Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness

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'Building a Safer NHS for Patients'[1] proposes significant changes to the reporting of adverse events in Britain's healthcare system including the place of inquiries in the analysis of adverse events. Within mental health services, since 1994 an independent inquiry has been mandatory for all homicides committed by persons in contact with mental health services. The inquiry reviews the care the patient was receiving at the time of the incident, the suitability of that care with regard to the patients history, health and social care needs, and the extent to which the care corresponded with statutory obligations of the health service.[2] A report is usually published following each inquiry including a set of recommendations based on the findings of the inquiry. The assumption is that these recommendations are intended to influence mental health policy and practice. However, many critics argue that inquiry reports and their recommendations have yet to substantially alter policy and practice.[3,4]

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1 *Department of Health (2001). Building a Safer NHS for Patients: Implementing Organisation with a Memory. London: DOH.*

2 *Department of Health (1994). Guidance on the discharge of mentally disordered people and their continuing care in the community. HSG (94)27. London: NHS Executive.*

3 *Eastman, N. (1996). Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. British Medical Journal, 313, 1069–71.*

4 *Crichton, J. & Sheppard, D. (1996). Psychiatric Inquiries: Learning the Lessons. In Peay, J. (ed.) Inquiries after Homicide. Duckworth: London.*

In the future, homicides by people in contact with mental health services will be monitored by new NHS-wide arrangements through the newly created National Patient Safety Agency (NPSA). The aim of the new system is to unify the way that adverse events in clinical care are recorded and reported. The NSPA will introduce guidance on procedures for the appropriate use of investigations, and disseminate findings from its analysis as well as other research.[5] What is implicit to these changes is that prior to the NSPA no systematic collation of adverse events within healthcare institutions existed including the inquiries after homicide. For example, to date, three authors have attempted to collate and review the recommendations from homicide inquiries. Sheppard[6] compiled the set of recommendations resulting from mental health inquiries since 1969; each recommendation was placed into an appropriate subject heading. Critics have commented that this document is no more than an archive in which recommendations are listed "out of context without any attempt at clarification of the intended messages".[7] Furthermore, some of the recommendations are repeated under different headings. In an effort to remedy these problems, Petch and Bradley[8] analysed 23 homicide inquiry reports in order to extract the meaning from their recommendations. The recommendations were examined for the general message and organised under headings representing various areas of psychiatric services. However, the recommendations were not annotated as to source or actual content. In addition, concrete examples of the recommendations were not given nor was any indication of the relative frequency of the theme of the recommendation given.

In Margaret Reith's study[9] the context of the recommendations is provided. She compiled the recommendations from 28 reports along with a short summary of the report from which the recommendation originated. The recommendations appear as found in individual reports and are indexed by subject area to allow the reader to access relevant topics more easily. Implication for policy and clinical practice are also discussed in detail. However, Reith's study is published in book form which may not be readily accessible to most interested parties, and her analysis only covered 28 reports.

The aim of the present study was to conduct a qualitative review of the recommendations from all reports of inquiries after homicide published between 1994 and 2001. This study investigated in detail all the recommendations including the total number of recommendations, the themes of these recommendations, and the agencies to which the recommendations are addressed. The intention was to include all the reports published and available to the researchers.

Method

The total number of inquiries published between 1994 and 2001 were obtained through a number of sources:

a) One list of published inquiries was obtained from a website prepared by Dave Sheppard.[10] The website provides details of the title of the inquiry and contact details of the publisher.

5 *Supra, n. 1*

6 *Sheppard, D. (1996). Learning the lessons: mental health inquiry reports published in England and Wales between 1969 and 1996 and their recommendations for improving practice, 2nd ed. London: Zito Trust.*

7 *Petch, E. & Bradley, C. (1997). Learning the lessons from homicide enquiries: adding insult to injury? Journal of Forensic Psychology, 8, 161–184.*

8 *Ibid.*

9 *Reith, M. (1998). Community Care Tragedies: a practice guide to mental health inquiries. Birmingham, UK: Venture Press*

10 *www.davesheppard.co.uk*

b) Another list of published inquiries was prepared by the Secretary of State for Health in response to Parliamentary Question 265 on 4 July 2001. The question called for the list, by name of report and Health Authority, of all independent inquiries into homicide published since February 1994.[11,12]

c) The final source included examining all publications on the topic of homicide inquiries and extracting details of inquiries. This source did not recover any additional reports.

The recommendations were analysed by importing the full text of the recommendations from each report into a qualitative software package, Atlas.ti.[13] Qualitative analysis involved coding the text of each individual recommendation using codes generated by the researchers. A 'grounded theory' approach was used to ascertain codes from the text itself.[14] In general, codes were created to describe which service agency or staff group should carry out the recommendation, what subject area the recommendation referred to, what action was needed, and which client group the recommendation was aimed at helping. The codes were periodically examined for amount of usage and degree of applicability. New codes were created as needed, and redundant or seldom used codes were discarded. Recommendations were then grouped according to their codes, examined for associations with other codes, and representative recommendations were chosen to illustrate each subject area.

The examples chosen for illustration were deemed to be representative if the recommendation embodied the meaning for several text passages in the same topic area. The decision to use this criterion was made in an effort to focus this paper on those recommendations that have the most utility for general application. An attempt has been made to select examples of recommendations from as many different reports as possible to illustrate the different categories. The authors will provide a more detailed report if requested.

Results

Eighty-five independent inquiry reports following homicide committed by a person with a mental illness were known to be published at the end of data collection in July 2001. Seventy-two of these reports were present on both the list prepared by Dave Sheppard and that prepared by the Department of Health of published inquiry reports. Seven additional reports were mentioned on the list prepared by Dave Sheppard, all of which were obtained for analysis. Six additional reports were named on the list prepared by the Department of Health which were not included in the present analysis. One of these reports was obtained after data collection was completed, and the remaining five reports could not be located by the Health Authority named responsible for publication. Therefore, seventy-nine independent inquiry reports were obtained for analysis. The total number of recommendations from these reports is 1959. The mean number of recommendations per report is 24.80 (SD = 18.92).

