Furthermore, Mr N was offered, and subsequently declined, transport to his accommodation. Mr N stated he did not wish to engage with any support, that he was a free man and could do whatever he liked.

2.156 Mr N was seen by Mental Health Nurse 3 on 22 October 2014. He was informed that a discharge summary was to be sent to his GP and to the local north Caerphilly CMHT for information. Mr N was due for release 23 October 2014 with no licence conditions as he had by now served his full sentence.

2.157 On 23 October 2014 Mr N was released from HMP Parc. Prison In-reach issued a discharge summary to GP 3 which stated: "*Psychiatrist did not feel medication needed to be prescribed at this time and along with [Mr N's] high level of functioning on the wing and his ability to perform all his ADL*[63] *effectively along with future plans identified it was discussed along with [Mr N] that a discharge summary be sent to his GP and no referral to local CMHT was required. [Mr N] is aware he can access GP if his mental health deteriorates and GP can make referral to local CMHT. Copy of this discharge summary will also be sent to north Caerphilly CMHT*".

2.158 Following his release Mr N was secured accommodation at the Sirhowy Arms Hotel, Argoed. Upon his arrival at the Sirhowy Arms Hotel he was turned away by the owner as she believed him to be "*drunk and stoned*". Mr N was told to return later in a better state upon which he would be allowed in. Mr N subsequently turned up some hours later with an acceptable presentation for which he was allowed to

[63] Activities of Daily Living (ADL).

enter the accommodation. A letter dated 24 October 2014 was issued to Mr N reminding him that his behaviour was unacceptable and not in line with the conditions of occupancy.

2.159 On 26 October an unauthorised absence letter[64] was issued to Mr N by Caerphilly County Borough Council as it was brought to their attention that Mr N had stayed out overnight on 25 October 2016 without gaining permission.

2.160 On 29 October 2014 Mr N went to South Street Surgery with the intention of obtaining a sick note. During their conversation Mr N was asked about his mental health and informed GP 3 that he had an appointment the following week with his CPN and Psychiatrist. GP 3 concluded that there were no concerns regarding Mr N and issued him with a sick note for a period of 4 weeks based upon his previous diagnosis of schizophrenia. It should be noted that records indicate that no appointments with a CPN or Psychiatrist were ever made.

2.161 On 3 November 2014 email correspondence between Caerphilly County Borough Council Accommodation Team and Wallich staff, indicates that Mr N did not return to his accommodation the night of 2 November 2014. It is not clear from the evidence available whether an unauthorised absence letter was issued to Mr N.

2.162 The Wallich Homeless Charity is commissioned by Caerphilly County Borough Council to provide help and advice to homeless and vulnerable people throughout the local area. Whilst specific dates aren't clear, it was identified during our fieldwork that following Mr N's release from HMP Parc, Wallich Senior Support Worker 1 met with Mr N for an initial assessment of needs. Wallich Senior Support Worker 1

[64] An unauthorised absence letter is issued to an individual who his absent overnight without permission. It reminds an individual that the accommodation is used for residential purposes and is their only principal home. Furthermore, that any absences, other than those authorised by the Emergency Housing Team, will result in the termination of accommodation.

provided the accommodation owner with a food parcel and recalled Mr N as appearing sad, relaying that he said he felt institutionalised.

2.163 Wallich Senior Support Worker 1 attempted to contact Mr N after this initial visit but was informed by the accommodation owner that he was not present and that police had searched his room that day. Wallich Senior Support Worker 1 left a message with the owner for Mr N to contact them; Mr N failed to do so and Wallich Senior Support Worker 1 attempted to contact Mr N a further three times without success. Wallich Senior Support Worker 1 informed the review team that Mr N also failed to attend two appointments.

2.164 On the evening of 5 November 2014 having spent time with him earlier in the evening, Ms J accompanied Mr N to his accommodation at the Sirhowy Arms Hotel, Argoed. In the early hours of 6 November 2014, Gwent Police received a telephone call from the owner of the hotel who reported that Mr N had attacked Ms J. Ms J suffered significant injuries and sadly died following the injuries she sustained.

2.165 Shortly after committing the homicide Mr N died. The circumstances of his death are subject to ongoing Independent Police Complaints Commission (IPCC) investigation and Coroner inquests.

Chapter Three: Findings

3.1 In investigating the care and support provided to Mr N prior to committing a homicide in November 2014, the review team has considered the periods of engagement that Mr N had with statutory services. These findings are described within the following sections:

- Care and Treatment in the Community
  - Engagement

- In Prison Care
  - Medication
  - Case Formulation
  - Presentation – During and Prior to release
  - Referral

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

- Offender Supervision and Management
  - Contact with Offender Management
  - Integrated Offender Management (IOM) Scheme

- Diagnosis
  - Background
  - Illicit Substances
  - Diagnosis: Our View

- Discharge and After Care Planning
  - Sentence Release Arrangements
  - Risk Assessment
  - Accommodation

- Care Co-ordination
- Community Mental Health Team

- Support
  - Professional Support
  - Support for Families

Care and Treatment in the Community

Engagement

3.2 It was evident both through our analysis of documentation and our fieldwork that Mr N proved a complex and challenging individual to supervise and support. This was demonstrated through his repeated poor compliance with various appointments, for example with the First Access Team, his local CMHT, outpatient reviews and probation services. Furthermore, clinical notes[65] indicate that Mr N was rarely compliant with prescribed medication.

3.3 Following Mr N's 2004 assessment at Ty Sirhowy Mental Health Unit and subsequent sustained period of engagement with Community Psychiatric Nurse (CPN 1), 2005 onwards proved sparse in terms of Mr N's contact with community mental health services. Significantly Mr N spent periods of this time serving various custodial sentences, subsequently limiting his contact with community based services.

3.4 During his time in the community Mr N self reported his own use of illicit substances, for example admitting to having had an "*illicit drug problem with heroin in the past and abuses amphetamines now*". This is complemented by reports documented within healthcare records that also indicate his continued use of drugs such as cannabis.

3.5 Despite his lack of inclination to engage with community services, Mr N did demonstrate a willingness to engage with CPN 1 on repeated

[65] Examples include clinical records (family session notes) and CPN 1 records.

occasions over periods of time in 2004 and 2010[66]. CPN 1 worked within the local Blackwood community and is understood to have had a significant amount of contact with Mr N. CPN 1 reports that during his contact with Mr N he found him to be *quite a straight forward* individual.

3.6 CPN 1 believed that Mr N was quite open and comfortable enough with him to share any problems he may have had. The only problem that was subsequently shared with CPN 1 was in 2004 in regards to not having a GP. Mr N had gone to see a GP to report physical problems, however, when he was unhappy with the GP's response, he became threatening and verbally abusive towards the GP. Mr N was subsequently struck off his own and all GP practices in the local area and placed on the Violent Patient Scheme (VPS)[67].

3.7 During the time that CPN 1 saw Mr N he (Mr N) reported that he had been hearing voices since his childhood but that he didn't see this as a problem. Mr N did on occasion report very violent experiences. One particular example relayed to CPN 1 was in regards to when Mr N stated that some local boys attacked him with baseball bats. Mr N stated that he was able to take one of the bats and proceeded to attack them. CPN 1 was surprised by the lack of emotion Mr N showed when recalling this occurrence.

3.8 CPN 1 saw Mr N a further seven times during 2010 in addition to attending a walk in clinic with Psychiatrist 3, a child protection conference and a core group meeting. There is one documented reference to a Did Not Attend (DNA) for a meeting he had scheduled with CPN 1.

3.9 During various periods of time in the community Mr N self reported both symptoms and use of drugs, for example:

[66] 2004: July–December / 2010: January-August
[67] Violent Patient Scheme (VPS) provides primary care services in a protected environment. In Mr N's instance this meant reporting to Maindee Police Station, Newport, to access GP services.

22 July 2004: '…*he was "mumbling to himself, having imaginary conversations. This is worse when he has smoked blow"*

24 December 2004: '*Mr N confirmed that he had been using speed which resulted in him "having thoughts he didn't know where they had come from"*

13 May 2010: "…*experiencing hallucinations, thought isolation and withdrawal. Smokes cannabis daily*…"

3.10 In September 2010 it was recommended that Mr N be deregistered from services as he was "…*not getting many strange experiences, working through job centre to start painting and decorating business with friend. Advice re cannabis given*".

3.11 During our fieldwork CPN 1 explained that he was of the opinion that Mr N did not suffer from schizophrenia, instead believing him to suffer from a personality disorder. Unfortunately this opinion was never documented anywhere.

3.12 The period of time between late 2010 and October 2014 is dominated by Mr N serving various custodial sentences and hence there is a scarcity of documented evidence for any care and treatment in the community.

3.13 On 23 October 2014 Mr N was released back into the community with no licence conditions, having served his whole 27 month sentence. Mr N spent fourteen days in the community before the serious and tragic incident of the 6 November 2014.

3.14 At his pre-release meeting (prior to his 23 October 2014 release) Mr N requested medication for when he was released, however, this was not agreed and medication not provided upon release. At the same

meeting Mr N stated that he would arrange to make the appropriate appointment with his GP.

3.15 We found that there was a lack of a formal procedure in which Mental Health In-reach Teams would be invited to a pre-release meeting, and/or provide up-to-date information about an individual's mental health to all meeting attendees. For example, Police Constable 1 (PC 1) and Integrated Offender Manager 1 (IOM 1) confirmed that they had received no information regarding Mr N's mental health in advance of the sentence planning meeting. The sharing of such information would have assisted in clarifying the reasoning behind Mr N's medication management.

3.16 Mr N subsequently went to South Street Surgery, without a prior appointment, on 29 October 2014. The reason for his attendance at the surgery was to obtain a sick note. During their consultation GP 3 asked about Mr N's mental health and Mr N informed GP 3 that he had an appointment the following week with his CPN and Psychiatrist at the CMHT. GP 3 concluded that there were no concerns regarding Mr N's presentation and he was issued with a MED3[68] doctor's note for a period of 4 weeks based upon his previous diagnosis of schizophrenia. It should be noted that Mr N had made no such appointments scheduled with either the CPN or the Psychiatrist.

3.17 During these 14 days in the community evidence indicates that, much like his pre-release meeting where he was disinterested and unengaged with the potential support available to him; Mr N was similarly disinterested in support available to him via community services.

