REPORT OF THE INDEPENDENT INQUIRY INTO THE CIRCUMSTANCES LEADING TO THE DEATH OF BRENDA HORROD

PROVIDED FOR EAST NORFOLK HEALTH AUTHORITY

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PART A - INTRODUCTION

BACKGROUND

1 The Department of Health document HSG (94) 27 sets out principles and practice which should be followed for all patients who are discharged following referral to specialist mental health services and, where a violent incident occurs, imposes obligations on health authorities to:-

(a) Hold an immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach.

(b) Additionally, after the completion of any legal proceedings, in a case of homicide, to hold an inquiry which is independent of the providers involved.

2 The document gives guidance on the remit of inquiries, the composition of inquiry panels and procedures for distribution of inquiry reports.

PETER HORROD AND BRENDA HORROD

1 On the 21st May 1995 Peter Horrod killed his disabled wife Brenda at their home. Mr Horrod had been known to Anglian Harbours Trust's mental health services since November 1994. He had been an inpatient at Northgate Hospital at Great Yarmouth for two periods - between the 11th November 1994 and the 13th January 1995 and then between the 17th April 1995 and the 12th May 1995.

2 On the 1st December 1995 Peter Horrod appeared before the Crown Court at Norwich when he pleaded guilty to the manslaughter of his wife Brenda and was made the subject of a Hospital Order under Section 37 of the Mental Health Act 1983 together with a Restriction Order under Section 41 of the same Act without limited time.

SETTING UP OF THE INQUIRY

1 East Norfolk Health Authority set up an independent inquiry in accordance with HSG (94) 27 with the following terms of reference:-

(a) To examine the care and treatment Mr Horrod was receiving at the time of the incident, including support for him as his wife's carer.

(b) To assess the suitability of that care in view of Mr Horrod's history and assessed health and social care needs.

(c) To examine the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies.

(d) To examine the exercise of professional judgment.

(e) To assess the adequacy of the care plan and its monitoring by the key worker.

(f) To assess the adequacy and appropriateness of inter-agency collaboration in respect of Mr Horrod's care.

(g) To report findings and recommendation to East Norfolk Health Authority.

COMPOSITION OF THE INQUIRY PANEL

The members of the Panel appointed to undertake this inquiry were:-

Chairman - Mr William Armstrong, Solicitor, HM Coroner for Norwich District and Mental Health Review Tribunal President.

Doctor Paul Calloway, Consultant Psychiatrist and Clinical Director of Adult Mental Health, Addenbrookes NHS Trust.

Ms Maralyn Arnold, Local Government Consultant, previously Director of Social Services for the London Borough of Enfield.

Mr Terry Schofield, Nursing Specialist, previously Director of Nursing, West Berkshire Priority Care Services NHS Trust.

INQUIRY PROCEDURE

1 East Norfolk Health Authority made a decision that the Inquiry should be held in private. For reasons which the Chairman is content to explain to any interested person the members of the Panel support entirely the decision for an inquiry of this kind to be held in private rather than in public.

2 HSG (94) 27 states, "Although it will not always be desirable for the final report to be made public, an undertaking should be given at the start of the inquiry that its main findings will be made available to interested parties." Such an undertaking has been given.

3 Mrs Geraldine Russell acted as Secretary to the Inquiry and the Panel members wish to express their gratitude to her for making the necessary practical arrangements and providing the essential administrative support. They would also like to thank Mrs Denise Winter for the considerable help and support that she gave during the course of the Inquiry. Our investigations were not impeded in any way and every help was afforded to us.

EVIDENCE

This report is based upon evidence obtained by means of the following:-

1 Direct oral evidence provided by witnesses who attended the Inquiry. The following persons gave oral evidence:-

Sarah Burton, Bridget Collins, Jane Pull, Joan Hamilton, Peter Harrison, Doctor Robert Jarvis, Robert Mee, Bella Parkinson, Andrew Ruddick, Doctor Louise Santori, Debra Green, John Horrod, Brian Perrin, Norma Howe, Doctor Anoup Dhesi, The Care Agency Occupational Therapist and Doctor Frederick McEvett.

Statements were provided in advance either made specifically for the purpose of the Inquiry or made previously for other purposes, for example, the criminal proceedings against Peter Horrod. A transcript of the evidence of each witness was made and provided to each person afterwards giving them the opportunity of clarifying any matter which needed clarification in their view. The witnesses were each given the opportunity to bring with them to the Inquiry a person who could offer support and some of them availed themselves of that facility including, in two cases, support by a lawyer.

2 Consideration of a substantial amount of written material including papers supplied in connection with the criminal proceedings against Peter Horrod, previous statements made, medical records and social work records. A list setting out all the documents considered is available.

3 A private discussion between Doctor Calloway, Mr Schofield and Peter Horrod at Heron Lodge, Challenging Behaviour Unit at Hellesdon Hospital in Norwich.

4 A discussion between the Chairman and Ms Arnold with Mr Kevin Gislam.

5 A visit to Northgate Hospital to inspect the facilities there undertaken by the Chairman, Ms Arnold and Mr Schofield.

6 A discussion between the Chairman and Ms Arnold with Brenda Jones, Approved Social Worker, and Sam Morton, Norfolk County Council Social Services District Manager for the Northern District.

The Panel would like to express their gratitude to all those who gave evidence to or provided information for the Inquiry.

PART B - PETER HORROD'S BACKGROUND

12.02.1933	Peter Horrod born.
1935	Parents separated and Peter taken into care.
1948	Peter left school, moved into lodgings and started apprenticeship in painting and decorating.
1954 - 1956	National Service for two years in an Army Catering Corp.
1956	Resumed work as painter and decorator.
1958	Married Brenda and moved to Palgrave Road.
17.03.1963	Daughter Debra born.
10.07.1967	Son John born.
1975	Peter became self-employed painter and decorator.
1988	Brenda first became ill with brain tumour.
07.1990	Norfolk Social Services Department first became involved providing assistance to Brenda.
11.1992	Peter gave up work to look after Brenda.
07.1993	Social Services assessment - range of services offered to Peter and Brenda.
10.1994	Peter's brother Ernest came to live with the family.
10.1994	Kevin Gislam became involved in helping Peter and Brenda with finances.
11.1994	Peter finding it more and more difficult to look after Brenda.

