BARNARD MS INQ NORTH WEST

http://www.schizophreniawatch.co.uk/INQ/Barnard%20MS%20NW%20SHA.html

This publication is not in keeping with the general import of mandatory Inquiries that information about what happened and the care and treatment given should be made available to the public so that general lessons can be drawn.

This seems to be a device to exculpate the SHA from any suggestion that the Trust giving the care and treatment was cursory in it's own Internal Inquiry and reflected on its systems and amended them where necessary

It may be that a process of moving to the mandatory external Inquiry which the circumstances warranted was overtaken by the changes in the overseeing Strategic Health Authorities

This attempt to overcome that delay and confusion is totally inadequate.

The whole point of the mandatory External Inquiries is that they are not by-passed by internal reviews which the public do not see, but that the public are fully informed so that they can see for themselves and can hold to account, what level of mental health public service is acceptable or not acceptable.

This way of asking for an external scrutiny which then comments but gives little or no information about the detail of the care and treatment delivered does nothing toward promoting confidence.

It is open to the conclusion that the managers and SHA Board, elected to act as a public body on our behalf, hold that such matters are best kept to themselves..

This secretive way of 'learning the lessons' is to be condemned.

1 Introduction

1.1 Why an independent review was needed

1. •A tragic death occurred on 12 February 2002. MS, a community patient of the Adult Forensic Mental Health Service in the Bolton Salford and Trafford Mental Health NHS Trust, was involved in an incident which lead to the death of another resident of the supported housing accommodation, Wilson Carlile House, in which they both lived. MS was subsequently convicted of manslaughter.

1. •A serious incident review was held by the Bolton Salford and Trafford Mental Health NHS Trust one week after the incident, in accordance with the Trust's Serious Untoward Incident policy. An Internal Inquiry was subsequently established, chaired by a non-executive director of the Trust. The report of the Internal Inquiry was received by the Trust board on 9th December 2002. An action plan was considered by the board on 13th January 2003.

1. •The Greater Manchester Strategic Health Authority, following their review of the report of the Internal Inquiry, took the view that an independent external review of the Internal Inquiry should be commissioned. The independent review would not take the form of a formal independent inquiry but would be undertaken in the spirit of the Department of Health Guidelines - HSG (94)27.

1.2 Terms of reference

The terms of reference state that the review's purpose;
□g□cis to provide independent scrutiny of the internal inquiry conducted by Bolton, Salford and Trafford Mental Health NHS Trust. This will include identifying any gaps in the Internal Inquiry and establishing what progress is being made implementing the recommendations." Full terms of reference are attached at Appendix C.

1.3 Who conducted the review

1. •The review was undertaken by Malcolm Barnard a former Area Director of Social Services and senior NHS manager and associate of Verita. His recent work has included chairing three independent mental health homicide inquiries in Kent, leading an independent review of three homicides commissioned by the Hampshire and Isle of Wight

Strategic Health Authority and leading a service evaluation review for a London strategic health authority.

1. •Verita is a specialist consultancy which undertakes the management and conduct of inquiries, investigations and reviews in the public sector in the UK. It has a wealth of recent experience in mental health inquiries and reviews.

1.4 How the review was conducted

1. •The Strategic Health Authority (SHA) concluded that while the issues and questions raised by the internal and external inquiry into MS's care and treatment should prompt a further independent review, this would not take the form of a traditional independent homicide inquiry. Instead the further work would be focussed on externally reviewing the work of the internal inquiry and on organisational learning and service improvement.

1. •The intention was to pursue a more open and collaborative approach to evaluate the robustness of the Internal Inquiry and the responses to its recommendations in terms of improvements in policies, systems, and practice.

1. •The approach developed by the external reviewer was discussed, before work commenced, with a senior representative of the Manchester Mental Health Joint Commissioning Executive.

1. •The first step was to review all relevant documents including the Internal Inquiry report, policies and procedures. Appendix A provides a list of the documentation reviewed.

1. •The external review then identified key themes from the documentation and produced a matrix showing, for each theme, the policy, organisational, practice, partnership or other issues to be explored.

1. •At this stage it was clear that a number of the themes and issues identified would require face to face discussion with a small number of key practitioners, managers and clinicians within the Trust.

1. •The matrix also therefore identified the people the review needed to meet to gain a range of views and perspectives to focus on and provide evidence for learning and service improvement opportunities. Appendix B provides a list of the people with whom meetings were held.

1. •In order to facilitate this review, MS gave his consent for access to his medical and other records including his mental health and GP records, court case records and associated reports and his housing and social care records.

2 Summary and conclusions

This section is intended to provide an overview of the main conclusions. The evidence is included and discussed in the main body of this report. Recommendations appear throughout this report and are summarised in Section 7.

The methodology adopted by the Internal Inquiry panel was consistent with that required for a comprehensive, robust internal investigation. The presentation and content of the Internal Inquiry report suggest that the

methodology was successfully implemented.

The Internal Inquiry report was well written and concise but undated. The context and history were well set out in the report and key themes were adequately covered. However some conclusions were not clearly summarised and three opportunities to make recommendations were missed. (These are dealt with later in this report).

I agree with a key conclusion of the Internal Inquiry that MS's care and treatment was planned within the spirit of the Care Programme Approach (CPA) but that there were ways in which it did not comply fully with the (then) existing CPA policy. I also agree with the conclusion that MS's care was effectively coordinated. The absence of conclusions or recommendations by the Internal Inquiry concerning the (then) existence of a local CPA policy within the Adult Forensic Service may have been an opportunity missed. I am however satisfied that this anomaly has subsequently been addressed and a single CPA Policy is now in use.

It was surprising that the Internal Inquiry did not conclude that work was required across the Trust as a whole on the consistency of risk assessment and the framework for risk management.

This tragic incident and the lessons learned from it have contributed to shared learning across the Trust and where appropriate this has been led by the Adult Forensic Mental Health Service Directorate. The Trust's clinical and social care governance framework has facilitated and enabled that learning.

The post-incident support offered to staff was of a high standard with the exception of the omission of an offer of support for MS's former Responsible Medical Officer (RMO). A recommendation from the Internal Inquiry concerning the offer of support to staff who may have left the Trust's employment, or who were seconded to another employer, would have been helpful. The Trust's policy still does not specifically cover this eventuality.

Coverage of "other issues arising" during the Internal Inquiry was helpful. It demonstrated a willingness to allow the process of the Internal Inquiry to be participative, interactive and not too constrained by terms of reference. This approach is to be commended.

