REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF JB

A report commissioned by

Brent & Harrow Health Authority

February 2001

PREFACE

We were jointly commissioned in May 1999 by Brent and Harrow Health Authority to undertake this Inquiry.

We regret that issues of confidentiality and witness availability have led to some delay but we are now able to present our Report, having followed the Terms of Reference and Procedures which were formulated by the Health Authority.

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ACKNOWLEDGEMENTS

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Officers of the Health Authority, with particular reference to Miss Catherine Afolabi who carried out the onerous duties of Secretary to the Inquiry competently, promptly and with great cheerfulness.

The staff of Messers Barnett Lenton & Co. for their excellent recording and transcription services.

To all witnesses of fact (and particularly JB and his sister) for their frankness and willingness to assist in a process which must have been inconvenient for all and personally demanding, and indeed distressing, for some.

CONTENTS

Independent Inquiry into the care and treatment of JB commissioned by Brent & Harrow Health Authority

1 The Offence.

In July 1998 at the Central Criminal Court, JB was convicted of manslaughter and sentenced to five years imprisonment. By his own admission he had killed his wife in August 1997.

2 Family.

2.1 JB was born on the 20th November 1945, at Edgware General Hospital.

2.2 His upbringing was difficult partly because his parents were frequently at loggerheads; he described two incidents in which his mother had attacked his father with, respectively, a carving knife and a poker.

2.3 His sister, six years his junior, also described an antagonistic relationship between mother and grandfather which she believed had resulted in her being favoured at JB's expense. She offered as examples her being given her brother's bedroom (with the consequence that into and beyond adolescence, JB had had to sleep in the same bed as his grandfather), and that she had received better educational opportunities in the sense that she had been able to attend a grammar school and her brother had not.

2.4 JB said in conversation with one of the consultant psychiatrists who prepared reports for the Court, that he had been sexually abused by his grandfather.

2.5 His sister believed that these difficulties had affected his ability to make and sustain social relationships.

3 Education.

JB attended infant school (which he disliked) from the age of 5; when he was 8 he moved on to primary school, where he did better and made some friends. From the age of 11 to 17, he attended a single sex secondary modern school where, although to some degree victimised because of his small size and without close friends, he passed four O'levels and two A'levels, the latter in English Literature and French.

4 Employment.

When he left school in 1962, JB found employment with musical instrument makers, where he worked until 1973, after which he had a succession of jobs. He was in employment until 1986, when he was dismissed for theft by his then employers, Edgware General Hospital. He was charged, convicted and made the subject of a two-year probation order. At this time, he was unemployed for some months but then obtained a job with Brent Council and remained in work with various employers until he accepted voluntary redundancy in May 1997 from a company where, for some five years, he had been engaged in scanning machine drawings.

5 Marriage.

5.1 JB met his wife at a party given by a friend at work in the early part of 1976. A relationship quickly developed, and when she said that she was pregnant, JB married her. He related that shortly after the marriage his wife disclosed that she was not pregnant and had in fact undergone a hysterectomy at some time in the past. He was very upset that he had been deceived but he accepted that he would have wished to marry anyway.

5.2 The marriage appears to have continued uneventfully until early 1987. There had been some disagreement about the possibilities of adoption, suggested

by JB and opposed by his wife on the grounds that one of them would have to give up work. However, in 1987, when tidying papers, he came across a photograph of children aged about 3 and 5. When he asked his wife about them, she said that they were a son and daughter from her first marriage, and that she had abandoned them when she left her first husband. She said she understood that they had been fostered, and that she did not know what had become of them. JB described himself as devastated by this revelation, and it appears that sexual relations after 1987 were virtually non-existent.

5.3 When speaking to the Inquiry about a hospital attendance in 1992, JB was asked why he had not followed up a suggestion that he should seek counselling about his marital problems. He replied, "Whatever I had done, I would still have to cope with our deteriorating relationship because, I mean, it was so unpredictable. It was days when it was quite calm and placid and weeks, rather, I should say, weeks when it was quite calm and placid, and weeks when we were having rows constantly. So it was up and down all the time...".

5.4 From external reports JB's wife appears to have had an unattractive personality. There seems little doubt that she was the dominant partner, thus to some extent repeating the conditions of the marriage of JB's parents. As already recorded, he gave an account of periods when things went relatively well. However, his wife gave up full-time employment, and when JB's subsequent redundancy in May 1997 threw them together for longer periods than before she began to abuse him with accusations of worthlessness, unwillingness to seek work and of having affairs with other women. As will appear later in this report JB went to see his GP at the end of June 1997 complaining of depression and asking for a referral to psychiatric services.

6 The Events of the 19th August 1997.

6.1 The following account is contained in the report of one of the two consultant psychiatrists advising the Court at JB's trial. It has been read by JB, and he has confirmed to the Inquiry that it is an accurate record.

6.2 "The account which JB gave me on the 25th June... was that on the morning of Tuesday the 19th August his wife had gone to work as usual and came back at about 11.00am. He had been mending a clothes post in the garden, using a hammer to do so. When his wife came in he was sitting at the kitchen table drinking coffee and filling in job application forms. He told me that as soon as she saw him she began to accuse him of being useless, saying that she would not support him for the rest of his life and accused him of having an affair with their young lodger.... He told me that she said she would bring her boyfriend into their marital home and she would get him thrown out and went on and on in this vein. He told me that the argument had started in the back living room. He had gone to the kitchen and put the coffee cup down and his wife had followed him, continuing to accuse him. He had barely spoken. He then went back to the living room at which point his wife threw a plate at him which missed him but shattered against the wall, before she herself came into the living room. He pushed past her to go back into the kitchen and she came in after him, red faced with anger, shouting at him from a distance of only about one foot away, face to face. She then slapped him around his face twice. He told me she was screaming "there is a mad man here". As she turned away from him he picked up the hammer from the kitchen counter and for a few seconds struck her repeatedly on the back of the head; she fell to the ground. He told me he remembered that at the time he was shouting "please stop". He then told me he went back to the living room where he sat, feeling as though his head was bursting".

6.3 It should be noted that although the two consultants recognised that there was evidence which might support a defence of provocation or of diminished

responsibility, both advised that this was not a case in which a disposal under the Mental Health Act 1983 would need to be considered.

7 Contacts with external services.

This Inquiry has thought it proper, within its terms of reference, to examine the history of JB's treatment and care, and his contact with available public services, up to the time of his arrest on the 29th October 1997. It should be explained here that although his wife died on the 19th August, her body was concealed and only discovered (as a result of Police investigations) some ten weeks later.

8 Social Services.

8.1 Social Services should have been involved if national guidelines concerning the Care Programme Approach (considered later in this report) had been followed. Although such involvement might have been particularly helpful to a man who felt lonely and friendless, it appears that no-one with knowledge of JB's condition of depression and isolation drew the case to the attention of Brent Council, the relevant Social Services authority. Accordingly there can be no criticism of the Council in this case.

8.2 The participation of Social Services in the Care Programme Approach is however referred to in paragraph 11 of this Report.

9 National Health Service.

9.1 From 1985 JB was a patient on the list of Dr T Ganesh M.B., M.R.C.P., M.R.C.G.P., a general practitioner with surgery premises in Barnet and Edgware. The Inquiry has seen GP records, not necessarily complete, going back as far as 1950 but there does not appear to have been any concern about psychiatric problems until 1984 when there are references to stress because of work and "feels very depressed". In October Maprotiline, an anti-

depressant, and Lorazepam, an anxiolytic, were prescribed; the prescription of Maprotiline was repeated in November, and JB was recorded as better and as having been given a final certificate on the 23rd November.