PART C - ADMISSION TO NORTHGATE HOSPITAL NOVEMBER 1994

10.11.1994	Peter presented to GP suffering from "acute anxiety state." Also complaining of prostate problems. Peter started acting "very strangely" whilst staying the night at the family's cottage at Palgrave Road.
11.11.1994	Peter taken to James Paget Hospital where catheter bag fitted to relieve prostate problem. Social Services contacted - social worker Graham Akers involved - arranged for short term emergency care for Brenda at Herondale Residential home at Acle. Brenda went to the home. Peter went to visit Brenda at Herondale - behaving aggressively - police called. Police found Peter walking along the A47 "Acle Straight." John informed and he picked Peter up in his car and took him to Herondale where he left Peter. Peter saw Brenda at Herondale and after a time rushed out in a "manic" state and started walking towards Yarmouth when picked up by the police and taken to Yarmouth Police Station. Peter seen by Joan Hamilton, Approved Social Worker and Doctor McEvett, Consultant Psychiatrist at Northgate Hospital, Great Yarmouth. Decision made to admit Peter informally to Northgate Hospital.
24.11.1994	Brenda returned home from Herondale.

OBSERVATIONS AND COMMENTS

1 Debra and John were clearly fully justified in being disturbed and alarmed about their father's behaviour which was very frightening to them. The decisions that they made to contact the police and Social Services with a view to arranging respite care for Brenda were wholly correct and it was right that Debra should support the decision for Peter to be admitted to hospital.

2 When the Police found Peter walking up the Acle Straight they were obviously right to make enquiries and of course it was appropriate for them to withdraw once John had appeared on the scene and taken Peter off to Herondale.

3 The staff at Herondale also behaved appropriately by trying to look after Peter when he arrived, by allowing him to shave so that he could be more presentable before he saw Brenda and of course by contacting the police when he disappeared in a very alarming frame of mind.

4 The decision by the police to pick Peter up and take him to hospital was obviously correct. In the very least he was giving reason to believe that he was suffering from a mental disorder and acting in a manner that was potentially dangerous to himself.

5 The assessment carried out by Joan Hamilton was as comprehensive as it needed to be in the circumstances. She obtained a full grasp of the situation and, in accordance with her obligations, interviewed Peter as well as speaking to Brenda and Debra. Informal admission to hospital was right because Peter was expressing willingness to be in hospital. (Mental Health Act 1983 Code of Practice (August 1993) para 2.7)

6 From the information supplied to Doctor McEvett and his assessment at the time it was appropriate for him to make a decision to arrange for Peter to be admitted to hospital.

PART D - PERIOD IN NORTHGATE HOSPITAL, 11TH NOVEMBER 1994 - 13TH JANUARY 1995

Social Services arranged for the Care Agency to be involved in caring for Brenda.

11.11.1994 — Peter admitted to Ward 5, Northgate Hospital under the care of Doctor McEvett.

Apart possibly from Debra general agreement that Peter improved during his stay at Northgate Hospital.

Assessed medically as suffering from psychotic depression.

Medical and nursing notes had no mention of the aggressive conduct of Peter which led to his admission.

Evidence of memory disturbance arose - no neuro-psychological assessment.

Peter Horrod spending time at home "on leave" - three nights on his own at the cottage at Hickling in early January and overnight at Palgrave Road with Brenda on 4th and 5th January 1995.

05.01.1995 — Meeting at Palgrave Road - social worker Graham Akers said that the Care Agency had informed him that Brenda Horrod had a red pitted mark on her left buttock and bruise in the same area.

13.01.1995 — Ward round - decision made to discharge Peter following periods of home leave and discussions with all concerned including relatives.

Discharge plan recorded.

OBSERVATIONS AND COMMENTS

1 Despite the circumstances of his admission it appears to have been agreed by all concerned, with the possible exception of Debra Green, that Peter improved quite substantially during this period of around two months in hospital.

2 The medical staff had formed the assessment that Peter was suffering from psychotic depression and, in the discharge

notification, reference is made to "depressive illness." There are two points that should be made:-

(a) the medical and nursing notes relating to this admission made no reference to the details of the aggressive conduct of Peter which led to his admission and

Recommendation 1
Recommendation 5

(b) evidence arose of memory disturbance and, in view of the fact that this was a late onset disorder, there might have been a case for further investigation including neuro-psychological assessment - had there been a psychologist available.

Recommendation 2

3 The decision to discharge Peter from hospital was appropriate. It followed periods of home leave and multi-disciplinary discussions with relatives being involved. The discharge was planned and took into account the care package which needed to be in place for Brenda.

4 The provision of services at Northgate Hospital, the management structures and the care provided are all issues which are dealt with in a separate section of this report.

5 The mark and bruising mentioned at the meeting on the 5th January remained unexplained and was never pursued further.

PART E - BETWEEN ADMISSIONS JANUARY TO APRIL 1995

Prior to discharge it had been made clear to all professionals concerned that Peter and Brenda intended to leave their home in Palgrave Road to move to the cottage which they owned in Hickling, which was in the jurisdiction of a different Social Services District and a different Health Service catchment area.

Graham Akers the social worker transferred care management to Sarah Burton, social worker. The Care Agency continued to be engaged to assist Brenda notwithstanding the move.

Peter did not attend Calthorpe House (Day Hospital) despite the fact that this was part of the Discharge Plan.

No steps were taken to transfer consultant psychiatrist responsibility from the Yarmouth area which covered Palgrave Road to the Norwich area which covered Hickling.

End of 01.1995	Peter's brother Ernest Horrod left the house.
01.02.1995	Peter and Brenda moved to Hickling.
06.02.1995	Peter and Brenda Horrod registered with the medical practice of Doctor Robert Jarvis at Ludham.
02.03.1995	Kevin Gislam contacted Doctor Jarvis' surgery to express concern about Peter.
03.03.1995	Doctor Jarvis visited Peter and then referred him to CPN Service, Bridget Collins.
09.03.1995	Bridget Collins visited Peter - Bella Parkinson, CPN, (A member of Bridget Collins' team) became involved. She compiled Nursing Care Plan and wrote to Doctor Jarvis on 10th March 1995.
12.04.1995	Discussion between Bridget Collins and social worker Sarah Burton.
17.04.1995	Peter behaved in a bizarre and aggressive fashion towards Brenda and John and Debra in

the presence of Debra's children. Police called.

Doctor Jarvis arrived and discussed situation with the family, the police officer attending and Kevin Gislam who was also present.

Doctor Jarvis decided that Peter should be readmitted to Northgate Hospital in Great Yarmouth and Peter agreed to admission.

OBSERVATIONS AND COMMENTS

1 Prior to Peter leaving Northgate Hospital on the 13th January 1995 all relevant professionals involved in his care and that of Brenda were aware of the intention of Peter and Brenda to move to Hickling on the 1st February 1995. This would result in their placing themselves in a different Social Services District and a different health service catchment area.

