Practice, Planning and Partnership

The Lessons to be Learned from the case of Susan Patricia Joughin

A REPORT TO THE COUNCIL OF MINISTERS OF THE ISLE OF MAN GOVERNMENT

VOLUME I

MARCH 1997

To:
Mr JF Kissack,
Chief Secretary,
Office of the Council of Ministers,
Isle of Man Government.

In April 1996 you asked me :

> 'To review the arrangements made for the community care support of Susan Patricia Joughin and her children and to report on the appropriateness of those arrangements in the light of the state of her mental health, as diagnosed from time to time, and having regard to the relevant recommendations of the McManus Commission of Inquiry into Child Care.'

This is my report.

Alyson Leslie.

Dundee,
March 1997

INQUIRY TEAM

Inquiry Chairman:	Alyson Leslie
Counsel to Inquiry:	Elizabeth Parkes
Clerk to Inquiry:	Mona Christian
Court Reporters	Ivan Tressler June Martin

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CHAPTER 1

Introduction

The Offences of 21 February 1995

1.1 On Tuesday, 21 February 1995 at 11.51 pm, police officers were finishing their shift at Pulrose Police Sub-station when Susan Patricia Joughin arrived at the door. She was dishevelled, barefoot and bloodstained but, not obviously injured. She said she had injured her children. An officer was dispatched to her home, a few minutes' drive away and an ambulance was summoned.

1.2 The officer attending Ms Joughin's home nearby found, upstairs in an unlit bedroom, two little girls who were clearly the victims of a violent attack. Emergency assistance was given until paramedics arrived.

1.3 On arrival at Nobles Hospital, the younger child was pronounced dead and the elder child underwent surgery before air transfer to Walton Hospital, Liverpool. The prompt and professional response of police, paramedics and accident and emergency staff at Nobles (Isle of Man) Hospital proved crucial in her survival.

1.4 Meanwhile, Susan Joughin was taken to Police HQ, where she was initially deemed to be unfit for questioning. She was later able to co-operate with the police investigation and was subsequently charged with the murder of her younger daughter and the attempted murder of her elder daughter.

1.5 On 8 March 1996, Susan Joughin pleaded guilty to manslaughter on the grounds of diminished responsibility. She was detained under a Hospital Order, with special restrictions set and without a limit of time, and transferred to a secure clinic facility in the North of England specialising in the care and treatment of offenders with a mental illness.

The Background to this Inquiry

1.6 There was grave public concern that a tragedy of this kind could happen in the Isle of Man, where people place a high value on the close-knit nature of their society. People wanted to know what had happened, why it had happened and what could be done to reduce the chances of something like this ever happening again.

1.7 In June 1991, an Inquiry chaired by Miss Patricia McManus had been set up by the Isle of Man Government to investigate aspects of a complex child care case on the Island. In August 1992 Miss McManus reported her findings in respect of that case. In May 1994 she submitted her broader findings and recommendations in respect of child care practice, resources and legislation in the Isle of Man.

1.8 On sentencing Susan Joughin, on 8 March 1996, Deemster Cain said:

> ' I think the circumstances of this case are tragic and I think that there are no doubt lessons that can be learned for the authorities in the Isle of Man. I therefore recommend that the DHSS look into the circumstances which led up to this tragedy, particularly having had regard to the recommendations made by the McManus Report.'

The Setting-up of the Inquiry

1.9 In April 1996 I was asked to undertake an Inquiry with the remit :

> ' To review the arrangements made for the community care support of Susan Patricia Joughin and her children and to report on the appropriateness of those arrangements in the light of the state of her mental health, as diagnosed from time to time, and having regard to the relevant recommendations of the McManus Commission of Inquiry into Child Care.'

1.10 From the outset there was agreement that this Inquiry had to be impartial, fair, thorough and that its focus had to be as much on the lessons to be learned for the future, as establishing an accurate, factual record of what had happened.

1.11 Initially it was envisaged that only a small number of witnesses might be interviewed and that this could be completed in a few weeks. It very soon became apparent that a vast amount of information existed amongst the professional agencies on the island regarding Susan Joughin and that she had a complex history of mental illness, and of contact with health and social work services, which had to be thoroughly explored.

1.12 The response to this Inquiry's request for assistance was quite unparalleled in my experience. After the Inquiry was announced, a large number of people were identified or came forward who had contact with Susan Joughin in the weeks or months leading up to the events of 21 February, or who had important observations to make on her illness, her history and her contact with professional agencies.

1.13 I am grateful to Mr JF Kissack, Chief Secretary to Council of Ministers for the speed and efficiency with which he secured the necessary resources and arrangements for the conduct of the Inquiry and for his support and assistance throughout its duration.

Mrs Elizabeth Parkes

1.14 The most important form of assistance I was given from the Council of Ministers was the appointment as Counsel to this Inquiry of Mrs Elizabeth Parkes, an advocate in the Isle of Man.

1.15 Mrs Parkes undertook the mammoth task of co-ordinating the Inquiry timetable and of liaising with those witnesses whom I had identified as being able to assist me. To her fell the task of indexing the substantial amount of documentation which the Inquiry received. Within the Inquiry she had primary responsibility for questioning witnesses on matters and issues which had been identified as relevant to the Inquiry's remit.

1.16 I want to record my admiration for her considerable abilities, not least her astounding command of many thousands of pages of evidence, her advocacy skills and her extensive knowledge of Manx legislation and child care issues.

1.17 The Inquiry made excessive demands on all those involved in it, especially Mrs Parkes who, for many months, worked extremely long hours. Her unfailing good humour kept all of us going through very onerous days. I am indebted to Mrs Parkes not only for her advocacy and administrative skills, her meticulous preparation and commitment to the work of the Inquiry, but also for the facilities which her firm extended to me throughout the period of the Inquiry. The Inquiry quickly outgrew the accommodation which had been provided for it and I am grateful to Gelling Johnson and Farrant for all the assistance which staff there ably and cheerfully provided.

1.18 My thanks are also due to Mrs Pamela Pringle, advocate, who acted as Counsel to the Inquiry in one session.

The Inquiry Process

1.19 At a Preliminary Open Meeting on 24 May 1996, I set out the procedures under which the Inquiry would be run. I determined the Inquiry would take a predominantly inquisitorial approach. In other words, while having the formality and objectivity of judicial proceedings, it would not have the processes of cross examination and re-examination by advocates, as in litigation.

1.20 In the interests of fairness and to reassure witnesses, I adopted two measures which I trusted would give them a degree of confidence in the objectivity of the proceedings and ensure that their rights were upheld. First, it was agreed that anyone could ask to be accompanied to the Inquiry. A number of witnesses did choose to be accompanied. Some professionals were accompanied by advocates, others by their trade union representative. Second, where specific criticisms against professionals were made or inferred in the evidence of other witnesses, these were passed in written form to that witness prior to their attending the Inquiry, or put to them in the course of their evidence. I am grateful to witnesses who took the time not only to deal in their evidence with criticisms and potential criticisms but also provided, in some cases, detailed written responses.

1.21 I wish to express my thanks to all the advocates and representatives who attended the Inquiry. Their courtesy and co-operation was much appreciated.

1.22 Inquiries by their very nature are stressful and demanding. Many witnesses had their appointments to give evidence rescheduled, or deferred at short notice for substantial periods of time. This added to the pressures they had to face. I am extremely grateful to everyone concerned for their patience and tolerance and their willingness to be flexible and helpful. Inevitably tensions do arise when dealing with such serious matters as the death of a child, the resourcing of community care and the performance of professionals. The co-operation which was given was exceptional in my experience.

The Criminal Investigation

1.23 This Inquiry was entirely separate from the criminal investigation by the Isle of Man Constabulary of the events of 21 February 1995. The role of criminal investigation was to find out what had happened and who might have been responsible. The role of the Inquiry has been to find out why things happened.

1.24 I would like to thank the Chief Constable and Officers of the Isle of Man Constabulary for their invaluable assistance to the Inquiry. The Police made available to the Inquiry a vast amount of information which they had gathered in the course of the criminal investigation. This was extremely useful to me in identifying potential witnesses and sources of information. The assistance and co-operation of police officers at all stages of the Inquiry has been excellent.

1.25 Having studied the information relating to the criminal investigation in depth, I would also wish to pay tribute to Isle of Man Constabulary for the meticulous and sensitive way in which the criminal investigation was carried out. They laid the foundation on which I was able to build in terms of securing the co-operation of many witnesses and obtaining access to documentation. The Police interviewed over two hundred witnesses and potential witnesses for the criminal investigation. Many of their statements were of great value to the Inquiry because they were made so soon after the events being examined.

The Evidence - General

1.26 Oral evidence was taken from 107 witnesses. The Inquiry received 22 other written statements of evidence or submissions from individuals or organisations. The Inquiry also considered 156 witness statements made to the Police in February 1995. In total, the Inquiry dealt with over 17,000 pages of documentary evidence.

The Evidence - Documentation and Records

1.27 DHSS departments volunteered to submit records of their contact with Susan Joughin. Despite the considerable volume of information received in this way, obvious gaps in the chronology of Susan Joughin's contact with agencies and in the course of her illness emerged. The accuracy, adequacy and reliability of records was often deficient. Sometimes there were inconsistencies in accounts of the same events by different

professionals. In some instances, important information had not been recorded.

1.28 The problems Mrs Parkes and I encountered with records have meant that we had to spend an inordinate amount of time trying to cross-check information, date events accurately, establish the basis and source of information offered in evidence and, in some cases, reconstruct sequences of events which had not been recorded. A detailed and extensive chronology of file entries which Mrs Parkes produced has been invaluable in these tasks.

1.29 The Inquiry also requested information on policies, procedures and practices from various agencies. Information was also sought from agencies on the volume of work they undertook and the demand for the services they offered. This proved to be more difficult to obtain. Few of the agencies had the resources to keep statistics on the workload they carried or the demands they were trying to meet in the community. I am grateful to the personnel who endeavoured to compile some statistics, for the Inquiry as it proved to be a very time consuming task.

1.30 Additionally, the Inquiry sought or received information on current trends on research and practice in community care and child protection matters in the United Kingdom and elsewhere. This background information proved useful and some material was from time to time distributed to witnesses for comment and discussion. A selected bibliography of some of the most important material consulted is included at Appendix I.

The Evidence - Site Visits

1.31 The Inquiry made a small number of site visits to clarify some points of evidence. I am grateful to Mr and Mrs Adrian and Carole Bentley, Manager and Assistant Manager of Griddles Restaurant, who allowed Mrs Parkes and me to look round the premises, in order to understand the logistics of events which happened there on the morning of 21 February 1995. This was done after Mr and Mrs Bentley had given evidence to the Inquiry.

1.32 Susan Joughin's house was demolished in the late spring of 1996. I am grateful to Douglas Corporation and the community police officers at Pulrose Sub-station who arranged for me to see this location prior to its demolition.

1.33 I would also thank Mrs Parkes for her assistance in helping me to become familiar with the location of various places on the Island which were significant in Susan Joughin's history.

The Evidence - Witnesses to the Inquiry

1.34 The Inquiry heard evidence from 107 witnesses who attended between 17 June and 17 October 1996. A number of other members of the community offered assistance to the Inquiry. While their interest was much appreciated, their evidence was deemed to be either of limited relevance to the matters at hand or available from other sources.

1.35 All witnesses who gave evidence came voluntarily and evidence was taken in private on oath or affirmation. I am especially grateful to those witnesses whose evidence was given over many hours. Wherever possible, witnesses were made aware beforehand of the broad areas on which they would be asked questions. Inevitably, many other matters arose and had to be explored. Throughout the taking of evidence it was important to try to differentiate between what people knew at the time and what they knew now with the benefit of hindsight. The passage of time has meant that some people's recollections of matters relating to Susan Joughin were imperfect.

Evidence of Susan Joughin

1.36 The Inquiry sat for two days at the Scott Clinic in Liverpool taking evidence from Susan Joughin and from professionals most closely involved with the current management of her care and treatment. I should like to express my thanks to the Scott Clinic for all their assistance.

1.37 I am grateful to Susan Joughin for her willingness to co-operate with this Inquiry and to discuss in detail aspects of her life, illness and relationships. I appreciate her readiness to encourage and allow people who had contact with her, including her advocates, to provide evidence to the Inquiry. I should also like to thank Susan Joughin's present advocate, Ms Sally Bolton, for the considerable amount of assistance she has given to the Inquiry and for the evidence which she herself has contributed.

Evidence of Witnesses - Family, Friends and Social Contacts

1.38 I am grateful to all the family, friends and contacts of Miss Joughin who gave evidence to the Inquiry. Often their evidence was distressing and

given at great personal cost. The openness of witnesses and their willingness to assist the Inquiry, was commendable.

1.39 Many witnesses impressed me with their compassion, their commitment to caring for people in their community and their ideas for developing or improving health or social care services in the Isle of Man.

1.40 The evidence of all such witnesses was valuable, whether they were able to describe only one incident or a period of prolonged contact with Susan Joughin. I am sorry that it is not possible to pay tribute to all their contributions in more detail. However, I feel it is important to single out and comment on the contribution of two witnesses.

Miss FM Joughin

1.41 Miss FM Joughin is Susan Joughin's aunt who raised her from the age of nine months. Miss Joughin is a lady of formidable strength of character and integrity to whom many witnesses, including Susan Joughin herself, paid tribute. Miss Joughin's assistance to the Inquiry was invaluable. I am grateful to her for her willingness to recount personal matters relating to Susan Joughin's history and relationships and for taking time to explain to me many aspects of Manx culture and the history of her family. Her unique contribution to the Inquiry was much appreciated.

Mr Paul Killen

1.42 Mr Paul Killen is the father of Susan Joughin's daughters. Although profoundly affected by the tragedy, he offered the Inquiry every assistance. His frankness about his own troubled history and about his relationship with Susan Joughin, was very much appreciated. Mr Killen proved to be an informative and reliable witness whose recall of events was always either corroborated or provided corroboration of the evidence of other witnesses.

1.43 While in prison during 1994-95, Mr Killen corresponded with the then Ms Pauline Rayment, now his wife, on a daily basis. He also kept letters he received from Ms Rayment and from members of his family while he was in prison. Mr and Mrs Killen made available to the Inquiry this correspondence and the diaries which Ms Rayment had kept daily throughout that period.

1.44 The contemporaneous information about Susan Joughin and about contacts with professional agencies, which these materials provided, was highly informative. Mr and Mrs Killen have my utmost respect for their willingness to share with strangers their very personal correspondence and reflections, in the hope that these would assist the purpose of the Inquiry.

Evidence of Witnesses - Expert Witnesses

1.45 Expert witnesses were consulted by the Inquiry. They were independent persons with particular knowledge or skills in technical areas such as child protection, community nursing care for people with a mental illness or the psychiatric or psychological care and treatment of people with a mental illness. None of the experts knew or saw Susan Joughin nor were they given access to her case records. All of them were given a very brief outline of the circumstances of the offences. These careful arrangements were made to ensure that the evidence we received from these experts was objective and fair. They were not asked to comment on the actions of fellow professionals who had been involved with Susan Joughin. Most of the evidence from expert witnesses was taken off the Island, where it was possible to see a number of witnesses at one time.

1.46 I am grateful to all the expert witnesses for their input, for the information and documentation which they made available to Mrs Parkes and me and for their patience in explaining some of the technicalities of their area of expertise to us. All the expert witnesses were admirable for their command of their subject and the clarity and conciseness with which they presented their evidence.

1.47 I should like to pay particular tribute, however, to Professor Richard Bentall, Professor of Clinical Psychology at the University of Liverpool, whose evidence on the treatment of people with an mental illness, on inter-agency working and on community care was particularly informative and valuable. Professor Bentall also assisted the Inquiry in identifying other possible expert witnesses and facilitated some of those arrangements. He also made available to the Inquiry a number of papers which he had written or which were relevant to the matters being explored.

Evidence of Witnesses - Professional Staff

1.48 There were two groups of professionals who gave evidence to the Inquiry. First, professionals who had had face to face contact with Susan Joughin. Their evidence helped me to reconstruct various events and decision making processes which were not always clear from the case records of the various agencies. These witnesses were also given the opportunity to respond to criticisms and consider potential criticism which might have been made of their actions or decisions.

1.49 Evidence was also taken from supervisors of front-line staff and from more senior managers of the agencies which had contact with Susan Joughin and which were responsible for providing care and support. This evidence was important because the performance of professionals has to be looked at within the context of the agencies in which they are working, the level of supervision they receive, the standards which are expected of them by their professional associations and their employing agencies, the resources available to them to carry out their work and the training and guidance they are given.

1.50 I appreciate how difficult giving evidence was for many professionals. When a tragedy of this nature occurs, very difficult and searching questions have to be asked. The judgements, practices, knowledge base and skills of many professionals are called into question, and criticisms are voiced. I am grateful to all the professional staff who gave evidence for their willingness to submit voluntarily to rigorous questioning about their contact with Susan Joughin or their involvement at management level in the provision of care services. I want to acknowledge the openness, dignity and composure of witnesses in coping with the pressures and demands of the Inquiry.

1.51 Where it has appeared to me that there were shortcomings in the practices or performance of individual workers, I have sought to establish whether these were due in any part to deficiencies in the training of the individual worker, the instructions or supervision they were being given by their managers, lack of resources, or the strategies, procedures and policies being pursued by the agency within which they were working.

1.52 A number of senior managers from government agencies on the Island assisted the Inquiry by providing evidence on organisational and management development, strategic planning and operational procedures.

They also helped me look at the feasibility of possible changes in policy or practice. I am grateful to everyone who has contributed to the process of developing the recommendations included at Chapter 7 of this Volume. Most of the recommendations which appear in this report have been discussed with at least some of the managers who would be responsible for their implementation, and would appear to have their support.

1.53 Managers and staff were frank about difficulties within their own services or in liaison with other services. Where professional witnesses gave evidence of existing difficulties in liaison with other services, I have drawn these to the attention of the relevant agency and asked for them to be addressed. The response has been positive in each case.

Evidence of Witnesses - Government Officials and Douglas Councillors

1.54 The Inquiry received evidence from former Douglas Corporation Councillor, Mr Peter Warriner, and from two MHKs, Mr David Cretney and Mr Stephen Roden. Their evidence was extremely useful in helping me to understand the local and national political context of Manx community care provision. I am grateful to Mr Warriner, Mr Cretney and to other officials who made available to the Inquiry correspondence they had received from Susan Joughin and who provided insights into her condition and history from their contact with her. I was impressed by the care they had taken in trying to assist Susan Joughin and by their desire to see levels of support for people with a mental illness strengthened on the Island.

1.55 In addition to his advice and evidence to the Inquiry in respect of the strategic role of housing in community care, Mr Roden also provided useful information to the Inquiry from his perspective as a practising pharmacist. I am grateful to him for all his assistance.

The Inquiry Findings

1.56 When an Inquiry looks in detail at the operation of agencies and the performance of professionals, it will inevitably see every flaw, crack and deficiency. The task of this Inquiry has been to try to differentiate between the flaws and fault-lines which exist in all human enterprises and those which were relevant to the level and quality of care and treatment Susan Joughin received, or which are likely to have an adverse bearing on the ability of agencies to provide community care in the future.

1.57 Because of the kind of questions which Inquiries have to ask, the focus of their findings tends to be the aspects of organisations that are not working well. I am conscious that because everyone is anxious to identify and resolve any problems in the provision of community care services, this Report looks predominantly at why some things did not work and how practices or procedures should be improved.

1.58 I do want to acknowledge, however, that, in the course of this Inquiry, I learned about much good practice and high standards of professionalism present at different levels in different organisations. It is my hope that the recommendations of this Report will support the extension of good practice initiatives and reinforce the work of committed professionals.

Further Acknowledgements

1.59 I would also wish to express my thanks to the Attorney General of the Isle of Man for his assistance in a number of matters related to the gathering of evidence. In particular, I would thank him for facilitating arrangements to ensure that Susan Joughin had appropriate legal advice and representation when giving evidence to the Inquiry and for arranging the appointment of Mrs Joyce Quine, an independent social worker, who was of assistance to the Inquiry in identifying possible sources of evidence.

1.60 The practical and logistical arrangements for the Inquiry were a huge task and I am extremely grateful to Mrs Mona Christian of the Chief Secretary's Office for all her valuable assistance in her role as Clerk to the Inquiry. Thanks are also due to her colleague administrators at Government Offices who assisted us from time to time and to Mrs Donna Wilson of Gelling Johnson Farrant for all the help she gave me.

1.61 The transcription work for the Inquiry was undertaken by Mr Ivan Tressler and Mrs June Martin of Harry Counsell and Co., London. Their service was impeccable. They worked extremely long hours to ensure we received the next morning, the transcripts of the previous day's proceedings. The accuracy of their work and their sensitivity to witnesses was excellent. They greatly assisted the work of the Inquiry and their flexibility and readiness to help out was much appreciated.

1.62 Some professionals who came to give evidence on specific aspects of Susan Joughin's case, also assisted me by providing more general evidence from their vast experience and expertise. In particular I am grateful to Dr

James Higgins, Consultant Psychiatrist at Scott Clinic in Liverpool, who, as well as providing assistance with regard to the evidence of Susan Joughin and the features of her mental illness, patiently and clearly explained to us some of the biochemical and physiological processes of various forms of mental illness. I also wish to thank Mr John Wright, advocate, not only for the co-operation he offered the Inquiry in his capacity as advocate to DHSS, but also for the assistance and evidence he provided in relation to Manx child care law, an area in which he has special expertise and vast experience.

Matters Falling Outwith the Scope of the Inquiry

1.63 In the course of this Inquiry, a number of matters were brought to my attention which were a cause of concern to me but which I believed fell outwith the scope of this Inquiry. Some of these matters related to Susan Joughin and others related to other people with mental health problems in the community or to the care and protection of children. Where such matters have been raised in the Inquiry I have brought them to the attention of relevant professional agencies and asked them to investigate and assess this matter.

Terminology - (I) - 'Care Management'

1.64 A number of commonplace phrases relating to community care have taken on specialised meanings in professional circles since the introduction in the United Kingdom of the NHS and Community Care Act 1990. 'Care management' in the UK now refers to the process undertaken by social workers or community nurses of purchasing services such as home care, day care, occupational therapy assistance to meet the needs of a person with serious illness or disability. This usage is not applicable in the Isle of Man.