One of the "other issues arising" was not adequately followed through by the Internal Inquiry to form a recommendation. This related to the ethnic diversity of the workforce. In other respects the Internal Inquiry did ensure that adequate attention was given to the issues covered by its terms of reference.

The timeliness of the Serious Incident Review within a week of the incident was commendable. However a delay of at least 10 months after the incident in having an action plan agreed to implement the recommendations of an Internal Inquiry does not represent best practice. This is though, to some extent, mitigated by the fact that some work on service improvement was underway very soon after the incident. For example, discussion of community psychiatric nurse care plans at all out-patient reviews and clarifying the appropriate adult role including who should and should not fulfill it.

The Trust's work on implementing the ICIS computerised records system is impressive and should be commended.

The current policy in the Trust for Reporting and Managing Untoward Incidents appears to be in line with current best practice.

Good progress has been made on the implementation of actions arising from the recommendations of the Internal Inquiry. The relatively few areas where progress has not been so clearly demonstrated, or where there were gaps in the conclusions or recommendations of the Internal Inquiry, are covered by recommendations in this report.

3 A brief overview of MS's care and treatment by the mental health services

The following background information has been extracted from the Internal Inquiry report produced by the Trust and has been validated by a review of the case notes. A case summary prepared for the Internal Inquiry panel by a Consultant Forensic Psychiatrist, was particularly helpful in this respect.

1. •The records confirm that MS was first in contact with the mental health services in central Manchester in 1984 when he was in his early twenties. His first admission to his local psychiatric hospital was in 1984, presenting with symptoms of a mood disorder

1. •In October 1986 MS was admitted to the Edenfield Centre, Regional Forensic Services, subject to a Hospital Order following his conviction for assault occasioning actual bodily harm after an attack on a woman police constable. He was discharged from the Edenfield Centre at the end of November 1986 to a psychiatric ward in central Manchester

1. •A number of further admissions to psychiatric wards followed between 1988 and 1992. These included two further admissions to the Edenfield Centre in 1989 and 1990

1. •MS was an in-patient at the Edenfield Centre again between February and May 1993 following an act of fire-setting. After a period of apparent improvement he was referred back to his local psychiatric hospital. A further admission to a medium secure bed at the Edenfield Centre was however necessary in September 1993 after MS had set fire to his bed in the local psychiatric ward

1. •By the early 1990's MS's diagnosis had been revised to "schizoaffective disorder"

1. •MS was made the subject of a Hospital Order with restrictions in November 1993. His detention at the Edenfield Centre continued until July 1997 when he was granted a conditional discharge under Section 42 of the Mental Health Act 1983 at a Mental Health Tribunal
2. •The conditions of MS's discharge included that he should reside at Wilson Carlile House, a residential hostel managed by a voluntary sector agency and comply with social supervision by his social worker and key worker

1. •The case notes show that supervision by social work and community nursing staff from the Regional Forensic Service continued after MS's discharge as did his supervision by his Consultant Psychiatrist

1. •Further brief, informal re-admissions to the Edenfield Centre occurred in 1997 and 1998 following concerns about MS's use of cannabis

1. •In September 2000 MS moved with support from his forensic social worker and forensic Community Psychiatric Nurse (CPN), to his own flat. He continued to be closely monitored and supported by members of the community mental health team from the forensic services. Following concerns about MS's escalating use of cannabis and the deterioration of his self care, re-admission to the Edenfield Centre was arranged on an informal basis in December 2000. MS was discharged back to Wilson Carlile House in January 2001. MS continued to reside at Wilson Carlile House until the tragic incident in February 2002 which led to the death of another resident and MS's subsequent arrest and admission to the Edenfield Centre

1. •On 26 February 2002 MS was admitted to Ashworth High Security Hospital because of fears that his risk could no longer be managed within the Edenfield Centre

4 The Internal Inquiry

Introduction

This section of the report deals with the membership, terms of reference and methodology of the Internal Inquiry and with the presentation of its report. The analysis, findings, conclusions and recommendations of the Internal Inquiry are considered in Section 5 below.

4.1 Panel Membership

The panel was constituted in accordance with the Trust's Untoward Incidents Policy. The panel was chaired by a non-executive director of the Trust. Its membership appropriately included a Consultant Forensic Psychiatrist who had not been involved in the care or treatment of MS, the Clinical Leader, Adult Forensic Services and the Acting Director of Mental Health Services for one of the localities (Boroughs) served by the Trust. Acknowledgement was given for the support received from the secretary to the panel and the Trust's Clinical Governance Manager.

4.2 Terms of reference

1. •The terms of reference were appropriate and fit for purpose. They focussed on key issues relating to the delivery of care and treatment for MS in the context of his being subject at the time of the incident to conditional discharge under the terms of the Mental Health Act 1983. They included Care Programme Approach arrangements and application

1. •Appropriate focus was also given to the assessment and management of risk in the health and social care of MS and in his care and treatment plan

1. •The terms of reference also included reference to the review the Serious Incident Review Procedure and the examination of arrangements for supporting staff involved in a serious incident and communication with the family after such an incident

1. •The focus within the terms of reference on the period in MS's care and treatment from the first granting of his leave in the community in October 1996 had the potential to restrict the examination of MS's whole history of involvement with the mental health services which stretched back to 1984. In the event, the panel chose to include a review of MS's whole psychiatric history in their deliberations and a summary is appropriately included in the Internal inquiry Report

4.3 Methodology

The panel's methodology included an overview of the (then) computerised information system, interviews with relevant members of staff and with the (then) Manager of Wilson Carlile House, scrutiny of clinical and social work case notes, scrutiny of policies and procedures (both Trust wide and service specific), scrutiny of Adult Forensic Service Serious Incident Review minutes and scrutiny of the Wilson Carlile House Internal inquiry report.

Comment

The methodology adopted was consistent with that required for a comprehensive and robust Internal Inquiry. The interviewees included all of the key staff involved in MS's care and treatment and also the appropriate managers within the service. An offer was made to MS's mother to participate

in the Inquiry but she chose not to take up the invitation. The presentation and content of the report suggest that the methodology was successfully implemented.

