REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF ALEXANDER CAMERON

Commissioned by Berkshire Health Authority

September 2000

PREFACE AND ACKNOWLEDGMENTS

On 26 April 1997, Alexander Cameron killed his mother, Mrs Eileen Cameron. Mr Cameron was receiving out-patient treatment at the time, having been discharged from Fair Mile Hospital on 12 December 1994. He was admitted to a secure hospital in May 1997, and he remains detained there, having since been convicted of manslaughter on the grounds of diminished responsibility.

There have already been two reviews of Mr Cameron's care and treatment during the period before his mother's death. One of these was an internal review undertaken by members of the NHS trust which manages Fair Mile. The other was undertaken by two external consultant psychiatrists. A third review, more than two years on, was a further source of distress for Mrs Cameron's daughter, Julie Cameron. We therefore particularly wish to acknowledge the constructive and measured way in which she and her partner helped us.

We also wish to acknowledge the way in which the professionals involved in Alexander Cameron's care and treatment worked with us during what was a difficult time for them. Their candour, and commitment to providing the best possible service to local people, was commendable. Such candour is to be encouraged because it is the ultimate test of professionalism. The mature professional who accepts that their practice, or local practice, can be improved upon thereby ensures that the future direction of the service is based, not on falsehood, but on a true, comprehensive, understanding of its current state.

We also commend the willingness of Berkshire Health Authority, the West Berkshire Priority Care Service NHS Trust, and the Reading Social Services, to work with us towards agreed conclusions and action plans. A constructive process is impossible without that commitment, but giving it, when many previous inquiries have been highly critical of individuals, took real courage.

Lastly, but certainly not least, we wish to thank Mrs Lynda Winchcombe, our inquiry manager, for her exemplary management of the process.

We have tried to conduct our inquiry more in the nature of a review. One directed at achieving consensus and the formulation of action plans designed to improve local services. Our report makes no reference to individual professionals: the value of such a review lies in identifying, and gaining support for, feasible improvements, not in apportioning blame. Mr Cameron, and not those who tried to help him, bears responsibility for his mother's death, albeit that his responsibility was diminished.

Some sections of this report duplicate sections of a report published in April 2000 concerning the care and treatment of Stephen Allum, who lived in Maidenhead. Two of the individuals who inquired into that tragedy were members of this review; and the overlap was necessary in order to ensure that services across Berkshire are developed according to a common standard.

Our report is a short one. It concerns services provided to people in the Reading area and we wish it to be available to, and read by, both local people and professionals. With this in mind we hope that Berkshire Health Authority will ensure its wide dissemination to community groups, including libraries, community mental health services, voluntary and statutory housing organisations, Citizens Advice Bureau; and to police, probation and social services, in-patient psychiatric units and specialist services.

As a final, personal, note, I would like to emphasise that my own impression of psychiatric wards is not one of fear or dangerousness, but of suffering, and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which may cause severe pain, most patients remain dignified and courteous, and somehow retain the compassion to respond to the plight of others in a similarly unfortunate situation.

Anselm Eldergill (Chairperson)

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INTRODUCTION

During the early hours of 26 April 1997, Alexander Cameron killed his mother, Mrs Eileen Cameron, at their home in Reading. He later pleaded guilty to manslaughter on the grounds of diminished responsibility. The court ordered that he be detained in a secure hospital under the Mental Health Act 1983, subject to what is known as a restriction order. The effect of such an order is that his release from hospital requires the approval of the Home Secretary or a mental health review tribunal.

WHY AN INDEPENDENT INQUIRY WAS NECESSARY

National Health Service Guidelines issued in May 1994 require an 'inquiry' independent of the service providers when a person in contact with mental health services commits homicide. However, we prefer the term 'review' to 'inquiry', because it is more constructive.

PURPOSE SERVED BY AN 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 a recurrence of the tragic event. 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.

Such inquiries serve important private and public needs. At a private level, individual tragedy requires a response, ideally determined by the individual circumstances: inquiries enable the bereaved to know that what happened is being fully and impartially investigated, and to be a party to that process. Equally, local people need to be reassured that the service is operating effectively. In such circumstances, it is wholly understandable, and wholly reasonable, that local people wish to be reassured that when family members come home, or friends or strangers return to their community, the risk of being seriously harmed is minimal.

Although agencies outside the locality may draw useful lessons from an inquiry report, the cost and usefulness of the exercise does not require national justification. The value of the process lies in systematically examining the way in which a particular service, and group of professionals, operate and co-ordinate *their* efforts.

WHO CONDUCTED THE INQUIRY

The inquiry was undertaken by a panel of three professionals from outside Berkshire:

Anselm Eldergill (Chairperson)	Solicitor, Mental Health Act Commissioner, Member of the Law Society's Mental Health Panel. Author of *Mental Health Review Tribunals, Law and Practice.*
Dr Helen Kelly (Medical member)	Consultant forensic pychiatrist.
Dave Sheppard (Social work member)	Co-Director of the Institute of Mental Health Law. Specialist trainer. Author of *Learning The Lessons.*

THE TERMS OF REFERENCE

The terms of reference were drafted by Berkshire Health Authority.

TERMS OF REFERENCE

General remit	1. To examine the circumstances surrounding the treatment and care of Mr Alexander Cameron by the Mental Health Services and Social Services. In particular:—
Assessments	i. the quality and scope of his health, social care and risk assessments
Treatment and care	ii. the appropriateness of his treatment, care and supervision in respect of • his assessed health and social needs; • his assessed risk of potential harm to himself and others; • his history of prescribed medication and compliance with that medication; • his previous psychiatric history and treatment; • the number and nature of any previous court convictions.
Compliance	iii. the extent to which Mr Cameron's care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Department of Health (Care Programme Approach (HC(90)23/LASSL(90)11) Supervision Registers (HSG(94)5); Discharge Guidance (HSG(94)27); and local operational policies.
Care plans	iv. the extent to which his care plans were effectively drawn up, delivered and complied with by Mr Cameron.
Joint working	2. To examine the adequacy and style of the collaboration and communication within CMHTs, and between the agencies involved in the care of Mr Cameron or in the provision of services to him and his family.
Training	3. To examine the appropriateness of the professional and in-service training of those involved in the care of Mr Cameron, or in the provision of services to him, and to consider any impact of 'The New NHS' white paper proposals.
Report	4. To prepare a report and to make recommendations to the Berkshire Health Authority.

1 HOW THE INQUIRY WAS CONDUCTED

ABOUT THIS CHAPTER

This chapter summarises the way in which the review was conducted. It deals with the principles which underpinned it, the timetable, the procedures, and the information we received.

OVERVIEW OF THE PROCESS

The idea of a constructive, independent, review, which seeks to develop a partnership with the individuals and the services affected by the death, led us to adopt the following procedure:

1	**Introductions**	Pre-review meetings were held with family members, Mr Cameron, and the teams, with the aim of allaying any fears they had about the process.
2	**Documents**	As the documents were received, they were indexed and a chronology was prepared.
3	**Induction**	An induction week was held, during which the panel visited relevant sites; received presentations concerning the organisation of services, and the local implementation of legislation and departmental guidelines; obtained independent perspectives from the Mental Health Act Commission, the Community Health Council, and local user groups; visited Mr Cameron, and spoke with his current treatment team. Having read the documents, visited the sites, and drawn on local expertise, the panel members defined the issues, identified those persons whom they wished to see or receive statements from, and commissioned further documents.
4	**Meetings**	Meetings were held with those involved in Mr Cameron's care, followed by informal meetings with managers, at which the panel communicated what they had read and heard, and any areas of concern.
5	**Action**	Following these discussions, action plans were drawn up for inclusion in the final report, and a steering group was formed, comprising the chairperson and a representative from each agency, in order to co-ordinate this process.
6	**Report**	The report was drafted, containing a brief history, the findings, and the action which had been, or is being, taken in response.
7	**Follow-up**	The panel will reconvene after six months, in order to assess the extent to which the action plans have been implemented, and to report further to the Health Authority.

The benefits of such a process are:

- that it seeks consensus;
- that it is productive (capable of producing necessary change); *and*
- that action is part of the process.

THE TIMETABLE

The conduct of the inquiry was co-ordinated with an inquiry being conducted in East Berkshire. The panel members were appointed by Berkshire Health Authority on 25 January 1999. Documentation concerning Alexander Cameron's care and treatment, and the organisation and delivery of local services, was then sought. Thereafter, the timetable was as follows.

INQUIRY TIMETABLE — 1999			
January	**February**	**March**	**April**
• *Appointments*	• *Introductions*	• *Documents*	
May	**June**	**July**	**August**
• *Induction*	• *More documents & chronology*	• *Meetings and initial feedback*	• *Vacation period*
September	**October**	**November**	**December**
• *Further meetings*		• *Preparation of report (first draft)*	
INQUIRY TIMETABLE — 2000			
January	**February**	**March**	**April**
• *Second draft*	• *Third draft*	• *Fourth draft*	• *Final draft*
May	**June**	**July**	
• *Action plans*	• *Action plans*	• *Publication*	

GUIDING PRINCIPLES

The inquiry panel were guided by the following principles:

1. A health service inquiry is a form of service review, and its main function is to learn lessons and bring about necessary change.

2. The process is not concerned with establishing whether the death was predictable or preventable, or who bears responsibility for it. Retribution, and the expiation of wrong-doing, are matters for the courts and for professional bodies.

3. Although always present, apprehension and fear on the part of those taking part should be minimised, so that the inquiry does not interfere with the service being provided to other patients.

4. The panel should seek to reduce the anguish and distress experienced by the bereaved and the patient's family by establishing early contact with them, sharing information, and securing legal representation for them.

5. The personal nature of information about a patient and his family, plus the importance of an uninhibited dialogue and reducing stress, makes privacy desirable, and meetings should be held in private.

6. An adversarial approach is incompatible with a review process which attempts to bring about change through uninhibited dialogue, partnership and consensus, and within which culpability is not an issue.

7. The process should be as informal as possible, developing into a partnership with those providing the services, and try to avoid the usual terminology of inquiries ('inquiry', 'witness', 'evidence', etc).

8. Candour should be encouraged because it ensures that the future direction of the service is based on a true, comprehensive, understanding of its current state.

9. Keeping confidential information gathered by professionals about patients and clients is essential to public confidence in medical and social services, and without such confidence the provision of these essential services to persons in need of them is undermined. There is therefore a considerable public interest in ensuring that confidentiality is respected wherever possible.

10. Procedural fairness remains important even when a review is not directed at establishing responsibility and culpability, and the panel therefore imposed on itself a set of procedures designed to ensure this (see below).

11. The report should be short and accompanied by an abstract of the main points; not disclose personal information unnecessarily; concentrate on the terms of reference and, in particular, local services; be confined to points on which the panel are agreed; set out what it is realistic for the public to expect in relation to psychiatric treatment, care, risk, and discharge planning; accept that all discharge decisions involve risk; make clear the legislative and other constraints to which practitioners are subject, so that decisions are measured against a realistic yardstick; recommend, or contain, a course of action for each and every problem (or explain why further improvement is not feasible); and avoid minor recommendations about form-filling, etc.

12. The report should be readily available locally.

13. The implementation of action plans set out in the report should be audited by the Health Authority, and the panel should contribute to that process.

PANEL PROCEDURES

Although not part of the terms of reference, the inquiry panel chose to adopt a set of procedures designed to ensure that those persons assisting the inquiry were treated fairly:

REVIEW PROCEDURES

1 Every professional who provided treatment or care to Mr Cameron prior to his mother's death will receive a letter before meeting with the inquiry team. This letter will ask them to provide a written statement to the inquiry and inform them:

a. of the terms of reference and the procedure adopted by the inquiry;

b. of the areas and matters to be covered with them;

c. that when they attend the meeting they may raise any matter they wish which they feel might be relevant to the inquiry;

d. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another person who has been asked to meet with the inquiry team;

e. that it is the person invited who will be asked questions and who will be expected to answer;

f. that what they say will be transcribed and a copy of the transcription sent to them afterwards for them to sign.

2 Persons attending meetings with the inquiry team may be asked to confirm that what they have said in their statement and at the meeting is true.

3 Any points of potential criticism will be put to the individual affected, either verbally at the meeting with the inquiry team, or in writing at a later time, and he/she will be give a full opportunity to respond.

4 Written representations may be invited from professional bodies and other interested parties regarding best practice for persons in similar circumstances to this case and as to any recommendations they may have for the future.

5 Those professional bodies or interested parties may be asked to speak with the inquiry team about their views and recommendations.

6 Anyone else who feels they may have something useful to contribute to the inquiry may make written submissions for the inquiry's consideration and, at the chairman of the panel's discretion, be invited to speak with the inquiry team.

7 All inquiry meetings will be held in private.

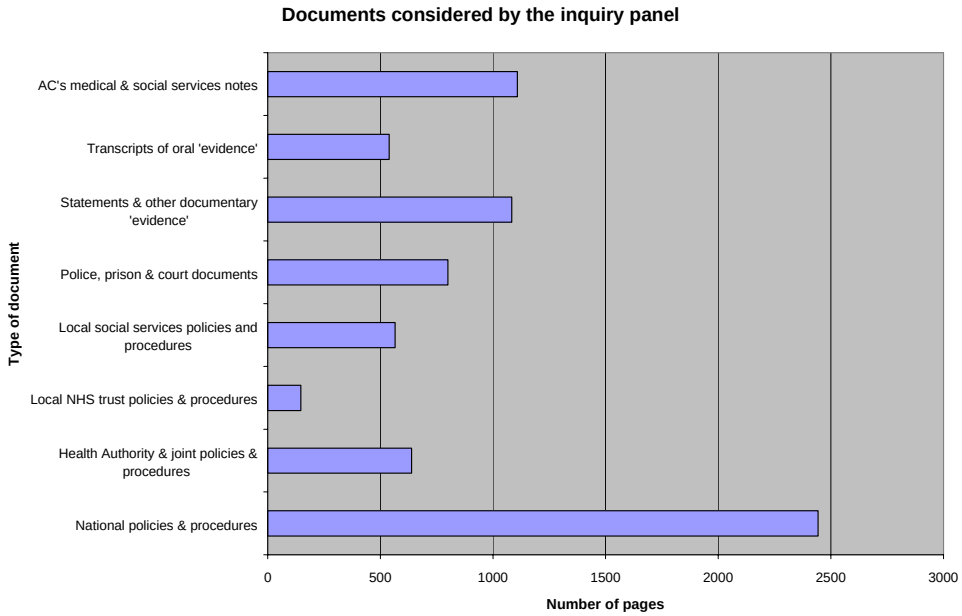
8 The draft report will be made available to the Health Authority and, with their consent, to the West Berkshire Priority Care Service NHS Trust and the Reading Unitary Authority, for any comments as to points of fact.

9 Information submitted to the inquiry either orally or in writing will not be made public by the inquiry, except insofar as it is disclosed within the body of the inquiry's report.

10 Findings of fact will be made on the basis of the information received by the inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

INFORMATION REVIEWED BY THE PANEL

During the course of the inquiry, the panel discussed Mr Cameron's care and treatment with many people. We also read over seven thousand pages of documents concerning his care and treatment or the way in which local services are provided. In order to keep our report short and readable, and so as not to disclose unnecessarily information about his family and professional carers, precise details do not appear in this report. However, it is important to emphasise that the inquiry was thorough and searching, and the following chart summarises the information received by us, upon which our findings are based. No professionals declined to meet with the panel.



2 THE NATIONAL FRAMEWORK

ABOUT THIS CHAPTER

Local practitioners work within a context set nationally. The purpose of this chapter is to explain briefly the legislation and national guidelines which guide, and sometimes limit, how they practice. One of the tasks given to the inquiry panel was to report on local compliance with the Mental Health Act, and national and local policies and procedures.

OVERVIEW

- The delivery of in-patient and community care from 1997 onwards has been governed by a number of Acts of Parliament, such as the *National Health Service Act 1977*, the *National Health Service and Community Care Act 1990*, and the *Health Act 1999.*

- The circumstances in which a person with mental health problems can be detained in hospital are set out in the *Mental Health Act 1983*.

- Under that Act, a *Code of Practice* is published periodically, the aim of which is to guide practitioners about what is, or is not, good practice.

- The Department of Health issues *Health Service Guidelines*, which require health and social services authorities to manage or deliver a service in a particular way, such as care plans and discharge arrangements.

NATIONAL HEALTH SERVICE

Many different individuals and bodies may be involved in the detention, treatment or care of an individual.

Unless the hospital is a private establishment, it will form part of the National Health Service for which the *Secretary of State for Health* is accountable to Parliament. This minister has a duty to provide hospital accommodation and such other mental health services as he considers appropriate as part of the health service, and to such extent as he considers necessary to meet all reasonable requirements. His department's funding is negotiated annually with the Treasury, through the public expenditure survey. The Secretary of State is not normally involved in the day-to-day management of the National Health Service. The *NHS Executive*, the headquarters of which is based in Leeds, provides the central management of the NHS, dealing with all operational matters. The size and complexity of the NHS means that it must operate through a regional structure, and there are eight NHS Executive regional offices. The one responsible for Berkshire is the South East Regional Office.

NHS hospitals are managed by NHS trusts, and Fair Mile Hospital is managed by the *West Berkshire Priority Care Service NHS Trust*. The core function of an NHS trust is to deliver health services according to the local Health Authority's specifications. Every trust has a board consisting of a chairperson appointed by the Secretary of State and executive and non-executive members (members who respectively are and are not employees of the trust). All of them are full and equal members of the board and jointly responsible for carrying out the trust's functions.

Health authorities, in this case *Berkshire Health Authority*, purchase in-patient and other medical services from these trusts. The Health Authority's functions include evaluating the health and healthcare needs of the local population; establishing a local health strategy which implements national priorities and meets local needs; implementing that strategy by purchasing services for patients through contracts with NHS and other providers; and monitoring the delivery of health services to ensure that the objectives are achieved.

Although the NHS Executive regional offices monitor the trusts within their area, and approve their business plans, they do not generally become involved in detailed operational matters, which are the responsibility of local health authorities and the trusts themselves.

Social services

The local authority responsible for people living in Reading in 1997 was *Berkshire County Council* but, following reorganisation, is now *Reading Unitary Authority*.

Community care refers to the policy of providing services and support which people affected by mental health problems need in order to be able to live as independently as possible. The *National Health Service and Community Care Act* requires local authorities to prepare and publish a plan for the provision of community care services in their area. It also gives local authorities primary responsibility for co-ordinating the assessment of community care needs. In general terms, any community care services which may be provided by a local authority may also be provided by the independent sector. Just as the role of Health Authorities has become one of purchasing health services provided by trusts, so local authorities are expected to seek out and purchase community care services from a range of public and non-public providers.

Section 117 of the 1983 Act imposes a duty on the Health Authority and the local social services authority to provide after-care services for patients who have been detained in hospital for treatment.

MENTAL HEALTH ACT 1983

The vast majority of people who receive psychiatric treatment in hospital are treated without resort to formal legal powers, and they are known as 'informal patients'. However, if an individual's actions are seriously jeopardising his welfare or that of others, the law countenances detention and treatment without consent.

The main statute which deals with the subject of mental disorder, the *Mental Health Act 1983*, includes powers authorising detention and restraint. Most applications for a person to be detained are made by an approved social worker (or ASW), that is by a social worker who has completed special training.