1.65 The term 'care management' in this Report is used in its Manx context and simply refers to any process of arranging and co-ordinating care services

Terminology - (II) -'Care in the Community' and 'Community Care'

1.66 Before proceeding to look at the community care arrangements for Susan Joughin, I want to clarify what is meant by the term 'community care'. The term 'care in the community' has been coined in the United Kingdom to describe the programme of discharging people with a serious mental illness from long-stay hospitals into the community. Problems, and even

fatalities, have occurred in the UK in recent years because of a lack of adequate support and monitoring for some former patients.

1.67 In the Isle of Man, efforts have been made in recent years to provide accommodation for people with serious mental health problems in a supportive environment in the community rather than in long-stay hospital beds. While the Inquiry has not looked in any detail at this hospital discharge programme, it is clear from the evidence of senior DHSS staff that the programme has been carefully planned and that a small number of former patients have been accommodated in a well-supported environment. It is important to stress, however, that Susan Joughin was not part of this programme and was never considered a 'long-stay' patient.

1.68 'Community care' simply means the care which is provided to people with physical or mental problems outwith a hospital environment. This care may be provided by professionals, by family or by friends. The needs of people with a mental illness will vary considerably from individual to individual. This has two vital implications for community care:

i) The needs of each individual have to be carefully assessed and responded to. This assessment must take into account the needs of those who are assisting in the care of people with a mental illness, such as family, friends, and those who are affected by those people with mental illness, such as partners, family or children. The assessment must also note the wishes of the patient or client and whether their illness will affect their ability to accept or respond to help offered to them.

ii) Because the support and assistance mentally ill people require will vary, it cannot usually be provided from one source. It is vital, therefore, that the various services involved co-ordinate their activities, collaborate in the assessment, planning and delivery of services, and liaise effectively over any change in the needs of the individuals for whom they are caring.

1.69 Community care is not the province of any one agency. While health and social service agencies may provide the largest input to individuals or groups of clients or patients, other services such as housing, social security, local pharmacists and community police officers may all have an important part to play in responding to the needs of individuals or groups of people with mental health problems. It is important that all professionals who have a role in dealing with people with a mental illness have a knowledge of such illness appropriate to their role and are aware of where they can secure more substantial assistance or support for anyone about whose mental health they have concerns.

1.70 People who have a mental illness, and those who befriend and care for them, need to be aware how they can secure advice and support, where health and social work agencies are based and how to make contact with them. They need to know what resources, benefits and assistance are available and how they can be readily accessed.

1.71 Community care for people with a mental illness brings special challenges. Mental illness occurs in many forms and many degrees of severity. It is not always immediately obvious that someone has a mental health problem. Sometimes some forms of mental illness can cause behaviour which is difficult or demanding for families or professionals to deal with.

1.72 All of us come into contact with mental illness, and most of us have fears or uncertainties about what mental illness is and how to respond to people who are suffering from it. Greater efforts have to be made to dispel myths about mental illness and to eliminate the stigma that sometimes surrounds it. Only as all of us learn about mental illness, can each of us play our part in caring for those members of our communities who suffer its effects and consequences.

Structure of this Report

1.73 This report has been prepared in two volumes. This first volume includes an account of the events of 21 February 1995 (Chapter 2), my findings in relation to the community care arrangements for Susan Joughin and her children (Chapter 3), my findings in relation to the McManus Report recommendations in respect of community care arrangements for Susan Joughin and her children (Chapter 4), comments on matters outwith the remit of the Inquiry (Chapter 5), a discussion of the direction future

developments in community care and child protection should take (Chapter 6) and recommendations (Chapter 7).

1.74 The second volume contains a detailed social and psychiatric history of Susan Joughin (Chapters 8 and 9), a commentary on professional interventions with her (Chapters 10 and 11) and a commentary on standards of community care case recording and file notes (Chapter 12).

1.75 Three appendices to Volume II give a selected bibliography (I), a list of Susan Joughin's admissions to Ballamona Hospital (II) and a list of witnesses who gave oral evidence to the Inquiry (III).

1.76 In order to protect the interests of Susan Joughin and her surviving daughter, I would ask that Volume II of this report have a restricted circulation and that the matters therein relating to Susan Joughin's psychiatric history and her children's social history are treated with due sensitivity and respect.

Publicity

1.77 I have appreciated the co-operation of the media in limiting the reporting of this Inquiry. While accepting that the subject matter of this Report is of great public interest, I would ask that consideration is given to the position of Susan Joughin's family and in particular, her young daughter. I would urge the media to show restraint in reporting any aspect of this Report. I ask for the sake of this young child that nothing relating to the case of Susan Joughin be reported in a sensational or dramatic way that would cause distress.

The Way Ahead

1.78 Nothing which this Inquiry achieves will change the tragic consequences of events of 21 February 1995. The loss of the life of a four-year old child is especially sad: not only has her family lost the quiet, beautiful, little girl they loved, but also the community has lost all the potential that child had to become and to give as she grew up. Nothing can make amends for that. However, if by the lessons learned from this tragedy, the quality, resilience and effectiveness of community care in the Isle of Man is strengthened, then she will have made an important contribution to the society in which she so briefly lived.

1.79 I believe that the constructive and positive co-operation this Inquiry was given is proof of the depth of goodwill and community spirit that exits in the Isle of Man. I trust this augurs well for taking forward the recommendations of this Report.

CHAPTER 2

The Events of 21 February 1995

Background and History

2.1 I have prepared, in Volume II at Chapters 8 and 9, a detailed history of Susan Joughin, her background, her contact with professional agencies and her illness in order to:

i) show how I have arrived at my conclusions about the adequacy and appropriateness of the community care arrangements for Susan Joughin in the light of the knowledge professionals had about her illness;

ii) reconcile some of the ambiguities, correct some of the inaccuracies and fill in some of the gaps in the various records relating to Susan Joughin.

2.2 It is a matter of some concern to me that prior, to February 1995, no detailed social or psychiatric history of Susan Joughin had ever been compiled. Over the years, professionals have sometimes responded to Susan Joughin on the basis of assumptions they have made or inherited about her rather than on the basis of accurate factual knowledge. For this reason, I have endeavoured to check every 'fact' presented to the Inquiry.

2.3 The social and psychiatric history in Volume II has been compiled from medical, nursing, social service, housing and social security files, and from the evidence of family, friends, professionals and other people with whom she came into contact on a regular basis. It covers fifteen years of Susan Joughin's life and examines in detail the features of her illness, her relationships, the contacts she had with professional agencies and the operation of those agencies. As it includes intimate details of Ms Joughin's psychiatric and medical history, I believe, in fairness to her, to her surviving daughter and to members of her family, the material should have a strictly limited circulation.

2.4 I have summarised below (paras. 2.6 - 2.14) the status of community care arrangements for Susan Joughin by 21 February 1995.

2.5 However, I believe a full account of the events of 21 February 1995 should be in the public domain because:

i) in the course of the Inquiry it became apparent that a number of inaccurate stories were circulating about the events of that day. In some cases these were causing distress to the people involved or to people close to Susan Joughin;

ii) Susan Joughin's behaviour, contacts with members of the public and with professionals on that day illustrate some of the immense difficulties faced by people with a mental illness and those who try to help them. It is my hope that insight into these difficulties may help raise awareness of mental health issues.

Summary of Susan Joughin's Community Care Arrangements

2.6 In February 1995, Susan Joughin, then aged 41, was living with her daughters, then aged 7 years and 4 years, in Lower Pulrose, Douglas. She had an extensive and complex history of mental illness and had been admitted to Ballamona Hospital 14 times between 1980 and 1992. By 1992, professionals from health and child care services had met formally on three separate occasions to respond to a need for closer inter-professional co-operation in the management of her case.

2.7 Susan Joughin's illness could be so severe, causing such disturbance and distress to her, that at times she was unable to look after herself or her children. This had caused some professionals at times to fear she might unintentionally harm her children when acutely ill. Professionals believed it was important that any indication of her becoming acutely ill was detected early. It was also considered important that she regularly took medication which helped to stabilise her condition. It was known that Susan Joughin was extremely reluctant to take any medication and frequently failed to do so.

2.8 Medical personnel knew that Susan Joughin suffered from a chronic mental illness, with acute exacerbations of her condition occurring at irregular and unpredictable intervals. The nature of her illness was such that acute episodes were likely to recur. The likelihood of this happening would be increased if she were not taking medication. She could have long periods without acute episodes of illness necessitating hospital

admission. Sometimes her hospital admissions recurred within days or weeks of discharge, at other times they were a year or more apart. The longest spell she had without an admission to hospital, prior to February 1995, was thirty-four months between 1984 and 1987.

2.9 In August 1992, following Susan Joughin's latest discharge from hospital, representatives of health and social service agencies met to discuss how they could avoid the children being adversely affected by their mother's bouts of acute mental illness. The approach agreed was that Susan Joughin would be followed up at weekly intervals by a consultant psychiatrist at an out-patient clinic where she would be given her medication or issued with a prescription for it. This contact would decrease to fortnightly if her condition remained stable. Susan Joughin would also be visited weekly, on a rota basis by a health visitor, community psychiatric nurse (CPN) and a social worker. They would liaise closely and review together their involvement with her. It was known that stress was detrimental to Susan Joughin's mental health and that attempts should be made to reduce this. One of the ways she was assisted was by Social Services Department (SSD) making funds available for her daughters to attend playgroups, to give her some respite.

2.10 By February 1995, however, although Susan Joughin was still seeing a CPN at 4-6 weekly intervals, she had not seen a psychiatrist for 20 months. She had not been followed up by psychiatric services after missing at least seven consecutive appointments. Her last prescription for medication was issued in August 1993 and was for two weeks' supply of drugs. She had had no contact with Social Services for 11 months. She changed GP in October 1994 but was removed from her new GP's practice list a month later, by one of his partners, without either GP having ever seen her. She was without a GP until 14 February 1995.

2.11 The intentions of professionals for effective inter-agency liaison, regular contact with Susan Joughin and for systems to respond rapidly to any change in her mental health had faltered or been changed on the assumption Susan Joughin was 'well'.

2.12 There is no evidence that Susan Joughin ever made threats against or actively tried to harm her children when in a chronic phase of her illness. There is, however, evidence that at times the children were unsettled and experienced some deprivation when she was not functioning well. Her

unpredictability caused them some distress and at times disrupted the normal flow of events in their lives. Even when not acutely ill, Susan Joughin's chronic condition, with its attendant mood swings of varying intensity, coupled with her unreliability and her tendency to pursue unrealistic ends, meant that, despite her good intentions, her care of her daughters and of herself was inconsistent.

2.13 The need for regular support and supervision was heightened by the unpredictability of the recurrence of the acute phases of Susan Joughin's illness, during which she could become violent and delusional. Her potential to neglect the children when becoming ill, or to harm them unintentionally when ill was known to several professionals. Susan Joughin had even told nursing staff at Ballamona Hospital that she did not trust herself when she was ill.

2.14 Susan Joughin was last seen by a CPN on 18 January 1995, five weeks before the incident of 21 February. The CPN did not know she had not been seen by a psychiatrist for over 18 months. He was also unaware she had not had medication in that period. It is my view that Susan Joughin could not have been receiving an adequate service from a CPN who was ignorant of this basic information about the status of her psychiatric care. I also believe, however, that the situation should never have arisen whereby this practitioner was alone in carrying the responsibility for such a complex and problematic case.

Events Leading up to 21 February 1995

2.15 It would appear that, in late December 1994, the mood swings Susan Joughin suffered became more pronounced. She was facing numerous pressures, including poor housing, financial problems and harassment from local youths. By mid-January, she was trying hard but struggling to care for her daughters. By mid-February, Susan Joughin's mood was fluctuating considerably and her behaviour was extremely bizarre at times. She was losing touch with reality on occasions. During the week leading up to 21 February her moods varied from weepiness and depression to elation and excitement. At times, however, she appeared calm and lucid and was able to hold short conversations with neighbours about everyday matters.

2.16 Over the weekend of 18-19 February, Susan Joughin carried the contents of her living room and kitchen on to the open ground adjoining the street

where she lived. She later moved most of the furnishings back in the house. Neighbours were not unduly concerned as she had done this previously, most recently a couple of weeks before.

2.17 Susan Joughin has subsequently indicated that during the days leading up to 21 February 1995 she had thought people were able to read her mind.

Tuesday, 21 February 1995

2.18 Tuesday, 21 February 1995 was the last day of the school half-term holiday. Susan Joughin set off with her daughters early in the morning for town to collect her Child Benefit. She stopped on the way at a local shop to buy sweets for her children but became confused because she did not have enough money, around 60p, and left.

2.19 Susan Joughin seemed quite cheerful when a neighbour passed her making her way through town, a short time later. She then spoke to an acquaintance at the bus station just before 10 a.m. Her conversation was rational for a few moments and then she became 'vacant' - as if she could not continue the conversation. She was asked if she was all right and her reply was to say her acquaintance's name over and over. Susan Joughin went on to the Post Office where she was known to staff by sight. She seemed subdued but otherwise fine.

2.20 Ten minutes later, Susan Joughin met a friend who found her to be having difficulty concentrating and following their short conversation. Susan Joughin then went into Griddles Restaurant where she was recognised and spoken to by a member of staff from her children's school. She seemed lucid and rational during their brief conversation. This person noticed nothing strange about Susan Joughin except that her hands were filthy.

2.21 The girls meantime had gone to play in the excellent play area upstairs . They had often visited Griddles with their mother. Normally, she would sit just outside the play area and watch them, but this day she stayed downstairs. From time to time the girls came downstairs to see their mother.

2.22 Susan Joughin remained in Griddles over an hour and a half. Some people who noticed her and recognised her thought she seemed fine.

Another person reported that she was sitting staring, looking distant and strange. She was seen by another customer to be sitting with her head in her hands, looking distressed. Susan Joughin bought items of food at different times from the self-service counter. Again, her concentration and demeanour varied. While one assistant saw nothing unusual about her, another noticed Susan Joughin had problems working out the value of money and stood staring into space for a time.

2.23 On one occasion when she approached the counter, she was served by the assistant manager, Mrs Carole Bentley. Susan Joughin simply stood looking blank for some moments when asked what she would like. She finally ordered some toast but again had difficulty sorting out her money and this had to be done for her by Mrs Bentley.

2.24 Eventually, at the urging of her daughters, she rose to leave. As the three of them reached the door, the older girl, who was slightly ahead of the others, walked out into the street. Susan Joughin suddenly closed the door behind her elder daughter and turned and sat down again. She sat at a table looking 'vacant'. Her younger daughter was seen to become upset. Susan Joughin picked her up and sat with her on her lap swaying back and forth.

2.25 Mrs Bentley had witnessed these events and became concerned about the older girl, who had set off, not realising her mother was no longer behind her. Susan Joughin seemed oblivious that her daughter was missing.

2.26 Mrs Bentley hurried out of the shop and caught up with the older girl several hundred yards along the road. She explained to her what had happened. The child quite readily took Mrs Bentley's hand and went back with her to Griddles. She told Mrs Bentley her mother was 'not very well today'. When she got back to the restaurant, the two sisters again went upstairs to play. Susan Joughin remained downstairs, sitting at her table with her head in her hands.

2.27 A few minutes later, Susan Joughin suddenly turned to a customer who was leaving the restaurant and asked her to get a doctor. The customer passed on the request to a member of staff. Mrs Bentley was now extremely concerned about Susan Joughin, who clearly had no idea what her daughters were doing or where they were.

2.28 Mrs Bentley decided to approach Susan Joughin. She took pains not to alarm her or cause her distress. She knelt down to speak with her and tried to find out whom they might contact to help her. Susan Joughin's response was garbled. Her first words were: 'The vicar would like a cup of tea.' She then said: 'Dr Gavin would like a cup of tea.' Dr Gavin was a GP in Douglas to whose practice Susan Joughin had been allocated only a few days before. She had never seen Dr Gavin.

2.29 Mrs Bentley consulted her husband, Mr Adrian Bentley, the manager of Griddles. They both knew Susan Joughin by sight but not by name. She had been in the restaurant several times but had never previously behaved like this.

2.30 Mrs Bentley decided to try contacting Dr Gavin at the Kensington Group Practice. The practice had only just received notification that Susan Joughin had been assigned to them. She had not been seen there.

2.31 The call to the practice was taken by a receptionist to whom Mrs Bentley briefly explained the situation. The receptionist relayed this information to one of the GPs who was in the office area, between seeing patients. His advice to be passed on to Mrs Bentley was that she should call an ambulance.

2.32 After her call to the GP practice, Mrs Bentley recognised one of the customers in the restaurant as a former nurse. She approached her, explained the situation and asked her to help. Ballamona Hospital was contacted and the switchboard there passed the call on to Ambulance Control.

2.33 Mrs Bentley explained the situation to the Ambulance Controller. She expressed her concern about a customer being unwell and not being in a fit state mentally to look after her two little girls. She said she thought it was important not to frighten the woman and asked if the ambulance could go to the back of the shop - she did not want it to arrive with sirens blaring lest it alarm the woman. She asked if the ambulance personnel could wait at the door and she would meet them and bring Susan Joughin to them. She realised Susan Joughin might need reassurance and coaxing to go in the ambulance.

2.34 An ambulance was dispatched with two crew members. The controller also contacted the Accident and Emergency Department at Nobles Hospital and advised them that the ambulance would be bringing in a mother and two children. Someone at the hospital undertook to contact Social Services Division when the children arrived. However, because Susan Joughin was never taken to hospital, Social Services Division was not contacted.

2.35 The ambulance arrived at Griddles at 11.22 am. By this time Susan Joughin had been in the restaurant for almost an hour and a half. The paramedics came to the back door and proceeded into the shop. This was not what Mrs Bentley had requested. However, the paramedics were concerned to move promptly to assess the situation in case someone needed urgent help. Mrs Bentley went to fetch Susan Joughin who initially reacted positively. Mrs Bentley then went to collect the children. She explained to Susan Joughin that the paramedics were there to help her and asked her to come and talk with them.

2.36 One of the paramedics immediately recognised Susan Joughin as a former Ballamona patient and began talking to her. Mrs Bentley noticed that Susan Joughin 'suddenly seemed to realise something was going on and pulled herself together'. According to one of the paramedics, prior to this point she had appeared to be 'zombified'.

2.37 The senior crew member asked Susan Joughin what the problem was. She replied she had sinus trouble. He asked her if she was on medication and she replied: 'I'm all right, I don't need medication but if I do I can get some.' She was asked if she wanted to go to hospital. She said: 'No'. She was then asked to sign a form to say she had refused treatment. There was mention made by one of the paramedics of the police having to be involved if she did not sign the form. Susan Joughin signed the form then hesitated. She turned and asked one of her daughters: 'Do you think we should go for half an hour or not?' The child just looked puzzled. Susan Joughin then said she thought she had signed the wrong thing. The paramedic assured her it was all right and told her to go straight home. Susan Joughin then wandered out of the shop with her children.

2.38 Mrs Bentley protested that she felt Susan Joughin needed help and was not capable of being in charge of two young children. She states she was told by one of the paramedics: 'This is as good as she gets.' The

paramedic does not recollect making this remark. However, as Mr Bentley states he was told: 'She is like that all the time.' I believe that words to this effect were used by a paramedic to describe Susan Joughin.

2.39 Mrs Bentley was worried about the children and asked what would happen if one of them were hurt. She became upset and tried to persuade the paramedics to do something more. She felt they had not listened to her concerns and that the assessment of the situation had been cursory and not geared to the needs of someone whom she believed was seriously mentally ill. Having heard evidence from all the persons concerned, I would agree with her entirely.

2.40 The senior paramedic conceded in evidence to the Inquiry that he had 'probably made the wrong assessment'.

2.41 On leaving Griddles, Susan Joughin and her children caught a bus to Pulrose. A neighbour who saw her on the bus thought she looked 'down in the dumps'. She was familiar by sight to the bus driver, Mr Charles Cowley. He was surprised that she did not get off the bus at her usual stop but instead continued past it for three more stops. Susan Joughin then approached Mr Cowley and asked if the bus could take her to Ballamona Hospital. She did not appear to be upset or distressed. Mr Cowley explained that Ballamona was not on the bus route. He had no radio in the bus with which to call for help and she did not appear to be in need of emergency assistance. He drove her to the next stop and pointed out to her the house of an acquaintance of his, near the bus stop. Mr Cowley suggested Susan Joughin call in there and ask to use the telephone to get an ambulance to take her to Ballamona. In my view, Mr Cowley acted appropriately in the situation.

2.42 On leaving the bus, Susan Joughin did not take up Mr Cowley's suggestion of phoning an ambulance. Instead, she and the girls crossed the road and took a bus back into town. A neighbour who saw her thought she looked happy. She and her daughters spent an hour wandering around the shops then took a taxi home. The taxi driver noticed nothing untoward about her.

2.43 For the remainder of the afternoon and early evening, the girls played with their friends. Susan Joughin's mood seems to have fluctuated throughout the rest of the day. Shortly after returning from town, she

was seen by a neighbour's child speaking lovingly to her elder daughter. A little later, the child saw Susan Joughin sitting with her head in her hands and wondered if she was ill. Susan Joughin then became upset and angry. She seemed unable to prepare food for the children's tea. Then, shortly afterwards, she was seen outside happily playing with her daughters.

2.44 Later in the evening, Susan Joughin and her daughters were seen by a neighbour walking in Laburnum Road. Susan Joughin exchanged greetings with the neighbour and seemed fine. A few minutes later she went into a shop alone and bought milk, crisps and sweets. She seemed to have difficulty talking, barely able to enunciate the words. The family returned home. A little later Susan Joughin was observed in the field behind her house, walking round in circles with her head bowed.

2.45 Later that evening she was heard from the street shouting in her house. This was not uncommon.

2.46 Nothing more is known of her actions until she walked into Pulrose Police Sub-station shortly before midnight to report she had attacked her children. Subsequently, Susan Joughin has indicated that she remembers little of the events of that night except that she sensed that her children were in great danger and she had to act to save them. It seems that, in her disturbed mind, she believed they were all caught up in events of cosmic significance and that she was protecting her daughters by attacking them before they were overpowered by a greater evil.

2.47 Something of the state of her mind can be gauged from the contemporaneous records of psychiatrists and others who saw her in the days after the offence. She was experiencing hallucinations, delusions and profoundly disturbed thoughts. She believed external forces were controlling her thoughts. Dr James Higgins of the Scott Clinic, Liverpool, who is now treating her believed:

> '....she was suffering from a severe abnormality of mind resulting from an acute exacerbation of her long-standing schizophrenic illness .... the symptoms of her condition...... caused her to feel that she and her family were under such a cataclysmic threat [and] caused her to act as she did.'

