Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Report of a review in respect of:

Mr K and the provision of Mental Health Services, following a Homicide committed in March 2011

March 2014

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Summary of the Index Offence

1.1 On 22 March 2011, Mr K attacked Mr Z whilst they both resided at a hostel in Claude Place, operated by Cardiff Mind. Mr Z sustained severe injuries and sadly died as a result of the wounds he received.

1.2 On 21 December 2011, Mr K was convicted at Cardiff Crown Court of the manslaughter of Mr Z on the grounds of diminished responsibility. Mr K was sentenced by means of a court order under section 37/41 of the Mental Health Act 1983[1] to be detained at a medium secure mental health unit indefinitely.

Mr K's Family and Social history

1.3 Mr K was born in 1984 and at the time of the incident was 27 years old. He had a history of periods of homelessness, alcohol and substance misuse.

1.4 Mr K was raised in Mountain Ash, part of Rhondda Cynon Taff; although during various periods he lived in Porthcawl, Pontypridd, Aberdare and Abercynon. Mr K also spent some time in Leicester where he was studying a university course in Physics.

1.5 Mr K is one of five biological siblings having three brothers and a sister, with Mr K being the youngest. He also has four step sisters. It was documented that Mr K's mother left the family home when he was very young, returning briefly for a period before leaving indefinitely when Mr K was seven years old. Despite this, Mr K maintained contact with his mother and had intermittent periods of time living with her since his mid- teens.

1.6 Mr K was raised by his father supported with the help of his paternal\grandmother who came to live with them following the death of her husband. Sadly after spending two years in the family home, when Mr K was approximately

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

eight or nine years old, his grandmother died. Mr K's stepmother moved into the family home shortly after and was heavily involved in the care of the children.

1.7 There were several reported incidents during his childhood of Mr K behaving strangely. He would climb onto buildings putting himself at risk and at times jump off. On one occasion, Mr K climbed onto the roof of a local swimming pool where he fell through the roof and fractured his skull. When Mr K was seventeen, he and a friend jumped off a bridge into a shallow river. Mr K escaped serious injury but was treated for shock. On another occasion, Mr K kicked in a shop window, injuring his leg in the process.

1.8 Mr K performed adequately at school and excelled particularly at Mathematics and Science. He made and kept many friends and enjoyed playing football. However, from an early age Mr K had problems with his feet (due to a variant of talipes[2]) and had to wear orthopaedic shoes for a time. It was reported that people would comment on Mr K's clothing and footwear in a derogatory fashion and make fun of him. Mr K was also a very small child and he was apparently bullied in both junior and comprehensive school.

1.9 It is believed that at the age of fourteen or fifteen Mr K left the family home and went to live with his mother. It was around this time that it is believed that he began drinking alcohol and using illegal substances. It was reported that his mother was not tolerant of Mr K's poor behaviour and as a result he only lived with her for a very short period of time. He subsequently moved to live with his biological sister. Mr K's use of drink and drugs led to him regularly getting into altercations, which often led to him being injured due to his small physical stature.

1.10 On leaving his sister's home, Mr K went to live with one of his brothers. He stayed with this brother for short periods in a number of properties over the years. On two occasions his brother went away and on his return he had found that he had been evicted and his property boarded up. It was reported that this was because Mr K had invited friends in to have parties which resulted in damage to the property, arguments with neighbours, and the police being called.

[2] Club foot is sometimes known as talipes. Club foot is a deformity of the foot and ankle that is present at birth (congenital). If it is treated early, the position and function of the foot can be greatly improved.

1.11 Mr K also spent periods living with various other family members. His moves between them were usually precipitated by Mr K's drinking, drug misuse and poor behaviour.

1.12 Mr K went on to live at 'Cynon Action for Single and Homeless' (The Old Bakery Housing Project)[3] in Aberdare.

Mr K's Criminal History

1.13 Mr K's first encounter with the Police was when he was sixteen years of age. In March 2000, he was arrested for being carried in a motor vehicle taken without consent. At this time it would appear that Mr K was living in the homeless accommodation referred to above 'Cynon Action for Single and Homeless' in Aberdare.

1.14 Between 2000 and 2011, prior to the index offence, Mr K had several convictions, namely theft, shoplifting and public order offences.

1.15 Between 2000 and 2003 Mr K was arrested eleven times. He was charged with the following offences:

- public Order
- theft
- shoplifting
- indecent assault on a female over sixteen years of age.

1.16 Five custody records indicate a high level of intoxication and violent behaviour whilst in police custody.

1.17 There were a further eight occurrence reports between 2003 and 2011 with alcohol being a key factor in these occurrences.

1.18 Where medical assessments were recorded, there were no disclosures of illness, medication or that he was suffering from a mental health illness, or had ever

[3] Cynon Action for Single and Homeless (The old Bakery Project) is temporary accommodation in Aberdare. This is now known as ADREF Ltd.

self harmed. Mr K had been offered a drug referral facility on an occasion when he was in police custody in January 2007.

1.19 It was recorded that Mr K had been fined and given community service on a number of occasions for being drunk and disorderly. It was also recorded that he spent time in Her Majesty's Prison (HMP) Leicester for a few weeks following non-payment of fines and not attending community service.

History of contact with Mental Health Services

September 2009

1.20 Mr K saw his General Practitioner, *GP 1* of Portway Surgery, Porthcawl on 28 September 2009, having recently registered with the Surgery (he had initially been seen as a temporary patient on 23 September 2009). He had attended the GP with one of his brothers who had encouraged him to make the appointment. It was recorded:

> *"He [Mr K] has moved from Leicester where he was studying physics although he has basically moved around a lot over the last few years and has actually had periods of being homeless. He is apparently having difficulty sleeping; he is speaking to himself and is low in confidence. He is not currently on any medications and he denied any previous illnesses in the past".*

1.21 Mr K's brother reported that their parents had split up when they were children and that things were "hard at home". Mr K explained that he had ended up living with his sister when he was fourteen years of age and then moved in to sheltered accommodation in Aberdare for two years. His brother reported that Mr K had changed a lot and was "no longer himself"; was more withdrawn and noticed that Mr K would avoid eye contact with him.

1.22 With regards to Mr K's drug and alcohol misuse, it was recorded that he was no longer smoking cannabis but smoking tobacco. He was drinking twelve cans of lager a week and smoking ten cigarettes a day. Mr K did report that he had

previously smoked cannabis although had not done so for a number of months. It was also recorded that he had a tendency of binge drinking but again had not done so for the last few months.

1.23 A 'mental health state examination'[4] noted that Mr K was slightly unkempt and engaged in no eye contact throughout the consultation and had a flat affect[5]. Mr K did report that he was hearing voices but could not describe who was speaking to him.

1.24 Bloods had been carried out on 24 September 2009 (following his first appointment as a temporary patient) and revealed a normal full blood count, glucose, thyroid function, Urea and Electrolytes (U&E)[6], Epidermal Growth Factor Receptor (EGFR)[7] and Liver Function Tests (LFT)[8] with a Gamma GT of 29.

1.25 At this appointment on 28 September 2009, Mr K stated he was depressed and was experiencing anxiety for the last four weeks.

1.26 Following GP 1's assessment Mr K was commenced on Effexor MR9 75 mgs once daily and an urgent psychiatric opinion was sought. Mr K was referred to Consultant Psychiatrist 1, at 'Mental Health Well Being and Out Patient Centre' at the Princess of Wales Hospital in Bridgend (Coity Clinic) on 30 September 2009.

October 2009

1.27 The Integrated Line Manager from Porthcawl Community Mental Health Team wrote to GP 1 on 12 October 2009 advising the GP 1 that they had received the

[4] The mental status examination or mental state examination, abbreviated MSE, is an important part of the clinical assessment process in psychiatric practice. It is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment.
[5] Flat affect: A severe reduction in emotional expressiveness. People with depression and schizophrenia often show flat affect. A person with schizophrenia may not show the signs of normal emotion, perhaps may speak in a monotonous voice, have diminished facial expressions, and appear extremely apathetic. Also known as blunted affect.
[6] U&E is a blood test and is often used as a screening test for patients who are generally unwell, to detect abnormalities of blood chemistry, including kidney failure and dehydration.
[7] EGFR is estimated Glomerular Filtration Rate, usually based on serum Creatinine level, age, sex, and race. Normal GFR is approximately 100mls/min/1.73m2.
[8] LFTs measure various chemicals in the blood made by the liver. An abnormal result indicates a problem with the liver, and may help to identify the cause. Further tests may be needed to clarify the cause of the liver problem.
[9] Effexor XR (venlafaxine hydrochloride) extended-release capsules is indicated for the treatment of major depressive disorder

referral and had discussed it in their Multi- Disciplinary Team meeting and agreed that a referral to the 'Mental Health Well Being and Out Patient Centre' for a Psychiatric Outpatient appointment would be the most appropriate course of action. All of Mr K's information was forwarded to the centre and *GP 1* would be informed of the outcome in due course.

November 2009

1.28 Mr K was subsequently assessed on 4 November 2009 by *Doctor 1*, Staff Grade to *Consultant Psychiatrist 1*. Mr K attended this appointment alone and it was recorded:

> *"He described his symptoms as not feeling focused, having lost weight, trying to do things and nothing seems to be working and that everything seemed to fall apart. He described a loss of interest in things and making excuses for not doing things. He is in the habit of sleeping most of the day and also complaining of feeling sluggish and drained".*

1.29 It was recorded that the symptoms appeared to have been present for the last four years along with a history of alcohol misuse. It was recorded:

> *"He said that he gets an urge to drink and when he starts drinking he cannot stop himself and usually ends up spending all his money. He has been drinking this much alcohol (five to eight cans of Budweiser two or three times per week) over the last four years. Mr K described his current alcohol intake as normal although commented that friends and family were concerned about his intake".*

1.30 On mental state examination undertaken by *Doctor 1*, Mr K was noted to be well dressed and well kempt. His eye contact was fleeting in nature but the rapport was spontaneous. He smelt of alcohol, appeared slightly drowsy and his speech appeared slurred. Initially Mr K denied having had any alcohol but later admitted to having a can of alcohol before arriving for the appointment. Mr K described his mood as feeling drained and sluggish. *Doctor 1* could not elicit any disorder of thought or perception and his cognition appeared 'grossly intact'. Mr K appeared to have poor insight into his condition as he did not see the increase in alcohol intake as a problem, rather that it was normal behaviour for him.

1.31 Following *Doctor 1*'s assessment, he stated that *'Mr K suffers from alcohol dependence syndrome with a lack of insight into his condition'*. *Doctor 1* provided Mr K with psycho education[10] around this disorder and encouraged him to attend the 'West Glamorgan Council on Alcohol and Drug Abuse' and Addiction' (WGCADA)[11] to alter his behaviour. Mr K was advised to continue to take Venlafaxine (Effexor MR) in addition to Thiamine and Vitamin B Complex. Mr K was recommended for a follow up appointment in eight weeks time to assess the level of progress he had made and also to ensure if he had engaged with WGCADA. However, there was no evidence to suggest that Mr K was given a follow up appointment within the eight weeks of having seen *Doctor 1*.

1.32 A follow up outpatients' appointment was scheduled for 2 June 2010, but Mr K failed to attend and consequently he was referred back to his GP.

March 2010

1.33 On 12 March 2010, Mr K registered with Butetown Medical Practice` in Cardiff and was under the care of General Practitioner, *GP 2*. It was recorded that Mr K had gone to the Practice as he had knee problems. He had fallen out with his family and 'kicked his right knee in'. His knee was swollen so *GP 2* referred Mr K for an x-ray.

[10] Psycho education refers to the education offered to people with a mental health condition. Frequently psycho educational training involves individuals with schizophrenia, clinical depression, anxiety disorders, psychotic illnesses, eating disorders, and personality disorders, as well as patient training courses in the context of the treatment of physical illnesses. Family members are also included. A goal is for the consumer to understand and be better able to deal with the presented illness. Also, the patient's own strengths, resources and coping skills are reinforced, in order to understand that relapse is a part of their recovery, and contribute to their own health and wellness on a long-term basis. The theory is, with better knowledge the consumer has of their illness, the better the consumer can live with their condition.

[11] WCADA provides a range of treatment interventions for those affected by substance misuse. WCADA is one of the leading substance misuse treatment agencies in Wales providing Minnesota 12-Step Abstinence treatment and Harm Reduction services, including needle exchange and outreach, targeted to individual need. Other services provided include information, advice and treatment for young people, older and disabled people, family members and carers

April 2010

1.34 On 26 April 2010, Mr K had an x-ray which recorded that he had an avulsion fracture[12] of the lateral tibial plateau (fractured tibia). An orthopaedic referral was advised for further evaluation.

Mr K's period at Ty Gobaith, Salvation Army

1.35 Mr K registered with the Butetown Medical Practice in March 2010, however it is not until April/May 2010 that Mr K is recorded as moving into Ty Gobaith, a Salvation Army hostel in Butetown, Cardiff. It is not known when Mr K moved to Cardiff from Porthcawl or where he was living until moving into Ty Gobaith. Mr K was a resident at Ty Gobaith for a period of approximately four months.

1.36 Mr K accessed Ty Gobaith through 'direct access' and a basic needs assessment tool[13] was completed upon Mr K's admission which recorded that Mr K's main issues were alcohol misuse, cocaine misuse and ability to manage his money. There was no evidence to suggest that Mr K's previous mental health assessment by *Doctor 1* was shared with, or requested by staff at Ty Gobaith.

1.37 Mr K was allocated a key worker, *key worker 1* within three days of being at Ty Gobaith. Key worker 1 saw Mr K every week and completed a support plan every four weeks. Mr K's last support plan was carried out on 9 July 2010, which took over three weeks to complete.

1.38 The application form to reside at a Cardiff Mind hostel was completed on Mr K's behalf on 2 June 2010, it recorded:

> *'[Mr K] suffers with stress and anxiety particularly with crowds. [Mr K] was diagnosed with depression but doesn't feel this was an accurate diagnosis and doesn't take his medication'.*

[12] An avulsion fracture is a bone fracture which occurs when a fragment of bone tears away from the main mass of bone as a result of physical trauma
[13] The Basic Needs Assessment at Ty Gobaith is an assessment that looks at somebody's heath problems, GP details etc.

1.39 The application form also recorded that Mr K would benefit from support with:

- drinking and gambling which he [Mr K] does when stressed and anxious;
- staying on an even keel mentally and maintaining motivation;
- finding a job
- ensuring benefits stay up and running.

1.40 The application form stated that Mr K was currently living in a hostel [Ty Gobaith] and would benefit from more secure accommodation in a smaller project. *GP 2* from Butetown Medical Practice and Mr K's key worker contact details were recorded on the form so that they could be contacted to discuss Mr K and his support needs and complete professional assessment pro forma.

1.41 On 3 June 2010, Mr K had an appointment with *GP 2*. The records state that *GP 2* wrote to the trauma clinic for appropriate treatment as Mr K was still experiencing pain following surgery after his fractured tibia. *GP 2* wrote that the referral made by *GP 3* on 6 May would not be soon enough as Mr K was showing increasing pain in his knee. *GP 2* recorded that Mr K's mood was low.

1.42 Mr K was seen in the Trauma Clinic on 15 June 2010, where it was recorded that Mr K had sustained an injury to his right knee and went to see his GP where an x-ray was requested and showed a second fracture.

1.43 Upon examination, Mr K was still slightly tender over his lateral aspect of his knee joint but had a full range of movement. However, Mr K still got a lot of discomfort when he tried to walk. An MRI scan of Mr K's right knee was requested to decide his further management.

1.44 *GP 2* saw Mr K again on 24 June 2010 at the surgery. Staff at Ty Gobaith had brought Mr K for the appointment following concerns about his mental state. *GP 2* referred Mr K for an urgent psychiatric assessment at Hamadryad CMHT as *GP 2* thought Mr K was exhibiting negative features of a schizophrenic illness. *GP 2* recorded:

> *'I am concerned about this 26 year old man who has been living in Ty Gobaith for 2 or 3 months. He was brought to see me on 24/6/2010 by his keyworker. She [keyworker] is concerned that his mental health is deteriorating over the*

time that she has known him. He certainly seemed unwell compared to the other time I met him on 2/6/2010.

He [Mr K] is vacant, restless- fiddling with things, he cannot maintain a train of thought for long, he feels his eyes are wrong and keeps rubbing them. He denies hearing voices or seeing hallucinations. His mood varies. He also looks quite dishevelled.'

1.45 Following the GP's referral Mr K failed to attend an initial outpatient appointment with *Consultant Psychiatrist 2* at the Hamadryad Centre on 1 July 2010; however, Mr K was eventually seen on 8 July 2010. It was recorded at this appointment that he had been living at Ty Gobaith for a few months and was complaining of feeling restless all the time and described what he felt as "rage inside" with difficulty enjoying pastimes, such as attending the gym. It was recorded that Mr K wished to be able to enjoy life and felt that others were enjoying themselves. Mr K stated that he felt detached "like I am not really here".

1.46 The member of staff from Ty Gobaith who accompanied Mr K to the appointment reported concerns that Mr K had a tendency to isolate himself and at times appeared paranoid. There was one recent incident with a female at the Huggard Centre[14] when Mr K allegedly had exposed himself whilst he was out walking with her. It later proved impossible to ascertain whether this had any sexual motivation or whether this was merely social ineptitude.

1.47 *Consultant Psychiatrist 2* also noted:

'another noticeable feature is that he [Mr K] continually rubbed his eyes, in particular his right eye during the course of the consultation. He says that the eye feels uncomfortable and that this mannerism becomes more apparent when he is in peoples' company and he says he prefers to be alone'.

1.48 On mental state examination, *Consultant Psychiatrist 2* elicited no evidence of psychotic phenomena and his affect and mood appeared euthymic. It was recorded that he did have some *'somatic symptoms of depression'* and that the most likely diagnosis was that of depression however a primary psychotic disorder could not be ruled out.

[14] A Cardiff based charity that operates a day centre called the Huggard Centre.

1.49 Having apparently responded well to Venlafaxine 75mgs once daily in the past, Mr K was consequently prescribed 150mgs once daily. Arrangements were made for Mr K to be reviewed in six weeks time and he was referred for Community Psychiatric Nurse (CPN) input.

1.50 On 20 July 2010, a Multi disciplinary meeting was held where Mr K was discussed. In line with *Consultant Psychiatrist 2*'s recommendation it was agreed that Mr K should have CPN input and on 27 July 2010, *CPN 1* was allocated as Mr K's CPN.

1.51 On 4 August 2010, *CPN 1* was contacted by Mr K's key worker at Ty Gobaith (*key worker 1*) to inform that Mr K would not be able to keep his appointment scheduled for the following day (5 August) due to it clashing with another appointment. The key worker also stated that Mr K was in personal payment arrears and consequently would be moving from his accommodation at Ty Gobaith within the next day or so to Tresillian House[15]. Staff at Ty Gobaith had reported Mr K to be demanding in his behaviours but no violence was recorded. Mr K was on notice for not paying his rent whilst at Ty Gobaith and for inappropriate behaviour towards female residents. However, it is unclear whether this was intentional or due to intoxication.

1.52 On 5 August 2010, Mr K was seen by *GP 3* from the Butetown Medical Practice. *GP 3* found it difficult to engage with Mr K so again referred Mr K to see *Consultant Psychiatrist 2* at the Hamadryad CMHT. Consequently, an outpatient appointment was made for Mr K to see *Consultant Psychiatrist 2* on 19 August 2010. Mr K did not attend this appointment and therefore a further appointment was arranged.

Mr K's period at Tresillian House

1.53 Mr K left Ty Gobaith on 9 August 2010 and moved to Tresillian House. Staff at Tresillian House made an appointment for Mr K to go for an assessment with

[15] Tresillian House is accommodation for single homeless people aged 16 and over. Specifically cater for ex-offenders and people with alcohol, drug and mental health issues. Can accept people with care packages and couples

Cardiff Mind which was scheduled for Friday 20 August 2010. It was also recorded that Mr K was appointed a key worker, *key worker 2,* at Tresillian and they were due to meet on Thursday 19 August 2010.

1.54 On 19 August 2010, Mr K was visited by *key worker 2*. It was recorded that they had a long discussion and it was noted that Mr K had an appointment with the Hamadryad Centre that had been due that day but had been re-arranged to 8 September 2010. Mr K expressed that he didn't want to go to this appointment as he felt it was "pointless" because it wasn't helping him. *Key worker 2* discussed this matter with Mr K and also the issues around him not taking his medication and encouraged him to have another go at taking them. *Key worker 2* also explained to Mr K that his benefits and housing options may depend on him being in contact with Hamadryad, with this it is recorded that Mr K agreed to go to his upcoming appointment.

1.55 Mr K expressed to *key worker 2* that he felt that "there was a war going on in his head", which impacted on him making decisions and that he could not focus. Although Mr K stated that he felt that the thoughts were his own and not someone else's; he could not control them and found it difficult and upsetting.

1.56 Mr K stated that he found living at Tresillian House ok, but found it difficult to make and carry out plans. *Key worker 2* suggested that Mr K engage with activities at the Huggard Centre but Mr K stated that he found it difficult to be in that atmosphere. *Key worker 2* agreed to contact them to see if Mr K could go on a cinema trip. *Key worker 2* also recorded that he would talk to Cardiff Mind at Mr K's meeting regarding housing the following day (20 August) to see if Mr K could access activities there. Mr K had also received a date for an MRI scan on his knee scheduled for 24 September 2010. *Key worker 2* recorded that the radiology questionnaire that had been sent to fill out prior to the appointment had been completed and returned and an outreach van had been booked to take Mr K to the appointment. Key worker recorded that Mr K continually rubbed his eyes and held his head during the session, as if he was trying to block something out.

1.57 On 23 August 2010, *CPN 1* contacted Mr K's previous key worker, *key worker 1*, from Ty Gobaith as he had had no information on Mr K's whereabouts. The records state that on 9 August 2010 Ty Gobaith informed *CPN 1* that Mr K was now residing at Tresillian House.

1.58 On 30 August 2010 Mr K's key worker met with Mr K as arranged. Mr K was communicative for most of the session, although at times seemed to be distracted and occasionally lost track of the conversation. It was recorded that it appeared that Mr K first experienced mental health problems whilst studying Physics at Leicester University. Mr K was unclear at times about his mental health history, but it appeared that he was first prescribed antidepressants (Effexor MR) by his GP (*GP 1*), which he stopped taking because they made him feel sleepy. Mr K was subsequently prescribed Effexor but again stopped taking them as he felt they stopped having an effect on him. Key worker 2 explained to Mr K that it could take a while to get the dose of the medication correct and that he should continue to engage with the Hamadryad Centre to help him with this. Mr K was not keen to return there but agreed to go to his next appointment, which was scheduled for the 8 September 2010.

1.59 Mr K stated that in addition to his knee he was also experiencing pain with one of his feet but could not give any further details on this. He also stated that he would like to look into studying plumbing.

1.60 Mr K briefly spoke about what appeared to be some sort of domestic violence during his childhood. He talked about arguments in relation to daily tasks and chores that would end in physical violence. However, Mr K was uncomfortable talking about this subject in any depth and it was difficult to gauge what exactly might have happened. *Key worker 2* told Mr K that he could talk to them if he felt he needed to and also offered the opportunity for him to speak to someone independent.

1.61 From this session, *key worker 2* also spoke with Mr K about him not paying the agreed service charge the week before. Mr K stated that he needed to buy a new pair of trainers. Mr K was subsequently put onto self catering while he worked off the arrears and agreed to pay a sum of £30 when he was next paid.

1.62 Mr K had another session with *key worker 2* on 31 August 2010 where they discussed his upcoming appointments with Hamadryad and Cardiff Mind at length. Mr K was still agreeing to attend but became upset to the point of tears when discussing the need to "answer lots of difficult questions". *Key worker 2* reassured Mr K that he would support him and that everyone he was seeing would be acting to

support him and that the aim was to ensure he would feel better. Mr K also stated that he no longer wished to study plumbing; instead he wanted to study construction.

1.63 On 31 August 2010, *CPN 1* wrote to Mr K at Tresillian House stating that he had an appointment with him scheduled for 7 September 2010.

1.64 On 3 September, Mr K was seen by *key worker 2*. Mr K told him that he had walked to Barry (a town approximately 10miles south west of Cardiff) the day before to try to enrol onto a college course. However, when he got there, there were no courses that he wanted to do. *Key worker 2* did record that Mr K was walking with a limp but the details of this apparent visit to the college were hazy. *Key worker 2* discussed with Mr K whether it was an appropriate time to engage in work/study as he may struggle to manage a busier schedule. *Key worker 2* suggested that for the time being Mr K focused on working with agencies such as Hamadryad to try to improve the way he was feeling and to balance/clear his mind to allow him to be able to manage the extra study.

1.65 *Key worker 2* recorded that during their discussion Mr K changed the topic that he wanted to study on two occasions, firstly to electronics and then onto business studies. It was recorded by *key worker 2* that Mr K had difficulty in engaging with this issue. Mr K discussed having continual appointments that would disrupt his routine; however when *key worker 2* tried to explore this further, Mr K could not describe his routine, nor what he would be doing if he was not attending the scheduled appointments.

1.66 *Key worker 2* suggested that Mr K go to Glan Hafren College[16] to talk to them about enrolment. However, Mr K stated that he was too tired, needed a bath and had no money. *Key worker 2* told Mr K that he did not think these were good reasons for not going and that if he was struggling to mange this then he might have problems studying full time.

1.67 *Key worker 2* tried to talk to Mr K about his feelings and thought it useful that Mr K should focus on what he was feeling on the 'inside' rather than 'outside'. Mr K stated that he was still finding it hard to control his thoughts. Specifically, Mr K stated that he was constantly concerned over managing all his appointments especially his

[16] A tertiary college located in Cardiff.

benefits. *Key worker 2* spent some time defining to Mr K exactly what he needed to do with regard to this.

1.68 On 7 September 2010, *CPN 1* wrote to Mr K stating that he was sorry he missed him for their appointment that day. He re-arranged another date and was now due to see Mr K on 5 October 2010 at 10:30am.

1.69 On 8 September 2010, Mr K met with the Deputy Manager for Support Services from Cardiff Mind and the 'Initial Contact Assessment' form was completed. When asked to describe Mr K's mental health problems or emotional problems the form recorded:

> *'Going over things all day long, searching. Prefer to be with less people than living with before- where its busy/ hectic and causing stress and anxiety hence wanting to move. Wanting to take extra meds to feel better (has CPN).'*

1.70 The form also recorded under 'Alcohol Abuse' that:

> *'Don't think I [Mr K] have an issue with drinking. Some days I don't, others I do. Like to drink with other people, had one can this morning- not too much. Drink more when stressed/ anxious for interviews and things like that.'*

1.71 When asked about his current housing situation Mr K recorded:

> *'So busy in hostel and noisy- cannot relax, its stressing me out'.*

1.72 Mr K also recorded that he had ongoing problems with his knee and was waiting for an MRI scan.

1.73 A 'Mental Health Assessment' form was also completed where it recorded that Mr K was currently under the care of *Consultant Psychiatrist 2* from the Hamadryad CMHT and his last contact with him was in August 2010. The form recorded that he was diagnosed with depression, stress and anxiety. Mr K described his current mental health problems and recorded:

> *'I get stressed and anxiety when I have formal meetings, also in crowds. I need peace and quiet and the hostel is very noisy. I am trying to find out who*

I am. I like to get quiet time to myself. I sometimes need help to find medication which will help me and make me have a good nights sleep. My Psychiatrist is helping with this.'

1.74 Mr K also recorded that he had tried to commit suicide twice between 2005-2006, by overdosing on medication and jumping off a bridge.

1.75 Mr K also recorded that he had experienced depression, anxiety/ panic attacks, recurring disturbing thoughts, suspicions/ paranoia and self harm.

1.76 On 9 September 2010, an appointment was made for Mr K to see *Consultant Psychiatrist 2* at the Hamadryad Centre on 29 September due to Mr K failing to attend his appointment on 8 September 2010.

1.77 Mr K met with *key worker 2* on the 12 September 2010 where Mr K requested he go back on full board basis. The key worker decided that he could on the condition he paid £70 on the 21 September which he agreed to.

1.78 The key worker also recorded that he had completed the professional assessment pro forma (Common Risk Assessment) requested by Cardiff Mind and that he would follow up the referral on his return from annual leave. It was recorded that Mr K:

'can become frustrated and has problems controlling anger in situations, but no aggression directed towards staff or service users at Tresillian House or Ty Gobaith.'

1.79 *Key worker 2* also recorded that Mr K:

'Has sometimes found it difficult to engage with mental health services, but can do this with support', 'has previously stopped taking medication when felt has become ineffective' and 'there is some concern that [Mr K] may be easily led by others due to his problems with social situations'.

1.80 *Key worker 2* recorded no known risk to '*Risk of serious violence to others*', '*Risk of self neglect or accidental self harm*', '*Risk due to mental ill health'* and '*Risk*

due to alcohol or substance misuse'. *Key worker 2* also recorded that Mr K did not display any obvious signs of risk to self or others.

