

<p>Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	 <p>Yorkshire and the Humber</p>
<p>Date: 3 November 2009</p>	<p>Report Author: Professor Sue Proctor, Director of Patient Care and Partnerships</p>
<p>Title of paper: Independent Investigation into SUI Ref 2006/8119</p>	
<p>Actions Requested:</p> <ul style="list-style-type: none"> i) Receive the executive summary of the report from the independent investigators who have reviewed the care and treatment of the mental health service user provided by South West Yorkshire Partnerships NHS Foundation Trust ii) Receive the action plan developed in response to the recommendations in the report and iii) Approve the publication of the independent investigation report following its presentation to and scrutiny by the Independent Investigation Committee. 	
<p>Governance Requirements</p>	
<p>SHA Objectives supported by this paper:</p> <p>Objective 1 : Ensure the three elements of quality, patient safety, patient experience and effectiveness of service are routinely measured and adopted across NHS regions;</p>	
<p>Risk Management:</p> <p>1.2 SHA does not identify and manage poor patient safety and clinical quality systems in Trusts or PCTs</p> <p>1.3 SHA does not adequately facilitate learning from key national and local incidents in PCTs and Trusts</p>	
<p>Board Assurances:</p> <p>The presentation of this report provides assurance to the Board that the SHA is complying with its duty under HSG(94)27 (as amended) and that the Trust has taken steps to ensure that the service it provides is safe and is commensurate with modern standards of care.</p> <p>The Independent Investigations Committee will review and monitor the action plans regularly and recommend closure when there is clear assurance that all of the actions have been taken</p>	
<p>Risk Assessment:</p> <p>The report has been shared with solicitors acting for the SHA and it has been concluded that the risk to the SHA is low.</p>	
<p>Legal Implications:</p> <p>In publishing the reports into these incidents the SHA is discharging its statutory duty under HSG(94)27, as amended</p> <p>The legal implications for the SHA are low. There may be some residual legal implications for the Trust.</p>	
<p>Equality and Diversity:</p> <p>Poor mental health is known to have a significant impact upon the health, lifestyle and life chances of the sufferer and their close family. These reports and the associated action plans have been prepared to ensure that the learning from such tragic incidents is taken forward to help improve the care and treatment of people with mental illness and subsequently their life chances.</p>	

Yorkshire and the Humber Strategic Health Authority

3 November 2009

Independent Investigation into SUI Ref 2006/8119

- At the Independent Investigations Committee on 23 July 2009 a report into the care and treatment of a service user involved in SUI Ref 2006/8119 was presented by the lead investigator from Consequence UK Ltd.
- The incident involved a service user under the care of an Assertive Outreach team working for South West Yorkshire Mental Health NHS Trust (now South West Yorkshire Partnerships NHS Foundation Trust. This individual had been apprehended by Police at Heathrow Airport on 24 November 2006 and escorted off the premises. A short time later he attacked a number of passers by in a nearby town, killing one and leaving another permanently brain damaged.
- The Trust immediately undertook a thorough investigation and prepared an action plan, most of which it has already implemented. As a result there are no actions arising from the recommendations in this report for the Trust. The recommendations are for the SHA to take forward to national level.
- The executive summary of the report can be found at appendix 1 and the action plan can be found at appendix 2.
- Following consideration at the 23 July meeting the Independent Investigations Committee recommends the publication of this report.
- As there are no recommendations for the Trust or PCT the action plan will be presented by the Director of Patient Care and Partnerships
- The Board is asked to:-
 - i) Receive the executive summary of the independent investigation;
 - ii) Receive the action plans developed by the Directorate of Patient Care and Partnerships in response to the recommendations in the independent investigation reports and
 - iii) Approve the publication of the independent investigation report.

Professor Sue Proctor
Director of Patient Care and Partnerships
3 November 2009

**Independent Investigation into SUI
2006/8119**

**Final Report
Executive Summary
November 2009**

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This independent investigation was commissioned by NHS Yorkshire and the Humber in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.

This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Professor Anthony Maden, Consultant Psychiatrist, Broadmoor Hospital
- Dr Jeremy Chase, Consultant Psychiatrist in Assertive Outreach and Crisis and Home Treatment Hertfordshire Partnership Foundation Trust
- Mr Stewart Smith, Clinical Services Manager (Mental Health) HMP Birmingham and Secretary of the National Forum for Assertive Outreach (NFAO)

Acknowledgements

The Investigation Team wishes to thank:

- Mr D, a victim of the MHSU incident, and his wife. Mr D is further referred to in this report as V2,
- Mr NP, son of the deceased, Mr P. Mr P is further referred to in this report as V1,
- the Metropolitan Police,
- staff at South West Yorkshire Partnership NHS Foundation Trust, (formerly known as South West Yorkshire Mental Health Trust and referred to as SWYMHT in this report)
- the MHSU,
- Refugee and Migrant Justice, Leeds, and
- Staff at the high secure special hospital caring for the MHSU

who all assisted in the completion of the investigation conducted.

