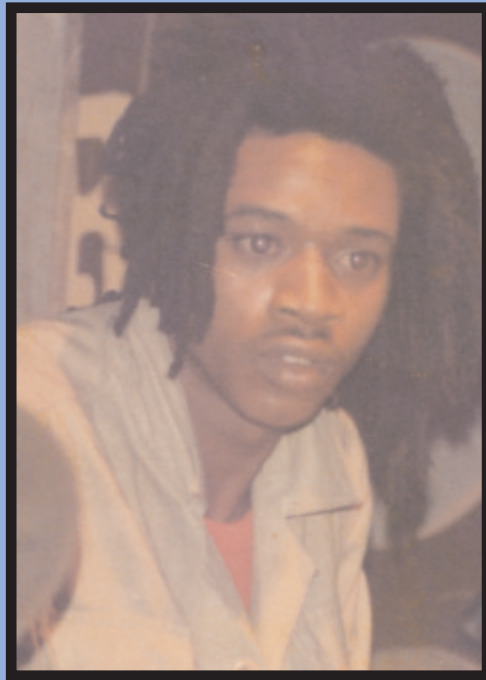


Independent Inquiry into the death of David Bennett



**David 'Rocky' Bennett
1960 - 1998**

An Independent Inquiry set up under HSG(94)27

CONTENTS

| | |
|---|----|
| Introduction | 2 |
| Terms of Reference | 3 |
| Panel Membership | 4 |
| PART I | |
| The history of David Bennett and his psychiatric care to October 1998 | 7 |
| Findings on David Bennett's mental illness | 12 |
| Last months of David Bennett's mental illness | 13 |
| Norfolk Mental Health Care NHS Trust and the Norvic Clinic | 15 |
| Events of 30/31 October 1998 | 16 |
| Findings | 23 |
| The Inquest | 35 |
| Developments at the Clinic since David Bennett's death | 36 |
| PART II | |
| Preface | 41 |
| Racism | 43 |
| Diagnosis | 46 |
| Contact with Family | 47 |
| Secure Accommodation | 48 |
| Medication | 49 |
| Managing Challenging Behaviour | 50 |
| Resuscitation | 55 |
| Availability of Doctors | 55 |
| Second Opinion Approved Doctor (SOAD) | 55 |
| Special Projects | 56 |
| The Way Ahead | 58 |
| Inquiries | 62 |
| RECOMMENDATIONS | 67 |
| APPENDICES | |
| Appendix I: Witnesses referred to in Part II of the report | 71 |
| Appendix II: Witnesses referred to in Part I of the report | 73 |
| Appendix III: Abbreviations used in both parts of the Inquiry report | 74 |
| Appendix IV: Documents/Papers studied by the Inquiry Panel | 75 |

INTRODUCTION

THIS is an Inquiry set up under HSG(94)27 by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority after consultation with the Department of Health as a result of the death of Mr David Bennett at The Norvic Clinic on 30 October 1998.

At the Department's request, the Inquiry has also examined some broader mental health issues. It was also required to inform the developing black and minority ethnic mental health strategy. But we only had the limited powers provided by HSG(94)27.

The terms of reference were formulated after careful consideration of all relevant factors, including the views expressed by Dr Joanna Bennett, the sister of the deceased and the recommendations made by the Coroner at the conclusion of the Inquest.

Mr David Bennett was an African-Caribbean. He suffered from schizophrenia.

He had been receiving treatment for his mental illness for some eighteen years before the date of his death. On that evening Mr David Bennett had been in an

incident with another patient who was white. During that incident each man struck out at the other. Mr David Bennett was also the recipient of repeated racist abuse from the other patient. After this incident, Mr David Bennett was moved to another ward.

While in that ward he hit a nurse. He was then restrained by a number of nurses and a struggle developed. He was taken to the floor and placed in a prone position, face-down, on the floor. During the prolonged struggle that then continued he collapsed and died.

The first part of our Inquiry covers the whole period of Mr David Bennett's illness, the events leading up to his death and certain other events that took place during the hours and days following his death.

Also, in this part of the Inquiry, we deal with some other matters individually. This part of the Inquiry deals with our terms of reference 1 to 6.

The other part of the Inquiry deals with the remaining terms of reference.

TERMS OF REFERENCE

The terms of reference are as follows:

1. To examine the care and treatment Mr Bennett was receiving at the time of the incident.

2. To assess the suitability of that care and treatment, in view of Mr Bennett's history and assessed health and social care needs, including:

- ☐ the planning and management of care
- ☐ medication prescribed
- ☐ physical health problems
- ☐ dental care
- ☐ ethnicity.

3. To examine the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies including, specifically:

- a.** standards for the prevention and management of aggression by psychiatric in-patients and to apply regular monitoring (particularly around control and restraint)
- b.** the Trust's manual on the 'Prevention and Management of Aggression'
- c.** response to violent incidents; to ensure that appropriate resources for resuscitation are available and that staff receive necessary training
- d.** the reporting of such deaths
- e.** the need to ensure that staff are pro-active in taking appropriate action in dealing with incidents of racial abuse by and against patients
- f.** staffing levels
- g.** the need to ensure that urgent medical assistance is readily and speedily available outside normal hours
- h.** the level and suitability of medication prescribed

4. To examine the exercise of professional judgement.

5. To assess the adequacy of the care plan and its monitoring by the key worker.

6. To examine and assess the adequacy of communications and involvement with members of the family, including:

- a.** family involvement in the care and treatment of the patient
- b.** notifying the family of emergencies or the sudden death
- c.** meeting family members.

7. To consider, at the Chairman's discretion, recommendations from similar independent mental health inquiry reports so that any significant common factors can be identified.

8. To consider whether there is the need for some of the issues in '3' above;

- a.** the management of aggression by psychiatric in-patients (3.a.)
- b.** resuscitation in psychiatric units (3.c.)
- c.** dealing with incidents of racial abuse (3.e.)

to be taken up nationally by linking to national policy development.

9. To consider whether there is the need to review the procedures for internal inquiries by hospital trusts following the deaths of psychiatric patients with emphasis on the need to provide appropriate care and support principally for the family of the deceased, but also for staff members affected.

10. To consider whether there is the need for a wide and informed debate on strategies for the care and management of patients suffering from schizophrenia who do not appear to be responding positively to medication.

11. To consider the need for medical personnel caring for detained patients to be made aware, through appropriate training of the importance of not medicating patients outside the limits prescribed by law and the need for more regular and effective monitoring to support the work undertaken by the Mental Health Act Commission in this field.

12. To ensure that the findings and recommendations inform all relevant parties including the developing black and minority ethnic mental health strategy.

13. To report findings and recommendations to Norfolk, Suffolk & Cambridgeshire Strategic Health Authority and to the Secretary of State for Health.

There is no specific section in this report which addresses term 3, which states that the Inquiry should:

“examine the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies including, specifically: b. the Trust's manual on the 'Prevention and Management of Aggression'.”

so we deal with that matter here.

We are satisfied that David Bennett's treatment did correspond with statutory obligations, relevant guidance from the Department of Health and local operational policies then existing, including the Trust's manual on the 'Prevention and Management of Aggression'.

PANEL MEMBERSHIP

The Panel was composed of:

❑ **Professor David Sallah**, a Professor of Mental Health, who was the nurse member;

❑ **Professor Sashi Sashidharan**, a Consultant Psychiatrist;

❑ **Dr Richard Stone**, a former General Practitioner with experience in race equality issues;

❑ **Mrs Joyce Struthers**, a Community Health Council (CHC) member and former chair of the Association of CHCs of England and Wales (ACHCEW);

❑ with **Sir John Blofeld**, a retired High Court Judge, in the Chair.

This report has been contributed to by all the Panel and represents their unanimous views.

We would express our gratitude for the hard work and commitment of our Secretary Mrs Geraldine Howard and her assistant Mrs June Jode, who were the two members of staff kindly seconded to this Inquiry by the Strategic Health Authority. We would also like to thank Mrs Barbara Bennett

who recorded all the oral evidence and provided us with accurate and timely transcripts.

The family of David Bennett were represented by Mr Sadiq Khan of Christian Khan, Solicitors during Part 2 of the Inquiry (the general part). No other party was legally represented, nor did the Inquiry itself have any legal representation.

The Panel members were appointed in September 2002.

The Panel decided to split the Inquiry. Part I of the Inquiry was dealt with in two ways. The first part dealt primarily with the events immediately before and after the death of Mr David Bennett. This part of the Inquiry was held in private. The second part was concerned with the history, care and treatment of Mr Bennett from the onset of his illness. Some of this was held in public and some in private. Part II of the Inquiry dealt with general matters and was held in public throughout. Thus, Part I concentrated on the terms of reference 1 to 6, and Part II on the terms of reference 7 to 11.

There was inevitably some minor degree of overlap between the parts. We heard evidence from Dr Joanna Bennett, on behalf of the Bennett family and submissions from Mr Sadiq Khan, their solicitor in relation to all parts of the Inquiry.

Part I

THE HISTORY OF DAVID BENNETT AND HIS PSYCHIATRIC CARE TO 30 OCTOBER 1998

MR David Roy Bennett was born on 5 February 1960 in Jamaica. He came to England in 1968 to join his family who were already living in Peterborough. His father worked as an engineer with the London Brick Company. David Bennett had eight siblings.

He gained five CSE's at school and worked as a sign writer for some three years after that. He left that job voluntarily and does not appear to have worked thereafter due to health problems. His nickname was "Rocky". Some of the witnesses used this nickname, but throughout this report we have referred to him as David Bennett.

As a young man David Bennett was a talented footballer. He was offered a trainee post with a football club shortly before his mental state first deteriorated but because of his illness he was unable to take it up. He was also a good musician, playing the drums. He was a Rastafarian. It is known that in 1980 he set up a club for the Rastafarian community in Peterborough.

In about 1980 he first showed signs of mental ill health. His sister, Dr Joanna Bennett said:

"David developed problems in April/May 1980 when he was just 20 years old. He had problems with his behaviour and his emotions. He saw his general practitioner who prescribed sleeping tablets for him but did not seem to be concerned about anything else. They did not work. We saw a spiritualist in London and that did not work. I took him to the local psychiatric unit at Peterborough General Hospital and he eventually saw the consultant psychiatrist Dr Feggetter. Dr Feggetter was dismissive. He said that maybe it was cannabis intoxication. We took David home. We continued to take care of him. At one stage he became paralysed down one side of his body. Eventually he was referred to The Gables, the local psychiatric hospital ward in Peterborough General Hospital. I again remember Dr Feggetter's attitude. He said that David had some kind of mental illness which was induced by smoking marijuana. At that stage I do not remember anyone telling us David had schizophrenia. Mental illness is not something that the every day person understands. Nobody explained anything to us. It would have been so useful in those early days if somebody had just said, "This is what is happening to him. This is what the family could do to help him."

The records show that David Bennett was first referred to Dr Feggetter, a Consultant Psychiatrist working at the Peterborough District Hospital, on 23 September 1980. His medical records for the 1980s are incomplete. David Bennett had at least two episodes of in-patient treatment between 1980 and 1984.

In November 1984, David Bennett was convicted of minor criminal offences. Before he was sentenced, at his solicitor's request, Dr Feggetter wrote a report to the Court recommending that he be made subject to a probation order with a condition that he received psychiatric treatment. The sentencing Court made this order. On 20 December 1984 the records show that, having been admitted to Peterborough District Hospital for psychiatric treatment as a condition of his probation order, he discharged himself. This was a breach of his Probation Order. He was arrested and remanded in custody at HMP Bedford. He was brought back to Court. That Court had a further report from Dr Feggetter, again suggesting that they made a probation order with a condition of treatment. But in January 1985 he was sentenced to six months' imprisonment, which he served predominantly at HMP Stafford. Dr Bennett visited him at Stafford Prison and was horrified at his appearance and behaviour. He appeared to be very unwell and to have been picked on and bullied by those around him. We attempted to obtain prison records from both HMP Bedford and HMP Stafford. In each case we were informed that, due to the passing of time, the records had been destroyed.

We observe that at this time Dr Feggetter had not made a positive diagnosis of Schizophrenia. His contemporaneous notes state that:

"The Mental Health Act unfortunately specifically excludes disorders which arise as a consequence of drugs."

Dr Feggetter had diagnosed him at that stage as suffering from a cannabis induced psychosis. He told us that even if there had been a diagnosis of schizophrenia, the treatment would have been the same.

Within a month of his release from prison David Bennett was back in The Gables, a psychiatric ward in Peterborough Hospital. In July 1985 a diagnosis of schizophrenia was made for the first time. There was reference to unprovoked assaults by David Bennett on both staff and patients. Dr Feggetter sought a transfer for him to The Norvic Clinic in Norwich, which was the medium secure unit for the Region. There was no vacancy. On 25 July 1985 he was admitted to St Andrew's Hospital, Northampton, a private hospital with medium secure facilities, under the care of Dr Comish, Consultant Psychiatrist, and the diagnosis of schizophrenia was confirmed.

On 4 October 1985, a vacancy having occurred, he was transferred to The Norvic Clinic. The diagnosis of schizophrenia was confirmed. His mother died in 1985. He had been very close to his mother.

On 31 January 1986 he was transferred from The Norvic Clinic to his home in Peterborough. There he remained for several months. Unfortunately, he then stopped taking his medication and his mental health deteriorated.

On 1 December 1986 David Bennett was re-admitted to St Andrew's Hospital, Northampton under Section 35 of the Mental Health Act 1983. He was then facing minor criminal charges but, as a result of his mental condition, they were not proceeded with. He remained at St Andrew's Hospital, Northampton until 21 January 1987. During this period there were some incidents of violence recorded against him. A full psychological assessment was not considered possible because of his mental state and the limited time available. In January 1987 there was a note indicating that he attended three social skill sessions a week and participated well.

On 21 January 1987 he was transferred back to Peterborough District Hospital. The records show that in the course of two days there he absconded twice and was violent and unmanageable. So on 23 January 1987 he was returned to St Andrew's where he stayed until May 1987.

In March 1987 the comment was made that he "mixes well with other patients, particularly those of the same ethnic group". He was then an inpatient at Peterborough again until he was returned once again to St Andrew's Hospital, Northampton on 18 November 1987. While at Peterborough in 1987 his illness became more severe. There was reference in his medical notes to bizarre speech, threatening karate-like stances, mood swings and episodes of violence. On 9 February 1988 he attacked a female nurse, kicking her in the chest and punching her, causing fractures to her ribs. There were also incidents involving the use of a knife on that day and on 30 March 1988.

In April 1988 Dr Holding, a Consultant Psychiatrist at St Andrew's, referred David Bennett to Rampton Hospital a high security hospital for consideration of admission stating that:

"With each succeeding episode of illness, both symptomatically and behaviourally, he has become more ill".

He was seen by Dr Murphy, a Consultant Psychiatrist at Rampton, who was of the view that he did not require treatment under conditions of maximum security. He made reference to his schizophrenia being exacerbated by his lack of co-operation with his treatment and supervision and, on occasions, by his misuse of cannabis.

A social report prepared on him dated 20 July 1988 specifi-

cally remarks that "Mr Bennett is closer to his sister Joanna who regularly phones the ward and is generally supportive of her brother". At that time, when in the community, he had his own council flat and there was a record that the flat was not suitable. Nor was he able to manage on his own. The report recorded that he was supported by his hospital social worker whilst he was living in the community.

Dealing with this period in his life, Dr Bennett said:

"The scenario is that he would be admitted to The Gables, a psychiatric ward in Peterborough General Hospital. He would be transferred to St Andrew's because of violent behaviour. It was a circle of going into custody, being discharged to The Gables and then being discharged from there and then being readmitted quickly again. In St Andrew's Rocky was just drugged up. I know he was referred to a high security hospital. He told me he was racially abused and that he was taunted and was not prepared to tolerate it. The community care he received primarily consisted of his injections. Nobody seemed concerned about what he did or did not do, or where he was going with his life or whether he wanted a job, or whether he wanted any education or how the family was coping".

On 14 October 1989 he was transferred from St Andrew's Hospital to Peterborough District Hospital and discharged home on 31 December 1990. All this time he was regularly visited by his father and other members of his family.

David Bennett lived in the community until 5 October 1991 when he was arrested for criminal damage. Three months earlier he had defaulted from out-patient treatment and was noted to be using cannabis. In October 1991 he was referred to The Gables. His condition did not improve and on 3 February 1992 he was transferred to The Norvic Clinic under Section 3 of the Mental Health Act 1983. There were records of case conferences during his stay at The Norvic Clinic. In July 1992 his case was considered by a Mental Health Review Tribunal (MHRT) which directed that he should not be discharged from Section 3 of the Mental Health Act 1983 or from The Norvic Clinic. But, his condition improved so in August 1992 he was transferred back to The Gables in Peterborough.

He was discharged from The Gables on 5 October 1992 but unfortunately did not comply with treatment in the community and was readmitted again under Section 3 to The Gables, Peterborough on 20 November 1992. There was police involvement in this admission. He assaulted a staff member and was aggressive.

A referral to The Norvic Clinic was made on 14 December 1992 and he was transferred there on 15 February 1993.

In May 1993 there was a note that there had been considerable improvement in his mental state over the previous three months.

David Bennett wrote a letter to the Head of Nursing Services at The Norvic Clinic in 1993, which indicates his alertness and his concerns. It includes the following:

“As you know, there are over half a dozen black boys in this clinic. I don’t know if you have realised that there are no Africans on your staff at the moment. We feel there should be at least two black persons in the medical or social work staff. For the obvious reasons of security and contentment for all concerned please do your best to remedy this appalling situation”.

He received a reply saying that there had been no application by any black person to join the staff for the previous two and a half years. There was no record of further action.

A MHRT took place on 14 July 1993 and a direction was made that David Bennett should not be discharged from Section 3 or The Norvic Clinic. Thereafter his condition did improve and on 18 January 1994 he was transferred to Peterborough psychiatric services, being admitted to The Gables. On 4 August 1995 he absconded. He then had an altercation with one of his brothers.

On 11 August 1995 he was admitted to Heron Lodge at Hellesdon Hospital near Norwich under the care of Dr Ward, Consultant Forensic Psychiatrist. On 13 September 1995 a further MHRT directed that he should not be discharged from Section 3 or from detention at Heron Lodge. His condition deteriorated and there was a record of him throwing a knife at a member of the nursing staff at Heron Lodge.

He was admitted to The Norvic Clinic on 19 October 1995. The records showed that on admission he was co-operative and not restless or agitated. But he was markedly thought-disordered, and there was loosening of associations and neologisms. He had paranoid ideas and grandiose delusions of ability. He was experiencing auditory hallucinations. He had no insight into his condition.

A note from The Norvic Clinic in January 1996 stated that on 11 December 1995 “David Bennett’s father was diagnosed as having lung cancer”. It continued “Obviously we will attempt to get David to see his father when we can but at the present time with his mental state this would make this very difficult”.

On 22 January 1996 The Norvic Clinic notes showed that David Bennett was subjected to an assault by a fellow patient, who also racially abused him. There was no record of any action being taken as a result of either the assault or the abuse. Initially David Bennett had been a patient in Thorpe Ward at The Norvic Clinic. He was transferred to

Drayton Ward, a less intensive, rehabilitation ward in the same clinic, on 26 January 1996.

On 9 February 1996 there was a violent incident in the course of which members of the nursing staff received minor injuries at the hands of David Bennett. David Bennett was physically restrained. On 12 February 1996 he was transferred back to Thorpe Ward.

On 20 May 1996 the records showed that a second opinion approved doctor (SOAD) approved an increase in depot medication to 1fi times the British National Formulary (BNF) limit, but stated that “as his mental state has been more stable over the last week or two, it was decided to hold back on this increase at this time”.

During the first six months of 1996 he visited his sister Winifred Bennett in Peterborough on occasions. In July 1996 there was a note that he saw his ill father and that his behaviour was appropriate during the visit. On 13 August 1996 his father died. The Norvic Clinic was in touch with his family and after some initial hesitation everybody concerned felt that he should go to the funeral if it were possible. On 21 August 1996 he attended his father’s funeral without incident.

On 11 September 1996 a MHRT decided that David Bennett should not be discharged from The Norvic Clinic or from Section 3. There was an incident on 10 October 1996 when David Bennett became verbally abusive towards a female taxi driver and caused damage to her car. He then assaulted a member of the nursing staff who had come to sort out the problem with the taxi driver.

There is a record that on 28 November 1996 Dr Bennett telephoned Thorpe Ward in response to a conversation she had had with David Bennett, who had complained of being over-medicated. There was also a record that in December 1996 he had a very good visit to his sister Winifred at Peterborough. A further visit later in the same month was equally positive. David Bennett’s reluctance to take medication was the subject of fairly frequent entries in the records. In March 1997 the records indicated that he was continuing to visit his sister Winifred every second or third weekend and that she had a good effect upon him.

On 2 July 1997 a case conference and care plan review meeting was held at The Norvic Clinic. As well as the doctors, the social worker, CPN, physiotherapist, occupational therapist and the primary nurse attended. David Bennett did not wish to attend. It was concluded that David Bennett would not be subject to supervision register but warranted the full tier of the Care Programme Approach (CPA).