4.4 Presentation of the report

1. •The report was not dated. I am unable therefore to comment precisely on the timeliness of the Internal Inquiry

1. •The report was clearly and concisely written

1. •The background to the incident is adequately summarised and the events on the day of the incident are described. A summary of the issues discussed at the Serious Incident Review on 19 February 2002 (one week after the incident) is included and a brief description is provided of the arrangements put in place after the incident for the support of staff and others closely affected by the incident, including MS's mother

1. •The section on "Patient Background" provides a helpful summary of MS's social history and a comprehensive and well presented psychiatric history. This section is particularly useful in setting the context for the report's later consideration of a number of key issues, for example risk assessment and risk management as part of the process of care planning for MS. The section is appropriately supplemented with appendices to the report which provide: a list of violent incidents involving MS; a chronology of offending behaviour and a medication review

1. •The report goes on to cover each of the key issues under headings which follow closely the Inquiry's terms of reference. An additional heading "Issues raised during the Internal Inquiry" allowed the presentation and consideration of issues raised during the Inquiry not specifically covered in the terms of reference

1. •Conclusions were then drawn from the examination and analysis of key issues and are clearly set out. Not all of the conclusions in the report are adequately summarised. The recommendations section of the report helpfully groups recommendations under sub headings covering the main themes emerging from the Inquiry. Three opportunities for making recommendations in the light of findings appear to have been missed. These related to CPA Policy, post-incident support for staff no longer employed by the Trust and the ethnic diversity of the workforce. They are dealt with later in this report

Comment

This was a well written, concise but undated Internal Inquiry report which set out the context and history well before covering the key themes and issues emerging from the Inquiry in a rational and "easy to follow" presentation. However, the "Conclusions" section of the report, whilst concise, did not include a summary of all conclusions. For example conclusions reached on the key issues concerning the use of the Care Programme Approach (CPA) were not included. Three opportunities to make recommendations in the light of findings appear not to have been taken.

Recommendation 1

The Trust should ensure that in future all copies of Internal Inquiry or Review reports are clearly dated.

1. **Review of the analysis, findings, conclusions and recommendations of the Internal Inquiry**

This section reviews whether the Internal Inquiry considered all the appropriate evidence and examines the consistency of conclusions and recommendations with that evidence. This part of the review is drawn from a close examination of a considerable (7 volumes) volume of health and social care records related to MS, a review of all relevant policies and procedures in place at the time of the incident and of versions of some policies and procedures updated since the incident. It has also been supported by meetings with a small number of practitioners, clinicians and managers from the Trust and the forensic service in which key issues and themes were explored and discussed. Those meetings were of considerable help to the reviewer in this part of the review. The following sub-headings reflect the key themes identified in the Internal Inquiry Report:

5.1 Trust wide and service specific policies and procedures

Overview - all of the policies, procedures and guidelines relevant to the Internal Inquiry appear to have been examined by the Internal Inquiry panel.

Context and Scope - the review of policies and procedures was however undertaken (as required by the terms of reference) in the context of whether service delivery had met statutory and policy requirements and of the application of protocols following a serious incident. The Internal Inquiry did not therefore examine all policies to establish their more general fitness for purpose. Nonetheless, with regard to the (then) Protocol for the Management of Incidents and Staff Debrief the Internal Inquiry report did identify the need for its review. Similarly, having examined the guidelines for escorting patients outside the unit, a need to combine the two (then) existing policies for the Trust and the Edenfield Centre respectively into a single policy document was identified.

Conclusions - the report identified no conclusions in respect of policies and procedures other than that protocols had been followed after the incident and that the issue of the Appropriate Adult role in the Police Liaison Protocol

required review. There were however by implication, in conclusions concerning MS's use of cannabis, documentation /record keeping and risk assessment/ risk management, a number of issues identified from which it might have been more clearly concluded that policy reviews were needed. In addition there was no clear conclusion presented regarding the use of the Care Planning Approach as the way of undertaking, monitoring and reviewing care plans for all patients in the Trust including those receiving care and treatment from the forensic service. However, in spite of the lack of firm and clear conclusions on these key issues in the "Conclusions" section of the report most of those issues were addressed, either in the main body of the report and/ or in the recommendations section.

Recommendations - the Internal Inquiry's recommendations concerning policies and procedures appear to be proportionate, appropriate and achievable. (See Paragraph 5.2 below)

1. 2 The care and treatment of MS with reference to the requirements of CPA and the existing CPA Policy

Overview - this aspect of the Internal Inquiry's work appears to have been adequately covered.

Context and Scope - the context at the time of the homicide i.e. that there was then a local CPA policy in operation within the Adult Forensic Service is appropriately addressed. The experience of the multi-disciplinary team members most closely involved in MS's care and treatment is also appropriately highlighted.

Conclusions - the findings and conclusions of the Internal Inquiry appear to have been appropriate. They were set out in the sub-section of the Internal Inquiry Report dealing with CPA and were not included or summarised in the "Conclusions" section of the report where they might have stood out more clearly.

Recommendations - the Internal Inquiry's recommendations concerning CPA adequately covered the key issues regarding risk management and risk assessment, adherence to policy, audit of policy compliance and documentation requirements for CPA meetings. There was no recommendation concerning the existence of a local CPA policy in the Adult Forensic Mental Health Service as distinct from the CPA policy for the Trust as a whole.

Comment

The care planning documentation in the clinical records is very well recorded using the Paragon computerised patient record system then in use. I agree with the key conclusion of the Internal Inquiry that MS's care and treatment was planned within the spirit of the Care Programme Approach, but that there were ways in which it did not comply fully with the (then) existing CPA policy. I also agree that MS's care was effectively co-ordinated. The evidence to support those conclusions can be clearly seen in the records and was reinforced in my meetings with practitioners, managers and clinicians.

The absence of conclusions or recommendations concerning the existence of a local CPA policy within the forensic service and how it operated with the Trust's CPA policy may have been an opportunity missed by the Internal Inquiry. However, from my fieldwork discussions it is clear that such anomalies have nonetheless subsequently been addressed so that a single CPA policy is now in place. (Please see Section 6 below)

1. **3 MS's care and treatment in the context of being subject of a conditional discharge (Mental Health Act 1983) and of the Social Services input into care and supervision**

Overview - this part of the Internal Inquiry's work appears to have been thorough and rigorous.

Context and Scope - the context in which MS's continuous monitoring and support from his social supervisor and input from the multidisciplinary team was provided is well established in the report.

Conclusions - the conclusions within this section of the report seem reasonable and are consistent with the evidence in the records. In the "Conclusions" section of the report the conclusion that social work supervision was frequent and adequate enough appears to be consistent with the evidence in the records.

Recommendations - there were no specific recommendations arising from this aspect of the Internal Inquiry report.

5.4 MS's medical care and treatment

Overview - this section of the Internal Inquiry report appears to be drawn in part from the comprehensive case summary available to the panel (See also Section 3 above). It appears to provide a thorough and rigorous assessment of the medical treatment received by MS, including a full medication review for the period from 10 July 1997 to 28 February 2002.