Two hundred and six codes were created in order to describe the recommendations. This illustrates the diversity of service agencies, staff groups, client groups and areas of service delivery that are

11 *Department of Health (2001). List of Independent inquiries into mental health services published since February 1994. House of Commons Deposited Papers 01/1105.*

12 *H.C. Deb. 10 July 2001. Vol. 371, Cc. 17.*

13 *Muhr, T. (1997). ATLAS.ti. The Knowledge Workbench. Version 4.1. Berlin: Scientific Software Development.*

14 *Miles, M.B. & Huberman, A.M. (1994). Qualitative Data Analysis, 2nd ed. Thousand Oaks, CA: Sage.*

represented by the inquiries and their recommendations. The main service agencies to which the recommendations are addressed are shown in table 1; the staff groups are shown in table 2; and particular aspects of mental illness explicitly targeted in the recommendations are shown in table 3. This analysis has identified a core set of issues, namely, improving routine psychiatric procedures, multidisciplinary working, quality assurance, staff issues, mental health law, and managing specific patient groups. Communication was a concept that ran through each of these issues. In an attempt to reduce as much repetition as possible, communication is mentioned within each of the main issue areas where appropriate. In the following analysis, the codes within each of the main areas are organised from highest to lowest according to the number of recommendations pertaining to the particular area.

Improving Routine Mental Health Care Practices

The bulk of the recommendations suggest improvements to everyday tasks essential to providing a good mental health service. It is here that many of the recommendations for communication and collaboration among mental health service agencies such as NHS Trusts, Health Authorities, and Social Services will be covered. Table 4 lists the categories coded within this area and Box 1 lists example recommendations from each category.

Firstly, the most numerous recommendations pertain to record keeping, which stresses the importance of accurately documenting the patient's travel through the healthcare system. It is emphasised that written care plans and patient records enable the sharing of information among professionals and agencies and that records must be readily available to all clinicians involved in the care of the patient. All mental health service sites (NHS Trusts, hospital, community) and allied services such as social services and probation are encouraged to unify records kept by medical, nursing, and social work staff. Case records should follow the patient during the processes of referral and transferring of cases. Clinical Records should be comprehensive, including information from the patient's previous treatment, previous episodes of violence, convictions, and family and carers' views.

There are recommendations regarding the care programme approach (CPA), assessment, care planning, risk assessment and management, and history taking. These recommendations are unified by the central theme of the quality of formal and structured assessments and the clinical decisions that flow naturally from these. The overall theme of the CPA recommendations is that this approach should be fully implemented in all mental health care agencies for all patients. CPA guidelines should be part of each clinician's training and the adherence to these guidelines should be strictly monitored. On a more practical level, proper application of CPA entails a co-ordinated care plan with multidisciplinary input at regular care planning meetings. All members of the mental health team should attend these meetings, especially the care co-ordinator.

With regard to assessment, it is recommended that assessments should endeavour to identify community care needs of patients, including health, social and housing needs. There are calls for guidance to be issued on assessments and adherence to these to be monitored through audit. Assessments should only be carried out by suitably trained clinicians and families should be included in assessments as informants. The needs of carers should also be assessed.

Risk assessment and management recommendations mostly relate to training in risk assessment. It is recommended that risk assessment should be done consistently, with a standardised tool,

and regularly. Risk assessments should include information from the family, evidence of non-compliance, substance use, and incidents of violence. Joint policies on risk assessments should be devised and implemented among health and social services, criminal justice agencies and housing agencies. Risk assessment should be documented in the patient records and inform the care plan which should be devised to manage assessed risks.

Recommendations regarding discharge planning delineate the arrangements that should take place before a patient is discharged into the community. It is essential that a multidisciplinary meeting take place prior to discharge to discuss the arrangements that have been made. The patient should be assessed before being discharged, and this should include a risk assessment and the patient's history of violence. Discharge summaries should be sent to the general practitioner in a timely manner, preferably within the first two weeks of discharge. The Trust should implement, give training in, and monitor adherence to discharge guidelines.

Planning the care and treatment of patients in mental health services is important because the care plan will designate how the patient is to be managed as an inpatient and in the community. The most numerous recommendation in this section stresses the importance of documenting the care plan in the patients notes. Just as importantly, regular multiagency care planning meetings should be held to exchange information, voice concerns, and discuss the care plan among all those agencies and individuals involved in the care of the patient. The care plan should be agreed by those providing care and there should be consultation with multidisciplinary team members and carers before any decisions or changes regarding the care plan are made. Care plans must address identified needs and the patient should be involved in this process. It is recommended that the care plan must designate the care co-ordinator who is responsible for making sure care plans are implemented and regularly reviewed.

Providing aftercare that offers continued support, rehabilitation, and treatment in the community for patients with serious mental illness is essential for ensuring patients can lead more normal lives outside of hospital. Aftercare needs should be assessed and arrangements made to meet these needs before the patient is discharged from hospital. A risk assessment should be included and this information should be given to the aftercare team. During aftercare planning, the patient, GP, family and carers should be involved. It is important for the aftercare team to communicate with each other regarding the aftercare arrangements of the patient along with the other agencies involved in aftercare, such as social services, housing, the voluntary sector and the Home Office (for restricted patients). The aftercare programme should be recorded in detail, including but not limited to the name of the care co-ordinator, all care decisions, and appointments made to see the patient.

Taking an accurate history of the patient is important to assessment. Admission, discharge, risk assessment, CPA screening and new or transferred cases should have a complete and accurate documented case history including psychiatric, medical, and social histories. In particular, attention should be paid to known risk factors such as history of violence, previous convictions, history of noncompliance, and history of substance use.

Some recommendations make suggestions for the referral process. There should be ongoing liaison between referring clinician/service and the agency to which a referral has been made, which includes drawing up a plan of communication which designates who is responsible for liaison. Guidance should be established for referral from all sources which can be monitored by the Health Authority to ensure a good quality of service especially for referral agencies outside the NHS.

Forensic Community Psychiatric Nurses and Forensic Psychiatrists make up part of the forensic psychiatric services which according to the set of inquiries, also need improvements. Mostly, the recommendations from this group suggest improving information sharing among forensic mental health staff and other practitioners for patients with a forensic history. Another recurring theme in this group of recommendations is strengthening the management and structure of forensic mental health services. There are recommendations for increases in the number of community forensic services, and the number of forensic staff, including nurses, psychiatrists and social workers and for all staff working within forensic services to have specialist knowledge of forensic issues and supervision.

Incident reporting recommendations focus on the need for Trusts to review policy on handling critical incidents. Critical incident policies should be developed where none are in place. Debriefing or specialist support should be given to staff involved and to the families of the victim and carers following an untoward incident, including homicide. An immediate thorough investigation should be carried out following serious incidents. A policy should govern if the police should be called and who to call in case of a serious incident. Professionals should review police statements regarding incidents.