The legal criteria for detention always comprise at least two grounds. The first of them (*the diagnostic ground*) requires that the individual is suffering from a severe mental disorder. The second of them (*the risk ground*) requires that his detention is 'necessary' or 'justified' on his own account (specifically for his health, safety or welfare) or that of others (in order to protect them).

Whether a particular person's detention is justified or necessary may depend on what arrangements have been, or can be, made for his treatment outside hospital. The individual's willingness to accept in-patient treatment on an informal basis, and her or his capacity to adhere to any agreed treatment programme and discharge plan, will also be highly relevant.

Applications for assessment under section 2

Under section 2 of the 1983 Act, an individual's nearest relative or an approved social worker may apply for that person to be detained in hospital for up to 28 days, so that his mental state can be assessed, and any treatment given which is assessed to be necessary. Such an application must be founded on two medical recommendations.

Emergency applications under section 4

In urgent cases, obtaining two medical recommendations may lead to undesirable delay in effecting admission. Section 4 sets out an emergency procedure which enables a person to be admitted for assessment on the basis of a single medical recommendation. If this procedure is adopted, the authority to detain the individual ceases after 72 hours unless the second recommendation has by then been received.

Applications for treatment under section 3

Detention beyond 28 days is generally only permissible if a fresh application, made under section 3, has been accepted by the managers of the relevant hospital. Their acceptance of an application under this section authorises them to detain and treat the person in hospital for up to six months. Where necessary, that authority to detain the patient may be renewed for a second period of six months, and thereafter for a year at a time.

Applications which relate to care outside hospital

When a patient is detained in hospital for treatment, section 25A now provides that an application may be made for him to be supervised in the community upon leaving hospital. Alternatively, an application may be made under section 7 for a person to be placed under the guardianship of a local social services authority, or a private individual, for up to six months. As with section 3 applications, a supervisor's authority and a guardian's authority lapse after six months unless renewed for a further six months, and thereafter at yearly intervals.

Relationship between the different applications

The various powers just referred to are not mutually exclusive. In the first place, a person detained in hospital may be transferred into guardianship, and vice-versa. Secondly, it is common for one application to be replaced by another. For example, section 4 might be used to admit a person in an emergency. If the second medical recommendation required by section 2 is then received within the permitted 72 hour period, the patient may be detained for the remainder of the usual 28 day assessment period. A section 3 application will follow if, before the 28 days expires, it becomes clear that a more prolonged period of detention and compulsory treatment is necessary. If it then becomes apparent that the patient will require statutory supervision after he ceases to be detained under section 3 and leaves hospital, a supervision application may be made.

Short-term powers not exceeding 72 hours

The procedures just described require the presence of the individual whose mental health is in issue and the attendance of those persons who must interview and examine him. Problems will occur where access cannot be obtained to a person's home in order to conduct an assessment of his need for admission; where the seriousness of a person's mental condition only becomes apparent at a time when no doctor or approved social worker is immediately available; or where an informal patient attempts to leave hospital in circumstances which suggest that it is necessary to make an application for him to be detained there.

The Act therefore includes a number of short-term powers of detention, which enable a person to be detained so that his mental state and situation may be assessed and/or any necessary application made.

Detention of in-patients under section 5(2)

If it appears to the doctor in charge of an informal in-patient's treatment that an application ought to be made under section 2 or 3, he may furnish a written report to that effect to the managers of the hospital. Once such a report is furnished, the patient may be detained in the hospital for a period of 72 hours.

Removal from a public place to a place of safety under section 136

If a police constable finds in a public place a person who appears to him to be suffering from mental disorder, and to be in immediate need of care or control, the constable may remove him to a place of safety, if he thinks it necessary to do so in that person's interests or to protect others. The individual may be detained there for a period not exceeding 72 hours, for the dual purpose of, *firstly*, enabling him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and, *secondly*, of making any necessary arrangements for his treatment or care. These arrangements not uncommonly involve making an application for the person's admission to hospital.

Powers of the Home Secretary

The Mental Health Act also contains various powers relating to patients involved in criminal proceedings. Under section 48, the Home Secretary can direct that a person who is in prison awaiting trial shall be transferred to hospital for treatment. This is known as a 'transfer direction'.

The use made of powers of detention

There were 12,990 patients detained in hospital under the Mental Health Act on 31 March 1999, compared with 12,680 a year earlier. Of, these 1,300 (10%) were detained in a high security NHS hospital; 10,500 (80%) were in other NHS facilities, and 1,170 (9%) were in private mental nursing homes. Most of the patients (80%) were recorded as suffering from mental illness.

CODE OF PRACTICE

The Secretary of State publishes a code of practice concerning the use of the 1983 Act and the medical treatment of patients. The second edition of the code was in force at the time Mr Cameron was in hospital. A third edition replaced it in April 1999.

According to this version, good practice now requires that greater emphasis is placed on risk assessment and management, and less on the importance of individual liberty. For example, the new code says that, '*A risk of* physical harm, or serious persistent psychological harm, to others is an indicator of the need for compulsory admission' (para. 2.9). The previous code stated that, '*Too high a risk* of physical harm, or serious persistent psychological harm to others, are indicators of the need for compulsory admission.'

Paragraphs 6.2 and 6.3 of the code deal with emergency admissions under section 4. They provide that section 4 should be used only in a genuine emergency, never for administrative convenience, and that to be satisfied that an emergency has arisen, there must be evidence of an 'immediate and significant risk' of mental or physical harm to the patient or to others.

Guiding principles

The third edition of the code contains, for the first time, a set of guiding principles under a number of headings. Some of these principles were enunciated in previous editions but grouping them together at the beginning emphasises their fundamental importance.

Paragraph 1.1 of the 3rd edition states that, 'The detailed guidance in the Code needs to be read in the light of the following broad principles, that people to whom the Act applies (including those being assessed for possible admission) should:

— receive recognition of their basic human rights under the European Convention of Human Rights (ECHR);

— be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics;

— have their needs taken fully into account, though it is recognised that, within available resources, it may not always be practicable to meet them in full;

— be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people;

— be treated and cared for in such a way as to promote to the greatest practicable degree their self-determination and personal responsibility, consistent with their own needs and wishes;

— be discharged from detention or other powers provided by the Act as soon as it is clear that their application is no longer justified.'

Other guiding principles referred to in chapter 1 include the care programme approach, confidentiality and victims' rights:

'The Care Programme Approach and Care Management

1.2 The delivery of all mental health services is framed within the Care Programme Approach (CPA) set out in Circular HC(90)23/LASSL(90)11, and in the Welsh Office Mental Illness Strategy (WHC(95)40). The CPA provides the framework for all patients, both in hospital and in the community, and Health Authorities, Trusts and Social Services Authorities are responsible for ensuring that the Act is always be applied within this context.

The key elements of the CPA are:

— systematic arrangements for assessing people's health and social care needs;

— the formulation of a care plan which addresses those needs;

— the appointment of a key worker to keep in close touch with the patient and monitor care;

— regular review and if need be, agreed changes to the care plan.

Confidentiality

1.8 Managers and staff in all Trusts, Authorities, Mental Nursing Homes, Social Service Departments and other organisations which provide services for patients should be familiar with the DH Guidance on confidentiality (*The Protection and Use of Patient Information, Department of Health 1996, HSG(96)24).* Ordinarily, information about a patient should not be disclosed without the patient's consent. Occasionally it may be necessary to pass on particular information to professionals or others in the public interest, for instance where personal health or safety is at risk. Any such disclosure should be in accordance with the principles set out in the Guidance ...

Victims

1.9 Where a patient detained under Part III of the Act is both competent and willing to agree to the disclosure of specified information about his or her care, this should be encouraged to enable victims and victims' families to be informed about progress. It can be important to a patient's rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour. Disclosure of such information also serves to reduce the danger of harmful confrontations after a discharge of which victims were unaware. Without prejudice to a patient's right to confidentiality, care teams should be ready to discuss with him or her the benefits of enabling some information to be given by professionals to victims, within the spirit of the *Victim's Charter (Home Office, 1996).* The patient's agreement to do so must be freely given and he or she will need to understand the implications of agreeing to information being given to the victim(s). Care must be taken not to exert any pressure on the patients or this may bring into question the validity of the consent.'

HEALTH SERVICE GUIDELINES

The following guidelines concerning discharge planning, supervision, risk management, after-care and care programmes were issued between 1989 and 1997.

A. Discharge of Patients from Hospital, Health Circular HC(89)5

The circular states that no patient may be discharged until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the care the patient will need in the community. This includes making arrangements for any necessary follow-up treatment, travel to, and support in, the home or other place to which they are being discharged. They or their relatives must also be fully informed about such things as medication, lifestyle, diet, symptoms to watch for, and where to get help if it is needed. Important points must be confirmed in writing. Their ability to cope and access to emergency services and out-of-hours advice must be taken into account.

Responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given to one member of the staff caring for that patient. This person should have a check-list of what should have been done. If the completed check-list is filed in the patient's notes it will provide a permanent record of action taken before discharge.

In many cases the patient, family or friends, will be capable of making all the arrangements for the return home. All that will then be required of the nominated member of the hospital staff is to ensure that they and the general practitioner have been given all the information they need. In other cases much more will be required; a range of services will have to be organised in advance, and several agencies involved.

B. Local Authority Circular LAC(89)7

Local Authority Circular LAC(89)7 draws the attention of local authorities to *Health Circular (89)5*, and asks them to review their existing procedures, so as to ensure that people do not leave hospital without adequate arrangements being made for their support in the community. The circular states that local authorities have a key role to play in ensuring that a range of services are available for patients who will need continuing care and support which cannot be provided by family and carers alone. Social workers can advise on the particular package of services available from both statutory and non-statutory suppliers which will best meet the patients needs and preferences. Suitable accommodation is essential if people are to be able to resume independent living in the community. Social services departments should make sure that local authority housing departments are involved at an early stage in the planning process if the patient is not able to return to his or her former home.

C. Care programme approach, Health Circular HC(90)23

The *care programme approach* applies to all patients who require psychiatric treatment or care, and it requires health and social services authorities to develop care programmes based on proper 'systematic arrangements' for treating patients in the community. The underlying purpose is to ensure the support of mentally ill people in the community, thereby minimising the risk of them losing contact with services, and maximising the effect of any therapeutic intervention. All care programmes should include systematic arrangements for assessing the health care needs of patients who can potentially be treated in the community. A key worker should be appointed for the patient, and that person's role is to keep in close touch with the patient, and to monitor that the agreed health and social care is given. A particular responsibility of the key worker is to maintain sufficient contact with the patient, and to advise professional colleagues of changes in circumstances which may require review and modification of the care programme. When the key worker is unavailable, proper arrangements should be made for an alternative point of contact for the patient and any carers. Every reasonable effort should be made to maintain contact with the patient and his carers, to find out what is happening, to seek to sustain the therapeutic relationship, and to ensure that the patient and carer knows how to make contact with the key worker or other professional staff.

D. Supervision registers, Health Service Guidelines HSG(94)5

Supervision registers represent an extension of the care programme approach. The purpose of the registers is to enable NHS trusts, and other NHS provider units, to identify all individuals known 'to be at significant risk of committing serious violence or suicide or of serious self-neglect, as a result of severe and enduring mental illness.' Consideration for registration should take place as a 'normal part' of discussing a patient's care programme before he leaves hospital. The decision as to whether a patient is registered rests with the consultant, although other members of the mental health team, including the social worker, should be consulted. Judgements about risk should be based on detailed evidence, and the evidence be recorded in written form and available to relevant professionals.

E. Guidance on Discharge, Health Service Guidelines HSG(94)27

The guidance seeks to ensure that psychiatric patients are discharged only when and if they are ready to leave hospital; that any risk to the public or to patients themselves is minimal; and that when patients are discharged they get the support and supervision they need from the responsible agencies.

According to the guidelines, the 'essential elements' of an effective care plan are systematic assessment, a care plan, the allocation of a key worker, and regular review. The professionals responsible for making discharge decisions must be satisfied that these conditions are fulfilled before any patient is discharged.

It is essential that arrangements for discharge and continuing care are agreed and understood by the patient and everyone else involved, including private carers. In particular, they should have a common understanding of the community care plan's first review date; information relating to any past violence or assessed risk of violence; the name of the key worker (prominently identified in clinical notes, computer records and the care plan); how the key worker or other service providers can be contacted if problems arise; and what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

There must be a full risk assessment prior to discharge, which involves: (1) ensuring that relevant information is available; (2) conducting a full assessment of risk; (3) seeking expert help; and (4) assessing the risk of suicide. A proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour. It is essential to take account of all relevant information, whatever its source. Too often, information indicating an increased risk has existed but was not communicated and acted upon.

F. Introduction of the departmental after-care form (February 1995)

In February 1995, the Department of Health circulated an after-care form designed to be used for all patients discharged from psychiatric in-patient treatment, including those subject to section 117. The use of the form, though not mandatory, was strongly recommended as constituting good practice, and was devised in response to a recommendation in the *Report of the Inquiry into the Care and Treatment of Christopher Clunis (North West London Mental Health NHS Trust, 1994).*

The form contains a number of sections: (1) About the patient; (2) Patient's nominated contact; (3) Key worker's details; (4) After-care plan; (5) Information to be included in the after-care plan; (6) Availability of information (7) Review; (8) Transfer of responsibility for patient's after-care; (9) Discharge from after-care.

G. **Building Bridges document (November 1995)**

Building Bridges stressed that the care programme approach is the cornerstone of the Government's mental health policy. It also emphasised the need to adopt a tiered approach. The purpose of this is to focus the most resource-intensive assessment, care and treatment on the most severely mentally ill people, while ensuring that all patients in the care of the specialist psychiatric services receive the basic elements of CPA. Patients with less complex needs should still receive systematic assessment, be assigned a key worker, and have a simple care plan monitored and reviewed.

Each patient's details should be entered on a CPA information system, and an initial needs assessment be carried out by a mental health professional ('pre-CPA assessment'). A minimal care programme approach is appropriate for patients with limited disability and health care needs arising from their illness, and low support needs which are likely to remain stable. Such persons will often need regular attention from only one practitioner, who will also fulfil the key worker role. There will be no need for a multi-disciplinary meeting.

All aspects of the care planning process should involve the user, his or her advocate, carers and/or interested relatives.

A full assessment of risk, covering both risk to the patient and others, should be part and parcel of the assessment process. Furthermore, those taking decisions on discharge have a duty to consider both the safety of the patient and the need to protect others.

If the patient has been an in-patient, the key worker should ensure before discharge that elements of the plan necessary for discharge are carried out. This will include the patient's need for medication, therapy, supervision and accommodation. No individual should be discharged from hospital unless and until those taking the decision are satisfied he or she can live safely in the community, and that proper treatment, supervision, support and care are available.

The key worker is the linchpin of the care programme approach. S/he should be selected at the needs assessment meeting and, since s/he is vital to the success of the whole process, identified as soon as possible. This is particularly the case when patients are soon to be discharged from hospital. The decision as to who should be the key worker should take into account the patient's needs: if housing and financial concerns and family problems are uppermost, a social worker is likely to be the most suitable candidate. The patient will need to know that the key worker (or an alternative worker) is available when things are difficult. Therefore, the key worker should ensure that patients and their carers have a contact point which is always accessible. Keeping in touch must also be assertive and key workers should not rely on the patient contacting them.

H. Subsequent guidance

In order to help the reader make sense of the recommendations and action plans in Chapter 6, it is necessary briefly to refer to two important documents published since 1997: *Modernising the care programme approach* and the *National Service Framework*.

Modernising the care programme approach (October 1999)

This document modifies some requirements of the care programme approach. Key developments include the integration of the CPA and care management; the appointment of lead officers in each trust and local social services authority; the introduction of two CPA levels (standard and enhanced); the removal of the previous requirement to maintain a supervision register; and the use of the term 'care co-ordinator' in place of 'key worker'.

National Service Framework (November 1999)

The *National Service Framework* is the single most important guide to the challenges ahead for mental healthcare (and the deployment of resources in general) over the next 5–10 years. It sets seven key standards in five areas, which are expected to be delivered from April 2000:

Standard 1	• Mental health promotion
Standards 2 & 3	• Primary care and access to services
Standards 4 & 5	• Effective services for people with severe mental illness
Standard 6	• Caring about carers
Standard 7	• Preventing suicide

Each standard is supported by a rationale, by a narrative that addresses service models, and by an indication of performance assessment methods. Each standard indicates the lead organisation and key partners.

Standards four and five aim to ensure that every person with a severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; that prompt and effective help is available if a crisis does occur; and that timely access to an appropriate and safe mental health place or hospital bed is available.

In the context of Mr Cameron's care and treatment, the following represent some of the most significant standards laid down in the framework:

Primary care	Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed. They should be offered effective treatments and, where appropriate, referral to specialist services for further assessment, treatment and care.
Access to services	Any individual with a common mental health problem should be able to make contact around the clock with the local services necessary to meet their needs.
Effective services (including CPA)	All mental health service users on the *Care Programme Approach* (CPA) should: • receive care which optimises engagement, prevents or anticipates crisis, and reduces risk. • have a copy of a written care plan which: i. includes the action to be taken in a crisis by service users, their carers and their care co-ordinators; ii. advises the GP how they should respond if the service users needs additional help; iii. is regularly reviewed by the care co-ordinator. • be able to access services 24 hours a day, 365 days a year. Each service user who receives a period of care away from their home should have a copy of a written after-care plan agreed on discharge. This must set out the care and rehabilitation to be provided, identify the care co-ordinator, and specify the action to be taken in a crisis.
Caring about carers	All individuals who provide regular and substantial care for a person on CPA should have an annual assessment of their caring, physical and mental health needs; and have their own written care plan, which is given to them and implemented in discussion with them.

Performance assessment

Performance will be assessed at a national level by measures which include the national psychiatric morbidity survey; access to psychological therapies and single sex accommodation; implementation of the 'caring for carers' action plans; and reductions in readmission rates, suicide rates, and the number of prisoners awaiting transfer to hospital.

Outcome indicators

The proposed outcome indicators for cases of severe mental illness include the prevalence of severe illness; user satisfaction measures and the proportion of CPA plans signed by service users; the number of in-patient admissions, and admissions of longer than 90 days duration; the number of patients discharged from follow-up, and the number lost to follow-up; the prevalence of side effects from antipsychotics; mortality amongst people with severe illness; the incidence of serious physical injury and the number of homicides.

3 THE LOCAL FRAMEWORK

ABOUT THIS CHAPTER

Chapter 2 explained the national framework for delivering mental health services. The purpose of this chapter is to explain the local framework, by summarising how local services were, and are, organised and delivered.

THE LOCAL POPULATION

There is a lack of accurate data about the mental health needs of Berkshire residents. In national terms, the Department of Health's Mental Health Task Force has estimated that, in an average population of a thousand people, one individual will be severely mental ill and have complex needs that require integrated and assertive care and follow up. A further five people in the group will have a severe illness which needs multidisciplinary long-term care of a slightly less intensive and assertive kind.