9.2 In August 1985 worries about work resurfaced, compounded by the stress of moving house. Lorazepam was again prescribed.

9.3 A further reference to depression is recorded in February 1986, and later that year JB, worried about his prosecution for theft, asked for specialist psychiatric help. Dr Ganesh's partner at the time, Dr Yiangou, referred him in December to the Psychiatric Out-Patient Department at Edgware General Hospital. This resulted, in the following February, in a letter from Dr Paula Taor, Psychiatric Registrar, in which she provided a diagnosis including problems of depression and compulsive stealing. For the former she prescribed the anti-depressant Prothiaden, and for the latter, long-term psychological treatment. Dr Taor commented "I was very struck by the vulnerable sensitive part of his personality and felt very sorry for his predicament".

9.4 Some months later, in June, JB was offered a place in a psychotherapy group at the Willesden Centre for Psychological Treatment. A letter from the Centre to Dr Taor dated the 27th August 1987, and copied to the GP, records that he had not attended, nor had he responded to letters. In October 1987, JB is recorded as having been prescribed Dothiepin, another anti-depressant.

9.5 In February 1988, JB's Probation Officer again referred him to the Willesden Centre for Psychological Treatment. In a report dated the 23rd June 1998 (sic), a Clinical Psychologist Maja Turcan recorded that he had been seen, usually with his wife, on seven occasions between the 27th April and the 5th October 1988. JB disclosed problems of compulsion to steal and impotence. Ms Turcan commented that his wife "usually presented as a tearful and frustrated woman who nagged her husband, telling him how inadequate he was. He, apparently, accepted his wife's accusations while giving an impression of an angry and unhappy man. He told us that he found no

satisfaction in any aspect of his life". Ms Turcan concluded that it would be appropriate for further counselling to be undertaken by the organisation known as Relate. JB told the Inquiry that in the event, contact with Relate was discontinued very shortly afterwards.

9.6 There followed a further referral to the Psychiatric Out-Patients Department at Edgware General Hospital on the 6th February 1989. JB had attended his GP complaining of "depression again - unhappy at work - wants time off - picking on him". However Dr Taor at the Edgware General Hospital wrote to the GP on the 30th March to report that he had not turned up for his out-patient appointment.

9.7 On the 3rd July 1991, GP notes record a visit to the surgery by JB. As a result, Dr Jeetle, another partner of Dr Ganesh, wrote to the Psychiatric Department at Edgware General Hospital. Part of the letter reads "I hope you can help this man who came to see me in a most distraught and desperate state. He just broke down and started crying saying that he could not take it any more. Most of his problems are with his wife with whom he has no communication whatever and both of them live in the house as completely uncommunicating individuals. He wanted children but she did not. He is basically living with her for convenience and the prospect of separation frightens him as it will entail selling the house. She accompanied him to a marriage counsellor which did not help. There has been no sexual relationship between them for years. He desperately wants to talk to someone".

9.8 This letter identifies in the clearest terms the isolation and stress suffered by JB. Similar expressions are found throughout the relevant records, but the unavoidable inference that JB needed support was not picked up and acted upon, apparently because no-one accepted the necessary responsibility.

9.9 It should be added here however that JB was reluctant to engage in arrangements to help him, and unreliable in the matter of keeping appointments. When this was put to him by the Inquiry he replied "Well, I

recognise that a lot of the problems that I have been through have been through my own failure to follow these things up and I had ample opportunity to do so. I am just trying to put them in the context of the sort of situation of our relationship, that was what was holding me back I think, from taking these things any further, the help that was on offer any further, was the sort of subconscious knowledge that when I got back to the home situation I would not be any better. It was the same way as the depression. I would feel stable and then a few days later I would be in a state of depression again".

9.10 It is a matter of concern that no action appeared to result from the letter from Dr Jeetle. There is no record of an attendance at Edgware General Hospital, and no report back from the Psychiatric Department there. A note in the GP records dated 11th July 1991 reads "talked to Dr Rhianna - told it's not purely psycho-sexual problem". However, since Dr Jeetle had identified a serious problem it was hardly sufficient to record simply that it was not "purely psycho-sexual". Dr Ganesh told the Inquiry that he did not know any doctor named Rhianna. The Inquiry did not take evidence from Dr Jeetle, who no longer works with Dr Ganesh.

9.11 On the 26th September 1992, JB attended the A & E Department at the Central Middlesex Hospital at the suggestion of Dr Ganesh. This resulted in a helpful letter to Dr Ganesh from Dr N Purandare, Psychiatric Registrar, dated the 16th November 1992 in which he mentions sadness, hopelessness and financial, marital and sexual problems. Dr Purandare diagnosed "depression with mood congruent ideas of reference". He (or she) prescribed Amitriptyline 25mg by day and 50mg at night (to be increased gradually) and to continue Fluanxol 1mg for one week only. Dr Purandare also recommended contact with MIND for help with JB's marital problems and mentioned the possibility of advice from the Area Social Worker about difficulties with Income Support. In his evidence to the Inquiry JB was uncertain as to whether, or to what extent, he had acted upon that advice.

9.12 After he had been made redundant in May 1997, JB attended Dr Ganesh's surgery with symptoms of depression. Dr Ganesh wrote immediately to the Psychiatric Department at Central Middlesex Hospital, asking for a psychiatric review and briefly identifying his patient's problems. As a result JB was offered an appointment at the Park Royal Centre on the 29th July. He did not attend, but included within the notes is a copy of the offer of appointment, on which JB had written "Please note: due to mis-delivery of this by PO I only received it on Friday the 25th July!. Apologies". In reply to a question on the printed part of the offer, he recorded that he would like an alternative date. When asked by the Inquiry why, having apparently received the offer of appointment on the 25th July, he had not been able to attend on the 29th, he was unable to provide an answer. On the 4th August, he was offered an alternative appointment on the 26th August which he accepted.

9.13 At this point it should be remembered that JB's wife died on the 19th August 1997.

9.14 On the 26th August, JB kept his appointment at the Park Royal Centre where Dr Thakrar made an excellent note. He recorded an impression of "Reactive depression – not actively suicidal but has suicidal ideation", and he wrote a full letter to Dr Ganesh concluding "Following a review by Dr Lewin we have come up with the following plan:-

1. the patient given a telephone number for Crisis in case of emergency
2. Prothiaden increased to 25mgs TDS
3. referral to Westmore Day Hospital
4. referral to COGS to help him get back to work
5. review him in one week's time".

9.15 Dr Thakrar saw JB for the second and last time on the 2nd September, and wrote to Dr Ganesh on the 8th recording some improvement, a concern that his patient was "going on a slight high" because of the medication, and indicating an intention to review again in one week.

9.16 In his first letter to the GP, Dr Thakrar mentioned the Westmore Day Hospital and a lengthy note records that JB was assessed there on the 22nd September and that a care plan was formulated. An entry in the Westmore notes dated the 15th September records that "Pt (patient) not allocated key worker - no spares". This last entry indicates that a key worker would need to be identified and a note, (probably made during the assessment on the 22nd September), recognises JB's principal problems and offers some solutions: "Needs some support through this difficult and traumatic time. Needs some structure to his day whilst he continues to look for work. Needs to meet and socialise with others as quite isolated. Needs to be put in touch with relevant agencies that can help him with his financial problems".