2 The Panel wishes to emphasise that the transfer and "handover" of social work responsibility from Graham Akers to Sarah Burton was effected in a very competent and professional manner. Moreover, Sarah Burton's record keeping relating to the transfer is very good. It ought also to be observed that Sarah Burton and the staff of the Care Agency worked very hard to good effect to transfer the care package from Great Yarmouth to Hickling.

3 Although it was part of the discharge plan that Peter should attend the Calthorpe House (Day Hospital) there is no evidence that he ever did. There was no system in place or any procedure designed to ensure that his GP, a CPN or any other professional was advised of this fact.

Recommendation 9

4 It would have been better, as part of the discharge plan, had consultant psychiatrist responsibility been transferred to a practitioner in Norwich in whose catchment area the Horrods had gone to live. This would have led to better established lines of communication between the patient's general practitioner, CPNs and the consultant psychiatrist concerned. It would have facilitated Peter Horrod's admission to an appropriate facility should that have become necessary in the event of his mental condition worsening.

Recommendation 8

5 Doctor Jarvis could of course have admitted Peter to a psychiatric hospital in Norwich which would have been within the appropriate catchment area but he chose not to do so and instead referred Peter Horrod to Northgate Hospital.

6 The Community Psychiatric Nurses involved in Peter Horrod's care were all doing their best to provide assistance but four observations are nevertheless appropriate. Firstly, the CPN records are not detailed and provide no real sense of continuity. Secondly, on the 12th April 1995 a discussion took place between Bridget Collins, CPN, and the social worker Sarah Burton which, although recorded in some detail by Ms Burton, is not recorded at all in the CPN notes. Thirdly, it was not demonstrated to the Panel that the CPNs involved in Peter Horrod's care were operating with any real sense of direction, purpose or evaluation. Fourthly, Peter's care in the community might have been managed better had there been in existence (as there is now) a Community Mental Health Team providing an established forum for discussions between different professionals as opposed to CPNs simply having patients referred to them by GPs.

Recommendation 4
Recommendation 5

PART F - SECOND ADMISSION TO NORTHGATE HOSPITAL (17.04.95 - 12.05.95)

17.04.1995	Peter admitted to Ward 5 at Northgate Hospital - medical notes made no specific reference to the behaviour at home which led to the admission.
18.04.1995	Debra Green telephoned the ward expressing concern about Peter Horrod having stopped his medication two weeks earlier and about his strange behaviour. Debra Green told the Panel that she telephoned the hospital a number of times during this admission expressing concern about her father. (There is no reference in the medical and nursing notes to any conversations with Debra Green apart from that on 18th April 1995.)
21.04.1995	Peter transferred from Ward 5 to the rehabilitation flats, a decision brought about largely by pressure on beds. Peter in a confusional state and suffering from memory impairment. All information does not appear to have been passed on from Ward 5 to the staff at the rehabilitation flats. Family were contacted from the hospital although unclear as to how often.
05.05.1995	Ward round - decision to allow Peter a week's "leave." Sarah Burton, social worker, not consulted about this decision. (She did not learn about Peter being at home on leave until she received a phone call from the Care Agency.)
09.05.1995	Sarah Burton contacted Northgate Hospital to express concern that Peter was out of hospital.
12.05.1995	Decision to discharge Peter - Peter wanted to leave and Brenda reported to want him home. Neither Sarah Burton nor any CPN present at the ward round when the discharge took place. The discharge plans were:-

1 To home address.

2 Follow up by CPN Jane Pull who will monitor mood swings and discuss with Peter the opportunity of moving to a consultant in the Norwich area.

3 To attend the Stalham Day Centre on Tuesdays.

4 To attend OT Department of the Northgate Hospital on Thursday.

5 Social worker Sarah Burton to assess home situation and his needs.

The discharge notification refers to "possible referral to Norwich area at later date."

Sarah Burton contacted the hospital late on 12th May 1995 and was then told that Peter Horrod had been discharged. She was provided with no discharge report nor details of any aftercare package. When she asked about Peter attending the Day Hospital she was told by the ward staff that they were monitoring Peter's health through the GP and CPN.

18.05.1995 Discharge letter sent by hospital doctor, Doctor Santori, to GP (which in our opinion was less comprehensive than it might have been) making no mention of the violence which led to the admission. This is not surprising since the medical notes on admission made no specific reference to the behaviour at home which led to the admission.

OBSERVATIONS AND COMMENTS

1 The decision to re-admit Peter to Northgate Hospital was understandable given the history and circumstances and in particular because he was known at that hospital. It was, however, unfortunate in the sense that consultant psychiatric responsibility had not been transferred to the Norwich District and, had that happened, he could have then been admitted without difficulty to the appropriate hospital for the area in which he was living. This would have led to the same personnel being involved in discharge planning and arrangements after discharge.

2 It is very clear from the evidence presented to the Inquiry that Ward Five at Northgate Hospital was under considerable

pressure at the time of this admission. The regime operating on Ward Five is considered in another section of this report.

Recommendation 3

3 The decision to transfer Peter from Ward Five to the rehabilitation flats after only four days in hospital was inappropriate in the circumstances. There is no doubt in the minds of the Panel that this decision was very much influenced by pressure on beds. However, Peter Horrod had been admitted to hospital after a bizarre episode of behaviour which included violence. Moreover, there was evidence of a confusional state and memory impairment. These matters should have indicated a longer period on the ward so that further investigations could have taken place - including a neuro-psychological assessment.

Recommendation 3
Recommendation 2

4 As a result of moving from Ward Five to the rehabilitation flats it appears that some information may not have been passed on clearly to the staff in the rehabilitation flats. The move of course meant that an entirely different set of nurses would be involved in Peter's care from those that had looked after him on the ward.

Recommendation 1
Recommendation 5

5 There was a lack of liaison with the relatives. The Panel can make no precise findings of fact about how often Debra was telephoning the hospital. It is possible that her calls may have been going to Ward Five rather than to the rehabilitation flats - after Peter's transfer to the flats.

6 The impression given to us by the evidence is that there was a breakdown of communication between certain professionals and no-one was really getting to grips with Peter, the circumstances of his admission and his clinical condition. It is worrying that the medical notes make no reference to the violence which precipitated the admission and this aspect of his behaviour does not appear to have figured in ward rounds either. When asked about the comments of Mr Horrod's relatives about the circumstances of this admission and the "incident" (ie the violent and erratic behaviour leading to it) Doctor McEvett replied, ".....When we discussed this on ward rounds this potentially violent bit of it never surfaced whatsoever, despite the letter by Doctor Jarvis which was read. I think that was taken to mean that he was very proprietorial about the care of his wife, so when his son and daughter tried to help out he sometimes got fed up and angry with them. I think it was taken as a tiff like that, rather than anything more serious - despite him then coming into hospital and showing some of these other psychotic-like, hypomanic-like things."

