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CHAPTER 1

INTRODUCTION

1.1 This is the report to the North West London Strategic Health Authority of an independent Inquiry into the treatment and care afforded to a patient, Mr A , by the mental health services prior to his commission of a homicide while in the community on the 13th May 1999.

1.2 The Inquiry was conducted by a Panel comprising :

Michael Curwen - a practising barrister and Recorder of the Crown Court on the South Eastern Circuit
Dr Frank Holloway - Consultant Psychiatrist and Honorary Senior Lecturer in Psychiatry, Bethlem Royal Hospital
Paul Tarbuck - Director of Specialist Mental Health Services, Salford NHS Trust

1.3 Our **Terms of Reference** were as follows :

1. To undertake an independent review of all the circumstances surrounding the care provided to Mr A by health and social care agencies to June 1999 and in particular the adequacy, scope and appropriateness of such care.

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

3. To examine the extent to which care and treatment provided corresponded

to statutory obligations, relevant guidance from the Department of Health and local operational policies.

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

5. To examine the support and supervision provided to Mr A, his family and members of staff involved.

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

7. To examine the operation of the Untoward Incident procedure in the Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust.

8. To make appropriate recommendations.

9. To prepare a report including recommendations for submission to North West London Health Authority (now Strategic Health Authority).

1.4 To assist us in the performance of these tasks we invited a number of persons to give oral testimony. None of them were under any compulsion to provide us with evidence and they were allowed to be accompanied by a representative, although only Mr A himself took advantage of this facility. The procedure consisted of questioning by the members of the Panel. It was informal and conducted in private.

1.5 We heard from the following witnesses (whose status is wherever possible given as it stood at the material time) :

Mr A

Mr A's father

Mr A's mother

Mr A's sister

Relatives of Stelios Economou

Dr V - General Practitioner

North West London Mental Health NHS Trust

Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust

Mr Edward Matt - Director of Operations

Dr Paul Mallett - Medical Director

Dr D - Consultant Psychiatrist

Dr M - Consultant Psychiatrist

Mrs B - Manager, North & West Sector

Mrs D - Deputy Manager, Westmore Resource Centre

Mr L - Receptionist, Park Royal Centre for Mental Health

Brent Council Social Services Department

Mr Robert Nesbitt - Service Director, Mental Health Fieldwork

Ashworth Hospital Authority

Dr S - Consultant Forensic Psychiatrist

Mr P - Senior Social Worker

1.6 We were additionally provided with a large quantity of written material, including documentation concerning the organisation, policies and procedures of the North West London Mental Health NHS Trust and successors, medical records relating

to Mr A's treatment and care in hospital and in the community, his GP notes and his Social Services case records.

1.7 We are particularly indebted to Catherine Afolabi, the Inquiry Secretary, for her skill and industry in collating the documents, organising the oral hearings and co-ordinating the Inquiry.

CHAPTER 2

THE BACKGROUND HISTORY

2.1 Mr A was born on the 12th June 1958. He is the eldest of four children. His sister is very close to him in age and he has twin brothers who are some years younger.

2.2 The family originated in the south east area of Ireland and they have a number of relatives there and in the United States of America. Throughout the period with which we are concerned they have been resident in the London Borough of Brent, initially in Kingsbury, then in NW2 and ultimately in Wembley.

2.3 Mr A enjoyed a happy childhood and attained normal milestones. He attended a local primary school in Dollis Hill and moved on at the age of 11 to St James Secondary School, Edgware. He was a good student and appears to have achieved satisfactory progress in both his educational and personal development. He is said to have been quiet, but this was not in any way remarkable. He was able to make friends and socialise. He told us that he used to think he was a bit strange and that he was different from everybody else, but there is no objective evidence to lead us to conclude that his mental state was other than entirely stable. He did not exhibit any signs of bad behaviour and in particular there were no episodes of aggression, nor was he destructive of property.

2.4 In due course Mr A obtained Ordinary Levels in 10 subjects and Advanced Levels in Economics, Mathematics and History. His grades varied across a broad range from A to E, but were sufficient to attract offers of a University place. It is interesting, although not of clinical significance, that he chose to turn these offers down, electing instead to go with friends to Hatfield Polytechnic on a business

studies course. From this point onwards success turned into under-achievement and his development from adolescence into mature adulthood became disrupted.

2.5 One year later he gave up his course, giving as his reason that he did not wish to become a businessman, and applied for another. Unfortunately he was unable to obtain the necessary funding and after staying around the college for a month or two he seems to have decided to give up, go back home and look for some form of employment.

2.6 In the first instance he obtained temporary work over the Christmas period as a stockroom assistant at Selfridges store. His supervisor then left and he was able to take over this position. However, a few months later he decided to go travelling around Europe and on his subsequent return in mid-1978 he commenced a career in the field of computing. Over the ensuing period of about one and a half years he was employed by Rank Hovis McDougall as a computer operator.

2.7 In 1980 Mr A again took a break abroad, on this occasion going to America. For the first two weeks he toured with a group, then he visited relatives. While he was in New York he began to experience unusual ideas about the workings of the world. He told us that he would go around the second hand bookshops acquiring books (which we take to have had a political content) and reading them in the city squares. He described how one night his head started to spin and explode, he went out into the street and walked around, imagining that there were people with guns going to shoot him. On the basis of this account he would appear to have suffered a mental breakdown.

2.8 The precise causation of the onset of mental illness is unclear. One possibility is that it was induced by drugs. There is some evidence that Mr A had begun to smoke cannabis while at Hatfield and that when he was in America he took drugs

of a more dangerous nature. However, it is equally conceivable that he possessed an underlying vulnerability to the development of mental illness and that it simply happened to surface at that particular time of his life.

2.9 In any event his behaviour became erratic and irrational. He had an impulse to travel to China, but could not get a direct flight and so went to Japan instead. At a hostel in which he was staying he threw a fire extinguisher through a window. He was consequently arrested and repatriated to England. On arrival at Heathrow Airport he somehow managed to get onto a runway and had to be removed by the police. These events inevitably made his parents very concerned about him and created a need for psychiatric intervention.

2.10 Mr A was therefore seen at home on the 22nd July 1980 by Dr A, a Consultant Psychiatrist, accompanied by Dr T, a partner of his General Practitioner, and Mr M, a Social Worker from Brent Area 3. He was found to be restless, irritable and over-talkative, produced a manifesto appearing to be a synthesis of Marxism and Christianity, and asserted that in New York he had believed he was Jesus. Dr A's initial diagnosis rested between a drug-induced psychosis and a manic illness which may or may not have been the beginning of schizophrenia and with the concurrence of Dr T she prescribed Haloperidol 3mg three times daily. Mr A was requested to attend at Willesden General Hospital for further assessment.

2.11 On the 1st August 1980 Mr A was visited again by Mr M, who noted that he appeared calmer and more rational and seemed to be getting better, although he had suffered side effects from the Haloperidol and had evidently stopped taking his medication.

2.12 Shortly afterwards Mr A's parents went to Ireland on holiday, while he stayed at home with his sister. On the night immediately preceding their return he went to

Hampstead and threw a brick through an estate agent's window, shouting that he wanted to become the king of England. Inevitably he was again arrested and charged with criminal damage and he spent the rest of the night in a police cell. His explanation for this incident is that he thought he had to do something to flush himself out and put himself in the public eye.

2.13 Unfortunately the Court was not in a position to effect a rapid psychiatric disposal of the case, as reports necessarily had to be sought, nor does it seem that Mr A was prepared to pursue the arrangements for voluntary assistance. His problems came to a head in October 1980 when in breach of his bail conditions he went off to Ireland, had to be rescued by his father and back at home smashed the glass in the front door with an umbrella. At that point it appears that he was remanded in custody.

2.14 It is to be noted that during this incipient period of illness in 1980 Mr A did at times become violent. However, on each occasion the object of his aggression was property; at no time did he assault a member of his family or anyone else. He could not therefore be described as a danger to the public and it is apparent that his loss of self-control was much more likely to expose him to a risk of coming to some kind of harm himself than to lead to an incident in which another person was injured.

2.15 Eventually on the 25th November 1980 the Court made an Order under section 60 of the Mental Health Act for Mr A's compulsory detention in hospital and he was admitted to Shenley Hospital.

2.16 The medical records in relation to this first admission are somewhat thin, while the more extensive nursing notes tend to be concentrated upon observations. There is a comparative shortage of information about Mr A's thought processes and

mental state. However, it appears that he was unwell for a period of about eight weeks. Two aspects of his presentation and behaviour during this time stand out. The first is that he could not be relied upon to stay in the hospital; he absconded on several occasions and there were times when he had to be placed in seclusion. Secondly he suffered from persecutory delusions which seem to have had both political and religious themes; he believed that organisations such as the IRA, the CIA and the KGB were in some way endeavouring to get at him and he also thought that he was associated with Jesus.

2.17 Treatment was given with Haloperidol and Clopixol (Zuclopenthixol Deconoate) and with Procyclidine to counter the side effects of these antipsychotic drugs. By mid-January 1981 Mr A seemed to be settling down, although he had little insight into his condition and was not integrating well with other patients. Then at the end of January he absconded again, on this occasion going to Ireland, but was picked up and returned to Shenley Hospital. Subsequently his conduct looks to have been unremarkable and on the 20th February 1981 he was given extended leave and went back to live with his family.

2.18 Technically the section 60 Order remained in force until the 21st November 1981, at which time Mr A was formally discharged from care. In the meantime it was intended that he should remain on medication and be seen at regular intervals in the Out-patient Clinic. This plan looks to have been implemented, but there is a dearth of relevant records.

2.19 During 1981 Mr A undertook a course in computer programming and found work as a programmer with Trace Computers, by whom he was employed for the ensuing five and a half years.

2.20 In 1982 Mr A moved away from home and until 1985 he shared a house with three

friends from his school and college, at first in Kenton and then in Wembley. In 1984 he became involved with a girlfriend. So far as we can tell, his lifestyle was normal and there were no real problems. He informed us that he was very happy at that time.

2.21 However, in June 1985 there was a sudden relapse in his condition. His account to us of what then happened was that he suffered a mental breakdown during the night, travelled by train to South Wales on the following day with a view to going to Ireland but had to return to London (apparently for lack of a passport), marched down the road to his house carrying an estate agent's sign, caused a scene with one of his housemates and was taken away by the police. This significant incident is described in rather more detail in subsequent medical notes. What emerges is that on the evening of the 22nd June 1985 Mr A became increasingly agitated, got embroiled in an argument with a housemate and then attacked his housemate's friends when they refused to leave, resulting in a fight for some ten minutes until the arrival of the police. Thus there does on this particular occasion seem to have been violence towards other individuals.

2.22 Mr A's General Practitioner, Dr U, was called out to see him, as was his father, and an application was made for his admission to Shenley Hospital under section 4 of the Mental Health Act.

2.23 On arrival at Shenley he was noted to be rather edgy and suspicious, but he was rational and did not appear to be reacting badly to his admission, although he did assert that there was nothing wrong with him. However, on the following morning he had to be placed in seclusion when he suddenly started to scream and shout and threw himself against a door and then on the floor. The nurses thought that he was trying to get away from something, but it seems more probable that he wanted to escape from his confinement in hospital. Explosive behaviour of this character is

a typical feature of subsequent admissions

2.24 There is an interesting entry in the notes two days later when he was more settled. He then revealed that for a week prior to his admission he had been suffering from insomnia and had been laying awake trying to sort out the world's problems. His illness does therefore seem to have developed gradually over a period of days and inability to sleep, accompanied by flight of ideas, were important markers of its onset.

2.25 The intention at that stage was that Mr A should remain under observation and receive treatment with medication for a period of time, but a problem arose as an irremediable error had been made in the admission process whereby it was invalid. Accordingly there was a need either to undertake a mental state re-assessment with a view to admission under section 2 or to obtain a voluntary agreement to stay in hospital. A re-assessment was duly carried out, but it resulted in a finding that Mr A was not detainable. Although initially he consented to stay, on the evening of the 25th June 1985 he changed his mind and additionally declined to take any further medication. He could not then be prevented from discharging himself from the hospital, albeit against medical advice.

2.26 This outcome was regrettable, since Mr A was still unwell and was not able to function normally. He could not concentrate on his work, was not eating and continued to behave in a bizarre manner. On the night of the 28th June 1985 he did not go to sleep and was very restless, at one point wandering around outside and later dancing to music. Ultimately at around 5.00 a.m. he jumped out of a first floor window, thereby fracturing his right lower leg, although such was his state of mind that he does not seem to have appreciated that he had sustained a serious injury. His parents were contacted and came round to the house. They found him in a psychotic condition, saying among other things that there would be a nuclear

war, that the Queen had left the country, and that he was Jesus and his friends were his disciples. His explanation for jumping was that he had a nightmare (in whieh, according to a subsequent account, his room was on fire and a large black man was in the corner aiming a gun at him). Attempts to administer first aid were resisted and he refused to attend hospital for medical attention. The section 4 procedure was therefore again invoked and he was taken under compulsion first to Central Middlesex Hospital for treatment to his leg by way of a plaster baek slab and then back to Shenley.

2.27 On this occasion the diagnosis on admission was hypomania. He was medicated with Chlorpromazine (an antipsychotic drug) and Procyclidine and kept under observation. As usual, he was not happy to be in hospital and repeatedly requested to be discharged. On the 1st July 1985 he made an attempt to leave the ward in a wheelchair and on the following day his medication was increased and his section was converted to a section 2. On the 8th July 1985 his behaviour was reported as continuing to be childlike, irrational, unreasonable and demanding. At review on the 9th July 1985 he expressed some grandiose and persecutory ideas and said that the only way he would ever get out of hospital would be if the Russians and Chinese invaded. He appeared to have little insight into his illness.

2.28 Mr A continued to press for his discharge and took procedural steps to appeal against his detention. A hearing by the Managers Appeals Panel was duly fixed for the 15th July 1985. On that morning he became apprehensive and aggressive, punching a Charge Nurse in the face; this looks to have been a further instance of violent behaviour in some way associated with his confinement.

2.29 Mr A then refused to attend the hearing, which proceeded in his absence. The Panel were presented with medical and nursing evidence and also with a report prepared by a Social Worker, Ms N. This indicated that the family were very

concerned and anxious about the prospect of his discharge, that his girlfriend was also worried and that his housemates did not want him back in his present state. Unsurprisingly the appeal was rejected.

2.30 On the 24th July 1985 the medication was revised by the addition of Lithium (a mood stabiliser) in a dosage of 800mg per day and a reduction in the dosage of Chlorpromazine.

2.31 On the 26th July 1985 the section 2 expired. By that time Mr A had become more stable and in any event he was not considered to be sufficiently ill to warrant detention under section 3. On the next day he was allowed to leave and returned to live with his parents on a temporary basis. Officially he was discharged on the 8th August 1985. The plan at that time was that he should be followed up as an out-patient at Wembley Hospital, that he should continue to take the medication prescribed and that he should receive further treatment in respect of his injury.

2.32 There was a statutory requirement for a report to the hospital managers in respect of a section 2 patient. In this connection and after a reminder Mr A was seen somewhat belatedly by a Social Worker on the 11th September 1985. He was still living with his parents, but looking for rented premises in which to reside together with his girlfriend. Some advice was dispensed about accommodation options, but he did not seek any further assistance from the Social Services and thereafter the file was closed. The requirement for a report was regarded as having been met by the report provided for the appeal.

2.33 Mr A was reviewed at intervals as an out-patient. We do not appear to have all the records of these attendances, but there is a letter in the file which indicates that on the 25th October 1985 he was reviewed by a Psychiatric Registrar, Dr B, who also had the opportunity to speak to his mother and to his girlfriend. Mr A had

returned to work two weeks previously and had since been exhibiting a resurgence of odd ideas, although not to the same extent as before. Dr B raised the possibility of another admission to hospital, but he was reluctant to go in and his mother was against compulsory action; in any event Dr B did not think that he was detainable. A further revision was made to his medication, as he was finding that the prescribed dosage of Chlorpromazine of 150mg three times a day was making him too sedated and he could only manage 100mg a day; it was suggested that he should instead take Stelazine (Trifluoperizine) spansules 10mg nightly. In fact he did not change over immediately and interestingly he appeared to be much better when seen again by Dr B on the 1st November 1985, but Stelazine was then started.

2.34 The next recurrence of illness took place in March 1986, at which time it appears that Mr A was still living with his parents. The deterioration in his condition followed a typical course, in that there was a period of several days when he was not sleeping, was wandering around aimlessly and was preoccupied with political ideas about Ireland, America and Russia. Ultimately on the 24th March 1986 his family was able to persuade him to go into Shenley voluntarily.

2.35 On the morning following his admission Mr A tried to leave the ward and had to be restrained by the nursing staff. He was seen by Dr B, who found him to be exhibiting flight of ideas and grandiosity, believing that he could intervene to cause or prevent war between the super-powers, that he was important in the Irish conflict and that he was St Peter. He was irritable and challenged Dr B to a fight. It was decided that he needed to be compulsorily detained under section 3. For this purpose an application was made by Ms N.

2.36 Mr A then proceeded to abscond from the hospital and was found by nurses in Shenley Village attempting to jump in front of passing vehicles. His mood was

aggressive and he hit and kicked out at the nurses. They were able to bring him back to the hospital, but he remained in a volatile state. Over the ensuing week there were further incidents of violence directed at the hospital staff and windows were broken, resulting in the need for seclusion. On several occasions he refused to take his oral medication and he was generally difficult and uncooperative.

2.37 Eventually, however, he did settle down. He was treated with oral Clopixol and then started on depot. On the 11th April 1986 he was given leave and on the 15th April 1986 he was transferred to Wembley Hospital. Unfortunately he once again absconded and walked all the way to Reading, where he lay down on the floor of a museum. He was consequently re-admitted to Shenley on the 18th April 1986, but walked home the following day and had to be brought back by his parents and nursed on a locked ward for another week. Thereafter his behaviour was greatly improved and there were no further problems.

2.38 Mr A appealed against his detention to the Mental Health Review Tribunal and this again produced a batch of reports favouring continued detention. One of them, dated the 2nd May 1986, was prepared by Ms N following a visit to the family home on the 29th April 1986. She stated that Mr A's mother was keen for him to resume living at home and that both of them were against the idea of his going into a hostel. Ms N felt that so long as this remained the position it was very unlikely that any aftercare package she could offer would succeed. Nevertheless she was willing to work with Mr A and his girlfriend conjointly with a view to encouraging his wish to live independently of his family. We should add that Mr A's mother and his girlfriend complained that they had not been able to get help for him expeditiously.

2.39 Mr A was actually discharged on the 9th June 1986 before the appeal could be heard. His prescribed medication on discharge was an intramuscular injection of

Clopixol 200mg two weekly, Haloperidol 20mg tds and Procyclidine 10mg tds. The depot was to be administered by a Community Psychiatric Nurse. In addition he was to attend out-patient appointments at Wembley Hospital. However, there was to be no input from the Social Services. It seems that Ms N had submitted a formal request for a local Social Worker to be allocated to the case, but that there was no-one available with sufficient time to take it on because there was a "flood of referrals" and a "backlog". The file had therefore been closed.

2.40 There is then a hiatus in the records until November 1987. In the meantime Mr A did move away from home and live with his girlfriend for a period of about a year. In March 1987 he gave up his employment as a computer programmer and in July 1987 he embarked upon new work as a systems analyst, but this proved to be beyond his capabilities and only lasted for three months.

2.41 On the 4th November 1987 Mr A was seen by a Social Worker and his girlfriend's General Practitioner, presumably at her instigation. The note indicates that he had stopped taking his depot medication three months earlier, that he was wandering and talking about the IRA and Russians, and that he had thrown away his keys and cheque books and torn up a cheque from work. However, he was found to be calm and "not sectionable" - ie. he was not suitable for compulsory admission under the provisions of the Mental Health Act. There is then a second note made on the 9th November 1987, which states that he had been seen in the meantime after he had hit his father who was trying to hold him in and seen again that day when he requested help by way of therapy and sleeping tablets. On each of these occasions Diazepam was prescribed, but no other action was taken because he still did not present as detainable under the Mental Health Act. This was hardly a satisfactory situation, as more assertive intervention was surely necessary.

2.42 On the 11th November 1987 he was involved in an incident in a public house. It

is not entirely clear what happened, but a bottle of whiskey was broken and he was charged with an offence of criminal damage. He was taken to Brixton Prison and found to be psychotic. His family engaged a psychiatrist privately and on the 26th November 1987 at Willesden Magistrates Court he was remanded to Shenley for 28 days so that a report could be prepared and submitted. Plainly there had been another relapse, as his mental state on admission was very similar to that observed on earlier occasions. However, his symptoms rapidly responded to medication and resolved completely within a period of two weeks. He was not thought to require further in-patient treatment and at the adjourned hearing on the 24th December 1987 the Court made no order for his detention.

2.43 On the 19th February 1988 Mr A was reviewed by a Psychiatric Registrar. He had been living with his parents and it appears that his relationship with his girlfriend had irretrievably broken down. He indicated that he had been spending all day at home doing nothing.

2.44 The next out-patient appointment on the 29th April 1988 was cancelled. Another date was given, but we have no further hospital records until July 1990. The GP notes contain four intervening entries; two refer to injections of Clopixol and one to prescription of Procyclidine, so that it seems likely that medication was being taken.

2.45 On the 20th July 1990 Mr A was seen at Wembley Hospital by Dr H. By that time he had been working for some months on a shift basis as a box office operative at Wembley Stadium. This employment was beneath his actual abilities, but he told us that he enjoyed it. In her report to his General Practitioner dated the 24th July 1990 Dr H said that he remained well and was still working, which leads us to conclude that there must in fact have been preceding reviews. At some time the frequency of his depot medication had been extended to every four weeks and on

this occasion the dosage was reduced to 150mg. It follows that he was to be given less than one half of the Clopixol advised in 1986.

2.46 Soon afterwards Mr A suffered another relapse, with the usual symptoms of inability to sleep and thought disorder. Subsequent records describe him as having been wandering the streets and giving his clothes and money away. He was then arrested by the police for what looks to have been a minor indecent assault on a female in Central London. This led to his appearance at Bow Street Magistrates Court on the 24th August 1990, when the charges were dropped on the advice of a Probation Officer but he was admitted informally to Central Middlesex Hospital. On admission he was found to be in a psychotic state, with auditory hallucinations and grandiose delusions.

2.47 On the following day Mr A typically demanded to leave and was held under section 5(2) of the Mental Health Act. However, on the 27th August 1990 he absconded and took a train to Manchester without a ticket, as a consequence of which he was arrested at Rugby and escorted back to the hospital. Steps were then taken with a view to his detention under section 3.

2.48 Mr A's reaction to his confinement was in line with what would have been expected. He was agitated and aggressive, struck out at the nursing staff, smashed a fire alarm, made several attempts to leave (one of which was successful but short lived), and consequently had to be secluded on a number of occasions. It became apparent that he needed to be nursed in a more secure environment and he was therefore transferred to Shenley on the 1st September 1990.

2.49 His behaviour at Shenley was initially disturbed and demanding and there was an incident when he soaked nursing staff with water from a fire hose. However, his illness was brought under control with medication and within a short timescale he

had settled down. By the 17th September 1990 it was considered appropriate for him to be returned to Central Middlesex Hospital and he was duly transferred on the next day. Thereafter he was allowed to return to his parents on leave and he was ultimately discharged on the 22nd October 1990.

2.50 The regular medication on discharge was limited to Lithium 1200mg at night and no depot was prescribed. It was suggested that any resurgence of his symptoms should be treated with Haloperidol.

2.51 On the day of his discharge Mr A was seen at the hospital by Mr O, a Social Worker in the Special Needs Division. He told Mr O that he was interested in attending assertiveness training and was given information about a group run by Mind. His work situation was discussed and he indicated that he felt unable to work as a computer programmer but would seek re-employment in the Wembley box office.

2.52 Mr O then visited him at home on the 6th November 1990. He was not at that time looking for work and we note that apart from a brief engagement as an administrative assistant in an office he remained unemployed for several years. However, he said that he did not require any assistance from the Social Services and Mr O seems to have thought that he was sufficiently well supported at home not to require intervention. Accordingly he closed the case. Given that Mr A's social circumstances and work situation were actually far from ideal, this was arguably a step in the wrong direction.

2.53 Upon review at the Central Middlesex Hospital on the 30th November 1990 Mr A presented with a normal mental state. However, on the 16th January 1991 he saw Dr V, one of the partners at the practice in Wembley at which he was registered, and said that he was again becoming manic and sleepless. Treatment

was given with Haloperidol, but he took it somewhat erratically and it also seems that he was taking his Lithium in low dosages. At the next out-patient review on the 1st February 1991 arrangements were made for him to be admitted informally to the hospital.

2.54 The notes in relation to this admission reveal that he stayed on the ward until the 20th February 1991 and that his behaviour was generally unremarkable. He then went home without leave, but returned two days later and was granted leave on a formal basis. His discharge followed on the 4th March 1991, at which point in time the recommended level of Lithium was 800mg daily and Haloperidol was also to be prescribed.

2.55 Until October 1991 Mr A was reviewed at intervals in the Out-patient Clinic by Dr C, a Locum Consultant Psychiatrist, or by a Senior House Officer. His condition remained relatively stable.

2.56 Dr C was then succeeded by Dr D, a Consultant Psychiatrist with a permanent appointment, and for the ensuing three years it was Dr D who had the overall responsibility for Mr A's care.

2.57 On the 3rd January 1992 Mr A was seen in the Out-patient Clinic by Dr D's Senior House Officer, Dr E. He was slightly restless, but there was no other evidence of mania and no problems were recounted. By this time he had commenced a full time course in computing at a Technical College.

2.58 At the next review on the 27th March 1992 Mr A was seen by Dr D, who noted that six weeks to two months earlier he had come off his Haloperidol and a week later had found that he was not sleeping properly and was experiencing his delusional thoughts. He had therefore resumed the medication and he had then

settled down. He was currently well, but did say that he still believed he could be John the Baptist. Dr D concluded that he should continue taking Lithium 800mg daily and Haloperidol 5mg up to three times daily and that in addition he should take Stelazine 10mg in slow release spansule form. He was to be reviewed again in the near future.

2.59 Mr A was duly seen by Dr D one month later on the 24th April 1992, when he reported no problems apart from some background religious thoughts.

2.60 On the 4th June 1992 he visited the Wembley practice and was seen by a locum. The note in his medical records for this visit relates entirely to medication and we should point out that the system which applied in Brent was that instructions in respect of medication were given by the psychiatrists but the prescriptions for oral drugs were issued by General Practitioners. On this occasion Mr A wanted a reduction of the dosage of Stelazine to 8mg and the practitioner appears to have complied with his request but prescribed the drug in a non-spansule form. That alteration was noted at the next out-patient review on the 26th June 1992, which was conducted by a Senior House Officer, and the point was made that it would probably be better if he took spansules and he could have 2 x 4mg per night. Mr A then saw the locum again on the 9th July 1992 and obtained a supply of medication including 2mg spansules. Subsequently on the 10th September 1992 he was prescribed 2mg spansules tds and he was taking a total of 6mg nightly. This level of medication was, however, approved by Dr D at review on the following day.

2.61 On the 9th November 1992 Mr A was seen at the practice by Dr W, an assistant who had prescribed for him on a number of occasions prior to June 1992 and knew him well. He told Dr W that he was now only taking his Lithium and Stelazine in a dosage of 4mg nightly and that he had stopped the Haloperidol completely due

to its side effects. He also said that he needed sedatives at times to sleep and was prescribed Temazepam. On the 14th November 1992 he told Dr W that he was feeling a bit better, but three days later he attended again and informed Dr W that he no longer wished to take Lithium and had gone back to Haloperidol in a dosage of 25mg daily, in addition to which he was taking both Temazepam and Nitrazepam (another hypnotic). Dr W's entry in the GP notes states that Mr A had been modifying his medication frivolously and that the matter required discussion with Dr D. We would entirely agree with that proposition; the situation was becoming close to unmanageable.

2.62 On the 19th November 1992 Dr W spoke to a member of staff at the Out-patient Clinic on the telephone and left a message for Dr D communicating his concern. However, on the same day and before any action could be taken, Mr A became involved in an incident when he took a shopping trolley to carry his computer course files and damaged a car with it. Later he drank almost the whole of a bottle of brandy and collapsed at home. He was therefore taken by ambulance to the Accident and Emergency Department at the Central Middlesex Hospital, after which he was admitted to the Mental Health Unit on an informal basis.

2.63 On admission a history was recorded of three weeks of racing thoughts, insomnia, arguments with parents, medication taken erratically and in excess of therapeutic doses, and abuse of alcohol. It is regrettable that Mr A's condition had been allowed to deteriorate to that extent over that length of time.

2.64 Mr A was an in-patient on this occasion for some two months and there are extensive clinical and nursing notes, but in summary the pattern of events was very much as on previous admissions. In the early stages he was clearly both psychotic and manic. He expressed grandiose delusions and in particular reiterated his belief that he was John the Baptist. He was extremely restless and agitated, there was an

episode when he harassed a female patient in her room and on being escorted away struck out at Dr D and nursing staff and had to be restrained, at other times he kicked at and banged on doors, he absconded twice and made further attempts to leave, and he was secluded. The section 5(2) procedure had to be invoked and then he was placed on a section 3. On the other hand after a period of about one week he responded to medication with Clopixol and Droperidol and his behaviour significantly improved; although for a while he remained somewhat disinhibited and throughout retained his most deep-seated delusional beliefs, his presentation was no longer a serious problem and his care was relatively uncomplicated.

2.65 He was discharged on the 15th January 1993. His recommended medication was Lithium 800mg nightly and Clopixol 200mg two weekly. Thus depot medication was re-introduced as a regular measure; this is readily understandable, given the uncertainty over Mr A's attitude towards his oral medication.

2.66 Mr A was reviewed in the Out-patient Clinic on the 19th February 1993 by a Locum Registrar. He said that he had remained well and had been sleeping longer than usual. His concentration was poor and he felt tired in the afternoon, but it was not affecting his day to day living. He specifically requested that the Clopixol be reduced to 200mg every three weeks and this was agreed. It is not clear why a clinician should have acceded to an alteration at the behest of the patient within a period of one month following discharge, but there was in any case to be another review in 6-8 weeks time at which the outcome could be considered.

2.67 We have recounted the history of events over the period of 13 years between 1980 and 1993 with some degree of detail, since although we have treated it essentially as falling into the category of background material, it was almost all recorded and available to the various professionals who subsequently came to be involved in the case and ought therefore to have been taken into consideration. The quality of the

care afforded to Mr A from 1993 onwards has to be judged in that context.

2.68 While we have desisted from a plethora of comment upon events so far removed in time from the homicide as not to warrant microscopic examination, we must now draw certain central conclusions from them as follows :

(i) Mr A suffered from a schizoaffective disorder characterised by episodes of mood disorder and non-mood congruent delusional beliefs.

(ii) He did not continuously exhibit evidence of active symptoms and for long periods of time his condition could be kept under control. Nonetheless there were repeated relapses into acute illness.

(iii) Relapses would develop over a timescale of between one and three weeks. They were marked by symptoms of restlessness, inability to sleep, thought disorder and increasingly bizarre behaviour. These indications could quite readily be observed.

(iv) Medication was necessary for the maintenance of stability, but it would not necessarily prevent a relapse.

(v) Mr A's parents were highly supportive, but they could not reasonably be expected to cope without a suitable level of professional assistance, not only in monitoring his condition but also in taking prompt action when it became required upon occasions of relapse.

(vi) Mr A could become violent when he was ill. Out in the community his outbursts tended to be directed against property and he was clearly more a danger to himself than to anyone else. On the other hand at times when he

was confined in hospital he was typically aggressive for several days.

(vii) He did not have particularly good insight into his condition and was neither inclined to take himself to hospital when he started to relapse nor willing to stay there upon admission.

(viii) As a consequence of his illness his social circumstances and employment situation were poor for someone of his age, background and intellectual ability. Some support in these areas would have been beneficial.

CHAPTER 3

THE CRITICAL YEARS

3.1 In one sense to draw a dividing line between background events and those of more critical significance is artificial, as Mr A's condition and lifestyle did not alter to a substantial extent at any particular time and there is a continuing account of similar problems. However, we can see the logic of concentrating our attention on Mr A's treatment and care during the years immediately leading up to the homicide, since policies and procedures are bound to undergo change over time and we would wish to focus the commentary in Chapter 5 on aspects of mental healthcare which are of relevance to the current system.

3.2 We have elected to draw the line at April 1993 for two main reasons. In the first place the responsibility for the provision and management of the mental health services in Brent was at that time transferred to the North West London Mental Health NHS Trust. Secondly, although the Care Programme Approach came into being in 1990, it was in 1993 that steps began to be taken in Brent to implement its provisions.

3.3 On the 16th April 1993 Mr A was reviewed in the Out-patient Clinic by Dr D. He was found to be well and in a stable condition, although he mentioned that his concentration was variable and he could lie around doing nothing. No change was made to his medication, but Dr D appears to have given some thought to the place where the depot injections were to be administered. So far as we can determine, up to that point Mr A had been given his depot by a Community Psychiatric Nurse on Shore Ward at the Central Middlesex Hospital. This was not convenient for him and Dr D therefore wrote to Nurse E, a Senior CPN, on the 4th May 1993

expressing his preference to have the injections at Crawford Avenue or John Wilson House but adding that he might be amenable to going to the Westmore Resource Centre.

3.4 Dr D reported his findings and proposals to the Wembley practice in a letter also dated the 4th May 1993. We note that it was directed to Dr X, the senior partner in the practice. The GP notes reveal that Mr A did see Dr X at around that time, but this looks purely to have been by chance. Patients registered at the multi-handed practice could be seen by any of the General Practitioners and although some consistency of personnel was intended (and indeed between 1991 and 1995 Mr A was usually seen by Dr W), it was not always achieved. Thus it would seem that letters from the hospital to the practice were addressed to Dr X either because Mr A was registered with him or because he was Dr W's principal or simply as a matter of convenience. In any event all reports were addressed to Dr X until 1995 and thereafter to Dr X or Dr V.

3.5 Dr D next saw Mr A on the 25th June 1993, when he had just finished his College course. The clinical note indicates that he was in fact still getting his depot on Shore Ward but would prefer to have it at Wembley. He told Dr D that four weeks previously, which was two weeks after an injection, he had woken up at 2.00 a.m. and could not get back to sleep. He had gone to the Accident and Emergency Department at Central Middlesex, tried to contact the psychiatrist on duty there, was instead given an appointment for the next day, and so went back home. This had, however, been an isolated incident. Dr D thought that it might have been associated with drinking and missing a dose of Lithium and he did not consider that the frequency of the depot injections should be increased to once every two weeks.

3.6 Mr A was seen again by Dr D on the 3rd September 1993. He was well and not

suffering from any affective disturbance. We observe that on this occasion he acknowledged that his core belief that he was John the Baptist was delusional, although Dr D quite rightly thought that it would return when he became ill. His treatment was accordingly continued as before and Dr D's note reveals that injections of Clopixol were still being given on Shore Ward.

3.7 Five days later on the 8th September 1993 Mr A attended at the Wembley practice to get his oral medication and saw Dr W. The entry in the GP notes is difficult to decipher, but he appears to have been complaining of tiredness and saying that as a result he had again stopped his Lithium for a few days (but then re-started). Dr W dealt with this problem by adding Droperidol 10mg to the prescription.

3.8 Mr A then returned on the 13th September 1993 and on this occasion was seen by Dr Y, a partner in the practice who does not look to have been involved in Mr A's recent care. He stated that his sleep was slightly improved, but that he was fed up because of poor sleep. No psychotic features were observed, but in retrospect we can detect here the early signs of trouble. To his credit Dr Y proposed only to continue a prescription of Droperidol 5mg three times a day for a period of one week before reviewing it. However, there is no indication in the GP notes that Mr A came back a week later.

3.9 The next entry in the notes is in fact dated the 4th October 1993, when Mr A was seen by Dr V. At that point he purported to be taking Droperidol 25mg a day, but he was observed to be manic. Dr V made a note that the position was to be discussed with Dr D and thereafter she recorded that there had been a discussion and that the prescription was to be increased to 10mg four times a day.

3.10 It is plain that the system whereby Mr A was obliged to get his medication from the Wembley practice was not working well. Were he to have been getting the

medication from a psychiatrist, no doubt that psychiatrist would have been in closer control of the situation. But, as it happens, Mr A did on this occasion attend at Central Middlesex Hospital before he became completely unmanageable, as he was taken there by his concerned parents on the night of the 4th/5th October 1993.

3.11 He arrived with a letter he had written for the Duty Psychiatrist, in which he said that he was the leader of the IRA and that his personality could best be described by an accompanying diagram. This suggested that in addition to being a political revolutionary he was God and a number of religious figures wrapped up together. He was duly referred to the Duty Psychiatrist and seen at 6.25 a.m., when he was found to be manic but not considered sufficiently ill to be detained. The situation was then discussed with Dr D, who thought that he ought to be admitted and arrangements were therefore made for this to be done informally. Unfortunately at 8.45 a.m. Mr A as usual insisted on leaving, but he appears to have agreed to return later and he was informally admitted at 5.30 p.m.

3.12 On admission it emerged that during the previous week he had gone to Ireland and at some stage he also revealed that in Swansea he had been arrested for shoplifting and cautioned. Accordingly the passage of time between the onset of symptoms of restlessness and agitation and the admission, which on his own account or that given by his parents was three weeks, did have at least one adverse consequence, although no member of the public came to any harm.

3.13 It also subsequently emerged that Mr A had been drinking quite heavily. We know from other records that he did not only take to drink when he was ill; he also drank lager in quite substantial quantities at times when he was stable. But there looks to have been some correlation between relapse and serious abuse of alcohol and his level of consumption was a factor which needed to be monitored.

3.14 On the ward Mr A's behaviour was not quite so consistently bad as on other occasions. There were two incidents when he came to blows with fellow patients and he also made a bomb hoax call to the police, but he did not assault any of the nurses. At one stage he attempted to leave and on the following day Dr D felt that his mental state warranted compulsory detention, but after the section 5(2) procedure had been invoked and action was being taken to proceed under section 3, he assured the Approved Social Worker that he would stay. On that footing and because his mother was against compulsory admission on the ground that he had entered hospital voluntarily and taken the positive step of assuming responsibility for his illness, the application did not proceed. He did then abide by his promise and he settled down after he had been in the hospital for about a week; thus his treatment followed the usual successful course.

3.15 Mr A was discharged on the 10th November 1993. Recommended medication was Lithium 1000mg nightly (an increase on the previous level), Procyclidine 5mg daily, Droperidol 10mg qds and Clopixol 200mg three weekly. On the Discharge Summary was a plan, which specified that depot was to be administered by Nurse E who was also to be the key worker. The depot records show that injections on Shore Ward had been administered by other nurses, so that there was now to be a change of direction to what must have been intended to be a greater element of monitoring of Mr A's compliance. We note that there had in fact been an official referral to the Community Psychiatric Nursing Service and that the reason for referral was stated to be that he would benefit from CPN input on compliance.

3.16 However, Nurse E does not personally appear to have undertaken the task of monitoring. Instead it was done by one of his colleagues, Nurse F. There is no evidence that she was ever formally designated as Mr A's key worker, nor at that time does any key working as such seem to have been done. On the other hand we have no cause to doubt that Nurse F was competent to give the injections and to

look out for signs of relapse. Mr A's records include notes made by her on each occasion that an injection was given; they reveal that this was done at his home and that she would ask him about his mental state.

3.17 On the 30th November 1993 Mr A was reviewed in the Out-patient Clinic by Dr D's Senior House Officer, Dr F. Given that he had been reviewed personally by Dr D since April 1993 and this was the first appointment after his relapse and hospitalisation, it is interesting that he was allocated to a junior doctor. However, Dr F had in fact been the admitting doctor on the 5th October 1993 and had been involved in Mr A's care as an in-patient.

3.18 Mr A told Dr F that he was feeling well. He kept shaking his hands, but otherwise did not seem to be agitated. His speech was normal, there was no flight of ideas and he claimed that his political beliefs had gone (but he still sometimes thought he was John the Baptist). He maintained that he was sleeping throughout the night, yet also said that he sometimes felt a bit sleepy in the morning and made a request for the Droperidol to be reduced. In this connection it is to be noted that he was then taking 20-30mg per day, which was less than had been prescribed, although still a relatively high dose. Dr F now agreed to a further reduction, which was specified in the clinical notes as 10mg bd but reported in the ensuing letter to Dr X dated the 6th December 1993 as 10 to 20mg a day. In effect Droperidol was being utilised as a top-up drug in accordance with Mr A's requirements.

3.19 He was next reviewed by Dr F on the 15th February 1994. He was sleeping well and there had been no change in his condition or circumstances, except that there is no longer any reference at all to Droperidol and we can only presume that he had by then decided that he did not wish to take any of this medication.

3.20 At neither of these reviews does Dr F appear to have investigated the extent to

which Mr A may have been drinking. This is a notable omission, as the in-patient records clearly demonstrate that he was aware of the problem. Moreover Mr A was in fact still consuming quite substantial quantities of alcohol, in the region of 4-5 pints a day, as this was communicated to Dr W on the 11th April 1994. Dr W stressed the importance of taking his medication regularly and we apprehend that he was also probably advised to cut back on his alcohol intake.

3.21 On the 19th April 1994 Mr A was seen again by Dr D. He said that he was well and currently attending a drop-in centre in Wembley and that he was sleeping through the night. He then alleged that he was not drinking a lot, no more than a few pints per week, which looks to have been an understatement. He was taking his medication as prescribed, but abusing the Procyclidine by taking it to get a kick in the afternoon. Dr D suggested that he should replace this drug with Sulpiride 100mg twice daily.

3.22 On the 19th July 1994 Mr A was reviewed by another Senior House Officer, Dr G. There was no change in his condition, but the clinical note incorporates the important information that Nurse F was leaving in August. In his report to Dr X dated the 21st July 1994 Dr G expressed the hope that another Psychiatric Nurse would be allocated. Unfortunately this did not turn out to be the case.

3.23 In a letter to Dr D dated the 16th August 1994 Nurse F stated that she had to ensure the continuing care of her patients and that following discussion with Mr A she had made arrangements for him to have his depot injections at the Westmore Resource Centre where he could also be monitored. She hoped that this would be satisfactory. But there was a missing piece of material information here, namely that she had not actually passed the case on to another CPN; her successor was to be Nurse G, who had not functioned in the role of a CPN previously. In all probability the reason why Nurse G was chosen was that at that time she was one

of the nurses who saw patients at the depot clinic at Westmore. We rather doubt that Dr D was involved in the decision, as he does not now recall discussing the matter with anyone and the terms of the letter do not imply any prior contact.

3.24 On the 18th October 1994 Mr A was reviewed by Dr D. He was well and sleeping on most nights and he maintained that his alcohol consumption was episodic, 5-10 pints a week and sometimes nil. He told Dr D that he was getting his Clopixol injections from Nurse G at Westmore. No change was made to his medication.

