AGENDA ITEM NO. 6(a)

Social Care, Housing and Health Policy and Performance Board

DATE: 8th January 2002

FFICER: Executive Director, Social Care, Housing and Health Directorate

Report of the Independent Inquiry into the Care and Treatment of Christopher and Eunice Watts

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 This Report summarises the findings and recommendations of the Independent Inquiry into the Care and Treatment of Christopher and Eunice Watts, conducted in the summer of 2001. It also describes the actions that are being taken to implement the recommendations.

2.0 It is RECOMMENDED that:

(1) the Report be noted; and

(2) the Policy and Performance Board be invited to comment upon the contents of the Report, with specific reference to the care and treatment provided to Mr and Mrs Watts by Halton Borough Council staff.

3.0 SUPPORTING INFORMATION

3.1 A brief summary of the events surrounding Christopher and Eunice Watts, along with the main findings and recommendations, are submitted in Appendix 1. Copies of the full Report have been circulating separately.

3.2 A number of Social Services staff were heavily involved in the case, particularly the care manager, another Approved Social Worker, and a member of the Mental Health Outreach Team. It should be understood that the effect on them – in terms of losing two patients who they knew very well and had invested considerable commitment, and in undergoing the very threatening scrutiny of an independent Inquiry – was considerable.

3.3 It is worth quoting from the letter written by the two Inquiry members to the Chairman of North Cheshire Health Authority, which is reproduced on the first page of the Inquiry Report:
"We have concluded that the care and treatment provided by the services for these patients was thorough and of a high standard...We are confident that in this case, individuals did their jobs well. To us this means that there are times when trying to find someone to blame for unpredictable events is not only wrong but may be very damaging to the people involved."

4.0 IMPLEMENTING THE RECOMMENDATIONS OF THE REPORT

4.1 North Cheshire Hospitals MHS Trust have developed an Action Plan, which is attached as Appendix 2 to this Report. Many of the recommendations relate to the secondary health care services alone; some, however, relate to multidisciplinary services which include a social care input, and the progress against the recommendations is also outlined in the Appendix.

4.2 In addition, an Inquiry Implementation Sub Committee has been established and is to have its first meeting at Hollins Park on 19th December 2001. Halton Borough Council will be represented at this meeting by Lindsay Smith (Operations Manager, Mental Health).

5. POLICY IMPLICATIONS

5.1 Some of the recommendations of the Inquiry report relate to specific policies which are operated jointly between local health and social care services. Where appropriate, each of these have been reviewed and amended as necessary (see Appendix 2).

5.2 There are no additional policy implications as a result of the Report.

6. OTHER IMPLICATIONS

6.1 Resource Implications: the only specific resource implications of this Report relate to the provision of joint training to address particular recommendations. The details of this are not yet known, but will be met in any case from the existing Training Budget.

6.2 Social Inclusion Implications: there are no specific social inclusion implications deriving from this Report.

6.3 Sustainability Checklist: there are no sustainability issues arising from this Report.

6.4 Best Value: there are no Best Value issues arising from this Report.

6.5 Legal Implications: the positive tone of the Report means that there are no legal implications arising as a result.

6.6 Crime and Disorder Issues: there is one recommendation relating to substance misuse issues within Community Mental Health Services. This Report is therefore being forwarded to the Drugs action Team for consideration.

7.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Inspection	Contact.
Report of the Independent Inquiry into the Care and Treatment of Christopher and Eunice Watts	Social care , Housing and Health Directorate: Grosvenor House John Briggs House	**ay Smith** Ext.4485

APPENDIX 1

Report of the Independent Inquiry into the Care and Treatment of Christopher and Eunice Watts - Summary of Events, Main Findings and Recommendations

1. Eunice and Christopher Watts were a married couple who both had a long history of severe mental illness, for which they received ongoing care from health and social services in Halton. Both had been diagnosed as suffering from schizophrenia. Christopher had a past history of alcohol and some substance abuse – although this was not considered to be a major issue in his later life. Eunice's disorder was characterised more by mood shift, into either depression or overactivity, although she had been relatively stable for some time.

2. Christopher Watts had a series of admissions to hospital after he was first diagnosed with mental illness in 1962. It seems that he became more stable over time, although the illness never really responded to treatment. The Inquiry Report states (page 7): "The records show that he was very thoroughly supervised by health and social services in recent years, with records of well over 200 home visits".

3. In 1999, Christopher's mental health deteriorated and he was again admitted to hospital. He became very anxious about his relationship with his wife and developed a belief – apparently unfounded – that she was seeing another man. The two of them were in fact very dependent on each other, and supported each other through bouts of ill health. Eunice's own mental health deteriorated throughout September and October 1999, and she was herself detained for treatment in the Brooker Unit under Section 3 Mental Health Act on 10th November 1999. There was evidence that either or both of them had not been taking their prescribed medication – on November 18th 1999, two social workers found a large amount of pills in the house, and removed "a few thousand tablets" from the house.