Commentary

2.48 On 21 February 1995, Susan Joughin did not receive the best possible response from the Ambulance Service. However, I want to make it clear that the tragedy which followed cannot simply be attributed to the shortcomings of that response. The roots of problems in the provision of community care for Susan Joughin go back many years.

2.49 The variations in Susan Joughin's behaviour on 21 February, and at other times when she was less acutely ill, are typical of some forms of mental illness. They demonstrate how difficult it can be, even for professionals, to determine the existence and severity of symptoms of mental illness. The problems faced by professionals were exacerbated in this case by Susan Joughin's unwillingness to accept she was suffering from a mental illness and by her capacity to allay the concerns of professionals and to discourage their further involvement with her.

2.50 During the onset of earlier acute episodes of her illness, and sometimes even when in hospital, she was able to present herself for short periods of time in a positive light to professionals. Hospital nurses who had seen in Susan Joughin signs of mental disturbance, recounted seeing her shortly afterwards pull herself together and give a plausible account of herself to a doctor coming into the ward, in order to be discharged.

2.51 Assessment of mental illness normally requires to take place over a reasonable length of time - it cannot be done in a few minutes or by brief observation or superficial conversation. Assessment has to explore whether the presenting behaviour of a patient who appears lucid and rational is indicative of mental stability, or of a temporary phase within a period of illness. Assessment will usually include seeking independent corroboration of the patient's account of recent events and current capability to care for themselves. This was rarely done in Susan Joughin's case. Professionals too readily accepted her accounts of events or her assurances that she was well and did not routinely check information she gave them.

2.52 The features of some forms of mental illness sometimes mean that some patients are not easy to deal with. Evidence to the Inquiry suggests that Susan Joughin was articulate and intelligent but could also be argumentative, demanding and difficult. Her inconsistency and unreliability were wearing. Her stubbornly unrealistic ideas and

intentions, and her refusal to acknowledge her difficulties or to accept she was ill, made work or contact with her frustrating.

2.53 Health and social services have to be organised and managed on the basis of responding to the needs of all the people in the community they serve regardless of how different, difficult or downright awkward they are. In dealing with the needs of people with mental illness, health and social care staff must be able to work together efficiently across traditional professional barriers. This is essential to ensure adequate assessments of patients or clients to provide the best and most accurate information about the patients' needs.

2.54 Accurate and comprehensive information and good inter-agency co-ordination will enable professionals to use creatively their reservoir of skills and knowledge in finding ways to engage with and respond to the needs of patients. For people with a recurring mental illness who have little insight into their condition, or try to mask their illness, that response will include ensuring a network of monitoring and support which can alert relevant agencies when problems arise or a patient's condition deteriorates. This did not happen consistently in Susan Joughin's situation.

2.55 It was not the case that Susan Joughin slipped through the net: the problem was that by 21 February 1995, there was no net.

CHAPTER 3

Findings of Fact and Conclusions

FACTS

The Features of Susan Joughin's Illness

3.1 Susan Joughin has suffered from a chronic psychiatric illness from at least 1980 onwards, a feature of which has been recurring acute episodes.

3.2 There is no definite pattern to the occurrence of acute episodes of her illness. Between 1980 and 1992, Susan Joughin was admitted to hospital on fourteen occasions. The shortest gap between admissions was three days; the longest gap was thirty-four months.

3.3 Serious psychotic or depressive symptoms of Susan Joughin's illness may develop suddenly or have a more insidious onset over days or weeks.

3.4 When she is acutely ill Susan Joughin's behaviour and reactions are unpredictable. She can fluctuate between periods of withdrawal or apathy and outbursts of violent or aggressive behaviour. She is also prone to hallucinations, delusions and disturbed thought patterns.

3.5 Susan Joughin's chronic condition makes her prone to mood swings of varying intensity, which sometimes cause debilitating depression and at other times cause her to act in a hysterical or over-excited manner.

3.6 There is no evidence that Susan Joughin was ever free of the effects of her chronic condition between 1980 and 1995.

3.7 Susan Joughin's condition is treatable by medication which can minimise the likelihood of an acute phase recurring and can reduce some of her chronic symptoms. Susan Joughin did not take medication regularly prior to February 1995, apart from one period during 1984-85. The chances of an acute episode recurring increased the longer she did not have medication.

3.8 Susan Joughin is an intelligent, articulate woman and can be extremely plausible. At times she can mask some of her symptoms and intentions.

It is important not to place too much reliance on her own uncorroborated accounts of her well-being and achievements.

The Possible Impact of Susan Joughin's Illness on her Daughters

3.9 Four features of Susan Joughin's illness had important implications for her ability to look after her children:

a) in acute phases, Susan Joughin could be extremely aggressive and become violent towards people around her. She had no control over her actions and at such times would act indiscriminately;

b) when acutely ill, Susan Joughin could experience psychotic symptoms (hearing voices, seeing hallucinations) which caused her to act irrationally. At such times she could not distinguish between reality and delusion or consider the effects or consequences of her actions;

c) in the chronic state of her illness, her changes of mood, her tendency to pursue unrealistic goals and her susceptibility to stress meant that her lifestyle was likely to be unstable and erratic;

d) Susan Joughin's unwillingness to acknowledge the nature and seriousness of her illness reduced her co-operation with agencies offering treatment or assistance. Her reluctance to take medication meant she was more likely to become acutely ill and less likely to cope with pressure in the chronic phases of her illness.

CONCLUSIONS

Assessment of Risks Related to Susan Joughin's Illness

3.10 While professionals from health and social service agencies were adept at describing some of the features of Susan Joughin's illness in acute or chronic phases, they failed to analyse the implications of the nature of Susan Joughin's illness for her capacity to care safely and consistently for her children.

3.11 The features of Susan Joughin's illness created a series of potential risks for her children because:

a) she might unintentionally harm them through erratic and irrational behaviour when acutely ill;

b) when she was suffering delusions she could not appreciate that her actions might have harmful consequences;

c) although her aggression and volatility when acutely ill had never been intentionally directed towards either daughter, she could become so out of control that she was unaware at whom she was targeting her aggression;

d) despite her best intentions, Susan Joughin's chronic illness caused her at times to neglect aspects of her children's physical and emotional welfare.

3.12 Susan Joughin's attack on her children was not an act of premeditated aggression. She appears to have acted under the delusion that she and her children were caught up in events of cosmic significance, and in the belief that if she took their lives she would be protecting them from an imminent greater evil.

3.13 Even if a thorough risk assessment had been made of Susan Joughin's circumstances, it is unlikely any professionals would have anticipated the exact nature or timing of the horrific attack on her children. However, a thorough and ongoing risk assessment would have identified that dangers persisted in the situation, arising out of the features described above.

3.14 The combination of the features of Susan Joughin's illness and the acknowledged difficulty in predicting what might happen and when, created a potentially hazardous situation. It was a situation which warranted continuing, consistent, focused and intrusive monitoring of the situation and a comprehensive, customised system of community care for Susan Joughin and for her daughters.

Attempts to Secure Help for Susan Joughin

3.15 In view of the extensive evidence and submissions I have received on the issue of attempts by people who knew Susan Joughin to secure help for her, I have described in some detail below the facts I believe are established on this matter and the conclusions I have reached. I have restricted my comments to attempts to secure assistance for Susan Joughin between August 1994 and February 1995.

3.16 Between August and January 1994, at least four people who had passing contact with Susan Joughin thought she or her children might need assistance but were either dissuaded by others from 'getting involved' or did not know where to find help. The basis of their concerns in each case had been behaviour which was typical of Susan Joughin's chronic condition, such as neglect of the house or her appearing withdrawn.

3.17 In August 1994, Mr Paul Killen, who was in prison, had been alerted by members of his family that Susan Joughin had reacted hysterically when his brother had called at her home with a birthday present for his younger daughter. He contacted the Probation and After Care Service and asked them to notify SSD. His sister-in-law, Mrs Jean Killen, also twice contacted SSD suggesting Susan Joughin was needing help or becoming acutely ill.

3.18 SSD had ceased contact with Susan Joughin in March 1994. On their being contacted in August 1994, SSD asked the CPN to visit, which he did. He reported back that Susan Joughin was 'in good form' and so the matter was not pursued. Mr Killen remained concerned about his former partner's mental health. On learning shortly afterwards that his children had changed schools, he wrote to the children's new Head Teacher and asked him to alert SSD if he had any concerns about Susan Joughin's mental health.

3.19 Not enough weight was given by SSD to Mr Killen's concerns or observations about Susan Joughin. They were not explored as fully as they should have been.

3.20 On 16 September 1994, Mr Paul Killen had written to his now wife:

> ' Why isn't Susan under a careful watch by the social worker - child welfare and the community psychiatric nurse ..... They are always very evident after something goes wrong and there is an accident.' [Mr Killen's underlining].

His view that Susan Joughin's mood swings were indicative of chronic mental illness and that she needed 'careful watch' was completely right.

3.21 In December 1994, Mrs Pauline Killen, then Mr Killen's fiancée, mentioned to a social worker her concern that Susan Joughin had been behaving in an over-excited manner in town. This concern was not recorded nor passed on to any senior member of staff by the social worker, who has since left the Island and could not be contacted by the Inquiry.

3.22 None of these concerns related to any specific threat to the children. Nor did they mark the onset of an acute phase of illness. They were, however, indicative of the fluctuating moods and irrational behaviour which were features of Susan Joughin's chronic mental illness. Because SSD staff were working from an understanding that Susan Joughin had become 'well', concerns about her were treated as isolated incidents and were not seen as a recurring pattern of illness. SSD had not been advised Susan Joughin was no longer receiving psychiatric consultant care or medication.

3.23 By 21 February 1995, Susan Joughin was acutely mentally ill. That day, two further attempts were made to secure help for her. The first of these was at Griddles restaurant and the second on a bus journey to Pulrose. The depth of concern and sensitivity shown at Griddles by Mrs Bentley, an untrained member of the public, was not matched by the response of the ambulance crew, particularly from the senior crew member, which fell short of the highest standards of professional care.

3.24 Within the constraints of his duties, Mr Cowley, the bus driver, whom Susan Joughin approached for help, gave as much assistance as he could.

3.25 In neither instance did Susan Joughin appear consistently unwell. She was not aggressive, nor was she threatening harm to her children. However, as Mrs Bentley had appreciated, her varying mental state meant that she was not fit to care for her children, as she was not coping with simple tasks and would have been oblivious to any potential for harm or any danger to the children.

3.26 I have concluded that the tragic events which followed are not attributable to any single failing in response to Susan Joughin in the period from August 1994 onwards or on 21 February 1995 itself. The systems which exist on the Isle of Man to provide care and support for people with mental illness in the community, had failed to deliver an adequate standard or level of care to Susan Joughin over an extended period of time.

3.27 I have given below my conclusions in respect of the community care arrangements for Susan Joughin and her children. I have restricted their scope to the period following Susan Joughin's discharge from hospital in the summer of 1992 until February 1995.

Community Care Arrangements for Susan Joughin

3.28 Although Susan Joughin's acute symptoms were well treated in hospital, her psychiatric care in the community was deficient because:

a) the features of her illness were not systematically explored by psychiatric services;

b) the implications of her illness for her ability to care for her children were never systematically assessed;

c) there was no coherent plan of psychiatric treatment or psychological support;

d) plans to follow up Susan Joughin after discharge from hospital failed to take account of her known unreliability and lack of co-operation;

e) undue weight was placed on Susan Joughin's accounts of her circumstances and capabilities, with no independent corroboration sought of her claims;

f) her medication was not systematically managed or consistently reviewed;

g) ineffective liaison between the responsible medical officer (i.e. the consultant psychiatrist) and the GPs, CPNs and social workers meant that there was little co-ordination of important information about Susan Joughin;

h) lack of adequate liaison with SSD led to social workers failing to appreciate the seriousness of Susan Joughin's illness;

i) there was no system in place to ensure Susan Joughin was not lost to psychiatric out-patient follow-up, despite this having happened on two occasions prior to 1992;

j) despite the known risks Susan Joughin's condition posed for her own well-being and for her ability to care for her children, her psychiatric out-patient file was simply closed after a series of missed appointments in 1993, without formal transfer of medical responsibility for her care to her GP and without SSD being alerted.

3.29 Social work intervention with Susan Joughin in the community was handicapped by the lack of a systematic approach to her medical care and assessment by psychiatric services. Notwithstanding this limitation, social work practice in this case was on many occasions flawed because:

a) no adequate and on-going assessment was undertaken of Susan Joughin's needs;

b) no effort was made to assess the specific needs of Susan Joughin's children or to collate information about their welfare from all available sources;

c) from September 1992, social work contact with Susan Joughin was ineffectual, uninformed, lacking in focus and failed to address adequately any of the concerns which were known to exist about the impact of Susan Joughin's illness on the care of her children;

d) inter-agency working arrangements after September 1992 were allowed to weaken and then cease;

e) there was a tendency to base decisions and interventions in the case on assumptions rather than established facts;

f) the decision of the case worker in 1994 to close the case was not based on an informed assessment of the situation;

g) at various times, case workers too readily accepted, unchallenged, Susan Joughin's own assessment of her situation and her claims to be taking medication and to be seeing a psychiatrist regularly.

3.30 Additionally, the social work management of the case was impaired by inadequacies in the oversight of the case by more senior personnel:

a) despite known gaps in case workers' information about some of the features of Susan Joughin's illness, attempts to seek clarification on these matters from the responsible medical officer were not pursued after September 1992;

b) the social worker dealing with the case from 1992 onwards was relatively inexperienced and had no detailed knowledge of psychiatric illness. He was not adequately supervised, given his limitations and the difficult and complex nature of the case;

c) there was no system in place to review progress in plans made at inter-agency meetings. Thus identical

community care arrangements failed on three successive occasions in 1989, June 1992 and then after September 1992;

d) there was no attempt to monitor the effectiveness of interventions or the performance of workers;

e) the decision of the case worker to cease contact in March 1994 and to close the case in August 1994 was not subject to sufficient scrutiny;

f) case workers were not encouraged to gather information from a range of sources, or systematically to identify Susan Joughin's needs, or assess the risks of her situation, develop or follow through coherent plans for addressing those needs and risks.

3.31 The service Susan Joughin received from the Community Psychiatric Nursing from 1992 onwards was ineffective because:

a) the CPN failed to find out whether Susan Joughin was being seen by a psychiatrist;

b) the CPN did not take steps to find out the fundamental information as to what medication Susan Joughin had been prescribed or whether or not she was taking it;

c) independent corroboration was not sought regarding information Susan Joughin volunteered about her activities and well-being;

d) CPN visits with Susan Joughin lacked focus and purpose: because there was a lack of clarity about what was to be achieved, nothing much was achieved.

3.32 Regardless of the tragic outcome of Susan Joughin's acute episode of illness on 21 February 1995, the three main care services, psychiatric services, community psychiatric nursing services and social services, jointly failed to provide her and her children with a good enough quality of care over a period of time. Specifically they failed to:

a) clarify who had overall responsibility for co-ordinating assessments and responses to Susan Joughin;

b) inform other agencies when their level of contact changed or ceased;

c) gather and check basic information;

d) assess fully the needs of Susan Joughin and her children or the risks in her situation;

e) devise an adequate response to Susan Joughin's needs which took account of the features of her illness, her known reluctance to comply with treatment or professional contact, the nature and level of risk in her situation;

f) be assertive enough or intrusive enough in their contacts with her;

g) review and revise their response to Susan Joughin when it became apparent it was not working;

h) keep adequate records of their contacts with Susan Joughin or of significant decisions or information relevant to the case.

3.33 In reaching these critical conclusions, I am mindful of some of the difficulties faced by skilled and able professionals on the Island who are trying to manage or deliver effective community care. It is my view that community care arrangements on the Isle of Man are compromised because:

a) there is no slack in the system: psychiatric services, social services and CPN services are in some areas seriously under-staffed;

b) there is a lack of clarity about what is expected of professionals and how it should be evidenced, which

can lead to inconsistent standards of service and poor professional performance going unchallenged;

c) there are inadequate mechanisms to promote joint planning, resourcing and co-ordination of community care services for people with a mental illness amongst health and social service agencies, at both management and operational levels;

d) there is an absence of legislation or codes of conduct defining both the duties and responsibilities of statutory agencies in planning and caring for people with a mental illness in the community and the rights of patients and their carers;

e) there is a lack of availability and accessibility of information or advice about mental illness or sources of help for patients, their families and members of the public;

f) current mental health legislation does not adequately reflect changes in the approaches to the treatment of people with a mental illness in the last ten years.

3.34 I also believe child protection work on the Isle of Man is compromised because:

a) there has been inadequate investment in training for social service professionals in assessment and on-going case management skills;

b) gaps in existing Manx child care law prevent social workers from acting in some situations where a child may be at risk;

c) there is a compartmentalisation of services which is reflected in the attitude of some professionals, who see child protection as solely the responsibility of social services or the police, and fail to recognise the important role they have to play in child protection

decisions or in contributing to efforts to support children and families;

d) in the absence of inter-agency practice guidance, there is ambivalence amongst some professionals about what constitutes good enough parenting: the unsettled, materially deprived and unduly stressful lifestyle which Susan Joughin's daughters endured from time to time was deemed acceptable by some professionals.

Lessons to be Learned

3.35 I have discussed in more detail in Chapter 6 of this Volume the direction in which I believe community care arrangements in the Isle of Man should develop. I have set out in detail in Chapter 7 of this Volume my recommendations for improving the quality and effectiveness of community care and child protection in the Isle of Man. I would summarise the lessons that should be learned from the case of Susan Joughin as :

- new standards of performance have to be set and met by all practitioners involved in the care of people with a mental illness;
- assessment, planning and reviews should become the cornerstones of an improved mental health service and more individualised patient care;
- a new legal framework for community care should outline:
    - the powers, duties and accountability of health and social work professionals;
    - the rights of patients and their carers;
    - the responsibilities of Government for planning, resourcing and monitoring mental health services;

- professionals must develop effective inter-disciplinary partnerships and new ways of working which are geared to meet the needs of patients rather than maintaining traditional divisions of role and responsibility, which tend to reinforce the segmentation of community care services;

- failures to staff health and social services adequately or to provide appropriate back-up for them, including the means to anticipate future mental health needs, will only undermine any attempts to raise the quality of the performance of individual practitioners and improve the effectiveness of agencies;

- the recommendations of the McManus Commission should be pursued in respect of the need for changes in child care legislation, to reflect recent developments and trends in child care policy and practice.

CHAPTER 4

Other Issues Arising from the Inquiry

Introduction

4.1 While it was no part of my remit to look at the care arrangements for Susan Joughin and her family beyond 21 February 1995 or to look at the response to those events, a number of important matters came to my attention in the course of the Inquiry on which I feel obliged to comment. I would stress that none of these matters has been explored with the same thoroughness as the issues arising from the remit, nor was it possible to take evidence on them from such a variety of sources, as it was with those matters central to the task of the Inquiry. I simply list these below for consideration in due course by the relevant departments or line managers.

The Aftermath of 21 February 1995

4.2 The tragedy of the 21 February had a significant impact on the lives and the emotions of a number of people. Most closely affected were family members. Some neighbours and acquaintances of Susan Joughin, professionals who had had a strong relationship with her and some professionals who attended the scene of the attack were also badly affected.

4.3 I would commend the Isle of Man Constabulary for the way they addressed this matter with regard to their own personnel, and the efforts made by police officers to advise neighbours and members of the community deeply upset by the events, as to possible sources of help. Some people made contact with the voluntary organisation CRUSE, which offers support to victims of bereavement. Their support was much appreciated, as was the assistance given by Mrs Jean Manson of Isle of Man Family Centre.

4.4 Some members of Susan Joughin's family were subsequently offered support by members of SSD. While some people have appreciated this offer, others have indicated, as often happens in the aftermath of a tragic event, that at the time they were too shocked and upset to see counselling as a priority but would have liked to have had the opportunity to take this up later. Others have expressed unease about seeking support from an organisation which was so closely involved with the care of Susan Joughin and her children.

4.5 In my view, more thought could have been given by SSD to the possible and recurring needs of family, immediate neighbours, and people who had social contact with Susan Joughin, including parents whose children had previously stayed overnight at her house. SSD's lack of knowledge of Susan Joughin's social network, and the uncertainty members of the community had about where to find sources of help, probably combined to deny some people the opportunity to talk through or resolve some of their feelings about this matter.

4.6 Of particular concern to me is the lack of counselling and professional support made available to Mr Paul Killen, father of Susan Joughin's daughters. Attempts should have been made to secure for him independent counselling and support, from off the Island if necessary, similar to the counselling that was made available to members of SSD.

4.7 The Island has an Emergency Planning Group which, from time to time, carries out major incident simulations. This includes members of the coastguard, fire, police and health services. In my view, this group would be strengthened by the addition of a representative from SSD and possibly from some of the voluntary agencies on the Island - such as CRUSE - which have experience in providing long term support to the families of the victims of tragedy. The major incident plan for the Island should include provision for co-ordinating a response to meet the emotional and psychological needs of victims and should identify one person, such as a consultant psychiatrist, clinical psychologist or the Director of SSD, to implement and oversee such response when it is required - whether as a result of a large-scale incident or of a much smaller scale, but very serious matter such as the events of 21 February 1995.

Mentally Ill Offenders and the Criminal Justice System - (I) Prison

4.8 I have been advised that the custody arrangement for mentally ill offenders or for offenders who are suspected of displaying features of a mental illness, are not adequate. I am concerned that, despite the best efforts of many people in the criminal justice system, the health service and those representing Susan Joughin, over two months elapsed after 21 February 1995 before she could be moved to a psychiatric clinic in order to receive the treatment which her very serious mental illness required. I would commend the strenuous efforts made on Miss Joughin's behalf, particularly by Ms Sally Bolton, Dr Chinn and Dr Higgins of the Scott Clinic, to expedite her move and would also wish to recognise the efforts made by staff at police

headquarters and the Isle of Man Prison, who tried to deal sensitively with her in surroundings totally unsuitable to someone with so serious a mental illness. Dr Chinn also endeavoured to provide Susan Joughin with the best possible treatment within the very difficult constraints of the custodial situation, prior to her being removed from the Island.

4.9 When a prisoner manifests a serious physical illness, the priority of the criminal justice system is to ensure that health concerns take precedence over the needs of the criminal justice system. When a prisoner is seriously mentally ill, the same compassionate response is essential. Neither police officers or prison officers are equipped to deal with the needs and demands of people with a mental illness in custody.