3.18 Once in the community, Wallich Senior Support Worker1 met Mr N for an initial assessment about his housing needs. Wallich Senior Support

[68] Statement of Fitness for Work or fit note, commonly known as a 'sick note'.

Worker 1 recalls that Mr N appeared to be sad and he stated that he felt institutionalised. Numerous further attempts were made by Wallich Senior Support Worker 1 and Integrated Offender Management to engage with Mr N to offer support, however, they were unsuccessful. Integrated Offender Management even took steps to contact Mr N's family via PC 1 to offer support, with the family responding that everything was fine but that they did not think Mr N would engage with anybody.

3.19 The review team believe that Mr N was a challenging and complex patient to supervise and support within the community due to his poor compliance with support appointments, and poor compliance with prescribed medication. Contributory factors may have been Mr N's frequent time in prison[69], his unstable accommodation arrangements, his reported feeling of being institutionalised and his erratic behaviour most often fuelled by his use of illicit substances.

Recommendations

None.

In Prison Care

3.20 During his time in both HMP Cardiff and Parc prisons, Mr N was the recipient of regular and well documented care from prison healthcare services. A consistent approach was taken by health staff at both prisons in order to provide greater stability regarding his mental health.

3.21 It was clear that Mr N developed positive therapeutic relationships with some of the healthcare professionals. One example of such a relationship appears to have been that formed with CPN 2 whilst at HMP Cardiff. In addition to providing professional support and assistance with healthcare needs, CPN 2 also secured Mr N

[69] Mr N's first custodial sentence was in 1995. This was a 12 month sentence for burglary and theft under s.9 (1) (b) of the Theft Act 1968.

employment in the painting and decorating unit where he subsequently worked well.

3.22 In regards to support programmes, in 2005 whilst in HMP Cardiff Mr N completed a Prisoners Addressing Substance Related Offending (P-ASRO)[70] drug rehabilitation and Enhanced Thinking Skills programme[71]. In terms of support to assist with reported mental health problems, Mr N was invited to attend a 'Hearing Voices'[72] group at HMP Parc in 2014 but declined. Further support was also offered by healthcare staff in terms of various courses regarding illicit substances, but Mr N declined these also.

3.23 Mr N had limited contact with psychological services whilst in custody. However, given his assessed risk level and sentence type this is not unusual. Forensic psychologists in public sector prisons within National Offender Management Service (NOMS) tend to work with high and very high risk offenders or those serving indeterminate sentences. Mr N would only have been seen by a forensic psychologist if referred by prison staff or an offender manager due to his concerning behaviours in custody, or if there had been concerns in relation to his risk on release. Whilst at HMP Cardiff Mr N received four counselling sessions with a Psychotherapist with indications that he displayed no signs of violence or aggression. Mr N was not seen by a psychologist while at Parc.

3.24 During our fieldwork it was indicated that the Mental Health In-Reach Team (MHIRT) [73] at HMP Parc is under resourced relative to the size of the prisoner population. However, in this instance the review team note

[70] https://www.justice.gov.uk/offenders/before-after-release/obp
[71] Enhanced Thinking Skills is not primarily aimed at those with a personality disorder and which recent evaluation has shown not to be particularly effective with acquisitive offenders
[72] Hearing Voices group aims to try and get clients to understand what they are hearing. The intention is to try and distinguish between a true hallucination and their own thoughts, and to introduce coping strategies.
[73] 2 FTE Psychiatric Nurses, 0.5 FTE Occupational Therapist, 4 sessional psychiatrists and 4 sessional psychologists.

that the good quality, consistent and well documented healthcare Mr N received was not impacted by these limited resources.

Medication

3.25 Whilst in prison Mr N was not fully compliant with prescribed medication. An individual's consent to take prescribed medication, or any form of treatment while in prison, has to be sought as parts of the Mental Health Act 1983[74] relating to compulsory treatment[75] do not apply to prison settings. Should a prisoner, following psychiatric assessment, meet the criteria for a mental illness (as defined within the MHA) that requires treatment and does not consent, then the prisoner can be transferred to a hospital for further assessment and treatment under sections 48 and 49 of the MHA[76]. At no point was it considered that Mr N met the criteria for compulsory detention and treatment under the MHA. As such it was difficult to compel Mr N to take his medication in prison.

3.26 Given Mr N's lack of compliance with prescribed medication when in prison, alongside a lack of current psychotic symptoms, the reasoning for his withdrawal from receiving prescribed medication from July 2014 onwards, is understandable and justified. Furthermore, as regular assessment of Mr N's mental state continued, should any relapse have occurred, it would have been identified in a timely manner. The section on Medication provides greater detail in terms of management of medication in regards to Mr N.

Case Formulation

3.27 A commonly accepted definition of case formulation is "*a hypothesis that relates all the presenting complaints to one another, explains why*

[74] Part IV MHA 1983 http://www.legislation.gov.uk/ukpga/1983/20/section/56
[75] For example, the level of mental illness being considered is so serious that treatment can be given legally without consent.
[76] In certain circumstances, for example if the mental illness presents with a risk of harm to themselves, or others and treatment is considered necessary for the improvement in their mental health, then a treatment convincingly shown to be of therapeutic necessity, can be given at that hospital without the persons consent

these difficulties have developed and provides predictions about the patients condition".[77] In other words, case formulation brings together and summarises, in a timely manner, all available information to help focus on presenting issues that are likely to impact on patient recovery. This allows a diagnosis to be formed and healthcare pathways to be developed to aid treatment, providing a baseline for further evaluation and review.

3.28 Mr N's 2004 diagnosis of suffering from schizophrenia does not appear to have been formally re-evaluated at any point thereafter. This issue will be addressed in the later section on diagnosis.

3.29 The review team believes that Mr N is likely to have fulfilled the criteria for having an antisocial personality disorder[78]. Examples of signs that an individual such as Mr N may have this diagnosis include:

- Persistent irresponsibility and disregard for social norms, rules and behaviour
- Callous unconcern and lack of guilt and remorse
- Inability to learn from their mistakes
- Be unable to control their anger
- Blame others for problems in their lives
- Frequent use of violence
- Inability to maintain relationships

3.30 Whilst evidence indicates that there were frequent communication flows between healthcare professionals, it was only towards the end of Mr N's time in HMP Parc in 2014 where steps were taken to gain greater clarity regarding his diagnosis. This was done through monitoring his presentation once his prescribed medication was halted.

[77] Wolpe and Turkat, 1985
[78] See: http://www.nhs.uk/conditions/antisocial-personality-disorder/Pages/Introduction.aspx

3.31 The Diagnosis section of this report provides greater detail in regards to Mr N's diagnosis, historic and probable.

3.32 One aspect of case formulation relates to ensuring the right people have the right information. One such example identified during our review is how MHIRT's do not routinely assess for violence, in the form of HCR-20[79], upon release. If such a routine was established, one that highlights both protective factors and risk factors, it would prove easier to manage individuals with mental health and substance misuse problems. However, it is important to note that in the case of Mr N such an assessment would not likely have predicted the level of reported violence that occurred on 6 November 2014.

3.33 Effective case formulation would have played a key role in summarising information from multiple healthcare professionals, providing greater focus on treatment. A case formulation approach would have also allowed a more informed ongoing review and testing process as appropriate. The review team does not believe that effective case formulation was undertaken in the case of Mr D which would have re-evaluated the original diagnosis of schizophrenia.

Presentation – During and prior to release

3.34 In the months leading up to his October 2014 release, Mr N's presentation appeared consistent - he was not presenting with psychotic symptoms. Examples taken from the patient record include:

1 July 2014: "…*pleasant polite able to share in humour…did not appear to be pre-occupied in any way this morning ie distracted, distressed in any way. Relaxed, good eye contact. Tone and content of conversation all appropriate"*

[79] The Historical Clinical Risk Management-20 (HCR-20) is a set of professional guidelines for the assessment and management of risk. HCR-20 assist with the development of appropriate risk management plans and helps inform communication of such risks.

16 July 2014: "…*still manages to function at a good level. His appetite and general physical health look good*…"

5 August 2014: "*[Mr N] pleasant polite able to share in humour…good eye contact and relaxed posture*".

26 September 2014: "…*high level of functioning on the wing…maintained ADL's effectively ie personal hygiene, appearance*…"

23 October 2014: Discharge Summary "…*high level of functioning*…"

3.35 Mr N also held a number of prison jobs in the months prior to his October 2014 release, for example he worked as a painter, as a cleaner[80] and latterly as a prison barber.

3.36 It is also of note that throughout his time in prison whilst he received two adjudications[81], Mr N was never segregated and individuals spoken to during fieldwork indicate that he did not stand out and that Mr N "…*was not an unusual prisoner*" in comparison to others.

3.37 Mr N presented as an individual functioning at a good level over the last year of his imprisonment. With his behaviour relatively stable, it was also appropriate to regularly monitor his presentation whilst he was no longer prescribed medication.

3.38 Due to his lack of contact with services it is extremely difficult to assess Mr N's presentation over the two weeks post release and prior to the fatal incident on 6 November 2014. Wallich Senior Support Worker 1 reported upon their initial assessment with Mr N that he appeared sad. Furthermore, that he: "…*presented as quiet, having strange eyes and*

[80] Case Note History for 23 August 2014 states that Mr N is "…*hard working, he sometimes helps the painters out when he has completed his tasks on the unit*…"
[81] A prisoner may receive an adjudication if it is said that they have committed an offence contained within prison rules.

seemed sad" as well as reporting that prior to the incident Mr N: "…*was quite chatty, was doing very well*".

3.39 Mr N's reported presentation was further corroborated by the owner of the Sirhowy Arms who reports Mr N as: "…*someone who looked sad not depressed*". The owner of the Sirhowy Arms also stated that: "*[Mr N] was very smart looking; he worked out, was clean-shaven and always turned out well*". The family of Mr N also reported him as emotionally sad, possibly depressed, following release from prison.

3.40 Mr N's last and only contact with a medical professional was with GP 3 on 29 October 2014. Mr N attended an appointment with GP 3 in order to obtain a MED3 doctor's note. GP 3 recalled Mr N's presentation as "…*gentle, polite, calm, well presented and chatted normally…during the appointment*…"

Referral

3.41 When referrals are made into secondary mental healthcare CMHT's (mainly from primary care) the CMHT will undertake screening assessments and allocate the patient to a professional within the team. When required, arrangements can be made for more specialist interventions and assessments.

