Berkshire Health Authority

NHS

REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF STEPHEN ALLUM

March 2000

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PREFACE AND ACKNOWLEDGMENTS

On 10 October 1997, Stephen Allum killed his wife, Thelma Allum. A few weeks previously he had been admitted to a psychiatric ward following a serious assault on another relative. After his discharge from hospital, and arrest on a charge of murder, he was admitted to a secure psychiatric unit. Later he was convicted of manslaughter on the grounds of diminished responsibility.

More than two years on, our review of the weeks leading up to that tragedy was yet a further source of great distress for Mrs Allum's family. We therefore particularly wish to thank, and acknowledge, the very constructive and measured way in which Mrs Allum's family helped us, and the tremendous contribution made by their solicitor, Margaret Stevenson, a partner in the firm of Brain Chase Coles, Basingstoke.

We wish also to acknowledge the way in which the professionals involved in Stephen Allum's care and treatment worked with us during what was a stressful 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 on 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 have tried to conduct an inquiry more in the nature of a review. One directed at achieving consensus and the formulation of action plans designed to improve the delivery of local services. Our report makes no reference to individual professionals: the value of reviews of this kind lies in identifying and then gaining support for feasible improvements to services, not in apportioning blame. Stephen Allum, and not those who tried to help him, bears responsibility for his wife's death, albeit that his responsibility was diminished.

We also commend the willingness of Berkshire Health Authority, the Heatherwood and Wexham Park Hospitals Trust, and the Royal Borough of Windsor and Maidenhead Social Services, to work with us towards agreed sets of conclusions and plans of action.

A constructive process is impossible without that willingness and commitment but giving it, when many previous inquiries have been highly critical of individuals, took real courage.

Our report is a short one. It concerns services provided to people in the Maidenhead area, and we wish it to be available to, and read by, local people and professionals. With this in mind we hope that Berkshire Health Authority will ensure its dissemination to libraries, community mental health services, voluntary and statutory housing organisations, citizens advice bureaux, the police, probation and social services, in-patient psychiatric units and specialist services. The report's publication on a website would also help to make it generally available.

Lastly, but certainly not least, we wish to thank Mrs Lynda Winchcombe, our inquiry manager, for her exemplary management of the process. General inquiries to her should be sent to Paddock House, Baughurst Road, Baughurst, Hampshire RG26 5LP.

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Anselm Eldergill (Chairperson)

Paul Bowden (Medical member)

Claire Murdoch (Nursing member)

Dave Sheppard (Social work member)

Berkshire Health Authority NHS

CONTENTS

Berkshire Health Authority NHS

INTRODUCTION

During the early hours of 10 October 1997, Stephen Allum killed his wife, Thelma Allum, at their home in Maidenhead. He later pleaded guilty to manslaughter on the grounds of diminished responsibility. The court ordered that he be detained in a medium 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

NHS 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 less threatening.

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 they 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 four 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.*
Paul Bowden (Medical member)	Consultant Forensic Psychiatrist. Joint editor of *Principles and Practice of Forensic Psychiatry* and former editor of the *Journal of Forensic Psychiatry.*

Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
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	**To examine all circumstances surrounding the treatment and care of Mr Stephen Lawrence Allum by the mental health services and related services from the criminal justice services and social services. In particular,**
Assessments	• **the quality and scope of his health and social care assessments and the related risk assessments**
Treatment and care	• **the appropriateness of his treatment, care and supervision in respect of** 1. **his assessed health and social needs;** 2. **his assessed risk of potential harm to himself and others;** 3. **his history of prescribed medication and compliance with it;** 4. **his previous psychiatric history and treatment;** 5. **his previous forensic history.**
Compliance	• **the extent to which Mr Allum'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	• **The extent to which care plans were effectively drawn up with Mr Allum, and how those plans were delivered and complied with.**
Joint working	• **To examine the process and style of the collaboration within and between the agencies involved in the care of Mr Allum and the provision of services to him and his family.**
Training	• **To examine any issues of in-service training that arise in [relation to] those caring or providing services to Mr Allum and to consider any impact of 'The New NHS' white paper proposals.**
Report	**To prepare a report and to make recommendations to Berkshire Health Authority.**

Berkshire Health Authority NHS

1 HOW THE INQUIRY WAS CONDUCTED

ABOUT THIS CHAPTER

This chapter summarises the way in which the panel conducted the review. It deals with matters such as the principles underpinning it, the timetable, the review procedures, and the written and oral 'evidence' received by us.

OVERVIEW OF THE PROCESS

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

1	**Introductions**	Pre-review meetings were held with family members, Stephen Allum, 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 Stephen Allum, 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 Stephen Allum'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.

In our opinion, 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 panel members were appointed by Berkshire Health Authority on 25 January 1999. Documentation concerning Stephen Allum's case, 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 and further documents*		• *Meetings*	
September	**October**	**November**	**December**
• *Meetings*	• *Initial Feedback*	• *Preparation of first draft, action plans*	
INQUIRY TIMETABLE — 2000			
January	**February**	**March**	**April**
• *Steering Group*	• *Report to relatives*	• *Final report*	

In January 1999, two of the panel members were also appointed to inquire into a homicide in West Berkshire, and the aim was to conclude both inquiries within 12 months of receiving the first documents.

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. Retribution, and the expiation of wrong-doing, are matters for the courts and for professional bodies.

2. The process is not concerned with establishing whether the death was predictable or preventable, or who bears responsibility for it. Stephen Allum bears responsibility for it, and professional interventions and omissions only ever make certain events more or less likely.

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 minimising 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 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 contain as few recommendations as possible.

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 Allum prior to his wife'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 s/he will be given 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.

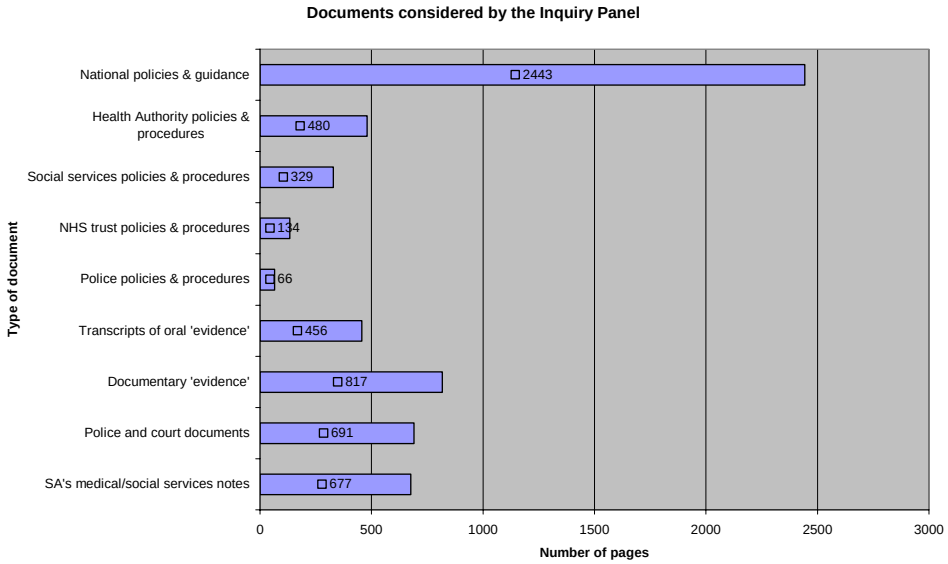
8 The draft report will be made available to the Health Authority and, with their consent, to the Wexham & Heatherwood Hospitals Trust and the Windsor & Maidenhead Unitary Authority, for any comments as to points of fact.

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 Stephen Allum's care and treatment with many people. We also read over six 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 Mr Allum's family, friends and professional carers, precise details are not set out 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.



Berkshire Health Authority NHS

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 practise. 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 mental health 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 all health and social services authorities to manage or deliver a service provided by them in a particular way; such as care plans and discharge arrangements.

- The way in which the police and the prosecution should deal with persons with mental health problems is set out, in particular, in a *Code for Crown Prosecutors* and a circular called *Mentally Disordered Offenders: Inter-Agency Working*.

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. The Secretary of State 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. The Department of Health'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 regional office responsible for Berkshire is the South East Regional Office.

NHS hospitals are managed by NHS trusts, and Wexham Park Hospital is managed by the *Heatherwood and Wexham Park Hospitals 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 (employee) and non-executive (non-employee) directors. All of the trust's directors 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 to implement national priorities and meet local health needs; implementing that local health strategy by purchasing health services for patients through contracts with NHS and other providers; and monitoring the delivery of health services to ensure that objectives are achieved.

Although the NHS Executive regional offices monitor the NHS 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 Maidenhead in 1997 was *Berkshire County Council* but, following reorganisation, is now the *Royal Borough of Windsor and Maidenhead*.

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 NHS 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 Mental Health Act 1983 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 and who then cease to be detained and leave hospital.