9.17 JB attended the Westmore Day Hospital on the 10th October to discuss his programme. A note dated 17th October shows that he was not responding to telephone calls requesting his participation, and on the 21st October he was discharged from the hospital. Later in the same month, he was arrested and charged with the murder of his wife.

10 The Care Programme Approach (CPA).

10.1 The CPA was introduced by Department of Health Circular HC(90)23, a copy of which is at Appendix 3 of this Report.

10.2 The Circular required local CPA policies to have been drawn up and implemented by the 1st April 1991.

10.3 The CPA policy presented to the Inquiry (and copied at Appendix 4), was included in the North West London Mental Health NHS Trust Code of Practice. The policy was entitled "JOINT POLICY - CARE PROGRAMME APPROACH AND CARE MANAGEMENT" and was said to have been formulated by the Trust and Social Services (unidentified). The persons who had been involved in the preparation of the policy were not named.

10.4 The policy (which was revised in 1998) stated that the CPA:

(a) "is a planned process of assessment and co-ordination of the delivery of care services for people being discharged from hospital and for people in the community who have mental health difficulties" and

(b) "applies to all persons (including those with dementia) accepted by the specialist psychiatric services whether they be in patients or out patients".

10.5 The policy specified two categories of patient to whom the CPA would apply:

(a) Level 1 for patients with a significant degree of health need and

(b) Level 2 for "all other patients who have no, or only one episode, of admission and do not require multidisciplinary assessment and care planning".

It added that for Level 2 patients "The assessment and care plan of one professional will usually be regarded as adequate".

10.6 In respect of the period from 1991 to 1995, Mr Alex Hamilton-Clark, a Service Manager with the local NHS Trust told the Inquiry "...there was an attempt to establish a CPA policy... sort of 1991" but "it was a very complicated system and... it really was not very well received". Asked about forms and whether they were completed he replied "Were they filled in? No, not always. I am being quite honest. With that first system, no, not at all. It was very very patchily done".

10.7 Mr John Martin was a Sector Manager with the local NHS Trust in 1997. It was put to him by the Inquiry that "... the CPA should have applied to somebody like JB and you are saying that, in practice (and it is no fault of yours), it did not apply to people like him who simply went to out patients and came away with, perhaps, a referral letter back to the GP". He replied "Yes, that is quite true" and he went on to point out the "enormous" resource implications of implementing CPA policy requirements for Level 2 patients. In answer to a further question he agreed that there was a disparity between the policy and what was actually achievable and he added "I think when you are talking about out patients, yes, I think there probably was a discrepancy. There was no formal multidisciplinary assessment of patients in out patients. It was just everything continued as it had for quite a long time that patients came to out patients and were seen by the medical staff. A letter was written to the GP". Mr Martin was then asked "So there was a disparity between the document and the reality" and he answered "I think so".

10.8 Mr Robert Nesbitt gave evidence that he was employed from August 1995 by Brent Council as Business Director (a title later changed to Service Unit Director) of the Council's Mental Health Field Work Unit. This "provided the Approved Social Worker (ASW) and Assessment Care Management services for people living in Brent, as well as a Court Liaison Service for Brent Magistrates' Court". He continued in that post until a date subsequent to the death of JB's wife in August 1997.

10.8.1 Mr Nesbitt gave a lucid account of the development of the CPA as it applied to Social Services during the time when he was working in Brent, and of the generally co-operative and constructive relationships which existed between Social Services and NHS Trust staff. However, as regards the funding of the Local Authority's contribution to the CPA he said that in

1995 "I think that the CPA process was still at that time perceived as a discharge process". CPA forms were re-designed in 1996 and joint working between the Trust and Social Services was improved by the appointment of a CPA Implementation Officer from (probably) late 1996. Further improvements followed from the re-designation of social work staff in the summer of 1997, and audits in 1998 and 1999 showed "massive improvement" in the files.

10.8.2 Despite the changes for the better, referred to above, Mr Nesbitt gave evidence of acute under-funding of the Local Authority contribution to the CPA. He agreed with a question which suggested that the service was "massively under-resourced" and added, "... we cut our cloth according to our means to some extent. The NHS cannot because it does not have the same ability to say no, and we always acknowledged that the Mental Health Field Work Service would be working with about ten percent of the people who were open to the mental health sectors, that we would be working with the most difficult end of the work and that is all we would do. So we provided no counselling, no psychological support. Whilst we might do preventative work in the sense of relapse prevention, we did not do anything in terms of mental health promotion and that is how it was".

10.8.3 Mr Nesbitt also told the Inquiry that there was an inconsistency between Social Services and Trust policies and practice as regards the groups of people for whom services could be provided. He said that "...the Trust would have a responsibility really to work with anybody who had an identifiable diagnosable mental disorder who could not be managed within primary care, but most of those people would not also have social care needs and certainly would not have those social care needs complex

enough to meet our criteria. So it is entirely appropriate that we work with a subgroup of the sector, and also that we work with some people who do not use mainstream mental health NHS services because they are alienated from them and will only use our Service". There appeared therefore to be a lack of congruence as regards the perception of the NHS Trust and Social Services concerning the categories of patient who represented the most urgent demand on their respective services and resources.

10.8.4 As regards the demand on social services CPA resources Mr Nesbitt said that from memory "...about ninety percent of allocated cases were CPA Level 1". This evidence of local authority spending on the Care Programme Approach is generally consistent with the evidence received about the concentration of NHS spending on Level 1 patients.

10.9 Dr D T Thakrar was a GP trainee at Park Royal Hospital from the 1st April to the 30th September 1997. He was working as a Senior House Officer (SHO), under the supervision of two consultant psychiatrists, Dr Huq and Dr Lewin. The Inquiry makes reference to his obvious ability and commitment only because it makes it difficult to understand his evidence (which the Inquiry accepted without reservation) that he knew nothing about the CPA. He was obviously unable to understand questions which were put to him in this regard.

10.10 Dr J Lewin told the Inquiry that he had taken up his appointment as consultant psychiatrist in Brent on the 1st April 1997. He gave credit to useful work done by the CPA Implementation Officer appointed in 1996 or early 1997, but as regards improvements to CPA procedures he said "There were difficulties with the form itself. It is several pages. There were difficulties in that it only had two categories while all other Trusts have three categories. They are different in that Level 1 is a

more intensive Level and 2, the lower intensive, while other Trusts have it the other way round, and there were attempts to harmonise it. But, at the end of the day, I think nothing changed".

10.11 Dr Lewin gave evidence of satisfactory arrangements for Level 1 CPA patients but as regards Level 2 he said, "I think it operates like before CPA". He described the criteria for deciding between Level 1 and Level 2 and continued, "I could not tell you the number of patients who come through our out-patient clinic, but there are large numbers and somebody with depression and anxieties is a very typical referral from a General Practitioner to our service". He was then asked "So, really, CPA does not involve the vast majority of out patients?" and he answered "No".

10.12 Given that CPA procedures emphasise the importance of the key worker, and the Inquiry's perception that a key worker might have helped JB, witnesses were asked to say who might be expected to fulfil that role for a Level 2 patient. They suggested that for an out patient this might be the consultant psychiatrist or the GP. However, such a conclusion might be thought to verge on the absurd if account is taken of the responsibilities of the key worker as set out in section 12 of the policy copied at Appendix 2. Dr Lewin, with an active caseload of 400-500 patients (some of them liable to be detained under the Mental Health Act) could not discharge such responsibilities, nor could the GP Dr Ganesh with his list of 2500 patients.