1.81 A phone call was received by *CPN 1* from staff at Tresillian House on 20 September 2010. Staff had become increasingly concerned about Mr K who had become more aggressive and demanding in his behaviours. Consequently Mr K's allocated CPN, *CPN 1* arranged to see him and an appointment was made. On 23 September 2010, Mr K's CPN attended Tresillian House, however Mr K had just woken up and did not feel that he could manage the appointment. The CPN was informed that Mr K generally stayed up late reading his engineering books and then slept through the morning. It was recorded that Mr K had been demanding of late and staff found themselves agreeing to some of his demands, mainly at night, to keep the situation calm. No violence was reported. The CPN offered Mr K a further appointment on 29 September 2010 at 2:00pm.

1.82 Mr K's CPN eventually reviewed Mr K on 29 September 2010 (7 weeks after the first scheduled appointment for 5 August 2010) where he appeared heavily intoxicated with alcohol. Mr K's speech was slurred and he was difficult to follow but not aggressive. It was recorded that Mr K felt the main problem at the time was his rage and anger which appeared to be triggered when people had unrealistic expectations of him as he perceived it. Mr K gave an example, of staff asking him to do things and then "going on" at him when it was not done straight away. There was no evidence of psychotic symptoms, or any suicidal or homicidal ideation. Mr K informed *CPN 1* that he was going to be moving to a Cardiff Mind hostel soon and had mixed feelings about it. Mr K was advised that Cardiff Mind would arrange an anger management course for him but he expressed that he may not be able to cope with a group setting.

1.83 *CPN 1*'s impression of Mr K following his assessment was one of Mr K having alcohol dependency and anger issues. *CPN 1* felt that Mr K would no longer benefit from regular CPN support because there was little evidence of major mental illness and Mr K was consequently discharged from the CPN's caseload but remained under the care of *Consultant Psychiatrist 2* at Hamadryad CMHT, in the form of out-patients appointments. There was no evidence in the records stating that Mr K was seen by *Consultant Psychiatrist 2* for his scheduled appointment on 29 September 2010.

1.84 The following day (30 September 2010), Mr K was due to attend an appointment with Cardiff Mind. However, it is recorded that that he did not feel up to it, stating that he felt stressed as he had had little notice about the appointment.

1.85 Mr K appeared to be in some genuine distress, so the staff offered to re-arrange the appointment. Mr K's keyworker, *key worker 2*, explained that he would have to attend the next appointment and he would need to play his part in arranging his move on from Tresillian House. Mr K was offered further support in helping him make and carry out plans more effectively.

Mr K's period at a Cardiff Mind Hostel

1.86 Mr K moved into a Cardiff Mind supported accommodation hostel on Claude Place in the Roath area of Cardiff on 4 October 2010. Upon admission, Mr K was appointed a key worker, *key worker 3*, who was based at Claude Place offering support to the 5 tenants who lived there.

1.87 It was recorded in the Cardiff Mind log book that Mr K had financial difficulties from the time he moved into Claude place, borrowing money on his first day of his tenancy and soon after he fell behind with his rent. Mr K stated that he was no longer getting ESA[17] money from the DWP[18] but following enquiries made by staff, it was established that while Mr K had been banking the cheques, Mr K could not account for his money. Staff at Cardiff Mind recorded that Mr K showed poor engagement with the other tenants and made little co-operation with his support which resulted in a warning letter being issued to him for failing to comply with the scheme.

1.88 A multi disciplinary team meeting was held on 4 October 2010 at the Hamadryad CMHT, where Mr K was discussed. It was agreed that in line with *CPN 1*'s view, that CPN input should be withdrawn as it was felt that Mr K's main issue was his anger. Mr K was informed of this decision by letter.

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[17] Employment and Support Allowance (ESA)

[18] Department for Work and Pensions (DWP)

1.89 Mr K, accompanied by his Cardiff Mind Key worker (*key worker 3*) was reviewed by *Consultant Psychiatrist 2*, on the 5 October in the outpatient' clinic. Mr K told *Consultant Psychiatrist 2* that he had problems with anger management and expressed an interest in attending an anger management course that Cardiff Mind facilitated. Mr K also stated that he was overwhelmed by having to do his own laundry on top of everything else, yet when this was explored he could not state what he meant by 'everything else'.

1.90 *Key worker 3* told *Consultant Psychiatrist 2* that Cardiff Mind staff had reported that whenever Mr K was spoken to for any length of time he would have difficulty in concentrating on the thread of conversation and would often go off on a tangent.

1.91 The main problems recorded were that Mr K was getting stressed about things, his anger was building and that the venlafaxine had made no difference.

1.92 *Consultant Psychiatrist 2*'s opinion was that Mr K showed no signs of a serious mental illness and that his main problem was one of anger management difficulty. It was recorded that his Cardiff Mind key worker (*key worker 3*) was to enlist Mr K for a six week course in anger management. Mr K was consequently discharged from the clinic and from the care of *Consultant Psychiatrist 2*. *Consultant Psychiatrist 2* sent a letter to *GP 2* detailing that he has discharged Mr K, but would be happy to see him again should she feel it necessary.

1.93 Mr K had no further direct contact with Mental Health Services until the index offence.

1.94 On 12 October 2010, *GP 3* received a letter from the Consultant Orthopaedic Surgeon from Llandough Hospital, stating that the results of Mr K's right knee MRI scan had been reviewed and Mr K was placed directly on to the urgent in-patient waiting list for a right knee Anterior Cruciate Ligament (ACL) reconstruction, which the consultant planned to carry out in the next few months. The consultant also sent a copy of the letter to Mr K, however this was incorrectly addressed to The Salvation Army (Ty Gobaith).

1.95 On 13 October 2010, Mr K's key worker (*key worker 3*) helped Mr K to complete his 'moving in' forms including the Housing Benefit form. The key worker

also reminded Mr K that he had not paid any rent for the last two weeks. Mr K stated that he would receive payment the following week and would make payment then.

1.96 On 15 October 2010, Mr K had still not paid anything towards his rent as he was waiting on payment from the Department of Work and Pensions (DWP). Mr K told his key worker (*key worker 3*) that he had some concerns about the recent change of address and that he might not get his money because of it. The key worker supported Mr K in making a telephone call to DWP to sort it out.

1.97 The key worker also explained to Mr K the Individual Support Plan (ISP) process and tried to encourage Mr K to complete it. Mr K stated that he couldn't function at that time as he felt very anxious about his benefit claim.

1.98 The key worker spoke with Mr K about his short term goals. Mr K expressed that he wanted to study Chemistry and was exploring the different courses available.

1.99 On 19 October 2010, Mr K received payment from the DWP. He was also due to go and familiarise himself with the local area but instead chose to go and buy cigarettes and failed to return to the house.

1.100 Mr K returned later that day and smelt of alcohol. It was recorded by *key worker 3* that Mr K paid him £20.00 for rent. Mr K told him that he had bought a PlayStation video games console from cash converter as he wanted to do something that would stop him spending money on alcohol. They discussed how Mr K was going to manage to buy food over the next two weeks as he only had £55.00 left to support himself. Mr K intended to spend this on jeans and a coat as he didn't have any warm clothing.

1.101 On 25 October 2010, *key worker 3* spent two hours discussing three payment arrears on Mr K's ISP. It was recorded that the discussion was 'hard going' and 'it took a lot of back tracking and energy to cover the arrears'. A further meeting was arranged for Thursday 28 October 2010 to continue the discussion.

1.102 On 10 November 2010, Mr K was asked about his ESA payment by *key worker 3* as he was falling behind with his rent once more. Mr K told *key worker 3* that he had not received payment but agreed he would contact the ESA to find out why he hadn't been paid. Mr K used the office phone but stated that he couldn't get

through. His keyworker offered to ring them for Mr K which he accepted. When *key worker 3* rang it was found that the number was an automated answer machine that you had to press the corresponding telephone number button to access the service, this was something Mr K had not done. *Key worker 3* managed to get through to the ESA department and explained that he was acting on behalf of Mr K. *Key worker 3* was told that a cheque had been sent to Mr K on 29 October 2010 that was cashed on 2 November 2010 and that Mr K's next payment was due on 16 November. *Key worker 3* asked Mr K why he had denied receiving payment; Mr K stated that he had forgotten he had received the money. *Key worker 3* recorded that Mr K looked uncomfortable and started rubbing his face, that he looked away and became 'confused''. Mr K could not recall what he had spent the money on.

1.103 On 16 November 2010, *Key worker 3* rang Mr K's GP at Butetown Medical Practice to make an appointment for the following day as he needed to renew his medical certificate for the ESA. *Key worker 3* also made a further appointment with support staff for Mr K as he had a large debt with a bank that he was now being charged for. Mr K had already missed one other appointment that had been set up for him.

1.104 On 18 November, *key worker 3* and the Deputy Manager for Support Services at Cardiff Mind met with Mr K to finish the discussion around his ISP. Mr K was drinking and had to be asked to stop, it was clear that he was intoxicated. *Key worker 3* and the Deputy Manager for Support Services at Cardiff Mind managed to complete the ISP but not without difficulty as Mr K's eye contact was very poor. Throughout the meeting, Mr K was unable to concentrate and kept going off on tangents and losing the thread of the questions that were being asked of him.

1.105 On 1 December 2010, *key worker 3* met with Mr K over a coffee in the dining room. Mr K told him that he was expecting a cheque from the DWP and agreed to pay £40.00 rent that day to assist with clearing his debt. . Mr K told *key worker 3* that he was feeling well within himself, but had mentioned that *resident 1* (another resident of the hostel) had spoken to him regarding the TV and lights being left on in the living room.

1.106 That evening, it was recorded that Mr K had invited a friend into the house and *key worker 3* recorded that he had strong suspicions that Mr K and his friend

were smoking marijuana. *Key worker 3* also had to ask Mr K not to drink in the living room, he complied with this request.

1.107 On 1 January 2011, Mr K was admitted to the University Hospital of Wales (UHW) in Cardiff as he was vomiting blood. It was recorded that Mr K had been drinking steadily all that day which appeared to have caused him gastric problems. Mr K was discharged back to the hostel the following day.

1.108 On 6 January 2011, Mr K came to the office and explained to *key worker 3* that he had run out of money and asked if he could reclaim £20.00 from the rent payment he had made a couple of days previous. Mr K had paid £50.00 on 29 December and a further £55.00 on 31 December 2010 after winning a bet. *Key worker 3* discussed with Mr K about his hospital admission due to excessive drinking and smoking and that the doctors had advised that he abstain from both. Mr K stated that he had no money to buy alcohol and that he needed the money to buy food. *Key worker 3* explained that he couldn't sanction giving Mr K money if he would go and buy alcohol or gamble it away. Mr K insisted the money was for food. *Key worker 3* escalated this to Deputy Manager for Support Services at Cardiff Mind who agreed that Mr K could have £20.00 to buy food only.

1.109 On 12 January 2011, *key worker 3* had a face to face discussion with Mr K. *Key worker 3* discussed an argument that had taken place the previous evening between Mr K and another female resident, *resident 1*, at Claude Place. Mr K stated that he was trying to "make things up with resident 1" as he didn't like ill feeling.

1.110 *Key worker 3* asked Mr K not to be rude to *resident 1* and try not to engage in conversation or contact with her unless *resident 1* indicated that she wanted this to happen.

1.111 *Key worker 3* also had an in depth discussion with Mr K about his mental health. Mr K disclosed that he felt that his mind was working too quickly and that he couldn't make sense of the world as it moved slower than he was thinking. Mr K stated that people thought he was "abnormal as a kid" but at the time did not realise that people thought differently to him and only started to notice this when he got older.

1.112 *Key worker 3* asked Mr K if he would commit to medication if it was prescribed to him. Mr K stated that "he would give it a go". *Key worker 3* suggested that he make an appointment with Mr K's GP that week and that he would go with Mr K and if necessary to assist Mr K to explain to the GP what Mr K had told him. Mr K agreed to this and told the key worker that he just "wanted to slow things down so that he could understand how other people think". An appointment was therefore made with the General Practitioner, *GP 4* for 4 February 2010 to discuss Mr K's mental health.

1.113 Mr K attended Llandough Hospital for a meeting with staff to discuss his knee operation scheduled to take place in February. During the discussion Mr K raised concerns about his sexual health as he had had unprotected sex in the past. Mr K was worried that he may have contacted HIV and could pass it on to others if he was to cut himself in the house or during the operation.

1.114 On 18 January 2011, Mr K completed a GP health questionnaire for Albany Surgery in Cardiff. On the form he denied taking any regular medication and answered 'yes' to having a disability, stating he had a bad knee. He did disclose that he had depression but was being supported by Cardiff Mind.

1.115 A letter from the Department of Orthopaedic Surgery at Llandough Hospital was also received by *GP 3* at the Butetown Practice on 18 January 2011. The letter stated that Mr K was reviewed in the pre-admission clinic that day and was scheduled for a right ACL reconstruction on 10 February 2011. Mr K had been told in great depth of the risks and benefits of the surgery and they had obtained his written consent for the surgery. However, a discharge letter from the Cardiff and Vale University Hospital stated that Mr K had been admitted for his right knee ACL operation on 27 January 2011, and was discharged the following day. There is no evidence as to why his operation was brought forward.

1.116 On 4 February 2011 there was a fire at the hostel which, according to Mr K, was caused when he got up in the early hours to make himself some toast. He stated that there must have been oil left on the grill pan which caught alight. This sounded the smoke alarm and subsequently woke one of the tenants, *resident 1*, who called the fire brigade and an ambulance.

1.117 Mr K also had a further altercation with *resident 1* that day (4 Feb) whereby she accused him of not answering the door or letting her know when someone telephoned for her. This frustrated Mr K and he threw his crutches at her which resulted in *resident 1* phoning the police, reporting she felt threatened by him. This prompted a meeting with the Project Manager at Cardiff Mind who warned Mr K that if he continued not to engage with his support then he would be in breach of his tenancy; however it would appear that Mr K continued not to engage.

1.118 Later that same day (4 Feb), Mr K, accompanied by his key worker, was seen by the GP, *GP 4*. Following this appointment, *GP 4* referred Mr K to LINKS CMHT in Cardiff due to concerns regarding certain aspects of his behaviour. *GP 4* recorded that he along with Mr K's key worker (*key worker 3*) were worried that Mr K was developing 'more overt psychiatric illness' and therefore requested an assessment due to Mr K being low in mood. *GP 4*'s referral letter stated:

> *'Since he [Mr K] has moved into the Cardiff Mind house his carers have become increasingly concerned about certain aspects of his behaviour. I have met Mr K on two occasions and on both occasions he has appeared very withdrawn and been unable to give a clear history. He appears to avoid eye contact and in our latest consultation was expressing some paranoid ideations regarding him not liking other people's thoughts and also thinking that people were aware of his thoughts. Both his careworkers and myself are concerned that he may be developing more overt psychiatric illness and would be grateful for your assessment as to whether or not you feel this is the case.*
>
> *I was unaware of his previous alcohol misuse the second time I saw Mr K but he has not been under the influence of alcohol on the two occasions that I have met him'.*

1.119 *GP 4* also stated that he had prescribed Mr K a small amount of Diazepam, however was aware that he had misused Diazepam in the past and would look to withdraw it in his next consultation with him and look to replace it with other medication.

1.120 On 14 February 2011, the LINKS CMHT wrote to Mr K following the referral made by *GP 4* on the 4 February 2011. The letter informed Mr K that he would need to contact them should he wish to make an appointment. The letter stated:

> *'As you are aware your General Practitioner has referred you to the Links Centre with a view to us helping you with your current problems. This appointment is an initial assessment which may last up to one hour and you will be seen by a member of our medical team……If I do not hear from you within two weeks from the date of this letter, I will assume that you no longer wish to access our service and will inform your GP accordingly.'*

1.121 Mr K did not make contact with the Links CMHT to make this appointment.

1.122 During a GP appointment with *GP 4* on 18 February Mr K stated that he had trouble sleeping and was short tempered and aggressive with the other tenants residing at Claude Place. Mr K was subsequently prescribed an antidepressant which was to be taken at night due to it causing drowsiness. *GP 4* recorded that Mr K was intoxicated during the appointment. *GP 4* also received a letter from the Department of Physiotherapy at the Cardiff Royal Infirmary stating that Mr K failed to make contact with them to arrange an appointment following their letter. Therefore, they were discharging Mr K back to *GP 4*'s care.

1.123 On 3 March 2011, Mr K was seen by *key worker 3*. Mr K showed signs of being able to budget and was on top if his laundry. Mr K stated that he would make a concerted effort to engage in social activities, however he explained that it depended on what day they were scheduled for. Mr K expressed that he wanted to attend the next anger management course that Cardiff Mind were running and that he felt a lot better since commencing the antidepressant medication. It was also recorded that Mr K was due to start having physio on his knee following his operation.

1.124 On 7 March 2011, Mr K ran out of his antidepressant medication and told a member of staff, Cardiff Mind *support worker 1*, that he needed to take them because without them he would start to feel down and would get into trouble and end up fighting. Mr K also stated that he had run out of money and was due to pay bills. This would leave him with no money after his next pay.

1.125 Later that day (7 March 2011), Mr K saw *GP 4*, where it was recorded that he was brighter in mood and was feeling better but agreed to continue with his antidepressant medication.

1.126 On 8 March 2011, Mr K was prescribed a months supply of the antidepressants following his appointment with his GP. Mr K had been paid some money so he paid his rent and it was recorded that he had a drink for "Dutch courage" before going out to do some shopping. Mr K then went to the Claude Pub with Mr Z (the eventual victim) and on their return it was noted that Mr K was bleeding from his forehead and ear. Mr K stated that he was attacked by Mr Y (an acquaintance of Mr Z) but later stated that he in fact had thrown the first punch as he had felt threatened.

1.127 On 14 March it is recorded that Mr K spent most of the day with Mr Z in his room watching television and listening to music. On the same day *GP 4* received a letter from the Department of Orthopaedic Surgery at Llandough Hospital, Cardiff stating that Mr K had failed to attend his physiotherapy appointment after his operation on his knee and therefore would not be offering Mr K a further appointment but would be happy to review him upon re-referral.

1.128 On 15 March 2011 Mr K showed Cardiff Mind *support worker 1* a letter stating that his ESA had been stopped. The Deputy Manager for Support Services at Cardiff Mind later spoke with Mr K regarding complaints from *resident 1* that Mr K was knocking her door at night which Mr K denied.

1.129 On 17 March 2011, Mr K's progress was reviewed by *key worker 3*. Mr K expressed his concerns about his ESA being stopped but showed no willingness to tackle the problem and has continually failed to attend appointments with Cardiff Mind advice personnel. Mr K stated that he felt tired all day as he was not sleeping at night and it was recorded that Mr K appeared confused regarding when he should be taking his medication. It was also noted that Mr K was spending a considerable amount of time with Mr Z, usually drinking. Later that day, it is recorded that Cardiff Mind *support worker 1* mediated between Mr K and *resident 1* so that they could clear the air between them.

1.130 On 18 March 2011, *GP 4* received a letter from *Consultant Psychiatrist 2* summarising his assessment of Mr K on 8 July 2010. *Consultant Psychiatrist 2* stated:

> *'I remember seeing him [Mr K] before when he was staying in the Huggard Centre and enclose an assessment letter from July 2010. Certainly at that point I thought he was depressed, however, a primary psychotic disorder could not be excluded'.*

1.131 On 21 March 2011, Mr K stated that he hadn't had any money for at least two weeks and was feeling very low in mood. He stated that he frequently felt angry and was afraid to go out in case he got himself into trouble. Mr K was encouraged to take action with regards to his ESA but again continued to show reluctance and unwillingness. Mr K was told that he "must" do something about his financial arrangements the following day.

1.132 On 22 March 2011, Cardiff Mind *support worker 1* met with Mr K and contacted the DWP on his behalf to resolve his ESA situation. Mr K was told that he must attend the Job Centre the following morning so that he could apply for a crisis loan.

1.133 Later that day at 21.55 hours, South Wales Police received a call from 9 Claude Place, Cardiff stating that a male body had been discovered. On attendance, Mr Z was discovered to be deceased and Mr K made comments at the scene that implicated him in Mr Z's murder. Mr K was observed to have blood on his clothing and police reports stated that Mr K informed them that his friend (Mr Z) had asked him (Mr K):

> *"three times in total to kill him. Some people need to kill themselves. He provoked me to do it saying he didn't want to live anymore".*

Mr Z's Background

1.134 Mr Z was a 54 year old man with a history of psychosis, alcohol misuse and self harm. He was a long standing client of mental health services with several

inpatient admissions and was considered to be an individual who was at risk of being exploited by others. He moved into the Cardiff Mind hostel at Claude Place on 16 June 2010 following concerns about him being vulnerable to exploitation at his previous Cardiff Mind address elsewhere within Cardiff.

1.135 Throughout his time residing at the Cardiff Mind hostel at Claude Place Mr Z had continued input from his CPN (from the Links CMHT), a social worker, and also spent time being treated for alcohol detox. On occasions during his time residing there Mr Z had been behaving in a threatening behaviour towards fellow residents at Claude Place and Cardiff Mind support workers. One such matter was referred to the Police and Mr Z was warned that his behaviour could lead to him being evicted from Claude Place. Mr Z showed remorse about the incident and committed to abstinence in future.

1.136 Mr Z's usage of alcohol continued to be an issue however during his time at Claude Place leading to fellow residents becoming conscious of his behaviour. Mr Z had also complained to his CPN of experiencing visual hallucinations and this was noted as being an idiosyncratic indication of deterioration in his mental state.

1.137 In March 2011, a Protection of Vulnerable Adult (PoVA) referral was made by Cardiff Mind in relation to Mr Z due to him apparently having been assaulted by Mr Y. Despite the referral Mr Z was noted to be in good spirits and continued to avoid further contact with Mr Y. Mr Z alleged that Mr Y had attacked Mr K at the Pub and that Mr K had responded by assaulting Mr Y. Mr Z was advised by Cardiff Mind to report the matter to the Police, however, Mr Z was considered to have the capacity to choose not to report the assault to the Police.

Mr K's Relationship with Mr Z

1.138 It was through their residence at Claude Place that Mr Z and Mr K met and became acquainted. Mr Z was already a resident when Mr K was moved in. Throughout the time that Mr K resided there, Mr K and Mr Z were regularly seen together. The relationship was observed as being platonic. From the evidence reviewed, there was no suggestion that the relationship between Mr K and Mr Z was not appropriate. In fact the records stated that there was more concern regarding Mr

Z's relationship with Mr Y, whereas Mr Z's relationship with Mr K was actually regarded as positive.

1.139 Despite this view being held, on 22 March 2011 Mr Z was tragically murdered by his fellow resident, Mr K.

Post Index Offence

1.140 Following the index offence, Mr K was arrested in the connection with the alleged murder of Mr Z. He was taken to Cardiff Bay Police Station and was then transferred to Caswell Clinic[19].

1.141 The Police were not allowed to question Mr K until late June 2011 because he was deemed to be too severely ill to be questioned. Mr K was diagnosed with Schizophrenia and given treatment shortly after his initial assessment by clinicians at the Caswell Clinic.

[19] The Caswell Clinic provides specialist healthcare services for people from South Wales with mental health problems who are offenders or have a potential to offend.

Management and Organisation of Services

Arrangements for the provision of Mental Health Services in Wales

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

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

The Links CMHT

1.144 The Links Centre is a community mental health centre which provides local services for people who are experiencing mental health problems to:

- promote mental health
- prevent mental illness
- provide a local response for local people.

1.145 The Links team is a multi- disciplinary team consisting of consultant psychiatrists, Senior House Officer (SHO), staff grade psychiatrist, clinical nurse leader, CPNs, nursing assistant, occupational therapist, physiotherapist, psychologist, team administration manager, medical secretary and receptionist. The team also includes three full- time and four part-time social workers and a social work assistant.

1.146 Referrals are usually made by GPs, the crisis team, Whitchurch Hospital and Llanfair Unit (part of general adult mental health services) as well as other health care professionals such as health visitors or prison liaison nurses.

The Hamadryad CMHT

1.147 The Hamadryad CMHT covers the areas of Grangetown, Butetown, Riverside, Canton, Pontcanna and Upper Grangetown in Cardiff.

1.148 The team is a multi-disciplinary team made up of psychiatrists, social workers, community psychiatric nurses, psychologists and therapists, providing assessment, treatment and care in the community, rather than in hospitals, for people with severe long-term mental health problems.

Cardiff Mind

1.149 Applications and referrals to Cardiff Mind supported accommodation can be made by individuals or agencies on behalf of individuals providing they complete and sign the Cardiff Mind application form. The application form can be handed in, sent via post, faxed or emailed to Cardiff Mind.

1.150 Prior to accepting a service user into supported accommodation, an initial assessment interview will be carried out in order to:

- check information gathered to date
- focus on any complex issues and/ or risks presented by the service user
- ascertain that risks and needs can be managed within supported accommodation.

1.151 The supported accommodation service works in partnership with Housing Associations and Cardiff City Council, to provide 26 bed spaces in shared houses and flats. The accommodation is provided with support between 9:00am and 7:00pm with 24 hour emergency cover.

1.152 A referral may be rejected should the service user fail to meet the eligibility criteria and particularly if the risk presented by any of the individuals concerned cannot be adequately managed within the project.

Chapter 2: Findings

Predictability of the Homicide Committed by Mr K

2.1 It is now clear, with the benefit of hindsight, that by the time that Mr K had tragically committed the murder of Mr Z his mental health had deteriorated significantly (Mr K has been diagnosed as suffering from Schizophrenia). In attempting to asses whether the homicide of Mr Z was predictable a number of factors must be taken into consideration.

2.2 Mr K had a chaotic upbringing and historically suffered periods of prolonged alcohol and substance misuse, it was also apparent that he occasionally had had problems in controlling his own anger. He had been involved in numerous altercations over many years, most of which appeared to be self-inflicted. Mr K himself had talked about his own rage, episodes of becoming violent, and an example of this became apparent only a matter of days prior to the death of Mr Z when Mr K had allegedly assaulted Mr Y, apparently in the act of defending Mr Z.

2.3 Although Mr K was quite guarded in talking about his experiences to the mental health professionals with whom he had contact (Mr K did not wish to speak to the review team for instance), detailed analysis of the case records showed that Mr K had reported symptoms of psychosis from 2009 onwards. We know that these symptoms, though apparent in hindsight, did not result in Mr K being acquired as a patient with psychosis within the three mental health services he was referred to. Mr K also had significant substance misuse problems which may have obscured the clinical picture and prevented a clear diagnosis being made. We also don't know whether Mr K was continually ill from 2009 to the time of the offence, or just experienced episodes of psychosis.

2.4 Mr K meanwhile had never been considered to have the potential to commit a homicide by any of the health professionals or key workers who had engaged with him over the years. A common theme noted by those who had contact with him however was of Mr K's potential to commit an act of violence. This potential for violence nonetheless was never related as being a risk to any specific individual.

2.5 Mr Z himself had been noted as a potentially vulnerable individual, also prone to episodes of anger and erratic behaviour, primarily due to his alcohol use. The PoVA referral made by Cardiff Mind in March 2011 was an example of Mr Z's vulnerability causing him to be a victim of apparent violence. It was not therefore surprising that Mr Z could, or would become a victim of violence, either by his own self harm or perpetrated by others.

2.6 It is clear that Mr K and Mr Z were two very vulnerable people who had been housed together in a low-support facility. Both had severe alcohol problems and made regular recourse to the local pub. One (Mr Z) was very well-known to psychiatric services and received a high level of support, including a PoVA meeting being held in the month that he died. One (Mr K) was undiagnosed and not in meaningful contact with mental health services.

2.7 With the benefit of hindsight it is clear that an incident would not have occurred had Mr K not been accepted and allocated to be housed alongside Mr Z by Cardiff Mind. However, despite the risk of violence that Mr K posed, we do not believe that it was predictable that Mr K would commit an act of murder. In particular it was not predictable that Mr K would murder Mr Z, with whom he was noted to have an excellent relationship.

2.8 We are of the opinion however that had Mr K's psychosis been diagnosed earlier and importantly, had Mr K complied with any subsequent treatment, that the homicide of Mr Z was preventable.

2.9 In taking this view we consider there to have been failings and deficiencies in a number of aspects of Mr K's engagement with services. Specifically:

- deficiency in the referral process when Mr K required access to mental health services
- opportunities were missed by mental health services to diagnose a serious mental illness
- difficulties in engagement with an individual who had led a nomadic life and had spent periods of time living in temporary residential settings
- there were weaknesses in communication and information sharing between those services and agencies/organisations that had contact with Mr K leading

to important information that could have influenced Mr K's care and treatment being missed

- weaknesses in the assessment of risks, in particular with regards to the allocation of suitable residence for individuals such as Mr Z and Mr K

2.10 In attempting to identify the root causes that led to the tragic death of Mr Z on 22 March 2011, the review team has considered the periods of engagement that Mr K had with statutory services. These findings are described in the following sections.

Engagement with mental health services

The referral process for a patient who is suspected of having a psychotic illness

2.11 Between 2009 and 2011 Mr K was referred to mental health services three times by three different GPs. All three GPs raised a similar question in that they each suspected that Mr K man may have schizophrenia and/or a psychotic illness.

2.12 A diagnosis of possible schizophrenia is seen as a serious and urgent medical problem by GPs. The diagnosis needs to be made as quickly as possible and treatment not delayed.