In August 1997, while at The Norvic Clinic, David Bennett suffered an episode of bradycardia (slow heart beat) and hypotension (low blood pressure). He was sent to the Norfolk and Norwich Hospital, a general hospital, where an electrocardiogram (ECG) was carried out.

A few days later he was seen by a cardiologist who concluded that he had suffered a vasovagal episode (ie a faint) and did not require further cardiac investigation. On 22 November 1997 a further case conference and care plan review meeting was held with the same people as the earlier meeting already referred to.

The meeting concluded that David Bennett should be subject to supervision register on discharge. He was not a significant risk of suicide but was a significant risk of serious harm to others. He was not a significant risk of severe self-neglect. He was assigned to the full tier of a CPA. It was concluded that he had a long history of severe mental illness, with a history of reluctance to take medication and an absence of insight. Components of the care plan were to involve David Bennett as much as possible in the planning and implementation of his care, to raise the awareness of the importance of medication with him, to educate him about his illness, and to facilitate home visits as frequently as possible.

Dr Feggetter was the consultant psychiatrist who had charge of David Bennett from 1980 to 1990. Dr Feggetter told us that he was reluctant to make a formal diagnosis of schizophrenia because he found that David Bennett did seem to get better reasonably quickly with treatment by anti-psychotic drugs. He described David Bennett as a nice young man who kept his personality and did not lose it as chronic schizophrenic patients tend to do. He had a sense of humour and when he was well he managed well for himself. He was treated with the standard drugs of the 1980s, namely Droperidol and Haloperidol and subsequently Depixol.

Dr Feggetter commented that now there are many more people, both in hospital and in the community, giving support and help to patients with mental health problems than there were in the 1980s and 1990s. He noted that community mental health teams came in in the 1990s. He also told us that black or minority ethnic cultural needs were not addressed particularly in those days, but said that all patients were treated as human beings and as patients with their own needs with no differentiation made for race or gender. He also described David Bennett as a troublesome patient.

On looking at his case, with the benefit of hindsight, he did not consider that it would have made any difference to the management of his illness if he had been diagnosed as suffering from schizophrenia at its outset. He told us that most patients with schizophrenia are now on a single anti-psychotic drug in a way they were not ten years or so ago. Medication, he said, had changed dramatically. This was, he told us, because the Royal College of Psychiatrists (RCPsych) now had anxieties about BNF levels, which did not exist in the 1980s. He further told us that now patients who had a history of drug abuse go off to drug awareness courses, which were not available in those days. Dr Sagovsky arrived at Peterborough District Hospital at the beginning of 1990 as a Consultant Psychiatrist. She

took over the care of David Bennett from Dr Feggetter. She gave details of her work and her involvement with David Bennett. She was also given the task of setting up a rehabilitation service at Peterborough District Hospital. Prior to that date, there had been a three-bedded high dependency unit to which patients could go for short periods.

The new rehabilitation ward was a long stay ward at the hospital. It was replaced in the mid 1990s by a specialist centre, the Lucille Van Geest Centre. This was for 20 beds with day facilities and a community team. There was no security in the Centre. It was purpose-built and had single rooms for each patient. It was excellent accommodation. In those days it was difficult to get people into any NHS secure facilities. She told us that David Bennett was not easy to work with because he did not like authority of any description. If he had a sense that anyone was not treating him as an equal or almost as a friend he would not "take anything from them".

Because of his violence, which the staff often saw as unprovoked, and because he was a very athletic young man, the staff were quite frightened of him. He had charm. He understood that a diagnosis had been made that his psychosis was due to his using cannabis. Sometimes he decided he would not use cannabis any more and then refuse all anti-psychotic medication as he considered it unnecessary. This brought him back to square one. She said that her team tried to get some structure into his life. He stayed on the rehabilitation ward for several months as an informal patient in the early 1990s. She said that at that time things were going quite well with him. He was not using drugs and was beginning to think about doing something with his life. Then there was a short period when he had a relationship with one of the nurses. Dr Sagovsky advised against it feeling that it would not work. It lasted a few months. She was fearful that David Bennett would feel very damaged if the relationship broke down and would revert to the use of cannabis and his mental symptoms would reappear.

This was what happened. On occasions he talked about Rastafarianism.

He was very much a leader.

Other West Indian patients would look up to David Bennett and see him as their "mascot". He was very good at football and used to play the drums. In many ways he was very able. She said that she did not doubt that he had chronic schizophrenia. You did not have to scrape the surface very far to find that his thoughts were quite disordered. She said that when he went to The Norvic Clinic in 1995, she was hopeful that the drug Clozapine would improve his condition. She hoped that he would be well enough to return to the rehabilitation centre and then to go to a supported flat or hostel with a considerable amount of outside support. He always found support quite difficult to take. Nowadays staff were much more skilled at giving support without people feeling patronised. David Bennett was quick to feel

patronised and did not like boundaries. He wanted all his professional contacts to be friends. For example, when he went to see her, he would want to put his arm round her and want to call her Ruth. Staff found his approach to them very difficult as he might be very friendly one day and the next day could be aggressive. She was aware that one of his relatives had mental health problems and was treated with Clozapine and did really well. Dr Sagovsky consequently anticipated that David Bennett would also do well on Clozapine. David Bennett was very conscious of being black. There was no way he could hold a job down. He did not have that level of concentration. "He was a lovely bloke but quite a handful".

Dr Sagovsky told us that, at times, the levels of medication that David Bennett was on were higher than almost any other patient she had known. He was sometimes on as many as three anti-psychotic drugs at one time. He was not given these because he was perceived as being dangerous. He could be very aggressive and impulsive and less predictable than other patients. Sometimes something would get on his nerves and he would just lash out. She said she did not think that being black had anything to do with it, only in as much as David Bennett might have perceived slights more readily.

Dr Sagovsky was concerned about the way informal patients in hospital are funded by state benefits. As they made progress so they were let out from hospital for longer peri-

ods, although they returned at night to the hospital. While being treated in this way they were only entitled to approximately £15 per week by way of State assistance. But effectively they were living in the community and having to pay their way. They did not have enough money to dress properly, or to live a normal life.

As she put it:

"They cannot go out, they cannot enjoy themselves or get a girl or boy friend. To see them go to Oxfam to get their clothes is not funny."

"Time and again these patients, who were getting better but were not yet well enough to leave hospital altogether, decided to leave because this was the only way they could obtain better financial assistance from the State."

She added:

"If only they would stay another six months we would really have them up and running".

In 1997, while at The Norvic Clinic David Bennett had visits to his sister Winifred at monthly intervals throughout the year. He was also in contact from time to time with his sister Dr Joanna Bennett who visited him in July of that year.

HAVING reviewed the history of David Bennett's mental illness and the treatment he received, we comment on its suitability. It is important to remind ourselves that we need to assess this in the light of standards then current in dealing with the onset and treatment of schizophrenia, in young African-Caribbeans.

We are aware that mental health practice has changed significantly in the last twenty years. Broadly, there used to be a greater concentration on hospital-based treatment and the options for treating mentally ill patients were more limited. We note that the first diagnosis of mental illness in David Bennett was of drug-induced psychosis.

There is no indication from the evidence we heard and the notes we have read that there was any real attempt to engage his family in the treatment and management of his illness during this period of 17 years from 1980 to 1998.

There is no indication that his racial, cultural or social needs

were adequately attended to.

The general impression throughout this lengthy period is of a man who was treated at times with consideration by individual nurses, at times with a degree of intolerance and at times as if he were a nuisance who had to be contained.

The notes at St Andrew's, Northampton in the 1980s, particularly give the impression that he was often considered a nuisance and was given heavy doses of anti-psychotic drugs to contain him. No secret was made of his medication. His notes were regularly seen by various psychiatrists at various institutions. But there is no indication that any doctor at any institution commented that the amount of drugs he was getting at that time was unusual or too high.

We should add that we found no evidence that David Bennett suffered from any major physical health problems. On the one occasion when there was a possibility that he had a cardiac problem, it was dealt with quickly and efficiently. He had routine dental care, which caused him no problems.

WE now consider events leading up to David Bennett's death. Dr Stanley started work as a Consultant Psychiatrist at The Norvic Clinic on 5 January 1998 and immediately took over from Dr Ward as David Bennett's Responsible Medical Officer (RMO).

She was responsible for his overall treatment in conjunction with other members of the team, which included his key worker Mr Ncube and his social worker Mr Corbould. She was also in touch with his psychologists, Mr Bailes and Dr Sedgwick. Dr Stanley maintained links with the relevant Peterborough medical, psychiatric and social services. She discussed David Bennett's progress with his Consultant Psychiatrist from Peterborough, Dr Sagovsky, from time to time. He had an individualised care plan. He had the opportunity to listen to music of his choice and to watch television programmes of his choice. He was taken regularly to the Norwich City Football Ground to watch football. She knew that he was a practising Rastafarian. He was given space to put up posters of his choice and to wear clothes pertaining to his faith. He went on community trips with the staff and visited his family regularly.

She did not recall meeting any members of his family before his death. She offered to do so but he did not want her to. He told her that two of his sisters had been in contact with his previous RMO. He received some financial support from his family. She considered that he suffered from hebephrenic schizophrenia. She considered that his symptoms had been best treated when he was on Clozapine. Shortly before she took over his care, his medication had been altered to Risperidone. But, after a few weeks, it was clear to her that his condition was deteriorating. Consequently, in March 1998, he was again placed on Clozapine.

The dosage of Clozapine was gradually increased as his mental state continued to deteriorate. She went on leave in the third week of October 1998, by which time he was on 650mg of Clozapine per day. The maximum BNF dose then was 900mg per day as a long-term option. He required intensive nursing intervention, which could only be offered in conditions of medium security. He was unpredictable. His stay at The Norvic Clinic had been far longer than was initially anticipated. She told us that there was a great deal of input into his care plan. During much of 1998, he was slowly continuing to deteriorate.

The World Football Cup was played in June 1998. With his deep interest in football this unsettled him. There had been a period in early summer 1998 before the World Cup when he had done extremely well but then he had a relapse.

He was better in August and September but there was a setback in early October. In 1998, people used to be on slightly higher doses of Clozapine than one would routinely use now. He had a very positive-symptom illness. Dr Stanley

felt that The Norvic Clinic had picked up good practice from multi-ethnic units. She told us that she had worked in a regional secure unit in Birmingham and that Dr Ball, the Clinical Director had come from Liverpool and that in both places there was a greater ethnic mix than was present in Norwich. The treatment of black patients at The Norvic Clinic was not in any overt way different from the way black people were treated in Birmingham.

By October 1998 the Trust had already started some training to look at issues of diversity and ethnicity because it was aware it had a small minority ethnic population and people needed to have exposure to the issues. Each patient had an individually tailored care plan. David Bennett did not have psychological intervention because the psychologist who was responsible for him, Dr Sedgwick, felt he was not at that time well enough for such intervention and it was therefore not appropriate.

Dr Sedgwick later told us that David Bennett had problems if he was asked to engage in activities where there were a number of people. Initially David Bennett was friendly but after Dr Sedgwick told him that she was a psychologist and suggested that it would be useful to get together and have a talk, he always refused. She had had a one-to-one session with him in April 1996, which was not satisfactory. After that he told her that she was a spy from Peterborough Football Club. He would not approach her any more.

In February 1998, she had a further one-to-one session with David Bennett to consider the use of cognitive behaviour therapy (CBT). But she could not make real progress with him. He had a programme of events.

She said that when people are very ill as he was, they have an awful lot going on inside their heads so there was a limited amount in terms of what they can take in from those around them. He had earlier filled up a self-assessment form in which he said he had no cultural needs. She told us that we had to trust her clinical judgement that he was simply not suitable for one-to-one psychological therapy.

The medical notes for 1998 indicated that some of the time David Bennett was unsettled and some of the time more settled. There were incidents of violence, but only a few. There was considerable discussion about organising the money he received from the DSS. At this time he was getting £12.95 per week from the DSS.

His care plan indicated that he was loaned £20 by the Clinic to help him ration his tobacco, on which he largely spent his money, to ensure that he had a supply throughout the week. This plan worked to a limited extent.

While Dr Stanley was on leave in October 1998, Dr Rudzinski was in charge of David Bennett. She was a Specialist Registrar in Forensic Psychiatry at The Norvic Clinic. She had been there for some years and knew David Bennett.

On 26 October 1998 she increased the dosage of Clozapine to 700 mg. On 27 October 1998, she recommended that he took Sodium Valproate as an anti-epileptic agent. That drug could also be used as a mood stabiliser. Her main reason for introducing it as a prophylactic agent was to prevent epileptic seizures, not as a mood stabiliser.

She said that if she had been prescribing Sodium Valproate primarily for its mood stabilising effect, she would have needed a second opinion. She was aware that Dr Devine, the SOAD, had already consented to his treatment by two anti-psychotic agents, namely Clozapine and Sulpiride. She did not administer Sulpiride under Section 2 Emergency Procedure. She considered there was a legal basis for the administration

of this drug as it was based on clinical need.

On 28 October 1998 David Bennett was receiving 700 mg of Clozapine daily, against a 900 mg BNF maximum and up to 30mg of Haloperidol, against a 200mg BNF maximum, and 200mg of Sulpiride, which is 17% of the BNF maximum. The combined dosage of these anti-psychotic drugs was high. After David Bennett's death this intake of drugs was considered by Professor Forrest, who is a Professor of Toxicological Medicine. A blood sample was taken from David Bennett after death, which was analysed in a laboratory. The drugs in David Bennett's blood were found to be of a concentration which was within therapeutic limits. Professor Forrest agreed with this interpretation of the analysis.

THE Norfolk Mental Health Care NHS Trust (NMHCT) was established in 1993. Prior to that date it had been the Norfolk Mental Health Care Unit. The Trust for its first few years catered for people with mental illness throughout most of Norfolk. In 1997 it took over the provision of services in further parts of Norfolk and also in North West Suffolk. It had always been responsible for The Norvic Clinic.

The Norvic Clinic was built in 1984 as a two-storey building. It is a quite small medium secure unit. For some years prior to 1998 it took patients primarily from the Norfolk, Suffolk and Cambridgeshire Health Authority area. It also took patients with homes in the same catchment area who had been in high security units but no longer needed that degree of security. The role of the Clinic was to provide a medium secure assessment, treatment and rehabilitation service.

As David Bennett's home was in Peterborough, in Cambridgeshire, if he required treatment in a medium secure unit he would go to The Norvic Clinic provided that they had a vacancy. The Norvic Clinic contains 3 wards, with a total of 34 beds. Thorpe Ward contains 8 beds, Drayton Ward 16 beds and Eaton Ward contains 10 beds. All wards were mixed gender. Each patient has their own room. It is common to have three or four patients in the Clinic from the black and ethnic minorities at any one time. Nursing and auxiliary staff are predominantly white. There are usually medical staff from the ethnic minorities, mainly of Asian origin. There is a higher ratio of staff to patients in Thorpe Ward compared to the other two wards. Thorpe Ward is the Admission Ward. Patients are admitted there for assessment and treatment of the acute phase of their mental illness. Sometimes patients are transferred to Thorpe Ward from one of the other two wards. Transfers can last from a few hours to several days or even longer. These patients are transferred to Thorpe Ward in order to treat a deterioration in mental state and disturbed behaviour, with a view to returning them to the original ward as soon as possible.

In 1998 each ward and the reception area had one public telephone for the patients' use. There are alarm systems throughout The Norvic Clinic, which were in working order on 30 October 1998. On the relevant shift on 30 October 1998, the appropriate number of staff with the appropriate skills were on duty in the two wards with which this Inquiry is concerned, namely Drayton Ward and Thorpe Ward.

At the last census in 2001, Norfolk had approximately 2% of black and minority ethnic people. The forensic service of the Norfolk Mental Health Care NHS Trust had 10% of patients in the forensic service from the black or ethnic minority. That is because the forensic service is a regional service and draws its patients from Cambridgeshire as well as from Suffolk and Norfolk.

We were provided with an analysis of patients from black and minority ethnic backgrounds admitted to The Norvic Clinic for the years 1995 to 2002. During those years, a total of 12 known black Caribbean and black "others" were admitted. During the same period, 102 white patients were admitted. This analysis included some 29 patients from a background described as "not known" and 17 described as "blank". This analysis did not indicate the length of period for which these patients were admitted or whether some of them were admitted on more than one occasion. Consequently, it is not possible to say more than 'there were at all times only a few black and minority ethnic patients'. We were unable to discover the number of black patients on any of the three wards at The Norvic Clinic at any one time. But these statistics would not have been very helpful as patients were moved from ward to ward according to their needs.

There has always been black and minority ethnic staff at The Norvic Clinic. We were told that it is not easy to find nurses to work there. Advertisements were made in the usual way and appropriate applicants employed. However, there has been no attempt made to attract applicants specifically from a black or ethnic minority background. We were told that as all staff have to live locally, advertisements for new staff have been aimed at securing applicants locally. All clinical posts are advertised in national professional journals to reach as wide an audience as possible.

In 1998 The Trust had a Medical Director and a Director of Nursing, based at the Headquarters of the Norfolk Mental Health Care NHS Trust, and a Clinical Director based at The Norvic Clinic.

Among those working at the Clinic were:

- (i) 5 consultant psychiatrists, who also had responsibilities in other areas of East Anglia
- (ii) 2 registrars
- (iii) 3 other doctors
- (iv) 2 psychologists

We also enquired into the numbers of nursing staff and security and auxiliary staff and were satisfied that, at all relevant times, the staff levels were maintained. We deal elsewhere in this report with the ethnic mix of staff.

The Clinic has, in addition to the three wards, a gym, small kitchen, workshop, adult education room, patients' library, WRVS shop and a clinical room, and about one-third of an acre of ground surrounded by a security fence.

In 1998 there was resuscitation equipment kept in the clinical room, namely a trolley with one defibrillator, one ambi bag, oxygen cylinder and medication. Each ward's nursing station had a Laerdal Pocket Mask. The clinical room was close to Thorpe Ward.

DAVID Bennett was formally pronounced dead at the Norfolk & Norwich Hospital at 0020 hours on 31 October 1998. But he had actually died some time earlier while at The Norvic Clinic Medium Secure Unit.

We heard from a number of witnesses who could throw light on the events of 30 October 1998. We have read the statements of those witnesses and of others who did not give evidence before us but who either gave evidence or whose statements were read at the Inquest. We have read the full transcript of the proceedings at the Inquest, which took place on six days between 3 May 2001 to 17 May 2001.

A substantial amount of the evidence at the Inquest related to matters that were not in dispute. Unfortunately, we were not able to call as witnesses everyone that we wished to call. Some people could not be traced or failed to respond to our enquiries and a small number declined to attend. We had no power to require witnesses to attend. We regret this as it may be that witnesses whom we wanted to call would have given us a greater insight into exactly what happened. But, nevertheless, as we were able to read the statements made by those whom we could not call as witnesses and as we had a full transcript of the evidence given at the Inquest, we consider it unlikely that, by their absence, facts have not come to light which would materially affect our conclusions and recommendations.

EVENTS OF 30 OCTOBER 1998

David Bennett spent the day on Drayton Ward. His key worker, Mr Ncube was on duty until 2100 hours that evening and saw him periodically during that day.

Mr Ncube's recollection is that on that day both he and David Bennett spoke to David Bennett's sister Winifred on the telephone about a home visit that was in the course of arrangement. Nothing untoward took place during that day nor did David Bennett behave in an unusual or inappropriate way. Mr Ncube went off duty at 2105 hours that evening. Just before leaving he had spoken to David Bennett, who appeared fine. Nothing further of any relevance to this Inquiry took place until about 2200 hours that evening.

At about 2200 hours in Drayton Ward, a patient (DW) was making a telephone call to his mother. There was one telephone in Drayton Ward for patients to use. Occasionally two or more patients wanted to use this telephone at the same time but normally there were no problems. That evening, DW had been on the telephone for about 45 to 60 seconds when David Bennett asked him how long he was going to be. DW described how David Bennett then left and a little later returned. He appeared quite angry and said, "Give me the fucking phone". DW told him to go away and David Bennett grabbed the phone out of DW's hand,

who grabbed it back again. Then David Bennett threw a punch at DW's face; his hand hit the phone which itself hit DW's face. It was quite a hard blow. DW put his hand to his mouth and saw blood on his hand.

DW's mother made a statement in which she confirmed the words used by David Bennett to her son. She also heard a thud and then DW say, "That was my fucking face". As soon as that call had ended, DW's mother telephoned The Norvic Clinic and was told that DW was being examined by a doctor.

Shortly after being hit, DW went to David Bennett's bedroom, kicked on his door and shouted at him. He was extremely offensive and racist in his remarks. The evidence is that he called him "A black bastard" and said, "You niggers are all the same". David Bennett opened his bedroom door suddenly and DW punched him on his chin. This too was quite a hard blow. David Bennett took a step back and said, "Please don't do that".

Nursing Assistant (NA) Bartlett was the first member of staff on the scene. He saw David Bennett come out of his bedroom and he saw the two men start to fight. He saw DW using his fists and David Bennett trying to kick DW in Karate style. He then saw DW hit David Bennett with a powerful punch to his jaw. By this time two other nurses had arrived. They took hold of DW and took him away from David Bennett. DW was still uttering obscenities and racist remarks.