4. Christopher had been discharged home following a Mental Health Review Tribunal in October 1999, this decision was taken against the advice of health and social care staff. He was clearly very unsettled by Eunice's hospital admission and was very keen for her to return home to be with him. Following normal aftercare procedures, Eunice was discharged home on leave, initially for a few hours at a time and, by the first week in December 1999, for an overnight stay.

5. Eunice was due to return to the ward following her first overnight stay at home on 4th December 1999. When she did not return as agreed, the Missing Person's procedure was activated by the hospital. When the police went to the house, they found Eunice dead of manual strangulation and multiple stab wounds to the neck and chest. Christopher was found unconscious in another part of the house, and died without regaining consciousness on 13th December. He was found to have taken a major overdose of prescribed medication. On searching the house in the course of their investigation, the police found a total of 10,290 tablets in the house, 20 types of which were used in psychiatric disorders and 11 in physical conditions.

6. Main findings of the Report (taken from a Parliamentary Briefing submitted by the North West NHS Regional Office):

- "There was no evidence of major systems failure in the provision of care for Mr and Mrs Watts

- The aftercare requirements of the Care Programme Approach seem to have been followed
- The Inquiry could not discover any mistakes or courses of action by the staff involved
- There was no evidence of poor communication. Information was shared readily
- A complex package of support was offered to the Watts in their home including frequent intervention
- The Mental Health Review Tribunal discontinued Christopher Watts' Section 2 assessment order on 6th November 1999 on the basis of information available to it. The Inquiry was confident that the decision of the Tribunal did not affect the final outcome
- The Inquiry found there were no routine objective methods of monitoring medication taken by patients in their homes. This appeared to be a general problem in psychiatric services and should be addressed at a national level
- The Inquiry was satisfied that all those that looked after the Watts were aware of an increased risk of violence in the situation. More, generally, decisions made about the risks of aggression or self-harm could be improved by better evidence-based risk assessment protocols, but only if clinical staff were regularly trained and refreshed in their techniques."

7. Recommendations of the Report: the report contains a total of 28 local and national recommendations, which were grouped in themes. The main recommendations can be summarised as follows (this is again taken from the Parliamentary Briefing submitted by the North West NHS Regional Office):

- Risk assessment: risk assessment documentation and protocols should continue to be developed. An assessment of risk should be included in the reports presented to the Mental Health Tribunal.
- Training & Development: there should be regular training for those staff responsible for direct patient care and those involved in treating patients at risk. Training should include mental health law. Service managers should convene discussions leading to practical policies on risk assessment, routine clinical audits and assessment of compliance with medication.
- Roles & Responsibilities: there should be review of the roles and responsibilities of the care co-ordinator, as well as consultant psychiatrists. Locum consultant psychiatrists should not be employed for substantive posts. Mental Health managers should revise the management structure of the mental health teams to ensure that function and accountability of each tier is clear.
- Joint Care: doctors and social workers should meet, wherever possible, to agree the reports before Mental Health Review Tribunals. There should be joint discussion between care teams of those care patients in continuing relationships, such as marriage.
- The Trust, Social Services and Health Authority: The Trust and Social Services Department should develop their mental health strategy in conjunction with the Health Authority in order to establish essential core services under direct local management.

APPENDIX 2

ACTION PLAN FOR WATTS REPORT

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#1 Clinical teams should continue to develop the assessment and recording of the risk of violence and self-harm in patients identified as presenting raised risk. This group will need to be defined through a review of the patients known to the services.	Recommendation mostly implemented. Risk Assessment documentation developed in line with Warrington Community NHS Trust documentation and a single CPA/Care Management format has been agreed with Social Services. This includes a full risk of violence and self-harm assessment. An initial risk screening is performed on all patients known to the service. Joint training has commenced.	New documentation to be introduced following completion of training programme (December 2001). Clinicians to undertake a full Risk Assessment on all patients to identify those with raised risk. Assessments to be recorded on the Trust's Risk Register through CPA (December 2001).
#2 The clinicians should identify the most suitable risk assessment protocol for their service. All staff involved in treating patients at risk should receive regular training in its use.	Recommendation implemented. Protocol has already been identified. Risk Assessment documentation and protocol ready to be introduced (as above).	Training to be addressed as above, including a regular updating process every 3 years as recommended in Safety First (2001).