10.13 Dr Lewin was asked whether, for Level 2 patients, compliance with CPA principles, which had been "notional" in 1997, was still notional three years later. He replied "Well, in a way, yes. I have about 400 or 500 cases for which I am responsible, the RMO, and it would make life very difficult if we had for every out patient formal discussions and formal reviews, CPA reviews, on my caseload".

10.14 The disparity, apparently current even now, between Level 1 and Level 2 was confirmed by Mr Edward Matt who took on the post of Director of Operations for the local NHS Trust in June 1999. He told the Inquiry that "People on Level 1 have care management, they have multidisciplinary input, they have got a form. It may be basic but they have actually a fairly decent service. Then you look at the vast majority; there is virtually very little left, and particularly medical staff struggle with actually coping with that enormous workload. Community Psychiatric Nurses, Occupational Therapists tend to focus on Level 1. I mean, about 350 people alone in Brent are on that Level, which is very significant".

10.15 As regards service demand, resources and workloads:

(a) Mr Matt referred to the deprivation index in Brent which he considered to be high, and complicated by issues of ethnic mix, addiction and dual diagnosis. He described Dr Lewin's caseload of 400-500 patients as "twice that I would have expected" from his previous employments.

(b) Dr Lewin told the Inquiry that the catchment area covered by Dr Huq and himself comprised some 90,000 persons, well above the recommended average of 30,000 per consultant. He too spoke of problems of refugees; asylum seekers; mental health issues due to biological factors; post traumatic stress disorder from loss of home and unfamiliar environment (in the case of immigrants); and of language difficulties.

(c) Mr Nesbitt, now working for an NHS Trust in Suffolk, told the Inquiry, in reference to the resources required for the provision of mental health services, that "it is really clear to me that to provide anything like the service which people in Suffolk get,

you would have to increase the field work service by something like three or four times its size".

11 Commentary on the services provided for JB.

11.1 Since Social Services had no knowledge of JB's possible need for the services which might have been available from that source no criticism can be made of the Brent Council in the particular case. The Inquiry notes however that the Council was a party to a joint CPA policy agreed in 1995 (revised in 1998), which records that the CPA is a "planned process of assessment and co-ordination of the delivery of care services for people being discharged from hospital and for people in the community who have mental health difficulties". The policy states also, under the heading "People eligible for CPA while in the Community" that "Clients with less severe mental health problems who correspond to CPA Level 2 will be able to be assessed for a range of services in the community e.g. Day Centre, Outreach Support, Out-Patients etc. Assessment for these services can be arranged through the local Social Services or health sector teams as appropriate". The policy does not however, explain who is expected to trigger the necessary assessment. In particular, it fails to suggest any responsibility on the part of the patient's GP, who is perhaps the person most likely to identify an actual or developing need. This problem is not addressed in the 1998 draft revision of the joint policy.

11.2 The knowledge of witnesses about the application of the CPA to patients like JB was disturbingly incomplete. He could have been assessed, and provided with services including the support of a key worker on the occasion of his attendance at the Central Middlesex Hospital in 1992 but this did not happen. It is a matter for regret that the opportunity to provide support for a patient whose main problems related to his social isolation, lack of friends and need to talk to someone, was not taken. The Inquiry notes that the first two

responsibilities of a key worker, as set out at paragraph 12 of the joint policy referred to above are to:

> "Use their professional skills in maintaining regular contact with the patient. This includes consultation with carers.
>
> Provide support and care in a positive, creative manner which aims to be as acceptable to the user as possible within their professional guidelines".

11.3 Dr Ganesh had minimal knowledge of CPA requirements. Dr Thakrar, now a GP, and clearly a knowledgeable and competent doctor, knew nothing about the CPA. Dr Lewin was aware of it but he told the Inquiry that in practice, it is reserved for patients being discharged from hospital in-patient care since it would be impossible to apply the Departmental Guidance or the joint policy to all the great number of patients who present at out-patient departments with symptoms of mental disorder.

11.4 Dr Ganesh has a list of about 2,500 patients and Dr Lewin told the Inquiry that he is the responsible medical officer for 400 to 500. These figures are considered excessive, particularly in an area such as Brent where ethnic factors, deprivation and immigrant issues give rise to problems not generally encountered in most other areas. The Government, the Health Authority and the Local Authority need to give serious thought to the practicability of the advice contained in such documents as HC(90)23 (which introduced the CPA concept), HSG(94)27 and in policies which ignore the practical impossibility of their implementation.

11.5 The GP records for the period from April 1988 to the 20th October 1997 show that JB was being given repeat prescriptions for Dothiepin, Co-proxamol, Fluanxol and Amitriptyline. There were periods during which

the four medications were being prescribed at the same time although this was not the invariable pattern. The Inquiry was concerned that prescriptions of potentially dangerous drugs were repeated over such a long period and apparently without any review by the GP of their effect, or of the need for their continuation.

12 Findings.

12.1 Health Circular HC(90)23 required that by the 1st April 1991 all District Health Authorities should have drawn up and implemented local care plans to apply to all new patients accepted by the specialist psychiatric services which they managed. The Circular emphasised the need to appoint a key worker for any patient to whom the CPA applied.

12.2 JB was referred to, or had contact with specialist psychiatric services on three occasions after the 1st April 1991

(a) on the 4th July 1991 by a letter from the GP to a Consultant Psychiatrist at Edgware General Hospital

(b) on the 26th September 1992 when he attended the A & E Department at Central Middlesex Hospital and

(c) on the 23rd June 1997 when he was referred by his GP to the Central Middlesex Hospital.

As regards (a) the referral did not result in the offer of a psychiatric appointment;

As regards (b) JB's attendance resulted in a good report from the Psychiatric Registrar to the GP, but it appears that nobody considered whether he was eligible for, or would have benefited from, the application of the CPA;

As regards (c) JB did not attend the first appointment which was offered. The second appointment which might have resulted in arrangements compatible with the CPA was after the date on which his wife was killed and his treatment (even if he had been prepared to persevere with it) was prevented by his arrest.

12.3 As was apparent from the evidence of Dr Lewin resource factors prevent the CPA from being applied otherwise than to patients with mental disorder who are being discharged from hospital.

12.4 The evidence of Dr Thakrar and Dr Ganesh suggests that knowledge of the principles and application of the CPA was deficient.

12.5 There was no evidence that practitioners (GPs or Consultants) were involved in the preparation of the joint CPA policy. Indeed, Dr Ganesh gave evidence that to the best of his knowledge GPs had not been consulted.

12.6 Social Services played no part in the care of JB. They were not alerted to his possible need for the services which they might have been able to offer.

12.7 The policy of Dr Ganesh (and possibly his colleagues) in respect of repeat prescriptions of potentially harmful psychiatric medications without periodic review of the patient's response to these medications, carries risk and is not in accordance with best practice.

12.8 The frequent references in this report to JB's non-attendance at appointments indicate that he was reluctant to engage in plans for his treatment and care.

12.9 Although it would not be proper to make an unqualified finding on the point, there is a possibility that if JB had been able to talk to and confide in someone like a key worker the build up of worries and

tensions which contributed to the tragic events of the 19th August 1997 might have been prevented.

12.10 The Inquiry also finds that the statement in HC(90)23 (see paragraph 11.1) that "Health authorities are expected to meet any health service costs arising from the introduction of more systematic **procedures** from existing resources" was not based on a realistic assessment of the consequences of the introduction of the CPA. Many of the problems which were found to have existed in Brent in respect of the operation of the CPA (in itself a valuable support to patients in need) resulted from initial and continuing under-funding.