There are recommendations regarding the transfer of patients. These recommendations are concerned to improve practice when a patient transfers between locations within the Trust, between psychiatric services, or between hospital and prison. Responsibility for the patient should remain with the original team/service until a formal transfer has been completed.

It is also recommended that out of office hours, users, carers and relatives should have access to help and advice 24 hours a day.

These recommended improvements will inevitably require more resources. The majority of recommendations regarding resources tend to refer to training and increasing staffing levels, which are mentioned in subsequent sections. The remaining resource requirements mentioned in the inquiry reports concern reviewing and increasing if necessary funding for specialist services for populations such as persons with substance use problems or learning difficulties. Health Authorities should review spending across mental health services in order to provide an adequate service. Funding should be made available to improve the condition of mental health facilities. The inquiries argue that an increase in the number of general psychiatric beds is needed. There is also a call for an increased number of secure beds, particularly medium secure beds, for mental health services across the country and for patients with personality disorders.

Finally, in light of the many recommendations calling for information sharing, a few recommendations also call for a regard for confidentiality issues. The Department of Health, health care agencies and other agencies in contact with mentally ill persons should design a protocol to address confidentiality when sharing information. The limits of confidentiality should be defined indicating the circumstances under which others should be informed, for example, when a danger to others may be apparent. Access and exchange of information should be allowed without loss of confidentiality. The Department of Health should determine how the confidentiality of patient information can be protected. Patient's consent should be sought for access to records and involvement of family or carers in the diagnosis or treatment of the patient.

Multiagency Working

There are numerous recommendations that are concerned with improvements in communication between different professional groups and between agencies. The essential point is that there should be collaboration and joint working. This section will focus on liaison among those providing community support to traditional mental health services. See Table 5 for the topics covered in this section and Box 2 for examples of recommendations.

The patient's family and carers should be included in discussions concerning the care, treatment, discharge, aftercare, and changes to the care plan for the patient. Specifically, this means inviting families and carers to meetings where the patients care will be discussed and listening to carers and families. In addition, the family and carers can be a valuable information source in assessments. Furthermore, carers and families should be informed about who to contact for help or to discuss concerns. Carers and families should be given patient information on diagnosis, medication, side effects and symptoms to watch for so that the patient's care in the community is enhanced. A separate needs assessment should be carried out on the carer.

Appropriate accommodation is an integral part of the aftercare plan. Above all, communication and information sharing between those involved in planning and delivering care (health and social services) and housing services should be in place to ensure that the housing needs of service users are identified and met. A partnership between health, housing, and social services should be encouraged in order to assess and meet the housing needs of the mentally ill in the community, including developing supported housing initiatives for this population. Two-way communication between mental health services and housing services which enables housing services to seek advice from health and social services, and health and social services to involve housing in the care planning process. There should be a range of suitable accommodation to meet the needs of people with mental illness. This is integral to enabling patients to reside in the community.

It is recommended that General Practitioners should have more involvement in and make a contribution to the planning and reviews of care and medication. GPs should receive up-to-date documentation on patients care, especially discharge summaries, but also assessments on referral, aftercare plans, and when the patient exhibits self-harm or noncompliance.

There are recommendations about improvements to police procedures and liaison between health care agencies and the police. A number of recommendations are aimed at improving communication and collaboration between mental health services and the police for detainees in police stations, and patients in the community. For instance, it is recommended that mental health services should be informed if a patient is causing concern to the police. Police stations should have a protocol for initiating a mental health assessment when there is a suspicion of mental illness in a detainee. Police surgeons and officers should be given training in mental illness.

Other recommendations are directed at the judiciary, particularly calling for increased communication between health services and judiciary services when dealing with clients who are facing court proceedings. Magistrates, CPS advocates and solicitors should be trained in mental health issues, and that training should be given to clinicians in court proceedings and preparation of court reports. Furthermore, it is recommended that court reports should contain information from prison services and mental health services about the mental state of the prisoner and that this must be verified beyond verbal statements given by the patient. It is recommended that the CPS should be in receipt of medical records and previous convictions of mentally disordered offenders

in question. Information on court diversion schemes should be circulated to solicitors and clinicians working with mentally disordered offenders.

Several recommendations endorse reviewing and improving liaison between prison medical staff and mental health services regarding prisoners with mental health problems. Improvements within prisons are called for in areas such as record keeping, health care assessments, and training in mental health issues.

Finally, there are recommendations for improvements to probation services. The most common suggestion for probation services involves improving communication and multiagency working arrangements. There is a call for probation services to be more actively involved in assertive outreach and in the supervision of conditionally discharged patients.

Quality Assurance

The recommendations in this category include issues relating to guidelines, evidence-based practice, monitoring of the use of guidelines or protocols, and audit (see Table 6 and Box 3).

Predominantly, there are calls for guidance to be issued by the Department of Health, the Home Office, Central Government, and Social Services on a variety of topics. The most commonly mentioned topic is guidelines to improve interagency communication and liaison. Guidance is also called for in the procedures of CPA, risk assessments and assessments in general, record keeping, and the appropriate use of the sections in the Mental Health Act 1983. Other notable areas which require guidance are for staff dealing with violent patients, on the role and purpose of inquiries, on confidentiality of patient information, on involving carers in the care and treatment of patients, and on child protection issues.

As well as guidance there are recommendations to monitor the use of national guidance as a standard to determine proper implementation and following of procedures. Audits, which are examined in detail next, will form part of the monitoring procedure. Purchasers are asked to ensure that local agencies are adhering to guidelines issued for CPA, risk assessment and management, record keeping, discharge planning, and patient care.

The recommendations about audit include the need to involve collaboration with other agencies, such as Trusts, Social Services, and Health Authorities and for information ascertained from audits to be disseminated to other agencies involved in the care of patients with mental health problems. Clinical issues that have been highlighted in this section include auditing many of the areas highlighted in the improving routine mental health care practice section above. Mainly, audits should examine the quality of assessments, involvement of carers in care planning, proper implementation of CPA, discharge planning, record keeping practices, risk assessment and management, and application of the Mental Health Act 1983. These areas should be audited against Trust policies, national guidance, and standards set by professional bodies (e.g. UKCC or Royal College of Psychiatrists).

Finally, there are several calls for government agencies and professional organisations to issue guidelines based on evidence and to disseminate examples of good practice.