3.25 At that stage Dr D wanted to transfer a number of his out-patients from the Central Middlesex Hospital to his clinic at the Wembley Hospital (located at the Westmore Resource Centre) and he proposed that Mr A should in future attend there. Mr A was reluctant but agreed and he was given an appointment to be seen by Dr D at Westmore on the 20th January 1995.

3.26 At around this time Mr A commenced a computer course on four days a week. He was unable to attend Westmore for his injections as usual on Wednesdays, but was informed by Nurse G that he could come on Saturdays instead.

3.27 Mr A was not in fact seen again by Dr D, as he had moved to another role within the Trust. His caseload was taken over by Dr H, who was at that time an associate specialist acting as a Locum Consultant Psychiatrist, and thus it was Dr H who reviewed Mr A on the 20th January 1995. He informed her that he was well, but Dr H thought that he looked a bit unkempt and showed slight signs of negative symptoms of schizophrenia. Nonetheless she considered that his mental state was within normal limits. As she had not personally been involved in the case for some time, it would have been difficult for her to judge whether his presentation was actually undergoing any change.

3.28 Towards the end of January 1995 he began to experience the typical symptoms of relapse. He stopped sleeping properly, became restless and could not concentrate on his course. He clearly appreciated that he ought to bring this to the attention of Dr H, because on the 29th January 1995 he wrote to her saying that he would like to see her. Then on the 31st January 1995 he attended at the A & E at Central Middlesex and complained of worsening illness, but did not wait to see the Duty Psychiatrist to whom he was referred. We do not know what happened here, but one of the complaints which were made to us by the family was that sometimes there could be a very long delay at the A & E and perhaps this was the problem. In his agitated state Mr A would not have been likely to stay put for any great length of time.

3.29 Instead he returned on the 1st February 1995, together with his father, having first visited the Wembley practice and obtained a letter of referral from Dr Z. On this occasion he did get to see a psychiatrist and it was agreed that he ought to be informally admitted.

3.30 At the outset of this period of in-patient care Mr A was in a psychotic state, expressing his core belief that he was John the Baptist and experiencing auditory hallucinations. His behaviour was typically disturbed; he attacked another patient, struck out at the nursing staff and on one occasion tried to jump through a plastic reinforced window. He absconded from the ward and had to be brought back by the police. For several days he was kept on heightened observation. Nonetheless he remained an informal patient and he did, as always, settle down eventually. He was medicated orally with Lithium 1000mg nightly and Droperidol 15-20mg three times a day, and the frequency of Clopixol 200mg was increased to fortnightly.

3.31 Because this relapse had undoubtedly occurred at a time when Mr A had been taking his regular medication, Dr H thought that it might be a good idea for the

combination of drugs to be altered. She therefore suggested that he should move from Lithium to Carbamazepine, but he did not accept this change.

3.32 He was discharged on the 15th March 1995. At that time we would have expected a formal meeting between the various professionals who were involved in his care and his parents, appointment of a key worker, and completion of a detailed care plan incorporating risk factors and proposals for action in the event of incipient relapse. But the Care Programme Approach does not as yet appear to have been properly in operation. There was in fact a meeting attended by Dr H, a junior doctor, a ward nurse and Mr A himself. A care plan was then prepared which simply stated that he should live at home, continue with his present medication, get his depot at Westmore, go to his next out-patient appointment and attend every Tuesday at Westmore (for an unspecified purpose - it may actually have been at Twyford Day Hospital for woodwork). This amounts to saying little more than that he should carry on as before, although there was also a recorded intention that a key worker should in due course be appointed.

3.33 On the 21st April 1995 Mr A was reviewed in the Out-patient Clinic by Dr I, a Senior House Officer. He asserted that he was feeling much better and no abnormality was observed. The clinical note includes reference to the fact that he was attending weekly woodwork sessions and that he had cut his Droperidol down to 10mg nightly. It also appears that Mr C, the Deputy Manager at Twyford Day Hospital, had by that time been appointed his key worker.

3.34 He was next seen by Dr H on the 5th May 1995, when he was well and there was no change in his condition or circumstances.

3.35 On the 13th July 1995 a meeting took place between Dr H and Mr C. The note written on this occasion is headed "CPA meeting", but Mr A did not attend and

nor were his parents or Nurse G present. The meeting appears essentially to have been an exchange of information.

3.36 Mr A was reviewed again by Dr H on the 21st July 1995. At that time he was reasonably stable, but he had not resumed working or started another course and apart from his woodwork his life remained unstructured. Dr H thought that he would benefit from part time employment; in her report to Dr X dated the 24th July 1995 she made the valid point that if he were not to try to return to work, he would be at a financial disadvantage and it would be easy for him to lapse into an unmotivated state.

3.37 He was reviewed three months later by Dr H on the 27th October 1995. He had not yet moved forward on the employment front, but said that his concentration was improving and appeared to be happy with his progress. It seems that he was at that time taking both Procyclidine and Sulpiride and thought that the Sulpiride was helping him to be more energetic.

3.38 The records held at the depot clinic demonstrate that Mr A was attending at the depot clinic on a regular basis. There was only a single instance when an entry was not made on the drug prescription sheet, namely on the 5th August 1995; it is not obvious what transpired on that occasion. The injections were not always administered by Nurse G; entries were also made by other nurses. On many occasions a separate nursing note was written. These notes suggest that attention was being addressed to Mr A's mental state, but we are not in a position to assess the extent to which effective monitoring was being achieved.

3.39 Mr A attended as usual for his injection on the 11th November 1995. There was no separate comment on that day. However, over that weekend his mood became elevated and he was unable to sleep. He increased his Droperidol to 20mg three

times a day. Realising that a problem might be developing, he sensibly went to Westmore on the 13th November 1995 and brought his altered condition to the attention of Dr L, a staff grade doctor who was based there. Dr L did not at that stage think that he was ill, but arranged to see him again two days later.

3.40 On the following day Mr A was seen in the Out-patient Clinic by a doctor who noted that he was feeling a bit high, having more ideas than normal and sleeping badly. Nonetheless he was considered to be managing his elevated mood well and no action was required.

3.41 There was no entry in the notes by Dr L on the 15th November 1995, but he saw Mr A again on the 24th November 1995 and by that time it seems that he was improving. At a further review in the Out-patient Clinic three days later he was still slightly high but sleeping adequately. He was advised to throw away his old medication and given a fresh prescription of Droperidol 35mg per day.

3.42 Thereafter Mr A made a good recovery and he also became more motivated. In December 1995 his sister offered him work on three days per week carrying out computerised bookkeeping for the business which she and her husband operated and it was agreed that he would start in January 1996. In some ways the work was ideal for him, as it utilised his skills, provided him with an income and allowed him to work in a friendly environment at his sister's address where he would feel comfortable and his progress could be monitored; it subsequently became almost a full time occupation. On the other hand it did mean that his lifestyle continued to be rather cloistered and that he was even more dependent upon his family.

3.43 On the 13th February 1996 the woodwork group at Twyford Day Hospital was closed down. The need for Mr A to undertake woodworking as a therapeutic activity was no longer particularly great in any event, but the main repercussion

of the closure was that he was to be discharged from Twyford and Mr C was no longer to be involved in his care. Effectively he was not only to lose the benefit of his regular contact with Mr C and the support he had received from that source, but in addition he was to lose his existing key worker. Instead Dr H was to carry out this function. We do not consider that she was as well placed as Mr C to meet its requirements, as her involvement was likely to be much more sporadic.

3.44. On the 16th February 1996 a CPA meeting was convened. During the course of 1995 formal CPA documentation had been devised and accordingly a printed form was on this occasion utilised. It was headed "For Level 1 Category Clients" and we conclude that Mr A was at that stage regarded as a patient on that upper level, although we have been unable to establish that he was ever officially placed on Level 1. Nonetheless he later looks to have received the standard of input that would be expected in respect of a Level 2 patient.

3.45 On the form the date of the meeting was incorrectly entered as the 30th November 1995. Presumably there was an administrative glitch, which is hardly helpful to anyone who might later have been reviewing the case.

3.46 The meeting was attended by Dr H, Mr C, Nurse H (a depot clinic nurse) and Mr A himself. A discussion took place between them in the course of which Mr A expressed an understandable desire to have no further relapses. The response of the professionals was that he needed regular monitoring and Carbamazepine added to his medication. Mr A also stated that he would like to have more friends and he was therefore encouraged to socialise more at the drop-in centre.

3.47 The care plan formulated at the meeting and set out on the form was as follows :

1. To discharge from Twyford Day Hospital

2. To receive depot from depot clinic at Westmore Resource Centre
3. Out-patient follow up
4. To continue to work with sister 2-3 days per week
   as computerised book-keeping
5. To continue to attend drop-in on Thursday,
   College on Monday, Information Technology Part II

3.48 There was then a section under a heading "Action(s) to be taken if client in danger of relapse / carer unable to cope". That action was to consist of Mr A getting in touch with Dr H, or his parents, if concerned, getting in touch with either Dr H or staff at Westmore. This in our view only scratched at the surface of what was a crucial aspect of the care plan. It did not identify the symptoms of relapse for which a close watch needed to be kept, specify the mechanisms by which any further deterioration might be controlled, indicate a procedure for dealing with an out-of-hours crisis, or provide the family with effective lines of communication with the medical and community teams.

3.49 In a letter to Dr X dated the 20th February 1996 Dr H reported that the meeting had taken place and that it had been agreed that there would be a trial of Carbamazepine and Lithium together. The letter did not purport to enclose a copy of the form (which was not signed until the 1st March 1996), but the GP notes do include a copy and presumably it must have been sent at some stage. Its contents would then have been available to the practitioners who saw Mr A and read his notes. Dr V was not one of them, as she did not see him after the 4th May 1994, although she was specified on the form as his General Practitioner.

3.50 On the 15th March 1996 Mr A was reviewed by Dr H in the Out-patient Clinic. His condition was stable and as he had not experienced any ill effects from the addition of Carbamazepine 100mg twice daily he was advised to increase the

dosage to 100mg in the morning and 200mg at night.

3.51 It was intended that the next review would be in about two months time, but for some reason the appointment was actually made for the 12th July 1996. Sadly Mr A again relapsed prior to this date. From about the end of May 1996 onwards there was the usual three week warning period of increasing difficulty in sleeping, irritability and high mood, but on this occasion he does not appear to have taken any steps to bring his symptoms to the attention of a doctor. Although on the 8th June 1996 he attended at the depot clinic for his injection, there is no indication of an attempt to contact Dr L. The depot itself was administered by a nurse whose previous involvement had been sporadic and who presumably did not pick up any signs of deterioration; no entry was then made in the notes.

3.52 On the 17th June 1996 Mr A was found wandering on the motorway in the Hereford area. He had telephoned the emergency services and told them that he was training with the IRA and SAS. It is plain that he had reached the point in the development of his illness when he was no longer in control of his actions. The reason why he had gone to that particular area is less obvious, but may have been related to the fact that the SAS were based in Hereford.

3.53 He was taken to the County Hospital in Hereford and informally admitted. He was observed to be agitated and in an inappropriately elated mood and he expressed deluded ideas about the IRA and other organisations and also said that he was John the Baptist. After disappearing from the ward and returning with scratches on his arms, he was detained under section 5(2) and then section 2. In accordance with his usual behaviour when ill he made several further attempts to leave, but there is no indication in the case summary of any violence.

3.54 On the 20th June 1996 he was transferred to the Central Middlesex. On admission

he stated that he had found himself unable to concentrate on work and had gone off for a holiday. He also said that he had gone to practice his combat skills and that he was a terrorist and secret agent in training. We should, however, point out that there is absolutely no evidence to suggest that he ever possessed any combat skills and the fact that he was expressing delusions down these lines does not in our view amount to any indication that he was dangerous. His conduct when he was travelling around was more likely to have exposed him to the risk of injuring himself than to have constituted a real threat to anyone else.

3.55 In hospital there were one or two incidents when he became aggressive, kicking at a door or throwing objects around. Otherwise he seems to have behaved in a reasonably controlled manner and responded to his regime of treatment.

3.56 There is an interesting note in respect of a ward round on the 1st July 1996 when he said that at the time he became unwell he had stopped taking his medication and started drinking heavily. What does not, however, emerge is whether those actions (which had been mirrored on other occasions) were factors causative of the relapse or alternatively whether they were consequential upon its occurrence. This is an important issue to which we shall return in due course.

3.57 On the 8th July 1996 a CPA meeting was held, attended by Dr H, her SHO Dr J, a member of the hospital staff Ms J, an Occupational Therapist Ms K, a Social Worker Mr O, Mr A and his parents. A standard form for a Level 1 patient was again completed. One of the pieces of information it contained was that a key worker had not been allocated. We have not been able to discover why this entry was made, as Dr H had previously held the status of key worker and no change had been recorded. If the intention was to appoint a new key worker, it was never taken to fruition.

3.58 During the course of the meeting Mr A's mother expressed the opinion that her son needed counselling. She also stated that he wanted to leave home.

3.59 A care plan was formulated and set out on the form. Some of it was relevant only to the remaining period of Mr A's stay in hospital, but it was also decided that Mr O would carry out a Care Management assessment and look into his housing need, that Ms K would undertake an Activities of Daily Living assessment, that he could go to Brent Mind, and that the SHO would counsel him in relation to his drinking habits.

3.60 Mr A was discharged on the 29th July 1996. A further CPA meeting was held on that day, attended by Dr J, Mr O, a senior nurse and Mr A's parents. Ms K was not present, but she submitted a report which indicated that Mr A possessed appropriate community skills, cognition, hygiene and safety awareness and his only domestic problem was lack of confidence and experience in the kitchen. This was not of great importance in the overall picture at that time.

3.61 On this occasion the main concern of Mr A's mother looks to have been that the Clopixol was making her son restless; she asked for a review of his medication in the future. However, it is clear that depot continued to be an essential feature of his treatment.

3.62 The care plan formulated at the meeting incorporated provision for Mr A to attend out-patient appointments, to obtain his depot at Westmore, to contact Mind and to be assisted in finding long term suitable housing. It also specified that his parents would contact the hospital early if he showed signs of becoming unwell. Under the heading of action to be taken if he was in danger of relapse, there was a short statement that the family were to inform Dr H. These arrangements for future monitoring in our judgement provided inadequate practical support for the family.

It must be borne in mind that the primary responsibility for care rested upon the health and social work staff. A significantly greater element of planning needed to be directed towards how that responsibility would in future appropriately be discharged.

3.63 No date was fixed for the next CPA review and we were surprised to discover that no more meetings were ever arranged. Our impression is that this was not simply an oversight, but that the necessity for multi-disciplinary reviews was dispensed with once Mr A had successfully been transferred out of the in-patient system back into the community. Instead there were solely reviews by clinicians in the Out-patient Clinic, a state of affairs typical for a Level 2 patient.

3.64 Following Mr A's return home Mr O took steps to fulfil his obligation to carry out a Care Management assessment and concluded that Mr A was a capable individual who would need minimal support in his own accommodation. He therefore made enquiries with a view to locating a suitable flat and learned that there were potentially appropriate apartments at Alliance Close, supported housing managed by the Brent internal mental health provider unit. However, there do not seem to have been any immediate vacancies and in any event the proposal entailed sharing with another supported resident. In a letter dated the 17th September 1996 Mr O (who was then commencing three months leave) advised Mr A that an application for a flat had been made, but Mr A was not willing to share and informed the Social Services that he had changed his mind about leaving his parents' home. As a result the file was closed on the 11th October 1996.

3.65 In the meantime reviews were undertaken in the Out-patient Clinic. The first was by Dr K, a Senior House Officer, on the 16th August 1996. Mr A was at that stage in a stable condition and sleeping well. His prescribed medication was Lithium 1000mg nightly, Carbamazepine 200mg twice daily, Procyclidine 5mg twice daily,

Droperidol 10mg three times a day, and Clopixol 200mg every two weeks. He complained of some tiredness, but generally he was doing well and no alteration was made.

3.66 He was next reviewed by Dr K on the 4th October 1996. He remained well and said that he no longer felt in need of Carbamazepine. He was advised to continue it for the time being, as he had only been out of hospital for a few months, but Dr K noted that a decrease or cessation would be considered upon review in three months time.

3.67 There is no indication in the clinical notes of these reviews or the reports to Dr X that the subject of drinking was specifically broached. We do not know whether at that time Mr A had succeeded in bringing his alcohol consumption down to a more acceptable level. But in any event we have reason to believe that it was never totally under control and that he remained especially susceptible to drinking excessively at times when traditionally increased consumption would be expected, such as during the Christmas and New Year festivities.

3.68 On the 3rd January 1997 he was seen by Dr L rather than Dr K (who may perhaps not have been available). He stated that he had been sleeping poorly over the Christmas period and attributed this to the alcohol he had been consuming. He explained that he had therefore increased his Lithium to 1000mg, but had now reverted back to 800mg. This implies that at some prior point he had unilaterally decreased the Lithium from the prescribed dosage to 800mg. Moreover it is not obvious that he was taking the prescribed level of Droperidol, as Dr L said that he should continue on Droperidol at 5mg as required. Accordingly there are some indications of erratic compliance and a desire on Mr A's part to keep his oral medication down to a minimum. In addition he failed to attend at the depot clinic on the 23rd December 1996 and 7th February 1997, although on the former

occasion he was given the injection of depot within a period of three weeks after the previous one and on the latter he attended on the next day.

3.69 On the 1st April 1997 Dr M came into post as one of the Consultant Psychiatrists in the North & West sector of Brent. It appears that Dr H had at some prior date transferred elsewhere and been succeeded for a short period of time by another locum. We note that neither of them had any personal input (other than possibly a supervisory one) into Mr A's treatment and care from the time of his discharge from hospital to the takeover of his case by Dr M. We were also told by Dr M that there was no official handover of the caseload to him and that Mr A was just one of 500-600 patients whose case he inherited.

3.70 With the exception of the ensuing review, which was on the 4th April 1997 and therefore very soon after Dr M's arrival, all of the out-patient reviews which Mr A subsequently attended took place at the Park Royal Centre for Mental Health on the Central Middlesex site rather than at Westmore. This was because Dr M's out-patient duties at Westmore were confined to those of his patients who received their everyday care there. His other patients, including Mr A, were reviewed at his Out-patient Clinic at Park Royal.

3.71 When Mr A attended for review on the 4th April 1997, he was seen by Dr M's Senior House Officer, Dr N. He seemed slightly agitated, but there was nothing otherwise abnormal in his presentation and the general impression was one of stability. Dr N continued his existing medication and thought that he did not need to be reviewed again until a further six months had elapsed. This was too long an interval and Dr M informed us that he was upset when he subsequently perused the files immediately prior to the next review on the 6th November 1997 and noted that Mr A had not been seen for several months.

3.72 Dr M nonetheless felt that the review could properly be allocated to Dr P, who had succeeded Dr N as his Senior House Officer, although he told Dr P that Mr A would need to be seen more frequently and on this occasion he was given an appointment for two months time. In fact the delay had not led to any problems, as he reported that he was doing well.

3.73 However, over the Christmas period there were again some signs of deterioration. On the 2nd January 1998 Mr A saw a locum GP at the Wembley practice and complained of insomnia. He said that he had stopped taking his medication at Christmas. He was now taking Nitrazepam and was asking for a further supply. The computerised records maintained at the practice in respect of prescriptions reveal that he was prescribed 10 x 5mg tablets. He then attended again at the practice on the 21st January 1998, when he was seen by a trainee, who noted that he had been sleeping better over the previous five days without Nitrazepam and rightly declined to prescribe more.

3.74 Mr A subsequently asserted that there had been a period of some five to six weeks during which he was off his medication, drinking far too heavily, not sleeping and constantly planning for the future. At one point he had left home and gone on a short trip to Scotland.

3.75 We are inclined to think that this episode of deterioration, at a time when again Mr A looks to have been drinking to an inappropriate extent, amounted to a full relapse. There is certainly evidence that his family noticed the typical signs of restlessness and thought disorder. However, the stage was not reached at which he was prepared to enter hospital informally and because he failed to attend at his out-patient review on the 15th January 1998 he was not seen by a psychiatrist who might well have considered him to be in need of hospitalisation. Fortunately he did in this exceptional instance manage to recover without an incident of some

kind resulting in an assessment pursuant to the Mental Health Act, but there was plainly an insufficiency of effective mechanisms for monitoring his condition and preventing a relapse.

3.76 On the 28th January 1998 there was a significant change of personnel in the depot clinic. Until that time Mr A had continued to get his injections from a variety of nurses attached to the Westmore Resource Centre, including Nurse G and Mrs D. But from that attendance onwards he was almost always given the injection by Nurse I, an E grade Registered Mental Nurse, who was put in charge of the depot clinic. Nurse I also had other responsibilities at Westmore and his own caseload of patients; he operated the clinic solely on Wednesdays.

3.77 In accordance with the standard practice Nurse I would record each depot injection on the Drug Prescription and Administration Sheet. However, he did not make any additional notes elsewhere. The position was that on a substantial number of attendances between July 1995 and January 1997 separate entries had continued to be made in relation to Mr A's condition on a document headed "Evaluation and Nursing Notes". That useful procedure had then seemingly come to an end and it was not re-instituted by Nurse I. Accordingly we have no material recording his perception of Mr A's state of mind and progress.

3.78 Mr A was given another out-patient appointment for the 5th March 1998. He was then seen by yet another Senior House Officer, Dr O. No doubt, were it to have been known that he had relapsed, Dr M would have conducted this review personally. As it was, Mr A purported to be one of a large number of patients whose condition was stable and who could reasonably be allocated to a junior doctor. It was only in the course of taking a history that Dr O came to realise that problems had been encountered. Mr A now described his mood as average, with a rating of five out of ten, and admitted to poor concentration. Dr O thought that

his speech was slightly elated and that at times he was smiling inappropriately. On the other hand he said that he was sleeping well and that he felt rested on waking. Apart from advising him to cut down on his alcohol intake, which he put at 2-3 pints a day and 8-10 pints a week, Dr O evidently did not consider that any specific action was immediately required. He recommended that Mr A should continue on his existing medication. In this connection we note that Droperidol ceased at that point to be specifically included in the list of drugs to be taken (but the prescription records show that a further supply was obtained in November 1998).

3.79 Dr M cannot recall discussing Mr A with Dr O following this review, but he believes that he must have done, as he decided that he needed to see Mr A himself. Accordingly it was Dr M who carried out the next review on the 4th June 1998. Given that this was the first occasion on which he had face to face contact with Mr A, the impression which Mr A left upon him was bound to be of considerable importance. That impression was essentially one of stability. No problems at all were reported and on the contrary the picture was one of a patient who was feeling well, happy in his home environment, working and generally asymptomatic.

3.80 Dr M's substantial caseload included innumerable patients whose presentation would have been of a much more severe illness. A proportion of them would have either patently constituted a risk to other persons or been potentially suicidal when in the community. The risk that Mr A would cause serious harm to another person or to himself was by comparison low. Dr M evidently did not view him as a patient who clearly fell into the higher of the two CPA categories, calling for a team of professionals to closely monitor his condition and movements and a significant degree of key working. We note that the records show Dr M as the key worker, but he does not seem to have thought that his personal role in this particular case would extend beyond participating in the out-patient reviews and

dealing with problems if they happened to arise and were brought to his attention.

3.81 The next review was three and a half months later on the 17th September 1998, when Mr A was again seen by Dr M. His condition and circumstances at that time were unchanged and he was considered to be stable.

3.82 On the 3rd December 1998 Mr A was reviewed by a Senior House Officer, Dr Q. This implies that he was not now regarded as a patient who Dr M necessarily had to see personally. Furthermore he remained well and without any symptoms of deterioration and his good progress would have been reassuring.

3.83 The last review before the homicide took place on the 4th March 1999. Mr A was then actually seen by Dr M himself and he was therefore reviewed by Dr M three times in the space of nine months. We were told that on this occasion they had a lengthy discussion about his life and how things had been, that he was quite pleased that for the previous two and a half years he had been out of hospital and that there was nothing which he wished to do differently. He said that he had in the past taken Droperidol when he was unable to sleep, but that this medication had not been required for the last three months. He was continuing to feel well, his mood was euthymic and there were no psychotic symptoms. Dr M thus had no reason to suspect that he might shortly be going to relapse, although there was of course the ever present underlying fact that there had always been another relapse at some point in time.

CHAPTER 4

THE INCIDENT AND ITS AFTERMATH

4.1 On Wednesday the 5th May 1999 Mr A failed to attend at the depot clinic for his injection. This was a highly unusual occurrence; it had hardly ever happened previously and there had not been a single recorded instance of default during the period of fifteen months when Nurse I had been running the clinic. We do not know precisely why it happened on this occasion. The only explanation that has been put forward is that Mr A forgot to attend, which seems odd in the light of his earlier compliance. However, the reason is less crucial than the very fact of the non-attendance itself, which was potentially a cause for concern.

4.2 Pursuant to the procedures for the operation of the clinic (which we will specify in our commentary upon the case) it was incumbent upon Nurse I to make contact with Mr A expeditiously and invite him to come to the next clinic for his injection. But it was not until the following Tuesday, six days later, that Nurse I spoke to Mr A's father on the telephone, informed him of the non-attendance and advised him to tell Mr A to come for his depot on the next day. According to a summary of events recorded subsequently by Nurse I at the foot of the Drug Prescription and Administration Sheet under the heading of "Comments" Mr A's father expressed concern that his son was not taking his medication and said that he was felt to be going high. At that point warning bells should have been sounding.

4.3 We have had the benefit of evidence from Mr A and his family in relation to the sequence of events and have additionally read the detailed account given by them to Mr P, a Senior Social Worker at Ashworth Hospital, and set out in his social history report dated the 17th July 2001. It appears that problems first arose on the

night of Saturday the 8th May 1999, when Mr A returned home at a very late hour from a social outing and did not take any oral medication, apart perhaps from some Droperidol. He told us that this was because he thought it was too late to take the prescribed drugs for that night, but we cannot rule out the possibility that consumption of alcohol may also have been a material factor. In any event he did not sleep properly that night.

4.4 On Sunday the 9th May 1999 Mr A, on his own account, resumed taking his medication and there was no further default. However, he thought that he might also have been taking some Droperidol on top, a marker that he was himself aware of the onset of problems. On Sunday night he did get some sleep, but he slept very little on the ensuing nights. He was preoccupied with thoughts of marrying and setting up house with a girl who he had met on Saturday and had arranged to see again a week later.

4.5 From Monday the 10th May 1999 onwards the family were aware of a change in Mr A. He was wakeful to an extent indicative of developing illness and his expressions became increasingly bizarre. At work on Tuesday the 11th May 1999 he asked his sister who she thought was the most powerful man in the world. On Wednesday the 12th May 1999 he told her that he wanted to be promoted, to be designated the accounts manager and to be given a pay rise. She knew that it was nonsense. Mr A's explanation for raising this subject is that in fact he wanted to leave his employment and thought that if he demanded more money he would be allowed to go; he was annoyed that his sister would not make him redundant.

4.6 Mr A did attend for his injection at the depot clinic on Wednesday morning. The record made by Nurse I includes a statement that "the only thing he felt was that he hadn't been sleeping well". That was a significant observation, as inability to sleep was a typical sign of mental deterioration, but Nurse I does not seem to have

appreciated its importance. Nor does he appear to have noticed anything unusual in Mr A's demeanour.

4.7 While Mr A was sitting in the reception area at Westmore before receiving his injection, Dr L passed by and they greeted one another. Dr L did not think that he was agitated, distressed, troubled or pre-occupied in any way, but we are unable to place much reliance upon such a fleeting encounter.

4.8 On Wednesday evening Mr A went round to a friend in order to watch football on television. That friend was sufficiently concerned about him to telephone his sister and ask her if she thought he was becoming unwell again (although not so concerned as to be unwilling to leave him on his own for a short time with three small children). Later he was taken home and spoke to his sister himself over the telephone. On this occasion she endeavoured to calm the situation down by saying that she would make him redundant. She also urged him to go to hospital, but he declined. She told Mr P that he had been reading books about self help for people suffering from manic depression and seemed to feel that he could manage his problems himself.

4.9 On Thursday the 13th May 1999 Mr A went to work at his sister's house as usual. He was accompanied by his parents, who were very worried about him and wanted to monitor his condition. During the course of the morning he worked on his computer normally, but when the family were taking lunch together he was especially quiet and then without warning jumped up and kicked his sister's chair from under her, shouting obscenities. This sudden outburst must have been related to his irrational thoughts about his employment, since it was directed specifically against his sister. He did not actually go so far as to strike her, but we note that in the past he had never used violence of any kind towards her. It was a unique and extraordinary occurrence and undoubtedly caused by his illness.

4.10 Mr A's mother then begged him to go to the Central Middlesex Hospital and get help. This he agreed to do and he proceeded to leave the house and walk to Hatch End Station, which was not far away. When he reached a footbridge over the line he saw Stelios Economou, who was a total stranger to him, sitting on a bench on the platform. He went and sat next to him and made an unpleasant comment. Two Kenyan girls were nearby and he directed racial abuse at them. This led to a nasty incident in which he slapped one of them in the face. They moved away, but one left her bag and umbrella behind and Mr Economou evidently retrieved it for her. It seems that Mr A's attention then became centred upon Mr Economou and he developed the deluded idea that he had to be killed. This could in some way have been associated with the delusions which had surfaced on previous occasions of illness - in particular he may have been thinking that his actions would save the world from disaster - but he may also have been impelled by an irrational belief that a dramatic event would provide him with a suitable means of escape from the irritations of his work and unsatisfactory social life. In any event, what he did was to push Mr Economou in front of an oncoming train, with a fatal outcome. There is conflicting evidence as to the time at which this happened, but it looks to have been shortly after 2.30 p.m.

4.11 Mr A then got on the train and told the passengers what he had done. The police were summoned and he was arrested. He told the officers that he was sorry for what he had done but that he may thereby have prevented a nuclear war. When they endeavoured to search him, he kicked one of them in the groin and struggled. This type of reaction is reminiscent of his behaviour when under threat of restraint in hospital.

4.12 The homicide itself cannot in our view be categorised as conduct of a foreseeable nature. While in the community Mr A had only become embroiled in what could be described as a significant incident of violence on a single occasion, when he

attacked the friends of his housemate; this happened in the distant past, serious injury was not sustained and no criminal charge was brought. While in a hospital Mr A had assaulted or attempted to assault staff and patients on a number of occasions, but he had never placed the life of any of those persons at risk or caused them to suffer more than minor bodily harm. The homicide was very different in nature and degree; no-one had ever suggested that he might be capable of such a dreadful act, even at the height of a psychotic episode.

4.13 We are satisfied that none of the professionals responsible for the treatment and care of Mr A could have predicted that nineteen years into the course of his illness he would kill someone he had never met before in circumstances in which there was no provocation or restraint. Only with the benefit of hindsight is it possible to construct a worst case scenario, to say that this was a catastrophe waiting to happen and it was just a matter of time before Mr A committed a more serious offence. However, it must be borne in mind that the professionals did not possess a crystal ball and they had to assess the situation as it appeared to them at the time.

4.14 Although the outcome could not have been foreseen, there remains the separate issue of whether it could have been avoided. Plainly it would not have occurred were Mr A to have been in hospital rather than out in the community or if his relapse could have been brought under control at an earlier point in time. We shall therefore discuss in Chapter 5 the various factors which influenced the nature and timing of intervention. The remainder of the present Chapter will be devoted to events which followed upon the homicide.

4.15 In the first place we will briefly outline what has happened to Mr A, although it is not strictly of materiality to our enquiry. Initially he was taken by the police to South Harrow Police Station and he was there assessed by Dr R, a Consultant Psychiatrist. Her resulting report, which was dated the 14th May 1999, contained

a considerable amount of information about his state of mind at that time and over the previous week and indicated that he was suffering from a psychotic illness. Mr A was held in a police cell overnight and was thereafter remanded in custody and transferred to the medium secure unit at Three Bridges in Ealing. On the 30th September 1999 he pleaded guilty at the Central Criminal Court to manslaughter on the ground of diminished responsibility. This plea was accepted and the case was adjourned for reports. He was then moved to Ashworth high security hospital at Liverpool on the 5th October 1999, apparently at the instigation of the staff at Three Bridges where his behaviour was threatening and aggressive. On the 29th November 1999 he was senteneed to detention at Ashworth under section 37 of the Mental Health Act and a section 41 restriction order was made. He has been held at Ashworth ever since and has made satisfactory progress. His medication has been altered to Clozapine with good effect and he remains in a stable condition. When we saw him at the hospital he was able to give us a comprehensive account of his past problems.

4.16 We turn next to actions taken by Mr A's sister after he had left her house on the day of the incident. She and her parents were understandably in a very anxious state and concerned that he should obtain treatment. During the course of the afternoon (subsequent to the homicide) she made three telephone calls to the Park Royal Centre for Mental Health. On the first occasion at about 3.15 p.m. she spoke to a porter, who was deputising for the receptionist Mr L while he was temporarily away from his desk, and informed him that her brother was on the way to the unit.

4.17 Then at about 3.30 p.m. she spoke to Mr L himself. According to his account of this conversation, documented on the following day, she told him that Mr A was having a bad bout of mental instability; that she believed he might be heading to the hospital for help; that he was acting irrationally and had a history of mental

illness; that his current problem was very acute; and that he could present as appearing to be better than he actually was, since he was usually articulate and intelligible when dealing with strangers.

4.18 The third call was made at about 3.45 p.m. and was again taken by Mr L. Mr A's sister said that she now thought that Mr A would not show up at the hospital, but had more than likely gone to a public house and would probably end up in trouble with the police; that he had been very unwell of late and had left after being physical with her, which had never happened before; that he needed to be kept in hospital and would probably be sectioned by the police for being in a fight or show up later that evening drunk and abusive; and that he was currently living with his parents, who were in their 60s and about whom she was concerned. Mr L enquired if she had been allocated any help outside the unit and offered her the telephone numbers of external services, including the out of hours service, but she did not feel that they would be useful as Mr A refused to get help.

4.19 Mr L told us that he passed on this information to the Mental Health Act Administrator at Park Royal at some time between 4.00 p.m. and 5.00 p.m. We cannot be certain that his recollection now is accurate. In any event it appears that no further action was taken that afternoon to bring the situation to the attention of Dr M or the community team. That is a less than satisfactory state of affairs, although Mr A had already committed the offence and was actually in custody so that no action could have made any difference to the outcome.

4.20 Finally, because an examination of the Serious Incidents procedure is within our remit, we will describe the steps taken by the Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust in the aftermath of the homicide.

4.21 At about 7.00 p.m. Mrs B, the manager of the North & West sector, was

telephoned by Dr M and notified of the homicide. Later in the evening she spoke again to Dr M and received a more detailed account of the incident, derived from Dr R. She then alerted the Chief Executive of the Trust Dr Peter Carter and its Medical Director Dr Paul Mallett to the situation.

4.22 On the 14th May 1999 Mrs B briefed all the sector staff, interviewed the staff at Westmore who had been involved in Mr A's care, requested Dr M to write a report (which he did) and secured the medical and nursing records. She also prepared a short written briefing note setting out the recent salient events.

4.23 An internal review was instituted, to be conducted by Dr Mallett and Mr Declan Jacob, the General Manager of Brent Services. The thinking would appear to have been that in his capacity as both a trained nurse and an administrator Mr Jacob possessed a breadth of expertise such as to render the appointment of more than two persons unnecessary.

4.24 Dr Mallett proceeded to interview Mrs B on the 14th May 1999 and Dr M and Nurse I on the 19th May 1999. We are surprised that he should have carried out this part of the investigation without Mr Jacob. His explanation is that they were trying to see people as quickly as they could and were dealing with the matter in a fluid way.

4.25 On the 26th May 1999 Nurse I was interviewed again, on this occasion by both Dr Mallett and Mr Jacob, and they also saw Mrs D, who at that time was the Deputy Manager at Westmore; the Manager was not interviewed, as she had been on leave.

4.26 In addition to the oral testimony, Dr Mallett and Mr Jacob took into account Mr A's records and a letter from Dr L dated the 26th May 1999, shortly setting out his

encounter with Mr A at the depot clinic. It is not apparent from their review that other evidence from the various professionals was considered, but we think that they also probably read Dr M's report and two letters from Nurse I respectively dated the 14th and 27th May 1999.

4.27 The letters from Nurse I are of particular interest to us, because we have not had the opportunity to see him ourselves. We understand that some time ago he was given compassionate leave to travel to his family home in Ghana as his mother had died. Surprisingly the Trust never heard from him again and he was therefore dismissed.

4.28 In his first letter, directed "To whom it may concern", Nurse I set out the same information as he had recorded on the Drug Prescription and Administration Sheet in relation to his contact with Mr A's father on the 11th May 1999 and with Mr A himself at the depot clinic. He then added that Mr A had said that apart from his not sleeping very well everything was fine; that they then had a conversation about how work was going and again all was fine; and that Mr A's mental state appeared stable and there was no indication he was high.

4.29 In his oral evidence and the second letter, directed to Mr Jacob, Nurse I stressed that if he had noticed anything abnormal or inappropriate he would have sought medical assistance. But this begs the question of whether he possessed the ability to recognise the aspects of Mr A's presentation which are likely to have been abnormal on the 12th May 1999. Nurse I does not seem to have appreciated the significance of Mr A's inability to sleep and it is not clear that he knew what questions needed to be asked with a view to determining whether Mr A might be relapsing.

4.30 In the second letter there was also another important addition to the effect that

prior to contacting Mr A's father Nurse I had made two unsuccessful attempts to make contact. This had not been mentioned at interview and we now have some difficulty in accepting that it had occurred.

4.31 Dr Mallett and Mr Jacob duly prepared a written report dated the 14th June 1999. We do not propose to set out their findings and recommendations here, but in Chapter 5 we shall comment upon both the nature of the investigation and the manifest inadequacy of the conclusions.

4.32 Independently of the review there was also a debriefing session in which members of staff were able to discuss what had happened and whether any mistakes had been made. The consensus of opinion was that the homicide was out of character and unforeseeable and that it could not have been avoided. We were told that this exchange of information and views was helpful to all concerned and we can well see that it would have provided reassurance and support.

4.33 The Social Services conducted their own investigation, which was carried out by Ms Marlies McDougall. We were informed by Mr Nesbitt that he had spoken to her at the time and she had stated that she could not see any obvious issues other than the absence of recording of the way in which the referral to Alliance Close had come to an end.

4.34 On the 19th May 1999 a letter was sent by a senior member of the North & West Sector Mental Health Fieldwork Team to Mr A's parents acknowledging their distress and inviting them to contact the Team for support, advice or information, but it seems that they did not avail themselves of this assistance. Neither the Trust nor the Social Services contacted the relatives of Mr Economou.

CHAPTER 5

COMMENTARY

The Structure of the Mental Health Community Services

5.1 Responsibility for the provision and management of the mental health services in the London Borough of Brent rested with the North West London Mental Health NHS Trust from April 1993 until March 1999. Our enquiry has been substantially concentrated upon the manner in which that Trust and its staff discharged their functions. We have also had to consider the actions of members of staff around the time of the homicide in May 1999. At that point responsibility lay with the Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust. For the sake of completeness we should indicate that this NHS Trust has since been re-named Central and North West London Mental Health NHS Trust.

5.2 The catchment population of Brent during the material period was approximately 240,000. It was an area of marked social deprivation, with particularly high levels of unemployment, overcrowding, homelessness and drug abuse. These problems engendered a considerable incidence of mental illness.

5.3 Prior to 1995 the general adult psychiatry service for Brent was divided into two components. Acute care was largely based on the beds and other facilities at the Central Middlesex Hospital, whereas rehabilitative care was undertaken at Shenley Hospital, some distance away.

5.4 A plan for the provision of community care centres in Willesden, Wembley and North Brent had been formulated, but it had not yet been implemented. Until 1995

no local premises of this kind existed and community mental health services were comparatively restricted in their scope.

5.5 Levels of medical staffing at the Central Middlesex Hospital were low. There were only five Consultants covering the adult psychiatric service (one of whom was the Medical Director of the Trust), whereas the workload was such as to call for some nine or ten. The number and seniority of nurses was likewise inadequate. It was not easy to find suitable staff who were prepared to work in what was viewed as a poor environment and under conditions of severe pressure.

5.6 Notwithstanding these deficiencies we consider that there were sufficient facilities for a patient such as Mr A. It must be borne in mind that he was by no means continuously ill, nor did he suffer from the kind of disorder that was difficult to treat successfully. There were short periods of acute relapse and hospitalisation, followed by longer periods of stability. When he became ill to the point of being either detainable or close to that condition, he was admitted to hospital and we have no cause to criticise the treatment and care he received as an in-patient. Out in the community he was regularly reviewed at intervals in the Out-patient Clinic, he was given his depot medication, and for a time he attended at the Twyford Day Hospital for therapeutic activity. We shall be indicating that more monitoring was required, but in principle there ought to have been enough nursing staff to achieve this; he did not require an unduly complicated network of assistance.

5.7 However, it is true to say that the facilities were not originally local to Mr A, who resided in Wembley, and localisation was a gradual and incomplete process. He did not fall into the category of patient for whom Westmore constituted the hub of his everyday life. Prior to December 1993 he went to Central Middlesex for his depot injections and he continued to attend there for out-patient reviews until January 1995. When he relapsed at the end of that month it does not appear that

there was anyone in his immediate area with whom he or his family felt that they could communicate; he was constrained to present himself at the Accident and Emergency Department at the hospital.

5.8 In 1995, following the closure of Shenley Hospital, there was a significant change in the delivery of the psychiatric services, iu that they were sectorised. Brent was divided into three sectors, namely North & West, South and East. Wembley was in the North & West sector. Each sector had its own Consultant Psychiatrists and a team of health workers (the Community Mental Health Team or CMHT) under the control of a Manager. Out-patient clinics continued to be held at the hospitals, but the teams operated out of separate premises.

5.9 Sectorisation was undoubtedly a move in the right direction, but it took a long time to bed down and for some years the systems werc fairly chaotic. Four difficulties of relevance to Mr A's care have been identified. In the first place the number of Consultants per sector was not adequate. In the North & Wcst sector there werc just two for a catchment population in excess of 100,000 (and we have noted that until the arrival of Dr M onc of those was a locum). It simply was not possible for them to manage that kind of caseload with full efficiency and to ensure that every patient received proper input. We understand that funding is now available for a third Consultant, but that recruitment has yet to be achieved.

5.10 Secondly, there was too little communication between the psychiatrists and the non-medical members of the CMHT. This was partly due to the separation of premises, but also caused by the lack of team meetings. Dr M told us that when he arrived there were in fact no meetings of the clinical team at all and it was not until later that weekly meetings were introduced as an essential measurc. No doubt urgent issues were raised on the telephone, but the opportunity for ongoing discussion of problems in worrying cases looks to have been far too limited.

5.11 Thirdly, there was a delay in establishing a system for initial team assessment of patients. Until this was put into place, the responsibility for determining the level of input required for an individual patient seems to have essentially rested upon the shoulders of the Consultant in the Out-patient Clinic. Now the team examines all referrals and decides who is the most appropriate person to deal with the case. If it is decided that no medical intervention is required, the patient is filtered out of Consultant care. In other cases the initial clinical assessment is undertaken by an additional Consultant employed on a half time contract.