13 Recommendations.

Note

The Inquiry's terms of reference were limited to an investigation of relevant requirements, practices and procedures up to a date in late 1997 (see paragraph 7). It was not required to undertake a review of practices and procedures developed or introduced after that time and has not done so. It recognises that action may already have been taken by the appropriate bodies in respect of the following recommendations.

13.1 The GP and consultant workloads described in paragraph 12.4 impose almost impossible demands which, regardless of the expertise and dedication of those involved, must have an effect on the quality of care available to patients. They might also be expected to affect the morale of the treating practitioners, although the Inquiry emphasises that it saw no evidence of reduced commitment on the part of the doctors whom it interviewed.

13.2 It is therefore recommended that immediate consideration should be given to the question as to what are proper ratios of GP and hospital psychiatric staff to the population which they serve (taking into account the special factors referred to for example in paragraph 10.15). Urgent action should then be taken to achieve those ratios.

13.3 The Health Authority should consider, with its Local Authorities and Health Trusts, whether the requirements of current joint CPA policies are capable of achievement. If they are not, they should review the policies, referring to the Department of Health if there is an unbridgeable gap between what can be done with available resources and what is required to be done pursuant to current Government guidelines.

13.4 Any review of CPA policies should ensure:

(a) that the eligibility criteria governing access to health and social care services are jointly agreed and published by the Health Authority, Health Trusts and Local Authorities;

(b) that the criteria are explained in such a way as to be readily understood by those they are intended to help;

(c) that the services which are provided respectively by Health Trusts and Social Services (subject to eligibility) are clearly set out and

(d) that guidelines are included to explain how services are accessed and to identify the person(s) responsible for putting in touch with those services any individual who might reasonably be expected to benefit from them.

13.5 Any review of CPA policies should include participation by those - Consultant Psychiatrists, GPs, (through Primary Care Group involvement) Psychiatric Nurses and Social Workers - who are expected to implement those policies.

13.6 At the earliest opportunity (and probably prior to any wholesale review of existing policies) the Health Authority and Brent Council should identify those responsible for bringing to the attention of the NHS Trust, or the Council, people who might be expected to benefit from the CPA. In particular, the responsibilities of hospital medical staff and GPs should, by agreement, be determined and publicised.

13.7 Dr Ganesh (a well qualified and competent GP) should, if this has not already been done, review his practice in respect of repeat prescriptions and their monitoring, and if necessary seek advice from his Primary Care Group or the Royal College of General Practitioners in this connection.

13.8 The local Primary Care Group (or Groups) should recommend and seek to ensure compliance with good standards in respect of repeat prescribing.

13.9 The Health Authority and the Primary Care Group(s) should, if practicable, establish and implement systems for the continuing audit of compliance with CPA requirements.

APPENDIX 1

INDEPENDENT INQUIRY INTO THE CARE & TREATMENT OF JB

TERMS OF REFERENCE

The Inquiry's Terms of Reference are as follows:

1. To undertake an independent review of all the circumstances surrounding the care provided to JB by health and social care agencies and, in particular, the adequacy, scope and appropriateness of such care

2. To examine the extent to which the care and treatment provided corresponded to statutory obligations, relevant guidance from the Department of Health and local operational policies

3. To examine the quality and scope of the assessment of health and social care needs in light of his available history, including the quality and scope of risk assessment

4. To examine the extent and nature of Care Plans provided and their delivery

5. To examine the support, supervision and care provide

6. To examine the adequacy of the collaboration and communication between the agencies and the professionals involved during the care of JB

7. To make appropriate recommendations

8. To prepare a report and make recommendations to Brent and Harrow Health Authority

APPENDIX 2

PROCEDURE ADOPTED BY THE JB INQUIRY

1. All sittings of the Inquiry will be held in private.
2. The findings and any recommendations of the Inquiry will be made public.
3. The evidence which is submitted to the Inquiry either orally or in writing will not be made public save as is disclosed in the findings and recommendations within the body of the Inquiry's final report.
4. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:
    a. Of the Terms of Reference and Procedure to be adopted by the Inquiry
    b. That when they give oral evidence they may raise any matter they wish and which they feel might be relevant to the Inquiry
    c. That they may bring with them a friend or relative, a member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness
    d. That it will be the witness who will be asked the questions and who will be expected to answer
    e. That their evidence will be recorded and a copy sent to them afterwards for them to sign and date
5. Witnesses of fact will be asked to affirm that their evidence is true.
6. Any points of potential criticism will be put to a witness of fact, either orally when they give evidence, or in writing at a later time, and they will be given a full opportunity to respond.
7. Representations will be invited from voluntary and professional organisations and other interested parties, as to present arrangements for persons in similar circumstances to those being considered by the Inquiry, and as to any recommendations they may have for the future. Such organisations and interested parties may be asked to give oral evidence to the Inquiry about their views and recommendations.
8. Anyone else who the Inquiry Panel members feel may have something to contribute to the Inquiry will be invited to make written submissions for the Inquiry's consideration, and/or to give evidence in person to it
9. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

APPENDIX 3

HC(90)23/
LASSL(90)11

DEPARTMENT OF HEALTH

JOINT HEALTH/SOCIAL SERVICES CIRCULAR

HEALTH AND SOCIAL SERVICES DEVELOPMENT
"CARING FOR PEOPLE"
THE CARE PROGRAMME APPROACH FOR PEOPLE WITH A MENTAL ILLNESS
REFERRED TO THE SPECIALIST PSYCHIATRIC SERVICES

This Circular will be cancelled on 10 September 1995

SUMMARY

This circular:

i. requires district health authorities, the Bethlem and Maudsley Special Health Authority and the Special Hospitals Service Authority to implement the care programme approach envisaged in HC(88)43 (Appendix 4, paragraph 3) for people with a mental illness, including dementia, whatever its cause, referred to the specialist psychiatric services;

ii. asks social services authorities to collaborate with health authorities in introducing this approach and, as resources allow, to continue to expand social care services to patients being treated in the community.

It builds on the general circular on hospital discharges (HC(89)5). The Annex to this circular sets out:-

i. the policy background to the care programme approach;

ii. how the care programme approach works;

and draws attention to some specific matters which will need to be addressed in establishing care programmes.

ACTION

By 1 April 1991 District health authorities and the Bethlem and Maudsley Special Health Authority must have drawn up and implemented, in consultation and agreement with social services authorities, local care programme policies to apply to all in-patients considered for discharge, and all new patients accepted, by the specialist psychiatric services they manage from that date. Where a district health authority purchases psychiatric services from a self-governing trust or elsewhere, the contractual arrangements should require these organisations to have adopted the care programme approach.

By 30 April 1991 Regional health authorities must confirm to the NHS Management Executive (via their Regional Liaison Principal) that all district health authorities in their areas have introduced the care programme approach.

By 30 April 1991 The Bethlem and Maudsley Special Health Authority must confirm (via its Regional Liaison Principal) that it has introduced the care programme approach.

ANNEX

THE CARE PROGRAMME APPROACH FOR PEOPLE WITH A MENTAL ILLNESS REFERRED TO THE SPECIALIST PSYCHIATRIC SERVICES

Introduction

1. This Annex sets out:

   a. the policy background to the care programme approach;

   b. how the care programme approach works;

and gives guidance on some key issues to be addressed in implementation.