3.42 Whilst Mr N was referred to his local CMHT in 2004, 2010 and 2011, he was not referred into a CMHT upon his last release from prison in October 2014. The reason being, as indicated within the prison discharge, Psychiatrist 5 did not feel medication was needed given his presentation and the fact that Mr N had been functioning well for the last four months without medication prior to release. Mr N was in agreement that should any concerns arise with his mental health that he could go to his GP who would be able to make a referral to his local CMHT.

Recommendations

1. **HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop a process whereby case formulation is routinely introduced and updated, as a prisoner moves from prison to prison and mental health care services. This supports and improves availability, continuity and sharing of information which helps clinicians understand and consider care and treatment planning programmes where appropriate, regarding longstanding and complex cases.**

Medication

Compliance with prescribed medication

3.43 From the evidence available, it was apparent Mr N had a repeated history of non-compliance with prescribed medication both in the community and whilst in prison. Reasons for this appear many and varied, some of which include the following:

26 March 2013: "...*he has been non concordant for the past few days – wing staff tell me that they ask him daily to attend for medication – but he states he does not want it*..."

8 February 2013: "...*he has not [been] taking his olanzapine medication for the past few nights, as he was having side effects from this, pain in his legs, was finding it difficult to sleep due to this*"

22 March 2013: "...*always found medication and services to be unhelpful*"

30 May 2013*: "...but can't be bothered to stand in queue to get medication*"

20 September 2013: "...*family members advising the Mr N had not been taking his medication and been using amphetamine, mephedrone, benzodiazapene and drinking alcohol daily*"

16 December 2013: "*...confirmed that he had stopped taking his medication as he wanted something in his personality to change*"

1 July 2014: "...*he believed his medication was doing nothing for him*..."

3.44 It is believed that Mr N may also have been exchanging or selling medication to other prisoners illegally. HMP Parc's Consultant Forensic Psychiatrist (CFP 1) and Clinical Manager (CM 1) both expressed the opinion that Mr N may have been selling or dealing using his medication whilst in prison. Furthermore it was reported within HMP Parc patient record that Mr N had: "...*been snorting subutex*[82]*, using for the last two months or so*" Therefore, evidence does appear to indicate that on occasion Mr N was selling or exchanging his medication with other prisoners.

Treatment response to medication prescribed

3.45 In 2004 when Mr N was first formally admitted under section two of the MHA (1983) he received an emergency anti-psychotic Acuphase[83] medication via depot injection[84]. This resulted in an acute dystonic[85] side effect reaction.

3.46 The patient records detail occasions when Mr N refused Olanzapine[86], reporting: "…*restless legs in the evening which is keeping him*

[82] http://www.netdoctor.co.uk/medicines/brain-and-nervous-system/a7763/subutex-buprenorphine/
[83] http://www.netdoctor.co.uk/medicines/brain-and-nervous-system/a6422/clopixol-acuphase-injection-zuclopenthixol/
[84] http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/depotmedication.aspx
[85] http://www.nhs.uk/Conditions/Dystonia/Pages/Introduction.aspx
[86] Olanzapine is used to relieve the symptoms of schizophrenia and other similar mental health problems. Such symptoms include hearing, seeing, or sensing things that are not real, have mistaken beliefs, and feeling unusually suspicious.
http://www.patient.co.uk/medicine/olanzapine

awake…" and: "…*having pain in his legs, and was finding difficult to sleep due to this*." Mr N self reported further symptoms of a cognitive[87] nature, for example hearing voices, having racing thoughts and paranoid ideas. However, during the same periods of time he was functioning well with no signs of deterioration or distress, was able to participate in leisure activities such as going to the gym and was able to work. Furthermore, at the same time he denied unusual thoughts or visual disturbances, reported no strong thoughts of paranoia and his appetite and physical health were reported as good.

3.47 As a result of reported complaints regarding the side effects associated with Olanzapine, a decision was made on the 4 March 2013 to provide an alternative medication in the form of Quetiapine. Subsequently Mr N did not report the same side effects, for example pain in his legs.

3.48 Mr N was monitored regularly, particularly in prison, to determine whether his medication was beneficial and whether any side effects or difficulties were encountered due to his lack of compliance and misuse of illicit substances. Besides the side effects reported in relation to Olanzapine, there is little information as to Mr N's response to prescribed medication.

Medicine Management and Prescribing Rationale

3.49 The review team analysed evidence relating to the medication that was prescribed to Mr N. The evidence consisted primarily of HMP Patient Records, Abertawe Bro Morgannwg University Health Board's (ABMUHB) clinical review report and prescription charts. The review team found that the management of medication was monitored on a consistent basis, particularly during his time in prison.

[87] Cognitive – mental action or process of acquiring knowledge and understanding through thought, experience and the senses.

3.50 From his diagnosis in 2004 of schizophrenia following which he was discharged with Olanzapine, Lorazepam[88] and Chlorpromazine[89], Mr N was routinely prescribed medication on the basis that it would help his mental state and reported symptoms, such as auditory hallucinations, thought insertion and thought withdrawal. Contrasting this however was a lack of willingness to comply with prescribed medication; this was particularly documented to be the case from 2004 onwards.

3.51 The review team found no documented evidence to indicate that consideration was given to the rationale of prescribing Mr N medication given that he demonstrated an unwillingness to comply. Mr N often reported denial of psychotic symptoms and presented as functioning well whilst in prison, this was particularly the case during his last year of detention.

3.52 Therefore, the evidence indicates that given the absence of reported psychotic symptoms, history of substance misuse, intermittent compliance with medication and overall presentation, that the decision to stop his medication in July 2014 and to continue regular monitoring to give greater clarity regarding his diagnosis was an appropriate one.

Recommendations

2. HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should ensure procedures are in place to check with the rationale for prescribed medication, especially when an individual presents a history of non-compliance.

[88] Lorazepam is a benzodiazepine prescribed for short periods of time to ease symptoms of anxiety, or sleeping difficulties caused by anxiety.
[89] Chlorpromazine is prescribed for a variety of conditions, one of which is for the symptoms of schizophrenia and other similar mental health problems which affect thoughts, feelings and behaviours. http://patient.info/medicine/chlorpromazine

Offender Supervision and Management

Contact with Offender Management

3.53 Prior to Mr N's October 2014 release, PC 1 and Mr N's Offender Manager, both from the Integrated Offender Management scheme, attended a pre-release meeting with Mr N. PC 1 confirmed that they received no documentation regarding Mr N's mental health in advance of the meeting. Mr N's Offender Supervisor (OM 2) was also in attendance and raised no concerns regarding Mr N's mental health.

3.54 The purpose of this meeting was to advise Mr N of what services would be open to him post release and how they would be able to help integrate him back into normal life. Mr N was informed that despite his imminent release without statutory supervision and hence no compulsory conditions (he had served his whole-sentence), these services would still be open to him on a voluntary basis.

3.55 Mr N was clear at this meeting that he did not wish to engage in any support, saying that "…*he had enough of police and probation over the years*". Furthermore, he stated that that he would be a free man and could do whatever he liked.

3.56 Medication issues were discussed with Mr N prior to his release, with Mr N stating that he wanted mediation when released. When questioned why, given he was no longer on medication, Mr N response was that he just did and that it would "…*be a back-up*". Mr N's request was not actioned and he was not released with any prescribed medication. However, Mr N was offered assistance by Integrated Offender Manager 1 and PC 1 in terms of arranging a GP appointment but this was subsequently declined, Mr N stated that he would organise a GP appointment himself upon release.

3.57 Assistance with Drug Intervention Programmes (DIP) was offered should it be required post release. Furthermore, support with

accommodation and a voluntary supervision appointment with an Offender Manager were both declined by Mr N. The evidence shows that probation service made numerous attempts to engage with Mr N prior to his release.

3.58 Prior to his release PC 1 also took steps to liaise with the family members of Mr N to advise them of his release date as well as offering support should they require. PC 1's last conversation with Mr N's mother was, we understand, to inform her that support was available for Mr N when he needed it.

3.59 Upon the day of his release assistance was offered by the police in the form of transport from the prison gate to accommodation. Mr N declined this, preferring to make his own way home[90]. However, given Mr N's experience of gate arrest[91] on 17th October 2013[92] and 5th December 2013[93], it is understandable as to why he should decline assistance from outside the prison gate.

3.60 At the pre-release meeting Mr N was informed that he would be managed under the IOM scheme.

Integrated Offender Management (IOM) Scheme

3.61 The IOM[94] scheme brings together a cross-agency response to the crime and reoffending threats faced by local communities. This is addressed through the management of the most persistent and problematic offenders. IOM helps to reduce the risk of harm they may

[90] Mr N's father collected him from prison.
[91] The arrest on or at prison service premises by police officers of a convicted prisoner on release from prison service custody, either on licence or any other conditional release or on completion of sentence.
[92] 17th October 2013: Arrested and in custody being questioned in relation to burglary alleged to have taken place prior to Mr N's recall.
[93] 5th December 2013: Charged with conspiracy to burgle.
[94] https://www.gov.uk/guidance/integrated-offender-management-iom

present to others as well as reducing the likelihood of their reoffending through rehabilitation[95].

3.62 There are a number of multi-agency forums that can contribute to the assessment and management of complex individuals in the community. For example, Multi Agency Public Protection Arrangements (MAPPA)[96] can be used for those assessed as posing a high / very high risk of harm. MARAC and Integrated Offender Management Scheme can be used for those identified as being Prolific and Priority Offenders (PPO).

3.63 In the case of Mr N, his risk of reoffending and harm assessment indicated management via the IOM scheme was necessary. This would have provided an enhanced level of monitoring and supervision on a multi-agency basis.

Recommendations

None.

