North & Mid Hampshire Health Authority NHS

Hampshire County Council Social Services

Report of an Independent Inquiry into the Care and Treatment of Mark Longman, Paul Huntingford and Christopher Moffatt

SUMMARY

A report commissioned by
North & Mid Hampshire Health Authority
and
Hampshire County Council Social Services Department

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SUMMARY OF THE REPORT

National Health Service Guidelines issued in May 1994 require that an independent inquiry is held when a person who has been in contact with mental health services takes another individual's life.

In this instance, the independent panel were asked to review the care and treatment of three patients who resided in north & mid Hampshire:

Mark Longman was discharged from Park Prewett Hospital on 10 January 1995. On 4 June 1996, he killed his father, Kenneth Longman, at their home in Basingstoke, by setting fire to him. He later pleaded guilty to manslaughter on the grounds of diminished responsibility, and is presently detained in hospital under the Mental Health Act 1983.

Paul Huntingford was admitted to Parklands Hospital in May 1997, and discharged home in June. During the afternoon of 23 December 1997, he was assessed at home by his consultant and an approved social worker, who considered that he required compulsory admission to hospital. However, his admission was delayed when it was discovered that a medical recommendation form had been incorrectly dated. On 24 December, his mother, Mrs Lena Huntingford, died during an attempt by him to exorcise her. He was subsequently found to have been insane at the time, and was not convicted of any criminal offence. He too is presently detained under the Mental Health Act.

Christopher Moffatt was admitted to Parklands Hospital in January 1997, where he was detained under section 3 of the Mental Health Act 1983. He left hospital without permission on 19 February 1998, and went to, and worked in, Andover. On 9 April 1998, he entered a private house in Hampshire and stabbed Anthony Harrison, killing him. He was later convicted of manslaughter on the grounds of diminished responsibility. Subsequently, he committed suicide in the hospital where he was detained under the Mental Health Act.

All three of the patients lived within the area served by the NORTH & MID HAMPSHIRE HEALTH AUTHORITY, HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES and the NORTH HAMPSHIRE LODDON COMMUNITY NHS TRUST, and received in-patient treatment in Basingstoke. They were not, however, cared for by the same mental health team. Mr Longman received in-patient treatment at the old Park Prewett Hospital, and was cared for in the community by the eastern sector team. Mr Huntingford and Mr Moffatt were treated in Basingstoke's new Parklands Hospital, and were cared for in the community by the southern sector team.

Patient	*Admitted to*	*Last left hospital*	*Community team*	*Date of homicide*
Mr Longman	Park Prewett	10 January 1995 (discharged)	Eastern team	4 June 1996
Mr Huntingford	Parklands	30 June 1997 (discharged)	Southern team	24 December 1997
Mr Moffatt	Parklands	19 February 1998 (absconded)	Southern team	9 April 1998

It should be noted that a need to reduce NHS overheads resulted in the Loddon Trust's dissolution on 31 March 2001, when the management of its mental health services was taken over by the Surrey Hampshire Borders NHS Trust. This decision was in no way performance related.

WHO CONDUCTED THE INQUIRY

The inquiry was undertaken by a panel of professionals from outside Hampshire. The care and treatment received by Mr Longman and Mr Moffatt was reviewed by Anselm Eldergill, Paul Bowden and Nick Welch. Mr Huntingford's care and treatment was also reviewed by Anselm Eldergill and Paul Bowden, who were joined for this review by Claire Murdoch and Jeremy Walker.

Anselm Eldergill (Chairperson)	Solicitor. Former Chairman of the Mental Health Act Commission's Legal & Ethics Committee. Author of *Mental Health Review Tribunals, Law and Practice*.
Paul Bowden (Medical member)	Consultant Forensic Psychiatrist. Joint editor of *Principles and Practice of Forensic Psychiatry* and former editor of the *Journal of Forensic Psychiatry.*
Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
Jeremy Walker (Social work member)	Approved social worker, Mental Health Act Commissioner.
Nick Welch (Social work member)	Assistant Director, Oxfordshire Social Services.

PURPOSE SERVED BY THE INQUIRY

The function of an independent inquiry is thoroughly and objectively to review the patient's care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. This is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone.

NATURE OF THE INQUIRY

The inquiry panel sought to achieve consensus with regard to its findings and recommendations, and to agree with the Health Authority and the service providers action plans designed to enhance the delivery of local services.