4.10 The Department of Home Affairs Circular No. 63/84, (The Prison Rules 1984), must be updated in respect of the sections dealing with treatment for prisoners who are suffering from mental illness or who appear to be in need of an assessment to determine whether features of a mental illness are present.

4.11 The revised procedures must emphasise the principle that the health needs of the prisoner, be they physical or mental, should take priority over the processes of the criminal justice system, with due care and attention being paid, particularly in respect of prisoners with psychotic symptoms, to ensuring the safety of such prisoners and others with whom they come into contact. Provision must be made for the transfer of responsibility for such prisoners from the Department of Home Affairs to DHSS to be expedited in order to ensure there are no delays in securing access to suitable assessment and treatment for such persons, whether this be on the Island or in the United Kingdom.

Mentally Ill Offenders and the Criminal Justice System - (II) Policing

4.12 Over the years, the police were contacted on several occasions by members of the public, Mr Killen and members of Susan Joughin's family, who were seriously worried about her mental condition. I understand from the evidence of police officers that this is not an unusual occurrence and that police officers are often summoned to deal with situations which arise from the behaviour of people with a mental illness. In most of these situations, the existence of the mental illness makes it inappropriate for the matter to be treated as a criminal one and the role of the police is restricted either to

providing transport to Ballamona Hospital or to alerting other services, as happened with Susan Joughin.

4.13 Because of their easy accessibility - the police are only ever a phone call away - and their visibility in the community, the police will often be the first point of contact for family members, members of the community or the patient themselves where a response is needed to a mental health problem. The serious under-resourcing of psychiatric services and social services, particularly in respect of the lack of qualified, trained psychiatric social workers, means that there is often inadequate back-up for the police when they respond to these situations and that they are faced with dealing with a situation for which they are not adequately trained or resourced.

Child Care Proceedings

4.14 All the professionals within the judicial and child care systems whom I met in the course of the Inquiry accede to the principle that the welfare of the child should be paramount when making decisions about children, their care, treatment and welfare. I remain unconvinced, however, that these good intentions are consistently reflected in practice. Central to the concept of the paramouncy of a child's welfare, is the principle that children have the right to have their needs independently reviewed and assessed and, wherever appropriate, their views represented. Clearly, the multifarious roles which social workers have to undertake mean that they are not always sufficiently independent to represent the interests of the child objectively or adequately.

4.15 There is inadequate provision in current Manx legislation for independent representation of the views and interests of a child in care proceedings under the summary jurisdiction of the Isle of Man. The practice has evolved of the Attorney-General arranging for a child to be separately represented in care proceedings in Magistrates Courts.

4.16 This arrangement is laudable in intention but inadequately formalised, being dependent on the discretion of the Attorney-General. The Attorney-General's position of neutrality may be jeopardised in cases where his office is also concerned in pursuing other matters related to the case. (For example where there are criminal proceedings against a member of a family, for whose child a care order is being sought.)

4.17 It is imperative to preserve the independence of the Attorney-General's office and he should not be placed in a position of even potential conflict of interest in the exercise of discretion in such instances.

4.18 There are other situations, outwith a court setting, where it is important that the child's interests and views are independently represented, e.g. a child protection case conference or review meeting. The situation may arise, for example, whereby a social worker may have to represent the views of the SSD at a case conference and also, at the same meeting, the views of the child. These two views may differ markedly. Clearly this potential for conflict of interest is unsatisfactory.

4.19 Provision needs to made within legislation, within Summary Jurisdiction (Children and Young Persons) Rules, within the Rules of the High Court of Justice and within the procedural guidance of the Department of Home Affairs and of the DHSS, for an independent person to be appointed for specific events or periods of time to determine, represent and safeguard the interests of children in any specified proceedings, and in the case of children who are subject to voluntary or statutory care measures, in any review or decision-making forum.

4.20 There are two options for ensuring the independence of persons so appointed:

i) the Department of Home Affairs could set-up and administer a panel of trained and experienced representatives. These would be suitably qualified persons such as guardians ad litem, independent social workers or advocates experienced in child care issues;

ii) alternatively, the Isle of Man could secure the impartiality of the Attorney-General and safeguard the interests of children through the appointment of a post equivalent to the Solicitor-General in England and Wales to represent the interests of children, but with a wider remit to act in respect of all key decision-making forums within the context of child care services.

Improving Customer Care

4.21 The Department of Health and Social Services should appoint a departmental client relations officer to investigate and facilitate the resolution of any misunderstandings or problems which arise between service users and professionals, to work to raise the profile of services and to encourage feedback from people who use health and social services. A positive approach to complaints and representations goes a long way to prevent their escalation, and customer feedback is vital if the quality and effectiveness of services is to be enhanced and evidenced.

CHAPTER 5

The Implications of the McManus Report

Background

5.1 Part of my remit requires me to look at the community care arrangements for Susan Joughin and her children in relation to the recommendations of the McManus Report. I have interpreted this part of the remit to mean that I should examine whether the policy and practices of the agencies providing community care for Miss Joughin duly reflected the recommendations made by Miss Patricia McManus in her reports of 1992 and 1994.

5.2 Miss McManus reported in August 1992 on the circumstances of a complex child case which had been subject of a Petition to Tynwald for Redress of Grievance. The Report's findings centre on the Petitioners' grievances and the circumstances of the case. The Report found that, while the Social Services and Health personnel involved in the case had made appropriate decisions in the care of the child, there were aspects of their practice, such as the recording of case conference decisions, which might have been improved. The Report highlighted the need for the Isle of Man to undertake a substantial review of child care legislation and arrangements. A Commission of Inquiry into children's services, chaired by Miss McManus, reported in August 1994.

5.3 The McManus Inquiry Report was not available until after Susan Joughin's last discharge from hospital in July 1992. The report contained no specific recommendations in respect of social work or health care practice. Observations made regarding the possible weaknesses in child protection procedures were addressed in due course by SSD as part of the process of developing inter-agency liaison and operational procedures.

5.4 Specific recommendations were made by the Commission of Inquiry in 1994 in respect of the organisation of child care services and the need for review of child protection child care legislation. These were published after contact with Susan Joughin by the health visitor and social services had ceased .

5.5 The recommendations of the 1994 McManus Commission cover over a hundred aspects of children's services on the Isle of Man. A joint committee

of representatives from the Government Departments most directly affected by these recommendations provided a response in May 1996 to the Council of Ministers on progress on implementation of these recommendations. I have studied the recommendations of the McManus Commission and the response of the Government Departments. My detailed comments in respect of each recommendation and the progress of its implementation have already been submitted to the Chief Secretary.

The Case for New Child Care Legislation

5.6 The cornerstone of the McManus Report is the recommendation that the Isle of Man should implement an adapted form of the 1989 English Children Act. In the course of this Inquiry I have become aware of issues which strengthen the case for new children and family legislation. I have outlined these below.

5.7 The three main problems in current Manx legislation are:

- outdated provisions;
- inconsistencies in legislation;
- ambiguities in drafting.

Outdated Provisions

5.8 The bulk of existing Manx child care legislation (i.e. public law relating to the care and control of young people) is over thirty years old and when enacted was based on English legislation then over thirty years old. Manx child care law fails to reflect adequately changes in society and changes in legal and child care practice on the Island in the last 60 years.

Inconsistencies in Legislation

5.9 A piecemeal approach to updating Manx legislation in recent years has caused inconsistencies between Manx private law (i.e. family law relating to custody and contact matters) and Manx public law. For example, wardship of a child is still possible in private law proceedings but was abolished in public law proceedings by the Manx Family Law Act 1991 (as it had been in English Children Act of 1989). No alternative measures were introduced in the Manx Family Law Act to replace wardship as had been done in the parallel English legislation.

5.10 Some of the current inconsistencies in Manx legislation have potentially serious consequences as they may prevent Social Services Division acting in situations where a child is at risk. For example, Section 83 of the Isle of Man Children and Young Persons Act 1966 provides that DHSS can take over the care of children on two grounds. If an objection is raised then the matter can be brought before a magistrate who has power to confirm or dismiss the DHSS resolution, depending on whether he believes the grounds to be established.

5.11 In 1969, three further grounds were added upon which SSD could pass a resolution to take over the care of a child, including in situations where the parent suffers from a mental disorder rendering him or her unfit to care for the child. However, the grounds on which the court could confirm or dismiss the resolution were not changed. Thus the court is impotent to act in a situation where a seriously mentally ill parent considered by SSD to be unfit to care for a child, refuses to accept the DHSS resolution and the child must be returned to a potentially hazardous situation.

5.12 A further inconsistency is that the principle of the paramouncy of the interests of a child is already inherent in the Manx Family Law Act 1991 which covers private law (e.g. Residence and Contact Orders.) This principle is not so clearly articulated in public law (e.g. care proceedings). In my view, the position of public and private law has to be consolidated. Public and private law affecting children must have the same welfare paramouncy principle, and, ideally, public and private child care law should be brought together in one statute.

Ambiguities in Drafting

5.13 Manx legislation tends to retain traditional formal legal language and cumbersome phrasing. Some of the ambiguities in Manx child care legislation might be resolved by drafting legislation in much clearer language. Attempts, not always entirely successful, have been made in the English Children Act 1989 and The Children (Scotland) Act 1995 to make the legislation more easily understandable to non-legal professionals and to the families to whom it applies.

5.14 One of the most problematic and potentially serious ambiguities in Manx law relates to the wording of the grounds on which SSD can take action to protect a child deemed to be at risk. These are currently laid down in Section 2 of the Isle of Man Children and Young Persons Act 1966.

5.15 The wording of the act at present requires that the child must currently be:

' experiencing a lack of care protection and guidance as a good parent may reasonably be expected to give.' (Section 2(1)(a))

and

' lack of care and protection or guidance is likely to cause unnecessary suffering or seriously to affect his health or proper development' (Section 2(2)(b)).

5.16 A situation such as Susan Joughin's might not have been covered by this provision, since although it could be anticipated that her children might be at risk of harm if Susan Joughin became acutely ill, it would be difficult to establish grounds for care order, if at the time of the hearing there was no overt evidence of current suffering or harm.

5.17 Rather than address these problems in a piecemeal way, I doubt anyone would dispute that the entire basis for Isle of Man child care legislation needs to be overhauled. A great deal of work has already been done on this since Miss McManus's recommendations.

The Adequacy of the English Children Act (1989) for a Manx Context

5.18 The argument for importing many the provisions of the English Children's Act 1989, as recommended by Miss McManus, is a strong one. Not only would this approach provide consistency in the traditional development of Manx family law, but also it would allow the Island to draw on the extensive practice and procedural guidance and multi-disciplinary training materials developed around the English Act. Additionally, social work practitioners working in the Manx context have generally trained in England and their work will already be reflecting some of the principles which informed the English legislation.

5.19 In many of its provisions, a Manx Children's Act based on most recent English legislation, would simply formalise current and developing trends in legal, police, social work policies and practice on the Island.

5.20 However, since the introduction of the Children Act in England in 1989, experience has shown that there are a few shortcomings in its drafting. I also believe that the culture and tradition of the Isle of Man require some aspects of the English Act to be adapted. In Chapter 7, (paras. 7.177 to

7.209), I have made recommendations about specific legislative provisions I believe are required in a Manx context. These relate to:

- The Welfare and Interests of Children
- Parental Powers and Responsibilities
- Care and Supervision Orders
- Emergency Protection Orders
- Safeguarding the Interests of Children

The Basis for Effective Child Protection Measures

5.21 I do not believe that new legislation alone is sufficient to protect children on the Isle of Man. The intentions of the legislators and those who have helped shape the legislation must be translated into specific detailed guidance. Such guidance would require to define, both at strategic planning level and at operational level, how professionals should carry out their duties and to what duties they should give priority.

5.22 This means not only making sure that principles, procedures and operational guidance are developed to inform the work of professionals, but also requiring managers to ensure their staff know the legislation and procedures, are competent to apply them, have access to information and advice as required and know the standard of professional performance which is required of them. Good child protection practice also demands that managers supervise and monitor the performance of staff against agreed criteria.

5.23 All the independent reports of which I am aware, dealing with the Island's response to the needs of vulnerable members of the community, including the McManus Commission, agree on the need for additional staffing resources in health and social services. This report endorses that view and makes specific recommendations.

5.24 I would stress, however, that employing additional staff in certain areas will be a fruitless exercise unless there is a commitment to ensure clarity about the tasks such staff would undertake and the standards to which they should aspire in their practice and performance. This must be

complemented by a systematic approach to monitoring and evaluating the quality of services which are being provided to the population of the Island.

5.25 Work has been underway for some time in nursing services on the Island to set standards for operational functions and professional performance and to ensure staff are informed, trained, equipped and competent to carry out these tasks and reach agreed standards of performance. A similar initiative is needed in other community care services, particularly social work to ensure the most effective use of resources.

5.26 The McManus Report pointed out that:

> ' Effective communication, collaboration and liaison is a structural problem requiring leadership at political and senior management levels and clear processes and systems based in properly negotiated agreements. '

5.27 I would endorse this view and emphasise that the responsibility for enhancing community care and child protection provision lies at all levels of government and across a wide range of service providers.

5.28 The constructive and informed recommendations of the McManus Commission are geared to ensuring that standards of practice in health and social services are consistently high. To achieve this, services will not only have to be operating effectively but also be based in a framework of efficient organisational structures, adequate resources and legislation which enables and maximises the contribution of professionals assisting and protecting vulnerable members of the island's population.

CHAPTER 6

The Way Ahead

Summary

6.1 The lessons to be learned from this tragedy can be summed up very simply: *practice, planning and partnership.* These lessons are equally applicable to the fields of community care and of child protection.

Introduction

6.2 The discussion of issues of practice, planning and partnership which follows outlines the directions in which I believe services on the Isle of Man have to develop over the next three to five years. These arise from my findings, (Vol. I, Chapter. 3), discussion of the Susan Joughin case, (Vol. II Chapters 10 and 11) and evidence to the Inquiry from managers and practitioners.

6.3 Many of these points have been discussed with witnesses; others try to build on service developments currently underway on the Island. I am heartened by the work of key DHSS personnel, who are actively seeking to improve the standards, co-ordination and focus of community care and child protection efforts.

6.4 I have been particularly impressed by the evidence of Mrs Kilmartin, Clinical Nurse Manager (Mental Health), Mrs Spittal, (Service Manager, Health Visiting), Dr Chinn, Consultant Psychiatrist, Mr Cooke and Mr Gibson of SSD and Mr Whiteside of the Ambulance Service on the structures and processes which they have introduced over the last two years to promote better planning and higher quality services. In many instances this has been done despite inordinate pressures on their time and resources. It is my hope that the suggestions in this chapter and the recommendations in Chapter 7 will endorse and strengthen their work.

6.5 Detailed recommendations in respect of child protection and community care are given in Chapter 7 of this Volume.

Practice Issues - (I) Standards

6.6 I have discussed the issues relating to practice of professionals under three headings: Standards, Procedural Guidance and Attitudes and Approaches.

6.7 The standards and quality of work which practitioners undertook in this case was determined very much by the experience and attitude of individual practitioners. At the time when Susan Joughin was receiving support from social services, psychiatric services and community psychiatric nursing services, there was very little procedural or practice guidance set down for professionals on the island. Some practitioners, such as doctors and nurses, are required to work to professional standards set out by their governing bodies. These professional standards cover matters such as ethics, confidentiality, case recording and clinical responsibilities. There are no equivalent professional standards for social workers.

6.8 In the Isle of Man there is nothing stipulated about the minimum quality of services which members of the public should receive from health and social service practitioners. This has two important consequences:

- standards of practice may vary considerably from practitioner to practitioner, as they are determined simply by that practitioner's application, skills and experience;

- members of the community do not know what they should expect as a minimum standard of health or social care.

6.9 I understand that both SSD and Nursing services are keen to introduce or enhance quality assurance measures in their work and I would commend their commitment to this issue. The suggestions which follow are offered with the intention of supporting and enhancing work which is already underway in some areas.

6.10 An initiative is needed to define or clarify standards to which practitioners should be working and define what service users can expect of them. Standards should incorporate not only quantitative indicators (things that can be counted, such as realistic response times to referrals or the number of visits made) but also should set out qualitative indicators to be measured (for example how satisfied carers are with the help they receive or whether outcomes were achieved).

6.11 Setting standards is a meaningless exercise unless it incorporates a system of monitoring and audit, so that staff and supervisors, and the public, have clear evidence of whether standards are being met and targets being achieved. It is clear from the case of Susan Joughin that systems for

monitoring the level and adequacy of practice were, at times, insufficient. All agencies need to look at how they will determine whether the standards they have set for their staff and for their managers are being met. It is no use, for example, saying that supervision of social workers should take place monthly, if there is no system in place for senior managers to check either on a routine or random basis that this is happening.

6.12 Wherever possible, the people who receive services, as well as those who provide them should be involved in setting service standards. It is often argued that service users may set unrealistically high targets and criteria for professionals. All my experience in this field and a great deal of research suggests the contrary. Most people who use health and social services are realistic and reasonable about what they expect. Some of the evidence this Inquiry heard suggests that the public places a higher priority on basic practice issues, such as keeping appointments, courteousness and accessibility than on complex and costly innovations.

6.13 Standards become reality not by being written down on paper but through the process of staff discussing and adapting their skills and approaches and through the training, management support and encouragement for them to continue to develop their skills.

6.14 Service Standards have to develop from the health and social policy decisions of Tynwald. I believe that the principles underpinning government mental health and child care policies in the Isle of Man should be clearly set out for service users. Such statements of principle can be set out in a few sentences and provide:

i) a simple concise sense of purpose and direction for services;

ii) a framework from which will flow specific planning objectives and practice standards.

Practice Issues - (II) Procedural Guidance

6.15 Problems cause by the lack of explicit standards for practice in a number of areas are exacerbated by lack of procedural and practice guidance relating to Isle of Man legislation.

6.16 It is standard practice throughout the United Kingdom and Northern Ireland that, when legislation is enacted in relation to health or social work matters, it is accompanied by detailed procedural and practice guidance. For example, the English Children Act 1989 requires that cases of children on a care order be subject to a review by social services departments. The statute simply says a review has to be carried out. Accompanying the Act, however, is detailed guidance explaining what a review entails, who should be involved, how often it should take place, what the functions of the chairperson are, how minutes are to be taken, etc.

6.17 The guidance for the Children Act runs to ten volumes. Alongside this, many authorities in England and Wales have also developed practice guidance which will set out advice for practitioners on what constitutes good practice and how to carry out certain functions. For example, in the case of reviews, this would include guidance on how social workers can prepare families and children to ensure they make an effective contribution to a review, how to deal with conflicting professional opinions at reviews, and monitoring the effectiveness of review decisions.

6.18 At the time when Susan Joughin was receiving assistance from Isle of Man care agencies, they had no such wealth of procedural and practice guidance on which to draw or which would inform their practice. Such guidance is invaluable, as it ensures that the duties required by statute are carried out consistently amongst all practitioners because there is clarity about what is expected of people and about the ends which they are trying to achieve.

6.19 The argument has been put forward to the Inquiry that similar practice and procedural guidance is not required on the Island, as its purpose in United Kingdom and Northern Ireland is to ensure consistency amongst local authorities. I believe this is a narrow and inaccurate view of procedural and practice guidance. Variations in practice, as this case shows, occur not only between different agencies, or in the case of United Kingdom between different authorities, but also within individual agencies. It is important, for example, that all case conferences relating to the protection of children are managed in the same way and that the quality of the case conference and the likely effectiveness of its decisions and outputs do not vary depending on who is chairing or who is present at the conference.

6.20 In my view it is important that all future legislation in the Isle of Man relating to health and social services is accompanied by adequate procedural and practice guidance.

6.21 In the last two years Mrs Kilmartin has introduced posts of 'Policy Standards Nurse' in the Nursing Service. Giving one individual oversight of the development and implementation of policies and procedures has been an efficient and effective means of improving the standards and consistency of practice. This initiative is to be commended and offers a valuable working model for other agencies of a practical and cost-effective means of quality assurance.

Practice Issues - (III) Attitudes and Approaches

6.22 Another aspect of enhancing the quality of services is the process of changing the attitudes and approaches of individual practitioners. On too many occasions in Susan Joughin's case, health and social services professionals were simply concerned with outputs of their service rather than the outcomes. For example, at one stage professionals agreed that they would visit weekly on a rotating basis. What these professionals were doing (i.e. visiting weekly) appeared to be more dominant in their thinking than what they were achieving.

6.23 If professionals are simply seeing a client or patient at regular intervals and asking them how they are, or engaging with them on a semi-social basis, they not using employing their skills in gathering and interpreting information and are wasting valuable resources. This type of contact, where no assessment or productive work is being undertaken can readily be undertaken, under supervision, by less qualified personnel, leaving the more costly resources of skilled personnel to be used in more appropriate roles.

6.24 Busy professionals can easily get caught in the traps of simply carrying out tasks from habit or of justifying their time and the cost of their input on the basis of the number of cases they have or the number of people they have visited. However, the number of cases a practitioner has or the number of people they have seen is far less important than what they have achieved with their clients and what the outcome and tangible benefits of their intervention have been.

6.25 Health and social services must ensure that they are not simply reckoning the value of their service on the basis of the numbers of people it deals with

but also on the benefits that it brings. Measuring benefits is a much more difficult task than counting numbers. Evidence of the effectiveness and the value for money of health and social care services will best be provided when there is clarity about the purpose of intervention, the goals of intervention, the focus of activities in professional intervention and the outcomes which are being sought.

6.26 Knowledge in the field of health and social services is continually growing and developing. Practitioners have to keep up-to-date with trends and should always be seeking to enhance their skills and learn new approaches to their work. The nursing profession in the UK has recognised this by introducing requirements for nurses to undertake a minimum number of training days each year as part of their ongoing professional development. This is applicable to all nursing practitioners registered with the UKCC, including nurses on the Isle of Man.

6.27 Continuing professional development training should be a feature of all areas of health and social services. It is especially important to acknowledge the professional training needs of SSD practitioners and managers as well as their managerial and supervisory training needs.

6.28 Systems of annual performance appraisal are in place in SSD. These are used to set personal development goals. There may be a need, however, for these Civil Service based systems to be adapted to recognise the need for social work staff, at all levels of SSD, to have on-going continuous professional development.