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.' In a minority of cases, where an individual lacks sufficient capacity to appreciate that his 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 which authorise such 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 criteria for detention always comprise at least two grounds. The first of these grounds (*the diagnostic ground*) requires that the individual is suffering from a severe mental disorder. The second ground (*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 person's detention is justified or necessary in a particular case will often partly depend on what arrangements have been, or can be, made for his treatment outside hospital. The patient's willingness to accept appropriate treatment as an informal in-patient, and his capacity to adhere to any agreed treatment programme and discharge plan, will also be highly relevant.

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 Mental Health Act Commission is a government body whose functions include publishing 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 Stephen Allum 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, 'Informal admission is usually appropriate when a mentally capable patient consents to admission, *but not if detention is necessary because of the danger the patient presents to him or herself or others*' (para. 2.7). It also states 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).

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 in 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 keyworker 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 might 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, it has been the case that information indicating an increased risk 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) Keyworker'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 receive monitoring and review of a simple care plan.

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 keyworker should ensure before discharge that elements of the plan necessary for discharge are carried out. This will include the patient's needs 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 keyworker 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 booklet sets out important changes to the CPA which take account of available evidence and experience. Some key developments are the integration of the CPA and care management; the appointment of lead officers within 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 'keyworker'.

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 each person with 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 Allum's care and treatment, the following represent some of the most significant standards set out 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.

CRIMINAL LAW SYSTEM

In 1994, the Crown Prosecution Service produced a *Code for Crown Prosecutors* in which mental health issues are discussed as a public interest factor which may mitigate against prosecution (section 6.5). The issues are also covered in Home Office Circular No. 12/95 *Mentally Disordered Offenders: Inter-Agency Working* (Home Office and Department of Health, 1995). The following extract from Circular No. 12/95 has a relevance to Mr Allum's case (at pp.19–20):

> ***'When to consider charging***
>
> The police have a crucial role to play in determining whether a mentally disordered person enters the criminal justice process. The existence of mental disorder should never be the only factor considered in reaching a decision about charging. The need to protect the safety of the public may indicate that formal action is needed ….
>
> Determining when prosecution is the proper course can be a finely balanced judgement. To help reach a decision, the police will need to find out whether the person has any history of mental disorder or has had any previous contact with the criminal justice system. Good links with the local psychiatric and social services are essential to provide a ready source of advice about the person's current mental state and any previous psychiatric history.
>
> This information should help the police to determine whether an incident can be assessed as an isolated event, and to decide an appropriate way forward, taking account of the gravity of the offending and the potential risk to others if the behaviour recurs. Although an incident may be a minor matter in itself, it is important to establish whether it represents the latest in a developing pattern of dangerous behaviour which requires intervention by the criminal justice system for the protection of the public.
>
> The police will want to consider any options offered by health and social services staff which may include compulsory admission to hospital using the powers available to doctors and social workers under the Mental Health Act.'

Berkshire Health Authority NHS

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

Berkshire has a population of 3/4 million spread roughly evenly across 6 unitary authority areas. It has a mixture of more rural areas (especially in the West), alongside major conurbations like Slough and Reading (which have relatively high mental health prevalence scores).

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, within an average population of a thousand people, one individual will be severely mentally ill and have complex needs which require integrated and assertive care and follow up. A further five people within the group will have a severe illness and need multidisciplinary long term care, but in a slightly less intensive and assertive fashion.

Applying these national figures to the 561,133 adults aged between 16-74 in Berkshire produces the estimate that 561 people within the county will experience severe mental illness and have complex needs which require integrated and assertive care and follow up. A further 2,805 people will have a severe illness which needs multidisciplinary long term care but in a slightly less intensive and assertive fashion. More locally, the needs of residents within the Maidenhead and Windsor area would then be as follows.

Population	*Most severely ill group*	*Less severely ill group*
99,142	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 are 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 took over the function of purchasing hospital and specialist psychiatric services from the old Berkshire District Health Authority. It is responsible for trying to ensure that the needs of people who become ill are met effectively and efficiently within the available resources. The majority of 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 *Heatherwood and Wexham Park Hospitals Trust.* In 1997/98, when Mr Allum was in hospital, 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.

The Health Authority is responsible for implementing national health policy. Its strategic role includes developing collaborative strategies to meet national and local priorities, and ensuring that national policy, and local strategy, are implemented effectively. It does this in part by monitoring the quality and standards of care of secondary care providers.

Implementation of the National Service Framework is currently being drawn together by Berkshire Health Authority, in consultation with individuals and organisations who have an interest in mental health in Berkshire. The *Mental Health Strategy* is being updated to reflect the NSF, and the Royal Borough will be revising their local mental health strategy in line with the national and countywide strategies.

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, 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 there was a period of consultation. 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 the 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 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 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 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 would require further service development and not all could 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 users' mental, physical, social, housing, financial, work and educational needs. • Particular emphasis will be laid 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 requires 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. Those of them 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 and 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

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

THE APPRAISED EVIDENCE FOR MENTAL HEALTH SERVICES		
	Intervention	***Outcomes***
Community Mental Health Teams	**Case management** brokerage of care by social services, co-ordinating purchasing from other agencies.	**Case 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)

IN-PATIENT AND RESIDENTIAL SERVICES

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, then 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	***Bed numbers in 1998***		***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
Continuing Care Wards	8	77	74.0	69.9
or Hostel Wards		(91)		

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

Wexham Park Hospital

Wexham Park Hospital is managed by the *Heatherwood and Wexham Park Hospitals Trust*, and Mr Allum was admitted to Ward 11 there. At the time of his admission, the ward consultant attended a full ward round on Monday mornings, and ward reviews with the ward manager on Wednesday and Friday mornings. On Thursday mornings, he met with the community mental health teams.

The associate specialist assigned to Ward 11 also attended these meetings, other than the Wednesday morning review; she did a ward round on Tuesday mornings instead. The junior doctor on the team, a senior house office, was on the ward every day.

Discharge planning and care programmes

The trust's policies and procedures aim to ensure that the care programme approach (the CPA) is implemented at Wexham Park Hospital in the following way. As soon as a patient is admitted, the CPA co-ordinator at the hospital will approach the community mental health team, identify the carers, housing needs, and any other issues, write to them, and co-ordinate a CPA meeting. The initial meeting is supposed to be held two weeks after the admission, although that is not always achievable. Some short-stay patients may be discharged prior to a meeting being held, if the ward is full and there is no clinical reason for them to remain in hospital. It is estimated that the needs of about 10% of the patients are complex and call for full multidisciplinary involvement, with the needs of some 10–20% being categorised as 'simple'. A CPA monitoring and risk management group has been developed since the time Mr Allum was a patient at Wexham Park Hospital.

An examination of the trust's audit reports, and reports of visits conducted by the Mental Health Act Commission, indicates a strong commitment on the trust's part to the care programme approach, but also somewhat variable (if slowly improving) compliance by staff with trust procedures. This variability is consistent with the national picture.

Readmission rates

One measure of the quality of discharge planning and community support, and the pressure on in-patient beds, is the rate of readmission to hospital. Readmission rates for the hospitals managed by the Heatherwood and Wexham Park Hospitals Trust during the period from 1996 to 1999 are given below. The level of readmission is well below the national average.

	1996-1997	**1997-1998**	**1998-1999**
No. of admissions	1069	1080	965
Readmissions (%)	7.58	4.81	10.47

Complaints

Another way of measuring a trust's performance and procedures is by examining complaints records and summaries. The inquiry panel inspected the trust's

complaints records covering the period from 1997 to 1999. 13 formal complaints were received during 1997–98 and 14 during 1998–99. The complaints procedures appeared to be effective, and the number of formal complaints was relatively low.

Training

Training on the Mental Health Act Code of Practice is mandatory, and the trust has its own trainers.

COMMUNITY CARE

Community care refers to the policy of providing services and support which people affected by mental ill-health need in order to be able to live as independently as possible in their own homes, or in 'homely' settings, in the community.

The Health Authority's *Mental Health Strategy* acknowledges that community services have been underdeveloped and makes explicit its commitment to improve the range of community mental health services, including the provision of 24 hour crisis response teams, adult day services and increased support to primary care from community mental health teams. The strategy identified an additional £2m being put into specific community initiatives.

Community Mental Health Teams (CMHTs)

The organisation of community services are centred on community mental health teams (CMHTs), and the Windsor & Maidenhead Community Mental Health Team is based at 5 Frascati Way, Maidenhead. It is multidisciplinary, as are all such teams. Social workers and community psychiatric nurses (CPNs) both act as keyworkers and care managers, and share operational systems and files. A comparison of the composition of Berkshire CMHTs at around the time of Mr Allum's admission appears in the *Mental Health Strategy* document of November 1998. It is reproduced below, and it may be noted that the psychologist's post was vacant, and that two consultant psychiatrists were 'associate members' of the service.