Policy Background

2. The 1975 White Paper "Better Services for the Mentally Ill" (Cmnd 6233) first set the general policy within which care programmes should be introduced: this general policy has been endorsed by the Government in the 1989 White Paper "Caring for People" (Cm 849), paragraph 7.4. Locally-based hospital and community health services, co-ordinated with services provided by social services authorities, voluntary and private sectors, and carers, can provide better care and treatment for many people with a mental illness than traditional specialist psychiatric hospitals.

3. Community based services are only an improvement when the patients who would otherwise have been hospital in-patients get satisfactory health care, and, where appropriate, social care. "Caring for People" acknowledged that providing adequate arrangements for the community care and treatment of some patients had proved more difficult and resource intensive than expected. In practice adequate arrangements have not always been achieved.

4. The care programme approach is being developed to seek to ensure that in future patients treated in the community receive the health and social care they need, by:

   i. introducing more systematic arrangements for deciding whether a patient referred to the specialist psychiatric services can, in the light of available resources and the views of the patient and, where appropriate, his/her carers, realistically be treated in the community;

   ii. ensuring proper arrangements are then made, and continue to be made, for the continuing health and social care of those patients who can be treated in the community.

How the Care Programme Approach Works

5. Individual health authorities, in discussion with relevant social services authorities, will agree the exact form the care programme approach will take locally. All care programmes should, however, include the following key elements:

   i. systematic arrangements for assessing the health care needs of patients who could, potentially, be treated in the community, and for regularly reviewing the health care needs of those being treatment in the community;

   ii. systematic arrangements, agreed with appropriate social services authorities, for assessing and regularly reviewing what social care such patients need to give them the opportunity of benefitting from treatment in the community;

   iii. effective systems for ensuring that agreed health and, where necessary, social care services are provided to those patients who can be treated in the community.

6. It will be for relevant health and social services staff to decide whether the resources available to them can enable acceptable arrangements to be made for treating specific patients in the community. If a patient's minimum needs for treatment in the community - both in terms of continuing health care and any necessary social care - cannot be met, in-patient treatment should be offered or continued, although (except for patients detained under the Mental Health Act) it is for individual patients to decide whether to accept treatment as an in-patient. Health authorities will need to ensure that any reduction in the number of hospital beds does not outpace the development of alternative community services.

Implementation

7. Within the broad framework described it is for health authorities, in discussion with consultant psychiatrists, nurses, social workers and other professional staff, and social services authorities to seek to establish suitable local arrangements, and to see that they are maintained in the context of purchaser/provider arrangements post 1 April 1991.

8. There are some specific issues which all authorities will however need to address in determining their local arrangements. These relate to:

- Inter-professional working;
- Involving patients and carers;
- Keeping in touch with patients and ensuring agreed services are provided;
- the role of key workers.

Inter-professional working

9. Although all the patients concerned will be patients of a consultant psychiatrist, modern psychiatric practice calls for effective inter-professional collaboration between psychiatrists, nurses, psychologists, occupational therapists and other health service professional staff; social workers employed by social services authorities, and general practitioners and the primary care team, and proper consultation with patients and their carers.

10. Where it is clear to a consultant and professional colleagues that continuing health and/or social care is necessary for a patient whom they propose to treat in the community, there must be proper arrangements for determining whether the services assessed as necessary can, within available resources, be provided. It is essential to obtain the agreement of all professional staff and carers (see paragraphs 12 and 13 below) expected to contribute to a patient's care programme that they are able to participate as planned.

Involving patients

11. It is important that proper opportunities are provided for patients themselves to take part in discussions about their proposed care programmes, so that they have the chance to discuss different treatment possibilities and agree the programme to be implemented.

Involving carers

12. Relatives and other carers often know a great deal about the patient's earlier life, previous interests, abilities and contacts and may have personal experience of the course of his/her illness spanning many years. Wherever consistent with the patient's wishes, professional staff should seek to involve them in the planning and subsequent oversight of community care and treatment.

13. Carers often make a major and valued contribution to the support received by many people with a mental illness being treated in the community. Where a care programme depends on such a contribution, it should be agreed in advance with the carer who should be properly advised both about such aspects of the patient's condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day-to-day basis. In addition, professional staff may be able to offer the carer help in coming to terms with his/her role vis-a-vis the patient.

Special Hospitals The requirements set out in this circular also apply to the Special Hospitals under the management of the Special Hospitals Service Authority. The SHSA will need to ensure that action has been taken to provide for the introduction of the care programme approach and should have received confirmation to that effect from each Special Hospital by 30 April 1991. In particular the SHSA will want to ensure that each patient's care plan enables any transfers to NHS or local authority social services facilities required by particular patients to be identified and arranged in good time.

RESOURCES

1. Health authorities are expected to meet any health service costs arising from the introduction of more systematic procedures from existing resources. Introducing the care programme approach places no new requirement to provide services on either health or social service authorities.

2. Health authorities will judge what resources they make available for such services. Social services authorities will make similar decisions but will have available specially targetted resources through the new specific grant which is to be used in ways agreed with relevant DHA(s). (Details of the new grant, payable from 1991/2, are set out in HC(90)24/LAC(90)10.

ENQUIRIES

3. Enquiries about this circular should be addressed to Mr G Payne, PHS3, Department of Health, Alexander Fleming House, London SE1 6BY.

Arrangements for keeping in touch with patients and making sure the services agreed as part of the programme are provided

14. Once an assessment has been made of the continuing health and social care needs to be met if a patient is to be treated in the community, and all the professional staff expected to contribute to its implementation have agreed that it is realistic for them to make the required contributions, it is necessary to have effective arrangements both for monitoring that the agreed services are, indeed, provided, and for keeping in contact with the patient and drawing attention to changes in his or her condition. This is a narrower concept than that of case management as envisaged in the White Paper "Caring for People" and upon which specific guidance will shortly be given to local authorities. In the Department's view the most effective means of undertaking this work is through named individuals, often called key workers, identified to carry the responsibilities outlined above in respect of individual patients.

15. Key workers. Where this can be agreed between a health authority and the relevant social services authority, the ideal is for one named person to be appointed as key worker to keep in close touch with the patient and to monitor that the agreed health and social care is given. The key worker can come from any discipline but should be sufficiently experienced to command the confidence of colleagues from other disciplines. When the key worker is unavailable, proper arrangements should be made for an alternative point of contact for the patient and any carer(s).

16. A particular responsibility of the key worker is to maintain sufficient contact with the patient to advise professional colleagues of changes in circumstances which might require review and modification of the care programme.

17. In addition to key worker arrangements, professional staff implementing a care programme may decide that they need a suitable information system as a means of keeping in touch and prompting action. Systems using a micro-computer are available and some relevant information about them is available from Research and Development for Psychiatry, 134 Borough High Street, London, SE1 1LB, Tel: 071-403-8790. When establishing such a system, those concerned have a duty to consider how to ensure the proper confidentiality of information about individual patients.

18. Sometimes patients being treated in the community will decline to co-operate with the agreed care programmes, for example by missing out-patient appointments. An informal patient is free to discharge himself/herself from patient status at any time, but often treatment may be missed due to the effects of the illness itself, and with limited understanding of the likely consequence.

19. Every reasonable effort should be made to maintain contact with the patient and, where appropriate, his/her carers, to find out what is happening, to seek to sustain the therapeutic relationship and, if this is not possible, to try to ensure that the patient and carer knows how to make contact with his/her key worker or the other professional staff involved. It is particularly important that the patient's general practitioner is kept fully informed of a patient's situation and especially of his or her withdrawal (partial or complete, see paragraph 20 below) from a care programme. The general practitioner will continue to have responsibility for the patient's general medical care if she/he withdraws from the care programme.