Context and Scope - the context of MS's earlier psychiatric history and of his long term use of cannabis is well covered. Appropriate references are made to clinical risks, relapse signatures and to issues relating to risk assessment and risk management.

Conclusions - are clearly set out in a sub section entitled "Conclusions on the Care and Treatment of MS". They appear to be appropriate and consistent with the evidence but are not included or summarised in the report's "Conclusions" section.

Recommendations - the report includes a relevant recommendation concerning regular clinical peer review of case files to ensure the quality of

clinical care, the quality of documentation and the adherence to relevant policies.

5.5 Risk assessment and management: The Edenfield Centre guidelines

Overview - this key area of the Internal Inquiry's work is covered in a very brief sub-section of the report. Whilst it covered matters relating specifically to guidance for staff at the Edenfield Centre, it did not examine the strengths and weaknesses of arrangements within the Adult Forensic Services or the Trust as a whole for risk assessment or risk management policies, procedures or practice. However, the earlier sub section "Conclusions on the Care and Treatment of MS (See Paragraph 5.4 above) had dealt more comprehensively with a number of risk assessment/ risk management issues and had noted that it had been very difficult for the panel to investigate issues of risk assessment because of the (poor) quality of the documentation available.

Context and Scope - the Internal Inquiry report provided some context for the Edenfield Centre's practice in risk assessment and risk management by reference to the Royal College of Psychiatrists 1996 publication "The Assessment and Management of Clinical Risk". This sub-section confined itself to reporting briefly on the incorporation in 2001 of a set of standards on risk assessment and risk management into the Edenfield Centre's "medical standards" and to the agreement of CPA guidelines (which included additional information on the management of patients and the documentation of issues relative to risk assessment and risk management) prepared in 2000 as unit based standards in October 2000.

Recommendations - eight of the report's 24 recommendations are grouped under a "Risk Assessment and Risk Management" heading. Two of those recommendations relate specifically to CPA and one to the consideration of risk assessment and risk management issues at CPA meetings. The recommendations appear to be appropriate and consistent with conclusions which appear in various parts of the report.

Comment

It is surprising that the Internal Inquiry did not conclude that work was needed across the Trust as a whole on the consistency of risk assessment and the framework for risk management, although I accept that the panel may have felt constrained by its terms of reference.

In practice, from my fieldwork meetings, it appears that this tragic case and the lessons learned have contributed to shared learning across the Trust (and where appropriate led by the Adult Forensic Service) using the Trust's clinical governance processes as an enabling framework. (See also Section 6 below)

5.6 Serious incident review procedure

Overview - in this section of their report the Internal Inquiry panel reviewed the use, by the multi disciplinary team, of the Trust's Serious Incident Review procedure after the incident on 12 February 2002. This included the appropriateness of MS's recall to the Edenfield Centre after the incident, liaison with the Police in the immediate post incident period, the Police Liaison Protocol in relation to Appropriate Adults and a lack of communication and offer of support from the Edenfield Centre to MS's former Responsible Medical Officer (RMO).

Context and Scope - the context for this section of the report was clear and the scope proportionate.

Conclusions - the conclusions from this section of the Internal Inquiry Report appear to be consistent with the evidence and relevant. Key conclusions were included in the "Conclusions" section of the report. For example conclusions regarding the timeliness of the Serious Incident Review and the need to review the Police Liaison Protocol regarding the Appropriate Adult role were both highlighted.

Recommendations - the recommendations under this heading appear to be comprehensive and appropriate.

5.7 Support to staff and others involved in the incident

Overview - the outcome of the Internal Inquiry's review of the support offered is reported concisely, dealing adequately with the feedback the panel had sought and received during interviews with all the key staff involved.

Context and Scope - the context had been adequately set earlier in the Internal Inquiry report. This section appropriately covered support offered to Edenfield Centre staff, support offered by Edenfield Centre staff to staff at Wilson Carlile House and the support offered and provided to MS's mother. The panel had offered to meet with MS's mother but she chose not to take up the offer. This section did not cover the absence of an offer of support to MS's former RMO; an issue which had been covered in an earlier section of the Report (See Paragraph 5.6 above) and which was adequately covered later in the Report's "Conclusions" section. Cross references would have been useful.

Conclusions - the panel concluded that "the support given to all members of staff and to those who were involved in the care and treatment of MS was beyond what could have been expected on an informal and formal level".

Recommendations - there were no recommendations covering this area of the Internal Inquiry's work.

Comment

The meetings during my field work confirmed that the support offered and received was of a high standard except for the omission of MS's former RMO. From the evidence available I would conclude that the support offered was timely, well received and within the agreed policies. It was (apart from the above mentioned omission) therefore within the high standards expected rather than beyond them.

A recommendation would have been appropriate concerning the need to ensure that support was offered to members of staff involved in serious untoward incidents who were no longer employed in the Trust or who were

seconded away from their usual place of work. I note that the Trust's current policy does not cover this eventuality.

Recommendation 2

The Trust should ensure that its policy for the reporting and management of untoward incidents makes explicit the need to ensure that any staff involved in such incidents who have left the Trust's employment, or have been seconded to another employer, are offered all the necessary and appropriate support.

5.8 Other issues arising during the Internal Inquiry

Overview - this section of the Internal Inquiry report deals with issues which arose during the work of the Internal Inquiry which may not have related directly to its terms of reference. It seems entirely appropriate that these issues should be considered by the panel and reported upon as part of the process of identifying and creating opportunities to learn lessons form this tragic incident.

Context and Scope - the context for this section was simply around issues raised by people who were interviewed by the panel. The scope was wide ranging. The issues were identified and included in the report as 13 sub-headings. Each issue was briefly described and some commentary from the panel was included

Conclusions - where appropriate conclusions were drawn and included in the "Conclusions" section of the Internal Inquiry Report e.g. concerning the use of cannabis and social worker input.

Recommendations - a number of the Internal Inquiry's recommendations arose from this section. In particular the seven recommendations sub-headed "Issues for Training" can all be tracked back to this section of the report. A number of important matters arising from subtle changes in MS's presentation and the need to recognise the importance of significant life events are covered

in the report's recommendations. However one opportunity to make a recommendation to reinforce or confirm the need for more work appears to have been missed. (See comment below)

Comment

This was a particularly useful section of the report, enabling issues not strictly related to the Internal Inquiry's terms of reference to be identified and considered. It demonstrates a willingness to allow the process of the Internal Inquiry to be participative and interactive. This approach is to be commended.