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#4 Decisions about the risk of violence or self-harm should wherever possible be shared by all members of the multi-disciplinary team.	Recommendation implemented. Correspondence identifying high-risk patients is routinely shared with members of the multi-disciplinary team Training programme for initial risk assessment has commenced.	Introduce guidelines for staff working outside multi-disciplinary teams e.g. SHO on-call, to relay relevant information to centrally held records (December 2001).
#5 The doctors and social workers who appear before Mental Health Review Tribunals should, whenever possible, meet to agree the form and content of reports to the Tribunal. Reports should always cover the questions raised by s. 2 and s.72 of the Mental Health Act. An assessment of risk should be included.	Recommendation implemented. Information is shared at s. 117 multi-disciplinary meetings. This ensures that the Registered Medical Officer and Approved Social Worker share relevant information before the Mental Health Review Tribunal takes place.	
#6 Doctors presenting medical reports and social workers presenting social circumstances reports to Tribunals should see and discuss each other's reports beforehand.	As above.	

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#7 There should be regular training occasions on Mental Health law. The content should include techniques of presentation and the study of cases arising from the introduction of the Human Rights Act 1998.	Recommendation implemented. Mental Health Act Training and Human Rights Act Training provided. Rolling programme in place.	Continuation of training but emphasis on techniques of presentation in further training provided in line with the recommendation.
#8 The use of the sections of the Mental Health Act should be subject to regular automatic clinical audit. Results should be made available to managers and clinicians.	Recommendation mostly implemented. Mandatory scrutiny of the use of the Mental Health Act takes place on a regular basis.	Clinical audit programme to be introduced and results made available to managers and clinicians (starting November 2001). Mental Health Act Manager to liaise with Mental Health Directorate's Audit Committee (November 2001).
#9 Clinical teams should examine what reports are expected from staff members who make regular contact with patients with enduring serious mental illness. If possible a reporting protocol should be adopted or devised which might alert the team to adverse changes at an early stage.	Recommendation implemented. Report format already in place. Nurse Consultant (SMI) leads Psycho Social Interventions (PSI) training and provides advice regarding all interventions and relapse planning. Reporting protocol in place.	

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#10 The role of the co-ordinator of care should be examined and revised to allow the individual to be given the scope to stand back from involvement that is too close.	Recommendation partially implemented. Care Co-ordinator role has been redefined as part of new CPA/Care Management policy.	Continuance of training of all relevant staff. We will be implementing the Mental Health Policy Implementation Guide (2000). Preparation of prioritised development bids against the Local Modernisation Review.
#11 Mental Health managers should examine and revise the management structure of the clinical and community mental health teams. The aims should be to clarify the function and accountability of the tiers of management.	Recommendation partially implemented. Agreement has been reached with Halton Social Services to review the structure of community mental health teams (CMHT), Approved Social Worker and Outreach Teams. NCH and the Trust have agreed to additional funding in the current year to strengthen the management structure to enable this process.	Introduce the changes (starting January 2002).

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#12 Mental Health managers should examine duplication of functions, both of personnel and reporting accountability in the provision of community care.	As above.	As above.
#13 There should be a review of the role and responsibilities of the consultant psychiatrist in a modern community based mental health service.	Debate regarding the role of Consultant Psychiatrists is taking place with reference to the Mental Health Policy Implementation Guide.	Review to be undertaken with the proposed 5 Borough Partnership Trust. Investment to recruit and retain Consultant Psychiatrists. Preparation of prioritised development bids against the Local Modernisation Review.
#14 There should be a review of the responsibilities of the care co-ordinator in complex cases.	As for item 10.	As for item 10.

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#15 If it is possible, locum consultant psychiatrists should not be employed, where a substantive post is vacant. Exceptional measures in recruitment and devising attractive jobs and conditions of employment may be necessary.	Recommendation implemented. The recent secondment of a substantive Consultant Psychiatrist from Warrington Community NHS Trust has improved consistency. We have advertised three substantive Consultant Psychiatrist and two Staff Grade posts.	Refine the medical manpower strategy with the proposed 5 Borough Partnership to recruit and retain Consultant Psychiatrists. Preparation of prioritised development bids against the Local Modernisation Review.
#16 Joint discussion between care teams of the care of patients who are in a continuing relationship, such as marriage, respecting both patients' confidentiality. We do not recommend joint CPA meetings, not only because of confidentiality but also because the needs of one patient may be submerged by more pressing matters in the other. The existence of serious risk will modify this view.	Recommendation agreed and implemented.	