The inquiry panel commended the constructive and measured way in which the families helped them, and the contribution made by their solicitors.

The panel also commended the candour and professionalism of the individuals involved in the patients' care and treatment, and their commitment to providing the best possible service to local people.

GENERAL FINDINGS

The panel's findings included the following:

1. LODDON COMMUNITY NHS TRUST staff were resolute in their attempts to close the old local asylum and modernise local mental health services, but their determined efforts were hampered by inadequate resources.

2. The resources made available to mental health services in Hampshire did not permit the mental health strategy of 1993 to be implemented, and the range of community resources was scaled down.

3. There was little additional investment in mental health services in north Hampshire until about four years ago.

4. Hampshire County Council was a relatively low spender on mental health services during the period reviewed by us.

5. Although the mental health strategy was 'revenue-neutral', its implementation involved developing a completely new range of services in Winchester, and this may have resulted in some disinvestment in north Hampshire.

6. There was a high concentration of trained staff on acute admission wards in the 1980s. Which is to say, there was a great deal of money tied up in acute admission wards. The need to implement the mental health strategy led to skill mix reviews, which were thinly disguised financial reviews. At the same time, increased drug and alcohol usage was beginning to affect the client population, who became more prone to violence and aggression. So the wards became harder to manage, rather than easier, at the same time as staffing was being diluted.

7. There was evidence that inadequate nursing levels meant that the use of observation was not always an effective means of detaining, or ensuring the safety of, patients.

8. Because the trust was unable to guarantee no redundancies during the reorganisation, all of the nursing staff were required to compete for their own jobs, and to be interviewed in a competitive situation. Not surprisingly, this led to pressure and tension, and staff morale was not particularly good.

9. The three-bed intensive care area built into the new Parklands Hospital was never opened, partly because the cost of staffing it safely would have caused disproportionate problems for the rest of the in-patient unit, and the risks of not staffing it safely were unacceptable.

10. The local mental health in-patient service ran an open service, with no locked doors or seclusion rooms. This philosophy, which was a prevalent one at the time, contributed to the decision not to open the intensive care area, and contributed to the difficulties experienced in treating patients locally.

11. As a philosophy, the idea that patients should not be managed on locked wards has nothing to commend it if local people with challenging behaviour are simply admitted to out-of-area locked wards.

12. The security of the new Parklands Hospital was inadequate during the period covered by the review.

13. Although the trust had access to locked facilities at the Oaktree Clinic in Surrey, and to the regional secure unit, these facilities were not always available in an emergency.

14. The lack of secure facilities, or access to them, required ward staff to look at what they could do within available resources. In other words, it skewed the management of risks.

15. During the period reviewed by us, the occupational and recreational facilities at Parklands Hospital were insufficient for patients who required a long period of in-patient treatment. There had been more space and more extensive occupational therapy at the old Park Prewett Hospital, and this may have made the management of disturbed behaviour easier.

16. Misplaced ideas about patient autonomy and empowerment contributed to a lack of assertive care. A philosophy of patient autonomy and empowerment also compromised what the Drug Advisory Service could offer.

17. The lack of a local intensive care facility, pressure on beds, nursing pressures, an open service ethos, and the need to manage increasing numbers of men whose behaviour was

disturbed, led at times to the use of inappropriate techniques for managing risks. Deprivation of daytime clothing was used, and the police and hospital porters were called upon to restrain patients. Informal, and hence unregulated, seclusion and 'time-out' were occasionally practised.

18. The demands on community teams made by general practitioners, as a result of fund holding and the opening of CMHT centres, further reduced the resources available to people with severe mental illnesses.

19. The hostels developed as part of the mental health strategy were for long-stay hospital patients, and the strategy took insufficient account of the new long-stay population.

20. An attempt to set up a hospital hostel in Tadley was unsuccessful, partly for financial reasons, and partly because of nasty public demonstrations. The consequence was that local people were less, not more, safe; and the demonstrators bear some responsibility for the lack of secure provision locally.

21. The consequence of all of this was that local people did not have the benefit of a comprehensive or adequate range of mental health services during the period covered by our review.

22. Although consultants and other mental health professionals attempt to base their decisions on clinical considerations, budgetary constraints and bed availability influence the treatment and care which patients receive.