Staff Issues

The recommendations dealing with staff issues are listed in table 7 and the examples are listed in Box 4. The majority of training issues involve collaborating and communicating with other agencies. Another issue involves staff being trained in national and/or local guidelines and policies, which includes CPA procedures, and assessing and managing risk. Also, specialised training for working with particular client groups is recommended. These client groups include forensic patients, children, dual diagnosis, learning disabilities personality disorders, mood disorders, and substance use. Police, social workers, and General Practitioners also require more training in mental illness.

There are recommendations about clinical supervision. It is recognised that clinical supervision policies need to be reviewed or introduced to ensure that staff are supported through the guidance of more experienced clinicians. Supervisors should be trained in providing supervision and should be accessible to those they are supervising. Clinicians should be supervised when taking on new or specialist roles, especially patients subject to CPA. Supervision should also be fully recorded and audited to ensure needs are being met.

Also, staffing levels should be reviewed by Trusts and Health Authorities to ensure that numbers are adequate for the service provided, and that resources are available to meet staffing needs. Nearly half of these recommendations call for increases in number of consultants and other medical staff. There are also calls for adequate numbers of nurses, social workers, and support staff.

Other Staff Issues cover issues such as recruitment and retention, qualifications and competencies, and leave arrangements. Staff need to have appropriate qualifications, and sufficient experience for the particular post they hold. Clinicians should ensure appropriate cover for seeing patients is in place when on leave.

Mental Health Legislation

The recommendations under this heading are in table 8 and the examples are set out in Box 5. There are a number of recommendations calling for improvements to the use of powers of detention in general. Most importantly, the Mental Health Act 1983 should be part of the continuing education and training of medical, nursing, management and social services staff. It is recommended that the Mental Health Act commission should have a larger role in the monitoring of adherence to proper procedures involved in the application of the Mental Health Act. There should also be a full review of the Mental Health Act at the national level, making it easier to detain mentally ill persons, especially those with a history of violence.

Few specific sections are mentioned in the recommendations. Only Section 117 is mentioned enough times to warrant discussion. Recommendations about aftercare in general have been covered previously. For mentally disordered offenders, a representative from the police and/or probation should attend the Section 117 meeting in addition to the more typical members of a multidisciplinary team. It is recommended that the Department of Health should devise a standardised Section 117 form and that Section 117 documentation should be regularly reviewed and monitored by the Trust management and Mental Health Act Commission to ensure that it complies with national guidelines.

Lastly, recommendations are made for improvements to the process of independent inquiries. Agencies implicated in inquiries should acknowledge the findings and conclusions of inquiries, produce an action plan and monitor performance. A nationally agreed policy should be set up for handling inquiries possibly headed by the National Confidential Inquiry. The inquiry team of the Trust should reconvene in 6 to 12 months time to monitor the progress of implementing inquiries. Inquiries should be eligible for subpoena powers to ensure sharing of information. Inquiry recommendations should be collated and circulated widely perhaps by the National Confidential Inquiry, which may aid Inquiries findings to inform government policy.

Managing Specific Client Groups

There are recommendations dealing with how to improve the management of particular client groups which are listed in table 9 with examples listed in Box 6. Many of these recommendations are variations on the recommendations described in the section on improving routine mental health care practices. Therefore, only those recommendations which add to the present discussion will be included here.

In relation to violence it is recommended that risk assessment of the dangerousness of a patient must be carried out on admission, prior to discharge into the community, and regularly during treatment in the community. The conclusions of assessments of risk of violence must be communicated to all members of the team providing care and treatment for the patient, as well as to other agencies such as the police, and Social Services.

In the event of non-compliance, patients must either be re-assessed or readmitted to hospital. The recommendations regarding substance use, self-harm and suicide, and relapse of patients deal with improvements record keeping, the quality of assessments including risk assessments. The recommendations dealing with personality disorders ask Social Services, NHS Trusts, and Health Authorities to specify what services are available for appropriate assessment and treatment of personality disorders.

There are recommendations pertaining to restricted or conditionally discharged patients. Most notable of these recommendations is that probation officers and nurses should have special training before working with restricted or conditionally discharged patients. Any changes to the conditions of discharge must be notified to the Home Office for response. Finally, medical members of Mental Health Review Tribunals for restricted patients must be forensic psychiatrists.

The recommendations regarding children suggest that more attention should be paid to children of parents with mental health problems through training in the impact of parents mental illness for child protection workers and training for mental health professionals in child development and protection. Risk assessment and needs assessment of children of the patient should be conducted before the patient is discharged. Awareness of access to child mental health services should be raised for education and social services.

Discussion

The recommendations from the 79 Inquiries analysed and reported in this paper are wide ranging and encompass the totality of the mental health care system. The main thematic areas that the recommendations address include a) improving routine health care procedures, b) multi-agency working arrangements, c) quality assurance systems, d) staff issues, and e) the management of specific patient groups. Within these themes, the recurring issues are communication and collaboration between all the interested parties in the care of a patient. We believe that our qualitative analyses have exhausted the themes of the recommendations of the inquiries studied.

An observation of changes in mental health policy reveals that homicide committed by psychiatric patients and inquiries after homicide have influenced mental health policy in the UK. For example, the supervision register was introduced following the recommendation in the inquiry into the murder of Jonathan Zito by Christopher Clunis as a measure designed both to identify and register those patients most likely to pose a risk to others.[15] In the same vein the addendum to Section 25 of the Mental Health Act 1983 as delineated in the Mental Health (Patients in the Community) Act 1995 allows doctors to manage potentially dangerous patients in the community by enforcing where they reside and where and when they attend for treatment.[16]

Furthermore, other current mental health policy appears to have taken on board many recommendations from inquiry reports after homicide has been committed by a mental health patient. In particular, changes to the Care Programme Approach as introduced in Effective Care Co-ordination in Mental Health Services[17] and the National Service Framework[18] reflect many of the recommendations of the inquiries.

The Care Programme Approach is conceived of as a systematic method for comprehensively assessing the needs of psychiatric patients with a view to developing a personalised care plan. Patients who require the services of a multiplicity of agencies are identified as in need of an enhanced level of CPA that should allow for the co-ordination their care across agencies and professional groups. One of the main findings of our study has been that many recommendations address improving the co-ordination of mental health care across the disparate agencies and professionals involved in the care of patients.