Diagnosis

Background

3.64 In order to gain a full understanding of the provision of mental health care and treatment provided to Mr N, it is important to understand the diagnosis given to him in July 2004, that of schizophrenia. Schizophrenia can be defined as:

'*...a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions. It*

[95] Rehabilitation can include behaviour programmes, provision of specialists services such as substance misuse and assistance with employment and training skills

[96] Process in which Police, Probation and Prison Services assess and manage the risks posed by sexual and violent offenders living in the community. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

can impair functioning through the loss of an acquired capability to earn a livelihood...'[97]

3.65 Mr N's diagnosis stems from his admission[98] and subsequent assessment under section 2 of the MHA (1983) at Ty Sirhowy inpatient Unit[99] in 2004. The patient admission form records Mr N as presenting "…*with symptoms of psychosis i.e. thought disorder, hallucinations. Query schizophrenia or drug induced psychosis*".

3.66 Whilst receiving treatment at Ty Sirhowy details taken from a nursing report dated 13 June 2004, provide some indication of how the diagnosis of schizophrenia was reached. For instance:

"*[Mr N] failed to return from, as agreed, phone call from [Mr N's] mother stating that he was at her home, upon return [Mr N] appeared paranoid, delusional and aroused he denied illicit substance misuse however staff observed [Mr N's] pupils were dilated and his behaviour bizarre"*.

"*[Mr N's] conversation appeared bizarre talking about 'dead babies in his nose'.*

"*[Mr N] was reviewed by the medical team and presented as experiencing third person derogatory hallucinations, thought echo and was discussing 'pictures in his mind and people controlling him by these pictures'*".

"*[Mr N] presented as experiencing psychotic like symptoms stating that he was being 'controlled by his peers expressions and feelings'*".

[97] http://www.who.int/mental_health/management/schizophrenia/en/
[98] Informal admission: 29 May 2004. Section 2 implemented from 11 June 2014
[99] http://www.wales.nhs.uk/sitesplus/866/page/58116

3.67 On 5 July 2004 Mr N was discharged from Ty Sirhowy having received a diagnosis of schizophrenia and commenced on Olanzapine[100] after spending just over five weeks as an inpatient. The discharge summary states that Mr N was: "*admitted due to deterioration in mental state. Very thought disordered and paranoid initially. Has a history of illicit drug use*". Furthermore the summary goes on to say that Mr N was being discharged following several periods of leave having gone well and his mental state having stabilised. The discharge summary states:

"*Condition on discharge: Radically improved*"

"*Prognosis: Good – if complies with medication*"

3.68 Schizophrenia is diagnosed when there is clear evidence of psychotic symptoms for a month. Schizophrenia should not be diagnosed during states of drug intoxication or withdrawal. Drug induced psychotic disorders occur during or after substance use and symptoms can be very similar to schizophrenia, usually resolving within one month. Schizophrenia will persist after one month unless treatment is provided.

3.69 The review team does not feel a sufficient drug free period occurred during Mr N's admission assessment at Ty Sirhowy for a diagnosis of schizophrenia to be confidently confirmed. The review team believes that it is more likely that he was experiencing drug induced psychotic episodes.

3.70 Throughout Mr N's documented healthcare records and through our own fieldwork, it is apparent that there was an inconsistency in both his compliance with anti-psychotic medication and in his reported symptoms. The following sample taken from healthcare records is a demonstration of such inconsistencies:

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

26 March 2013*: "…he has been non concordant for the past few days – wing staff tell me that they ask him daily to attend for medication - but he states he does not want it…"*

30 May 2013: "*Now on quetiapin[e]…but can't be bothered to stand in queue to get medication*"

15 September 2013: Stated that he had been taking his medication for a period since 2013 but an offender manager found: "…*there wouldn't have been enough medication for this to be the case if Mr N was taking his tablets as advised*"

15 April 2014: "*…and stated that he was not experiencing any adverse effects from recommencing prescribed antipsychotic medication*"

"…*stopped taking his medication a month ago and reports feeling well…doctor noted no evidence of thought disorder*…"

"…*my thoughts are not my own, every day I learned to block them out*…"

18 January 2010: "…*he can't sleep, thinks he is changing colour 'sits there getting angry', can see something around people, can read people's minds, sees fluorescent, sees through images*…"

7 December 2013: "*…denied any psychotic symptoms and nil presented with any affective symptoms*"

29 January 2014: "*Doesn't get any symptoms at the moment – not had any symptoms for the last month*"

3.71 There were no reports of psychotic symptoms affecting Mr N's day to day functioning. During our fieldwork we were informed that whilst in

prison Mr N was regarded as a “run of the mill prisoner”, who did not stand out. Healthcare records substantiate this by reporting that he coped well within the prison environment, participating in leisure activities and holding several jobs.

3.72 It should also be noted that during his time in custody spanning a timeframe of many years, Mr N was not considered to require care in prison hospital wings or transfer to a psychiatric hospital under the provision of the Mental Health Act.

Illicit Substances

3.73 It is apparent from records that Mr N had a long history of harmful substance misuse. One of the earliest official records relate to Gwent Specialist Substance Misuse Service (GSSMS) notes which indicate that when Mr N was 15 years of age he self referred to north Gwent drugs service for ‘…*present cannabis use and past amphetamine injecting*.’

3.74 Subsequently, throughout his contact with both health and non-health services, Mr N continued to report substance misuse, reporting at various points his use of amphetamines[101], ecstasy[102], benzodiazepines[103], mephedrone[104], cannabis[105] and LSD[106]. However, it does not appear to the review team that Mr N recognised any problem with his use of, or dependency upon, illicit substances. Neither is there evidence to indicate that Mr N was proactive in seeking any assistance. This is supported by the availability to Mr N of a detox programme, however, Mr N did not take the opportunity to engage with this programme.

[101] http://www.druginfo.adf.org.au/drug-facts/amphetamines
[102] http://www.druginfo.adf.org.au/drug-facts/ecstasy
[103] http://www.druginfo.adf.org.au/drug-facts/benzodiazepines
[104] http://www.druginfo.adf.org.au/drug-facts/mephedrone
[105] http://www.druginfo.adf.org.au/drug-facts/cannabis
[106] http://www.druginfo.adf.org.au/drug-facts/lsd

3.75 However, whilst not proactive in seeking assistance offered via drug and alcohol programmes, in 2005 Mr N did complete a Prisoners Addressing Substance Related Offending (P-ASRO)[107] drug rehabilitation programme whilst at HMP Cardiff.

3.76 Whilst Mr N had access to, and is known to have used illicit substances within the community, whilst serving various custodial sentences Mr N never tested positive for drugs. However, many of the new psychoactive substances available in prison are not detected through traditional testing methods. Our analysis of evidence and information gained from our fieldwork identifies that there is an issue regarding the availability of new psychoactive substances (commonly known as Legal Highs) within the prison system.

3.77 Legal highs are substances that have similar effects to illegal drugs like cocaine or cannabis[108]. NHS information on legal highs states: "*legal highs can carry serious health risks. The chemicals they contain have in most cases never been used before in drugs for human consumption. This means they haven't been tested to show they are safe. Users can never be certain what they are taking and what the effects may be*".

3.78 It was highlighted to the review team that legal highs known as Spice[109] and MCAT[110] are a particular problem within the prison environment[111]. It was shared with the review team that use of Spice has resulted in "...*people becoming psychotic,*" "*causing major issues within prison*" and that: "...*it is very dangerous and has caused prisoners to become very aggressive, threatening and violent – the prisoner's personality changes*".

[107] https://www.justice.gov.uk/offenders/before-after-release/obp
[108] http://www.nhs.uk/Livewell/drugs/Pages/legalhighs.aspx
[109] http://www.drugabuse.gov/publications/drugfacts/synthetic-cannabinoids
[110] See: http://www.talktofrank.com/drug/mephedrone
[111] Further supported by official statistics as reported in: http://www.theguardian.com/society/2015/dec/01/prisons-introduce-tests-legal-highs-bid-reduce-violence

3.79 Current drug testing regimes in prisons are not able to confirm whether an individual has taken any 'legal highs'. However, it is not unreasonable to assume that should an individual who had previously reported psychotic symptoms taken 'legal highs', that these would have most likely exacerbated reported psychotic symptoms.

3.80 It is important to acknowledge that issues with substance misuse, particularly legal highs, are not isolated to HMP Cardiff and Parc, with this being a national issue. HM Inspectorate of Prisons (HMIP) recently published a thematic report titled '*Changing patterns of substance misuse in adult prisons and service responses*'[112]. This report[113] examines drug misuse in prisons, recognising the shift away from the use of opiates and Class A drugs towards the misuse of medication in prisons.

Diagnosis: Our View

3.81 It is the opinion of the review team that Mr N fulfilled the criteria for having antisocial personality disorder. Whilst a number of clinicians involved in Mr N's care, who we engaged with as part of the review, also felt he had a personality disorder, the review team is unaware of any formal assessment ever being undertaken to substantiate this view.

3.82 In regards to an antisocial personality disorder diagnosis, an individual is likely to demonstrate a history of conduct disorder during childhood, evidenced by delinquency, anti-authoritarian attitudes, aggression and early substance misuse. As an adult the individual may behave

[112] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/changing-patterns-of-substance-misuse-in-adult-prisons-and-service-responses/

[113] The report provides detail on the movement towards the use of new psychoactive substances (NPS), or legal highs, and in particular synthetic cannabis such as Spice. HMIP's report examines changing patters in adult prisons, assessing effectiveness of current policy and operation responses in order to suggest ways of improvement.

irresponsibly, lack guilt or fail to learn from their mistakes, be unable to control their anger and repeatedly be violent.

3.83 Although information regarding Mr N's childhood development is limited, his documented behaviours indicate that he conformed to the key characteristics of antisocial personality disorder, as demonstrated through the following examples:

- Received his first custodial sentence at a young offenders institute for a period of two years in 1995 at the age of 15
- Mr N relayed a violent experience to CPN 1 in which a number of local boys attacked him with baseball bats. He then took one of the bats and proceeded to attack them. CPN 1 recalls that when Mr N told this he showed no emotion, much to CPN 1's surprise
- Mr N formed the opinion that his Offender Manager was involved in a conspiracy against him in regards to planting evidence which led to his conviction for burglary
- Mr N's numerous convictions that spanned both his juvenile and adult life
- Considerable evidence of continuous misuse of illicit substances from an early age (smoked cannabis from the ages of 11-12), his use of Gwent Drug Misuse Services at 15 years of age, or his reported misuse of substances post 23 October 2014 release from prison. Furthermore, evidence shows that Mr N's use of illicit substances proved harmful and led to psychiatric complications.