About this time Staff Nurse (SN) Deeks appeared on the scene. One of the nurses suggested that David Bennett went back to his own room. He did so but was clearly very agitated and repeatedly saying that DW had hit him in the mouth. While in his room David Bennett washed his mouth out. It had been bleeding. NA Bartlett asked if he could have a look but David Bennett said no. He then said that nobody cared for him and he had nothing to look forward to. He then referred to DW and said he was "going to fucking kill him". David Bennett then asked NA Bartlett to leave his bedroom, which he did. He was followed by David Bennett who walked towards the area of the ward to which DW had gone saying repeatedly that he was going to kill him. NA Bartlett tried to calm David Bennett down to prevent another incident between the two men. DW was taken to his bedroom by other members of staff to avoid any further confrontation. David Bennett then sat on a chair in the Day Area in Drayton Ward.

SN Deeks came on duty in Drayton Ward at about 2045 hours. Shortly after 2200 hours, he heard loud banging coming from the corridor where the male bedrooms were. He saw NA Bartlett go to investigate. He joined him and saw David Bennett and DW. Both were shouting. DW was being racially offensive. He saw blood coming from DW's mouth. David Bennett was repeatedly saying "I'll have him for this". David Bennett went from his room to the day room

where he was pacing about. He still appeared to be very angry. SN Deeks then saw DW and asked how the incident had started and what had happened. DW told him. SN Deeks then spoke to David Bennett and told him that DW had said that he had hit him. David Bennett just ignored that and said that DW had been hassling him. He was quite agitated.

SN Deeks considered that the two men should be separated because David Bennett was still saying that he was going to have DW. He telephoned Thorpe Ward and asked SN Fixter, the senior nurse on duty on that ward, whether it would be possible for David Bennett to go across to that ward, possibly overnight. SN Deeks considered that David Bennett's mental state was fragile. He did not think it was appropriate to transfer DW to Thorpe Ward because his mental state was not in question. SN Deeks discussed the matter on the telephone with Mrs Chambers (General Manager) who was the nurse on-call that evening. He then gave David Bennett his medication, which he took without any problem. He asked him if he would like some Haloperidol as well, but David Bennett declined it. SN Deeks then arranged his transfer to Thorpe Ward.

That evening, although staff levels were correct in Thorpe Ward, there was only one male nurse on duty there. As a result of this episode, an off duty male nurse, NA Clapham, was contacted. He agreed to come in and assist. SN Deeks then decided to contact SN Hadley who was on duty on Eaton Ward. She knew David Bennett well. SN Hadley and SN Fixter then jointly approached David Bennett. SN Deeks was also present.

David Bennett was told that it might be better if he went across to Thorpe Ward. David Bennett responded well and stood up, but as he walked out of the Ward ahead of the nursing staff he said, "I don't know why it's me that's going". SN Deeks replied, "Well you need to". It was then approximately 2255 hours. SN Deeks said that he intended to talk to DW about the racist abuse but in view of what then happened, as he put it "events took over".

SN Hadley arrived on Drayton Ward shortly after 2230 hours. She made enquiries from SN Deeks about the incident between David Bennett and DW and spoke to a patient who had seen the initial incident when David Bennett struck DW while he was on the telephone. She also talked to DW. She and SN Fixter then approached David Bennett. He did not look relaxed and appeared agitated. In her view there was a need to defuse the situation and move David Bennett from one area to another. They told him that they would like him to come on to Thorpe Ward. David Bennett immediately sat bolt upright and threw his arms in the air and asked if this was official. SN Hadley told him it was. She asked him to put his cigarette out as the Clinic rules did not allow people to smoke in the corridors. She told him that he could light up again once he got to Thorpe Ward. While talking to David Bennett, he said to her "I won't mind a little while on Thorpe Ward". That night Thorpe Ward was quiet.

On arrival he was told that he could smoke and he proceeded to roll a cigarette. He appeared calmer. SN Hadley was told that a decision had been taken that he should stay on Thorpe Ward that night. Having learnt that, she went over to David Bennett. She bent down, putting her hand on his arm and said, "I'm going back to Eaton Ward and I just want to tell you that you are going to stay the night here on Thorpe Ward". David Bennett said, "Yep, yep, OK". Then he said "What about DW?". She said "No he will be staying...". That is as far as she got because David Bennett then punched her on the left side of her face at least three times. The blows were very hard. The first punch knocked her backwards and she tried to block the other punches. She put her arms up to shield her face. SN Hadley considered that in hindsight the trigger factor was probably the fact that DW was staying on Drayton Ward.

She did not remember falling to the ground but remembered being on the ground and being dragged away by another patient. Her vision was blurred as a result of the blow. She felt very hot and very dizzy and was very scared. The next thing she remembered was sitting on the floor in the office. In due course an ambulance crew arrived and took her to the Norfolk & Norwich Hospital for treatment. By the time of the Inquest in May 2001, she had not been able to return to full duties and was still continuing to receive treatment. She had still not fully recovered by the time of our Inquiry.

We are able to pin-point the time of this violent incident between David Bennett and SN Hadley at 2256 hours because the attack alarm was activated on Thorpe Ward almost immediately after it happened.

NA Clapham also saw David Bennett hit SN Hadley. He and SN Fixter immediately attempted to restrain David Bennett. SN Fixter took hold of David Bennett's left arm. He described the violence as "just horrendous". NA Clapham had hold of his right arm and all three went to the floor. During this period David Bennett seized NA Farrow's jumper near her neck and started to twist it, which caused her to gag and say, "He is strangling me". She fell to the floor with the others. NA Clapham used a thumb lock to release David Bennett's hand from NA Farrow's jumper. He recollected trapping David Bennett's left arm between his knees before getting a good hold of it. He was saying, "Calm down" and David Bennett was shouting, "God doesn't love me", "the devil is after me" and "they are trying to kill me". NA Clapham continued to try and calm him down to de-escalate the situation.

SN Fixter recalled that SN Robson and Student Nurse Moore were assisting but could not say precisely where they were as he had his back to them. He thought that they were on David Bennett's legs. About this time SN Fixter saw Mrs Chambers arrive in Thorpe Ward. He asked her to take SN Hadley to hospital. By then an ambulance had arrived for her. Mrs Chambers left with SN Hadley in this ambulance. SN Fixter's recollection was that it was not until they had left that he realised that David Bennett had gone quiet.

After he went quiet, SN Fixter took David Bennett's blood pressure, which was 120/60. He said that it was not possible on that night for a nurse to have hold of David Bennett's head so there was no nurse in that position. He said that that was the correct thing to do in rôle play, but in a live situation, when you were dealing with somebody who was extremely psychotic, it did not work. Even when David Bennett was pinned to the ground, his body was still bucking up and down.

There came a time when SN Fixter instructed all physical restraints to be lifted. He took a wrist pulse, which was very weak. He could not detect a radial pulse. Later he contradicted himself and said that he found no pulse. He turned David Bennett on his right side in the recovery position and cleared his airway. He then decided to attempt cardiac resuscitation. Oxygen was brought in and SN Fixter applied four litres through the facemask. This had no effect. By this time an ambulance had been summoned to take David Bennett to hospital. He had been apparently unconscious for about ten minutes.

The paramedics applied defibrillation devices without success. They used an ambi-bag and SN Fixter did chest compression. David Bennett was placed on a stretcher.

A paramedic told SN Fixter that in his opinion David Bennett was dead. He was taken to the Norfolk & Norwich Hospital accompanied by NA Clapham and SN Evans.

SN Fixter felt that that evening at The Norvic Clinic there was a shortage of staff, a shortage of medical cover and no adequate response team. SN Fixter said that the appropriate number of staff for Thorpe Ward on that night should have been four.

There were, in fact, four nurses on duty on Thorpe Ward at the time of the incident. But he still maintained that he was short staffed that night in terms of patient/staff ratio. He said that he was never able to obtain an approved lock on David Bennett's left arm because he was struggling so violently. He never leant on his chest or his shoulder. He added that as far as he was aware his legs were being pinned by SN Robson and NA Marris. He believed that they were across David Bennett's buttocks, just below his buttocks and his ankles - just securing him to stop movement.

He was unable to say how long it was before David Bennett went to the ground after he had intervened to try and restrain him. SN Robson telephoned at 2255 hours for an ambulance for SN Hadley at SN Fixter's request. His recollection was that he asked her to do this before David Bennett went to the ground. SN Robson thought David Bennett was already on the floor when she made that telephone call. The records show that the ambulance took SN Hadley to hospital at 2325 hours, having been at The Norvic Clinic for some ten minutes, so it arrived at 2315 hours. He said that during that period, David Bennett was

still bucking up and down with his body, but may have been beginning to calm down.

SN Fixter declined to give evidence before us. His account is taken from the evidence given at the Inquest. As there were some differences between the evidence of other witnesses and his evidence given at the Inquest, we regret his decision not to give evidence. There is no doubt that he was the senior nurse involved in the restraint of David Bennett.

Mr Clapham went to The Norvic Clinic in 1992 as a Nursing Assistant, where he remained until after the death of David Bennett. He now works in the private sector but still went to the Clinic from time to time for an individual shift if they were short of staff. He had been trained in control and restraint. He was not trained in the use of defibrillators, but was aware that one was kept at The Norvic Clinic in the medical room, which was close to Thorpe Ward. Nor was he trained in the use of oxygen, but he learnt mouth-to-mouth resuscitation. He organised the patients' workouts in the gym. In addition he played football with the patients. He was very sports minded.

He knew David Bennett well and had a good relationship with him. He helped to raise money to buy pinball football tables for the patients. He said:

"if you are restraining somebody, first and foremost you have to make sure they are comfortable while you are restraining them because it is not a nice thing being held down on the floor."

On that evening, while being restrained, David Bennett was talking to him constantly about football and about anything else that came into his mind. He talked back to him. He said:

"I wanted the boy to be as calm as can be before I am prepared to let him up."

He used to take him to see Winifred in Peterborough regularly. He had played football with him. At one time David Bennett used to play for his team every Sunday. When they went to his sister Winifred's home in Peterborough, they always had a good day. She made them a different dinner each time because she liked her Caribbean food. Sometimes they would go shopping. If she had money she would spend it on David. If they were in the house they would sit with David. Sometimes he would mope around the house. He did a lot of talking to himself. NA Clapham said that when David was well, he was a super lad. When he was ill, he would be looking around the ashtrays for cigarettes and bumming cigarettes off people. He could be nasty and intimidating to other patients.

He said David Bennett never talked to him saying that he was not happy as a black man in a predominantly white environ-

ment. It never came up in conversation with him that he was black or white or whatever. He had never heard any "racist stuff" towards David Bennett in the years he had known him. He said you get a good rapport with patients. He had had training in race awareness. He never had a problem with colour at all. Some of his best friends are black. He never saw David Bennett being treated badly.

It was suggested that David Bennett had complained about being a black man in a white environment and NA Clapham replied that he may have complained to other people but not to him. He said he had come across other members of the family but had never come across Dr Joanna Bennett until the Inquest. He said that he got on really well with Winifred; "she is the sort of person you can talk to all day long if you have got any problems or anything. You need to talk about these things."

In the hours after David Bennett's death, NA Clapham said that the staff did not talk about it. They were not allowed to by the police. He said:

"Regardless of what the boy has done, that's still someone who has died in my arms and that is a hard thing to live with."

He said he had seen David Bennett punch SN Hadley with as hard a punch as he had ever seen. He said the staff then tried to get hold of him. He was still punching out at the time - it was like a big scuffle. He had hold of David Bennett's right arm and SN Fixter was holding his left arm. He lay on the floor by David Bennett's right side, but was not lying on him. He put his right leg across the bottom of his legs as he was still thrashing his legs around. He said David Bennett was a powerful lad. The idea was to try to get him to calm down. Initially he said he could not hold him because he was so powerful. He said the idea was not to keep patients on the floor, but if they were thrashing away and you wanted to keep them calm, that was the only way to do so.

NA Clapham then described how David Bennett went quiet and how his pulse and blood pressure were taken. He described how earlier in the struggle NA Farrow had her jumper taken hold of by David Bennett. He went to hospital with David Bennett and SN Evans. He said that when it came to restraining patients as violent as David Bennett was that night, you could throw the classroom stuff out of the window. The female nurses were on his legs and he was still thrashing them up and down. He said no one was holding his head because his head was in a comfortable position and he was not thrashing his head up and down. NA Clapham said the only reason for someone to hold a patient's head was to give it support and to stop the head butting the floor.

NA Clapham returned to the Clinic from the Norfolk & Norwich Hospital at about 0130 hours to find the police there. They refused to let him go home. They said that if he did not stay

they would "bang him up for the night". They wanted his clothes for forensic testing- he said he felt he was treated like a criminal that night. He said that Mr Shelton (the Chief Executive) came in that night and so did Mrs Chambers the General Manager and Dr Hughes, the Medical Director. He told us that during the incident the seclusion room was not used. He considered that the incident took place about three yards away from the seclusion room.

NA Clapham said that the staff thought they could contain the incident better on the floor where they went down than they could in the seclusion room. He added that you had to remember that there were other patients around so the nurses had to keep an eye on their backs. If they went into the seclusion room there was nobody left to look after the patients in the ward. He said that you had to remember that the only extra nurse on duty that night was himself. If they all went into the seclusion room the ward would be left very vulnerable. He said that in his personal opinion he would not have moved David Bennett from Drayton Ward to Thorpe Ward but it was not his decision. He was only a Nursing Assistant.

We considered the evidence of NA Marris. She saw the injury received by the patient DW. She heard the abusive and racist language. She was present when David Bennett declined to take the Haloperidol that was offered to him.

NA Marris and Student Nurse Moore were on duty in Drayton Ward at the time of the incident between David Bennett and SN Hadley. The alarm given at 2254 hours activated their beepers. They went straight to Thorpe Ward. SN Hadley was on the floor with staff who were struggling with David Bennett. NA Marris lay across David Bennett's legs and secured his ankles. She recollected seeing SN Robson lying across his buttocks. As NA Marris lay down, David Bennett managed to kick her in the ribs. Student Nurse Moore then lay next to her, slightly higher up the legs. David Bennett was shouting:

"They are going to kill me, get them off, they are going to kill me."

SN Fixter was constantly trying to reassure him and trying to get him to calm down. She recollected that at some stage, David Bennett had hold of NA Farrow's jumper. But he eventually let go. There came a time when Student Nurse Moore got up and was replaced by NA Farrow. Eventually David Bennett ceased struggling.

We also considered the evidence of Student Nurse Moore. She had been employed by The Norvic Clinic since January 1995.

She first saw David Bennett in Drayton Ward after his altercation with DW. She sat in the Quiet Room in that ward with DW asking him what had happened and trying to de-escalate the situation. After David Bennett was transferred to Thorpe Ward she remained on Drayton Ward until her

bleeper went at 2254 hours, indicating that there was an emergency on Thorpe Ward. She and NA Marris went there straight away. She saw SN Hadley slumped on the floor and David Bennett being restrained on the floor. NA Clapham had hold of his right arm and NA Farrow his left. David Bennett managed to break free from NA Farrow. He grabbed the back of her jumper and pulled it tight across the front of her neck.

SN Moore thought that it was SN Fixter who broke David Bennett's grip on NA Farrow. She said that SN Fixter then took hold of the left arm of David Bennett as he was struggling violently. Student Nurse Moore was asked to hold his legs. SN Fixter was in charge.

SN Moore described how she was holding David Bennett's knees and leaning across him. By then an ambulance had been called for SN Hadley. On its arrival, NA Farrow took over from Student Nurse Moore. She remembered that Mrs Chambers, the General Manager, came to Thorpe Ward about the same time as the ambulance. When she released David Bennett, he was still struggling and shouting out. SN Fixter was talking to him. She left in order to fetch SN Hadley's personal possessions from Eaton Ward. She was away about five to ten minutes. When she returned to Thorpe Ward, David Bennett was still being restrained by SN Fixter, NA Clapham, NA Farrow and NA Marris. There came a stage after that when David Bennett calmed down. SN Fixter and NA Clapham were talking to him once he had calmed down, and then rolled him over. She then saw that he was incontinent of urine. SN Fixter checked his pulse and then Student Nurse Moore checked it. She could feel a faint pulse in both his wrist and neck. SN Fixter then checked his blood pressure and he was put into a recovery position.

SN Robson fetched an oxygen cylinder and oxygen was administered to him. It was then realised he was not breathing and SN Fixter and SN Evans administered Cardio-Pulmonary Resuscitation (CPR). Then the ambulance crew arrived and took over. The paramedics used a defibrillator, placing a tube in his throat and using an air bag.

Then they put him on a trolley and took him away. She added that when NA Marris was holding David Bennett's ankles she was not putting her full body weight across them. Student Nurse Moore was holding his knees. She could not remember precisely where SN Robson was but thought that she was next to her, higher up his body. They had not been taught to restrain a patient by having two or three persons on their legs, but were in a situation where one person could not adequately restrain David Bennett from using his legs.

Further evidence was given by NA Farrow. NA Farrow saw David Bennett hit SN Hadley. NA Clapham and NA Farrow went across to David Bennett. NA Clapham took his right arm and she took his left arm for the safety of patients and

other members of staff. NA Farrow tried to put a lock on his left wrist but he flung his arm backwards a couple of times and slipped away from her. Then David Bennett grabbed the back of her jumper. It was a double crew-neck jumper. She had her back to him in case he punched her in the face. He twisted the back of her jumper, tightening the neck at the front. It was choking her. She put both her hands up and used all her strength to pull the jumper away from her neck. David Bennett finally released his grip. She then left the immediate area to look after SN Hadley. A little later she returned to the Day Area in Thorpe Ward. On her return, David Bennett was lying face down on the floor. NA Clapham still had hold of his right arm and SN Fixter his left arm. SN Fixter was lying beside David Bennett on his left side. Student Nurse Moore was lying above the upper part of his knees. NA Marris was lying at his feet. David Bennett was not struggling much. At one stage she heard David Bennett say to NA Clapham "Brian, let's talk about football".

NA Farrow moved some of the furniture away from the group in case David Bennett renewed his violence. There came a time when she took over from Student Nurse Moore. She lay across David Bennett but with her weight on her elbows. He was calm at that time. While there, she remembered SN Fixter saying "Rocky" and getting no response. Then SN Fixter ordered everyone to get off him. He checked David Bennett's eyelids and pulse. She never heard SN Fixter giving any instructions to anybody about the holds they should be using until he asked them all to release their holds at the end. SN Fixter did not tell people what to do to restrain David Bennett but he was asking people not involved in the restraint to do things while David Bennett was on the floor.

Mr Holdsworth was an ambulance paramedic. He and his wife, another paramedic, went to The Norvic Clinic as a result of an emergency message that a female member of staff had been assaulted. We took his evidence from his written statement. He stated that, as they entered Thorpe Ward, he noticed a person lying on the floor, face down. He took a look for a few seconds. He could see four people attending to the person, two females lying on their fronts over the person's legs, one male lying over the person's upper torso with his body on the far side of the person and with his face looking towards him and a fourth person, a male, who was by the person's head, but was unable to say in what position except that he seemed to be leant over. He said that as he walked by the group, everything seemed calm. The person on the floor did not appear to be struggling. He recalls one of the males saying; "Are you all right?". He and his wife then attended the member of staff who had been injured. She was placed on a trolley. He said that as they wheeled the trolley out of the ward he noticed that the man was still lying in the same position as before and all was still quiet.

Mrs Holdsworth's evidence was that she too went to The Norvic Clinic. She was the driver; her husband acting as

the attendant. On arrival they were told that a nurse (SN Hadley) had been assaulted. They went to Thorpe Ward. Mrs Holdsworth saw a man being restrained by four or five people. She could see two females lying face down over the person's legs, and one male lying over the person's upper torso with his body on the far side of the person. A fourth person, a male, was by the person's head. Everything seemed calm. She recalled one of the males saying; "Are you all right?". She then turned to deal with SN Hadley. She said she had no further recollection of the events concerning the man who was being restrained. She said that as they came into the ward they just looked at the man on the floor and carried on.

Mrs Chambers was the General Manager of The Norvic Clinic in October 1998. She still is. She had the responsibility for the management and coordination of the nursing and administrative staff there. On the evening of 30 October 1998 she was at home but on call. At approximately 2215 hours she received a telephone call and was informed that there had been an incident involving David Bennett and the patient DW. She spoke to SN Deeks. About 2241 hours she spoke to SN Fixter. He told her that a decision had been made to manage David Bennett by moving him to Thorpe Ward. The various alternatives were discussed and she was satisfied that the appropriate clinical decision had been made. She did not recall being told about racist abuse at that stage. At approximately 2305 hours she received a telephone call from NA Farrow informing her that there had been a further incident in which a member of staff had been hurt. Mrs Chambers immediately went to the Clinic and arrived at approximately 2315 hours.