5.12 Fourthly, although the Social Services were also sectorised at about the same time as the Health Services, dovetailing of the organisations was a slow process and it was handicapped by lack of co-operation. We shall be drawing attention to certain aspects of this problem in due course.

5.13 In theory sectorisation ought to have produced benefits for Mr A in the form of better planning of his treatment and care, a greater degree of communication between the professionals involved, more efficient key working, and an enhanced response to the development of deterioration in his condition. In practice it hardly impinged upon his care at all; he did not fall into the net of patients for whom team working in the proper sense was provided. Furthermore, even the advantage of his local out-patient review was discontinued in 1997.

5.14 In Brent as a whole a comparative shortage of funding created a need for rationing of the available resources. Rationing did contribute to the unsatisfactory features of Mr A's care highlighted hereafter, but we do not really think that this was the root problem. It was more a case of disorganisation of the system and a failure to make it work in a way which would yield him the maximum advantage. Were the psychiatric services to have been as streamlined as they are today, there would have been a better prospect of avoiding crises in his life and adverse incidents.

The Care Programme Approach

5.15 The CPA came into existence in 1990 as the framework by which the new plan of care in the community was effectively to be delivered to patients. By April 1993 it ought to have been operating in Brent. There should have been local systematic arrangements for assessing and reviewing the health care needs of all patients in the community and also, in conjunction with the Social Services, for assessing and reviewing the social care required by those patients in order for them to benefit from treatment in the community.

5.16 In fact the CPA was not operational at that time and the process of implementation was only set in motion in 1993 when the North West London Mental Health NHS Trust appointed Mr McKervey to the post of Adult Services Operations Manager. So it is hardly surprising that when Mr A came to be discharged from hospital on the 10th November 1993 there was neither a CPA review meeting nor CPA documentation as such. Nonetheless a care plan was formulated; Mr A's care was to be multi-factorial, there was to be a suitable key worker, and a respectable level of monitoring was to be provided. But this did not in reality amount to more than the bare bones of a plan; vital ingredients were missing, including effective channels of communication and relapse planning.

5.17 In July 1995 the Trust and Brent Social Services produced an agreed scheme of CPA and Care Management arrangements. This was incorporated in a document headed "Joint Policy - Care Programme Approach and Care Management" (see Annex 1).

5.18 There were essentially two tiers of patient. The upper tier, which was known as Level 1, consisted of patients who had complex needs and posed a high degree of risk. The lower tier, known as Level 2, comprised all the other patients. It follows

that the needs of patients on Level 2 ought to have been uncomplicated and they should not have been at serious risk of harming either themselves or anyone else. Whereas patients on Level 1 required multi-disciplinary assessment and planning, those on Level 2 would normally be assessed by a single professional and the care plan would be relatively straightforward.

5.19 The majority of patients in Brent were either specifically placed on Level 2 or received their care on the footing that they came into that category. They would either be reviewed from time to time by a psychiatrist in the Out-patient Clinic or attend a specialist unit or be seen in the community at intervals by a CPN or Social Worker.

5.20 A patient such as Mr A who had a recurrent mental illness, had been admitted to hospital on a number of occasions and was receiving his care from more than one professional must in our view have qualified for inclusion on Level 1. We are moreover supported in that regard by the fact that, although there is no evidence that he was ever officially placed on Level 1 by a psychiatrist, CPA meetings were convened in 1996 at which a group of professionals discussed his needs and in respect of which CPA forms for use in Level 1 cases were completed. It has been suggested that these forms were utilised for all patients discharged from in-patient care, but we have some difficulty in comprehending why they should have been headed "For Level 1 Category Clients" if they were actually being employed in a Level 2 case.

5.21 It is therefore unsatisfactory that after Mr A's discharge from hospital on the 29th July 1996 he appears to have become regarded as a Level 2 patient; this was certainly the approach adopted by Dr M to the case and in addition there was never again a CPA meeting. The question has to be asked how that state of affairs came to arise. So far as we can tell, no conscious decision was specifically taken to

downgrade Mr A; there is no documentary evidence indicative of a decision down those lines. Our impression is that the alteration to his status resulted from a downward drift in concern about his condition and circumstances.

5.22 The following factors would appear to have influenced that drift :

(i) Key working was left to the Consultant; no Community Psychiatric Nurse or other person based at the CMHT premises was allocated to the case.

(ii) Once the issue of accommodation had been resolved in favour of Mr A remaining at his parents' home, the Social Services also ceased to have any involvement.

(iii) For almost two years Mr A was not seen by a Consultant and it follows that for that length of time his key worker had no direct contact with him.

(iv) Mr A's condition stabilised, so that when Dr M reviewed the files and more particularly when he did eventually become personally involved in the out-patient reviews the situation looked much healthier than it had been in mid 1996.

(v) There was no further hospital admission; when Mr A suffered another relapse at the end of 1997 he managed to recover without the intensity of treatment required in the past.

(vi) The administrative system for follow up of CPA patients did not operate with sufficient efficiency.

5.23 For these reasons immediately prior to the time of the homicide Mr A was in effect

just one of a very large number of patients who were essentially viewed as only in need of a periodic out-patient appointment. The fact that he was also being seen by a depot clinic nurse was incidental to his requirement for injections and not regarded as of real import to his status.

5.24 That Mr A should only have been receiviug the kind of input to be expected of a Level 2 patient is the more surprising in the light of CPA developments in general after 1995. In that year the Department of Health published guidance on the structuring of the CPA entitled "Building Bridges". It was there suggested that between the extremes of those patients with a severe mental illness who posed a significant risk and those with a stable condition and low support needs was a class of patient who came into the middle ground - a class likely to require more than one type of service or whose needs were less likely to remain stable. Arguably Mr A fell into exactly that category rather than further up the scale. However, the recommended arrangement for that category necessitated both key working and co-operation between professionals.

5.25 In 1997 a steering group was established, chaired by Mr Nesbitt, to consider the local CPA procedures. This led to draft revisions to the Joint Policy, one of which was to re-define the ambit of the two existing tiers. Level 1 was now to apply to "users who are likely to need more than one type of service or whose needs are less likely to remain stable", whereas Level 2 was to be applicable to "users who have limited disability/health/social care needs arising from their illness and have low support needs which are likely to remain stable". Accordingly the thinking of the steering group would seem to have been that patients in the medium range should be placed on Level 1 rather than Level 2.

5.26 However, the draft revisions were uot at that stage put into effect, as new guidance was anticipated from the Department. The 1995 Joint Policy remained in force,

albeit with some adjustments in practice, until it was superseded in Brent by a new policy and implementation guidelines on the 20th March 2001. These have now been replaced by the 2002 edition of the Brent Mental Health Service CPA Policy Document and Care Co-ordinator Practice Guidelines (see Annexes 4 and 5).

5.27 Levels 1 and 2 have been replaced with Standard and Enhanced CPA. There are specified criteria for determining to which category a patient should be allotted. We would expect a patient such as Mr A to be on Enhanced CPA because he required input from more than one professional, was not always compliant with his medication, had a tendency to drink excessively, relapsed at intervals into a hypomanic and psychotic state, and in that condition became at risk of coming to harm. Some of the criteria for Standard CPA could equally be said to apply, but they are not sufficiently applicable across the board.

5.28 Whether the current policy can effectively be delivered remains to be seen. Much depends upon the resources available for dealing with the cases which ought to be Enhanced. The sheer size of the mental health problem in Brent is likely to create continuing difficulties in this area. Dr Mallett believes that it is impossible to run Enhanced CPA for more than about 100 patients in each sector at any one time.

5.29 A more effective implementation of the CPA between 1993 and 1999 might in our view have altered the sequence of events which led to the homicide. Although it cannot be said that the monitoring at the out-patient clinic was in any material way deficient, the overall arrangements for supporting Mr A and checking on his progress were not adequate to ensure that deterioration in his condition was noted and expeditious steps taken to assess his mental state and secure his admission to hospital whenever necessary. The stage ought not have been reached at which he had fully relapsed without any attempt at intervention.

Reviews at the Out-Patient Clinic

5.30 Responsibility for the clinical care and treatment of Mr A in the community rested at all times with the Consultant Psychiatrist to whom his case was allocated. In April 1993 it was Dr D who bore that obligation, but he ceased to be one of the Consultants in the sector towards the end of 1994. There was then a period of some two and a half years when the sector did not have two members of staff of full Consultant status and Mr A therefore came under the care of a locum. From April 1997 onwards he was included in Dr M's caseload.

5.31 It is perhaps less than ideal that there should have been three changes of personnel during the critical years and that for a considerable length of time Mr A was under the care of clinicians who were not qualified as Consultants, but we can well see that in Brent there would have been considerable difficulty in recruitment of suitable staff and continuity of care could not practicably have been achieved.

5.32 In any event we do not consider that Mr A needed to be reviewed on every occasion by a Consultant. His records were commodious, but his case was not in reality unduly complicated. His psychiatric problems were clearly delineated and essentially he went through a cycle of relapse, recovery and stability at intervals. There was nothing especially unusual in his treatment and until the homicide it is probably true to say that his actions fell within unsurprising parameters.

5.33 Dr D told us that he would see his particularly difficult patients himself, but that otherwise the patients who attended at the Out-patient Clinic would be shared out between him and his Senior House Officer. We appreciate that the division of work in this way between members of a clinical team is inevitable and that it is common practice for out-patients to be seen by an SHO. Dr D would go through the cases with his SHO afterwards as a training and supervisory exercise.

5.34 As it happens Mr A was quite often seen by Dr D himself, but this was not always the case and no obvious pattern emerges from the sequence of clinical reviews. Presumably therefore he was not regarded as a particularly difficult patient.

5.35 At Westmore between January 1995 and March 1996 Mr A was almost always seen by Dr H. The position at those premises was that there was one list for the Consultant and one for the Senior House Officer and they were both pre-booked. Mr A must have been on Dr H's list.

5.36 Following his discharge from hospital on the 29th July 1996 he was reviewed at Westmore by Senior House Officers and on one occasion by Dr L. At that particular stage therefore he seems to have found his way onto the SHO list, but this would not in itself have been remarkable or inappropriate. Subsequently Dr M took over the case and Mr A went back to the Out-patient Clinic at the Central Middlesex Hospital (held at the Park Royal Centre). Dr M told us that he changed the system back to having a pool of out-patients which he shared out between himself and his SHO on the morning of the clinic. On the basis that Mr A still presented as a patient whose condition and circumstances did not call for any prioritisation, he continued to be seen by junior doctors until reviewed by Dr M on the 4th June 1998.

5.37 Accordingly, as we have already indicated, there was a period of almost two years when Mr A was not seen at all by his Consultant. In retrospect this was too long, not because the quality of medical input was unsatisfactory, but because Dr M did not have a grip on the case in his capacity as key worker and Mr A on his side may have felt that he was being passed from pillar to post. Those two aspects of his case may partially explain why neither he nor his family sought help when he relapsed at the end of 1997 and why he was not at that point in time being effectively monitored.

5.38 Three of the last four reviews were, however, undertaken by Dr M and it can hardly be said that the homicide was a product of inadequate input at Consultant level. The problem was that clinical reviews by their very nature only took place at two to four monthly intervals, whereas Mr A was liable to deteriorate to the point of full relapse in a matter of three weeks. There needed to be some effective mechanisms for monitoring over and above the reviews themselves.

5.39 On the whole we are quite impressed with the efficiency of the Out-patient Clinic. With one notable exception (when there was a gap of six months) Mr A was given appointments at suitable intervals and he almost always attended. Although he was seen on a number of occasions by junior doctors, we have been given no cause to conclude that any of them exhibited poor clinical skill and judgement.

5.40 We have considered whether there ought nevertheless to be a tighter control over the running of the clinic and in particular whether patients who are on Enhanced CPA or who have been attending for prolonged periods should be allocated to the Consultant as a matter of course rather than discretion. But there is undoubtedly a logistics problem here; too many patients would qualify and in all probability the Consultant would be overburdened. We therefore consider that a strict procedure would not be practicable and that it should be left to the Consultant to determine whether a particular patient can properly be seen by a junior doctor.

5.41 On the other hand no patient should be treated as having been downgraded from Enhanced to Standard CPA on the basis of drift to junior doctor review. Decisions to downgrade (or upgrade) should be effected in specific terms and they should be made by the Consultant after discussion with other professionals involved in the case. Furthermore decisions of this nature ought not to be reached at the first out-patient review after discharge; that is too early a point in time for a fully informed judgement. At least three months should be allowed to elapse before regrading.

Evaluation of Risk

5.42 The process of assessment of Mr A's needs and planning of his care called for a full evaluation of the risk which he posed either to himself or to others. This was an ongoing process requiring reconsideration in the event of material changes in his circumstances.

5.43 The key factors to be borne in mind in risk assessment were set out in the 1995 Joint Policy. They included repeated admission to hospital, a history of aggressive behaviour or of deliberate self harm, a lack of family and other social contacts, an unwillingness to accept help and a reluctance to engage in and sustain treatment. But at that time there were no forms to be completed in respect of such matters. The CPA documentation made provision for recording risks in respect of patients who were on the Supervision Register, but not other patients. It was therefore left somewhat to chance whether a full and proper risk assessment was actually made.

5.44 The risks in Mr A's case were by no means dramatic, but they did need to be spelt out. In our view they did not extend to a real prospect of violence directed towards others in the community; this contrasted with the very high probability of aggression within a hospital setting. Nor was there a very substantial risk that Mr A would deliberately injure himself. But when his condition deteriorated he lost his inhibitions; this meant that he was vulnerable to accidental harm and for example he could have been knocked down by a passing vehicle while wandering in the road; and he was also liable to damage private property.

5.45 It is fair to say that these risks did not stand in isolation as requiring special action to be taken. We view them as aspects of Mr A's case to be taken into account, together with other features of his illness, in the task of relapse planning. But it would manifestly have been helpful if they had been specifically recorded.

5.46 Mr A's records do incorporate repeated references to incidents in which he was involved, but they do not establish that the risk factors were being addressed. As a matter of common sense it seems likely that they were, that this would have been an automatic response. But there was always the possibility that a clinician who came to the case for the first time would not fully grasp the nature and extent of Mr A's vulnerability. At no stage after April 1993 does there seem to have been an attempt to set down in clear and comprehensive terms the problems which were potentially likely to arise and the action to be taken by way of avoidance or response. It was not even done when the CPA meetings took place in 1996.

5.47 The absence of recorded risk evaluation is another illustration of the weakness of CPA procedures in Brent during the period with which we are concerned.

5.48 When the revisions were made to the 1995 Joint Policy, it was emphasised that professionals had to place themselves in a position to demonstrate that decisions were taken after consideration of evidence in relation to risks. The intention was that a detailed risk assessment should be carried out and that the results should be recorded on the CPA form. However, we would reiterate that the Joint Policy was not then effectively replaced and it would have been difficult for staff at ground level to know exactly what was required of them.

5.49 In February 1999 the North West London Mental Health NHS Trust and Brent Council Fieldwork published detailed risk assessment and management procedures (see Annex 2). It is to be noted that they included completion of a risk indicator checklist and an assessment. This was a significant step forward, but it came too late to be of any assistance in the care of Mr A; no form was completed in his case and even if this had been done at about the time of his final out-patient review we do not suppose that it would at that stage have made any difference.

5.50 In any event we were given to understand that the forms were not initially a great success. They were only introduced for new cases and were not utilised for any of the existing patients. They were, moreover, complicated and staff did not know how to complete them properly; as a result they were largely ignored. When Mr Matt took up his post as the Director of Operations of the Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust in June 1999 he realised that training in their use was essential; for the time being they were placed in abeyance.

5.51 It seems that some further drafting was then undertaken and in November 1999 the Trust proceeded to publish revised guidance and procedures in a document entitled "The Assessment and Management of Clinical Risk "(see Annex 3). However, we were informed that it was not until a much later date that this scheme was actually put into operation and that it is currently in force with some minor revisions and a differently formatted front page.

5.52 A training programme was duly implemented and the forms are now utilised. An initial assessment should lead to a complex one if risk factors are identified. But Mr Matt told us that although the Risk Indicator Checklist (AOR1) is signed by the clinician, it is normally completed by the key worker (now known as the Care Co-ordinator) rather than in a multi-disciplinary setting. It is his perception that the quality of initial assessments continues to be poor, because a high proportion of the staff concerned still do not know how to assess risk.

The Care Plan

5.53 The formulation of a care plan addressing the health and social needs of a patient was from the outset a key feature of the CPA. It was required irrespective of the level on which the patient was placed.

5.54 It was not until 1996 that a proper approach to care planning for Mr A was adopted. We have already made the point that the plan produced when he was discharged from hospital on the 10th November 1993 was too basic and did no more than set out the structure of what was to be done. The same was true of the plan upon his discharge on the 15th March 1995.

5.55 The planning process in 1996 was certainly better, but it still left something to be desired because it did not address in a sufficiently structured way the problem which Mr A presented, namely that he suffered from a psychiatric condition which never completely went away and that sooner or later he was destined to deteriorate again. This was of course recognised, but there was a failure to provide the machinery to cover the three aspects of the problem which called for detailed provision; these were firstly how to maintain a state of relative stability for as long as reasonably possible, secondly how to identify the symptoms of deterioration, and thirdly what to do in the event of impending relapse.

5.56 As to the maintenance of stability, the primary provision was necessarily suitable medication and this was appropriately planned in oral and depot form. But there were also socio-economic aspects in Mr A's presentation. He was still living with his parents, his employment was familial, he said that he did not have enough friends, and he had a drink problem. There was evidence of a tendency in the past to relapse at times of stress at work, social difficulties or alcohol abuse. The plans gave recognition to these matters, but the proposals for dealing with them do not look to have been particularly robust. It is therefore unsurprising that not much was actually done to provide practical support for Mr A. Efforts to find him suitable alternative housing rapidly came to an end, there was no alteration to his social circumstances and he was not afforded a programme for control of his alcohol consumption.

5.57 As to the identification of symptoms of deterioration, it was well established that Mr A would initially stop sleeping properly, that he would become restless, that this would develop into agitation, that he would express bizarre ideas, and that he would often cease to comply with his medication. But the fact that symptoms of this nature were typical did not mean that each and every professional who was to be involved in his care would have them in mind. There were to be changes in personnel; in particular different Senior House Officers were to see him and in the depot clinic different nurses. Each of those persons needed to know the relapse indicators; thus they should have been listed and recorded, but this was not done.

5.58 As to the action to be taken in the face of relapse, we have already made the point that inadequate practical support was provided for the family. The arrangements should have incorporated effective monitoring by the professional team at short intervals. This could have been done in the depot clinic, but only by nurses who possessed the knowledge and training to recognise what was happening. Perhaps more importantly, there had to be good channels of communication. A key worker in the sector nursing team was desirable here, because communication with staff at the hospital was erratic and unpredictable in its efficiency. Both Mr A and his family needed someone to whom they could directly and confidently turn when a crisis was in the offing, not a list of helplines to organisations they did not know, nor an Accident and Emergency Department with a potentially long wait and a Duty Psychiatrist who probably knew nothing about the case.

5.59 When Mr A reached the stage of impending relapse, he would almost always require admission to hospital. His ability on one occasion to recover while in the community should not disguise the basic necessity of in-patient treatment. The necessity for the admission to be achieved expeditiously is equally clear. Once the point had been reached at which he was exhibiting florid signs of illness, there was a risk of an incident if action was delayed. These matters needed to be spelt out.

5.60 When the crisis arose in May 1999 Mr A did not get to be admitted before an incident (albeit one of a unforeseeable nature and gravity) occurred. To criticise his family for not having taken steps to effect his hospitalisation at an earlier point in time would in our view be wholly unjust. He had been stable for a substantial period, they would have been hoping that his symptoms would settle, and it was only when he kicked the chair away from under his sister that the full extent of his deterioration became obvious to them. Given the absence of a specified point of contact with the professional carers and a specified procedure to be followed, they were left in the position of having to devise their own mechanism for dealing with the situation and they could not realistically have been expected to cope.

5.61 Better relapse planning might in our opinion have prevented the homicide. Were there to have been an established and effective procedure for ensuring that signs of deterioration were picked up by the professionals or brought to their attention with reasonable rapidity and for getting Mr A to come into hospital voluntarily while he was still thinking rationally and able to form a judgement as to his need for treatment, we think that he might well have been admitted by Wednesday the 12th May 1999.

5.62 The alterations that have been made to the CPA since 1999 should be productive of improvements in relapse planning, but we consider that the existing forms do not sufficiently address this important aspect of patient care, that nursing staff may need more training in the identification of warning signs, and that attention should be focused on establishing effective channels of communication with carers.

Key Working

5.63 Implementation of the CPA from 1993 onwards should have meant that patients

discharged from hospital and being cared for in the community had a key worker. In the case of a Level 2 patient key working may well not have amounted to more than seeing the patient at intervals in the Out-patient Clinic and the task could then reasonably have been entrusted to the Consultant. A patient who was (or should have been) on Level 1 would generally require a higher degree of input, involving responsibility for development of the care plan, regular contact and monitoring, and co-ordination of the services being provided. This enhanced input was in our view essential for Mr A, even when he was stable, because there was always a risk of relapse. It was therefore important that he should have a key worker who was experienced in performing the duties and had the capacity and availability to undertake them. The most obvious (although not necessarily the only) candidate would have been a Community Psychiatric Nurse.

5.64 This was indeed recognised when Mr A was discharged from hospital on the 10th November 1993; the intention was that Nurse E, an established member of the psychiatric nursing staff, should perform the key worker role in conjunction with administering the depot injections. However, we have drawn attention in the narrative to the fact that it was Nurse F who gave the injections. Whether she also perceived herself to be the key worker is unclear, but in any event she left her employment in August 1994 and we have seen no evidence that her successor, Nurse G, was officially given the task.

5.65 Subsequently key working was performed by Mr C, who frequently saw Mr A at the Day Hospital and no doubt possessed the necessary credentials. Unfortunately this ceased to be the position in February 1996; thereafter the role of Mr A's key worker was always officially allocated to his Consultant. That was not conducive to effective implementation of the care plans which were put together at the CPA meetings in July 1996 and the problem was then exacerbated by the changes in medical staffing over the ensuing nine months. We do not think that Dr M, who

had to take on a large caseload of patients and did not get to know Mr A personally until a much later date, could fairly have been expected to undertake key working for him. It is unsurprising that Dr M did not in fact do more than peruse and sort out the clinical records, review Mr A on three occasions and supervise the input of his junior doctors and that he regarded Mr A as one of the many patients whose condition was not giving rise to great concern and who could be followed up on a Level 2 footing.

5.66 In retrospect it is a pity that the administration of depot medication and the task of key working came to be separated. If a CPN were to have been undertaking both aspects of Mr A's care throughout, there would have been regular contact on a two weekly basis with the key worker, providing not only a good mechanism for intensive monitoring but also the opportunity to build up a close rapport. In those circumstances Mr A would have been more likely to seek help when needed and in any event his symptoms of deterioration would have been less likely to go unrecognised. As it was, he got his injections from a variety of different nurses until the beginning of 1998 and although there was continuity with Nurse I thereafter the contact between them looks to have been short and of a mechanical character.

5.67 A key worker who had a lasting and successful relationship with Mr A could also have fulfilled two other important functions. One was to link the strands of his medical treatment by ensuring that the psychiatrists and the nursing staff were working together rather than on separate tracks. The other was to appreciate the need for assistance in the social sphere and endeavour to supply him with suitable means of support.

5.68 We note that the current CPA Policy and Care Co-ordinator Practice Guidelines contain detailed provisions for planning and co-ordination of cases. Clearly this

is an area in which change is being effected and forward movement ought to be achieved. But we must stress that progress is dependent upon classification of all patients upon a needs led and not a resources led basis and upon training of staff so that they are fully aware of the ambit of their responsibilities and competent to discharge them.

The Depot Clinic

5.69 Mr A received his injections of depot medication at Westmore from the 23rd August 1994 onwards. Initially he attended at three weekly intervals; after the 1st April 1995 the frequency was every two weeks. As we have already indicated, his compliance was excellent and he clearly understood the need for his injections to be given in accordance with the prescribed regime.

5.70 The depot clinic ought to have been operated in accordance with a written policy which had applied to all such clinics in the area for some time previously (see Annex 6). This incorporated provision for the recording of injections not only on the Drug Prescription and Administration Sheet but also in the patient's notes, for informing a CPN in the event of the patient relapsing or requiring further nursing intervention, and for taking action to follow up any default.

5.71 Patients who were being afforded care at Westmore and who were being reviewed there either by a Consultant or by Dr L would have their clinical notes and other records on site. On the other hand the clinical notes for patients such as Mr A who were reviewed at the Out-patient Clinic at Park Royal but received their depot medication at Westmore were quite understandably kept at Park Royal. In those circumstances we would have expected the system of record keeping to have incorporated an exchange of information between the two centres, so that each of

them had ready access to knowledge of the overall situation rather than just what was happening at one location. Unfortunately there does not appear to have been a procedure for this exchange to be effected. Thus the Consultant at Park Royal did not have any material from Westmore unless it was specifically requested or sent and equally the depot nurse did not have the care plan or even a copy of the report despatched to the patient's General Practitioner following a review. Aside of alterations to the depot medication, the nurse would therefore not have been formally made aware of the thinking of the treating psychiatrist and would have been reliant upon questioning of the patient.

5.72 Until January 1997 the nurses did make separate notes about Mr A on most of the occasions that he received his injections. They were fairly short, but would have been sufficient to provide a nurse coming to the case for the first time or after a lengthy gap with a running account of recent progress. However, the practice of making notes then seems to have been abandoned and Nurse I did not make any entries of a descriptive kind. That omission constituted a breach of the operational policy.

5.73 Mr A's attendances at the depot clinic provided an opportunity for monitoring of his condition. We have no doubt that to some extent this was done. However, the depot nurse was generally not a CPN and in addition prior to the arrival of Nurse I there was comparatively poor continuity of personnel. It is therefore inherently unlikely that the standard of monitoring was better than basic.

5.74 Over a period of months Nurse I would have got to know Mr A well and at least the problem of discontinuity would then have evaporated. But Nurse I was not involved in any care planning, nor do we think that he was particularly well equipped to undertake the task of monitoring. Essentially his role was to give Mr A his injections and while there would have been some conversation we are

unconvinced that he was watching for indications of relapse or able to interpret them. Of course we have not enjoyed the advantage of being able to discuss this matter with him, but the extrinsic evidence all points in the same direction. His input was in our view at a fundamentally mechanical level.

5.75 We are reinforced in this assessment by what happened immediately prior to the homicide. The concern expressed by Mr A's father over the telephone was duly recorded by Nurse I on the Drug Prescription and Administration Sheet, but he did not bring it to the attention of a doctor or the Westmore management. When Mr A attended on the Wednesday morning, the deterioration which had occurred in his condition was not picked up at all. This may partly have been due to Mr A's ability to disguise his symptoms, but it still strikes us as inconsistent with an adequate depth of questioning and observation. Accordingly the provision in the operational policy for dealing with relapse also failed to bite in this instance.

5.76 In effect two opportunities for effective action were missed, the first on Tuesday the 11th May 1999 following the telephonic communication and the second on the next day when the depot medication was administered. On the latter occasion Mr A could have been referred to Dr L and assessment of his mental state undertaken without delay. Were that to have been done, an informal admission to hospital might well have come onto the agenda.

5.77 We have not categorised the delay between Mr A's default in attendance on the 5th May 1999 and the subsequent contact with his father six days later as yet another lost chance for action, as the clinic only operated on Wednesdays and he did attend on the next available date. The default was unusual, but not in itself so remarkable that it should necessarily have been brought to the immediate attention of a doctor. Its significance in the overall picture would have been greater on the following Tuesday in conjunction with the concerns of Mr A's father.

5.78 We are nonetheless critical of this delay, because we see no good reason why it should have occurred. Nurse I could have endeavoured to make contact with Mr A over the telephone immediately. If he was not at home at that time and his parents were also out, a further attempt could have been made later on the same day or on the following morning. As we have said above, we find it difficult to accept that something of this kind was actually done. But even if it was done, the operational policy required in addition a written reminder and on any showing Nurse I did not act in accordance with that procedure. We realise that no time was specifically stipulated for sending the reminder, but it ought to have been a simple matter which did not involve a significant time lag and a potential absence of contact prior to the ensuing Wednesday.

5.79 One further complication also needs to be mentioned in passing, which is that Mr A's six monthly depot prescription had actually expired. Attention was drawn to this fact by Dr Mallett and Mr Jacob in the course of their review.

5.80 As a direct result of the homicide the operational policy was altered in June 1999 (see Annex 7). Patients who attended the Westmore depot clinic were in future to have an obligatory clinical review at Westmore at least once in every six months and non-attendance by a patient on Level 1 or the Supervision Register was to be raised at the weekly Westmore staff meeting.

5.81 The position now would appear to be that the cases of patients receiving depot at Westmore who are on Enhanced CPA are duly reviewed at Westmore at not less than six monthly intervals. This review is undertaken by the Consultant or one of his clinical team together with the depot nurse and if the patient has carers they are invited to attend. The entirety of the patient's notes are retained at Westmore and are therefore available upon the review and at all other times. Thus in these cases the depot nurse has a substantial amount of involvement and ought to be fully

aware of ongoing problems and factors influencing relapse. However, it is by no means clear that a similar procedure is being operated for Standard CPA patients. Our impression is that there is more flexibility in approach so far as their cases are concerned.

Medication

5.82 In addition to the injections of Clopixol Mr A was treated with Droperidol and on occasion Sulpiride for control of his psychotic illness, with Procyclidine to combat the side effects of those drugs, and with Lithium alone or in combination with Carbamazepine as mood stabilisers.

5.83 There was nothing unusual in this regime of medication and we consider that the recommendations which were made from time to time by the treating psychiatrists were by and large justifiable. We now know from experience at Ashworth that Clozapine has worked better than Clopixol, but Clozapine is not a depot drug and there was good cause to require injections as Mr A could not be absolutely relied upon to take oral preparations.

5.84 Two aspects of the regime do, however, call for comment. The first is the system whereby oral medication was recommended by the psychiatrists but prescribed by the General Practitioners. This was not in our view ideal, because it allowed scope for Mr A to place pressure upon the GPs to prescribe in different dosages. If any change was to be made, we think that it should only have been effected by one of the clinical team following a review at which the matter was discussed in detail with Mr A and proper consideration given to the impact of a variation upon his treatment plan. His own perception of what was working well for him may have been a relevant factor, but careful control of his intake was most important.

5.85 Secondly, there is the interesting issue of whether non-compliance with the regime by Mr A was causative of his relapses. We have approached this issue from two directions by examining the extent to which the relapses were preceded by non-compliance and by considering whether his illness followed the pattern which would ordinarily have been expected.

5.86 It is true to say that the destabilising combination of increased consumption of alcohol and discontinued or reduced oral medication featured too frequently on occasions of illness to be regarded as coincidental. However, it does not seem that there was a shortage of oral medication in every single instance; moreover Mr A was also being treated with a long lasting depot drug. We therefore cannot safely conclude that deterioration in his mental state began with non-compliance.

5.87 Mr A's diagnosis was of schizoaffective disorder; he exhibited symptoms of both bipolar affective disorder and mood incongruent delusions. His illness was always present in a mild form even when he felt well and was functioning with relative normality. There was a distinct possibility of relapse at times of stress or change and it would not have taken much to tip the balance. We do not find it remarkable that he was in and out of hospital; this is a typical history for someone with his presentation.

5.88 When Mr A started to become manic, he would naturally have lost some of his inhibitions. In that state his control over his alcohol intake, which does not look to have been particularly good when he was stable, would have diminished further. Mania would also have weakened his resolve to take his medication and heavy drinking in the evening (and over Christmas and New Year during the afternoon) would have created an additional disincentive. It is accordingly wholly explicable that his compliance with prescribed oral medication should have become erratic, whereas attendance at the depot clinic remained manageable as it was a daytime

activity and only had to be undertaken at fortnightly intervals.

5.89 We can see here a vicious circle; non-compliance with medication is likely to have hastened the onset of full relapse. However, we are satisfied that it was not the root initiating cause of Mr A's episodes of instability and that the psychiatrists cannot be criticised for not achieving his complete cooperation.

Psychotherapy and Counselling

5.90 There were three routes by which Mr A could have obtained services of this nature. One was by referral to the Willesden Centre for Psychological Therapies, which offered a highly sophisticated analytical approach to the patient's problems. But it has not been suggested that he would have been a suitable candidate for that kind of therapy.

5.91 There was next a psychotherapy service at Central Middlesex Hospital, operated by the Clinical Psychology Department, which specialised in short term focused therapeutic measures such as cognitive behavioural therapy. This might have been appropriate for Mr A, as he could conceivably have derived some benefit from cognitive behavioural work relating to relapse planning. However, there was a limitation upon its availability and it was by no means as well developed a service as currently is the case. We can readily appreciate why Mr A was not pointed in that direction.

5.92 Further services in the form of counselling were provided by the voluntary sector. A broad range of organisations in Brent offered these services. Referral was not direct; the patient was given the name, address and telephone number of a suitable organisation and advised to make contact. We note that upon his discharge from

hospital in July 1996 Mr A was advised to contact Brent Mind. It is unclear whether he actually did so, but there is no evidence to suggest that he was keen to obtain help on a voluntary basis. At times when he was stable, he thought that he had his situation under control.

The Social Services

5.93 It is an interesting feature of this case that although social workers were involved on several occasions in the process of securing Mr A's admission to hospital and his records include reports prepared by them in connection with his care while an in-patient, the Social Services had little input into his management at home. At first sight this seems surprising, because he did have difficulties with his work and in his social life in addition to his purely clinical symptoms.

5.94 There were, however, historical reasons for the low level of intervention by the Social Services in cases in which there was no pressing need for accommodation, assistance with transport, or support with daily tasks. Their foundation comprised shortage of resources and a poor relationship with the Health Services.

5.95 Prior to April 1993 and for some time afterwards multi-disciplinary working for mental health patients was at a basic level. It was not that the staff were unable to relate to one another, but rather that the operational policies did not coincide.

5.96 A number of separate problems can be specifically identified. These were that the Social Services had a large number of vacancies and a high rate of sickness, with the consequence that they were lacking in available staff; that they imposed strict eligibility criteria for taking clients; that they felt unable to offer a service to many patients who were considered by the psychiatrists to require one; that the Health

and Social Services operated out of different premises; that there was insufficient communication between their respective workers; and that there was no integration of the CPA and Care Management.

5.97 These problems explain why Mr A was not viewed by the Social Services as a patient to whom a social worker could permanently be allocated and why they were not pressed by the clinicians to intervene to a greater extent; his needs were not so great as to satisfy the eligibility criteria. They also explain why there was no continuing dialogue between the clinicians and social work staff in relation to his case.

5.98 From about 1995 onwards changes began to be made by senior management with a view to rectifying these deficiencies. The first important step was that when the North West London Mental Health NHS Trust introduced sectorisation the Social Services adopted the same division and subsequently the two teams moved into the same premises.

5.99 The next stage was the rewriting of the Social Services policies for day-to-day working. This was primarily done by Mr Nesbitt, who told us that for the first two years after his appointment in August 1995 to the post of Service Director, Mental Health Fieldwork he was heavily engaged in the task. A new assessment form was devised and the eligibility criteria were revisited. But it was still apparent to Mr Nesbitt that Care Management was not being properly embraced.

5.100 In 1997 he therefore proposed a substantial re-structuring of the whole unit. This entailed disbanding the social work posts, redesignating the social workers as Care Managers and requiring them to opt into Care Management and the CPA. In 1998 as part of the re-structuring process he produced new Care Management standards.

5.101 It has to be said that these efforts to reform the system did not have an immediate impact upon cases such as that of Mr A, which were still perceived to fall below the level of need at which consistent intervention could be expected. We have noted that Mr O attended the CPA meetings in July 1996 and took action towards the objective of finding suitable alternative accommodation, but this incentive petered out and the file was closed. Thereafter the Social Services were not in any way involved in the case until the homicide.

5.102 There has now been a further radical revision to the system. The health and social work teams have been fully integrated and they are working under the single code contained in the 2002 CPA Policy and Care Co-ordinator Practice Guidelines.

5.103 It remains to be seen what improvements at ground level the new arrangements will actually achieve. For a patient such as Mr A we would wish there to be a broader approach towards the maintenance of stability and avoidance of relapse than purely concentration upon medication. We would not necessarily expect the task of Care Coordination for that patient to be undertaken by a social worker, but the care plan ought to incorporate suitably designed measures for social support and every effort should be made to implement them.

5.104 Of course there can be no guarantee of cooperation from the patient. We do not know what the outcome would have been were Mr A to have been offered a greater degree of assistance with his personal life. He did exhibit a preference for managing his own affairs in his own way. It is doubtful whether he would have been prepared to return to the open market place for employment. On the other hand he might conceivably have been willing to move away from his parents if alternative accommodation of a suitable nature were to have been found; he might have been receptive to help with his drinking problem and in forming relationships with persons outside the family circle; and he might also have been amenable to

support in the form of discussion of problems at times of stress and strain.

The Role of the General Practitioner

5.105 Mr A attended at the Wembley practice on numerous occasions and his GP notes extend to several pages. Examination of the various entries in the notes reveals that the attendances were almost entirely related to his mental condition; his health in other respects looks to have been good.

5.106 We have no doubt that the attendance rate was associated with the requirement for Mr A to have his oral medication prescribed by a General Practitioner; during the period when he was not working he also needed medical certificates.

5.107 It did not fall to the General Practitioners to decide upon the regime of medication, as this was always subject to the recommendations of the psychiatrists. However, the obligation to prescribe imported a duty of care. From time to time Mr A would seek a variation to his prescription; he would also sometimes report that he was not taking his medication in accordance with the prescription. It was unusual for him to report symptoms of deterioration, as any voluntary request for assistance was normally directed to the psychiatrists, but he did take this action in January 1998. For these reasons it was important that the practice was fully aware of his progress and working in conjunction with the psychiatric services to maintain his stability and so far as possible avoid relapses.

5.108 The GP records include a series of reports from the clinicians following out-patient reviews, together with notifications of admission to and discharge from hospital and discharge summaries. Thus the practice was certainly kept informed of what was happening. We have drawn attention to the fact that the documentation was

always sent to Dr X or Dr V, who rarely saw Mr A themselves, but it would have been placed together with his other records and available to whoever saw him on subsequent occasions.

5.109 Given the system of reporting and the need for a consistent approach towards Mr A's treatment and care, it was desirable for him to be seen at the practice so far as reasonably practicable by the same General Practitioner. If he was seen by a doctor who was unfamiliar with his case and who could only get up to speed by reading a quantity of documentation and absorbing the significance of his various symptoms and pattern of treatment, there was potential for an alteration to be made to the medication on an ad hoc basis and also a possibility that the development of problems calling for expeditious referral back to the clinicians might be missed.

5.110 Between 1991 and 1995 Mr A was in fact largely seen by the same person, namely Dr W. This leads us to conclude that although the practice operated a system whereby patients could be seen by whichever doctor was available and sometimes this meant that Dr W was not personally consulted, there was an underlying policy and procedure aimed at achieving consistency.

5.111 Nonetheless, after Dr W left the practice in 1995, Mr A was seen by a succession of different practitioners and when he was relapsing in January 1998 they were evidently a locum and a trainee. This may have been unavoidable, even though there was a computerised appointments system from about 1995 onwards, but it cannot be described as satisfactory.

5.112 A likely corollary of the loss of a personal relationship between Mr A and a particular doctor is that from February 1995 onwards the notes made upon his attendances generally ceased to be as detailed as they were previously.

5.113 There was also during this period of time no liaison between the practice and the other professionals who had input into Mr A's treatment and care. The only link was the communication of information in writing to the practice, a process which did not involve any discussion or exchange of views.

5.114 It is not obvious from the records that anyone from the practice was invited to attend the CPA meeting which was held on the 16th February 1996, but they do reveal that Dr V was invited to the subsequent meetings on the 8th and 29th July. However, neither Dr V nor any other doctor from the practice actually took up this invitation. That was in itself unremarkable, as we would not necessarily have expected someone from a busy practice to have been available; presumably a call was made to say that no-one would be able to attend. But it seems improbable that any of the doctors would have been in a position to make much of a contribution to the discussion and planning of the case in any event, as Mr A did not have a longstanding relationship with them.

5.115 Copies of the completed CPA forms were sent to the practice and would have been added to Mr A's records. The practitioners who saw him subsequently would have been able to discern the bare bones of his planned treatment and care. They would not have got any flesh, because the care plan did not descend to any detail of the symptoms to look out for or the action to be taken in the event of impending relapse. Nor did it make any reference to GP involvement in the case other than was implicit in the prescription of medication.

5.116 What was essentially missing at that stage and over the ensuing period of almost three years was more than merely continuity of personnel at the practice end; it was any mechanism for linking the practice into the ongoing care process. There was no key worker who could visit the practice from time to time, go through the salient features of the case, check that prescribing was in line with recommended

medication, and ensure that there was adequate liaison. Nor at that time do we understand there to have been any other health worker whose duties involved this kind of linkage between primary and secondary care.

5.117 The current CPA organisational arrangements do not specifically fill this lacuna, although in principle they should result in better channels of communication with General Practitioners. We consider it to be an aspect of care co-ordination which needs to be addressed. Although the lack of linkage cannot be regarded as actually having affected the outcome in this particular instance, it could have a significant impact in other cases.

Communication with the Family

5.118 For most of the duration of his underlying mental illness Mr A resided with his parents. As an adult he was not technically in their care, but they did look after him and provide him with a substantial measure of support. From January 1996 onwards he was also working for his sister (and brother-in-law) and she likewise had a close and supportive relationship with him.

5.119 The family were obviously aware of the general nature of Mr A's illness and they had considerable knowledge and experience of how he would behave when he was relapsing. This was acquired largely from their own observation but in part from discussions with the clinicians.

5.120 One or both of Mr A's parents attended at the hospital on occasions when he was admitted or discharged. They were present at the CPA meetings in July 1996. Much of the responsibility for his monitoring was loaded upon their shoulders. In those circumstances they needed to have comprehensive information about his

clinical presentation, a full understanding of what to do in the event of impending relapse, and the means by which to take effective action.

5.121 In the course of their evidence to us the family and the professionals with direct involvement in the case raised either explicitly or by implication the following matters which indicate that those essential requirements were not met :

(i) The family were not aware of the fact that Mr A had used force against other persons while he was in hospital. Their perception of him was that he was not someone who might resort to violence.

(ii) They never had a meeting with any of the professionals after 1996.

(iii) They were not in possession of a defined list of relapse indicators.

(iv) They were not provided with a detailed action plan.

(v) They did not have a clear idea of the person with whom they should make contact if a problem arose.

(vi) They did not know of any organisation which would give them immediate assistance outside normal working hours.

(vii) They thought that there was nowhere to which Mr A could directly go for help other than the Accident and Emergency Department at the Central Middlesex Hospital.

5.122 The extent of the difficulty for the family is illustrated by the events on the day of the homicide. In the first instance they did not realise that Mr A had already

reached the stage of total relapse. Then, following the incident with the chair, they thought that he would go to the hospital and that this was the best course of action. Later Mr A's sister sought to communicate her concerns to the hospital but got no further than leaving messages with the receptionist (initially a porter deputising for him) at the Park Royal Centre. Ultimately she feared that Mr A would end up in trouble elsewhere, yet her point of contact was again the receptionist.