	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

During the year ending 30 September 1997, the team dealt with nearly 400 enquiries and carried out almost 370 assessments. It was responsible for an active caseload of close to 400 cases, some 63% of which were regarded as representing a high priority level of need. There was evidence of an increase in the team's workload during the previous eighteen months.

During the whole of 1996/97, the team also dealt with 70 formal approved social worker assessments under the Mental Health Act, representing over 82% of all such assessments carried out within the Borough area.

Since sectorisation, in November 1998, the community mental health team in Maidenhead now works with only one consultant. Previously, it had to relate to four consultants at Wexham Park Hospital, which thus required attendance at four ward reviews.

Social Services

The multidisciplinary nature of community mental health teams means that they are made up of employees of both the local NHS trust and the local social services authority. During the autumn of 1997, the local authority responsible for people in Maidenhead was *Berkshire County Council*. However, by then, it was in the last six months of its existence, and the organisation of social services was in a state of considerable flux. There was at this time a very clear purchaser/provider split in the management of the services, and community mental health teams were on the purchasing side. Social services was a county-wide service, housing and housing policy a borough responsibility. On 1 April 1998, the Royal Borough of Windsor & Maidenhead took over responsibility for all local government services. It produced its first community plan that month, and its mental health services now combine both purchaser and provider functions.

Specialist accommodation

There is no truly high dependency accommodation in East Berkshire, and it is not uncommon for individuals to be sent to private high dependency hostels up to 80 or 90 miles away. The only supported accommodation in Windsor and Maidenhead is Peter House, which is managed by Advance Housing, and provides 24 hour staffing for eight residents. A relatively new development in Albert Street provides short-term accommodation for about 20 young single homeless people. At any one time some five or six or them are likely to have mental health problems.

PREVIOUS INQUIRIES IN BERKSHIRE

Since 1997, Berkshire Health Authority has published the reports of two other independent inquiries into the care and treatment of patients who subsequently 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.

Darren Carr Report (April 1997)

Mr Carr received psychiatric treatment in Berkshire. 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 ... 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, including Berkshire Health Authority, established a joint agency group to take forward implementation of the recommendations. They agreed to invite the panel to review their progress in 12 months time, as recommended in the report.

Berkshire Health Authority NHS

4 THE HUMAN FRAMEWORK

ABOUT THIS CHAPTER

The service which professionals can provide to persons with mental health problems is defined not 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 it is realistic for the public to 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. Nevertheless, it needs to be emphasised that the enduring impression left after many years visiting psychiatric wards is for most people 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 physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

The risk of suicide

In statistical terms, 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%, affective (mood) disorder 15%, and personality disorder 15%.

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 reveal 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 over the 38 years, 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 difficult tasks of ensuring both that members of the public are not unnecessarily detained and also that members of the public are protected from people who must necessarily be detained. Balancing these different considerations is a formidable task.

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.

Berkshire Health Authority NHS

5 STEPHEN ALLUM'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The purpose of this chapter is to summarise the most important aspects of Stephen Allum's personal history, care and treatment.

In the early hours of Thursday 9 October 1997 Stephen Allum was arrested on suspicion of the murder of his wife Thelma. Present in the house at the time of the killing were his two teenage sons and two young relatives. He was assessed as mentally fit for interview and did not at first admit the killing. On 14 November 1997 Mr Allum was transferred from prison to a secure psychiatric hospital on the grounds that he urgently required medical treatment which could not be provided in prison. On 9 July 1998, the Central Criminal Court heard that Mr Allum was mentally disordered and suffering from mental illness at the time of the killing; he was found guilty of manslaughter on the grounds of diminished responsibility. He was made subject to a hospital order, and an order restricting his discharge without limit of time.

Born in April 1961, Stephen Allum grew up in Earley, Reading. There was a family history of respiratory disease and Stephen was admitted to a chest hospital at 11 months. He was discharged six months later but asthma and a skin complaint plagued his childhood. When he was eight Stephen was referred to a child guidance clinic: he was sensitive, anxious, and misbehaved. His mother was receiving psychiatric treatment at the time. His intelligence was found to lie in the normal range; a school transfer was arranged. In 1973 the family moved to Maidenhead. Shortly after leaving school in 1977 Stephen Allum met his future wife (and the victim of the homicide). She was one year older than him. They married a year later, and in the same year their daughter was born. In about 1985 the Allums moved house to live near to his parents; they then had a further two children, both boys. In 1990 Mr Allum's mother died. Three years later he was treated for depression by his GP. In 1995 Stephen Allum's father remarried, and Stephen met another woman with whom he pursued a relationship until his wife's death. Also in 1995, Stephen Allum lived for a time at his older sister's home in York where his female friend joined him for a time.

On leaving school Stephen Allum found factory work. He was then employed as a chef's assistant before moving to a paper mill where he spent several years. In the mid-1980s he trained as a bus driver and he remained in this work for the next 10 years. Mr Allum began drinking on his way home from work but latterly his use of alcohol became less controlled. He also used illicit drugs, mostly cannabis, and also stimulants. He gambled and debts were to cause problems at home and make him seek help to repay loans he had taken. In the months before the homicide the picture is of a man taking alcohol and cannabis regularly, becoming less competent at work (and eventually being made redundant), burdened by debts and yet continuing to gamble. For her part Mrs Allum became severely disabled with a spinal complaint which had been operated on in 1993. She disliked going out on her own and was dependant on both her family for household chores, and a car for travelling. The family knew of Mr Allum's affair and he brought the woman home to meet his family.

Mr Allum was often home late, the boys sometimes being left to look after their mother.

On about 23 August 1997 Mr Allum visited his father to express concern that he was being threatened. On Saturday 30 August he visited his GP with physical complaints; he admitted drinking and drug use and was advised to contact a community drug and alcohol treatment agency. Driven by delusions (false beliefs) Mr Allum visited his stepmother on the evening of the 30th. He attacked her and held broken glass to her face. The assault was interrupted by the arrival of Mr Allum senior. Stephen Allum threatened to kill and his father tricked him into contacting the police. After his arrest for actual bodily harm Stephen Allum told the police surgeon that he feared he was being poisoned. The next day Mr Allum was seen by a second police surgeon and an approved social worker. He gave a history of delusional ideas extending back several weeks and was clearly frightened by his beliefs. Psychiatric hospital admission was indicated and because Mr Allum agreed to being admitted he was not admitted formally (involuntarily, and subject to the Mental Health Act).

On the same day (31st) Mr Allum was admitted to ward 11 at Wexham Park Hospital. The admitting doctor recorded Mr Allum's delusional ideas which included beliefs that his family were at risk. In addition to the paranoid psychosis Mr Allum was sometimes hostile and uncooperative; he was prescribed a tranquilliser and told not to leave the ward. Over the next few days it became clear that Mr Allum then planned to leave his wife. His delusional ideas related to illegal drug use and it was thought that his own drug use may have precipitated the psychosis. By 4 September it had been decided that Mr Allum should seek his own help with accommodation and financial matters; his ward consultant would see him as an out patient; he would not be able to use the services of the community mental health team. On 5 September Mr Allum was given leave to walk in the hospital grounds. On the 6th he was visited by his wife, who had been brought to the hospital by her mother, and on 7th by his female friend. On the 8th, 9th, 10th September Mr Allum was given day leave with his female friend. On 11th Mr Allum was advised to contact the Citizens' Advice Bureau (CAB) and Maidenhead Housing concerning his problems; he spent the nights of the 11th and the weekend of the 12th/13th at his female friend's home.

By Monday 15 September it was known that Mr Allum would not be able to live permanently at his friend's and Mr Allum went to the CAB who in turn contacted ward 11 because of his distress at his situation and impending discharge. In the evening Mr Allum's father contacted the ward because his son had turned up unannounced on his door step. Mr Allum spent the night of the 16th at his female friend's and on 17 September the ward staff's intention was that he should either find his own room or be sent to bed-and-breakfast accommodation. Mr Allum spent the weekend of 20/21 September at his female friend's. Mr Allum was discharged from hospital on 22 September. At a ward review beforehand he announced that he would be returning to his wife because his female friend would not have him. A care programme approach meeting planned for 29 September was moved to 9 October and Mr Allum was given 2 weeks supply of medication. Seventeen days later Mrs Thelma Allum was killed.

INTERPRETATION OF THE FACTS

Some of the findings set out in the next chapter of the report depend in part upon the view taken by the panel members about Mr Allum's mental state, and the extent to which mental disorder contributed to his violent behaviour. It is only fair therefore to spell out the view taken by us with regard to these important issues.