23. In our opinion, inadequate resources required families and professional carers to accept risks which they ought not to have had to bear.

24. The government and the county council of the day must accept responsibility for consequences arising from, or associated with, their funding decisions.

25. Confidence in the implementation of the mental health strategy was affected by a House of Commons review concerning the discharge of a number of older patients, a review of local suicides, and three homicide reviews.

26. Local reports of the deaths and the subsequent court proceedings were mostly sensitive and informative. However, some of the language could not be supported. For example, the headline, 'Widow's Plea as Killer is Caged', and using the word 'schizophrenic' to describe a person, rather than an illness.

PARTICULAR FINDINGS

These findings included the following:

MARK LONGMAN

1. Mr Longman had a devastating mental illness which required intensive treatment but which, for many reasons, was not treated intensively.
2. Mr Longman's treatment and care were compromised by inadequate resources; a lack of assertive care, inadequate implementation of the care programme approach and after care under section 117; inadequate communication between professionals; inadequate record-keeping; inadequate supervision; and insufficient attention to his family circumstances.
3. Inadequate resources had a significant impact on his care and treatment, and his health. This compromised his safety and the safety of his family, and required them, and professional carers, to accept risks which they ought not to have had to bear.
4. The care programme approach was not effectively carried into practice, and professionals did not have a systematic approach to it.
5. There was no evidence that section 117 was implemented.

6. Communication between members of the community mental health team and other individuals and services was inadequate.

7. The standard of record-keeping was inadequate in some respects and in-patient records were disorganised. There were separate medical, nursing, and occupational therapy records, and it took the internal trust reviewers two days to put them into some sort of order.

8. An adequate system of clinical supervision did not exist. There was little reflection, in the sense of examining cases, how they were being managed, issues arising from them, and what alternative strategies might be deployed.

9. There was considerable information, dating back to 1987, which indicated that the family home was the last place Mr Longman should have been, given his serious mental illness. His illness and behaviour, and his parents' different ways of dealing with his and their distress, were the source of much ill-feeling and frequent arguments. This intolerable situation affected the health of all of them.

10. Although Mr Longman's observed behaviour outside the home was known to be disruptive, provocative, and disturbing, the professionals did not properly address the probability that, if he could behave in this way on the ward when unwell, this might also be the behaviour which his family had to contend with at home. It had no, or insufficient, impact on their thinking.

11. There was almost no contact between mental health services and Mr Longman's family during periods when they were caring for him at home, and no real support was given to them. There was no strategy for reducing family tension, or for alleviating the effect of this tension on his mental state and treatment.

12. The hospital social work department failed to allocate his case, or to take any long-term interest in him.

13. The contribution made by the Vyne Road day service was affected by staffing difficulties in the autumn of 1995, unsystematic liaison with health service colleagues, unsatisfactory closure mechanisms, and a misunderstanding of the effect of Mr Longman's mental illness on his behaviour. He was not a client who was able to make expert decisions about the services which he needed, and this sat uneasily with their philosophy.

14. The internal reviews were inadequate in many respects; and the Department of Health ought to postpone its plans to replace independent reviews of homicides and untoward incidents with non-independent local reviews until there is more evidence that mental health services are better able to review shortcomings within their services.

PAUL HUNTINGFORD

1. Mr Huntingford was not found guilty of having committed a criminal offence, and we saw no evidence that he intended to harm his mother. Rather, the intensity of his belief that she was possessed by Satan, and of his wish to exorcise her, made him unaware that her life or safety was in danger.

2. The circumstances of Mrs Huntingford's death were therefore highly unusual. The panel's medical member had not come across a similar case, where death was caused seemingly inadvertently during the pursuit of psychotically-driven actions, despite having assessed some 1500 homicide suspects, about 200 of whom were mentally abnormal.

3. Given Mr Huntingford's long psychiatric history, it is remarkable how little information was held in his current hospital/CMHT file. The medical files contained very little information concerning his psychiatric and personal histories, and his social circumstances. Important information held by the GP was not sought by or made available to the hospital and community mental health services.

4. At some stage during Mr Huntingford's long contact with services, his mother should have been seen, perhaps quite formally, on her own. Too many assumptions were made about her relationship with her son, and more attention should have been given to the nature of this relationship, and its effect on the course of his illness. There was some evidence that she found it difficult to acknowledge his illness, may not have fully understood the importance of medication, and was sympathetic to the negative effect that previous admissions had had on him.