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#17 Managers should co-ordinate the continuous clinical audit of the use of the Mental Health Act and its sections as a routine of service management. ("Scrutineering" of the medical recommendations and other papers for compulsory detention serves as a model that works).	Recommendation partially implemented. See item 8. Continuous audit of s. 5.2 in place. Report from the Mental Health Act Commission visit on 15 June 2001 praised documentation.	Improved continuous clinical audit to be implemented. Also see item 8.
#18 Service managers should establish and support the training programmes outlined in our recommendations for staff responsible for direct patient care.	Recommendation implemented. Training programmes have been developed	Prioritisation of training in line with the local re-focusing of mental health services, the Mental Health Implementation Policy Guide and outcomes from the Local Modernisation Review.
#19 Service managers should convene discussions, within Department of Mental Health leading to practical policies on: The assessment and recording of risk of violence and self-harm. Routine clinical audits. The assessment of compliance with medication.	First two recommendations implemented.	Discussions to be convened on the assessment of compliance with medication (also see item 23).

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#20 The Trust and Social Services department should develop their Mental Health Strategy in conjunction with the Health Authority. The aim should be to establish the essential core services under direct local management, which complete a comprehensive community, based service for the people of Runcorn.	NSF for Mental Health Local Implementation Team are completing the Comprehensive Service Review, to identify the mental health needs of Halton residents, including those in Runcorn (end October 2001). The proposed 5 Borough Partnership will agree locally based services with the proposed Halton PCT.	Continuing discussion and consultation. Preparation of prioritised development bids against the Local Modernisation Review.
#21 Services and facilities for alcohol and drug misuse within local general psychiatry teams but liasing with specialist (tertiary) services, possibly from outside the district.	As above. Development need was included within the North Cheshire Hospitals NHS Trust, Mental Health Directorate Business Plan 2001 – 2002. A Business Case has been prepared for a local alcohol detoxification unit within North Cheshire Hospitals NHS Trust.	As above. Outcome of Comprehensive Review awaited. Preparation of prioritised development bids against the Local Modernisation Review.

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#22 A community based rehabilitation department responsible for the continuing care and rehabilitation of patients with enduring severe mental disorder.	This is a feature of the refocusing of mental health services in Halton in line with the Mental Health Policy Implementation Guide and Local Modernisation Review, which would include community based rehabilitation units.	As above.
#23 Guaranteed and timely treatment programmes for the management of behavioural patterns associated with persisting mental illness and personality disorders. These include anger management, response to psychotic experience and the problems associated with compliance with prescribed medication.	Recommendation in the process of being implemented. PSI training is taking place. The majority of staff are able to demonstrate PSI skills. Protocols for the treatment of schizophrenia, depression and anxiety have been agreed with the local PCGs. There has been an identification of 80 plus people on a waiting list for Cognitive Behavioural Therapy (CBT) for which 30K has been invested to reduce the waiting list this financial year.	The Comprehensive Service Review will identify key priorities for further modernisation. The staff, such as CBT Therapists, have been identified to address needs that include anger management. The CMHTs will work within agreed protocols to address the problems associated with compliance with prescribed medication (see item 19).

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#24 A Psychiatric Intensive Care Unit (PICU) within the in-patient unit to give high quality safe care to the acutely disturbed and to allow the admission wards to concentrate on the needs of less demanding patients.	North Cheshire Health Authority recently purchased private ICU beds on our behalf. A PICU was not included within the original specification drawn up by the Halton mental health services project management team in 1996. However, experience since then has highlighted the urgent need for a local PICU. A Business Case was prepared in October 2000. This is a major issue across acute services nationally and is also being addressed by the proposed 5 Borough Partnership.	Outcome of Comprehensive Review awaited. Preparation of prioritised development bids against the Local Modernisation Review.
#25 Direct access for mentally ill mothers with babies to a specialist unit in the local region.	NSF for Mental Health Local Implementation Team are completing the Comprehensive Service Review of a mental health service for the people of Runcorn (end October 2001). A Business Case was prepared in October 2000. The proposed Halton PCT will agree locally based services with the proposed 5 Borough Partnership Trust.	Outcome of Comprehensive Review awaited. Preparation of prioritised development bids against the Local Modernisation Review.

RECOMMENDATION	IMPLEMENTED ACTION	FURTHER ACTION
#27 Firstly, it would be immensely helpful for clinicians directly managing patients to have a well researched protocol for the continued follow up of severely mentally ill people, especially aimed at the early detection of relapse. International protocols for the follow up of diabetes would be a model to emulate.	The Department of Health guidance on the Care Programme Approach makes clear the roles and responsibilities of clinicians and other mental health staff in risk assessment and management and crisis and contingency planning for people with severe mental illness.	
#28 Secondly, improved routine laboratory investigations to detect or measure the levels of the drugs prescribed for severe mental illness would almost certainly lead to fewer relapses, readmissions or untoward incidents. The fact that present measurements are not helpful should be a stimulus to research on such an exceedingly practical matter.	The Department notes the recommendation on routine laboratory investigations with interest.	