One issue raised in this section of the report appears not to have been adequately carried through to form recommendations: the Internal Inquiry report states that "A member of staff from the Wilson Carlile House raised the lack of staff from ethnic backgrounds within the Edenfield Centre. The lack of racial diversity amongst the Trust staff is a recognised issue, which is currently being dealt with by the Human Resources Department". The matter was not further pursued by the Internal Inquiry and should have formed the basis of an additional recommendation to reinforce the need for the Edenfield Centre and the Trust to pursue, in the light of the Inquiry, a review of ethnic diversity in its workforce and to report progress on the review and its subsequent recommendations and action plan to the Trust Board.

Nevertheless action to address this important issue has since been taken by the Trust. The Equality and Strategy Action Plan which incorporated the Race Equality Scheme April 2005-April 2008 was published by the Trust in 2005. It includes a section on workforce and service user data, providing information on the communities and populations served and the Trust's workforce and patients. Information is presented for gender, ethnicity, disability, age, faith, religion and spirituality and sexual orientation. In relation to the Adult Forensic Directorate,u data on ethnicity of the workforce is included. However, data was not available across the Directorates for the ethnicity of existing patients and it is at present still not possible to compare the ethnicity of patients in the Forensic Service (or other services in the Trust) with the ethnicity of the workforce. This has been identified within the Strategy and Action Plan as a

clear area for improvement and from January 2005 action has been taken to effect the necessary consistent collection and recording of ethnicity data across the Directorates in the Trust. There is therefore evidence that the issue is being taken very seriously by the Trust .The Action Plan should ensure that any necessary further action in the light of data on patient and workforce ethnicity data can be identified and put in place.

Comment

From the above review I can conclude that, with the exception of the matters identified in this section of the report, the Internal Inquiry did ensure that adequate and appropriate attention was given to the issues highlighted in their terms of reference for their work. (See Paragraph 1.2 above)

6 Learning the lessons

This section outlines and comments upon the progress the Trust is making towards implementing the recommendations of the Internal Inquiry.

6.1 The action plan

1. •The processes for ensuring that the recommendations of the Internal Inquiry were implemented and lessons learned and shared were focussed, within the Trust as a whole and within the Adult Forensic Services, around an action plan developed in response to the Internal Inquiry report. Unfortunately the Action Plan was not dated and I am therefore unable to comment precisely on the timeliness of response to the report. However there is evidence from the Trust's Board meeting in December 2002 that the Board asked the Executive Team to develop and implement an action plan. There is evidence that a number of actions were identified and acted upon before December 2002. I have seen copies of e-mails from March and April 2002 checking the progress of a number of actions, for example related to communications, serious untoward incident reporting and discussion of care plans at out patient reviews. There is also evidence from the

minutes of the Trust's Clinical and Social Care Governance Committee meetings held on 29 August and 14 November 2002 that some discussion was by then underway about the Internal Inquiry's findings. There is however no evidence that the action plan was developed finalised or agreed before the Board discussion in December 2002.

Comment

Whilst the timeliness of the Serious Untoward Incident Review, within a week of the incident, is commendable, a delay of at least 10 months i.e. from March to December 2002 in having an action plan in place does not represent best practice. This is to some extent mitigated by the fact that some work on immediate actions was underway soon after the incident.

Recommendation 3

The Trust should ensure that in future all action plans arising from Internal Inquiries and Reviews are clearly dated.

Recommendation 4

The Trust should review the expected timetables for the completion of Internal Inquiries and Reviews and consider asking that reports of such Inquiries and Reviews are accompanied by draft action plans at the time of their consideration by the Board in order to save time. (For an Internal Inquiry of this scope and complexity a period before reporting of six months would appear to be sufficient)

1. •The action plan was broken down into two sections: "Corporate specific" and "Service specific". The format of the action plan was appropriate - allowing space for the issue identified, action required, lead officer and a target date for completion. No provision was made in the format for evidence of completion and such a space would be helpful for monitoring purposes. I was however given a copy of a form in use within the Adult Forensic Service to monitor action plans (in this

case related directly to the MS action plan) which does include such an "evidence" column which is regularly updated at monitoring meetings.

Recommendation 5

The Trust should review the format for action plans arising from SUIs, internal inquiries and reviews to ensure consistency and to include space for recording evidence of implementation.

1. •The action plan covered all of the recommendations of the Internal Inquiry report.

1. •There is evidence of substantial progress in the completion of agreed actions to implement the recommendations of the internal Inquiry. There does not appear to be an up to date "signed off" copy of the action plan with an indication of the dates on which actions were completed. Ideally a monitoring system, within the Trust's Clinical and Social Care Governance arrangements, would provide such a "live" monitoring tool.

Recommendation 6

The Trust should consider developing a monitoring tool to enable the recording and continuous review of the status of actions within action plans until all are signed off with evidence of completion recorded. (Some work on such a model appears to have been done within the Adult Forensic Mental Health Service Directorate)

6.2 Completed actions and gaps in action

From my review of documentation and fieldwork meetings I was able to quickly establish that 15 of the 24 recommendations had been implemented. Of the remaining nine recommendations, seven have been implemented and I have commented on them individually below.

1. •Two of the remaining nine recommendations were concerned with the Paragon (computerised records) system - regarding inclusion of a case summary and availability of documentation at CPA meetings respectively - and I have seen by means of a demonstration of the ICIS system which has replaced Paragon, evidence that both recommendations have been implemented with the introduction of the ICIS computerised records system.

Comment

The Trust's work on implementing the ICIS computerised records system is impressive and should be commended.

I have commented individually on implementation of the remaining seven recommendations.

1. **The need for clarity regarding the two policies covering escorting of patients outside the (Edenfield Centre) Unit and possible adoption of a single policy**

Following discussion of this recommendation during my fieldwork meetings I have now seen the single policy now in existence. It was most recently reviewed in April 2004 and signed off as such by the Risk and Security Manager. I note that the policy was due for review again in May 2005 but have not seen the confirmation that the review was completed. This recommendation appears therefore to have been implemented.

2 The timing and procedure for SUI Reviews and Internal Inquiries

The current policy for the reporting and management of untoward incidents - dated September 2003 and updated and re-approved by the Trust's Clinical and Social Care Governance Committee on 1 September 2005 - is explicit about timetables for completion of SUI Reviews and Internal Reviews and procedures are very adequately set out. This recommendation has therefore been implemented.

3 Opportunity for those appearing before a panel to review relevant notes

There is no reference to this in the policy for the reporting and management of untoward incidents. I have therefore seen no clear evidence that this recommendation, which concerned both existing Trust staff and those "who are no longer employed in the service", has been implemented.