5. Formal (CMHT, *etc*) and informal (relatives) systems worked in parallel: those with the expertise didn't have the knowledge of him and his social networks, and those with the knowledge didn't have the expertise. More contact between the two would have helped both.

6. The care plan devised in July 1997 was over-inclusive and unfocused, and not enough attention was paid to properly engaging Mr Huntingford. The notion that Mr Huntingford need only have a key worker for a period of two months played a part in his breaking off contact.

7. Because Mr Huntingford was not considered a risk to others (although there was evidence available that he was) his views prevailed as to what, and how much, prophylactic medication he would take, and which health care professionals he would see, and under what circumstances.

8. In the months following his discharge from hospital in June 1997, Mr Huntingford succeeded in terminating contact with his consultant psychiatrist (25.09.97), his Stonham project worker (08.09.97), and his CPN (28.08.97 last home visit, case closed 27.11.97).

9. For three months before the death of his mother, during which time both his consultant and CPN discharged him, Mr Huntingford believed his mother was possessed by Satan.

10. We were struck by the different way in which Mr Huntingford was described by his general practitioner (religious, kind, considerate, intense, serious) and by members of the community mental health team (haughty, dismissive, narcissistic, difficult, opinionated, prickly). This might have accounted in part for the GP's greater success in engaging him.

11. The visit on 23 December 1997 should have been better planned, although staff should be praised for responding promptly to the request for a Mental Health Act assessment. It was unsatisfactory (although common practice) that two social workers, who had never met Mr Huntingford and his mother before, were left to arrange and manage his admission.

12. There are some disparities in the accounts given by the four professionals involved in the assessment (the consultant psychiatrist, general practitioner and two social workers). These disparities cannot be accounted for by the passage of time or forgetfulness.

13. Mrs Huntingford was relied on as an informant although she was not given the opportunity to speak in confidence about any concerns which she may have had. If any of the extended family had been seen it would have been clear that she could not be relied upon in terms of either notifying relapse or accurately reflecting its effect.

14. In some respects, the trainee approved social worker acted as the approved social worker. The practice of delegating the interviewing of patients to a social worker who is training to be an ASW, though understandable, is questionable.

15. Although there was no evidence that Mr Huntingford intended to harm his mother when the approved social worker was asked to leave his home on the evening of 23 December, she left a situation destabilised by their visit. It was unfortunate that the patient's consultant was unavailable for consultation, and that there was therefore no medical opinion of the risks involved in deferring admission until the following day.

16. Following Mrs Huntingford's death, the fact that one of the medical recommendations had been incorrectly dated received considerable attention. This ought to have been properly scrutinised before the doctor who completed it left the Huntingford household.

However, there is some case law that supports the approved social worker's interpretation of the effect of the incorrectly dated recommendation; and therefore, even if this view was incorrect, she cannot properly be criticised for taking the view she did.

17. The commitment of Mr Huntingford's relatives to him and his mother was exemplary. However, his cousins and their families, who held the roles of extended carers, were not contacted by mental health services following the homicide.