5.123 In our judgement the family did not have the quality of support which was needed for them to deal effectively with this kind of crisis. It was not enough simply to tell them in 1996 that the Consultant should be informed.

5.124 We also feel that more could have been done by way of support after the homicide. It is true that the family did not take up the offer made by the Social Services, but that may well have been because it was made in a very formal letter; personal contact would have had a better prospect of success. Involvement of the Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust (from whom there does not appear to have been even a letter) might equally have been helpful.

5.125 In this connection we must additionally point out that the close relatives of the victim of the homicide felt completely marginalised, left not only without any kind of apology but also for some time largely ignorant of what had actually happened. It is outside the remit of our inquiry to comment upon this unfortunate aspect of the incident and we recognise that it is a difficult and sensitive area, but we do think that it needs to be borne in mind.

The Serious Incidents Procedure

5.126 In May 1999 the procedure for dealing with a serious incident was to be found in

a document which had been published by the North West London Mental Health NHS Trust in May 1996 (see Annex 8). This called for an initial fact finding exercise and whenever necessary a further management investigation.

5.127 The investigation could sometimes be undertaken by the General Manager, but if the incident involved more than one professional area the heads of the professions or persons identified by them were to be involved. There was then provision for an independent review by a senior clinician or manager not employed by the Trust. In this instance, however, the investigation was internal and it was carried out by the General Manager and the Medical Director. We are inclined to think that the head of the nursing service should also have been one of the team.

5.128 The rationale for an investigation was not just to determine whether members of staff were at fault, but also to identify whether any changes in policies, procedures or service delivery arrangements were necessary.

5.129 It appears that Dr Mallett and Mr Jacob intentionally adopted a narrow approach towards this task. We were told by Dr Mallett that they focused upon the incident itself and the preceding actions of the individuals concerned with the case. They did not consider that they should address broader issues such as whether a tighter approach to risk management and care planning was needed, because those were issues anyway under scrutiny by the Trust in a much wider context than a single incident. We can readily understand this point of view, but we think that at least some consideration should have been given to whether there might have been a causative connection between inadequacies in the system and the homicide.

5.130 In their report Dr Mallett and Mr Jacob concluded that there had been no recent significant changes in Mr A's mental state or circumstances, that he was not considered to be a high risk individual, that appropriate procedures had been

followed when he defaulted from his medication, and that it was difficult to see how any other action taken by staff could have averted the tragic incident.

5.131 Dr Mallett and Mr Jacob then went on to make just two recommendations, namely that the procedures in the depot clinic had not been updated for some time and could usefully be reviewed and that a more robust system needed to be in place to ensure that prescriptions had not expired.

5.132 It follows that there was no criticism of the actions of Nurse I. Nor was any adverse comment made in relation to Mr A's care package and support system, which we note had been described by Mrs B as having adequately met his needs. In both these respects we have to say that we cannot agree with the findings. It will be obvious from our commentary on the case that we do not think the depot clinic procedures were observed and that more importantly there were a substantial number of deficiencies in the planning of Mr A's treatment and care and in the monitoring of his condition.

5.133 In fairness to Dr Mallett and Mr Jacob we must acknowledge that internal reviews by clinicians and managers are inherently awkward procedures. They have to be undertaken quickly and without the assistance of an administrative infrastructure, staff are liable to be defensive, and it is not easy for a team of investigators who are themselves heavily involved in the running of a local service to condemn a spectrum of its existing practices on the basis of a single unfortunate incident.

5.134 On the 19th October 1999 the guidelines for investigation of serious untoward incidents were revised (see Annex 9). We would now expect an investigation into a homicide in the community by a patient to be conducted by a panel chaired by a Non-Executive Director of the Trust and the terms of reference to be framed so as to extend to examination of material policies and procedures.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 This case highlights some of the problems faced by the authorities which have the obligation to provide care in the community for individuals who suffer from the type of mental illness that for most of the time is well controlled but at intervals necessitates re-admission to hospital.

6.2 Mr A had a history of schizoaffective disorder extending back to 1980. This mental condition was enduring but susceptible to treatment with combinations of drugs. So long as they maintained him in a stable state, his outward manner and behaviour were quite normal, although inwardly he was still troubled and lacking in confidence.

6.3 Over the years he relapsed on a significant number of occasions. On average this would happen about once in a period of two years; sometimes the timescale was a little shorter, sometimes it was longer, but he never succeeded in keeping out of hospital altogether. At first sight he seemed to be doing remarkably well during the period from the end of July 1996 onwards. However, there was in fact a time approximately one and a half years later when he probably ought to have been in hospital and he would undoubtedly have ended up there in May 1999 even if the homicide had not taken place.

6.4 When he relapsed, his mind became focused upon bizarre religious and political ideas. They were not usually intrinsically dangerous thoughts, but they influenced his behaviour to the point at which he would have appeared very strange to those who did not know him. He also became manic, with the consequence that he was

both restless and disinhibited; this led him to do other abnormal things such as wandering on a motorway.

6.5 Until he completely lost control of his emotions he did not pose a particular threat either to himself or to others, although there was an increasingly great risk of an accidental injury. At the point when he went over the edge, he was quite likely to damage property and on one occasion he did get into a fight. But it was only when there was the added element of confinement or restraint that he could be expected consistently to react in an aggressive manner and to strike out.

6.6 The management of a patient such as Mr A was not particularly complicated. His illness was of a recognised and common nature, the combinations of drugs for its treatment were well known, until the homicide his behaviour conformed to a predictable pattern, and periods of hospitalisation were always relatively short.

6.7 The keys to his successful care in the community were easily identifiable. Given that medication would not in itself be sufficient to keep him stable indefinitely, he needed (i) measures by way of support designed to help him manage the stresses of life, (ii) regular monitoring, and (iii) effective relapse planning.

6.8 Support was substantially provided by his family. His parents gave him a home and looked after him and after an extended period of unemployment his sister supplied him with an occupation. But we do not think that was enough; the Health and Social Services were under an obligation to ensure that his lifestyle was not unduly circumscribed and to help him find ways of becoming more confident and less dependent on others. In that regard we consider that he was not well served, partly as a direct result of shortage of resources but also due to the absence of an effective multi-disciplinary approach to his case.

6.9 We are satisfied that monitoring in the Out-patient Clinic was by and large carried out to a high standard. The clinicians were competent, they made good notes and with only one exception their reviews were undertaken at appropriate intervals. Between 1995 and 1997 there was some discontinuity of personnel and this meant that Mr A was not seen at Consultant level over a longer period of time than was desirable, but the problem was subsequently rectified and did not in our view have more than short term consequences.

6.10 On the other hand monitoring in the depot clinic was less satisfactory and during the period when Mr A was receiving his injections from Nurse I we do not believe that it was more than superficial. In addition there was no liaison between the psychiatrists and the depot clinic nurses.

6.11 From February 1996 onwards there was no input into monitoring from any other professional source, primarily because a Community Psychiatric Nurse was not allocated to the case and key working was negligible.

6.12 That would have mattered less were there to have been a high quality of relapse planning, so that everyone concerned in the case knew exactly what they should be looking out for and what action was then required. But it is in respect of this vital aspect of Mr A's care that we have found the greatest weakness. There was in reality only the skeleton of a plan.

6.13 We have come to the conclusion that the deficiencies in Mr A's care may have had a material bearing on the homicide. It was not on any showing a foreseeable outcome, as his previous behaviour did not raise even the suspicion that he might one day cause serious harm to another person in the community, but we think that it might have been avoided were suitable mechanisms for the provision of support, monitoring and dealing with impending relapse to have been in place.

6.14 On a broader front we consider that the North West London Mental Health NHS Trust was dilatory in the formation and implementation of suitable policies and procedures and that the service which it provided between 1993 and 1999 was not of a particularly high standard. Similar observations apply to the Social Services Department of Brent Council in the exercise of its duties in the field of mental health.

6.15 In the light of the general inadequacy of the system in which they were obliged to work, the performance of the various professionals who had involvement in the case was generally as we would have expected. We have directed criticism at the actions of Nurse I, but it must be borne in mind that he did not have the qualification and training of a Community Psychiatric Nurse (nor did he have the opportunity to explain his actions to us). We do not consider that he or any other member of staff ought to bear the blame for the homicide.

6.16 We doubt that any of our observations in relation to the quality of the service at the material time will come as any surprise. The need for improvements was well recognised by senior management and attempts were being made to effect them. Those efforts have since continued and progress has unquestionably been made, especially in the integration of the two branches of the service and the production of a comprehensive policy and guidelines for the operation of the CPA. What is now required in our estimation is a period of consolidation, with emphasis upon implementation of the procedures, auditing of their outcomes, revisions to their machinery wherever necessary, and above all instruction and training of staff in their application.

6.17 Our **recommendations** are as follows :

(i) The Central and North West London Mental Health NHS Trust and Brent Council should ensure that the health and social care needs of every service user entitled to aftercare pursuant to section 117 of the Mental Health Act are fully and properly assessed in accordance with the procedures set out in the current CPA Policy Document.

(ii) The Trust and Council should ensure that assessments are undertaken by mental health professionals who are sufficiently qualified and experienced to be able to perform the task in a competent manner.

(iii) The Trust and Council should ensure that risk assessment is appropriately carried out and properly recorded on the forms provided for that purpose.

(iv) The Trust and Council should provide a course of instruction and training for mental health staff in assessment and management of risk.

(v) The Trust and Council should ensure that every service user is accurately categorised as a Standard or Enhanced CPA case.

(vi) The Trust and Council should establish a procedure whereby a decision to regrade the service user (whether to a lower or higher category) is restricted to a Consultant following discussion with other professionals involved in the case and made not less than three months after discharge from hospital.

(vii) The Trust and Council should ensure that following assessment of a service user entitled to aftercare a care plan is formulated which complies with the requirements of the CPA and Care Management.

(viii) The Trust and Council should ensure that the care plan for a service user on Enhanced CPA includes a contingency plan and a crisis plan and that they contain the information prescribed in the CPA Policy Document.

(ix) The Trust and Council should ensure that details of the contingency plan and crisis plan are made known to carers of the service user and any other persons who are voluntarily involved in the monitoring process and that they are provided with defined channels of communication to the mental health services both during and out of working hours.

(x) The Trust and Council should undertake an audit of the process of care co-ordination with a view to establishing that suitable professionals are being assigned to service users on Enhanced CPA and that co-ordination is being effectively carried out in accordance with the current Practice Guidelines.

(xi) The Trust and Council should introduce a course of instruction and training for mental health staff undertaking care co-ordination.

(xii) The Trust and Council should ensure that arrangements are effectively in place for regular monitoring by professionals of the mental state of every service user who is considered to be at risk of relapse.

(xiii) The Trust should carry out a review of the arrangements for monitoring in the depot clinics.

(xiv) The Trust should devise and operate a definitive system of liaison between psychiatrists and depot clinic nurses for both Enhanced and Standard CPA cases.

(xv) The Trust should make arrangements for a system of record keeping which enables clinicians and all other mental health staff with responsibility for monitoring a service user to have access to the entirety of the case notes.

(xvi) The Trust should devise and operate a system whereby the prescription of all medication for service users is undertaken solely by psychiatrists unless General Practitioner treatment is in accordance with agreed shared care protocols.

(xvii) The Trust should impress upon service users and their General Practitioners the importance of adherence to the prescribed regime of medication.

(xviii) The Trust should devise and operate a definitive system of link working between mental health staff and General Practitioners.

(xix) The Council should ensure that in any case in which there is an assessed substantial need for assistance with a social problem careful consideration is given to the feasibility and best means of providing the requisite support.

(xx) The Trust and Council should audit the outcomes of the CPA procedures at intervals of not less than two years and should revise them as necessary.

(xxi) The Trust should conduct investigations into serious incidents according to the current guidelines and frame terms of reference so that they extend to examination of material policies and procedures.

ANNEX 1

JOINT POLICY - CARE PROGRAMME APPROACH AND CARE MANAGEMENT

NORTH WEST LONDON MENTAL HEALTH NHS TRUST AND SOCIAL SERVICES

1. Context

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

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

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

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

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

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

2. Who can receive this service?

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

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

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

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

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

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

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

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

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

Key components of CPA and Care Management are:

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

4. Assessment

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

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

5. The Care Plan

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

The Care Plan should include:

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

6. Procedure for those eligible for CPA while in hospital

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

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

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

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

7. People eligible for CPA while in the Community

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

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

8. Users and Carers

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

9. Care Plan Review

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

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

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

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

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

10. The Multidisciplinary Team

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

The Team is identified at the CPA Planning meeting.

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

11. Role and Responsibilities of the Responsible Medical Officer

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

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

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

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

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

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

12. Role and Responsibility of the Key Worker

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

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

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

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

The Key Worker will be expected to:

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

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

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

Ensure that the user has registered with a GP.

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

Closely monitor the agreed care package and documents.

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

Attend the review meetings as outlined in the Care Plan.

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

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

13. Role and Responsibilities of the Care Manager

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

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

14. Section 117 Arrangements

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

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

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

15. Broad Factors to be Considered in Assessing Risk

Clients with High Risk

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

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

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

Key Factors to be Considered in Assessment of Risk

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

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

16. Documentation

Individual professionals should complete documentation as required by their agency.

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

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

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

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

17. Audit Arrangements

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

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

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

July 1995

ANNEX 2

RISK ASSESSMENT AND MANAGEMENT PROCEDURES

NORTHWEST LONDON MENTAL HEALTH NHS TRUST &

BRENT COUNCIL MENTAL HEALTH FIELD WORK

February 8TH 1999

Risk assessment and management procedures

1. Completion of the form	The risk indicator checklist should be completed for all patients who are accepted by the specialist mental health services
On the ward	The risk indicator checklist should be started at the point of admission (*as part of the admission process and an immediate risk care plan should be drawn up*). This will be the responsibility of the ward manager and the duty doctor. The assessment should be discussed at the ward round and decisions made on any further action to be taken and whether a more comprehensive assessment is needed. The risk indicator checklist should be completed within 5 days of admission. The risk indicator and/or comprehensive assessment should be repeated prior to consideration of hospital discharge
At Accident and Emergency	The duty psychiatrist and senior nurse should take responsibility for beginning the risk indicator checklist and ensuring that the information gathered is passed to the appropriate team for follow-up and completion.
In the community	The risk indicator checklist should be discussed at the referral meeting. Where it is decided that further action is needed by means of face to face contact the risk indicator should be started at the first contact. A professional identified at the referral meeting should be responsible for ensuring relevant information is available to complete the form (*this does not mean that one person will necessarily be solely responsible for obtaining the information but for co-ordinating the process – this may be the key worker)*. The information should be brought back to the meeting for discussion and a decision on further action. The risk indicator checklist should be completed within 4 weeks of referral.
2.	Teams need to decide in individual cases whether to proceed with the more comprehensive"Assessment of Risk" form. This should be discussed at the clinical review meeting and should involve Mental Health fieldwork .The consultant should make the final decision in consultation with the team.
3.	Teams need to agree local procedures for initiating the comprehensive "Assessment of Risk"form.
4.	All CPA participants who are going to be actively involved in the care plan need to familiarise themselves with the risk assessment and management plan. The teams need to decide how the information in the risk assessment and management plan is shared and how the information can be accessed. It is a matter of clinical judgement whether the complete risk assessment and management plan, or an appropriate part of it is shared. the final decision for this rests with Responsible Medical Officer(RMO)
5.	The risk assessment and management plan should be reviewed at the same time as the rest of the care plan. Teams need to discuss how this should be done, in individual cases, and whether a separate meeting or separate part of the meeting needs to be identified to discuss issues relating to risk.

Risk assessment and management procedures

1. Completion of the form	The risk indicator checklist should be completed for all patients who are accepted by the specialist mental health services
On the ward	The risk indicator checklist should be started at the point of admission (*as part of the admission process and an immediate risk care plan should be drawn up*). This will be the responsibility of the ward manager and the duty doctor. The assessment should be discussed at the ward round and decisions made on any further action to be taken and whether a more comprehensive assessment is needed. The risk indicator checklist should be completed within 5 days of admission. The risk indicator and/or comprehensive assessment should be repeated prior to consideration of hospital discharge
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5.	The risk assessment and management plan should be reviewed at the same time as the rest of the care plan. Teams need to discuss how this should be done, in individual cases, and whether a separate meeting or separate part of the meeting needs to be identified to discuss issues relating to risk.

6.	It should be a matter of clinical judgement whether and how the risk assessment is shared with the user.
7.	For clients who meet the criteria for inclusion on the Supervision Register. The appropriate Supervision Register documentation should be completed.
8.	For both the initial risk indicator checklist and the more comprehensive assessment for risk, the RMO should sign the form to ensure that the information contained in the form and the decision on further action has been agreed.
9.	Where the box "unable to assess" has been marked, an indication of the reasons should be given and the team should follow this up, if appropriate.
10.	It is important that the risk assessment it discussed in a multi-disciplinary team setting, including Mental Health Fieldwork, and that individual team members do not feel that they are solely responsible for completing the risk assessment Consideration should be given to the most appropriate team members to be involved in the assessment for example it may not be appropriate for unqualified members of the team to complete the assessment.
11.	All information contained in the risk assessment should include details of the risk and the context in which the risk behaviour occurred
12.	The risk assessment and management process should be based on anti-discriminatory and anti-racist practice.
13.	The risk assessment should be reviewed as often as required. It should reflect any additional information, which becomes known. Any changes to the risk management plan should also be indicated. This should be reflected on the CPA care plan and circulated as appropriate.
14.	Consideration needs to be given as to how the risk assessment and management plan is integrated with the CPA care plan summary. In some case it may be appropriate to distribute the risk assessment with the CPA care plan and in others it may be sufficient to reflect the plan on the CPA care plan summary.
15.	All risk assessment documentation should be on green paper and should be clearly identified in the clinical notes.

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BRIEF RISK INDICATOR CHECKLIST – to be completed for all patients

Patient / client name:..... D.O.B. .....

Sector Team:..... Date assessment started.....

RISK ASSESSMENT HISTORY

History of violence (ever)
None ☐
One incident ☐
Two incidents ☐
Three incidents ☐
More than three incidents ☐
Threats of violence ☐
Not able to assess ☐

Most serious harm caused
None ☐
Minor injury ☐
Serious injury ☐
Fatality ☐
Not able to assess ☐

History of arson (ever)
No ☐
Yes ☐
Threats ☐
Not able to assess ☐

History of suicide attempts (ever)
None ☐
One ☐
Two ☐
More than two ☐
Threats of suicide ☐
Not able to assess ☐

History of severe self-neglect (ever)
No ☐
Yes ☐
Not able to assess ☐

History of harm to children (ever)
No ☐
Yes ☐
Threats of harm ☐
Unable to assess ☐

History of containment (ever)
None ☐
Special hospital ☐
Secure unit ☐
Prison ☐
Locked ward ☐
Detained under the MHA 1983 ☐
Detained under section 136 ☐
Detained at the police station ☐

History of dropping out of contact with mental health services Yes ☐ No ☐

RISK BEHAVIOURS IN THE PAST YEAR

	Yes	No	Threats
Accidental harm at home (e.g. falling, careless smoking)	☐	☐	
Not able to assess	☐		
Accidental harm outside the home (e.g.) wandering into the road	☐	☐	
Not able to assess	☐		
Lack of awareness of danger	☐	☐	
Not able to assess	☐		
Abuse/exploitation from others	☐	☐	☐
Not able to assess	☐		
Drug abuse	☐	☐	
Not able to assess	☐		
Alcohol abuse	☐	☐	
Not able to assess	☐		
Non-compliance with medication	☐	☐	☐
Not able to assess	☐		
Arson (deliberate fire setting only)	☐	☐	☐
Not able to assess	☐		
Self-injury (e.g. cutting)	☐	☐	☐
Not able to assess	☐		
Overdose	☐	☐	☐
Not able to assess	☐		
Other method of self-harm	☐	☐	☐
Not able to assess	☐		
Harm to children	☐	☐	☐
Not able to assess	☐		
Sexual assault (including touching/exposure)	☐	☐	☐
Not able to assess	☐		
Violence to family	☐	☐	☐
Not able to assess	☐		
Violence to staff	☐	☐	☐
Not able to assess	☐		
Violence to other patients	☐	☐	☐
Not able to assess	☐		
Violence to the general public	☐	☐	☐
Not able to assess	☐		
Incidents involving the police	☐	☐	☐
Not able to assess	☐		

Current mental state: are there any active symptoms that indicate an increased risk of harm to self or others? **No** ☐ **Yes** ☐

Please describe:

Is further risk assessment required?

No ☐ *If necessary please give details in the box below*
Yes ☐ *If yes, please complete "Assessment of Risk Form"*

Does the client meet the criteria for inclusion on the Supervision Register? **No** ☐
Yes ☐ **if yes please complete the "Assessment of Risk Form" and the Supervision Register form.**

Brief summary /action plan (please include reasons for no further assessment)

Main sources of information – please note whether relatives/carers/ significant others and GP have been consulted as part of the assessment

Form completed by: ..... **Designation** .....

Date of completion:.....

RMO Name:..... **Signature** .....

Key worker name: ..... **Signature**.....

ASSESSMENT OF RISK FORM

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Patient/client name:..... DOB:.....

Please tick ✓ to indicate a history of risk behaviour or specific areas of concern:

SELF-HARM ☐ SELF-NEGLECT ☐ RISK TO OTHERS ☐ RISK FROM OTHERS ☐ FIRE RISK ☐

1. HISTORY

1.1 Please give details of any previous risk behaviour as identified in the categories above:

1.2 Is there evidence of rootlessness or "social restlessness" (for example few relationships, frequent change of address or employment)	YES ☐	NO ☐

1.3 Is there evidence of poor compliance with treatment or disengagement from psychiatric aftercare/ or discontinuation of medication	YES ☐	NO ☐

1.4 Is there evidence of substance misuse or other potential disinhibiting factors(for example a social background promoting violence)	YES ☐	NO ☐

1.5 Can any precipitants or any changes in mental state or behaviour that have preceded earlier violence/ or other risks (e.g. self –harm, arson, self-neglect) be identified?	YES ☐	NO ☐

Are these risk factors stable or have they changed recently?

1.6 Is there any evidence of recent severe stress?	YES ☐	NO ☐

1.7 Have there been any loss events or any threat of loss	YES ☐	NO ☐

2. ENVIRONMENT

2.1 Does the patient have access to potential victims, particularly individuals the patient has identified in mental state abnormalities e.g elders/children	YES ☐	NO ☐

2.2 are there any features in the environment which may exacerbate the identified risks	YES ☐	NO ☐

3.MENTAL STATE

3.1 Does the patient have firmly held beliefs of persecution by others? (persecutory delusions)	YES ☐	NO ☐

3.2 Does the patient report experiences of mind or body being controlled or interfered with by external forces? (delusions of passivity or command auditory hallucinations)	YES ☐	NO ☐

3.3 Does the patient show any of the emotions related to violence (for example irritability, anger, hostility suspiciousness)?	YES ☐	NO ☐

3.3 1. Does the patient show any of the emotions related to self-harm /suicide (e.g. feelings of hopelessness ,low self-esteem, no hope for the future)	YES ☐	NO ☐

3.4 Are there any specific threats made by the patient?	YES ☐	NO ☐

3.5 Are there particular difficulties in gaining access to the patient's mental state?	YES ☐	NO ☐

4. INTENTION

4.1 Has the patient expressed any clear intention to harm self or others?	YES ☐	NO ☐

5. PLANNING

5.1 Has the patient made any specific plans in relation to harm to self or others?	YES ☐	NO ☐

6. please use this space to identify any risk factors which have not already been covered

6. SUMMARY

This should be based on these and all other items of history and mental state. It should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions:

SUMMARY OF ASSESSMENT (6.1 – 6.4)

6.1 How serious is the risk of harm	
6.2 Is the risk of harm specific or general?	
6.3 How immediate is the risk of harm	
6.4 How likely is the risk of harm	

RISK ASSESSMENT AND MANAGEMENT GUIDANCE NOTES.

NORTH WEST LONDON MENTAL HEALTH NHS TRUST &
BRENT COUNCIL MENTAL HEALTH FIELD WORK
February 8TH 1999.

Risk assessment and management guidance

Introduction

Users with long term difficulties and particularly those known to have potential for risk taking behaviour need special attention, both at the time of discharge and during follow-up in the community. Assessment of this group of patients is an important role of all mental health professionals. There are no risk assessment tools that will enable anyone to say with complete accuracy that one patient is at risk and another is not. However there is a considerable body of evidence that indicates which factors are associated with risk and how predication of risk can be made on the basis of assessment information.
In reality all mental health professionals are involved in making judgement on risk, based on assessment information every day.
If is important that a thorough assessment is made and a clear reasoned judgement is made which can show that the best possible practice was followed, this process should be clearly documented.
The decision to discharge a patient form the caseload must be agreed by the RMO.
No decision to discharge a patient from hospital should be agreed unless those taking the clinical decision are satisfied that the behaviour can be controlled without serious risk to the patient or to other people.
Clinicians should pay particular attention to the period immediately following hospital discharge, which is a particularly vulnerable time for patients with mental health problems

Note – it is essential that in respect of all new referrals and patients previously unknown to the service that every effort is made to ascertain any relevant history from other services that have had previous contact with the patient. In consideration of all new referrals an appropriate clinician should be identified to take responsibility for gathering this information.

In relation to recent inquiries it is important that there is evidence of risk assessment and management documentation to demonstrate that risk assessment has been shared and understood by those involved.

This guidance sets out good practice for risk assessment and management, which should be followed for all patients. It is based on the application of the Care Programme Approach, with particular emphasis on the assessment of risk for the Supervision Register.[1]

"Local factors for Risk Management for Brent Residents – applying anti-racist and anti-discriminatory practice"

In Brent we have to be aware that 55% of the population is from an ethnic community and that certain groups of these residents are over and under represented in the local community mental health services. All groups will be subject to racism in their daily lives. Other discriminatory factors will also come into play for other groups, which need to be taken into account as part of the staff members' assessments; including women and elders, lesbians and gay men and people with disabilities.

Looking specifically at race issues, staff have to be especially careful in assessing risk to others to take into account the stereo-typing of some groups such as young black men is common in our society. This can also affect the selectivity of information recorded and presented about black people we work with. It can also affect the way that incidents are emphasised and contextualised. A key part of the service we offer is to make sense of information we are presented with and to analyse it from the point of view of race and culture so that the plan which we develop is balanced, based on evidenced facts and sensitive to that individual's needs.
Equally, for some groups such as Asian women, there can be an under representation with mental health services. There can be a tendency to stereo-type Asian communities as supportive or attribute psychological problems to cultural issues (such as arranged marriages) which leads to a loss of understanding of the individual's needs rather than an increase in understanding.

Under the Risk Assessment and Management Procedures Point 12 states, "the risk assessment and management process should be based on anti-discriminatory and anti-racist practice"

For further information see Brent Council Mental Health Fieldwork's Risk Assessment and Management Policy, and Anti Discriminatory and Anti-racist Policy and NWLMMHT's Equal Opportunity Policy and Code of Practice

Context for Risk Assessment

The nature of the risk assessment will depend on the context in which it is made, such as:

- **Initial and comprehensive assessments** –first contacts and ongoing management of severe mental disorder;
- **Assessments following an untoward incident.**

Initial assessment: first contact

At first contact the psychiatric assessment must always include the proper evaluation of risk of harm to self or others and should consider the following areas:

- Risk factors e.g. age, gender/ethnicity
- History – **this must include history from any previous contact with mental health services, wherever this has taken place.**
- Ideation/mental state
- Intent
- Planning
- Formulation

As far as is possible with the information available, consider the pattern, frequency and severity of any risk factors and how recently they took place (recency)

Management of Severe Mental Disorder

At CPA reviews of a person suffering from severe mental disorder, an assessment of risk should be repeated. The degree of detail should be related to the responsible clinician's judgement of the severity of the disorder, and will be related to the CPA level. Again attention should be paid to the above areas. In addition, consider previous notes, which will provide a fuller picture of the history. It will also be important to consult with other professionals and carers involved in the patient's care. Careful attention to these sources of information will help to reveal any past history of violence and/or self-harm, plus its pattern, frequency, recency and severity

Assessment following a Serious incident

A more detailed risk assessment is required following a suicide attempt or a violent incident. The assessment should generally include the following:

- Detailed reconstruction of the incident based on evidence from the patient,
- witnesses and/or the victim
- Details of the trigger factors e.g. use of alcohol or drugs, events such as contact with relatives, children, contact with authority, refusal of requests for money/services/prescriptions;
- Details of any situational factors e.g. is the person living with vulnerable others or people who they have threatened before?
- Are friends, relatives, or carers available to offer support and monitoring?
- Consideration of the patient's current feelings and attitude to past incidents e.g. acceptance of responsibility and remorse
- Observations by staff of the patient's responses to stressful situations

Risk assessment –harm to others and suicide

	Risk assessment and management of risk of harm to others	Risk assessment and management for suicide
History	An accurate history of violent incidents is very important. This information should be obtained from all possible sources, including the patient themselves Staff should also look for evidence of: • Poor compliance with treatment or disengagement from after-care • Triggers or any changes in mental state which may have occurred prior to the violence or relapse • Recent severe stress, particularly loss events or the threat of loss • Recent discontinuation of medication.	An accurate history of past self-harm incidents and suicide attempts is vital for the risk assessment process. The recency, severity and pattern of these attempts should be examined, as with risk of harm to others. For example when considering severity of attempt, persons who attempt to hand themselves when alone in the house and who take steps to avoid interruptions and are only rescued by chance are at much higher suicide risk than persons who have taken an overdose they know is not lethal and present themselves at casualty
Recency	The more recent the incident of harm to others, the higher the current risk.	
Severity	The more severe an incident, the higher the current risk.	
Frequency	The more frequent the events or incidents, the higher the current risk. Persistent and repeated assaults on others are strong indicators of high risk.	
Pattern	Is there a common pattern to the type of incident or the context in which it occurs?	When considering the pattern of self-harm or suicide attempts, a suicide attempt may typically be made at the ending of a relationship. If that pattern is now repeating itself and the relationship is now ending, this indicates higher risk. Anniversaries and recent traumas and losses may increase risk, usually temporarily, particularly if it leads to a sense of entrapment and hopelessness The patient's view of anticipated events may also increase risk as they approach. It is also important to remember that substance misuse, particularly of alcohol greatly increases risk
Ideation and mental state	What is the person thinking or feeling now.? It is important to assess the patient's mental state and in particular look for evidence of the following. • Evidence of persecutory delusions or delusions of passivity(being controlled by external people or forces) • Emotions related to violence e.g. anger, irritability • Specific threats made by the patient • Command hallucinations	An examination of the person's ideas on suicide can help to assess the risk. • Does the person see suicide as an answer to their problems? • Does the person think or fantasise about suicide? • How frequently does the person think about suicide? • How does he or she respond to these thoughts? The greater the prominence and rigidity of these thoughts in the person's life, the higher the risk of suicide. Fleeting thoughts quickly rejected represent low risk, while persistent, intrusive thoughts and painful thoughts indicate high risk even in the absence of planning. Consider constraints on action e.g. religious beliefs, family obligations

Intent	A statement from an individual that they intend to harm another person is the clearest indication of risk and should never be ignored. Intent, whether declared or not, is the strongest and most powerful predictor of future behaviour.	A statement from an individual that they intend to harm themselves is the clearest indication of risk and should never be ignored. Intent, whether declared or not, is the strongest and most powerful predictor of future behaviour.
Planning	If a person admits to having thoughts of harming others, it is important to establish if they have considered how they might do this. This can be extracted from their own statements or other objective evidence The presence of a plan indicates still higher risk. If the person also has the means to carry the plan out, the degree of risk rises again	If the person admits to suicidal ideas, has he/she taken it a stage further to planning how to do it? How likely in your judgement is the plan to succeed? Plans to avoid detection are of particular significance. For-example, if a person has continual thoughts of suicide, has the person determined that he or she will shoot themselves when the rest of the family are away and does the person have the means to do so, for example owning a shotgun- this would indicate very high risk Thoughts of suicide without any plan or without access to the means to do so carry a lower risk
Formulation	Following the assessment a risk management plan should be formulated which should, as far as possible, specify factors which are likely to increase the risk and those likely to decrease it. It should include the factors listed above and how their interaction increases risk. The formulation should seek to answer the following questions • How serious is the risk of harm? • Is the risk of harm specific or general? • How immediate is the risk of harm? • How volatile is the risk of harm? • Are circumstances likely to arise, which will increase it? • What specific treatment and management plan can best reduce the risk of harm?	A formulation should be made as with the risk of violence, including an appreciation of all the risk factors described above and the role of their interaction in increasing risk • How serious is the risk of harm? • Is the risk of harm specific or general? • How immediate is the risk of harm? • Is the risk of harm liable to diminish fairly quickly? • Are circumstances likely to arise, which will increase it? • What specific treatment and management plan can best reduce the risk of harm? **It is important to note that the patient's responses should not always be taken at face value.**

Risk assessment: severe self-neglect

Risk assessment and management for severe self-neglect	Self-neglect is a common problem with severe and enduring mental illness. In this document we are concerned with severe levels of self-neglect. Assessing the risk of self-neglect is not a straightforward process, except in the most severe situations. It is made more complex by difficulties in relative standards. The areas that should be covered in the assessment process are • Hygiene • Diet • Infestation • Household safety • Warmth.
Management of people who neglect themselves	As for the risk of harm to others and suicide, the principle of negotiating safety should be followed. Although self-neglect can be quite serious it is rare that it should require compulsory admission under the Mental Health Act (1983). Through the CPA and careful liaison between health care agencies the risk of harm from severe self-neglect can be minimised but rarely eliminated. For patients with severe and enduring mental illness the risk of severe self-neglect is often associated with non-compliance with medication, therefore putting effective monitoring mechanisms in place as part of the CPA reduces the risk. For patients being managed in the community under the CPA, the following questions should be considered • Is the patient on the appropriate CPA level? • Has the use of legal powers been considered? • Is inclusion on the Supervision Register appropriate? • What community supports are available? • Do the carers and family have appropriate support and help? • Have the carers and family been adequately informed about services needed and how they can be accessed?(include any independent sector support network) • Are they realistic about their expectations?

The clinical management of the risk of violence

The clinical management of the risk of Violence

General principles

- A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that the risk is reduced and is managed effectively.
- The management plan should seek to increase the safety of the patient and the public but should recognise that some risks may have to be taken.
- When seeing a patient, who presents a risk of dangerous behaviour, a clinician, having assessed the risk, should then aim to make the patient feel safer and less distressed as a result of the interview.

The management plan

The management plan must be based on an accurate and thorough assessment, and adoption of the principles above.
Clinicians should consider the appropriate level of support and containment.
The following list is not exhaustive but covers options that clinicians may need to consider in formulating a management plan

- Is admission as an inpatient necessary?
- Should the patient be detained in hospital
- What level of physical security is needed
- Should the patient be placed in locked or secure accommodation?
- What level of observation and monitoring is required?
- How should medication be used?
- How would further episodes of violence be managed?
- Should the police or security be called?
- What has helped to reduce the risk in the past?

If care other than as an inpatient is being considered:

- Has the person been included in the Care Programme Approach?
- Is inclusion on the Supervision Register appropriate?
- Has the use of legal powers been considered?
- What community supports are available?
- Do the carers and family have access to the appropriate support and help
- Have the carers been adequately informed about the services needed and how they can be accessed?

Clinical management of the risk of Suicide

Management of the imminently suicidal requires careful judgement of the risk involved balanced against the support and care that can be provided in the community. Although admission to hospital may appear to be the safest course of action, it is not necessarily always the best

	Clinical management of the risk of suicide
The management plan	The management plan should consider the same options as those listed for the management of harm to others, following the principle of negotiating safety. Hospital care under the Mental Health Act should be considered when the suicide risk is high. Risk is high when: • the person has a history of serious suicide attempts, • is isolated and without support, • has clear suicidal ideas and plans, • is non-compliant with treatment and • is under stress in the home environment. **If the patient is to be managed in hospital, their safety must be paramount and consideration should be given for the need for the following interventions:** • What level of physical security is needed? • What level of observation and monitoring is needed? • Should the patient be placed in locked or secure accommodation? • Has the patient had their belongings checked for dangerous/sharp objects? • Is there a system for ensuring that the multi-disciplinary team reviews the management plan? • How should medication be used? • Should the patient be detained in hospital if necessary? **If care other than as an inpatient is being considered, once again the same questions should be asked as with risk of harm to others. In addition there are several strategies which can make community care safer.** • Ensure that as a matter of urgency that the community mental health team is involved under the CPA guidelines. • Increase the frequency of home visits and outpatient appointments. • Work with the patient to make them feel safer, both by providing emotional support and by putting practical interventions into place. • Agree a timetable of care and support with relatives and/or friends • Arrange day hospital or day care attendance on a regular basis, with rapid follow-up for failure to attend. • Liase with the patients GP to make sure that if anti-depressants are prescribed, relatively non-toxic drugs are chosen, of they are prescribed frequently in small quantities. • Make sure that the patient and their relatives know how to access help quickly from services, at any time of the day or night. • Agree a contract with the patient that they will not deliberately harm themselves between appointments.

Longer term management of the risk of suicide

Longer term management of suicide risk	The need for the longer-term management of the potentially suicidal person can arise where someone has made more than one serious suicide attempt over a lengthy period of time, possibly linked to a relapsing depressive condition, an affective psychosis or schizophrenia. It is particularly important in those circumstances to identify any precipitating factors like: • Sudden life changes and losses. • Changes in mood. • Increases in symptomatology or relapses. It may be necessary to keep in fairly close contact so that if any of these circumstances repeat themselves, a further risk assessment can take place and appropriate action can be taken. Carers and relatives can be asked to help in this monitoring process and will need to know where to gain help quickly if a crisis arises. **Note that even where someone has made a series of attempts at self-harm that do not seem intended to end in death, the risk of completed suicide still exist, and accumulates over time.**

Risk management strategies for staff

	Risk management strategies for staff
General	There are definite risks for staff working in mental health services in the day to day course of their work. The following guidance aims to assist clinicians by identifying areas of safe and good practice.
Precautions for home visiting	The most important measure is based upon good risk assessment, communication and therefore prediction. If it can be predicted that there will be a high risk of violence during a visit, workers should visit in pairs or make appointments at the office base. Other strategies to minimise risk include: • Access to mobile phones and personal alarms • Avoiding home visits to high risk areas after dark • Use of a checking in policy – where workers leave details of where they will be etc.
Precautions for offices such as mental health resource centres	All buildings in which people are seen should be equipped with an alarm system. An alarm system is only valuable if people know what to do if the alarm sounds and participate in regular practices. A worker who is alone in the building should not see patients, as backup will not be available. Vigilance needs to be exercised about general building security. Combination locks between patient-accessible and staff areas must be installed. Prior to the building being locked in the evening it must be checked to ensure all patients have left.
Communication	This is a crucial part of the risk assessment process, however there are particular points in the psychiatric care process that commonly trigger communication failures. These failures can have serious consequences. The danger points are all related to transitions in care • **Discharge from hospital** – a full assessment of risk need to take place prior to discharge from hospital. The results of the assessment need to be communicated to the care team in the community. • **Referrals to another care provider** – this can be from one provider trust to another, or from one key worker to another. All referrals should contain information about past history of harm to self or others and a current assessment of risk.
Communication between mental health professionals and other agencies	This usually poses a difficulty because of the desire to maintain confidentiality and not stigmatise the patient in the eyes of others. This issue is raised most frequently in contacts with housing or hostels. Despite the wish to prevent stigmatisation, it is clear that other agencies do need to know what the risks are and how they can best be managed. Occasionally, members of the public who are at specific risk may also need to be informed. In these circumstances the public interest overrides professional confidentiality. Staff may on occasions require advice from their manager or professional organisations on the issue Other agencies may need to be helped to develop procedures whereby information that is passed on remains confidential and protected. The CPA community care plan as formulated by the key worker is the ideal means of communication between the agencies. It contains not just the plan, but the names and contact numbers of those involved, plus information about risks. Copies of the care plan must be sent to all those involved. The communication of risk needs to be considered by the team. **The Consultant and the responsible key worker should consider in individual circumstances whether a full copy of the risk assessment should be attached and circulated with the CPA Care Plan.**
Multi-disciplinary team working	Multi-disciplinary assessment a shared care plan and good interdisciplinary communication are important aspects of risk management by the multi-disciplinary team. In order to promote consistency, multi-disciplinary teams should agree local risk assessment practices, taking into consideration differences in training and levels of expertise.
Clinical supervision	There are many reasons why one to one supervision is recommended for mental health workers. It can provide emotional support in the face of difficult and stressful work. It is the means by which workers can grow and develop in expertise and also managers can ensure that policy is being followed and professional standards maintained. The content of clinical supervision is mostly about patient care. The supervisor can contribute to higher standards of care and safer practice by making sure that risk and its assessment is a regular aspect of the discussions on patient care.

[1] This guidance reflects the requirements set out by t he Department of Health in guidance "Introduction of Supervision Registers for Mentally Ill People" HSG (94) 5 and "Guidance on the Discharge of Mentally Disordered People and their continuing care in the Community" HSG (94) 27.

ANNEX 3

Brent, Kensington & Chelsea and Westminster
Mental Health NHS Trust

The Assessment and Management of Clinical Risk

Guidance and
Procedures

Contents

1 INTRODUCTION

This guidance reflects the requirements set out by the Department of Health in their guidance "Introduction of Supervision Registers for Mentally Ill People" HSG(94)5 and "Guidance on the discharge of mentally disordered people and their continuing care in the community" HSG(94)27.

The guidance sets out good risk assessment and management practice which should be followed for all patients. It is based on the application of the Care Programme structured around the assessment of risk for inclusion on the Supervision Register.

Service users with long-term difficulties and those known to have potential for risk-taking behaviour need special attention. Assessment of this group is an important role of all mental health professionals. Risk assessment tools do not enable us to predict incidents, but there is a considerable body of evidence that indicates which factors are associated with risk.

All mental health professionals are involved in making judgements on risk every day. It is important that these assessments are thorough and that both the assessment and formulation of risk are clearly documented so that they are easily accessed and communicated and so that the best possible practice can be demonstrated.

It is essential that in respect of new referrals that every effort is made to ascertain any relevant history from other services that have had previous contact with the patient. Appropriate clinicians should be identified to take responsibility for gathering this information.

Clinicians should pay particular attention to the period immediately following hospital discharge or other reductions in the intensity of care, which is a particularly vulnerable time for patients with mental health problems. The decision to discharge a patient from the caseload must be agreed by the RMO.

The risk assessment and management process should be based on anti-discriminatory and anti-racist practice.