The assault on Stephen Allum's stepmother

Stephen Allum's mental state and behaviour deteriorated during the two years prior to his admission. He was gambling and drinking excessively; using a range of illegal drugs; in debt and stealing from work; at times depressed; having problems coping with the consequences of his wife's ill-health; experiencing matrimonial and sexual difficulties; engaged in an affair which led him to leave home; and in conflict with his children and blood-relatives. This was a serious attack, which was a direct result of Mr Allum's delusional beliefs. In less fortunate circumstances, it could have resulted in extreme physical harm to his victims.

The nature of Stephen Allum's mental illness

Stephen Allum suffered an acute paranoid psychosis before the first admission. His psychosis had not completely resolved at the time of his discharge from hospital. The psychosis became more florid following his remand into custody. The diagnosis remains uncertain, as do the contributions which substance abuse and brain damage make (and made) to his mental states. Psychological factors could have influenced the clinical picture during the custodial remand.

The relationship between Stephen Allum's mental illness and the homicide

It is probable that Stephen Allum continued to experience symptoms of mental illness, including paranoid ideas, at the time of his discharge from hospital. Although his mental health had improved, he remained vulnerable and desperate throughout. Some of the reasons for this were that he had lost his job; he had mounting debts; his relationship with his female friend was in difficulties; he did not want to go home to his wife; and he faced possible criminal proceedings for assault. The homicide was planned. Its motivation appears to have been based largely on matters not related directly to mental disorder. Residual mental disorder probably played some part on his affect, and thence his judgement, thereby facilitating the killing. The parts, if any, played by substance abuse and brain damage are unclear.

Berkshire Health Authority NHS

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 further improve local practices. A common feature of many of the action plans is that they are intended to help ensure that busy professionals implement important national and local guidance directed at minimising risk of harm to the patient or others. 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. HOW THE SIGNIFICANCE OF THE FIRST ASSAULT WAS ASSESSED

The Inquiry's findings

Important information about the assault was not sought by, or communicated to, those responsible for assessing, treating, and caring for Stephen Allum, both in hospital and in the community. Even within the police station, important details concerning the assault were unknown to those assessing his mental state and the risks associated with it. The decision not to detain him under the Mental Health Act 1983 was made in the context of limited and unconfirmed information regarding risk (there was no independent source). It cannot be good practice to make decisions about the need for compulsory powers without such information, when that information is readily available.

This lack of awareness of the circumstances of the initial offence contributed to, and helps to explain:

- the lack of rigour in the in-patient and community assessment he then received;
- the failure on the part of hospital staff to understand the seriousness, context and possible consequences of the attack, which affected their decisions about what discharge and after-care were appropriate;
- the failure to conduct a proper risk assessment, and an impaired understanding of the risks that he might pose in the future;
- key family members not being adequately involved in the assessment process;
- a lack of appreciation of the victim's family's concerns about leave and discharge arrangements, and a failure to properly inform them of leave and discharge decisions;
- a failure to consider the welfare and safety of his children when making the decision to discharge him to his home address.

Observations of those affected by the findings

The *Heatherwood and Wexham Park Hospitals Trust* and the *Royal Borough of Windsor and Maidenhead* accepts that details of the index offence were important, and should have been known by those assessing and caring for Stephen Allum.

Recommendations and action plans

Recommendations	*Action plans*	
1. that *simple* arrangements are developed which 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.	***Police*** • **Thames Valley Police agree that a simple procedure is introduced in order to ensure that details of the allegation that have led to the arrest and subsequent sectioning under the Mental Health Act are conveyed to the health professionals conducting the assessment.**	**By April 2000**

The primary duty should be on the police to furnish this information, but NHS and CMHT staff should be under a duty to obtain it if they are aware that it has not been provided in a particular case.	This will be in the form of witness statements (with address details *etc* blanked through to protect witnesses privacy), or a report detailing the allegations. This is to be given during the time that the detained person is in the place of safety (normally the custody area but sometimes the local hospital, *etc*). *NHS trust, social services* The *Allum Report* will be shared by the trust with representatives from the police, social services and other agencies to enable the development of a shared protocol.	
2. that, to this end, a protocol should be developed which addresses the issue of confidentiality and the sharing of information between agencies. This should emphasise the importance of considering— • who is most at risk of violence; • whether these individuals are aware of the risk, the history of violence, the context within which it occurred, and any warning signs; • whether strictly observing the confidentiality of patient information will place any person(s) at greater risk; and, therefore, • whether information about the risks should be shared with those bearing the risks, as part of the risk management strategy.	*NHS trust, social services* • The current protocol is being updated.	By April 2000
3. that each police station should, at all times, have a named duty officer who is to act as the primary point of contact with mental health professionals regarding police investigations of violent offences alleged to have been committed by in-patients and out-patients.	*Police* • The duty Inspector on the Thames Forest area is the nominated person to act as primary point of contact for ongoing incidents.	By April 2000

		The Criminal Justice Inspector will be the point of contact for incidents already dealt with, where subsequent information is sought by mental health professionals. The arrangements on other police areas may be different depending on local structures.	
4.	that *simple* arrangements are developed which ensure that the suspected victim(s) of the assault, and any adults with whom the patient proposes to reside, are consulted about, and notified of, hospital leave and discharge decisions.	*NHS trust* • Interim arrangements, involving the development and use of a checklist, will be in place by January 2000. They will then be integrated into the new care planning documentation.	By January 2000
5.	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.15).	*NHS trust* • Mental Health Act training continues on a monthly basis. The training has now been thoroughly reviewed to ensure it addresses the areas of concern expressed by the panel. Joint training with social services staff took place in July, September, October and November 1999. • Training sessions on the *Code of Practice* have already been purchased from, and delivered by, the Mental Health Act Commission. Additional sessions will continue to occur with MHAC help.	Ongoing

B. POLICE LIAISON FOLLOWING ADMISSION AND CHARGING PROCEDURES

The Inquiry's findings

Circular 12/95 emphasises that determining when prosecution is the proper course can be a finely balanced judgement, and that good links with the local psychiatric and social services are essential (see p.14). In Stephen Allum's case, the decision making process concerning whether or not to charge him for the assault on his stepmother was very confused, indicating that communication between the ward, the family and the police was not good. There was a general failure of communication on both sides.

The ward staff were told by the police that they were still deciding how to proceed, and would let either them or Stephen know when they had reached their decision. However, for their part, the police were waiting for Stephen Allum's stepmother to decide whether she wished to press charges. Her decision was apparently going to be based on the outcome of the hospital's assessment of the cause of Stephen's behaviour.

Although the police were notified of Stephen's discharge on 22 September, the officers in the case were not informed until several days later.

Because of the lack of dialogue, it is hard to see how a decision about whether to prosecute or not could be made in a timely manner.

Observations of those affected by the findings

Heatherwood and Wexham Park Hospitals Trust: Health professionals play no part in the decision making process concerning whether or not to prefer criminal charges against a patient involved in an assault of this type, nor are they aware of the arrangements within the police service for the dissemination of information about the discharge of a patient.

Police: The police cannot generally prosecute offences where the aggrieved person has not made a definite allegation supported by a witness statement including a commitment to attend court and give evidence if needed. The decision to prosecute or not will be affected by the seriousness of the incident and also the likely mental state of the offender following a period of treatment. The police have not had access to this information. Thames Valley police do wish to enter into such an arrangement.

Recommendations and action plans

Recommendations	*Action plans*	
	See also recommendations 1and 2 above.	
6. that the named duty police officer (see *recommendation 3*) will consult the patient's consultant about the advisability of prosecuting a person in such circumstances, and that the outcome of that discussion will be recorded in the patient's notes.	***Police*** • **The Police representation on the local mental health liaison groups wishes to extend the terms of reference to include an assessment group to consider prosecution of mentally ill offenders.**	**By July 2000**

	• The police wish to be involved in a partnership where information can be shared to ensure public safety.	
	NHS trust, social services	By April 2000
	• The current protocol concerning confidentiality, and the sharing of information, is being updated.	
7. that the police or the Crown Prosecution Service should record their reasons for not charging an arrested person who is removed to hospital without charge, given that the absence of a caution or conviction may be important, including to the victim. The police should then communicate this information to the relevant NHS trust.	*Police, Crown Prosecution Service*	By July 2000
	• Agreed (see recommendation 3)	

C. ACUTE SERVICES

The Inquiry's findings

The third edition of the *Code of Practice* states that, 'as a general rule it is preferable for a person thought to be suffering from mental disorder to be detained in a hospital rather than a police station' (para. 10.5). The local arrangements need to be revised in order to reduce the use of police stations in such cases.

The small intensive observation unit at Wexham Park Hospital is designed only for the containment of acutely disturbed behaviour, and the panel accepts that it is an unsuitable environment for the assessment of *undisturbed* patients who present a risk. It also accepts that the vast majority of acute admission wards in England and Wales are, as in the case of Ward 11, unlocked. Because this is so, it is particularly important that at all times at least one of the nurses on each acute ward is qualified to exercise the power of detention conferred by section 5(4) of the 1983 Act.