CHRISTOPHER MOFFATT

1. Mr Moffatt was a kind and popular man, who formed many close friendships. He suffered a devastating illness which, in the short space of five years caused two homicides, the second being the killing of himself.
2. Mr Moffatt received, and benefited from, tremendous support from his mother, stepfather and sister, all of whom had an excellent understanding of his kindness, his illness and his needs.
3. He remained psychotic during the entire period that he received treatment. Because he consistently believed that he was Jesus Christ, obtaining his compliance with a care plan which was about him being ill was always going to be unlikely. There is, quite obviously, a dissonance about accepting a care plan and clozapine when you believe you are Jesus Christ.
4. Mr Moffatt's mental state improved during the short period he was detained on a locked close supervision unit in Epsom (the Burnham Unit). This reflected consistent medication with clozapine, the fact that he was not taking cannabis and, linked to both these things, the fact that his treatment was not disrupted by periods of absence from hospital (which gave access to cannabis and no access to prescribed medication).
5. Financial constraints and the implementation of the mental health strategy compromised his treatment, insofar as they contributed to the lack of an intensive care facility at Parklands Hospital; his absconding; a lack of rehabilitation facilities for in-patients; and his placements in the community.
6. The lack of an intensive care unit at Parklands Hospital meant that staff had to resort to quite intrusive policies of continuous observation, as a way of managing his absences. For some people, particularly if it is for a long time, this is impossible to bear.
7. The lack of access to secure facilities required ward staff to look at what they could do within available resources. When treating someone with Mr Moffatt's needs, they might have no real option except to carry on trying to provide the treatment, and manage any risks, within the local acute in-patient unit.
8. The occupational and recreational facilities at Parklands Hospital were not adequate for those patients who required a long period of in-patient treatment there.
9. The philosophy of the substance abuse service, which was based on a motivation to give up illegal drugs, made it impossible for the service to help someone like Mr Moffatt, whose illness involved seeing the drug as bringing about an improvement in his mental state.
10. After such a tragedy, there is a natural tendency to judge the quality of the patient's care according to the outcome. On reflection, however, it is obvious that even the best available treatment of a devastating illness, such as cancer or schizophrenia, does not preclude a devastating outcome. The point is important because our belief is that, *given available resources*, the overall quality of Mr Moffatt's care and treatment was high. In reaching this finding, we have at all times tried to be independent, thorough and objective. We hope that the individuals personally affected by the tragedy will accept this, even if they do not accept the finding or everything in the report.

11. Mr Moffatt's mother highlighted for us a number of limitations in the care he received. For example, that he would have benefited from more support and supervision, more extensive occupational therapy, a clinical psychologist, cognitive behavioural therapy, continuing drug counselling, and secure supervised accommodation. However, these concerns and reservations were shared by professional staff. A comprehensive range of mental health services, meeting all needs, was not, and is not, available locally; nor, sadly, anywhere else in the country. Mr Moffatt did, however, receive the full range of services available locally, and a high standard of professional care. We cannot support the view that there was a general failure to treat him adequately and in fact, as a general statement, we feel the opposite.

12. Important information about the risk to others known to staff at the MACA hostel in Normandy Street was not shared with his consultant, or with the other professionals who assessed him for compulsory admission to hospital in January 1997. This placed them at unnecessary risk. It also undermined the assessments of risk performed by his consultant during his time at Parklands Hospital, and therefore the management of risks.

13. Apart from when Mr Moffatt was at the Burnham Unit, the risk that he would abscond was managed by placing him under observation. It was suggested to us that his absences were not treated with appropriate concern. This we cannot accept, bearing in mind the level of observation to which he was subject, his transfer to the Burnham Unit, and the public appeal following his last disappearance. Furthermore, given that he had not absconded since 25 July the previous year, and given the need to build some sort of therapeutic alliance with him, the decision to grant him 30 minutes ground leave on 19 February 1998 was justifiable.

14. Mr Moffatt made an excellent response to clozaril, and there were times when his psychotic symptoms receded, so that they had to be probed for. The dilemma was that he had not responded in the past to older anti-psychotics. The choice was between oral medication which, when taken, was effective and injections which were not, albeit that one knew he was receiving them. Furthermore, given the present law, once he was in the community and not on section, he could not be compelled to have injections. Given that they at best only moderately alleviated his symptoms, voluntary compliance would then be unlikely. Accordingly, the decision to prescribe clozaril was a considered one, made for good reasons, and cannot properly be criticised.

15. Mr Moffatt's very limited compliance with medication, and his use of cannabis to relieve his distress, meant that it was not feasible for him to live independently in the community. He needed a community facility which could provide intense support and supervision but such a facility was not available.

16. The morality and wisdom of placing people with severe mental illnesses in ex-council accommodation which is hard to let must be doubtful.

17. The staff then at MACA'S Normandy Street house did not take a robust approach to Mr Moffatt's medication, and they had a limited understanding of risk management. They did not inform the professionals who visited to detain Mr Moffatt under section 3 that he had been experiencing violent and sexual thoughts about his project worker, and that staff had found magazines in his room in which adverts for rifles were circled.

18. Following Mr Moffatt's arrest, the duty psychiatrist refused to attend the police station to examine him and provide any treatment he might require.

19. The health service professionals who cared for Mr Moffatt felt supported following Mr Harrison's tragic death, and supported in relation to our review.