Applying these national figures to the 561,133 adults in Berkshire aged between 16 and 74 produces the estimates that:

- 561 of them will experience severe mental illness and have complex needs which require integrated and assertive care and follow up; *and*

- A further 2,805 people will have a severe illness which necessitates multidisciplinary long term care in a slightly less intensive and assertive fashion.

More locally still, the needs of residents in Reading would then be as follows.

Population	*Most severe*	*Less severe*
99,157	99	495

Such extrapolations are, of course, very imprecise. Published evidence links social disadvantage and deprivation with psychiatric morbidity and illness. Areas of high social deprivation correlate with increased prevalence of mental illness and use of services, such as admission to hospital. Vulnerability factors which precipitate the development of mental illness, such as homelessness, poor housing, unemployment, low social status, feeling of isolation, and the effects of poverty, are all associated with higher social deprivation scores.

There are two measures of deprivation frequently used, the Jarman and Townsend scores. According to these models, Slough and Reading are the most deprived localities in Berkshire, while Bracknell, Newbury (West Berkshire), Windsor and Maidenhead fall below the average UK level of deprivation. This suggests that Reading and Slough have higher numbers of people who are more likely to require specialist mental health services.

More particularly, the Jarman model predicts that the highest admission rates will be in Reading and Slough, while the lowest will be in Wokingham. However, Reading and Slough have significantly higher admission rates than predicted, and Wokingham, Newbury and Windsor and Maidenhead have significantly lower admission rates than expected.

BERKSHIRE HEALTH AUTHORITY

Berkshire Health Authority came into being on 1 April 1996, and it took over the function of purchasing hospital and specialist psychiatric services from the old Berkshire District Health Authority.

The Health Authority is responsible for trying to ensure that the needs of people who become ill are met effectively and efficiently within available resources. Its strategic role includes developing collaborative strategies to meet national and local priorities, and it is responsible for ensuring that national policy, and the local strategy, are implemented effectively. It does this in part by monitoring the quality and standards of care of secondary care providers.

Most of the expenditure on mental health services in Berkshire is incurred by the Health Authority, in the main through contracts with the NHS trusts which manage the services, such as the *West Berkshire Priority Care Service NHS Trust*.

In 1997/98, Berkshire Health Authority planned to spend £35.7m on its mental health services. This figure included the contribution of £477,000 made by it to mental health services through joint finance schemes with social services. The level of expenditure was slightly below the average for the other Health Authorities within the region.

Mental Health Services

A conference held in Maidenhead on 7 May 1996 reached broad agreement about the future direction and pattern of mental health services. It was agreed:

- that a single strategy for mental health services should exist across Berkshire;
- that this strategy should ensure that comprehensive and responsive services are in place to serve the needs of the mentally ill in the community and hospital settings;
- that the forensic psychiatric service should be planned and delivered on a county-wide basis, with locally planned outreach or outpatient services;
- that 12 forensic beds in Oxford should be developed; that current bed levels in the east should be maintained; *and*
- that there should be three centres in the county with adult acute inpatient beds — situated at Wexham Park Hospital, Heatherwood Hospital and a new site in Reading.

A key issue facing the Health Authority was, and is, the closure of Fair Mile Hospital, and the reprovision of its services. This has for some years been the focus of mental health work within Berkshire Health Authority.

A strategic discussion document was then issued in June 1997, after which a period of consultation took place. The responses indicated strong support for the concept of community health teams, with many respondents wanting the teams to be strengthened in order to provide more intervention and support.

Mental Health Strategy (November 1998)

Following this consultation exercise, Berkshire Health Authority published its mental health strategy in November 1998.

Service principles

According to the strategy, mental health services in Berkshire should meet the following seven principles.

1	*An ordinary life*	• Services should enable people with mental health problems to enjoy a quality of life equal to that of other citizens. Care and treatment in the community is preferable to that of an institution wherever possible.
2	*Promote independence and individual needs*	• Services must be unified, responsive and comprehensive. People should be considered as individuals. There should be proper protection for those who are unable to protect themselves against exploitation, abuse or neglect.
3	*Local and accessible*	• Mental health services must be easily accessible and delivered wherever possible on a frequent or daily basis. Information about all mental health services and how to access resources and information in a local area should be widely publicised.
4	*Equity*	• Services should be equitable and based on local need.
5	*Choice of services*	• Services should be wide ranging and offer a choice of care, treatment and support.
6	*Involvement of users*	• Users should be involved from the individual care plan to the development of policy and services. People should be treated and cared for in a way that promotes self-determination and personal responsibility.
7	*The needs of carers*	• Carers' needs and rights must be addressed by providing information and support as quickly as possible in a way that is most appropriate for the individual carer or family, and by involving them in the development of care plans.

Service objectives

The Health Authority's strategy stated that, in order to achieve these service principles, the service in each area should meet the following seven service objectives. It was, however, recognised that many of the aims require further service development and not all can be achieved rapidly.

1	*Co-ordinated range of services*	• To offer a co-ordinated range of resources that will provide assessment, care, treatment, advice and support for people with varying mental health problems. • Attention will be given to their mental, physical, social, housing, financial, work and educational needs. • Particular emphasis will placed on providing comprehensive support to people with a severe and enduring mental illness, and meeting their residential needs.
2	*Multi-disciplinary service*	• To develop a seamless multidisciplinary service so that duplication is avoided by the adoption of a unified and comprehensive assessment, discharge planning and monitoring process. Involvement and liaison with GPs is essential to this process. This will require a single system of recording and storing information.
3	*Single managerial structure*	• To adopt and to develop a single locality based managerial structure. All professionals should work within this structure, and those who must be based in an acute setting should still have a clear community focus.
4	*Partnership*	• To establish partnership arrangements to plan, commission and organise the contractual framework for delivering mental health, social care and housing services; with local accountability and targeting of services to local need. This will involve shared resources and aligned budgets wherever possible. It also requires working with other agencies whose services and resources have direct implications for people with mental health problems (*e.g.* housing associations, independent providers, the police and probation service, and the Benefits Agency).
5	*Reprovision from institutions*	• To support the move of people with a mental illness from large institutions to the community.
6	*Education*	• To pursue appropriate consultation and educative programmes to ensure the effective integration of people with mental health problems into local communities.
7	*Users and carers*	• To develop and encourage local users and carers groups and networks, and the formation of multi-agency mental health forums.

Service interventions and outcomes

The Health Authority is developing an evidence-based mental health strategy. To this end, it has surveyed 189 professional journals in order to appraise the evidence of effectiveness for a number of service models. The main findings were published in the Director of Public Health's Report for 1997, and are reproduced below.

THE APPRAISED EVIDENCE FOR MENTAL HEALTH SERVICES		
	Intervention	***Outcomes***
Community Mental Health Teams	**Care management** brokerage of care by social services, co-ordinating purchasing from other agencies.	**Care management** • doubles admission rates • some maintenance of continuity of care • little evidence of improving mental and social functioning
	Assertive Care Treatment teams (ACTs), *i.e.* single managed, multidisciplinary teams with social services providing intensive proactive care for the targeted care group (with criteria) and rehabilitation, and some offering 'Home based Daily Living Programme.'	**Assertive Care Treatment (ACTs)** • appears to reduce admission rates • improved social/mental functioning • improved reported patient satisfaction rates • reduced family burden • increased employment rates (esp. if occupational therapist is part of the team)
Crisis Intervention	Early intervention response by community teams, crisis residence, assertive outreach (variant of ACT)	**Early community Intervention** • greater patient satisfaction than inpatient care • small clinical improvement, and reduced bed use **Proactive variant of crisis response** *(outreach/assertive treatment)* • more effective than reactive response once crisis has developed (although no direct comparison), and reduced in-patient bed use. **Day hospital versus crisis residence** • little difference in outcome but crisis residence was 20% cheaper (greater for non-psychotic patients) • crisis response patients may have higher readmission rates
Day care	day care vs. crisis respite vs. in-patient care	*day care and in-patient care* • no significant differences on clinical improvement (one study showed more rapid improvement for in-patient care) • day care cheaper • less family burden at one year • for acutely ill, day care can reduce admission rates if diverted • greater patient satisfaction • If day care is supported by employment programme, then higher rates of employment than rehabilitation day treatment

Optimum length of stay	in-patient care	• No definitive length of stay clearly identified • factors shown to influence included degree of severity of illness, community support, residential care provision, early detection and management by PHC staff, staffing levels, departmental philosophy • suggested that patients who were kept in for 30 days or less relapsed sooner
Comprehensive mental health service	Comprehensive (or spectrum of care) vs. single components of mental health service	• Not one study directly addressed this important question • The RCT was flawed due to very high exclusions including admission in last 12 months • Home based intervention was more effective than comprehensive service (*but caution here)

Berkshire and the National Service Framework

The government released its national service framework for mental health on 30 September 1999 (see p.15). The first draft of Berkshire's *Implementation Plan* was completed in December 1999. This was widely circulated, and comments were then amalgamated within a second draft during February 2000. The final plan was agreed in March 2000, and it will be reviewed in April 2001. Berkshire's Mental Health Strategy of 1998, and local authority strategies and community care plans, are being updated in line with the final NSF plan.

Those involved in implementing the NSF locally are clear about the need to prioritise their efforts, and to choose achievable deadlines. Of the key priorities set out in the current implementation plan, the very first focus will be on opening low secure beds, creating better 24 hour access to services across the county (with special emphasis on those on enhanced CPA), and developing supported accommodation/24 hour staffed beds in the community.

IN-PATIENT AND RESIDENTIAL BEDS

The following table, from the Health Authority's *Mental Health Strategy* of November 1998, sets out the number of in-patient beds, and residential beds with staff awake at night, which were available to Berkshire residents. It also assesses the level of beds required to meet local needs, by using the MINI score developed by the Department of Health for assessing mental health needs.

Type of accommodation	***Current bed numbers***		***Mini Score Bed No. Estimate***	
Staff Awake at Night	*East*	*West*	*East*	*West*
Acute and Crisis Care	71	78	89.4	83.1
Intensive Care Unit	6	8	18.0	13.9
Rehabilitation and Continuing Care Wards	8	77	74.0	69.9

The table suggests that there is some inequity in provision between the East and West Berkshire, and a shortfall in terms of in-patient provision in East Berkshire.

Fair Mile Hospital

Fair Mile Hospital provides an in-patient service for acutely ill adults, and also rehabilitation and continuing care. There are 91 acute beds on four locality based admission wards (although the number of beds was only 64 during part of 1999, due to severe difficulties recruiting qualified nursing staff). Ipsden Ward is the acute ward for persons in South Reading, while Henley caters for those in North Reading. There are also 16 intensive care beds on Rotherfield Ward, which is situated on the Fair Mile site. Mr Cameron spent some time on Grazeley Ward, which was Fair Mile's intensive care unit before Rotherfield opened.

Closure of Fair Mile Hospital

Fair Mile Hospital is a Victorian mental health asylum which is in a very unsatisfactory condition. A Private Finance Initiative project, supported by the NHS Executive, will enable it to be replaced by modern, accessible, services in a more appropriate style and location. It is planned that the new hospital at Prospect Park will open in 2002, and include 91 general mental health beds, 15 intensive care beds, 20 rehabilitation beds, and a 12 place 24-hour nursed ward in a house.

Medium secure services

The 13 bed medium secure unit at the Wallingford Clinic, Fair Mile Hospital, closed in the autumn of 1999, and was replaced by a new 40 bed medium secure unit at Littlemore Hospital in Oxford. 14 of these beds are for Berkshire residents, which represents an increase of four beds. A new medium secure ten bed special needs unit on the same site will provide a service for people with complex problems. Berkshire Health Authority is contracting for five of these beds.

WEST BERKSHIRE PRIORITY CARE SERVICE NHS TRUST

Fair Mile Hospital is managed by *West Berkshire Priority Care Service NHS Trust.* The trust was officially formed on 1 April 1993. During 1996/97, it employed over 2300 people, had a turnover of £58m, and provided community health care services, mental health services, and services for people with learning disabilities. Its catchment area stretched from Wokingham in the east to Hungerford in the west, and from the Hampshire border in the south to South Oxfordshire in the north, covering a population of over 450,000 people. Some of the mental health services provided by the trust during 1996/97 were as follows:

Fair Mile Hospital, Cholsey

- Acute in-patient services
- Day care and therapies
- Rehabilitation, also community psychiatric nursing
- Psychology service
- Occupational therapy
- Pharmacy

Coley Clinic, Reading

- Community mental health service

Eldon Day Hospital, Reading

- Day hospital services for the adult mentally ill

Winterbourne House, Reading

- Psychotherapy service, including therapeutic community

The day hospital moved to the Prospect Park Hospital site in Reading in August 1997, and the community mental health team has also relocated.

General Adult Psychiatry

Patients are assigned to a consultant psychiatrist according to the locality of their GP. General adult psychiatry services were reorganised in April 1994, and are now based on four, rather than three, localities. As part of the reorganisation, each locality was assigned two consultant psychiatrist posts and two junior psychiatric posts (either senior house officer or staff grade doctor). The long-term strategy is for the consultant psychiatrists who cover Reading to be based together with the CMHT, but this is unlikely to be achievable until 2003. At present, one of the consultants is based at Prospect House and the other at Erleigh Road.

Reading North team (population 135,404)

The consultant responsible for Mr Cameron's treatment until March 1995 was part of the Reading North team. A staff grade psychiatrist within the team cared for him, under the consultant's supervision, during two in-patient admissions in 1993 and 1994. At about the time that Mr Cameron was referred to the Reading South team in March 1995, having changed his GP, this staff grade psychiatrist transferred to that team. She then saw Mr Cameron as an out-patient until April 1996, after which his consultant saw him.

Reading South team (population 113,065)

There was only one consultant psychiatrist in Reading South when the locality was created. In April 1995, a second consultant, who was responsible for Mr Cameron's treatment from then on, joined the team. When the original consultant then moved on in December 1995, Mr Cameron's doctor did not have a fellow consultant for three months. Two locum consultants were then in post from April 1996 until December 1996, after which another consultant started work in January 1997.

COMMUNITY MENTAL HEALTH TEAMS (CMHTs)

The organisation of community services is based on multi-disciplinary community mental health teams (CMHTs). Their boundaries reflect the historical boundaries of the trust, and it is only in Wokingham that CMHT boundaries broadly align with those of the local unitary authority and primary care group.

A recent comparison of the composition of Berkshire CMHTs appears in the *Mental Health Strategy* of November 1998, and it is reproduced below.

	Slough	*Windsor/M'head*	*Bracknell*	*Reading*	*Wok'ham*	*Newbury*
CPN	7	5.5	8	10 north	5.5	8
Psychologist	0.2	0	0	0	0	0
Community Worker	4	2.3	1.5	1	2.3	2
OT	1.4	0	0.2	1.5	1.5	2
Social Worker	8	5.5	6	11	5.5	5.5
Total/10,000	2.6	1.34	1.98	2.2	1.4	1.7

Integration and management

Community mental health teams include employees of both the local NHS trust and the local social services authority. Reading has had a joint CMHT manager since October 1999, and this individual manages both the Reading teams. The joint manager regularly meets with the service managers from the trust and Reading Social Services, and he is a member of the locality steering group responsible for planning and developing local services. Considerable work has been done to integrate community health and social services, and there now exist joint eligibility criteria, joint allocation and referral meetings, and a new on-call system.

Social Services

On 1 April 1998, Reading Borough took over responsibility for *all* local government services within the locality, including social services. Prior to then, social services was a county-wide service provided by *Berkshire County Council*, while housing and housing policy *was* a borough responsibility.

At the time of Mrs Cameron's death, in April 1997, Berkshire County Council was therefore in the last year of its existence, and the organisation of social services was in a state of flux.

Purchaser-provider split

Under Berkshire County Council, there was a very clear purchaser/provider split in the management of social services:

- residential, day care and domicilliary services were the responsibility of the 'provider side' of the organisation, *and*

- assessment and care purchase functions, including core social work activity, were allocated to the 'purchase (and care management) side'.

A senior assistant director was responsible for the purchasing (and care management) side of the service. S/he was assisted by two assistant directors, one for East Berkshire and one for West Berkshire. Spread across East and West Berkshire were 16 locality teams, each headed by a locality manager who reported to the relevant Assistant Director.

There were three locality teams in Reading: Reading Central, and Caversham, Whitley and Tilehurst. These teams were responsible for assessing individual need and arranged for the provision of appropriate services, as well as subsequent monitoring and review. In September 1996, the three locality managers were replaced by a single area manager.

Community mental health teams

At the time Mr Cameron received social care, community mental health teams were on the purchasing side of Berkshire Social Services' organisation. However, mental health was resourced by a small group of staff who could not readily be split into a large number of locality teams. Some separate arrangement was therefore necessary. The social services contribution to the community mental health team came under the line management of the Tilehurst locality manager. Coley Clinic contained the purchasing arm of the social services department's mental health services, together with some of the community psychiatric nurses who were separately managed. Bucknell House, jointly administered by the NHS and social services, contained the provider (treatment) facilities.

Assertive Community Treatment

The *Mental Health Strategy* emphasises the need to develop a co-ordinated range of resources within the community. One option is assertive community treatment for severely ill patients who tend to need long periods of inpatient care, or repeated short admissions, and those who tend to lose touch with the service altogether. An assertive community treatment team has been operating in Reading South since the spring of 1999. It was established with a team leader and four workers, to include two with a nursing background, an occupational therapist and a social worker.

User and carer involvement

The *Mental Health Strategy* identified the need to more appropriately involve service users and their carers, both in the broad planning of services and in the specific service which an individual service user receives. There are a number of initiatives seeking to move this forward. These include user and carer involvement in locality steering groups; the development of user groups through initiatives funded by some of the unitary authorities; and the development of an advocacy service for those patients planning to be resettled as part of the closure programme for Fair Mile.

PREVIOUS INQUIRIES IN BERKSHIRE

Since 1997, Berkshire Health Authority has commissioned and published three other independent inquiry reports into the care and treatment of psychiatric patients who have committed homicide:

> *The Report of the Inquiry into the Treatment and Care of Darren Carr* was published in April 1997.
>
> *Strengthening the Net: An Independent Inquiry into the Mental Health and Social Services Care given to Mrs Anne Murrie* was published in May 1999.
>
> *The Report of the Inquiry into the Treatment and Care of Stephen Allum* was published in April 2000.

It is important to emphasise that Reading Social Services were not involved in providing services to any of these patients, and the West Berkshire Priority Care Service NHS Trust was only briefly involved in providing medical care to two of the patients.

Darren Carr Report (April 1997)

Mr Carr received treatment at Heatherwood Hospital and at the Wallingford Clinic. In June 1995, he set fire to a house in Abingdon, causing the death of a woman and two children. The independent inquiry into his care and treatment made a number of recommendations, amongst which were:

1. that the Thames Valley Police Authority and the Heatherwood and Wexham Park Hospitals NHS Trust should establish guidelines to deal with situations where a suspect is brought by the police to the casualty department and subsequently referred to the psychiatric service. These guidelines should consider how and at what stage the police decide whether or not to proceed.

2. that Berkshire Health Authority should ensure that the commissioning of intensive psychiatric care beds proceeds with the utmost urgency.

3. that Berkshire Social Services Department should review the provision of supported accommodation for patients discharged from psychiatric hospitals with particular reference to emergency provision.