Observations of those affected by the findings

Berkshire Health Authority accepts that the present situation is undesirable. Together with Slough Social Services and Advance Housing Association, the Health Authority has planned a new service in East Berkshire which will open in June 2000, and offer a diversion from hospital bed which can be accessed quickly, and used for assessment.

Recommendations and action plans

Recommendations	*Action plans*	
8. that at all times one of the nurses on each acute ward should be qualified to detain a patient under section 5(4) should the need arise.	***NHS trust***	***Immediate***
	• **At all times one of the nurses on night duty will be qualified to detain a patient under section 5(4) should the need arise.**	
9. that the arrangements concerning the use of police stations in East Berkshire as places of safety be reviewed (s.136)	***Health Authority (lead), NHS trust, Social services***	***Immediate***
	• **The Health Authority will ask the local authority and NHS trust to formulate aims for this service. Discussion has already been initiated to identify potential resources.**	
	• **In liaison with social services, the Health Authority will locate an out of hours alternative to a hospital place of safety.**	***Within two years***

D. THE ASSESSMENT PROCESS

The Inquiry's findings

There is no evidence of a proper assessment of Stephen Allum's mental illness, history, social circumstances, finances, drink and drug use, relationships, employment status and emotional state.

Good practice should emphasise the importance of seeing informants and that, without this, the absence of information does not mean that all is well. However, in Stephen Allum's case:

- Information was not sought from Thelma Allum or their children, and her view concerning Stephen Allum's return home was not canvassed.

- His female friend and her daughter were potentially valuable informants but were not interviewed; any risk which they may have faced was not considered.

- The stepmother's concerns, and those of her family, were also not addressed adequately. Her husband and son were understandably frightened and made attempts to contact the ward and the community mental health team, to find out about leave and discharge arrangements. Their attempts were wholly unsuccessful because staff were perhaps over concerned with maintaining strict confidentiality of patient information essential to risk management.

Following admission, there was little evidence of any regular on-going systematic assessment of Mr Allum's mental state or difficult social circumstances. The view seems to have emerged during his stay in hospital that he was able to sort out his many problems himself, and was either malingering or being manipulative, using the mental health service to resolve family, police and accommodation problems. This view, which was largely untested, influenced his management, and, in particular, the decision not to offer a service to him. It might not have been adopted had a more thorough assessment taken place.

The lack of adequate assessment was most typified by:

- a poor primary nursing model on the ward;

- the lack of a nursing care plan;

- the lack of a formal risk assessment;

- the history that was taken;

- the quality of the pre-CPA assessment (see p.11, *Building Bridges*).

The assessment of Stephen Allum would have been enhanced by:

- knowledge of the alleged offence against Stephen Allum's stepmother;

- involvement of the family, and other informants such as the police, when taking the history and monitoring his changing mental state;

- regular and ongoing assessment of his mental state, both informally and formally, by the senior house officer and primary nurse;

- the taking of a full drug history and a full social history.

Had the above taken place, a more accurate picture of his mental state, of his ability to solve his problems, and of the suitability of unsupported community discharge, might have been obtained prior to discharge. In particular, the decisions not to offer him community mental health team or keyworker support, despite being discharged prior to a full CPA taking place, might not have been made.

Observations of those affected by the findings

The *Heatherwood and Wexham Park Hospitals Trust* agrees that:

- Risk management should include seeking evidence to confirm provisional opinions about risk. The family members and others with close attachments to Stephen Allum should have been more closely involved with decision making. Those within the service should have been proactive in seeking that involvement when it was not forthcoming.

- Decisions during and after Stephen Allum's stay in hospital, regarding discharge arrangements, his need for community mental health team services and housing, and delaying the CPA from the time when it was originally planned, were based on partial, and sometimes inaccurate information.

- Neither substance misuse nor personality disorder should be assumed to be the cause of behaviour without clinical evidence to support this, and ruling out other alternatives.

- Sharing of information is fundamental to the care programme approach and risk management, and risk management can override considerations of confidentiality.

- Since the time when Stephen Allum was in hospital, the NHS Executive (South East Regional Office) has initiated work regionally and locally concerning the development and implementation of an appropriate training programme for risk assessment and management.

Recommendations and action plans

Recommendations	*Action plans*	
10. that *simple* arrangements are made to bring about more active and enquiring approaches to the assessment of patients on acute wards, including:	***NHS trust, social services***	
(a) the development of an operational policy for the acute service;	• **Agreed.**	***By June 2001***
(b) clarification of the roles of the primary nurse and the senior house officer;	• **The primary nursing model is being reviewed by the trust.**	***By June 2000***
(c) training in teams in the following areas:	• **These training issues will be addressed with the new care planning documentation.**	***By June 2000***

i) the importance and scope of a comprehensive assessment which addresses all of the key areas of the individual's life, from medical through to social;	• (i)–(v) The trust is integrating update training in mental health assessments into the in-service training programme.	*In place*
ii) history taking;		
iii) the dangers of making assumptions about the contributions of substance abuse and personality to an individual's mental state and care management;	• A project is currently being studied under the Achieving Clinical Excellence Project regarding substance misuse and its contribution to mental state.	*Ongoing*
iv) the importance of involving a wide range of informants;	• (iv) and (v) A risk assessment policy is being agreed between the trust and the unitary authorities in East Berkshire.	*By March 2000*
v) the importance of sharing information with carers and other non-professionals if their safety, or that of the patient, is likely to be compromised unless they have that information.		
11. that care planning processes are in place which ensure that staff interview informants as a routine part of mental state assessment, that each patient's consultant ensures that this is done, and that the patient's needs are continuously reviewed upon the basis of new information obtained.	*NHS trust* • New care planning documentation will require continuous reviewing of patient information.	*By June 2000*
12. that clinical audit looks at the quality of assessments on acute wards and focuses on: • the use of informants; in order to verify that informants have been seen; • 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.	*NHS trust* • The Clinical Audit Department are auditing risk assessment in June 2000.	*By June 2000*

13. 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* • A package of training for clinical supervision, brought in from the Tavistock Institute, commenced in April 1999. The Institute's trainers are training ward managers and a programme of extending this to all staff is in progress.	*Ongoing*

E. PRIMARY NURSING

The Inquiry's findings

The inquiry panel recognise the multidisciplinary nature of much of the care provided on the wards. However, the role of the primary nurse on an acute ward comprises certain key components which can be briefly summarised as follows:

- co-ordinating the contributions made to patient care by the multi-disciplinary team, the family, carers, agencies such as social services, and the patient;
- pursuing and obtaining all information which will enhance the quality of the assessment of the patient's needs;
- communicating all relevant information to the relevant parties;
- actively assessing and supporting the needs of the patient and, where appropriate, those of their family and carers.
- formulating, and thereafter regularly reviewing, an effective nursing care plan, which feeds into and forms a major component of the multidisciplinary/multi-agency care plan.
- ensuring that effective CPA processes are initiated in a timely manner, and implemented as part of a thorough and inclusive process which ties together the in-patient and community inputs to care.

In order to effectively fulfil this role, the primary nurse needs to establish regular one to one contact with the patient (both formal and informal).

In Stephen Allum's case, his primary nurse was on night duty for the whole of his admission, with the exception of one late shift worked through the bank. As result, the nurse could not:

- establish effective contact with the wider multi-disciplinary team, other agencies, or Stephen's family;
- attend ward reviews or pre-CPA assessments;
- be actively involved in his discharge planning.

None of those questioned seemed to think that the primary nurse being on night duty for the entire admission was a problem. Explanations of team nursing were given but within this concept the role of the primary nurse was so diminished as to be pointless. Under these circumstances the existence of a primary nurse in name only lends a false sense of security, implying that a system is in place to co-ordinate care effectively, when in fact it is not.

Recommendations and action plans

Recommendations	*Action plans*	
14. that nurses on night duty do not act as primary nurses for patients.	• **No patient will be allocated a primary nurse who is on night duty in the future.**	***Immediate***

F. NURSING CARE PLAN

The Inquiry's findings

The co-ordination of an inpatient's care and treatment is a complex task, and the clarity brought to this process by a relevant, properly documented, and regularly reviewed, nursing care plan is essential. It is regrettable that no care plan for Stephen Allum was available to the panel, although it is reported that one did exist, and was available to the internal inquiry panel.

Observations of those affected by the findings

Heatherwood and Wexham Park Hospitals Trust: Although the hospital records do not contain a care plan, there are references to it in other contemporaneous documents.