ACTIONS

The following action has been, or is being, taken by local mental health services to address these matters:

1. Hampshire County Council's expenditure on mental health services has increased by 24% (£2.8 million) since 1997/98.

2. North and Mid Hampshire Health Authority has increased total spending on Mental Illness by 44% from £23,754,000 in 1997/98 to £34,125,000 in 2000/01.

3. In this year, an extra £2.4m has been invested by North and Mid Hampshire to meet the growing costs of existing mental illness services. In addition, service developments totalling £1.8m have been funded on a recurring basis:

   - £99K for mental health inreach service to Winchester prison
   - £247K for development of a new medium secure facility
   - £500K (plus a £60,000 social services contribution) for new Assertive Outreach teams
   - £940K for development of low secure beds

4. The number of beds at Parklands Hospital available to north Hampshire adults was increased from 40 in December 1996 to 53 in April 1998. There is also access now to a supported living scheme for up to 7 people at any one time, which provides an alternative to hospital admission.

5. When a formal risk assessment indicates that an individual requires admission, a bed is always found.

6. The two wards at Parklands Hospital have been reorganised in order to provide more security. While Hawthorns II functions as an open ward, Hawthorns I now operates a locked door policy. In practice, all assessments are done on Hawthorns I, with patients moving to Hawthorns II when their clinical condition makes it appropriate.

7. Annual expenditure on out-of-area placements has increased from £200,000 in 1997 to a projected £800,000 in the current year.

8. The services plan to provide eight low secure places for north and mid Hampshire residents by April 2002. A team led by the North and Mid Hampshire Health Authority is in the process of finalising the details.

9. Ward team leaders have completed a 12-week leadership development programme.

10. Surrey Hampshire Borders NHS Trust and Hampshire County Council Social Services Department have developed a Rapid Assessment Service for people in crisis.

11. The Surrey Hampshire Borders NHS Trust has a policy in place designed to minimise the occurrence of unauthorised absences.

12. It is now trust policy that social services, the patient's GP, and neighbouring trusts are alerted when a patient is absent. The police attend the ward to complete a missing persons form with staff, and to talk with them about any risks. The general manager and the director must be informed after three days, or earlier if there are felt to be special risks. The director must then review the procedures that have been put into place, to see if there are any special risks and whether additional agencies need to be involved or informed.

13. Security arrangements at Parklands Hospital are to be periodically reviewed by an independent organisation approved by the local health authority.

14. It is now trust policy that non-care staff, including porters, are not to be involved in the management of aggressive behaviour.

15. Assessing and managing potential violence and levels of dangerousness posed by patients' behaviour is now subject to a formal risk assessment procedure introduced in April 2001.

16. A competency framework introduced for health and social services qualified staff requires them to demonstrate that they are competent to carry out this formal risk assessment procedure by April 2002.

17. Notes of admissions and treatment outside the Surrey Hampshire Borders NHS Trust are routinely obtained as part of the formal risk assessment procedure.

18. Each patient has one current record, which is held by the team that is currently providing care and treatment for the patient.

19. In-patient summaries are completed at every ward round. To ensure that all teams have up-to-date information about patients, these are routinely copied to the Community Mental Health Team and the Rapid Assessment Service as well as to the current file.

20. All correspondence about the patient is kept in the current file.

21. As part of a review taking place in July 2001, clinical audit of the quality of assessments on acute wards will include a focus on: the use of information from family members, in order to verify that they have been seen; the range of issues considered within the assessment process; the nexus between the treatment being provided and the needs which were identified; and the way in which risks have been identified and managed.

22. Since June 2001, all patients receive a therapy assessment on admission, and the Parklands Hospital therapy team has been increased from two to seven full-time posts.

23. ASWs conducting Mental Health Act assessments, and trust staff, now rely on the rectification provisions in section 15 of the 1983 Act in any case where a date is incorrectly entered on a medical recommendation.

24. The third edition of Hampshire County Council's Mental Health Practice Handbook, published in April 2001, includes guidance on the role of trainees. They must not undertake Mental Health Act assessment work unless accompanied by an experienced ASW. The experienced ASW must be present, actively oversee the assessment process, and sign the statutory documents.

25. The handbook also requires that the ASW informs the patient, the nearest relative, the doctors, and the CPA care co-ordinator (if applicable) of any delayed admission, together with the reasons. The ASW must consider the impact of the delay on anyone whose welfare may be affected by it, and ensure that alternative care planning arrangements are made where necessary.