7 The decision to discharge Peter on the 12th May was made principally on the basis of what appeared to have been an uneventful week's home leave. Peter wanted to be discharged and Brenda wanted him home. The Care Agency staff did not appear to be expressing any concerns.

8 Peter's discharge took place at the ward round. Neither Brenda's social worker Sarah Burton nor any CPN was present. The decision to discharge would have been better informed had both either been there or at least given their views before hand. Sarah Burton had not even been made aware of the ward round and was given no opportunity to express any views about whether Peter should have been discharged.

9 The decision to discharge Peter at that stage appeared to be appropriate on the basis of the information available relating to the apparent success of the leave period. However, there would have been a case for a longer admission and there is a basis for suggesting that the decision may in retrospect appear to have been somewhat premature. In his first admission Peter had responded well to a combination of anti-depressants and anti-psychotic drugs. Moreover, he had responded to anti-psychotic drugs during this admission but, by the time of discharge, he was no longer taking these drugs. A longer admission would have allowed for a period of observation of his mental state and behaviour while he was simply on the Fluoxetine. Reference has been made earlier in relation to the first admission to the possible desirability of a neuro-psychological assessment. Because of observations made during the second admission there was clearly a stronger argument for such an assessment to take place. It is fully understood that there were difficulties in getting this done and this was clearly a service deficiency.

Recommendation 7

10 The discharge plan on this occasion was somewhat less than comprehensive. Part of the discharge plan should have been an arrangement for the transfer of Peter's care to the appropriate psychiatric team from the Norwich area. There does not appear to have been a clear communication to the GP making him aware of the arrangements. A discharge letter was not sent until the 18th May by Doctor Santori and this discharge letter is not very full. In particular the letter does not mention the violence leading to the admission. The letter did not deal with evidence of psychosis and the response to treatment with anti-psychotic drugs. The diagnosis was stated as "recurrent depression with treatment on discharge - Temazepam and Fluoxetine." It is impossible to say that the discharge failed to comply with the Trust's policies because, as has been pointed out in a separate section of this report, the policies themselves were general in nature, vague and imprecise.

Recommendation 7

PART G - THE PERIOD FROM DISCHARGE FROM NORTHGATE HOSPITAL ON 15.05.95 UNTIL THE DEATH OF BRENDA ON 21.05.95

15.05.1995	Peter returned home to live with Brenda.
19.05.1995	Peter took an overdose of medication and admitted to James Paget Hospital in Gorleston.
20.05.1995 (Early hours)	Seen by Doctor Van Houten and Doctor Santori, psychiatric SHO. Decision made to discharge Peter and he was sent home by taxi.
20.05.1995	Peter seen by Doctor Jarvis. Brenda told the Care Agency Carer that Peter had proposed suicide pact with her. Brenda appeared concerned about Peter and the Carer sought authority from Social Services to enable her to stay overnight. This authority was refused but the Carer decided to stay in any event. The Carer spoke to Doctor Jarvis on the telephone. Peter killed Brenda.

OBSERVATIONS AND COMMENTS

1 The decision by the standby social worker Brenda Jones not to authorise night sitting for Brenda and therefore commit the Social Services Department to paying for the Carer to stay with her during the night of the 20th/21st May, was a wholly understandable and appropriate decision based upon the information made available to her at the time during the course of a full conversation with the Carer. Had the social worker felt that night sitting was appropriate then the Social Services Department would have paid for this.

2 The Panel has thought long and hard about the decision made by Doctor Santori to send Peter home and not to admit him - struggling obviously to avoid "hindsight bias." We are mindful of the fact that in view of the large number of overdoses at the James Paget Hospital and the resource limitations (especially inpatient psychiatric beds and the lack of overnight facilities at the hospital) there would clearly have been an expectation that the threshold for admission would be high. There were no medical indications

apparent to Doctor Santori to justify keeping Peter in hospital, and, despite the concerns expressed by Doctor Van Houten, she judged that there was no immediate risk of suicide. She would certainly have had no reason to have suspected that Peter might have inflicted violence on anyone else. However, whilst recognising that Doctor Santori made a conscientious clinical judgment it is nevertheless considered that Peter ought to have been admitted and not sent home. There are a number of reasons. These include the fact that he had had a very recent admission to hospital with a mental illness, his age, the fact that this was the first time that he had overdosed, the suicide pact that he had proposed with Brenda and his home circumstances as the husband of a seriously disabled and therefore very dependant woman. Moreover, on the basis of everything that is known about Peter and his history, the Panel considers that he would have accepted admission had it been offered.

3 The Panel feels it appropriate to make the following observations about Doctor Santori's decision to send Peter home:-

(a) Doctor Santori was a GP trainee who had only two weeks earlier begun a three month psychiatric placement. The Panel was shown the "training pack" issued to doctors undergoing such placements as part of their GP training. It appears, however, that no specific induction or training is given to such doctors on risk assessment. The information given, such as it was, in our opinion, would not have been any real help to Doctor Santori on the night in question.

(b) Doctor Santori did not have access to Peter's notes at the time that she made this decision. Of course it should be borne in mind that when Peter was admitted to Ward 5 at Northgate Hospital on 17th April 1995 the medical notes made no specific reference to the behaviour at home which led to the admission. However, she had previously been involved with his care at Northgate Hospital and she had written the discharge summary on 18th May 1995.

(c) Doctor Santori made no attempt to contact the on-duty consultant psychiatrist whose advice would have been readily available to her. The Panel's view was that had the consultant on duty been contacted he would have said that Peter should have been at least admitted overnight until a full assessment could be carried out. Of course it is recognised that this is a very difficult position for a junior doctor to be in.

(d) Doctor Santori ought to have made contact with Peter's home and communicated with Brenda. Had she done so of course she might well have found out that there was no one else in the house in which event she might have thought again about letting Peter go home.

(e) Although it might well have been usual practice the Panel fully understands the criticism made by John and Brenda about Peter being sent home by taxi. This was obviously inappropriate but in the circumstances not a matter for which any specific individual can be criticised.