Planning - General

6.29 Following on from the recommendations of the McManus Commission, there is now a strategic planning process in the Isle of Man for children's services. This is co-ordinated by Mr David Gibson of SSD who oversees the production of Children's Service Plans. These are five year strategic planning documents co-ordinated by social services which set out how services will be planned and developed for children and families on the island. The plans are developed in collaboration with other agencies and will be reviewed on a year to year basis and revised accordingly. This will greatly assist elected representatives, government officers and service managers in identifying likely needs and trends and responding to them.

6.30 I understand the process of preparing the Children's Service Plans has been beneficial in promoting inter-agency liaison and in helping to identify likely needs and demands on services for children. Much valuable work has been done by Mr Gibson and Mr Trevor Noden of SSD in promoting this work.

6.31 There has been progress in implementing a systematic and consistent approach to child protection work in the Isle of Man since 1992. This has been expedited by the appointment of senior personnel in SSD who have encouraged inter-agency co-operation at individual case levels and who have standardised some of the procedures and protocols for working with children. While some problems of inter-agency co-operation persist, there is a greater emphasis on agencies trying to plan work together with individual children and families, and on practitioners trying to set goals and to review them regularly.

6.32 Similar developments in community care planning in the Isle of Man are required at two levels:

i) at the level of individual case planning, so that interventions and inputs by professionals are more focused and targeted, and outcomes closely monitored;

i) at the level of inter-agency strategic planning, so that efforts of different services can be co-ordinated, resources maximised and levels of need and demand anticipated.

6.33 There are two ways in which community care can be provided. First, agencies can decide how they are going to run their services and what sort of service they will provide: e.g. visits at specified intervals to see a client, appointments only available at fixed times, etc. This approach is called 'service-led provision'. Users of the service have to fit in with the way the service is run and what it has to offer. This is the way that traditionally health and social work services have been organised.

6.34 Alternatively, agencies can identify the types of need present in the population (e.g. mental health needs and needs to minimise the risks to children) and gear their service to respond to those needs. In this approach, the agency will carefully identify the needs of individuals and of people

closely linked with them, and will develop plans to meet those needs. The situation will be reviewed regularly to ensure that the service people receive is addressing their identified needs. This approach is called 'needs-led' provision. Service providers have to devise ways of working that fit in with the needs of the group they serve. The 'needs-led' approach has generally superseded the 'service-led' approach in the developed world. Community Care in the Isle of Man has to move more markedly in the direction of needs-led services at both strategic and operational planning levels.

Planning - (I) Individual Case Level

6.35 At individual case level, practitioners need to be clear about what they are trying to achieve, how they are trying to achieve it, and to regularly review the effectiveness of their input or treatment to determine whether their objectives are being met or whether they should be revised.

6.36 Planning should be neither a luxury nor an additional burden for busy practitioners but an integral component of good practice. Work undertaken, particularly with people with mental illness, must be planned on the basis of a thorough assessment which takes account of all relevant information and provides a benchmark against which changes in the clients circumstances or condition can be monitored.

6.37 Forward planning ensures that the needs of mentally ill people are anticipated and that services are not put under excessive pressure in future when different or greater demands arise.

6.38 After Susan Joughin's discharge from Ballamona Hospital in 1992 a new system of developing discharge plans for patients was introduced. This has been enhanced by closer co-operation between psychiatrists, nurses and a hospital based social worker. These developments offer a sound basis on which to extend and strengthen care planning for people with a mental illness.

Planning - Inter-Agency Strategic Level

6.39 An initiative similar to the new Child Care Strategic Plans is required in the area of mental health.

6.40 Dr Chinn and Mrs Kilmartin have been instrumental in setting up mental health policy planning forum where health service personnel could discuss and plan service developments. I believe that the complex nature of

community care provision for people with a mental illness requires this model to be extended to include inter-agency liaison and planning for mental health services.

6.41 Susan Joughin's case illustrates the wide range of complex issues involved at different levels of planning and operations in the successful provision of community care for people with a mental illness. Liaison and co-ordinated plans amongst all the agencies involved are crucial. In my view, there should be a forum established in which strategic matters related to the management of mental illness in the community, and operational matters arising from complex cases, can be discussed and any problems addressed. Such a forum should include a psychiatrist, clinical nurse manager for mental health, a senior Social Services manager and a senior Police Officer. The forum should meet at least twice a year and should have proper administrative back-up. The forum could from time to time invite other professionals to join them to look at particular matters - such as housing, or raising awareness of mental health issues on the Island.

6.42 The purpose of the forum should be to anticipate and deflect any likely operational or procedural difficulties in the care, management and treatment of people in the community with a mental illness. and to resolve any problems which do occur and which need a change in approach or policy from individual agencies. This forum could also play a vital role in identifying short-falls in service provision and new trends on the Island. It could identify areas for inter-agency training and development in the area of mental health. Importantly, the forum could also highlight areas of good practice on the Island to be built on. I would also suggest that this forum find ways of involving people with personal experience of mental illness or of caring for people with a mental illness to inform some of their work.

6.43 This proposed forum of senior managers could oversee the production of a Five-Year Isle of Man Community Care (Mental Health) Strategic Plan. This plan would identify likely demands for services, state how these would be met, and identify initiatives to be undertaken in the areas of training, standards, liaison with service users and inter-agency liaison.

6.44 As well as a forum at senior management level, I would also recommend that a Practice Development Forum for Mental Health be set up for practitioners. This would be open to all professionals whose work brings them in contact with people with a mental illness. It should meet at least

quarterly and have a training and information focus, with different professionals offering inputs on topics such as their role, problems they face, new developments in care and treatment of people with a mental illness, legislative changes. The Island has a pool of highly skilled people - psychiatric social workers, CPNs, GPs and psychiatrists whose expertise could be drawn on in such a forum. Recent training initiatives between social work mental health specialists and police officers on the Isle of Man have confirmed the benefits of professionals meeting in a structured way to learn about issues of common interest. The practice development forum could also contribute to the proposed five-year strategic planning process.

6.45 One of the difficulties which arose during the course of this Inquiry was the problem of identifying the volume and intensity of demands being made on various health and social services on the Isle of Man. This type of information is not routinely collected. Planning for future service health and social developments in mental health care on the island is thus not always being made on the basis of what is known about the current volume and intensity of demand. Steps need to be taken to ensure good quality information is available to those with responsibility for planning the future developments and resourcing of health and care services. This will enable needs to be anticipated and the appropriate resources directed towards meeting those needs. As with individual cases, without proper assessment and planning, the efforts and responses of services are more likely to be ineffective and wasteful of resources.

6.46 All Manx agencies involved in health and social care have difficulty in gathering adequate management information on which to base their forward planning and service development proposals. Clearly it is important that senior managers and physicians do not have to spend large amounts of time trying to compile basic statistical information. In my view, the appointment of a Planning and Information Officer - to be shared jointly between health and social services - would be an extremely cost effective resource and would free up valuable clinical or casework time for senior practitioners.

6.47 A Planning and Information Officer could be responsible for collating information for five-year strategic plans for child care and for mental health services, in co-operation with the senior managers in the relevant departments. The postholder would be expected to set up basic information gathering systems which would provide the data essential to enable

ministers and senior managers to carry out strategic and financial planning in health and social services .

6.48 The officer could also be asked to identify research and developments off Island which might be of benefit to practitioners of various disciplines in the Isle of Man, and to help develop links between the Isle and of Man and various UK university departments who might be encouraged to undertake research into aspects of health and social policy and practice in the Isle of Man.

Planning - Resourcing Mental Health Services

6.49 According to some Inquiry witnesses, mental health service developments on the Island have tended to have lower priority than more acute medical services. Making available additional resources for mental health services, however, is only justified when there is evidence such additional resources will be deployed efficiently to achieve both the overall service objectives of the provider agency and improved outcomes in respect of individual patients.

6.50 In the United Kingdom, similar problems have arisen in relation to mental health services, which have traditionally been regarded as 'the Cinderella service' of the UK National Health Service. In an attempt to rectify this and to protect investment in mental health services, arrangements have been made from time to time whereby money for mental health services has been ring-fenced - i.e. protected within a budget and given on the basis that it may be spent only on mental health services, including voluntary sector provision, and may not be transferred to other budgets to make up any shortfalls or support developments in other services.

6.51 It seems to me that an adapted form of this mechanism could be readily used in the Isle of Man to redress earlier under-funding of mental health services. I suggest that an agreed proportion of the DHSS budget - for example, current spending on mental health services plus an agreed annual increment for an agreed period of time - should be protected within the budget. The additional money would only be released to the relevant services on the production of detailed plans of how this money will be spent and evidence of the enhanced benefits that it will bring to the users of the services.

Partnership - Amongst Professionals

6.52 From the evidence I have heard and from the observations of health and social service witnesses, I have been surprised by the relative lack of co-ordination and integration of community care services on the Isle of Man. Some of the professionals in health and social services who gave evidence to the Inquiry had a highly compartmentalised view of their own and other services. They gave rise to a view of professional responsibility being limited to carrying out certain tasks; thus one professional would be very clear that it was not their function to deal with or identify any need a client might have outwith their role.

6.53 The problems this brings were compounded in Susan Joughin's case by poor collaboration and information sharing amongst agencies. Thus, apart from calling the May 1989 case discussion, psychiatric services did not initiate any action to address the child care implications of Susan Joughin's illness when she missed appointments or stopped taking medication: because child care was seen as the province of SSD. One CPN did not see housing needs or financial problems as something he should address: because that was the province of SSD. A social worker did not seek information about Susan Joughin's illness and her compliance with medication: because that was a CPN task.

6.54 A change in approach and attitude amongst community care agencies is required to move away from this fragmentation of effort and to replace it with strong working partnerships amongst professionals. This can best be achieved by promoting working together and training together for staff at all levels of organisations.

6.55 Social workers, CPNs, psychiatrists and psychologists have to see each other not as separate, or even rival professionals, but as part of a team working together in the best interests of clients. I understand that there are excellent working relationships between the hospital psychiatric social worker and Dr Chinn and his colleagues at Ballamona. This level of partnership and sharing needs to be built on. There has to be a closing of the gap between hospital and community services, with all professionals seeing themselves as part of a continuum of care and committed to providing the same high standards and carefully planned approach to patient care within and outside hospital settings.

6.56 Partnership is about professionals taking responsibility for their actions and working to make the contribution of other professional colleagues as effective as possible. This includes alerting another professional if they perceive some need or difficulty emerging in a service user's attitude, circumstances or relationships. It is important that professionals focus on the needs of service users and ensure that, where they encounter a situation or a need for which they do not have the information or the expertise, it is communicated to the relevant person.

6.57 Mental illness occurs in many forms and many degrees of severity. It is not always immediately obvious that someone has a mental health problem and, sometimes some forms of mental illness can cause patterns of behaviour by the sufferer which are difficult or demanding for families or professionals to deal with. It is important that all professionals who have a role in dealing with people with a mental illness have a knowledge of mental illness appropriate to their role, and are aware of where they can secure more substantial assistance and support for anyone they encounter about whose mental health they have concerns.

6.58 It is important that practitioners working with people with mental illness are properly supported by colleagues and by managers in this demanding and stressful area of work. Practitioners must not be allowed to become over-burdened or to lose their professional perspective through overwork and excessive stress. All mental health practitioners have a responsibility to support their colleagues and all managers have a responsibility to ensure that staff are not put into situations which are unsafe or for which they are not trained or sufficiently experienced.

Partnership - With Service Users

6.59 Partnership in community care is not limited to the co-operation required amongst different professionals. It is important that service users, their families and carers are seen as part of a team working towards the same goals.

6.60 True partnership with service users means professionals being open about the basis of their involvement. It is never appropriate to allow a client to think that a professional is simply there to befriend them. It is a duty of professionals, when they feel their involvement is becoming less effective, to review the situation, possibly with a more senior member of staff, and determine what course of action should be taken.

6.61 On a number of occasions, the more Susan Joughin tried to distance herself and withdraw her co-operation, the less intrusive and less effective the services she was receiving became. Professionals have to see the refusal or dissatisfaction of clients with service not as the end point of their involvement but as the starting point for determining where the problems lie, and what can be done to address them.

6.62 Working with the sufferers from some forms of mental illness is not easy. It has been stressed to the Inquiry by many professionals that Susan Joughin is never the easiest of people to deal with. Since 21 February 1995, Susan Joughin herself has acknowledged this. It is implicit in the responsibilities of all professionals:- nurses, social workers and doctors - that they need to build relationships with people who resent their presence and who are reluctant to engage with them. Their relationship with their client or patient must have clear parameters and must be built on professional responsibilities rather than personal likes or attributes. In the course of this Inquiry I have met committed and skilled professionals who are adept at managing this demanding role. However, I am aware this degree of competence is by no means universal.

6.63 Professionals sometimes have to be persistent and assertive in their work with people with a mental illness. This means not avoiding important issues, nor being less thorough with those patients or clients who are not easy to work with. It is also important that professionals do not continually shift the boundaries of behaviour they will accept, to the point where certain behaviours go unchallenged - e.g. failures to attend clinic or non-compliance with treatment regimes.

6.64 Partnership with sufferers of mental illness has unique dimensions and demands, because some forms of mental illness create in their victims a lack of insight or awareness into their behaviour or into a possibly deteriorating state of mental health.

6.65 Where the situation arises, as it does in dealing with people with some forms of mental illness, where the patient refuses all overtures and all help, then, before withdrawing from the situation, careful assessment has to be made of the patient's needs, and of the likely risks inherent in the situation if they lose contact with care agencies.

6.66 A risk assessment should be undertaken where appropriate to consider immediate and longer term risks, factors influencing risk and any risks to the patients themselves, or to others with whom they have contact or for whom they have care responsibility. Where the risk assessment suggests that patient or client may intentionally or unintentionally harm themselves or others, then it is entirely appropriate to consider taking steps under the relevant statutory provisions to secure assistance for the patient.

Partnership - with Carers

6.67 Community care for people with a mental illness is often most ably undertaken by committed family members, friends or neighbours. It is vital that all those who assist people with a mental illness are seen as partners with the professional agencies, are consulted along with the patients or clients on decisions that are being made and are provided with adequate information, advice and support for the work that they do. People who have mental illness, and those who befriend and care for them, need to be aware how they can secure assistance, where agencies are based and who the contact persons are. They need to know what resources, benefits and other help is available and how this can be accessed.

6.68 Susan Joughin had no strong network of support and care. Part of the assessment of the needs of a service user must be the identification of possible sources of assistance and the support and encouragement of existing links and relationships important to the service user.

Partnership - with Voluntary Agencies

6.69 Health and Social work practitioners on the Isle of Man do not have access to the same range of voluntary service provision and options which practitioners have in the United Kingdom and Northern Ireland.

6.70 A number of small voluntary agencies on the Island provide competent services, although there appears to be little help available for people with a mental illness or their carers. In my opinion, some funding from the DHSS mental health budget could be targeted at the development of voluntary agencies dealing with mental health issues. People with a mental illness and their carers may sometimes find it easier to do deal with a non-statutory agency when discussing the distressing effects of mental illness and their feelings about it.

6.71 The Inquiry has been greatly helped in its understanding of mental illness by evidence and information from the National Schizophrenia Fellowship in the United Kingdom. Despite its name, this organisation's interests and services are not limited to sufferers of schizophrenia but cover the whole range of mental illnesses.

6.72 The National Schizophrenia Fellowship (NSF) has a vast database of information on mental illness, medication, sources of expert help, support groups, research and policy. Assistance and information from NSF can be obtained by telephone. Around ten thousand calls are received each year in England from patients, carers, medical practitioners, CPNs and social workers seeking information or advice. NSF reports that, since the Susan Joughin case, there have been a number of contacts from persons in the Isle of Man, which they have welcomed. I also understand that Dr Chinn has encouraged patients and their families to make contact with NSF.

6.73 I believe that Isle of Man practitioners, patients and their carers would benefit from access to the wide range of information and services this organisation provides. For little cost, a publicity campaign could be undertaken, in co-operation with NSF, to make the public and professionals more aware of available resources and information and to adapt some of the NSF materials for the Manx context.

Partnership - in the Community: the Public

6.74 Good community care has to involve the whole community in caring for its more vulnerable members. A lot of the people have fears or misunderstandings about mental illness. People very often do not appreciate the variety of the forms and the severity of mental illness. CPNs have an important role in health education and promoting knowledge about mental illness. However, the pressure of their caseloads limits their ability to work with the wider community.

6.75 To raise awareness of mental illness issues and dispel some of the myths about the topic, DHSS should have occasional campaigns on the Island to raise awareness of mental health issues. for example a Mental Health Awareness Week could be organised, perhaps in partnership with local media and an organisation such as the United Kingdom NSF. This could encourage a more sympathetic understanding of mental health problems and make people aware of sources of help and information.

6.76 Members of the community are often reluctant to approach statutory agencies because of fears about the response they will receive. All health and social care agencies must ensure that they do all they can to dispel these uncertainties, by providing a consistently courteous, prompt and sympathetic response.

6.77 It is essential that members of the community know where they can obtain advice and assistance in respect of any questions they have about mental illness and that these are treated sympathetically by CPNs, community police, pharmacists and other professionals approached. Everyone on the Island knows what to do if they come across someone needing emergency medical help. It is important that there is a similar level of knowledge and confidence about where to secure help for people who are experiencing symptoms of mental illness.

6.78 The depth of community spirit in the Isle of Man is a rare and valuable resource. Agencies need to look at how they can build links within communities and inform and utilise the very significant levels of care, compassion and commitment that exist on the Island.

Partnership - in the Community: Police

6.79 Efforts to promote good community care on the Isle of Man can involve many professionals outwith DHSS agencies, such as community police officers. People with a mental illness can sometimes be extremely vulnerable in the community. On several occasions over the years, the police were called to Susan Joughin's home when things had reached crisis point. They were unaware of the ongoing concerns about her ability to look after the children.

6.80 Community police officers are skilled in liaising sympathetically with members of the community with special needs and at diffusing situations and securing the co-operation of other members of the community. This is an important resource upon which other professionals can draw. Health and social work personnel need to see the police as allies in the work of supporting people with a mental illness who may be vulnerable to exploitation or who may be overreacting to stresses in their situation.

Partnership - in the Community: Housing Providers

6.81 Some forms of mental illness limit sufferers' ability to maintain the fabric of their homes or to build positive and constructive relationships with

neighbours. These difficulties, which derive from mental illness, are sometimes simply seen as housing problems by housing agencies who do not fully appreciate the mental health component involved. As more people with mental illness start to live in the community, it will become increasingly important that housing officers are given appropriate information and encouraged to develop skills which will allow them to deal sensitively with people with a mental illness.

6.82 All housing officers who have contact with the public should be given training in dealing with tenants who display great distress or potentially aggressive behaviour. Housing officers should be well informed about the role of health and social services and how to obtain help or advice if they have particular concerns about a tenant.

6.83 A stronger liaison between social services and housing providers is essential. I appreciate the difficulties of this given the number of housing providers on the Island. However, where housing providers become aware of families or individuals experiencing difficulty in maintaining their tenancy - either due to financial problems or to health or mental health problems - SSD should be alerted early in order to undertake an assessment of the situation. It is important that SSD and the public housing providers see themselves as partners working together to minimise the pressures on people with a mental illness and increase the chances of vulnerable people sustaining a tenancy.

6.84 Housing providers must also work together with health and social services to look strategically at the housing needs of people with a mental illness.

6.85 As more people, with more severe forms of mental illness, are living in the community it is likely that new forms of supported accommodation will be required. This will not only include very sheltered accommodation for people who need round-the- clock support, but also low-dependency care housing for people who can mostly live independently but who would need varying degrees of support at different times.

6.86 There exist within the Isle of Man, the statutory powers to encourage and fund the development of non-profit-making housing associations. In my view, any savings secured from the reduction in hospital care for people with a mental illness should be channelled into encouraging the development of Manx Housing Associations to provide supported

accommodation for people with a mental illness in the community. Expertise gained in the United Kingdom and Northern Ireland developing such resources could be drawn on and complemented by experience of providing supported accommodation which already exists on the Island.

6.87 Housing providers need to ensure they have good quality information on which to base decisions about the allocation of houses to people with special needs arising from mental health problems. Douglas Corporation, and I understand, other housing providers in the Isle of Man, allocate housing mainly on the basis of length of time on waiting lists. Priority may be given to people with special medical needs but this may not based on standard medical criteria. In making decisions they are relying on limited information about the tenant's housing record and the limited personal knowledge some councillors may have of some tenants. Sometimes a letter of support will be available from a medical practitioner or from a social worker.

6.88 Clearly this is not always the best way of determining housing needs, particularly of persons with complex medical or psychiatric problems. Councillors or Commissioners cannot be expected to know from personal contact with tenants the complex details of their condition nor can they be expected as lay people to determine the respective priorities of people with physical or psychiatric problems. It is important that accommodation needs are properly assessed, and that a fair system is in place to ensure that priority is awarded objectively, in accordance with pre-determined criteria. This is essential when determining priorities in respect of mental health problems, which are often difficult to assess and quantify and which may have implications for other tenants.

6.89 I believe that it is less important for officials making decisions about housing to know the details of diagnosis of a mental or physical problem, than it is for them to know the needs such problems generate. It would greatly assist the housing allocation processes on the Island if objective criteria were set as to priorities for medical (including psychiatric) and social needs and that the priority to be awarded for such needs was determined by an independent medical practitioner, on the basis of information supplied by doctors, CPNs, health visitors, social workers and others in support of the application

6.90 As well as the benefits of objectivity and fairness, it seems to me such an approach would also have the advantage of freeing Councillors and

Commissioners from dealing with the details of individual allocation and transfer requests and allowing them to consider more strategic issues. Councillors and Commissioners would have an enhanced role, however, in ensuring that the agreed housing priority criteria were being applied fairly and consistently to all applications.

Integrating Practice, Planning and Partnership: Introducing the Care Programme Approach

6.91 Suitable arrangements for support and follow-up must be in place for all patients with a mental illness discharged from hospital, whether after a long or short stay. For some patients, these can only be made after careful assessment of the patient's illness, prognosis, history, abilities and circumstances. This may involve collating information from a number of sources. For example, a social worker can identify matters to be addressed in respect of accommodation or social relationships; a CPN can identify how the patients' illness affects other members of their family, and any problems the medication regime presents; furthermore, ward staff may be able to identify particular anxieties a patient has. The collation and interpretation of this information should lead to a clear plan of specific actions by particular professionals or by patients themselves. Some of these actions may be undertaken prior to the patient's discharge, some may be short-term goals and some may be longer term.