EXECUTIVE SUMMARY

Intention

This report sets out the findings of the Independent Investigation Team (IIT) regarding the care and management of the mental health service user, herewith referred to as the "MHSU", by South West Yorkshire Mental Health Trust, now, South West Yorkshire Partnership NHS Foundation Trust. The organisation is referred to as SWYMHT throughout this report. The MHSU attacked eight individuals near Heathrow Airport on 24 November 2006. The attacks were unprovoked and had particularly tragic consequences for two victims (V1 and V2). V1 died and V2 was left with lifelong brain injury.

Purpose

The terms of reference for the team were:

- ❑ to undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require further independent investigation;
- ❑ to examine the care and treatment the service user was receiving at the time of the incident and to comment on: its suitability, the extent to which it corresponded with local and statutory obligations, the adequacy of the risk assessment, the interface and communication with other statutory and non-statutory agencies, the exercise of professional judgment and the service users' engagement with the mental health service; and
- ❑ to make recommendations.

In addition to the above the IIT agreed with the Strategic Health Authority that it would comment on the predictability and potential preventability of the incident. This was an issue of importance to the families of V1 and V2.

OUTLINE OF THE REVIEW PROCESS

The team conducted:

- ❑ A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- ❑ A critical appraisal of the Trust's internal investigation report.
- ❑ Interviews with staff working in the Trust's Assertive Outreach Team (AOT).
- ❑ Review of key policies and procedures.
- ❑ Meetings and/or discussions with the Metropolitan Police, Refugee and Migrant Justice and the family of one of the victims.

Main conclusions

The IIT concludes that:

- For the most part the care and management of the MHSU was reasonable. The AOT had regular weekly contact with the MHSU, with some short periods of fortnightly contact. It also provided appropriate support to the MHSU when he was stressed or needed assertive follow-up.
- Medications management for the MHSU was reasonable. In 2005 and 2006 it is difficult to see how the AOT could have managed the MHSU's medications differently. If he was a patient of any AOT today one would strongly consider placing him on a Community Treatment Order.
- There is one instance in May 2006 where a member of the medical staff requested twice-weekly visits for the MHSU because he appeared to be showing signs of early relapse. These enhanced contact visits did not occur and there is no adequate explanation for this. For the four weeks between this instruction and the subsequent outpatient appointment, where the MHSU was again considered to be in remission, his care management fell below the standards expected of an AOT and the purpose of him being with the AOT was thwarted.
- On 6 November 2006, the MHSU self presented and was assessed, and as a result the plan was to continue with weekly contacts. Because of the nature of the MHSU's stressors at the time, he should have received enhanced contact at least twice a week after 6 November. That no such decision was taken is the collective responsibility of AOT and not any individual practitioner.
- Following assessment on 6 November and then subsequently on 8 November, there should have been a clearly agreed plan for what action was to be taken if the MHSU could not be contacted.
- Although the AOT did have contact with the MHSU on 6, 8, 13, 15, and 17 November, only two of these contacts constituted a face-to-face assessment. On 22 November, the MHSU was not contactable by telephone as had been planned. There should have been assertive follow up of this, but there was none.
- The IIT discovered during its attendance at New Scotland Yard that there was the facility for the MHSU's AOT to have core information about the MHSU entered on to the Police National Computer (PNC) as part of its risk management plan. Although it was part of the AOT's plan to notify the police if the MHSU went absent without leave (AWOL), proactive logging of his details on to the PNC and what actions were recommended if the MHSU were to attend at an airport without money, identification, or a means of boarding an aeroplane were not. The main reasons for this were as follows:
 - The AOT believed that the police records would already show that the MHSU had a history of attending at airports when unwell as this had occurred in 2002, 2003, and 2005. On all occasions the MHSU had come to the attention of the police. The AOT did not know that the trespass offences are not criminal offences and therefore should not generate a record on the PNC¹.

¹ It would not be reasonable to expect mental health professionals to be aware of this.