4. that the West Berkshire Priority Care Service NHS Trust should ensure that high priority is given to the initiation of medium term housing plans at an early stage in discharge planning in cases where hostel accommodation is anticipated to be relatively short term, and that local housing agencies be involved in the preparation and execution of these plans.

5. that the relevant local government authorities in Berkshire and Oxfordshire should take urgent action to review the provision of appropriate housing for mentally disordered people moving to the community.

Anne Murrie Report (May 1999)

In February 1994, Mrs Anne Murrie took the life of her nine year old daughter Louise, and was subsequently admitted to Broadmoor Hospital. She had had several episodes of psychiatric care prior to the homicide, and her care was provided by four different agencies, including Berkshire County Council and the West Berkshire Priority Care Service NHS Trust (which manages Fair Mile Hospital).

An independent inquiry into Mrs Murrie's care and treatment identified good practice in some areas. For example her discharge from Fair Mile Hospital to Oxfordshire social services was described as 'faultless and is an example of good professional practice.' However, the panel's report also highlighted unsatisfactory communication between and within agencies; unsatisfactory implementation of the care programme approach (the CPA was not fully implemented and there was an absence of a written care plan); the lack of an effective mental health strategy; insufficient resources for mental health services; delay in reproviding Fair Mile Hospital; and a lack of community services. The agencies affected by the report established a joint agency group to take forward implementation of the recommendations. They agreed to invite the panel to review their progress after 12 months.

Stephen Allum Report (April 2000)

Stephen Allum assaulted his stepmother on 30 August 1997, holding a broken glass to her face. Following his arrest for causing actual bodily harm, he was admitted to Wexham Park Hospital as an informal patient. Subsequently, he was discharged home on 22 September, and seventeen days later killed his wife, Thelma Allum. He was convicted of manslaughter on the grounds of diminished responsibility, and admitted to a medium secure unit, subject to a restriction order.

Mr Allum lived in Maidenhead, which is within the area served by Berkshire Health Authority and (until) by Berkshire Social Services. Neither the West Berkshire Priority Care Service NHS Trust nor Reading Social Services were involved in providing medical treatment or social services to him.

The inquiry panel found that Mr Allum's mental state and behaviour had deteriorated during the two years prior to his admission to Wexham Park Hospital; that he was suffering from an acute paranoid psychosis at the time of this admission; that, in less fortunate circumstances, the assault on his stepmother could have caused extreme physical harm; that he continued to experience symptoms of mental illness, including paranoid ideas, at the time of his discharge from hospital; that he remained vulnerable and desperate throughout; that the homicide was planned, and its motivation probably based largely on matters not related directly to mental disorder; but also that residual mental disorder probably played some part on his affect, and thence his judgement, thereby facilitating the killing.

In terms of the care and treatment provided to Mr Allum, the panel found that important details concerning Mr Allum's assault on his stepmother were unknown to those assessing his mental state and the risks associated with it; that the quality of the pre-CPA assessment and records was inadequate; that a key worker was not agreed at the time of his discharge from Wexham Park; and that there was a widespread failure to implement *Health Service Guidelines*; and that professional intervention concerning Mr Allum's need for housing was belated, and the advice he was then given was 'counter-enabling'.

The action plans agreed with the panel included the development of *simple* arrangements designed to ensure that mental health professionals who conduct police station assessments of persons arrested for assault, and those conducting risk assessments following admission and prior to discharge, possess detailed information about the suspected assault; the development of improved assessment procedures on acute wards, of an operational policy for the acute service, and of standards which ensure that all clinical staff receive regular clinical supervision; and the appointment of a senior health service manager with responsibility for ensuring adherence to *Health Service Guidelines*.

The overall standard of mental health services in East Berkshire was found to be high. The action taken represented a further improvement, and deserved the support of local people.

4 THE HUMAN FRAMEWORK

ABOUT THIS CHAPTER

The service which professionals can provide to persons with mental health problems is not defined only by resources and patterns of service delivery set nationally and locally. It is also determined by many other factors, such as the chronic course of some mental disorders; the fact that presently there are no available cures for severe mental disorder; the limited efficacy of the treatments presently available; and the speculative nature of all assessments of an individual's likely future behaviour. The purpose of this chapter is to set out briefly some of these problems, and what the public may reasonably expect in relation to psychiatric treatment and care, so that professional decisions are measured against a realistic yardstick.

MENTAL DISORDER

Psychiatry is that branch of medicine concerned with the study, diagnosis, treatment and prevention of mental disorder. The term 'disorder' is not an exact term but simply implies the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. In practice, the classification of certain disorders as mental or psychiatric is largely determined by the historical fact that these conditions have generally been treated by psychiatrists.

RISKS ASSOCIATED WITH MENTAL DISORDERS

The current emphasis in mental health practice is very much on public safety. However, statistically, the risk that a mentally ill person will kill her or himself is substantially higher than the risk that s/he will kill another person. According to one study, persons suffering from schizophrenia are one hundred times more likely to kill themselves than another person, and persons with a mood disorder are one thousand times more likely (Häfner & Böker, *Crimes of violence by mentally disordered offenders,* Cambridge University Press, 1982).

Serious mental disorder has a marked effect on lifetime suicide rates. They have been estimated at schizophrenia 10 per cent., affective (mood) disorder 15 per cent., and personality disorder 15 per cent.

The risk of homicide and violence to others

There are about forty homicides per 100,000 psychiatric admissions, compared with ten maternal deaths in child-birth per 100,000 deliveries (Tidmarsh, *Psychiatric risk, safety cultures and homicide inquiries*, The Journal of Forensic Psychiatry (1997) 8(1): 138–151).

Despite understandable public anxiety about the closure of many old asylums, and the move towards care in the community, the criminal statistics for England and Wales between 1957 and 1995 do not show any increase in the number of homicides committed by persons with mental health problems during this period. There has, in fact, been little fluctuation in the number of people with a mental illness who commit criminal homicide during this 38 year period, and a three per cent annual decline in their contribution to the official statistics (Taylor & Gunn, *Homicides by people with mental illness: myth and reality*, British Journal of Psychiatry (1999) 174: 9–14).

Although research findings tend to demonstrate a positive relationship between mental illness and offending, including violence, this must be seen against the general level of violence in homes and public houses, and on the roads. Mentally ill people contribute proportionately very little to the general problem of dangerous behaviour. Measured against the full range of modern social hazards, the contribution to public safety of preventively confining persons with mental health problems is tiny, as also is the likely impact on the rates at which serious offences are committed.

It must also be borne in mind that in-patients are themselves members of the public. Practitioners therefore face the formidable task of ensuring that members of the public are not unnecessarily detained, and also that people protected from members of the public who must necessarily be detained.

GOOD PRACTICE AND RISK MANAGEMENT

There is much written and said nowadays about risk management, of which risk assessment is the first step. Risk management has become a sort of cure-all; as if, recently discovered, it holds the key to a safe future. In fact risk management has existed for years, simply as good practice. Good practice includes skills in communication and understanding, and the capacities to listen, be flexible, and empathic. It is built on sound training, and effective supervision and support; it is not judgemental or discriminatory; it is broadly based, fair and thorough, and its policies and practices are the product of multi-disciplinary consensus. The same comments apply to the care programme approach (CPA) about which, again, much is said in this report.

WHY NO SERVICE CAN EVER BE TOTALLY SAFE

It is impossible for a mental health service to be totally safe. However, some of the principles which psychiatric practice takes account of, and which we have borne in mind, are that:

- there is tension within any resource limited service between the utilitarian ideal of producing the greatest good for the greatest number and the desire to perfect the care for individuals. A utilitarian service attempting to provide 'good enough' care for all will inevitably have some individuals experience a poor outcome. In practice, this usually means that there is subsequently a reworking of the poor outcome cases to a more thorough level.

- in-patients are members of the public, and at increased risk of being victims of violence for as long as they are detained on a psychiatric ward.

- risk cannot be avoided and even a very low risk, such as winning the lottery, from time to time becomes an actuality.

- every decision about the need to detain a person involves the assumption of a risk and, however careful the assessment, it is inevitable that some patients will later take their own lives or commit a serious offence.

- the purpose of compulsory powers is not to eliminate that element of risk in human life which is a consequence of being free to act, and to make choices and decisions; it is to protect the individual and others from risks that arise when a person's judgement of risk, or capacity to control behaviour associated with serious risk, is significantly impaired by mental disorder.

- good practice relies on good morale and a feeling amongst practitioners that they will be supported if they act reasonably; it is unjust to criticise them when decisions properly made have unfortunate, even catastrophic, consequences.

- the occurrence of such tragedies does not *per se* demonstrate any error of judgement on the part of those who decided that allowing the patient their liberty did not involve unacceptable risks.

- an outcome often occurs as a result of a complex of events, and the choice of one particular causal factor may be arbitrary.

- small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.

- unless the individual's propensity for violence has a simple and readily understandable trigger, it is impossible to identify all of the relevant situations; some of them lie in the future and will not yet have been encountered by the patient.

- understanding the situations in which a person has previously been dangerous, and avoiding their repetition, can give a false sense of security about the future.

- although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction is therefore significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

- predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').

- a risk can in theory be measured and is the basis of actuarial prediction — in theory because in practice all of the critical variables never are known. While the risk depends on the situation, all of the situations in which the patient may find himself in the future can only be speculated upon.

- all violence takes place in the present, and the past is a past, and so unreliable, guide to present and future events.

- because future events can never be predicted, it is important to put in place an adequate system for supervising any individual whose own safety may potentially be at risk or who may pose a threat to the safety of others.

- this approach is not fail-safe: it is based on an assumption that most attacks do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.

- all human beings, regardless of their skills, abilities and specialist knowledge, make fallible decisions and commit unsafe acts, and this human propensity for committing errors and violating safety procedures can be moderated but never entirely eliminated.

- introducing the concept of 'hindsight bias' in a defensive way cannot justify a lack of reasonable foresight, or simple failure to think about what one is doing.

5 MR CAMERON'S CARE AND TREATMENT

ABOUT THIS CHAPTER

This chapter serves two purposes. Firstly, it summarises Mr Cameron's care and treatment. Secondly, it highlights some of the main concerns of his sister, Julie Cameron, which our findings, set out in the following chapter, try to address. Her observations appear in italics.

During the early hours of 26 April 1997, Alexander Cameron killed his mother, Eileen Cameron, at their home in Reading. Eight days later, on 4 May 1997, he was admitted to a high security hospital under section 48 of the Mental Health Act 1983 (see p.10). On 17 October 1997, Reading Crown Court heard that he was mentally disordered and had been suffering from mental illness at the time of the killing. He was found guilty of manslaughter on the grounds of diminished responsibility, and made subject both to a hospital order and an order restricting his discharge without limit of time.

Alexander Cameron was born on 16 April 1965 and was 32 years old at the time of his mother's death. His parents, who married in 1952, had a strong and contented relationship. His father, a bus driver, was a pleasant and intelligent man popular in the local community, who got on well with him. Mrs Cameron, who was born in 1926, worked as an accounts supervisor until her retirement in 1986. In 1991, after her husband's death, she returned to work as an accounts administrator at the Royal Berkshire Hospital, where she was employed until the time of her death. She was an independent, intelligent, lively and amusing woman, with a wide circle of friends, and a loving and caring parent. The Camerons had two children, their daughter, Julie, being six years older than Alexander. She supported him, and looked after him, in numerous ways since his early childhood.

Alexander Cameron was a sensitive and kind child, but also an anxious one. From the age of four onwards, he developed irrational fears, which he talked about constantly, and for which he required regular reassurance. At four years old he was afraid to go to bed at night, in case the fluff from the blanket accumulated in his throat and gave him a fur ball. At the age of five or six, following a casual comment that privet leaves could be dangerous, he became convinced that he had a privet leaf in his mouth. For months he walked around asking people to check his mouth to make sure no leaf was there. At the age of eleven, he would carry all of his school books with him, 'just in case' he should be asked for a particular book.

This anxiety continued into adolescence and adulthood, and he continued to need support from his family. He was unduly preoccupied with his health, and imagined himself to be suffering from various conditions which the medical profession were unable to diagnose. This resulted in frequent visits to his general practitioner and several outpatient referrals. He experienced panic attacks and was prescribed tranquillising medication.

Almost inevitably, this anxiety and sensitivity came to interfere with Mr Cameron's education and employment. Having obtained nine O levels at good grades, his academic performance declined. From 1984 onwards, after leaving full-time education, he had a succession of jobs. Although initially thrilled with the new job, it is said that he soon become convinced that people were talking about him at work, and would leave the job shortly afterwards; this process would repeat itself when he next gained employment.

In April 1985, at the age of 19, he was referred to an opthalmologist following persistent complaints that he was going blind. The opthalmologist could find nothing wrong and recommended that he see a psychiatrist. The diagnosis made at that time was of a severe phobic disorder and obsessional hypochondriasis, with some underlying depression. The approach to his problems was unsympathetic and censorious, and no treatment was provided.

Mr Cameron was anxious to have a girlfriend, and a distressing first relationship caused him, in March 1988, to have an unsuccessful operation to rectify one aspect of his appearance. From this time onwards, he also received treatment for high blood pressure of unknown cause.

Mr Cameron's father died in 1990, having contracted cancer in 1986. The situation at the beginning of 1991, when he was first detained, was a sad one, both for him and his family. He was aged 25, and he, his mother, and his sister were trying to come to terms with his father's death. He had not been able to attain regular employment, or to form close relationships outside a supportive family, upon whom he was highly dependent. He did not feel comfortable in groups, was afraid of offending people, and felt that he could not think of anything to say. He was preoccupied with his health and physical appearance. All of these difficulties were manifestations of an innate sensitivity, self-consciousness and anxiety. When not anxious he was articulate, pleasant, compassionate, witty and fun. In forensic terms, he was a man of good character, who did not take illegal drugs, and who was not dependent on alcohol.

January 1991. Detention in London under section 5(2)

In January 1991, Alexander Cameron underwent further surgery, this time in London, to correct the complications of his earlier operation in March 1988. Four days after the operation, while still in hospital, he became acutely psychotic. He believed that the telephones were tapped and that the nurses were listening; that he was going to die; that he was yellow with liver secondaries, like his father; that he could smell gangrene; and that he was going to be amputated from the waist down. His urine was beetroot red. He was detained under section 5(2) of the Mental Health Act 1983 (see p.10), and given antipsychotic medication. He made a fairly rapid recovery, and was discharged home six days later, still on this medication. He was referred to a consultant at Fair Mile Hospital, but there was no follow-up because the papers went astray.

13 August to 13 September 1993. Detention at Fair Mile under section 2

In July 1993, Mr Cameron attended an anxiety management day workshop. On 8 August, he was admitted to the Royal Berkshire Hospital, in order to investigate a possible thrombosis. Being in hospital and undergoing surgical procedures was a terrifying experience, given his lifelong hypochondria and his father's recent death, and it again produced an acute psychotic reaction. He became mentally unwell over the next two days, no longer recognising his mother, asking her where his mother was, and saying that he had been turned into a woman. He thought that a group of hospital doctors and health workers were experimenting on the minds of 'loners and misfits', and that the nurses had drugged his bedtime drink. Being frightened for his safety, he walked out of the hospital before the investigations had been completed. Having returned home, he drank weedkiller in 'an attempt to escape the nightmare' he was living. He was taken to the casualty unit at the Royal Berkshire Hospital, where he was seen by a consultant psychiatrist who, after his admission to Fair Mile, became responsible for his treatment until March 1995. He told her that his mind was being bent, that people knew what he was thinking, that men were changing into women, that people were saying bad things about him, that faces changed as he looked at them, and that others were not who they said they were. He agreed to being informally admitted to Fair Mile Hospital, although the consultant 'took the

precaution' of completing a recommendation for admission under section 2 of the Mental Health Act (see p.9).

Believing that Fair Mile Hospital had been closed, and fearful that people were not who they seemed or purported to be, Mr Cameron ran off while waiting for the ambulance, and went to the town centre. He became violent when the police tried to return him to the casualty unit because of his belief that hospital staff were trying to harm him. As a result, he was detained by the officers under section 136 (see p.000) and taken to Reading Police Station. Such was his fear and his strength (6'2" in height and weighing 14 stones) that seven police officers attempted to restrain him in a cell, and plastic handcuffs and ankle straps were applied. His arms and legs were extensively bruised and swollen, causing restricted movement. Mr Cameron was assessed in the police station by an approved social worker and a police surgeon, who completed the remaining forms necessary to authorise his detention in Fair Mile under section 2. Around midnight, he was escorted there in an ambulance by four police officers, in what by then must have been a state of complete terror, and they had to restrain him because he kept trying to escape during the long journey.

On arriving at Fair Mile, Mr Cameron punched a female nurse, which led to him being restrained by six male nurses, given intramuscular medication, and admitted to the locked ward. He was still being restrained by five male nurses on his arrival there at 3.30am, and so was given further medication, and placed in an isolation room with two nurses. At 8.20am he attempted to break the door down, in order to leave, and was restrained and given further medication. He remained difficult to manage, his fear in the company of others causing him to try to escape, or to take action to defend himself. He sometimes refused medication and required physical restraint to administer intramuscular injections. He thought that he had died and was in hell, and saw female faces superimposed on male faces. His doctor was the devil, the medical profession were in league with 'forces of darkness', and he had been 'selected' for reasons connected with his birth on Good Friday. Given his beliefs, he was naturally reluctant to communicate with those treating him.

By 23 August, Mr Cameron's mental state had been settled for some days and he was readmitted to the open ward. He was described by nursing staff as calm, rational, insightful, coherent and symptom-free. However, he said that he was depressed, had no interest in anything, and derived no enjoyment from life. He agreed that he lacked self-confidence and social skills, and expressed an interest in psychotherapy or counselling, and help with anxiety/stress management. It was felt that he would benefit from attending Eldon Day Hospital, to which he was therefore referred. The aim was to develop his self-esteem, social life and communication skills, and anxiety management. According to the referral form, he lacked 'the necessary social skills and self-confidence to mix with people or hold down jobs, which he would very much like to do.'

Two possible causes of Mr Cameron's difficulties were investigated at this point, although the tests proved negative. Firstly, it was noted that he experienced abnormal tastes and smells prior to psychotic episodes, which raised the possibility of temporal lobe epilepsy. Secondly, his sister informed staff that he had reported abdominal pain and passing bright red urine prior to admission (later variously described as being dark, orange, and orange-red in colour). This raised the possibility that he might have a rare inherited disease called porphyria.

On 30 August 1993, Mr Cameron's sister reported that he had been acting very strangely while on weekend leave, in a manner similar to that when he first became ill. He thought that he was possessed, and was suspicious of the treatment he had received at the Royal Berkshire Hospital. He shouted at his sister and her partner, saying that he had been brainwashed, refusing to go back to hospital with her, and insisting that his mother take him back. The following day, he tried to leave the hospital on more than one occasion, was restrained, and readmitted to the locked

ward. While being nursed there in an open side room, he attempted to run from the dormitory, and grabbed a nurse in the process.