Recommendation 11
Recommendation 12
Recommendation 14

4 The Panel has taken note of the views expressed by Doctor D. A. Ellis, Medical Director of the James Paget Hospital NHS Trust who has said in writing to the Panel, "The value of a clinically effective liaison service to emergency medicine and trauma is proven. The Royal College of Medicine and the Royal College of Psychiatrists has issued jointly guidance on the nature of an effective liaison service to district general hospitals. The James Paget Hospital does not have such a service and this is doubly significant given the acknowledged under resourcing of mental health services in our catchment area. The existing liaison "service" to the James Paget Hospital is represented mainly by trainees, usually at senior house officer grade, supported at a distance by a consultant. These trainees may be very junior and part of 6 monthly rotating training programmes in other specialities.....unless there is an effective safety net provided to vulnerable patients with acute mental health problems the acute general hospital service will not be able to provide an assured high quality service to patients."

Recommendation 10

5 Doctor Jarvis was of course the last doctor to see Peter Horrod before the homicide. On the information available to him at the time there would have been no grounds to detain Peter compulsorily in hospital. Doctor Jarvis did not have the information from the hospital about Peter's condition and the circumstances in which he had been admitted following the overdose. It is possible that had he known about this he would have sought psychiatric advice. This would obviously have been easier had Peter been known to the local psychiatric services. Doctor Jarvis was reassured by the fact that the Carer was staying the night with Brenda.

Recommendation 13

PART H - NORTHGATE HOSPITAL DECEMBER 1994 TO MAY 1995 - OBSERVATIONS ON THE REGIME.

Because so much has happened and so many things have moved on since May 1995 the Inquiry Panel has concluded that it would be sensible for it to confine itself to identifying those shortcomings which had a particular bearing on the management and care of Peter Horrod at Northgate Hospital.

1 There were important management shortcomings as a result of the structure which existed. The amalgamation of the mental health services with the community services which led to the creation of Anglian Harbours Trust and the transfer of adult mental health services from St. Nicholas Hospital to Northgate Hospital produced a number of difficulties - organisational and operational.

When Anglian Harbours Trust was first established as one of the "first wave" trusts in 1992 there was one single purchasing authority - Great Yarmouth and Waveney. This authority ceased to exist in 1994 and thereafter the Trust was providing services for two commissions - East Norfolk and Suffolk - each of course wanting its providers to make available services from within its own geographical locality. In addition obviously, as far as social work was concerned, there were two separate Social Services Departments involved - Norfolk County Council and Suffolk County Council.

2 In addition to these basic difficulties the management structure was not the most appropriate one for delivering mental health services effectively. Peter Harrison the Chief Executive of the Trust was assisted by Robert Mee who was the Health Care Provision Manager and also the nurse member of the Trust Board. Mr Mee, by his own admission to the Panel, had no mental health training and little significant experience of psychiatric services. Andrew Ruddick, Care Co-ordinator Mental Health, was assisting Robert Mee in helping to introduce this "flat management structure" which is being described. Paralleling the managerial organisation was an advisory "directorate structure" which included a Clinical Director of Mental Health. The function of the Clinical Director, as described to the Panel by Mr Harrison, was "to provide balanced medical advice, to oversee the service, to advise the Chief Executive of the way he thought things were going." The Clinical Director did not have a line responsibility as a manager. It is not the function of this inquiry to scrutinise in detail the management structures of the Trust. The point, however, that has to be made is that there were no specialist managers to oversee or consider the particular needs of the acute psychiatric services. The most senior nurses with mental

health experience were the two nurses who were operating in and directly in charge of Ward Five. Apart therefore from the Clinical Director, who was of course a Consultant Psychiatrist, there was no-one above Charge Nurse/Sister level in the mental health service who was able to advise on clinical or strategic matters. The management structure had no intermediary officer between the Charge Nurse grade and Mr Mee. This was justified as being a "flat organisation" which inevitably produced a short chain of command. Whilst such organisational profiles may appear attractive in management theory the operational reality is that the gaps in the structure mean that there is no-one available to manage day to day problems presented by acute psychiatric patients. It is difficult to believe that, given the nature and scope of Mr Mee's post, he was able to monitor or appreciate the ongoing clinical issues, nor would it have been reasonable to have expected him to have done so.

3 We turn now to the organisation of Ward Five at the time when Peter Horrod was a patient. Following the closure of St. Nicholas Hospital there was a reduction in the number of acute psychiatric beds. According to Mr Mee's evidence to the Inquiry, "the closure of St. Nicholas led to re-configuring at Northgate - a massive re-configuration - to accommodate all the acute psychiatric services." Prior to the closure of St. Nicholas, Ward Five at Northgate had been used for elderly psychiatric patients and these had to be moved to rehabilitation facilities in the hospital. Not only was there a loss of beds but, again according to Mr Mee, "Ward Five did not have the same type of facilities as the previous psychiatric ward in relation to the ability to use more single rooms - so you had the sex problems coming in." Again, according to Mr Mee, the general policy of reducing psychiatric inpatient admissions throughout the 80's and the lack of other local services to whom patients in the Yarmouth area could be referred, meant that the staff on Ward Five at Northgate were looking after patients who, historically, they would have moved on. Moreover, Mr Mee told us that there was a general increase in the number of people living in the locality who required acute treatment, whether inpatient or community based, and this development was coupled with only a slow increase in community resources. This inevitably led to severe pressure on bed space.

4 At the time of Peter Horrod's admissions there were certainly problems with bed availability. When the psychiatric beds were moved to the Northgate site in 1992 acute bed numbers were reduced from 31 to 25 despite serious concerns being raised by medical and nursing staff. At the time of Peter Horrod's second admission in April/May 1995 there were 25 beds on Ward Five and 14 beds on Ward Nine (the rehabilitation flats). During the period of this admission both Ward Five and Ward Nine consistently had severe pressure on beds with bed occupancy at times up to

110%. As has been observed earlier this pressure on beds was clearly a major influence on the decision to move Peter Horrod to the rehabilitation flats and indeed may well have been a major factor in his being discharged when he was.

Recommendation 3

5 At the time Ward Five was managed on the ground by two G grade nurses of equivalent status who were jointly responsible for the management and nursing practises of the ward. This was a strange and inappropriate set up. The 1988 Clinical Grading Structure (per 1 E 1 (1988) 67) provided guidance on the process of grading posts and outlined definitions for particular grades. Annex C of this circular defined ward based G grades as broadly having continuing responsibility for care and management of a ward including the deployment, supervision and training of staff. The clear implication from this was that there would be one G grade post per ward or equivalent sphere of responsibility. The idea was that this officer would be solely accountable for the performance of the area. The arrangement whereby there were two G grade nurses jointly responsible for managing the ward as well as having a good deal of responsibility for individual patients was ambiguous and unhelpful to say the least. This situation was of course compounded by a management structure, to which reference has already been made, which made the level of management above the ward managers inaccessible and too distant from the work place to influence day to day matters. Those giving evidence to the Inquiry accept fully this criticism and the Panel has been advised that the situation has now been changed with the appointment of one Ward Manager whose role is very much in relation to management and clinical direction of staff.