3.84 In addition there was evidence of aggressive behaviour in his personal relationships and extensive use of illicit substances. Evidence indicates that misuse of illicit substances proved harmful to Mr N and led to psychiatric complications characterised by psychotic episodes.

3.85 There is no evidence to indicate that Mr N received any treatment to help him manage his personality disorder traits other than attending an offender behaviour programme at HMP Cardiff. Whilst Mr N attended an Enhanced Thinking Skills programme, this is not aimed specifically at those with personality disorder but aims to help tackle cognitive deficits. Particular focus is given to managing impulsivity, developing better perspective taking and problem solving skills, and developing abstract as well as critical reasoning. Whilst documented evidence shows that several clinicians considered the possibility of a case formulation, this was not completed. Had a case formulation been completed for Mr N, the MHIRT may have referred him for a personality disorder assessment and referral in line with Operational Policy[114].

3.86 The review team were informed that had Mr N been diagnosed with a personality disorder, there would have only been limited treatment services available in the community at that time. This is because such services are usually reserved for those who present as high or very high risk of harm, or where a member of the team are sufficiently concerned about an individual's behaviour to refer to the forensic team. However, because there was no formal diagnosis of a personality disorder, together with an uncertainty about his diagnosis of psychoses, Mr N may not have been clearly identified with a particular service. Whilst personality disorder services in the community have improved since this time, Mr N would only be screened in to such a service if his Offender Manager had sufficient concern about his presenting behaviour to then refer to such a service.

3.87 Across Wales, there is a need to improve the level of training that staff providing mental health services within a prison environment receive. This would help support those staff when dealing with individuals who

[114] Operational Policy for Par and Swansea Mental Health In-Reach Team (MHIRT) 2014. Includes guidance on Inclusion Criteria 'Personality Disorder – In some cases there will be co-morbidity of personality disorder with other mental health problems…decisions regarding their care at all levels should be clinical based'. Referral Tertiary Mental Health Services include Management of complex personality disorder.

are diagnosed with personality disorder. Whilst some areas within Wales have dedicated personality disorder treatment services, this remains inconsistent nationally. However, it is anticipated that the relatively new joint project between NOMS and NHS England (launched October 2013), working with individuals with personality disorder, will improve the level of understanding staff have when dealing with such individuals. NOMS in Wales now has a SLA with health boards in Wales outlining their role in the support and treatment of individuals with personality disorder in the community. This involves up-skilling the knowledge and understanding of staff in custodial and community settings, approved premises and those working in housing.

3.88 Mr N's treatment was complicated by him being in custody for the majority of his adult life and his less than proactive or enthusiastic approach in obtaining and/or engaging in treatment. Treatment was further complicated by his use of illicit substances and a lack of a sustained period in which he was free from such substances so as to fully assess his mental state.

3.89 Given the questions raised by clinicians regarding Mr N's original diagnosis, his lack of compliance with prescribed medication, substance misuse history and lack of persistent reported psychotic symptoms, a case formulation would have been helpful. This would have helped to clarify any clinical issues, problematic behaviours and best approaches for the management of these issues and behaviours, including indicators of de-stabilisation.

3.90 As a result of Mr N's lack of compliance with prescribed medication, the inconsistencies in reported psychotic symptoms and history of substance misuse, Psychiatrist 5 in July 2014, in agreement with Mr N, stopped prescribing antipsychotic medication and arranged for Mr N to be monitored on a regular basis. This is the first documented instance of an attempted re-evaluation of Mr N's mental state.

3.91 It can be concluded that Mr N was a complex individual who had longstanding mental and social problems. There was clear evidence that he had drug induced psychotic episodes. Whilst there was one episode of diagnosed schizophrenia in 2004, it is without certainty that he was free of illicit substances at the time of assessment. The review team recognise that it can be difficult to clinically assess psychotic illnesses, particularly when there is likely concurrent drug consumption. However, our conclusion is that there was insufficient evidence to support the diagnosis of schizophrenia.

3.92 In subsequent years there was insufficient evidence of persistent psychotic symptoms and social deterioration in the absence of drug use to support a diagnosis of schizophrenia. Instead the review team concluded that Mr N had vulnerability towards developing psychosis if using illicit substances. It is of note that there was good evidence his mental health improved if he remained drug free.

Recommendations

3. Welsh Government to review the provision and the availability of more structured interventions for individuals within the community that have both a personality disorder, mental health issues and substance misuse concerns.

Discharge and Aftercare Planning

Sentence Release Arrangements

3.93 Upon his release from HMP Parc on the 23 October 2014 Mr N had served his full sentence and therefore was not subject to any further supervision arrangements from probation services. Mr N declined any of the support and assistance that was offered in securing accommodation, employment or help addressing his substance misuse. Mr N was aware that support was still available to him should he required it.

Risk Assessment

3.94 Offender Management Public Protection Record for Information Sharing (PPRIS) documentation[115] shows that prior to his October 2014 release from prison, Mr N was subject to a risk assessment. The risk assessment[116] includes information relating to his offences, his time in prison, ongoing risk to children and monitoring of communication. PPRIS documentation also provides evidence of multi-agency working and sharing of information between Police IOM Unit and NOMS regards to Mr N's release.

3.95 PPRIS contact sheets for the 23 October 2014 indicate that, as Mr N had been released without licence conditions, he was under no supervision, however he was considered a Prolific and Priority Offender (PPO).

3.96 During our fieldwork it was identified that information relating to risk could be better utilised as part of improved case formulation. For example, during our fieldwork it was indicated that information relating to Mr N's 2010 domestic incident was not known by all parties involved with Mr N's healthcare. The result being more detailed information could then be shared more appropriately and assist with suitable support arrangements.

Accommodation

3.97 In October 2014 Mr N was deemed homeless and in need of accommodation, however his placement was impacted by the lack of availability of temporary accommodation within the Caerphilly area.

3.98 A further factor impacting availability related to Mr N needing to establish a connection to a certain area. Mr N initially tried to gain

[115] PPRIS documentation is property of HMP & YOI Parc's Offender Management Unit and was completed by numerous parties including Offender Supervisor, Offender Manager and HMP Parc Custodial Detention Services

[116] PPRIS Sections: Risk Assessment and Victim Information; Monitoring and Communication; Authorisation for the offence related reading of mail and monitoring of telephone calls; Assessment of ongoing risk to children; Contact Sheets

immediate accommodation in Newport to be near his father; he was unsuccessful as he could not prove an established connection to that area.

3.99 As a result, accommodation was secured for Mr N by Caerphilly County Borough Council at the Sirhowy Arms Hotel. The Sirhowy Arms Hotel had been used by Caerphilly County Borough Council since 2008 as emergency bed and breakfast accommodation.

3.100 The review team is of the view that Mr N's return to his local area would lead to a higher risk of re-offending due to contact with criminal affiliates and access to drug dealers/users. However, given Mr N was deemed homeless and the lack of available accommodation, the review team understand that there were pressures upon the local authority to find accommodation for Mr N. As such the decision was made to place Mr N at the Sirhowy Arms Hotel.

3.101 Concerns were expressed to us during our fieldwork about the absence of risk information that was routinely shared with the owners of those providing accommodation, in this case the Sirhowy Arms Hotel. Our fieldwork indicated owners of such establishments are not told of an individual's offence due to data protection concerns, however, they are provided with information including age, whether they have any mental health issues, if they had a history of self-harm, etc.

3.102 We learnt that some bed and breakfast providers go beyond their remit and try to provide assistance and support to individuals. However, local authorities do not provide any training to proprietors (in relation to providing assistance and support) because they are deemed to be solely a bed a breakfast provision and not a supported housing scheme. Housing related support is provided through a floating support service by a specialist provider[117] appointed by the local authority.

[117] Specialist provider in this instance refers to the Wallich Homeless Charity

3.103 We learnt that the owner of the hotel often went beyond their remit, for example, taking residents to the local GP surgery to ensure they are registered, and organising and taking residents on day trips, cooking their food and helping with laundry.

3.104 It was unclear to the review team whether there was a well defined understanding of roles and responsibilities between the Sirhowy Arms bed and breakfast and Caerphilly County Borough Council.

Care Co-ordination

3.105 When an individual known to healthcare services has issues regarding their mental health and illicit substance use, issues that are often intertwined, co-ordination of the types of healthcare available to an individual is essential in terms of improved health outcomes.

3.106 Up until June 2012, the Care Programme Approach (CPA) [118] was the main assessment approach in identifying care needs for individuals receiving secondary mental health services. From June 2012 this was replaced by Part 2 of the Mental Health (Wales) Measure 2010[119]. Part 2 of the Measure sets out new arrangements for the coordination of and care and treatment planning for secondary mental health users.

3.107 The Code of Practice to Parts 2 and 3 of the Measure states:

"*As with hospital discharge, prison release needs to be carefully planned and coordinated. The mental health prison in-reach service should ensure that local services are notified in advance of release and at the point of release. This will ensure that where secondary mental health services are required these are available upon release from*

[118] Care Programme Approach (CPA) was a system of delivering community mental health services to individuals diagnosed with mental illness
[119] http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en

prison and that the services planned are recorded within the care and treatment plan".

3.108 Mr N was allocated CPN 1 as a care coordinator during the periods that he was on the caseload of the CMHT. For instance in 2004 following discharge from Ty Sirhowy and in 2010 following discharge from Prison. CPA Care Plans were completed for Mr N by CPN 1 who regularly met and attempted to meet with Mr N, his family and partner in order to support his ongoing mental health care. The review team is of the opinion that CPN 1 discharged the role of care coordinator effectively and appears to have had a stabilising effect on Mr N.

3.109 The discharge summary for Mr N's release from HMP Parc on the 23 October 2014 stated that no referral would be made to the CMHT. The discharge summary was sent to Mr N's GP and local CMHT for information.

3.110 Mr N was discharged from prison with a referral to his local CMHT deemed unnecessary. Consequently no secondary mental health services were implemented and no support arrangements engaged.