- Although this AOT was clearly willing to share information with the police the team, as with many other health teams, would not usually share information in advance of there being a developing or actual concern because of perceived risk of breaching the Data Protection Act.

This concern around the Data Protection Act, as an impediment to proactive and prudent information sharing with agencies such as the police, is not unique to the MHSU's AOT.

On 9 September 2009 the Department of Health issued up to date guidance to mental health trusts entitled "Information haring and Mental Health – Guidance to Support Information Sharing by Mental Health Services"²

This guidance states:

A reluctance to share information because of fear or uncertainty – about the law or the lack of suitable arrangements to do so has been a feature of some public services in recent years and a factor in numerous accounts of untoward incidents, including homicides. A natural reaction to uncertainty is to take what appears to be the least risky option and, for information sharing, that can often mean doing nothing – and that may be the worst outcome for the individual and the public.

The Department of Health guidance is in the opinion of the IIT essential reading for all community based mental health practitioners.

With regards to the predictability of the MHSU's attack on members of the public the IIT do not believe that it was predictable that he would present a high and immediate risk to the public. It was however predictable that if he relapsed he may make his way to an airport, attract attention and possibly put himself at risk.

With regards to preventability had information about the MHSU and his known behaviour of attending at airports, when in relapse, been entered onto the PNC and had the police been aware of the MHSU's change of name in 2006 then the police officer, who asked for a check of the MHSU's name on the PNC on 24 November 2006, could have been given information about him that would have better informed his decision making that day. Under these circumstances it is reasonable to suggest that there was the opportunity for incident prevention.

This being said the MHSU's consent would have been required for the AOT to have been able to share information with the police in advance of there being serious concern about him. The reason for this is there was nothing in the MHSU's history to suggest that he posed a serious risk of harm to the general public. Had the MHSU withheld his consent for this the AOT would have had to consider very carefully whether his 'best interests' outweighed its duty of confidentiality, and the lawfulness of any information exchange made without the MHSU's consent. The IIT cannot guess at what may have happened if the AOT had asked the MHSU for consent. What the IIT can say is that the information it gathered suggests that it would not be common place for information sharing to occur so proactively where there is no emerging or immediate cause for concern, and where there is no known risk to the public. One of the reasons for this seems to be a lack of understanding of the Data Protection Act and mental health staff's anxiety about being in breach of this.

² http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

Could anything else have prevented the incident? The IIT does not believe so. Although aspects of the MHSU's care could have been managed differently one cannot say that the following would have prevented the incident:

- Enhanced contact with the MHSU by the AOT between 8 and 22 November.
- Implementation of assertive tracking of the MHSU on 22 / 23 November.
- Notification to the police of the MHSU's change of name in the summer of 2006.

The reason the IIT does not believe that the points cited above would have prevented this incident are as follows:

- The MHSU's sudden and unpredictable past relapses. This was a service user who could present as well and then rapidly relapse without any warning at all. In November 2006 the AOT identified no clear signs of early relapse in the MHSU.
- Even had the AOT instituted efforts to follow up the MHSU on 22 November it is unlikely that this would have occurred until the following day, or even the day after, given the team's relative lack of concern about his relapse risk at the time.
- Even had the AOT advised the police of the MHSU's name change there was nothing on the PNC that would have alerted the police officer at Heathrow Airport of the need for the MHSU to be taken to a place of safety.³

The families of V1 and V2 were particularly interested in preventability based on the police knowing the MHSU's real name at the time of the incident, and whether a change is required as to how we in the UK are enabled to change our name by deed poll. The IIT is aware, from information exchanged between the wife of V2 and the Home Office that in the near future there are plans for biometric testing to be available across all police forces and this will more frequently be used to assist in the identification of individuals. Technology is now available to enable this to occur without requiring an individual to attend at a police station. This technology will mitigate against any perceived weakness in the system of deed poll as fingerprint recognition is a far more reliable approach. It is important to note that even had biometric tools been available to the police at Heathrow Airport on 24 November 2006 it is highly unlikely that their actions would have differed because there was, at the time, no information on the PNC to alert them to the fact that the MHSU had a serious mental health illness and had a history of attending at airports when acutely unwell.

The key therefore to preventability of future incidents in similar circumstances, in the opinion of the IIT, is a greater degree of information sharing between the police and the mental health services that is supported by national policy and clear operational systems for how to, and with whom, information needs to be communicated so that it finds its way on to the PNC in a timely manner.

³ Note: The offences that the MHSU had been involved in preceding November 2006 were not of a criminal nature and he should not have had a PNC record at all as a result of these.