6 As a consequence of what has been described above there was no effective monitoring of the services provided on Ward Five. Indeed what monitoring there was appears to have been crisis driven. The Panel has gained the clear impression that there was no-one who was really evaluating what was happening and why. The service was in crisis and no-one appeared to know how to manage the situation or introduce changes which would have the effect of alleviating the problems.

7 The supervision of staff seems to have been flawed. There was a wholesale reliance on the "key nurse" system but no sense in which this was operating as an integral part of a framework of care. There is no evidence that staff were regularly monitored and supported with care plans being checked and endorsed by senior Ward Managers. The key nurse system operating was not part of any formal downward delegation. The impression that we have is that the amount of clinical information filtering through to the Ward Managers from the key nurses about individual patients was minimal. There seemed to be no appreciation that the key nurse system was deficient in respect of disseminating and

auditing clinical information. The only exception to this appears to have been the "problem patients" - the people causing difficulties who were therefore drawn to the attention of senior staff. Peter Horrod did not of course come into this category. It appeared to the Panel that the less challenging patients like Peter seemed to merge into a background of partial anonymity with no-one, apart from the key nurse, knowing much about them.

8 The key nurse system seems to have partially operated in isolation from the other organisational processes. The approach on Ward Five appears to have allocated primary nurse status by some arbitrary and undeclared method. Apart from the weekly case conferences, the system did not seem to have any mechanism which regularly checked that care objectives were appropriate, that information about patients was exchanged and that the progress of patients was evaluated. The exchange of essential information about patients was far too random. Information was more likely to have been conveyed if a patient was troublesome. There was no proper framework which facilitated communications and permitted senior staff to have a detailed understanding of all the patients on the ward and the attendant care issues.

9 There was not in place a proper regular system of supervising nursing staff. Individual supervision seems to have been replaced by the weekly multi-disciplinary case conferences/ward rounds which were the major monitored forums for the delivery and review of care. Whilst case conferences have their place in the order of events they are no substitute for individualised professional supervision to promote good care practices and to advance the worth of the practitioner to the organisation.

10 Although Ward Five offered a pleasant, non-institutional environment which may well have been in some respects an improvement on the previous accommodation at St. Nicholas Hospital, there were physical defects impeding the quality of patient care. The plan of the ward at the time showed it to have many deficiencies and subdivisions creating a rather rambling structure where patients could remain unobserved for long periods. The whole layout of the ward would have made continuous observation of patients very difficult. The immediacy of the external doors giving ready access to nearby buildings and roadways meant that patients wishing to leave the premises unseen could do so with relative ease. Moreover, the internal fabric of the building was in a poor state and it would have been difficult to have contained noise which is an important factor when attempts are made to manage a disturbed episode while at the same time trying not to unsettle a ward where acute psychiatric patients were being treated. There was a rarely used seclusion room but even that had little noise suppressing qualities.

11 It ought to be observed of course that the independent living units on the rehabilitation ward provided a much more positive environment and these units appeared to have been liked by both patients and staff.

12 The whole issue of inter-disciplinary and inter-agency liaison seems at times to have been quite fragmented. There was little to suggest to us the easy flow of information between professionals or the various organisations. So much relied on the individual practitioner pursuing issues themselves rather than systems being in place which ensure the exchange of prime and timely information.

13 Communications with relatives and carers of patients does not appear to have been given priority and was certainly not the subject of any established procedure. Whilst it was clearly accepted that consulting with relatives was a desirable practice the fact that it happened at all seems to have been the result of initiatives taken by relatives and carers rather than medical or nursing staff being proactive in seeking out the views of relatives. This was a major shortcoming. No-one knows a patient better than their relatives and carers and procedures should be in place to ensure that their views are not only listened to when received but also actively sought out.

14 The Panel feels obliged to comment upon record taking in Ward Five. Peter Horrod's nursing records are not wholly satisfactory. The initial nursing assessment had a series of omissions and the day to day Kardex reports lacked continuity. The content of these reports is not particularly descriptive or helpful. It ought also to be observed that the documentation for the rehabilitation ward was really quite different. All the sections of the admission profile were completed and the discharge information reflected what care had been agreed after discharge although the information still lacked enough detail. The daily reports from staff on the rehabilitation ward gave good accounts of Peter Horrod's prevailing condition along with other associated events pertinent to his care. When Peter Horrod was transferred from Ward Five to the rehabilitation flats he had a completely different nursing team.

Recommendation 1
Recommendation 5

15 Another difficulty appears to have been that there were problems in arranging transfer of appropriate patients at Northgate Hospital to secure facilities. There is a challenging behaviour unit at Heron Lodge at Hellesdon Hospital in Norwich and a regional secure unit at the Norvic Clinic in Norwich for forensic patients. Mr Mee, in his evidence to the Inquiry, said that it was difficult to transfer patients to either of these facilities and

sometimes patients were having to be transferred to hospitals in London.

16 There was a shortage of clinical psychologists available to patients at the hospital. It appears that neuro-psychological assessment was not routinely available but depended upon the clinical interests of individual practitioners.

Recommendation 2

17 The Panel has been referred to the Anglian Harbours Trust documents "Policy on the Care Programme Approach and Supervisional Register" (January 1995) and "Policy for the Discharge of Patients from Hospital" (March 1992). These were the policy documents operating at the time and it has to be said that they were wholly inadequate. The Care Programme Approach policy was a generic policy covering all patients with mental health problems who fell within the remit of the Trust and there was no specific policy or sub-section of the main policy devoted to mentally ill patients. This was a serious omission which shows that the Trust was not complying with guidelines issued to all health authorities from 1990 onwards regarding the care programme approach in relation to specialist psychiatric services. Likewise the discharge policy was extremely brief and vague and contained no detailed guidance on discharge of patients who had been admitted with mental health problems.

Recommendation 7

18 The evidence from the documentation suggests that early discharge planning was not at the forefront of anyone's thinking during the course of Peter Horrod's two admissions. There is little reference to relatives or community care staff. There was a failure to encourage relative participation and to make it clear to them that their contributions would be welcomed.

Recommendation 7

19 We were told that recruitment and retention of staff was a major problem. The combination of high bed occupancy, lack of managerial direction and inadequate professional supervision and support might have led to nurses concluding that Northgate Hospital was not the best place to advance their careers.

20 Indeed it is no exaggeration to say that this was a service in crisis reaching breaking point. Brian Perrin told the Panel, "We were constantly under pressure." Robert Mee said, "We were not happy with the situation on Ward Five, which was not just about the number of beds we have; it is how we deal with patients." He went on to say, "We were already in a situation of knowing we needed to do something."