The National Service Framework set standards for the modernisation of mental health service in England and Wales. Several of these standards reiterate the findings of the current study. For example, standard three states that 'any individual with a common mental health problem should be able to make contact round the clock with local services.'[19] Standard Four requires that all patients should have a copy of the written care plan which regularly reviewed by the care co-ordinator. Together with standard 5, these two standards provide the basis for the development of assertive outreach services across the country. These services are for patients who are the most difficult to engage and pose a danger to themselves or others. However, research findings on the

15 *Nolan, P., Oyebode, F. & Liburd, M. (1998). A survey of patients placed on the supervision register in one mental health trust. International Journal of Nursing Studies, 35, 65–71.*

16 *Mental Health (Patients in the Community) Act 1995. London: HMSO.*

17 *Department of Health (1999). Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. London: NHS Executive.*

18 *Department of Health (1999). National Service Framework for Mental Health: Modern Standards and Service Models. London: Department of Health.*

19 *Ibid., p.8.*

efficacy of assertive outreach have been inconclusive.[20] Thus, the NSF in setting these standards has sought to address the problems posed by some of the patients described in the homicide inquiries particularly those prone to disengage from services.

The inquiries into homicide committed by a person in contact with mental health services have greatly influenced public policy in mental health. However, the most recent inquiry in our collection which was published in July 2001, two years after publication of the NSF, still recommends that CPA should involve co-ordinated care across agencies and disciplines.[21] This suggests either that government policy is yet to be fully implemented or that inquiries are likely to reveal the less than perfect world in which psychiatry is practised.

In the future, the National Patient Safety Agency (NSPA) will be responsible for changing the way adverse incidents are reported so that a culture of learning from mistakes may be encouraged.[22] There is awareness that at present there is no systematic collation of data in order to improve our understanding of the nature and causes of adverse events in medicine. The new system set up by the NSPA endeavours to identify and record adverse events, report to local sites and the national system, analyse incidents and trends, learn lessons from analysis and research, disseminate findings and to implement change. In mental health, the homicide inquiries have been the response to the problem of adverse events. However, these inquiries are not systematic inquiries into the nature and causes of the adverse incidents. The inquiry reports have not been systematically collated to improve practice. Since adverse events in mental health services are a subset of adverse events in health care in general, it would be reasonable for adverse events in mental health to be dealt with under the same system as other adverse events. Therefore, it is right homicide committed by patients in contact with mental health services should be included under the terms of the new NSPA arrangements.

In more subtle ways the climate within which psychiatry is now practised has altered significantly to the degree that assessment of risk has become one of the principal tasks of clinicians. The Mental Health Bill, with its focus on risk to others and the control of mentally ill patients, is one of the changes evident in current psychiatric practice. It is the case that the public in Western countries is concerned with errors in medical arena and adverse effects of clinical interventions. However, errors and adverse events are the outcome of a complex interaction between the actions of individual practitioners, the systems of care, and the resources available to clinicians. Inquiries into adverse events should be concerned into failures of systems of care rather than attribute blame to individual practitioners.[23]

20 *Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders (Cochrane Review). In: The Cochrane Library, Issue 4, 2002. Oxford: Update Software.*

21 *Rassaby, E., Bull, D., McCollin, D. & Murray, K. (2001). Report of the Independent Inquiry into the Care and Treatment of Kevin Hewitt. Leicester, UK: Leicestershire Health Authority.*

22 *Department of Health (2000). Organisation with a memory: A report of an expert group on learning from adverse events in the NHS. London: HMSO.*

23 *Reason (2000). Human error: models and management. British Medical Journal, 320, 768–770.*

Table 1. Service Agencies

Service Agency	*Number*
NHS Trusts	558
Social Services	270
Health Authorities	233
Mental Health Services NOS	184
Housing Agencies	103
Police	90
Local Authorities	79
Prisons	61
Department of Health	59
Probation	58
Home Office	56
Judicial System	42
Voluntary Organisation	30
NHS Executive	26
Central Government	25
Health Care Agency NOS	22
Drug Misuse Agency	17
Primary Care Services	8
Regional Office	7
No Service Agency	707

Table 2. Staff Groups

Staff Group	*Number*
Psychiatrists	159
Managers and executives	144
Care co-ordinators	128
Nurses	120
Unspecified clinical staff	104
General Practitioners	84
Unspecified medical staff	67
Social workers	62
Psychologists	13

Table 3. Aspects of Mental Illness

Target aspect	*Number*
Violent behaviour	116
Substance use	53
Mentally disordered offenders	52
Personality disorder	19
Learning disability	12
Schizophrenia	8
Mood disorder	2

Table 4. Improving Routine Psychiatric Services

Code	*Number*	*Reports*
Admission	67	35
Aftercare	85	18
Assessment	183	56
Care planning	156	57
CPA	219	62
Confidentiality	47	32
Discharge	162	47
Documentation	365	71
Forensic	51	17
History taking	74	41
Incidents	44	31
Moving Patients	33	17
Out of Office Hours	23	16
Referral	69	37
Resources	96	44
Risk Assessment	155	61

Table 5. Multiagency Working

Code	*Number*	*Reports*
Collaboration	159	52
Communication	543	75
Families and Carers	162	59
General Practitioners	84	44
Housing Services	103	28
Judiciary	42	14
Police	90	33
Prison	61	9
Probation	58	16

Table 6. Quality Assurance

Code	*Number*	*Reports*
Audit	100	40
Evidence-Based Practice	23	13
Guidelines	140	51
Monitoring	120	51

Table 7. Staff Issues

Code	*Number*	*Reports*
Clinical Supervision	71	44
Staffing Levels	32	19
Training and Professional Development	229	65
Other Staff Issues	97	45

Table 8. Mental Health Legislation

Code	*Number*	*Reports*
Inquiries	76	35
Mental Health Law	53	21
Section 117	36	12

Table 9. Managing Specific Client Groups

Code	*Number*	*Reports*
Children	63	11
Conditional discharge/ Restricted	29	5
Noncompliance	50	35
Personality Disorder	19	9
Relapse	23	12
Self harm or suicide	34	19
Substance use	53	22
Violence	116	43

Box 1. Improving Routine Psychiatric Services

Documentation. "Improve communication between those staff who care for patients by introducing 'shared' records into which all the health professionals involved in the care and treatment of an individual make entries in a single record in accordance with a broadly agreed local protocol".[24]

CPA. "We recommend that the Trust should ensure that all patients receiving enhanced CPA are subject to regular and audited multi-disciplinary review. CPA systems must reflect reality. In the light of difficulties evident in continuity of care, the Directorate should consider the use of mandatory rolling case summaries for all patients on enhanced CPA. If such a system is not developed, alternative methods of keeping track of patients' care must be developed".[25]