Recommendations and action plans

Recommendations	*Action plans*	
15. that multidisciplinary care plans and records are introduced, in conjunction with minimum, audited, standards for record-keeping. Such standards could include legibility, date, signature; risk assessment and monitoring; the existence of a care plan which is reviewed, and updated.	• **Clinical Audit is now in place for all care planning. The Department of Mental Health is designing a Project Plan for new Mental Health Case Notes appropriate for the Directorate. This is being introduced for all new patients from April, and a Business Case will be submitted for Capital Funding for existing case notes.**	***By April 2000***

G. MEDICAL MANAGEMENT

The Inquiry's findings

The usual medical cover on Stephen Allum's ward comprised a consultant, an associate specialist, and a senior house officer. The absence on leave of both the consultant and the associate specialist had the effect that the diagnostic formulation and management plan made early in the admission were not amenable to change, and the diagnosis of drug-induced psychosis was never confirmed. Furthermore, the medical cover when they were on leave, which was provided by the daily on-call consultant, was inadequate.

Too much emphasis was placed on medical management decisions being taken in the ward round, and too little emphasis on active assessment outside this forum.

Observations of those affected by the findings

Heatherwood and Wexham Park Hospitals Trust: Most clinical teams have no associate specialist, so that it is usual for the junior to be left by her/himself when the Consultant is on leave. However, more formal arrangements do need to be made for covering consultants on leave.

Recommendations and action plans

Recommendations	*Action plans*	
16. that proper medical cover is established during periods when a responsible medical officer goes on leave.	***NHS trust*** • **The adult team consultants have agreed to form a pairing system for the purpose of cross cover.**	***Immediate***

H. CPA, DISCHARGE AND AFTER-CARE

The Inquiry's findings

Stephen Allum was discharged some three weeks after a severe psychotic episode which resulted in a very serious and unprovoked assault on his stepmother. He was in a desperate state and was obviously vulnerable to a relapse of his illness. Despite this, he was discharged prior to CPA.

The quality and accuracy of some of the pre-CPA records was wholly unacceptable.

The quality of the pre-CPA assessment itself was undermined by the fact that it was based on partial, and sometimes inaccurate, information. Had the information about the assault on Mr Allum's stepmother been available, it must have changed the outcome of the initial assessment, which resulted in the early, significant, view being taken that he did not need a service from the community mental health team.

The evidence received by the inquiry indicates that a keyworker was not agreed at the time of discharge — his consultant was on leave, and his CPA meeting was therefore postponed — and that discharge planning was retrospective. For example, a CMHT note compiled on the day of his discharge states, 'Discharged today — CPA next week. No offer of service (GPOR duty).' And a further CMHT note made that day states, 'Stephen Allum now discharged. CPA 9th October, registrar has done this !!'

Given the severity of the attack on his stepmother, a proper risk assessment should have been done prior to discharge, particularly because he was being sent home to a house with children in it.

Neither the primary nurse nor the senior house officer made any real attempt to involve the family, and in particular Stephen Allum's wife, in the discharge process.

It is necessarily a matter of concern that he was discharged prior to a proper CPA, and that problems concerning his need for housing and interim support were left unresolved.

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.9)

There is no evidence:

- that responsibility for checking that necessary pre-discharge arrangements had been made before Stephen Allum 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 arrangements were made to provide necessary support at home;
- 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.10)

There is no evidence:

- that the local authority's procedures served to ensure that Stephen Allum 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.10)

There is no evidence:

- that a keyworker was agreed with Mr Allum;

- that systematic arrangements for his care outside hospital were made prior to discharge;

- that any professional remained in contact with him and monitored his circumstances during the period between his discharge on 22 September 1997 and what was to be his first CPA meeting;

- that '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 p.10)

There is no evidence:

- that the arrangements for discharge and continuing care were agreed and understood by private carers;

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

- that there was a keyworker, who was prominently identified in clinical notes, computer records and the care plan;

- that the patient and carers knew how to contact service providers if problems arose;

- that there was a full risk assessment prior to discharge, 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;

- that professionals heeded the warning in the guidance that 'too often, it has proved that information indicating an increased risk existed but had not been communicated and acted upon';

- that the components of an effective care plan were in place prior to discharge (systematic assessment, a care plan, and the allocation of a key worker), and that the professionals were satisfied that the conditions were fulfilled before the patient was discharged.

Use of the departmental after-care form (see p.11)

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.

Building Bridges (see p.11)

The initial assessment failed to adequately identify Stephen Allum's general health and social care needs. A decision seems to have been made early on that the implementation of the CPA in his case was relatively straightforward, that he probably needed little more than regular outpatient appointments, and that fuller assessments by members of the team, and holding an assessment meeting, were unnecessary.

There was no proper appointment of a keyworker; no formulation or recording of a care plan; no attempt to ensure that he and his carers understood and agreed any (informal) care plan; and no implementation of arrangements to support him in the community prior to discharge, other than prescribing medication.

There is no evidence:

- that Stephen Allum received systematic assessment;

- that his carers were involved as much as possible in the care planning process, or that this process involved the user, his advocate, carers and interested relatives;

- that a full assessment of risk, covering both risk to the patient and others, was conducted, even though it 'should be part and parcel of the assessment process';

- that those taking the decision to discharge exercised their 'duty' to consider both the safety of the patient and the protection of other people.

- that a keyworker was identified as soon as possible, or that consideration was given to appointing a social worker to perform this role, given that housing, financial concerns and family problems were uppermost;

- that a keyworker ensured that a proper discharge plan was implemented, which addressed the patient's need for supervision and accommodation;

- that the patient had a contact point and an alternative worker to him when things were difficult;

- that a professional was nominated to perform the keyworker's function of keeping in touch with the patient, and ensuring that professionals did not rely on the patient contacting them.

Observations of those affected by the findings

Berkshire Health Authority: (1) Risk assessment/CPA. A risk assessment/CPA working party has been meeting in the east of county, to review practice and to implement a clear audit process, and this is now a recognised NSF target. In essence, each of the working parties are seeking to revise and update their CPA procedures and processes in line with the latest Department of Health guidelines issued at the end of 1999. From a Health Authority perspective, the aims of the two groups should be the same, namely:

- to produce revised guidelines on how CPA should be practically applied;
- to integrate a risk assessment process within CPA;
- to achieve the above by October 2000;
- to actively apply the issues brought up in the *Murrie*, *Cameron* and *Allum* inquiries;
- to suggest an audit/self monitoring procedure which produces qualitative data on compliance;
- to make recommendations on the required training to apply the new CPA procedures.

Berkshire Health Authority: (2) Responding to crises. An acute psychiatric emergency occurs when an individual's behaviour requires an immediate response, high levels of observation and supervision, and intensive medical and therapeutic input. For some people, this will be because they are at risk of self-harm or of harming others and may need to be detained under the Mental Health Act. These sorts of crises will often require active intervention by specialist mental health services, including admission to hospital. People may also need help to identify the circumstances that may trigger crises for them, and encouragement to monitor those triggers and seek support when a crisis threatens. For some people, community mental health services will need to adopt assertive approaches to monitoring people who are especially vulnerable and/or unlikely to monitor these triggers themselves. A variety of intensive help should be available to prevent the escalation of problems.

Berkshire Health Authority: (3) Advice and support for carers. Carers are entitled to a separate assessment of their needs if they undertake significant care for a user. Information and education about the nature of the mental illness and its implications are crucial to enable the carer and/or family to maintain a constructive relationship and their support for the user. Carers themselves also need support, and this may come through individuals or groups.

Berkshire Health Authority: (4) Implementation of the National Service Framework. The local strategy for implementing the NSF is approaching finalisation. At present, it is intended that the following actions will be completed by the given dates:

Integrate CPA and care management	• Trusts and social services to harmonise this into a single procedure in line with latest Department of Health guidance (risk assessment to be integral)	*By April 2001*

CPA	• Trusts to make sure all users on CPA have a full plan which is also with their GP and carer.	*By October 2000*
Assertive outreach for those at risk/on enhanced CPA	• Trusts to review outreach to patients and ensure those fitting the highest criteria are followed up as per procedure.	*By April 2001*
Caring about carers	• Social services. to have implemented a plan which PCGs/Trusts approve.	*By April 2001*
Consulting carers	• Social services to have reviewed carers satisfaction with the plan.	*By April 2002*
Access to a service in a crisis	• Health Authority to review how many patients actually need and want such a service and make recommendations concerning their development.	*By April 2002*
Crisis support and early intervention	• Trusts/social services to jointly agree what local early intervention/crisis services should exist as alternatives to admissions and advise PCG.	*By April 2001*

Heatherwood and Wexham Park Hospitals Trust: Some discharge planning was undertaken, although it is true to say that the care programme approach meeting was scheduled for a day following the discharge of Stephen Allum from hospital.

Decisions regarding discharge arrangements, Stephen Allum's need for community mental health team services and housing, and delaying the CPA from the time at which it was originally planned, were based on partial, and sometimes inaccurate information.