20. Often patients only wish to withdraw from part of a care programme and the programme should be sufficiently flexible to accept such a partial rather than a complete withdrawal. It is important that, within proper limits of confidentiality, social services day care, residential and domiciliary staff (including those from the voluntary and private sectors) are given sufficient information about the situation to enable them to fulfill completely their responsibility of care to the patient. Similarly, relatives and carers should also be kept properly informed.

APPENDIX 4

JOINT POLICY - CARE PROGRAMME APPROACH AND CARE MANAGEMENT

NORTH WEST LONDON MENTAL HEALTH NHS TRUST AND SOCIAL SERVICES

1. Context

This policy has been jointly produced between Health and Social Services as required by the Department of Health and outlined in Circulars LASSL(90)11 HC(90)63 and HSG(94)27.

In the context of the purchaser/provider arrangements in Health and Social Services post-April 1991, this document outlines the local arrangements for multidisciplinary working in relation to Care Programme Approach (CPA) and Assessment and Care Management.

Care Programme Approach - This is a planned process of assessment and co-ordination of the delivery of care services for people being discharged from hospital and for people in the community who have mental health difficulties.

Care Management - This is a parallel process undertaken by the Local Authority with the additional function of purchasing and review of services to meet the client's needs as a result of a social needs assessment.

Because both systems overlap in many cases, this document seeks to clarify roles and responsibilities of each agency in caring and supporting people with significant mental health difficulties and their carers.

This policy document also incorporates by definition S. 1 17 and Supervision Register arrangements. However, refer to additional guidelines for Supervision Register.

2. Who can receive this service?

The CPA applies to all persons (including those with dementia) accepted by the specialist psychiatric services whether they be inpatients or outpatients.

For Health Services, it is appropriate to divide care programmes into two levels.

Level I - a multi-disciplinary assessment and agreed Care Plan are required where a client has a significant level of health need eg. usually has had 2 admissions or more and has reasonably satisfied the CPA Checklist of Risk Factors (as listed in section 15 of this document).

Level 2 - applies to all other patients who have no or only one episode of admission and do not require multidisciplinary assessment and care planning. The assessment and Care Plan of one professional will usually be regarded as adequate (unless the level of need indicates the person should be placed on level 1 irrespective of whether they have been admitted or not).

Social Services, in addition to its role as a partner with Health in the planning and delivering of services under CPA, has the responsibility under Care Management for purchasing and monitoring services required to be arranged by the Local Authority. For people with complex needs requiring a high level of co-ordination, a Care Manager will be appointed. Social Services are required to make initial or comprehensive assessments for services according to level of need. The criteria for these assessments are as follows:

They must be aged 16-64 years and have a recognised psychiatric difficulty, and the following applies:

- a) there is a recent or imminent discharge from Psychiatric Hospital
- b) referrer states there are social care needs which are not being met
- c) assessment under the Mental Health Act 1983 is requested
- d) there is an immediate risk of psychiatric breakdown
- e) the referral is from the Court
- f) statutory Duties require Social Services Department involvement

Clients being discharged from hospital will usually correspond to CPA Level 1 and will probably require a comprehensive multidisciplinary assessment.

It is recognised that not all clients living in the community who are referred to Social Services Sector Teams will need multidisciplinary assessment. These will usually correspond to Level 2 criteria and only require an initial assessment by Social Services.

Key components of CPA and Care Management are:

- a) identification of the members of the multidisciplinary team
- b) an assessment by the multidisciplinary team to consider the needs of the client
- c) formulation of a Care Plan with the multidisciplinary team, taking into account the wishes and needs of the client, and the views of carers and any other relevant agencies
- d) the purchasing and commissioning of care services when appropriate
- e) regular review of the Care Plan
- f) allocation of a Key Worker, and Care Manager as appropriate
- g) a system of monitoring CPA arrangements and a system to seek to prevent clients losing touch with services
- h) identification of any unmet needs

4. Assessment

There are planned arrangements for the assessment and delivery of the health care and the social care needs, where appropriate, of all clients living in the community and those who will be discharged to the community.

The Multidisciplinary Assessment will address the health and social needs of the client with reference to information about psychiatric, social and forensic history.

5. The Care Plan

The Care Plan is based on the assessment of the client's needs and is designed with the patient and carer to support the client in order for them to maintain their mental health in the community.

The Care Plan should include:

- a) identification of services available in the community which best meet the individual needs of the client on discharge, e.g. Day Hospital, Counselling, Outreach support, Drop-In, Day Centre, Carers Group, Supportive Accommodation etc.
- b) the name of the professional with responsibility for providing each component of the Care Plan
- c) the name of the Key Worker
- d) any other professionals involved in the care of the client
- e) a review date
- f) strategy for action, if for any reason the Care Plan breaks down.

6. Procedure for those eligible for CPA while in hospital

All new referrals must be registered in accordance with the Trust's and Social Services' procedures.

An initial assessment must be carried out by the Ward Manager in liaison with one or two mental health workers involved with the client and then referred to the CPA meeting/predischarge meeting for discussion, if considered to be eligible for Level I CPA.

A predischarge meeting of the appropriate personnel will be convened by the Ward Manager to discuss the Care Plan. This should include the client, carer and/or advocate.

All inpatients will have a ward-based named nurse who will be expected to attend all predischarge meetings for Level I clients.

7. People eligible for CPA while in the Community

Existing clients living in the community who have severe mental health difficulties (CPA Level 1) ,will have their needs assessed at a multidisciplinary Care Plan Review meeting of the appropriate Sector.

Clients with less severe mental health problems who correspond to CPA. Level 2 will be able to be assessed for a range of services in the community e.g. Day Centre, Outreach Support, Outpatients etc. Assessment for these services can be arranged through the local Social Services of Health Sector Teams as appropriate.

8. Users and Carers

Users and carers should be fully involved in the process where appropriate. The client should always be given a copy of their Care Plan.

9. Care Plan Review

The Circulars require that reviews of the Care Programme are conducted regularly for clients with significant mental health difficulties (CPA Level 1).

Where there are particular concerns about a client, reviews should be held frequently. In all cases the first post-discharge meeting should be held within 6 weeks of discharge.

The Team Administrator will convene the Care Plan Review meeting in liaison with the Key Worker and as directed by the multidisciplinary team.

They should be attended only by persons who are directly involved in the care of the client.

These will normally be held in the Sector Team, unless another venue may be appropriate, e.g. at a residential hostel.

10. The Multidisciplinary Team

The Team consists primarily of the Consultant, Social Worker, Community Psychiatric Nurse and other Health, Social Services and independent sector staff who are involved in the assessment and planning of the client's care. eg. Housing Officer, Day Centre/Day Hospital staff, etc.

The Team is identified at the CPA Planning meeting.

It is stressed that individual team members are accountable for their own practice as laid down by their professional bodies.

11. Role and Responsibilities of the Responsible Medical Officer

The Consultant will be the RMO and will retain clinical responsibility for all clients on Level 1.

Level 2 clients will be the responsibility of either the GP or the Consultant Psychiatrist. Where a GP referral is dealt with solely by any other health professional, the GP retains responsibility.

The RMO, or in their absence, his/her nominated deputy, will ensure that the CPA meeting is chaired. The chairperson must ensure that:

- a) at or before the pre-discharge and review meetings, a comprehensive risk assessment is carried out as detailed in Section 15 of the policy
- b) the members of the multidisciplinary team are identified
- c) a full discussion takes place about the contribution that each agency is able to make in supporting the client in the community
- d) the community key worker is identified and agrees his/her role and ability and responsibility

The Chairman, in liaison with the Team Administrator, will ensure that decisions and actions as agreed at the CPA meeting are systematically recorded on the proforma and arrangements for communication between members of the care team are clear.