Assessment. "The Milton Keynes Community NHS Trust should ensure that people with learning disability are automatically reassessed at regular intervals using the WHO recommended multiaxial system of diagnosis to record diagnoses in their psychiatric, developmental, intellectual, physical and psychosocial domains. Life events, changing clinical presentations (including frequent contact with services) and regular risk assessments should trigger a CPA review. The Department of Health and Royal College of Psychiatrists should consider issuing appropriate guidance to all Mental Health and Learning Disabilities Services on this issue of regular re-assessment".[26]

Risk Assessment and Management. "That Risk Assessment must not be considered as a 'one off' process at the time of admission into hospital or care. It must be seen as a continuing process and be reviewed at regular intervals to ensure that any revision and updating of care and treatment programmes can be implemented appropriately".[27]

Discharge. "Patients should not be discharged without an adequately prepared discharge plan or any outpatient or follow up appointments required after discharge being made and the details communicated to the patient. Discharge should be to an identified General Practitioner with whom the patient has already registered".[28]

Care Planning. "The Trust should ensure that, as part of the care plan, there are regular reviews of the progress of patients attending the Outpatients Clinic by senior doctors, if possible with other members of the multidisciplinary team, so that social and Psychological dimensions can be identified and dealt with".[29]

24 *Williams, W. J., Campbell, A., Hayward, T. & Tallentire, P. (1997). Inquiry into the Circumstances Surrounding the Deaths of Michael and Hazel Homer. Nelson, UK: East Lancashire Health Authority*

25 *Mackay, J., Poole, R. & Sinclair, S. (2001). The Report of the Independent Inquiry into the Care and Treatment of Paul Horrocks. Birkenhead, UK. Wirral Health Authority.*

26 *Rubenstein, V., Lavin Smith, M., Lindsey, M., Richardson, D. & Roy, A. (2000). Report of the Independent Inquiry into the Care and Treatment of Lorna Thomas and Nicholas Arnold. Aylesbury, UK: Buckinghamshire Health Authority .*

27 *Brown, T., Fraser, K., Morley, A. & Swapp, G. (1999). Report of the Inquiry into the Care and Treatment of Jonathan Crisp. Middlesborough, UK: Tees Health Authority.*

28 *Adams, J., Douglas, P., McIntegart, J. & Mitchell, S. (1997). Report of the Independent Inquiry into the Care and Treatment of James Ross Stemp. Leicester, UK: Leicestershire Health Authority.*

29 *Hughes, J. Mason, L., Pinto, R. & Williams, P. (1995). Report of the Independent Panel into the circumstances surrounding the deaths of Ellen and Alan Boland. London: North West London Mental Health NHS Trust.*

Aftercare. "The Aftercare Plan should be more than a list of discharge arrangements. It should include a plan for the patient's rehabilitation and continued treatment within the community. The patient should be aware of the care plan and should be encouraged to adopt its aims and targets. The care plan is of little use without the patient's active participation".[30]

History Taking. "On every admission the Ward Doctor and the Named Nurse should fully acquaint themselves with the patient's previous clinical notes and detail any relevant information from the past medical history into a new case review which should then be recorded in the notes for the current admission".[31]

Referral. "Any referral by a CPA care co-ordinator for a specific service from another agency should be confirmed in writing and a copy of any care plan should be made available".[32]

Forensic. "The Purchasing Authority should consider developing quality standards applicable to the care of patients with histories of violent offending. Such standards might include requiring Providers to ensure that a full range of assessment approaches, including access to forensic psychiatry services, is available to such patients".[33]

Incidents. "As soon as possible after an incident involving a homicide by a patient (including an outpatient) in the care of the psychiatric services, there should be: (a) a clinical audit at immediate service level under the management of a clinician not involved in providing care for the patient, and (b) an internal inquiry. The treating clinical staff (including any Community Psychiatric Nurses who have been involved in the care of the patient) should be interviewed and detailed statements taken from them".[34]

Transfer of Patients. "We recommend that where a patient is transferred from one hospital to another within the Trust before his/her care plan becomes operational, the plan must also be transferred with the patient and should be taken into account when a fresh plan is being devised. All the case notes in total must always accompany a patient who moves within the Trust to ensure continuity of care".[35]

30 *Scotland, P., Kelly, H. & Devaux, M. (1998). Report of the Luke Warm Luke Mental Health Inquiry. London: Lambeth, Southwark and Lewisham Health Authority.*

31 *Mishcon, J., Mason, L., Stanner, S., Dick, D. & Mackay, I. (1997). Report of the Independent Inquiry into the treatment and Care of Doris Walsh. Coventry, UK: Coventry Health Authority.*

32 *Harbour, A., Brunning, I., Bolter, L. & Hally, H. (1996). The Viner Report: The Report of the Independent Inquiry into the Circumstances Surrounding the Deaths of Robert and Muriel Viner. Ferndown, UK: Dorset Health Commission.*

33 *Blom-Cooper, L., Grounds, A., Guinon, P., Parker, A. & Taylor, M. (1996). The case of Jason Mitchell: Report of the Independent Panel of Inquiry. London: Duckworth.*

34 *Mischon, J., Dick, D., Milne, I., Beard, P. & Mackay, J. (1996). The Hampshire Report: Report of the Independent Inquiry into the Care and Treatment of Francis Hampshire. Ilford, UK: Redbridge and Waltham Forest Health Authority.*

35 *Crawford, L., Devaux, M., Ferris, R. & Hayward, P. (1997). The Report into the Care and Treatment of Martin Mursell. London: Camden and Islington Health Authority.*

Out of office hours. "That the Health Authority, [Social Service Department] and the Trust should together consider ways of developing an out of hours service for the use of those with mental health problems. Such a service should be set up involving all other relevant agencies, (including Primary Medical Health Care Services), and arrangements should be made to publicise the service and give information to potential users as to how the service may be accessed. The service could incorporate a 24 hour telephone helpline".[36]

Resources. "The panel recommends that priority be given and appropriate resources allocated to the establishment of sufficient mental health services and facilities in [the] District, which the panel considers is necessary to reduce the fragmentation and lack of co-ordination of services, to raise morale of those working in mental health care, and to encourage recruitment and retention of key staff".[37]

Confidentiality. "The limits of confidentiality between the various professionals concerned with a patients' care should be carefully define indicating the circumstances in which others must be informed".[38]