On arrival at the Clinic she saw an ambulance in the driveway. The ambulance crew went inside the Clinic. They all went directly to Thorpe Ward. SN Fixter indicated to her where SN Hadley was and told her that she was going to hospital. Mrs Chambers went with SN Hadley leaving at approximately 2327 hours. But before leaving Thorpe Ward she was concerned about David Bennett. She looked across to where he was to check what was happening. She did not get close to him as instructions were clear that it was undesirable to have an audience near any violent incident so as to allow the staff who were involved in the situation to get on with their job. People stayed away unless they had been asked to help. When she saw David Bennett he was not struggling but motionless. The nurses were talking to him. She saw SN Fixter by David Bennett's head, holding one of his arms. She said she did not pay particular attention to the incident because everything seemed to be under control. She would not have gone to the hospital with SN Hadley if she had not thought everything was under control.

She was still at the hospital when David Bennett was brought there and she saw him. She could not understand what had happened at The Norvic Clinic. She was very upset. She went back to the Clinic and remained on duty all night. Mr Evans was a Staff Nurse at The Norvic Clinic. On 30

October 1998 he had a day off. He received a telephone call from NA Farrow at about 2255 hours asking if he could come in to the Clinic. He agreed and arrived about 2330-35 hours. He went to Thorpe Ward to the corner where David Bennett was. He saw NA Clapham kneeling on his left and SN Fixter on his right side.

His recollection was that NA Marris was at his feet, Student Nurse Moore was standing at his feet and SN Robson and NA Farrow were standing at the back of his head. He was not being restrained. SN Fixter informed him that there had been a violent struggle and that it had taken them a long long time to restrain David Bennett. When he arrived David Bennett was lying on his back, with a folded blanket and a pillow to support the back of his head. He checked David Bennett's radial pulse and put his hand to his mouth to see if he was breathing and there appeared to be no vital signs. A decision was taken to do CPR.

A patient in Thorpe Ward who was identified to us only by his initials (DS) to protect his privacy gave evidence at the Inquest. He did not give evidence to our Inquiry but we have considered the oral evidence he gave at the Inquest. He saw David Bennett come into Thorpe Ward and sit down with his back to the TV and a little later punch SN Hadley. He said that he did not get on with SN Fixter. "They had their ups and downs" was how he put it. He remembered David Bennett being "sort of struggled on to the floor" and restrained by his throat. Pressure was being put on his throat. David Bennett said:

"Get off me, get off me, I can't breathe. Get off my throat."

SN Fixter had his hand round his throat. He was not putting pressure on any other part of his body. He was categorical that David Bennett was lying on the floor on his back. He said that in 1998 he did not tell any of the staff that he had seen SN Fixter hold David Bennett by the throat because he thought that if he did they would send him to a special hospital. He said that he first mentioned this officially in January 2001. He did not do so before that as he did not think anyone would believe him. In that statement, which was made 27 months after the incident, he also said that SN Evans and SN Fixter were the nurses there at the time. He added that he could not remember if SN Fixter put one or both hands on David Bennett's throat.

Dr Ball was then interposed to give evidence about DS's mental health in October 1998. Dr Ball said DS was very ill in October 1998. He had paranoid thinking and his behaviour was very disturbed. He was a very irritable patient who was very difficult to interview. In November 1998 he went to court, received a hospital order and a restriction order. He had been transferred to The Norvic Clinic from prison in September 1998.

A further patient GC was also called as a witness at the Inquest but not at our Inquiry. His evidence disclosed that

he had been in The Norvic Clinic since about September 1998. At about 2200 hours on 30 October he was sitting in Thorpe Ward when David Bennett came in. He said:

"I saw him hit Sharon Hadley. The nurses got him to the floor."

He said that David Bennett was laid on his back; his arms were being pinned "just restraining him". He then went to his room. He said that the period between the staff rushing forward and David Bennett being on the ground was about two or three minutes. In his statement he described David Bennett as having been lying face down. At the Inquest he said that he was sure he was lying on his back. The day after the incident he remembers DS telling him that he had seen SN Fixter lying with his hands round David Bennett's throat.

A third patient's (GH) statement was read at the Inquest. We considered that statement. The relevant extract states:

"One of the nurses from another ward came over and spoke to Rocky (David Bennett). Rocky jumped up and hit her in the jaw; the force of the blow threw the nurse up against the radiator. Both I and another patient tried to help the nurse. Several nurses came into the room. Bruce Fixter told us all to go to bed. Bruce (Fixter) and two lady nurses held Rocky (DB) on the floor. Bruce (Fixter) was lying across Rocky's (DB's) legs. Rocky (DB) was rolling around the floor struggling, trying to get away and saying 'they are trying to kill me'. I did not see anything wrong with the way the nurses were dealing with Rocky (DB)".

EMERGENCY PROCEDURES

Once it was appreciated that David Bennett had collapsed and was not responding by word of mouth or by actions, SN

Fixter took his blood pressure. The reading was within normal limits, namely 120/60. He then took his wrist pulse. It was not clear from his evidence whether he obtained a weak pulse, or no pulse at all as he said both. He told SN Evans, who arrived at about 2334 hours that he did not believe David Bennett had a pulse. He turned David Bennett into the recovery position. He examined his airways and made sure they were clear.

David Bennett was then laid on his back with his head supported by a rolled up blanket. SN Fixter shone a torch into his eyes, but could see no reaction. At some stage NA Marris said that she thought David Bennett had stopped breathing.

During this period other nurses said that they had found a pulse. A joint decision was made to conduct Cardio-Pulmonary Resuscitation (CPR). SN Fixter carried out mouth-to-mouth resuscitation while SN Evans compressed the chest at a 5-1 ratio. They observed some slight signs that he was breathing. SN Evans instructed SN Robson to bring an oxygen cylinder, which was in the Clinic but not in the ward. Four litres of oxygen were applied through the facemask, but with no result. By this time some ten minutes had elapsed since the staff were first seriously worried about David Bennett. At an early stage of that period an ambulance had been summoned. During this period it was noted that David Bennett was incontinent of urine.

The ambulance arrived at 2345 hours. The ambulance paramedics were told that David Bennett had been unconscious for some time and that CPR had been carried out. The paramedics applied a defibrillator to David Bennett's chest. They operated it for about five minutes but with no result. An Ambi bag was then used but with no success. Mr Rogers, one of the ambulance paramedics, formed the view that "he was dead". He noticed a stiffness in his arms, suggestive of rigor mortis. David Bennett was taken to the Norfolk and Norwich Hospital, where he was examined and formally pronounced dead at 0020 hours. But the evidence is conclusive that he had died whilst still at The Norvic Clinic.

HAVING set out the facts as described by the witnesses in evidence of the events of the final hours of David Bennett's life, we now turn to consider a number of individual issues raised in evidence.

RACISM AT THE NORVIC CLINIC

We consider the question of racism to be very important.

At the time of David Bennett's death and to the present day, The Norvic Clinic is the only unit providing medium secure security for mentally ill patients for Cambridgeshire, Norfolk and Suffolk. It is situated in Norwich.

The local nursing staff are usually recruited locally and are predominantly white. The vast majority of the patients are also white. The Panel questioned the relevant witnesses who were called before them in Part 1 of this Inquiry about racial issues at The Norvic Clinic. We find that prior to 1998 there was no specific directive set out by either the Norfolk Mental Health Care NHS Trust or the relevant Health Authority to assess people's ethnic or cultural needs. There does, however, seem to have been some limited awareness from all who worked in the Clinic that people from the ethnic minorities might need special consideration. But the approach differed from staff member to staff member.

We came across no instance of any member of staff being deliberately racist. We found no instances of racist abuse directed at David Bennett by any member of staff. There were instances of racist abuse directed at David Bennett by other patients. We have to some extent dealt with these earlier in this Report. As there was no firm practice for nurses or other members of staff to write down every incident of racist abuse, we have concluded that there were very likely to have been other instances of racist abuse against David Bennett by patients which had not been recorded.

The evidence we have heard, together with our own experience, leads us to the conclusion that racist abuse is highly insidious. Where there is racist abuse it inevitably has an effect upon its victim. The victim is bound to feel acutely sensitive and frequently has the desire to retaliate, particularly if their perception is that no action may be taken to prevent racist abuse. Where victims are mentally ill and subjected to racist abuse they will have greater difficulty in dealing with it.

Further, if a patient's cultural, social and religious needs are not scrupulously considered, these will inevitably affect his reactions and may exacerbate his symptoms. It is essential that every patient is treated according to his needs. Dr Joanna Bennett has told us that:

"When you are mentally ill and isolated from your family in a predominantly white area, when you feel oppressed and are experiencing racial abuse, you think that you are a lesser being".

She also told us that her brother had informed her that it was not unusual for him to be racially abused and physically attacked by other patients.

We now turn to consider another aspect of racism.

Dr Shetty, a consultant psychiatrist at The Norvic Clinic said:

"There is a risk that, in places like Norwich, people may never develop the awareness and skills to deal with black people because there are so few of them".

Dr Solomka, a consultant psychiatrist at The Norvic Clinic who carried out an internal inquiry into the death of David Bennett, told the Panel that his Inquiry could not find the perception of racism at The Norvic Clinic. He heard no comments about race of a derogatory nature, nor did he ever hear racist jokes. He read through his records and noted that David Bennett's religious beliefs were never discussed. He could not say whether that was because David Bennett was not particularly interested or if it was for some other reason. He could find no pattern of racist abuse by one patient to another and save for one instance of a member of staff making a joke of a racist nature to an Asian patient, he could find no instance of any inappropriate racist behaviour by members of staff. But he added that there were very limited facilities for black and minority ethnic groups in the Norwich area, particularly for African-Caribbeans. There were no clubs for black people in Norwich. There were no advocacy groups and there were no recreational activities specifically provided for black people.

Miss Kant, who took over the Chair of the Trust after the death of David Bennett, told us that she had found a measure of complacency about culture in Norfolk - the pace of life was quieter. She genuinely believed from everything she had read and heard that David Bennett's carers at the hospital cared for him in a very affectionate and deep-rooted way. She told us that people whose lives are based in an institution do build a very close and developed relationship with their carers. The nurses often funded David Bennett. They looked after him in quite an intimate way. They looked after his clothes and purchased things for him. She said that there was a real difference between unconscious misunderstanding and deliberate racism.

Dr Stanley was aware that David Bennett was a practising Rastafarian. She observed that he was given space to put

up posters of his choice relating to that faith and to wear clothes pertaining to it. He played the drums. She considered that the treatment of black patients at The Norvic Clinic was in no overt way different from the way black people were treated when she had been in practice in Birmingham. She never discussed the issue of race with David Bennett because she felt it never posed itself as an issue. She asked him if there was any aspect of care about which he thought The Norvic Clinic was not doing enough. He made no criticisms. She was not aware of the letter, to which we have already referred in the section of this report "the History of David Bennett" that he and another patient had written in 1993 during an earlier stay at The Norvic Clinic.

Nor was she aware that a reply had been written explaining that there were no Africans on the staff because for the past two and a half years there had been no application from a black person to join the staff. The Inquiry heard no evidence that there was ever an attempt actively to recruit black or minority ethnic staff at the Clinic. Dr Stanley told us that David Bennett did not wear dreadlocks during the time she looked after him. She had considered whether his spiritual needs were being looked after but, having thought carefully about it, did not think it was an issue for David Bennett. She did not ever see that the fact that he was either the only black man, or possibly one of two or three in the ward, might have had an effect on his mood and aggression. She considered that when on the final night of his life David Bennett was racially abused by the other patient, that issue should have been dealt with at the time.

Having considered Dr Stanley's evidence on this topic, we observe that while she did enquire to some extent about his ethnic, cultural and spiritual needs, we regret that neither she nor her clinical team pursued the matter in greater depth with David Bennett. We are confident that in the climate that prevails today it would have been incumbent for this to have happened, bearing in mind that David Bennett was for much of the time the only African-Caribbean in his ward at the Clinic and would inevitably have felt safer and more contented if his needs had been more fully attended to.

We turn to the evidence of David Bennett's key worker, Mr Ncube, a black Zimbabwean. He was a highly motivated and competent nurse. He said that the people he worked with at The Norvic Clinic were nice people and he developed good relationships with them. He felt that all the patients were treated the same at the Clinic.

During his time at work at The Norvic Clinic, which was over five years, he had never met anybody who was racist. He considered that The Norvic Clinic went out of its way to make sure that David Bennett's cultural needs were met. He told us that the Clinic obtained the African-Caribbean newspaper "The Voice" from London for David Bennett, as it did not circulate in the Norwich area. He pointed out that in respect of another patient who was a Muslim, halal

meals were brought in for him. He personally had brought David Bennett some Bob Marley CDs. Mr Ncube told us that he was a Rastafarian and so were most of his friends. He said that David Bennett was aware that he was a Rastafarian. He said David Bennett used to talk to him about smoking Cannabis but not about Rastafarianism. He told us that it was difficult to recruit black and minority ethnic nurses in the Norwich area. He had tried, without success, to persuade some friends of his own background to work at the Clinic. He knew that efforts were made now to try and get recruits from the ethnic minorities from other areas. Recently there had been an attempt to recruit nurses direct from Ghana. He had never experienced racism from members of staff in the Clinic but sometimes had from patients.

While dealing with the evidence of David Bennett's key worker, it is appropriate to state specifically that we examined with care David Bennett's care plan, which fully conformed with prevailing standards. We were satisfied that it was properly monitored by his key worker in conjunction with other members of staff at The Norvic Clinic.

Certain of the other nurses at The Norvic Clinic commented on racism. They told us that it was difficult to control racist abuse from one patient to another because of the mental fragility of the patients. We heard no evidence of racist abuse from members of staff at the Clinic. NA Bartlett told us that he remembered David Bennett once saying to him something like "Don't you know I am black. Why do you treat me like everybody else?". He replied, "Well you are no different to everybody. I do not see you as different from anybody else". He further told us that if one patient racially abused another patient, the staff would need to get both sides and speak to both patients and deal with the situation. SN Robson said:

"There has never been any indication of racism at all in all the time I have worked at the Clinic. That made me cross, to think that would be insinuated - that it was racially motivated in any way."

Having seen a number of the members of staff and considered their evidence in relation to this issue with the greatest care, we do not find any evidence of deliberate racism in The Norvic Clinic. Nor can we find any instance of deliberate racism in respect of David Bennett's earlier treatment at other mental health institutions. But there certainly was insufficient attention paid to his cultural, social and religious needs. Individually, the nurses impressed us as being kind, considerate and helpful, and often generous with their time and money in looking after David Bennett. We also find that not enough effort was made to recruit black and minority ethnic staff at The Norvic Clinic.

We deal with the question of institutional racism in Part 2 of this Inquiry. We stress that although David Bennett was treated kindly, we are satisfied that his cultural needs in

particular were not fully met. We broadly accept Dr Bennett's criticisms in relation to race and treatment of his cultural needs while at The Norvic Clinic and at other mental health institutions where her brother was treated. But it is appropriate to state here that, after hearing the evidence in Part 1 of this Inquiry, we concluded that there was evidence of incidents of institutional racism from time to time through the lengthy period that David Bennett was suffering from mental health problems. We have not isolated these incidents as they are contained in the detailed recital of the facts. They indicate that institutional racism has been present in the mental health services, both NHS and private, for many years.

THE DECISION TO MOVE DAVID BENNETT TO THORPE WARD

We do not consider that the decision to move David Bennett from Drayton Ward to Thorpe Ward was handled with sufficient care and sensitivity. We accept that David Bennett acted inappropriately in trying to persuade the patient DW to let him use the telephone and was at fault in punching him when he refused to do so. But the reaction of DW by using violence accompanied by repeated racist abuse inevitably left David Bennett feeling that he was the injured party.

The failure by staff to take up the issue of racist abuse before either patient was removed from Drayton Ward was regrettable. Nurses had the opportunity to talk to both patients at that stage. When the decision was made to move David Bennett to Thorpe Ward, David Bennett by his words and actions showed that he considered that it was taken because he was a black man and DW was white. No attempt was made to explain to David Bennett that this was not the case.

We have formed the strong and disturbing view that the issue of race was not taken into account when this decision was taken to move David Bennett to Thorpe Ward.

We are satisfied that this was not just an isolated occasion on which racist abuse had been directed at David Bennett. It, therefore, needed to be considered in the context of earlier instances of racist abuse. But this was not the way the staff approached this matter.

Once David Bennett had been taken to Thorpe Ward, we consider that the further decision that he was to remain there overnight was taken without consideration of these factors. The possibility of moving David Bennett to Thorpe Ward should have been discussed with him carefully and gently before a final decision was made. He should not have been presented with the decision already made. When he arrived in Thorpe Ward the evidence indicates that he had calmed down further and was capable of having a rational conversation.

Some witnesses have told us that, with the benefit of hind-

sight, their view is that David Bennett should never have been transferred to Thorpe Ward. We recognise that when a situation of violence occurs, it is difficult for the staff to deal with. Immediate decisions have to be made and it is possible to get them wrong. But we have formed the strong impression that on that evening David Bennett was not treated by the nurses as if he were capable of being talked to like a rational human being, but was treated as if he was "a lesser being" to use Dr Bennett's phrase, who should be ordered about and not be given a chance to put his own views about the situation before a decision was made.

MEDICATION

The importance of the BNF recommended maximum dose limit is that, on the basis of scientific clinical research, there is established what are believed to be effective dose ranges for each medication. The pharmaceutical company manufacturing the drug has a product licence issued by the Medicines Control Agency. The accompanying data sheet, which is summarised in the BNF, indicates the normal maximum dose, this being based on toxicological and response data.

It is by no means unheard of for medical practitioners to prescribe doses greater than these recommended limits. In some intractably ill or treatment-resistant patients supra-maximal doses are sometimes used. They nevertheless carry increased risks, and the potential benefits must be carefully weighed against these risks. If more than one drug is being prescribed from the same broad class of substances, good practice recognises the importance of considering the effect of additive doses.

The practitioner may fully intend to use one or other compound to the top limit of its recommended dose range, but care should be taken not unintentionally to exceed aggregate maximum doses by, for example, giving three quarters maximum dose of one drug together with three quarters maximum dose of another, thus resulting in an equivalence of one and one half times the maximum dose.

In March 1998 the SOAD concluded that David Bennett was not capable of giving consent to treatment as he did not have the appropriate mental capacity. This remained the situation up to the time of his death. It is relatively unusual to change the doses of drugs and add multiple additional drugs in close temporal relation to each other, this is so because any resultant effect would be difficult to attribute to any one particular compound.

The SOAD, by 28 October, had authorised two anti-psychotics. But at the time of his death, David Bennett was receiving three anti-psychotics. These were daily doses of Clozapine 900mgs, Haloperidol 40mgs and Solpiride 200mgs. In addition to this, he was also receiving Sodium Valproate which can be used as an anti-epileptic and/or mood stabilising drug. It was given to David Bennett as an anti-epileptic because of the high dosage of Clozapine that

he was receiving. Sodium Valproate was never approved for use by the SOAD. The Mental Health Act 1983 has a provision for administering treatment which is urgently necessary without the necessity of waiting for the logistics of arranging for a second opinion doctor to attend. The documentation in the case of David Bennett makes no reference to emergency treatment on the relevant day. It is clear that at the time of his death David Bennett was receiving three anti-psychotic drugs daily when only two anti-psychotic drugs were authorised by the SOAD.

The conclusion is that at the time of David Bennett's death he was being prescribed a number of different medicines, although not all covered within the provisions of Part IV of the Mental Health Act 1983. But it is unlikely that the type, dosage and the combination had any significant influence on his death.

Some of the above comments were contained in a statement made by Dr Wood, a Consultant Forensic Psychiatrist, whose opinion was sought by the Norfolk Constabulary. We have incorporated his views at some length because the question of medication is a complicated one. Dr Wood further considered the available records of David Bennett's medication over a number of years. There was no indication that there had been medication on earlier occasions which was not covered within the provisions of Part IV of the Mental Health Act 1983.

The combination of drugs issued to David Bennett on 28 October appears to have been an isolated phenomenon. We have already stated that the pathologist did not consider that the combination of drugs David Bennett received during the days leading up to his death in any way contributed to his death. We are, nevertheless, troubled by the combination of drugs prescribed on 28 October because it was bad practice and consider that systems should be in place to ensure compliance with the Mental Health Act 1983 and the authorisations of the SOAD.

CONTROL AND RESTRAINT

We approached the question of the length of David Bennett's restraint with particular caution because the evidence was confused.

Fortunately, some of the timings are recorded. We also know that all the clocks at The Norvic Clinic were two minutes slow. We have used adjusted times throughout. The attack alarm was activated on Thorpe Ward at 2256 hours shortly after David Bennett hit SN Hadley. Consequently, the attempt to restrain him started after that, but obviously took a little time.

We know that at 2259 hours SN Robson telephoned for an ambulance to take SN Hadley to the Norfolk and Norwich Hospital. The evidence indicates that by then David Bennett was being restrained on the floor. That ambulance arrived at 2317 hours.

The ambulance left with SN Hadley at 2327 hours. The ambulance crew would have taken time after leaving Thorpe Ward to have secured SN Hadley in the ambulance, so we assume that they left Thorpe Ward at about 2325 hours. A call for an ambulance for David Bennett was at 2328 hours. This was after the nurses who were involved in the restraint had attempted to find his pulse and to take a reading of his blood pressure.