6.92 Patients themselves and the persons most closely linked to them should be involved in this process of identifying their needs and planning a response. It is also important that the patient's GP is encouraged to contribute to the assessment and planning process and that the GP is informed on the patient's discharge not only of the patient's medication and follow-up treatment but also details of support arrangements for the patient in the community.

6.93 This type of planning and co-ordination, known as the 'Care Programme Approach' (CPA) is required by law in England and Wales for long-term psychiatric patients who are being discharged into the community. The CPA is also now widely used for a whole range of patients with mental illness including those who have frequent recurrence of their illness or who have admissions lasting more than two or three weeks. The key features of this approach are that the progress of the patient and the inputs of professionals are regularly reviewed at agreed intervals and that one

professional is designated as 'keyworker' to ensure all the professional inputs are co-ordinated.

6.94 The Royal College of Psychiatrists now recommends that, before discharge of a vulnerable patient, the consultant should agree with a social worker, and ideally also with the patient's GP, a joint plan, and how it is to be followed up and what happens if there are deviations from it. The CPA also recognises that some plans will not work after discharge and that the action to be taken in this eventuality should be agreed beforehand.

6.95 While this approach requires considerable professional input at the stage of patient discharge, there is already evidence in England that careful preparation and planning of community care arrangements, prior to a patient's discharge, are more cost-effective in targeting resources where most needed and in encouraging interventions with patients before problems develop into demanding and costly crises.

6.96 This approach calls for close liaison and integrated working by psychiatrists, psychologists, community and ward nursing staff and social work staff. It requires all the professionals to see themselves as part of a team working to improve the quality of life, social functioning and opportunities of the patient. Patients themselves and those most closely supporting them also have to be seen as part of the team working to the same goals.

6.97 The Care Programme Approach provides psychiatrists with improved feedback on which to make subsequent treatment decisions. Although more work is required at the assessment and planning stages, in the long term staff, workloads would reduce through better targeting of services.

6.98 It cannot be stressed highly enough, however, that the care planning exercise must not be allowed to degenerate into a bureaucratic exercise of form filling, but that at its heart must be the relationship and communication links between the patient and members of the care team, and between members of the team themselves.

6.99 Central to the CPA is the appointment of a keyworker for each individual with a care plan. The keyworker is responsible for ensuring that all elements of the plan are co-ordinated. This keyworker will usually be a CPN but may also be a clinical psychologist or a social worker and or in

exceptional circumstances, a medical practitioner. The keyworker will be responsible for ensuring that all professionals and agencies involved are kept up to date with the progress of the case, that their efforts are co-ordinated and that any problems in liaison are resolved.

6.100 It is implicit in good patient care that the responsible physician will ensure that continuity of care is achieved in the community when a patient is discharged. The CPA will allow an assessment is made of how an individual patient will cope with the demands and factors specific to their situation. It will also involve determining what assistance is required from which sources and over what period of time, to support the patient and enable them to achieve maximum independence and social functioning.

6.101 Assessment of patients must cover their history, their home circumstances, their illness, their needs and any risks. Collation and analysis of this information must lead to a realistic plan of intervention and achievable goals geared to meet the needs of the patient.

6.102 The care plan record can act as a useful aide memoire and clinical tool for psychiatrists reviewing patients in clinic. It is important when reviewing patients or when assessing their responses to medication that psychiatrists have a benchmark for that patient against which change can be monitored. It is also important that psychiatrists seek corroboration from other sources when reviewing the progress of patient and prior to making decisions to change the treatment plan or course of medication.

6.103 The treatment of psychiatric illness with medication has to be planned and reviewed as carefully as all other elements of the care plan. I note that there have been changes in the last few years in the trends in prescribing medication for psychiatric illness. For example, Dr Balakrishna has advised the Inquiry that his practice now is to use as simple regime as possible and to try to stabilise patients on the minimum necessary dose which will secure maximum benefits.

6.104 The skilled and time-consuming work required to ensure that medication is carefully customised to the needs and responses of an individual patient cannot be underestimated. This work requires considerable follow up and feedback from the patient and others. This approach, however, has much to commend it. Research studies and the expert evidence before this Inquiry suggest that this approach is also cost effective. Although more

time is spent in the short term, planning and customising medication and in assessing its impact on patients, the evidence suggests this pays off in the long term with a reduced likelihood of longer-term problems and of non-compliance with medication.

6.105 The CPA encourages professionals to see themselves as part of a multi-agency team. Any decision which might affect the involvement or decisions of other agencies must be communicated to those agencies. This will include, for example, changes in medication regime, which should be notified to the GP and to CPN, and changes in the level of involvement of professionals, which should be notified to all relevant agencies.

6.106 Where a patient subject to a care plan fails to attend day hospital of out-patient clinic on two consecutive occasions, the key worker and RMO will devise a plan of action to ensure that the situation is assessed and appropriate action is taken. Where a patient proves reluctant to comply with follow up, an assessment has to be made as to whether that person can be safely left without support or without medication. This needs to be discussed with all relevant personnel, including carers, and the decisions carefully recorded. Where it is considered the person presents a risk to themselves or to others, then compulsory measures may need to be considered.

6.107 Where a decision is taken not to follow up a patient, this must be recorded in the patient's notes by the responsible medical officer, along with the rationale for this decision. It is important in all cases that those most closely connected with the patient, particularly anyone with responsibilities as a carer, must be advised where help can be sought in future and as to any particular matters which should be drawn to the attention of the relevant medical agencies. Medical responsibility for the patient must be formally transferred to the patient's GP, who should also be advised of any medication the patient requires and details of any other professionals involved.

6.108 The CPA approach should be adopted on the Isle of Man for the discharge of people with a mental illness who are either (a) long term patients being moved into the community, (b) people with a history of recurring episodes of acute mental illness, (c) people who are deemed to be a possible risk to themselves or to others, or (d) people who have responsibilities for the care of others which might be impaired by their mental illness. It would be a

logical development of recent initiatives in nursing where, in some cases, a hospital-based link nurse retains management of the patient's care for up to six weeks after discharge into the community and the oversees a smooth transfer to an incoming CPN.

6.109 In my view CPA is both a natural extension of this type of initiative and a common sense, low-cost mechanism for providing the kind of focused intervention and on-going community care safety net that was not continuously present in Susan Joughin's case.

Equipping Health and Social Services to Meet Community Care Needs

6.110 Some of the changes which will make the greatest difference in the quality of community care in the Isle of Man are not large, costly actions but quite simple straightforward ones: for example, professionals being clear about what is expected of them, and the public being clear about what are the minimum standards they should expect from professional.

6.111 Undoubtedly though, investment will have to be made in training staff and resourcing services to ensure that the growing needs for community care, child care and family support on the Island can be met. In the sections which follow, I have outlined some of the changes which I believe are essential to equip key agencies to respond to meet the needs of vulnerable people in the community.

Social Services Division

6.112 It must be remembered that the tradition of integrated social work services is a relatively young on the Isle of Man. The current SSD was only set up in 1990. At that time, there was still a relatively high proportion of unqualified social work staff and there were relatively few procedures or protocols in place. Mr Cooke took up his current position as Director of Social Services after a period as acting Director of Social Services prior to the retirement of his predecessor Mr Dunn. Mr Cooke has effected significant change within the Department. Following research by the English Social Services Inspectorate, he carried out a departmental restructuring in 1994 which has the potential to improve services. As well as creating specialist teams, Mr Cooke has established a tier of senior management posts to assist with the supervision of staff and the planning and development of services.

6.113 In my view the structure adopted by Mr Cooke is eminently sensible. The only modification I would suggest is that the current division of casework into 'short-term' and 'long-term' work should be modified to reflect instead the two main social work functions of assessment and case management. I would recommend that 'short-term' teams be redesignated as 'assessment' teams, to underline the emphasis on ensuring a proper assessment is undertaken of client needs adequate to underpin on-going social work. 'Long-term' teams should be redesignated 'case management' teams. Within teams which carry both 'short-term and 'long-term' work, I would like to see either (a) individuals designated as assessment practitioners, or (b) steps taken to ensure that all staff have a good knowledge of and skills in assessment, and an appreciation that thorough assessments are the basis for all case management work.

6.114 It will not be necessary in all cases to undertake detailed and comprehensive assessments, perhaps involving staff from many agencies. Comprehensive assessments should be reserved for complex cases such as those of Susan Joughin, where there were elements of mental health, child protection, social isolation, relationship problems, etc. In many cases a short, basic single agency assessment will suffice to identify client needs.

6.115 At the point of allocation of the referral, there should be some clarification as to whether a basic or a comprehensive assessment is required. It may well be that, once an assessment is underway, it becomes clear that a more detailed or a less detailed form of assessment is actually needed. In other situations it will be necessary to take immediate action to protect an individual, after which a full assessment can be undertaken.

6.116 Casework should only be undertaken after an assessment has been made and the purpose and objectives of social work intervention are clear. Progress on specific objectives should be regularly reviewed.

6.117 I believe that, having established a sound operational structure, the natural progression for the development of SSD is to focus on matters of practice. I was encouraged and impressed by the evidence of Mr Cooke and of his deputy, Mr Gibson, who both clearly understand the need to ensure that social work services are effective, efficient and provide good value for money. They are both committed to ensuring that service users are involved in key decisions and both want to see the development of good quality services.

6.118 In my opinion, this would be best approached by setting standards for key social work functions such as receiving referrals, carrying out assessments, undertaking care management, undertaking reviews, liaising with other agencies and liaising with clients and the public at large. There are many examples in the United Kingdom and Northern Ireland of work which has been done in this area, which could be drawn on. One of the best working models of community care standards has been developed by in Northern Ireland by North Down and Ards Community Health and Social Services Trust/Eastern Health and Social Services Board. Child protection standards have been devised by the Social Services Inspectorate in England and by CCETSW in Scotland.

6.119 SSD is already making advances in the area of setting performance standards for staff through promoting competency-based training for home care and other staff. They have also enlisted support from experts off Island to enhance standards of practice in child care and other areas of social work. This initiatives are to be commended and encouraged.

6.120 The McManus Commission highlighted that spending on social services in the Isle of Man is by some measures markedly less than in comparable local authorities in the United Kingdom. It is difficult to determine how far the staffing level of social services actually meets the demand for social work on the Island as only limited information is available regarding the demand for services. This information tends to be based on numbers of cases rather than the demands these cases make on resources in terms of spending or of time or of the number of workers are involved. As yet, no work appears to have been carried out on the Island to identify areas of unmet need.

6.121 I understand that Mr Gibson is working on developments in caseload management systems which will refine the SSD management information systems by focusing on the complexity of cases and the volume of resources they require. This will assist SSD to anticipate future likely demands for services.

6.122 In terms of straight numbers of staff involved in social work in the Isle of Man, comparison with similar-sized local authorities in the United Kingdom would suggest that there is significant under-resourcing in terms of the number of social work staff on the Island.

6.123 However, I would be reluctant to make too many specific recommendations about increasing staffing levels in social services without further evidence that current resources were being used effectively and efficiently and that they were achieving optimum benefits for clients. SSD has to be sure that additional staff are only appointed when there is clarity about what level of performance is expected of them, how that will be monitored and what support they will be given.

6.124 There are two areas, however, where I would recommend that additional staff are appointed as soon as possible. First, it is my understanding that, apart from Mrs Lannen, who now manages a social work team, there is only one fully qualified psychiatric social worker for adults employed on the Island. This is clearly inadequate for the size of the island's population. I would recommend the appointment, as soon as practicable, of at least one other suitably qualified (i.e. Approved Social Worker or Mental Health Officer) psychiatric social worker with a view to increasing the establishment to four qualified psychiatric social workers on the Island by the year 2000.

6.125 The second recommendation arises from my perception that there was a lack of independent scrutiny in the child care decisions involving Susan Joughin's children. It is not always easy for social workers or their immediate supervisors to distance themselves from the detail of the case and look at patterns or identify gaps in information or in services. Currently the Children's Services Manager, Mr Noden, chairs case conferences and reviews, but this creates an excessive workload for him in addition to his other managerial duties.

6.126 In my view, all cases where concerns have been raised about the welfare of children, and not just cases of children on the Child Protection Register, should be reviewed at intervals between of 3 - 6 months. This should be a statutory obligation for all children subject to Care Orders - with initial reviews at 6 weeks, 3 months and then 3-6 monthly intervals. Regular independent reviews should also be accepted practice in non-statutory cases where concerns have been expressed about the welfare of children.

6.127 To facilitate this, I recommend the establishment, as soon as practicable, of a child care Case Review Officer post. This should be someone of at least Principal Social Worker level, with experience in a similar role and

preferably experience in child care training and policy development. This person would be responsible for setting up the administration of a case review system and would chair all child care case conferences and reviews. He or she would also be a source of advice and consultancy on complex or unusually difficult child care matters, but would hold no cases or line management responsibility, thereby remaining independent in reviews.

Psychiatric Services

6.128 Dr James Higgins' report of 1988 pointed out the under-resourcing of psychiatric services on the Isle of Man. It is a matter of some concern to me that this situation has persisted so long. As the Inquiry finished taking evidence, it was indicated that two consultant psychiatrist posts were about to be advertised. One appointment would in effect be a replacement for Dr Costain's post which had not been continuously filled since his retirement in 1994. The Island has been seriously under-staffed in terms of consultant psychiatrists for some time. This inevitably affects the amount of clinic time available to see patients.

6.129 The McManus report recommended the establishment of a consultant psychiatrist post specialising in child and adolescent psychiatry. This appointment has not been made. In my view, the Isle of Man should be working towards the establishment of such a fourth consultant psychiatrist post in the next two years, with the establishment of a further specialist post, for community based psychiatric care, by the year 2000.

6.130 The administrative burden and planning burden on psychiatrists has been mentioned. This is likely to increase as arrangements progress for the building of a new hospital on the Ballamona site. It is important that steps are taken to ensure that the need to involve senior clinicians in planning duties does not have an adverse effect on patient care.

Psychological Services

6.131 The Higgins - Parry Report noted that the Isle of Man had only limited input from a clinical psychologist. The limited availability of psychological input means that work which in other places might have been delegated to a psychologist is carried out in the Isle of Man by psychiatrists or is not undertaken.

6.132 Psychiatrists on the Island would benefit greatly from access to more psychological support for their patients. The current establishment of one

psychologist post on the island is not acceptable. In terms of Island population, the establishment should be four psychologists.

6.133 While I believe that at least another two psychologists should be recruited, in due course, it is important that there should be clarity about the role and accountability of the clinical psychologist. Procedures should be clarified about the type of cases which will be referred to psychologist and about inter-professional liaison with the responsible medical officer.

6.134 All patient contacts must be recorded by the psychologist. Psychologists must record their involvement, the date, time and purpose of their involvement, what they sought to achieve, how far these ends were met by that contact, and what future work they intend to undertake.

6.135 Clinical psychologists can make a valuable input to patient care both in the assessment process and in on-going work which complements the work of other professionals, to deal with personality or relationship difficulties

Community Psychiatric Nursing Services

6.136 CPNs are an important component of good community care. Their work can enable people who would traditionally be cared for in a hospital environment to function in their own or supported accommodation. They can also work with people with less serious forms of mental illness to provide support which may relieve stress or prevent admission to hospital.

6.137 CPNs can work with carers, family and friends of patients to provide advice and information on patient care and support. CPNs can also assist relieve stress patients' stress by counselling advice or liaison with agencies, such as Department of Social Security over financial worries or Douglas Corporation over housing problems.

6.138 The problems of mental illness do not occur neatly between the hours of 8.00 am and 5.00 pm Monday to Friday. Individual CPNs recognise this and put in extra personal effort to deal with situations outside working hours. In evidence, one CPN indicated that he sometimes visited clients at weekends. Another CPN explained that, because of her concern that patients were unable to get help outwith office hours, she gave Susan Joughin and other clients her home telephone number. These arrangements are not a normal part of the official CPN service.

Consideration needs to be given to extending the CPN work rota to cover seven days.

6.139 Patients and families are sometimes advised that, if they have concerns outside normal working hours, they should contact the GP or contact Ballamona Hospital directly. Because there is not a dedicated number for psychiatric enquiries or assistance, callers may have difficulty getting through to the right personnel. When people are experiencing symptoms of mental illness or are dealing with those symptoms in a family member or friend, it is not always easy for them to be articulate and concise on the phone or to be clear about the type of help they need.

6.140 Additionally, it would be helpful if former patients and their carers were given the number of a dedicated phone line by which they could contact one of the wards at Ballamona. This would allow them to receive advice from members of staff who were familiar with, or had access to, their psychiatric history and thereby provide a better of response out of hours. Nursing staff would have on hand medical staff on whom they could call for advice or would be able to advise when a GP or psychiatric social worker should be contacted.

6.141 CPNs must be much more accountable for their time in terms of not only the number of visits they make but also the quality and purpose of the work they are undertaking and the benefits being achieved.

6.142 I have been very impressed by the evidence of Mrs Patricia Kilmartin, the Clinical Nurse Manager (Mental Health) at Ballamona Hospital. Mrs Kilmartin is committed to ensuring that there is a consistently high standard of service from nursing staff. She has been instrumental in promoting the development of procedural guidance and is currently working to ensure that there is closer liaison between ward staff and CPN staff. Mrs Kilmartin is clear about setting and monitoring standards of work. I believe that with the support of committed CPN staff she will ensure resources are targeted on people with the greatest need in the community and that CPN work is carefully structured and regularly reviewed.

6.143 CPNs should always tell GP's when they are involved in a case and when making reports to a psychiatrist, should copy these to the general practitioner. CPNs may want to check at the outset of their involvement

with a patient whether the GP is in regular contact with the patient and seek any observations or information the GP may have.

6.144 CPNs have an important role in explaining to other professionals, such as social workers, teachers, and community police, as well as patients and family members, the purpose of medication, its likely effects, possible side effects and the reason why certain medication or combinations of medication are being tried. When a CPN identifies problems with a patient's medication, including failure to take medication, which they are not able to resolve, these must be reported to the responsible medical officer.

6.145 It is important that the CPNs are aware of the main carers or contacts of patients and liaise with these persons as appropriate. While there are limits to the extent to which an individual's medical details could be discussed with a carer in some cases, it is important in some cases that CPNs have sources of information other than the patient so that they can seek corroboration of the patient's account of their condition and their perceptions of how well they are faring. CPNs should make themselves known to carers and professionals involved in the support of a person with mental illness and provide advice or information as required. It is important that people supporting a patient are advised when CPN ceases to be involved so that alternative arrangements can be made.

6.146 CPNs also have a valuable role to play in educating the community about mental illness. By explaining its features, describing new developments in treatment and the like, they can help to allay fears and bring understanding and reassurance to the community. This in turn will help to develop a greater awareness and sympathy towards people with a mental illness.

6.147 In the United Kingdom and Northern Ireland, CPN and social work services are increasingly merging. In some places, jointly managed Community Mental Health Teams have been set up comprised CPNs and psychiatric social workers. In others, individual psychiatric social workers and CPNs have been based together at GP surgeries and, in some areas, CPNs have been seconded to work in social work teams specialising in mental illness.

6.148 The benefits of an integrated service are widely acknowledged: duplication of effort is reduced, the client has one point of contact for all services and information and specialist advice is more readily available to professionals.

I believe that, during the next three-to-five years, the Isle of Man should look at integrating more closely the work of CPNs and social workers. In the meantime, opportunities should be given for staff from both services to have short secondments to each other's agencies to strengthen inter-agency working relationships, to learn more about the work of fellow professionals and to develop new skills and knowledge.

GP Services

6.149 GPs play a vital role in the community care of people with mental health problems. Studies in London in 1992 suggest that one-fifth to one-quarter of all consultations with GPs have a mental health component. It is essential GPs are competent and skilled in diagnosis and in the management of mental health problems. It is also vital that they are seen as partners in the management of people with a mental illness who have been discharged from hospital or who are receiving on-going support from psychiatrists, social workers and CPNs.

6.150 Continuity of care for people with a mental illness leaving hospital is vital. The role of GPs must be strengthened through a greater exchange of information and involvement in the planning for the community care of their patients through a new Care Programme Approach.

6.151 Better links and fuller sharing of information with GPs can only result in improved patient care. GPs need to have access to all reports and information about their patients, e.g. from CPNs and social workers. GPs should be advised of care arrangements in respect of professional contact with SSD and CPNs. They should be kept informed of any changes in arrangements, any major difficulties encountered or any change in the welfare or well-being of their patient.

6.152 For their part, GPs should make every effort to attend case conferences, discussions and care planning meetings and, where this is not possible, they should make contact with the professional responsible for chairing such meetings and ensure they are adequately briefed on care plans and on the responsibilities of individual professionals.

6.153 GPs must be advised and consulted about children in respect of whom SSD or other agencies have concerns. The current Isle of Man child protection procedures promote this approach.

6.154 Psychiatric clinics provided by consultants or associate specialists in GP surgeries have taken place throughout the Island from time to time. This is an constructive initiative and should be encouraged and expanded if possible.

Administrative Support for Community Care Services

6.155 Services such as social services, community nursing services and psychiatric services can be undermined by inadequate administrative back-up. I would like to see a review taking place in SSD and at Ballamona Hospital to determine and plan for the appropriate ratio of administrative support to social work staff and to clinicians. Time which social workers or psychiatrists currently spend on administrative tasks is time lost to clients and patients.

6.156 An additional pressure on psychiatrists has been the growing amount of administrative work they have to undertake. Dr Costain has explained to the Inquiry some of the difficulties he experienced as a consultant because of the lack of administrative back-up including inadequate secretarial support. This at times led to important communications to other professionals being delayed. More recently, considerable demands have been made of psychiatric staff, particularly Dr Chinn, to contribute to the planning and development of hospital services in the light of major changes in the siting of psychiatric services on the Island. All these demands reduce the time which these highly skilled practitioners can give to their patients and to the supervision of junior staff.

New Legislation - Mental Health and Community Care

6.157 There is an urgent need update mental health legislation to reflect new developments in practice and patient care. In my view, this would best be undertaken through the enactment of legislation combining mental health and community care issues. I believe that it is valid to separate out the legislative basis for community care of people with a mental illness from other groups because of the complexities of work in this area. An integrated Mental Health / Community Care Act would also underpin the need for consistency and co-ordination between hospital and community care.

6.158 New Manx legislation can also establish the framework for planning and co-ordinating mental health services.

6.159 The opportunity can be taken while reviewing and redrafting community care legislation to update some of the provisions of the Chronically Sick and Disabled Persons Act 1969 in respect of people with mental illness.