As before, Mr Cameron's mental state settled, and he started visiting the open ward on 6 September 1993. On 10 September, his consultant completed a section 3 recommendation (see p.9), noting that his detention under section 2 had been allowed to lapse because he appeared to be recovering and had agreed to stay. However, he was now irritable and demanding to go to Reading to see his mother, and the nurses felt that he had relapsed 'a bit'. Notwithstanding these observations, and the recommendation, he was allowed to discharge himself from hospital on 13 September without further steps being taken to detain him. In all, he had spent a month in hospital, during 17 days of which he had been on the locked ward. The discharge diagnosis was schizophrenia.

During this first admission to Fair Mile, Mr Cameron's consultant devoted considerable time to discussing his care and treatment with his immediate family. Both his mother and sister felt that they were listened to and taken seriously, and that they had ready access to the hospital staff when necessary.

13 September 1993–4 October 1993. Discharged from hospital

Mr Cameron returned home, to live with his mother. An outpatient appointment was made for him, he was given 14 days supply of medication, and referred to a psychologist. He had already been referred to the Eldon Day Hospital. Social services were not involved with his discharge or after-care.

Mr Cameron remained unwell. He believed himself to be in an alternative dimension, with his 'real family' desperately searching for him 'on another plane'. He repeatedly accused his mother of being the devil, and would talk about what had 'been done to him' for hours on end. It was an intolerable situation for them and, on 17 September, he was seen as an outpatient at his own request. His mood was low. He was anxious, withdrawn, and lacking motivation, spending nearly all day in bed, hardly speaking. The outside world had an unreal quality to it. He was next seen on 20 September 1993, when he made remarks such as, 'how do you know you're not dead.' On 27 September, he was admitted to Eldon Day Hospital and saw a senior house officer. He told her that people were laughing at him in town, and talking about him, and that they knew he had been in Fair Mile. He thought that he had woken up on a parallel planet. On 29 September, he said that he still felt that people were changing.

Matters came to a head on 3 October, when Mrs Cameron rang the day hospital and spoke with a staff grade psychiatrist about his behaviour over the weekend. His mother thought that he might have stopped taking his medication, and reported that he had put his hands around her neck, or tried to, calling her the antichrist. She was 'very frightened'.

When asked about this, Mr Cameron accepted that he was sometimes unsure whether Mrs Cameron was his mother, and also that he had wondered if she might be the devil. However, he denied wanting to harm her, and said that he had put his hands round her throat 'as a joke'. This, it seems, had been a frequent expression of his since childhood, used to indicate the absence of any serious or malicious intent. Notwithstanding this, he 'virtually asked to go into hospital' and agreed to informal admission on 4 October. The senior house officer stressed that he would 'be in for some time and that it would not be appropriate to self-discharge after a few days as previously'.

4–6 October 1993. Informal admission to Fair Mile Hospital

On 4 October 1993, Mr Cameron was informally admitted to the same open ward as before, under the same consultant. His case notes were not available, still being en

route to the day hospital. He agreed to have injectable antipsychotic medication (depixol) and was discharged on 6 October without seeing his consultant, after Mrs Cameron said she accepted that he had only been 'joking'.

Sometime later, Mrs Cameron explained her outward acceptance of his explanation as being caused by feeling guilty that she had betrayed him in reporting the incident. According to her daughter, the doctor who assessed him should have realised that it is 'nigh impossible' for a mother to believe that her child is capable of killing or seriously harming her. The judgement of a loving parent is inevitably clouded by their knowledge of the individual when well, by their love, and by a desire to end their child's own torment. They cannot view the issue objectively, and it is inappropriate to rely on their opinions about risk.

6 October 1993–12 July 1994. Discharged from hospital

It was agreed that Mr Cameron would continue his medication and return to the Eldon Day Hospital. He attended there as a day patient for the next nine months and, in October, was referred to a psychologist at Fair Mile Hospital, for an opinion on his diagnosis and vocational advice. The resulting psychological report, prepared on 23 December, stated that he was still unsure whether his mother and other close relations were who they appeared. Emotionally he had very poor contact with his world, and his emotions and feelings were very constricted. He had not yet recovered sufficiently for a realistic assessment of his vocational options to be possible.

During this nine month period outside hospital, Mr Cameron's depixol injection was increased to 100mg each week, and his oral medication reduced. However, his psychotic symptoms continued, according to his own and his family's reports. He would repeat obsessively to Mrs Cameron his version of reality; believed that the devil was significant in his life; and looked at family members in a way which suggested that he remained unsure of their identity. He talked of people being associated with a medicated or scented smell, and was very afraid of his sister's partner, who supposedly gave off this smell. He also complained of 'medicated' tastes, manneristically tasting the air, and eating large quantities of mints in order to disguise them. He spent most of his days in bed, suffering from profound lethargy, which he attributed to the medication. He was unable to concentrate and became incapable of even watching television or reading a book. He believed that he had been robbed of the ability to write, and would lie in his room covering the floor with sheets of paper bearing half formed words and scribble.

In early I994, Mrs Cameron became seriously ill with pneumonia and heart failure, and was hospitalised. Mr Cameron lived alone while his mother was in hospital, although his sister visited him. The house was unclean, and he was unkempt, living off tinned foods, which he ate straight from the can.

In February 1994, Mr Cameron took an overdose of Paracetamol tablets, and was prescribed antidepressant medication. In April, he was seen by an occupational therapist at the day hospital, who noted poor self-care skills and suggested a Richmond Fellowship placement. This resulted in his case being transferred, on 3 May 1994, to a social work care manager, who made the referral. Unfortunately, he then closed his file when Mr Cameron decided not to proceed, without referring the case back.

12 July-12 December 1994. Final admission to Fair Mile, under section 3

In July I994, Mr Cameron took an overdose of eighty Paracetamol tablets. He was admitted to the Royal Berkshire Hospital, and was then detained under section 3 and admitted to Fair Mile Hospital, under the same consultant as before. He was not placed on the secure ward because it had been so distressing for him on the last occasion.

Mr Cameron's mother and sister visited him regularly during his stay in hospital. For several weeks, he remained unwell, being preoccupied with the devil and fears of being harmed. He was then commenced on a drug called Clozaril, which at the time was a relatively new treatment for schizophrenia, recommended for people who had not responded to older drugs. His consultant discussed this option with his mother and sister before starting the treatment; and they were told that he would need regular blood tests, to ensure that his bone marrow function was not compromised. The dosage was increased gradually to 300mg daily, which produced a good response. According to his sister, 'his whole personality was restored and a lot of his anxieties lifted'. He seemed to be happier and more settled, and his ideas of people being imposters, and the devil, appeared to recede. His tendency to imagine illnesses was also no longer apparent. Whether he ceased to have such thoughts and fears, or simply ceased to express them, is less clear. For example, one person told us that 'he took his delusions, put them away somewhere, and rarely looked at them; but if you scratched the surface they were there.'

On 18 November 1994, a CPA meeting (see p.13) was held. At this meeting, a social work care manager based at the Coley Clinic was appointed as his key worker; and, following discussion, his consultant decided not to place him on the supervision register. This was 'in part because the family were concerned about having their details recorded on file'.

Mr Cameron's sister again believes that the doctor taking the decision deferred too readily to family opinion. Knowing now, as she does, the guidance on registration (see p.13), she feels that the decision not to register her brother was 'incomprehensible' — given his history of two suicide attempts (one nearly fatal); extreme violent behaviour when psychotic; and the strangling incident involving his mother (and primary carer).

On 29 November, a care plan was agreed, which was signed by Mr Cameron's consultant and key worker, and agreed to by him and his mother. Because his behaviour had become difficult for his mother to manage, due to her increasing age and his increasing needs, a bedsit was found for him at a property in Blenheim Road, Reading, managed by Paramount Housing. The discharge arrangements were that he receive Clozaril 350mg daily; live at the Paramount Housing property; and attend Eldon Day Hospital. A letter sent to him the following day by a ward sister told him who would be his key worker, adding that another worker would give him contact numbers where he could reach a worker in a crisis. Mr Cameron was then discharged from hospital on 12 December 1994, although he remained subject to section 3 for a number of weeks.

12 December 1994. Discharged from hospital. Attending the day hospital

Following discharge, Mr Cameron did initially live at the property managed by Paramount Housing. However, the other occupants appeared chronically ill and uncommunicative, and he felt isolated. He was unhappy, and increasingly lived with his mother at her home.

Mr Cameron's key worker was on sick leave from January to April 1995. However, his consultant arranged for the care programme to be reviewed at Battle Hospital on 1 March 1995. The key worker's deputy was not informed, and the records of that meeting are missing, if they ever existed. Shortly after this, on 3 March 1995, responsibility for Mr Cameron's psychiatric treatment was transferred to a different consultant. In practice, the staff grade psychiatrist who had known him since 1994 continued to see him, rather than the new consultant.

Mr Cameron attended Eldon Day Hospital until he was discharged from there in June I995. It was agreed that henceforth he would attend outpatients appointments; take medication; and be monitored by the local community mental health team (in

particular, by his key worker) and his general practitioner. He continued to see the staff grade psychiatrist, initially monthly, and then every two months, until January 1996; and she prepared a discharge summary, in which she described him as having a very serious illness, adding that she would be happy to see him as an emergency if there were any concerns. According to this summary, his mother felt he was as well as he had ever been, and had no worries about him being discharged.

It was also agreed that Mr Cameron would continue to collect his medication from the day hospital but that in future the blood tests would be done at his GP's surgery. It appears that he was often late collecting the tablets or having his blood tested. Indeed, he told us that he only took the Clozaril for about two months after being discharged from Fair Mile Hospital, continuing to collect the medication, and to periodically request a reduction in the dosage at out-patient appointments, merely in order to give the impression of compliance.

14 June 1995-5 February 1996. Not attending the day hospital but CMHT file open

By the summer of 1995, Mr Cameron was in effect living with his mother once again, as a result of which his place at Blenheim Road eventually lapsed. Mrs Cameron allowed him to live with her because he was profoundly unhappy at Blenheim Road, and her home seemed the only alternative. She was a supportive mother, who did everything in her power to ensure that he had the best possible life given his illness. At the same time, the fact that once more she found herself having to cope virtually alone was distressing and stressful. She did the best she could to maintain her own quality of life, but inevitably it was eroded by the continual strain of caring for her son.

By early 1996, Mr Cameron's mental health had improved to the point where he was able to attend a horticultural project as a volunteer. He appeared outwardly normal for most of the time. However, if questioned, it became apparent that he still held the same beliefs about past events, and did not acknowledge himself to be, or to have been, mentally ill. He rejected entirely the suggestion that he could be suffering from schizophrenia, and he became quite agitated if the subject was mentioned, or anything relating to schizophrenia was shown on television. His condition was therefore controlled, rather than cured, by the Clozaril.

5 February 1996-26 April 1997. Not attending day hospital and CMHT file closed

By 5 February 1996, it was obvious that Mr Cameron and the community mental health team were not engaging, and a decision was made 'to leave his case open'. What this meant in practice was that the CMHT file was dormant (shut down for the time being) but could be reactivated immediately should this be deemed appropriate.

From this time onwards therefore, the key worker, community mental health team and day hospital were no longer involved with Mr Cameron. Furthermore, his contact with his consultant was limited to one out-patient appointment every six months, the staff grade psychiatrist having moved posts.

On 13 June 1996, this consultant wrote to Mr Cameron's general practitioner, stating that it seems 'he has been essentially symptom-free for a considerable period of time. He states that he is getting on well with his parents *(sic)* with whom he now lives.' On 4 November 1996, Mr Cameron, accompanied by his mother, attended what was to be his last appointment with the consultant. According to a follow-up letter dated 6 November, he remained well, a reduction in his Clozaril having had no adverse effect.

At the beginning of I997, Mr Cameron started his own small gardening business. He was able to visit the homes of strangers, to meet with them and prepare estimates. He managed to develop several private customers, and this was probably his most

sustained period of regular employment. He showed more motivation and self-confidence than he had for many years. He started to talk of going to college to study horticulture, of getting his life in order, and of the possibility of finding a girlfriend. He was described as being sociable and good company, and as perhaps the best mentally that he had been for a long time. All seemed to be going well and, in relative terms, Mr Cameron had indeed been very well during the previous year. However, he still did not recognise his illness and referred occasionally to his particular version of past events. Furthermore, according to him, he was still experiencing some symptoms of mental illness throughout this time, although they were not of a nature which distressed him. For example, during the six months to April 1997, he had the experience that television programmes could read his mind and affect his thoughts. The action he took to prevent this affecting him was simply not to watch the television.

20–24 April 1997. Mr Cameron's mental health deteriorates

Good Friday fell on 28 March in 1997, and Mr Cameron celebrated his thirty second birthday on 16 April. It appears that his mental state may have begun to deteriorate some three or four weeks before his mother's death (from around the beginning of April); and his beliefs about the devil, or people being imposters, began to trouble him once again.

For several days prior to his mother's death, Mr Cameron experienced the same symptoms that he had experienced in the past when he required hospitalisation. He started to feel physically unwell, lost his appetite and became highly anxious. He then experienced a feeling that something was going to happen and had a strange taste and smell. He began to believe that people around him were not who they seemed, and were in fact the devil or possessed by the devil. These beliefs included his sister's partner and his mother.

At this stage, Mr Cameron knew he was becoming unwell again but was unable to trust the doctors sufficiently to contact them. According to him, this was because he believed he had been over-medicated in the past to the extent that he was unable to get out of bed. His fear that hospital staff had tried to harm him may also have been a factor, and indeed the two may be related.

On Sunday 20 April 1997, he visited Julie Cameron and her family on his own. His sister noticed that he was prone to misinterpreting harmless comments, and she was uneasy about his mental health.

On Tuesday 22 April, Mr Cameron told his mother that he had found eating difficult, and made cryptic comments implying that he believed she was poisoning him.

On Thursday 24 April, Mr Cameron arrived at his sister's home shortly after she had left for work. According to her partner, he was tearful, distressed and agitated, saying that he felt depressed, and that everything was going wrong again. He seemed distant and distracted, constantly repeating himself. Ms Cameron's partner tried to persuade him to seek help from his consultant, which he agreed to do, although suspicious. The family's concern at this time was that he was very depressed, on the verge of an acute psychotic episode, and, without intervention, possibly at risk of suicide.

Having been told of the visit, Julie Cameron telephoned her mother to let her know of it. The two of them always went out together on Thursday evenings, and they agreed to discuss the situation further when they met. At dinner, Mrs Cameron recalled how her son had prevented her from using the telephone in the past, and asked her daughter to check that everything was all right if she didn't hear from her. She said that Mr Cameron had told her that he was taking his medication. However, as he had often been evasive when questioned about his tablets, and furtive in the

taking of them, neither of them placed much reliance on this. They agreed that Julie Cameron would ring Fair Mile in the morning, and speak with the consultant. After dinner, they returned to Julie Cameron's home. Mr Cameron had telephoned on several occasions during their absence, asking where his mother was, even though he knew they always went out on Thursdays, and had been told where they were going. His manner had been 'strange'. When Julie Cameron returned his calls, he seemed agitated, talking of how he must find a partner, and wanting to come round to compile an ad for a dating agency. This was not practicable given that it was after eleven o'clock. Mrs Cameron then left to go home; and, tragically, this was the last time her daughter saw her.

25 April 1997. Mr Cameron's sister contacts psychiatric services

On Friday 25 April, Julie Cameron decided to go to work late, so that she could telephone Fair Mile Hospital from home. Her partner agreed to stay with her until matters were resolved. Before she could ring, Mr Cameron telephoned her, in a very distressed and agitated state. As on the previous morning, he was crying, talking of his feelings of depression and despair, saying that everything was out of control, and wanting help. He was not entirely lucid, and he referred to things which his sister could not understand.

Julie Cameron asked her brother to come to her house. She telephoned the consultant at about 9am and, having asked to speak with him, was put through to his secretary. Having introduced herself, she says that she explained that her brother suffered from schizophrenia; that he had last seen the consultant some five months previously; that the family were concerned about his mental state, which had been deteriorating since his birthday; that he seemed very depressed and confused; and that she would like to speak to the consultant. Since the consultant was seeing other patients, the secretary agreed to relay the message, and phone back.

Before the secretary telephoned, Mr Cameron turned up at his sister's home. He was clearly very unwell: perspiring, tasting the air in a manneristic way, questioning and suspicious, with the staring eyes and facial mannerisms that he had previously displayed when psychotic. He wanted to know why they were not at work, and why their telephone had been engaged again after he called. He made frequent references to the devil and accused them of being impostors. He claimed that his sister was not his real sister, that she was 'the other sister', and said that he could hear her partner's 'devil voice underneath his real voice'. He talked about God, the devil and punishment.

When the consultant's secretary phoned back after half an hour, or so, she told Julie Cameron that the consultant would see her brother the following working day, during the morning on Monday 28 April.

Julie Cameron says that, during this conversation, she emphasised that her brother was now with her, and that he was clearly in need of immediate help. More particularly, she emphasised that her brother was psychotic; that he was making references to the devil; that he was questioning the identity of family members; that the situation was urgent; and that an emergency might arise over the weekend. Notwithstanding this, she says that she was told that an appointment on Monday was the best that could be offered, that the consultant was too busy to speak with her, and that Mr Cameron's general practitioner should be telephoned if help was needed before Monday. Despite severe misgivings, Julie Cameron says that she reluctantly telephoned to confirm his attendance, and rang her mother to tell her of the arrangements.

Ms Cameron and her partner spent the rest of the morning trying to calm her brother, who eventually agreed to keep the appointment. At lunch-time, Ms Cameron went to work. Her partner stayed with Mr Cameron, and managed to further calm

him. Although he was still sweating and distressed, he stopped talking about the devil. Indeed, he was sufficiently composed that he gave their daughter a lift to the riding stables on his way home. That this occurred only hours before Mrs Cameron's death further emphasises that the family's main anxiety at this time was that he would again become increasingly unwell, attempt suicide, and be sectioned. At no point did they think that anybody's life was in danger. The final decline in Mr Cameron's mental state was therefore extremely rapid, and could not be foreseen even by those best acquainted with him. As his sister put it, his condition 'deteriorated such that he killed her at around half past ten in the evening. It was exponential, he just went completely out of control.'

Mr Cameron then returned home, and had a meal with his mother. Julie Cameron telephoned during the evening, to see how things were. Mrs Cameron said that he seemed a bit better; he had managed to eat some dinner, appeared calmer, and had gone to bed. They agreed to meet the next day. This conversation was the last contact anybody other than Mr Cameron had with his mother.

Evening of 25/26 April 1997. Death of Mrs Cameron

At around 8.30pm on Friday 25 April, Mr Cameron says that he experienced the strange smell and taste which he describes as always happening when he becomes psychotic. He could hear doors opening and closing, and was very frightened. He went up to bed at around 9.00pm but, due to the strange and unfamiliar experiences and sounds, he went back downstairs after about an hour. His mother was in the sitting room, and he went to sit near her. As he looked at her, he became increasingly convinced that she was the devil. He put his hands round her throat and strangled her.

At 4.30 am the following morning, Mr Cameron telephoned his sister and told her that he had done something terrible, and that he needed to see his consultant psychiatrist. When his sister asked to speak with their mother, Mr Cameron told her that she was dead. He indicated that he was on his way over to see her. His sister alerted the rest of the household. When Mr Cameron arrived he was met by his sister's partner, who told him to go away. Mr Cameron appeared intent on entering the house and there was a violent struggle. He was shouting 'Satan' and 'devil'. He demanded the keys to his sister's car, which eventually were thrown to him from the house where the family were now sheltering. He took the car and drove off at speed. He was then involved in an accident with another car, and was arrested just before 7am, having broken into an empty house nearby. Neighbours subsequently reported to the police that they had periodically heard Mr Cameron arguing with his mother.