Box 2. Multiagency Working

Carers and Families. "Written guidance should be given to all staff regarding the involvement of carers and other family members in the care and treatment of patients and so that their views are sought and recorded when Care Programme Approach plans are made and reviewed".[39]

Housing. "Action to improve communication and joint working between LMHTs and the Housing Department: Priority should be given to the further development of supported housing initiatives for mentally ill people based on an analysis of the current research being undertaken on housing need".[40]

GP. "The West Berkshire Priority Care Service NHS Trust should introduce a system to ensure the adequate involvement of general practitioners on discharge from inpatient care. In particular, it is essential to ensure that information is conveyed where possible to the general practitioner immediately, followed by a formal discharge summary within ten days".[41]

36 *Sedgman, J., Graham, M., Moran. J. & Wilkins, J. (1997). Conclusions and Recommendations from: Report of the Inquiry into the Treatment and care of 5 individual patients by Oldham NHS Trust Mental Health Services commissioned by West Pennine Health Authority. Oldham, UK: West Pennine Health Authority.*

37 *Galbraith, A., Simpson, C., Childs, A. & Parkin, D. (2000). Report of the Independent Inquiry into the Care and Treatment of Patient R and Patient Y. Durham, UK: County Durham and Darlington Health Authority.*

38 *Wood, I., Ashman, M., Davies, C., Lloyd, H. & Lockett, K. (1996). Report of the Inquiry into the Care of Anthony Smith. Derby, UK: Southern Derbyshire Health Authority.*

39 *Lingham, R. & Candy, J. (1997). Inquiry into the Treatment and Care of Damian Witts. Gloucester, UK: Gloucestershire Health Authority.*

40 *Dimond, B., Carter, P., Jolley, A. & Watts, T. (2000). Independent Inquiry into the Care and Treatment of Feza M. London: East London and The City Health Authority.*

41 *Richardson, G., Chiswick, D. & Nutting, I. (1997). Report of the Inquiry into the Treatment and Care of Darren Carr. Reading, UK: Berkshire Health Authority.*

Police. "The Mental Health Services of the Healthcare Trust and the Local Authority should establish an inter-agency working group to address the issue of the sharing of information between themselves and Police, Probation, Social Services and Housing. The Group should agree a policy for sharing information about mutual clients and for establishing a workable means of monitoring clients who may be involved with one or more of the services".[42]

Judiciary. "Multi-agency risk assessment and attendant communication is more formally established as a safeguard by the Family Courts. For example, there should be communication between relevant agencies in circumstances such as the discharge of a Family Assistance Order, where family members are known to be under the care of mental health services. In such circumstances, court decisions and their implications (assessed by the court welfare officer) should be communicated to the local statutory services involved in a given individual's programme of care".[43]

Prison. "Forensic medical examiners should inform the medical officer of the local prison of any information which relates to a prisoner's physical or mental health, and particularly of any assessment which has been carried out by a psychiatrist or approved social worker. (When the PER Form is introduced, such information should be in a sealed envelope attached to the Form".[44]

Probation. "Such an assessment should include gathering as much information about the patient from as many sources as possible. If the patient has been transferred from prison, the probation service should be contacted to provide any relevant information and a check should be made of his antecedents for convictions involving violence".[45]

Box 3. Quality Assurance.

Guidance. "That the Department of Health harmonise guidance Section 117 Registers, proposed supervision registers, and the care programme approach with community care assessment and care management in respect of people who have a severe mental illness and their carers. Such guidance should include clarification of clinical, management and practitioner responsibilities, and the importance of choice by the service user in who their psychiatrist or key worker is to be for purposes of sustaining a therapeutic relationship".[46]

42 *Mishcon, J., Hayes, L., Lowe, M. & Talbot, M. (1997). Report of the Independent Panel of Inquiry into the Treatment and Care of Paul Smith. Peterborough, UK: North West Anglia Health Authority.*

43 *Williams, R., Hennessey, M. & Green, C. (1999). Report of the Inquiry into the Care and Treatment of Anne Murrie. Reading, UK: Berkshire Health Authority.*

44 *Coonan, K., Bluglass, R., Halliday, G., Jenkins, M. & Kelly, O. (1998). Report of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford. Witham, UK: North Essex Health Authority.*

45 *Mishcon, J., Dick, D., Welch, N., Sheehan, A. & Mackay, J. (1995). The Grey Report: Report of the Independent Inquiry Team into the Care and Treatment of Kenneth Grey. London: East London and The City Health Authority.*

46 *Woodley, L., Dixon, K., Lindow, V., Oyebode, O., Sandford, T. & Simblet, S. (1995). The Woodley Team Report: Report of the Independent Review Panel to East London and the City Health Authority and Newham Council. London: East London and The City Health Authority.*

Monitoring. "That the Trust should make it part of the task of each of its managers to identify whether its staff are carrying into actual effect its basic aims, like providing care in accordance with best practice. Wherever possible any monitoring carried out by managers should have, as a specific object, the identification of success or failure in such areas. Even though monitoring success or failure in these respects is not as easy as in some other aspects of the work of a hospital, because it is not as easily analysed in a statistical fashion, it must be recognised that they are the raison d'être of a hospital and must therefore be at the forefront of management's concerns".[47]

Audit. "Clinical audit examines quality of out-patient assessments of previously detained patients and focuses on: the use of informants, in order to verify that informants have been seen; 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".[48]

Evidence-based Practice. "The Department of Health should identify research-based interventions into families with histories of dysfunction and deprivation with a view to offering assistance at the earliest stage aimed at preventing and managing the development of early childhood conduct disorders and possible associated personality disorders".[49]

Box 4. Staff Issues.