26. It is now local trust policy that if a doctor who provides a recommendation has to leave the scene before the application procedures have been completed, s/he must remain available for consultation until those procedures have been concluded.

27. Duty psychiatrists may not refuse to attend police stations when a psychiatric assessment is required.

28. On admission, all patients are assessed using the formal risk assessment procedure. This includes assessing each patient in terms of the immediate and potential risks of going missing, suicide, self harm, harm to others and self neglect, taking into account their social and clinical history. An individual care plan is then devised, which includes the measures required to manage those risks appropriately.

29. The formal risk assessment procedure includes an assessment of the risk of dangerousness, and this is included in the discharge summary.

30. Signs and symptoms that may indicate that the patient is likely to relapse are included in the newly revised care plan for people on enhanced CPA.

31. Before discharging or granting leave of absence to a patient who is liable to be detained, the responsible medical officer is now formally responsible for ensuring both that a proper assessment is made of the risks to the patient or others, and that the individual's care programme sets out the measures required to manage risks safely.

32. All service level agreements with voluntary sector providers require that training in the assessment and management of risk is provided to staff.

33. All social care providers have received written instructions from Hampshire County Council Social Services Department stating that no referral should be accepted without adequate risk assessment.

34. ASWs leave an outline report at the hospital when a patient is admitted, and this requirement is reiterated in the Mental Health Practice Handbook. Outline reports include the reasons for the admission and information concerning risk.

35. Guidelines between Accident and Emergency and Mental Health services for the referral and assessment of people who attempt self-harm are in place.

36. As required in the NHS Plan, a shared protocol to support the sharing of information is being agreed and will be in place by April 2002. This will ensure that CMHTs and in-patient facilities have access to information about in-patients held by GPs.

37. MACA now has effective systems and policies in place which promote and guide good practice in communications and risk management. These emphasise the need for collaborative work with local mental health teams and for a rigorous approach to:

- ❖ risk assessment and management;
- ❖ sharing and communicating information;
- ❖ recording information, when and with whom shared (a basic practice which was not adequately followed in this case).

38. A revised care programme approach (CPA) has been implemented (in April 2001). For people on enhanced CPA, the revised care plan now includes identified needs and risks in relation to medical, social, employment, occupation, housing, finance and welfare benefits, family issues, forensic matters, substance misuse, treatment provided and crisis prevention.

39. A board level trust manager, the Director of Mental Health, has overall responsibility for ensuring that Health Service Guidelines concerning the care programme approach are adhered to, and adherence is routinely monitored.

40. The trust also has a care programme approach development manager, whose sole task it is to ensure the effective implementation and delivery of the CPA across the trust, in keeping with NSF standards.

41. Monitoring is carried out through audit, user involvement and quarterly data collection.

42. North and Mid Hampshire Health Authority is enhancing its monitoring of the trust's compliance with Health Service Guidelines, by way of regular random audits, in particular of compliance with the CPA and discharge planning.

43. The Social Services Department introduced a new procedure in November 1999, to ensure that it meets its responsibilities under section 117.

44. Care management and the care programme approach is now an integrated process.

45. A protocol for the transfer of care from secondary to primary services is being developed with PCTs and a clear policy, which is workable and realistic, will be drawn up. This will ensure periodic review by the mental health service of patients with a severe mental illness who are being cared for by primary services. Decisions to transfer care will be multi-disciplinary and discussed in advance with the GP.

46. Two assertive outreach workers have been appointed for north Hampshire, and funding and proposals have been agreed to extend this service across North and Mid Hampshire during the current year.

47. Assertive outreach training will be available to staff across north and mid Hampshire from September 2001. The training emphasises, and will continue to emphasise, that teams must have a clear strategy for following-up partially treated, non-compliant, out-patients, which does not involve waiting for the patient to re-present.

48. The system of clinical supervision now in place seeks to promote a culture of active engagement, and provide the skills necessary to achieve this.

49. 3 Vyne Road's business plan no longer refers to 'upholding the [client's] right to self determination and choice', nor does it state that 'the individual is the expert' (although social services emphasise that self-determination and choice continue to be important values in mental health care).

50. The Vyne Road service is delivered in accordance with the departmental risk assessment and management policy agreed by Hampshire County Council's Social Services Committee in January 2000.