Mr Cameron was examined at the police station by a consultant psychiatrist from Fair Mile Hospital, who concluded that he was unfit to be interviewed. The consultant requested a Mental Health Act assessment, and completed a section 3 recommendation. Despite strenuous efforts on her part, a medium secure bed could not be found, and he was therefore remanded in custody to HMP Bullingdon on 28 April 1997. On 30 April 1997, he was seen there by a locum forensic psychiatrist from one of the high security hospitals, to which he was transferred on 4 May.

On 17 October 1997, Reading Crown Court heard that he was mentally disordered and had been suffering from mental illness at the time of the killing. He was found guilty of manslaughter on the grounds of diminished responsibility, and made subject both to a hospital order and an order restricting his discharge without limit of time. His mental state has subsequently settled.

6 FINDINGS AND ACTION PLANS

ABOUT THIS CHAPTER

The purpose of this chapter is to set out the inquiry panel's findings and recommendations, the responses of the local agencies, and the action which has been, or is being, taken to improve further local services. The various matters are dealt with under the following headings:

Each section starts with the inquiry's findings, followed by the observations of those affected by them, the inquiry panel's recommendations, and the resulting action plans.

A. EXAMPLES OF GOOD PRACTICE

THE INQUIRY'S FINDINGS

We wish to acknowledge the co-operation and assistance that we received from the professionals asked to assist us. Each of them worked to very short notice, and this enabled us to meet them, and to consider several thousand pages of documents and statements, within four months of first meeting as a panel.

The way in which Reading Social Services and their solicitor, Mr Leslie, prepared and presented their information was exemplary. Their input was co-ordinated, without ever being controlled, and they approached a stressful process in a constructive and open manner.

The way in which Dr Nehring, a local consultant psychiatrist, assessed Mr Cameron's mental state at the police station following his arrest, and her efforts to find him a medium secure bed, was also exemplary, and could serve as a teaching model for other professionals.

The clinical notes of the senior house officers who examined Mr Cameron were almost uniformly excellent: in particular those of Dr Pharoah and Dr Fitzherbert Jones.

The differential diagnoses of porphyria and temporal lobe epilepsy were thoroughly investigated during Mr Cameron's first admission to Fair Mile Hospital.

There was prompt intervention in other areas: Mr Cameron was referred to the local day hospital, his housing needs were addressed, a place was found for him locally, and he was prescribed clozaril.

The support given by the police to Ms Julie Cameron, and her partner, following Mrs Cameron's death was commendable.

The work done since 1997 to develop local services, and to improve implementation of the care programme approach, deserves praise.

B. RISK MANAGEMENT

THE INQUIRY'S FINDINGS

Mr Cameron was terrified about being given treatment in hospital. This fear, which was sometimes uncontrollable, reached psychotic levels in March 1991 and August 1993, and it helps to explain his violence during August 1993. He reacted violently to the police's attempt to return him to the Royal Berkshire Hospital, and to his conveyance to Fair Mile, and detention there. He came to believe that medical practitioners and nurses were trying to harm him, and at one stage thought that his doctor was the devil. His size and strength made him difficult to restrain.

Admission and detention in August 1993

There is no evidence that the way in which these risks were managed within Fair Mile Hospital was inappropriate. His initial admission there was a relatively short one, and it has not been suggested that he was ever restrained inappropriately. He spent 17 days on a locked ward, but he was returned to an open ward, and granted some home leave, as soon as these fears and beliefs settled.

Discharge from hospital in September 1993

The circumstances in which Mr Cameron was permitted to discharge himself from hospital on 13 September 1993 were unsatisfactory. He had only recommenced visiting the open ward on 6 September, and on 10 September his consultant completed a section 3 recommendation, when it was noted that he wanted to leave and had relapsed to some extent. His psychosis had not entirely remitted and, during the week following discharge, he was observed to be anxious, withdrawn, lacking motivation, hardly speaking, and saying things like, 'how do you know you're not dead.' Within two weeks, he was expressing the thought that he had woken up on parallel planet.

Because his consultant's opinion on 10 September was that detention in hospital under section 3, not discharge, was appropriate, this should have led to a full Mental Health Act assessment, in order to prevent inappropriate early discharge. The consequence of not arranging this was that he left hospital, and, given the beliefs still held by him, this inevitably involved some risk to his health or safety, and to others.

Admission in October 1993

Prior to Mrs Cameron's death, the only substantiated violence unrelated to Mr Cameron's fear of being treated in hospital was when, in October 1993, he placed his hands around her neck, and spoke of her as the antichrist. The way in which the risk of violence to his mother was managed when she reported this event was unsatisfactory.

Mrs Cameron immediately reported what had happened. This fact, taken with her son's acknowledgement that he sometimes doubted her identity, and had wondered if she might be the devil, ought to have ensured that he did not return home after two days without his consultant's involvement and a comprehensive risk assessment. The circumstances in which Mr Cameron might cause grave harm, the strength or persistence of his inclination to do so in such circumstances, and the likelihood that he would find himself in such circumstances again in the foreseeable future, should all have been systematically assessed (see J. Gunn, 'Clinical approaches to the assessment of risk', in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies*. SLE Publications Ltd, 1990, pp.15-16).

The staff grade psychiatrist's case notes during this period were cursory, and show no evidence that a detailed risk assessment took place, or that steps were taken to manage the risk. Without such an assessment and management plan, it was not appropriate or sensible to rely on Mrs Cameron's subsequent acceptance of her son's assurance that he was only joking. The more so given his violent behaviour in August and September, and the fact that his psychosis was known not to have remitted.

Overdose in February 1994

There is no evidence that the risk of self-harm was systematically reassessed after Mr Cameron took an overdose of Paracetamol tablets in February 1994.

Admission and detention in July 1994

Again, the quality of Mr Cameron's in-patient care was good. He was commenced on a relatively new treatment for schizophrenia, which produced a good response, and there is good evidence of a considered approach to CPA and discharge planning.

Decision not to register Mr Cameron in November 1994

It is possible that the subsequent response of professionals to Mr Cameron's disengagement from services would have been different had his name been on the supervision register. The reason for not registering him in November 1994 (family concern that that a computerised record might be kept) was insufficient. Even if this was a material consideration, the decision should have been made by his consultant applying departmental guidelines and criteria.

The decision not to register him should also have been periodically reviewed.

Transfer of consultant responsibility in March 1995

The letter sent to Mr Cameron's new consultant, to whom responsibility was transferred in 3 March 1995, was unacceptably brief. In particular, it contained no information about known risks and warning signs, his care plan, and other similarly fundamental information.

There is no evidence that the consultant responsible for Mr Cameron's treatment from 3 March 1995 until his mother's death ever systematically reassessed the risks, in particular following his disengagement from the care programme, the day hospital and the community mental health team.

The telephone calls of 25 April 1997

The consultant's secretary does not share, and therefore cannot agree, Julie Cameron's recollection of their telephone conversation on 25 April. Since there are no contemporaneous records, and their honesty and good faith are not in doubt, it would be wholly unfair and inappropriate for us now to attempt to reconstruct precisely what was said. That being the case, nothing in our report should be interpreted as implying that the consultant's secretary responded inappropriately.

The general point can, nevertheless, be made that a secretary is not qualified to elicit from a disturbed patient, or a distressed relative, details of the patient's mental state and behaviour, or to assess the urgency of a particular situation, and can therefore never properly be expected or left to fulfil this function. From this, it follows that the telephone calls made to the consultant's office on Friday 25 April 1997 were not dealt with appropriately.

The fact that an appointment was made for the following working day suggests that Mr Cameron's consultant was aware, from the information communicated to him, of the possibility of a significant and worrying deterioration in his mental state and/or behaviour. That being so, it was inappropriate to rely upon information gathered and reported to him by an untrained secretary unfamiliar with the history. Either he or the junior doctor should have spoken with Mr Cameron's sister or, if this was impossible, she should have been put in touch with the key worker and the community mental health team.

Communication of information

There was a failure to share information about incidents of violence, in particular with CMHT staff (including Mr Cameron's key worker) and his general practitioner. For example, Mr Cameron's social worker (who was also his care manager and key worker) was unaware that he had placed his hands around his mother's neck, whilst speaking of her as the antichrist.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

The Health Authority is committed to improving the process of risk identification and management.

By end of 2000, approximately £750,000 of modernisation funds, recurring for three years, will have been deployed locally on assertive outreach services, secure beds and additional prescribing. In addition, the Health Authority intends to invest another £1m over the coming year to aid community developments and to increase clinical posts.

In partnership with other agencies, Berkshire Health Authority last year commissioned Thames Valley Partnership to develop guidelines on confidentiality, and the sharing of information concerning mentally disordered offenders and other individuals at risk in the community. The final report was delivered in August 1999, and the resulting protocol reflects a common, enhanced, understanding of the need for a closer exchange of sensitive information between key partners, especially probation, health, social services and housing. The development of the protocol was followed by a number of planning days and training sessions.

Implementation of Berkshire's National Service Framework plan, details of which appear in this report, will further enhance the quality of services provided to patients with Mr Cameron's range of needs, and its agreement is being followed by a full set of quality and target statements. The key priorities set out in Berkshire's *Mental Health National Service Framework Implementation Plan* of April 2000 include the following:

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Integrate CPA and care management	Risk assessment to be integral.	April 2001

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Crisis support/early intervention	Trusts and social services to agree what local early intervention/crisis services should exist. 24-hour access options to be prioritised. Services to be developed from April 2001.	April 2001

NSF standard 5	*Gap to be filled/improvement to be made*	*By when*
Use of high/medium and low secure beds	Not to be more than 95% occupied. Open new low secure unit beds (15–20 beds)	April 2001 April 2002

NSF standard 7	*Gap to be filled/improvement to be made*	*By when*
Self-harm as part of A&E liaison service	Health Authority to review.	April 2002

Information/data	*Gap to be filled/improvement to be made*	*By when*
CPA IT strategy	Trusts to be more consistent in use of CPA procedure and software which enables sharing of info between agencies. There is a clear need to develop software which aids the rapid movement of care information around the system between GPs, hospitals, social services, etc. This needs development.	2002/03

Of the key priorities listed in the NSF implementation plan, the very first focus will be on the key issues of opening the low secure beds, creating better 24 hour access to mental health services across the county (with special emphasis on those on enhanced CPA), and developing supported accommodation and 24-hour staffed beds in the community.

West Berkshire Priority Care Service NHS Trust

The trust is committed to continually reviewing and developing effective ways of managing risks; and it accepts that a more formal and systematic identification of clinical risk can ensure more appropriate planning of effective care.

The trust readily acknowledges that there were omissions in Mr Cameron's care and treatment, and that there are important lessons for all professional carers. Following Mrs Cameron's death, a special trust board sub-committee was established, in May 1998, and its report and recommendations were accepted by the board in September 1999.

The way in which risks are identified and managed has been enhanced by improving the response to crises, the co-ordination of services, communication between professionals, assessments of risk, and record-keeping:

1. A mental health clinical risk group, chaired by the trust's General Manager for Mental Health, has been established, and it includes inpatient and community nurses, social workers, doctors, psychologists and occupational therapists.

2. The way in which crises are dealt with has been improved: when a medical secretary or administrator receives such a telephone call from a patient or relative, it is now the responsibility of the mental health clinician to contact them personally. The operational manager will audit this to ensure that it takes place.

3. The Reading Community Mental Health Team has had a joint manager in post since October 1999, who manages both teams within the Reading locality. This manager regularly meets with the service managers from the trust and the social services authority, and is a member of the locality steering group responsible for planning and developing local mental health services.

4. The multidisciplinary team have, during the past year, developed joint eligibility criteria, joint allocation and referral meetings, and a new on-call system.

5. The co-ordination of in-patient and community care has been improved by having a named member of the CMHT attend ward rounds on acute admission wards; and a pilot scheme is being implemented which involves an E grade nurse, based on Henley Ward, spending half their time in the community and half on the ward.

6. The co-ordination of primary and secondary care has been improved by allocating a member of the CMHT to liase with each general practice in the Reading locality. In addition, funding from the Reading Abbey PCG has enabled CPNs to provide a triage service for people who present with mental health problems in primary care.

7. Multidisciplinary records have been introduced within both in-patient units and Reading Community Mental Health. Work is currently being undertaken to ensure that they are in a standard format, with the basic information form, and the most recent risk assessment form and CPA, being held at the front of the notes where there are easily accessible. The records are audited regularly, to ensure that they are contemporaneous and that there is evidence of a risk assessment.

8. A risk management policy is being introduced with the new CPA policy (*Modernizing the Care Programme Approach*) by September 2000. This policy will be implemented jointly with local authorities and its implementation audited; and there will be a programme of training in clinical risk assessment and management.

9. As part of a region-wide initiative, the trust is working towards developing and implementing a clinical risk policy, following the recommendations of the Mental Health National Service Framework.

Reading Social Services

The social services authority also accepts that important lessons must (and have) been learned from reviewing Mr Cameron's care and treatment. In particular, the importance of clear lines of accountability, with all professionals fully understanding their responsibility for cases they hold; the importance of good communication between everyone involved in providing or monitoring care plans, particularly when

there are changes; the pivotal role of the key worker in ensuring this communication; and the need regularly to monitor and evaluate policy implementation.

Reading Social Services have adopted the mental health risk assessment and management policy jointly agreed by Berkshire Social Services, Berkshire Health Authority, and the relevant trusts. As part of that policy, CMHT staff are, in all cases, expected to assess and record the risks, including the risk of self-harm and the risk to family members, carers, the public, staff and children. This can be demonstrated, as risk assessment records are held as a front sheet on mental health client files.

A great deal of work has been put into planning mental health training, and Reading Borough Council currently run regular courses on risk assessment and mental health issues. These courses are open to both health and social services staff. Since October 1999, it has been compulsory for CMHT staff to attend a minimum of five training days per year, three days of which are dedicated to risk assessment and management, the CPA and child protection issues. More formal joint multi-agency mental health training is being planned. Details are set out in the Reading Social Services Training Plan for 1999/2000, and staff training records are monitored by the Service Manager.

The authority recognises the importance of providing out-of-hours service contact numbers for patients and carers, and this has been a standard procedure since October 1999.

Recommendations and action plans

Recommendations	*Action plans*	
1. that *simple* arrangements are made which ensure that when a medical recommendation is completed by a ward doctor this triggers a full Mental Health Act assessment.	***NHS trust***	
	• **The trust will devise a policy which ensures that the completion of a medical recommendation triggers a full Mental Health Act assessment.**	**By December 2000**
2. that *simple* arrangements are made which ensure that all in-patients receive a comprehensive risk assessment following admission and prior to discharge.	***NHS trust***	
	• **Risk assessments are now routinely carried out, on all acute admission wards and by CMHTs.**	**In place**
	• **The front of patient files now contain a risk factor sheet and copies of the most recent care programme and risk assessment/management plan.**	**In place**
	• **All of these developments are being supported and monitored by the service managers; and training is being developed to implement these changes.**	**On-going**

3. that consultants are reminded that decisions about whether to place a patient's name on the supervision register are their professional responsibility, to be taken with reference to the departmental guidelines, and the reasons fully recorded.	*NHS trust* • From October 2000, such patients will be subject to enhanced CPA. The issue will be highlighted during training on the new procedures, which consultants will be required to attend.	By December 2000
4. that letters transferring responsibility for an out-patient from one consultant to another contain a detailed history, including information about the care programme, the patient's mental state, previous violence, and warning signs.	*NHS trust* • The SHO will write a discharge letter whenever a patient is discharged from hospital OR to the care of another consultant. • The introduction of new medical records and risk factor sheets will help to ensure that such information is readily accessible to the new consultant.	By December 2000 In place
5. that *simple* arrangements are made which ensure that when a former in-patient, or a relative of theirs, telephones the consultant, to notify her/him that the patient is relapsing and needs professional assistance, the caller is put through to the doctor or another mental health professional.	*NHS trust* • When such a call is received by a medical secretary or administrator, it is now the responsibility of the doctor to take the call personally. If this is impossible for some reason (for example, because the doctor is off-duty, or is dealing with another crisis), the call must be diverted to, and immediately dealt with by, another qualified professional. The Operational Manager will be auditing this, and the requirement is emphasised in induction and training. • All calls to the CMHT base are now routed to the on-call duty worker if the relevant clinician is not available.	In place In place
6. that a protocol is agreed which addresses confidentiality and the sharing of information between agencies.	*NHS trust* • Agreed.	By March 2001

7.	that training on the *Code of Practice* covers the new guidance in the third edition as to the factors to consider when deciding whether or not informal admission is appropriate (see p.10).	*NHS trust* • A solicitor specialising in mental health law has run training courses on the 3rd edition of the code. Further training courses for 2000–2001 are being developed. *Social services* • The county-wide refresher training for approved social workers includes training on the new code of practice.	Ongoing Ongoing

C. MEDICAL MANAGEMENT

THE INQUIRY'S FINDINGS

In January 1991, Mr Cameron was referred to a consultant at Fair Mile Hospital, but there was no follow-up because the papers went astray.

The assessment of Mr Cameron's mental state and needs following his admission in August 1993 was of a high standard. It was recognised that he was depressed, lacked self-confidence and social skills, needed help with anxiety management, and had a poor work record. As a result, he was referred to the Eldon Day Hospital and a psychologist at an early stage of his treatment; and the possibilities that he might suffer from temporal lobe epilepsy or porphyria were investigated. The two key informants concerning his mental state, namely his mother and sister, were involved in the assessment, and provided much valuable information.

There is no evidence that Mr Cameron's needs were systematically reassessed after he took an overdose of Paracetamol tablets in February 1994.

There is no evidence that Mr Cameron's consultant from 3 March 1995 onwards assessed his mental state, or the risks associated with it, in any systematic way. Indeed, he did not see Mr Cameron until June 1996.

During the year to May 1996, Mr Cameron disengaged from the day hospital and his key worker, and the staff grade psychiatrist familiar with his case left the team. Given that outpatient appointments were then his only contact with the mental health service, and he was subject to section 117, these should have been more frequent than they were. The evidence suggests that Mr Cameron's consultant was not fully conversant with his case. He did not keep notes of his out-patient examinations, did not communicate to the pharmacy a reduction in the clozaril dosage, and recorded on13 June 1996 that Mr Cameron was getting on well with his parents (*sic*). There was no involvement from the multi-disciplinary team.

There were times when assessments were hampered by the absence of Mr Cameron's case notes. For example, they were not available, being in transit between Fair Mile and the day hospital, when he was readmitted to Fair Mile Hospital on one occasion.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority, West Berkshire Trust, Reading Social Services

The findings are accepted.