2 Contexts For Risk Assessment

2.1 First Psychiatric Assessment

At first contact, the psychiatric assessment must always include a proper evaluation of risk of harm to self or others, and should consider the following areas :

- Risk Factors (e.g, age/gender etc)
- History (including any information from contact with other mental health services)
- Mental State
- Intent
- Planning

2.2 Routine Management of Severe Mental Disorder

At CPA reviews of a person suffering from severe mental disorder, an assessment of risk should be repeated. The degree of detail should be commensurate with the responsible clinician's judgement of the severity of the disorder, and will be related to the CPA level. Attention should be paid to the areas above. There will usually be previous notes which will provide a fuller picture of the history. **It will also be important to consult with other professionals and carers clinically involved in the patient's care.** Careful attention to these sources of information will help to reveal any past history of violence and / or self-harm, plus its pattern, frequency and severity.

2.3 Assessment Following an Incident

A more detailed risk assessment is required following a suicide attempt or a violent incident. The assessment should generally include the following :

- Detailed reconstruction based on evidence of the incident from the patient, witnesses and/or the victim;
- Details of trigger factors, e.g, use of alcohol or drugs, events such as contact with relatives/children, refused requests etc;
- Details of situational factors, e.g, is the person living with vulnerable others or people whom the person has threatened before? Are relatives, carers available to offer support?
- Consideration of the patient's current feelings and attitude to past incidents;
- Observations by staff of the patient's responses to stressful situations.

3 Risk Assessment And Management - Harm To Other People

3.1 Risk Factors

The assessment and management of this risk is an integral part of psychiatric practice. Research has provided evidence of a number of factors that are associated with risk to others. Not all risk factors are of equal weight, therefore it is not possible to provide an exact formula to assess risk. Staff need to assess risk based upon reasoned judgement plus their in-depth knowledge of the patient. Nevertheless, certain risk factors can be usefully used in assessment to draw attention to the possibility of increased risk. The risk factors identified by the research are:

RISK FACTORS FOR HARM TO OTHERS

Age	Younger
Sex	Male
Living Arrangements	Unstable, changeable
Employment Status	Unstable, changeable
Educational Attainment	Low
Mental Health Diagnosis	Clinical Depression, Schizophrenia, Paranoid Psychosis, Personality Disorder
Substance Misuse	Alcohol Dependence, Drug Use / Dependence

3.2 History

An accurate history of violent incidents is perhaps the most important information to obtain in making an assessment of risk. This information can be obtained from records, referral letters, patients themselves and carers. It is important to obtain past records from other hospitals or social services departments and a full history of criminal offences should be sought. Staff should also look for evidence of:

- Poor compliance with treatment or disengagement with aftercare;
- Precipitants and any changes in mental state or behaviour which may have occurred prior to violence and / or relapse;
- Recent severe stress, particularly of loss events or the threat of loss;
- Recent discontinuation of medication.

Information about a history of harm to others has four components: recency, severity, frequency and pattern.

3.2.1 Recency

The more recent an event or incident of harm to others, the higher the current risk. An assault upon a stranger committed today, indicates higher risk for the present than the same incident last year, or five years ago.

3.2.2 Severity

The more severe an incident, the higher the current risk.

3.2.3 Frequency

The more frequent the events or incidents of harm to others, the higher the current risk. Persistent and repeated assaults on others are strong indicators of high risk.

3.2.4 Pattern

Is there a common pattern to the type of incident or the context in which it occurs ?

3.3 Mental State

What is the person thinking or feeling now ? It is important to assess the patients mental state and in particular look for evidence of the following :

- Evidence of any threat / control override symptoms : that is, firmly held beliefs of persecution by others (persecutory delusions) of mind or body being controlled or interfered with by external forces (delusions of passivity);
- Emotions related to violence, e.g, irritability, anger, hostility, suspiciousness;
- Specific threats made by the patient;
- Command hallucinations, e.g, voices telling patient to attack a particular person.

3.4 Intent

A statement from an individual that they intend to harm another person is the clearest indication of risk and should never be ignored. Intent, whether declared or not, is the strongest and most powerful predictor of future behaviour.

3.5 Planning

If the person has intent to harm others, the next thing to be established is whether they have considered exactly how they might do so. This can be extracted from their own statements or other objective evidence. The presence of a plan as to how they harm another person indicates yet higher risk. **If the person also has access to the means for carrying out that**

plan, the degree of risk rises still higher. The man with paranoid delusions about his neighbours who has considered exactly how he might deal with them using his kitchen knife, poses a greater risk than the person who has more vague ideas and no clear plan.

3.6 Formulation

Following the assessment, a formulation should be made which should, so far as possible, specify factors likely to increase risk or dangerous behaviour and those likely to decrease it. It should include an appreciation of all the risk factors described above, in particular, how their interactions increases risk. The formulation should aim to answer the following questions :

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- Are circumstances likely to arise that will increase it?
- What specific treatment and management plan can best reduce the risk?

3.7 The Clinical Management of the Risk of Violence

General Principles

Three principles underlie the management of patients who present a risk of dangerous behaviour.

- A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that risk is reduced and is managed effectively.

- The management plan should change the balance between risk and safety but it is recognised that in judging this balance consideration also needs to be given to the risk of unnecessarily restrictive practise.

- When seeing a patient who presents a risk the clinician should aim to make the patient feel safer and less distressed following the interview.

3.7.1 The Management Plan

The management plan must be based on an accurate and thorough assessment. **Clinicians should consider the appropriate level of support and containment.**

The following list is not exhaustive but covers options that clinicians may need to consider in formulating a management plan.

- Is admission as an in-patient necessary?
- Should the patient be detained formally?

- What level of physical security is needed?
- What level of observation and monitoring is required?
- How should medication be used?
- How should further episodes of violence be managed?
- Should the police or security be called?
- What has helped to reduce risk in the past?

If care other than as an in-patient is being considered:

- Has the person been included in the Care Programme Approach?
- Is inclusion on the Supervision Register appropriate?
- Has the use of legal powers been considered (e.g, S117, Supervised Discharge guardianship orders or legal injunctions)?
- What community supports are available?
- Do the carers and family have access to appropriate help and support, including self-help groups?
- Have the carers and family been adequately informed about the services needed and how they can be accessed?

4. Risk Assessment and Management - Suicide

A similar risk assessment process as documented in part 3 for risk of harm to others is relevant to ascertain the risk for suicide. Once again, the following issues should be examined:

- Risk Factors
- History
- Mental State
- Intent
- Planning
- Formulation

4.1 Risk Factors for Suicide

The following risk factors for harm to self and suicide have been identified in the research literature. Each of the risk factors is of different importance, depending on the individual circumstances of the patient. Clinicians will have to use their professional judgement and their knowledge of the client to assess the risk.

RISK FACTORS FOR HARM TO SELF

Age	Older
Sex	Male
Marital Status	Separated, Divorced, Widowed
Physical Health	Poor, especially terminal, painful, debilitating illness
Mental Health	Mental illness, especially depression, schizophrenia and chronic sleep disorders
Substance Misuse	Alcohol, drug misuse and / or dependence

4.2 History

An accurate history of past self-harm incidents and suicide attempts is vital for the risk assessment process. The recent, severity, frequency and pattern of these attempts should be examined as explained in part 2. For example, when considering severity of attempt, persons who attempt to hang themselves when alone in a house who take steps to avoid interruption and are only rescued by chance are at a much higher suicide risk than persons who have taken

an overdose which they know is not lethal and present themselves at casualty. Similarly, when considering the pattern of self-harm or suicide attempts, a suicide attempt may be typically made by one person at the ending of a relationship. If that pattern is now repeating itself and a relationship is ending, this indicates a higher risk. Anniversaries and recent traumas and losses may increase risk, usually temporarily, particularly as it leads to a sense of entrapment and hopelessness. The patient's view of anticipated events may also increase risk as they approach. It is also important to remember that substance misuse greatly increases risk.

4.3 Relatives and Carers Often Have Information and Opinions Worth Considering

4.4 Mental State

An examination of the person's ideas on suicide can help assess the risk. Consider whether the person sees suicide as a solution to his or her problems.

Does the person think or fantasise about suicide ? How frequently does the person think about suicide and how does he or she respond to these thoughts ? The greater the prominence and rigidity of these thoughts in the person's life, the higher the risk of suicide. Fleeting thoughts quickly rejected represent low risk, while persistent, intrusive and painful thoughts indicate high risk even in the absence of planning. Consider constraints on action (religious beliefs, family obligations).

4.5 Intent

As with the intention of harming others, **a statement from the patient that they intend to kill themselves is the strongest indicator of** risk and should never be dismissed. Intent, whether declared or not, is the strongest indicator or future behaviour.

4.6 Planning

If the person admits to suicidal ideas, has he or she taken it a stage further to planning how to do it ? How likely in your judgement is the plan to succeed ? Plans to avoid detection are of particular significance. For example, if a person has continual thoughts of suicide, has the person determined that he or she will shoot him or herself when the rest of the family are away, and does the person have the means to do so (for example, owning a shotgun) - this would indicate very high risk. Thoughts of suicide without any plan or without access to the means to do so carry a lower risk.

4.7 Formulation

Once again, a formulation should be made as for risk of violence, including an appreciation of all the risk factors described above and their interaction in increasing risk. It should aim to answer the following questions:

- How serious is the risk?
- How immediate is the risk?
- Are circumstances likely to arise that will increase the risk?
- What specific treatment and which management plan can best reduce the risk?

It is important to note that patients' responses should not always be taken at face value - e.g. a patient might categorically deny feeling suicidal when this if far from the case.

4.8 The Clinical Management of the Risk of Suicide

Management of the imminently suicidal requires careful judgement of the risks involved, balanced against the support that can be provided in the community. Although admission to hospital may appear to be the safest course of action, it may not necessarily always be the best.

4.8.1 The Management Plan

The management plan should consider the same options as those listed for the management of harm to others.

Hospital care, possibly under the Mental Health Act, should be considered when the suicide risk is high. Risk is high when the person has a history of serious suicide attempts, is isolated and without support, has clear suicidal ideas and plans, is non-compliant with treatment, and is under stress in the home environment.

If the patient is to be managed in hospital, their safety must be paramount and consideration should be given to the need for the following interventions :

- What level of physical security is needed?
- What level of observation and monitoring is required?
- Has the patient had their belongings checked for dangerous / sharp objects?
- Is there a system for ensuring that the multi- disciplinary team reviews the management plan?
- How should medication be used?
- Should the patient be detained formally?

If care other than as an in-patient is being considered, once again the same questions should be asked as for risk of harm to others. In addition, there are several strategies which can make the community care safer.

- Consider referral urgently to local Community Mental Health;
- Consider increasing the frequency of home visits and out-patient appointments;
- Work with the patient to make them feel safer, both by providing emotional support and by putting in place practical interventions;
- Agree a timetable for care and support with relatives and / or friends;
- Arrange day hospital or day care attendance;

- Consider contingency plan for DNAs;
- Consider liaison with GP to ensure that, if anti-depressants are prescribed, relatively non-toxic drugs are chosen, or they are prescribed frequently in small quantities;
- Make sure that the patient and their relatives know how to access help quickly from services;
- Agree a contract with the patient that they will not harm themselves between appointments.

4.8.2 Longer-term management of suicide risk

The need for longer-term management of the potentially suicidal person can arise where someone had made more than one serious suicide attempt over a lengthy period of time, possibly linked to a relapsing affective disorder or schizophrenia. It is important in these situations to identify precipitating factors, like life changes and losses, changes in mood, increases in symptomatology or relapses. It may be necessary to keep in fairly close contact so that if any of these circumstances repeat themselves, a further risk assessment can take place and appropriate action taken. Carers and relatives can be asked to help with this monitoring process and will need to know where to gain help if a crisis arises.

Note that even where someone has made a series of attempts at self-harm that do not seem intended to end in death, the risk of completed suicide still exists, and accumulates over time.

5 Risk Assessment and Management - Severe Self Neglect

Self neglect is a common problem with severe and enduring mental illness. However, in this document we are particularly concerned with severe levels of self neglect which may warrant inclusion on the supervision register. Assessing the risk of self neglect is not a straightforward process. It is made complex by differences is relative standards. The areas that should be covered by the assessment process are:

- Hygiene
- Diet
- Infestation
- Household safety
- Warmth.

5.1 Management of People Who Neglect Themselves

As for risk of harm to others and risk of suicide, the principal of negotiating safety should be followed. Although self neglect can be serious, it is rare to require compulsory admission under the Mental Health Act. Through CPA and liaison between community care agencies, the risk of harm from severe self neglect can be minimised but rarely eliminated. For patients with severe and enduring mental illness, self neglect is often associated with non-compliance of medication.

For patients being managed in the community under the Care Programme Approach, the following questions should again be considered :

- Is the patient on the appropriate CPA level/Supervision Register
- Has the use of legal powers been considered (section 117, supervised discharge guardianship order or Section 47 of the National Assistance Act)?
- What community supports are available (e.g, carers, family, community mental health workers, care management, housing support workers, etc)?
- Do the carers and family have access to appropriate support and help?
- Have the carers been adequately informed, and do they know how to access services?

6 Risk Management Strategies For Staff Working In Specialist Mental Health Services

There are definite risks for staff working in mental health services in their day to day work. The following guidance identifies areas of safe practice.

It is the duty of every employee to be aware of and have read the local Violence Awareness Policy and to be aware of their professional body's approach to such issues.

6.1 Precautions for Home Visiting

The most important measure is based upon good risk assessment, communication and therefore prediction. If it can be predicted that there will be a high risk of violence during a visit, then workers should consider how this risk can be reduced and how help can be summoned in an emergency. The following options should be considered :

- Visiting in pairs;
- Asking the patient to attend appointments at the office base;
- Requesting the attendance of the police at MHA assessments;
- Not making home visits to high risk areas after dark;
- Regular and routine use of systems for recording the whereabouts of staff and checking when staff have not returned;
- Use of mobile phones and personal alarms should be considered, although staff need to be aware that they can be of very limited value in summoning help in an emergency.

Furthermore, staff need to remain aware that these strategies do not eliminate risk and they should not, therefore, develop an over-reliance upon them. This is not safe practise.

It is also important to bear in mind that there may be risks which are not directly associated with the patient being visited, e.g, the patient's family.

6.2 Precautions for Offices Such as Mental Health Resource Centres

All buildings in which patients are seen, should be equipped with an alarm system. The alarm system is only of value if people know what to do when it is activated and participate in regular practice runs.

Patients should not be seen by a worker who is alone in a building, as backup will not be available. Vigilance needs to be exercised about general building security. Combination locks between "patient accessible" and "staff only" areas must be installed. Prior to the building being locked in the evening, it should be checked to make sure that all patients have left.

6.3 Communication

This is a crucial part of the risk assessment process, however there are particular points in the psychiatric care process that commonly trigger communication failures. The potential consequences have now been well catalogued in a series of public inquiries into community care for the severely mentally ill. The danger points are all related to transitions in care and are highlighted below.

6.3.1 Discharge from hospital

A full assessment of risk needs to take place prior to discharge from hospital. The results of the assessment need to be communicated to the care team in the community.

6.3.2 Referral to another care provider

This can be from one provider Trust to another, or from one key worker to another. All referrals should contain information about past history of harm to self or others, and a current assessment of risk.

6.3.3 Communication between mental health professionals and other agencies

This usually poses a difficulty because of the desire to maintain confidentiality and not stigmatise the patients in the eyes of others. The issue is raised most frequently in contacts with housing or hostels. Despite the wish to prevent stigmatisation, it is clear that other agencies do need to know what the risks are and how they can best be managed. It is clear that in cases where there is a significant risk of harm, other agencies do need to know. Occasionally, members of the public who are at specific risk may also need to be informed. In these circumstances, the public interest may override professional confidentiality. Staff may on occasions require advice from their manager or professional organisation. Other agencies need to be helped to develop procedures whereby information that is passed on remains confidential and protected.

The CPA community care plan as formulated by the key worker is the ideal means of communication between the agencies. It contains not just the plan, but the names and contact numbers of those involved, plus information about risk. Copies of the plan must be sent to all those involved.

In every case, the CPA care plan must have a copy of the form AOR1 (and AOR2 where appropriate) attached to it.

7 Multi-Disciplinary Team Working

Multi-disciplinary assessment, a shared care plan and good interdisciplinary communication are important aspects of risk management by a multi-disciplinary team. in order to promote consistency, multi-disciplinary teams should agree local risk assessment practices to take into consideration differences in training and levels of expertise. Teams should also develop supportive structure for staff debriefings and post-incident analysis.

8 Residential and Day Care Services

There are specific policy requirements for these settings. Firstly, at all times staffing needs to be adequate, in terms of numbers and training, to deal with crises that occur. Secondly, all staff should be aware of the procedures that should be followed if there is a violent incident. They should know whether they are expected to tackle the situation themselves or, if not, how to call for the police or other help quickly.

9 Clinical Supervision

There are many reasons why one-to-one clinical supervision is recommended for mental health workers. It can provide emotional support in the face of difficult and stressful work. It is a means by which workers can continually grow and develop in expertise and also managers can ensure that policy is being followed and professional standards being maintained. The content of clinical supervision sessions is mostly about patient care. The supervisor can contribute to higher standards of care and safer practice by making sure that risk and its assessment is a regular aspect of the discussions on patient care.

10 Completing the Forms

The Risk Indicator Checklist (form AOR1) should be completed for all patients who are accepted by the specialist mental health services.

The more comprehensive Assessment of Risk (form AOR2) should be completed when the Checklist has raised areas of concern. A decision on whether to proceed with this assessment should be made in each case at the clinical review meeting and should, therefore, be based on full multi-disciplinary discussion, with particular regard to the views of the RMO and keyworker.

Teams may, therefore, decide to complete and Assessment of Risk (form AOR2) for any patient who has a complex or high risk presentation. The following events should trigger the completion of this form in appropriate cases:

- Prior to discharge from hospital;
- Where there concerns over non-compliance;
- Following a major clinical event.

Furthermore, this form should always be completed following a serious incident.

Teams need to agree local procedures for initiating the comprehensive Assessment of Risk Form (AOR2).

In order that the forms are highlighted within the notes and are easily located, both forms will always be yellow.

Each teams' stock of yellow paper will need to be sufficient to ensure that copies are always made only on to the appropriate colour of paper.

Where information is unavailable, or it is not possible to fully assess, an indication of the reasons should be given in the appropriate section, and the team should follow this up, if appropriate.

It is important that risk assessment is discussed in a multi-disciplinary and multi-agency forum and that individual team members do not feel that they are solely responsible for the assessment process. Consideration should be given to the most appropriate team members to be involved in the assessment - e.g, it may not be appropriate for unqualified members of the team to complete the assessment.

As with all other areas of practice, the risk assessment and management process should be based upon anti-racist and anti-discriminatory practise.

10.1 On the Ward

The Risk Indicator Checklist (Form AOR1) should be started at the point of admission. As **part of the admission process, a care plan must be drawn up which immediately addresses the issue of risk - Quality Standard 3C.** This is the responsibility of the duty doctor and the nurse in charge of the shift.

The assessment should be discussed further at the first and subsequent ward rounds and decisions made on any further action to be taken and whether a more comprehensive assessment is needed. **The Risk Indicator Checklist (Form AOR1) should be completed within five days of admission - Quality Standard 1B.** The Risk Indicator Checklist (Form AOR1) and / or the Assessment of Risk (Form AOR2) should be repeated prior to consideration of hospital discharge. These matters are the responsibility of the RMO and Ward Manager. **The Assessment of Risk (Form AOR2) should be completed for all patients on the ICU and / or patients on Sections 37; 37/41; and 41 - Quality Standard 2B.**

10.2 At Accident and Emergency

The Duty Psychiatrist and Senior Nurse should take responsibility for beginning the Risk Indicator Checklist (Form AOR1) and ensuring that the information gathered in passed on to the appropriate team for follow-up and completion.

10.3 In the Community

A Risk Indicator Checklist (Form AOR1) is expected for every patient accepted by and allocated within the team - Quality Standard 1A. However, there may be patients who are referred but not accepted by the team - for example, they are being held on duty or seen at drop-in or surgery settings where assessment is ongoing. A Risk indicator Checklist (Form AOR1) is not necessarily expected on file until such time as the assessment is completed and the patient is accepted by and allocated within the team. If the case is closed (i.e, not allocated), it is good practice to note as much information as possible regarding risk factors and to advise the referrer of these.

The Risk Indicator Checklist (Form AOR1) should be discussed at the referral meeting. If the patient is accepted by the team, the completion of this checklist should be started at the first face-to-face contact.

A professional identified at the referral meeting should be responsible for ensuring that the relevant information is available to complete the form. This may be the keyworker. *This does not mean that one person will necessarily be solely responsible for obtaining the information, but does mean that one person will co-ordinate the process.* The information should be brought back to the meeting for discussion and decision on further action.

The Risk Indicator Checklist (Form AOR1) will be completed within four weeks of

referral - Quality Standard Statement 1A. The Assessment of Risk (Form AOR2) should be completed for all patients on the Supervision Register or Section 37/41, or those with complex needs - Quality Standard 2B.

10.4 In Residential Care Settings

The Risk Indicator Checklist (Form AOR1) should be completed for residents in all of the following accommodation :

- ISH;
- 96, Cambridge Street;
- Queens Gardens;
- Other Trust services.

It is recommended that the Assessment of Risk (Form AOR2) is also completed - Quality Standard 2B. The Team Manager of these houses should make an active and considered decision not to complete this form if it is deemed unnecessary. Other services should complete the Assessment of Risk (Form AOR2) as part of the referral to these services.

10.5 Assessment of Risk and CPA

The assessment of risk should be viewed as part of the CPA process. Consequently, it should also involve discussion with and input from the full multi-disciplinary and multi-agency team. **The documentation should become part of the CPA form and should be distributed with this document - Quality Standard 4A.** The Risk Indicator Checklist (Form AOR1) and, where appropriate, the Assessment of Risk (Form AOR2) should be completed and subsequently reviewed at all regular CPA meetings, as a minimum. Teams need to devise and follow local arrangements as to how this should be done. The risk assessment should additionally be reviewed as part of a CPA review if circumstances dictate (e.g, following a serious incident) and any change to the management plan should be reflected on the CPA care plan and circulated accordingly.

All CPA community care plans should contain agreed interventions which aim to manage and / or reduce the risk behaviours identified in the assessment - Quality Standard 3A. Contingency plans for the management of non-compliance and loss of contact with services should be clearly recorded as part of the CPA community care plan - Quality Standard 3B.

10.6 Assessment of Risk and the Supervision Register

An Assessment of Risk (Form AOR2) should be completed for all patients already on, or added to, the Supervision Register. The appropriate Supervision Register documentation should also be completed.

10.7 Sharing Information from the Forms

All team members who are going to be actively involved in the care plan need to familiarise themselves with the risk assessment and management plan. This information should also be shared with others outside the team who need to know. It is assumed that if it is deemed necessary to share the CPA care plan with someone then it is also necessary to share the risk assessment and management plan with them.

Consequently, the risk forms should be circulated with the CPA forms. It should be a matter of clinical judgement whether and how the risk assessment is shared with the patient.

10.8 Responsibility for Assessment and Documentation

The Team Consultant is clinically responsible for ensuring that the appropriate level of assessment and documentation are completed for all the teams' clients and that the completed document accurately reflects the information and action agreed. Consequently, all risk assessment forms should be signed by the RMO.

The team's manager is responsible for ensuring that the Risk Assessment and Management Policy is followed and consequently is responsible for auditing and monitoring their team's performance in this area.

The community keyworker will usually be the person delegated to collate risk assessment information for community clients. They are responsible for ensuring that the information is gathered and documented and that a plan is agreed for the clients on their caseload.

The junior doctor will usually be the person delegated to collate risk assessment information for previously unknown patients. They are responsible for ensuring that the information is gathered and documented. The Consultant and Ward Manager are responsible for ensuring that both an immediate and a pre-discharge plan are agreed for all in-patients.

APPENDIX ONE

RISK ASSESSMENT QUALITY STANDARDS

Standard One - Initial Assessment

A. All clients accepted by the community team will have a Risk Indicator Checklist (Form AOR1) initiated on first contact and completed within four weeks.

B. All in-patients will have a Risk Indicator Checklist (Form AOR1) initiated on admission and completed within five days.

Standard Two - Documentation of Risk Assessment

A. Form AOR1 should record the outcome of the risk assessment in all cases (see above).

B. Patients who require a full assessment of risk (i.e, all ICU patients, Supervision Register patients, patients on Sections 37/41 and 41 and patients with very complex needs) must have Form AOR2 completed within four weeks of contact or prior to discharge if this is sooner.

Standard Three - Risk Management Interventions

A. All CPA community careplans should contain interventions which aim to manage and/or reduce the risk of any behaviours identified in the assessment.

B. Contingency plans for the management of non-compliance and loss of contact with services should be clearly recorded as part of the CPA careplan.

C. All in-patients should have an initial risk management plan documented on the first day of admission.

Standard Four - Communication of Risk Information

A. A copy of the Risk Assessment should be attached to and circulated with the CPA careplan to all those involved in the aftercare (including the GP), within five working days.

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RISK INDICATOR CHECKLIST (AOR1)

Patient/Client Name _____ Service Area _____

Date of Birth _____ Consultant _____

Date Assessment Started _____

1. RISK ASSESSMENT – HISTORY

Tick appropriate box for each question

History of violence (ever)

- None ☐
- One Incident ☐
- Two Incidents ☐
- Three Incidents ☐
- More than three incidents ☐
- Threats of violence ☐

Most serious harm caused

- None ☐
- Minor Injury ☐
- Serious Injury ☐
- Fatality ☐

History of suicide attempts (ever)

- One ☐
- Two ☐
- Three ☐
- More than Three ☐

History of severe self neglect (ever)

- No ☐
- Yes ☐

History of arson (ever)

- No ☐
- Yes ☐
- Threats ☐

History of harm to child (ever)

- No ☐
- Yes ☐
- Threats of harm ☐

History of containment (ever)

- Special Hospital ☐
- Secure Unit ☐
- Prison ☐
- Locked Ward ☐
- Detained at a police station ☐
- Detained under MHA 1983 ☐
- Detained under Section 136 ☐
- None ☐

History of dropping out of contact with mental health services

- No ☐
- Yes ☐

2. RISK BEHAVIOURS IN PAST YEAR

Tick any risk behaviours in past year

- Accidental harm at home (eg. falling, careless smoking)
- Lack of awareness of danger
- Accidental harm outside the home (eg. wandering into the road)
- Alcohol abuse
- Arson (deliberate fire setting)
- Drug abuse
- Non-compliance with medication
- Overdose
- Risk of abuse from others
- Harm or risk of harm to child
- Self injury (eg. cutting)
- Other method of self harm
- Self neglect
- Sexual assault (including touching/exposure)
- Violence to family
- Violence to staff
- Violence to other patients
- Violence to general public
- Incidents involving the police

Please T

3. CURRENT MENTAL STATE:
Are there any active symptoms that indicate an increased risk of harm to self or others? No ☐ Ye

Please describe:

4. FAMILY/CARERS:
Are there concerns expressed by the family or carers? No ☐ Yes ☐

Please describe:

5. AVAILABILITY OF INFORMATION/ABILITY TO ASSESS
Are you lacking appropriate information or unable to fully assess for other reasons? No ☐ Yes ☐

Please describe:

6. Is further Risk Assessment required? No ☐ Yes ☐
If yes please complete Assessment of Risk (Form AOR2).

7. Does the patient meet the criteria for inclusion on the Supervision Register? No ☐ Yes ☐
If yes please complete the Supervision Register form *and* AOR2.

8. Is a specialist Forensic Assessment indicated? No ☐ Yes ☐

9. Brief Summary/Action Plan

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ASSESSMENT OF RISK FORM (AOR2)

Patient/Client Name: ..... DOB: .....

Please tick to indicate a history of risk behaviour or specific area of concern:

SELF-HARM ☐ SELF-NEGLECT ☐ RISK TO OTHERS ☐ FIRE RISK ☐

1. HISTORY

1.1	Please give details of any previous risk behaviour as identified in the categories above:

1.2	Is there evidence of rootlessness or "social restlessness" (for example: for relationships, frequent changes of address or employment)?	Yes ☐	No ☐

1.3	Is there evidence of poor compliance with treatment or disengagement from psychiatric aftercare?	Yes ☐	No ☐

1.4	Is there evidence of recent discontinuation of medication or withdrawal from services?	Yes ☐	No ☐

1.5	Is there evidence of substance misuse or other potential disinhibiting factors (eg a social background promoting violence).	Yes ☐	No ☐

1.6	Can any precipitants or any changes in mental state or behaviour that have preceded earlier violence or other risks (eg self harm, arson, self neglect) be identified.	Yes ☐	No ☐
	Are these risk factors stable or has there been a recent change?	Yes ☐	No ☐

1.7	Is there any evidence of recent stress?	Yes ☐	No ☐

1.8	Have there been any loss events or any threat of loss?	Yes ☐	No ☐

2. ENVIRONMENT

2.1	Does the patient have access to potential victims, particularly individuals identified in mental state abnormalities?	Yes ☐	No ☐

2.2	Are there concerns from family/carer(s) regarding risk?	Yes ☐	No ☐

2.5	Are there any features in the environment which may exacerbate the identified risks?	Yes ☐	No ☐

3. MENTAL STATE

3.1	Does the patient have firmly held beliefs of persecution by others? (Persecutory delusions)	Yes ☐	No ☐

3.2	Does the patient report experiences of mind or body being controlled or interfered with by external forces? (Delusions of passivity or command auditory hallucinations)	Yes ☐	No ☐

3.3	Does the patient show any of the emotions related to violence (for example irritability, anger, hostility, suspiciousness)?	Yes ☐	No ☐

3.4	Does the patient show any of the emotions related to self-harm/suicide (eg hopelessness, low self esteem).	Yes ☐	No ☐

3.5	Are there any specific threats made by the patient?	Yes ☐	No ☐

3.6	Are there particular difficulties in gaining access to the patient's mental state?	Yes ☐	No ☐

4. INTENTION

4.1	Has the Patient expressed any clear intention of harm to self or others?	Yes ☐	No ☐

5. PLANNING

5.1	Has the patient made any specific plans in relation to harm to self or others?	Yes ☐	No ☐

Please use this space to identify any risk factors which have not already been covered.

6. SUMMARY

This should be based on these and all other items of history and mental state. It should, so far as possible, specify factors likely to increase risk of dangerous behaviour and those likely to decrease it.

6.1	How serious is the risk?

6.2	Is the risk specific or general?

6.3	How immediate is the risk?

6.4	How likely is the risk?

6.5	What specific treatment and interventions can best reduce the risk?

6.6	What plan of management is needed to reduce the risk? (Include responsibility for action).

Date of assessment ..... **Service Area** .....

Assessed by ..... **Signature** .....
(PRINT NAME CLEARLY)

Consultant ..... **Signature** .....
(PRINT NAME CLEARLY)

Central and North West London NHS
Mental Health NHS Trust

ANNEX 4

BRENT MENTAL HEALTH SERVICE

CPA POLICY DOCUMENT

JULY 2002

Central and North West London NHS
Mental Health NHS Trust

BRENT MENTAL HEALTH SERVICE

CPA POLICY DOCUMENT

July 2002

Compiled on behalf of Brent Mental Health Service by James Olweny

BRENT MENTAL HEALTH SERVICES

CPA POLICY DOCUMENT

3. Criteria for Enhanced and Standard CPA

The CPA framework applies to all adults of working age accepted by specialist Mental Health Services and consists of two categories, namely **Standard and Enhanced.**

Standard CPA – This applies to individuals:

- who require the support or intervention of one agency or discipline or require low key support from one agency or discipline;
- are able to self manage their mental health needs;
- have an active informal support network;
- who pose no danger to themselves or others;
- who will not be at high risk if they lose contact with services;
- are more likely to maintain appropriate contact with services.

Enhanced CPA – This applies to individuals:

- who have multiple needs, including housing, employment etc requiring inter-agency co-ordination;
- are only willing to co-operate with one professional or agency but have multiple care needs;
- need to be in contact with more than one professional or agencies (including criminal justice agencies);
- require more frequent and intensive intervention from a range of services,
- have more than one clinical condition, or a condition than is made worse by alcohol or drug misuse;
- are difficult to engage / more likely to disengage with services, unwilling to co-operate with agreed plans, or with whom it is difficult to maintain contact;
- would pose a risk if they lost contact with services *(NSF – Mental Health p.53)*
- are more likely to be at risk of harming themselves, or others;

Key elements of the Care Programme Approach include:

a) The systematic assessment of Health and Social Care needs so that appropriate services can be offered to service users.

b) The development of a care plan, incorporating crisis plans, and contingency plans.

c) Allocation of a Care Co-ordinator for service users who are either on Standard or Enhanced CPA with a responsibility of ensuring the implementation and review of their care plan.

d) Everyone involved in the service users care plans working in partnership and sharing responsibility to support the Care Co-ordinator.

e) Service users and their carers, relatives, or advocates being be involved / consulted in all aspects of the care planning process.

1. Introduction

The Care Programme Approach was introduced in **April 1990** through a **Department of Health Circular HC (90) 23/LASS (90) 11)** to offer guidance on a systematic and collaborated response in the assessment, planning, and review of client's Health and Social needs.

This document outlines the framework for integrating Care Management and the Care Programme Approach across Brent Mental Health Service. It contains some guidelines for a single point of referral and access to services; unified health and social care assessment; and the co-ordination of respective roles and responsibilities of each professional / agency through an agreed care plan.

These guidelines have been drawn up within the legal framework of:

- **Section 117 (aftercare planning) of the Mental Health Act 1983**
- **Carer's (Recognition and Services) Act 1995**
- **The NHS and Community Care Act 1990 (s 47)**
  and
- **The Human Rights Act 1998.**

and they also incorporate key elements of the following policies:

- **National Service Framework for Mental Health**
- **Effective Care Co-ordination in Mental Health Services**
- **Building Bridges Report, 1995**
- **The Health Advisory Service Standards for Care Planning and Discharge (HAS);**
  as well as

Central and North West London Mental Health NHS Trust CPA Policy, 2000.

The key changes in the National CPA policy include:

- **The integration of Care Management with the CPA to form a single Care Co-ordination approach**
- **Change of role name from Key Worker to Care Co-ordination**
- **Crisis and contingency plans for all Service User's**
- **The abolition of the Supervision Register**
- **A reduction in bureaucracy and duplication**
- **Support for Carers**
- **Removal of requirement for six monthly reviews, however, the date of the next review must be set and recorded at each review.**

2. Philosophy

Brent Mental Health Service is committed to implementing of a high standard of service that can appropriately meet the needs of our service user's and some of the values that underpin this commitment include:

- An emphasis of a user focused approach, which places the service user at heart of the CPA process by:
    - Ensuring that the framework for Care Co-ordination recognises and responds to diversity. Care plans should also reflect this diversity by focusing attention to the service user's culture, gender and sexuality.
    - Enabling service user's to have an optimum influence in the development of local services and arrangements for their own care by developing systems to encourage their participation in planning, and monitoring of services.
- A Framework for the provision of a seamless service
- Recognition of the support needs of carers
- A single assessment process to facilitate access to both health and social care services
- Clear procedures for risk assessment / management, crisis management, and contingency planning
- Provision of a high standard of service that is relevant to needs of the local population [resources / services not available will be aggregated during the periodic audits]
- A reduction in bureaucracy and improving organisational efficiency

4. Eligibility Criteria for Brent Mental Health Service

Criteria...	Level of service...
Age 16 - 64* Concern about mental health**	Advice to referrer OR Assessment followed by advice to referrer OR Assessment followed by acceptance into the Service
Age 16 – 64* Severe and enduring mental health problems	Ongoing mental health treatment under **Standard CPA** ****
Age 16 – 64* Severe and enduring mental health problems, which seriously jeopardise the person's ability to live at home and may lead to or have resulted in an in-patient admission **and** either a] Recently discharged from a psychiatric hospital or referred via court or prison, **or** b] Having unmet social care needs which may lead to breakdown in community living **or** c] Showing an immediate risk of psychiatric breakdown, **or** d] Needing involvement of social services under a statutory duty, **or** e] Where carer support is at risk of imminent breakdown.	Treatment and services to meet mental health and social needs under either **Standard or Enhanced CPA****

* except for requests for assessment under the Mental Health Act 1983, or by court request

** there are agreed protocols with Primary Care, which clarify when referrals should be made Brent One Stop Shops have guidance about when it is appropriate to refer to the service

*** if needs cannot be met due to lack of resources, the Mental Health Commissioner should be informed of the unmet need

**** refer to previous page for further details on the criteria for Standard and Enhanced CPA.

5. REFERRAL AND ASSSESSMENT PROCESS

Everyone who is referred to specialist mental health services is entitled to receive a systematic assessment to ascertain their needs and determine the appropriate levels of support. Service users receiving the CPA should have their health and social care needs assessed as well as their vulnerability and levels of risk. Wherever possible they should take part in their assessment and understand its purpose.

The assessment should be led by the person's need, not by services available and should consider immediate issues as well as those, which might require further assessment.

a) All new referrals should be processed through a single point of entry and an assessment undertaken to determine if they meet the eligibility criteria.

b) Referrals that meet the eligibility criteria should be screened for the appropriate CPA level within an agreed time scale. This screening process should also be carried for all inpatients that are entitled to section 117 of the Mental Health Act Aftercare, or during every new episode of care for referrals that are not already on CPA *[admission of a patient already on CPA should not constitute a new episode of care]*.

c) Referrals that do not meet the eligibility criteria should be referred back to the referrer with appropriate recommendations relating to their care.

d) The person completing the 'initial' assessment process should determine what further assessments are required and who should be involved in them *[the decision as to whether a more detailed assessment is required should result from the initial assessment]*.

e) The assessment process should be completed before the care-planning meeting, or, if the service user is in hospital, at an agreed interval before discharge takes place.

f) The assessment process should be carried out by an appropriately qualified mental health professional, though this person need not be the Care co-ordinator, and they should also have:

- competence in carrying out needs led assessments.
- the knowledge and skills to work effectively with diverse communities *(NSF p.43)*.
- training in risk assessment and risk management *(NFS p.43)*.

g) Assessment of need and risk should be repeated at regular intervals and whenever necessary. CPA reviews should help this process and should be used to record any change in status and what should happen as a consequence.

h) Assessments should not be done without the knowledge of the service user and they should also be consulted before sharing information with others such as carer's, friends, or relatives *[confidentiality should not be compromised unless there is due course or good reason to do so].*

i) A written summary of the assessment should be offered to the service user either at the time of the CPA meeting or soon afterwards and evidence of the assessment should be available on the service users file.

6. GUIDELINES FOR CPA MEETINGS

One formal meeting with the client should be used to determine all care planning aspects including Mental Health status and discharge planning where required without further requirement to hold separate meetings, regardless of whether the service user is in hospital or community setting *(ECC p.15, para. 52)*.

CPA meetings should not be considered simply as a framework for aftercare and should be time tabled around the needs of the service user, and their carer's with the right to advocacy *(ECC p.15 para 53)*.

All inpatients should not be discharged before a CPA meeting. CPA meetings should also be convened before a Tribunal Hearing. The initial review for inpatients on Enhanced CPA should be held within 5 weeks of being discharged. The date, time and venue for subsequent reviews should be set and recorded at each review.

a) The chairing of meetings and minute taking should be separate roles. It would be more appropriate for the Care Co-ordinator to chair the meeting unless they would like to concentrate on taking minutes. The **Chairperson** should ensure that:

- introductions are made, and facilitate the discussions so that everyone has an opportunity to contribute to the discussion and maintain a balance of views.
- the relevant assessments are completed, or are in the process of being completed and a care plan formulated to meet the identified needs.
- monitor with the Care Co-ordinator that any previous decisions have been carried through, or alternative strategies considered, and that the care plans are evaluated.
- ensure that a Care Co-ordinator is confirmed in the Care Plan and that a date and time for the next meeting has been agreed.

b) **Service users on Enhanced CPA** should be **allocated a Care Co-ordinator** and it is their responsibility to arrange CPA meetings and ensure that the CPA forms are completed and circulated to the relevant parties.

c) **CPA meetings for inpatients** should only be convened nearer the time for discharge, after the needs of the patient have been properly assessed and a care plan formulated to address the identified needs, or before a tribunal hearing. ***[Other multi-faceted forums for pre-planning discussions or progress reviews should be designated another meeting title, i.e. ward round review, case conference or professional's meeting].***

d) Service users should be offered information about the CPA process before the meeting and an opportunity to discuss their participation. Whenever possible they should be consulted before, and after the meeting.

e) Service users should always be present at their CPA meetings. However, in event of a service user refusing to participate, or is unable to attend the CPA meeting, the meeting should still proceed and the CPA documents completed as far as possible. The Care Co-ordinator should ensure that attempts are made to implement the care plan and to engage the service user.

f) Service users should be consulted about whom they would like to invite to the meeting, which may include carer's, friends, family members, or advocates. If the service user objects to their carer being present at the meeting they should be made aware of their carer's right to an assessment and the potential implication on the care planning process.

g) Any factors, which may hamper the service users participation in the meetings, should be managed effectively and sensitively.

h) Interruptions during the meeting should be avoided (mobile phones or pagers muted) but if any of the attendees expects to be called away on an emergency they should mention this before the meeting starts and endeavour to make prior arrangements that will minimise disruption.

i) Appropriate arrangements should be made for service users who require an interpreter or who have other disadvantages and consideration given to other needs or preferences.

j) The service users General Practitioner and other relevant professionals, or agencies involved should always be invited to the meeting and their participation encouraged.

k) The Care Co-ordinator should liase with any of the relevant professionals or Agencies not represented at the meeting to obtain their views so that they can be incorporated in the service user's care plans.

8. THE CARE CO-ORDINATOR ROLE

All service users subject to the CPA must have an allocated Care Co-ordinator. This should be the person best placed to oversee care planning and resource allocation. This could be a qualified professional or an unqualified member of the mental health team who is adequately experienced and sufficiently trained.

The Care Co-ordinator should have access to training to equip them for their role and adequate levels of support and supervision.

a) The Care Co-ordinator is a focal point of contact and co-ordination of information for everyone involved in the care planning process and they must have:
   - The authority to co-ordinate the delivery of the care plan
   - The ability to combine the care manager and CPA Care Co-ordinator roles
   - Understanding and ability to respond to the specific needs of service user that may relate to their culture or ethnic background.
   - Competence in delivering mental health care, including understanding of mental illness.
   - Knowledge of the service user / family
   - Knowledge of community services and the role of other agencies
   - Co-ordination skills
   - Access to resources

b) The Care Co-ordinator is also responsible for:

   - Updating the service user's basic care plan and crisis plan
   - Keeping in close contact with the service user regardless of their setting, whether at home or in hospital,
   - Advising other members of the care team of changes in the circumstances of the service user which may require review or modification of the care plan
   - Ensuring that the care plan is based on a thorough assessment of health and social care needs, which involve the user and carer
   - Giving the service user full information about the CPA
   - Ensuring that the care plans are reviewed as required and the next review date is agreed at each meeting
   - Giving the service user an opportunity to sign the care plan and providing them with a copy of the care plan.
   - Ensuring that contingency plan is part of the care plan for service users on Enhanced CPA
   - Facilitate service user's participation during CPA meetings.

c) They should ensure that service user and their carers have been properly consulted prior to, and after the CPA meeting, and that their views are recorded.

d) It is the Care Co-ordinator's responsibility to ensure that all the CPA documents have been completed fully and are a true reflection of the issues discussed.

e) They should also ensure that a carer's assessment and care plan has been completed [if applicable].