2.13 On the first two occasions that Mr K was referred, 30 September 2009 and 24 June 2010, Mr K was seen promptly by a psychiatrist. The third occasion was less timely. In February 2011 the GP referred Mr K to the Links CMHT stating:

> *'Since he [Mr K] has moved into the Cardiff Mind house his carers have become increasingly concerned about certain aspects of his behaviour. I have met Mr K on two occasions and on both occasions he has appeared very withdrawn and been unable to give a clear history. He appears to avoid eye contact and in our latest consultation was expressing some paranoid ideations regarding him not liking other people's thoughts and also thinking that people were aware of his thoughts. Both his careworkers and myself are concerned that he may be developing more overt psychiatric illness and would be grateful for your assessment as to whether or not you feel this is the case.*

I was unaware of his previous alcohol misuse the second time I saw Mr K but he has not been under the influence of alcohol on the two occasions that I have met him'.

2.14 As a response to this GP referral, Links CMHT sent an 'opt in letter' to Mr K as opposed to being directly offered an appointment. Mr K chose not to contact the Links CMHT in order to make this appointment. *Consultant Psychiatrist 2*, the psychiatrist of the Hamadryad CMHT who had previously seen Mr K in the summer of 2010, also saw this referral on the health records computer system. *Consultant Psychiatrist 2* made his assessment letter of 8July 2010 known to the Links CMHT, but it does not appear that they responded by offering Mr K an earlier appointment.

2.15 The mental health service in Bridgend in 2009, and the Hamadryad CMHT in 2010 both responded promptly to the GP letters and suspected diagnosis.

2.16 However the Links CMHT response to the third GP referral in February 2011 was less responsive. The Links CMHT did not change the way in which they dealt with Mr K even though *Consultant Psychiatrist 2* had highlighted his letter to the CMHT. The Links CMHT was content to allow Mr K to wait 8 weeks from referral to being seen (February to early April). Tragically Mr K was to commit the murder of Mr Z in March 2011.

2.17 We consider there to have been deficiencies in the referral process. Namely:

- While the referral letter sent by the GP to the Links CMHT was appropriately marked as routine (and not 'urgent'), the decision to send Mr K an 'opt in' letter meant that Mr K elected not to contact Links CMHT himself to make an appointment. We believe this to be in part down to a lack of scrutiny on the part of the CMHT in scrutinising GP referrals and a weakness of the MDT[20] process within the Links CMHT at that time
- Mr K's historical lack of engagement with services meant that whilst offering an appointment to him may not have resulted him in choosing to attend, it was even less likely that Mr K would proactively follow-up, making an

[20] Multi Disciplinary Team – a team consisting of various mental health professionals, typically may include Mental Health Nurses, Psychiatrists, Social Workers.

appointment himself. We note that the Links CMHT may not have had knowledge of Mr K's historic lack of engagement with services

- There was a delay in the Links CMHT response to the GP's referral that ultimately led to the last opportunity to engage Mr K with mental health services prior to the homicide of Mr Z being lost.

Missed opportunities to diagnose a serious mental illness

2.18 After his arrest on 22 March 2011, Mr K was deemed to be so ill that the Police were not given permission to question him about his offence for three months, which suggests how unwell Mr K had become by the time of the index offence.

2.19 On the first occasion that Mr K was seen by a psychiatrist (*Doctor 1*) in November 2009 it was noted that 'Mr K suffers from alcohol dependence syndrome with a lack of insight into his condition'. The psychiatrist who saw Mr K did not have the benefit of the attendance of Mr K's family in his assessment, unlike the referring GP who had the benefit of Mr K's brother being present at assessment. This psychiatrist however did not refer Mr K for follow up by community mental health services. *Doctor 1* prescribed venlafaxine and asked Mr K to return in 8 weeks. This assessment did not involve the wider CMHT and Mr K was not given the opportunity to see a Community Psychiatric Nurse (CPN). This was the first missed opportunity to engage with Mr K and make a diagnosis. Unfortunately Mr K never returned and was not seen again by services in Bridgend.

2.20 In June 2010 Mr K was referred for the second time by a GP who was very experienced in dealing with the problems of the homeless. The referral letter written by this GP was very clear stating:

> *'I am concerned about this 26 year old man who has been living in Ty Gobaith for 2 or 3 months. He was brought to see me on 24/6/2010 by his keyworker. She [keyworker] is concerned that his mental health is deteriorating over the time that she has known him. He certainly seemed unwell compared to the other time I met him on 2/6/2010.*
>
> *He [Mr K] is vacant, restless- fiddling with things, he cannot maintain a train of thought for long, he feels his eyes are wrong and keeps rubbing them. He*

denies hearing voices or seeing hallucinations. His mood varies. He also looks quite dishevelled'.

2.21 Mr K was seen promptly by the Hamadryad CMHT, even though he failed to attend the first appointment. The Consultant Psychiatrist (*Consultant Psychiatrist 2*) undertook a careful and reasonable assessment and came to an initial view that Mr K's main problem was 'that of depression however a primary psychotic disorder could not be ruled out'. The Consultant Psychiatrist prescribed anti-depressant medication; referred Mr K to the CMHT and the multi-disciplinary team allocated Mr K to a CPN (*CPN 1*) two weeks later.

2.22 Engaging with Mr K was to prove problematic for the CPN due to Mr K frequently not attending or cancelling appointments. The CPN tried to see Mr K on several occasions before finally seeing Mr K and completing an assessment on 29 September 2010, some seven weeks after the first attempt. The CPN only saw Mr K once and at a subsequent multidisciplinary team meeting on 4 October 2010 said that he felt Mr K would not benefit from further CPN involvement and Mr K was therefore discharged. The CPN's view was that Mr K did not have any major mental illness and that his main issues were alcohol dependency and anger issues.

2.23 Mr K did see the Consultant Psychiatrist (*Consultant Psychiatrist 2*) on 5 October 2010. The Consultant Psychiatrist's opinion was that Mr K showed no signs of a serious mental illness and that his main problem was one of anger management difficulty. This was the last time that the Hamadryad CMHT saw or engaged with Mr K.

2.24 Whilst it was clear that Mr K was difficult to engage with, guarded in talking about his experiences, and would frequently not attend appointments, it is also clear that this was part of his pattern of behaviour. We feel that despite the prolonged and valiant efforts of the CPN to engage with Mr K, and the fact that Mr K was seen on more than one occasion by the Consultant Psychiatrist, an opportunity was missed to thoroughly assess Mr K and review him regularly.

2.25 Further to this we found little or no evidence of any consistent or structured engagement or sharing of information between the Ty Gobaith and Tresillian House and the Hamadryad CMHT. This may have led to important information that may

have influenced the Consultant Psychiatrist or the CPN's assessment of Mr K being missed.

2.26 Mr K again agreed to see a GP about his mental health problems in February 2011 following concerns being raised by staff at the Cardiff Mind hostel in Claude Place. On 4 February 2011, the GP referred Mr K to the Links CMHT, again suspecting a serious mental health problem. The response from Links CMHT was not swift but went through a process of asking Mr K to confirm he required an appointment. *Consultant Psychiatrist 2* also alerted the Links CMHT to his previous involvement with Mr K.

2.27 As stated in the previous section, this mechanism for obtaining an appointment with the Links CMHT mental health team did not operate effectively and as a consequence a further opportunity to engage Mr K with mental health services was missed.

2.28 Mr K first presented with symptoms indicative of a serious mental health problem in September 2009. Sadly it took until March 2011 for a diagnosis of psychosis to be made, by which time the murder of Mr Z had tragically been committed.

2.29 The root causes in relation to missed opportunities were:

- The assessment undertaken by the psychiatrist in 2009, despite the detailed referral letter provided by the GP, concluded that Mr K's primary issue was alcohol dependency. This lead to Mr K not being referred for further mental health service input with no follow up planned
- Mr K's guarded nature, in particular when seen by mental health professionals, meant that it was difficult to make a clear and definitive diagnosis of his mental illness. However, key information held by keyworkers at both Ty Gobaith and Tresillian House regarding Mr K's symptoms was not systematically shared with the Hamadryad CMHT. This information may have provided insight into Mr K's wellbeing that could have influenced assessments or decisions over Mr K's care and treatment, or indeed his diagnosis
- Whilst it is clear that the CPN unfailingly attempted to see Mr K on numerous occasions following referral by the Consultant Psychiatrist, had the key information held by Ty Gobaith and Tresillian House been shared, the CPN

may have sought to maintain engagement with Mr K over a longer period in order to gain a more complete picture of Mr K's mental wellbeing

- The decision taken by the Links CMHT not to directly offer an appointment to Mr K ultimately led to the last opportunity of engaging with him and possibly diagnosing a serious mental illness, being lost

Communication, Information Sharing and Assessments

Mental health services for the homeless in Cardiff

2.30 A theme that emerged during this review was of the difficulties that were apparent in engaging with peripatetic individuals, such as Mr K, often living in temporary accommodation or within hostels run by the voluntary sector. We were told by many of the individuals whom we spoke to from Cardiff Mind, Ty Gobaith and Tresillian House that they missed the input that they felt was missing from the CPN attached to the CHMTs who used to visit them regularly and see patients in their own home. This CPN role had the task of linking the homeless services with those of the CMHTs and was looked upon as an excellent resource for the homeless in Cardiff. We were told that the CPN who performed this role had left the service and had not been replaced.

2.31 Staff at the homeless hostels in particular said their clients found it more and more difficult to engage with the Hamadryad CMHT. The clients were expected to go to the Hamadryad Centre as opposed to being visited at their own home (although in this case the CPN made several efforts to visit Mr K at Tresillian House). When the linked CPN was in post, this individual saw the clients in their own homes/flats. As a regular visitor to the hostels, the CPN was well known and respected. This attendance also allowed key workers to pass on and share information to the CPN about clients who were resident there.

2.32 In Mr K's case, the key workers had vital information and intelligence about his mental state which was apparently not passed to the CMHT or any mental health professionals. As stated in the previous section, this process of information sharing between agencies and organisations dealing with homeless service users, or those in temporary accommodation on a daily basis needs to be strengthened ensuring that

key information that may influence the care and treatment of those known to mental health services is shared routinely. This responsibility lies with both the NHS mental health services and the hostels and voluntary organisations, and not merely with one organisation.

Access to information within mental health services

2.33 Whilst we believe that processes for sharing information between mental health services and other organisations needs to be improved, we also believe that the ability to access information within mental health services also needs strengthening.

2.34 It was not clear to us what information had been, or could be accessed or shared between CMHTs in South Wales about previous referrals and assessments. Whilst the CMHTs in Cardiff share the same IT system – Paris, it was unclear to us whether services in Cardiff had access to the referral made in Bridgend in 2009 (part of a neighbouring Health Board – the then ABM University NHS Trust[21]). This information, had it been available to the Hamadryad CMHT in 2010 may have provided information that could have influenced any subsequent assessment of Mr K's mental health. However, it also seems that the previous information noted by the Hamadryad CMHT in 2010 was not used by the Links CMHT when it came to assessing Mr K's referral or offering him a prompt appointment in February 2011.

The Cardiff Mind admission process

2.35 We believe that this case highlights deficiencies in the admission process to Cardiff Mind premises. This in part, is due to the lack of information sharing arrangements noted in the previous section, but also in part due to the lack of rigour and thoroughness attached to Cardiff Mind's assessment process.

2.36 It is clear that Cardiff Mind, or indeed any similar voluntary organisation that operates hostels, needs to make every effort possible to ensure that the client mix at its hostels is appropriate and takes fully into consideration the risks associated with

[21] In October 2009, Abertawe Bro Morgannwg University Health Board was created when ABM University NHS Trust formally merged with the Local Health Boards of Swansea, Neath Port Talbot and Bridgend.

housing individuals who may be of a risk to themselves, to others, or vulnerable, within the same building.

2.37 We were told that in their experience Cardiff Mind felt that they did not routinely receive information from the CMHTs in Cardiff about those individuals who they were either considering to house, or who were already resident at their hostels. In particular we were told that Cardiff Mind were not routinely invited to any Care Programme Approach (CPA) meetings held to discuss current mental health service users residing at their properties.

2.38 We were also told however of the pressure that is sometimes apparent to fill vacant beds at the hostels, and the financial implications of operating at less than full capacity. This may, on occasion, lead to the potential of an inappropriate placement of a resident at a hostel, in particular if little is known about the individual's background. Ultimately this has the possibility of individuals being housed together who have very different support needs.

2.39 Staff at Cardiff Mind were very critical of the information they had received about Mr K prior to his move to Claude Street. We asked the question if this was a good placement in view of Mr K's known mental health problems. Staff at Cardiff Mind told the review team that in their experience information flowed in one direction – from Cardiff Mind to the CMHT. We were informed that they rarely received full information about a potential client from a CMHT.

2.40 We were told for instance that if a client was on CPA[22] and the CPA review was due, Cardiff Mind may be asked for information by the CMHT but seldom were they asked to be present at the CPA review. Cardiff Mind would not receive the result of a CPA review.

2.41 Whilst it does not appear that information was shared by the Hamadryad CHMT prior to Mr K's placement at Claude Street, we also are not clear whether Cardiff Mind made any specific request to access and receive this information during

[22] Care Programme Approach – CPA - Anyone experiencing mental health problems is entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that's regularly reviewed by that professional.

its own assessment of Mr K's application and any subsequent decision over where he should reside.

2.42 Having taken the decision to house Mr K at Claude Street, it is clear that staff at Cardiff Mind made assiduous attempts to get Mr K in contact with services once it became apparent that Mr K wasn't well. However, it is clear in hindsight that the decision by Cardiff Mind to offer residency to Mr K at their hostel in Claude Place was, in part, a contributory factor to the tragic events on 22 March 2011. We believe that a key factor that undermined this decision and increased the risk of an adverse event occurring was the lack of information that Cardiff Mind had regarding Mr K's background that may have led to the decision being taken to provide residency at an alternative hostel.

2.43 We believe that the root causes of the issues highlighted within this section are:

- the lack of any systematised process or approach in place to facilitate the sharing of vital information between those services and organisations that current, or potential mental health service users are engaged with, led to vital information about Mr K's symptoms not being shared with the CMHTs
- the lack of clarity regarding the access that mental health services had to information about Mr K's previous involvement with mental health services, either in other Health Board areas, or within the same Health Board, and how this information, if it was accessed or provided, influenced any decisions regarding care and treatment
- the allocation of Mr K by Cardiff Mind to its hostel in Claude Place was inappropriate. This was due in part to a lack of information available to Cardiff Mind about Mr K's previous engagement with mental health services, but also symptomatic of the lack of any process for the routine sharing of information between mental health services and Cardiff Mind.

Chapter 3: Recommendations

Cardiff and Vale University Health Board

1. The Health Board should review the referral process for individuals attempting to access mental health services ensuring that:

    a. Clarity is gained regarding the urgency level attached to each referral with clear guidance issued to both primary care and the community teams.

    b. The process of MDT referral meetings at each of its CMHT's is reviewed and audited, ensuring that the level of urgency attached to GP referrals correlates to the content of any referral.

    c. In line with Welsh Government guidance[23], individuals who are referred to CMHT's are offered an appointment within the allotted timeframe.

    d. Assertive attempts are made with those individuals who are difficult to engage with, who are homeless, or reside in temporary or hostel accommodation.

2. The Health Board, in conjunction with Welsh Government, should review the ability of its mental health professionals to access information about previous mental health referrals or engagement with services. Each assessment of a service user should have full access of any previous periods of engagement to ensure that any decision regarding any care and treatment is fully informed.

3. The Health Board should review what arrangements it has in place in order to reduce the Duration of Untreated Psychosis (DUP)[24]. DUP can be reduced by the

[23] The role of community mental health teams in delivering community mental health services, July 2010, Welsh Government (http://wales.gov.uk/topics/health/publications/health/guidance/mentalhealth/?lang=en)

[24] Psychosis and schizophrenia in adults: treatment and management: NICE guideline, Draft for consultation, August 2013: www.nice.org.uk/nicemedia/live/13569/64925/64925.pdf

effective use of early intervention teams and by mental health promotion campaigns[25].

Cardiff and Vale University Health Board and Cardiff County Council

4. The Health Board and Local Authority should review the adequacy of the arrangements currently in place to provide psychiatric services for homeless, vulnerable people. This review should consider arrangements that are in place in other areas of the UK.

Health, Local Authority and Voluntary Organisations: Communication and Information Sharing

5. In respect of service responses to homeless people, arrangements for the consistent sharing of information between mental health services and voluntary organisations, or local authority run accommodation, should be significantly strengthened. These arrangements should give consideration to:

    a. Improve liaison and the flows of information between respective organisations, in particular including keyworkers from voluntary organisations at any case review, or CPA meetings being held to discuss care and treatment of service users.

    b. Improvement of the links between the CMHTs and the homeless/temporary accommodation residences within Cardiff, including where possible regular input from mental health professionals.

    c. For individuals who are difficult to engage with, making appointments to see them at their home, minimising the possibility of appointments being missed, cancelled, or not attended. This should be done with appropriate risk assessments having been considered.

[25] http://www.jcpmh.info/commissioning-tools/cases-for-change/severe-problems/what-works/early-intervention/

6. Cardiff Mind should fully review its assessment and allocation processes, ensuring that key information relating to risk and to previous involvement with mental health services is fully taken into consideration when assessing where they may seek to reside clients. This review should include consideration of:

    a. The information required to make a fully informed assessment and being proactive in attempting to access that information.

    b. Ensuring that clients are always appropriately homed, taking full consideration of the risks of housing individuals together who have very different support needs.

Annex A

Review Terms of Reference

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

Healthcare Inspectorate Wales (HIW) is to undertake an independent review of a homicide carried out by a mental health service user in the Cardiff area on the 22 March 2011.

The review will investigate the care and support provided to Mr K and Mr Z prior to Mr K attacking Mr Z whilst residing at a MIND hostel in Cardiff.

In taking this review forward HIW will:

- Consider the care provided to Mr K as far back as his first contact with health and social care services to provide an understanding and background to the fatal incident that occurred on the 22 March 2011.

- Consider the care provided to Mr Z as far back as his first contact with Mr K whilst under the care of Health and Social Services to gain an understanding of the relationship between Mr K and Mr Z leading to the fatal incident.

- Review the decisions made in relation to the care of Mr K.

- Review the decisions made in relation to the care of Mr Z.

- Identify any change or changes in Mr K's behaviour and presentation and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident that occurred 22 March 2011.

- 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[26].

[26] As part of this exercise consideration will be given also to the personal history of Mr K and Mr Z.

Methodology and timescale for the review

The review will be managed by HIW and consist of:

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

Mr K did not wish to be interviewed for the purposes of this review.

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

Annex B

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

The annual report produced by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report[27] notes that homicide by mental health patients has fallen substantially since 2006, with the most recent confirmed years (2009/2010) being the lowest since data began to be collected. During 2001-2010 an average of 74 patients were convicted of homicide in the UK, which rises to 115 when symptoms of mental illness is added. These figures appear to be falling.

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

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

Arrangements for Reviews in Wales

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

[27] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013

Annex C

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

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

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

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

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

Dr Frank Holloway – Consultant Psychiatrist
Dr Rob Hall – General Practitioner
Mr Martin Thornton- Mental Health Nurse
Mrs Freya Ellard – Lay Reviewer
Mr Rhys Jones – Head of Investigations
Miss Lisa Bresner – Assistant Investigations Manager
Mrs Lianne Willetts- Investigations Officer

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

- Examination of documents relating to the organisation and delivery of services by the Cardiff and Vale University Health Board. Although we have no authority to require information from the police, the review team also had access to the police records relating to the case and held discussion with the senior investigation officers. We are grateful to the police for their collaboration

- Reading the case records maintained by the Health Board, Cardiff Mind, and Local Authorities concerning Mr K

- Reading interview notes and written statements provided by staff working with Mr K and Mr Z which was provided as part of the police or internal investigation processes

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

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

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

Annex D

The Roles and Responsibilities of Healthcare Inspectorate Wales

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

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

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

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

- Health and Social Care (Community Health and Standards) Act 2003.

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

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

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Adroddiad ar Adolygiad ynglŷn â:

Mr K a darpariaeth Gwasanaethau Iechyd meddwl ar ôl Lladdiad a gyflawnwyd ym mis Mawrth 2011

Mawrth 2014

Gall y cyhoeddiad hwn a gwybodaeth arall Arolygiaeth Gofal Iechyd Cymru (AGIC) gael eu darparu mewn ffurf neu iaith arall ar gais. Bydd oedi byr wrth i ni baratoi ieithoedd a fformatau gwahanol er mwyn diwallu anghenion unigol. Cysylltwch â ni am gymorth.

Mae copïau o bob adroddiad, ar ôl ei gyhoeddi, ar gael ar ein gwefan, neu cysylltwch â ni:

Yn ysgrifenedig:

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Arolygiaeth Gofal Iechyd Cymru
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Pennod 1: Y Dystiolaeth

Crynodeb o'r Drosedd Berthnasol

1.1 Ar 22 Mawrth 2011, ymosododd Mr K ar Mr Z pan oedd y ddau yn aros mewn hostel yn Claude Place, a weithredir gan Mind Caerdydd. Cafodd Mr Z anafiadau difrifol ac yn drist, bu farw o ganlyniad i'r clwyfau a gafodd.

1.2 Ar 21 Rhagfyr 2011, cafwyd Mr K yn euog yn Llys y Goron Caerdydd o ddynladdiad Mr Z ar sail cyfrifoldeb lleiedig. Dedfrydwyd Mr K trwy orchymyn llys dan adran 37/41 o Ddeddf Iechyd Meddwl 1983[1] i gael ei gadw mewn uned iechyd meddwl ddiogel am gyfnod amhenodol.

Teulu a Hanes Cymdeithasol Mr K

1.3 Ganwyd Mr K yn 1984 ac ar adeg y digwyddiad roedd yn 27 mlwydd oed. Roedd ganddo hanes o dreulio cyfnodau yn ddigartref ac o gamddefnyddio alcohol a sylweddau.

1.4 Magwyd Mr K yn Aberpennar, rhan o Rondda Cynon Taf; ond ar wahanol adegau bu'n byw ym Mhorthcawl, Pontypridd, Aberdâr ac Abercynon. Treuliodd Mr K beth amser yng Nghaerlŷr lle'r oedd yn dilyn cwrs prifysgol mewn Ffiseg.

1.5 Mae Mr K yn un o bump o frodyr a chwiorydd biolegol. Mae ganddo dri brawd ac un chwaer, a Mr K yw'r ieuengaf. Mae ganddo bedair llyschwaer hefyd. Nodwyd bod mam Mr K wedi gadael y cartref teuluol pan oedd yn ifanc iawn, gan ddychwelyd am gyfnod byr, cyn gadael yn barhaol pan oedd Mr K yn saith mlwydd oed. Er gwaethaf hyn, cadwodd Mr K mewn cysylltiad â'i fam a threuliodd gyfnodau ysbeidiol yn byw gyda hi ers pan oedd yng nghanol ei arddegau.

1.6 Magwyd Mr K gan ei dad, gyda chymorth ei famgu ar ochr ei dad, a ddaeth i fyw gyda nhw ar ôl i'w gŵr farw. Yn drist, ar ôl treulio dwy flynedd yn y cartref teuluol, pan oedd Mr K tua wyth neu naw mlwydd oed, bu farw ei famgu. Symudodd llysfam

[1] Gelwir gorchymyn adran 37 yn "orchymyn ysbyty". Gelwir gorchymyn adran 41 yn "orchymyn cyfyngu". Llys sy'n gwneud y gorchymyn, ond mae'n ofynnol cael tystiolaeth feddygol gan ddau feddyg

Mr K i gartref y teulu yn fuan wedi hynny ac roedd yn rhan fawr o'r gwaith o ofalu am y plant.

1.7 Bu sawl digwyddiad yn ystod ei blentyndod pan nodwyd bod Mr K yn ymddwyn yn rhyfedd. Byddai'n dringo adeiladau gan beryglu ei hun ac weithiau byddai'n neidio oddi arnynt. Ar un achlysur, dringodd Mr K ar do pwll nofio lleol a chwympodd drwy'r to a thorri asgwrn yn ei benglog. Pan oedd Mr K yn ddwy ar bymtheg mlwydd oed, neidiodd gyda ffrind oddi ar bont i afon fas. Ni chafodd Mr K unrhyw anafiadau difrifol ond cafodd driniaeth ar gyfer sioc. Ar achlysur arall, ciciodd Mr K ffenest siop, gan anafu ei goes wrth wneud hynny.

1.8 Roedd perfformiad Mr K yn yr ysgol yn ddigonol ac roedd yn rhagori yn benodol ar Fathemateg a Gwyddoniaeth. Gwnaeth lawer o ffrindiau a hynny dros gyfnod hir ac roedd yn mwynhau chwarae pêl-droed. Er hyn, roedd Mr K wedi bod yn dioddef problemau â'i draed (oherwydd amrywiad ar talipes[2]) ers pan oedd yn ifanc ac roedd angen iddo wisgo esgidiau orthopaedig am gyfnod. Dywedwyd y byddai pobl yn dweud pethau dirmygus am ddillad ac esgidiau Mr K ac yn gwneud hwyl am ei ben. Roedd Mr K yn blentyn bach iawn hefyd ac mae'n ymddangos iddo gael ei fwlio yn yr ysgol iau ac yn yr ysgol gyfun.

1.9 Credir i Mr K adael cartref y teulu pan oedd yn bedair ar ddeg neu'n bymtheg oed ac aeth i fyw gyda'i fam. Credir iddo ddechrau yfed alcohol a defnyddio sylweddau anghyfreithlon tua'r adeg hon. Dywedwyd nad oedd ei fam yn goddef ymddygiad gwael Mr K ac o ganlyniad dim ond am gyfnod byr iawn y bu'n byw gyda hi. Aeth i fyw gyda'i chwaer fiolegol ar ôl hynny. Roedd Mr K yn cweryla'n rheolaidd oherwydd ei fod yn defnyddio diod a chyffuriau, ac roedd yn aml yn cael ei anafu oherwydd ei fod yn fach yn gorfforol.

1.10 Ar ôl gadael cartref ei chwaer, aeth Mr K i fyw gydag un o'i frodyr. Arhosodd gyda'r brawd hwn am gyfnodau byr mewn sawl gwahanol gartref dros y blynyddoedd. Ar ddau achlysur, aeth y brawd i ffwrdd ac ar ôl iddo ddychwelyd yr oedd wedi cael ei yrru allan o'i gartref a'r tŷ wedi ei rwystro â bordiau pren. Dywedwyd bod hyn wedi

[2] Weithiau gelwir troed clwb yn talipes. Camffurfiad o'r droed a'r pigwrn sy'n bresennol pan fydd unigolyn yn cael ei eni (cynhenid) yw troed clwb. Os caiff ei drin yn gynnar, gellir gwella llawer ar safle a gweithrediad y droed.

digwydd oherwydd bod Mr K wedi gwahodd ffrindiau i gael partïon gan arwain at ddifrod i'r cartref a dadlau gyda'r cymdogion, a pheri i'r heddlu gael eu galw.

1.11 Treuliodd Mr K gyfnodau yn byw gydag aelodau eraill o'r teulu hefyd. Fel arfer, y ffaith ei fod yn yfed, yn camddefnyddio cyffuriau ac yn ymddwyn yn wael oedd yn achosi iddo symud o un lle i'r llall.

1.12 Aeth Mr K i fyw yn 'Cynon Action for Single and Homeless' (The Old Bakery Housing Project)[3] yn Aberdâr.

Hanes Troseddol Mr K

1.13 Y tro cyntaf i Mr K ddod i gysylltiad â'r Heddlu roedd yn un ar bymtheg mlwydd oed. Ym mis Mawrth 2000, cafodd ei arestio am gael ei gario mewn cerbyd oedd wedi ei gymryd heb ganiatâd. Mae'n ymddangos bod Mr K ar y pryd yn byw yn y llety i'r digartref y cyfeirir ato uchod 'Cynon Action for Single and Homeless' yn Aberdâr.

1.14 Rhwng 2000 a 2011, cyn y drosedd berthnasol, cafwyd Mr K yn euog sawl gwaith am ladrad, dwyn o siop a throseddau yn erbyn y drefn gyhoeddus.

1.15 Rhwng 2000 a 2003 cafodd Mr K ei arestio un ar ddeg o weithiau. Cafodd ei gyhuddo o'r troseddau canlynol:

- Trefn Gyhoeddus
- Lladrad
- Dwyn o siop
- Ymosodiad anweddus ar fenyw dros un ar bymtheg mlwydd oed

1.16 Mae pump o'r cofnodion ar gyfer yr adegau pan oedd yn y ddalfa yn nodi ei fod yn feddw iawn ac yn ymddwyn yn dreisgar iawn pan oedd yn nwylo'r heddlu.

1.17 Bu wyth adroddiad o ddigwyddiadau eraill rhwng 2003 a 2011 ac roedd alcohol yn ffactor allweddol yn y digwyddiadau hyn.

[3] Mae Cynon Action for Single and Homeless (The Old Bakery Project) yn cynnig llety dros dro yn Aberdâr. Gelwir hwn bellach yn ADREF Ltd.

1.18 Pan gofnodwyd asesiadau meddygol, ni ddatgelwyd unrhyw salwch, meddyginiaeth na'i fod yn dioddef o salwch meddwl, na'i fod erioed wedi hunan-niweidio. Cynigiwyd atgyfeirio Mr K i gyfleuster ar gyfer cyffuriau ar un achlysur pan oedd yn nwylo'r heddlu, ym mis Ionawr 2007.