Comment

The current policy for the reporting and management of untoward incidents is largely in line with current best practice.

Recommendation 7

The Trust should consider the insertion of a paragraph in its policy for the reporting and management of untoward incidents to cover the offer of an opportunity for existing or former staff who are invited to appear before an internal inquiry or review panel, to have prior access to the appropriate notes

1. **Developing a relationship with the Police Service to ensure effective and timely communication between the two services**

This recommendation was made in the context of the police not informing the Edenfield Centre of the incident. My fieldwork meetings confirmed that a Police Liaison Officer had been appointed since the incident and that day to day relationships with the police were consequently improved, with a greater mutual understanding of demands on the respective services.
It was also encouraging to hear of joint work towards producing a memorandum of understanding for the local Multi Agency Public Protection Arrangements (MAPPA) (though it is unlikely that MS would have met the criteria for inclusion). I was pleased to hear about a pilot for dealing with people at MAPPA Level 3. There was however some concern expressed that the predicted number of people at MAPPA Level 3 is likely to exceed the resources available to meet their needs. This together with questions concerning the sharing of information and thresholds for MAPPA, particularly for people considered to be dangerous or potentially dangerous but who do not meet MAPPA criteria, are national issues.

Recommendation 8

The Trust should consider commissioning with its partners in MAPPA a multi agency case-study based workshop. The workshop could explore the interface between MAPPA, adult mental health services, housing and child protection services.

1. Addressing (through training) the importance of subtle changes in the presentation of a patient

Whilst I was reassured in discussions during fieldwork meetings that this recommendation has been addressed through the buddy system for all Consultant Psychiatrists and via regular weekly supervision for all junior staff, it does not appear to be explicitly covered in the (otherwise excellent) draft multi-disciplinary standards under development within the Adult Forensic Mental Health Service Directorate. I have not seen clear evidence to confirm that this recommendation has been fully implemented across all disciplines.

1.

Recommendation 9

The Trust should review its training programmes to ensure that appropriate training is available to all relevant staff across disciplines regarding relapse signatures and subtle changes in a patient's presentation. Such training could be extended where necessary to staff working in partner organisations.

Recommendation 10

The Trust should consider whether specific references to relapse signatures and subtle changes in a patient's presentation should be included in the Multi-

Disciplinary Standards being developed by the Adult Forensic Mental Health Service Directorate.

1. **Addressing (through training) the attitude of staff and the need for community patients being re-admitted (to the Edenfield Centre)**

This recommendation of the Internal Inquiry arose from an issue identified during panel interviews about the attitude of inpatient staff to community staff when community patients were re-admitted. Whilst I have not seen any documentary evidence to confirm that the implementation of this recommendation has been completed, I am satisfied that the spirit of this recommendation has been satisfied from the consistent answers I received during my fieldwork meetings, and from the fact that an audit of community re-admissions was undertaken by the Directorate's Clinical Leader and that the findings formed the basis of a presentation within the service.

1. **Provision of guidance on appropriate care plans for patients who use illicit drugs and for whom it is acknowledged this behaviour will not cease**

In the action plan the defined action was: "core care plans to be developed for all patients (of the Adult Forensic Mental Health service) in the community and inpatient service where this is an identified issue". I have been unable to find clear evidence that such "core care plans" have been developed, although I accept that the format, recording and documentation of care plans within the Adult Forensic Mental Health Service is generally much improved since 2002 and that this satisfies the spirit of the recommendation. The identified "action required" only partially matched the recommendation which was (in the context of narrative in the main body of the Internal Inquiry report) that guidelines were needed for each individual patient within their nursing care plan. My fieldwork discussions confirmed that this issue is in practice discussed in clinical supervision. The view was expressed that experience, training and awareness were more important for front line staff around this issue than guidelines.

1.

Comment

This recommendation in the Internal Inquiry report was ambiguous. It suggests guidelines but on closer examination appears to be intended to be more to do with clarity in respect of individual patients about the appropriate responses to continuing and unremitting illicit drug use. Because of this it is difficult to be sure whether the implementation of the recommendation is complete.

Recommendation 11

The Adult Forensic Mental Health Service Directorate should consider, as part of its clinical and social care governance agenda, commissioning an audit of a sample of current care plans for patients with continuing and unremitting illicit drug use. The findings of the audit should be used to identify any training, supervision and practice guidance issues to assist in service improvement. The outcomes should be shared across the Trust as a whole.

Comment

This review has confirmed that 22 of the 24 recommendations have been implemented. Two recommendations appear not to have been fully implemented. They are discussed above. Where further work is indicated recommendations are included above.

One recommendation in the Internal Inquiry report and its subsequent identified action appear to have been somewhat ambiguous. A recommendation above identifies the need for further work on this within the Adult Forensic Service which could be shared across the Trust as a whole.

Overall, as should be expected given the time span between this review and the Internal Inquiry, good progress has been made in the implementation of changes arising from the recommendations of the Internal Inquiry.

6.3 A Learning Organisation

During my review of documentation and in the helpful and open discussions in fieldwork meetings, a number of issues arose concerned with the framework within the Trust for learning lessons from such tragic incidents and sharing the learning across the organisation to help with the processes of service improvement. These were mostly reflections on positive progress made over the past three or four years in a number of key areas. It seemed appropriate that a summary of those reflections should be included in this report as a validation of work in the Trust to secure improvements and as an encouragement to build on the momentum created.

1. •The Clinical and Social Care Governance Framework
2. conclusion of the Commission for Health Improvement's Clinical Governance Review in April 2004 was that the Trust "has a well developed understanding of the Clinical Governance framework and is making progress in all areas".
    1. review of documentation, including policies and procedures and minutes of a number of meetings of the Clinical and Social Care Governance Committee, suggests that progress is being maintained. It was particularly encouraging to hear during fieldwork meetings that the framework for the Trust corporately, was now mirrored in the Directorates. There is good cross-representation on the respective committees.
    2. also had the opportunity of discussing and receiving a copy of the Adult Forensic Mental Health Directorate's Service Plan 2006 which relates directly to Healthcare Commission core standards.
3. in the directorate in developing multidisciplinary standards is further evidence of practical improvements being actively pursued. In the Trust as a whole, the development of nurse consultant roles, for example in relation to clinical risk, self harm, suicide and homicide and in dual diagnosis and psychotherapy were seen as an important contribution to the development of professional expertise, skills and competences. This mirrors the success I have observed in some other mental health

and social care trusts of using such posts as champions of and vehicles for change and improvement.