Recommendations and action plans

Recommendations	*Action plans*	
17. that arrangements are urgently made which ensure adherence to *Health Service Guidelines* concerning the care programme approach and discharge procedures.	***NHS trust***	***Immediate***
18. that a senior manager within the trust is made responsible for ensuring that these *Health Service Guidelines* are put into practice.	• **(17) & (18). Agreed. The General Manager has, with immediate effect, taken responsibility for ensuring adherence to Health Service Guidelines. A CPA and risk monitoring group has been formed.**	
19. that random audits of compliance with the guidelines are conducted regularly, and that these include verifying:	• **Clinical Audit will audit CPA and care planning, along with risk management.**	***Immediate***

- that the pre-CPA assessment involved obtaining detailed information both from the police about violent offences under investigation, and from the patient, her/his family, primary nurse and senior house officer;
- that a keyworker (care co-ordinator) was identified for the patient following admission, and that s/he had a keyworker when discharged;
- that the patient had a care plan prior to discharge, with review dates, and s/he 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 had been made before the patient left hospital was given to one member of staff caring for her or 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;
- 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;

- The pre-CPA assessment has been improved and includes the details recommended by the inquiry panel. *Immediate*
- A training programme is also in place for ward managers which addresses these points. *Immediate*

• 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.		
20. 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 February 2000*
21. that the trust, in consultation with the Health Authority, consider whether the departmental after-care form issued in February 1995 should be used by hospital staff (see p.11).	• The trust, in consultation with the Health Authority, is in the process of modernising CPA and discharge processes, in line with *Modernising the Care Programme Approach* (see p.12).	*By April 2001*
22. 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*

I. HOUSING

The Inquiry's findings

Stephen Allum was, in reality, left to find his own accommodation, because the view was taken that he was using mental health services to resolve a range of personal problems. His presumed capacity to obtain accommodation for himself was not based on a full and accurate assessment of his needs. Professional intervention was belated, and the advice that he approach the housing department was given in the knowledge that it would not help him (it was 'counter-enabling'). In order to qualify for housing in the area as a priority, clear criteria based on need had to be met. However, on the basis of the reference provided by the referrer, it was obvious that he would not meet the criteria for being housed, so why refer him in the first place? This could surely only have added to his stress.

Observations of those affected by the findings

Berkshire Health Authority: A long term strategic approach is required for the planning of a range of accommodation along the continuum from 24-hour staffed accommodation to occasional support in own homes. The local strategy for implementing the NSF is approaching finalisation. At present, it is intended that the following actions will be completed by the given dates:

Supported accommodation	• Trusts to review with each unitary authority social services, in order to make sure that sufficient accommodation exists to prevent bed-blocking	*By October 2000*
24-hour staffed accommodation	• Trusts/social services to jointly agree what local services should exist as alternatives to admissions and advise PCG.	*By April 2001*

Heatherwood and Wexham Park Hospitals Trust: Decisions during Stephen Allum's stay in hospital regarding his need for housing were based on partial, and sometimes inaccurate, information.

Extra time and effort is taken up on the ward, and in the community, with trying to find accommodation in the community. A proposal three years ago to site a 20 place post-discharge unit in the community has never come to fruition.

Royal Borough of Windsor and Maidenhead: The development of a unitary authority responsible for Maidenhead has brought significant benefits both in terms of a more local focus for strategic planning and development and the single management, in one Directorate, of Social Services and Housing Policy.

Discussions with the Housing Associations are underway to try and develop a range of resources that could be used for post hospital discharge.

Recommendations and action plans

Recommendations	*Action plans*	
23. that referrals be made to housing only when there is a possibility that the applicant may meet the criteria for assistance.	***NHS trust, local authority*** • **Agreed**	***Immediate***
24. that, whenever possible, in-patients should not be discharged to bed & breakfast accommodation. When this happens, it should be subject to agreement between the trust and the local authority, and reported to the Health Authority.	***NHS trust, local authority*** • **Agreed**	***Immediate***

J. PERSONALITY DISORDERS AND DUAL DIAGNOSIS

The Inquiry's findings

The dangers of making assumptions about the contributions of substance abuse and personality to a mental state and care management need to be emphasised. Too often patients are labelled 'manipulative', or 'personality disordered', or their difficulties are put down drug and alcohol use. As a consequence they are deemed 'responsible' for their behaviour and unworthy of time from mental health professionals.

In fact the personality disordered do not have a monopoly on being self-seeking and generally irresponsible; the mentally ill and the non-mentally ill can share these attributes. People who later develop mental illness often show changes in their personality before the signs of mental illness are present, and mental illness itself is associated with personality change. Alternatively, mental illness and a disorder of personality can exist independently, although there is almost always some overlap between the two conditions. To these complexities we must add the increasingly important contribution which drug and alcohol use make both to the way mental illnesses present themselves, and to care management. The technical jargon for mental illness and substance abuse co-existing is 'co-morbidity' or 'dual diagnosis'; it is encountered with increasing frequency; it increases risk greatly; it complicates case management enormously.

Observations of those affected by the findings

Heatherwood and Wexham Park Hospitals Trust: One important component, in the treatment of personality disorders is psychological treatment. Heatherwood & Wexham Park Hospitals Trust has built up a psychology service in the last two years. However, the waiting time for assessment is about six months, and there is insufficient psychological time for input to admission wards. The psychotherapy department consists of one consultant, and five assistant sessions.

Psychology services in East Berkshire are fragmented between acute and community trusts and private providers, and overall are inadequate. Defragmentation of all the provisions, with a single line management of all East Berkshire Psychology Services, would allow rational use of resources and appropriate targeting.

Berkshire Health Authority. Further attention to this area is required. The local NSF strategy presently aims to have a whole county psychological therapy service by October 2001, with waiting times for treatment of no more than six weeks.

Royal Borough of Windsor and Maidenhead: The limited availability of resources for people with dual diagnosis has implications for community mental health teams in providing care and management for those individuals.

Recommendations and action plans

Recommendations	*Action plans*	
25. that a protocol for the management of patients with personality disorder and co-morbidity (dual diagnosis) needs to be established.	***NHS trust*** • **A personality disorders forum meets bimonthly, at which issues concerning care of people with personality disorder are discussed in a clinical context.**	***Ongoing***

- **A longer term aim of this forum will be to produce an appropriate policy for the management of patients with personality disorder and co-morbidity.**

- **An evidenced-based health care programme is being run by Thames Valley University for the department. One of the multi-disciplinary team groups involved in this is reviewing the diagnosis of personality disorders, the objective of which is to recommend evidence based changes of practice.** ***By September 2000***

Social Services ***Ongoing***

- **The Royal Borough of Maidenhead & Windsor are progressing the development of Assertive Outreach Services which will provide additional support for dual diagnosis patients. Discussions are underway with Heatherwood & Wexham Park Hospitals Trust to ensure a nursing component to this new service.**

K. SUBSTANCE MISUSE

The Inquiry's findings

The dangers of making assumptions about the contributions of substance abuse to a individual's mental state and care management need to be emphasised. In Mr Allum's case, the part played by substance use was not based on reliable evidence. Having assumed that it was a major issue it was not followed by referral to a substance abuse assessment and treatment service. Furthermore, the provision of substance abuse services relied upon him initiating and maintaining contact.

Observations of those affected by the findings

Berkshire Health Authority: There are a number of people who have a mental illness and who also use alcohol or drugs (or indeed other substances) to a significant extent. It is important that people with this combination of complex needs receive a well co-ordinated, shared-care approach with close liaison between the specialist mental health services, primary care and the specialist substance misuse services. There will be close inter-agency working encompassing the range of statutory sector agencies and voluntary sector agencies who come into contact with or support this client group.

There will need to be access to local specialist inpatient beds for some people. However, the emphasis will be on community-based support, including detoxification. The assertive outreach arrangements in each area will operate as the specialist arm of the community mental health services, to maintain contact with people with complex needs or chaotic lifestyles, including those with substance misuse problems as well as severe mental illness.

Heatherwood and Wexham Park Hospitals Trust: The investigation of Stephen Allum's substance misuse history was not adequate, given that it was ascribed a significant aetiological role in his psychotic condition. Neither substance misuse nor personality disorder should be assumed to be the cause of behaviour without clinical evidence to support this, and ruling out other alternatives.

In-patient alcohol and drugs detoxification is undertaken by all consultants at Heatherwood & Wexham Park Hospitals Trust.

Implementing a policy of assertive assessment has significant resource implications. At present, less than £0.5M is spent on the joint health, social services and probation substance misuse services for East Berkshire. The total staffing is two consultant sessions, one of whom is supported by a senior house officer; one clinical assistant (GP) session; a 0.5 wte Probation Officer (drugs/alcohol); three wte counselling psychologists (drugs); one wte social worker (alcohol); and two community psychiatric nurses (alcohol).

Referrals to the substance abuse service in East Berkshire have risen from 450 to 1400 per annum over the last four years. Some two-thirds of these people attend their referral appointment, and the majority are offered an appointment within four weeks. Approximately 150 patients were *medically* assessed by the service last year, of whom about half had a 'dual diagnosis'.