It therefore seems that the period of restraint during which David Bennett was held face down on the floor lasted about 25 minutes, namely from about 2258 hours to about 2325 hours.

For the period that David Bennett was being restrained on the ground after his initial attack on SN Hadley until the telephone call made by SN Robson at 2259 hours, there were five people involved in restraining him and no one at his head. We know that SN Robson left his side to make the telephone call at 2259 hours. After that there were four people involved in his restraint for most of the time. We know that SN Fixter spoke to Dr Shetty at about 2315 hours.

We turn to consider the instructions that the nursing staff of The Norvic Clinic were given about the restraint of patients who became violent. It is important to bear in mind that we are not considering here what instructions they should have had.

First we refer to the evidence of two experts, Dr Cary and Dr Lipsedge. Dr Cary, a Consultant Forensic Pathologist who carried out a post mortem on David Bennett at the request of the Bennett family said:

"Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when they are restrained for long periods. And that I think is a matter of fact. There is some debate however, as regards what sort of mechanisms may be involved in causing those deaths. But we do know that the deaths occur, firstly when people have been restrained in the prone position in particular. And just to clarify that, that means that they are face downwards, lying down. And secondly, that the deaths seem to occur when the restraint and the struggling against the restraint goes on for a long period and those, as I say, are two quite well established facts."

He said that there was a recognised risk that with patients in a medium secure unit like The Norvic Clinic there will from time to time be violent confrontational situations in which restraint is necessary.

Dr Lipsedge, a Consultant Psychiatrist, was asked by the Bennett family's solicitors to consider expert's reports from witnesses, including Dr Cary, who were called at the Inquest. He said:

"I should mention, and this has not been mentioned in my hearing today, that trying to subdue a violently struggling patient is not only a dreadful experience for the patient, but it is also dreadful for the staff, for the nurses, as you can imagine, and for the doctors. And the longer it goes on the worse the ordeal is, in terms of psychological (stress) to the whole team, and to the patient and indeed to the relatives and to the other patients, and everybody who might witness it. So there are very good reasons, if you like, non medical reasons, reasons to do with the humane approach to patients, to try and get to limit the period of restraint as much as possible."

The actual trainer, Mr Loudon, was a Charge Nurse (CN) at the Norvic Clinic. He had been a qualified instructor in Control and Restraint, now named Prevention and Management of Aggression (PMA) (including physical intervention training) for a considerable period. He not only trained nurses but also trained other trainers. CN Loudon attended a three-day course annually in Norfolk and a five-day national course each year. Each nurse whom he taught attended a course for seven days in PMA. Thereafter, each nurse was required to attend an annual two-day refresher course.

All the nurses involved in the restraint of David Bennett had attended both the initial course and at least one refresher course. CN Loudon described how in those courses he taught nurses about team work and how to look out for signs and symptoms of any distress on the part of the patient in the technical sense like breathing and colour of skin. He taught that it was necessary to ensure that neck holds were not used, in order to prevent the obstruction of airways. He was not aware of the term "positional asphyxia" prior to David Bennett's death.

Mr Loudon taught techniques of de-escalation in order to reduce the need for physical restraint. He emphasised the necessity of avoiding pressure on the chest areas and on the need to try and get the person upright as quickly as is safely possible, provided that it was compatible with the circumstances of the individual incident. He taught people not to pin the abdomen or the buttocks but to maintain leg safety just above the knees. He said that team work consisted essentially of three members of staff, sometimes four if the legs need to be controlled, with two members of staff immobilising the arms and one member of staff making sure that the head and neck were being kept safe and the fourth controlling the legs.

One member of the staff always had special responsibility for the head. His was the No 1 role. He described this a difficult role because the No 1 would be communicating with the patient as well as with the staff and trying to organise things. He said that it had happened that there had to be more than four people involved where the patient's legs had been very strong and giving particular problems. He considered that it might need more than one person on the legs in a face down position. It would be unacceptable to have three members of staff lying over a patient's legs and lying on top of them with their body weight at the same time. He told us that there was a seclusion room in Thorpe Ward, about six paces away from where the incident took place. The staff had to decide whether or not to take a patient into a seclusion room depending on the level of the struggle. If they felt that even that short walk was going to be dangerous for all concerned the decision should be made to take the person to the floor.

We accept the accounts given by the nursing staff of the events of this evening as broadly accurate. We find, however, that there were errors and misjudgements on their part from the onset of this incident between David Bennett and patient DW.

We have already said that staff on Drayton Ward should have confronted the patient DW about his behaviour, particularly his racist abuse to David Bennett, before any decision was taken to move David Bennett to another ward. Similarly, David Bennett should have been told that the use of racist abuse was totally unacceptable and that DW had been told so. At the same time he could also have been told that he should not have punched DW while he was using the telephone. All these actions would have helped de-escalate the incident and might have prevented David Bennett from becoming aggressive.

But we conclude that the staff did not appreciate the need to speak to either patient in order to attempt to de-escalate the incident. They also did not appreciate the importance of doing this because they were unaware of the corrosive and cumulative effect of racist abuse upon a black patient. As it was, when the decision to remove David Bennett was taken, it was bound to have left him with the overwhelming feeling that he had been wrongly criticised and wrongly removed from Drayton Ward. By that time, he had not only thrown a blow himself but had been severely punched by DW and been repeatedly insulted by the use of racist abuse. The nursing staff should have seen this as wholly intolerable behaviour by DW. We are not in a position to dispute that it may have been a proper clinical decision to remove David Bennett to Thorpe Ward rather than the patient DW.

Some nurses expressed the view that he should not have been removed from Drayton Ward. We can see that it was necessary for the two men to be separated and we have not been able to decide conclusively which of the two should have been removed to Thorpe Ward. But the cir-

cumstances were such that even if it was a correct clinical decision to take David Bennett to Thorpe Ward temporarily, further consideration should have been given to the problem before deciding to keep him there for the night. This decision too was not dealt with in a sensitive way. He was simply informed of the decision. We consider that this must have seemed to him to be the last straw. But we wish to make it clear that despite the criticisms we have made, we do not condone his actions in hitting out at SN Hadley. We also note with concern that there is no indication that DW was ever spoken to about his behaviour, even after David Bennett's death.

With this background we turn to consider the issue of restraint. While appreciating that there is always a difference between an actual incident involving violence and a demonstration at a training session, we are of the view that it was negligent not to have a nurse taking proper control of David Bennett's head throughout the incident. The training was specific that that control should take place whenever possible. Despite SN Fixter's evidence to the Inquest that it was not necessary, we are of the opinion that it was both possible and appropriate.

The evidence indicates that SN Fixter was in charge throughout the period of restraint. During that period he gave instructions to others, including instructions about telephoning for ambulances. He was the senior nurse on Thorpe Ward. It may have been appropriate for him initially to restrain David Bennett physically if there was no other way of containing the situation by attempting to get a firm hold of one of his arms. But, once David Bennett was on the floor, he should either himself have moved to his head or instructed one of the other nurses to do so. The training that he had received clearly indicated that the nurse at the head is the No1 nurse in charge. In view of the fact that there were only two male nurses involved, it might have been difficult for SN Fixter to have relinquished his hold on David Bennett's arm so that he could move to the head. That does not excuse his failure to ensure that some other nurse was at his head. If that had been done, we consider that signs of distress would have been detected earlier than they were and that there was a real possibility that this death might never have occurred.

We also consider it regrettable that none of the other nurses drew SN Fixter's attention to the fact that there was no No 1 at David Bennett's head. Having heard the evidence about the restraint, and having taken into account the findings made by the pathologists, we are satisfied that the injuries to David Bennett are consistent with excess pressure being used in the attempt to restrain him. We are satisfied that this excess pressure was not caused deliberately. We find that five nurses were involved early in the restraint for a period of approximately two or three minutes, but after that the number was never more than four. We consider that five nurses should not have been involved at any one time. It may have been necessary for four nurses to restrain him during the first few minutes, but thereafter

we consider that that number should have been reduced to three. There is no evidence of deliberate misbehaviour by any of the nurses involved but evidence of negligence, particularly on the part of the senior nurse involved.

In coming to these conclusions, we have considered the evidence from a patient (DS) who was called at the Inquest. DS spoke of SN Fixter having his hand round David Bennett's throat and hearing David Bennett say "Get off me, get off me, I can't breathe. Get off my throat". DS also said that at all times David Bennett was lying on his back during the restraint. This was inaccurate. He also was positive that SN Evans took part in the restraint. This too was inaccurate. We noted that he did not tell anyone in authority until January 2001 that SN Fixter had hold of David Bennett's throat.

In considering his evidence we have borne in mind that marks of superficial bruising were found on David Bennett's throat, which were consistent with finger marks and which may have been caused during attempted resuscitation or in the struggle, according to the opinion of the pathologist. These indicated that at some stage he had been gripped round the neck but according to the Pathologist, not with any force. This causes us concern. But taking this fully into consideration we, nevertheless, find ourselves unable to accept DS's evidence. It was too inaccurate in other material matters.

We also took into account the evidence of the two ambulance paramedics who dealt with SN Hadley. Both were primarily concerned with SN Hadley whom they put on a stretcher and took away. But both looked over to the group on the floor. Neither was aware of any struggle taking place but both made it clear that they did not concentrate on that incident but were concentrating on the injured nurse. It could be that their evidence simply indicated a brief lull in the struggle. But the timing of their arrival was significant. They arrived at 2317 hours. We consider it is probable that by that stage David Bennett had effectively ceased to struggle. We are fortified in that view because it was at that stage that Mrs Chambers also arrived at the Clinic and came into Thorpe Ward to see SN Hadley.

She too was unaware of any struggle taking place on the floor. As the senior nurse at the Clinic, we are confident that if she had seen a struggle going on she would have not have left the ward with SN Hadley but would have stayed to monitor the restraint of David Bennett. This evidence indicates that by the time she arrived the struggle had effectively ended.

We conclude that the restraint was mishandled by the nursing staff. There were nurses pressing on to David Bennett's body when they should not have done so. His capacity to breathe adequately was restricted so that he was unable to inhale sufficient oxygen.

We also conclude that the restraint continued for substantial-

ly longer than was safe. We recognise that the training in control and restraint given to the staff at The Norvic Clinic at that time put no limit on the time that a patient could be restrained in the prone position, so we do not make any criticism of the nursing staff about this but we regard it as a serious failure of training.

There is no indication that the type of instruction and training given to staff at the Clinic at that date differed from that given to staff at other mental health hospitals in the National Health Service.

EMERGENCY PROCEDURES

The evidence indicates that the nurses should have attempted resuscitation earlier. It should have been appreciated earlier than it was that David Bennett had not simply stopped struggling, but was in a state of collapse. If there had been a nurse at his head observing the situation we consider that this delay was less likely to have occurred. Once the emergency procedures were started they were carried out as well as the available equipment allowed. But there should have been nurses there who were trained in the use of a defibrillator.

There should have been a fully equipped resuscitation trolley available and people trained to use all the equipment and medication it contained.

We recommend that there should always be a fully equipped resuscitation trolley wherever a mentally ill patient is detained and people available at all times who are trained in the use of all the equipment upon it.

MEDICAL PRESENCE AT THE NORVIC CLINIC

The evidence was that on the evening of David Bennett's death there was inordinate delay before a doctor arrived at The Norvic Clinic to see him. This issue was fully explored at the Inquest and, as the facts were not in dispute, we have been able to deal with this subject mainly from the written evidence. But, in addition, we received helpful oral evidence from Detective Inspector Deacon who investigated this matter very thoroughly in the course of the police enquiries. We also have taken into account further evidence given to us by Dr Ball and Mrs Chambers.

After the initial incident between David Bennett and DW the reception staff at The Norvic Clinic contacted, by telephone, the Hellesdon Hospital switchboard operator, in accordance with Standing Instructions, so that he could contact the duty doctor who covered Hellesdon Hospital as well as The Norvic Clinic. Hellesdon Hospital made contact with Dr Bishram at 2245 hours. He requested a taxi to take him to The Norvic Clinic. This was normal procedure. Hellesdon requested a taxi from their usual firm to go and collect him. Dr Bishram had told Hellesdon Hospital that he was to be picked up at Woodlands House where he lived

and the taxi firm was so informed. Unfortunately there was a misunderstanding as the taxi firm confused Woodlands House with Woodlands Nursing Home, which is in a different area of Norwich, and the taxi was sent to Woodlands Nursing Home by mistake. This muddle took a long time to sort out. Dr Bishram did not arrive at the Clinic until about an hour and a half after the first telephone call.

The taxi firm had been used on many occasions before. In the contract between the Hospital Trust and the taxi service, it states that there should be a response by the taxi service within 30 minutes of a call at night. By 2236 hours on Friday, 30 October Dr Bishram had not arrived at the Clinic so Dr Shetty, who was the on-call consultant, received a telephone call at his home from SN Fixter telling him that there had been a serious incident and that a patient was being resuscitated. Dr Shetty told SN Fixter that he would attend the Clinic straight away. Dr Shetty then telephoned the senior house officer on call, Dr Bishram, who was waiting for his taxi. Dr Shetty arrived at the Clinic at 2345 hours. When Dr Bishram eventually arrived he again told Dr Shetty that he had been waiting for his taxi. He also told Dr Shetty that initially he was not told that it was an emergency but that it was because two patients had been involved in an incident. He later received a further call saying it was an emergency but by then he was already waiting for the taxi.

Mr Hall worked for ABC Taxis of Paddock Street, Norwich, the relevant firm of taxis. A call was received from Hellesdon Hospital for a doctor to go to The Norvic Clinic. The screen showed that the doctor was to be picked up from Woodlands, Taverham, near Norwich, which is the Woodlands Nursing Home, so a taxi was sent there. Eventually a taxi was sent to Woodlands House, which is attached to West Norwich Hospital at about 2346 hours, picked up Dr Bishram and took him to The Norvic Clinic.

Dr Bishram has left the United Kingdom. In his statement he said that he was bleeped first at 2240 hours. He then rang the switchboard at Hellesdon Hospital, which put him through to The Norvic Clinic. He spoke to SN Fixter who described an altercation between David Bennett and another patient on Drayton Ward and asked if Dr Bishram would attend and see both patients. Dr Bishram then telephoned Hellesdon Hospital again and asked them to call a taxi for him. He waited for a taxi until 2315 hours. He was then paged again and he rang The Norvic Clinic and spoke to SN Fixter who told him that the patient's condition was unchanged. He then spoke to the switchboard at Hellesdon Hospital again and was informed there was some confusion and the taxi had been sent to the wrong location. Eventually a taxi picked him up. He arrived at The Norvic Clinic just before midnight.

This catalogue of mistakes and muddle was not satisfactory. Human error is never totally avoidable. But as The Norvic Clinic looked after a number of seriously ill patients, who might require urgent medical assistance, there should have

been a foolproof system in operation that ensured that a doctor would be at the Clinic at least within 30 minutes of the initial telephone call, at any time of day or night. If Dr Bishram had been present shortly after he had first been asked to attend he might have saved David Bennett's life. He could have monitored the nurses use of restraint. Alternatively, he could have asked them to move David Bennett to the seclusion room or he could have administered an intravenous injection of tranquillising medicine.

If David Bennett had collapsed while a doctor was present, the doctor could have organised emergency safety procedures more quickly and more effectively.

We recommend that there should always be a doctor in every place where a mentally ill patient is detained, or if that is not possible, foolproof arrangements should be in place twenty-four hours a day, that a doctor will attend within twenty minutes of any request by staff to do so.

STAFF ATTITUDES TO DAVID BENNETT

The detailed examination by the Inquiry of the treatment of David Bennett from 1980 until his death in 1998 enables us to comment on the attitude of those with whom he came into contact in the National Health Service and in the private sector at St Andrew's Hospital, Northampton. As he spent lengthy periods at The Norvic Clinic, we are well placed to observe the attitude of those in that hospital, particularly as their records are substantially complete, although there are gaps from time to time.

There is no indication that the attitude of doctors or nurses in respect of his ethnicity changed during these years. Nowhere do we find any detailed assessment of his overall ethnic needs. We found occasional references to some of his cultural, social and spiritual needs, but these were made by individual sympathetic nurses who looked after him.

We find no coherent pattern or plan for the treatment of these highly important needs, nor do we find any pattern of engaging members of his family in the problems that faced him. We note that he was seen by numerous different doctors and nurses in the various hospitals he attended, many of whom had had experience in other parts of the country where there are more patients from the black and minority ethnic communities. But, there was no evidence that any of them suggested any alteration in the way David Bennett's ethnic needs were met or made any criticism of his existing regime of treatment. This leads us to suppose that the treatment received by David Bennett, as an African-Caribbean, is likely to have been the same as the treatment received by other patients from the black and minority ethnic communities with similar mental health problems. They too are likely to have spent lengthy periods in locked wards or hospitals and to have been treated with high doses of anti-psychotic medication.

These failures contributed to David Bennett's problems. We do not go so far as to suggest that, without them, his mental health problems would have been radically alleviated, but we are left in no doubt that they seriously diminished the quality of his life. If the National Health Service does not look at the whole man or woman, as the case may be, it is failing in its duty.

THE FAILURE TO INFORM THE FAMILY OF DAVID BENNETT'S DEATH

Mrs Chambers reported the death of David Bennett to Police Headquarters Control Room at 0040 hours on 31 October 1998 from the Accident and Emergency Department of the Norfolk and Norwich Hospital. Uniformed police officers arrived at The Norvic Clinic at 0043 hours at her request. At about the same time other police officers attended the Norfolk and Norwich Hospital. Further uniformed police officers attended The Norvic Clinic, arriving at 0135 hours. The Duty Inspector also arranged for a detective officer to attend.

At 0200 hours Detective Inspector (DI) Deacon was contacted by telephone at his home. Further enquiries were then made as a result of which DI Deacon told the police officers already at The Norvic Clinic to preserve the scene in Thorpe Ward as a crime scene. At 0245 hours DI Deacon attended Bethel Street Police Station in Norwich. There he contacted Detective Superintendent (D.Supt) Swain. D.Supt Swain decided to attend The Norvic Clinic with DI Deacon. They arrived at 0530 hours and were met by Mrs Chambers, Mr Shelton, the Chief Executive of the Trust and Dr Hughes, the Medical Director who had been there for some time. By this time parts of the Clinic were cordoned off. Some of the police officers were wearing protective clothing and rubber gloves.

The uniformed police had, on their arrival at 0043 hours, told the staff at The Norvic Clinic not to contact the family of David Bennett. Mr Shelton described it as a bizarre situation. He pressed the matter of informing the family as a matter of urgency but was repeatedly told that the police would themselves arrange for that to be done. Police records show that the Cambridgeshire Police were not asked until 0808 hours to inform Mrs Winifred Bennett of David Bennett's death. Dr Bennett told us that a police officer visited her sister Winifred at about 0900 hours to tell her that her brother David Bennett had died and that the family should contact the Accident and Emergency Department in Norwich. Winifred rang her sister Joanna at about 0930 hours who immediately rang the Norfolk and Norwich Hospital. She was told that David Bennett had been taken there with breathing problems. By this time Winifred had telephoned SN Ncube (David Bennett's key worker at The Norvic Clinic) who told her that he had left David Bennett at 2200 hours the previous night and that everything was then all right and that he could not understand what had happened.

Later Winifred spoke to the Clinical Nurse Specialist who told her that, as an internal investigation was being carried out, she could not tell the family anything other than that David Bennett had died. Mrs Chambers had been at The Norvic Clinic throughout the night of 30/31 October. She had been deeply concerned about the need to inform the family of David Bennett's death as soon as possible. She asked the police to make certain that they went round and informed Winifred at Peterborough and to tell her to ring her (Mrs Chambers) at the Clinic so that she could give her more information.

She approached the police several times during the night to find out if the relatives had been informed. She went off duty at about 0900 hours the next morning. There appears to have been no further communication between members of the family and the staff at The Norvic Clinic during the remainder of that weekend, except to arrange a meeting on the following Monday at the Clinic.

Dr Stanley and Mrs Chambers met three members of David Bennett's family early on the Monday morning at The Norvic Clinic. It was a difficult meeting. Present in the Clinic, but in a separate room, were the NMHCT's Chief Executive, Mr Shelton, the Medical Director, Dr Hughes and the Clinical Director, Dr Ball. It was thought better for Dr Stanley, as David Bennett's RMO, and Mrs Chambers, as the General Manager, to see the family members first and for the family then to see the Chief Executive and the two directors.

Dr Stanley told the family that she was unable to answer their questions about David Bennett's death in detail because she had not been there. She explained that the Trust had been hampered by the police instructions not to contact the family. The Bennett family said that the Trust had a duty to tell them the full facts and they were getting no help from the Trust. They also said that the way they had been informed of David Bennett's death was lamentable. This meeting ended in disorder. The family thereafter declined to see either the Chief Executive or the directors. Subsequently, through solicitors, the family intimated they wished to have no further dealings with the Trust.

Those members of the Trust who were involved in this meeting, or waiting to see the family, have all told us that they remain deeply unhappy about the way in which this matter was handled by the Trust and the police. They recognise that the Bennett family was treated with a marked lack of understanding and sympathy and greatly regret it. This is an aspect of this Inquiry which has deeply troubled us. In our view, the police made a grave error in preventing the Trust from informing David Bennett's close relatives of his death. Equally, the staff at The Norvic Clinic failed in their duty by being unable or unwilling to disclose to the family any details about the way in which David Bennett met his death.