51. MACA's procedures involve two staff administering medication wherever possible, one always being a senior worker; and it is fully committed to supporting patients' care and treatment plans.

52. The philosophy of the substance misuse services has changed. Risk assessments are carried out on all users of substance misuse services, and assertive outreach is conducted with users who are deemed to be at risk and are difficult to engage. There are much closer working relationships between the adult mental health and substance misuse services, and both services now use a common Patient Information System. Therefore, any member of the adult mental health service will be aware that a patient is also accessing the Drugs/Alcohol Service.

53. Personality disorder will not be used as a criterion for acceptance or rejection from CMHT services. Other indicators of severity and disability associated with mental health problems will be applied, including psychiatric history.

54. It is trust policy that a multi-disciplinary review should be conducted before any patient is excluded from a service. In all cases a strategy will be agreed for the patient's future care.

55. A clear model of caring for mentally disordered offenders in the community will be agreed locally, by June 2002, so that there is a common understanding of who is responsible for providing care to them.

56. It is trust policy that the views of the immediate family must be sought and considered as part of the CPA assessment, when taking the history or assessing a patient's current condition, especially if the patient is being cared for outside hospital and is not attending out-patient appointments or taking medication.

57. A training programme is in place to ensure that care co-ordinators are competent to assess carers' needs.

58. Local organisations are working to meet the target set in the NHS Plan to ensure that all regular carers of people on enhanced CPA have a written care plan by March 2002.

59. A procedure for handling serious incidents has been developed by the trust and the Social Services Department. When a person commits a homicide, the needs of the immediate family of both the deceased and the patient must be ascertained, and they must be offered appropriate professional support.

60. Services for users provided by Vyne Road are now only ended following explicit agreement in the formal CPA process.

61. Assessments of housing need are an integral part of the revised care programme approach.

62. The trust now manages two community-based 'hospital-hostels' in Basingstoke and Farnborough. This enables patients to be placed in settings outside the main hospital which are staffed by skilled and experienced practitioners and within which medication can be given without consent.

63. The Social Services Department employs its own housing support officer, who assists mental health staff and service users with applications for priority housing, and can advocate for them at resource panel hearings.

64. Health and social services are undertaking a review of 24-hour staffed accommodation, which will report in October 2001.

65. A clinical supervision training programme is in place. Attendance at, and the frequency of, this training is monitored through the trust's Clinical Governance Forum.

66. Surrey Hampshire Borders Trust agreed a revised serious untoward incident policy in February 2001 that complies with new NHS Regional Guidance. This procedure makes some provision for external investigation.

67. Hampshire Social Services introduced a more rigorous internal inquiry procedure in October 1998. This procedure introduced improved quality checks and independent expert investigation in the inquiry process; incorporated requirements for joint working with Health Authorities and trusts to comply with national guidance regarding inquiries; and introduced additional reporting requirements to the Social Services Committee.

CONCLUSION

The resources made available to mental health services in Hampshire did not permit the mental health strategy of 1993 to be implemented, and the range of community resources was scaled down. There was little additional investment in mental health services in north Hampshire until about four years ago.

The modernisation of mental health services in north and mid Hampshire has been, and continues to be, circumscribed by resources. The action which has been taken therefore represents part of an ongoing process of improving the range of services.

Given resources, the way in which the Loddon Community NHS Trust and (since 1 April 2001) the Surrey Hampshire Borders NHS Trust have sought to develop services deserves support. Their staff are committed to providing the best possible service, and they have throughout this difficult process been open and professional with us.

Although it is common to select professionals for criticism following such tragedies, there is only so much that individuals can achieve within any given level of resources. Further significant improvements, and in particular more developed and localised secure intensive care facilities, will require additional investment.

Because the resources available to mental health services are partly determined by the decisions of national and local government, concerns about the range of services available to patients, families and professionals, as opposed to their management, must also be raised at this level.

In a democracy, such decisions are, in turn, partly determined by the decisions of local and national electors about levels of taxation and spending on public services, so that the quality of mental health services, and the deaths of Mr Longman, Mrs Huntingford and Mr Harrison, are a national responsibility.

Accordingly, it would be unjust to select for criticism those who have committed their working lives to supporting individuals with serious mental health problems, and we hope that others will likewise refrain from doing so.