The substance misuse services are aware of deficiencies in liaison, both with community mental health teams and with the in-patient areas of psychiatric and general hospitals. They have met with representatives of community mental health teams to try to improve cross service liaison. Given the serious under-resourcing of the service, there are limits to what can be achieved.

Additional resources would vastly improve liaison and allow integration of substance misuse services with services in the general hospital and with hospital and community psychiatric services. Three substance misuse CPNs attached to CASCADE, and working with the CMHTs, would allow general hospital and psychiatric liaison services, CMHT liaison services.

The management and integration of substance misuse services would be facilitated by a change in the management arrangements. Inpatient, outpatient and community services should be managed by a single provider. It is suggested that they be brought under the umbrella of general psychiatry services.

Recommendations and action plans

Recommendations	*Action plans*	
26. that a protocol for the assertive assessment and management of patients with a mental illness who abuse substances is established.	***Health Authority***	***By July 2000***
	• **The Health Authority will ask the trust to set out specific protocols with regard to mental health patients who substance misuse and may access services from different routes.**	
	NHS trust	***By February 2000***
	• **A multidisciplinary team group reviewing evidence relating to treatment of dual diagnosis, mental illness and substance misuse patients will be recommending changes to practice following the completion of their work in February.**	
27. that a review of local service models for caring for people with mental illness who have a substance misuse problem should be undertaken; and that this should seek a way of financing the trust's proposals for enhancing the substance misuse services.	***Health Authority***	***By October 2000***
	• **Substance misuse services will be reviewed to incorporate good practice, specifically with regard to persons with severe mental illness.**	
	Social services	***Imminent***
	• **Recruitment of a specialist approved social worker, specifically to work with substance abuse clients, is underway.**	

L. BERKSHIRE HEALTH AUTHORITY

The Inquiry's findings

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

The monitoring by the Health Authority of the trust's compliance with *Health Service Guidelines* needs to be significantly 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. The following qualitative performance matters are now picked up at bimonthly reviews with the trust:

Strategy	• Development of services
	• Outcomes-monitoring and feedback from new services
	• MHAC visit reports
	• CPA compliance
	• NSF implementation
	• New service development
SLA performance	• Activity
	• Finance
	• Variations
	• Day to day management of SLA
	• Delayed discharge
	• Waiting lists/time
	• Clinical governance issues
Services	• CMHTs
	• Day services
	• Children & adolescent mental health services
	• Elderly mentally ill
	• Specialist services (drugs, addiction, rehabilitation)
	• Professions allied to medicine (psychology, psychotherapy, occupational therapy)
	• Inpatient/tertiary services

Recommendations and action plans

Recommendations	*Action plans*	
28. that the Health Authority should enhance its monitoring of the trust's compliance with *Health Service Guidelines*, and 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 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.**	***Immediate***
29. that the Health Authority should ensure that this report is readily available to individual practitioners and people in East Berkshire.	***Health Authority*** • **Agreed**	***Immediate***

M. THE INTERNAL TRUST INQUIRY

The Inquiry's findings

The trust's review of Stephen Allum's care and treatment was inadequate. Its conclusion that Stephen Allum received entirely appropriate care, treatment and discharge was based on limited information, and cannot be sustained.

Observations of those affected by the findings

Heatherwood and Wexham Park Hospitals Trust: Internal inquiries should include a remit to discover what information was missing, rather than simply assess the action taken on the basis of what was known or assumed.

Although, by definition, an internal inquiry cannot be wholly independent, an independent element was brought to the inquiry by the inclusion on the panel of a non-executive director of the trust, as well as relevant managers and professionals. Nevertheless, the internal inquiry based its conclusions on the information readily available, and the trust accepts that its conclusions cannot be fully supported.

Recommendations and action plans

Recommendations	*Action plans*	
30. That NHS trust inquiries following homicides and untoward events must be, and be seen to be, thorough, independently-led, and dispassionate. They should be chaired by an independent professional who is not a member of the trust board, and has no other connection with the trust, and whose appointment has been approved by the Health Authority. Social services inquiries should likewise be chaired by an independent professional.	***Health Authority, NHS trust, social services*** • **Agreed.**	***Immediate***

Berkshire Health Authority NHS

7 SUMMARY

INQUIRY INTO THE CARE AND TREATMENT OF STEPHEN ALLUM (BERKSHIRE HEALTH AUTHORITY, MARCH 2000)

Stephen Allum visited his general practitioner on 30 August 1997, when he admitted drinking and using illegal drugs, and was advised to contact a community drug and alcohol treatment agency. Driven by delusions, he then visited his stepmother and attacked her, holding a broken glass to her face. The assault was interrupted by the arrival of his father, who tricked him into contacting the police. Following his arrest for causing actual bodily harm, Mr Allum was admitted to Wexham Park Hospital as an informal patient.

Mr Allum was discharged home on 22 September. A care programme approach meeting planned for 29 September was postponed, and he was given two weeks supply of medication. Seventeen days later he killed his wife, Thelma Allum. He was subsequently convicted of manslaughter on the grounds of diminished responsibility, and admitted to a medium secure unit, subject to a restriction order.

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.

Nature of the inquiry

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

Stephen Allum's care and treatment

In terms of the care and treatment provided to Mr Allum, the panel's findings included the following:

- 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 decision not to detain him under the Mental Health Act 1983 was made in the context of limited and unconfirmed information regarding risk.

- that the lack of awareness of the circumstances of the initial offence contributed to an inadequate assessment of his mental state and social circumstances, a failure to conduct a proper risk assessment, a lack of appreciation of his stepmother's family's concerns about leave and discharge arrangements, and a failure to properly inform them of leave and discharge decisions.

- that the decision making process concerning whether to charge him for the assault on his stepmother was confused.

- that the fact that his primary nurse was on night duty meant that she could not establish effective contact with the wider multidisciplinary team, other agencies, and Mr Allum's family.

- that the medical cover provided on the ward when Mr Allum's consultant and associate specialist were on leave was inadequate.

- that the quality of the pre-CPA assessment and records was inadequate; that a keyworker was not agreed at the time of his discharge from Wexham Park; and that there was a widespread failure to implement *Health Service Guidelines*.

- that professional intervention concerning Mr Allum's need for housing was belated, and the advice he was then given was 'counter-enabling'.

- that unwarranted assumptions were made about the contributions of personality and substance abuse to his mental state.

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

- that the monitoring by the Health Authority of the trust's compliance with *Health Service Guidelines* was in need of improvement.

- that the trust's review of Mr Allum's care and treatment was inadequate, and its conclusions could not be sustained.

Action plans

The inquiry panel commended the constructive and measured way in which Mrs Allum's family helped them, and the contribution made by their solicitor, Margaret Stevenson.

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

The willingness of Berkshire Health Authority, the Heatherwood and Wexham Park Hospitals Trust, and Windsor and Maidenhead Social Services, to work together, and with the panel, towards agreed sets of conclusions and plans of action was noteworthy. Without that willingness a constructive process would have been impossible. However, giving it, when many previous inquiries have been highly critical of individuals, took real courage. The action plans agreed with the panel, each of which has an implementation or review date, included the following:

- 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 a protocol which addresses the issue of confidentiality and the sharing of information between agencies.

- the appointment by local police of a named duty officer who will act as the primary point of contact with mental health professionals regarding police investigations of violent offences alleged to have been committed by patients.

- the development of *simple* arrangements designed to ensure that the suspected victim of an assault, and any adults with whom the patient proposes to reside, are consulted about, and notified of, hospital leave and discharge decisions.

- the provision of further training on the Mental Health Act 1983 and the *Code of Practice*.

- the making of arrangements which ensure that that at all times one of the nurses on night duty is qualified to detain a patient under the Mental Health Act.

- 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.

- the making of arrangements which ensure that no patient is allocated a primary nurse who is on night duty, and a review of the trust's primary nursing model.

- improvements in the standard of multidisciplinary care plans and records.

- improved medical cover during periods when a consultant psychiatrist is on leave.

- the appointment of a senior health service manager with responsibility for ensuring adherence to *Health Service Guidelines*.

- the formation of a care programme approach and risk monitoring group, new auditing arrangements for CPA, and enhanced CPA assessment procedures and training.

- better monitoring of the use of bed & breakfast accommodation following discharge from hospital.

- the development of protocols and strategies concerning substance misuse and the management of dual-diagnosis patients.

- new arrangements designed to improve the monitoring of the trust's performance by the Health Authority.

- agreement that any future inquiries conducted by the trust or local authority in such circumstances will be chaired by an independent professional.

Conclusion

Many of these action plans are already in place and the remainder soon will be. That they have quickly been agreed, and are now being implemented, is a tribute to the commitment of those who developed them to providing a safe and supportive service for local people. The overall standard of mental health services in East Berkshire was, and is, high. The action now being taken represents a further improvement, and deserves the support of local people.