Recommendations and action plans

Recommendations	*Action plans*	
8. that clinical audit examines the quality of out-patient assessments of previously detained patients and focuses on: **- the use of informants, in order to verify that informants have been seen;**	***NHS trust*** • **The clinical audit department will arrange a risk assessment audit which addresses these issues.**	**By March 2001**

	- the range of issues considered within the assessment process (*e.g.* medical, social, employment, financial, family, forensic, substance misuse, etc.); - the nexus between the treatment being provided and the needs which were identified; - the way in which risks have been identified and managed.		
9.	that the frequency with which previously detained out-patients are seen is reviewed.	*NHS trust, social services* • The level of contact which a patient needs with her/his consultant and junior doctor as part of their care programme, and the steps to be taken if the patient fails to maintain this contact, will be discussed at CPA meetings, and the outcome recorded.	By October 2000

D. HOSPITAL FACILITIES

THE INQUIRY'S FINDINGS

The panel were of the opinion that the condition of the locked ward at Fair Mile Hospital, where Mr Cameron was detained in 1993, was wholly unacceptable.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

A private finance initiative has been developed to fund a new mental health hospital to replace Fair Mile, and associated community services. A single specialist mental health trust is also being created for Berkshire, which will help to develop services, by increasing the focus on mental health, economies of scale, the development of specialist in-county services, and better career options for staff. The strategy is consistent with the National Service Framework, and the Government's White Paper *Modernising Mental Health Services*, which advises against combining general acute services and mental health services within the same organisation.

West Berkshire Priority Care Service NHS Trust

The trust fully acknowledges that Fair Mile Hospital is ill-suited to providing modern mental health care. It has received outline planning permission for a new hospital at Prospect Park, in Reading, and permission to seek private finance in connection with its development. It is hoped that the new facilities will open in 2002.

The locked (intensive care) ward at Fair Mile Hospital has now moved to premises on the Fair Mile site vacated by medium secure unit. These premises have been refurbished, and what is now *Rotherfield Ward* provides a more appropriate environment for intensive care. Patients have access to an enclosed outside area for fresh air and exercise, and most of them have their own room.

Recommendations and action plans

10. A Health & Safety Executive notice has been served which requires the trust to vacate Fair Mile Hospital by 2002. The panel are strongly of the opinion that it is imperative that the development of a new hospital on the Prospect Park site is not delayed. While some anxiety on the part of local residents is natural and understandable, the development of a modern, safe, service is in everyone's interest.

E. CPA, DISCHARGE AND AFTER-CARE

THE INQUIRY'S FINDINGS

Neither the trust nor the local authority appear to have attached any practical significance to their statutory obligations under section 117, and the delivery of statutory after-care was not properly co-ordinated and monitored.

Likewise, neither body appears to have understood, or at any rate properly implemented, departmental guidelines concerning discharge and care programmes. For example, CPA case reviews were sometimes arranged by medical staff without inviting the key worker.

The importance of care programme approach documentation was not understood by the professionals involved with Mr Cameron; and the quality and accuracy of most of the records was unacceptable.

Information about emergency/crisis services was not clearly communicated to Mr Cameron or his carers (nor, possibly, to secretarial staff).

Following Mr Cameron's detention in a London hospital in January 1991, the loss of the correspondence from that hospital meant that he received no follow-up or support from mental health services on his return home.

Proper after-care and follow-up arrangements were not in place when he discharged himself from Fair Mile on 13 September 1993. He was discharged without support from a community psychiatric nurse or social worker and without a day hospital appointment. A key worker was not identified for him, and the discharge planning was retrospective. There was no clear treatment plan, or plan of action in the event of default, and no co-ordinated care plan.

Mr Cameron's care manager should not have closed his case on 30 June 1994, but transferred responsibility for him back to the community psychiatric nurse who had referred the case to him.

There is no evidence that those responsible for Mr Cameron's treatment and care after he left hospital in December 1994 had a strategy for dealing with his failure to reside at Blenheim Road. Simply allowing him to return to live with his mother was not a considered response, given that the placement was found because she could no longer cope, and he was unable to manage independently.

The decision to discharge him from Eldon Day Hospital on 14 June 1995 was made without the fact that he was subject to section 117, and subject to the care programme approach, being taken into account. The decision was inadequately recorded.

The decision to leave his case open on 5 February 1996 was made without the fact that he was subject to section 117, and subject to the care programme approach, being taken into account. The decision was inadequately recorded.

The quality of these decisions was undermined by the fact that they were based on partial information about his history of violence.

The steps taken to maintain contact with Mr Cameron and his family after 5 February 1996, and/or to gather information about his mental state and circumstances, were negligible. The community mental health team did not have a strategy for dealing with his disengagement from the service other than to permit him to disengage.

It was important to have a strategy for disengagement because of his beliefs that medical practitioners and nurses had tried to harm him.

There was a general lack of support for Mrs Cameron, Mr Cameron's primary carer.

There appears to have been a widespread failure to understand, or implement, the requirements set down in *Health Service Guidelines*, and the omissions are described below.

Discharge of Patients from Hospital, Health Circular HC(89)5 (see p.12)

There is no evidence:

- that responsibility for checking that necessary pre-discharge arrangements had been made before Mr Cameron left hospital was given to one member of staff caring for him;

- that a member of staff had a checklist of what should have been done prior to that date;

- that a manager scrutinised the after-care arrangements prior to discharge;

- that relatives were informed, orally or in writing, of the arrangements, or about matters such as medication, symptoms to watch for, and where to get help;

- that their ability to cope, and access to emergency services and out-of-hours advice, was taken into account.

Local Authority Circular LAC(89)7 (see p.13)

There is no evidence:

- that the local authority's procedures served to ensure that Mr Cameron did not leave hospital without adequate arrangements being made for his support in the community;

- that the social services department was involved in addressing his need for alternative accommodation.

Care programme approach, Health Circular HC(90)23 (see p.13)

There is no evidence:

- that a key worker was appointed for Mr Cameron prior to, or following, his discharges from hospital in 1993;

- that systematic arrangements for his care outside hospital were made prior to those discharges.

- that, following the effective closure of his file in February 1996, any professional was designated to remain in contact with him, and to monitor his circumstances, during the periods between his six-monthly outpatient appointments.

- that, after February 1996, 'every reasonable effort' was made to maintain contact with him and his carers, to find out what was happening, or to ensure that he and his family knew how to make contact with professional staff.

Guidance on Discharge, Health Service Guidelines HSG(94)27 (see pp.13–14)

There is no evidence:

- that professionals and carers had a common understanding of information relating to past violence or assessed risk of violence;

- that there was a full risk assessment prior to his discharge in December 1994, which involved ensuring that relevant information was available, and included detailed information about the patient's background, present mental state and social functioning, and past behaviour;

Use of the departmental after-care form (see p.14)

There is no evidence:

- that staff were aware of the form's existence or used it;

- that, had they used it, they had gathered the information necessary to complete much of it.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

The Health Authority recognises that people need to be able to access local community-based services in an emergency, and it is encouraging the development of 24-hour access to services, assertive outreach, and out-of-hours crisis services.

Following a crisis, it is important to fast-track people to the relevant service. A range of options is required, which include dedicated crisis response teams, access to inpatient acute beds, and access to community-based facilities, including day hospitals and other services.

The Health Authority also accepts that people with a severe and enduring mental illness, such as Mr Cameron, need to have their needs and care reviewed on a rigorous and regular basis; and that users, and their families and carers, should be centrally involved in this process.

Maintaining contact with clients is a general function of all community mental health services, and teams therefore need to adopt assertive and innovative approaches to keeping in touch with clients who are unable or unwilling to use conventional services. Some clients will need a highly tailored 'total' service, including long term and short term crisis residential care, and constant assertive outreach in order to maintain contact with them. Thorough implementation of integrated CPA, the supervision register and 'supervised discharge', supported by case registers, will minimise problems.

The care programme approach (CPA) continues to be the cornerstone, both nationally and in Berkshire. The National Service Framework requires that all mental health service users subject to the care programme approach should:

- be able to access services 24 hours a day, 365 days a year;
- have a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis;
- receive care which optimises engagement, prevents or anticipates crisis, and reduces risk; *and*
- have a copy of a written care plan which:
  - includes the action to be taken in a crisis by service users, their carers and their care co-ordinators;
  - advises the GP how they should respond if the service user needs additional help;
  - is regularly reviewed by the care co-ordinator.

The key priorities set out Berkshire's *Mental Health National Service Framework Implementation Plan* of April 2000 include the following:

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Integrate CPA and care management	Trusts and social services to agree a single procedure in line with the latest guidance from the Department of Health, and risk assessment to be integral.	April 2001

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
CPA	Trusts to make sure that all users on CPA have a full plan, which is also with their GP and carer.	Oct 2000

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Assertive outreach for those at risk/on enhanced CPA	Trusts to review outreach to patients and ensure that those fitting the highest criteria are followed up, as *per* procedure.	Oct 2001

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Crisis support/early intervention	Trusts/social services to jointly agree what local early intervention/crisis services should exist, as alternative to admissions, and advise PCG. 24-hour access options to be prioritised. Services to be developed from April 2001	April 2001

Of the key priorities, the very first focus will be on opening low secure beds, creating better 24-hour access to services across the county (with special focus on those on enhanced CPA), and developing supported accommodation/24-hour staffed beds in the community.

West Berkshire Priority Care Service NHS Trust

1. The trust is fully committed to the standards set out in the care programme approach and the National Service Framework, each of which impact on care programmes, clinical risk and discharge procedures.

2. Local CPA and discharge policies and procedures were reviewed immediately after Mrs Cameron's death. They are now being reviewed again, in partnership with social services and Berkshire Health Authority, and the final policy will be published by September 2000. It is planned that the policy and the new CPA form will be fully implemented by October 2000.

3. The trust has successfully developed an Assertive Community Treatment Team in Reading. This service plays an invaluable role in supporting and following up patients like Mr Cameron, who need this intensive and proactive level of care.

4. Funding in excess of £250,000 has also been agreed to develop a rapid response service across Berkshire, the planning of which will be complete by April 2001.

5. Since 1 April 2000, the local Abbey Primary Care Group in Reading has funded two CPNS (one full time and one part time) to provide a service to people with mental health problems about whom a general practitioner is concerned. A third CPN will become part of this scheme during the next two months.

6. There is to be an annual audit of the local discharge policy, by way of a random sample of both users and carers.

7. A booklet developed with the Wokingham Carers Group is being introduced in the other areas served by the trust.

Reading Social Services

Reading Social Services is fully committed to the care programme approach and the standards set out in the NSF, and it is participating fully with the above initiatives. It recognises the importance for many clients and their carers of assertive care and effective crisis support.

Since January 1998, it has not been permissible for CMHT staff to manage cases on an 'open inactive' basis. That this is so can be demonstrated by examining the client record information system and CMHT client records.

Recommendations and action plans

Recommendations	*Action plans*	
11. that arrangements are made which ensure adherence to *Health Service Guidelines* concerning the care programme approach and discharge procedures. **12. that a senior manager within the trust is made responsible for ensuring that these *Health Service Guidelines* are put into practice.**	**NHS trust** • **(11) & (12). Agreed. The General Manager for Mental Health has, with immediate effect, taken responsibility for ensuring adherence to *Health Service guidelines*. A CPA and risk monitoring group has also been formed.**	**Immediate**
13. that random audits of compliance with the guidelines are conducted regularly, and that these include verifying: • **that a key worker (care co-ordinator) is identified for the patient following admission, and that s/he had a key worker when discharged;** • **that the patient had a care plan prior to discharge, with review dates, and that s/he and the carer have received a copy of it;** • **that a full assessment of risk, covering both risk to the patient and others, was conducted prior to discharge, and a plan devised to manage assessed risks;** • **that responsibility for checking that necessary pre-discharge arrangements were made before the patient left hospital was given to one member of staff caring for her/him;** • **that this member of staff had (and used) a checklist of what should have been done prior to that date;** • **that a manager scrutinised the after-care arrangements prior to discharge;** • **that carers were involved in the care planning process, and that their ability to cope, and access to emergency services and out-of-hours advice, was taken into account;**	• **Clinical Audit will audit CPA and care planning, along with risk management.** • **Except when a patient discharges her/himself against advice, CPA plans will be scrutinised by a manager prior to discharge, to ensure adherence with departmental guidance and trust procedures.**	**By October 2000** **By October 2000**

• that they were informed about matters such as medication, symptoms to watch for, and where to get help; • that arrangements were made to provide necessary support at home; • that the needs of any children of the patient were actively assessed prior to discharge; and that the patient was not discharged to a home with children unless the risk to them had been thoroughly assessed. • that professionals and carers had a common understanding of information about past violence or assessed risk of violence.		
14. that where a patient discharges her/himself against medical advice, and a care plan cannot be completed prior to discharge, this is subject to exception reporting within the trust; and this information is shared with the Health Authority through routine monitoring.	• An incident form will be completed when a patient discharges her/himself against medical advice.	By December 2000
15. that the trust, in consultation with the Health Authority, considers whether the departmental after-care form issued in 1995 should be used by hospital staff (see p.14).	• Agreed. The matter will be considered during the process of modernising CPA and discharge processes, in line with *Modernising the Care Programme Approach* (see p.15).	By October 2000
16. that the trust should require staff to undergo further training on the care programme approach and discharge guidance, which deals specifically with the above requirements, and also involves local authority staff; and that records should be kept of those who have completed the training.	*NHS trust* • The care programme approach training has been reviewed in order that deficits may be addressed. • More active monitoring of attendance at mandatory training will be undertaken.	Ongoing

F. HOUSING

THE INQUIRY'S FINDINGS

It was universally accepted that Mr Cameron's accommodation at Blenheim Road was not well suited to his needs, and that he needed more supportive accommodation. That he was placed there was due to a lack of suitable specialist accommodation for local residents. The panel noted that strenuous efforts are being made to improve the range of accommodation available locally, and that the present Government has significantly increased the level of investment in mental health services. It therefore makes no recommendations.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

The Health Authority recognises that a long term strategy is necessary in order to develop a range of accommodation, from 24-hour staffed accommodation to occasional support within the individual's own home. Of the key priorities listed in the NSF implementation plan, the initial focus will be on developing supported accommodation/24 hour staffed beds in the community. Over £250,000 (recurring) is being invested on up to 20 staffed beds.

Individuals living outside hospital will need to be connected to mainstream services, including adult education, employment, social and leisure activities. Some of them will also require careers guidance, an individual work plan, and an advocate (in order to receive an appropriate response from statutory and other agencies).

The key priorities set out Berkshire's *Mental Health National Service Framework Implementation Plan* of April 2000 include the following:

NSF standard 4	*Gap to be filled/improvement to be made*	*By when*
Supported accommodation	Trusts to conduct a review with each social services authority, in order to ensure that sufficient accommodation is planned to prevent bed-blocking. A sub-group to establish needs and to propose a plan for developing needed services.	Oct 2000

Recommendations and action plans

None. The situation in Berkshire reflects the national picture, and the Health Authority's response is appropriate and commendable. The panel does wish to emphasise that consistent investment over many years will be necessary in order to reverse the present situation.

G. GUARDIANSHIP

THE INQUIRY'S FINDINGS

There was a failure to consider guardianship when Mr Cameron resumed living with his mother in 1995, soon after his discharge from hospital to Blenheim Road.

It also seems to be the case that his refusal to accept supported accommodation at Rutland House may have been linked to his fear of professional staff (delivering himself into the hands of the enemy).

In both instances, guardianship could usefully have been considered, as a means of requiring him to live independently of his mother. This may have benefited Mr Cameron; and it would certainly have better recognised his mother's needs, her decreasing ability to care for him, and the dilemma facing her:

> 'What she ideally wanted was something that was supervised, where he perhaps had a little flat, there were people overseeing his activities, and he had some structure to his day ... my mother ... would have welcomed some kind of supervised accommodation, where he lived elsewhere, where he could perhaps visit her and she could visit him, and she could see him in a pleasant environment where he was being looked after appropriately. She certainly did not want him at home in the condition he was in.'

It is worth observing in this context that the fact that a guardian lacks a power to convey is irrelevant when a patient is subject to section 3: the patient can initially be placed on leave at the designated accommodation, and then transferred into guardianship once there. If he then leaves, he is absent without leave, and can be returned.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Reading Social Services

It has been agreed that the trust's policies and those of Reading Social Services will be reviewed and rewritten as necessary. It is intended that, as part of the CPA policy, CMHT staff will be expected to consider guardianship as a matter of course, and will be expected to provide a written record of their considerations.

Recommendations and action plans

	Recommendations	*Action plans*	
17.	**that guardianship is considered during care programme approach reviews whenever a client has ceased to reside at specialist accommodation to which he has been discharged.**	***Reading Social Services***	
		• **Instructions to CMHT staff, and also request via senior management in each agency, for formal inclusion in the CPA policy and appropriate communication of this.**	**Immediate**

H. MEDICATION

THE INQUIRY'S FINDINGS

Treatment by regular depixol injections (100mgs each week) between October 1993 and July 1994 resulted in Mr Cameron feeling depressed and lethargic, without fully treating his psychotic symptoms. This is a frequent adverse effect, and it had unfortunate repercussions in terms of his subsequent compliance with medication.

Mr Cameron's treatment was changed following his admission in July 1994, in view of partial symptom response and adverse effects, including possible neuroleptic malignant syndrome. He was started on an oral drug, Clozaril. This was a relatively new drug at the time; and, as well as requiring the patient's full co-operation with daily oral medication, it required regular blood tests to monitor the blood picture.

Following his discharge in December 1994, it was agreed that Mr Cameron would collect his medication from the day hospital and attend his general practitioner's surgery for blood tests (a procedure carried out by the practice nurse). He was often late collecting the medication and having the tests.

Mr Cameron subsequently arranged for his mother to collect his medication, as she worked near the day hospital. Furthermore, following his arrest, the police found eight unused blood test kits at his house. It transpired that he was given a year's worth of kits at the start of 1997, and was left to make his own arrangements for the collection and dispatch of his blood samples. He was going to the Royal Berkshire Phlebotomy Department and getting one of the ladies there to bleed him, and was then posting off his blood.

It is clear therefore that, although monitoring and ensuring compliance can only be done if there is full communication between all of the professionals involved, there was no regular monitoring of Mr Cameron's mental state by psychiatrically trained staff.

Clozaril has a very short half life and is metabolised in 12 hours. Any monitoring of blood plasma levels (and, therefore, compliance) is only valid for the last dose. Mr Cameron told us that he only took Clozaril for two months after his discharge from hospital in December 1994. Notwithstanding this, he sometimes requested a reduction in dosage at out-patient appointments, possibly in order to give the impression of compliance.

Everyone else with whom we spoke expressed surprise that Mr Cameron was able to remain well for so long without medication, and were doubtful about the accuracy of his recollection.

Whatever the truth, the evidence does suggest that he never accepted that he was or had been mentally ill, nor therefore that Clozaril had made him better. He was better because the forces of evil had stopped doing what they had done to him in the past.

Having regard to the history, the panel believe that it is particularly important that:

- regular assessment of the mental state of patients who are being prescribed clozaril is carried out by a named professional; and

- communication of changes in a patient's prescription should be by an agreed standardised procedure.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

West Berkshire Priority Care Service NHS Trust

The mental state of all patients who are prescribed Clozaril, including those who attend their GP, is now regularly assessed by a mental heath professional.

Furthermore, all such patients have their treatment details, including routine blood count results, recorded on a computer updated twice daily by the drug company (Novartis). Because of this, the pharmacy at Fair Mile is immediately aware of any failure to have the required blood test.