4. •Risk Management and Risk Assessment
5. following points are indicators of the efforts within the Trust to ensure continuing improvement in its risk management and risk assessment arrangements
6. •The appointment of an Associate Director for Risk and Patient Safety for the Trust in April 2004 and of Nurse Consultants (see above), including a Nurse Consultant in the Adult Mental Health Forensic Service with specific responsibilities for clinical risk.

1. •The appointment in the Forensic Service of a Risk and Security Manager.
2. •The current work of a Risk Assessment Working Group in the Forensic Service in relation to the development of outcome measures and assessment pathways.

1. •The Care Programme Approach (CPA)
2. demonstration I was given of the ICIS computerised records system showed clearly how all of the documentation needed for effective and efficient CPA review meetings is now available at the press of a button. This was most impressive and the Trust is ahead of many others in England in this respect. The impression gained during the fieldwork meetings is that CPA is, within the Forensic Service, now *the* way of undertaking care planning. I was not, however able to confirm this with a wider staff group within the constraints of this review. It was encouraging to hear that the three Regional Secure Units around Manchester have spot checked a random sample of each other's cases for CPA compliance. This is in addition to regular audit by spot check of random cases within the Trust. I was also told that the Trust is currently undertaking a further review of CPA and that a final revised policy

document is close to completion. As in all mental health and social care trusts it will remain very important to ensure that compliance with all CPA policies and procedures is carefully audited and monitored.

1. •Sharing learning across the Trust
2. CHI Report of April 2004 identified that action was needed to strengthen ways of sharing good practice across directorates. My experience of leading a number of external reviews and inquiries in mental health NHS Trusts across the country suggests that this remains a challenge in many Trusts.
    1. challenge was understood by the people I met both from Trust Headquarters and within the Adult Mental Health Forensic Directorate. Structurally, the Clinical and Social Care Governance framework in the Directorate and the Trust corporately, mirror each other and cross representation on respective committees is helpful.

The Trust's Learning Forum now appears to be an important vehicle for encouraging and enabling shared learning. The Forensic Services Directorate's Nurse Consultant for clinical risk and the Forensic Services Site Manager are both members of the forum. The key messages for learning across the Trust and Directorates are promoted regularly via the "Factfile" newsletter. Roles of nurse consultants in driving and facilitation of good practice and change were discussed as reported above. The Trust's investment in these posts provides evidence to confirm that shared learning and good practice remains a high priority.

1. •The investigation and inquiry process and post incident support
2. During my fieldwork meetings the view was expressed that the Serious Incident Review and Internal Inquiry processes following this tragic incident had been helpful in identifying lessons to be learned. The processes were seen as having provided impetus within the Trust and

the city of Salford Social Services Department to improve services. However there was some concern about the long delay between the Internal Inquiry and this external review. The people I met did however appreciate the less formal, more participative approach to this external review. They saw the forward looking, developmental methodology as more helpful than a formal external inquiry which would probably have covered similar issues to those already covered in the Internal Inquiry.

1.

3. was some discussion around the use of root cause analysis (RCA). This was seen as helpful, particularly at the initial Serious Untoward Incident Review stage. The Trust has been investing in training staff in RCA.

1.

Comment

It could be helpful to focus further RCA training on a smaller number of managers who could form a panel of RCA expertise within and across the Trust and which could operate as a "virtual team" sharing and developing expertise and practice.

Post incident support for staff and others involved in this incident appears to have been good. As well as access to counselling and / or one to one support, a support group was quickly set up and met regularly guided by the Forensic Service's Associate Clinical Director. The gap in support offered to staff who may have left the employment of the Trust was discussed in Paragraph 5.7 above.

Recommendation 12

The Greater Manchester Strategic Health Authority should look at ways of speeding up the commissioning of external independent reviews in cases involving homicide.

Recommendation 13

The Trust should consider identifying an appropriate number (around 6-10) of suitably qualified and experienced managers to undertake further training in root cause analysis (RCA) as a group. These RCA trained managers could then form a RCA panel for the Trust. Once the RCA panel is in place, all internal reviews of critical incidents should be led by a RCA panel member who does not have direct line responsibility for the service or locality in which the incident happened.

7 Summary of Recommendations

1. The Trust should ensure that in future all copies of Internal Inquiry or review reports are clearly dated. (Page 14)

1. The Trust should ensure that its policy for the reporting and management of untoward incidents makes explicit the need to ensure that any staff involved in such incidents who have left the Trust's employment, or have been seconded to another employer, are offered all the necessary and appropriate support. (Page 21)

1. The Trust should ensure that in future all action plans arising from Internal Inquiries and Reviews are clearly dated. (Page 25)

1. The Trust should review the expected timetables for the completion of Internal Inquiries and Reviews and consider asking that reports of such Inquires and Reviews are accompanied by draft action plans at the time of their consideration by the Board in order to save time. (For an Internal Inquiry of this scope and complexity a period before reporting of six months would appear to be sufficient). (Page 25)

1. The Trust should review the format for action plans arising from Sues, internal inquiries and reviews to ensure consistency and to include space for recording evidence of implementation. (Page 25)

1. The Trust should consider developing a monitoring tool to enable the recording and continuous review of the status of actions within action plans until off with evidence of completion recorded. (Some work on such a model appears to have been done within the Adult Forensic Mental Health Service Directorate). (Page 26)

1. The Trust should consider the insertion of a paragraph in its policy for the reporting and management of untoward incidents to cover the offer of an opportunity for existing or former staff who are invited to appear before an internal inquiry or review panel, to have prior access to the appropriate notes. (Page 27)

1. The Trust should consider commissioning with its partners in MAPPA a multi agency case-study based workshop. The workshop could explore the interfaces between MAPPA, adult mental health services, housing and child protection services. (Page 28)

1. The Trust should review its training programmes to ensure that appropriate training is available to all relevant staff across disciplines regarding relapse signatures and subtle changes in a patient's presentation. Such training could be extended where necessary to staff working in partner organisations. (Page 28)

1. The Trust should consider whether specific references to relapse signatures and subtle changes in a patient's presentation should be included in the Multi Disciplinary Standards being developed by the Adult Forensic Mental Health Service Directorate. (Page 29)
2. The Adult Forensic Mental Health Service Directorate should consider, as part of its clinical and social care governance agenda, commissioning an audit of a sample of current care plans for patients with continuing and unremitting illicit drug use. The findings of the audit should be used to identify any training, supervision and practice guidance issues to assist in service improvement. The outcomes should be shared across the Trust as a whole. (Page 30)