In event of unplanned or planned leave, appropriate arrangements should be made to re-delegate the Care Co-ordinator's responsibilities. Wherever possible the Care Co-ordinator should prepare the care plan in advance and ensure that the person deputising on their behalf has all the relevant information.

Further guidance on the Care Co-ordinator role / functions can be obtained the Brent Mental Health Services Care Co-ordinator practice guidelines.

9. PRINCIPLES FOR CARE PLANNING

A pre-requisite for effective care planning is that agencies must have policies, which enable information sharing on a confidential / need to know basis. Professional in Adult Mental Health Services should be familiar with local Child Protection Procedures and know how to obtain specific advice quickly *(NSF p.45)*.

There should also be policies on effective transfer of care for a young person to adult service *(NSF p.45)*.

a) All mental health service users on CPA (regardless of the category) should have a written care plan with clearly defined crisis / contingency plans and advice to their GP about they should respond if the service user requires additional help. The care plan should be reviewed regularly *(NSF Standard 4)*.

b) Each service user who is assessed as requiring a period of care away from their home should have a copy of a written care plan agreed on discharge which sets out the care rehabilitation to be provided, identifies the Care Co-ordinator, and specifies the action to taken in a crisis *(NSF Standard 5)*.

c) Care planning is a multi-agency endeavour *(NSF p.45)* and should meet the requirements of CPA and Care Management *(ECC part 2)*. It should be co-ordinated by the Care Co-ordinator *(ECC para 82)* and focus on the user's strengths, and seek to promote their recovery *(ECC para 87)*.

d) Care Plans should be based on a thorough assessment of an individuals health and social care needs and record all the actions necessary to achieve the agreed goals. They should also include the reasons in the event of disagreements and detail the contribution of the agencies involved.

e) They should identify the interventions and anticipated outcomes and give an estimated timescale by which the outcomes or goals will be achieved, or reviewed.

f) Care plans must state clear objects and should include the person whom the client is most responsive to; how to contact that person; and previous strategies that have been successful in engaging the service user. This information must be easily accessible by the 'Out of Hours' services *(ECC para 80)*.

g) Community based staff, including children's services staff, where issues of child care have a bearing on assessment and care planning, should be involved in hospital discharge planning at an early stage.

h) In the case of service users on **Standard CPA** clinical notes may constitute the care plan and record of review *(ECC para 19)*. Central record must be maintained on all those in contact with services. Care planning and review must take place regularly. Elements of risk and how the care plan manages these must be recorded *(ECC para 63)*.

i) If the patient / service user refuses to participate in the care planning process a multi-disciplinary discussion may establish alternative ways of presenting a care plan which is appropriate / acceptable to the patient / service user. The patient / service user may opt only to accept a part of the care plan offered and the care plan should be sufficiently flexible to accommodate this.

j) Even if the care plan is wholly rejected, the offer of contact on a regular basis in consultation with the GP should continue. The carers should also be offered assistance on a regular basis and reliable point of contact.

10. CONTINGENCY PLANS AND CRISIS PLANS [RISK ASSESSMENTS]

The National Service Framework requires that care plans specify contingency plans and the action to taken in a crisis for all people on enhanced CPA. [2]Risk assessments should not be more than a year old and should be reviewed during each CPA to ensure that appropriate contingency plans and crisis plans are formulated.

a) All service users who are on Enhanced CPA must have contingency plans and crisis plans as part of their care plan

b) Contingency plans are intended to prevent a crises developing by detailing the arrangements to be used , for example, where at short notice the Care Co-ordinator is not available, or part of the care plan cannot be provided.

c) The contingency plan should include the information necessary to continue implementing the care plan in the interim, for example contact numbers for substitutes who have agreed to provide interim care *(ECCp.22 para 78).*

d) Crisis plans should set out the action to be taken based on previous experience if the user becomes very ill or their mental health is rapidly deteriorating.

e) These plans should also set out care provisions for service users living with dependant children who require a period of hospitalisation.

f) Crisis plans should include early warning and relapse indicators; who the client is most responsive to and how to contact that person; previous strategies which have been successful in improving responses or getting agreement for change in care / treatment.

g) Crisis plans should also ensure that all service users and their carers know how to contact the out of hour's team and they in turn should have access to information on service user's care plan.

h) The welfare and safety of children living with a severely mentally ill parent must be considered with social services if there is a risk that the child could subjected to sexual, physical or emotional abuse, or neglect. Behaviour that indicates a risk to other children outside the family home must also be taken into account *(NSF care planning and review p.45).*

[2] *[Refer to CNWL's Risk Assessment policy and procedures for further guidance]*

11. SUPPORT FOR CARERS

The needs of service users often also have an impact on the needs of their wider family.

For parents with mental illness it should not be assumed that the child or children can undertake the necessary caring responsibilities. The parent should be supported in their parenting role and services provided so that the young carer is able to benefit from the same opportunities as all other children *(NSF-Standard 6 p. 71/72).*

a) All individuals who provide 'regular and substantial care for a person on CPA should:

- be offered an assessment of their caring, physical and mental health needs repeated on an annual basis, and for younger carers this should also cover their educational and welfare needs.

- have their own written care plan, which should be given to them and implemented in discussion with them.

b) Carers should receive information about the help available to them and services being provided for the person for whom they are caring for. The service user's consent should be sought before any information relating to them is shared.

c) The CPA Care Co-ordinator should inform service users and their carers of the carers right to request an assessment and co-ordinate these assessments.

d) Young carer's care plan should take account of the adverse impact, which mental health problems in a parent can have on the child *(NSF p.72)*

(Carer's [Recognition and Services] Act 1995 and Standard6 NSF 1999).

12. MONITORING AND REVIEWS

There is no longer a requirement for a National period of six monthly reviews of the client's care plan (ECC p.19 para 66).

Service user's basic details should be checked at each review to ensure that it is correct and up to date and their CPA category should be reviewed at each review to establish its appropriateness.

Service users subject to s. 117 of the Mental Health Act 1983 should have this reviewed during each CPA meeting and outcome recorded in the care plan.

a) The initial review for inpatients should be held within 5 weeks of being discharged and the date, time and venue of subsequent review should be arranged at the meeting.

b) For service users with severe mental illness who are at high risk of suicide, the care plan should include **more intensive provision for the first three months** after discharge from in-patient care, and **specific follow-up in the first week** after discharge *(ECC para 85)*.

c) A **'case conference'** should be convened, but not necessarily a CPA review meeting unless if there are any significant/ adverse changes into the service user's circumstances, or concerns about the appropriateness of the care plan.

d) Any minor changes can be agreed between the Care Co-ordinator and the service user and the care plan amended accordingly without recourse to convene a CPA meeting.

e) If a service user is regraded from Enhanced to Standard CPA or vice-versa, this should be recorded in the CPA form with clear reasons for this decision.

f) If a service user is discharged from the CPA, the Care Co-ordinator should record this in the clinical / case notes (***Standard CPA***), or CPA form (***Enhanced CPA***) and a copy of the discharge care plan forwarded to the Primary Health Care team.

13. TRANSFER PROTOCALS

13. 1 - TRANSFERS WITHIN BRENT MENTAL HEALTH SERVICE

The local transfer policy applies to service users on Enhanced CPA who have moved to another Sector permanently and have been resident there for a minimum of three months. It also applies to those transfering from Willow, and Juniper Lodge. It does not include service users in Bed and Breakfast accommodation, Crown house, those who has had a recent relapse in mental health state or behaviour within the last four weeks, or those who have temporarily moved to a Sector and will be moving on to another Borough or re returning to their sector within six months *[Brent Mental Health Service – Procedure for the transfer for Service User's on Enhanced CPA].*

a) The decision to transfer must be done within the context of the CPA process by multi- disciplinary care team, the service user, and their carer.

b) The Care Co-ordinator or nominated deputy will then send a letter requesting the transfer of the patient and the transfer letter must be accompanied by the following documents as appropriate:

- a risk assessment, which has completed or updated within the last three months
- a completed assessment form / letter
- minutes of the last CPA
- comprehensive Care Plan with evidence of review and contact within the last three months
- medical report and or a discharge summary.
- other significant reports such as ADL and psychology
- recent mental health state assessment
- names of significant others the patient may wish to attend

c) It is the responsibility of the team receiving the transfer request to organise a handover CPA within four weeks at a time and venue, which is convenient for all involved *[they should also decide which members of their team to invite]*.

d) The Care Co-ordinator of the referring team must attend the CPA. In exceptional circumstances a sufficiently senior professional with adequate knowledge of the case may deputise.

e) At the hand over, a complete transfer of care will take place to include the following:

- RMO responsibility
- CMHT staff
- Any other professional care provided within the Sector
- Updating of information on the patient information system

f) Clinical responsibility must remain with the team requesting the transfer until the new team has agreed, at the CPA.

g) The receiving team may refuse to accept the transfer if the information provided prior to the CPA is inaccurate/ insufficient, or if vital information is missing. In which case clinical responsibility remains with the transferring team.

h) If the transfer does not take place the teams need to agree an action plan. Either a new date is arranged for transfer with agreement about the requirements or the entire process is stopped.

i) Transfer to and from the **Residential and Rehabilitation Services, Willow ward,** and **Juniper Lodge** will entail the following process:

- a pre-transfer CPA will be held on the day of admission to the residential and rehabilitation services
- at the end of the trial period (4-6 weeks) another CPA will be held as confirmation of the transfer.

j) A discharge CPA must be convened before a service user is discharged from the Service.

[If there is a dispute within Brent Mental Health Service, which both parties are unable to resolve, the BMT will act as arbitration. Their decision will be final.]

NB: Further reference can be obtained from Brent Mental Health Service Procedure for the Transfer of Service User's on Enhanced CPA – August 2001.

13.2 - EXTERNAL TRANSFERS

In routine, planned, transfers to other Health Authorities and Boroughs the referring team retains responsibility for providing and co-ordinating care until the transfer has been effected and agreed. The Care Co-ordinator should liase with the receiving Mental Health Services to arrange a transfer CPA meeting to handover the case.

In some cases ongoing care management will remain with the Borough of ordinary Residence. This needs to be agreed and made clear in any information transferred. Clarity will also be required about any funding arrangements.

Transfer of care needs to be agreed / negotiated with NHS / Social Services Department's and not solely with residential homes etc *(NHSE / SSI Transfer protocol)*.

Unplanned transfers

a) It is the duty of any service (*either the current or the new*) whichever is first aware of the movement of an **individual subject to 'CPA'**, to promptly initiate contact with the other service to establish the relevant facts and provide / request the necessary transfer summary for and **CPA documentation.**

b) The possible risk of an delay in obtaining information or contacting distant workers etc., need to be part of a multi-disciplinary decision making process *(NHSE / SSI Transfer protocol).*

Planned transfers

a) It is the duty of the referring service to provide adequate notice and information, which must include the transfer summary form and a referral letter, and should also include **full CPA documentation.**

b) Where there is significant risk (either to the service user or others including potential assessors) direct contact must be made either in person or by phone to advise the receiving service.

c) In complex cases senior clinicians (e.g. consultant, CMHT manager or their equivalent) should be involved.

Negotiations should take into account:

- Current mental state and legal status
- Perceived permanency of the move
- Ongoing financial responsibility for social care
- Interim arrangements for monitoring care
- The need for a transfer meeting

Communication and negotiation must begin immediately a move is anticipated. A transfer plan must be agreed within four weeks. Acceptance of transfer of responsibility should not be delayed beyond four weeks from the move without joint agreement.

NB: For further details please refer to the National Health Service Executive and Social Services Inspectorate transfer protocol/s, and Brent Mental Health Service Procedures for the Transfer of Service User's on Enhanced CPA – August 2001.

14. REQUEST FOR PROVISIONS / SERVICES

Secondary Mental Health Services should have a framework for the provision of a seamless service and a single assessment process to facilitate access to both health and social care services [NSF for Mental Health 1999 and Modernising the Care Programme Approach *(NHSE October 1999 Catalogue No.16736)*. It is therefore no necessary to have request / referral for Service / forms.

a) It is expected that if a service user needs additional resources i.e. Day Care or Day Hospital, the Care Co-ordinator needs to have telephone contact with the service, invite them to meet with the service user, and then send a copy of the care plan and a brief letter *[Item 2 BMT News issue 21 – 10th October 2001]*

b) Transfers / request for Day Care services should be through the CPA process and day service staff should be included in the CPA meeting and the development of the care plan with the relevant care team.

c) Day service staff should always be invited to review CPA meetings and contribute to the progress discussions.

d) Discussions need to occur across professional groups within Community Mental Health Teams groups to clarify what assistance is required.

15. PROCEDURES FOR DOCUMENTING CPA INFORMATION

Written care plans should be drawn up by the named Care Co-ordinator, with the involvement of the service user, and where appropriate their carer. A copy should be given to the service user and their GP. *(NSF p.53).*

Standard CPA

The CPA Care Plan form is optional. Clinical / case notes could constitute the care plan and records of review *(ECC para 19).* Care planning and review must take place regularly. Elements of risk and how the care plan manages these must also be recorded *(ECC para 63).* Care Co-ordinator should also ensure that the relevant information on Protechnic is updated.

Enhanced CPA

Care plans should be completed within a week *[5 working days]* and circulated promptly to all the relevant parties. A copy should also be filed in the patient's / service user's notes. A copy of the Basic Details information and Care Plan should be saved electronically on the Health Shared Drive *[in a designated folder]* and the Care Co-ordinator should also ensure that Protechnic has been updated *[status of meeting outcome and date for next meeting must be recorded].*

Invitations

The Care Co-ordinator should ensure that invitations are sent out in sufficient time before the next scheduled CPA meeting with their contact details as the main contact person. The service user's information leaflet should also be sent out *[if necessary].*

Changes and cancellations

Ideally only the service user's Care Co-ordinator should make changes or cancellations of the CPA meeting and notify the relevant parties.

[The completeness and accuracy of CPA information would enable service user's, in the absence of their Care Co-ordinator, to obtain advice and support from other members of the care team, colleagues on duty, A&E Liaison team, and the police.].

16. EXTRA CONTRACTUAL REFERRALS

a) In event that a service user is admitted to an out of catchment area hospital, the allocated Care Co-ordinator should liase with the admitting hospital to arrange a CPA meeting. Otherwise the sector team should make the most appropriate arrangements practicable to liase with the hospital to arrange the CPA meeting.

b) If a patient from another catchment area is admitted to one of our acute hospitals it is the responsibility of the admitting ward to liase with the Mental Health Services of the patients originating catchment area to arrange a meeting.

17. CONFIDENTIALITY

Involving service users and their carers as fully as possible in the CPA means that there is an expectation that personal information will be shared with others to provide effective care. This may, in some cases, conflict with the common law duty workers have to respect the confidentiality of personal information

Note: - Reference should be made to Central and North West London Mental Health NHS Trust, Brent Council and Brent Mental Health Services confidentiality policy/ procedures for further guidance.

a) Personal information is required to deliver individual care and treatment. However, practitioners should obtain the service users consent before this sharing information, though it is acknowledged that obtaining this consent on a day-to-day basis can prove impractical.

b) As people should be involved in negotiating the care they receive, practitioners need to be very clear, as part the negotiation process, that they explain the need to share some personal information. This would ensure that individuals receive the appropriate support to safely meet their needs.

c) It is also important that the Care Co-ordinator negotiates with the service users about the amount and nature of information they would be happy to share with their carer's. Practitioners should also familiarise themselves with the policy on confidentiality relevant to the organisation for which they work, and if in any doubt seek advice from their managers and professional organisation *[as this document only contains brief advice which should not be considered as final].*

Giving information to informal carers and nearest relatives

It is important to make a distinction between giving information to informal cares and giving information to nearest relatives who may not be informal carers.

Building Bridges (1996) is helpful. Page 24, Paragraph 2 states:-

"Usually it is a good idea if the patient and his or her closest relatives are fully involved in his, or her care. However, if a patient specifically asks that his family and carers are not involved, his or her wishes must be respected, unless they have been appointed by a court to manage his or her affairs, or if there is a public interest ground to give them information (e.g. if they are at risk of violence). Under the Mental Health Act 1983, there are circumstances in which patient's "nearest relative' is entitled to receive information even where the patient objects (e.g. that an application for assessment in relation to the patient has been made, or that the patient's mental disorder has been reclassified)."

The Health Service guidelines HSG(96)11 give further clarification:-

'The (1995 Mental Health) Act requires a patient's nearest relative to be consulted, (unless it is impracticable to do so) about the initial application for supervised discharge and subsequently about its review, renewal, or ending. A patient may however object to consultation with the nearest relative, unless he or she will be acting as the patient's informal carer. The RMO may then consult the nearest relative only if the patient is known to have a propensity to violence or dangerous behaviour towards others and the RMO thinks such consultation is appropriate. The patient's objection should not lightly be set aside and it is for the RMO to judge whether the patient has a propensity to violent or dangerous behaviour (which must be directed towards other people) and if so whether consultation with the nearest relative is advisable in all circumstances.'

Giving information to fellow professionals

There is a well-established common law of confidence covering patient information. If the information is held on computer then the Data Protection Act 1984 is applicable.

As a general rule information given for one purpose may not be disclosed to a third party or used for a different purpose without the consent of the patient. This is covered extensively in Building Bridges – Chapter 1 and Chapter 3.

Note: - Please refer to Central and North West London Mental Health NHS Trust and Brent Council's confidentiality policy / procedures for further guidance.

18. QUALITY CONTROL / TRAINING

A quality strategy will be implemented to monitor and support the aims of the Care Programme Approach by the following methods: Training needs will be identified through information collated from audits and other relevant surveys and will be repeated periodically to improve practice standards and disseminate any changes in legislation, policies or procedures information

- National Standard CPA Audit tools will be used periodically to evaluate the standard of the care plans and other CPA documents / data. A random sample of files and CPA information may also be examined at unspecified timeframes.

- The CPA Manager will provide the team with any other relevant updates about policy changes or other CPA related information and will also publish outcomes of any audit exercise.

- Use of service user and carer satisfaction surveys particularly service users on Enhanced CPA. Service user and carer's views will also be sought to establish areas for further improvement.

- Define what we aim to provide for the service user's group and sharing those aims with service user, their carer's, and user groups, so that they know what to expect from the service. These aims should be applied in care planning and clinical supervision.

- Information leaflets about the CPA process must be offered to service users and their carer's, and if necessary explained to them.

- A reference library with relevant information and specimen documents will be offered to practitioners. Training and advice will also be offered.

- Information technology is in place to monitor and support the CPA objectives and provide information to assist in the management of planning of the CPA process.

- Care Co-ordinator should regularly check, particularly during reach review, that the service user's basic details information is correct and that both the manual and electronic records are updated.

- Resources that are not available should be recorded in the care plan and this information will be aggregated and reported to the Service Manager's.

Brent Mental Health Services

REFERRAL FORM

Sector

Sector address Telephone: 020 8937 Fax: 020 8937

REFERRERS DETAILS:

Name:..... Telephone: .....

Address: .....

..... Is client aware of this referral? Yes / No

Post Code .....

CLIENT DETAILS

Title		M F
Surname		
Forename		
Date of Birth		
Preferred name		
Alias		
Religion		
Marital Status		
Dependants under 18		

Address:	
Post Code	
Telephone No	
NHS No.	

OTHER INFORMATION

Accommodation Type	.....
Language	.....
Interpreter required	Yes No
Working	Yes No
GP Name	.....
Address	.....
	.....
Post Code	.....
Telephone No.	.....

ETHNIC GROUP (PLEASE CIRCLE)

Asian or Asian British			
Bangladeshi (K)	Indian (H)	Pakistani (J)	Other (L)
Black or Black British			
Caribbean (M)	African (N)		Other (P)
Chinese or Other Ethnic Group			
Chinese (R)	Arab (ST)		Other (S)
Mixed			
White & Asian (F)	White & Black African (E)	White & Black Caribbean (D)	Other (G)
White			
British (A)	Irish (B)		Other (C)
Not Known (ZY)	Refused to state (ZX)		

Appendix 1

REASON FOR REFERRAL

Presenting Problem

Background Information

Relevant Psychiatric History

Forensic History

Does client have a history of:	YES	NO
Suicidal or self harm behaviour		
Physically violent behaviour		
Verbally aggressive behaviour		
Self neglect behaviour		
Present/past excessive alcohol use		
Present/past use of illicit drugs		

Urgency of referral – *Please indicate and give reasons*

MEDICATION

Current prescribed psychiatric medication and duration
Current physical health medication

Signed:..... Date.....

Please attach copies of any relevant, recent correspondence, psychiatric assessments etc.

CONFIDENTIAL

Brent Mental Health Service
Assessment Form

PERSONAL DETAILS

Name:		**Date of Birth:**	
Date of Assessment:		**Sector / Ward**	

NB:- Please ensure that this form is completed in conjunction with the Basic Details Sheet and where appropriate the In-Patient Admission Form (for inpatient use only).

REASON FOR REFERRAL / ADMISSION AND CURRENT SITUATION *

SERVICE USER'S / PATIENT'S VIEW

CARER'S VIEW (including willingness to continue caring role, any conflicts of interest)

Does the Carer need a separate assessment? Yes ☐ No ☐

PERSONAL HISTORY AND FAMILY CIRCUMSTANCES, including needs of any dependent children and effects of mental health problems on service user's ability to be a good parent and provide for the needs of the child(ren).

Brent Mental Health Service
Assessment Form

MENTAL STATE/PRESENTATION AT INTERVIEW - (continued).

Perception/Sensory Distortions:

Mood:

Orientation:

Memory:

Thought Processes or Content:

Insight:

Attention/Concentration Span:

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Brent Mental Health Service
Assessment Form

HISTORY OF MENTAL HEALTH PROBLEMS (e.g. episodes of treatment by GP or mental health professionals, previous admissions and duration, past treatment, compliance, age at first admission or first contact, family history of illness

MENTAL STATE/PRESENTATION AT INTERVIEW

Behaviour:

Speech pattern/content:

Expression of Abnormal Belief or Strange Ideas:

OTHER PHYSICAL HEALTH / MEDICAL FACTORS (e.g. medical examination, history of head injuries, serious illnesses or operations, disabilities)

MEDICATION (past and current, therapeutic dose, compliance issues, any adverse reactions and side effects)

DRUG AND ALCOHOL USE (type of non-prescribed drugs/alcohol, how often, what impact these have on other areas including mental state)

FORENSIC HISTORY (including involvement with other agencies e.g. probation)

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Brent Mental Health Service
Assessment Form

RISK indicators whether there is any evidence of risk of suicide or self-harm violence to others, self-neglect or exploitation. **Please attach Risk Assessment form.**

PERSONAL/SOCIAL NEEDS

Housing – type, tenancy, suitability, history

Finance – income, benefits, debts including any rent arrears, ability to manage money;

Brent Mental Health Service
Assessment Form

PERSONAL SOCIAL NEEDS (continued)

Cultural Needs / Issues – being part of their community;

Occupation and Leisure – work, leisure, treatment activities;

Daily Living Skills – self-care, childcare, household chores, pet care, literacy, use of telephone/ public transport/public amenities etc;

Is an ADL Assessment Required? Yes ☐ No☐

Social Support – friends, relatives, carers, social and communications skills;

Legal Issues – forensic and civil issues;

CONFIDENTIAL

Brent Mental Health Service
In-Patient Admission Form

IN- PATIENT ADMISSION FORM

PERSONAL DETAILS

Name:		Date of Birth:	
Occupation:		Marital Status:	
Religion:		Accommodation type:	

ADMISSION DETAILS

Date of Admission:	Time:
Ward:	Admission Source:
Admission Method:	Admission Type (Acute/ Detox/ Respite):
Consultants Name:	Legal Status on Admission:

PHYSICAL DESCRIPTION / PHYSICAL OBSERVATIONS

Height:	Distinguishing Marks:
Weight:	Urinalysis:
Eye colour:	Temperature:
Skin colour:	Pulse:
Hair:	Blood Pressure:
Glasses:	Physical Disabilities/ Physical Health Problems:
Dentures:	

Admitting Nurse:	Position:
Signature:	Date:

CONFIDENTIAL

Brent Mental Health Service
In-Patient Admission Form

ADMISSION SHEET CODES

OCCUPATION

COMS	Community Service
EMP	Employed
HP	House Person
NK	Not Known
PT	Part Time Employment
RET	Retired
STU	Student
TRAS	Training Scheme
UNEM	Unemployed
UNID	Unable to Work
VOL	Voluntary

ACCOMMODATION

CREN	Council Rented
FOSTC	Foster Care,
GRPH	Group Home
HASS	Housing Association
HOBB	Hotel Bed & Breakfast
HOST	Hostel
NFA	No Fixed Abode
NK	Not Known
POWN	Privately Owned
PREN	Privately Rented
RESH	Residential Home
SHEL	Sheltered Housing
SQUA	Squat

ADMISSION SOURCE

AEST	A & E St Mary's
CMHT	CMH Trust (Not MHU)
DCAR	Day Care Facility
DOMV	Domiciliary Visit
EMHV	Emergency Home Visit
GENH	General Hospital
LAAC	Local Authority Accommodation
MATU	Maternity Unit
MCHW	Chelsea & Westminster Hospital
MCHX	Charing Cross Hospital MHU
MGOR	Gordon Hospital MHU
MNWP	Northwick Park Hospital MHU
MROF	Royal Free Hospital
MSTA	St Mary Abbots Hospital
OHOS	Other Hospital
OPSY	Other Psychiatric Unit
PENE	Penal Establishment
SPEH	Special Hospital
SSEM	Social Services Emergency Assessment
TEMP	Temporary Place of Residence
UPRE	Usual Place of Residence
VALA	Admitted from Voluntary Agency

ADMISSION METHOD

DV	Domiciliary Visit
ELEC	Elective
EMAE	Emergency A & F,
EMGP	Emergency GP
EMO	Emergency Other
EMOP	Emergency O.P. Clinic
OTH	Other HC Provider
TRA	Inter-Ward Transfer

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Working with Brent, Harrow, Kensington & Chelsea and Westminster Social Services

Basic Details

(to be kept in the front of patient's notes)

Date completed _____

Personal Details

Title: Surname: Forename: Date of Birth: Preferred name: Alias: Gender: Diagnosis/ ICD 10 Code:		Address: Postcode: Telephone No: Trust No: NHS No: SSD No: National Insurance no:	

Further Personal Details

First Language: Religious/Spiritual Needs: Drug Allergies/Intolerance:		Interpreter needed: Dietary Needs: Disability/Special Requirements *(please specify)*	Yes☐ / No ☐

Ethnic Group *(Please Tick)*

Asian or Asian British **Bangladeshi (K)** ☐	Asian or Asian British **Indian (H)** ☐	Asian or Asian British **Pakistani (J)** ☐	Asian or Asian British **Other (L)** ☐
Black or Black British **Caribbean (M)** ☐	Black or Black British **African (N)** ☐		Black or Black British **Other (P)** ☐
Chinese or Other Ethnic Group **Chinese (R)** ☐	Chinese or Other Ethnic Group **Arab (ST)** ☐		Chinese or Other Ethnic Group **Other (S)** ☐
Mixed **White & Asian (F)** ☐	Mixed **White & Black African (E)** ☐	Mixed **White & Black Caribbean (D)** ☐	Mixed **Other (G)** ☐
White **British (A)** ☐	White **Irish (B)** ☐		White **Other (C)** ☐
Not Known (ZY) ☐	**Refused to state (ZX)** ☐		

Other Information:

Does the service user see themselves as a Refugee or Asylum Seeker:	Yes ☐ / No ☐ (please tick)	If yes, from which Country?	_____

Family/Social Network:

Next of Kin : Are they the nearest relative Under the MH Act : Yes ☐ / No ☐	**Significant Other (Relatives, friends etc.)**
Address: Telephone No: Relationship: Permission to inform: Yes ☐ / No ☐	Address: Telephone No: Relationship:

Dependent Children (List and give dates of birth)		**Needs of any Dependent Children**
Name	Date of Birth	

Key People Involved

		Address:	Telephone No:
RMO:			
Care Co-ordinator:			
G.P.:			

Multi-disciplinary Network/Carers Network (Please Specify)

Name:	Relationship:		

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STANDARD or ***ENHANCED***
CARE PROGRAMME APPROACH/
CARE MANAGEMENT
(incorporating S117)

Working with Brent, Harrow, Kensington & Chelsea and Westminster Social Services

CARE PLAN For:

Name:			
Date & Venue of CPA Review:		Date Next Review:	
Care Co-ordinator:		Team:	

CPA/CM meeting attendance:

Name:	Relationship/Job	Please tick		
		Attended CPA	Discussed with (If did not attend meeting)	Circulation
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Comments & Signatures

Client's Comments (on needs & plans) :
Client's Signature: Date: / /
Carer's Comments:
Carer's Signature: Date: / /
Care Co-ordinator's Signature: Date : / /

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ENHANCED/STANDARD

(please delete as appropriate)
CARE PROGRAMME APPROACH/
CARE MANAGEMENT (incorporating S117)

Summary of Needs	
Mental Health	Tick if Part of Care Plan ☐
Physical Health	☐
Housing	☐
Finances	☐
Cultural Needs/Issues	☐
Occupation and Leisure	☐
Daily Living Skills	☐
Social Support	☐
Legal Issues (not MHA Issues)	☐
Alcohol and Drug Use	☐
Service User's Perception of Needs	☐
Carer's Needs	☐

***ENHANCED*/STANDARD**

(please delete as appropriate)
CARE PROGRAMME APPROACH/
CARE MANAGEMENT (incorporating S117)

Care Plan

Needs/Problems/Issues from Assessment	Desired Outcome	Actions by Name & Timescale
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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ENHANCED/STANDARD

(please delete as appropriate)
CARE PROGRAMME APPROACH/
CARE MANAGEMENT (incorporating S117)

Carer's Care Plan

Needs/Problems/Issues from Assessment	Desired Outcome	Action by Name & Timescale
1.		
2.		
3.		

See Local Assessment Practices

Services Not Available

A.
B.
C.
D.

ENHANCED/STANDARD

(please delete as appropriate)
CARE PROGRAMME APPROACH/
CARE MANAGEMENT (incorporating S117)

Medication at CPA date

Date:

MHA Status

MHA Status:

Risk Assessment

Please complete and attach appropriate risk assessment form(s):

Crisis/Contingency Plan

Indications of Relapse:

Contingency Plan:

Crisis Plan:

Useful numbers in event of a crisis include:

- Your Care Co-ordinator directly on ..... or the:
- Sector Team during weekdays, except Statutory Bank holidays, between 9.00am and 5.00pm on:
- A&E Liaison Service at Central Middlesex Hospital between 5.00pm and 9.00am on weekdays, all day on weekends and Statutory Bank Holidays on the following numbers:

Another useful phone number is the Social Services Emergency Duty Team on :
(weekdays between 5.30pm – 8.00am and all day on weekends and Statutory Bank Holidays).

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RISK INDICATOR CHECKLIST (AOR1)

Patient / client name:..... D.O.B.....

Sector Team:..... Date assessment started.....

1 RISK ASSESSMENT HISTORY

Tick appropriate box for each question

History of violence (ever)
None
One incident
Two incidents
Three incidents
More than three incidents
Threats of violence

Most serious harm caused
None
Minor injury
Serious injury
Fatality

History of arson (ever)
No
Yes
Threats

History of suicide attempts (ever)
None
One
Two
Three
More than three

History of severe self-neglect (ever)
No
Yes

History of harm to children (ever)
No
Yes
Threats of harm

History of containment (ever)
None
Special hospital
Secure unit
Prison
Locked ward
Detained under the MHA 1983
Detained under Section 136
Detained at a police station

History of dropping out of contact with mental health services
Yes
No

2 RISK BEHAVIOURS IN THE PAST YEAR

Tick any risk behaviours in the last year

Accidental harm at home
(e.g. falling, careless smoking)

Accidental harm outside the home
(e.g.) wandering into the road

Lack of awareness of danger

Risk of abuse from others

Drug abuse

Alcohol abuse

Non-compliance with medication

Arson (deliberate fire setting)

Self-neglect

Self-injury (e.g. cutting)

Overdose

Other method of self-harm

Harm to risk of harm to children

Sexual assault
(including touching/exposure)

Violence to family

Violence to staff

Violence to other patients

Violence to the general public

Incidents involving the police

Please turn over the page.

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3 CURRENT MENTAL STATE:

Are there any active symptoms that indicate an increased risk of harm to self or others? No Yes

Please describe:

4 FAMILY/CARERS:

Are there concerns expressed by the family or carers?

Please describe

5 AVAILABILITY OF INFORMATION/ABILITY TO ASSESS

Are you lacking appropriate information or unable to fully assess for other reasons?

Please describe

6 Is further risk assessment required? No Yes

If yes, please complete Assessment of Risk (Form A0R2)

7 Does the client meet the criteria for inclusion on the Supervision Register? No Yes

If yes please complete the Supervision Register form and AOR2.

8 Is a specialist Forensic Assessment indicated? No Yes

9

Brief Summary/Action Plan

Name: ..... Signature: ..... Date: .....

Consultant: ..... Signature: ..... Date: .....

CENTRAL AND NORTH WEST LONDON NHS MENTAL HEALTH TRUST

ASSESSMENT OF RISK FORM (AOR2)

Patient/Client Name:.....DOB:.....

Please tick ☐ to indicate a history of risk behaviour or specific areas of concern:

SELF-HARM SELF-NEGLECT RISK TO OTHERS RISK FROM OTHERS FIRE RISK

1. HISTORY

1.1 Please give details of any previous risk behaviour as identified in the categories above:

1.2 Is there evidence of rootlessness or "social restlessness" (for example few relationships, frequent change of address or employment)	YES	NO

1.3 Is there evidence of poor compliance with treatment or disengagement from psychiatric aftercare?	YES	NO

1.4 Is there evidence of recent discontinuation of medication or withdrawal from services?	Yes	No

1.5 Is there evidence of substance misuse or other potential disinhibiting factors(for example a social background promoting violence)	YES	NO

1.6 Can any precipitants or any changes in mental state or behaviour that have preceded earlier violence/ or other risks (e.g. self –harm, arson, self-neglect) be identified?	YES	NO

1.7 Are these risk factors stable or has there been a recent change?	YES	NO

1.8 Have there been any loss events or any threat of loss	YES	NO

2. ENVIRONMENT

2.1 Does the patient have access to potential victims, particularly individuals the patient has identified in mental state abnormalities e.g. elders/children	YES	NO

2.2 Are there concerns from family/carer(s) regarding risk?	YES	NO

2.3 Are there any features in the environment which may exacerbate the identified risks	YES	NO

3.MENTAL STATE

3.1 Does the patient have firmly held beliefs of persecution by others? (persecutory delusions)	YES	NO

3.2 Does the patient report experiences of mind or body being controlled or interfered with by external forces? (delusions of passivity or command auditory hallucinations)	YES	NO

3.3 Does the patient show any of the emotions related to violence (for example irritability, anger, hostility suspiciousness)?	YES	NO

3.4 Does the patient show any of the emotions related to self-harm /suicide (e.g. feelings of hopelessness ,low self-esteem, no hope for the future)	YES	NO

Please use this space to identify any risk factors which have not already been covered

6. SUMMARY

This should be based on these and all other items of history and mental state. It should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it.

6.1 How serious is the risk of harm?

6.2 Is the risk of harm specific or general?

6.3 How immediate is the risk of harm

6.4 How likely is the risk of harm

3.5 Are there any specific threats made by the patient?	YES	NO

3.6 Are there particular difficulties in gaining access to the patient's mental state?	YES	NO

4. INTENTION

4.1 Has the patient expressed any clear intention to harm self or others?	YES	NO

5. PLANNING

5.1 Has the patient made any specific plans in relation to harm to self or others?	YES	NO

Brent Mental Health Service

Carers Assessment Form & Care Plan

Name & Address of Carer:	**Tel. No.:**
Service User Details **Surname:**	
Other Family Name:	Forename(s):
Date of Birth:	Ethnic Origin:
Name of Care Co-ordinator:	
Date of Referral:	
Date Carer's Assessment Completed:	

This form is divided into three parts:

- **Part 1** sets out some information about the person for whom you care for
- **Part 2** identifies your mental and physical health needs and how you think they might be addressed
- **Part 3** sets out a plan for addressing your needs and identifies any needs that will not be met by the plan. It also gives you a chance to comment on the plan.

At the end of the form is some contact information that may be helpful to you.

Part 1 – The Person For Whom You Care

His/her mental health needs are:

Professionals involved in his/her care (please identify the Care Co-ordinator):

Role:	Name:	Address:	Tel. No.:
Psychiatrist:	.....	.....	.....
CPN:	.....	.....	.....
Social Worker:	.....	.....	.....
Outreach Worker:	.....	.....	.....
Other:	.....	.....	.....
	.....	.....	.....

He/she is on the following treatment

Medication:

Predictable side- effects:

He/she is receiving the following support. Please also list any support services that the person may have arranged themselves

Part 2 - Your Needs

Your Role: What do you do for the person you care for? E.g. practical tasks (i.e. managing finances), personal care (i.e. bathing, laundry), emotional support. How often do you give this help and how long does it take?

Cultural, religious or gender issues affecting the care you give to the person you care for:

What effect does caring have on your life? e.g. relationship with the person you care for, your health, your social life, privacy, employment, finances, missing school

What support do you have from friends, family or services (i.e. Social Services, Education Dept)? Are you able to take a break?

Are you able and do you want to continue to provide the current/proposed level of caring? What help do you need? (e.g. services, taking a break, special equipment, advice and information about benefits, someone to talk to, support groups)

Would you like any information on: e.g.			
Benefits		Young Carers Project	
Brent MIND		Education Welfare Officer	
Respite Care		Carers Support Groups	
Brent Carers Centre		Community Groups	
O.T for Equipment/Adaptation		Other (please specify below)	

.....

.....

Young Carers (identified as 'Children in Need'):
Where a young carer has been identified, has the assessment been completed in conjunction with the Children and Social Work Unit Yes☐ No☐
If yes, please state the name of social worker:

Tel. No.:

NB.: In assessing the needs of children (including those aged 16 and 17) the *Framework for the Assessment of Children in Need and their Families* should be the main source of guidance.

Assessor's summary of needs:

Confidentiality:

The information you provide is confidential and will not be passed on without your permission. This includes information provided by you as a carer not being shared with the person you care for and vice versa. This can only be over-ridden if justified through risk or if law requires this. However, it may not be possible to make changes to the support provided to the person you care for without discussing your views with them.

Are you happy for information provided on this form to be discussed with the person you care for: Yes ☐ No ☐

Is there any specific information that you do not wish to be shared with the person you care for:

Signature:

Name (print): ..... Signature:.....

Date: .....

Assessor's Name: .....

Date of Assessment: .....

Part 3 - The Care Plan

Name of Carer:
Name of Person Cared For:
Date of Care Plan:

Action to secure advice on income, housing, educational and employment matters:

Arrangements for short term breaks, either for yourself or for the person you care for in order to give you a break:

Arrangements for support (social, emotional, when unwell), including access to carers' support groups:

Other planned arrangements and actions:

This care plan does not meet the following needs:

Your comments on the care plan are as follows:

Has the carer been give a copy of:		
The Brent Carers' Information Pack	Yes ☐	No ☐
The leaflet ' How to get help in looking after someone – A Carers Guide To A Carers Assessment'	Yes ☐	No ☐
The Benefits Guide 'Caring for Someone'	Yes ☐	No ☐

Signed:

_____	_____
Carer	Care Co-ordinator
Date:_____	Date: _____

This care plan will be reviewed in twelve months, unless your situation changes in which case you can request an earlier review.

Contact Information

1. In a crisis, or if you need support or a break, contact your Care Co-ordinator, whose details are given at the beginning of this care plan.

2. If your Care Co-ordinator is not available for any reason, between 9 am and 5 pm on weekdays you can contact the Brent Mental Health Duty Social Worker on Tel: ..... Outside these hours, in an emergency, you can contact the Mental Health Emergency Duty Social Worker on 020 8863 5250.

3. If you wish to complain about the service that you have received, or to appeal against a decision, you should contact the Brent Mental Health Service Manager.

   Name: _____

   Address: _____

   Contact Tel: _____

4. Other useful telephone numbers are as follows:

Brent Carers Centre
The Centre can link you in with other voluntary agencies and support groups. They can also advise on benefit, housing, educational and employment matters.
Tel. No.: 020 8795 6240

Brent Mind
This is the main voluntary organisation in Brent that supports people with mental health problems. They can provide information about local services.
Tel. No.: 020 8451 3200

Saneline
Out-of-hours (2pm – 12am) telephone help line which offers support and reassurance during a crisis, provides details of new medical and psychological treatments, offers advice on legal rights and mental health legislation, etc.
Tel. No: 034567 8000 (local call rate).

African & Caribbean Resource Centre
Unit provides services which are culturally specific for people (and their carers) from the African & Caribbean Community who are experiencing mental health difficulties. It also offers a service for sufferers of dementia and their carers from all ethnic groups as well as vocational rehabilitation/training. Other services include: informal counselling service; community outreach support; welfare rights advice and carers' group.
Tel. No.: 020 8937 4754

There are also other several groups for people from ethnic minorities in Brent. You can get details about these from either Brent Mind or Brent Carers Centre.

(We will use the information in this form to manage the services we provide to you and the person for whom you care. This may involve disclosure of information, for example to other agencies, in an emergency or otherwise where necessary for the purposes of those services. Please let the CPA Care Co-ordinator know if you consider that any of the information in this form, or any other information that we hold, about you or the person for whom you care, needs to be up-dated).

How long do I need to be on CPA?

This should be reviewed periodically or during each CPA review meeting.

If I am not happy with the service

Your views are very important and it is therefore essential that you are involved or consulted in every aspect of the CPA process. However, we have clear procedures to deal with or complain about any aspects of our service that you may not be happy with.

We regularly review our services and welcome any comments you may have to aid this process.

Where to get more assistance?

If you live in Barnhill, Fryent, Kenton, Kingsbury, Queensbury, Roe Green, St Andrews, Alperton, Barham, Preston, Sudbury, Sudbury Court, Tokyngton and Wembley Central – this would be:

North/ West Sector Community Mental Health Team
36 London Road, Wembley, HA2 6NE
Tel No. 0208 937 6343

If you live in Chamberlyne, Harlesden, Kensal Rise, Manor, Queens Park, Roundwood, St. Raphaels, and Stonebridge – this would be:

South Sector Community Mental Health Team
The Courtyard, 5-6 Avenue Road, Harlesden
NW10 4UG
Tel No. 0208 937 6360

If you live in Brentwater, Brondesbury Park, Carlton, Church End, Cricklewood, Gladstone, Kilburn, Mapesbury, and Willesden – this would be:

East Sector Community Mental Health Team
13-15 Brondesbury Road, London, NW 6 6BX
Tel No. 0208 937 6330

Alternatively you could contact **Brent One Stop Shop on Tel No. 0208 937 1200**

Central and North West London NHS
Mental Health NHS Trust

BRENT MENTAL HEALTH SERVICE

This is an information leaflet to explain the Care Programme Approach and how this affects you.