It was wholly unsatisfactory for the family to attend The Norvic

Clinic on the Monday morning in order to find out what happened and then to be told by Dr Stanley that she was unable to help. It was also, in our view, unsatisfactory for the Chief Executive and the directors not to be present at this interview. All concerned must have appreciated that the family wanted to know what had happened.

To allow the members of the Bennett family to go away without a reasonably full disclosure of the relevant facts was not only inhumane but also bound to lead the family to suspect that there was some cover up going on.

We express our deep sympathy to the Bennett family. We regard the behaviour of both the Trust and the police with dismay.

On 18 December 1998 Mr Shelton wrote to Christian Fisher (now Christian Khan), Solicitors to the Bennett family. This was a detailed letter setting out the events of Saturday night and including these words:

"I cannot emphasise how badly we felt and continue to feel about this delay (in informing the family). As the night wore on twice or three times I enquired and subsequently urged fresh action by the police in this particular matter."

In our view, this letter was an example of too little too late.

The Trust should have written such a letter much earlier. This letter also failed to give any account of the circumstances in which David Bennett died. It is right to say that by this time there were continuing police inquiries which might have resulted in a criminal prosecution and there was also a reluctance by some members of staff to give details of what had occurred on that night, as they had been advised that it would not be in their interest to say anything at that time.

But there is no reason why the full picture should not have been given as far as the Trust knew it. If it was incomplete, at least it would have indicated the Trust was trying to help the Bennett family. As it was, their approach was thoroughly insensitive.

The evidence we heard from board members of the Trust indicates that if a death or any serious untoward incident occurs in future, then the Trust will take it upon themselves to inform the family as quickly as possible and to give them proper details of how the death came about. We welcome this approach and consider that it should be adopted throughout the National Health Service.

POST MORTEM FINDINGS

Dr Harrison is a Consultant Pathologist. He and Dr Cary, who was the Consultant Pathologist appointed by the Bennett

family, both carried out post mortem examinations on David Bennett. Both were in agreement about their findings. They found that:

"There was clearly evidence of both superficial and deep bruising at autopsy but there was no evidence of any fractures or typical assault-type injuries. All the findings would have been in keeping with struggle and restraint".

Dr Harrison said in evidence to us that the most important factor leading to death was restraint in the prone position for a length of time. He said:

"I understand that restraint in that position can be carried out relatively safely, although some people say you should never restrain in the prone position; but the time interval is critical. In this case I understand it was fifteen to twenty minutes which I think was far too long."

Dr Harrison described how potassium leaks out of damaged muscles and told us that that can be fatal because it causes irregularities, which can stop the heart immediately. He also noted that the level of creatine kinase, which is an enzyme in the muscle, was very high in the bloodstream.

He pointed out that restraint can produce stress with which the heart can normally cope but, if there is restraint which produces stress and continued struggling so that the stress continues, that can cause the heart to stop more easily.

He said there were a myriad of factors in this case. It was extremely complex. But in the end death had been caused as a result of continued struggling against restraint.

David Bennett did not suffer from sickle cell disease, which can increase the chances of death as a result of restraint. He noted there were eight punctate abrasions on the left side of the neck with a single bruised abrasion beneath the chin on the right side.

He said:

"It is very difficult trying to age bruising. He (David Bennett) was resuscitated and I think the problem here is that if he had not been dead particularly long, he might have bruised. Some of the bruising might have been done in resuscitation. If not, then it obviously indicated that he had been gripped round the neck - not particularly with any force because this was superficial bruising".

He added that he would not be surprised if rigor mortis came on very quickly in the circumstances of this death. We were told that the medication taken by David Bennett did not contribute to the immediate cause of death.

THE INTERNAL INQUIRY

Dr Ball, in October 1998, was the Clinical Director of The Norvic Clinic. He was in contact with the Trust shortly after the death of David Bennett. He was concerned that an inquiry be held to try and establish the full circumstances that led to his death. He mentioned this matter to some directors of the Trust but no action was taken.

After two or three weeks, he decided that the Clinic should arrange an internal review. He asked Dr Solomka to chair the inquiry. Dr Solomka, a consultant psychiatrist of minority ethnic origin, had not been involved in the care of David Bennett and was therefore in Dr Ball's opinion the most appropriate person to chair this committee. The other members of the panel consisted of Dr Sedgwick, who was a Forensic Clinical Psychologist, Mr Parr, a senior social worker, Mrs Egmore, the administrator and Mr McMahon, Senior Charge Nurse, all from The Norvic Clinic. Dr Ball discussed the setting up of the internal review and its terms of reference with the Chief Executive of the Trust, Mr Shelton, and obtained his approval. We heard from the Chief Executive. He told us that he had expected that there would be a separate independent inquiry into the circumstances of the death, set up by the Health Authority as the Commissioners of the Service. On the Monday after the death, he had conversations with the Health Authority about this. He also remembers talking to Dr Ball about an internal clinical review.

Miss Kant became Chair of the Trust one month after David Bennett's death. She said in evidence that if a serious incident occurred now, ie in 2003, the Trust board would immediately set up an internal inquiry. One of the directors of the Trust would be appointed with at least one external person, and probably the chair would also be an external person. When she became Chair, she told us that she had some difficulty in trying to discover what was going on in relation to the death of David Bennett. Her impression was that there was a general defensiveness about what had taken place.

The internal inquiry produced an interim report in March 1999. By that stage the Inquest had not yet taken place. Certain members of staff who were going to be called at the Inquest had been advised not to take part in this internal inquiry and declined to give evidence. This made the job of the internal inquiry difficult.

By March 1999 only three members of staff had been interviewed. The police had not yet released to the Inquiry the statements, which they had taken from members of staff. On receiving the interim report in March 1999, Dr Ball wrote a lengthy letter to the Chief Executive on 17 March 1999. He made specific reference to the transfer to Thorpe Ward of David Bennett after the incident with the patient DW.

He added this comment in that letter:

“His sense of injustice together with the singularly grievous sense of insult generated by a racist taunt should not be underestimated.”

It became clear that the final report of the Inquiry could not be completed until both the police investigation and the Inquest were finished. The relevant statements were then released by the police, which enabled the Inquiry to complete its task. It reported in the spring of 2002. Considering the difficulties that the internal inquiry had in obtaining all evidence, we are of the opinion that they produced a good report. Our criticism is that it took far too long to be completed.

An internal inquiry should be completed quickly. The delays were largely due to the continued adjournment of the Inquest and the length of the police enquiries but we still consider it would have been possible to produce an adequate final report much earlier.

We do not consider it necessary to refer to its various findings or to comment upon them. Our Inquiry covers all matters which they considered and we have had the benefit of having greater information than was available to them.

The Bennett family was never contacted by the internal inquiry. We can understand the reasons for this as after the death the family, through their solicitors, made it clear that they did not wish to have any dealings with the Clinic. They never changed their mind. But, we hope that if another tragedy requires an inquiry to be set up, every effort will be made to involve the family of the deceased person. The Bennett family have helped us greatly in our Inquiry. In the absence of any input from them, the Internal Inquiry never obtained a fully rounded picture of David Bennett.

While we appreciate that in due course, after the Inquest had been completed, the Norfolk Health Authority would inevitably have set up an inquiry under HSG(94)27 of the Health Service Guidelines, we consider that the response of the Trust at the time of the death was inadequate. It was essential, and should have been obvious that a contemporaneous inquiry with at least one board member and proper outside representation should have been set up. We have heard no satisfactory explanation for this failure.

In the circumstances, Dr Ball did well to set up the inquiry. But, by reason of it being purely an internal inquiry, chaired by a member of The Norvic Clinic staff and with no outside representation, it was clearly flawed. In these circumstances, Dr Solomka and his members did what they could and we pay tribute to them.

POLICE INQUIRY

On 1 November 1998, the police decided to seek a formal link with the Crown Prosecution Service (CPS) to assist in the investigation into the cause of the death of David Bennett. On the next day, the first meeting between the police and

the CPS took place and thereafter, throughout the course of the investigation until its conclusion in November 2000, the CPS was regularly consulted.

From time to time the Bennett family, solicitors representing the Norfolk Mental Health Care NHS Trust, solicitors representing employees of the Norvic Clinic, the Mental Health Act Commission and the Health and Safety Executive were kept informed of the investigation. The Inquest was opened shortly after the death of David Bennett and adjourned sine die until the police investigation had been concluded.

The police inquiry took considerably longer than had been anticipated because of the nature of the expert evidence relating to the cause of death. There was continued reference back to the two pathologists, Dr Harrison and Dr Cary. This occupied a considerable period of time. Even so, there were still some matters that they were unable to resolve and consequently the police approached Dr Wood, a Consultant Psychiatrist and Professor Forrest who is Professor of Toxicological Medicine. The enquiries were hampered by the pressure of work of all the doctors concerned and also by delays through ill health.

Professor Forrest's report was not received until November 2000. Once that had been considered by the CPS a decision was made that there would be no criminal prosecution. The police told us that this was a very difficult investigation, which raised extremely complex medical matters. Dr Harrison confirmed this when he gave evidence before us. He regarded his pathological enquiries into the cause of death of David Bennett as one of the most difficult cases he had dealt with in his experience. But we do consider that, despite all the difficulties, it was inappropriate to take over two years to come to a final conclusion whether to prosecute or not. We remind ourselves that justice delayed is justice denied. It was unfair to the Bennett family, unfair to the individual nurses and unfair to the Norfolk Mental Health Care NHS Trust.

The police were aware of the deep concern that the Bennett family had about investigations into David Bennett's death. Officers were instructed to keep them informed. There was contact with their solicitors, particularly in respect of Dr Cary's pathological report which was commissioned by the family. The Bennett family were also told that this report raised additional issues which needed considerable further investigation, which would cause further delay.

In August 1999 the officer in charge of the case, DI Deacon, visited Dr Bennett at her home and explained to her the difficulty in finding an expert witness available to carry out the work identified by Dr Cary's report. Further contact was made with the Bennett family in November 1999 and again in April 2000.

On 21 August 2000 a meeting was held by the Coroner at which the family attended. Dr Bennett was informed on 24 November 2000 of the decision that no criminal proceed-

ings would be taken. There was a further pre-Inquest meeting at City Hall, Norwich, on 25 January 2001. Having expressed our criticisms, it is only right that we should quote the Coroner's remarks at the conclusion of the Inquest, where he said:

"I particularly wish to pay tribute to the police who were involved in the comprehensive investigation into the circumstances of David Bennett's death which I know took some considerable time but, during the course of that investigation, no stone was left unturned."

Finally, we wish to pay tribute to Mrs Clark MP and Dr Gibson MP who have done their best to hurry matters along. Both have asked a number of parliamentary questions on behalf of the Bennett family to try and ensure that a full inquiry was made of all the events leading to David Bennett's death. Dr Bennett at all times has exerted such pressure as she could both personally and with the help of INQUEST.

Explanations have been given for all the delays, which were individually reasonable, but the fact remains that David Bennett died in October 1998 and this Inquiry will not be completed until the closing months of 2003.

THE INQUEST

IN November 1998 the inquest on David Bennett was opened, but adjourned pending the completion of police enquiries. After the lengthy police enquiries had been completed and after consultation with the parties, the inquest started on 3 May 2001. It concluded on 17 May 2001. The inquest was conducted by Mr William J Armstrong, HM Coroner for Norwich and Central Norfolk. The Bennett family were legally represented. So were a number of other interested parties.

There can be no possible criticism of the careful way in which the Coroner concerned carried out his duties at this inquest. After the verdict had been recorded, the Coroner made the following recommendations:

1. The need to formulate, adopt and apply national standards for the prevention and management of aggression by psychiatric in-patients and to apply regular monitoring. The Department of Health should liaise with the Home Office over this issue because of the knowledge and expertise possessed by the Prison Service and the Police Service in control and restraint techniques and policies.
2. The need for the Norfolk Mental Health Care NHS Trust to revisit and revise its current manual on the "Prevention and Management of Aggression" to take into account all available expertise and the evidence presented at the inquest.
3. The need to ensure that urgent medical assistance is readily and speedily available to psychiatric in-patients outside normal hours.
4. The need to make sure that appropriate resources for resuscitation are available in psychiatric units and that staff are given the necessary training.
5. The need to ensure that staff in psychiatric hospitals are pro-active in taking appropriate action in dealing with incidents of racial abuse by and against patients.
6. The need to review the procedures for internal inquiries by hospital trusts following the deaths of psychiatric patients with emphasis on the need to provide appropriate care and support principally for the family of the deceased, but also for staff members affected.
7. The need for a wide and informed debate on strategies for the care and management of patients suffering from schizophrenia who do not appear to be responding positively to medication.
8. The need for medical personnel caring for detained patients to be made aware, through appropriate training, of the importance of not medicating patients outside the limits prescribed by law. Also the need for more regular and effective monitoring to support the work undertaken by the Mental Health Act Commission in this field.

It can be seen that these recommendations have largely been included in our terms of reference. This Inquiry would like to express its gratitude to the Coroner for making these recommendations.

DEVELOPMENTS AT THE CLINIC SINCE DAVID BENNETT'S DEATH

THERE is now a manual defibrillator and an ambu bag in each ward at The Norvic Clinic. Nursing staff have received appropriate training in their use in case of a medical emergency. There has also been further training in all resuscitation techniques.

Careful consideration has been given to installing extra telephones for the use of patients. But a risk assessment showed that this would increase the risks on the ward. This risk assessment is regularly reviewed.

The Race Relations (Amendment) Act 2000 has placed on public authorities a general duty to promote racial equality. This requires each public body in executing its functions to have due regard to the need to:

- 1 Eliminate unlawful discrimination**
- 2 Promote equality of opportunity**
- 3 Promote good race relations between persons of different racial groups"**

The legislation also imposes on public bodies the specific duty to publish a race equality scheme. The Act came into effect in April 2001. In addition, it placed a general duty on public bodies to have due regard to the need to eliminate unlawful discrimination and promote equality of opportunity and good race relations in carrying out all of their functions. Under the Act, the race equality scheme had to be in place by 31 May 2002.

The Trust has complied with the Race Relations (Amendment) Act of 2000. They produced their race equality scheme on 24 May 2002. They have reviewed their human resources policies. This is a continuing process.

Mr Thain is the Director of Strategic Development in the Trust. He told us that facilities in Norwich cater for the population it serves. He considers that local interpretations and applications of certain policies are the best way forward. There are linkages with other mental health trusts in other areas.

The taking of notes by nurses has been improved so as to ensure that there is a detailed note of all specific incidents.

Race and diversity training has taken place, provided by an outside organisation. The training was done by "slice groups" across the organisation so a mixture of disciplines and staff hierarchy, including board members, would be in the same group. Some of the training was done by a team that included a trainer from the black and minority ethnic community and some was not. The trainers included people of both sexes. We consider it important that on all training occasions at least one of the trainers should come from the black or minority ethnic communities.

He also told us that there is now more provision for community involvement in the care of patients and a greater number of clinical psychologists are available.

Dr Ball provided the Panel with a schedule headed "Post Inquest Action Plan", which lists various different practices that need to be considered as a result of the internal inquiry report and the Inquest. These refer to Prevention and Management of Aggression; urgent medical assistance; prescription of psychotropic medicine; resuscitation; standards and resources, psychological treatment in refractory patients; dealing with racist abuse by and against a patient; review of internal procedures and an internal clinical review. Many of these are ongoing.

There appears to be more sensitivity about the way all patients are treated at The Norvic Clinic, particularly those from the black and ethnic minorities. This change of approach is due to a number of factors. There has been governmental pressure on all NHS institutions to give appropriate consideration to black and minority ethnic patients, which previously was sadly lacking. More staff have also been made available, which has improved the situation.

The Clinic now contacts leaders of local communities on a regular basis. They also work through the Norfolk and Norwich Race Equality Council. Both these are excellent initiatives and we hope they will continue. The shock of David Bennett's death has heightened awareness at the Clinic. Together, these factors indicate that all patients there are more appropriately treated than they used to be. But there is no room for complacency.

There is one subject that still particularly concerns us to which we have already referred earlier in our report. At the time of David Bennett's death, there was no medical doctor on site. As we have already described, the on call doctor was some miles away and had no direct access to a vehicle. He relied upon a taxi, which failed to turn up in time. At present we do not consider that the question of the availability of a doctor at the Clinic has yet been satisfactorily resolved. We are told that there is now a doctor at the Julian Hospital, a hospital for elderly mentally ill patients some five miles away, who can come by car to the Clinic in an emergency if there is no doctor there at the time. But the Julian Hospital is as far from the Clinic as the place where Dr Bishram lived, who was the doctor who should have come on 30 October 1998.

We recognise medical emergencies are unlikely to arise often at The Norvic Clinic. We do not equate the situation there with that of a general hospital, where medical emergencies are much more frequent.

But we consider that provisions should be made that will make it certain that a doctor can be present at The Norvic Clinic within twenty minutes of being notified, in all the circumstances.

It must be remembered that medical intervention to a patient in an emergency can only be carried out by a doctor.

Dr Ball wrote a letter on 8 March 1999 to Mr Shelton saying:

"There is the question of the delay in the arrival of the on-call junior doctor. If a doctor had arrived within 20 minutes (which ordinarily would be the case) then he would have been present at the start of the restraint and it could be argued, quite reasonably, that if sedation had been given at that stage, the requirement for prolonged restraint would have disappeared. Further, if he had arrived during the restraint then again sedation could have been given, perhaps terminating the restraint. If the doctor had arrived towards the end of the restraining episode, then he would have been present when attempts at resuscitation were made.

"It is this particular area which causes me most concern and, I think, is potentially extremely dangerous for the Trust. I note that this is the issue immediately lighted upon by the Mental Health Act Commission (MHAC). I personally think that the Trust's position in continuing to have a junior doctor covering three sites and relying upon a taxi service will not be accepted and could result in severe criticism.

"I think it is necessary, therefore, to at least consider the prospect of having a doctor resident on each site."

In December 1999 Dr Ball again wrote to Mr Shelton saying:

"Personally I remain of the view that we are not at liberty to assert that the senior doctor's more immediate presence could not have helped the situation possibly towards a different outcome".

No significant change in practice has yet been made.

We are told that there are plans for a doctor to be able to come within a guaranteed time of half an hour of any incident in The Norvic Clinic.

The Norvic Clinic does more now to try and involve close relatives and to keep social contacts with patients who have been discharged. It is not easy because sometimes patients do not wish their family to be involved. It should be borne in mind that, at the time of David Bennett's death, this Clinic did not usually discharge patients directly into the community, but to another hospital or, sometimes a hostel. There have been changes in the overall culture of the Clinic since 1998. There is now more emphasis on patient involvement and family involvement. There is, also, more interaction with the relevant social services. This is an area that needs constant revision as we feel that it is an important element in the attempt to place the patient successfully in the community.

Part II

PREFACE

In Part 2 of our Inquiry there was a high degree of agreement expressed by witnesses on many of the subjects referred to in our terms of reference. Consequently, there was no need for us to spend much time considering which evidence we accepted and which we rejected.

We have not expressed a view on all the evidence and at times have left the evidence to speak for itself. Obviously, some witnesses expressed different opinions to others. This was only to be expected as we deliberately chose witnesses who came from many different fields of expertise.

The clear message we received on almost every subject in our terms of reference was that no, or insufficient, action was presently being taken to deal with problems in the mental health services that have been recognised for years.

In our report we have highlighted examples of good practice in treating people with mental health problems, hoping that these will indicate what can be done where there is the will and the resources to do it.

Many witnesses dealt with the subject of racism. This is a subject of great importance in our multi-ethnic society. The views of our witnesses were virtually unanimous. Institutional racism is present throughout the National Health Service (NHS). Greater effort is needed to combat it. Until the problem is properly addressed, people from the black and minority ethnic communities will not be treated fairly.

We note that the implementation of the provisions of the Race Relations (Amendment) Act 2000 is setting new parameters in this field. But, despite the work that has been done, we receive the message that progress is slow and more needs to be done.

We have included many summaries of witnesses' evidence in order to give as full a picture as we can. At times the evidence is rather repetitive.

We consider that it is important that the reader knows who is saying what. Inevitably we have tidied up the language of the witnesses to some extent as they did not always give evidence in neat grammatical sentences. But on occasions we have left in colloquial phrases used by some of them without putting those phrases in inverted commas as these can be a distraction to the reader.

There are some subjects which we deal with in this part of the report on which we have quoted the evidence extensively, particularly in the section headed "The Way Ahead". In that section the evidence largely came from witnesses who are likely to be in a position to take action to improve existing practices, so we considered that it

was necessary to set out their views at length. We hold them to their promises and do not expect excuses in the future for delay, lack of action or failure.

We have concentrated on the specific terms of reference that relate to Part 2 of this Inquiry but sometimes the evidence has ranged fairly widely. This has enabled us to fit the specific matters which we are considering into the context of the general picture.