Recommendations

Unusually for this type of investigation, the IIT has no specific recommendations for SWYMHT or the MHSU's AOT. We were impressed by the developments in systems and processes within this AOT that have continued since 2006. The AOT has good leadership in both its consultant psychiatrist and its team leader. For this team this case has already resulted in more proactive information sharing with the police and the development of solid relationships with the local vulnerable person's officer and the police liaison officer. This now needs to be achieved across all mental health community based services.

The IIT has four recommendations, which it believes need to be addressed nationally. It does however ask Yorkshire and the Humber SHA to communicate the recommendations to other SHA mental health leads so that local consideration can be given to recommendations one, two, and four.

The management team at SWYMHT are also asked to ensure that all of its community based services are cognisant of the key findings and recommendations of this report and that it double checks its own systems and polices against the principles espoused in recommendations one and two.

Recommendation 1: information sharing

It has been requested that the National Patient Safety Agency work with the Department of Health to ensure that the Department of Health's recent information sharing guidance⁴ is translated into clear workable operational policies in individual mental health trusts. The message that needs to be underlined is that in all circumstances where there is benefit to the service user in sharing information with other agencies, such as the police, third sector agencies and probation, then all reasonable efforts should be made to obtain the consent of the service user to do so. In circumstances where the service user withholds consent, or obtaining consent is not possible, the healthcare team must then consider the risk to the service user and the wider public of not sharing the information. The issues considered and the output of this consideration must be documented in the service user's clinical record and risk management plan. Furthermore the professionals should seek advice from:

- the Trust's Caldicott Guardian,
- the vulnerable persons officer,
- the police liaison officer,

where appropriate, particularly if there is any uncertainty whatsoever as to the most reasonable course of action to take, i.e. 'to share' or 'not to share'.

In this case the AOT did not tell other agencies that the MHSU had changed his name by deed poll because of concerns around client confidentiality. Furthermore it did not proactively engage with the police in the risk and contingency planning for the service user because of similar concerns. These concerns are commonplace amongst mental health professionals. However, to have shared information with the police in this case would have undeniably been in the MHSU's best interests. In this case, lack of clarity about when it is acceptable and not acceptable to share information without consent contributed to a lack of opportunity for incident prevention.

⁴ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

Recommendation 2: information sharing and the police national computer

It was the working assumption of the Assertive Outreach Team caring for the MHSU that if he was 'picked up' at an airport without any money, identification, or tickets to board a plane, then he would be taken to a place of safety and mental health services would therefore become immediately involved with him. This is what had occurred on two of the previous three occasions he had attended at an international airport. The AOT believed that because the MHSU had been arrested by the police before that there would automatically be a record on the Police National Computer (PNC) about him and the circumstances of his arrests. Unfortunately this was not the case.

Trespass is not a criminal offence and therefore does not generate a PNC record.

The PNC does however have the facility to record core information about service users about whom the mental health services have significant concerns if they go 'absent without leave' (AWOL), or fall out of contact with the services. Furthermore the PNC can accommodate instructions on what actions to take, and who to contact, should the service user be stopped by the police in 'identified circumstances' and a check made against their identity. A service user does not have to have any previous criminal record for this facility to be utilised.

An ad hoc survey of a small number of mental health professionals revealed that about 50% were unaware that the PNC could be used positively as part of the risk management planning for a service user. It also revealed that 100% of those professionals approached believed that if a person arrested for any reason a PNC record would be generated and that the circumstances of the arrest would also be recorded. The responses received also suggested that the bar is set quite high when it comes to sharing information with other agencies because professionals are anxious of being in breach of the Data Protection Act. (See recommendation 1.)

In this case had important information about the MHSU been entered onto the PNC in advance of the incident, as part of a proactive risk management and contingency plan, then this incident in all probability would have been prevented.

Because of the numbers of victims as a result of this incident, and its potential preventability, it is essential that all mental health professionals are aware:

- Of the importance of proactive information sharing with other agencies where to do so enhances the safety of the service user and/or the safety of the public, even if the service user withholds consent.
- Of the optimal times to address the issue of information sharing and the obtaining of consent with a service user. For example after a relapse and in the early period of wellness.
- Of the practical measures professionals can take to determine whether the information sharing is lawful if a service user refuses consent, or is unable to give consent (i.e. liaison with the Caldicott Guardian, the Trust's vulnerable person's officer and the police liaison officer – essentially reasoning it out with others).
- Of the scope of the PNC for logging the details of service users who are known to go AWOL when unwell and place themselves in high risk

To achieve the above it is essential that training workshops on data protection, clinical risk assessment (as it pertains to service users) and local and national guidance documents and policy on information sharing ensure that the above messages are incorporated and that staff do not have an ungrounded fear of information sharing that is detrimental to the delivery of safe and effective care.