1. The Greater Manchester Strategic Health Authority should look at ways of speeding up the commissioning of external independent reviews in cases involving homicide. (Page 34)

1. The Trust should consider identifying an appropriate number (around 6-10) of suitably qualified and experienced managers to undertake further training in root cause analysis (RCA) as a group. These RCA trained managers could then form a RCA panel for the Trust. Once the RCA panel is in place, all internal reviews of critical incidents should be led by a RCA panel member who does not have direct line management responsibility for the service or locality in which the incident happened. (Page 34)

Appendix A

Bibliography and list of documents examined

Serious Incident Review Internal Inquiry and Action Plans

Internal Inquiry Report MS Serious Incident Bolton Salford and
12 Feb 2002 – undated Trafford Mental Health

NHS Trust (BSTMHT)

Specialist Services Directorate Mental Health Services
Report- Local Multi-Disciplinary Review of Salford NHS Trust
Into a Serious Incident -19 Feb 2002 (MHSMHT)

Adult Forensic Services BSTMHT
Serious Incident Review - Incident Details form and
(Completed) Action Plan form -undated

Adult Forensic Services BSTMHT
Action Plan in Response to the Internal Review of MS
undated

Policies and Procedures

Policy for Reporting and Management BSTMHT
of Untoward Incidents - Sep 2003 - Revised Sep 2005
Untoward Incident -Policy and Procedure - Jul 2000 MHSMHT
reviewed Feb 2002

Protocol for the Post Incident Debriefing and Support MHSMHT
(of patients and staff following serious incidents)
Feb 2002

Care Programme Approach Policy - Edenfield Centre MHSMHT
Oct 2000

Key Policy Renewal Dates - Jan 2005 BSTMHT

Adult Forensic Mental Health Service Directorate BSMHT
Index to the Procedures and Guidance Manual

Transporting Patients Under Escort - Feb 2002 MHSMHT

Forensic and High Dependency Service Directorate MHSMHT
Guidelines for Escorting Patients Outside the Unit
Jul 1998 - reviewed Jan 2000

Adult Forensic Mental Health Service Directorate BSTMHT
Guidelines for Escorting Patients Outside the Unit
(Nursing) and (Occupational Therapy)
Reviewed Apr 2004

Forensic and High Dependency Directorate MHSMHT
Police Liaison Protocol - Oct 1997

Forensic and High Dependency Service Directorate MHSMHT
Protocol for Out of Hours/On Call Service
Provided by the Forensic Community Mental Health
Nurses - Jun 2001

Information Sharing Protocol -2005 BSTMHT
Equality Strategy and Action Plan - 2005-2008 BSTMHT

Service Standards

Adult Forensic Mental Health Service Directorate BSTMHT
Multi disciplinary Standards - Draft 4 -Sep 2005

Adult Forensic Mental Health Service Directorate BSTMHT
Service Plan 2006 and Health Commission Core
Standards

Minutes and Notes of Meetings

Trust Board Meeting Minutes - 9 Dec 2002 BSTMHT

Policy and Procedures Group Minutes - 8 Jun 2005 BSTMHT

Policy and Procedures Group Minutes - 14 Oct 2005 BSTMHT

Clinical and Social Care Governance Committee BSTMHT
Minutes - 1 Sep 2005, 3 Nov 2005 & 12 Jan 2006

Working Group (Multi disciplinary Standards) BSTMHT
Adult Forensic Mental Health Services Directorate
10 Nov 2005

Other Documents and Reports

National Service Framework for Mental Health: Department of Health
Sep 1999

Guidance on the Discharge of Mentally Disordered NHS Executive
People and their Continuing Care in the Community
(HSG(94)27

Notes for the Guidance of Social Supervisors – Mental Home Office/DOH/
Health Act 1983 – 1997 Welsh Office

Clinical Governance Review -Bolton Salford and Healthcare Commission
Trafford Mental Health NHS Trust - Apr 2004

Appendix B

Individuals and groups who met the reviewer

John Rimmer- Forensic CPN and John Kinsella Adult Forensic Mental Health
Team Leader Social Work Service Directorate -BSTMHT
Diane Turnbull- Clinical and Social Care BSTMHT
Governance Manager and Gary McNamee -

Associate Director of Risk and Patient Safety

Dr Josanne Holloway- Clinical Director and Adult Forensic Mental Health
Nicola Lees - Associate Clinical Director Service Directorate -BSTMHT

Appendix C

Greater Manchester Strategic Health Authority

Terms of reference: Independent review of the internal inquiry into the care and treatment of MS

Greater Manchester Strategic Health Authority are the commissioners of this independent review. The review is commissioned to be in keeping with the spirit of Health Service Guidance 94/27 *The Discharge of Mentally Disordered People and their Continuing Care in the Community*. Its purpose is to provide independent scrutiny of the internal inquiry conducted by Bolton, Salford and Trafford Mental Health NHS Trust. This will include identifying any gaps in the internal inquiry and establishing what progress is being made implementing the recommendations.

Stage One – Review of internal inquiry

1. To review the case notes, policies and procedures, other relevant documents and notes of evidence provided to the internal inquiry.

Stage Two – Evaluation

1. To report on whether or not the internal inquiry considered all the appropriate evidence and, if so, whether their findings, conclusions and recommendations were consistent with that evidence. In particular, to ensure that appropriate attention was given to the following issues:

1. the care MS was receiving at the time of the homicide

2. the suitability of that care in the light of his history and assessed health and social care needs
3. the extent to which the care corresponded with statutory obligations, relevant guidance and local operational policies, in particular the application of the Care Programme Approach and the undertaking of appropriate and timely risk assessments
4. the exercise of professional judgment
5. the adequacy of the care plan and its monitoring by the key worker

1. To report on what progress the trust is making implementing the recommendations arising from the inquiry. This should include seeking evidence of demonstrable change and improvement to services.

1. To present findings and make recommendations to the SHA.

If necessary, both stages will be supplemented by interviews and appropriate consultation as the reviewer sees fit.

Timetable

The reviewer is asked to complete the review within three months of starting the work. Monthly progress reports should be provided to the strategic health authority. Day to day commissioning of the review will be the responsibility of Manchester Mental Health Joint Commissioning Team, on behalf of the three Manchester City Primary Care Trusts.

Publication

The outcome of the review will be made public. The nature and form of this publication will be the decision of the Greater Manchester Strategic Health Authority. In reaching the decision the SHA will confer with the independent reviewer.

On receipt of the review, the SHA will determine whether or not to proceed to an independent inquiry as per the terms of HSG 94(27).

19 October 2004