WHAT IS THE CRITERIA?

Brent Mental Health Service's criteria for services and the Care Programme Approach applies to all adults between the age of 16 to 64. We also have a single assessment process to facilitate access to the our services.

If there is a concern about your mental health

There are three possible outcomes, which include:

- Advice to the person making the referral
- An assessment followed by advice to person making the referring
- An assessment followed by acceptance into the service

If you suffer from severe and enduring mental health problems

You will be offered support under **Standard CPA**

If you suffer from severe and enduring mental health problems, which could seriously affect your ability to live at home and may lead to or have resulted in an admission to hospital

You will be offered treatment and support services to meet your mental health and social needs under either **Standard or Enhanced CPA**

[a full version of the criteria can be obtained by contacting any the Community Mental Health Teams listed at the back of the this leoflet or from the Brent Councils Intranet Web Site]

WHAT IS THE CARE PROGRAMME APPROACH (also known as CPA)?

The CPA process is intended to ensure that you get the help and support you require by finding out what your care needs are and planning the best way to meet them. You will be offered an opportunity to say what you need or want, and be involved in making a care plan. If appropriate, we may also contact or consult your relatives or carer about their views and a meeting arranged to plan with you about how best to meet your needs.

At any stage of the CPA process you have a right to involve an advocate who may be a friend, or relative to support you, or speak on your behalf. You also have the right to information and feedback about assessments and plans, which relate to you.

You will also be provided with information about whom to contact if you have a crisis and will also have a say about who is involved.

Who is Standard CPA for?

You will be supported under Standard CPA if:

- Your needs are not too complex
- You only require support or intervention from one discipline or agency or low level's of support form more than one agency
- Are adequately able to manage most areas of your life independently

Who is Enhanced CPA for?

You will be involved in the Enhanced CPA if you:

- Have had a formal admission to hospital
- Are very vulnerable and require high levels of support from a more that one agency
- Have complex needs

Care Co-ordinator

You will be allocated a Care Co-ordinator who is someone who will keep in touch with you and other people who work with you. They will also oversee your care plan and will be your main point of contact to listen to what you have to say, and support you to get your views over to others. You should be able to speak with your Care Co-ordinator before and after the CPA meeting to make sure that you understand what is going on and that they understand what you want.

Care plans

A care plan form will be completed so that you and the people involved in planning your care know / understand what has been agreed. You will also be given a copy to keep for yourself and copies will also be sent to your G.P. and your carer. You will be consulted about other relevant people who may require a copy of your care plan.

If you are on Standard CPA **your care plan and review may be recorded in your clinical notes.**

How often are care plans reviewed?

If you are on **Enhanced CPA** and are leaving hospital the initial review of your care plan will be done within 5 weeks and the date, time and venue of subsequent reviews should be arranged at each the meeting. You, your carer, advocate, or any member of your care team can request for a CPA meeting at any time.

If you are on Standard CPA **your care plan should be agreed with the professional or agency involved and reviewed at regular intervals.**

A] Starting

a[] Read any existing information

b[] Notify the user of allocation, explain your role and reason for involvement.

c[] Identify existing support network, including carers, and make contact as appropriate.

d[] Identify any children residing with the user. If they are young carers carry out a carer's assessment. Consider if it is appropriate to make a referral to Children Social Work Team or Child and Family Services.

e[] Begin to create a file, if one does not already exist using the *file recording standards*.

f[] State in the file; purpose for involvement, initial goals.

B] NLA's

a[] Make adequate provisions taking into account the user and carers first language or any other disadvantages to enhance their participation. If necessary involve sign language or spoken language interpreter, or even an advocate.

b[] Explain to the user the purpose of the assessment, likely outcomes and time scales, and their entitlement to information and representation.

c[] Establish details of any informal or formal networks of support including carers and with the users consent establish contact with them to notify them of your involvement. Obtain any information that may be relevant to the assessment.

d[] Collate any existing factual information which could be relevant to the assessment and begin to establish the users individual needs taking into account their strengths and cultural needs.

e[] Liase with other professionals and collate their assessments.

f[] Study the information obtained and formulate an assessment of the users strengths and needs. Distinguish fact from opinion.

g[] Identify clearly the causes[s] of any difficulties.

h[] Identify any risk concerns based on the information gathered. Complete a risk assessment form.

i[] Share the outcome of your assessment with the user, carers and other relevant parties and make any appropriate amendments. [Ensure that this is in compliance the BMHS confidentiality procedures].

j[] Complete all sections of the NLA form but if any heading does not apply, state why.

k[] Discuss the outcome of assessments at the CPA meeting.

l[] Derive a clear set of goals and objectives from your assessment and record disagreements.

C] Carer Assessment

a[] Identify the primary carer and [with the users consent] and make contact to explain your role / reason of involvement.

b[] Explain to the carer their right, under the *Carers' Recognition Act, and National Service Framework to* an assessment. Explain the purpose and possible outcome of the assessment.

c[] A Carer's Assessment Form should be completed.

d[] Advise the Carer about carer support groups

e[] The assessment should take into account the carer's ethnicity and ensure that they have information to access services appropriate to meet their cultural needs.

f[] Check if it is possible to arrange the users services to benefit the Carer. Include the client's contingency plan in the carer's care plan.

g[] Give the Carer a copy of their assessment and care plan.

D] Care Planning

a[] Ensure that needs are clearly identified and derived from the NLA and that differences of opinion are documented

b[] Discuss with the user the purpose and desired outcomes of the care plan and consult with them about their views, or preferences.

c[] If the user is unable or unwilling to be involved in the care planning process, explore ways of encouraging their participation.

d[] Formulate the care plan with clear objectives and time frames.

e[] Ensure that risk concerns are addressed as part of the care plan and demonstrate how the care plans will contribute to the management of risks.

f[] Ensure that the care plan takes into account the users ethnicity, life-style, disadvantages, preferences, and any other social issues.

g[] Ensure that the care plan addresses employment, educational and training needs; housing needs; benefit issues.

h[] Ensure service provision matches the care plan and is able to address the identified needs.

i[] Take into account any uncontrollable variables, which may include a users unpredictable mental health and formulate the care plan accordingly. Include crisis plans and contingency plans.

j[] Take into account any additional factors such as dual diagnosis, homelessness, or rootless ness.

k[] Consider the services available to meet objectives and the cost of the care package. Where possible offer choice.

l[] Specify support plans and, which may include monitoring, and who will do what, and when.

m[] Arrange the date for the next review meeting at the CPA meeting and specify who needs to be invited.

n[] Complete the care plan objectively, include the users views [avoid jargon].

o[] Sign the care plan and ensure that the user understands the care plan before they sign it, otherwise suggest that they involve an advocate.

p[] Discuss with the user who you intend to copy the care plan to, and consider their views. They may have objections but risk factors could over-rule issues of choice or confidentiality.

E] Monitoring & Reviewing

a[] The user and all parties involved are clear about the purpose, method and frequency of reviewing of the agreed care plan.

b[] The reasons for monitoring are clear and the actions to be taken if concerns are triggered are recorded and known to the care network

c[] The next CPA review date and time should be clearly indicated on the CPA form.

d[] Unplanned changes made to the care plan should be documented, and all parties involved notified on an interim basis until this can be formally reviewed at the next CPA meeting.

f[] Significant changes in needs or other circumstances may warrant a reassessment and new care plan.

g[] The financial and paperwork processes which support the care plan should be accurate and up-to-date.

h[] Cost changes should be monitored and where possible are anticipated and planned for.

G] Purchasing Standards

a[] Clearly link the expenditure to the care plan and the identified need.

b[] Demonstrate on file that the expenditure is the most appropriate way to address the need.

c[] Determine the minimum standards of quality, which will appropriately meet the need.

d[] Investigate options from a number of suppliers [usually 3, but where very urgent needs identified this may be waived with the agreement from the team manager]

e[] Where any price is composite, get a breakdown of the components.

f[] Exclude any options, which are do not meet minimum standards. Choose the lowest cost option that meets the predetermined quality standard.

g[] Check any unusual or possibly controversial decisions with the Team Manager.

F] Joint Working

a[] When exploring service options be specific about the objectives, methods and skills required.

b[] Provide the service provider with a copy of the care plan.

c[] Consider providing a more detailed service specification to assist in the meeting of the objectives.

d[] Ensure that service providers understand the risk assessment for the client and what to do if concerns are identified.

c[] Ensure that individuals and agencies are clear about what they can contribute to the care planning discussion and objectives.

h[] Follow Brent Mental Health Services financial procedures.

G] Working with Allocated cases on Duty

a[] Only take actions, which are necessary and, where possible, with agreement of the care network.

b[] Record the assessment leading to any decision to intervene.

c[] Follow the agreed contingency plan and crisis plan.

d[] Any variation to the care plan should be recorded.

e[] Ensure that the Care Co-ordinator is aware of the action taken on return.

f[] Ensure that the user and their carer have details of how to contact services 24 hours a day.

H] Closing / Transferring

a[] The decision to close / transfer the case is made in a planned and thoughtful way with the involvement of the user and care network.

b[] The decision is taken as part of the CPA process and, where needed, the CPA Care Co-ordinator role is formally transferred to another professional.

c[] The file is in the same state as for a case transfer [refer to File Transfer procedures].

d[] The user and care network receive written confirmation of the change and how to re-refer.

e[] Monitoring arrangements responsibilities after Brent Mental Health Services, or sector teams withdrawal are clearly documented.

f[] The Team Manager signs the file for closure.

BRENT MENTAL HEALTH SERVICE
CPA FLOW CHART FOR NEW REFERRAL'S / PATIENT'S

REFERRAL / ADMISSION

Assessment process begins to determine if the Service User meets the Eligibility Criteria and to screen for the appropriate CPA level. Risk issues, urgency and priority should be considered.

(The Person completing the assessment should determine what further assessments are required and who should be involved in them).

No ← Refer back to the referrer with suggestions or recommendations relating to their care.

Enhanced → CPA

Allocate care co-ordinator to co-ordinate completion of assessment of needs, risks, carer's assessments and any other additional specialist assessments [if applicable].

→ Discuss outcome of assessments and formulate / complete as much of the care plan as possible.

Proceed to arrange date, time, and venue, for CPA meeting.

↓

CPA meeting proceeds and a Care Co-ordinator confirms care plan, crisis plan, and contingency plan. They should also ensure that risk assessment / risk management plan is completed and is reflected to the contingency plans and crisis plans.

All Inpatients should not be discharged before a CPA meeting.

CPA meetings can be convened before a Tribunal Hearing.

CPA care plan should be written up within 5 working days of the meeting.

← Agree resources, implement care plan, and monitor progress.

← The Initial review for Inpatients on Enhanced CPA should be held within 5 weeks of being discharged. The date, time, and venue of subsequent reviews should be set and recorded at each review.

For service users with severe mental illness who are at high risk of suicide, the care plan should include more intensive provision for the first three months after discharge from In-patient care, and specific follow-up in the first week after discharge. *(ECC para 85)*

↓

Review needs, risks, care plans, and crisis / contingency plans

↓

Standard **CPA**

Agreed care plan to continue with professional involved, taking into account any risk factors.

Clinical notes could constitute the care plan and records of review *(ECC para 19)*. Care planning and review must take place regularly.

Elements of risk and how the care plan manages these must also be recorded *(ECC para 63)*

Reference

- National Service Framework for Mental Health 1999
- Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach *(NHSE October 1999 Catalogue No.16736)*
- DoH: HC (89)5, HC (90)23/LASSL (90)11,
- CNWL NHS Mental Health Trust Integrated Care Management and CPA policy (BKCW CPA Policy - April 2001)
- DoH HSC 1999/223:LAC(99)34 30.9.99
- HSG(95)56: Building Bridges – A guide to arrangements for inter-agency working for care and protection of severely mentally ill people
- National Standards and Audit Tool *(CPA Association)*
- Modernising Mental Health Services: Safe, Sound and Supportive DoH 1998.

Glossary of terms

- **NSF** - National Standard Frameworks
- **CPA** - Care Programme Approach
- **MHA 1983** - Mental Health Act 1983
- **NHS & CCA 1990** - National Health Service and Community Care Act 1990
- **CNWL** - Central and North West London NHS Mental Health Trust
- **SSD** - Social Services Department.
- **HImP** - Health Improvement Plan
- **CPAA** - Care Programme Approach Association
- **HC** - Health Circular
- **DoH** - Department of Health

Services Users,/ Client/Patient: Terms usually used by Health Care professionals, for purposes of the CPA policy and training we have chosen the term service user

Care Management (CM) - Describes a procedure followed through by social services / local authority to assess need and arrange the provision of services under the NHS and the Community Care Act 1990.

Central and North West London NHS
Mental Health NHS Trust

ANNEX 5

BRENT MENTAL HEALTH SERVICE

CARE CO-ORDINATOR PRACTICE GUIDELINES

APRIL 2002

Central and North West London NHS
Mental Health NHS Trust

BRENT MENTAL HEALTH SERVICE

CARE CO-ORDINATOR PRACTICE GUIDELINES

BRENT MENTAL HEALTH SERVICE

CARE CO-ORDINATOR PRACTICE GUIDELINES

CONTENTS

Introduction

What are the key functions of the Care Co-ordinator

Clients who are subject to Enhanced CPA should have a nominated Care Co-ordinator whose role is the lynch pin of the CPA process and carries the same responsibilities whichever professional discipline the worker comes from.

The Care Co-ordinator should be identified by the first CPA meeting and they should have agreed to at the meeting or in advance to take on this role.

They are the focal point of contact and liaison for others involved in the care plan and should be fully recognised in terms of authority, workload and training. Assessment and Care Planning are integral parts of Care Co-ordination role but it is only one of six core tasks that include:

1. Assessing need
2. Care planning
3. Carer's assessments
4. Implementation of the care plan
5. Monitoring
6. Reviewing

The Values Which Under-Pin Community Care

A commitment to ensure that all users and carers enjoy the same **rights of citizenship** as everyone else in the community, offering equal access to service provision, irrespective of gender, race or disability.

A respect for the **independence** of individuals and their right to self-determination and to take risks, minimising any restraint upon that freedom of action.

A regard for the **privacy** of the individual, intruding no more than necessary to achieve the agreed purpose and guaranteeing confidentiality.

An understanding of the **dignity** and **individuality** of every user and carer.

A quest, within the available resources, to maximise **individual choice** in the type of services on offer and the way in which those services are delivered.

A responsibility to provide services in a way that promotes the realisation of an **individual's aspirations and abilities** in all aspects of daily life.

Care Management & Assessment - Managers' Guide

SSI [1991]

Benefits of Care Co-ordination

Care Co-ordination offers a range of benefits for clients, which can be summarised into ten main areas:

1. A needs-led approach to assessment and the use of resources, tailoring services to individual requirements

2. A commitment to individual care planning, specifying desired outcomes

3. A clearer division of responsibility between assessment and service provision. Separating the interests of service users and providers.

4. More responsive services as a result of linking assessment and purchasing / commissioning.

5. A wider choice of services across the statutory and independent sectors.

6. A partnership in which users / carers play a more active part alongside practitioners in determining the services they receive.

7. Improved opportunities for representation and advocacy.

8. Promoting anti-oppressive and anti-discriminatory practice by implementing a positive and effective strategy to encouraging the participation of clients who may have other disadvantages.

9. Greater continuity of care and greater accountability to users and carers.

10. Better joint working with service providers.

Using the Practice Guidelines

The **Care Co-ordinator Practice Guidelines** policy provides checklists of minimum core actions, which must always be addressed with each individual case and are a foundation for best practice. They are intended to provide a framework for creative care co-ordination whilst ensuring that essential points are not over-looked.

As with all checklists, there is a danger that they could be misinterpreted as offering a prescriptive approach but they are not a set of exhaustive lists to cover every possible eventuality. They are also not a substitute for creative and skilled work in collaboration with users, carers, and colleagues ~ but rather they should provide guidance on situations where such effective work is not occurring.

It is, for example, inconsistent to argue that a client having initial contact with the service has been empowered, if they have not been informed of the service aims and their rights, or entitlements.

Although many of the points are very basic indeed, but there is substantial evidence that even these basic points are not always being applied in practice and that as a result, clients are losing out. The application of these checklists will help ensure that clients do not lose out in this way in the future.

1. Starting Work with A Client on Enhanced CPA

Key Questions

- Does the client understand my role?
- What is the best way I can explain my role?
- Who are the formal or informal carers involved?
- If the client does not want to see me, how can I try to engage him/her?
- What is the significance of my gender, ethnic origin, etc. to this person?

Minimum Core Actions

a[] Read any existing information

b[] Notify client of allocation, and explain who you are, your role and reasons for involvement.

c[] Identify existing support network and make contact as appropriate.

d[] Identify any carer[s](see *3. Carer Assessment* for definition) and notify them of their right to an assessment.

e[] Identify any children residing with the client. If they are Young Carers, carry out a Carer Assessment. Consider a referral to Children's Social Work or Child and Family Services to ensure their well being.

f[] Begin to create file, if one does not already exists in line with the File Standards.

g[] State in file; purpose for our involvement, initial goals.

h[] Follow the recording 'Code of Practice' found at the back of the file.

2. Needs-led Assessment

Purpose:

It is a requirement of the NSF that anyone referred to and accepted by Specialist Mental Health Services is entitled to have their needs assessed and identified.

Key Questions

- What is the purpose of the assessment?
- How can I best plan and carry out the assessment to enable the client's participation?
- How can I best understand this client's individual circumstances, history, culture, and any other relevant issues?
- Who else can I involve to contribute to the assessment?
- Is there a carer involved?

Minimum Core Actions

a[] Make adequate provisions taking into account the clients and carers first language and any other disadvantages so that their participation may be maximised, for example, by using interpreters or signers.

b[] Explain to the client the purpose of the assessment, likely outcomes and time scales, and their entitlement to information, and representation.

c[] Establish details of any relevant informal or formal networks of support including carer's and with the client's consent make contact with them to notify them of your involvement. Obtain any information, which may be relevant to the assessment.

d[] Gather known facts and build picture of the clients individual needs taking into account their cultural needs.

e[] Take into account the social and any psychiatric / criminal history, checking out whether existing accounts are correct / substantiated.

f[] Liase with other professionals and gather their assessments together.

g[] Study all the information provided and formulate it into an assessment of the client's strengths and needs. Balance out strengths and needs and distinguish fact from opinion.

h[] Identify clearly the cause[s] of any difficulties.

i[] Identify any risk concerns based on information or evidence gathered. Formulate a risk assessment, using the risk management format.

j[] Share your assessment with the client, carers and others and be prepared to modify it. Within the guidance / parameters outlined in the departments confidentiality procedures, give a copy of the finalised assessment to the client and others who it is deemed appropriate to issues copies.

k[] Complete the NLA Assessment Form creatively using the headings suggested, with particular emphasis on needs relating to race and culture; housing ; benefits; potential for employment, education or training.

l[] Leave no gaps in the Needs-led Assessment Form; if a heading does not apply, say why.

m[] Discuss outcome of your assessment at the CPA meeting

n[] Derive a clear set of goals and objectives from your assessment and record disagreements.

3. Carer's Assessment / Review

Purpose:

To identify the carer's needs in relation to their caring role. Carer's who provide regular and substantial care are entitled to have their needs assessed and a care plan, which should be reviewed annually (National Service Frameworks - Mental Health, Standard 6).

Key Questions

- Does the carer provide regular and substantial care and what does this entail?
- What impact does this involvement have on them; are they being exploited?
- Does the carer want to continue in the same role?
- What support does the carer require to continue their role?
- What does the caring role mean in for that individual in their culture?
- How old is the carer? Is their role appropriate to their age?

Minimum Core Actions

a[] Identify the primary carer and [with client permission] make contact to explain to the carer your role in relation to the client

b[] Explain to the carer their right, under the *Carers' Recognition Act*, and *The National Service Framework* to an assessment at the same time as you do the NLA with the person they care for. Explain any benefits and limitations of this assessment.

c[] Having gained an understanding of the carer's caring, physical and mental needs, record it on a Carer Care Plan.

d[] Advise Carer about carer support groups and Brent Carers' Centre

e[] Consider the needs of black and ethnic minority carers, ensure they have access to information they need and to culturally appropriate services

f[] Consider the needs of Young Carers, and refer them to young peoples services where relevant to ensure that caring is not a detriment to enjoying the same life chances as other children and that educational, social and leisure opportunities are safeguarded.

g[] Consider whether it is possible to arrange the client services to benefit the carer. Include any contingency plan for the client in the Carer's Care Plan.

h[] Give Carer Care Plan to carer and copy to others with a need to know and arrange the next review (refer to confidentiality policy).

4. Care Planning

Purpose:

This should be based on identified needs and should be the most appropriate ways of achieving the objectives identified from the assessment. There should also be a clearly documented contingency and crisis plan.

Process:

This should be outlined during the client's CPA meeting so that all those involved are clear about their involvement.

Key Questions

- Is there a clear consensus between professionals about the care needs to be addressed by the client's care plan? Is the client in agreement with their assessed needs?
- If not, what implications does this have for the implementation of the care plan?

Minimum Core Actions

a[] Ensure that needs are clearly identified and derived from the NLA and that differences of opinion are documented

b[] Discuss the purpose and objectives of the care plan with the client and consult with them about their views and preferences.

c[] If the client is unable, or unwilling to be involved in the care planning process, explore ways, or avenues of encouraging their participation, for example using an advocate.

d[] Formulate the care plan with clear objectives and time frame.

e[] Ensure that risk concerns are addressed as part of the care plan and show how the care plans contribute to the management of any risk concerns.

f[] Ensure that the care plan reflects the client's ethnicity, life-style, disadvantages, preferences, and any other social issues.

g[] Ensure that the care plan addresses employment, education and training needs; housing needs; benefit issues.

h[] Ensure service provision matches the care plan and is working well.

i[] Take into account any uncontrollable variables, which may include a clients unpredictable mental health needs are and frame the care plan accordingly, including options and contingency plans.

j[] Take into account any additional factors such as dual diagnosis, homelessness, or an unsettled way of life.

k[] Having considered what resources are available to meet objectives, cost the care package, and offer choice wherever possible.

l[] Specify support plans, which may include monitoring, and who will do what, and when.

m[] Arrange the next review meeting at the CPA meeting and specify who needs to be invited.

n[] Complete the care plan, including client views as carefully as possible and using objective language that the client will understand.

o[] Sign the care plan and ask your client understands the care plan before they sign it, otherwise consider involving an advocate. Record on file the level of engagement / understanding the client has and the implications for the plan.

p[] Discuss with the client who you intend to copy the care plan to, and consider their views if they object, however, risk factors may over-rule issues of choice or confidentiality.

5. Monitoring & Reviewing

Purpose of Monitoring:

To support the implementation the agreed care plans on a continual basis.

Purpose of Reviewing:

To review the agreed care plan and client's situation thus ensuring that it is still relevant. To also check that agreed care plan has been implemented and record any unmet needs.

Key Questions

- Was the Care Plan implemented and is it still relevant to the client's situation?
- Is there an adequate balance between the monitoring arrangements, the quality / reliability and co-ordination of services supporting the client?
- Are the support plans adequately reliable and robust?
- Does the level of monitoring and review match the known risk concerns?
- Are there special issues, which may make monitoring, and review difficult e.g. placement outside Brent?

Minimum Core Actions

a[] The client and all parties involved are clear about the purpose, method and frequency of reviewing the agreed care plan.

b[] The reasons for monitoring are clear and the actions to be taken if concerns are triggered are recorded and known to the care network. The frequency of review should vary directly with the fluidity of the client situation.

c[] The next review date should be clearly indicated on the CPA form.

d[] Unplanned changes made to the care plan should be documented, and the client and all parties involved should be notified on interim basis until the process is formally reviewed at a CPA.

f[] Significant changes in the client's situation needs or other circumstances trigger a re-assessment and new care plan.

g[] The financial and paperwork processes, which support the care plan, are accurate and up-to-date.

h[] Cost changes are monitored and where possible are anticipated and planned for.

6. Working with Allocated Cases on Duty

Key Questions

- Why is intervention necessary in this case now?
- Who is the allocated Care Co-ordinator?
- Who / which agency is best placed to become involved?
- What is the current state of the NLA and care plan?
- How can a measured response be given under to secure client well being until the Care Co-ordinator is available?
- Can the team manager provide guidance?

Core Minimum Actions

a[] Only take actions which are necessary and, where possible, with the agreement of the care network.

b[] Record the assessment leading to any decision to intervene

c[] Ensure that any departure from the care plan is documented.

d[] Ensure that the Care Co-ordinator is aware of the action taken on return by leaving note in message book or on file.

f[] Ensure that the client and their carer have the contact details of the 24 hour service.

7. Joint Working with Other Agencies / Service Providers

Only genuine partnerships with service providers, based on mutual respect and trust will elicit effective assistance to clients.

Key Questions

- Does the care plan help the service provider to serve the client?
- Are the service providers clear what their objectives are and how they intend to measure the effectiveness of their intervention?
- Are the communication arrangements between the parties involved satisfactory?
- Have concerns about users who have become vulnerable been raised regularly at the Sector's multi-disciplinary meetings?

Minimum Core Actions

a[] When exploring service options be specific about the objectives, methods and skills required.

b[] Provide the service provider with a copy of the care plan.

c[] Consider providing a more detailed service specification to assist in the meeting objectives.

d[] Ensure that service providers understand the risk assessment for the client and action to be taken if there are any concerns.

e[] Ensure that individuals and agencies are clear about what they can contribute to care planning discussion and objectives.

8. Purchasing Standards - Achieving Quality & Value for Money

Key Questions

- What is the minimum standard of service / 'commodities' required to address this identified need?
- Does this expenditure solely benefit the client / carer / public?
- Is there any conflict of interest in this transaction? If so refer to conflict of interest policy.
- Would this expenditure be justifiable by taxpayers and local council taxpayers?
- Are there any concerns /risks of fraud in this transaction? If so how have these been addressed?

Minimum Core Actions

a[] Clearly link the expenditure to the care plan and the identified need.

b[] Demonstrate on file that the expenditure is the most appropriate way to address the need.

c[] Determine the minimum standards of quality, which will meet the need.

d[] Investigate options from a number of suppliers [usually 3, but where very urgent needs identified this can be waived with team manager agreement]

e[] Where any price is composite, get a breakdown of the components.

f[] Exclude any options, which are do not meet minimum standards. Choose the lowest cost option that meets the predetermined quality standard.

g[] Record reasoning for decisions.

h[] Check any unusual or possibly controversial decision outcomes with Team Manager before proceeding.

i[] Follow ***Brent Mental Health Services*** financial procedures [as detailed in supporting paperwork].

9. Closing A Case

Key Questions

- Are there any anticipated risk concerns? and if so would the support plans be adequate to address this?
- What impact will this change have on the care network?
- Have the views of all the involved parties been taken into account?

Minimum Core Actions

a[] The decision to close the case is made in a planned / thoughtful way and in consultation with the client and other involved.

b[] The decision is taken as part of the CPA process and, where needed, the CPA Care Co-ordinator role is formally transferred to another professional.

c[] The file is in the same state as for a case transfer [see File Transfer policy].

d[] The client and care network receive written confirmation of the change and how to re-refer.

e[] Monitoring arrangements / responsibilities after Brent Mental Services withdrawal should be clearly documented.

f[] The Team Manager signs the file for closure.

ANNEX 6

MANAGEMENT OF CLINICS

1 All patients must have a valid prescription as per the Parkside CPN drug policy.

2 All patients are to be reviewed at six monthly intervals with the responsible medical officer and at the same time the prescription card re-written.

3 All injections are to be recorded (i) in the patient's notes, (ii) on the prescription sheet and (iii) on the patient's personal record card.

4 Each patient should be given a date for his/her next injection. This date should be recorded in an appointment book and on the depot card and the patients personal record card.

5 In the event of a patient relapsing, or further nursing intervention being required the clinic should inform the C.P.N. who will assess the patient.

6 Conversely, when appropriate he/she may be transferred back to the Clinic.

DEFAULTING

1 If a patient defaults. he/she should be sent a reminder to attend the next clinic. If contact is by telephone a written reminder will also be sent.

2 Should the patient respond, the reasons should be discussed as it may indicate a change in circumstances.

3 Should they not respond, a home visit should be carried out to establish the reason; by the clinic nurse.

4 Should the patient consistently default, his or her status as a clinic patient should be reviewed and appropriate action taken.

ANNEX 7

NORTH WEST SECTOR

POLICY AND PROCEDURES FOR PATIENTS WHO RECEIVE DEPOT INJECTIONS

This policy is to provide clarification around all the factors involved in the administering of depots either at home or in the 2 clinics and polices for non attendance.

A. Administration and Depot Cards

Prior to administration of a depot injection, the nurse must ensure the following details on the deport card are correct and legible

Patients name
Address
DoB

Drug Name
Dose
Route
Frequency
Duration – maximum of 6 months

Doctors signature and date of prescription

Discontinued medication has a clear stop date

Following administration of a depot injection the nurse will sign and date the record card. If the dose is not given the reason should be entered on the card and the RMO notified.

YOU ARE NOT AUTHORISISED TO ADMINISTER ANY DRUG IF THERE ARE ANY DISCREPENCIES IN THE PRESCRIPTION.

Prior to administration the nurse will check the name, dose and expiry date on the ampoule

Do not administer if you feel it is unsafe to do so, consult a senior member of staff or contact the Doctor

If Patient refuses the depot, record on the card and inform the RMO

c. Assessment

During your time with the patient at the clinic or in their own home you are required to assess the current mental state of the patient and ascertain any problems they may be having
The following areas should be covered.

Patients mood, any unusual experiences, any sleeping, eating worries, if on oral medication is that still being taken, any changes to oral meds, any side effects, any significant changes to circumstances, any physical or mental health complaints any other concems.

If patients report any significant changes this must be recorded in their file.

Defaulting

A. At the Clinic

If a patient does not attend for his or her injection :

Telephone, if possible, the same day as a non attendance and make a time for or the following week.

If unable to contact patient by telephone then please send a standard letter inviting the patient to come to the next clinic or to telephone. Copy this to the G.P. and Consultant.

Tell all others involved in the patient care that the patient has not showed for their depot.

Ensure all this is recorded in the clinical notes and on protechnic.

b. Depot given at home

If patient is not home, and an appointment had been arranged, send a letter and a copy to the Consultant and G.P.

Record in the file and protechnic.

Ensure all involved in patient care knows of their non attendance.

Enlist the support of family members and others if necessary.

For non attendance at the Depot Clinic or not being at home for the administering of the depot if an appointment has been made, and the patient is on CPA Level I and/or Supervision Register the person must be raised in cases of concern at our regular weekly meeting.

Patient Reviews

All depot patients must be reviewed by the RMO or their nominated representative at least 6 monthly.

For Westmore Depot clinic patients this will be at a regular clinical review at Westmore

For other depot clinic patients this will be at a time set up with the medical staff and the clinic nurse and will take place at the clinic in order to course as little inconvenience to patients as possible.

Diana
June 1999

ANNEX 8

NORTH WEST LONDON MENTAL HEALTH NHS TRUST

SERIOUS INCIDENTS PROCEDURE

MAY 1996

NB: FOR LESS SERIOUS INCIDENTS REFER TO UNTOWARD INCIDENT POLICY IN NURSING POLICY MANUAL

NORTH WEST LONDON MENTAL HEALTH NHS TRUST

SERIOUS INCIDENTS PROCEDURE

LIST OF CONTENTS

NORTH WEST LONDON MENTAL HEALTH NHS TRUST

SERIOUS INCIDENTS PROCEDURE

1 INTRODUCTION

1.1 The Trust has developed this procedure to provide staff with a clear outline of action that needs to be taken when serious incidents occur. Prompt action in response to serious incidents is necessary both to ensure that they are dealt with effectively and, equally importantly, for lessons to be learnt so that the causes of the incident do not recur. The process for dealing with serious incidents has been developed to ensure that members of staff are treated fairly.

1.2 This procedure is not intended to be used for the majority of the incidents that occur on wards, which are not regarded as serious. Such incidents, commonly known as untoward incidents, are reported via Patient Accident/Incident Report forms which are held at each site and the Untoward Incidents Procedure should be followed accordingly.

2 DEFINITION OF A SERIOUS INCIDENT

2.1 It is extremely difficult to define what constitutes a serious incident. However, in most cases it will be apparent from the facts that an incident should be treated as serious. It may be the potential dangerousness of a situation that makes it serious, eg a threat with a knife, or an unsuccessful, but serious, suicide attempt.

2.2 A serious incident can involve a current inpatient, outpatient or day-patient or someone who has recently been discharged from inpatient, outpatient or daycare. Generally the person involved would have had contact with, or may have attempted to have had contact with, the Trust during the previous year.

2.3 It is inevitable that a degree of subjective judgement has to be applied in respect of individual cases, but it is best, however, to err on the side of prudence. Where there is any doubt about whether an incident should be treated as serious, it should be deemed to be such pending further information. While the list below is not exhaustive, the following would be regarded as serious incidents:

i) The unexpected death or serious injury of a patient, member of staff, or member of the public, whether this occurs as a result of an incident on Trust premises, or elsewhere involving a patient who is currently or has recently been under the care of the Trust;

ii) Failure of a procedure or its application in a way which could endanger the life of a patient, member of the public or member of staff, or could pose a serious security risk;

iii) Failure or misuse of equipment or plant which could constitute a risk of injury or could have endangered the life of a patient, member of the public or member of staff.

2.4 The final decision on whether an incident is serious will be made by the Chief Executive. In the interim, if an incident occurs for which there is sufficient concern that it MAY be considered serious, then it is prudent to work on the basis that it is and to follow this procedure until a final decision is made.

3 REPORTING PROCEDURE

3.1 When a serious incident has occurred the most senior clinical manager or nurse on site (usually the Bleepholder) must be immediately informed. A Patient Accident/Incident Report form should be completed before the end of the working shift, as it would if it were an ordinary untoward incident.

3.2 Where there is doubt whether an incident is serious, it should be treated as such until a decision is made otherwise.

3.3 The Bleepholder should assess the seriousness of the incident and after ensuring that the patient concerned is provided with appropriate treatment/care the appropriate General Manager should be informed. If the incident occurs out of hours, the On-call Manager should be immediately notified.

NOTE: If the incident involves the unexpected death of a patient, the police and Coroner's Office must be notified by the Bleepholder without delay.

3.4 The Bleepholder should identify if any evidence relating to the incident exists and ensure that it is safeguarded.

3.5 The General Manager or On-call Manager will need to

i) inform the Chief Executive of the Trust or, in his absence, the Director of Corporate Development, the Director of Operations or any other Executive Director who will advise purchasers/NHS Executive as necessary. NOTE: If the incident relates to the death of a patient being detained under a section of the Mental Health Act 1983, the Chief Executive will inform the Mental Health Act Commission without delay.

ii) inform the Responsible Medical Officer. If she/he cannot be contacted, advise the On-call Consultant and provide details of the incident.

iii) attend the scene and initiate internal fact-finding without delay. Although this may be delegated to the Service or Sector Manager, the General Manager retains responsibility for the process. The General Manager should talk to relevant staff and, where possible and appropriate, patients. It may become clear that members of staff or patients have been affected by the incident. The General Manager in conjunction with the Service Manager should consider whether it is appropriate to offer counselling and support to all those involved, or to specific individuals, and make arrangements for that support to be put into place quickly.

iv) take care to secure all relevant documentation related to the incident. This may include the clinical/multi-professional notes for the patient, medicine cards and other records contained in the clinical or management file, as well as information about the ward, eg the ward report book, duty rotas, seclusion and/or supervision register, if appropriate. In consultation with the Information Manager a hard copy record of any computerised data should be made. The documentation should then be forwarded by hand to the Trust Administration Manager within 3 working days. If the records cannot be removed from the ward a photocopy should be taken.

v) on completion of fact-finding prepare an interim report for the Chief Executive setting out the facts and recommending whether further investigation is required. The initial fact-finding investigation should be zealous, but positive and objective. This process should not be delayed by the absence of any individuals involved and should be completed within, at the very most, 72 hours of the incident occurring.

3.6 The Chief Executive, on receipt of the interim report from the General Manager, will ensure that the Chairman is advised of the serious incident and arrange for its reporting to the next meeting of the Trust Board and/or Managers Committee. Where appropriate the Trust's insurers will be advised.

3.7 The Chief Executive will determine further action which could include:

i) establishing further management investigation, undertaken by the General Manager, which would comprise the interviewing of staff, taking of statements and a case note review. Where the incident involves more than one professional area, the heads of the professions, or persons identified by them, should be involved in the investigation. The results of the internal investigation may be subject to independent review by a senior clinician or manager, not employed by the Trust.

ii) with the relevant purchasing agency, establishing an external investigation by a Panel of Inquiry, including a representative of the relevant purchasing agency and an independent expert, if appropriate. The Chief Executive should prepare the terms of reference in unison with the Panel Chairman, taking account of the guidelines attached at Appendix A. In the event of an apparent homicide by a patient, an independent inquiry will need to be established.

iii) informing solicitors/CHC/MIND/Mental Health Act Commission/other organisations.

iv) in the event of a patient dying as a result of possible staff fault, the Chief Executive should ensure that the police have been informed and discuss with the relevant purchaser the establishment of an independent inquiry.

v) consideration of other forms of redress, eg. clinical complaints procedure.

vi) deciding whether the matter should be referred to the police, if not already done.

vii) initiating a review of policies/procedures implicated in the incident, by the Clinical Policy Board.

viii) examining the potential for disciplinary action and/or suspension of staff.

3.8 The patient or relatives of the patient, if appropriate, should be advised of the incident as soon as they can be contacted. When a decision is taken on how to further investigate the matter, the patient and/or relatives should be given full details of the process, the objectives of the investigation and offered the opportunity to contribute to the investigation. It is important to ensure that the patient and/or relatives are kept informed of progress of the investigation.

3.9 The Responsible Medical Officer, in the event of an apparent suicide of, or homicide by, a patient, should advise the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. In unison with the Medical Director and Clinical Audit Co-ordinator, a local internal clinical audit should be conducted. In the case of a suicide it is not necessary to await the outcome of an Inquest before doing this.

4 FORMAL INVESTIGATION

4.1 Care should be taken to ensure that the investigation is comprehensive and that conclusions are not reached prematurely. Statements should be taken using the form attached at Appendix B. The investigation must extend to consideration of the background and context of the incident and all the persons involved. Any factors which play a part in the incident should be identified.

4.2 Access to personal health data is permitted without the consent of the subject or the responsible health professional as the data disclosed will not be used for any purpose other than the investigation of the incident. Due regard must be given wherever possible to confidentiality and ensuring that all information gathered in the course of the investigation is treated accordingly.

4.3 The investigation may reveal a pattern of evidence from a variety of sources; witnesses among staff, patients or visitors; documentary record; physical damage or injury; medical staff assessment, etc. Sometimes the evidence will be clear-cut, sometimes the investigating officer or panel may have to exercise a judgement about what happened when faced with evidence that does not universally point in the same direction. Always give consideration to the evidence or background information which could be provided by patients or their relatives.

4.4 There may be incidents in which there is only one witness; where it is one person's word against another. The principles incorporated into this procedure (concerning the full range of investigation and the requirements and protection of staff) are designed to ensure that the conclusions drawn about what happened are as fully-informed and reasonable as the information available allows.

4.5 All staff and managers involved in a serious incident should receive feedback on the outcome of the investigation. This will be provided at regular communication meetings or bespoke meetings as required.

5 STATEMENTS

5.1 Statements should be taken from all staff and other witnesses as soon after the incident as possible. When statements are taken from patients a report should be obtained from their RMO as to their mental health status at the time of the statement being made.

5.2 Members of staff and others who are witnesses should be offered assistance in composing their statements and encouraged to provide as much detail as they can recall. The form shown at Appendix B should be used as it will assist in obtaining the essential information needed.

6 FOLLOW-UP ACTION

6.1 The findings of the investigation into the serious incident must be carefully considered to identify whether any changes in policies, procedures or service delivery arrangements are necessary.

6.2 After the Chief Executive has seen the report it must be presented to the Clinical Policy Board to agree whether it contains recommendations regarding clinical policy action or not. Similarly it must be presented to the Executive Group to consider, determine and implement any managerial recommendations.

6.3 The Clinical Policy and Executive Group must consider the recommendations and determine whether and how they may best be implemented. An action plan including a timetable for implementation should be created by the Operations Director and forwarded to each meeting of the Executive Board and Trust Board until all of the recommendations have been addressed.

6.4 The Managers Committee of the Board should receive a copy of the full report of each serious incident. It should review the effectiveness of the investigation until it is satisfied that all issues have been identified and addressed. The Managers Committee should monitor the progress of the implementation of the recommendations and review the effectiveness of changes made. Where appropriate a copy of the report should be forwarded to the relevant purchasing agency.

6.5 It is the responsibility of the relevant Director to ensure the implementation of recommendations. Once implementation is complete the Director should report to the Clinical Policy Board or Executive Board as appropriate, which in turn will report progress to the Trust Board.

7 POLICE INVOLVEMENT

7.1 Where an investigation reveals prima facie evidence of a criminal offence by a member of staff, the General Manager must advise the Director of Operations immediately. She/he will consult either the Chief Executive, the Director of Corporate Development or the Medical Director, to decide whether the police should be asked to investigate. In the event of a police investigation managers should ensure that their own enquiries do not prejudice the outcome of the police investigation. Nevertheless, so far as is compatible with the need not to prejudice the police investigation, any action necessary to ensure the proper running of the Trust should be taken.

7.2 If appropriate, recourse to disciplinary action against staff should proceed regardless of the investigation by police. If the police take no action, or when all police enquiries and court proceedings are over, managers will consider what further investigation and action may be needed, bearing in mind any immediate action that has been taken at an earlier stage.

8 REPORTING ADVERSE INCIDENTS AND REACTIONS, AND DEFECTIVE PRODUCTS RELATING TO MEDICAL AND NON-MEDICAL EQUIPMENT AND SUPPLIES, FOOD, BUILDINGS AND PLANT AND MEDICINAL PRODUCTS

8.1 Where a serious incident is suspected to have been caused by any of the above, it will fall under the category of an 'adverse incident' and immediate action should be taken to ensure that a recurrence does not take place. An adverse incident is one which gives rise to, or has the potential to produce, unexpected or unwanted effects involving the safety of patients, users or other persons. This includes serious deficiencies in the technical or economic performance of products.

8.2 The reporting of adverse incidents and reactions can be categorised as:

8.2.1 Reports relating to all medical devices; equipment, hospital laboratory equipment and medical supplies which are defective or unreliable.

8.2.2 Reports relating to food where contamination is suspected (the Infection Control Nurse must be advised and can be contacted via the Shenley Switchboard).

8.2.3 Reports relating to non-medical equipment, engineering plant, installed services (eg fire protection equipment, bed-pan washers, communication equipment), buildings and building fabric.

8.2.4 Reports relating to medicinal products, eg suspected adverse drug reactions).

8.3 The Service Manager should ensure that all adverse incidents are reported promptly to the Trust Fire, Health and Safety Advisor who is the nominated liaison officer on behalf of the Trust. In his absence the Associate Facilities Manager (Hotel Services) should be informed. Outside of normal working hours (Monday to Friday 9.00am to 5.00pm) the responsibility for reporting adverse incidents rests with the appropriate On-call/Duty Manager.