Because of this tragedy, consultants and other practitioners are very much aware of the fundamental importance of notifying the pharmacy of changes of prescription or any failure to collect it.

Funding has been made available for two nurses to follow up patients who do not collect their prescriptions or attend for their blood tests. This is operational.

Recommendations and action plans

Recommendations	*Action plans*	
18. that, in line with the Cambridge model, **a. the trust's pharmacy department takes over control of Clozaril prescriptions, which are limited to 28 days at a time;** **b. a Clozaril clinic is set up, which is staffed by a dedicated community psychiatric nurse (to assess the patient's mental state) and a member of the pharmacy department (to co-ordinate the prescribing); and that funding is made available by the Health Authority for this.**	***NHS trust*** **(18 & 19). The trust's Chief Pharmicist will lead a working group to consider these recommendations, and the group will agree its findings and recommendations, and report them to the trust board, by December 2000.**	**By December 2000**
19. that consideration is given to linking this development with the development of a depot clinic and a lithium clinic.		

I. SUPPORT FOR FAMILY AND CARERS

THE INQUIRY'S FINDINGS

It is apparent that Mr Cameron sometimes prevented his mother from telephoning professionals for help or advice; that her own health was declining, and she found caring for her son a tremendous strain; and that the effect of her son's illness and behaviour on her health and quality of life was not assessed or taken into account after his final discharge from hospital. The consequence was that she was not supported by professionals:

> 'She was concerned about the fact that he had stopped her from using the telephone in the past. I don't think she really knew what to do. She would sometimes say to me: you don't think he would actually harm me do you? Sometimes I'm afraid he'll harm me. It is very difficult to say to somebody: I think my child will kill me, that my life is in danger ... He was pleading with her not to go back to Grazeley and so forth. She was always willing to give him just one more chance. On balance she probably thought the risk was insignificant, even if it was there at this time ... She couldn't make that leap – none of us could.'

Support following Mrs Cameron's death

Julie Cameron's own general practitioner was very supportive following her mother's death and her brother's arrest, and did all that he could to support her. She and her partner did, however, feel totally abandoned by mental health services. The emergency GP service merely offered valium, and no support was given to them by the trust or social services. Although her only parent had been killed by her only sibling, neither service contacted her about whether she needed *professional* support and counselling. This is unacceptable.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

Individuals who provide significant care to a service user are entitled to have their own needs separately assessed. Information and education about the nature of the illness, and its implications, is crucial to enable them and other family members to support the user, and to maintain a constructive relationship with her/him. Carers themselves also need support, and the National Service Framework provides that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; and
- have their own written care plan, which is given to them and implemented in discussion with them.

The key priorities set out Berkshire's *Mental Health National Service Framework Implementation Plan* of April 2000 include the following:

NSF standard 6	*Gap to be filled/improvement to be made*	*By when*
Caring about carers	Social services to have set out and started to implement a plan which PCGs/trusts approve.	April 2001

NSF standard 6	*Gap to be filled/improvement to be made*	*By when*
Consult carers	Carers will be asked for their opinions on the assessments they get each year. Social services to have reviewed carers' satisfaction with the plan.	April 2002

West Berkshire Priority Care Service NHS Trust

It is unacceptable that Ms Cameron was not offered support following her mother's death. The trust should offer immediate support, and this will happen in future. The trust, in partnership with social services, will develop a local strategy to provide support for the families of the deceased and the patient in such circumstances. It will also establish a system to ensure that staff are supported.

In terms of general support for carers, there has been considerable work to establish partnership arrangements, and local mental health planning steering groups have been established which include users and carers.

Reading Social Services

Reading Social Services agrees that it was unacceptable that Mrs Cameron, and her family, were not supported following her mother's death, and it will co-operate fully with the trust to ensure that this does not happen again.

The involvement of carers in discharge planning was relatively infrequent in February 1997. This was unacceptable and is not now the case. Where appropriate, carers are involved in CPA planning, as are the Housing Department. That this is so can be demonstrated by sampling the CPA forms for clients.

Recommendations and action plans

	Recommendations	*Action plans*	
20.	**that the trust and the social services authority devise simple procedures which ensure that, when a person in contact with either service commits homicide, the needs of the immediate family of both the deceased and the patient are ascertained, and they are supported; and that this includes offering support from a clinical psychologist.**	***NHS trust, social services***	
		• **Agreed. A joint policy is being developed to support family members, carers and staff following a homicide or suicide within the service.**	**By December 2000**

J. MANAGERIAL AND CLINICAL SUPERVISION

THE INQUIRY'S FINDINGS

Section 117 was introduced in 1983 and the CPA guidance in 1990. Given that fact, the panel were concerned to find that the requirements were not effectively implemented in Mr Cameron's case.

This raises the important issue of why it is that departmental legislation and guidance is not followed by a speedy, practical response at local level.

The panel were also concerned that omissions in his care and treatment were not identified and rectified by managers and supervisors at the time.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority

The key priorities set out Berkshire's *Mental Health National Service Framework Implementation Plan* of April 2000 include the following:

Workforce planning	*Gap to be filled/improvement to be made*	*By when*
Workforce pressures	Trusts to ensure minimum use of temporary and agency staff, and effective recruitment to vacant posts.	Oct 2000

Workforce planning	*Gap to be filled/improvement to be made*	*By when*
Training	Trusts to submit a training plan for all professions, including consideration of CPA training. Link up to training consortia.	April 2001

Workforce planning	*Gap to be filled/improvement to be made*	*By when*
Retention	Trusts to produce a strategy for improving working conditions and reducing stress (including proper supervision/management).	April 2001

CMHT staff (Trust and social services)

All staff within the Reading CMHT now receive structured and recorded supervision regarding individual client casework, quality, line management and professional issues. Supervision of staff is provided by the senior social workers and senior community psychiatric nurses, who in turn are line managed and supervised by the team manager.

West Berkshire Priority Care Service NHS Trust

Clinical Directorates have been established within mental health services. The clinical directors have a key role, which includes strategy, planning, ensuring quality, and working with the service manager to ensure operational delivery.

Consultant psychiatrists receive peer supervision through regular case presentations and discussions.

All psychiatric medical trainees receive regular clinical supervision, as required by the Royal College of Psychiatrists, and the trust is currently exploring supervision of staff grade doctors.

The trust is looking at ways of providing professional support and supervision for nurses and professions ancillary to medicine. It has set up a programme of clinical supervision, supported by training, for all nurses. This nursing framework is to be used to develop a similar system for members of professions ancillary to medicine.

Reading Social Services

Managers are required to ensure that staff are appropriately supported, through training and other methods. Targeted snapshot audits have recently been introduced, the first of which was carried out in January 2000. The Strategic Policy Manager is responsible for ensuring that these audits are carried out.

Recommendations and action plans

Recommendations	*Action plans*	
21. that clear standards are established, and then audited, which ensure that all clinical staff receive regular clinical supervision. Such standards should include frequency of supervision, those responsible for providing it, and methods for auditing its effectiveness.	***NHS Trust*** • **Such procedures will be developed in consultation with the mental health trust in East Berkshire, prior to the formation of a single focus trust.**	**By March 2001**

K. BERKSHIRE HEALTH AUTHORITY

THE INQUIRY'S FINDINGS

The appointment of an independent panel of inquiry was subject to avoidable, and hence unnecessary, delay. In future, we suggest that an independent review panel is appointed immediately when a person in contact with the services is charged with homicide; and that the panel members progress the inquiry as far as possible prior to the conclusion of the criminal proceedings.

The monitoring by the Health Authority of the trust's compliance with *Health Service Guidelines* needs to be improved.

OBSERVATIONS OF THOSE AFFECTED BY THE FINDINGS

Berkshire Health Authority. The Health Authority accepts that it has an important role to play in monitoring what service providers are doing, and also that detailed monitoring has not been carried out in the past.

It also accepts the need to appoint an independent review panel at an earlier stage, and this will be done in future.

Recommendations and action plans

	Recommendations	*Action plans*	
22.	**that the Health Authority should enhance its monitoring of the trust's compliance with *Health Service Guidelines*, in particular compliance with the care programme approach and discharge planning, using external consultants where necessary.**	***Health Authority*** • **The *Head of Service Development – Mental Health* will attend all regular service level agreement contract reviews with NHS trusts which provide mental health care.** • **These reviews will include a focus on the quality of services, as well as activity and finance, including compliance with the care programme approach, the *Code of Practice*, *Health Service Guidelines*, and the action plans contained in this report.**	**In place**
23.	**that the Health Authority should ensure that this report is readily available to individual practitioners and people in West Berkshire.**	***Health Authority*** • **Agreed**	**Immediate**

7 SUMMARY

INQUIRY INTO THE CARE AND TREATMENT OF ALEXANDER CAMERON

(Berkshire Health Authority, September 2000)

During the early hours of 26 April 1997, Alexander Cameron killed his mother, Eileen Cameron, at their home in Reading. On 17 October 1997, Reading Crown Court heard that he was mentally disordered and had been suffering from mental illness at the time of the killing. He was found guilty of manslaughter on the grounds of diminished responsibility, and made subject both to a hospital order and an order restricting his discharge without limit of time.

Mr Cameron was 32 years old at the time of his mother's death and was suffering from schizophrenia. He was a man of good character, who did not take illegal drugs, and who was not dependent on alcohol. His mother, who was a widow, lived alone with him. She was an independent, intelligent, lively and amusing woman, with a wide circle of friends, and a loving and caring parent.

Mr Cameron was admitted to Fair Mile Hospital under section 2 in August 1993, spending 17 days on the locked ward there. Following the completion of a section 3 recommendation, he discharged himself home after a month in hospital. He remained unwell, repeatedly accusing his mother of being the devil, and talking incessantly about what had 'been done to him'. On 3 October, his mother reported that he had put his hands around her neck and referred to her as the antichrist. He was informally admitted on 4 October but was discharged on the sixth. He attended the local day hospital for the next nine months, during which his depixol injection was increased and his oral medication reduced. His psychotic symptoms continued and, in February 1994, he took an overdose of Paracetamol. In July I994, he took a further overdose and was admitted to Fair Mile under section 3. He was commenced on Clozaril, as a result of which 'his whole personality was restored and a lot of his anxieties lifted'. He was discharged from hospital on 12 December 1994, and the care plan involved him living at a bedsit managed by a specialist housing association, receiving Clozaril, and attending the local day hospital. He was not placed on the supervision register, mainly because of family concerns about computer records.

Following discharge, Mr Cameron attended the day hospital until he was discharged from there in June I995, by which time he was again living with his mother. By 5 February 1996, it was obvious that he was not engaging with the community mental health team, and a decision was made to suspend their involvement with him. From then onwards, the key worker, community mental health team and day hospital were no longer involved, and consultant contact was limited to one out-patient appointment every six months. It is unclear whether he was taking his Clozaril.

Mr Cameron's mental state deteriorated significantly during the week prior to his mother's death. He again began to believe that people around him were not who they seemed, and were either the devil or possessed by the devil. These beliefs incorporated his mother and his sister's partner.

On Thursday 24 April, he arrived at his sister's home, tearful and distressed, saying that everything was going wrong again. On the morning of Friday 25 April, she telephoned Fair Mile, to inform his consultant of the relapse. She was, however, unable to speak with the consultant, who offered Mr Cameron an appointment on the Monday. At around 10pm that evening, Mr Cameron was with his mother in their

sitting room. As he looked at her, he became increasingly convinced that she was the devil. He put his hands around her throat and strangled her. At 4.30am, he went to his sister's home. He was shouting 'Satan' and 'devil', and appeared intent on entering her house. There was a violent struggle, which ended with him taking his sister's car and driving away at speed. He was involved in an accident with another car, and was arrested just before 7am, having broken into an empty house.

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 concerning the delivery of local services.

Alexander Cameron's care and treatment

The panel's findings concerning Mr Cameron's care and treatment included the following:

- The way in which he discharged himself from hospital in September 1993 was unsatisfactory. The completion of a section 3 recommendation three days previously should have triggered a full Mental Health Act assessment.

- The way in which the risk of violence to his mother was managed in October 1993, when he put his hands around her neck and spoke of her as the antichrist, was unsatisfactory. He ought not to have been allowed to return home after two days without seeing his consultant and a comprehensive risk assessment.

- There were times when assessments were hampered by the absence of his case notes.

- The reasons why Mr Cameron's name was not placed on the supervision register in November 1994 were insufficient. The decision should have been made by his consultant applying departmental guidelines and criteria.

- There was no evidence that those responsible for his care and treatment from December 1994 onwards had a strategy for dealing with his failure to reside at the bedsit found for him. In particular, there was a failure to consider guardianship. Simply allowing him to return to live with his mother was not a considered response, given that the placement had been found because she could no longer cope, and he could not manage independently.

- There was, and is, a lack of suitable specialist accommodation for local residents.

- The letter sent to Mr Cameron's new consultant, to whom responsibility was transferred on 3 March 1995, was unduly brief and contained no information about previous violence, known risks and warning signs, and his care plan.

- There was no evidence that the consultant responsible for Mr Cameron's treatment from 3 March 1995 onwards assessed his mental state, or the risks associated with it, in a systematic way. Indeed, he did not himself see Mr Cameron until June 1996. He did not keep notes of his out-patient examinations, and did not communicate to the pharmacy a reduction in the Clozaril dosage.

- The decision to discharge Mr Cameron from the day hospital on 14 June 1995 was made without the fact that he was subject to section 117, and subject to the care programme approach, being taken into account. The decision was inadequately recorded.

- The key worker's decision to 'leave his case open' (suspended) on 5 February 1996 was made without the fact that he was subject to section 117, and subject to the care programme approach, being taken into account.

- Both of these decisions were inadequately recorded. The importance of care programme approach documentation was not understood by the professionals involved with Mr Cameron; and the quality and accuracy of most of the records was unacceptable.

- The quality of these decisions was undermined by the fact that they were based on partial information about his history of violence.

- The CMHT did not have a strategy for dealing with his disengagement other than to permit him to disengage.

- The failure to implement section 117 (introduced in 1983) and the CPA guidance (introduced in 1990) was a matter of concern, and it raises the important issue of why it is that departmental legislation and guidance is not followed by a speedy, practical response at local level.

- The steps taken to maintain contact with Mr Cameron and his family after 5 February 1996, and/or to gather information about his mental state and circumstances, were negligible. Because Mr Cameron's mother collected his Clozaril, and his general practitioner provided him with a year's supply of blood test kits, there was no regular monitoring of his mental state. Given that outpatient appointments were then his only contact with services, and he was subject to section 117, these should have been more frequent than once every six months.

- Mrs Cameron's own health was declining and she found caring for her son a tremendous strain. The effect of her son's illness and behaviour on her health and quality of life was not independently assessed or taken into account, and the consequence was that she was not supported by professionals.

- The way in which the family's call on the morning of the homicide was dealt with was unsatisfactory. Mr Cameron's consultant ought not to have relied upon information gathered and reported to him by an untrained secretary unfamiliar with the history. Either he or the junior doctor should have spoken with Mr Cameron's sister or, if this was impossible, she should have been put in touch with the key worker and the community mental health team.

- Although Ms Cameron's only parent had been killed by her only sibling, neither service contacted her, either to express their sympathies or to inquire about her need for professional support and counselling. This was unacceptable.

- The appointment of an independent panel of inquiry was subject to avoidable, and hence unnecessary, delay.

Action plans

The panel commended the helpful and measured way in which Mrs Cameron's daughter and her partner helped them, during what was a stressful and upsetting process for them.

The panel also paid tribute to the professionalism of those who treated and cared for Mr Cameron, and their commitment to providing the best possible service to local people.

The willingness of local agencies to work together, and with the panel, towards agreed conclusions and action plans was noteworthy. Without it, a constructive process would have been impossible. Giving it, when many inquiries had been highly critical of individuals, took real courage.

The action which has been, or is being, taken by the agencies to address the concerns highlighted in the report include the following, and each action plan has either been implemented or has an implementation date:

- The development of an assertive community treatment team in Reading, which can support and follow up people who require intensive, active, care.

- The expenditure of £750,000 on assertive outreach services, secure beds and additional prescribing.

- The investment of a further £1m next year on community developments and clinical posts.

- Funding in excess of £250,000 for a rapid response service across Berkshire, the planning of which will be complete by April 2001.

- Funding of over £250,000 (recurring) for up to twenty 24-hour staffed beds in the community.

- A new system for dealing with crisis calls taken by medical secretaries and administrative staff: it is now the responsibility of the clinician to deal with the caller personally, and all calls to the CMHT base are routed to the on-call duty worker if the relevant clinician is unavailable.

- Funding for three community psychiatric nurses to provide a service to people with mental health problems about whom a general practitioner is concerned.

- The introduction of routine risk assessments on all acute admission wards and within CMHTs; and a policy which requires a full Mental Health Act assessment following the completion of a medical recommendation.

- The introduction of a standard format for records, with a risk factor sheet, and the most recent care programme and risk assessment/management plan, located at the front of patients' notes.

- The development of guidelines on sharing information concerning individuals at risk in the community.

- Improvements in the co-ordination of mental health services: the appointment of a joint CMHT manager; the development of joint eligibility criteria, and joint allocation and referral meetings; a new on-call system; a requirement that the senior house officer will write a discharge letter when a patient is discharged to the care of another consultant; and the appointment of in-patient and community care liaison staff.

- Improvements in the provision of out-patient care: the level of doctor:patient contact which a patient needs as part of their care programme will be agreed at CPA meetings; the *quality* of out-patient assessments of previously detained patients will be audited; and clear standards are to be established which ensure that all clinical staff receive regular clinical supervision.

- Improved in-patient facilities: the locked ward at Fair Mile Hospital has been moved to refurbished premises vacated by medium secure unit; and outline planning permission for a new hospital in Reading, together with permission to seek private finance for it, has been secured.

- Improvements in discharge, care programme and after-care procedures: the General Manager for Mental Health is now responsible for ensuring adherence to *Health Service guidelines*; CPA plans will be scrutinised by a manager prior to discharge, to ensure compliance with national and local requirements; CMHT staff can no longer suspend their involvement with clients subject to CPA; and local discharge, CPA and care planning and risk management procedures are being audited.

- Improved monitoring of patients who have been prescribed Clozaril: their mental state is now regularly assessed by a mental heath professional, and funding has been made available for two nurses to follow up patients who do not collect their prescriptions or attend their blood tests.

- Better support for carers: all individuals who provide regular and substantial care for a person on CPA will have an annual assessment of their needs; and a local strategy is being developed to support the families of the deceased and the patient following a suicide or homicide.

Conclusion

The value of such a review lies in identifying, and gaining support for, feasible improvements, not in apportioning blame. Mr Cameron, and not those who tried to help him, bears responsibility for his mother's death.

Many of the action plans are already in place, and the remainder soon will be. That they have readily been agreed, and are being implemented, reflects the commitment of the Health Authority, the local trust and Reading Social Services to continually improving mental health services for people in Reading.

The overall standard of mental health services in West Berkshire is good. The action being taken represents a further improvement, and deserves the support of local people.

It is particularly important that the new hospital proposed for the Prospect Park site is not delayed, and opens on schedule in 2002. While some anxiety on the part of local residents is understandable, the development of modern in-patient services is in everyone's interest.