6.160 In drawing up an Isle of Man Act, it will be useful to consider aspects of the UK NHS and Community Care Act 1990 ('the UK Act'), such as the emphasis on service user and carer involvement in identifying needs, complaints procedures, inter-agency planning. However, it must be remembered that the purpose of the UK was to establish a market system in the purchase and provision of social and health services. This is irrelevant in the Isle of Man, and much of the UK Act's provisions are not thus not applicable in a Manx setting.

6.161 I believe that the Isle of Man can remedy some of the problems which have arisen or been left unresolved by recent UK community care and mental health legislation. In particular, provision should be made in Manx legislation for Community Supervision Orders to allow more rigorous follow-up of patients who have a history of refusing treatment or CPN assistance in the community.

6.162 To balance an increase in the powers of professionals I would also urge the creation of an independent panel of curators or representatives to oversee the welfare of individual patients subject to statutory mental health measures and to ensure that everything is being done in accordance with the patient's best interests.

6.163 It has been argued in the course of the Inquiry that a system should be introduced into the Island akin to the English system of Supervision Registers for people with a mental illness to prevent patients being lost to follow-up. In my view this is unnecessary. Supervision registers exist in England to allow information to be exchanged about patients who are likely to move amongst different health care providers. This situation does not arise on the Isle of Man and I believe that better systems of recording and management within individual services, some of which are already underway, will suffice to lessen the chance of a patient being lost to follow-up.

New Legislation - Child Care

6.164 I have outlined future directions for child care legislation in Chapter 5 paras. 5.7 - 5.20. Considerable work has been done on the Island since the

McManus Commission Report to develop new child care legislation which will reflect changes in society and in practice in recent years.

Conclusion

6.165 The need for specificity in the plans and activities of professionals is crucial. Without clear and specific objectives professionals can drift into purposeless activities whose outcomes and benefits cannot be determined. Consequently scarce and costly public resources can be wasted. What counts in community care and in child protection is not the *number or type* of professional contacts or inputs but the *quality and effectiveness* of those inputs. A recurring feature of every fatal child abuse inquiry in the UK in the past ten years is not absence of professional input but rather the absence of effective co-ordination, collaboration and communication within and between agencies.

6.166 None of these issues are particularly obvious or dramatic. It must be remembered that when things go very wrong in community care it is rarely because one professional has made an error of such magnitude that a tragic outcome inevitably follows. The chilling reality of caring is that small oversights or apparently insignificant liaison problems can accumulate and have very serious consequences for individual clients or patients. A commitment to raise standards of practice, to break down traditional barriers between agencies and to move towards a planned and integrated approach to community care will greatly reduce the chances of this occurring.

CHAPTER 7

Recommendations

7.1 I have tried to make these recommendations as practicable and workable as possible in the context of the Isle of Man. I am pleased to note that in some areas, positive developments have already taken place since February 1995.

7.2 Agencies tend to worry most about recommendations which involve additional spending. In practice, recommendations which involve straightforward financial outlays are often far easier to implement than those which involve little cost but a great deal of human collaboration. Some of the recommendations which follow will require additional spending to improve or develop services. Many, however, will require changes to working practices and enhanced inter-professional communication: these may prove the more challenging to implement.

7.3 Recommendations with significant resource implications are underlined.

7.4 Some of the recommendations relate to matters in Volume II, to which not all readers will have access. I have therefore not provided detailed cross-referencing for all recommendations. Instead, I have simply drawn readers' attention to other sections of this Volume where some of the issues are discussed more fully.

7.5 My recommendations are set out in four sections:

- Practice, Planning and Partnership;
- Case Recording
- Legislation - Children and Families
- Legislation - Mental Health

7.6 The basis for the Council of Ministers accepting of any of the following recommendations must be that any changes will result in superior, measurable benefits to present services and to service users.

RECOMMENDATIONS

Section I
PRACTICE, PLANNING AND PARTNERSHIP

Recommendations - General

7.7 I recommend that the relevant departments are asked to prepare an implementation plan for each of the following recommendations.

7.8 Simply counting the numbers of recommendations or the percentage of items on which work is in different stages of progress is meaningless. It does not differentiate between essential and less significant recommendations nor give any indication of the quality or effectiveness of the work being done. Therefore, to enable the Council of Ministers to keep track of the progress and effectiveness of implementation, the plan for each recommendation should include details of:

- who will be responsible for implementation;
- whose co-operation will be required;
- what resources will be needed;
- what training would be required of which staff;
- what specific steps will be taken, by whom, to implement the recommendation;
- when the implementation will be commenced;
- when the implementation will be completed;
- how implementation will be evidenced;
- when progress will be reported or reviewed.

General Recommendations - Improving Practice and Performance

(see also 6.6 - 6.14)

7.9 Standards of performance and systems of audit should be developed or extended to cover all health and social work services.

7.10 Wherever possible service users should be involved in setting performance standards for health and social services.

7.11 All health and social service users should be made aware of:

- who will be dealing with them;
- the purpose of the contact;
- the quality of service they can expect from health and social services;
- what to do if they are unhappy about any aspect of service.

Recommendations - Social Services Division - Assessment

(see also 6.91 - 6.109)

7.12 Consideration should be given to modifying the function of specialist child care teams, with the current 'short-term' team becoming responsible for responding to referrals and carrying out assessments, and the current 'long-term' team being responsible for developing and implementing planned care on the basis of the initial assessments, and for monitoring progress and undertaking reviews.

7.13 A separation of assessment and on-going planning and care functions should be emphasised in the work of the specialist Adult Services Teams. This could be achieved either by some designated team members undertaking assessments and others taking on on-going care work, or by ensuring all team members are skilled in assessing need, planning, carrying out, co-ordinating and reviewing professional interventions.

7.14 In family situations, the needs of each family member, including individual children, must be assessed and planned for separately.

7.15 In making assessments of the needs of people with mental illness, social workers should explore their eligibility for disability benefits and ensure all relevant benefits are being claimed.

7.16 The provisions of the Chronically Sick and Disabled Persons Act 1969 should be used to support seriously mentally ill persons in the community.

In particular, consideration should be given to meeting some of the costs of installing and renting a telephone line where this is assessed as necessary and practicable for vulnerable persons.

Recommendations - Social Services Division - Supervision

7.17 All social workers must have a formal supervision session by their line manager at least once every four weeks.

7.18 New staff and newly qualified staff should be supervised at least fortnightly for the first three to six months after taking up post.

7.19 Supervisors should keep a note of supervision meetings and of issues and cases discussed.

7.20 Supervision by line managers should include the audit of at least one case file per worker, selected at random, every six months.

7.21 Supervision records must be open to random audit by more senior managers.

7.22 Supervision discussions of specific cases should focus on:

- the adequacy of known information;
- points for action and objectives;
- the focus of intervention;
- quality of liaison with other professionals;
- views of clients;
- any risks which need to be addressed;
- whether the skills and experience of staff member dealing with the case are appropriate to the demands of the work.

7.23 In allocating cases, SSD managers must take into account the needs of clients, the skills, experience and competencies of the worker and the features and complexities of the cases.

7.24 Where SSD staff are working in conjunction with other professionals, supervisors must ensure there is clarity about the respective roles, and responsibilities and that good communication links exist between the workers involved.

7.25 Contact between social workers and their clients must be purposeful and assertive.

7.26 A minimum of five days training per year should be made available to SSD line managers to ensure that they are kept up-to-date about developments in social work practice and in the management and supervision of staff in a social work setting.

7.27 Training in assessment of risk should be made available to managers and members of staff working with people with a mental illness and with children and families.

Recommendations - Social Services Division - Administration

7.28 A procedure should be devised to ensure all referrals forwarded to the Director of SSD by other agencies or government departments, such as the Judiciary, the Council of Ministers or MHKs, are noted and a date set by which any investigation will be completed and a response given.

7.29 A review of secretarial and administrative support services for SSD should be undertaken within the next 12 months.

Recommendations - Social Services Division - Case Conferences

(see also 6125 - 6.127)

7.30 A Case Review Officer should be appointed to chair all case conferences and child care order reviews and to advise on complex cases.

7.31 The timing of case conferences organised by social services should take into account constraints on other professionals, such as school hours, ward rounds and surgery hours.

7.32 Persons sending apologies to a case conference should be sent a conference report form to complete and return. This will allow them to record any issues, information or concerns they would like addressed by the meeting.

7.33 Wherever practicable, parents should be involved in least part of the case conference.

7.34 Parents should always be advised of the outcomes of case conferences.

7.35 A leaflet should be published by SSD explaining the purpose of case conferences, the constitution of case conferences and advising parents on their rights in respect of case conferences.

7.36 Case conference recommendations should be the basis of planning and focus for future work with families, and should be made available to all persons at the case conference and those invited to the case conference.

7.37 Case conference minutes should have priority for typing and for rapid dissemination.

7.38 Head Teachers and class teachers should always be invited to case conferences about children who attend or are about to attend their school.

7.39 Head teachers and class teachers should always be made aware of any concerns SSD have for the welfare of a child and should be advised when a child's name is placed on or removed from the 'At Risk' register.

Recommendations - Social Services Division - Liaison with Probation and After-Care Services

7.40 Where a probation officer is involved in a case open to SSD, the name of the probation officer should be recorded in the SSD file, and they should be advised of all significant developments in the case and invited to all relevant meetings.

7.41 To avoid duplication of effort and resources, agreement should be reached at the outset of an order on the functions and goals of the social worker and of the probation officer.

Recommendations Social Services Division - Caring for People with a Mental Illness

7.42 SSD should have made available to them resources to recruit, as soon as possible, an additional psychiatric social worker. This should be an experienced practitioner with specialist qualifications equivalent to UK Approved Social Worker/Mental Health Officer.

7.43 A further two similarly qualified psychiatric social workers should be added to the SSD staff establishment by the year 2000.

7.44 Social workers with casework responsibility for people with a mental illness being discharged from hospital should, wherever practicable, avail themselves of the opportunity to read hospital notes.

7.45 Agreements should be reached between the SSD and CPNs to promote access to each other's files when working with the same patient.

Recommendations - Community Psychiatric Nursing

(see also 6.136 - 6.148)

7.46 CPNs must know, and record on file, for each of their patients, the name of the Responsible Medical Officer (RMO) and the patient's medication regime.

7.47 Where a community psychiatric nurse holds a case which involves child protection issues, this must be drawn to attention of the Clinical Nurse Manager who will agree at the outset the amount of supervision and support the CPN will require.

7.48 The Clinical Nurse Manager (Mental Health) or her representative should be informed of any invitations to CPNs to attend child protection case conferences.

7.49 The RMO must be advised by CPNs, at least every six months, of each patient's progress.

7.50 A patient should not be discharged from a CPN caseload unless as part of a carefully agreed plan.

7.51 Where a patient has refused contact with a CPN or gone missing, the patient must not be discharged by the CPN without discussion with the RMO and other relevant professionals.

7.52 A patient's general practitioner should be notified of the commencement and cessation of CPN contact.

7.53 CPNs should promote links between their service and other agencies, such as housing providers, police and DSS, in order to widen understanding of their role and of the needs of people with a mental illness, and to build professional relationships which will benefit liaison about clients.

7.54 Consideration should be given, in the next three-to-five years, to integrating the work of CPNs and social workers working with people with a mental illness, through a combined team or closer working arrangements.

7.55 Opportunities should be created within the current year for secondments of CPNs and social workers to each other's teams, to enhance their skills and strengthen inter-agency working relationships.

7.56 Consideration should be given to extending the availability of CPN services to evenings and weekends.

7.57 An out-of-clinic hours telephone helpline should be established for people with a mental illness and their carers to get assistance and advice.

Recommendations - Psychiatric Services

(see also 6.91 - 6.109 and 6.128 - 6.130)

7.58 By the year 2000 there should be five consultant psychiatrist posts established on the Island, with at least one post being designated for specialist community psychiatric care.

7.59 A review of secretarial and administrative support services for consultants and associate specialists should be undertaken within the next 12 months.

7.60 There must be clear lines of medical and clinical responsibility for patients, particularly when patients are referred to non-medical services such as social services. Where this happens medical responsibility should be retained by the referring physician - GP or Psychiatrist.

7.61 A system must be in place for keeping track of what prescriptions have been issued to long-term patient and of alerting the relevant medical practitioners when patients have clearly run out of medication but have not received a recent prescription. In such instances a prescription should not simply be sent out to the patient without their being seen.

7.62 All physicians must record all prescriptions issued in whatever setting.

7.63 Psychiatrists must develop a treatment plan for each patient. The treatment plan has to recognise the difference in the features and complexity of individual conditions and must be flexible enough to adapt to changes in the situation.

7.64 Psychiatrists should where ever possible seek corroboration about a patient's condition and circumstances from others concerned with patient, such as family, social workers, General Practitioners, CPNs and psychologists.

7.65 Where a patient discharges himself against the advice of a psychiatrist, all relevant personnel should be informed and the best possible arrangements in the circumstances should be made. Where this has implications for the safety of children or for others, a case conference or case review must be called as soon as possible, and the patient's GP should be informed immediately.

7.66 Psychiatrists should always inform a patient's GP and other relevant members of the multi-disciplinary team of any significant changes in the patient's condition and any changes in treatment or medication.

7.67 Psychiatrists must always take into consideration the implications of a patient's illness for any members of their family who have carer responsibilities towards them, and for any persons for whom the patient has carer responsibilities. This is of particular importance where children are concerned.

7.68 A system must be put in place to identify any patient who misses two consecutive appointments. When this happens, the consultant responsible for the patient's treatment and a psychiatric social worker or CPN should be alerted and should together review the case and determine what action ought to be taken.

7.69 Treatment regimes should aim to achieve the maximum effect for the minimum level of medication. Medication should be reviewed regularly and customised to the response and needs of the patient.

7.70 Patients and carers should be given information about their medication and have the reasons for changes in medication explained to them.

7.71 Non-compliance with medication should trigger a review of the medication regime and of any possible side effects, to determine whether these are discouraging compliance.

7.72 Where decisions are made to cease contact with a patient or to discharge them from further follow-up in the community, all relevant people must be notified, including the patient. The patient and their carers must be advised how they can make contact or get help if problems arise in future.

Recommendations - Psychiatric Services - Care Programme Approach

(See also 6.91 - 6.109)

7.73 The care programme approach must be adopted for all patients being discharged from hospital who:

- are or have been subject to a section or mental health order;
- have a pattern of recurring relapses or admissions;
- are deemed to be a risk under certain conditions to themselves or others;
- are known to present problems of compliance with medication.

7.74 <u>All relevant staff must be trained in the care programme approach and must be knowledgeable about liaison arrangements, the roles and responsibilities of other disciplines.</u>

7.75 Care plans should be developed prior to discharge of patients. This will normally be done through an assessment of the patient's needs, by one or more professionals, followed by an inter-disciplinary care programme case conference at which the components of the care plan will be identified.

7.76 Good assessment should be the cornerstone of the care programme approach. It must take into account the nature, type, complexity and volatility of any risks, and must include health and social needs.

7.77 A chronology and social history should be drawn up as part of the care plan assessment. This should be updated at least twice a year by the keyworker, in consultation with other members of the care group.

7.78 The care programme approach should provide systematic arrangements for assessing health and social needs, lead on to the formulation of a care plan which addresses those health and social care needs, identify a keyworker who will be responsible for co-ordinating all elements of the plan and indicate when the plan will be reviewed.

7.79 The assessment of patients must take into account whether a patient can be realistically treated in the community, their likelihood of complying with the programme and the availability of resources of support.

7.80 The care plan should aim to secure the safety of patient and of others linked to the patient, promote the optimum level of functioning for the patient, offer choice and ensure effective deployment of resources.

7.81 Where there is a conflict amongst these aims within a care plan for an individual patient, objectives must be prioritised in the order of safety, functioning and choice.

7.82 Care plans and the care planning processes must be flexible enough to respond to changes in the patient's circumstances or condition and ensure consistency and continuity.

7.83 Care plans must take into account any unrealistic views or aspirations of the patient and identify how these will be acknowledged and addressed.

7.84 The RMO must make sure that assessment needs will be realistically met before agreeing to the discharge of patients from hospital.

7.85 The RMO must also ensure that all relevant information has been sought to enable them to make a decision about the discharge of a patient.

7.86 Each person subject to a care plan must have a designated keyworker.

7.87 Individual professionals must be accountable for delivering their part of the care plan.

7.88 The keyworker must be responsible not only for fulfilling the functions of their own professional role but also for monitoring the effectiveness of the overall plan and the co-ordination of inputs.

7.89 All persons charged with keyworker responsibility must be able to:

- recognise and respond to changes in symptoms and features of mental illness;

- understand what changes should be referred to the responsible medical officer;

- record all changes, developments and responses to the plan;

- maintain regular liaison with the responsible medical officer.

7.90 The keyworker should be responsible for monitoring all interventions, including outpatient appointments, medication, care services and for determining whether further action or adjustments in service level are required in the light of any changes in the patient's circumstances.

7.91 Staff who will act as key workers must be trained in working with patients, with their families and carers, and must be able to facilitate contact with families and friends and build up support networks for the patient.

7.92 Wherever practicable, the decisions of initial care programme case conferences and subsequent reviews should be summarised and explained to the patient and to other carers involved in the plan.

7.93 The care plan should include the opinions and views of the patient and of the family and social contacts most closely involved in their care.

7.94 The care plan should contain details about medication, what it is hoped medication will achieve, and any side effects or adverse reactions to which professionals should be alerted.

7.95 Care plans must recognise the values of the patient and how these affect their ability to comply with the plan, and must take into account the person's strength, abilities, attitudes, nature and features of the illness, their social abilities and strength of social interactions.

7.96 Where risks exist in a situation, it is important that these are assessed and wherever possible quantified, and strategies put in place, as part of the care plan, for dealing with these risks.

7.97 Risk assessments should be detailed, specific and analytical and not purely descriptive. They should indicate which factors add to the risk and which steps will minimise it. The assessment also needs to include details of who is at risk and of what.

7.98 Social and health services must clear about how they will secure the information which they need to review the patient's welfare and to make decisions about the continuing level of risk and how it should be dealt with.

7.99 Risks due to non-compliance with medication should be detailed. All members of the care planning group should be familiar with the purpose of medication and likely indicators of relapse.

7.100 Care plans and discharge information should be faxed on the day of discharge or prior to discharge to the relevant agencies.

7.101 All patients subject to a care plan must have a named RMO, even when their key worker is a CPN.

7.102 All patients subject to a careplan must be formally reviewed every six months. All changes in the care plan must be notified to all relevant personnel.

7.103 When a patient subject to a care plan is admitted to hospital, the care programme should be reviewed and adapted.

7.104 Community personnel must keep in touch with developments and changes in the situation while a patient is in hospital and must liaise with hospital staff regarding discharge.

7.105 The care plan must be made available to members of the hospital team when patient is admitted and must be adapted to reflect any changes in the patient's circumstances or condition on discharge.

7.106 Where problems arise in a care plan, a review should be triggered to adapt the plan or resolve the problems.

7.107 Incidents of violence or potential dangerousness should be communicated to all members of care group.

7.108 If contact is lost by one of the professionals involved in the care plan, all members should be informed. A review should be undertaken to determine what course of action should follow.

7.109 General practitioners must be invited to care programme meetings and should always be sent a copy of the care plan.

7.110 Where the decision is taken to discharge someone subject to a care plan from psychiatric outpatient follow-up, responsibility must be formally transferred to the patients GP.

7.111 Where responsibility for a patient subject to a care plan is transferred to a GP, the GP should be informed of the diagnosis and features of the illness, treatment plans, any risk indicators or concerns and the names of professionals involved.

7.112 The GP should see the patient within two weeks of such a transfer, and should make contact within that period with other personnel to ensure that effective arrangements are in place for carrying through the care plan and for liaison.

7.113 Where the GP is the responsible medical officer, it is the responsibility of the keyworker to liaise with them and advise them of any adverse changes in the patient's situation.

7.114 All care plans must have a contingency measures to be implemented if the care plan fails.

7.115 When patient is discharged from the care programme all relevant personnel should be advised.

7.116 Where a patient withdraws from a care plan, all reasonable efforts should be made to engage them.

7.117 Where a patient refuses medication, the RMO and the keyworker should review the care plan and consider the implications of this for the patient's situation. Where non - compliance is considered to present serious risks all members of the care planning group should be advised.

7.118 Where housing issues are an important part of a care plan, a housing officer should be invited to contribute to at least part of the care programme planning case conference or review.

7.119 Where a patient who is subject to a care plan is known to have moved off island, steps should be taken to alert the relevant health authorities.

Recommendations - Clinical Psychology Service

(see also 6.131 - 6.135)

7.120 Two further additional clinical psychologist posts should be established by the end of 1998.

7.121 Clinical psychologists must develop treatment plans for each patient who is referred to them.

7.122 Liaison between the psychologist and the responsible medical officer should take place on a regular basis.

7.123 Clinical psychologists must liaise with social workers, CPNs, probation officers and other professionals seeing the same patient, to ensure that there is co-ordination of inputs and activities.

Recommendations - Police

(see also 6.79 - 6.80)

7.124 Joint training of police officers and social workers in mental health issues should be continued and extended.

7.125 Police community liaison officers should be informed by CPNs and social workers of any vulnerable people with mental illness in their area, who may need protection from harassment or exploitation.

7.126 Where harassment, offending or other problems in the community are anticipated prior to a patient's discharge, or emerge in the implementation of a care plan, the police should be involved in the care plan conferences and reviews.

Recommendations - Ambulance Service

7.127 <u>All Ambulance Service personnel should receive training on the features of mental illness and on dealing with patients with mental illness.</u>

7.128 <u>The assessment form used by attending crews should be adapted to include a section on mental state / behaviour, to be completed only in situations where this appears to be relevant to the presenting problem or management of the patient.</u>

Recommendations - GPs

(see also 6.149 - 6.154)

7.129 The records of all patients subject to a CPA should be reviewed by a member of the practice at least once every six months to ensure that information and details of contacts are correct.

7.130 GPs should not remove from their lists any patient who is suffering from mental illness without consultation with psychiatric services and the Health Services Division.

7.131 Where it is agreed that a patient with a mental illness may be transferred from the GP's list, the original GP will retain responsibility until a new general practitioner is allocated.

7.132 The Health Services Division. should advise such patients that they are being removed from the GP's list and that unless they provide confirmation, within five days, of having registered with another practitioner, they will automatically be assigned to another GP. A system should be put in place for ensuring such action is expedited and all relevant personnel notified.