1.19 Cofnodwyd bod Mr K wedi cael dirwy ac wedi gwneud gwasanaeth cymunedol ar sawl achlysur am fod yn feddw ac yn afreolus. Cofnodwyd ei fod wedi treulio amser yng Ngharchar EM yng Nghaerlŷr am rai wythnosau ar ôl peidio â thalu dirwyon a pheidio â mynd i wneud gwasanaethau cymunedol.

Hanes cyswllt Mr K gyda'r Gwasanaethau Iechyd Meddwl

Mis Medi 2009

1.20 Gwelodd Mr K ei Feddyg Teulu, *GP 1* o Feddygfa Portway, ym Mhorthcawl ar 28 Medi 2009, ar ôl cofrestru gyda'r Feddygfa yn ddiweddar (cafodd ei weld fel claf dros dro i ddechrau ar 23 Medi 2009). Roedd wedi mynd at y meddyg gydag un o'i frodyr a oedd wedi ei annog i wneud yr apwyntiad. Cofnodwyd:

> *"Mae ef [Mr K] wedi symud o Gaerlŷr lle'r oedd yn astudio ffiseg ond mae wedi bod yn symud o gwmpas llawer yn ystod y blynyddoedd diwethaf ac wedi treulio cyfnodau'n ddigartref. Mae'n ymddangos ei fod yn cael anhawster cysgu; mae'n siarad â'i hun ac mae ei hyder yn isel. Nid yw'n cymryd unrhyw feddyginiaeth ar hyn o bryd ac mae'n gwadu iddo ddioddef unrhyw salwch blaenorol yn y gorffennol".*

1.21 Dywedodd brawd Mr K fod eu rhieni wedi gwahanu pan oeddynt yn blant a bod pethau'n "anodd gartref". Esboniodd Mr K ei fod wedi mynd i fyw gyda'i chwaer pan oedd yn bedair ar bymtheg mlwydd oed ac yna wedi symud i lety gwarchod yn Aberdâr am ddwy flynedd. Dywedodd ei frawd fod Mr K wedi newid llawer ac "nad oedd fel fe'i hun bellach"; roedd wedi mynd i'w gragen ac roedd wedi sylwi bod Mr K yn osgoi edrych i'w lygaid.

1.22 O ran camddefnyddio cyffuriau ac alcohol, cofnodwyd nad oedd Mr K yn ysmygu cannabis bellach ond ei fod yn ysmygu tybaco. Roedd yn yfed deuddeg can o lager yr wythnos ac yn ysmygu deg sigarét y dydd. Dywedodd Mr K ei fod yn arfer ysmygu cannabis ond nad oedd wedi gwneud hynny am rai misoedd. Cofnodwyd hefyd bod ganddo dueddiad i oryfed mewn pyliau ond eto nad oedd wedi gwneud hynny yn ystod y misoedd diwethaf.

1.23 Nododd 'archwiliad o gyflwr iechyd meddwl'[4] fod Mr K ychydig yn flêr ac nad edrychodd i lygaid y sawl a oedd yn cynnal yr asesiad trwy gydol yr ymgynghoriad a bod ganddo affaith diemosiwn[5]. Dywedodd Mr K ei fod yn clywed lleisiau ond nid oedd yn gallu disgrifio pwy oedd yn siarad ag ef.

1.24 Cynhaliwyd profion gwaed ar 24 Medi 2009 (ar ôl ei apwyntiad cyntaf fel claf dros dro) a oedd yn dangos bod ganddo gyfrif gwaed llawn, glwcos, gweithrediad thyroid, Wrea ac Electrolytau[6], Ffactor Derbynnydd Twf yr Epidermis (EGFR)[7] a Phrofion Gweithrediad yr Iau[8] arferol gyda Gamma GT o 29.

1.25 Yn ystod yr apwyntiad hwn ar 28 Medi 2009, nododd Mr K ei fod yn dioddef o iselder a'i fod wedi bod yn dioddef o orbryder am y pedair wythnos diwethaf.

1.26 Ar ôl asesiad Mr K gan GP 1 dechreuodd gymryd 75 miligram o Effexor MR9 unwaith y dydd a cheisiwyd barn seiciatrig ar frys. Atgyfeiriwyd Mr K at Seiciatrydd Ymgynghorol 1, yn y 'Ganolfan Iechyd Meddwl, Lles a Chleifion Allanol' yn Ysbyty Tywysoges Cymru ym Mhen-y-bont ar Ogwr (Clinig Coety) ar 30 Medi 2009.

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[4] Mae'r archwiliad o statws meddwl, sy'n cael ei dalfyrru i MSE yn Saesneg, yn rhan bwysig o'r broses asesu clinigol mewn gwaith seiciatrig. Mae'n fodd strwythuredig o arsylwi a disgrifio cyflwr meddwl presennol claf, gan ystyried ei olwg, agwedd, ymddygiad, hwyliau ac affaith diemosiwn, lleferydd, proses meddwl, cynnwys ei feddyliau, canfyddiad, gwybyddiaeth, dirnadaeth a chrebwyll.

[5] Affaith diemosiwn: Lleihad difrifol o ran mynegiant emosiwn. Mae pobl sy'n dioddef o iselder a sgitsoffrenia yn aml dangos affaith diemosiwn. Mae'n bosibl na fydd unigolyn sy'n dioddef o sgitsoffrenia yn dangos arwyddion emosiwn arferol, efaillai'n siarad mewn llais undonnog, yn dangos llai o fynegiant yn yr wyneb, ac yn ymddangos yn hynod o ddifater.

[6] Prawf gwaed yw Wrea ac Electrolytau, ac yn aml fe'i defnyddir fel prawf i sgrinio cleifion sy'n sâl yn gyffredinol, i ddatgelu annormaleddau yng nghemeg y gwaed, gan gynnwys methiant yr arennau a diffyg hylif.

[7] Mae EGFR yn cynrychioli Cyfradd Hidlo Glomerwlaidd, sydd fel arfer wedi ei seilio ar lefel Creatinine yn y serwm, oed, rhyw a hil. Mae GFR arferol tua 100 o fililitrau/y funud/1.73m2.

[8] Mae profion gweithrediad yr iau yn mesur cemegau amrywiol yn y gwaed a wneir gan yr iau. Mae canlyniad annormal yn dangos bod problem â'r iau, a gallai helpu i ganfod beth sy'n ei achosi. Gallai fod angen profion ychwanegol i nodi achos y broblem â'r iau.

[9] Nodir tabledi Effexor XR (venlafaxine hydrochloride), sy'n rhyddhau dros gyfnod hir, ar gyfer trin anhwylder iselder difrifol

Mis Hydref 2009

1.27 Ysgrifennodd Rheolwr Llinell Integredig Tîm Iechyd Meddwl Cymunedol Porthcawl at GP 1 ar 12 Hydref 2009 i roi gwybod i'r meddyg eu bod wedi derbyn yr atgyfeiriad, wedi ei drafod yng nghyfarfod y Tîm Amlddisgyblaethol, ac wedi cytuno mai'r cam mwyaf priodol fyddai atgyfeirio i'r Ganolfan Iechyd Meddwl, Lles a Chleifion Allanol' ar gyfer apwyntiad Claf Allanol Seiciatrig. Anfonwyd holl wybodaeth Mr K i'r ganolfan a byddai *GP 1* yn cael gwybod am y canlyniad maes o law.

Mis Tachwedd 2009

1.28 Cafodd Mr K asesiad wedi hynny ar 4 Tachwedd 2009 gan *Feddyg 1*, sy'n feddyg Graddfa Staff atebol i *Seiciatrydd Ymgynghorol 1*. Aeth Mr K i'r apwyntiad hwn ar ei ben ei hun a nodwyd:

> *"Disgrifiodd ei symptomau sef teimlo nad oedd yn gallu canolbwyntio, wedi colli pwysau, yn ceisio gwneud pethau ond ei bod yn ymddangos nad oedd dim yn gweithio a'i bod yn ymddangos bod popeth yn chwalu. Dywedodd ei fod wedi colli diddordeb mewn pethau ac yn gwneud esgusodion dros beidio â gwneud pethau. Mae wedi mynd i'r arfer o gysgu drwy'r rhan fwyaf o'r dydd ac mae'n cwyno ei fod yn teimlo'n ddiegni ac yn flinedig".*

1.29 Nodwyd ei bod yn ymddangos y bu'r symptomau'n bresennol am y pedair blynedd ddiwethaf, a bod ganddo hanes o gamddefnyddio alcohol. Nodwyd:

> *"Mae'n cael awydd i yfed a phan mae'n dechrau yfed nid yw'n gallu peidio, ac fel arfer mae'n gwario ei arian i gyd yn y pen draw. Mae wedi bod yn yfed cymaint â hyn o alcohol (pump i wyth can o Budweiser ddwy neu dair gwaith yr wythnos) dros y pedair blynedd ddiwethaf. Dywedodd Mr K ei fod yn yfed swm arferol o alcohol ar hyn o bryd ond dywedodd fod ei ffrindiau a'i deulu'n poeni ynghylch faint yr oedd yn ei yfed".*

1.30 Yn ystod yr archwiliad o gyflwr meddwl a gynhaliwyd gan *Feddyg 1*, nodwyd bod Mr K wedi ei wisgo'n daclus a'i fod yn edrych yn drwsiadus. Nid oedd yn edrych i lygaid y meddyg rhyw lawer ond roedd y berthynas rhyngddynt yn naturiol. Roedd arogl alcohol arno, ac roedd yn ymddangos ychydig yn gysglyd ac yn siarad yn

anneglur. I ddechrau, gwadodd Mr K ei fod wedi yfed unrhyw alcohol ond wedyn cyfaddefodd ei fod wedi cael can cyn cyrraedd ar gyfer yr apwyntiad. Dywedodd Mr K ei fod yn teimlo'n flinedig ac yn gysglyd. Nid oedd *Meddyg 1* yn gallu canfod unrhyw ddryswch o ran meddyliau neu ganfyddiad, ac roedd ei wybyddiaeth yn ymddangos yn gyflawn i raddau helaeth ('grossly intact'). Roedd yn ymddangos bod dirnadaeth Mr K wael o'i gyflwr yn wael gan nad oedd yn ystyried y ffaith ei fod yn yfed mwy o alcohol yn broblem. Yn hytrach roedd yn ei weld fel ymddygiad arferol.

1.31 Ar ôl asesiad *Meddyg 1*, nododd bod *'Mr K yn dioddef o syndrom dibyniaeth alcohol gyda diffyg dirnadaeth o'i gyflwr'*. Rhoddodd *Meddyg 1* addysg seiciatrig[10] ynglŷn â'r anhwylder hwn i Mr K, a'i annog i fynd at Gyngor Gorllewin Morgannwg ar Gamddefnyddio Cyffuriau (WGCADA)[11] i newid ei ymddygiad. Cynghorwyd Mr K i barhau i gymryd Venlafaxine (Effexor MR) yn ogystal â Thiamine a Chymysgedd o Fitamin B. Argymhellwyd bod Mr K yn dod i apwyntiad arall mewn wyth wythnos i asesu lefel y datblygiad yr oedd wedi ei wneud ac i sicrhau ei fod wedi ymgysylltu â WGCADA. Fodd bynnag, nid oedd unrhyw dystiolaeth a oedd yn awgrymu bod Mr K wedi derbyn apwyntiad dilynol o fewn wyth wythnos iddo gael ei weld gan *Feddyg 1*.

1.32 Trefnwyd apwyntiad fel claf allanol ar gyfer 2 Mehefin 2010, ond ni ddaeth Mr K iddo a chafodd ei atgyfeirio'n ôl i'w feddyg teulu.

Mis Mawrth 2010

1.33 Ar 12 Mawrth 2010, cofrestrodd Mr K gyda Phractis Meddygol Butetown yng Nghaerdydd ac roedd dan ofal meddyg teulu, *GP 2*. Cofnodwyd bod Mr K wedi mynd

[10] Mae addysg seicolegol yn cyfeirio at yr addysg a gynigir i bobl â chyflwr iechyd meddwl. Yn aml, mae hyfforddiant addysg seicolegol yn cynnwys unigolion â sgitsoffrenia, iselder clinigol, anhwylderau gorbryder, anhwylderau seicotig, anhwylderau bwyta, ac anhwylderau personoliaeth, yn ogystal â chyrsiau hyfforddi cleifion yng nghyd-destun trin anhwylderau corfforol. Caiff aelodau o'r teulu eu cynnwys hefyd. Y nod yw i'r cwsmer ddeall a gallu ymdopi'n well â'r salwch dan sylw. Hefyd, mae cryfderau, adnoddau a sgiliau ymdopi'r claf ei hun yn cael eu hatgyfnerthu, er mwyn deall bod ailwaelu yn rhan o'r adferiad, ac er mwyn cyfrannu at ei iechyd a'i les ei hun yn y tymor hir. Y ddamcaniaeth yw y bydd y defnyddiwr yn gallu byw'n well gyda'r cyflwr, os oes ganddo wybodaeth well am ei gyflwr.

[11] Mae WGCADA yn darparu amrywiaeth o ymyriadau triniaeth ar gyfer pobl sydd wedi eu heffeithio gan gamddefnydd sylweddau. Mae WGCADA yn un o'r prif asiantaethau trin camddefnydd sylweddau yng Nghymru ac mae'n darparu gwasanaethau triniaeth Ymwrthod a Lleihau Niwed 12-Cam Minnesota, gan gynnwys cyfnewid nodwyddau ac allgymorth, wedi ei dargedu at anghenion unigol. Mae'r gwasanaethau eraill a ddarperir yn cynnwys gwybodaeth, cyngor a thriniaeth i bobl ifanc, hŷn ac anabl, aelodau'r teulu a gofalwyr.

i'r practis gan fod ganddo broblemau â'i ben-glin. Roedd wedi dadlau gyda'i deulu ac wedi 'gwneud niwed i'w ben-glin trwy gicio'. Roedd ei ben-glin wedi chwyddo felly cafodd Mr K ei atgyfeirio gan *GP 2* am archwiliad pelydr-x.

Mis Ebrill 2010

1.34 Ar 26 Ebrill 2010, cafodd Mr K archwiliad pelydr-x a oedd yn dangos bod ganddo doriad rhwygo[12] ar ran uchaf y grimog. Cynghorwyd y dylid ei atgyfeirio am archwiliad orthopaedig er mwyn ei werthuso eto.

Cyfnod Mr K yn Nhŷ Gobaith, Byddin yr Iachawdwriaeth

1.35 Cofrestrodd Mr K gyda Phractis Meddygol Butetown ym mis Mawrth 2010, ond ni chofnodir fod Mr K wedi symud i fyw i Dŷ Gobaith, hostel Byddin yr Iachadwriaeth yn Butetown, Caerdydd, tan fis Ebrill/Mai 2010. Nid ydym yn gwybod pryd y symudodd Mr K i Gaerdydd o Borthcawl lle'r oedd wedi bod yn byw cyn symud i Dŷ Gobaith. Bu Mr K yn byw yn Nhŷ Gobaith am gyfnod o ryw bedwar mis.

1.36 Cafodd Mr K fynd i Dŷ Gobaith trwy 'fynediad uniongyrchol' a chynhaliwyd asesiad anghenion sylfaenol[13] pan dderbyniwyd Mr K, gan gofnodi mai prif broblemau Mr K oedd camddefnyddio alcohol a cocên a'r ffaith nad oedd yn gallu rheoli ei arian. Nid oedd unrhyw dystiolaeth i awgrymu bod asesiad iechyd meddwl blaenorol Mr K gan *Feddyg 1* wedi ei rannu gyda staff Tŷ Gobaith na'u bod wedi gofyn amdano.

1.37 Neilltuwyd gweithiwr allweddol i Mr K, *gweithiwr allweddol 1,* o fewn tri diwrnod o fod yn Nhŷ Gobaith. Roedd gweithiwr allweddol 1 yn gweld Mr K bob wythnos ac yn llunio cynllun cymorth bob pedair wythnos. Lluniwyd cynllun cymorth olaf Mr K ar 9 Gorffennaf 2010, a chymerwyd dros dair wythnos i wneud hynny.

1.38 Llenwyd y ffurflen gais i fyw yn hostel Mind Caerdydd ar ran Mr K ar 2 Mehefin 2010, ac roedd yn cofnodi:

[12] Toriad i asgwrn yw toriad rhwygo, sy'n digwydd pan fo darn bach o'r asgwrn yn rhwygo i ffwrdd o'r prif asgwrn o ganlyniad i drawma corfforol
[13] Mae'r Asesiad Anghenion Sylfaenol yn Nhŷ Gobaith yn asesiad sy'n edrych ar broblemau iechyd rhywun, manylion y meddyg teulu ac ati.

'Mae [Mr K] yn dioddef o straen a gorbryder yn enwedig mewn torf. Cafodd [Mr K] ddiagnosis o iselder ond nid yw o'r farn bod hwn yn ddiagnosis cywir ac nid yw'n cymryd ei feddyginiaeth'.

1.39 Roedd y ffurflen gais hefyd yn nodi y byddai o fudd i Mr K gael cymorth â'r canlynol:

- Yfed a hapchwarae y mae [Mr K] yn ei wneud pan fo dan straen neu'n dioddef o orbryder;
- Cadw'n sefydlog yn feddyliol a chynnal cymhelliant;
- Dod o hyd i swydd; a
- Sicrhau ei fod yn parhau i dderbyn ei fudd-daliadau

1.40 Roedd y ffurflen gais yn nodi bod Mr K yn byw mewn hostel [Tŷ Gobaith] ac y byddai o fudd iddo gael llety mwy diogel mewn prosiect llai. Cofnodwyd manylion cyswllt *GP 2* o Bractis Meddygol Butetown a gweithiwr allweddol Mr K ar y ffurflen er mwyn gallu cysylltu â nhw i drafod Mr K a'i anghenion cymorth ac i lenwi ffurflen asesiad proffesiynol.

1.41 Ar 3 Mehefin 2010, roedd gan Mr K apwyntiad gyda *GP 2*. Mae'r cofnodion yn dangos bod *GP 2* wedi ysgrifennu at y clinig trawma yn gofyn am driniaeth briodol gan fod Mr K yn dal i ddioddef poen ar ôl cael llawdriniaeth wedi iddo dorri ei grimog. Ysgrifennodd *GP 2* na fyddai'r atgyfeiriad a wnaed gan *GP 3* ar 6 Mai yn ddigon buan gan fod Mr K yn dioddef mwy o boen yn ei ben-glin. Cofnododd *GP 2* fod hwyliau Mr K yn isel.

1.42 Gwelwyd Mr K yn y Clinig Trawma ar 15 Mehefin 2010, pryd y cofnodwyd bod Mr K wedi dioddef anaf i'w ben-glin dde a'i fod wedi mynd at ei feddyg teulu pryd y gofynnwyd am archwiliad pelydr-x a oedd yn dangos toriad arall.

1.43 Wrth ei archwilio, roedd ochr cymal pen-glin Mr K yn dal i fod yn eithaf poenus ond roedd yn gallu ei symud i bob cyfeiriad. Er hyn, roedd yn dal i fod yn anghyfforddus iawn i Mr K pan oedd yn ceisio cerdded. Gofynnwyd am sgan MRI o ben-glin dde Mr K i benderfynu beth fyddai'r camau nesaf.

1.44 Gwelodd *GP 2* Mr K eto ar 24 Mehefin 2010 yn y feddygfa. Roedd staff Tŷ Gobaith wedi dod â Mr K i'r apwyntiad gan eu bod yn pryderu am ei gyflwr meddwl. Cafodd Mr K ei atgyfeirio gan *GP 2* am asesiad seiciatrig brys yng Nghanolfan Hamadryad y Tîm Iechyd Meddwl Cymunedol gan fod *GP 2* o'r farn bod Mr K yn arddangos nodweddion negyddol salwch sgitsoffrenig. Cofnododd *GP 2*:

> *'Rwyf yn pryderu am y dyn 26 mlwydd oed hwn sydd wedi bod yn byw yn Nhŷ Gobaith ers 2 neu 3 mis. Daeth ei weithiwr allweddol ag ef i fy ngweld ar 24/6/2010. Mae hi [y gweithiwr allweddol] yn pryderu bod ei iechyd meddwl wedi dirywio ers iddi ei adnabod. Yn sicr, roedd yn ymddangos yn wael o'i gymharu â'r tro arall i mi gyfarfod ag ef ar 2/6/2010. Mae ef [Mr K] yn ddifynegiant, aflonydd - yn ffidlan â phethau, ac nid yw'n gallu cynnal trywydd meddwl yn hir, mae o'r farn bod rhywbeth o'i le ar ei lygaid ac mae'n eu rhwbio drwy'r adeg. Mae'n gwadu ei fod yn clywed lleisiau nac yn gweld rhithweledigaethau. Mae ei hwyliau'n amrywio. Mae hefyd yn ymddangos yn eithaf anniben.'*

1.45 Ar ôl atgyfeiriad y meddyg teulu, nid aeth Mr K i'w apwyntiad claf allanol cychwynnol gyda *Seiciatrydd Ymgynghorol 2* yng Nghanolfan Hamadryad ar 1 Gorffennaf 2010; ond gwelwyd Mr K ar 8 Gorffennaf 2010. Cofnodwyd yn ystod yr apwyntiad hwn ei fod yn byw yn Nhŷ Gobaith ers rhai misoedd a'i fod yn cwyno ei fod yn teimlo'n aflonydd drwy'r amser ac yn teimlo'r hyn yr oedd yn ei ddisgrifio fel "cynddaredd y tu mewn". Ychwanegodd ei fod yn ei chael yn anodd mwynhau gweithgareddau amser hamdden, fel mynd i'r gampfa. Cofnodwyd bod Mr K yn dymuno gallu mwynhau bywyd a'i fod yn teimlo bod pobl eraill yn mwynhau eu hunain. Dywedodd Mr K ei fod yn teimlo ei fod ar wahân "fel pe byddwn ddim yma mewn gwirionedd".

1.46 Nododd yr aelod o staff o Dŷ Gobaith a ddaeth gyda Mr K i'r apwyntiad ei bod yn pryderu bod gan Mr K dueddiad i'w gadw ei hun ar wahân ac ar adegau ei fod yn ymddangos yn baranoiaidd. Roedd un digwyddiad diweddar wedi bod pan yr honnwyd bod Mr K wedi dinoethi ei hun yn anweddus i fenyw yng Nghanolfan Huggard[14] pan oedd allan yn cerdded gyda hi. Roedd yn amhosibl profi'n ddiweddarach a oedd unrhyw gymhelliant rhywiol i'r weithred ynteu ai anfedrusrwydd cymdeithasol yn unig a oedd yn gyfrifol am y digwyddiad.

[14] Elusen yng Nghaerdydd sy'n gweithredu canolfan ddydd o'r enw y Ganolfan Huggard.

1.47 Nododd *Seiciatrydd Ymgynghorol 2* hefyd:

> *'nodwedd arall amlwg yw bod [Mr K] yn rhwbio ei lygaid yn barhaus, yn enwedig ei lygad dde yn ystod yr ymgynghoriad. Mae'n dweud bod y llygad yn teimlo'n anghyfforddus a bod y nodwedd hon yn dod yn fwy amlwg pan fydd yng nghwmni pobl, ac mae'n dweud ei bod yn well ganddo fod ar ei ben ei hun'.*

1.48 Wrth archwilio ei gyflwr meddwl, ni ddaeth *Seiciatrydd Ymgynghorol 2* o hyd i unrhyw dystiolaeth o ffenomena seicotig ac roedd ei affaith a'i hwyliau yn ymddangos yn niwtral. Cofnodwyd bod ganddo rai *'symptomau corfforol o iselder'* ac mai'r diagnosis mwyaf tebygol oedd iselder ond nad oedd yn bosibl diystyru anhwylder seicotig sylfaenol.

1.49 Gan ei bod yn ymddangos iddo ymateb yn dda i 75 miligram o Venlafaxine unwaith y dydd yn y gorffennol, rhagnodwyd 150 miligram unwaith y dydd i Mr K. Gwnaethpwyd trefniadau i Mr K gael ei adolygu mewn chwe wythnos a chafodd ei atgyfeirio i gael cyfraniad gan Nyrs Seiciatrig Gymunedol.

1.50 Ar 20 Gorffennaf 2010, cynhaliwyd cyfarfod amlddisgyblaethol pan drafodwyd Mr K. Yn unol ag argymhelliad *Seiciatrydd Ymgynghorol 2*, cytunwyd y dylai Mr K gael cyfraniad gan Nyrs Seiciatrig Gymunedol ac ar 27 Gorffennaf 2010, neilltuwyd *CPN 1* fel Nyrs Seiciatrig Gymunedol i Mr K.

1.51 Ar 4 Awst 2010, cysylltodd gweithiwr allweddol Mr K yn Nhŷ Gobaith (*gweithiwr allweddol 1*) â *CPN 1* i roi gwybod iddi na fyddai Mr K yn gallu cadw ei apwyntiad ar y diwrnod canlynol (5 Awst) gan fod ganddo apwyntiad arall. Dywedodd y gweithiwr allweddol hefyd fod gan Mr K ôl-ddyledion ar ei daliadau personol ac o ganlyniad y byddai'n symud o'i lety yn Nhŷ Gobaith yn ystod y dyddiau nesaf i Dŷ Tresillian[15]. Nododd staff Tŷ Gobaith fod ymddygiad Mr K yn anodd ond ni chofnodwyd unrhyw drais. Roedd Mr K ar gyfnod o rybudd am beidio â thalu ei rent pan oedd yn Nhŷ Gobaith ac am ymddygiad amhriodol tuag at rai o'r menywod a

[15] Mae Tŷ Tresillian yn cynnig llety i bobl sengl ddigartref sy'n 16 mlwydd oed neu hŷn. Yn benodol, mae'n darparu ar gyfer cyn droseddwyr a phobl â phroblemau alcohol, cyffuriau a iechyd meddwl. Gellir derbyn pobl â phecynnau gofal a chyplau.

oedd yn byw yno. Er hyn, nid yw'n amlwg a oedd hyn yn fwriadol neu oherwydd ei fod wedi meddwi.

1.52 Ar 5 Awst 2010, gwelwyd Mr K gan *GP 3* o Bractis Meddygol Butetown. Roedd *GP 3* yn ei chael yn anodd ymgysylltu â Mr K felly atgyfeiriodd ef eto i weld *Seiciatrydd Ymgynghorol 2* yng Nghanolfan Hamadryad y Tîm Iechyd Meddwl Cymunedol. O ganlyniad, gwnaethpwyd apwyntiad i Mr K weld *Seiciatrydd Ymgynghorol 2* fel claf allanol ar 19 Awst 2010. Ni ddaeth Mr K i'r apwyntiad hwn felly trefnwyd apwyntiad arall.

Cyfnod Mr K yn Nhŷ Tresillian

1.53 Gadawodd Mr K Dŷ Gobaith ar 9 Awst 2010 a symudodd i Dŷ Tresillian. Gwnaeth y staff yn Nhŷ Tresillian apwyntiad i Mr K gael asesiad gyda Mind Caerdydd, gan ei drefnu ar gyfer dydd Gwener 20 Awst 2010. Cofnodwyd hefyd bod gweithiwr allweddol wedi ei benodi i Mr K, sef *gweithiwr allweddol 2,* yn Nhŷ Tresillian ac roeddynt i fod i gyfarfod ddydd Iau 19 Awst 2010.

1.54 Ar 19 Awst 2010, daeth *gweithiwr allweddol 2* i ymweld â Mr K. Cofnodwyd eu bod wedi cael trafodaeth hir a nodwyd bod gan Mr K apwyntiad gyda'r Ganolfan Hamadryad. Roedd i fod i'w gynnal ar y diwrnod hwnnw ond cafodd ei aildrefnu ar gyfer 8 Medi 2010. Dywedodd Mr K nad oedd yn dymuno mynd i'r apwyntiad hwn gan ei fod yn teimlo nad oedd unrhyw ddiben gwneud hynny am nad oedd yn ei helpu. Trafododd *gweithiwr allweddol 2* y mater hwn gyda Mr K, yn ogystal â'r problemau'n ymwneud â'r ffaith nad oedd yn cymryd ei feddyginiaeth, ac anogodd ef i roi cynnig arall ar eu cymryd. Esboniodd *gweithiwr allweddol 2* wrth Mr K hefyd y gallai ei fudd-daliadau a'i ddewisiadau o ran llety ddibynnu ar ei gyswllt â Chanolfan Hamadryad, a gyda hynny cofnodwyd bod Mr K yn cytuno i fynd i'r apwyntiad nesaf.

1.55 Dywedodd Mr K wrth *weithiwr allweddol 2* ei fod yn teimlo fel petai "rhyfel yn digwydd yn ei ben", a oedd yn effeithio ar ei allu i wneud penderfyniadau a chanolbwyntio. Er i Mr K nodi ei fod o'r farn mai ei feddyliau ef ei hun oeddynt ac nid rhai rhywun arall; nid oedd yn gallu eu rheoli ac roedd hynny'n anodd ac yn peri gofid iddo.