To ensure that this very important issue, in particular the scope of the PNC to support effective risk management planning, receives the attention it needs, the Director of Patient Care and Partnerships/Chief Nurse for NHS Yorkshire and the Humber is asked to bring this recommendation to the attention of the Chief Nursing Officer for the NHS and the NHS Medical Director so that an effective risk reduction solution can be generated, working with relevant partners such as the police and the Information Commissioner's Office.

Recommendation 3: occupational therapists and medicines management

One of the relapse triggers for the MHSU was medication non-compliance and on numerous occasions staff underlined for the MHSU the absolute importance of taking his medication. However, at some times the MHSU took only very low doses of his medication and his care coordinator, an occupational therapist (OT), and other non-medical staff were not sufficiently aware that this posed an inherent risk of relapse.

Discussions between the IIT and the OT identified a potential professional conflict between the guidance provided by the College of Occupational Therapists (COT) to its members about medicines management and the role and responsibility of a care coordinator. It was the OT's understanding, in 2005, that the College advised that OT's did not need to have any knowledge about medicines. However, with the evolution of New Ways of Working⁵ in mental health, in the opinion of the IIT, a care coordinator, regardless of his/her professional background, does need to have at least a basic understanding of the medicines their clients are on and the usual dose range of these.

Clearly it would be unreasonable for an OT to take responsibility for complex medicines management. However it should be within their capability to be informed about the medications prescribed for clients for whom they are care coordinator. Guidance issued by the COT to its members in September 2008 makes clear the responsibility for an OT to ensure that he/she has the competencies to fulfil their job role. For a care coordinator this must include a basic knowledge of common mental health medications, the normal dosage and common side effects.

It is recommended that the allied health professionals (AHP) lead in the Directorate of Patient Care and Partnerships at NHS Yorkshire and the Humber

⁵ Mental Health: New Ways of Working for Everyone Department of Health May 2007

and the SWYMHT OT liaise with the COT on the matter of what skills and competencies are required by OTs who are care coordinators for service users. The COT should take an active role in working with relevant partners in defining these core competencies, especially as they relate to medicines management, for the sake of consistency nationally.

Recommendation 4: Client Focused Risk Management Training and Risk Assessment

This investigation highlighted two issues which need to be addressed in client-focused risk assessment training delivered in all mental health trusts and in documented risk assessments.

The first is the concept of 'risk vulnerability', a concept that was not well understood by all members of the MHSU's care team. Furthermore it does not appear to be routinely included in risk assessment training. In the case of the MHSU, situational stress increased his risk vulnerability but was not a 'relapse indicator' per se. The lack of appreciation of this concept did adversely affect the risk management plan agreed within his care team.

The second is staff's awareness of the risks posed by service users engaged in sports such as karate, kick boxing, boxing, kung fu etc. When individuals become competent in any of these sports their hands and feet are considered to be dangerous weapons. For some of these sports such as kick boxing, it does not take long for some degree of competency to be achieved as this case highlights. It is essential that mental health professionals' awareness of this is enhanced as it has real implications within the process of risk assessment, and the documentation of identified risk, especially where service users are prone to relapse and to hit out with their hands and feet.

It is therefore recommended that the Adult Services Lead for NHS Yorkshire and the Humber liaise with the chairs of the national Mental Health and Learning Disability Nurse Directors' and Leads' Forum and national Mental Health Medical Directors' Forum respectively, so that this case can be used for learning lessons nationally. The appropriateness of incorporating the issue of (i) risk vulnerability and (ii) awareness of risks associated with martial arts and other contact sports, such as boxing, into risk training programmes shall be considered by these fora. Consideration should also be given to liaising with the Royal College of Psychiatrists.

ACTION PLAN

TO BE PRESENTED TO THE BOARD OF YORKSHIRE AND THE HUMBER SHA

3 November 2009

Introduction

This Independent Investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance titled “Independent Investigation of Adverse Events in Mental Health Services” issued in June 2005. The SHA, South West Yorkshire Partnerships NHS Foundation Trust and Calderdale Primary Care Trust, the commissioner of services to the Mental Health Service User involved in this case accept the findings in this report.