Community Mental Health Team (CMHT)

3.111 We found that there did not appear to be any formal or active relationship between the local Caerphilly CMHT and In-reach prison psychiatric services. Our fieldwork identified that in terms of information flow, Mental Health In-reach services view the relationship as quite one sided from prison to CMHT, for example the provision of discharge summaries for individuals of note. However, from Caerphilly CMHT's perspective there was an aspiration for the provision of further information. For example, when an individual is referred to a local CMHT that there is a clearer understanding of existing mental health diagnosis, prescribed medication and the sentence served by the

individual (to enable an appropriate risk assessment), would be appreciated.

3.112 There was a lack of clear lines of communication about those individuals classified as Did Not Attend (DNA) within the community and In-reach / GP services. No one service appears proactive in terms of resolving issues around patient non-compliance and taking responsibility to ensure continuing, documented attempts at engagement.

3.113 The review team believe cases such as Mr N require an inquisitive and proactive approach from the CMHT to establish treatment needs and take appropriate action. This would then replace the current method in which a discharge summary is read before waiting for other agencies / individuals to be proactive.

Recommendations

4. Caerphilly County Borough Council should ensure that, where possible, a summary of risk is shared with managers of community accommodation with the permission of the individual being housed.

5. Caerphilly County Borough Council to take steps to ensure regular and appropriate communication with the managers of community accommodation to assist with awareness of roles, responsibilities and any current or ongoing issues regarding individuals provided with accommodation.

6. Caerphilly County Borough Council should offer to provide training to the staff of establishments providing accommodation. Training would primarily relate to: illicit substances; prescribed medication needs; risk assessments; safeguarding issues

relating to children and adults; mental health awareness; and break away/de-escalation techniques.

7. Stakeholders involved in prison discharge and aftercare planning such as local Community Mental Health Teams and Prison In-reach Mental Health Teams, should:

a) ensure systems are in place to allow better sharing of healthcare information prior to discharge from prison. This would help ensure consistency and act as a protective measure against possible relapse in any mental health condition; and

b) Prison In-reach Mental Health Teams and CMHTs to implement a voluntary follow-up appointment within one month of an individual's release from prison. The offer of such a follow-up appointment would help with consistency of care and help support any immediate care issues in an initial period of high risk.

8. Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop clear lines of accountability regarding the responsibility for attempting to engage with individuals who regularly do not attend appointments.

Support

3.114 The events that took place on 6 November 2014 were extremely traumatic and distressing to all involved. The review team feels that those affected by the events of the 6 November 2014, whether in a professional or personal capacity, should be afforded appropriate support. Furthermore, where appropriate continued or more intensive support should be offered. Providing support helps the rehabilitation process both with physical and mental psychological wellbeing.

Professional Support

3.115 All stakeholders, either directly or indirectly involved with the care of Mr N, need to be aware of the impact of such a serious incident as that which occurred on 6 November 2014 upon all staff, thus ensuring the availability of support services following traumatic events such as this one.

3.116 During our fieldwork we received a mixed response from staff about how they perceived the effectiveness of the support provided post the incident of the 6 November 2014. Some positive examples shared with the review team included senior management speaking to staff and offering support, the opportunity for private counselling and access to psychological therapies to no support offered at all.

3.117 The review team learnt that neither the owner of The Sirhowy Arms, nor the owner's family had not been offered or had received any support after this incident. Given both the nature and their close proximity to the events at their home on the 6 November 2014, it is disappointing to hear that no support has been provided by the relevant agencies.

Support for Families

3.118 As part of the review process HIW engaged with the respective families of those affected by the traumatic and life changing incident of the 6 November 2014. The review team was informed that some family members did not feel that they had received the support needed and in the majority of cases no support had been provided.

3.119 Part of an effective support structure is the inclusion of not only information to help with GP referral or signposting towards counselling or therapy, but also in the provision of clarity and regular communications regarding any ongoing investigation processes. This

clarity does not necessarily have to be detailed in terms of specific work being undertaken, but it should include updates regarding progress, even where no significant progress has been made. Furthermore, an effective support structure should also provide families with the opportunity to raise queries they may have with the appropriate organisations. It was identified to the review team by a majority of the family members that no such support was forthcoming, and in some cases it was felt they had been treated insensitively.

Recommendations

9. Stakeholders who have staff involved either directly or indirectly in, or with serious incidents, should have clear and confidential procedures in place to offer them appropriate and timely psychological and trauma support services[120].

10. Stakeholders should ensure that support is provided, either directly or via signposting, to families affected by such incidents. Support should also include ongoing dialogue regarding investigation processes that enables the basis for mutual understanding and trust.

[120] Victim Support Homicide Service being one such avenue of support. https://www.victimsupport.org.uk/what-we-do/national-services/homicide-service

Chapter Four: Recommendations

1. **HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop a process whereby case formulation is routinely introduced and updated, as a prisoner moves from prison to prison and mental health care services. This supports and improves availability, continuity and sharing of information which helps clinicians understand and consider care and treatment planning programmes where appropriate, regarding longstanding and complex cases.**

2. **HMP Cardiff, HMP Parc, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should ensure procedures are in place to check the rationale for prescribed medication, especially when an individual presents a history of non-compliance.**

3. **Welsh Government to review the provision and the availability of more structured interventions for individuals within the community that have both a personality disorder, mental health issues and substance misuse concerns.**

4. **Caerphilly County Borough Council should ensure that, where possible, a summary of risk is shared with managers of community accommodation with the permission of the individual being housed.**

5. **Caerphilly County Borough Council to take steps to ensure regular and appropriate communication with the managers of community accommodation to assist with awareness of roles, responsibilities and any current or ongoing issues regarding individuals provided with accommodation.**

6. **Caerphilly County Borough Council should offer to provide training to the staff of establishments providing accommodation. Training would primarily relate to: illicit substances; prescribed medication needs; risk assessments; safeguarding issues relating to children and adults; mental health awareness; and break away/de-escalation techniques.**

7. **Stakeholders involved in prison discharge and aftercare planning such as local Community Mental Health Teams and Prison In-reach Mental Health Teams, should:**

   a) **ensure systems are in place to allow better sharing of healthcare information prior to discharge from prison. This would help ensure consistency and act as a protective measure against possible relapse in any mental health condition; and**

   b) **Prison In-reach Mental Health Teams and CMHTs to implement a voluntary follow-up appointment within one month of an individual's release from prison. The offer of such a follow-up appointment would help with consistency of care and help support any immediate care issues in an initial period of high risk.**

8. **Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board should develop clear lines of accountability regarding the responsibility for attempting to engage with individuals who regularly do not attend appointments.**

9. **Stakeholders who have staff involved either directly or indirectly in, or with serious incidents, should have clear and confidential**

procedures in place to offer them appropriate and timely psychological and trauma support services.

10. **Stakeholders should ensure that support is provided, either directly or via signposting, to families affected by such incidents. Support should also include ongoing dialogue regarding investigation processes that enables the basis for mutual understanding and trust.**

Annex A: Stakeholder Information

Background to Aneurin Bevan University Health Board (ABUHB)

Aneurin Bevan University Health Board is an NHS Wales organisation in south east Wales headquartered in Caerleon, Newport. The Local Health Board was created in October 2009 through the merger of Gwent Healthcare NHS Trust and Blaenau Gwent, Caerphilly, Newport, Torfaen and Monmouthshire Local Health Boards.

The total catchment area for healthcare services contains a population of approximately 580,400.[121]The health board provides a full range of primary, community, mental health and acute hospital services across five local authority areas in south east Wales.[122]

The health board is responsible for the operation of three district general hospitals and ten other acute, community and mental health hospitals. It co-ordinates the work of 129 GP practices and other NHS services provided in south east Wales by dentists, opticians and pharmacies.

As of March 2014 the health board employed 10,765 Full Time Equivalent (FTE) staff, with 1,257 FTE staff employed within the Mental Health and Learning Disability Division. There are 75 FTE medical, 517 FTE registered nursing and 387 non-registered healthcare support workers involved in mental health or learning disability services. Within each local authority area a range of professionals[123] work within integrated mental health services, with formal shared management structures in place in Caerphilly and Newport boroughs.

[121] 2014 mid-year population estimates – Office of National Statistics (ONS)
[122] Newport, Caerphilly, Blaenau Gwent, Torfaen and Monmouthshire
[123] Professionals such as nurses, medics, psychologists, occupational therapists, social workers and administration staff

Background to Cardiff and Vale University Health Board (C&VUHB)

Cardiff and Vale University Health Board is an NHS organisation in south Wales headquartered in Cardiff. The LHB was created in October 2009 through the amalgamation of the three NHS organisations in the Cardiff and Vale of Glamorgan area.

The total catchment area for healthcare services contains a population of approximately 482,000[124]. The health board provides a full range of primary, community, mental health and acute hospital services across two local authority areas in south east Wales[125].

The health board is responsible for the operation of two district general hospitals and seven other acute, community and mental health hospitals. It co-ordinates the work of 89 GP practices and other NHS services provided in south east Wales by dentists, opticians and pharmacies.

As of March 2014 the health board employed 12,000 FTE staff with approximately 1,112 FTE staff involved in mental health. There are around 77 medical, 867 FTE qualified nursing staff, 145 FTE health care assistants, support workers and technical staff involved in mental health services. Within each local authority area, social workers and nurses work for integrated CMHTs with shared health and social services management arrangements.

Background to Abertawe Bro Morgannwg University Health Board (ABMUHB)

Abertawe Bro Morgannwg University Health Board is an NHS Wales organisation created in October 2009 when Abertawe Bro Morgannwg University Health Trust formally merged with the local health boards of Swansea, Neath Port Talbot and Bridgend.

[124] 2004 mid-year population estimates - ONS
[125] Cardiff and the Vale of Glamorgan

The total catchment area for healthcare services contains a population of approximately 523,000[126]. The health board provides a full range of primary, community, mental health and acute hospital services across three local authority areas in south Wales[127].

The board is responsible for the operation of three district general hospitals and 11 other acute and community hospitals. It co-ordinates the work of 93 GP practices and other NHS services provided in south Wales by dentists, opticians and pharmacies.

As of March 2014 the health board employed 13,130 FTE staff, with approximately 1,300 FTE staff involved in mental health. There are around 85 medical, 1154 FTE qualified nursing staff, 61 FTE healthcare assistants, support workers and technical staff involved with mental health services. Within each local authority area, social workers and nurses work for integrated CMHTs with shared health and social services management arrangements.