Training and Professional Development. "The programme of in-service training for employed staff and for volunteers should be intensified and be better directed to the needs of the severely mentally ill and the staff caring for them. To be more specific, without implying their relative importance or the amount of time that should be spent on each, the following should be considered: i. The signs and symptoms of major mental illness, ii. Understanding and learning to talk with severely mentally ill people, iii. Substance abuse and its management: alcohol and drugs, iv. Treatment and management of mental illness: physical, psychological and social, v. Mental Health Act and its application, vi. Care Programme Approach: Supervision Registers; power of supervised discharge. vii. Risk assessment; viii. Emergency assessment and admission procedures; ix. Record keeping".[50]

47 *Barlow, R., Crook, J., Kingdon, D. & McGinnis, P. (1996). Caring for the Carer: Report of the Inquiry into the Care of Keith Taylor. Middlesborough, UK: Tees Health Authority.*

48 *Eldergill, A., Bowden, P., Murdoch, C. & Sheppard, D. (2000). Report of the Independent Inquiry Panel into the Care and Treatment of Stephen Allum. Reading, UK: Berkshire Health Authority, and Eldergill, A., Kelly, H. & Sheppard, D. (2000). Report of the Independent Inquiry into the Care and Treatment of Alexander Cameron. Reading, UK: Berkshire Health Authority.*

49 *Weereratne, A., Hunter, C. & Newland, A. (2000). Report of the Independent Inquiry into the Care and Treatment of Shane Bath. Ferndown, UK: Dorset Health Authority.*

50 *Davies, N., Lingham, R., Prior, C. & Sims, A. (1995). Report of the Inquiry into the Circumstances Leading to the Death of Jonathan New by (a Volunteer Worker). Oxford: Oxfordshire Health Authority.*

Clinical Supervision. "An effective and efficient system should be in place to ensure all professional staff receive appropriate supervision of their work and have their work regularly reviewed. Independent practitioners should operate to the same standards. The system should balance managerial, educational and clinical supervision of staff and provide an opportunity to reflect on and explore clinical standards, case analysis and staff workloads".[51]

Staff Levels. "There need to be more Consultant Psychiatrists and other CMHT members employed, to enable more detailed assessments and documentation to be implemented".[52]

Other staff Issues. "The Panel recommends that Brent Social Services Department should be asked to give careful consideration to the deployment, training and support of social workers and ensure that the most able and experienced staff are allocated to difficult and demanding patients [...]".[53]

Box 5. Mental Health Law and Inquiries.

Mental Health Law. "It is essential that anyone in the mental health system should have had some tuition in the Act and the Code of Practice. Anyone exercising the powers and duties derived from statute must be aware of their nature and extent. It is the primary task of management to ensure that practitioners are adequately versed in the law and practice in mental health and, further, that policies and procedures are properly formulated to instruct and guide all practitioners".[54]

Section 117. "We would recommend that where a person with a severe and enduring mental illness, who comes within the remit of s.117 of the Mental Health Act 1983, moves away from the area of the local Health and Social Services, then the following principles should apply: The need for on-going monitoring of that person's progress in the community should be recognised by both Health Services and Social Services (by means of a care programme or care management). Responsibility should be retained until the s.117 statutory after-duty is properly transferred to the local Health and Social Services in the area to which the individual has moved. A document that would contain all pertinent information, including any history of violence and risk assessment should be passed to the local Health and Social Services to whom s.117 duties are conferred".[55]

Inquiries. "The Inquiry Panel should be invited to reconvene one year after the publication of this Report to consider and report on the progress made in implementing these Recommendations".[56]

51 *Laming, H., Claydon, D., Davies, C. & Womack, J. (2000). Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings. Taunton, UK: Somerset Health Authority and Somerset Social Services.*

52 *Taylor, J., Longhurst, N., Oldridge, P. & Brown, T. (2000). Mental Health Inquiry: Mrs Marie Alawode. Huntington, UK: Cambridgeshire Health Authority.*

53 *Heginbotham, C., Carr, I., Hale, R., Walsh, T. & Warren, L. (1994). Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan. London: North West London Mental Health NHS Trust.*

54 *Blom-Cooper, L., Hally, H. & Murphy, E. (1995). The Falling Shadow: One Patient's Mental Health Care 1978–1993. London: Duckworth.*

55 *Dixon, K., Herbert, P., Marshall, S. & Pinto, R. (1999). The Dixon Team Inquiry Report. London: Kensington and Chelsea and Westminster Health Authority .*

56 *Mishcon, J., Sensky, T., Lindsey, M. & Cook, S. (2000). Report of the Independent Inquiry Team into the Care and Treatment of Daniel Joseph. London: Lambeth, Southwark and Lewisham Health Authority.*

Box 6. Patient Variables

Violence. "We recommend that within the multi-agency approach there must be mutually consistent systems of assessment of risk to the mentally disordered offender, him or herself; the community, or any significant individual likely to be targeted. Such a system must adopt mutually consistent assessments covering the propensity for violence to people and property, threats uttered, previous offending behaviour, and the likely threshold at which the risk assessment/dangerousness is likely to enter a higher risk category".[57]

Non-compliance. "The Trust and Health Authority should agree guidelines for ensuring regular contact is maintained with non-compliant or unco-operative patients by whatever measures are deemed appropriate in individual circumstances".[58]

Personality disorder. "the Authority and the Trust give specific consideration to the peculiar problems presented by people with personality disorder and arrive at an agreed position on what, if any, services are to be offered locally and what action local professionals should take when presented with the case of a person with personality disorder, which can include referral to other agencies".[59]

Conditional discharge or restricted. "Where there is such a case in which a conditionally discharged patient with this type of background is placed in the care and management of a multidisciplinary team it is, in our view, important that members of that care team have the training, experience and background which suits them for such a role – and we refer particularly to the training recommendations and requirements for Probation Officers and Community Psychiatric Nurses who have to fill a role in such a Care Team and the need for the Consultant Psychiatrist to be an appropriately placed and experienced person".[60]

Children. "The Chair [of the Area Child Protection Committee] should routinely ask for the children's views on the situation under discussion and be informed of the efforts made to gain their views… The difficulties for social workers visiting families in child protection cases where adult needs can dominate are appreciated but time should be set aside to engage the children separately. In this case it would have been appropriate to refer the children for more specialist help [...]. The child's right to be heard and his/her wishes taken into consideration is a duty laid on the local authority in the Children Act 1989".[61]

57 *Herbert, P., Ghosh, C. & Walters, I. (1999). Report of the Inquiry into the Care and Treatment of Michael Donnelly. Witham, UK: North Essex Health Authority.*

58 *Branthwaite, M., Fisher, N., Milne, I. & Mackay, J. (2000). Report of the Independent Inquiry into the Treatment and Care of Richard Allott. Warwick, UK: Warwickshire Health Authority*

59 *Gunn, M., Daniels, G., Foster, T. & Middleton, H. (1999). Report of the Independent Inquiry into the Treatment and Care of Bradley Sears-Prince. Leicester, UK: Leicestershire Health Authority*

60 *Brown, A., Harrop, F., Cronin, H. & Harman, J. (1996). Report of the Independent Inquiry into the Care and Treatment of Richard Stoker. Northumberland Health Authority*

61 *Gabbott, J. & Hill, O. (1994). Inquiry into the deaths of Jason and Natalia Henry. London: Haringey Child Protection Committee.*