This action plan addresses the recommendations from the Independent Inquiry report into SUI Ref 2006/8119, and is published alongside it. Unusually the actions in this report are of a national nature and the SHA will ensure that these are brought to the attention of the relevant authorities and identify opportunities to implement the recommendations to the full.

This action plan will be monitored by Yorkshire and the Humber Strategic Health Authority through its Independent Investigations Committee, a standing committee of the Board.

Bill McCarthy
Chief Executive

No.	Recommendation	Action taken to date	Further action to take	Leads	Timescales
1	<p>The NPSA to work with DoH to ensure that its recent information sharing guidance (Information Sharing and Mental Health - Guidance to Support Information Sharing by Mental Health Services) is translated into workable operational policies in individual mental health trusts.</p> <p>Where there is benefit to the service user in sharing information with other agencies eg police, third sector agencies and probation then all reasonable efforts should be made to obtain the consent of the service user to do so. If consent is withheld or is not possible to be obtained, the healthcare team must consider the risk to the service user and the wider public of not sharing the information.</p> <p>The issues considered and the output of the consideration must be documented in the service user's clinical record and risk management plan.</p>		<ol style="list-style-type: none"> 1. The Director of Patient Care and partnerships to write to the Chief Executive of the NPSA including a copy of the report and inviting them to attend a meeting to discuss the issues 2. Copies of the report to be circulated to all trusts and PCTs in the region with Mental Health Services with letter alerting them to the issues involved – copies to the commissioning PCT 3. Request commissioning PCTs in Y & H to seek assurances from providers on information sharing policies 	<p>Director PCP/Integrated Governance Manager</p> <p>Director PCP/Integrated Governance Manager</p> <p>Associate Director, Integrated Governance</p>	<p>October 2009</p> <p>November 2009</p> <p>December 2009</p>

1 conti nued	Where appropriate the professionals must seek advice from; The Trusts Caldicott Guardian The vulnerable persons officer The police liaison officer				
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2	<p>The Director of Patient Care and Partnerships/Chief Nurse for NHS Yorkshire and the Humber is asked to bring to the attention of the Chief Nursing Officer for the NHS and the NHS Medical Director the need to develop training on;</p> <ul style="list-style-type: none"> • Proactive data sharing with other agencies where to do so would enhance the safety of the service user and/or the public safety of the public even if the service user withholds consent. • The optimal times to address the issue of information sharing and the obtaining of consent with a service user • The practical measures professionals can take to determine whether the information sharing is lawful if a service user refuses or is unable to give consent. • The scope of the PNC for recording details of service users who are known to go AWOL when unwell and place themselves in high risk situations and/or pose a potential serious risk of harm to others and the absolute acceptability of adding a service user to PNC to enhance the risk management plan and the safety and well being of the service user. 		<p>Director of Patient Care and Partnerships to hold discussion with Chief Nursing Officer and DH Medical Director to identify way forward and develop a strategy to implement this recommendation</p>	<p>Director of Patient Care and Partnerships</p>	<p>November 2009</p>
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3	<p>The Allied Health Professionals lead in the directorate of patient care and partnerships at Y & H SHA and the Occupational therapy lead from SYMHT liaise with the College of Occupational Therapists of what skills and competencies are required by Occupational Therapists who are care coordinators for service users.</p> <p>The College of Occupational therapists should take an active role in working with relevant partners in defining these core competencies, especially as they relate to medicines management, for the sake of national consistency</p>	<p>AHP lead has discussed some of these issues with leaders at the COT</p>	<p>AHP Lead at SHA to work with College of Occupational Therapists on Medicines Management guidance for OTs across the country</p> <p>AHP of the SHA to work with COT on skills and competencies required by OT's who are care co-ordinators.</p>	<p>AHP Lead</p>	<p>December 2009</p>
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4	<p>The Adult Services Lead for NHS Yorkshire and the Humber liaise with the chairs of the national Mental Health and Learning Disability Nurse Directors' and Leads' Forum and national Mental Health Directors' Forum respectively, so that this case can be used for learning lessons nationally. The appropriateness of incorporating (i) the issue of risk vulnerability, (ii) the documentation of identified risk and (iii) awareness of risks associated with martial arts training into risk training programmes shall be considered by these Fora. Consideration should also be given to liaising with the Royal College of Psychiatrists.</p>		<p>Adult Services Lead for NHS Yorkshire and Humber to ensure that the issues are raised at appropriate fora and with the Royal College.</p>	<p>Adult Services Lead</p>	<p>November 2009</p>
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