Background to HMP Prison Parc

HM Prison (HMP) and Young Offenders' Institution (YOI) Parc is located in Bridgend, south Wales and was one of the first prisons to be built in the UK under the Government's Private Finance Initiative (PFI).

HMP & YOI Parc (HMP Parc) is a category B[128] local training prison with an operational capacity of sixteen hundred male prisoners. The prison provides places for convicted adults, convicted young offenders (both convicted and remand), vulnerable adults and young offenders and convicted and remand young people.

[126] 2014 mid-year population estimates - ONS
[127] Swansea, Neath Port Talbot and Bridgend
[128] Category B prisoners do not need to be held in the highest security conditions but, for category B prisoners, the potential for escape should be made very difficult.

The prison opened in November 1997 and is the only private prison in Wales. It is managed by G4S Care and Justice Services[129] on behalf of the Prison Service.

Healthcare services are commissioned via the National Offender Management Service (NOMS)[130]; integrated services of G4S provide primary health and primary mental health services to the prison population. Primary Mental Health services are supported on site by secondary care providers and a Community Mental Health In Reach Team (CMIRT) commissioned by ABMUHB.

Background to HMP Cardiff

HMP Cardiff is located in Cardiff, south Wales and is a category B local training prison serving the courts in the eastern half of south Wales. HMP Cardiff has an operational capacity of eight hundred and four prisoners. The prison provides places for un-convicted and male prisoners from local courts and short-term prisoners serving up to two years.

The prison dates its origins back to 1827 and currently operates as one of 3[131] public prisons in Wales, run by Her Majesty's Prison Service[132], part of the NOMS.

HMP Cardiff opened a brand new health care centre in May 2008. This facility provides twenty one beds, mostly commissioned by Cardiff and Vale University Health Board (C&VUHB).

The responsibility for primary healthcare services within the three public sector prisons in Wales, including Cardiff, falls to Welsh Government. In April

[129] See: http://www.g4s.uk.com/en-GB/What%20we%20do/Services/Care%20and%20justice%20services/
[130] NOMS, as an executive agency of the Ministry of Justice, are accountable for how prisons are run in England and Wales. Through HM Prison Service NOMS manage public sector prisons in England and Wales. NOMS also oversee probation delivery in England and Wales through the National Probation Service and community rehabilitation companies. See: https://www.gov.uk/government/organisations/national-offender-management-service/about
[131] HMP Cardiff, HMP Usk and Prescoed and HMP Swansea
[132] See: https://www.gov.uk/government/organisations/hm-prison-service

2006 responsibility was devolved to the relevant local health boards. Responsibility for meeting secondary and tertiary healthcare needs for prisoners, regardless of whether public or private run, rests with the National Health Service (NHS) and subsequently with the relevant health boards.

Background to Sirhowy Arms Argoed

The Sirhowy Arms Hotel is a family run bed and breakfast offering accommodation for up to 19 guests. The hotel is situated in the Sirhowy Valley, approximately 29 miles from Cardiff. The Sirhowy Arms Hotel had been used by Caerphilly County Borough Council as emergency bed and breakfast accommodation to accommodate homeless individuals since early 2008.

Background to Caerphilly County Borough Council

Caerphilly County Borough Council is the governing body for the county of Caerphilly, situated in south Wales. The council currently employs approximately 6,757 FTE staff across the many services provided to the population of Caerphilly.

Background to National Offenders Management Services (NOMS) in Wales

NOMS is accountable for the running of prisons in England and Wales. Through the HM Prison service, NOMS manages public sector prisons as well as overseeing probation delivery in England and Wales through the National Probation Service and community rehabilitation services.

NOMS in Wales ensures organisations delivering services involving prisoners in Wales work closely together. NOMS in Wales works with the Welsh Government to ensure that delivery is in line with the policies the Welsh Government creates for the people of Wales.

NOMS in Wales also works closely with charities, independent inspectors, local councils, the courts and police to support the justice system.

Within Wales, NOMS in Wales:

- Directly carries out the sentencing of the courts through the public sector prisons and the National Probation Service in Wales
- Manages the contracts for the Wales Community Rehabilitation Company and HMP Parc
- Implements the overall aims of NOMS agency
- Represents NOMS to the Welsh Government and local partners, working with them to support an integrated system that complements the Welsh Government's strategic programme
- Leads the programme to establish the new prison in north Wales

NOMS in Wales supports the justice system and prevents future victims by cutting crimes and reducing reoffending.

Background to the Wallich Homeless Shelter in Wales

The Wallich[133] has been providing accommodation and support services for homeless people for over 35 years. The Wallich supports service users to engage with partner agencies in order to deal with a range of issues which may include mental health, poor physical health, substance misuse, offending or domestic abuse.

The Wallich employs more than 250 people who look to make life better for those who are experiencing homelessness.

Background to Welsh Ambulance Service NHS Trust

Welsh Ambulance Services NHS Trust[134] (WAST) covers an area of just over 20,640 kilometres and serves a population of 2.9 million. WAST attends more than 250,000 emergency calls per annum, over 50,000 urgent calls and transports over 1.3 million non-emergency patients to over 200 treatment centres throughout Wales and England.

[133] See: http://www.thewallich.com/about-us/
[134] See: http://www.ambulance.wales.nhs.uk/Default.aspx?pageId=8&lan=en

WAST employs[135] 2,855 FTE staff, approximately 1,540 of which are employed as ambulance staff, with a further 500 staff classed as healthcare assistants or support workers. The remaining 810 staff are either employed as administration, estates or other non-medical staff.

[135] As of March 2014

Annex B: Terms of Reference

HEALTHCARE INSPECTORATE WALES (HIW):
REVIEW INTO THE CARE, MEDICAL HISTORY AND EVENTS SURROUNDING THE HOMICIDE COMMITTED AT THE SIRHOWY ARMS HOTEL, ARGOED, BLACKWOOD IN NOVEMBER 2014

HIW is to undertake an independent review of an individual known to mental health services at Aneurin Bevan, Abertawe Bro Morgannwg and Cardiff and Vale University Health Board's, prior to committing a homicide at Sirhowy Arms Hotel in Argoed, on the 6 November 2014.

The review will investigate the care, medical history and events surrounding the homicide committed by Mr N at the Sirhowy Arms, Argoed, Blackwood on 6 November 2014.

In taking this review forward HIW will:

- Consider the care provided to Mr N as far back as his first contact with health and social care services, or further as determined by the review team, in south Wales to provide an understanding and background to the fatal incident that occurred on the 6 November 2014

- Review the decisions made in relation to the care of Mr N

- Consider the effectiveness of multi-agency interfaces and any potential barriers to effective partnership working in the provision of care for Mr N

- Identify any change or changes in Mr N's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred 6 November 2014

- 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[136]

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

HIW will report upon its findings and where appropriate make any recommendations to ensure any necessary improvements in relation to the quality and safety of care are made.

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

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

List of medication prescribed, dose and for how long

Using the evidence available to the review team, the following presents a chronology of Mr N's prescribed medication and dosage from:

Admission Three: 29 May 2004 – 3 July 2004

As Required Medication (PRN)

Date	Medication	Dose
29 May 2004	Lorazepam[137]	1mg @ 2300
	Haloperidol[138]	5mg @ 2300
30 May 2004	Lorazepam	1mg @ 1200 and 2200
	Haloperidol	5mg @ 1200 and 2200
31 May 2004	Lorazepam	1mg @ 2210
	Haloperidol	5mg @ 0930
	Procyclidine[139]	5mg @1600 and 1620
1 June 2004	Lorazepam	1mg @ 1920
	Procyclidine	5mg @ 0200 and 1920
	Olanzapine[140]	5mg @ 0200 and 1730
2 June 2004	Lorazepam	1mg @ 0900. 2mg @ 1625
	Chlorpromazine[141]	50mg @ 1625 and 2230
3 June 2004	Lorazepam	2 mg @ 1820 and 1950
	Olanzapine	5mg @ 0945

[137] http://www.drugs.com/lorazepam.html Lorazepam is used to treat anxiety disorders
[138] http://www.drugs.com/mtm/haloperidol.html An antipsychotic medicine, used to treat schizophrenia
[139] http://patient.info/medicine/procyclidine-arpicolin-kemadrin Procyclidine is used to relieve unwanted side-effects caused by some antipsychotic medicines.
[140] http://www.drugs.com/mtm/olanzapine.html Antipsychotic medication used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.
[141] http://www.drugs.com/mtm/chlorpromazine.html Antipsychotic medication used to treat psychotic disorders such as schizophrenia or manic-depression.

	Chlorpromazine	50mg @ 1820 and 1950
4 June 2004	Chlorpromazine	50mg @ 2025
5 June 2004	Chlorpromazine	50mg prescribed twice (times unclear)
	Lorazepam	2mg @ 2300
6 June 2004	Lorazepam	2mg @ 1005, 1700, 2335
	Chlorpromazine	50mg @ 1005, 1700, 2100
7 June 2004	Lorazepam	2mg @ 0035
	Chlorpromazine	50mg @ 0015, 0925, 1640
8 June 2004	Chlorpromazine	100mg @ 1215
	Lorazepam	2mg @ 1855
9 June 2004	Procyclidine	10mg @ 1515, 1535, 1930
	Lorazepam	2mg @ 2100
10 June 2004	Lorazepam	2mg @ 1710
	Quetiapine[142]	50mg @ 1210
11 June 2004	Procyclidine	5mg @ 1610, 2015
	Lorazepam	2 mg @ 1830, 2230
12 June 2004	Lorazepam	2 mg @ 1135, 1810, 1950, 2020
	Quetiapine	50mg @ 1135, 2200
13 June 2004	Procyclidine	5mg @ 1000
	Lorazepam	2mg @ 0930, 1815, 2100
	Quetiapine	50mg @ 0940
	Olanzapine	10mg @ 1215
	Zopiclone[144]	7.5mg @ 2150
14 June 2004	Lorazepam	2mg @ 1345, 1830
	Olanzapine	10mg @ 0920, 1835
	Zopiclone	7.5mg @ 2130
15 June 2004	Lorazepam	2mg @ 2230
	Zopiclone	7.5mg @ 2230
16 June 2004	Lorazepam	2mg @ 2200

[142] http://www.drugs.com/cdi/quetiapine.html An antipsychotic medication used to treat schizophrenia or bipolar disorder.
[144] http://www.drugs.com/cons/zopiclone.html Medication used to treat insomnia.