We asked the Department of Health for their views about which witnesses we might wish to call. They made no specific recommendations. We invited the Bennett family to recommend witnesses and are grateful to them for their suggestions, which we followed up. They were also made aware of the witnesses we intended to call. We also publicised this part of the Inquiry by using the Head of Communication of the Strategic Health Authority. The Inquiry finally decided for itself which witnesses it wished to hear. Everyone who was asked has either attended or sent written evidence. All oral evidence in this part of the Inquiry was heard in public at Methodist Central Hall, Westminster.

Although our Panel includes members with medical expertise, we have at all times been conscious that we are not sitting as an expert medical body.

We start with the subject of "Racism". After considering this crucial subject we have approached the remainder of our report as if we were dealing with the care pathway of a typical patient who developed and was treated for schizophrenia. So we first consider the question of access to the NHS, then diagnosis, then treatment, which includes contact with the family, community care, medication and control of aggression. Finally, we have dealt with the remaining issues raised in our terms of reference.

Many witnesses made specific references to the difficulties that face people from the black and minority ethnic communities who have mental health problems. Some of these problems are shared by people from the white community. We found that people from all communities, but particularly from the black and minority ethnic communities, find it difficult to access mental health services.

A further problem concerns the initial diagnosis of schizophrenia in a patient. Some psychiatrists are hesitant to make such a diagnosis feeling that it carries a stigma, which they wish to avoid. Some make such a diagnosis with very little clinical evidence to support it. Psychiatrists sometimes make a diagnosis of "drug induced psychosis" which, as far as African-Caribbeans are concerned, nearly always relates to the use of cannabis. There appears to be no clear medical basis

for this diagnosis. The indications are that this diagnosis may prevent proper treatment of early signs of schizophrenia.

Many witnesses told us that the black and minority ethnic community have a very real fear of the Mental Health Service. They fear that if they engage with the mental health services they will be locked up for a long time, if not for life, and treated with medication which may eventually kill them. Fear is dealt with in detail in the Sainsbury Centre's report "Breaking the Circles of Fear" (published in 2002). Young black men with signs of mental illness frequently, out of fear, do not go to their doctor until their illness is so pronounced that their family and friends can no longer cope with them. By this time they tend to be isolated, not only from their own family but also from their own peer group. Their illness is by then more difficult to treat and treatment in the community may not be a real option. As a schizophrenic illness continues, it tends to become harder to control and/or to cure.

Statistics show that there is a substantial over-representation from black and minority ethnic groups diagnosed as suffering from schizophrenia (see "Inside Outside" published in 2003). To summarise, the problems faced by the sufferers are exacerbated by their failure to present themselves for treatment at an early stage of their mental illness, inadequate or inappropriate diagnosis and inadequate or inappropriate treatment arising from one or both of the previous factors. A disproportionate number of people from the black and minority ethnic communities are being detained under the provisions of the Mental Health Act 1983. In Greater London this over-representation is by a figure of some 40%. We heard that there is over-representation occurring in black people who fail to respond to treatment for schizophrenia. They tend to receive higher doses of anti-psychotic medication than white people with similar health problems. They are generally regarded by mental health staff as more aggressive, more alarming, more dangerous and more difficult to treat. Instead of being discharged back into the community they are more likely remain as long-term in-patients.

There are specific services which deal mainly with black and minority ethnic community patients, such as the Frantz Fanon Centre in Birmingham and the Antenna Centre in Haringey. These centres demonstrate that better results can be obtained by markedly lower doses of medication and by treatment mainly in the community. But services like these are few and far between. They tend to deal with young black people with symptoms of mental illness.

However, despite these isolated initiatives, in most parts of this country black and minority ethnic patients are not obtaining the treatment they need. We were told that it is more expensive to treat patients in hospital. Early treatment, mainly in the community, gives value for money.

African cultures are different from Caribbean cultures and people from different African cultures are also diverse.

Statistics show that the black patient group from these backgrounds is more likely to be restrained, more likely to be secluded and more likely to be prescribed medication than any other group. These patients are also less likely to be given psychological treatment rather than physical treatment. Statistics from the USA present much the same picture.

It is clear that the cultural needs of the black and minority ethnic patients are not yet being adequately addressed. This is deeply worrying. The evidence we have heard indicates that the problems we identify in this report have been known to the NHS for many years.

Time and again we were told that nothing meaningful has been done. We were glad to hear of the Department of Health's present initiatives, but are bound to say that it has taken too long for these to be put in place. It is vital that these initiatives have the necessary commitment and resources. Continuity of leadership is also crucial.

The confidence of the black and minority ethnic communities, as far as the mental health services are concerned, has been lost. There is widespread appreciation that it will take time and dedicated work to regain this trust and confidence, but it must be done.

This failure to engage properly with those communities leads to feelings of frustration particularly in black patients, often coupled with an inability to communicate in an appropriate way with nursing staff. A further factor is that hospital staff members are sometimes themselves frightened by aggression from a black man who is perceived as more threatening than a white man.

Some witnesses described the initiatives that have been brought forward by government and government agencies. We note that witnesses expressed their dissatisfaction with the existing training and practice of dealing with violence in mental health settings. They appreciated that government agencies were taking steps to articulate the way forward, but could not point to much that had already been done. New initiatives were always round the corner. We urge the Department to do more to translate their intentions into action. It is essential that practices change. It is now five years since David Bennett's death.

During this part of the report we frequently give the views of the witnesses. Sometimes we summarise the views of a number of witnesses without identifying them but often we refer to the view of a specific witness. When we do this we give their name, but not their qualifications or the post they now hold. Instead we have put this information as an appendix to this part of our report.

When we heard evidence from a team of witnesses representing different aspects of the same organisation we do not give their names but refer to the organisation they represent.

WE have adopted the definition of “Institutional Racism” as set out by Sir William Macpherson in the Stephen Lawrence inquiry (1999):

“Institutional Racism is the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people”.

The evidence we heard shows that although some people understand the Macpherson definition, there are others who did not appreciate that unwitting prejudice, ignorance or thoughtlessness, or racist stereotyping leads to institutional racism. They considered that institutional racism must be deliberate. This is a serious and important misconception which needs to be put right.

Some witnesses stressed that while there was institutional racism in the NHS, it was important to go on beyond that and concentrate on what active steps should be taken to improve the lot of all patients from the black and minority ethnic communities. It was not enough, they said, for this Inquiry simply to make a finding of institutional racism, as that, by itself, although a useful first step did little to alleviate any of the problems faced by the black and ethnic minorities. An institution could not change without action by the people who work in it.

We acknowledge the commitment by the NHS to treat all patients according to their needs. Once it is fully recognised by everyone in the NHS that a patient’s needs include cultural, social and spiritual needs, real progress can be made in eradicating institutional racism. But at present there are indications from the evidence that this broad definition of “needs” is not sufficiently appreciated.

Professor Gournay told us that there was institutional racism in the mental health services. He said that he thought that institutional racism was an element of institutional arrogance.

The representatives of MIND said that there was institutional racism in the NHS. They told us that when there was talk about institutional racism, that meant talking about a heart-and-mind attitude to black people. There was a lack of awareness of cultural issues, a lack of awareness of how people come from within their communities and of the values they have and their aspirations. The starting point should be to go to the description that black service users give of their experience of mental health services. This approach should be one that was done on a regular basis.

It was essential to have a continuous linkage between strategy, local management and local service delivery.

Mr Francis had comments to make about racism which we found very useful. He said that using the word “racism” was not very helpful. It was necessary to de-construct what racism was about. It was about human relationships and was based on power, namely the power of one person over another. Just using the word “racism” did not communicate to people what it was that was discriminatory about what they did. To make things better it was necessary to explain that something was wrong with the relationship and to try and put it right.

He therefore had some hesitation about the use of the term “institutional racism”, which he considered had its own complexities and its own history. But he told us that the sum total of his view was that the mental health services and the NHS were racist within the meaning of the Macpherson definition of institutional racism. He emphasised that black patients were particularly sensitive to any hint of regulation, control or disrespect because they have been primed by their experiences to expect to be treated badly in society.

Mr Thain said that the potential for institutional racism existed in all organisations. It would be arrogant, naive and inaccurate to say that one had eradicated institutional racism completely in any organisation or any element of an organisation.

Professor Patel said there was institutional racism in the NHS.

Professor Sheehan said that the NHS was racist in parts and that “Institutional racism was a true accusation that should be levelled at the NHS who should have no tolerance of it”.

Other witnesses, either directly or by implication, accepted that institutional racism was rife throughout the mental health service of the NHS but it is unnecessary to refer further to their evidence on this subject as the conclusion is already clear. It is a conclusion that this Inquiry accepts unreservedly.

Dr Bennett told us that people sometimes failed to understand that there was a huge variation in defining blackness. Individual experiences by different black people may be totally different. Just putting two black people together did not necessarily mean that the first black person understood the second black person. Nor by putting two black people together as patient and practitioner did that mean that a patient was getting the appropriate cultural care.

There were huge differences between different people who are called black, or who come from the ethnic minorities. We should pay more attention to what the person had to say about their own experiences, namely, what were the

things that were significant and important for them. If doctors and nurses were prepared to spend more time talking with families that would help.

Dr Bennett emphasised that she was not saying, “that all nurses should learn about everybody’s culture, because that was a nonsense. That suggested that only people of ethnic minorities had culture, which again was a nonsense”. She said that ultimately, “we are dealing with an individual and their needs”. It was about our value systems and the way we perceived people.

Rather than mental health services focusing on cultural matching, whatever that was supposed to mean, we should be focusing more on how we enable practitioners to deal with people as people, with some humanity, because that was how you were going to find out what really matters to that person. If we took time to respect an individual and say to him, “What is it that is troubling you, what are your needs?” we were more likely to get it right than if we started to talk about culture, ethnicity and cultural competence. We also needed to understand about the ideology of racism and how that creates stereotypes, assumptions and values. That had nothing to do with culture.

People, she said, wanted to recover from the experience of mental illness. They wanted to be like you and me. They wanted to have relationships. They wanted to have leisure activities. They wanted a home. Community care had to be about what the person needs for themselves to recover or to help them recover.

Professor Gournay told us that we did not do enough to train nurses and doctors at university or college level to appreciate the issues of culture and the way that people manifest their mental health problems. We should be training those in medical schools and nurses before they qualify about these matters.

If they were not trained until they qualify and had been doing their jobs for two or three years, their attitudes and expectations were entrenched. They already saw black patients, for instance, as potential crack dealers and a source of violent incidents. It was then too late to do anything about training. It must be done early on.

Professor Sheehan told us that staff should be as aware, in a hospital which has a low ethnic mix just as much as one with a high ethnic mix, of the needs of every person who may come into their care whatever their ethnic background. It is essential that every local service which the community provides should be appreciated.

Mr Ford said that if you came from the black or minority ethnic communities you were really at the bottom in the mental health service.

The Royal College of Psychiatrists (RCPsych) published the “Report of the Ethnic Issues Project Group” in February 2001, which states:

“It is becoming increasingly evident that psychiatric services have largely failed to take account of the very real concerns of service users. . .”

College members have a key role to play in the local development of services to ensure that the voices of all in their local community are heard”.

Dr Pereira told us that African-Caribbean patients on the whole received a more coercive spectrum of care in the NHS and the research indicates that psychiatrists tend to over-predict dangerousness in black people. His experience was that young black men were more likely to suffer fatal injuries under control and restraint in proportion to their numbers in the population than young white men. Also, more black men were likely to find themselves in secure in-patient environments.

Dr Cary said that sometimes hospital staff used control and restraint as if it were a pre-emptive strike, which may well be a manifestation of racism. This problem often arose from fear and a lack of proper knowledge and education. He emphasised that it was absolute nonsense to say that black people had some sort of physiological susceptibility to asphyxia.

Ms Spence told the Inquiry that there was over-representation of both Africans and African-Caribbeans within the mental health system. The whole black community had considerable reluctance for sufferers to engage with the mental health side of the NHS because they were fearful of being sucked in and never being released. This fear was shared in many instances by their families. The mental health service in this country was almost devoid of humanity. When a black person presented himself because of possible mental illness, he might be talking louder than normal or gesticulating, but mental health symptoms were often misunderstood and misinterpreted because when faced with a black person the professionals who saw them were expecting trouble or problems. It followed that their response was sometimes inappropriate.

It was very necessary to have an understanding of other people’s culture and their mannerisms. Language was a big issue too. When under stress, people reverted to their mother tongue. If healthcare professionals did not understand fully what they were saying, there was room for misinterpretation and misunderstanding. On some occasions an interpreter might be needed.

Dr Fernando submitted that black patients were unfortunately perceived as “aggressive” to start with. This was racist stereotyping. This is aggravated by the stigma of “schizophrenia”. Training should include understanding the history of racism. Training to promote “cultural sensitivity” and/or “cultural awareness” had, in the past, aggravated rather than reduced racism in the psychiatric services.

RACIST ABUSE

Dr Pereira said that where there was racist abuse between patients it should always be dealt with then and there. The culture of all hospitals and other institutions where patients were treated should be clear that racist remarks would never be tolerated.

Dr Lipsedge said that it was self-evident that racist abuse would compound feelings of persecution in the black and minority ethnic communities. If there was a climate on the ward in a psychiatric unit, where profoundly damaging expressions of racism were tolerated or disregarded by staff or given low priority, then the patients would take their cue in the sense that these patients with racist attitudes would feel that it was all right to express them. The victims would feel unsupported, devalued, dehumanised and objectified. He quoted Frantz Fanon, a distinguished French West Indian psychiatrist, who described how racism objectified and made a person into a thing and that a thing, by definition, had no capacity for human relationships.

Dr Fanon did not wish for the unique complexity of a human being to be summed up and reduced by the colour of their skin. The patient who felt understood and cared for, who felt taken seriously and respected, was less likely to be assaultative than one who felt rejected, powerless, despised, put down or dismissed. Dr Lipsedge wished to have clear written notices in each ward visible to patients, visitors and staff, that racist language was not tolerated nor permitted. All institutions where mental health patients reside should have an atmosphere where it was recognised and accepted that the use of such words will not be tolerated. He noted that the situation which black people were experiencing in mental health hospitals had improved over the last few years, according to his own experience. He drew particular attention to one mental health hospital where the staff always ate with their patients. That had a marked effect for good on the patients.

Dr Ghosh stressed that the young black men who ended up in secure facilities were black British. Their needs were quite different from what might have been the difficulties and the cultural needs of their grandparents or great grandparents. There should be more training for all concerned

into all the problems and facets of racism. That training programme should include the history of black immigration and black slavery.

Sometimes it was necessary for a black professional to engage with a black patient, particularly with sex offenders, and with mentally ill young men or women with problems in terms of their own identity and what racism has done to them. "If you do not do this" she said "it is like asking a woman who has been abused by a man to engage with a male psychotherapist". She referred to the feeling of fear generated by the interaction between patients and staff, which was magnified if the patient was from the black or minority ethnic community.

Ms Tweedie said that many local policies covered racist harassment involving patients harassing staff but did not necessarily deal with patient-to-patient harassment. She was very concerned about this. It needed to be given a much higher profile. There needed to be intervention by staff. It needed to be explained to the patient that this was not acceptable behaviour. Staff needed to be very proactive. It was also very important that there should not be any penalising of the victim of the abuse. This happened on some occasions where the victim of the abuse was moved to another ward.

WORKFORCE

The Inquiry found that it is essential that the workforce is representative of the communities they serve. This means that there should always be staff from the black and minority ethnic communities.

The NHS needs to be more flexible about who can contribute to mental health care and should always encourage staff from these communities to work for them. We should not expect people necessarily to come to work in mental health institutions through the traditional routes. We should be asking users and practitioners and the black and minority ethnic communities what is the way forward.

Mr Rae told us that it was essential that the workforce was representative of the community it served.

CONSIDERABLE concern was expressed by a number of witnesses about the diagnosis of some mental illnesses. As we have said elsewhere in this report, there is no clear medical evidence that there is a mental illness which merits the diagnosis of drug-induced psychosis caused by cannabis. Yet it remains the case that this diagnosis is still being made. On many occasions when this diagnosis is made, the proper diagnosis should be schizophrenia. If it is certain that a person is suffering from schizophrenia, then that diagnosis should be made.

More research is needed to discover whether people benefit from early diagnosis and early treatment of schizophrenia. It is misleading to patients and to their families to give a wrong diagnosis when the doctors concerned know what the proper diagnosis is. It is also misleading to give a diagnosis of drug-induced psychosis if no such mental illness exists. We recommend that further research is necessary to find out why such a diagnosis continues to be made and whether there is a link between using illicit drugs and the onset of mental illness. We are also troubled by the evidence that we heard that the diagnosis of drug-induced psychosis is given far more commonly to African-Caribbeans than to people from other ethnic backgrounds. This, too, merits further research.

Professor Appleby said that there was a humane view that if a pejorative diagnostic label, such as schizophrenia, was attached to a patient too early it was potentially a bad thing. But there were occasions when a doctor could give a clear diagnosis. There were also other times when a doctor could not give a clear diagnosis especially in the initial stages. There was emerging evidence that if you detected and treated schizophrenia early there were benefits to the short and long-term outcome. It was impossible now to say if the original diagnosis made on David Bennett, of having a cannabis-related psychosis, made a difference to the way he was treated or not, or to the subsequent progression of his schizophrenic illness. But, someone who was thought to have a cannabis-induced psychosis might not be given the kind of follow-up, the kind of psycho-social therapies and/or the access to occupational therapists that would be part of a modern treatment package, and this could lead to delays in treatment.

But there were still holes in research evidence on exactly what the benefits of early treatment might be. If, however,

the diagnosis was certain and the patient did not receive it when that diagnosis might lead the patient to more intensive and more comprehensive services, then not receiving the right diagnosis would be to the patient's disadvantage.

Professor Appleby told us that it was known that troubled children become troubled adults but that did not mean that we could draw a link between troubled children and the development of schizophrenia. Emphasis in research at present was more on the early symptoms. Opinions varied across psychiatry about this approach. It was believed that the longer a patient remains untreated the worse the outcome was likely to be. But it could not be shown conclusively that if there was intervention by the health services the converse applied, namely that the outcome was then better.

Dr Pereira said there were doubts as to the validity of a diagnosis of "cannabis psychosis" or "drug-induced psychosis". That diagnosis was disproportionately applied to patients from an African-Caribbean background. The more potent forms of cannabis could bring about mental and behavioural changes but there was no scientific evidence to support the view that these changes were any more pronounced in black patients than white patients. No differentiation should be made between black and white patients or between patients of any other ethnic group.

Dr McKenzie said that sometimes his clients told him that they were suffering from a drug-induced psychosis. His reply was to ask them what was the primary cause, if the psychosis was induced by drugs. He would then explain that some of their friends took the same drugs but did not become ill. Therefore, he would tell them, they had a particular vulnerability which might be due to other factors in their history or their life, so that when they took these drugs they had a problem whereas their friends did not.

Dr Fernando's view was that schizophrenia was a concept that was outdated and that it should be replaced by a more meaningful set of terms that indicated the nature of people's problems. This view, in his opinion, had been covered in the relevant literature. There were many reasons for reconsidering the use of this diagnosis. An important one was that those who were "given" this diagnosis were often treated as if they were some sort of alien. Black people given the diagnosis thus suffered, as it were, by double jeopardy.

THE Inquiry has heard convincing evidence that, at present, there is too little contact with the family of the patient by those who provide treatment and care. It is important that there should be meaningful contact. Family contacts and family involvement are vital if the patient is to be successfully treated in the community. When a patient is in a mental health hospital, this contact should still be maintained.

The importance of visits to the family by an in-patient is well recognised. The concept of contact with the family needs to be expanded. Some families find it difficult to come to terms with the fact that one of their relatives suffers from mental health problems. Many families from all communities have great difficulty in talking about such matters. Families need assistance so that they can help the person with mental health problems.

Sometimes patients, for a variety of reasons often connected with their mental health problems, are reluctant to allow their family to be involved. This is an issue that needs to be tackled more positively.

Communication with the family can also help those who are caring for a patient to choose the appropriate treatment for that patient. It is often easier for black and minority ethnic families to communicate with someone from their own cultural background. Doctors can appear remote and alarming to them. In the section of this report entitled "Special Projects" we set out evidence on this subject, which seems to us to be sensible and realistic.

Dr Bennett told us that there was not enough involvement with David Bennett's family by mental health services during the many years of his mental illness. She illustrated particular matters on which the family could easily have helped if they had been made aware of them such as provision of clothing, money and advice on culture and social issues. She also explained about the lack of communication about the treatment he was receiving. Once a patient was, as it were, in the system, the family were largely ignored. This was not good treatment for the patient. It

also increased the antagonism that some families of patients already had towards the NHS.

Mrs Teasdale said that there were sometimes perceptions among staff that prevented them from accepting information from families of those suffering mental health problems when they should. She commented that the best predictor of violent behaviour was a history of previous incidents of violent behaviour. Accurate information about previous violence was essential for assessment of risk. Family members were often perceptive observers of patients' behaviour and were aware of the subtle signs that heralded an aggressive outburst. It was essential that the psychiatric team evaluated and utilised this information that the family had to offer and shared with them the professional assessment of the risk of violence. Rethink, which she represented, rejected the assertion that there were ethical objections stemming from the doctor/patient relationship which prevented the sharing of this type of information with family members.