1.56 Dywedodd Mr K fod byw yn Nhŷ Tresillian yn iawn, ond ei bod yn anodd gwneud a gweithredu cynlluniau. Awgrymodd *gweithiwr allweddol 2* y dylai Mr K gymryd rhan mewn gweithgareddau yng Nghanolfan Huggard ond dywedodd Mr K ei bod yn anodd iddo fod yn yr awyrgylch honno. Cytunodd *gweithiwr allweddol 2* i gysylltu â nhw i weld a allai Mr K fynd ar drip i'r sinema. Nododd *gweithiwr allweddol 2* hefyd y byddai'n siarad â Mind Caerdydd yng nghyfarfod Mr K ynglŷn â llety y diwrnod canlynol (20 Awst) i ofyn a fyddai Mr K yn gallu cymryd rhan mewn gweithgareddau yno. Roedd Mr K hefyd wedi derbyn dyddiad i gael sgan MRI ar ei ben-glin ar 24 Medi 2010. Cofnododd *gweithiwr allweddol 2* fod yr holiadur radioleg a anfonwyd cyn yr apwyntiad wedi ei lenwi a'i ddychwelyd, a bod fan allgymorth wedi ei threfnu i fynd â Mr K i'r apwyntiad. Cofnododd y gweithiwr allweddol fod Mr K yn rhwbio ei lygaid yn barhaus ac yn dal ei ben yn ystod y sesiwn, fel petai'n ceisio cau rhywbeth o'i feddwl.

1.57 Ar 23 Awst 2010, cysylltodd *CPN 1 â* gweithiwr allweddol blaenorol Mr K, *gweithiwr allweddol 1*, o Dŷ Gobaith gan nad oedd ganddo unrhyw wybodaeth ynglŷn â lle'r oedd Mr K. Mae'r cofnodion yn nodi bod Tŷ Gobaith ar 9 Awst 2010 wedi rhoi gwybod i *CPN 1* bod Mr K bellach yn byw yn Nhŷ Tresillian.

1.58 Ar 30 Awst 2010 cafodd gweithiwr allweddol Mr K gyfarfod gydag ef fel a drefnwyd. Roedd Mr K yn barod i siarad trwy'r rhan fwyaf o'r sesiwn, ond ar adegau roedd yn ymddangos ei fod yn synfyfyrio ac o bryd i'w gilydd roedd yn colli gafael ar y sgwrs. Cofnodwyd ei bod yn ymddangos i Mr K ddioddef problemau iechyd meddwl am y tro cyntaf pan yr oedd yn astudio Ffiseg ym Mhrifysgol Caerlŷr. Nid oedd Mr K bob amser yn sicr o'i hanes iechyd meddwl, ond roedd yn ymddangos iddo gael y presgripsiwn cyntaf o feddyginiaeth gwrth-iselder (Effexor MR) gan ei feddyg teulu (*GP 1*), ond rhoddodd y gorau i'w cymryd oherwydd eu bod yn ei wneud yn gysglyd. Rhagnodwyd Effexor i Mr K ar ôl hynny ond eto rhoddodd y gorau i'w cymryd gan ei fod yn teimlo nad oeddynt yn cael effaith arno. Esboniodd gweithiwr allweddol 2 wrth Mr K y gallai gymryd amser i sicrhau bod dos y feddyginiaeth yn gywir ac y dylai aros mewn cyswllt â Chanolfan Hamadryad er mwyn iddo gael cymorth yn hyn o beth. Nid oedd Mr K yn awyddus i ddychwelyd yno ond cytunodd i fynd i'w apwyntiad nesaf, a oedd wedi ei drefnu ar gyfer 8 Medi 2010.

1.59 Dywedodd Mr K hefyd ei fod yn dioddef poen yn un o'i draed, yn ogystal â'i ben-glin, ond nid oedd yn gallu rhoi rhagor o fanylion ynglŷn â hyn. Dywedodd hefyd y byddai'n hoffi astudio gwaith plymio.

1.60 Siaradodd Mr K ychydig ynglŷn â'r rhyw fath o drais domestig yn ystod ei blentyndod, yn ôl pob golwg. Siaradodd am ddadleuon ynglŷn â thasgau dyddiol a gwaith tŷ a fyddai'n arwain at drais corfforol. Er hyn, nid oedd Mr K yn gyfforddus i siarad yn fanwl am y pwnc hwn ac roedd yn anodd gwybod beth yn union a allai fod wedi digwydd. Dywedodd *gweithiwr allweddol 2* wrth Mr K y gallai siarad â nhw os oedd yn teimlo bod angen, a chynigiodd gyfle iddo siarad â rhywun annibynnol.

1.61 Yn ystod y sesiwn hon, siaradodd *gweithiwr allweddol 2* â Mr K hefyd ynglŷn â'r ffaith nad oedd wedi talu'r ffi gwasanaeth y cytunwyd arno'r wythnos cynt. Dywedodd Mr K fod angen iddo brynu pâr newydd o esgidiau rhedeg. Rhoddwyd Mr K ar delerau hunanarlwyo tra'i fod yn gweithio i dalu'r ôl-ddyledion a chytunodd i dalu swm o £30 y tro nesaf y byddai'n cael ei dalu.

1.62 Cafodd Mr K sesiwn arall gyda *gweithiwr allweddol 2* ar 31 Awst 2010 a chafwyd trafodaeth hir ynglŷn â'r apwyntiadau a oedd i ddod gyda Chanolfan Hamadryad a Mind Caerdydd. Roedd Mr K yn dal i gytuno ei fod am fynd i'r apwyntiadau ond roedd yn gofidio, hyd at ddagrau bron, pan drafodwyd yr angen i "ateb llawer o gwestiynau anodd". Rhoddodd *gweithiwr allweddol 2* sicrwydd i Mr K y byddai'n ei gefnogi, a bod pawb y byddai'n eu gweld yn gweithredu er mwyn ei gynorthwyo ac mai'r nod oedd sicrhau ei fod yn teimlo'n well. Dywedodd Mr K hefyd nad oedd bellach yn dymuno astudio gwaith plymio; yn hytrach roedd yn dymuno astudio adeiladu.

1.63 Ar 31 Awst 2010, ysgrifennodd *CPN 1* at Mr K yn Nhŷ Tresillian i ddweud bod apwyntiad wedi ei drefnu gydag ef ar gyfer 7 Medi 2010.

1.64 Ar 3 Medi, gwelwyd Mr K gan *weithiwr allweddol 2*. Dywedodd Mr K wrtho ei fod wedi cerdded i'r Barri (tref tua 10 milltir i'r de o Gaerdydd) y diwrnod cynt i geisio cofrestru ar gwrs coleg. Er hyn, pan gyrhaeddodd, nid oedd unrhyw gyrsiau yr oedd yn dymuno eu dilyn. Cofnododd *gweithiwr allweddol 2* bod Mr K yn gloff ond roedd manylion yr ymweliad honedig hwn â'r coleg yn annelwig. Trafododd *gweithiwr allweddol 2* gyda Mr K pa un a oedd hwn yn amser priodol i weithio/astudio gan y gallai gael trafferthion o ran ceisio ymdopi ag amserlen fwy prysur. Awgrymodd *gweithiwr allweddol 2* y dylai Mr K ganolbwyntio ar weithio gydag asiantaethau fel Hamadryad i geisio gwella sut yr oedd yn teimlo ac i gydbwyso/clirio ei feddwl er mwyn iddo allu ymdopi â'r gwaith astudio ychwanegol.

1.65 Cofnododd *gweithiwr allweddol 2* bod Mr K wedi newid y pwnc yr oedd am ei astudio ar ddau achlysur yn ystod eu trafodaethau, yn gyntaf i electroneg ac yna i astudiaethau busnes. Cofnodwyd gan *weithiwr allweddol 2* ei bod yn anodd i Mr K ymdrin â'r mater hwn. Dywedodd Mr K y byddai cael apwyntiadau parhaus yn amharu ar ei drefn arferol; ond pan geisiodd *gweithiwr allweddol 2* archwilio hyn ymhellach, ni allai Mr K ddisgrifio ei drefn arferol, na'r hyn y byddai yn ei wneud pe na byddai'n mynychu'r apwyntiadau a oedd wedi eu trefnu.

1.66 Awgrymodd *gweithiwr allweddol 2* y dylai Mr K fynd i Goleg Glan Hafren[16] i drafod cofrestru, ond dywedodd Mr K ei fod yn rhy flinedig, bod angen iddo gael bath ac nad oedd ganddo arian. Dywedodd *gweithiwr allweddol 2* wrth Mr K nad oedd yn ystyried y rhain yn rhesymau da am beidio mynd ac os oedd yn ei chael hi'n anodd ymdopi â hyn, yna gallai gael problemau wrth astudio'n llawn amser.

1.67 Ceisiodd *gweithiwr allweddol 2* siarad â Mr K am ei deimladau ac roedd o'r farn y byddai'n ddefnyddiol i Mr K ganolbwyntio ar yr hyn yr oedd yn ei deimlo y 'tu mewn' yn hytrach na'r 'tu allan'. Dywedodd Mr K ei fod yn dal yn ei chael yn anodd rheoli ei feddyliau. Yn benodol, dywedodd Mr K ei fod yn pryderu'n barhaus am reoli ei holl apwyntiadau yn enwedig ei fudd-daliadau. Treuliodd *gweithiwr allweddol 2* beth amser yn diffinio wrth Mr K yr hyn yn union yr oedd angen iddo ei wneud ynglŷn â hyn.

1.68 Ar 7 Medi 2010, ysgrifennodd *CPN 1* at Mr K yn nodi ei bod yn ddrwg ganddo nad oedd wedi ei weld ar gyfer eu hapwyntiad y diwrnod hwnnw. Aildrefnodd ddyddiad arall ac roedd bellach i fod i weld Mr K ar 5 Hydref 2010 am 10:30am.

1.69 Ar 8 Medi 2010, cyfarfu Mr K â Dirprwy Reolwr Gwasanaethau Cymorth Mind Caerdydd a llenwyd y ffurflen 'Asesiad Cyswllt Cychwynnol'. Pan ofynnwyd iddo ddisgrifio problemau iechyd meddwl neu emosiynol Mr K cofnodwyd y canlynol ar y ffurflen:

> *'Yn meddwl am bethau trwy'r dydd, yn chwilio. Mae'n well gennyf fod gyda llai o bobl nag yr oeddwn yn byw gyda nhw o'r blaen- lle mae'n brysur / llawn cynnwrf ac mae'n achosi straen a gorbryder felly roeddwn eisiau symud.*

[16] Coleg trydyddol yng Nghaerdydd.

Eisiau cymryd mwy o feddyginiaeth er mwyn teimlo'n well (mae ganddo Nyrs Seiciatrig Gymunedol).'

1.70 Roedd y ffurflen hefyd yn cofnodi, dan 'Camddefnyddio Alcohol':

'Nid wyf yn credu bod gennyf i [Mr K] broblem yfed. Ni fyddaf yn yfed ar rai dyddiau, ond mi fyddaf ar ddyddiau eraill. Rwyf yn hoffi yfed gyda phobl eraill, rwyf wedi yfed un can y bore yma- dim gormod. Rwyf yn yfed mwy pan fyddaf dan bwysau/ yn pryderu am gyfweliadau a phethau felly.'

1.71 Pan ofynnwyd am ei sefyllfa llety presennol cofnododd Mr K:

'Mae hi mor brysur yn yr hostel ac yn swnllyd- mae'n amhosibl i mi ymlacio, mae'n achosi straen'.

1.72 Cofnododd Mr K hefyd ei fod yn parhau i ddioddef problemau gyda'i ben-glin ac roedd yn aros am sgan MRI.

1.73 Llenwyd ffurflen 'Asesiad Iechyd Meddwl' hefyd lle cofnodwyd bod Mr K ar y pryd dan ofal *Seiciatrydd Ymgynghorol 2* o Ganolfan Hamadryad y Tîm Iechyd Meddwl Cymunedol a bu'r cyswllt olaf rhyngddynt ym mis Awst 2010. Roedd y ffurflen yn nodi ei fod wedi cael diagnosis o iselder, straen a gorbryder. Disgrifiodd Mr K ei broblemau iechyd meddwl presennol trwy gofnodi:

'Rwyf yn teimlo dan straen ac yn dioddef pryder pan fyddaf yn cael cyfarfodydd ffurfiol, ac mewn torfeydd hefyd. Mae angen heddwch a thawelwch arnaf ac mae'r hostel yn swnllyd iawn. Rwyf yn ceisio canfod pwy ydw i. Rwyf yn hoffi cael amser tawel i fy hunan. Weithiau mae angen cymorth arnaf i ddod o hyd i fy meddyginiaeth, sy'n fy helpu i ac yn gwneud i mi gael noson dda o gwsg. Mae fy seiciatrydd yn fy helpu i â hyn.'

1.74 Cofnododd Mr K hefyd ei fod wedi ceisio cyflawni hunanladdiad ddwywaith rhwng 2005 a 2006, trwy gymryd gorddos o feddyginiaeth a thrwy neidio oddi ar bont.

1.75 Cofnododd Mr K hefyd ei fod wedi dioddef o iselder, gorbryder / pyliau o banig, meddyliau cythryblus mynych, amheuon / paranoia ac wedi hunan-niweidio.

1.76 Ar 9 Medi 2010, gwnaethpwyd apwyntiad i Mr K weld *Seiciatrydd Ymgynghorol 2* yng Nghanolfan Hamadryad ar 29 Medi oherwydd i Mr K fethu â mynd i'w apwyntiad ar 8 Medi 2010.

1.77 Cyfarfu Mr K â *gweithiwr allweddol 2* ar 12 Medi 2010 pan ofynodd Mr K i gael mynd yn ôl i delerau llety â phob pryd bwyd. Penderfynodd y gweithiwr allweddol y câi wneud hynny ar yr amod ei fod yn talu £70 ar 21 Medi, a chytunodd i wneud hynny.

1.78 Cofnododd y gweithiwr allweddol hefyd ei fod wedi llenwi'r ffurflen asesiad proffesiynol (Asesiad Risg Cyffredin) y gofynnwyd amdano gan Mind Caerdydd ac y byddai'n ymdrin â'r atgyfeiriad ar ôl iddo ddychwelyd o'i wyliau blynyddol. Cofnodwyd bod Mr K:

> *'yn gallu mynd yn rhwystredig ac mae ganddo broblemau o ran rheoli ei ddicter mewn sefyllfaoedd, ond nid yw wedi ymosod ar staff na defnyddwyr gwasanaeth yn Nhŷ Tresillian na Thŷ Gobaith.'*

1.79 Cofnododd *gweithiwr allweddol 2* hefyd bod Mr K:

> *'Weithiau'n ei chael hi'n anodd ymgysylltu â gwasanaethau iechyd meddwl, ond mae'n gallu gwneud hynny gyda chymorth', 'mae wedi peidio â chymryd meddyginiaeth yn y gorffennol pan ei fod yn teimlo nad ydynt yn gweithio mwyach'* ac *'mae peth pryder y gallai eraill ddylanwadu arno [Mr K] yn rhwydd oherwydd ei broblemau â sefyllfaoedd cymdeithasol'.*

1.80 Cofnododd *gweithiwr allweddol 2* nad oedd unrhyw berygl hysbys o '*Risg difrifol i bobl eraill'*, '*Risg o hunan-esgeuluso na hunan-niweidio damweiniol'*, '*Risg oherwydd salwch meddwl'* a '*Risg oherwydd camddefnyddio alcohol neu sylweddau*'. Cofnododd *gweithiwr allweddol 2* hefyd nad oedd Mr K yn arddangos unrhyw arwyddion amlwg o risg i'w hunan nac i eraill.

1.81 Derbyniodd *CPN 1* alwad ffôn gan staff Tŷ Tresillian ar 20 Medi 2010. Roedd y staff yn pryderu fwyfwy am Mr K a oedd yn arddangos ymddygiad mwy anodd ac ymosodol. O ganlyniad, trefnodd Nyrs Seiciatrig Cymunedol Mr K, *CPN 1* i'w weld a gwnaethpwyd apwyntiad. Ar 23 Medi 2010, daeth Nyrs Seiciatrig Cymunedol Mr K i Dŷ Tresillian, ond dim ond newydd ddeffro oedd Mr K ac nid oedd yn teimlo y gallai

ymdopi â'r apwyntiad. Dywedwyd wrth y Nyrs Seiciatrig Cymunedol bod Mr K fel arfer yn aros yn effro'n hwyr yn darllen ei lyfrau peirianneg ac yna'n cysgu drwy'r bore. Cofnodwyd bod ymddygiad Mr K wedi bod yn anodd yn ddiweddar gan fynnu ei ffordd ei hun ac roedd y staff yn canfod eu hunain yn cytuno i rai o'i geisiadau, yn ystod y nos yn bennaf, i dawelu'r sefyllfa. Nid oedd unrhyw adroddiadau o drais. Cynigiodd y Nyrs Seiciatrig Cymunedol apwyntiad arall i Mr K ar 29 Medi 2010 am 2:00pm.

1.82 Yn y pen draw, llwyddodd Nyrs Seiciatrig Cymunedol Mr K i gynnal adolygiad ohono ar 29 Medi 2010 (7 wythnos ar ôl yr apwyntiad cyntaf a drefnwyd ar gyfer 5 Awst 2010) pryd yr oedd yn ymddangos o fod yn drwm dan ddylanwad alcohol. Roedd lleferydd Mr K yn anneglur ac roedd yn anodd deall yr hyn yr oedd yn ei ddweud ond nid oedd yn ymosodol. Cofnodwyd bod Mr K yn credu mai'r brif broblem ar y pryd oedd ei dymer a'i ddicter a oedd yn cael ei sbarduno pan yr oedd gan bobl ddisgwyliadau afrealistig ohono, yn ei farn ef. Rhoddodd Mr K enghraifft o'r staff yn gofyn iddo wneud pethau ac yna'n "swnian" arno pan nad oedd yn eu gwneud ar unwaith. Nid oedd unrhyw dystiolaeth o symptomau seicotig, nac unrhyw syniadau ganddo am gyflawni hunanladdiad na lladdiad. Dywedodd Mr K wrth *CPN 1* ei fod yn mynd i symud i hostel Mind Caerdydd yn fuan a bod ganddo deimladau cymysglyd am hynny. Dywedwyd wrth Mr K y byddai Mind Caerdydd yn trefnu cwrs rheoli dicter ar ei gyfer ond mynegodd na fyddai o bosibl yn gallu ymdopi â sefyllfa grŵp.

1.83 Yr argraff a gafodd *CPN o* Mr K ar ôl ei asesiad oedd bod ganddo ddibyniaeth ar alcohol a phroblemau rheoli dicter. Roedd *CPN 1* o'r farn na fyddai Mr K yn elwa ar gymorth rheolaidd gan Nyrs Seiciatrig Gymunedol mwyach gan nad oedd llawer o dystiolaeth bod ganddo salwch meddwl difrifol a rhyddhawyd Mr K o lwyth gwaith y Nyrs Seiciatrig Gymunedol ond parhaodd i fod dan ofal *Seiciatrydd Ymgynghorol 2* yng Nghanolfan Hamadryad y Tîm Iechyd Meddwl Cymunedol, ar ffurf apwyntiadau claf allanol. Nid oedd unrhyw dystiolaeth yn y cofnodion yn nodi bod Mr K wedi gweld *Seiciatrydd Ymgynghorol 2* yn yr apwyntiad a oedd wedi ei drefnu ar 29 Medi 2010.

1.84 Y diwrnod canlynol (30 Medi 2010), roedd Mr K i fod i fynd i apwyntiad gyda Mind Caerdydd. Fodd bynnag, cofnodir nad oedd yn teimlo'n ddigon da i fynd, gan ddweud ei fod dan bwysau oherwydd mai ychydig iawn o rybudd yr oedd wedi'i gael am yr apwyntiad.

1.85 Roedd yn ymddangos bod Mr K yn gofidio'n wirioneddol felly cynigiodd y staff aildrefnu'r apwyntiad. Esboniodd gweithiwr allweddol Mr K, *gweithiwr allweddol 2*, y byddai'n rhaid iddo fynd i'r apwyntiad nesaf ac y byddai angen iddo fod yn rhan o'r trefniadau i symud ymlaen o Dŷ Tresillian. Cynigiwyd mwy o gymorth i Mr K i'w gynorthwyo i wneud cynlluniau a'u gweithredu'n fwy effeithiol.

Cyfnod Mr K yn Hostel Mind Caerdydd

1.86 Symudodd Mr K i hostel a gefnogir gan Mind Caerdydd yn Claude Place yn ardal y Rhath o Gaerdydd ar 4 Hydref 2010. Ar adeg ei dderbyn, neilltuwyd gweithiwr allweddol, *gweithiwr allweddol 3* i Mr K, a oedd wedi ei leoli yn Claude Place ac yn cynnig cymorth i'r 5 tenant a oedd yn byw yno.

1.87 Cofnodwyd yn llyfr cofnodion Mind Caerdydd bod gan Mr K anhawsterau ariannol o'r adeg y symudodd i Claude Place, gan fenthyg arian ar ddiwrnod cyntaf ei denantiaeth ac yn fuan roedd yn hwyr yn talu ei rent. Dywedodd Mr K nad oedd yn derbyn arian Lwfans Cyflogaeth a Chymorth gan yr Adran Gwaith a Phensiynau mwyach ond ar ôl i'r staff wneud ymholiadau, sefydlwyd nad oedd Mr K yn gallu dweud beth oedd wedi digwydd i'w arian, er ei fod wedi talu'r sieciau i mewn i'r banc. Cofnododd staff yn Mind Caerdydd nad oedd Mr K yn ymgysylltu'n dda â'r tenantiaid eraill ac mai prin yr oedd yn cydweithredu â'r bobl a oedd yn ei gynorthwyo ac o ganlyniad cafodd llythyr yn ei rybuddio nad oedd yn cydymffurfio â'r cynllun.

1.88 Cynhaliwyd cyfarfod tîm amlddisgyblaethol ar 4 Hydref 2010 yng Nghanolfan Hamadryad y Tîm Iechyd Meddwl Cymunedol, pryd y trafodwyd Mr K. Cytunwyd yn unol â barn *CPN 1*, y dylid tynnu'n ôl cyfraniad gan Nyrs Seiciatrig Gymunedol gan yr ystyriwyd mai dicter oedd prif broblem Mr K. Rhoddwyd gwybod i Mr K am y penderfyniad hwn trwy lythyr.

1.89 Cafodd Mr K, yng nghwmni ei weithiwr allweddol o Mind Caerdydd (gweithiwr allweddol *3*), adolygiad gan *Seiciatrydd Ymgynghorol 2*, ar 5 Hydref yn y clinig i gleifion allanol. Dywedodd Mr K wrth *Seiciatrydd Ymgynghorol 2* bod ganddo broblemau rheoli dicter a mynegodd ddiddordeb mewn dilyn cwrs rheoli dicter yr oedd Mind Caerdydd yn ei hwyluso. Dywedodd Mr K hefyd ei fod yn cael ei lethu oherwydd ei fod yn gorfod golchi ei ddillad ei hun yn ogystal â phopeth arall, ond pan ofynnwyd iddo nid oedd yn gallu dweud beth yr oedd yn ei olygu wrth 'popeth arall'.

1.90 Dywedodd *gweithiwr allweddol 3* wrth *Seiciatrydd Ymgynghorol 2* bod staff Mind Caerdydd yn nodi bod Mr K yn cael anhawster i ganolbwyntio ar lif y sgwrs, pan oeddynt yn siarad ag ef am unrhyw gyfnod o amser, a byddai'n aml yn troi i siarad am rywbeth arall.

1.91 Y prif broblemau a gofnodwyd oedd bod pethau'n achosi straen i Mr K, ei ddicter yn cynyddu ac nad oedd y venlafaxine wedi gwneud unrhyw wahaniaeth.

1.92 Ym marn *Seiciatrydd Ymgynghorol 2,* nid oedd Mr K yn dangos unrhyw arwyddion o salwch meddwl difrifol a'r brif broblem oedd anhawster o ran rheoli dicter. Cofnodwyd bod ei weithiwr allweddol yn Mind Caerdydd (*gweithiwr allweddol 3*) am gofrestru Mr K ar gwrs rheoli dicter am chwe wythnos. O ganlyniad, rhyddhawyd Mr K o'r clinig ac o ofal *Seiciatrydd Ymgynghorol 2*. Anfonodd *Seiciatrydd Ymgynghorol 2* lythyr at *GP 2* yn nodi ei fod wedi rhyddhau Mr K, ond y byddai'n fodlon ei weld eto, pe byddai hi o'r farn bod hynny'n angenrheidiol.

1.93 Ni chafodd Mr K unrhyw gyswllt uniongyrchol pellach gyda'r Gwasanaethau Iechyd Meddwl tan y drosedd dan sylw.

1.94 Ar 12 Hydref 2010, derbyniodd *GP 3* lythyr gan y Llawfeddyg Orthopaedig Ymgynghorol yn Ysbyty Llandochau, yn nodi bod canlyniadau y sgan MRI ar ben-glin dde Mr K wedi cael eu hadolygu a bod Mr K wedi ei osod ar y rhestr aros frys i gleifion mewnol ar unwaith er mwyn adlunio Ligament Croesffurf Blaen y ben-glin dde, ac roedd yr ymgynghorydd yn bwriadu gwneud hynny yn yr ychydig fisoedd nesaf. Anfonodd yr ymgynghorydd gopi o'r llythyr at Mr K hefyd, ond roedd wedi ei anfon trwy gamgymeriad i Fyddin yr Iachawdwriaeth (Tŷ Gobaith).

1.95 Ar 13 Hydref 2010, cafodd Mr K gymorth ei weithiwr allweddol (*gweithiwr allweddol 3*) i lenwi ei ffurflenni 'symud i mewn' gan gynnwys y ffurflen Budd-dal Tai. Atgoffodd y gweithiwr allweddol Mr K hefyd nad oedd wedi talu unrhyw rent ers pythefnos. Dywedodd Mr K y byddai'n derbyn taliad yr wythnos ganlynol ac y byddai'n talu bryd hynny.

1.96 Ar 15 Hydref 2010, nid oedd Mr K wedi talu unrhyw swm tuag at ei rent o hyd gan ei fod yn dal i aros am daliad gan yr Adran Gwaith a Phensiynau. Dywedodd Mr K wrth ei weithiwr allweddol (*gweithiwr allweddol 3*) bod ganddo bryderon ynglŷn â'r

ffaith ei fod wedi newid ei gyfeiriad yn ddiweddar ac na fyddai'n cael ei arian o bosibl oherwydd hynny. Cynorthwyodd y gweithiwr allweddol Mr K i wneud galwad ffôn i'r Adran Gwaith a Phensiynau i roi trefn ar bethau.

1.97 Esboniodd y gweithiwr allweddol y broses Cynllun Cymorth Unigol i Mr K hefyd a cheisiodd annog Mr K i'w gwblhau. Dywedodd Mr K nad oedd yn gallu gwneud hynny ar y pryd a'i fod yn teimlo'n bryderus iawn ynglŷn â'i hawliad am fudd-daliadau.

1.98 Siaradodd y gweithiwr allweddol â Mr K ynglŷn â'i amcanion byr dymor. Mynegodd Mr K ei fod yn dymuno astudio Cemeg a'i fod yn ymchwilio i'r gwahanol gyrsiau oedd ar gael.

1.99 Ar 19 Hydref 2010, derbyniodd Mr K daliad gan yr Adran Gwaith a Phensiynau. Roedd hefyd i fod i fynd i ymgyfarwyddo â'r ardal leol ond yn hytrach dewisodd fynd i brynu sigarennau ac ni ddaeth yn ôl i'r tŷ.

1.100 Dychwelodd Mr K yn hwyrach y diwrnod hwnnw ac roedd yn drewi o alcohol. Cofnododd *gweithiwr allweddol 3* bod Mr K wedi talu £20.00 tuag at y rhent. Dywedodd Mr K wrtho ei fod wedi prynu consol gemau fideo PlayStation o Cash Converter gan ei fod am wneud rhywbeth a fyddai'n ei atal rhag gwario arian ar alcohol. Trafodwyd sut yr oedd Mr K yn mynd i allu prynu bwyd dros y bythefnos nesaf gan mai dim ond £55.00 oedd ganddo ar ôl i gynnal ei hun. Roedd Mr K yn bwriadu gwario'r arian hwn ar jîns a chôt gan nad oedd ganddo ddillad cynnes.

1.101 Ar 25 Hydref 2010, treuliodd *gweithiwr allweddol 3* ddwy awr yn trafod tair ôl-ddyled yng Nghynllun Cymorth Unigol Mr K. Cofnodwyd bod y drafodaeth yn 'anodd' ac y 'bu'n rhaid mynd yn ôl dros ddigwyddiadau diweddar a'i bod wedi cymryd llawer o ymdrech i gael gwybodaeth am yr ôl-ddyledion'. Trefnwyd cyfarfod arall ar gyfer dydd Iau 28 Hydref 2010 i barhau â'r drafodaeth.