If a client is discharged or transfers to another catchment area, the RMO, in liaison with the Key Worker and Team Administrator and, where appropriate, the Care Manager, must ensure that a thorough handover takes place between the two multidisciplinary teams and recorded in writing.

12. Role and Responsibility of the Key Worker

It is recognised that clients who require coordinated services are best supported by an identified case worker who has an active role and will provide most immediate feedback to the other multidisciplinary team members regarding any concerns or changes in respect of the client.

The Key Worker must be a qualified practitioner from either Health or Social Services.

The Key Worker has the authority to monitor the Care Plan effectively and to highlight areas where individual team members' responsibilities have not been carried out as agreed in the Care Plan.

The Key Worker may not be the main care/treatment provider. However, it is preferable that this is the case.

The Key Worker will be expected to:

Use their professional skills in maintaining regular contact with the client. This includes consultation with carers.

Provide support and care in a positive, creative manner which aims to be as acceptable to the user as possible within their professional guidelines.

Act as a consistent point of reference for users, carers, GPs, Care Managers (if not Key Worker) and other professionals re concerns about client's welfare.

Ensure that the user has registered with a GP.

Encourage the user to maintain contact with appropriate agencies, eg. Probation Services etc.

Closely monitor the agreed care package and documents.

Immediately alert the RMO and any other appropriate agency about any untoward incident, particularly when identified in the Care Plan, which might compromise the health and safety of the user or the public. In this event the Key Worker will convene an early review.

Attend the review meetings as outlined in the Care Plan.

Only discharge Level I clients from caseload following full discussion at the Review Meeting with the RMO and all others involved in the care. The Key Worker will inform all relevant personnel that the client is discharged.

In liaison with the RMO and Team Administrator, arrange review meetings as outlined in the Care Plan.

13. Role and Responsibilities of the Care Manager

- a) completion of a Local Authority Needs-Led Assessment
- b) purchasing of services on behalf of the Local Authority
- c) monitor and review individual services being purchased eg. Care Home. This might take place at a different time to the Care Plan Review.
- d) contribute to the overall assessment and care planning coordination of clients' needs with the multidisciplinary team.

The Care Manager and the Key Worker are not necessarily the same person.

14. Section 117 Arrangements

There is a legal requirement for Health and Social Services to consider and provide aftercare services for clients detained on Section 3, S.37, S.37/41 , S.47 and S.47/49.

For the latter two categories, there are additional considerations to be taken into account (see Code of Practice).

Procedures for S. 117 clients will follow those for the CPA as detailed. There is a legal responsibility to ensure that all aspects of the procedures are followed (see Code of Practice for further guidance).

15. Broad Factors to be Considered in Assessing Risk

Clients with High Risk

Clients with a forensic history or a history of violence, severe self-harm or neglect need special consideration.

A more careful and detailed Risk Assessment should be made of the client's needs with the information available, and a detailed Care Plan formulated which seeks to minimise the risk.

> •Patients with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour, need special consideration, both at the time of discharge and during follow-up in the community. No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions have been taken after full and prompt consideration of any evidence about the risk the patient presents". (HSG(94)27).

Key Factors to be Considered in Assessment of Risk

- -History of severe mental illness and more than one admission to psychiatric hospital
- -History of aggressive behaviour
- -Reported concerns about the patient's behaviour from whatever source
- -Self-reported incidents by the patient at interview
- -Observation of the patient's behaviour and physical and mental state
- -Discrepancies between what is reported and what is observed
- -Previous history of offending
- -History of alcohol and/or drug abuse
- -Lack of family and other social contacts and/or unwillingness to accept help
- -Reluctance to engage in and sustain treatment
- -History of deliberate self-harm including overdosing
- - History of homelessness and drifting
- - History of self-neglect
- - Pregnant clients who have a history of mental health difficulties

Further consideration may be made regarding placing the client on the Supervision Register (see Supervision Register Procedure).

16. Documentation

Individual professionals should complete documentation as required by their agency.

A copy of the CPA Proforma must be held within each agency's case files.

There should be evidence in the Care Plan that the client's and their carer/relatives' views have been taken into account.

Copies of CPA Forms must be kept in the client's case notes of each Case Worker involved in the care delivery.

All new clients who qualify for Level I CPA should have completed by the Trust's Sector Team Administrator.

17. Audit Arrangements

These CPA procedures will be monitored by each agency at 6-monthly intervals to evaluate their effectiveness and outcomes reported to each Commissioning Agency.

A percentage of Care Plans will be sampled regularly by the Trust's Audit Department to ascertain:

- a) the numbers of patients who have recorded Care Plans
- b) evidence of reviews
- c) rates of discharge from care
- d) loss to follow-up

July 1995

APPENDIX 5

The JB Independent Inquiry
Room 346
40 Eastbourne Terrace
London W2 3QR

Tel: 020 7725 5515
Fax: 020 7725 5495

[Date]

STRICTLY PERSONAL, PRIVATE & CONFIDENTIAL
[Name]
[Address]

Dear [Name]

Independent Inquiry into the care and treatment of JB
Request for evidence from witnesses

You may be aware that Brent & Harrow Health Authority has set up this Inquiry after discussion with the National Health Services Executive and Social Services Inspectorate. The members of the Inquiry panel are myself as chairperson, Dr David James (Consultant Forensic Psychiatrist), and Mr Ted Unsworth (former Director of Social Services).

I enclose copies of the Terms of Reference set for this Inquiry and of the Procedure adopted by the Inquiry.

From an initial examination of available documents, it appears to the panel that you may be able to provide relevant evidence which would assist the Inquiry, and we would therefore request that you attend a Hearing on **[Date] at [Time]** in order to provide such evidence. Please telephone Catherine Afolabi, the Inquiry Secretary to confirm your attendance on [telephone number].

If however, this date is not possible, please contact the Inquiry Secretary who will endeavour to re-arrange the hearing schedule.

Your reasonable travel expenses and subsistence costs arising from your attendance will be reimbursed. The hearing will be held at [location] (a map is enclosed for your information).

When giving this evidence you may be accompanied by a friend or relative, trade union representative, lawyer or member of a defence organisation, or anyone else, with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. Your evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign, date and return. At the hearing, we shall be happy for you to raise any matter that you feel may be relevant to the Inquiry.

Should you feel that you would like to send in any comments, information or observations about the matters we are considering, prior to our meeting, we would be pleased to hear from you within two weeks of receiving this letter.

I would like to thank you for your co-operation and assistance. If there is any matter on which I can give further explanation, please let me know. I look forward to meeting you.

Yours sincerely

Hugh Chapman
Inquiry Chair

APPENDIX 6

List of witnesses who gave oral evidence to the Inquiry

JB		
JB's sister		
Dr T Ganesh	-	General Medical Practitioner
Mr A Hamilton-Clark	-	NHS Trust Service Manager
Dr J Lewin	-	Consultant Psychiatrist
Mr J Martin	-	NHS Trust Sector Manager
Mr E Matt	-	NHS Trust Director of Operations
Mr R Nesbitt	-	Social Services Service Unit Director (at the relevant time)
Mr D Sheehan	-	Health Authority Director of Health Impact
Dr D T Thakrar	-	General Medical Practitioner (who was Dr Lewin's Senior House Officer from April to September 1997)