PART I - ACTION TAKEN BY TRUST FOLLOWING THE HOMICIDE

Under the Department of Health Circular HSG (94) 27 issued on the 10th May 1994, as well as setting up an independent inquiry, there is an obligation on the part of the health authority to take action straight away when "a violent incident occurs." Paragraph 33 of the circular states, "Action by local management must include:- an immediate investigation to identify and rectify possible short comings in operation procedures, with particular reference to the Care Programme Approach. The Panel has felt it appropriate to set out what action was taken by the Trust after the "incident" and to comment upon the extent to which the Trust complied with the provisions of paragraph 33 of the circular.

After Peter had killed Brenda it appears that Mr Robert Mee (the Health Care Provision Manager) "went to carry out an investigation into the circumstances around (Peter Horrod's) care," (words used to the Inquiry Panel by Peter Harrison then Chief Executive of Anglian Harbours Trust.)

Mr Harrison told the Panel, "All the indications at that time were that we had acted reasonably; that the doctor on call had acted reasonably, and that there seemed little else we would have done in the circumstances. There was not a full investigation, because the issue was about communication - which is my main concern about this - had not been raised by the relatives back in May. It was when it came to Court in December that the issue around communication and not listening came to the forefront."

The "investigation into the circumstances" undertaken by Mr Mee produced a report dated 24th May which consisted of nothing more than a one page summary.

In fact very little, if anything, appears to have happened following the homicide until Peter's appearance at the Crown Court at Norwich on the 1st December 1995. The Judge at the hearing, Mr Justice Harrison, in sentencing Peter Horrod made no observations about the care given to him. However, Mr David Stokes QC, who appeared on behalf of Peter Horrod, in the course of his mitigation, made the following comments, "It seems to me to be futile and unattractive if one starts casting blame. The fact is that this man, twenty four hours before he killed his wife, was discharged back home at 2.30 in the morning, having just taken an overdose, with two periods of lengthy hospitalisation behind him. What on earth people thought they were doing sending him back home is one of the tragedies of this case. There it is. It may be that they did not spot something which they should have done with the dreadful result that he killed his wife." The case inevitably attracted media attention.

Following this Mr Harrison had a meeting with John Horrod on the 6th December 1995. After this Mr Harrison wrote to John on the

11th December 1995 enclosing a list of questions which he felt that John had indicated he would like addressed.

Mr Harrison arranged a further meeting on the 19th December. This meeting took place at the home of Debra Green. As well as Mr Harrison, John and Debra, there were also present Doctor McEvett, Robert Mee and Sister Norma Howe (then Charles.) Shortly before this meeting John had written a letter in reply to the one that he had received from Mr Harrison raising certain other questions which he felt should be addressed.

Following the meeting on the 19th December Mr Harrison wrote at length to John and Debra on the 2nd January 1996 setting out his replies to the questions that they had raised and also stating that it was agreed that certain action would be taken.

One of the actions that was agreed would be taken would be the introduction of a system which would provide for the more active involvement of relatives and carers in the treatment of patients.

A draft document entitled "Taking Account of Relatives and Carers Views" was subsequently drawn up and on the 29th January 1996. A copy of this document was sent with a letter to both John and Debra. The letter also referred to the appointment of a new overall manager for Ward Five.

Apart from the action outlined above, and of course the setting up of this Inquiry, it should also be recorded that Mr Harrison had a meeting with Doctor Santori on the 8th December 1995.

Although Mr Harrison's actions in arranging to have personal meetings with John and Debra were impressive and the draft document produced a very important step forward, we feel bound to observe that the Trust failed to comply with its obligations to hold an "immediate investigation to identify and rectify possible shortcomings in operation procedures, with particular reference to the Care Programme Approach, as provided by paragraph 33 of the circular." The "investigation" carried out by Mr Mee was perfunctory although, in fairness to him, he doubtless felt that that was all that was required. It seems manifestly clear that the Trust saw no need whatsoever to take any real action or launch any proper investigation, or even have any kind of dialogue with the relatives, until after Peter's appearance in Court when this whole matter became the subject of public scrutiny for the first time.

It was wrong that Debra and John should have had to wait until after the Court hearing before anyone made any real attempt to have any dialogue with them or listen to their comments and anxieties. In giving evidence to our Inquiry Mr Harrison conceded that there was no procedure in place for making immediate intensive enquiries following serious incidents of this kind.

Recommendation 15

PART J - SUMMARY OF DEVELOPMENTS SINCE MAY 1995

It is important to stress that, owing to a number of reasons none of which imply any criticism of anyone, the Independent Inquiry was not set up until 18 months after the homicide. This means inevitably that much has moved on and there have been many changes.

As has been recorded Peter Horrod spent two periods of time as an inpatient at Northgate Hospital, Great Yarmouth, between the 11th November 1994 and the 13th January 1995 and between the 17th April 1995 and the 12th May 1995. Northgate Hospital came under Anglian Harbours Trust which was a "first wave" trust set up in 1991. Prior to then inpatient psychiatric beds in Great Yarmouth were at St. Nicholas Hospital. This hospital was closed down in 1992 when the psychiatric beds were all moved to Northgate Hospital to which the Adult Mental Health Service was transferred.

During March to April 1995 a review of Mental Health Services at Anglian Harbours Trust was undertaken by the Audit Commission and Advisory Group and this group produced a final report in December 1995.

No useful purpose would be served by setting out, in our report, the conclusions reached by the Advisory Group. Suffice it to say that it reached conclusions which contained a number of criticisms and made certain recommendations the implementation of which would require fundamental changes.

Norfolk Health subsequently carried out a comprehensive assessment of the health needs of severely mentally ill adults under the age of 65 living within Norfolk Health Area to be used as a basis for future planning of these services. In January 1996 Norfolk Health published the results of this assessment in a document entitled, "Needs Assessment for Severely Mentally Ill Adults under 65."

The results of the assessment were accepted by the Health Commission.

Concerns were expressed about a number of issues including the worry that mental health services in Great Yarmouth, which Norfolk Health had identified as a "high need area" in terms of mental health would be placed at risk if Anglian Harbours Trust was unable to recruit the consultant psychiatrists it needed.

In its Annual Report 1995/1996 Norfolk Health stated, "This turned out to be the case and so Norfolk Health and Suffolk Health Authority jointly decided to transfer mental health services away from that trust as from the 1st April 1997 because they did not want to put the health services for local mentally ill people at risk."