7.133 Where a person who suffers from a mental illness is transferred to a new general practitioner, practitioners should familiarise themselves with the patients history and should ensure that they have up-to date information on the names of other professionals involved and the nature of their contacts.

7.134 GPs must make every effort to attend child protection and mental health care planning case conferences. If unable to attend they should forward any relevant information or opinions to the chairman.

7.135 Copies of minutes of case conferences and care programme meetings should be held in the patient's file and should be prominently highlighted so that the information within them is readily available to any practitioner seeing the patient.

Recommendations - Housing Providers

(see also 6.81 - 6.90)

7.136 Housing officers who have frequent contact with members of the public should be trained in the features of mental disorders and on sources of assistance for dealing with tenants who may be suffering from mental illness. This training will raise their awareness of the issues and help them gain skills in dealing with referrals and securing appropriate help.

7.137 Each housing provider must hold a central record of violent or potentially violent incidents encountered by housing officers. This should be reviewed at quarterly intervals by a senior manager or by commissioners or committee members.

7.138 Housing providers on the Island must work together with health and social services agencies to ensure that appropriate accommodation is made available to people with mental health needs, and that adequate levels of community support are available to ensure that the tenancy is successful.

7.139 Objective, standard criteria for awarding medical or social priority for the allocation of housing, should be developed by all housing providers throughout the Island.

7.140 The allocation of priority for re-housing on the basis of medical need should be undertaken for all housing providers by an independent medical practitioner.

7.141 Councillors and commissioners charged with the responsibility of managing public housing, and DoLGE, should be invited to contribute to the production of mental health community care strategic plans and consulted on the specialist housing needs of people with a mental illness.

7.142 DoLGE should liaise with housing associations with experience in development and management of accommodation for people with mental health needs in United Kingdom, Northern Ireland and the Republic of Ireland, and seek with their assistance to enlarge housing association provision on the Island for people with a mental illness.

Recommendations - Inter-Agency Strategic Planning

(see also 6.39 - 6.48)

7.143 A forum should be established involving social services, psychiatric services, CPN, psychologists and police to address the strategic issues in the development and management of services for people with a mental illness.

7.144 This group should be responsible for the development of Five-Year Mental Health Strategic Plans, for resolving difficulties in the management of very complex cases, for identifying issues where the services are not fully meeting the needs of people with a mental illness and for advising ministers on trends in mental health needs in the community.

7.145 A planning and information officer should be appointed to assist health and social services staff in collating information for five-year strategic plans for child care and for mental health services.

7.146 The planning and information officer would be expected to:

- set up basic information gathering systems;
- provide the data essential to enable ministers and senior managers to carry out strategic and financial planning in health and social services;
- identify research and developments off Island which might be of benefit to practitioners of various disciplines in the Isle of Man;
- develop links between the Isle of Man and other sources of research and information.

Recommendations - Government Policy

7.147 The Council of Ministers should issue very brief statements of the principles which they wish to see under-pinning community care and child protection services on the Island. These principles will provide focus and direction for professionals and should be revised every five years.

7.148 <u>The Government should develop specific social strategy measures over an agreed timescale to deal with the problems of economically disadvantaged and inadequately housed persons on the Island.</u>

7.149 <u>For the next five years, an amount of growth at least equivalent to the level of inflation, should be added to the mental health services budgets of health and social services. This additional money should be ring-fenced for mental health projects and be used specifically to improve the quality and levels of mental health services and should not be diverted to other budgets.</u>

Recommendations - Practice Development

(see also 6.44)

7.150 A mental health practice development forum should be established for all professionals who deal with people suffering from mental illness, to learn about the work of colleagues and to enhance their knowledge and skills. The responsibility for arranging meetings should rotate between the main agencies involved. Membership of the forum would be self-selecting and voluntary.

Recommendations - Correspondence to MHKs, Councillors and Commissioners

7.151 Letters received from MHKs, councillors and commissioners from tenants in respect of housing issues should be copied to the relevant housing manager / director of housing where applicable, and a copy of the letter should be placed in the tenant's housing file.

Recommendations - Information and Publicity

(see also 6.74 - 6.78)

7.152 <u>A campaign should take place on the Island to promote awareness of mental health and sources of help for people with a mental illness and their carers.</u>

7.153 <u>The United Kingdom National Schizophrenia Fellowship should be encouraged to set up links with the Island and to advise on publicity campaigns and to provide information to professionals and members of the public.</u>

7.154 The Social Security Division should run a campaign to highlight the potential eligibility of people with a mental illness to claim Disability Living Allowance. All social workers and CPNs should be aware of the eligibility criteria for this benefit and should be able to assist potential claimants to apply.

Recommendations - Education

7.155 <u>All teachers should be given basic training in child protection issues and be familiar with Isle of Man child protection procedures.</u>

7.156 School admission forms for recording essential information about new pupils should be standardised across the Island and should require parents to advise the school of any current legal orders in respect of their child.

Recommendations - Aftermath Support

(see also 4.2 - 4.7)

7.157 The Isle of Man Emergency Planning Group should expand to include a representatives from SSD and from one of the voluntary agencies on the Island - such as CRUSE - which have experience in providing long term support to the families of the victims of tragedy.

7.158 The major incident response plan for the Island should be revised to include provision for co-ordinating a response to meet the emotional and psychological needs of victims and should identify one person to implement and oversee such response.

Recommendations - Mentally Ill Offenders

(see also 4.8 - 4.13)

7.159 The Department of Home Affairs must draw up procedural guidance on expediting treatment for prisoners who are suffering from mental illness, or who appear to be in need of an assessment to determine whether features of a mental illness are present.

7.160 These procedures must be directed by the principle that the health needs of prisoner, be they physical or mental, should take priority over the processes of the criminal justice system, with due care and attention being paid, particularly in respect of prisoners with psychotic symptoms, to ensuring the safety of the prisoner and others with whom they come into contact.

RECOMMENDATIONS

Section II
CASE RECORDING

General

7.161 Recording must be recognised as an activity essential to good management and good practice to which appropriate attention must be paid.

7.162 Adequate uninterrupted time and facilities must be made available to professionals to ensure effective and efficient recording practice. As part of their management role, supervisors must plan and monitor the allocation of time for recording.

7.163 DHSS must ensure all staff who maintain records are familiar with any relevant statutory recording requirements.(e.g. Data Protection Act) and agency requirements.

7.164 The responsibility should lie with individual professional staff to familiarise themselves with the standards and requirements on recording set out by their professional body and to keep themselves up-to-date with developments in good recording practice in their profession.

7.165 DHSS must draw up its own agency recording standards and guidelines. These must be consistent with and complement relevant existing national standards and codes of conduct.

7.166 It is the responsibility of agency managers to see that checks are carried out at agreed intervals to ensure records are kept in accordance with agency standards.

7.167 Each department must have clear guidelines about the storage and preservation of records. This will include instructions on how long files will be retained and under what circumstances they should be destroyed.

Standards for CPN, SSD, Health Visitor and Medical Records

7.168 The minimum standard for records is that all records must be:

- legible;

- chronologically accurate;

- written up within three working days of events to which they relate. (The SSD practice is to be commended of noting both the date of an event and the date of its recording);

- maintained in an agreed format;

- cross-referenced with other relevant files and information;

- free of tippexed blocks, deletions or amendments unless these are dated and signed and a reason for amendments is given;

- signed and dated. (Where the practice of a team is to initial records, a central record should be held of all team members' signatures and initials);

- sequential and continuous;

- complete records of contact. Entries will be made for all contacts and communications with the service user, for all attempts to contact the service user and for all contacts with other professionals relating to service user. All contacts and attempted contacts must be recorded. It is important that the diaries and logs of social workers, health visitors and community psychiatric nurses should reconcile with their casefile records;

- checked for accuracy, if typed, by the person requesting the typing. All amendments or deletions in typed files should be signed and dated;

- distinguishing clearly between fact, opinion and hearsay in the information they contain.

7.169 Records will show clearly:

- the name of the main agency worker and details of the main contacts in other agencies;
- statutory provisions, court orders or sections in force;
- statutory limitation dates, e.g. date of expiry of section;
- essential action / decisions due to be taken.

Content of Health and Social Service Records

7.170 All records should contain:

- *Source and reason for referral*
- *Professional assessment of each new matter*
  The assessment should identify specific problems, difficulties, preferences and options, clarification of needs and requirements. These should be described in the context of the service user's social and psychiatric history. This may include the worker's assessment, the views and assessment of the service user and their family or other persons caring for them, and the assessments of other professionals.
- *An assessment of any risks in the situation*
  Risk assessments should describe specific elements of risk. The assessments should also analyse the level of risk to the service user and others and indicate whether this risk fluctuates. All options for minimising risk should be indicated.
- *Objectives of professional contact*
  Objectives should be specific, measurable, achievable, realistic and time-limited. The name of the persons responsible for achieving objectives should be clearly highlighted.
- *Details of unmet needs*

Identified needs which are not being met should be noted, along with plans for how this will be managed.

- *Work plans and treatment plans*
  The proposed frequency of contact by each worker should be recorded along with details of courses of treatment or action.

- *List of contacts and interventions*
  This will include for each contact:
  - date of contact
  - person contacted
  - type of contact
  - purpose of contact
  - action taken/brief detail of contact
  - action arising from the contact

  Fuller details should be recorded of any critical incidents or interventions.

- *Monitoring and review arrangements*
  The process and timescale for reviewing progress should be noted.

Input from Service Users

7.171 Records should note the views of service-users.

7.172 Where a service user or carer has any concern or disagreement with the objectives of professionals details should be recorded, along with a description of efforts to explore or attempt to resolve differences of opinion.

7.173 Where a service user is unwilling or unable to participate in the decision-making process, details of the circumstances should be recorded on file.

Records of the Case Management Process

7.174 All discussions or meetings about a case must be noted. All decisions to amend objectives or change particular forms of intervention, treatment or resources, must be recorded. This includes decisions taken as a result of supervision sessions or case reviews or case conferences.

7.175 Records should identify:

- what decisions have been made, why, when, and by whom;

- when, how, why and by whom decisions, objectives or plans have been revised or changed;

- with whom specific responsibilities for action lie.

Records of Case Conferences and Reviews

7.176 Records of case conferences and reviews, relating to both children and to mentally ill persons, should:

- identify the type of review e.g.. case conference, statutory review, inter-agency review, operational review between manager and staff member;

- indicate who was present at the review. For case conferences and formal review meetings where a minute is taken, the minute should record who attended reviews, who was invited, any apologies and the date, time and venue of the review. The decisions of the meeting should be clearly recorded along with any dissenting views. The decisions or minute of the meeting should be circulated to those attending and those invited. Participants must agree a process for amending and redistributing minutes;

- evidence what consideration has been given to the views of the service user and of significant carers and record any input by service users or carers;

- show that consideration has been given to changes in needs and to any needs that are not being met When reviews have led to changes in service, care plans or objectives, this should be recorded;

- evidence that levels of risk and changes in level of risk have been considered;

- record any changes in responsibility for specific objectives or any changes in personnel;
- indicate the latest date by which a further review or meeting should occur, unless the case is to be closed following the current review.

RECOMMENDATIONS

Section III
LEGISLATION - CHILDREN AND FAMILY LAW

Recommendations - General

(see also 5.6 - 5.20)

7.177 I recommend that private and public child care and family law be put on the same basis, be entirely consistent and be underpinned by the same principles.

7.178 I recommend that consideration be given to achieving consistency through the introduction of an integrated Children and Family Act.

7.179 In updating Manx legislation it is important to recognise the need to ensure all staff are properly trained to work under new provisions. I recommend that wherever possible the Isle of Man draws on the work which has been done in creating guidance, training packs etc. for the English setting to equip staff and promote good practice.

7.180 I would recommend, however, that English materials are not imported entirely unrevised into a Manx setting. Sometimes where changes have been made in Manx legislation which have brought in provisions similar to English legislation, forms and other materials have been imported which are make reference to London Courts and English settings. This does not add to the dignity or uniqueness of Manx judicial proceedings. Arrangements should be set in hand to check and revise such materials.

Recommendations - The Welfare and Interests of Children

7.181 Manx law must articulate the principle of the children's interest as paramount in any question determined by a court in respect of the care of a child or the administration of a child's property or income.

7.182 Manx law must state that this principle should guide any decision taken by agents of the state, for example DHSS, when making decisions about or on behalf of a child towards whom they have a responsibility or public duty.

7.183 Manx law must also recognise that the principle of the paramouncy of a child's welfare does not mean that all other considerations are irrelevant

nor that decisions must always favour the child's interests above those of all other persons.

7.184 Adequate provision should be made in law for the views of children to be taken into account in any decision involving parental responsibility, or exercise of care or control of a child by any persons not having parental rights, or when making resolutions about the rights of a child, their health development or welfare.

7.185 Family and child care law in the Isle of Man must reflect the provisions of the United Nations Convention on the Rights of a Child, Article 12 of which states :

> *' State parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child either directly or through a representative or an appropriate body in a manner consistent with the procedural rules of natural law.'*

Recommendations - Parental Powers and Responsibilities

7.186 I recommend that new legislation defines parental powers and parental responsibilities.

7.187 I recommend that the terminology 'parental powers and parental responsibilities' is adopted in Manx legislation to overcome ambiguities and problems such as those being experienced in current English and Scottish legislation. (The English Children Act (1989) ('the English Act') defines parental responsibilities predominantly in terms of what, in the Isle of Man, would be considered private law matters. In my view, the matters legislated for in Sections 2 through 7 of the English Act are a confusing mixture of powers and responsibilities and are not a helpful model for the Isle of Man. The Children (Scotland) Act 1995 ('the Scottish Act') describes the same responsibilities or powers as 'parental rights'. These are not rights, however, in the normal sense of the word because the introduction of the paramouncy principle in child care legislation

means that an action to enforce the 'right' will not be determined by the strength of its validity, but will be determined according to the best interests of the child's welfare. The term 'parental powers' is thus to be preferred to 'parental rights.')

7.188 Parental powers to be defined and regulated in Manx law are the powers to:

- regulate a child's residence;
- maintain contact in a relationship with a child;
- direct or guide a child's development or upbringing;
- act as legal representative of the child;

in so far as exercise of these responsibilities is practicable and in the best interests of the child.

7.189 Corresponding parental responsibilities should be to:

- safeguard and promote the child's development and welfare;
- maintain personal relations and direct contact with the child even if not living with the child;
- provide in a manner appropriate to the stage of development of the child, direction and guidance to the child;
- to act as the child's legal representative;

in so far as compliance with these responsibilities is practicable and in the best interests of the child.

7.190 In defining parental power and responsibilities, Manx legislation must take into account societal changes in respect of parenthood. Specifically, this will include:

i) the powers and responsibilities which may be exercised by parents who themselves are under the legal age of majority;

ii) parental powers and responsibilities in respect of children conceived by artificial means.

Recommendations - Care and Supervision Orders

7.191 I recommend that the grounds for care orders be redrafted and that the revised grounds should be as follows:

'(1) Compulsory measures of care or supervision for a child are necessary if at least one of the conditions of (2) is satisfied:

(2) Conditions referred to in (1) above are that the child :

- is beyond the control of any relevant person;
- is exposed to moral danger or bad association;
- is likely to suffer unnecessarily or be exposed unnecessarily to danger or be impaired in his health or development;
- has committed an offence;
- has misused alcohol, any drug or volatile substance;
- is the child in respect of whom any offences in Schedule 1 of the principal Act have been committed;
- is or is likely to become the member of the same household as a child in respect of whom any offences in Schedule 1 of the principal act have been committed;

- is or is likely to become a member of the same household as person in respect of whom an offence under Section 9 of the Sexual Offences Act 1967 has been committed;

- is a child in respect of whom the court is otherwise satisfied that there is evidence of harm likely to occur, which is attributable to the absence of a reasonable standard of parental care, or to the child being outwith the control of any relevant person, or in respect of whom any relevant person has failed to meet their responsibilities as defined by the act.'

7.192 I further recommend that in making a care order, the court must be satisfied that such an order is the most effective means available to secure and safeguard the welfare of the child.

7.193 The principle of the welfare of the child (see above) should not alone be sufficient to determine whether the conditions or grounds for an order are satisfied, but may determine whether one might be made.

7.194 I would recommend that the current provision for DHSS to assume parental rights in respect of a child by passing a resolution to that effect, be abolished; and be replaced by a care and responsibility order to be made by a magistrate transferring parental powers and responsibilities for the child to a named individual or institution.

7.195 Such an order should not be made unless a magistrate is satisfied that:

- each relevant person is fully aware of what they are consenting to freely and unconditionally,

and

- they agree to the order;

or

- the relevant person is a person who is:

    - unknown,

    - cannot be traced,

- incapable of giving agreement,
- withholding agreement unreasonably,
- has persistently, without reasonable cause, failed to fulfil parental responsibilities (as defined above),
- has ill-treated, neglected or caused harm to a child and the child cannot be reintegrated into the same household.

7.196 The provisions listed in the preceding paragraph should not include orders relating to the adoption or freeing for adoption of a child.

7.197 In making a care and responsibility order, a magistrate may impose such conditions as he thinks fit or such time limits as he deems appropriate for the order.

7.198 In making the order, the magistrate must be satisfied that failure to make the order would be contrary to the best interests and the welfare of the child.

7.199 Legislation in respect of care orders should define the duty of care that DHSS has towards children in respect of whom care orders have been made and hold DHSS accountable for discharging appropriately in respect of such children the responsibilities of a reasonable parent.

7.200 In discharging their duties of care, DHSS must ensure:

- the welfare of the child;
- that the needs of a child are appropriately assessed and, as far as is practicable, are met;
- that, wherever practicable, the views of the child are taken into consideration in any plans or decisions;
- that, wherever practicable, the views of relevant persons are taken into consideration in any plans or decisions.

7.201 All children subject to a care order must have that order reviewed at regular intervals by those responsible for their care.

7.202 Care order reviews should contain an independent element to ensure the child's best interests are being recognised and pursued.

Recommendations - Emergency Protection Orders

7.203 A new emergency protection order should be introduced, similar to Section 44 (1) - (16) of the English Act

7.204 I would suggest, however, that this provision reflect the special features of the Manx environment and unite the English concepts of separate child assessment orders and child protection orders, in one 'emergency child protection order.'

7.205 An emergency protection order should be made where:

- reasonable grounds exist to suspect a child is being or will be treated or neglected in a way which will cause suffering or significant harm,

  and

- where social services are making or causing enquiries to be made to decide whether they need to take action to protect the child,

  and

- those enquiries are being frustrated or unreasonably denied;

  or

- where reasonable cause exists to believe that a child is being so treated and neglected or suffering harm or will suffer harm if not removed to accommodation provided by or on behalf of social services, (or other applicant), or does not remain in the place where currently accommodated,

  and

- an order is necessary to protect the child from harm or future harm.

Safeguarding the Interests of Children

7.206 It is currently unacceptable that conflicts of interest can arise where DHSS are acting for both a parent and a child whose interests may be separate: for example in a situation where SSD are involved in sectioning a mentally ill mother and then have to act for her child. I recommend that provision be made within legislation, within court rules and within procedural guidance of the Department of Home Affairs and of DHSS for an independent person to be appointed for specific events or periods of time to:

i) determine, represent and safeguard the interests of children in any specified court proceedings;

ii) determine, represent and safeguard the interests of children who are subject to voluntary or statutory care measures, in any review or decision-making forum.

7.207 <u>To facilitate the separate representation of children I recommend either :</u>

i) <u>the establishment of a panel of trained, experienced and suitably qualified representatives such as guardians ad litem, independent social workers or advocates experienced in child care issues.</u>

<u>or</u>

ii) <u>the creation of a post equivalent to the Solicitor-General in England and Wales to represent the interests of children, but with a wider remit to act in respect of all key decision making forums within the context of child care services.</u>

7.208 There should also be provision in law for a complaints procedure relating to the welfare of children who are subject to care or who receive services from the DHSS.

7.209 The investigation of such complaints or representations should be carried out by someone who is not directly involved in the decision-making process related to the individual child.

RECOMMENDATIONS

Section IV
LEGISLATION - MENTAL HEALTH LEGISLATION

Introduction

7.210 The recommendations about community care legislation which follow are very broad. I have avoided being over-prescriptive of detail as I believe such legislation should emerge from extensive discussion and debate and the same type of extensive consultative process that has been undertaken for forthcoming children's legislation.

A Framework for Mental Health and Community Care Legislation

(see also 6.157 - 6.163)

7.211 I recommend that an integrated Mental Health and Community Care Act be created.

7.212 The community care elements of such an Act should be used in due course as a model for future statutory provisions for the care of other groups with special needs, such as people with physical disabilities.

7.213 Such an Act should ensure compatibility with provisions of current English mental health legislation to facilitate the transfer of patients between the jurisdictions, while retaining distinctly Manx features, such as an integrated approach to mental health and community care, reflecting the Island's particular needs and practices.

7.214 New legislation should:

- update existing Isle of Man mental health legislation to reflect new approaches and practices in the care and treatment of people with a mental illness;
- clarify the powers, duties and accountability of health and social work professionals;
- introduce the Care Programme Approach, making it a legal requirement that patients who leave

hospital after detention on a section or on a community supervision order have a carefully assessed and adequately resourced care plan;

- make provision for the Care Programme Approach to be extended to all clients who are deemed to have special needs - such as social isolation, caring responsibility, history of non-compliance with medication, violence, frequent re-admissions, history of self-harm or any other needs deemed relevant by the responsible medical officer;

- define the rights of patients and their carers;

- set out the responsibilities of Government for planning, resourcing and developing mental health services;

- create a requirement for the production of inter-agency Five-Year Mental Health Strategic Plans, which will be subject to public consultation, and will shape the direction, standards and funding of the services.

Supervision Orders

7.215 I recommend that the Isle of Man legislation should improve on some of the weaknesses current English mental health statutory provisions, and provide a better framework for the care of patients who present potential risk to themselves or others, by introducing community supervision orders. These would give mental health professionals, in defined circumstances, powers to pursue contact with people who were deemed to be at risk of mental instability if they lost contact with the care support network. This should include the power of recall to hospital.

Safeguarding the Rights of Patients

7.216 The enhanced power of supervision should be balanced by additional legal provision to promote and uphold the rights of patients. A mechanism should be established for the independent monitoring of the welfare of patients in hospital and provision must be made to give patients access to independent advice, support and representation.