17 June 2004	Lorazepam	2mg @ 1005, 1815
	Zopiclone	7.5mg @ 2300
	Chlorpromazine	50mg @ 1005, 1815, 2300
18 June 2004	Chlorpromazine	50mg @ 1630
19 June 2004	Procyclidine	5mg @ 1505
20 June 2004	Lorazepam	2mg @ 2225
	Zopiclone	7.5mg @ 2230
22 June 2004	Lorazepam	2mg @ 2110
	Zopiclone	7.5mg @ 2210
23 June 2004	Lorazepam	2mg @ 1130, 2000
	Procyclidine	5mg @ 1700
	Zopiclone	7.5mg @ 2045
	Chlorpromazine	50mg @ 1130, 1700
24 June 2004	Lorazepam	2mg @ 1600, 1830, 2200
	Zopiclone	7.5mg @ 2200
	Chlorpromazine	50mg @ 1830
26 June 2004	Zopiclone	7.5mg @ 2155
27 June 2004	Zopiclone	7.5mg @ 2200
29 June 2004	Chlorpromazine	50mg @ 1730
1 July 2004	Lorazepam	2mg x 2 (unclear times)
	Chlorpromazine	50mg @ 1750, 2100

Once-Only medication

Date	Medication	Dose
8 June 2004	Acuphase[145]	150mg @ 1530

Regular Prescriptions

Date	Medication	Dose
2 – 8 June 2004	Olanzapine	15mg @ bedtime

[145] http://www.netdoctor.co.uk/medicines/brain-and-nervous-system/a6422/clopixol-acuphase-injection-zuclopenthixol/ Antipsychotic medication used in the treatment of psychotic illnesses. Used for short-term initial treatment of acute psychotic illnesses such as mania or schizophrenia.

(inclusive)		
13 – 15 June 2004 (inclusive)	Olanzapine	10mg @ bedtime
13 – 14 June 2004	Procyclidine	5mg prescribed @ morning, midday, bedtime.
13 June 2004	Procyclidine	5mg given @ midday, bedtime
14 June 2004	Procyclidine	5mg given @ morning, midday
16 – 17 June 2004 (inclusive)	Olanzapine	20mg @ bedtime
19 – 20 June 2004 (inclusive)	Olanzapine	20mg @ bedtime
23 – 24 June 2004 (inclusive)	Olanzapine	20mg @ bedtime
25 – 29 June 2004 (inclusive)	Olanzapine	25mg @ bedtime
<u>Discharge</u>		
4 July 2004	Olanzapine	25mg @ bedtime
	Loranzepam	1mg PRN 1/52
	Chlorpromazine	50mg PRN 2/52
<u>HMP Cardiff[143]</u>		
30 December 2009	Seroquel[146] (Queitiapine)	600mg daily
<u>Community</u>		
14 January 2010	Olanzapine	10mg @ nocte[147] for 1

[143] Noted within the primary care records. Information only shows that a fax was received by the GP surgery on the 30 December 2009. However, unclear as to when the actual prescription was given to Mr N whilst at HMP Cardiff.
[146] http://www.drugs.com/seroquel.html Antipsychotic medication used to treat schizophrenia and bipolar.

		month by CMHT
13 May 2010	Abilify	10mg OD – f/u 2/52 Walk in clinic prescribed by Psychiatrist 3
<u>Prison Medication</u>		
17 November 2012	Olanzapine	28 x 15mg orodispersible[148] tablets. 1
10 January 2013	Olanzapine	in the AM 28 x 10mg tablets. 1 in the
12 February 2013	Olanzapine	PM 28 x 10mg orodispersible tablets. 1 tablet in the AM
7 March 2013	Quetiapine	Ended 7 March 2013 6 x 100mg tablets. 1x AM
	Quetiapine	1x PM 56 x 200mg tablets. 1xAM
	Quetiapine	1xPM 12 x 25mg tablets. 2xAM
8 March 2013	Quetiapine	2xPM 12 x 25mg tablets. 2xAM
11 March 2013	Quetiapine	2xPM 6 x 100mg tablets. 1xAM
14 March 2013	Quetiapine	1xPM 56 x 200mg tablets. 1xAM
15 March 2013	Quetiapine	1xPM 56 x 200mg tablets. 1xAM 1xPM
21 March 2013	Quetiapine	Ended 21 March 2013 56 x 100mg tablets. 1xAM
12 April 2013	Quetiapine	1xPM

[147] http://medical-dictionary.thefreedictionary.com/NOCTE At night
[148] http://www.encyclo.co.uk/meaning-of-Orodispersible Tablets which dissolve in the mouth and therefore easy to swallow.

		56 x 100mg tablets. 1xAM 1xPM
18 April 2013	Quetiapine	Ended 18 April 2013
	Quetiapine	28 x 100mg tablets. 1xAM
9 May 2013	Quetiapine	28 x 200mg tablets. 1xPM
		168 x 100mg tablets. 1xAM. Ended 30 May 2013
9 May 2013	Quetiapine	168 x 200mg tablets. 1x PM
30 May 2013	Quetiapine	28 x 300mg modified release[149] tablets 1xPM
24 June 2013	Quetiapine	28 x 300mg modified release tablets 1xPM
22 July 2013	Quetiapine	28 x 300mg modified release tablets 1xPM
20 August 2013	Quetiapine	168 x 300mg modified release tablets 1x PM
2 September 2013	Quetiapine	5 x 300mg modified release tablets 1xPM
24 September 2013	Quetiapine	28 x mg tablets 1xPM
19 October 2013	Quetiapine	168 x 300mg modified release tablets 1x PM Ended 26 February 2014 – end of course
15 November 2013	Quetiapine	28 x 300mg tablets. 1xPM
7 December 2013	Quetiapine	168 x 300mg modified release tablets 1xPM Ended on 26 February 2014 – end of course
9 January 2014	Quetiapine	3 x 150mg modified release tablets 1xPM

[149] http://dictionary.reference.com/browse/modified-release A medicinal drug taken orally that releases the active ingredients over several hours.

12 January 2014	Quetiapine	28 x 150mg tablets 1xPM
26 February 2014	Quetiapine	28 x 300mg modified release tablets 1xbedtime
25 March 2014	Quetiapine	28 x 300mg modified release tablets 1xbedtime. Ended 26 March 2014 – end of course.
26 March 2014	Quetiapine	28 x 300mg modified release tablets 1xbedtime. Ended 26 March 2014 – end of course.
24 April 2014	Quetiapine	28 x 300mg modified release tablets 1xbedtime
21 May 2014	Quetiapine	60 x 400mg modified release tablets 1 @ night. Ended early 5 June 2014
5 June 2014	Quetiapine	28 x 400mg modified release tablets 1xPM
26 June 2014	Quetiapine	28 x 400mg modified release tablets 1xPM. Ended early 11 July 2014: Patient Preference.

Annex D: Mr N's known residence

May 2004 – July 2004

29 May 2004 – 4 July 2004	Ty Sirhowy

June 2011 – November 2014

2 June 2011 – 22 September 2011	HMP Cardiff
23 September 2011 – July 2012	Community
6 July 2012 – 10 February 2013	HMP Cardiff
11 February 2013 - 8 September 2013	HMP Parc
9 September 2013 – 20 September 2013	Community
23 September 2013 – 26 January 2014	HMP Cardiff
27 January 2014 – 22 October 2014	HMP Parc
23 October 2014 – 6 November 2014	Community / Sirhowy Arms Hotel

Inferences from available evidence as to residence:

3 February 2005	Sentenced to 5 years at Cardiff Crown Court, unknown which prison
July 2007	Reference to time in HMP Channings Wood and HMP Dartmoor
[date unclear] - 22 December 2009	Released from HMP Cardiff

Annex E: Arrangements for the Review

Approach

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

The Review Team

The review began in March 2015. A review team was constructed to include relevant expertise.

The review team included a representative from the National Offender Management Service (NOMS), drawing upon their expertise and perspective in regards to offender management services.

The review team also sought the expertise of Care and Social Services Inspectorate for Wales (CSSIW) for matters relating to social care in Wales.

The members of the team were:

Dr Siriol David	Head of Forensic Psychological Services – Ministry of Justice, NOMS in Wales. Chair of the Welsh branch of the British Psychological Society division of Forensic Psychology.

Dr Anthony Calland M.B.E.	General Practitioner. Previously a GP for 34 years and chaired, GP committee of the BMA in Wales, Welsh Council of the BMA, the BMA Medical Ethics committee. and is currently joint vice chair of the Royal College of GPs in Wales. Member of the Bevan Commission.
Dr Tim McInerny	Consultant Forensic Psychiatrist – South London and Maudsley NHS Foundation Trust. Committee member for the Forensic Faculty, Royal College of Psychiatrists, visiting psychiatrist to the Falkland Islands and visiting forensic psychiatrist to St Helena.
Hannah Williams	Deputy LDU Head, NOMS. Former Probation Officer with experience in offender management both operationally and strategically, with interests in the fields of multi-agency public protection arrangements, substance misuse, domestic abuse and integrated management approaches.
Jane Mackenzie	Retired Mental Health Nurse. Master of Social Science (MSc) Quality Management in Healthcare. Trained as a Registered Mental Health Nurse (RMN), formerly Registered Nurse (General) (RNG) and a member of HIW Investigation and Inspection teams in Mental Health Services across Wales.

Jenny Hepworth	HIW Lay Reviewer. External associate of the General Medical Council (GMC). Royal College of General Practioners Lay Advisor. Member of both the National GP Speciality Advisory Committee and the Steering Group for the National Recruitment of GPs. Lay Representative for South West Health Education England
Rhys Jones	Head of Investigation
Christopher Bristow	Investigations Manager
Lisa Bresner	Assistant Investigations Manager
Rebecca Collier	Assistant Investigations Manager

The review consisted of three stages:

a. Collection and analysis of documents
b. Fieldwork interviews undertaken with relevant stakeholders
c. Identification of findings, formulation of recommendations and completion of this report

Annex F: The roles and responsibilities of Healthcare Inspectorate Wales

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

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

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers on Wales and is the Local Supervising Authority for the statutory supervision of midwives.

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

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

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