1.102 Ar 10 Tachwedd 2010, gofynnodd g*weithiwr allweddol 3* i Mr K am hanes ei daliad Lwfans Cyflogaeth a Chymorth oherwydd ei fod mewn dyled ar gyfer ei rent unwaith eto. Dywedodd Mr K wrth *weithiwr allweddol 3* nad oedd wedi derbyn taliad ond cytunodd y byddai'n cysylltu â'r adran Lwfans Cyflogaeth a Chymorth i ofyn pam nad oedd wedi cael ei dalu. Defnyddiodd Mr K ffôn y swyddfa ond dywedodd nad oedd yn gallu mynd drwodd. Cynigiodd ei weithiwr allweddol eu ffonio ar ei ran a

derbyniodd Mr K y cynnig hwnnw. Pan geisiodd *gweithiwr allweddol 3* ffonio canfuwyd bod y rhif yn un i beiriant ateb awtomatig yr oedd angen gwasgu'r botwm perthnasol ar y ffôn i fynd at y gwasanaeth, ac nid oedd Mr K wedi gwneud hynny. Llwyddodd *gweithiwr allweddol 3* fynd trwodd ar yr adran Lwfans Cyflogaeth a Chymorth ac esboniodd ei fod yn gweithredu ar ran Mr K. Dywedwyd wrth *weithiwr allweddol 3* bod siec wedi ei hanfon at Mr K ar 29 Hydref 2010 a gyfnewidiwyd am arian parod ar 2 Tachwedd 2010 ac mai dyddiad taliad nesaf y lwfans i Mr K fyddai 16 Tachwedd. Gofynnodd *gweithiwr allweddol 3* i Mr K pam yr oedd wedi gwadu derbyn taliad; dywedodd Mr K ei fod wedi anghofio ei fod wedi derbyn yr arian. Cofnododd *Gweithiwr allweddol 3* bod Mr K yn edrych yn anghyfforddus a'i fod wedi dechrau rhwbio ei wyneb, ei fod wedi edrych i ffwrdd a'i fod wedi mynd yn 'ddryslyd'. Nid oedd Mr K yn gallu cofio beth yr oedd wedi gwario'r arian arno.

1.103 Ar 16 Tachwedd 2010, ffoniodd *gweithiwr allweddol 3* feddyg teulu Mr K ym Mhractis Meddygol Butetown i wneud apwyntiad ar gyfer y diwrnod wedyn gan fod angen iddo adnewyddu ei dystysgrif feddygol ar gyfer y Lwfans Cyflogaeth a Chymorth. Gwnaeth *gweithiwr allweddol 3* apwyntiad arall gyda staff cymorth ar gyfer Mr K gan fod ganddo ddyled fawr gyda banc a oedd yn codi tâl arno bellach. Roedd Mr K eisoes wedi methu a dod i un apwyntiad arall a oedd wedi ei drefnu ar ei gyfer.

1.104 Ar 18 Tachwedd, cyfarfu *gweithiwr allweddol 3* a Dirprwy Reolwr Gwasanaethau Cymorth Mind Caerdydd gyda Mr K i orffen y drafodaeth ynglŷn â'i Gynllun Cymorth Unigol. Roedd Mr K yn yfed a bu'n rhaid gofyn iddo beidio â gwneud hynny, roedd yn amlwg ei fod wedi meddwi. Llwyddodd *gweithiwr allweddol 3* a Dirprwy Reolwr Gwasanaethau Cymorth Mind Caerdydd i lenwi'r Cynllun Cymorth Unigol ond bu hynny gyda pheth anhawster gan fod cyswllt llygaid Mr K yn wael iawn. Trwy gydol y cyfarfod, nid oedd Mr K yn gallu canolbwyntio ac roedd yn mynd ar drywydd gwahanol yn barhaus a ddim yn deall y cwestiynau a ofynnwyd iddo.

1.105 Ar 1 Rhagfyr 2010, cyfarfu *gweithiwr allweddol 3* gyda Mr K dros goffi yn yr ystafell fwyta. Dywedodd Mr K wrtho ei fod yn disgwyl siec gan yr Adran Gwaith a Phensiynau a chytunodd i dalu £40.00 o rent y diwrnod hwnnw i gynorthwyo i dalu ei ddyledion. Dywedodd Mr K wrth *weithiwr allweddol 3* ei fod yn teimlo'n iach, ond dywedodd bod *preswylydd 1* (preswylydd arall yn yr hostel) wedi siarad ag ef ynglŷn â gadael y teledu a'r goleuadau ymlaen yn y lolfa.

1.106 Y noson honno, cofnodwyd bod Mr K wedi gwahodd ffrind i'r tŷ a chofnododd *gweithiwr allweddol 3* bod ganddo amheuon cryf bod Mr K a'i ffrind yn ysmygu marijuana. Bu'n rhaid i *weithiwr allweddol 3* ofyn hefyd i Mr K beidio ag yfed yn y lolfa, a chydymffurfiodd â'r cais hwn.

1.107 Ar 1 Ionawr 2011, derbyniwyd Mr K i Ysbyty Athrofaol Cymru yng Nghaerdydd gan ei fod yn chwydu gwaed. Cofnodwyd bod Mr K wedi bod yn yfed yn barhaus drwy'r diwrnod hwnnw a'i bod yn ymddangos bod hynny wedi achosi problemau stumog. Rhyddhawyd Mr K yn ôl i'r hostel y diwrnod canlynol.

1.108 Ar 6 Ionawr 2011, daeth Mr K i'r swyddfa ac esboniodd wrth *weithiwr allweddol 3* nad oedd ganddo arian ar ôl a gofynnodd a allai ad-hawlio £20.00 o'r rhent yr oedd wedi ei dalu ddau ddiwrnod ynghynt. Roedd Mr K wedi talu £50.00 ar 29 Rhagfyr a £55.00 arall ar 31 Rhagfyr 2010 ar ôl ennill bet. Trafododd *gweithiwr allweddol 3* gyda Mr K ei dderbyniad i'r ysbyty oherwydd ei fod wedi yfed ac ysmygu gormod a bod y meddygon wedi ei gynghori i ymwrthod â'r ddau. Dywedodd Mr K nad oedd ganddo unrhyw arian i brynu alcohol a bod angen yr arian arno i brynu bwyd. Esboniodd *gweithiwr allweddol 3* na fyddai'n gallu rhoi caniatâd i Mr K gael yr arian os oedd am ei wario ar alcohol neu hapchwarae. Mynnodd Mr K mai ar gyfer bwyd oedd yr arian. Hysbysodd *gweithiwr allweddol 3* Dirprwy Reolwr Gwasanaethau Cymorth Mind Caerdydd a chytunodd y gallai Mr K gael £20.00 i brynu bwyd yn unig.

1.109 Ar 12 Ionawr 2011, cafodd *gweithiwr allweddol 3* drafodaeth wyneb yn wyneb gyda Mr K. Trafododd *gweithiwr allweddol 3* ddadl a oedd wedi digwydd y noson flaenorol rhwng Mr K a menyw, *preswylydd 1,* a oedd hefyd yn preswylio yn y tŷ yn Claude Place. Dywedodd Mr K ei fod yn ceisio "cymodi gyda phreswylydd 1" gan nad oedd yn hoffi drwgdeimlad.

1.110 Gofynnodd *gweithiwr allweddol 3* i Mr K beidio â bod yn anghwrtais wrth *breswylydd 1* a cheisio peidio â dechrau sgwrs â hi neu gysylltu â hi oni bai bod *preswylydd 1* yn dangos ei bod yn dymuno i hynny ddigwydd.

1.111 Cafodd *gweithiwr allweddol 3* hefyd drafodaeth fanwl gyda Mr K am gyflwr ei feddwl. Datgelodd Mr K ei fod yn teimlo bod ei feddwl yn gweithio'n rhy gyflym ac nad oedd yn gallu gwneud synnwyr o'r byd gan ei fod yn symud yn arafach na'i feddwl. Dywedodd Mr K fod pobl yn meddwl ei fod yn "annormal fel plentyn" ond ar y pryd nid

oedd yn sylweddoli bod pobl yn meddwl yn wahanol iddo ef a dim ond ar ôl iddo fynd yn hŷn y dechreuodd sylwi ar hyn.

1.112 Gofynnodd *gweithiwr allweddol 3* i Mr K pe byddai'n fodlon cymryd meddyginiaeth, pe byddai'n cael ei rhagnodi ar ei gyfer. Dywedodd Mr K y byddai'n "rhoi cynnig arni". Awgrymodd *gweithiwr allweddol 3* y gallai wneud apwyntiad gyda meddyg teulu Mr K yr wythnos honno ac y byddai'n mynd gydag Mr K ac yn ei gynorthwyo i esbonio i'r meddyg teulu, pe byddai angen, yr hyn yr oedd Mr K wedi ei ddweud wrtho. Cytunodd Mr K i hyn a dywedodd wrth y gweithiwr allweddol ei fod eisiau "arafu pethau er mwyn gallu deall sut y mae pobl eraill yn meddwl". Gwnaethpwyd apwyntiad felly gyda'r meddyg teulu, *GP 4* ar 4 Chwefror 2010 i drafod iechyd meddwl Mr K.

1.113 Aeth Mr K i gyfarfod â staff yn Ysbyty Llandochau i drafod y llawdriniaeth ar ei ben-glin a oedd wedi ei drefnu ar gyfer mis Chwefror. Yn ystod y drafodaeth mynegodd Mr K bryderon am ei iechyd rhywiol gan ei fod wedi cael rhyw heb ddiogelwch yn y gorffennol. Roedd Mr K yn poeni y gallai fod wedi cael HIV ac y gallai ei drosglwyddo i bobl eraill pe byddai'n anafu ei hun yn y tŷ neu yn ystod y llawdriniaeth.

1.114 Ar 18 Ionawr 2011, llenwodd Mr K holiadur iechyd meddyg teulu ar gyfer Meddygfa Albany yng Nghaerdydd. Ar y ffurflen gwadodd ei fod yn cymryd unrhyw feddyginiaeth reolaidd ac atebodd 'oes' i'r cwestiwn ynglŷn ag a oedd ganddo anabledd, gan nodi bod ganddo ben-glin wael. Datgelodd ei fod yn dioddef o iselder ond ei fod yn cael cymorth gan Mind Caerdydd.

1.115 Derbyniodd *GP 3* ym Mhractis Butetown lythyr gan Adran Orthopaedig Ysbyty Llandochau hefyd ar 18 Ionawr 2011. Roedd y llythyr yn nodi bod Mr K wedi cael ei asesu yn y clinig cyn derbyn y diwrnod hwnnw a bod llawdriniaeth i adlunio ei ben-glin dde wedi ei threfnu ar gyfer 10 Chwefror 2011. Roedd Mr K wedi derbyn gwybodaeth fanwl ynglŷn â risgiau a buddion y llawdriniaeth ac roeddynt wedi cael ei ganiatâd ysgrifenedig ar gyfer y llawdriniaeth. Fodd bynnag, roedd llythyr rhyddhau o ysbyty Prifysgol Caerdydd a'r Fro yn nodi bod Mr K wedi ei dderbyn ar gyfer llawdriniaeth i'w ben-glin dde ar 27 Ionawr 2011, a'i fod wedi ei ryddhau y diwrnod wedyn. Nid oes unrhyw dystiolaeth yn nodi pam y symudwyd y llawdriniaeth i ddyddiad cynharach.

1.116 Ar 4 Chwefror 2011 bu tân yn yr hostel, a achoswyd, yn ôl Mr K, pan gododd yn oriau mân y bore i wneud tost iddo'i hun. Dywedodd ei bod yn debygol bod olew yn y badell grilio a oedd wedi mynd ar dân. Achosodd hyn i'r larwm mwg ganu gan ddeffro un o'r tenantiaid, *preswylydd 1*, a alwodd y frigâd dân ac ambiwlans.

1.117 Bu gwrthdaro eto rhwng Mr K â *phreswylydd 1* y diwrnod hwnnw (4 Chwefror) pan gyhuddodd hi ef o beidio ag ateb y drws na rhoi gwybod iddi pan ffoniodd rhywun i siarad â hi. Achosodd hyn rwystredigaeth i Mr K a thaflodd ei faglau ati. Ffoniodd *preswylydd 1* yr heddlu, gan ddweud ei bod yn teimlo dan fygythiad ganddo. Sbardunodd hyn gyfarfod gyda'r Rheolwr Prosiect yn Mind Caerdydd a rybuddiodd Mr K y byddai'n torri amodau ei denantiaeth pe byddai'n parhau i beidio ag ymgysylltu â'i weithiwr cymorth; ond mae'n ymddangos bod Mr K wedi parhau i beidio ag ymgysylltu.

1.118 Yn hwyrach y diwrnod hwnnw (4 Chwefror), gwelwyd Mr K, yng nghwmni ei weithiwr allweddol, gan y meddyg teulu, *GP 4*. Ar ôl yr apwyntiad hwn, atgyfeiriodd *GP 4* Mr K at ganolfan LINKS y Tîm Iechyd Meddwl Cymunedol yng Nghaerdydd oherwydd pryderon ynglŷn â rhai agweddau ar ei ymddygiad. Cofnododd *GP 4* ei fod ef a gweithiwr allweddol Mr K (*gweithiwr allweddol 3*) yn poeni bod Mr K yn datblygu 'salwch seiciatrig mwy amlwg' ac felly gwnaeth gais am asesiad oherwydd bod Mr K yn isel o ran ei hwyliau. Roedd llythyr atgyfeirio *GP 4* yn nodi:

> *'Ers iddo [Mr K] symud i dŷ Mind Caerdydd mae ei ofalwyr wedi mynd yn fwy a mwy pryderus am rai agweddau penodol ar ei ymddygiad. Rwyf wedi cyfarfod â Mr K ddwywaith, ac ar y ddau achlysur mae wedi encilio ac wedi methu â rhoi hanes clir. Mae'n ymddangos ei fod yn osgoi cyswllt llygad ac yn ein hymgynghoriad diwethaf roedd yn mynegi syniadaethau paranoid gan ddweud nad oedd yn hoff o feddyliau pobl eraill a'i fod yn meddwl bod pobl yn ymwybodol o'i feddyliau ef. Mae ei weithwyr gofal a minnau'n pryderu y gallai fod yn datblygu salwch seiciatrig amlycach a byddem yn ddiolchgar o'ch asesiad i ddweud a ydych yn cyd-fynd â hyn.*
>
> *Nid oeddwn yn ymwybodol bod Mr K yn arfer camddefnyddio alcohol yr ail dro i mi ei weld, ond nid yw wedi bod dan ddylanwad alcohol ar y ddau achlysur yr wyf wedi cyfarfod ag ef'.*

1.119 Dywedodd *GP 4* hefyd ei fod wedi rhagnodi ychydig bach o Diazepam i Mr K ond roedd yn ymwybodol ei fod wedi camddefnyddio Diazepam yn y gorffennol a'i fod yn bwriadu peidio â'i ragnodi yn ei ymgynghoriad nesaf gydag ef a rhagnodi meddyginiaeth arall yn ei le.

1.120 Ar 14 Chwefror 2011, ysgrifennodd Tîm Iechyd Meddwl Cymunedol LINKS at Mr K ar ôl yr atgyfeiriad a wnaed gan *GP 4* ar 4 Chwefror 2011. Roedd y llythyr yn hysbysu Mr K y byddai angen iddo gysylltu â nhw pe byddai'n dymuno gwneud apwyntiad. Roedd y llythyr yn nodi:

> *'Fel yr ydych yn gwybod, mae eich meddyg teulu wedi eich cyfeirio at Ganolfan Links gyda'r bwriad i ni eich helpu â'ch problemau presennol. Mae'r apwyntiad hwn ar gyfer asesiad cychwynnol a allai barhau am hyd at awr a bydd aelod o'n tîm meddygol yn eich gweld……Os na fyddwn yn clywed gennych o fewn pythefnos i ddyddiad y llythyr hwn, byddaf yn cymryd yn ganiataol nad ydych yn dymuno defnyddio ein gwasanaeth a byddwn yn hysbysu eich meddyg teulu yn unol â hynny.'*

1.121 Ni chysylltodd Mr K â Thîm Iechyd Meddwl Cymunedol Links i wneud yr apwyntiad hwn.

1.122 Yn ystod apwyntiad meddyg teulu gyda *GP 4* ar 18 Chwefror dywedodd Mr K ei fod yn cael trafferth cysgu a'i fod yn fyr ei dymer ac yn ymosodol tuag at y tenantiaid eraill a oedd yn byw yn Claude Place. Rhagnodwyd gwrth-iselydd i Mr K yn dilyn hynny, ac roedd i'w gymryd yn y nos gan ei fod yn ei wneud yn gysglyd. Cofnododd *GP 4* bod Mr K wedi meddwi yn ystod yr apwyntiad. Derbyniodd *GP 4* lythyr hefyd gan yr Adran Ffisiotherapi yn Ysbyty Brenhinol Caerdydd yn nodi nad oedd Mr K wedi cysylltu â'r adran i drefnu apwyntiad yn dilyn eu llythyr. Roeddynt felly'n rhyddhau Mr K yn ôl i ofal *GP 4*.

1.123 Ar 3 Mawrth 2011, gwelwyd Mr K gan *weithiwr allweddol 3*. Roedd Mr K yn dangos arwyddion ei fod yn gallu trefnu ei gyllideb a'i fod yn gallu ymdopi â golchi ei ddillad. Dywedodd Mr K y byddai'n gwneud ymdrech gadarn i gymryd rhan mewn gweithgareddau cymdeithasol, ond esboniodd bod hynny yn dibynnu ar ba ddiwrnod y byddent yn digwydd. Mynegodd Mr K ei fod yn dymuno dilyn y cwrs rheoli dicter nesaf yr oedd Mind Caerdydd yn ei gynnal a'i fod yn teimlo llawer yn well ers dechrau

cymryd ei feddyginiaeth gwrth iselder. Cofnodwyd hefyd bod Mr K i fod i ddechrau cael ffisiotherapi ar ei ben-glin yn dilyn y llawdriniaeth yr oedd wedi ei chael.

1.124 Ar 7 Mawrth 2011, nid oedd gan Mr K unrhyw feddyginiaeth gwrth iselder ar ôl a dywedodd wrth aelod o staff, *gweithiwr cymorth 1* Mind Caerdydd, bod angen iddo ei chymryd oherwydd y byddai'n dechrau teimlo'n isel hebddi ac y byddai'n mynd i drwbl ac yn dechrau ymladd. Dywedodd Mr K hefyd nad oedd ganddo arian ar ôl a bod ganddo filiau i'w talu. Byddai hyn yn ei adael heb arian ar ôl ei dâl nesaf.

1.125 Yn ddiweddarach y diwrnod hwnnw (7 Mawrth 2011), gwelodd Mr K *GP 4*, a chofnodwyd ei fod mewn gwell hwyliau a'i fod yn teimlo'n well ond cytunodd i barhau i gymryd ei feddyginiaeth gwrth iselder.

1.126 Ar 8 Mawrth 2011, rhagnodwyd cyflenwad mis o feddyginiaeth gwrth iselder i Mr K ar ôl ei apwyntiad gyda'i feddyg teulu. Roedd Mr K wedi derbyn rhywfaint o arian felly talodd ei rent a chofnodwyd ei fod wedi cael diod i roi hyder iddo cyn mynd allan i wneud ychydig o siopa. Aeth Mr K i dafarn y Claude gyda Mr Z (y dioddefwr yn y pen draw) ac ar ôl iddynt ddychwelyd sylwyd bod gwaed yn dod o dalcen a chlust Mr K. Dywedodd Mr K bod Mr Y (rhywun yr oedd Mr Z yn ei adnabod) wedi ymosod arno ond dywedodd yn hwyrach mai ef mewn gwirionedd a oedd wedi dechrau'r ymladd oherwydd ei fod yn teimlo dan fygythiad.

1.127 Ar 14 Mawrth cofnodir bod Mr K wedi treulio'r rhan fwyaf o'r dydd gyda Mr Z yn ei ystafell yn gwylio'r teledu a gwrando ar gerddoriaeth. Ar y diwrnod hwnnw, derbyniodd *GP 4* lythyr gan Adran Llawdriniaeth Orthopaedig Ysbyty Llandochau, Caerdydd yn nodi nad oedd Mr K wedi dod i'w apwyntiad ffisiotherapi ar ôl y llawdriniaeth ar ei ben-glin ac felly ni fyddent yn cynnig apwyntiad arall i Mr K ond byddent yn fodlon ei adolygu ar ôl cael ail atgyfeiriad.

1.128 Ar 15 Mawrth 2011 dangosodd Mr K lythyr i *weithiwr cymorth 1* Mind Caerdydd yn nodi bod ei Lwfans Cyflogaeth a Chymorth wedi ei atal. Siaradodd Dirprwy Reolwr Gwasanaethau Cymorth Mind Caerdydd â Mr K yn hwyrach ynglŷn â chwynion gan *breswylydd 1* bod Mr K yn curo ar ei drws yn ystod y nos, ond roedd Mr K yn gwadu hynny.

1.129 Ar 17 Mawrth 2011, adolygwyd cynnydd Mr K gan *weithiwr allweddol 3*. Mynegodd Mr K ei bryderon gan fod ei Lwfans Cyflogaeth a Chymorth wedi ei atal

ond ni ddangosodd unrhyw barodrwydd i fynd i'r afael â'r broblem a methodd fynychu apwyntiadau gyda staff cynghori Mind Caerdydd dro ar ôl tro. Dywedodd Mr K ei fod yn teimlo'n flinedig drwy'r dydd gan nad oedd yn cysgu yn ystod y nos a chofnodwyd ei bod yn ymddangos bod Mr K yn ddryslyd ynglŷn â phryd y dylai gymryd ei feddyginiaeth. Nodwyd hefyd bod Mr K yn treulio llawer o amser gyda Mr Z, yn yfed fel arfer. Yn hwyrach y diwrnod hwnnw, cofnodir bod *gweithiwr allweddol 1* Mind Caerdydd wedi cyfryngu rhwng Mr K a *phreswylydd 1* er mwyn cael gwared ar y drwgdeimlad rhyngddynt.

1.130 Ar 18 Mawrth 2011, derbyniodd *GP 4* lythyr gan *Seiciatrydd Ymgynghorol 2* yn crynhoi ei asesiad o Mr K ar 8 Gorffennaf 2010. Nododd *Seiciatrydd Ymgynghorol 2*:

> *'Rwyf yn cofio ei weld ef [Mr K] o'r blaen pan oedd yn byw yng Nghanolfan Huggard ac rwyf yn cynnwys llythyr asesu o fis Gorffennaf 2010. Yn sicr ar yr adeg honno roeddwn o'r farn ei fod yn dioddef o iselder, ond ni ellid diystyrru anhwylder seicotig sylfaenol'.*

1.131 Ar 21 Mawrth 2011, nododd Mr K na fu ganddo arian ers pythefnos o leiaf a'i fod yn teimlo'n isel iawn. Dywedodd ei fod yn aml yn teimlo dicter a bod arno ofn mynd allan rhag ofn iddo gael ei hun i drwbl. Anogwyd Mr K i gymryd camau ynglŷn â'i Lwfans Cyflogaeth a Chymorth ond eto roedd yn parhau i fod yn amharod ac yn anfodlon. Dywedwyd wrth Mr K bod yn "rhaid" iddo wneud rhywbeth am ei drefniadau ariannol y diwrnod canlynol.

1.132 Ar 22 Mawrth 2011, cyfarfu *gweithiwr cymorth 1* Mind Caerdydd â Mr K a chysylltodd â'r Adran Gwaith a Phensiynau ar ei ran i ddatrys y sefyllfa gyda'i Lwfans Cyflogaeth a Chymorth. Dywedwyd wrth Mr K ei bod yn ofynnol iddo fynd i'r Ganolfan Waith y bore wedyn er mwyn gwneud cais am fenthyciad argyfwng.

1.133 Yn hwyrach y diwrnod hwnnw am 21.55 o'r gloch, derbyniodd Heddlu De Cymru alwad o 9 Claude Place, Caerdydd yn nodi bod corff dyn wedi ei ddarganfod. Pan aethant yno, canfuwyd bod Mr Z wedi marw a gwnaeth Mr K sylwadau yn y fan a'r lle a oedd yn ei gysylltu â llofruddiaeth Mr Z. Gwelwyd bod gan Mr K waed ar ei ddillad ac mae adroddiadau'r heddlu yn nodi bod Mr K wedi dweud wrthynt fod ei ffrind (Mr Z) wedi gofyn iddo ef (Mr K):

“dair gwaith i gyd i’w ladd. Mae rhai pobl angen lladd eu hunain. Fe wnaeth fy ngwthio i i'w ladd drwy ddweud nad oedd eisiau byw bellach”.

Cefndir Mr Z

1.134 Roedd Mr Z yn ddyn 54 mlwydd oed â hanes o seicosis, camddefnyddio alcohol a hunan-niweidio. Roedd wedi bod yn defnyddio gwasanaethau iechyd meddwl ers amser maith ac wedi ei dderbyn fel claf mewnol sawl gwaith ac ystyriwyd ei fod yn unigolyn a oedd mewn perygl oherwydd y gallai pobl eraill gamfanteisio arno. Symudodd i hostel Mind Caerdydd yn Claude Place ar 16 Mehefin 2010 yn dilyn pryderon ei fod yn agored i bobl eraill gamfanteisio arno yn ei gyfeiriad Mind Caerdydd blaenorol mewn man gwahanol yng Nghaerdydd.

1.135 Trwy gydol ei amser yn byw yn hostel Mind Caerdydd yn Claude Place cafodd Mr Z gyfraniad parhaus gan ei Nyrs Seiciatrig Gymunedol (o Dîm Iechyd Meddwl Cymunedol Links), a gan weithiwr cymdeithasol, a threuliodd amser yn cael triniaeth ar gyfer dadwenwyno oherwydd alcohol. O bryd i'w gilydd yn ystod ei amser yn byw yno roedd Mr Z wedi bod yn ymddwyn mewn modd bygythiol tuag at ei gydbreswylwyr yn Claude Place a gweithwyr cymorth Mind Caerdydd. Atgyfeiriwyd un mater o’r fath i'r Heddlu a rhybuddiwyd Mr Z y gallai ei ymddygiad arwain at ei droi allan o Claude Place. Dangosodd Mr Z edifeirwch ynglŷn â’r digwyddiad ac ymrwymodd i ymatal yn y dyfodol.

1.136 Fodd bynnag, roedd defnydd Mr Z o alcohol yn parhau i fod yn broblem yn ystod ei amser yn Claude Place a oedd yn golygu bod ei gydbreswylwyr yn ymwybodol o’i ymddygiad. Roedd Mr Z wedi cwyno wrth ei Nyrs Seiciatrig Gymunedol hefyd ei fod yn dioddef o rithweledigaethau gweledol a nodwyd bod hwn yn arwydd idiosyncratig o ddirywiad i gyflwr ei feddwl.

1.137 Ym mis Mawrth 2011, gwnaethpwyd atgyfeiriad Amddiffyn Oedolyn sy’n Agored i Niwed gan Mind Caerdydd ynglŷn â Mr Z oherwydd ei bod yn ymddangos bod Mr Y wedi ymosod arno. Er gwaethaf yr atgyfeiriad, nodwyd bod Mr Z mewn hwyliau da a’i fod yn parhau i osgoi unrhyw gyswllt pellach â Mr Y. Honnodd Mr Z fod Mr Y wedi ymosod ar Mr K yn y dafarn a bod Mr K wedi ymateb trwy ymosod ar Mr Y. Cynghorwyd Mr Z gan Mind Caerdydd i roi gwybod i’r Heddlu am y mater ond

ystyriwyd bod gan Mr Z y gallu i ddewis peidio â rhoi gwybod i'r Heddlu am yr ymosodiad.

Perthynas Mr K â Mr Z

1.138 Cyfarfu Mr Z a Mr K drwy eu bod yn byw yn Claude Place a daethant i adnabod ei gilydd. Roedd Mr Z eisoes yn byw yno pan symudodd Mr K i mewn. Trwy gydol yr amser y bu Mr K yn byw yno, gwelwyd Mr K a Mr Z gyda'i gilydd yn aml. Ystyriwyd y berthynas yn un blatonig. O'r dystiolaeth a adolygwyd, nid oedd unrhyw awgrym bod y berthynas rhwng Mr K a Mr Z yn amhriodol. Yn wir, mae'r cofnodion yn nodi bod mwy o bryder am berthynas Mr Z â Mr Y, tra bod perthynas Mr Z â Mr K yn cael ei hystyried yn berthynas gadarnhaol.

1.139 Er gwaethaf y farn hon, ar 22 Mawrth 2011, yn drasig, llofruddiwyd Mr Z gan ei gydbreswylydd, Mr K.

Ar ôl y Drosedd Berthnasol

1.140 Yn dilyn y drosedd dan sylw, arestiwyd Mr K mewn cysylltiad â llofruddiaeth honedig Mr Z. Aethpwyd ag ef i Orsaf Heddlu Bae Caerdydd ac yna fe'i trosglwyddwyd i Glinig Caswell[17].

1.141 Ni chaniatawyd i'r Heddlu gwestiynu Mr K tan ddiwedd Mehefin 2011 oherwydd y penderfynwyd ei fod yn rhy ddifrifol wael i gael ei gwestiynu. Cafodd Mr K ddiagnosis o Sgitsoffrenia a chafodd driniaeth yn fuan ar ôl ei asesiad cychwynnol gan y clinigwyr yng Nghlinig Caswell.

[17] Mae Clinig Caswell yn cynnig gwasanaethau gofal iechyd arbenigol i bobl o dde Cymru â phroblemau iechyd meddwl sy'n droseddwyr neu sydd â photensial i droseddu.

Rheolaeth a Threfniadaeth y Gwasanaethau

Trefniadau ar gyfer darparu Gwasanaethau Iechyd Meddwl yng Nghymru

1.142 Ad-drefnwyd y Gwasanaeth Iechyd Gwladol (GIG) yng Nghymru yn 2003. O ganlyniad i hyn, diddymwyd Awdurdodau Iechyd Cymru a sefydlwyd Ymddiriedolaethau GIG a Byrddau Iechyd Lleol.