As a result the mental health services formerly managed by Anglian Harbours Trust were transferred to the Norfolk Mental Health Care Trust on 1st April 1997 although the services have continued to be arranged locally in Great Yarmouth.

The Norfolk Health Annual Report 1995/1996 also refers to the production of a new mental health services strategy by the Norfolk Mental Health Care Trust.

This strategy has addressed many of the general issues which have arisen during the course of our Inquiry.

PART K - CONCLUSIONS

The Panel has examined carefully all the circumstances which led to the horrendous killing of Brenda Horrod by her husband Peter.

Whilst seeking to fulfil our terms of reference we have also been mindful of two factors. Firstly, a substantial number of inquiries of a similar nature have taken place over the last three years, many of which have reached similar conclusions and made similar recommendations. "Learning the Lessons" (Second Edition: July 1996) compiled by Dave Sheppard, Director of the Institute of Mental Health Law, very helpfully summarises a number of inquiry reports and sets out under appropriate headings the recommendations that have been made. Secondly, over the last 12-18 months there has been criticism from various quarters of the inquiry process. Questions have been asked - whether there are lessons to be learned from every violent incident and indeed, if there are, whether there are any more lessons that can be usefully learned from further inquiries.

Edward Petch and Caroline Bradley writing in the Journal of Forensic Psychiatry, Volume 8, No: 1, May 1997 (161-184), state, "It has not yet been established why psychiatric patients kill other patients. However, many inquiries in their reports imply that there is something psychiatric services can do to prevent this happening. The implication is that if a gold standard of care was provided, psychiatric patients would either not kill other people or would do so far less frequently. This is far from certain....."

The Panel has concluded that the killing of Brenda Horrod was wholly unpredictable.

The care package provided for Brenda, managed by the social worker Sarah Burton and organised by the Care Agency, was comprehensive. This would incidentally perhaps be an appropriate stage at which to express the Panel's sympathy for the terrible predicament in which the Carer of the Care Agency found herself placed on the night of the killing - only because she chose, out of care and concern for Brenda, to stay with her - notwithstanding the fact that Social Services had declined funding for this.

There is no single simple explantation for this tragedy. It came about as a result of a constellation of factors converging to produce the state of mind which led to Peter ending the life of a woman whom we are sure he loved.

Certainly his personality was a factor as was Brenda's condition. So was his mental illness which could have been related to an impairment of intellectual functioning. Peter may also have experienced a progressive feeling, through no fault of anyone, that he was losing control of his life, having given up his work

to look after Brenda and then having to accept that he was not able to fulfil that task without considerable outside support.

We would like to end this report by conveying our deepest sympathy to John Horrod and Debra Green for the terrible tragedy and loss that they have incurred. We hope that they may be able to derive some comfort from the fact that the circumstances of their mother's death have been rigorously scrutinised, issues have been addressed, lessons have been learned and improvements have taken place. That all this has happened is, we hope, in part, not only a comfort to her family, but in a sense some small tribute to Brenda's memory.

PART L - RECOMMENDATIONS

1 A review should be undertaken to consider the ways in which case notes on psychiatric inpatients are kept and what improvements might be appropriate. Particular regard should be had to the need to compile a comprehensive admission summary together with a chronological record of all significant matters including discussions between professionals and information provided by the patients' relatives.

D.2 (a)
F.4
H.14

2 Appropriate steps should be taken to ensure that an adequate number of psychologists is available to carry out neuro-psychological assessments when necessary.

D.2 (b)
F.3
H.16

3 The Health Authority and Trust should give consideration to the numbers of acute beds available to the population. This should be done in consultation with local psychiatrists and nursing staff. It should be recognised that it is unacceptable to have average occupancy levels approaching 100%.

F.2
F.3
H.4

4 A review should be undertaken of the way in which Community Psychiatric Nurse records are kept with a view to considering what improvements might be appropriate and provisions should be made for auditing such records.

E.6

5 An investigation should be made into the practicability of maintaining single mental health records for all patients irrespective of where they are treated or by whom.

D.2 (a)
E.6
F.4
H.14

6 All professionals involved in the care of psychiatric patients should be made fully aware of the need to be proactive in eliciting information from and obtaining the views of close relatives of the patient under their care. Leaflets must be made available to relatives emphasising the need for them to pass on appropriate information and ensuring that they are aware of the identity of the patient's key worker. Furthermore, relatives should, where

appropriate, be actively involved in planning the care and aftercare of the patient and care plans should be discussed with them. H.13

7 A review of discharge procedures should be carried out and regular auditing take place with emphasis being placed on the following factors:-

(a) the need for comprehensive multi-disciplinary information from all relevant professionals to be made available, together with information provided by and the views of relatives and carers where appropriate, before a decision to discharge is made;

(b) a requirement that the discharge plan formulated for the patient should be comprehensive setting out the name of the key worker, all other professionals involved, the facilities that will be made available to the patient in the community and procedures for monitoring the use of these and the attendance of the patient;

F.9
F.10
H.17
H.18

8 Where a patient is discharged from hospital and then moves to another district immediate steps should be taken for his aftercare arrangements to be formally transferred to the psychiatric services responsible for his care in the district into which he has moved.

E.4

9 An urgent review should take place of all day care and outpatient units with a view to ensuring that there is in place, for each facility, a clear and properly monitored procedure for following up patients who fail to attend appointments including provision for advising their General Practitioners and other relevant professionals involved in their care. E.3

10 Appropriate steps should be taken to address the issues regarding the assessment of and, if necessary, the admission to psychiatric wards of patients who have been admitted to accident and emergency departments following incidents of violence whether to themselves or to others. The need to establish an effective liaison service to the James Paget Hospital should be investigated as a priority.

G.4

11 Steps should be taken to review the effectiveness of the supervision and "back up" available to junior medical staff required to carry out psychiatric assessments in accident and emergency departments by consultant psychiatrists.

G.3

12 In addition, junior hospital doctors undertaking a psychiatric placement as part of their training should be given appropriate training in risk assessment and comprehensive guidance on the assessment of patients generally and circumstances in which it would be appropriate to seek the guidance of a consultant psychiatrist.

G.3

13 Where a patient has been admitted to hospital following an overdose or any form of self harming or any kind of suicide attempt, then the patient's GP should be advised by the hospital of this at the earliest possible time.

G.5

14 It should not be routine that all patients with a psychiatric history seen at Accident and Emergency after an overdose should be sent home by taxi. Judgment should be made in each individual case and, where appropriate, other travel arrangements made.

G.3

15 Careful consideration should be given to how trusts should hold immediate thorough investigations following violent incidents so that any shortcomings in operational procedures can be identified and rectified as soon as possible.

I