8.4 The report is to be in the form of a brief but comprehensive written statement of fact, to include as much essential detail as necessary. Where a patient or a member of staff is affected the appropriate incident report form should be completed as well as a comprehensive written statement.

8.5 Serious cases should be reported by the fastest means (eg by telephone) and a written report should follow without delay. The Trust Fire, Health and Safety Advisor will maintain a record of all reportable incidents.

8.6 All products and evidence involved in an adverse incident are to be retained until the case has been properly investigated.

8.7 It is the responsibility of the Service Manager to ensure that their staff are aware of the responsibilities for dealing with adverse incidents and with regard to reporting, isolation and retention of defective items.

8.8 The Trust Fire, Health and Safety Advisor will report all reportable adverse incidents as appropriate to the NHS Executive, Health and Safety Executive or Environmental Health Office.

8.9 Where necessary the Chief Executive will determine whether further forms of investigation or enquiry are required, in accordance with the provisions of section 3 above.

9 RESPONSIBILITIES OF STAFF AND PROTECTION OF STAFF INTERESTS

9.1 Staff have a clear duty to provide reasonable assistance in the investigation of an incident. Staff assisting in the investigation of an incident are unlikely to be in any personal jeopardy, but of course they have the right to seek the advice of their trade union or staff association. The General Manager will take care to ensure that there is no confusion between the operation of the Serious Incidents Procedure, on the one hand, and the disciplinary procedure on the other. Members of staff may be accompanied by a staff organisation representative, or by a friend, during any interviews related to the incident.

9.2 If, in the course of an investigation into an incident, it begins to emerge that there might be a prima facie need for staff counselling or disciplinary action, the investigating officer will advise the member of staff concerned and draw his/her attention to the advisability of seeking trade union or staff association representation or advice in any further interviews held during the investigation of the incident. The relevant manager of the member of staff concerned will decide whether or not the person should be suspended from duty on full pay in accordance with the Trust's disciplinary procedure. Whenever possible this decision should be taken after liaising with the Human Resources Department.

9.3 Any interview of a member of staff under the terms of the disciplinary procedure which arises out of an incident will only take place when the investigation of the incident has reached the stage at which fair and reasonable conclusions can be drawn from the evidence gathered during the investigation.

9.4 It is the responsibility of managers to ensure that staff are advised beforehand of the status of an interview, ie. whether it is being convened to investigate an incident or as part of the disciplinary procedure.

10 PROFESSIONAL MISCONDUCT

10.1 Where there is prima facie evidence that there has been a breach of the rules of professional conduct the General Manager will immediately advise the head of the profession within the Trust. The head of the profession concerned will be involved with the further investigation of the incident and if the misconduct is found to be proven, report the incident to the relevant professional body.

11 SUSPENSION FROM DUTY

11.1 There may be circumstances where, following a serious incident, it is appropriate to remove immediately a member of staff involved from the working situation by means of suspension from duty on full pay. The decision on whether suspension is appropriate will depend on the nature of the incident and on management's ability to conduct an open investigation. Suspension does not presume guilt. In such cases the General Manager, or the manager initiating the suspension, will make it clear in advance of suspension actually taking place, that he/she may exercise their right to representation and to personally state their case or point of view. A list of managers empowered to suspend members of staff is contained in the Disciplinary Procedure

11.2 Staff who are suspended from duty will be notified, in writing, by the General Manager confirming the suspension and the reasons why suspension is considered appropriate. Where the member of staff requests it, a copy of the notice will be sent to the trade union/staff association or friend. The Director of Human Resources will be notified at the earliest opportunity where action has been taken to suspend a member of staff.

12 DEBRIEFING SESSIONS

12.1 Whenever serious incidents occur it is important that a debriefing session is held at the conclusion of the investigation.

12.2 Debriefing sessions should be designed to give individuals and/or team members the opportunity to ventilate their feelings, to receive information about the findings of the investigation and to put the situation in perspective.

12.3 The debriefing session should be initiated by the Service or Sector Manager and will be facilitated by that manager or another staff member, as the situation warrants. Only those individuals involved in the situation and its investigation should attend.

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12.4 Guidelines for running debriefing sessions can be found at Appendix C. These should be used to support the facilitator but are not intended to be prescriptive. Every situation is different and will need to be assessed individually. It must be made clear at the time that alternative and independent support can be sought for individuals if required.

APPENDIX A

CHECKLIST FOR UNDERTAKING AN INQUIRY

1. COMMISSIONING AN INQUIRY

- Who commissions the inquiry? (eg Health Authority/NHSE/Trust Board)
- Who will be the point of contact for the inquiry team?
- Who can alter the terms of reference for the inquiry?
- Who funds external experts and how?
- Who funds administrative support for the panel?

2. THE PANEL OF INQUIRY

- Internal or external? (consider need for independence)
- Joint? (eg with local authority)
- Is a Chairman required?
- Should the Purchaser be represented?
- Would representation from solicitors/voluntary organisations/CHC be helpful?
- Identify admin support and a physical base for the panel.
- Male and female mix of panel members can be helpful.
- Some local knowledge can be helpful.

3. TERMS OF REFERENCE

- Clarity of purpose (eg not to establish the cause of death, look at specific cases, to look at general service provision).
- What outcomes are wanted?
- Will the investigation look at details of individual incidents or general themes?
- What is the position with respect to potential disciplinary action?

4. METHODOLOGY

4.1 Initial

- Undertake an initial fact finding investigation urgently (eg within 72 hours) to get prima facie evidence and help determine the nature and scope of the inquiry.
- Secure copies of all relevant documentation including case notes.
- Get statements from key parties of the outline of events with chronology and synopsis.
- Develop a central chronology of events.
- Obtain a list of all staff concerned and contact details.
- Schedule meetings of the panel - block out time early.
- Schedule regular meetings of the panel with the commissioners of the inquiry to discuss progress.

4.2 Main Inquiry

- Hold a briefing session for the Inquiry Panel.
- Determine whether a case note review is required.
- What style will the panel adopt?
- Remember the need for confidentiality of patients, staff, the investigation and the report.
- Work on a multi disciplinary basis to ensure consistency across staff groups.
- Keep notes of key matters.
- Determine format for final report to facilitate Panel working.
- Determine a timetable for the inquiry and milestones.

4.3 Continuation of services under investigation.

- Ensure services made safe (eg need to change practice immediately/clear instructions/suspensions).
- Ensure no planning blight.

- Continue to manage services as usual.
- Follow up any new problems as usual but notify Panel if any potential crossover.

5. COMMUNICATIONS

- Identify a communications plan for the Inquiry.

  Initiation.
  Ongoing progress.
  Reporting outcome.

- Identify audiences with communications needs.

  Patients
  Relatives
  Staff
  Trade Unions
  CHC
  Public
  Trust Board
  Purchasers
  NHSE
  Voluntary organisations
  Obtain public relations advice.

- Recognise that once an Inquiry has been established, the matter will become public. Thus needs for press statements and early communication with any patient or relative concerned.

- Co-ordinate communications as required with key meetings, eg report to Trust Board.

- Staff asked to appear as witnesses should be invited to bring a friend or trade union representative with them.

- Recognise the need for support for staff during an investigation. This can include briefings/communications. Staff closely concerned may be anxious about disciplinary action.

- Identify someone to be the channel of communication with the patient/relatives and ensure they keep in touch regularly.

- Offer patients/relatives the opportunity to submit evidence to the Inquiry if they wish, and offer a meeting with the Panel.

- Arrange any meetings with the patients/relatives close to their homes in pleasant surroundings (not the Boardroom) with refreshments and plenty of time for discussion.

- Recognise that relatives may not be a homogenous group and may not have agreed a common approach before your meeting.

- Offer a meeting with the Panel to patients/relatives where the outcome of the Inquiry is known and where the findings can be explained and copies of the report given out.

- Offer a further meeting with the Panel when the patients/relatives have had time to consider the findings.

6. THE REPORT

- Block out time to draft and write the report.

- Prepare only one report and assume it to be public. Summaries or public copies in addition to confidential copies lead to distrust and accusations of cover up.

- Check the final draft in confidence with the organisations concerned to check factual accuracy and seek their action plans. They do not have a right to alter the findings of the Panel otherwise.

- Seek legal advice.

- Determine circulation of the report and appropriate communications plan. Remember the communications needs of the organisations concerned.

- Determine whether to publish the report with action plans proposed by the organisations concerned.

7. IMPLEMENTATION

- Identify responsibilities for implementation.

- Identify the monitoring process to ensure effective implementation.

- Seek early identification of resources to ensure implementation.

SERIOUS INCIDENT - STATEMENT
APPENDIX B

Name (Caps)..... Job Title .....

Date of Incident..... Time of Incident .....(am/pm)

Describe your responsibilities at the time of the incident .....

.....

.....

Did you witness the incident? Yes / No

Describe what you know about the incident .....

.....

.....

.....

.....

.....

.....

.....

.....

.....

What happened after the incident (ie action taken) .....

.....

.....

.....

Signed.....

Date.....

Use a continuation sheet if necessary

GUIDELINES FOR DEBRIEFING SESSIONS
APPENDIX C

Defusion of particularly difficult or serious situations can often help to control stress. The following points may be useful when facilitating a debriefing session. Each situation is different and the debriefing session should reflect this.

1. When to Hold a Debriefing Session ?

- Whenever a serious incident has caused or is likely to cause undue distress to individuals and/or team members. The debrief is an opportunity for all those involved to discuss the incident, how it happened, and what scope there is for making changes to avoid such an incident recurring

- Whether the incident involves a current inpatient, outpatient or someone who has recently been discharged from inpatient, outpatient or daycare

2. Who Should Facilitate a Debriefing Sessions ?

- The debriefing session should be initiated by the service manager or the on-call manager

- The debriefing session should be facilitated by that manager or another staff member as the situation warrants

3. Who To Involve In A Debriefing Session ?

- The facilitator and as many of the individuals and/or members of the team involved in the situation as possible

4. Planning A Debriefing Session

- Inform individuals and/or team members that a debriefing session will be held

- Encourage staff to attend but make them aware that they are not obliged to so

- Prepare a private and quiet area with refreshments

- Ensure that there will be no interruptions

STRUCTURING A DEBRIEFING SESSION

1. Introduction

- Introduce and explain the aim of the session. Explain that it is not mandatory to contribute to the session but encourage people to do so
- Reinforce the fact that the session is not an investigation or critique
- Let all participants know that individual counselling can be arranged if requested

2. Debriefing Process

- Outline the facts surrounding the situation.
- Encourage the participants to describe what happened. This helps to recreate the atmosphere surrounding the situation
- Ask members of the group to discuss their first thought during the event as this may help to unfold some of the more personal aspects of the situation. It also confirms that individual thoughts and feelings are important and should not be lost in the midst of facts
- The group should discuss how they felt at the time and are now feeling. For example, this could be encouraged by asking "what was the worst thing about the event?"
- The group members need to be reminded that they are experiencing normal feelings about an abnormal situation

3. Conclusion

- The facilitator should summarise what has been said
- If helpful, an action plan may be devised and/or a further meeting set
- All members must be informed of how to gain access to further support if this is required

ANNEX 9

SERIOUS UNTOWARD INCIDENT REPORTING POLICY

This policy is for immediate implementation and adoption throughout the Trust. This document supersedes all previous policies/procedures. Please destroy all previous policies.

19th OCTOBER 1999

CONTENTS

Definition *An Untoward Incident is a deviation from a normal pattern of behaviour resulting in physical or psychological discomfort for patients or staff within the Trust, or those affected by the Trust's activities. A Serious Incident is where loss of life, or serious injury has been threatened or sustained.*

1.0 PURPOSE

1.1 The purpose of this policy is to:

a. Monitor the nature and frequency of serious/untoward incidents and in light of the findings:

b. Make recommendations for appropriate action with the aim of preventing recurrences.

c. Improve care by critical analysis of the incident.

2.0 INTRODUCTION

2.1 This document represents the agreed policy of the Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust and should be freely available in all hospitals, care centres, community or residence homes, wards, departments and offices. The policy must be read, understood and actively supported by all staff employed by the Trust.

2.2 The procedures herein must be viewed as an overall policy of Risk Management and a contribution to the provision of a quality service for patients and staff within Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust. It combines and supersedes any previously Trust policies.

2.3 **Where staff sustain injury, a Staff Accident/Incident form, must be completed in accordance with current Trust health and safety at work procedures.**

2.4 The policy describes procedures for notification, investigation, follow-up of incidents and reinforces the Trust's commitment to seek the highest possible standards of patient care and staff development.

2.5 Each member of staff has a duty to ensure that all accidents/incidents are reported, including 'near misses'. This can be achieved through adequate and timely reporting, and may include, health and safety, environmental or security issues.

Definition: *A near miss is an unplanned event which does not cause injury or damage, but in the opinion of the clinician/individual concerned, serves as a reminder of a potential serious error or incident.*

2.6 Where an incident occurs, it is the responsibility of the Operations and Service Directors/Senior Managers on call to initiate the appropriate investigation to be undertaken in the best interests of patients and staff alike.

2.7 The reporting procedures described below apply to all incidents relating to patients, staff, clients, visitors, and others, including independent contractors involved directly, or indirectly with the business of the Trust.

2.8 All press/media contacts are to be referred to the office of the Chief Executive. However, contacts made outside normal Trust HQ working hours, public holidays, weekends and statutory days are to be referred to the On-call Manager.

2.9 Actual or potential legal action or investigation of a particular incident by police should not necessarily be regarded as grounds for deferring an incident investigation and implementing any necessary clinical/managerial action, although this may need to be done in conjunction with the Trust's solicitors.

3.0 CATEGORISATION OF INCIDENTS

3.1 There are five categories of Incidents: A/B/C/D and E. Those identified, as A/B will normally be considered as Serious Incidents.

Incidents in category C/D will normally be reported on an Accident/Incident Form.

If there is any doubt about the categorisation of an incident, the Service Director, Senior Nurse or On-call Manager should be consulted.

3.2 Staff Injuries

3.2.1 **Where staff sustain injury:**

3.2.2 **A Staff Accident form must be completed in accordance with current Trust Health and Safety at Work procedures, and:**

3.2.3 **In addition a Serious/Untoward incident report form as set out at Appendix 1 should be completed if categorised as A, B or serious C.**

3.3 Category A

Incidents resulting in death, or severe and enduring physical or emotional ill effects. They include but are not limited to: homicide, attempted homicide, sudden and unexpected death, suicide, attempted suicide by violent or determined means, rape, and hostage taking situations

3.4 Category B

Incidents that are not immediately life threatening but which acutely jeopardise the well being of patients, staff or visitors and include, but are not limited to; allegations of patient abuse or neglect, sexual assaults, attempted suicide, aggravated assaults, unexplained injuries, and serious errors of medication.

3.5 Category C

Incidents, which seriously affect, or have the potential to affect the health and safety or psychological well being of the individual(s) concerned. These include: sexual improprieties, sexual, racial and gender harassment, accidental injuries, assaults and acts of deliberate self-harm.

3.6 Class D

Incidents resulting in no injury, or only in very minor injury . Incidents involving verbal abuse and aggression. Errors of medication, which do not involve any lasting or serious outcome, are also included in this category.

NB: Categories C and D will normally be reported on an Accident / Incident form.

3.7 Category E

Any incident not covered/interpreted from the above guidelines and would include: fire, flood or other 'Act of God' event, (such incidents could also be reported under categories A/B), or incidents notifiable under the classification of infectious diseases, those attracting significant media or political interest, or persons masquerading as clinical staff.

3.8 If there are any doubts regarding the categorisation of serious/untoward incidents, the Operations/Service Director is to be informed who may then seek advice from the Director of Operations or from the On-call Manager for incidents occurring out of normal Trust HQ working hours.

4.0 SERIOUS INCIDENT REPORTING

4.1 The reporting procedures of this policy follows guidance from The Mental Health Act Commission, national legislation, quality standards and other criteria demanded by health care purchasers. It also builds upon existing Trust procedures used by staff.

4.2 When an incident occurs it should be reported within 24 hours using the form at appendix I for category A,B and serious C, and sent to be signed by the relevant Operations Director

4.3 The form will then be faxed to the Trust Risk Advisor who will forward it to the Chief Executive. At this stage a decision will be taken as to whether advice should be sought from the Trust's solicitors.

4.4 Where category A and B incidents occur outside normal Trust HQ working hours, public holidays, week ends and statutory days, the Director/ On-call Manager shall contact the Chief Executive who will decide whether advice should be sought from the Trust solicitors.

4.5 Where a serious incident is suspected to have been caused by defective products relating to medical and non-medical equipment and supplies, food, buildings and plant and medicinal products, it is essential that the serious incident report details fully the part played in events by the defective products.

4.6 When reporting serious incidents involving defective products, the following categorisations may be helpful: -

4.6.1 Reports relating to all medical devices; equipment, hospital laboratory equipment and medical supplies which are defective or unreliable.

4.6.2 Reports relating to food where contamination is suspected (the Infection Control nurse must be advised)

4.6.3 Reports relating to non-medical equipment, engineering plant, installed services (e.g. fire protection equipment, bed-pan washers, communication equipment), buildings and building fabric.

4.6.4 Reports relating to medicinal products, (e.g. suspected adverse drug reactions).

4.7 All Serious/Untoward Incident initial notifications are to be faxed to the Trust Risk Advisor who is the nominated liaison officer on behalf of the Trust.

4.8 The report is to be in the form of a brief but comprehensive written statement of fact to include as much detail as necessary using the serious/untoward incident form at appendix 1. All products and evidence involved in an adverse incident are to be retained until the case has been properly investigated.

4.9 Serious cases are to be reported by the fastest means (e.g. telephone) and the written report should follow without delay. The Trust Risk Advisor will maintain a record of all reportable incidents and where necessary advise the NHS Executive, Health and Safety Executive or Environmental Health.

5.0 EVIDENCE

5.1 Evidence sought in the course of an investigation will be more reliable and accurate the sooner after the Serious/Untoward incident it is taken. Staff involved in an incident should be encouraged to write a statement which they retain as soon after the event as is practical.

5.2 All material evidence relating to a serious/untoward incident must be preserved. It is the responsibility of the relevant Operations/ Service Director and the Secretary of any inquiry board to ensure that appropriate arrangements exist for the safe keeping of all such documentation and material.

5.3 Where items of plant or equipment are involved, or where the state of buildings or grounds may be relevant to the investigation, these should be inspected at the earliest possible opportunity by the officer(s) investigating the incident, and appropriate records including photographs kept of the findings.

5.4 Thorough investigations of a serious / untoward incident will require written evidence to be obtained from all staff involved and any independent or specialist witnesses. If necessary, these statements will be obtained in conjunction with the Trust's solicitors so that legal advice on possible claims may be obtained.

6.0 OTHER POLICIES / PROCEDURES

6.1 COMPLAINTS

The S/U Incident policy is also separate from the complaints policy. If however, a complaint is received about an incident under investigation, the S/U incident policy should take preference in terms of the investigation. The complaint will still require a response.

6.2 ACCIDENT AND INCIDENT REPORTING

Where accidents/incidents to patients and staff fall into the categories C and D in this policy or where defective medical products, buildings, plant and equipment or other supplies need to be reported, the "Accident/Incident" reporting form should be used and sent directly to the Trust Risk Advisor.

6.3 MEDIA INVOLVEMENT

Any media interest in a S/U incident must be co-ordinated by the Chief Executive. Care will be taken to ensure that those directly involved (especially patient, family, GP, purchasing authority, Regional Office etc.) will be informed before the media.

7.0 MANAGEMENT INVESTIGATION AND REPORTING

7.1 There are three levels at which an inquiry is undertaken. The level of inquiry is determined by the Chief Executive advised by Executive Directors. The levels are:

7.2 (a) Level 1 - Management Inquiry - (Categories A - C)

- Usually undertaken by the Operations/Service Director following, where appropriate advice from the Trust's solicitors, and includes the gathering of information, statements and evidence from all individuals involved in the incident and the compilation of a management report

- In the shortest possible period of time but within 15 working days of the incident being reported, or first coming to light. If a delay in the submission of the Management Report becomes apparent, the appropriate Operations/Service Director will advise the Chief Executive in writing of the reasons for the delay.

7.3 (b) Level 2 - Peer Review

- The investigation of a clinical incident where concern over practice exists, identified through the Management Inquiry.

- This is undertaken by fellow clinicians, minimum 2 usually 3. The Peer Group will not usually work within the immediate geographical area and will be appointed by the Chief Executive.

- Convened by the Chief Executive as soon as is practicable, or following receipt of the Management Report. There are no strict time limits but the review should be undertaken as promptly as the circumstances allow.

- The outcome will be reported to the Chief Executive who will, determine the circulation of the review report

7.4 (c) Level 3 - Board Level Inquiry - "Serious Incident Reports"

Convened by the Chief Executive following consultation with the Trust Chair, and the Executive Directors. While the following list is not exhaustive, each may be subject to Board Level Inquiry.

- Class A and B incidents, possibly Class C, depending upon the nature of the incident, e.g. serious fire, flood, car accident, grand theft, etc.

- Failure of procedures or their application, so serious as to endanger the life of the individual, pose a serious risk to the health of the individual, pose a serious security or environmental risk.

- The investigation will be undertaken by a panel of three or more members, with a Non-Executive Director as Chair. A member from the relevant purchasing authority may be included on the panel, which will include a medical and/or nursing representative when the incident relates to clinical issues.

- A secretary to the panel will be appointed who will be nominated by the Chief Executive.

- The panel will submit a written report of their findings and recommendations to the Trust Board, who will determine the circulation of the report and it's recommendations.

- The report is to be presented as soon, as is practical in consultation with the Chief Executive and the Trust Chairman.

8.0 Involvement of the Trusts' solicitors

8.1 Some incidents may result in legal action being taken against the Trust. Where this is the case, legal advice will be sought on the evidence to be collated and the issues to be considered so that the Trust may obtain advice on anticipated future legal claims or liabilities. The following procedure has been established in order to ensure that the Trust obtains early legal advice.

8.2 As soon as practicable, the Chief Executive will notify the Trusts solicitors by Fax of the incident on the form set out in appendix 4, providing the names of all the persons who may be able to give relevant evidence (excluding the patient and his/her family)

8.3 Upon receipt, the solicitors will respond and advise whether statements need to be obtained in conjunction with them in order to advise on anticipated litigation.

8.4 If so, the memorandum (appendix 6) witness statement form (appendix 5) and guidance notes (appendix 7) will be delivered by hand (where possible) by the Operations Director to the staff identified as witnesses.

8.5 Witness statements should be based on the guidelines provided by the Trusts' solicitors (appendix 7) and written in the form of appendix 5

8.6 Upon receipt of witness statements the clinical/service director will return them to the Trusts' solicitors who will retain these to ensure they are available for the purpose of any further litigation and for legal advice.

8.7 Statements will be available for review by the Trust and in particular by a board level inquiry panel. The original statements will be forwarded on request to the secretary of the panel. Original statements must be returned to the Trusts' solicitors once they have been considered by the panel.

8.8 Where relevant and appropriate, the Board in their discretion will consider reporting the outcome to external professional and national agencies, eg, The Mental Health Act Commission, General Medical Council, United Kingdom Central Council for nurses midwifes and health visitors, the Health and Safety Executive, or The Committee on the Safety of Medicine. However, it will be very rare for the report itself to be circulated and this will not be done without obtaining prior legal advice. The inquiry panel will invite the next of kin or nearest relative, friend or advocate, as appropriate, to voice their concerns and consider any views they may have.

9.0 FOLLOW UP ACTION

9.1 It will be the responsibility of the Operations/Service Director to monitor and implement recommendations arising from the investigation of a serious/untoward incident. Where this has involved a Board Level Inquiry, the responsible Executive Director, or the Chief Executive will approve any proposed action.

9.2 Operations/Service Directors will ensure that, all staff involved in the investigation of a Serious/Untoward Incident are informed of the inquiry outcome and of the recommendations for action. Where appropriate, provision of necessary support and counselling is provided as soon as is possible.

9.3 Members of staff affected by the incident and patients, or their relatives, will be advised of the outcome of any investigation and will be given the opportunity to discuss the findings.

9.4 Serious incident reports must remain in interim form until the outcome of all investigations is known.

9.5 Summaries of Serious/Untoward Incident inquiries will be widely distributed within Directorates. Particular attention will be given to any training implications and to ensure these are subsequently met.

9.6 The Trust will publish a quarterly register for the implementation and recommendations of Serious/Untoward Incidents. Where no further action is required, details of the specific incident will be deleted from the monthly register.

10.0 TRAINING IN THE APPLICATION OF THE PROCEDURE

10.1 It is important that all staff who work for the Trust are familiar with this policy, that its purpose and principles are well understood and that the procedures are appropriately applied.

10.2 It is the responsibility of the Human Resources Director to ensure that appropriate training is included in the Induction Programme for all new staff, and all on-going training programmes. Operations/Service Directors should also satisfy themselves that other staff under their supervision remain familiar with the procedure, and that all managers are competent in its application.

PRACTICE GUIDELINES FOR REPORTING SERIOUS UNTOWARD INCIDENTS

These guidelines must be used in conjunction with the Serious Untoward Incident Polic

1. Reporting and Documentation

1.1 When a SUI (Category A, B or C, as defined in the Trust Serious Untoward Incident Policy) occu must be immediately verbally reported to the appropriate Service Manager/Lead Nurse and Dirc of Operations. The Senior Manager on-Call should be contacted if it occurs out of hours.

1.2 A SUI form must be completed (by the manager who has reported the above to the Chief Execut and faxed or given to the Service Director/Manager's office. A copy is to be sent to the Risk Advi:

1.3 Once the form has been received and considered appropriate for investigation, a copy will be faxec the Director of Operations office to the Chief Executive by the Trust's Risk Advisor.

1.4 The above should happen immediately or as soon as possible (notwithstanding the formal proced being actioned the following day) when a SUI occurs or is reported to a member of Trust Staff. If incident occurs outside of normal working hours, or is reported at the weekend then Director/Manager's should receive the form by the next working day.

2. Investigation

2.1 Having received the original form, the Director will designate a senior member of staff to investig the incident.

2.2 The initial investigation and written report must be completed within 15 working days of t incident being reported. The format of the report should be that in APPENDIX 2 of the Serio Incident Policy.

2.3 This report will be forwarded to the Director of Operations for discussion with the Manageme Team. (A copy should be kept on disk.)

2.4 If the Management Team endorses the report, it will be signed by the Director and forwarded to th Trust Risk Advisor for circulation.

The Chief Executive must receive this report within 15 working days of the inciden occurring/coming to attention.

3. Follow-up

3.1 All recommendations made as a result of management inquiries, peer reviews or Board-level inquirie will be actioned by the Management Team.

3.2 Clinical recommendations will be audited quarterly after they are actioned by the Clinical Audi Department, and again at regular intervals.

3.3 The internal reports will also be submitted every quarterly to the Executive Board.

3.4 Information about the outcome of inquiries, including any recommendations, will be communicated to all appropriate staff via: - *Area Team meetings/Consultant meetings/Senior Nurses meetings.*

DESIGNATED TRUST OFFICERS ACCOUNTABLE FOR INVESTIGATING SERIOUS/UNTOWARD INCIDENTS

The following Trust officers are authorised to investigate Serious/Untoward Incidents in accordance with Department of Health circular (88/51).

Executive Directors

The Chief Executive

Medical Director

Director of Finance

Director of Human Resources

Director of Operations, BRENT

Director of Operations, KENSINGTON and CHELSEA

Director of Operations, WESTMINSTER

Service Directors

Service Director - People with Learning Difficulties

Service Director - Substance Misuse Service

Service Director - Child and Adolescent Services

APPENDIX 1

INITIAL SERIOUS OR UNTOWARD INCIDENT REPORT

NAME OF PATIENT

DATE OF REPORT

DATE OF INCIDENT

DATE OF BIRTH

SUPERVISION REG
yes/no

CPA
level 1 yes/no
level 2 yes/no

ETHNICITY

CARE GROUP/DIRECTORATE

RMO

LOCATION OF INCIDENT

PURCHASER

BRIEF DESCRIPTION OF INCIDENT

A / B / C / D / E	IN PATIENT / OUT PATIENT	LEGAL STATUS INFORMAL/FORMAL/SECTION MHA

IMMEDIATE ACTION TAKEN

DATE	ACTION	PERSON RESPONSIBLE

OTHER AGENCIES INVOLVED

PERSON COMPLETING FORM

POSITION

SIGNATURE

DATE

DIRECTORS SIGNATURE

DATE

TO BE SENT TO CHIEF EXECUTIVE C/O TRUST RISK ADVISOR AT HQ

APPENDIX 2

REPORTING FORMAT FOR SERIOUS/UNTOWARD INCIDENTS

Cover Page

- Directorate /Location
- Type of Report
- Client Details
    - Date of Birth
    - Date of Admission
    - Legal Status (Formal, Informal, Detained on Section)
- Place and date of incident
- Confidentiality grading top and bottom of all pages

Introduction

- Inquiry Status e.g. (Management Inquiry, Peer Review, or Board Level)
- Who conducted inquiry, Board or panel members
- Nature of incident and precise details

Client Psychiatric History

- Previous History - significant life events e.g. prison
- BKCW initial involvement, first admission/care
- Where treated, any significant events
- Clinical description of patient or service user
- Subject to CPA/Supervision register
- Detention under MHA, give details

Incident Chronology

- Detailed incident chronology
- Details of supporting witness statements or relevant photography
- Who involved
- Context in which incident occurred

Conclusion

- Result of Inquiry

Recommendations

- Further action to be taken with timescales and target dates
- Statement of any action(s) already taken or implemented
- Action plan

Subscription

- Signature of Service Director/author and date

Annexes

- List of individuals interviewed
- List of relevant documents/statements

APPENDIX 3

SERIOUS INCIDENT REPORT GUIDELINES

1. Notwithstanding the NHS code on openness, legal matters are an exception to this and most serious incident inquiries will involve consideration of legal issues. Care should therefore be taken to consider the following guidelines to ensure confidentiality is maintained where appropriate and that legal privilege is not waived unnecessarily.

2. There is an important distinction between confidential and privileged information. Most information obtained by the Trust or its staff in caring for patients is confidential (for example, medical records) including the investigation and report relating to a serious incident. However, just because a document is confidential does not make it privileged. Only documents that are privileged may be protected from disclosure in any subsequent legal proceedings. Regardless of its confidential nature, a document will only also be privileged from disclosure if it falls within one of the recognised categories of privileged documents:

   (a) Documents created for the dominant purpose of anticipated litigation.

   (b) Communications between the Trust and its solicitors for the purposes of obtaining legal advice.

3. The distinction is important to protect the Trust's interests and to ensure that it is not compelled to disclose documentation that it would not otherwise be in its interests to do. There are currently several methods by which the Trust may be forced to disclose documentation (even confidential documentation) unless it is privileged:

   (a) A claimant with a potential claim for damages for personal injury is entitled to copies of any documents that are not privileged and that may be relevant to the action even before any formal court proceedings have been commenced.

   (b) Once court proceedings have been commenced in respect of any type of claim (be it personal injury or any other claim) the Trust would be obliged to disclose all relevant documentation that is not privileged. This rule applies even if the Trust is not a party to the court proceedings.

   (c) Access to Health Records Act 1990 confers a right of access on the part of the patient or those acting on their behalf to non computerised health records made after 1st November 1991.

   (d) Data Protection Act 1984 entitles an individual to be informed by any data user whether the data held by him includes personal data of which that individual is a data subject and to be supplied with a copy of any such computerised information held.

Although there are some exceptions, they are very restricted.

4. In considering whether a document is relevant and therefore subject to disclosure, the courts have held that the test for relevance is wide and will include any document that would put a claimant onto a train of enquiry. All documentation relating to the investigation and final completion of a Serious Incident Report may therefore potentially be discloseable unless otherwise privileged.

5. In order to preserve privilege and to avoid unintentionally waiving this, statements from witnesses in connection with Serious Incident Reports will be obtained by the Trust under the direction of its solicitors in accordance with the Trust's policy. More importantly, the Trust will be able to obtain early legal advice on a serious incident. The Serious Incident Inquiry Panel (Level 3) will have access to the Statements but copies (which may not attract the same privilege as the originals) are not to be taken. In addition to the final report, working papers relating to the Serious Incident Investigation could potentially be discoverable and should therefore be kept to a minimum.

6. It is important that clear and complete medical records are kept. All medical and other records relating to a serious incident should be collected by the secretary to the Serious Incident Investigation Panel as soon as possible and checked for completeness and legibility. Alternative or additional sources of records should be considered and any such records obtained (e.g. prescriptions, test reports or x-ray charts kept away from medical records, separate accident reporting forms, telephone logs, etc.). The secretary should also ensure that all equipment and all staff referred to in the records are identified, located and (if relevant evidence is likely to be obtainable) advice sought from the Trust's solicitors in accordance with the policy. Any missing records should be vigorously sought.

7. In preparing the Report, the panel should take account of the following points:-

   (a) Statements that may be defamatory should be avoided.

   (b) References to other documents in the Serious Incident Report may result in loss of privilege for those documents (e.g. Witness Statements themselves should not be referred to, only the substance of the evidence given in such statements).

   (c) The report may at the discretion of the Board be disclosed to the patient or his family (but not any draft of the report).

   (d) The report itself will almost always not be privileged from disclosure and may have to be disclosed to a claimant who wishes to pursue court proceedings.

   (e) Precise accuracy should be ensured at all times.

(f) Where a coroner's inquest is to be held, the report should not be published, circulated or completed until after the inquest has been held and the outcome considered.

(g) Hearsay or opinion evidence should not be given undue weight unless properly verified.

(h) The Report should be sent in draft to the Trust's insurers and solicitors for approval before distribution or publication and copied to the CNST.

(i) The Trust's insurance policies include an express provision prohibiting admissions being made without the consent of the insurers. Breach of this provision could seriously prejudice the Trust's ability to claim under insurance policies and careful drafting of the Report is therefore essential.

APPENDIX 4

Letter format to notify solicitors

BRENT, KENSINGTON, CHELSEA AND WESTMINSTER MENTAL HEALTH NHS TRUS
ADDRESS, ETC

RADCLIFFES CROSSMAN BLOCK
Address, etc.

For the Attention of Mr A E Parsons

Dear Sirs,

[Patient Name and Date of Birth]

I am writing to inform you of the following incident:

Date of Incident:

Patient(s) or other individual(s) involved:

Mental Health Act Status:

Place of Incident:

Nature of Incident:

Brief Description:

Names of Witnesses/Staff Involved:

[Incident Report Form attached]

Would you please advise on the legal implications of this and the steps that you consider the Trust should take as a result of this incident.

Yours sincerely
[Name of Manager]

Appendix 5

Radcliffes

CROSSMAN BLOCK

SOLICITORS

SERIOUS INCIDENT STATEMNT FORM

On behalf of BRENT, KENSINGTON, CHELSEA AND WESTMINSTER MENTAL HEALTH NHS TRUST

Name of Patient/Service User:

SUPERVISION REGISTER: YES/NO

CPA: YES/NO

RMO/CRMO: Dr:

LOCATION AND DATE OF INCIDENT

DESCRIPTION OF INCIDENT

IN PATIENT/OUT PATIENT
{delete as applicable}

LEGALSTATUS: - INFORMAL/FORMAL/MHA SECTION
{delete as applicable}

{Set out here in your own words, a detailed explanation of your involvement and knowledge of the incident}.

(continue if necessary on separate sheet)

IMMEDIATE ACTION TAKEN/ TO BE TAKEN

DATE ACTION PERSON RESPONSIBLE

OTHER PERSONS INVOLVED:

PERSON COMPLETING STATEMENT (name) POSITION

.....
SIGNATURE

.....
PRINT NAME

DATE.....

Appendix 6

Radcliffes

CROSSMAN BLOCK

SOLICITORS

MEMORANDUM

TO:

FROM: Radcliffes Crossman Block

PATIENT:

We are the Trust's solicitors.

We have been asked to obtain Statements from all staff who may be able to assist in an investigation of the above incident. We understand that you can assist with this and we have therefore been asked by the Trust to write to you to request that you prepare a Statement. A Statement Form is enclosed for you to complete in your words, providing specific details of the incident.

To assist in the completion of this Witness Statement, explanatory notes are enclosed.

Would you please complete the Statement and return it to this office within 7 days.

If you have any queries or would like any assistance in the completion of the Statement, please contact the Director of Nursing Practice, BRENT, KENSINGTON, CHELSEA AND WESTMINSTER MENTAL HEALTH NHS TRUST (Tel: 0181 846 5559)

Thank you for your assistance.

Andrew E Parsons
Radcliffes Crossman Block

(vii) should not make reference to any solicitors' correspondence or statements of other witnesses.

D Conclusion

1. Statement should be signed and dated by witness.

2. If a witness has any specific concerns or opinions that they wish to draw our attention, please ask for these to be put in a separate covering letter.

Radcliffes Crossman Block
5 Great College Street, Westminster, London SW1P 3SJ
Tel: 0171 222 7040

(Ref.: AEP)

Appendix 7

Radcliffes
CROSSMAN BLOCK

GUIDELINES ON PREPARATION OF WITNESS STATEMENTS

A Introduction

The Witness should state:-

(i) his/her full name and qualifications

(ii) his/her residence and professional address

(iii) current post

(iv) post held at time of incident

B Format

The statement should:-

(i) have numbered paragraphs; each dealing with a distinct aspect of evidence

(ii) be paginated

(iii) clearly identify documents referred to in statement e.g. by reference to date and parties of letters

(iv) have double line spacing, text on one side of the page only and;

(v) any dates, sums or other numbers should be in figures and words.

C Contents

(i) clear straightforward narrative dealing with events in chronological order simply to relate the "story" of the event.

(ii) should be full and complete; "truth", the whole truth and nothing but the truth"

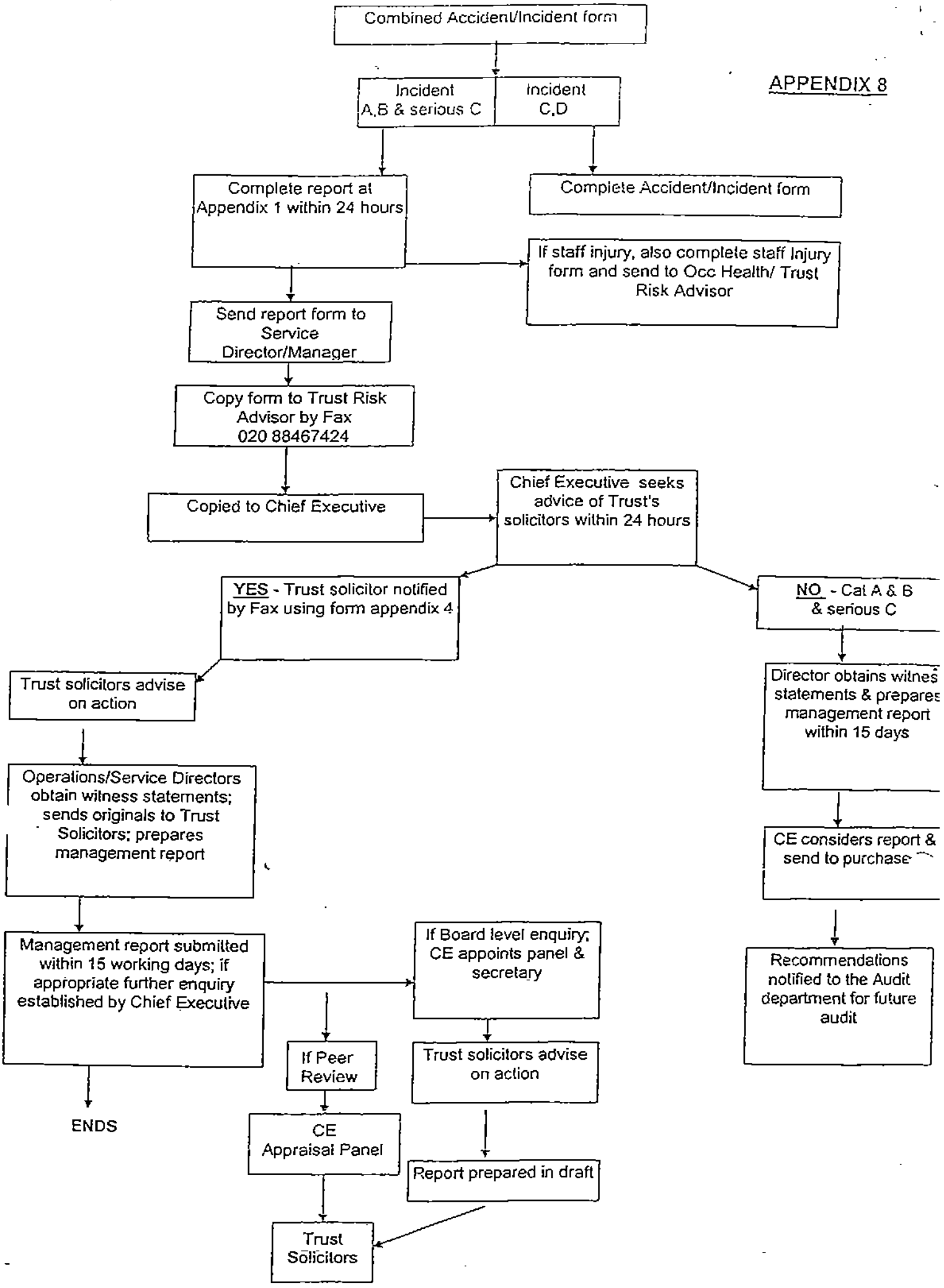
(iii) should be detailed as possible, providing full names, dates, time, location and amounts

(iv) wherever possible, evidence that can be confirmed or cross-referenced to a document should refer to that document (e.g. letters, protocols, medical records)

(v) should contain only material facts. statements of opinion should only be made where they are within the professional expertise of the witness and it should be made clear in the statement that that is the personal opinion of the witness.

(vi) should not report facts of which the witness does not have direct knowledge and should only relate conversations heard by the witness (i.e. not what the witness has been told someone else said)

APPENDIX 8


Combined Accident/Incident form
Incident A,B & serious C
Incident C,D
Complete report at Appendix 1 within 24 hours
Complete Accident/Incident form
If staff injury, also complete staff Injury form and send to Occ Health/ Trust Risk Advisor
Send report form to Service Director/Manager
Copy form to Trust Risk Advisor by Fax 020 88467424
Copied to Chief Executive
Chief Executive seeks advice of Trust's solicitors within 24 hours
YES - Trust solicitor notified by Fax using form appendix 4
NO - Cat A & B & serious C
Trust solicitors advise on action
Director obtains witnes statements & prepares management report within 15 days
Operations/Service Directors obtain witness statements; sends originals to Trust Solicitors; prepares management report
CE considers report & send to purchase
Management report submitted within 15 working days; if appropriate further enquiry established by Chief Executive
If Board level enquiry; CE appoints panel & secretary
Recommendations notified to the Audit department for future audit
If Peer Review
Trust solicitors advise on action
ENDS
CE Appraisal Panel
Report prepared in draft
Trust Solicitors