1.143 Ad-drefnwyd GIG Cymru eto ym mis Hydref 2009 a chyfunwyd Ymddiriedolaethau'r GIG a'r Byrddau Iechyd Lleol yn saith Bwrdd Iechyd. Disodlwyd Ymddiriedolaeth GIG Caerdydd a'r Fro, Bwrdd Iechyd Lleol Caerdydd a Bwrdd Iechyd Lleol Bro Morgannwg gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro.

Canolfan Links y Tîm Iechyd Meddwl Cymunedol

1.144 Canolfan iechyd meddwl cymunedol yw Canolfan Links, sy'n darparu gwasanaethau lleol i bobl sy'n dioddef problemau iechyd meddwl er mwyn:

- Hybu iechyd meddwl
- Atal salwch meddwl
- Darparu ymateb lleol i bobl leol

1.145 Mae tîm Links yn dîm amlddisgyblaethol sy'n cynnwys seiciatryddion ymgynghorol, Uwch-swyddog Preswyl, seiciatrydd graddfa staff, arweinydd nyrsio clinigol, Nyrsys Seiciatrig Cymunedol, cynorthwyw-ydd nyrsio, therapydd galwedigaethol, seicotherapydd, seicolegydd, rheolwr gweinyddu'r tîm, ysgrifennydd meddygol a derbynnydd. Mae'r tîm hefyd yn cynnwys tri gweithiwr cymdeithasol llawn amser a phedwar gweithiwr cymdeithasol rhan-amser, yn ogystal â chynorthwy-ydd gwaith cymdeithasol.

1.146 Gwneir atgyfeiriadau gan feddygon teulu, y tîm argyfwng, Ysbyty'r Eglwys Newydd ac Uned Llanfair (rhan o wasanaethau iechyd meddwl cyffredinol i oedolion) yn ogystal â gweithwyr gofal iechyd proffesiynol eraill fel ymwelwyr iechyd a nyrsys cydgysylltu â charchardai.

Tîm Iechyd Meddwl Cymunedol Hamadryad

1.147 Mae Tîm Iechyd Meddwl Cymunedol Hamadryad yn cwmpasu ardaloedd Grangetown, Butetown, Glan-yr-afon, Treganna, Pontcanna a Grangetown Uchaf yng Nghaerdydd.

1.148 Mae'r tîm yn un amlddisgyblaethol sy'n cynnwys seiciatryddion, gweithwyr cymdeithasol, nyrsys seiciatrig cymunedol, seicolegwyr a therapyddion, sy'n darparu asesiadau, triniaeth a gofal yn y gymuned, yn hytrach na mewn ysbyty, i bobl â phroblemau iechyd meddwl hirdymor difrifol.

Mind Caerdydd

1.149 Caiff unigolion neu asiantaethau wneud ceisiadau neu atgyfeiriadau i Mind Caerdydd am lety â chymorth ar ran unigolion, ar yr amod eu bod yn llenwi ac yn llofnodi ffurflen gais Mind Caerdydd. Ceir cyflwyno'r ffurflen gais yn bersonol, ei hanfon drwy'r post, drwy ffacs, neu drwy e-bost i Mind Caerdydd.

1.150 Cyn derbyn defnyddiwr gwasanaeth i lety â chymorth, cynhelir cyfweliad asesu cychwynnol er mwyn:

- Gwirio gwybodaeth sydd wedi ei chasglu hyd yn hyn
- Canolbwyntio ar unrhyw faterion cymhleth a/neu risgiau y gellid eu hachosi gan y defnyddiwr gwasanaeth
- Penderfynu ar ba un a ellir rheoli risgiau ac anghenion mewn llety â chymorth

1.151 Mae'r gwasanaeth llety â chymorth yn gweithio mewn partneriaeth â Chymdeithasau Tai a Chyngor Dinas Caerdydd, i ddarparu 26 o welyau mewn fflatiau a thai a rennir. Darperir y llety â chymorth rhwng 9:00am a 7:00pm ac mae staff ar ddyletswydd 24 awr y dydd ar gyfer argyfwng.

1.152 Gellid gwrthod atgyfeiriad pe byddai'r defnyddiwr gwasanaeth yn methu â bodloni'r meini prawf cymhwysedd ac yn enwedig os nad yw'n bosibl rheoli'r risg a achosir gan unrhyw un o'r unigolion dan sylw yn ddigonol o fewn y prosiect.

Pennod 2: Canfyddiadau

Rhagweladwyedd y Lladdiad a Gyflawnwyd gan Mr K

2.1 Wrth edrych yn ôl, mae'n amlwg bod iechyd meddwl Mr K wedi dirywio'n sylweddol erbyn y digwyddiad trasig pan lofruddiodd Mr Z (mae Mr K wedi cael diagnosis o fod yn dioddef o sgitsoffrenia). Wrth geisio asesu a oedd lladdiad Mr Z yn rhagweladwy, mae'n rhaid ystyried nifer o ffactorau.

2.2 Cafodd Mr K fagwraeth anhrefnus ac mae wedi dioddef cyfnodau hir o gamddefnyddio alcohol a sylweddau. Roedd hefyd yn amlwg ei fod wedi ei chael hi'n anodd rheoli ei ddicter ei hun ar adegau. Roedd wedi bod mewn nifer o gwerylon dros lawer o flynyddoedd, ac roedd yn ymddangos mai ef ei hun oedd wedi dechrau'r rhan fwyaf ohonynt. Roedd Mr K ei hun wedi siarad am ei ddicter ei hun, am achosion o droi'n dreisgar, a chafwyd enghraifft o hyn ddyddiau'n unig cyn marwolaeth Mr Z pan honnwyd bod Mr K wedi ymosod ar Mr Y, yn ôl pob tebyg wrth iddo amddiffyn Mr Z.

2.3 Er bod Mr K yn eithaf gofalus wrth siarad am ei brofiadau â'r gweithwyr iechyd meddwl proffesiynol y bu mewn cysylltiad â hwy (nid oedd Mr K yn dymuno siarad â'r tîm adolygu, er enghraifft), roedd dadansoddiad manwl o'r cofnodion achos yn dangos bod Mr K wedi dweud am symptomau seicosis o 2009 ymlaen. Rydym yn gwybod nad arweiniodd y symptomau hyn, er eu bod yn amlwg wrth edrych yn ôl, at i Mr K gael ei dderbyn fel claf â seicosis o fewn y tri gwasanaeth iechyd meddwl y'i hatgyfeiriwyd atynt. Roedd gan Mr K hefyd broblemau sylweddol o ran camddefnyddio sylweddau; gallai fod hynny wedi gwneud y darlun clinigol yn aneglur ac atal gwneud diagnosis clir. Nid ydym yn gwybod ychwaith a oedd Mr K yn wael yn barhaus o 2009 hyd adeg y trosedd, neu'n profi cyfnodau o seicosis yn unig.

2.4 Yn y cyfamser, nid oedd dim un o'r gweithwyr iechyd proffesiynol na'r gweithwyr allweddol a fu'n ymwneud â Mr K dros y blynyddoedd yn credu bod ganddo'r potensial i gyflawni lladdiad. Un thema gyffredin a nodwyd gan y rhai a fu mewn cysylltiad ag ef, fodd bynnag, oedd potensial Mr K i gyflawni gweithred dreisgar. Fodd bynnag, ni nodwyd erioed bod y potensial hwn o drais yn peri risg i unrhyw unigolyn penodol.

2.5 Nodwyd bod Mr Z ei hun yn unigolyn a allai fod yn agored i niwed, a oedd hefyd yn dueddol i gael cyfnodau o ddicter ac ymddygiad anwadal, yn bennaf oherwydd ei ddefnydd o alcohol. Roedd yr atgyfeiriad PoVA a wnaethpwyd gan Mind Caerdydd ym mis Mawrth 2011 yn enghraifft o Mr Z yn dioddef trais ymddangosol oherwydd ei fod yn agored i niwed. Felly, nid oedd yn syndod y gallai Mr Z ddioddef trais neu y byddai'n dioddef trais, naill ai drwy hunan-niwed neu wedi'i gyflawni gan eraill.

2.6 Mae'n amlwg bod Mr K a Mr Z yn ddau unigolyn agored iawn i niwed a oedd yn byw gyda'i gilydd mewn cyfleuster heb lawer o gymorth. Roedd gan y ddau broblemau difrifol ag alcohol ac yn mynd i'r dafarn leol yn rheolaidd. Roedd un ohonynt (Mr Z) yn hysbys iawn i'r gwasanaethau seiciatrig ac yn cael llawer o gymorth; cynhaliwyd cyfarfod PoVA yn y mis y bu farw. Nid oedd Mr K wedi cael diagnosis ac nid oedd mewn cysylltiad ystyrlon â'r gwasanaethau iechyd meddwl.

2.7 Wrth edrych yn ôl, mae'n amlwg na fyddai digwyddiad wedi digwydd pe na byddai Mind Caerdydd wedi derbyn Mr K a'i neilltuo i fyw gyda Mr Z. Fodd bynnag, er gwaethaf y risg o drais yr oedd Mr K yn ei achosi, nid ydym yn credu y gellid bod wedi rhagweld y byddai Mr K yn cyflawni llofruddiaeth. Yn arbennig, nid oedd yn rhagweladwy y byddai Mr K yn llofruddio Mr Z, dyn y nodwyd bod ganddo berthynas ragorol ag ef.

2.8 Rydym o'r farn, fodd bynnag, pe byddai Mr K wedi cael diagnosis o seicosis yn gynharach ac yn bwysig, pe byddai Mr K wedi cydymffurfio ag unrhyw driniaeth wedi hynny, y gellid bod wedi atal lladdiad Mr Z.

2.9 Wrth gymryd y safbwynt hwn, rydym yn ystyried y bu methiannau a diffygion mewn nifer o agweddau ar gysylltiad Mr K â gwasanaethau. Yn benodol:

- Diffyg yn y broses atgyfeirio pan oedd ar Mr K angen gwasanaethau iechyd meddwl
- Methwyd cyfleoedd gan y gwasanaethau iechyd meddwl i roi diagnosis o salwch meddwl difrifol
- Anawsterau i ymgysylltu ag unigolyn a oedd wedi byw bywyd crwydrol ac a oedd wedi treulio cyfnodau'n byw mewn lleoliadau preswyl dros dro

- Gwendidau o ran cyfathrebu a rhannu gwybodaeth rhwng y gwasanaethau a'r asiantaethau/sefydliadau hynny a fu mewn cysylltiad â Mr K gan eu hachosi i fethu gwybodaeth bwysig a allai fod wedi dylanwadu ar ofal a thriniaeth Mr K
- Gwendidau wrth asesu risgiau, yn enwedig o ran neilltuo llety preswyl addas i unigolion fel Mr Z a Mr K

2.10 Wrth geisio canfod gwraidd yr achosion a arweiniodd at farwolaeth drasig Mr Z ar 22 Mawrth 2011, mae'r tîm adolygu wedi ystyried y cyfnodau pan fu Mr K yn ymgysylltu â gwasanaethau statudol. Mae'r canfyddiadau hyn wedi'u disgrifio yn yr adrannau canlynol.

Ymgysylltiad â gwasanaethau iechyd meddwl

Y broses o atgyfeirio claf yr amheuir bod ganddo salwch seicotig

2.11 Rhwng 2009 a 2011, atgyfeiriwyd Mr K at wasanaethau iechyd meddwl deirgwaith gan dri meddyg teulu gwahanol. Cododd pob un o'r tri meddyg teulu gwestiwn tebyg; roeddent i gyd yn amau y gallai fod gan Mr K sgitsoffrenia a/neu salwch seicotig.

2.12 Mae meddygon teulu'n ystyried bod diagnosis o sgitsoffrenia posibl yn broblem feddygol ddifrifol a brys. Mae angen gwneud y diagnosis cyn gynted â phosibl a pheidio ag oedi cyn dechrau triniaeth.

2.13 Y ddau dro cyntaf i Mr K gael ei atgyfeirio, ar 30 Medi 2009 a 24 Mehefin 2010, cafodd Mr K ei weld yn fuan gan seiciatrydd. Roedd y trydydd achlysur yn llai prydlon. Ym mis Chwefror 2011, atgyfeiriodd y meddyg teulu Mr K at Dîm Iechyd Meddwl Cymuned Links gan ddatgan:

> *'Ers iddo [Mr K] symud i dŷ Mind Caerdydd mae ei ofalwyr wedi mynd yn fwy a mwy pryderus am rai agweddau penodol ar ei ymddygiad. Rwyf wedi cyfarfod â Mr K ddwywaith, ac ar y ddau achlysur mae wedi encilio ac wedi methu â rhoi hanes clir. Mae'n ymddangos ei fod yn osgoi cyswllt llygad ac yn ein hymgynghoriad diwethaf roedd yn mynegi syniadaethau paranoid gan ddweud nad oedd yn hoff o feddyliau pobl eraill a'i fod yn meddwl bod pobl yn ymwybodol o'i feddyliau ef. Mae ei weithwyr gofal a minnau'n pryderu y gallai*

fod yn datblygu salwch seiciatrig amlycach a byddem yn ddiolchgar o'ch asesiad i ddweud a ydych yn cyd-fynd â hyn.

Nid oeddwn yn ymwybodol bod Mr K yn arfer camddefnyddio alcohol yr ail dro i mi ei weld, ond nid yw wedi bod dan ddylanwad alcohol ar y ddau achlysur yr wyf wedi cyfarfod ag ef'.

2.14 Mewn ymateb i'r atgyfeiriad meddyg teulu hwn, anfonodd Tîm Iechyd Meddwl Cymuned Links 'lythyr optio i mewn' at Mr K yn hytrach na chynnig apwyntiad iddo'n uniongyrchol. Dewisodd Mr K beidio â chysylltu â Thîm Iechyd Meddwl Cymuned Links i wneud yr apwyntiad hwn. Gwelodd *Seiciatrydd Ymgynghorol 2*, seiciatrydd Tîm Iechyd Meddwl Cymuned Hamadryad a oedd wedi gweld Mr K yn ystod haf 2010, yr atgyfeiriad hwn hefyd ar y system gyfrifiadurol cofnodion iechyd. Dywedodd *Seiciatrydd Ymgynghorol 2* wrth Dîm Iechyd Meddwl Cymuned Links am ei lythyr asesu ar 8 Gorffennaf 2010, ond nid yw'n ymddangos eu bod wedi ymateb drwy gynnig apwyntiad cynharach i Mr K.

2.15 Atebodd y gwasanaeth iechyd meddwl ym Mhen-y-bont ar Ogwr yn 2009, a Thîm Iechyd Meddwl Cymuned Hamadryad yn 2010, yn brydlon i'r llythyrau gan feddygon teulu ac i'r diagnosis a amheuwyd.

2.16 Fodd bynnag, roedd ymateb Tîm Iechyd Meddwl Cymuned Links i'r trydydd atgyfeiriad meddyg teulu ym mis Chwefror 2011 yn llai ymatebol. Ni wnaeth Tîm Iechyd Meddwl Cymuned Links newid y ffordd yr oeddent yn ymdrin â Mr K, er bod *Seiciatrydd Ymgynghorol 2* wedi tynnu sylw'r Tîm Iechyd Meddwl Cymuned at ei lythyr. Roedd Tîm Iechyd Meddwl Cymuned Links yn fodlon i adael Mr K i aros 8 wythnos ar ôl yr atgyfeiriad cyn iddo gael ei weld (Chwefror hyd at ddechrau mis Ebrill). Yn druenus, llofruddiodd Mr K Mr Z ym mis Mawrth 2011.

2.17 Rydym o'r farn y bu diffygion yn y broses atgyfeirio. Sef:

- Er bod y llythyr atgyfeirio a anfonodd y meddyg teulu i Dîm Iechyd Meddwl Cymuned Links wedi'i farcio'n briodol fel arferol (ac nid 'brys'), roedd y penderfyniad i anfon llythyr 'optio i mewn' at Mr K yn golygu bod Mr K wedi dewis peidio â chysylltu â Thîm Iechyd Meddwl Cymuned Links ei hun i wneud apwyntiad. Rydym yn credu bod hyn yn rhannol oherwydd diffyg craffu

ar ran y Tîm Iechyd Meddwl Cymuned o ran craffu ar atgyfeiriadau meddygon teulu a gwendid yn y broses MDT[18] yn Nhîm Iechyd Meddwl Cymuned Links ar y pryd

- Roedd y diffyg ymgysylltu hanesyddol rhwng Mr K a gwasanaethau'n golygu, er y gallai fod wedi dewis peidio â mynd i apwyntiad a gâi ei gynnig iddo, ei bod yn llai tebygol fyth y byddai Mr K yn gwneud y gwaith dilynol rhagweithiol o drefnu apwyntiad iddo'i hun. Rydym yn nodi ei bod yn bosibl nad oedd Tîm Iechyd Meddwl Cymuned Links yn gwybod am y diffyg ymgysylltu hanesyddol rhwng Mr K a gwasanaethau
- Bu oedi cyn i Dîm Iechyd Meddwl Cymuned Links ymateb i'r atgyfeiriad gan y meddyg teulu, ac yn y pen draw dyma sut y collwyd y cyfle olaf i roi Mr K mewn cysylltiad â gwasanaethau iechyd meddwl cyn lladdiad Mr Z

Cyfleoedd a gollwyd i roi diagnosis o salwch meddwl difrifol

2.18 Ar ôl ei arestiad ar 22 Mawrth 2011, ystyriwyd bod Mr K mor wael fel na chafodd yr Heddlu ganiatâd i'w holi am ei drosedd am dri mis, sy'n awgrymu pa mor wael oedd Mr K erbyn amser y trosedd dan sylw.

2.19 Y tro cyntaf i Mr K gael ei weld gan seiciatrydd (*Meddyg 1*) ym mis Tachwedd 2009, nodwyd bod 'Mr K yn dioddef o syndrom dibyniaeth ar alcohol a bod ganddo ddiffyg dealltwriaeth o'i gyflwr'. Nid oedd teulu Mr K yn bresennol i helpu'r seiciatrydd i'w asesu, yn wahanol i'r meddyg teulu a wnaeth yr atgyfeiriad; roedd brawd Mr K yn bresennol yn ei asesiad ef i'w helpu. Fodd bynnag, ni wnaeth y seiciatrydd atgyfeirio Mr K ar gyfer gwaith dilynol gan wasanaethau iechyd meddwl cymunedol. Rhoddodd *Meddyg 1* ragnodyn ar gyfer venlafaxine a gofynnodd i Mr K ddychwelyd mewn 8 wythnos. Nid oedd yr asesiad hwn yn cynnwys y Tîm Iechyd Meddwl Cymuned ehangach, ac ni chafodd Mr K y cyfle i weld Nyrs Seiciatrig Gymunedol. Hwn oedd y cyfle cyntaf a gollwyd i ymgysylltu â Mr K a gwneud diagnosis. Yn anffodus, ni ddychwelodd Mr K erioed ac ni chafodd ei weld eto gan wasanaethau ym Mhen-y-bont ar Ogwr.

2.20 Ym mis Mehefin 2010, cafodd Mr K ei atgyfeirio am yr eildro gan feddyg teulu â llawer o brofiad o ymdrin â phroblemau pobl ddigartref. Roedd y llythyr atgyfeirio a ysgrifennodd y meddyg teulu hwn yn glir iawn, ac roedd yn datgan:

[18] Tîm Amlddisgyblaethol – tîm yn cynnwys amryw o weithwyr iechyd meddwl proffesiynol, fel arfer yn cynnwys Nyrsys Iechyd Meddwl, Seiciatryddion, Gweithwyr Cymdeithasol.

'Rwyf yn pryderu am y dyn 26 mlwydd oed hwn sydd wedi bod yn byw yn Nhŷ Gobaith ers 2 neu 3 mis. Daeth ei weithiwr allweddol ag ef i fy ngweld ar 24/6/2010. Mae hi [y gweithiwr allweddol] yn pryderu bod ei iechyd meddwl wedi dirywio ers iddi ei adnabod. Yn sicr, roedd yn ymddangos yn wael o'i gymharu â'r tro arall i mi gyfarfod ag ef ar 2/6/2010.

Mae ef [Mr K] yn ddifynegiant, aflonydd - yn ffidlan â phethau, ac nid yw'n gallu cynnal trywydd meddwl yn hir, mae o'r farn bod rhywbeth o'i le ar ei lygaid ac mae'n eu rhwbio drwy'r adeg. Mae'n gwadu ei fod yn clywed lleisiau nac yn gweld rhithweledigaethau. Mae ei hwyliau'n amrywio. Mae hefyd yn ymddangos yn eithaf anniben'.

2.21 Cafodd Mr K ei weld yn fuan ar ôl hyn gan Dîm Iechyd Meddwl Cymuned Hamadryad, er iddo fethu â bod yn bresennol yn yr apwyntiad cyntaf. Cynhaliodd y Seiciatrydd Ymgynghorol (*Seiciatrydd Ymgynghorol 2*) asesiad gofalus a rhesymol gan ffurfio'r farn gychwynnol mai prif broblem Mr K oedd 'iselder, ond ni ellir diystyru anhwylder seicotig sylfaenol'. Rhoddodd y Seiciatrydd Ymgynghorol ragnodyn am feddyginiaeth wrthiselder; atgyfeiriodd Mr K at y Tîm Iechyd Meddwl Cymuned a neilltuodd y tîm amlddisgyblaethol CPN (*CPN 1*) i Mr K bythefnos yn ddiweddarach.

2.22 Bu'n anodd i'r CPN ymgysylltu â Mr K oherwydd bod Mr K yn aml yn absennol o apwyntiadau neu'n eu canslo. Ceisiodd y CPN weld Mr K ar sawl achlysur cyn gweld Mr K o'r diwedd a chwblhau asesiad ar 29 Medi 2010, tua saith wythnos ar ôl yr ymgais gyntaf. Dim ond unwaith y gwelodd y CPN Mr K, ac mewn cyfarfod tîm amlddisgyblaethol ar 4 Hydref 2010, dywedodd nad oedd yn teimlo y byddai Mr K yn elwa o fwy o gysylltiad â CPN felly cafodd Mr K ei ryddhau. Ym marn y CPN, nid oedd gan Mr K salwch meddwl difrifol, ac roedd ei brif broblemau'n ymwneud â dicter a dibyniaeth ar alcohol.

2.23 Aeth Mr K i weld y Seiciatrydd Ymgynghorol (*Seiciatrydd Ymgynghorol 2*) ar 5 Hydref 2010. Ym marn y Seiciatrydd Ymgynghorol, nid oedd Mr K yn dangos unrhyw arwyddion o salwch meddwl difrifol a'i brif broblem oedd anhawster i reoli ei ddicter. Hwn oedd y tro olaf i Dîm Iechyd Meddwl Cymuned Hamadryad weld Mr K neu ymgysylltu ag ef.

2.24 Er ei bod yn amlwg ei bod yn anodd ymgysylltu â Mr K, ei fod yn ofalus wrth siarad am ei brofiadau, a'i fod yn methu apwyntiadau'n aml, mae hefyd yn amlwg bod hyn yn rhan o'i batrwm o ran ymddygiad. Rydym yn teimlo, er gwaethaf ymdrechion hir a glew'r CPN i ymgysylltu â Mr K, a'r ffaith bod Mr K wedi gweld y Seiciatrydd Ymgynghorol fwy nag unwaith, bod cyfle wedi'i golli i asesu Mr K yn drwyadl a'i adolygu'n rheolaidd.

2.25 Hefyd, ni welsom fawr neu ddim tystiolaeth o unrhyw rannu gwybodaeth nac ymgysylltu cyson neu strwythuredig rhwng Tŷ Gobaith a Thŷ Tresilian a Thîm Iechyd Meddwl Cymuned Hamadryad. Gallai hyn fod wedi arwain at fethu gwybodaeth bwysig a allai fod wedi dylanwadu ar asesiad y Seiciatrydd Ymgynghorol neu'r CPN o Mr K.

2.26 Cytunodd Mr K unwaith eto i weld meddyg teulu ynglŷn â'i broblemau iechyd meddwl ym mis Chwefror 2011 ar ôl i staff hostel Mind Caerdydd yn Claude Place fynegi pryderon. Ar 4 Chwefror 2011, atgyfeiriodd y meddyg teulu Mr K at Dîm Iechyd Meddwl Cymuned Links, unwaith eto'n amau problem iechyd meddwl ddifrifol. Ni chafwyd ymateb cyflym gan Dîm Iechyd Meddwl Cymuned Links, ond aethant drwy broses o ofyn i Mr K gadarnhau bod angen apwyntiad arno. Hefyd, tynnodd *Seiciatrydd Ymgynghorol 2* sylw Tîm Iechyd Meddwl Cymuned Links at y ffaith ei fod wedi bod mewn cysylltiad â Mr K.

2.27 Fel y nodwyd yn yr adran flaenorol, ni wnaeth y dull hwn o gael apwyntiad gyda thîm iechyd meddwl Dîm Iechyd Meddwl Cymuned Links weithio'n effeithiol, ac o ganlyniad collwyd cyfle arall i greu cysylltiad rhwng Mr K a gwasanaethau iechyd meddwl.

2.28 Y tro cyntaf i Mr K ddangos symptomau'n dynodi problem iechyd meddwl ddifrifol oedd ym mis Medi 2009. Yn anffodus, cymerodd tan fis Mawrth 2011 iddo gael diagnosis o seicosis, ac erbyn hynny roedd llofruddiaeth drasig Mr Z wedi digwydd.

2.29 Y rhesymau sylfaenol dros golli'r cyfleoedd oedd:

- Cynhaliwyd asesiad gan y seiciatrydd yn 2009, ac er gwaethaf y llythyr atgyfeirio manwl gan y meddyg teulu, daeth i'r casgliad mai prif broblem Mr K

oedd dibyniaeth ar alcohol. O ganlyniad, ni chafodd Mr K ei atgyfeirio am fwy o fewnbwn gan wasanaethau iechyd meddwl ac ni chynlluniwyd gwaith dilynol

- Roedd natur ofalus Mr K wrth siarad â gweithwyr iechyd meddwl proffesiynol yn golygu ei bod yn anodd gwneud diagnosis clir a phendant o'i salwch meddwl. Fodd bynnag, ni chafodd gwybodaeth allweddol am symptomau Mr K oedd gan weithwyr allweddol Tŷ Gobaith a Thŷ Tresilian ei rhannu'n systematig â Thîm Iechyd Meddwl Cymuned Hamadryad. Gallai'r wybodaeth hon fod wedi datgelu rhywbeth am les Mr K a allai fod wedi dylanwadu ar asesiadau neu benderfyniadau am ofal a thriniaeth Mr K, neu yn wir ei ddiagnosis
- Er ei bod yn glir bod y CPN wedi ymdrechu'n gyson i weld Mr K sawl gwaith ar ôl yr atgyfeiriad gan y Seiciatrydd Ymgynghorol, pe byddai'r wybodaeth allweddol a oedd gan Dŷ Gobaith a Thŷ Tresilian wedi'i rhannu, efallai y byddai'r CPN wedi ceisio ymgysylltu â Mr K dros gyfnod hwy er mwyn cael darlun mwy cyflawn o les meddyliol Mr K
- Yn y pen draw, o ganlyniad i benderfyniad Tîm Iechyd Meddwl Cymuned Links i beidio â chynnig apwyntiad yn uniongyrchol i Mr K, collwyd y cyfle olaf i ymgysylltu ag ef ac efallai o roi diagnosis o salwch meddwl difrifol

Cyfathrebu, Rhannu Gwybodaeth ac Asesiadau

Gwasanaethau iechyd meddwl i bobl ddigartref yng Nghaerdydd

2.30 Un thema a ddaeth i'r amlwg yn ystod yr adolygiad hwn oedd yr anawsterau a geir wrth ymgysylltu ag unigolion peripatetig, megis Mr K, sy'n aml yn byw mewn llety dros dro neu mewn hostelau a gynhelir gan y sector gwirfoddol. Cawsom wybod gan lawer o'r unigolion y siaradwyd â hwy o Mind Caerdydd, Tŷ Gobaith a Thŷ Tresilian eu bod yn colli'r mewnbwn yr oeddent yn teimlo ei fod ar goll gan y CPN gysylltiedig â'r Timau Iechyd Meddwl Cymuned a oedd yn arfer ymweld â hwy'n rheolaidd a gweld cleifion yn eu cartrefi eu hunain. Un o swyddogaethu'r CPN oedd cysylltu'r gwasanaethau digartrefedd â gwasanaethau'r Timau Iechyd Meddwl Cymuned, ac roedd hyn yn cael ei hystyried yn adnodd ragorol i bobl ddigartref yng Nghaerdydd. Cawsom wybod bod y CPN a oedd yn cyflawni'r swyddogaeth hon wedi gadael y gwasanaeth ac na phenodwyd unrhyw un arall i'r gwaith.

2.31 Dywedodd staff yr hostelau i bobl ddigartref yn benodol fod eu cleientiaid yn ei chael yn fwyfwy anodd ymgysylltu â Thîm Iechyd Meddwl Cymuned Hamadryad. Roedd disgwyl i'r cleientiaid fynd i Ganolfan Hamadryad yn hytrach na chael ymweliad yn eu cartrefi eu hunain (er, yn yr achos hwn, gwnaeth y CPN sawl ymdrech i ymweld â Mr K yn Nhŷ Tresilian). Pan oedd y CPN gysylltiedig yn y swydd, roedd yr unigolyn hwn yn gweld y cleientiaid yn eu cartrefi/fflatiau eu hunain. Roedd y CPN yn ymweld â'r hostelau'n rheolaidd, ac roedd pobl yn adnabod a pharchu'r CPN. Roedd y presenoldeb hwn hefyd yn rhoi cyfle i weithwyr allweddol drosglwyddo a rhannu gwybodaeth i'r CPN am gleientiaid a oedd yn preswylio yno.

