A REPORT ON THE RECOMMENDATIONS ON THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PAUL HORROCKS

Executive Summary

This report seeks to outline the Independent Inquiry into the care and treatment of Paul Horrocks and the recommendations of the Inquiry and subsequent action that is being taken to address the recommendations.

1 Background

1.1 In June 1999 Mr Horrocks was found guilty of the manslaughter of Carol Houghton by reason of diminished responsibility. He is detained under the Mental Health Act 1983 at a secure unit.

1.2 Subsequently, an Inquiry Panel was set up which reviewed a wide range of issues affecting the Adult Mental Health Services in Birkenhead. It did not scrutinise Adult Mental Health Services in other sectors or parts of the Wirral.

1.3 The Inquiry Panel found that there were clear risk factors, indicating that Mr Horrocks would act violently if his mental health condition deteriorated or relapsed while in the community and these should have been recognised by the professionals caring for him

1.4 Mr Horrocks had recently moved from Neston, which is the responsibility of Cheshire Social Services, to Birkenhead and a referral was made to a Community Mental Health Team. Mr Horrocks was allocated a Community Psychiatric Nurse with an extremely high case load, as there was no shared allocation method with the social work team based in the same building.

1.5 The objective of the Panel was to identify lessons to be learnt from the tragedy and to highlight deficiencies in the Birkenhead service which existed at the time of the tragedy. A series of recommendations was made and which are now in the process of implementation.

2 Recommendations

2.1 The Panel recommended that a Joint Commissioning Board made up of Wirral Health Authority, Wirral Social Services and Local Primary Care Groups should be rapidly developed. The Panel recognised that Wirral Health and Social Services have a track record of working together to improve Mental Health Services. Several services are already jointly commissioned and include:

- Assertive Outreach Team
- Crisis Resolution Service

A Partnership Group has been established and is responsible for developing effective working arrangements. The full integration of Community Mental Health Services will be in place by October 2001, which will create a single

point of referral and allocation for Community Psychiatric Nurses and Social Workers, and a single assessment tool will also be in operation. Such developments will be the single biggest contributing factor to improving local Mental Health Services and improving communication between Health and Social Services.

2.2 The Panel recommended that conditions in the Birkenhead Mental Health Services be raised to an acceptable standard and that service development should take place across both Wirral and West Cheshire to address the serious deficiencies highlighted in the full Inquiry Report.

A result of this recommendation is a heavy investment by Wirral Health Authority to improve Adult Mental Health Services on the Wirral. The result of such developments are the reduction in workload for community based Psychiatrist Nurses, enabling a much higher quality of individual care. A Resource Centre is due to be developed and based at St Catherine's Hospital, which will improve the efficiency and effectiveness of care for adults.

In-patient services based at Clatterbridge Hospital are also due to benefit from a major refurbishment.

Management arrangements for Wirral Mental Health Services have been made more robust, and all service developments take place jointly between Health and Social Services.

2.3 The Panel recommended that the Trust establish a programme of change management to take account of the findings in the Inquiry Report.

Positive steps have been taken around:

- Prioritisation of case loads
- Development of the Assertive Outreach Service
- Smaller case loads
- Improved clinical supervision
- Service user involvement

2.4 The Inquiry Panel made a series of recommendations about the infrastructure developments which are needed locally and include:

- Setting critical targets for improvement against specific deadlines
- Benchmarking against other Authorities which would also include comparisons about the level of funding for the services
- Reviewing clinical and operational policies to ensure they are routed in good practice
- Reviewing information systems to reduce staff time spent on paper work and facilitate good communication
- Staff receiving appropriate supervision which is regular, timely and meaningful

2.5 The Panel also recommended that protocols be developed between Primary Care and Mental Health Services and this is being addressed through the Mental Health Partnership Group

2.6 The Panel recommended that a review of the Accident and Emergency Liaison Psychiatry Service functions and relationship to the rest of the Service take place.

This has been highlighted by the Partnership Group as a priority area for development. It is recognised that the level of needs on the Wirral are such that the Service would benefit from expansion and from Social Care involvement, and from clarity of purpose.

2.8 Other recommendations are concerned with the case load mix of all Practitioners and with clear management structures for Community Mental Health Services. These recommendations are being built on with the integration of Community Mental Health Services into a single management structure.

3 Implementation Team

An Implementation Team which will oversee, review, monitor and evaluate the recommendations of the Inquiry has been set up by the Wirral and West Cheshire Community NHS Trust. It is chaired by the Chair of the Trust and is attended by Clinical Director for the Trust, the Director of Mental Health Services of the Trust, Primary Care representatives, user, carer and advocacy representatives, and by Social Services. The Team has already met and will present regular reports to the Trust Board and to Select Committee, in order to report on progress.

4 Conclusion

There are undoubtedly many lessons to be learnt by Mental Health Services as a result of this tragic event. Mr Horrocks and Ms Houghton had a volatile relationship which erupted into violence on more than one occasion, resulting in Ms Houghton visiting the Accident and Emergency Services. It must be noted that a tragedy such as this can never be completely prevented from happening but, by implementing the recommendations of the Inquiry by working across both Health and Social Services, by not attributing blame between agencies and by a willingness to learn from past events, the risk of a repetition will certainly be reduced.

Maura Noone
Assistant Director, Adults with Special Needs
ext no 3630
Date 24.4.01