2.32 Yn achos Mr K, roedd gan y gweithwyr allweddol wybodaeth hanfodol am ei gyflwr meddyliol, ac nid yw'n ymddangos bod y wybodaeth hon wedi'i throsglwyddo i'r Tîm Iechyd Meddwl Cymuned nac i unrhyw weithwyr iechyd meddwl proffesiynol. Fel y nodwyd yn yr adran flaenorol, mae angen cryfhau'r broses hon o rannu gwybodaeth rhwng asiantaethau a sefydliadau sy'n ymdrin â defnyddwyr gwasanaeth digartref, neu rai sydd mewn llety dros dro o ddydd i ddydd, i sicrhau bod gwybodaeth allweddol a allai ddylanwadu ar ofal a thriniaeth pobl sy'n hysbys i'r gwasanaethau iechyd meddwl yn cael ei rhannu fel mater o drefn. Mae hyn yn gyfrifoldeb ar wasanaethau iechyd meddwl y GIG ac ar yr hostelau a'r mudiadau gwirfoddol, ac nid ar un sefydliad yn unig.

Mynediad at wybodaeth o fewn gwasanaethau iechyd meddwl

2.33 Er ein bod yn credu bod angen gwella prosesau rhannu gwybodaeth rhwng gwasanaethau iechyd meddwl a sefydliadau eraill, rydym hefyd yn credu bod angen cryfhau'r gallu i gael mynediad at wybodaeth o fewn gwasanaethau iechyd meddwl.

2.34 Nid oedd yn glir i ni pa wybodaeth a gafodd neu a allai gael ei chyrchu neu ei rhannu rhwng timau Timau Iechyd Meddwl Cymuned De Cymru am atgyfeiriadau ac asesiadau blaenorol. Er bod Tîm Iechyd Meddwl Cymuned Caerdydd yn rhannu'r un system TG – Paris, nid oedd yn glir i ni a oedd yr atgyfeiriad a wnaethpwyd ym Mhen-y-bont ar Ogwr yn 2009 ar gael i wasanaethau Caerdydd (rhan o Fwrdd Iechyd cyfagos – Ymddiriedolaeth GIG Prifysgol ABM ar y pryd[19]). Pe byddai'r wybodaeth hon ar gael i Dîm Iechyd Meddwl Cymuned Hamadryad yn 2010, gallai fod wedi rhoi

[19] Ym mis Hydref 2009, crëwyd Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg drwy uno Ymddiriedolaeth GIG Prifysgol ABM yn ffurfiol â Byrddau Iechyd Lleol Abertawe, Castell-nedd Port Talbot a Phen-y-bont ar Ogwr.

gwybodaeth a allai fod wedi dylanwadu ar unrhyw asesiad o iechyd meddwl Mr K wedi hynny. Fodd bynnag, mae hefyd yn ymddangos na chafodd y wybodaeth flaenorol a nodwyd gan Dîm Iechyd Meddwl Cymuned Hamadryad yn 2010 ei defnyddio gan Dîm Iechyd Meddwl Cymuned Links i asesu atgyfeiriad Mr K nac i gynnig apwyntiad cyflym iddo ym mis Chwefror 2011.

Proses derbyn Mind Caerdydd

2.35 Rydym yn credu bod yr achos hwn yn tynnu sylw at ddiffygion ym mhroses derbyn safleoedd Mind Caerdydd. Mae hyn yn rhannol oherwydd y diffyg trefniadau rhannu gwybodaeth a nodwyd yn yr adran ddiwethaf, ond hefyd yn rhannol oherwydd diffyg trylwyredd a thrwyadledd proses asesu Mind Caerdydd.

2.36 Mae'n amlwg bod angen i Mind Caerdydd, neu yn wir unrhyw fudiad gwirfoddol tebyg sy'n cynnal hostelau, wneud pob ymdrech bosibl i sicrhau bod y cymysgedd o gleientiaid yn eu hostelau'n briodol ac ystyried yn llawn y risgiau sy'n gysylltiedig â lletya unigolion a all beri risg iddynt eu hunain, neu i eraill, neu fod yn agored i niwed, yn yr un adeilad.

2.37 Dywedwyd wrthym bod Mind Caerdydd, o'u profiad hwy, yn teimlo nad oeddent yn cael gwybodaeth yn rheolaidd gan Dimau Iechyd Meddwl Cymuned Caerdydd am yr unigolion hynny yr oeddent naill ai'n ystyried eu lletya, neu a oedd eisoes yn preswylio yn eu hostelau. Yn arbennig, cawsom wybod nad oedd Mind Caerdydd yn cael eu gwahodd yn rheolaidd i unrhyw gyfarfodydd Dulliau Rhaglenni Gofal (CPA) a gynhelir i drafod y defnyddwyr gwasanaeth iechyd meddwl sy'n byw yn eu safleoedd ar y pryd.

2.38 Fodd bynnag, cawsom hefyd wybod am y pwysau sydd weithiau'n bodoli i lenwi gwelyau gwag yn yr hostelau, ac am oblygiadau ariannol gweithredu heb i'r lle fod yn llawn. Gall hyn, ar achlysur, arwain at leoli preswyliwr mewn hostel yn amhriodol, yn enwedig os nad oes ganddynt fawr o wybodaeth am gefndir yr unigolyn. Yn y pen draw, gallai hyn olygu bod unigolion ag anghenion cymorth gwahanol iawn yn byw gyda'i gilydd.

2.39 Roedd staff Mind Caerdydd yn feirniadol iawn o'r wybodaeth a gawsant am Mr K cyn iddo symud i Claude Street. Gofynasom a oedd hwn yn lleoliad da ac ystyried problemau iechyd meddwl hysbys Mr K. Dywedodd staff Mind Caerdydd

wrth y tîm adolygu bod gwybodaeth, yn eu profiad hwy, yn llifo i un cyfeiriad – o Mind Caerdydd i'r Tîm Iechyd Meddwl Cymuned. Dywedwyd wrthym mai yn aml iawn yr oeddent yn cael gwybodaeth lawn am gleient posibl gan Dîm Iechyd Meddwl Cymuned.

2.40 Dywedwyd wrthym, er enghraifft, pe byddai cleient ar CPA[20] a'i bod yn amser adolygiad CPA, y gallai'r Tîm Iechyd Meddwl Cymuned ofyn i Mind Caerdydd am wybodaeth ond nad oeddent yn aml yn gofyn iddynt fod yn bresennol yn yr adolygiad CPA. Ni fyddai Mind Caerdydd yn cael canlyniad adolygiad CPA.

2.41 Er nad yw'n ymddangos bod Tîm Iechyd Meddwl Cymuned Hamadryad wedi rhannu gwybodaeth cyn i Mr K gael ei leoli yn Claude Street, nid ydym ychwaith yn glir pa un a wnaeth Mind Caerdydd unrhyw gais penodol i weld a derbyn y wybodaeth hon yn ystod eu hasesiad eu hunain o gais Mr K nac wrth wneud unrhyw benderfyniad wedi hynny ynghylch ble y dylai fyw.

2.42 Ar ôl penderfynu lletya Mr K yn Claude Street, mae'n glir bod staff Mind Caerdydd wedi ymdrechu'n ddyfal i sefydlu cysylltiad rhwng Mr K a gwasanaethau wedi iddi ddod yn amlwg nad oedd Mr K yn dda. Fodd bynnag, wrth edrych yn ôl, mae'n amlwg bod penderfyniad Mind Caerdydd i gynnig i Mr K breswylio yn eu hostel yn Claude Place, yn rhannol, yn ffactor a gyfrannodd at ddigwyddiadau trasig 22 Mawrth 2011. Rydym yn credu mai un ffactor allweddol a danseiliodd y penderfyniad hwn ac a gynyddodd y risg y byddai digwyddiad anffodus yn digwydd oedd y diffyg gwybodaeth a oedd gan Mind Caerdydd am gefndir Mr K a allai fod wedi arwain at benderfyniad i ddarparu llety iddo mewn hostel arall.

2.43 Credwn mai'r rhesymau sylfaenol dros y materion y rhoddwyd sylw iddynt yn yr adran hon yw:

- Diffyg unrhyw broses neu ddull cyfundrefnol i hwyluso rhannu gwybodaeth hanfodol rhwng y gwasanaethau a'r mudiadau hynny y mae defnyddwyr gwasanaeth iechyd meddwl presennol, neu bosibl, yn ymgysylltu â hwy, a arweiniodd at beidio â rhannu gwybodaeth hanfodol am symptomau Mr K â'r Timau Iechyd Meddwl Cymuned

[20] Dulliau Rhaglenni Gofal – CPA – Mae gan unrhyw un â phroblemau iechyd meddwl hawl i gael asesiad o'i anghenion gyda gweithiwr gofal iechyd meddwl proffesiynol, ac i gael cynllun gofal wedi'i adolygu'n rheolaidd gan y gweithiwr proffesiynol hwnnw.

- Diffyg eglurder am y wybodaeth a oedd ar gael i wasanaethau iechyd meddwl am ymgysylltiad blaenorol Mr K â gwasanaethau iechyd meddwl, naill ai mewn ardaloedd Byrddau Iechyd eraill, neu o fewn yr un Bwrdd Iechyd, a sut y byddai'r wybodaeth hon, pe byddai ar gael neu wedi'i darparu, yn dylanwadu ar unrhyw benderfyniadau am ofal a thriniaeth
- Roedd yn amhriodol i Mind Caerdydd neilltuo Mr K i'w hostel yn Claude Place. Roedd hyn yn rhannol oherwydd diffyg gwybodaeth a oedd ar gael i Mind Caerdydd am ymgysylltiad blaenorol Mr K â'r gwasanaethau iechyd meddwl, ond mae hefyd yn symptom o'r ffaith nad oes unrhyw broses o rannu gwybodaeth fel mater o drefn rhwng gwasanaethau iechyd meddwl a Mind Caerdydd

Pennod 3: Argymhellion

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

1. Dylai'r Bwrdd Iechyd adolygu'r broses atgyfeirio ar gyfer unigolion sy'n ceisio cael gafael ar wasanaethau iechyd meddwl i sicrhau'r canlynol:

    a. Ceir eglurder am lefel y brys sy'n gysylltiedig â phob atgyfeiriad, a rhoddir arweiniad clir i dimau gofal sylfaenol a'r timau cymunedol.

    b. Caiff proses cyfarfodydd atgyfeirio MDT ym mhob Tîm Iechyd Meddwl Cymuned ei hadolygu a'i harchwilio, gan sicrhau bod lefel y brys sy'n gysylltiedig ag atgyfeiriadau meddygon teulu'n cyd-fynd â chynnwys unrhyw atgyfeiriad.

    c. Yn unol â chanllawiau Llywodraeth Cymru[21], bydd unigolion sy'n cael eu hatgyfeirio at Dimau Iechyd Meddwl Cymuned yn cael cynnig apwyntiad o fewn y cyfnod amser penodedig.

    ch. Gwneir ymdrechion penderfynol ag unigolion y mae'n anodd ymgysylltu â hwy, sy'n ddigartref, neu sy'n byw mewn llety dros dro neu hostel.

2. Dylai'r Bwrdd Iechyd, ar y cyd â Llywodraeth Cymru, adolygu gallu eu gweithwyr iechyd meddwl proffesiynol i gael gwybodaeth am atgyfeiriadau iechyd meddwl blaenorol neu am ymgysylltiad â gwasanaethau. Dylai pob asesiad o ddefnyddiwr gwasanaeth gynnwys mynediad llawn at unrhyw wybodaeth am gyfnodau ymgysylltu blaenorol i sicrhau bod unrhyw benderfyniad am unrhyw ofal a thriniaeth yn seiliedig ar yr holl wybodaeth sy'n bodoli.

3. Dylai'r Bwrdd Iechyd adolygu'r trefniadau sydd ganddynt ar waith i leihau'r Cyfnod Seicosis Heb ei Drin (DUP)[22]. Gellir lleihau DUP drwy ddefnyddio timau

[21] Swyddogaeth timau iechyd meddwl cymunedol wrth ddarparu gwasanaethau iechyd meddwl cymunedol, Gorffennaf 2010, Llywodraeth Cymru (http://wales.gov.uk/topics/health/publications/health/guidance/mentalhealth/?lang=en)

[22] Seicosis a sgitsoffrenia mewn oedolion: trin a rheoli: canllawiau NICE, Drafft ar gyfer ymgynghoriad, Awst 2013: www.**nice**.org.uk/**nice**media/live/13569/64925/64925.pdf

ymyrraeth gynnar yn effeithiol a drwy gyfrwng ymgyrchoedd hybu iechyd meddwl[23].

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro a Chyngor Sir Caerdydd

4. Dylai'r Bwrdd Iechyd a'r Awdurdod Lleol adolygu digonoldeb y trefniadau sydd ar waith ar hyn o bryd i ddarparu gwasanaethau seiciatrig i bobl ddigartref, agored i niwed. Dylai'r adolygiad hwn ystyried trefniadau sydd ar waith mewn rhannau eraill o'r DU.

Sefydliadau Iechyd, Awdurdodau Lleol a Mudiadau Gwirfoddol: Cyfathrebu a Rhannu Gwybodaeth

5. O ran sut y mae gwasanaethau'n ymateb i bobl ddigartref, mae angen gwneud llawer i gryfhau trefniadau ar gyfer rhannu gwybodaeth yn gyson rhwng gwasanaethau iechyd meddwl a mudiadau gwirfoddol, neu letyau a gynhelir gan awdurdodau lleol. Dylai'r trefniadau hyn ystyried y canlynol:

    a. Gwella'r cyswllt a llif gwybodaeth rhwng priod sefydliadau, yn benodol gan gynnwys gweithwyr allweddol o fudiadau gwirfoddol mewn unrhyw adolygiad achos, neu gynnal cyfarfodydd CPA i drafod gofal a thriniaeth defnyddwyr gwasanaeth.

    b. Gwella'r cysylltiadau rhwng y Timau Iechyd Meddwl Cymuned a'r preswylfeydd i bobl ddigartref/llety dros dro yng Nghaerdydd, gan gynnwys cyfraniadau rheolaidd gan weithwyr iechyd meddwl proffesiynol pan fo hynny'n bosibl.

    c. Ar gyfer unigolion y mae'n anodd ymgysylltu â hwy, dylid gwneud apwyntiadau i'w gweld yn eu cartrefi er mwyn lleihau'r posibilrwydd o fethu apwyntiadau, eu canslo neu fod yn absennol ohonynt. Dylid ystyried asesiadau risg priodol cyn gwneud hyn.

[23] http://www.jcpmh.info/commissioning-tools/cases-for-change/severe-problems/what-works/early-intervention/

6. Dylai Mind Caerdydd gynnal adolygiad llawn o'u prosesau asesu a neilltuo, gan sicrhau bod gwybodaeth allweddol am risg a chysylltiad blaenorol â gwasanaethau iechyd meddwl yn cael ei hystyried yn llawn wrth asesu ble y gallai cleientiaid fyw. Dylai'r adolygiad hwn ystyried y canlynol:

    a. Y wybodaeth sydd ei hangen i gynnal asesiad cynhwysfawr a mynd ati'n rhagweithiol i geisio cael mynediad at y wybodaeth honno.

    b. Sicrhau bod cleientiaid yn cael eu rhoi mewn cartref priodol bob amser, gan ystyried yn llawn unrhyw risgiau sy'n gysylltiedig â lletya unigolion gyda'i gilydd os oes ganddynt anghenion cymorth gwahanol iawn.

Atodiad A

Cylch Gorchwyl yr Adolygiad

ADOLYGIAD ARBENNIG AROLYGIAETH GOFAL IECHYD CYMRU O'R GOFAL A'R DRINIAETH A DDARPARWYD I Mr K

Bydd Arolygiaeth Gofal Iechyd Cymru (AGIC) yn cynnal adolygiad annibynnol o laddiad a gyflawnwyd gan ddefnyddiwr gwasanaethau iechyd meddwl yn ardal Caerdydd ar 22 Mawrth 2011.

Bydd yr adolygiad yn ymchwilio'r gofal a'r cymorth a ddarparwyd i Mr K ac i Mr Z cyn i Mr K ymosod ar Mr Z tra'i fod yn byw mewn Hostal MIND yng Nghaerdydd.

Wrth gynnal yr adolygiad hwn, bydd AGIC yn:

- Ystyried y gofal a ddarparwyd i Mr K cyn belled yn ôl â'i gysylltiad cyntaf â gwasanaethau iechyd a gofal cymdeithasol er mwyn cael dealltwriaeth o'r digwyddiad angheuol a ddigwyddodd ar 22 Mawrth 2011.

- Ystyried y gofal a ddarparwyd i Mr Z cyn belled yn ôl â'i gysylltiad cyntaf â Mr K tra'i fod dan ofal y Gwasanaethau Iechyd a Chymdeithasol er mwyn dod i ddeall y berthynas rhwng Mr K a Mr Z yn y cyfnod yn arwain at y digwyddiad angheuol.

- Adolygu'r penderfyniadau a wnaed o ran gofal Mr K.

- Adolygu'r penderfyniadau a wnaed o ran gofal Mr Z.

- Nodi unrhyw newid neu newidiadau yn ymddygiad ac ymarweddiad Mr K a gwerthuso digonolrwydd unrhyw asesiadau risg a chamau

cysylltiedig a gymerwyd yn arwain at y digwyddiad a ddigwyddodd ar 22 Mawrth 2011.

- Paratoi adroddiad a fydd ar gael i'r cyhoedd sy'n nodi'r canfyddiadau perthnasol ac argymhellion ar gyfer gwella.

- Gweithio gyda rhanddeiliaid allweddol i ddatblygu cynllun(iau) gweithredu er mwyn sicrhau y dysgir gwersi o'r achos hwn [24].

[24] Rhoddir ystyriaeth hefyd i hanes personol Mr K a Mr Z yn rhan o'r ymarfer hwn.

Dull gweithio ac amserlen yr adolygiad

AGIC fydd yn rheoli'r adolygiad a bydd yn cynnwys y canlynol:

- Adolygu dogfennau a data;
- Cynnal cyfweliadau â'r staff a gyfrannodd at ofal Mr K;
- Meincnodi protocolau ac arferion gweithrediadol sy'n ymwneud â rheoli gofal a monitro Mr K.

Nid oedd Mr K yn dymuno cael ei gyfweld at ddibenion yr adolygiad hwn.

Bydd AGIC yn sefydlu tîm adolygu bychan a fydd yn meddu ar yr arbenigedd angenrheidiol.

Atodiad B

Adolygiad o Wasanaethau Iechyd Meddwl yn dilyn Lladdiadau a gyflawnwyd gan bobl a oedd yn defnyddio Gwasanaethau Iechyd Meddwl

Mae'r adroddiad blynyddol a baratowyd gan yr Ymchwiliad Cenedlaethol i Laddiad a Hunanladdiad gan Bobl â Salwch Meddwl[25] yn nodi bod nifer y lladdiadau gan gleifion iechyd meddwl wedi gostwng yn sylweddol ers 2006. Cafwyd y niferoedd lleiaf, ers dechrau casglu data, yn ystod y blynyddoedd diweddaraf i gael eu cadarnhau (2009/2010). Cafwyd 74 o gleifion ar gyfartaledd yn euog o laddiad yn y DU yn ystod 2001-2010, ac mae'r ffigur yn codi i 115 pan ychwanegir symptomau salwch meddwl. Ymddengys fod y ffigurau hyn yn gostwng.

Wrth reswm, mater i'r system cyfiawnder troseddol yw sicrhau y cynhelir ymchwiliadau ac y gwneir dyfarniadau ynglŷn â'r lladdiadau hynny. Fodd bynnag, mae'n briodol hefyd fod pob digwyddiad yn cael ei archwilio o safbwynt y gwasanaethau a sefydlwyd i ddarparu gofal a thriniaeth ar gyfer y rheini sy'n profi problemau iechyd meddwl. Yng Nghymru, mae Llywodraeth Cymru wedi disgwyl bod adolygiad allanol annibynnol yn cael ei gynnal ynglŷn â phob achos o laddiad a gyflawnwyd gan unigolyn sydd â hanes o gysylltiad â gwasanaethau iechyd meddwl.

Mae adroddiadau'r adolygiadau allanol annibynnol yn cyfrannu at y broses ehangach a gynhelir gan yr Ymchwiliad Cyfrinachol Cenedlaethol i Hunanladdiad a Lladdiad gan Bobl â Salwch Meddwl.

Y Trefniadau ar gyfer Adolygiadau yng Nghymru

O fis Ionawr 2007 ymlaen, bydd yr holl adolygiadau allanol annibynnol o'r achosion hyn yn cael eu cynnal gan Arolygiaeth Gofal Iechyd Cymru. Pan fo'r gwasanaethau a adolygir yn cynnwys y gwasanaethau cymdeithasol, gwneir trefniadau i gynnwys

[25] 'The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report' mis Gorffennaf 2013

Arolygwyr Gwasanaethau Cymdeithasol o Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru yn y tîm adolygu.

Atodiad C

Y Trefniadau ar gyfer Adolygu Gwasanaethau Iechyd Meddwl o ran Mr K

Mae adolygiadau ac ymchwiliadau gan AGIC yn defnyddio'r dulliau, y technegau a'r sgiliau a fydd yn fwyaf effeithlon ac effeithiol yn unol â natur y mater sydd i'w ymchwilio, ei helaethrwydd ac unrhyw gyfyngiadau o ran amser neu adnoddau eraill.

Fodd bynnag, mae AGIC yn cydnabod pwysigrwydd ymchwiliadau strwythuredig, ac mae'n ymroddedig i ddefnyddio *'Dadansoddiad o Wraidd y Broblem'* (RCA) i ddarparu strwythur ffurfiol ar gyfer ymchwiliadau. Gellid addasu'r strwythur hwnnw os yw'r amgylchiadau'n golygu bod hynny'n briodol. Wrth gynnal yr adolygiad hwn, mae AGIC wedi sicrhau y dilynwyd yr egwyddorion cyffredinol sy'n berthnasol i ymchwilio ac y mae'r RCA yn darparu canllawiau ar eu cyfer. Mae hefyd wedi defnyddio nifer o'r dulliau sydd wedi eu cynnwys yn yr RCA.

Yn ei chais i AGIC ymgymryd â'r adolygiad hwn, nododd Adran Iechyd a Gwasanaethau Cymdeithasol Llywodraeth Cynulliad Cymru ei bod yn cefnogi dull adolygu a fyddai'n defnyddio'r RCA.

Cychwynnodd yr ymchwiliad hwn trwy nodi'r math o arbenigedd y byddai ei angen i ymgymryd â'r adolygiad. Sefydlwyd tîm adolygu a oedd yn darparu'r ystod o sgiliau a gwybodaeth yr oedd eu hangen. Roedd y tîm yn cynnwys:

Dr Frank Holloway – Seiciatrydd Ymgynghorol
Dr Rob Hall – Meddyg Teulu
Mr Martin Thornton- Nyrs Iechyd Meddwl
Mrs Freya Ellard – Adolygydd Lleyg
Mr Rhys Jones – Pennaeth Ymchwiliadau
Miss Lisa Bresner – Rheolwr Ymchwiliadau Cynorthwyol
Mrs Lianne Willetts- Swyddog Ymchwiliadau

Cynhaliwyd y cam o'r adolygiad a oedd yn cynnwys casglu gwybodaeth rhwng mis Ebrill 2012 a mis Ionawr 2013. Roedd y gwaith hwn yn cynnwys:

- Archwilio dogfennau'n ymwneud â'r modd yr oedd Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yn trefnu ac yn darparu gwasanaethau. Er nad oes gennym yr awdurdod i fynnu gwybodaeth gan yr heddlu, cafodd y tîm adolygu hefyd weld cofnodion yr heddlu yn ymwneud â'r achos a chynnal trafodaeth â'r uwch swyddog ymchwilio. Rydym yn ddiolchgar i'r heddlu am eu cydweithrediad

- Darllen y nodiadau achos a gedwid gan y Bwrdd Iechyd, Mind Caerdydd a'r Awdurdodau Lleol ynglŷn â Mr K

- Darllen nodiadau cyfweliad a datganiadau ysgrifenedig a ddarparwyd gan staff a oedd yn gweithio gyda Mr K a Mr Z fel rhan o brosesau ymchwilio mewnol neu brosesau ymchwilio'r heddlu

- Cyfweld pobl allweddol, yn enwedig pobl â chyfrifoldeb strategol am ddarparu gwasanaethau

Proseswyd y wybodaeth gan uned archwilio fewnol AGIC. Yn ogystal â hyn, darllenodd pob aelod o'r tîm adolygu yr holl ddeunydd a gynhyrchwyd gan yr adolygiad.

Datblygwyd y cam dadansoddi gan y tîm adolygu. Darparodd adolygwyr sy'n gymheiriaid eu dadansoddiad cychwynnol eu hunain o'r materion allweddol. Yn dilyn hynny, cyfarfu'r tîm adolygu i ymgymryd â dadansoddiad trylwyr, gan gyfeirio ei ystyriaeth trwy'r materion allweddol i'r achosion sylfaenol wrth wraidd y broblem. Canlyniad y broses honno oedd pennu i ba raddau y gellid sefydlu systemau neu brosesau i atal digwyddiadau pellach a natur y systemau neu'r prosesau hynny. Amlinellir canlyniadau'r cam hwnnw yn yr adroddiad hwn fel canfyddiadau ac argymhellion.

Swyddogaethau a Chyfrifoldebau Arolygiaeth Gofal Iechyd Cymru

Arolygiaeth Gofal Iechyd Cymru (AGIC) yw'r arolygiaeth a'r rheoleiddiwr annibynnol ar gyfer pob gwasanaeth gofal iechyd yng Nghymru. Mae AGIC yn canolbwyntio'n bennaf ar:

- Wneud cyfraniad sylweddol i wella diogelwch ac ansawdd gwasanaethau gofal iechyd yng Nghymru.
- Gwella profiad dinasyddion o ofal iechyd yng Nghymru pa un ai fel claf, defnyddiwr gwasanaeth, gofalwr, perthynas neu weithiwr.
- Atgyfnerthu llais cleifion a'r cyhoedd yn y modd yr adolygir gwasanaethau iechyd.
- Sicrhau bod gwybodaeth amserol, ddefnyddiol, berthnasol a rhwydd cael gafael arni am ddiogelwch ac ansawdd gofal iechyd yng Nghymru ar gael i bawb.

Swyddogaeth graidd AGIC yw adolygu ac archwilio sefydliadau'r GIG a sefydliadau gofal iechyd annibynnol yng Nghymru er mwyn darparu sicrwydd annibynnol i gleifion, y cyhoedd, Llywodraeth Cymru a darparwyr gofal iechyd bod gwasanaethau yn ddiogel ac o ansawdd da. Adolygir gwasanaethau yn erbyn amrywiaeth o safonau, polisïau, canllawiau a rheoliadau cyhoeddedig. Yn rhan o'r gwaith hwn, bydd AGIC yn ceisio nodi a chefnogi gwelliannau mewn gwasanaethau a'r camau sydd eu hangen i gyflawni hyn. Os bydd angen, bydd AGIC hefyd yn cynnal adolygiadau ac ymchwiliadau arbennig lle y mae'n ymddangos bod diffygion systematig wrth ddarparu gwasanaethau gofal iechyd, er mwyn sicrhau bod modd gwella a dysgu yn gyflym. Yn ogystal, AGIC yw rheoleiddiwr darparwyr gofal iechyd annibynnol yng Nghymru, a'r Awdurdod Goruchwylio Lleol ar gyfer Goruchwyliaeth Statudol Bydwragedd.

Mae AGIC yn cyflawni ei swyddogaethau ar ran Gweinidogion Cymru ac, er ei bod yn rhan o Lywodraeth Cynulliad Cymru, mae protocolau wedi eu sefydlu i ddiogelu ei

hannibyniaeth weithredol. Mae prif swyddogaethau a chyfrifoldebau AGIC yn deillio o'r ddeddfwriaeth ganlynol:

- Deddf Iechyd a Gofal Cymdeithasol (Iechyd Cymunedol a Safonau) 2003.
- Deddf Safonau Gofal 2000 a'r rheoliadau cysylltiedig.
- Deddf Iechyd Meddwl 1983 a Deddf Iechyd Meddwl 2007.
- Goruchwyliaeth Statudol Bydwragedd fel y'i nodir yn Erthyglau 42 a 43 o Orchymyn Nyrsio a Bydwreigiaeth 2001.
- Rheoliadau Ymbelydredd Ïoneiddio (Datguddio Meddygol) 2000 a Rheoliadau Diwygio 2006.

Mae AGIC yn gweithio'n agos gydag arolygiaethau a rheoleiddwyr eraill wrth gynnal adolygiadau traws-sector ym maes gofal cymdeithasol, addysg a chyfiawnder troseddol, ac wrth ddatblygu dulliau mwy cymesur a chydgysylltiedig o adolygu a rheoleiddio gofal iechyd yng Nghymru.