Ms Spence said that families sometimes felt unable to go to a review of a patient to whom they were related through a mixture of fear and perceived inadequacy and to challenge the health professional's views or to ask the real questions they wanted to ask. They felt intimidated. Reviews were consequently seen by families as one-sided.

Dr Ghosh said that staff, when dealing with black patients, saw families as nuisances. Black families were seen as particularly difficult and black mothers as highly problematic. There was not only an attempt by staff not to give them information but there was a great feeling of hostility towards the family because they created problems.

The Inquiry heard from Dr Ball who told us that he considered the family to be very important and said that they should always be in the consciousness of the management of clinical teams who were responsible for the care of the patient.

THE Inquiry heard from Dr Ball who told us that very few patients needed long-term secure accommodation. The vast majority could be catered for by supportive accommodation. Secure units had never been set up for medical reasons. Physical security in psychiatry had a very little role to play therapeutically. It was a political reality.

The majority of patients who were admitted to medium secure units came through the criminal justice system and a significant proportion of such patients had committed extremely violent criminal offences, or were charged with very serious violent criminal offences. For a patient to be admitted into secure conditions made the public feel comfortable. This was the primary reason for secure conditions. He did not feel that patients who came into medium secure units from general psychiatric services in civil detention, rather than

through the criminal justice system, were done any good by their detention. He said he could give no quantitative data to support his view.

Dr Ndegwa said that there was a case for serious modification to be made to the work done in medium secure units. People working in these units felt that they needed to keep patients in a structured environment for a long time and somehow they would get better even if they were difficult to manage. It was unclear whether they would get better as a result of their treatment. Patients were frequently sent to these units because the service could not manage them elsewhere. There needed to be specialist places where there was expertise in treating people with chronic mental conditions who did not appear to be getting better according to present conventional standard treatment.

THE evidence we heard about medication in cases of schizophrenia leads this Inquiry to recommend strongly that there is an urgent need for further research and investigation into this subject by government agencies and other relevant organisations, including the Royal Colleges. The views of patients should be an important part of these investigations.

As we mention elsewhere in this report, there has been evidence that a “drug-free holiday” might be a useful way forward with some patients. We are also aware that in the case of patients with psychosis, although there will be those who are treatment resistant, there is no indication that high doses of anti-psychotic drugs help to cure them of their illnesses although it may be that such treatment enables the patients to be more easily cared for.

Dr Bennett said that there needed to be further research into medication. This needed to be looked at particularly in the context of over-medication of black patients. Clearer guidance needed to be given about giving more than one type of anti-psychotic drugs at any one time. There also needed to be research on the link between anti-psychotic drugs and the possible adverse effect they might have on the patient if that patient had to be physically restrained.

Mr Francis told us that the African-Caribbeans suffering from schizophrenia were getting far too much medication.

Professor Appleby said it was a widespread suspicion that in clinical care young people from the black community tended to be treated with higher doses of individual anti-psychotic drugs or with poly-medication because they were perceived by the staff to be more dangerous or more of a nuisance. But it was not something, he added, that had been picked up in research. More research was needed about this subject.

Dr Pereira said that in 1993 the RCPsych issued “a consensus statement on the use of high dose anti-psychotic medication”. This indicated that 10%-30% of psychotic patients would be treatment resistant and would show significant residual symptoms of psychosis, which impaired their everyday activities of living, despite full dose treatment of two different classes of anti-psychotic drugs successively. He drew our attention to the current edition of the British National Formulary (BNF) which stated that, “Prescribing of more than one anti-psychotic drug at the same time was not recommended. It might constitute a hazard and there was no significant evidence that side effects were minimised”. But he added that there might be occasional patients with whom it had been proved necessary by experience over several years of dealing with their illness. The College was now looking at alternative strategies, such as in-patient environment and features within the environment that could cause people to become disturbed. It was looking at additional diagnosis such as personality difficulties. It was also looking at nurse-related interventions, which

might minimise the use of high-dose medication. He told us that clinical practice changed very slowly and that there were a substantial number of psychiatrists who used medication which they were familiar with and were reluctant to change.

Ms. Tweedie said that research indicated that there were many cases where medication was being administered beyond the recommended limits authorised by Form 38 (the consent of the patient to treatment) and/or Form 39 (the second opinion form).

In 20% of Form 38 and 9% of Form 39 examined by Commissioners over 2002/03, treatment was prescribed above the authorised limits. In 20 per cent Forms 38 and 9% of Forms 39 examined by Commissioners over 2002/03, treatment was prescribed over the authorised limit. These figures raised concerns. She said that better audit tools and flagging systems were needed to ensure that Trusts took these matters seriously.

Dr McKenzie's view was that much of the prescription of anti-psychotic medication was too high. Once high doses of anti-psychotic medication had been commenced, this created a need for more and more anti-psychotic medication. In some wards, if a patient was very disturbed and was big and black, the staff tended to say that he needed a great deal of medication. Dr McKenzie said that anti-psychotic medicines took time to work. He had had experience in Brussels of “The Night Hospital” where it was found that giving large doses of medication did not work on patients, so they stopped medication and used other methods, such as therapy or letting their patients let off steam or by the use of quiet rooms. The research evidence base for the use of mega-dose medication was limited.

Dr Cary warned that there were interactions between drugs which needed to be recognised. It was not just a case of adding one drug to another.

We learnt from Dr Lipsedge that there were now new drugs for people who had “treatment resistant schizophrenia”. He said that cognitive behaviour therapy (CBT) was a recognised way of treating people with schizophrenia. This taught them how to challenge and talk themselves out of frightening delusional ideas and also how to cope with their hallucinations. Insufficient staff were trained in these techniques. It was time-consuming but important.

Dr Ghosh said medication should be kept as low as possible. She said that she would not go so far as to say medication had no place within the treatment of schizophrenia, but one should not constantly blame the patient for not getting well. If patients did not get well on anti-psychotic medication, it was illogical to keep giving them more and more of the same medication, which was not making them any better and was, in some cases, making them worse.

THE Inquiry found that the behaviour of people who suffer from mental illness may from time to time be difficult for their practitioners to deal with. This challenging behaviour always requires a sensitive and sympathetic approach.

Prevention is always the best way of dealing with possible aggression. But sometimes this may not be possible, although this Inquiry has a clear view that it is possible much more often than some practitioners appreciate. If prevention fails, de-escalation should be tried. This can be done in many different ways, such as by talking with the patient, by moving the patient to different surroundings or, where there is an argument between two or more patients, by separating them firmly but gently. De-escalation, like prevention, may take time. In a busy ward, time is sometimes at a premium. But prevention and de-escalation are not only useful but essential. In consequence, existing working practices in this field need to be changed.

In a few instances neither prevention nor de-escalation will work. In some cases oral medication, for the purposes of sedation, may need to be given. If the patient declines this medication, it would normally be appropriate to explain to the patient that it will be necessary to administer medicine by injection. The patient should be told that this may have to be done without their consent. If medication does not work, or is for some reason inappropriate, then the only other alternatives are some form of restraint or seclusion. Some hospitals have seclusion rooms, some do not. Some practitioners favour seclusion, some do not. The use of a quiet room, which sometimes is the patient's own bedroom, may be the appropriate place. A patient may have been taken to a quiet room as part of prevention or de-escalation. But, if some form of isolation or seclusion is not appropriate or feasible, then physical restraint is almost certainly the only remaining alternative.

Our witnesses deal with all of these strategies. It needs to be stressed that once prevention and de-escalation have been tried and have failed or are impractical, the remaining options of medication, seclusion or restraint each have very real dangers. In a struggle, patients and practitioners may be hurt. But in every case of restraint the patient will have a greater risk than the practitioners of suffering harm, both physical and mental and, on occasions, even death.

PREVENTION

Professor Gournay said that the right order of action in controlling aggression is prevention, de-escalation, breakaway techniques and finally control and restraint. He told us that there is a deficiency of training in prevention and de-escalation as well as in control and restraint.

Dr Lipsedge said that CBT is a recognised way of teaching people with schizophrenia how to challenge and talk them-

selves out of frightening delusional ideas or how to cope with hallucinations. Not sufficient staff are trained in these techniques. These techniques are time-consuming but very important. Research should be carried out into how patients spend their time on the wards. Recreational activity is not sufficient. There should be more in the way of educational/vocational training. This can reduce the frequency of violent incidents.

Dr Pereira said it was good common clinical sense to have a care plan written out, which contained details of what to do in case of violence by a patient.

DE-ESCALATION

Dr Lipsedge told us that if it appeared that a patient was going to become aggressive and needed medication, a member of staff could say something like, "You can either drink this tranquillising liquid, or we will give you an injection and that will require force". But, in general, rapid tranquillisation required physical restraint. Whenever restraint or tranquillisation was used, it was essential that the people involved in the incident talk to the patient as soon as possible afterwards to discuss what had happened. Violence on psychiatric wards generally had nothing to do with the psychosis. It was not motivated by hallucinations or by delusions. Petty incidents were extremely important in the life of a detained patient and these could escalate into violence.

Dr Pereira said that good practice would indicate there should be an attempt at de-escalation by talking down a potentially fraught situation, which should be exercised before medication or other exit strategies were considered. Consideration should be given to moving the patient to have time-out in another part of the ward. Placement became an important issue, particularly if the ward was overcrowded or fraught. He said there were occasional situations where no choice could be made as there was not time for this sort of dialogue. The Royal College of Nursing (RCN) commented that control and restraint was used too early on all patients. Once you actually laid hands on the patient you were likely to turn a threatening situation into a violent one.

Dr Ndegwa's view was that the principle should be that you should do what was least invasive and in the best interest of the person you were treating. If you came to the conclusion that control and restraint, seclusion or rapid medical tranquillisation were interventions of last resort, you had to make sure that you had set up a system where it was possible to do other non-coercive, more acceptable things first. For example, before thinking of seclusion you should think of time-out. Staff should talk to patients telling them things like, "I am so seriously concerned about you that I am going to do something". They could then go on to tell patients what they had in mind to do.

Dr Pereira said that if medical and nursing staff were consid-

ering medication in times of violence, it was good practice for them to know the potential range of drugs that could be administered to that particular patient. They should always look at the patient's prescription chart to make sure what medication had been prescribed before administering any further medication in times of violence. He emphasised the importance of de-escalation and then oral medication being offered before consideration was given to an injection.

Dr Cary emphasised that you did not die of a primary psychiatric illness and said that terms like "excited delirium" and "acute exhaustive mania" mean very little. He also said that urgent medication where a patient was violent was usually by injection. But if an injection had to be given, it should be remembered that there were dangers in giving it, so there must be people around capable of giving resuscitation in case something happened. In mental health hospitals it was likely that patients who became violent were already on potent underlying medication, so one needed to be particularly vigilant about giving them further urgent medication to calm them down. All intravenous or intramuscular injections in these circumstances had a risk attached to them. That risk should not be put on to the nursing staff. Many consultant psychiatrists believed that urgent medication in these circumstances was strongly contra-indicated. It was sometimes called "the chemical cosh". It must be remembered that an intra-muscular injection given to someone who was taking very vigorous exercise, such as struggling hard because he was violent, gets into the bloodstream much more quickly than normal. It might be almost the equivalent of an intravenous injection in some people.

SECLUSION

The Inquiry considered that the use of seclusion should be handled with great care. Patients in seclusion should be constantly monitored.

Dr Cary said that the downside to using seclusion was the risk of self-harm. He regularly saw people in police custody going absolutely berserk when put into cells and the door being shut behind them. But it was a way of buying time possibly until a doctor became available to give medication and it was thus a way of delaying the problem. In the end, it was just as problematic a solution as medication or restraint.

Dr Ndegwa said that some staff believed that seclusion worked but patients hated it. It was better to try to de-escalate the situation and separate the parties.

We also heard evidence that if a patient was placed in seclusion, he must be constantly monitored.

Some witnesses told us that it was unnecessary to have seclusion rooms and that where there were none they had not been found to be needed.

Ms Tweedie, however, said that the Mental Health Act

Commission (MHAC) was not against seclusion; it was an alternative to mechanical restraint. They had concerns about it but considered that it could be used on occasions.

Dr Ball also said that he found seclusion for patients beneficial on occasions.

RESTRAINT

The recommendations of the Inquiry on the subject of restraint are at the conclusion of this part of our report.

Professor Appleby said that it was generally accepted within mental health services that restraint should be the last resort in a difficult situation. It should be seen as a therapeutic process. It needed to follow strict guidelines. If someone needed restraint, by definition that person was in a medical emergency.

Dr Ball told us that once acute disturbance and/or aggression started, the immediate response, if possible, should be psychological and social. An attempt should be made to engage a patient in human contact and to try to restore calm. It was only when that sort of approach was not possible, or there was a very real danger of harm to another individual or to the patient himself, that more forceful techniques came into play. Patients had psychological reactions to being restrained. Female patients, particularly those with a history of having been the victim of a sexual assault by a male, felt traumatised if restrained by male staff

The RCN told us that once you actually laid hands on a patient, you were likely to turn a threatening situation into a violent one because the person reacted to being touched. Restraint might be initiated early in respect of black and ethnic minority people because of the perceptions of the nurses who initiated restraint. There was a tendency to turn to control and restraint far too quickly instead of going down the "let's go for a cup of tea and talk about it" approach.

Mr Tucker, told us that the management of violence in in-patient units was part of a therapeutic process.

Mr Francis was of the opinion that to meet force with force was a very crude way of dealing with violence in a medical environment. Staff needed to learn much more about the whole psychology of the relationships between patients and staff. They needed to understand what started people off becoming violent. They needed to understand how to handle people and how to be polite and how to de-fuse things and how to talk things down.

Dr Ndegwa said that the principle should be that you should do what was least invasive in the best interests of the patient. If possible, you should talk to the patient before being invasive in any way.

Dr Ghosh considered that control and restraint was degrad-

ing. It was perfectly possible to manage patients, even within high security units, without control and restraint. There had always been violent patients in psychiatry and they had always been managed. They did not have to be degraded with control and restraint.

INFLECTING PAIN DURING RESTRAINT

The Inquiry heard conflicting evidence on this difficult subject. The Panel formed a firm view that it was not appropriate to inflict deliberate pain during any form of restraint of a patient, whatever the circumstances might be. Any patient who required physical restraint was by definition in a medical emergency.

Professor Appleby was against deliberately causing pain to prevent damage by the patient to himself or others.

Professor Gournay saw a potential for terrible abuse of patients if the application of pain was allowed. But he added that it was very difficult to provide specific guidance about particular types of restraint and to attempt to make them universal because the situations in each case were so different from each other.

Dr Cary considered that sometimes a very carefully applied painful hold could be the most humane way of dealing with a person. It was distasteful to think of someone having to be controlled through the use of pain but, from the point of view of safety to life, it was sometimes safer to use a painful hold than to restrain by other methods.

Professor Sheehan said that his personal view was that one should not inflict pain as a necessary part of controlling violence.

The RCN said that in this country many systems for controlling violence were based on pain, which was not acceptable.

PRONE POSITION

The Inquiry was convinced that it was always dangerous to place a person in a face-down prone position, but accepted that there were occasions when it was necessary to do so. We heard powerful evidence that the longer a person was held in a face-down prone position the more dangerous it became.

We accepted the evidence that there should be a time limit to restraint in a prone position. We recognised that it was arbitrary to impose a specific time limit, but we concluded that the imposition of a time limit was essential in order to minimise the risk. We therefore recommend that a person should not be restrained in a prone position for more than three minutes.

Dr Ball said that restraint in the prone position was particular-

ly dangerous. He was sympathetic to the view that prone restraint should not happen or, if it did, for it to be ended almost instantaneously or changed to restraint with the person lying on their back.

The RCN considered that face-down positions were more dangerous than face-up, but said that it must not be forgotten that face-up positions could still be dangerous. They said that there was a need to articulate the legitimate concerns of nurses as well as patients. It was necessary to get the balance right between safety of the mental health patients and the safety of staff.

Mr Tucker said that progressive trainers would say you never put people in a face down position.

Dr Shepherd said that the safest way of dealing with violence was a rapid episode of initial restraint by people who have had proper training. This should always be treated as an acute medical emergency. He would hope that control could be gained within seconds. It might be necessary to place the person being violent on the floor to start with, in order to gain control, but one had to be aware of the risks to the patient in keeping them face-down. If they were kept face-down, there was a risk of causing death. One could construct a timescale of two or three minutes for a patient to be face-down but any time limit was entirely arbitrary. While they were face-down it was a very difficult and dangerous phase for the patient. There was no risk free option.

Dr Cary pointed out that if a patient was struggling while being restrained, that person ran out of oxygen incredibly fast particularly if his chest was squeezed and his lungs were empty. You should never restrain to exhaustion. He was not totally against using face-down restraint in order to gain initial control in what otherwise might be a dangerous situation, but it was not satisfactory where the only obvious escape from face-down restraint was when the person either became limp or was unable to go on struggling.

The Police Complaints Authority in their publication "Policing Acute Behavioural Disturbance (2002)" cited Dr Cary's view that:

"The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised".

INQUEST drew our attention to the current prison service's control and restraint manual, which sets out their procedures for the applications of control and restraint. That manual stated:

"Whenever an inmate is held face-down on the floor the maximum period of continuous restraint should not exceed five minutes".

Professor Appleby said that if you had people in the prone

position on the floor it should be for the shortest possible time and he would support a recommendation for a time limit, even if it were arbitrary.

Dr Shepherd favoured a time limit of, say, two or three minutes, but added that any limit was likely to be entirely arbitrary.

Mr Tucker said that there was no harm in imposing an arbitrary limit and even an arbitrary limit would be better than no limit at all.

Finally, Dr Pereira said that the RCPsych did not have a policy regarding the prone position.

MECHANICAL RESTRAINTS

The Inquiry was against mechanical restraints in a therapeutic setting. We were not satisfied that these were effective and considered that they were degrading and that if permitted, their use could easily be abused.

Ms Tweedie said that the Commission was against mechanical restraint, absolutely, because there was so much potential for abuse. Within a health care setting they would want to stress the importance of de-escalation techniques, of looking at the ward environment, patient care and treatment as a whole. If it were to be recommended that on isolated occasions mechanical restraint would be acceptable, they would suggest very strongly that there should be outside monitoring to ensure that there was someone present after every incident to check and make appropriate enquiries to ensure that it was absolutely the last possible resort. She said that they would support some form of national research and debate on this but would not be supporting the use of mechanical restraint as a proposal. She added that it was a very difficult area.

The prison service used mechanical restraints, but in a very different setting.

Professor Gournay pointed out that in America it was quite common to use mechanical restraint. He said that there they had four-point restraint and the job of the nursing staff was to get people into that four-point restraint so that their hands and legs were mechanically restrained. The American view was that that way of restraint was humane and safe, whereas in England, instead, you piled two, three, four or five nurses on some poor individual at a time. But he stressed that mechanical restraint should not be used, except possibly on very rare occasions.

Dr Shepherd said that there were political difficulties with mechanical restraints, such as handcuffs. He said that at present they do not have statistics relating to restraint to know what works best.

Dr Carey confirmed that in America nurses were more ready to use mechanical restraint. He expressed doubts about it.

But he said that Velcro wrapped round the legs was sometimes effective at stopping a person from kicking out. He added that one had to be extremely careful that mechanical restraints did not create a horrendous image of humiliation or control. Using a chair into which a patient could be strapped might sometimes be an alternative, but there were objections to this too. In all cases where there was restraint he would like to see someone appointed whose principle role was not to restrain but to be the guardian of the person being restrained in order to make sure that their airways were unrestricted and that they were not being mistreated.

Dr Ndegwa was not in favour of mechanical restraints in a clinical setting.

Professor Appleby had no views on the use of mechanical restraints as he had no knowledge of them and had never been in a situation where they had been used or thought to be needed.

TRAINING IN CONTROL AND RESTRAINT

Our recommendations on training in control and restraint are set out at the conclusion of the report.

The Inquiry heard from many witnesses who dealt with the problem of aggression. All were agreed that this was a problem that needed to be resolved. All were agreed that the problem had been obvious for many years. We discovered no important new aspect of this problem from the evidence we heard. But there were a number of slightly differing views on some aspects. At present the problem of aggression was tackled by different Health Trusts in different ways. There was no central training, no central accreditation of trainers, no clear definition of the content of the training or of the people who should go for training or on the time they should spend being trained.

In our view, this is a subject that badly needs central control. We have no doubt that it should be controlled by the Department of Health. We welcome the work that the National Institute of Clinical Excellence (NICE) is now doing on this subject, under the chairmanship of Professor Gournay, but were concerned to learn that it will take a long time for reforms to be formulated and agreed with all relevant organisations and even longer for reforms to be implemented. In the meantime, existing inadequate practices continue. We also considered that it would be appropriate for the Nursing and Midwifery Council (NMC) to review their own strategies with urgency.

We could find no indication of any interim measures being put in place in the meantime. As interim measures, we recommend that medical and nursing staff should all receive the same training, which should be brought up-to-date at regular intervals. We also recommend that a directive should be issued by the Department with urgency stating that people should never be held face-down in a prone position for more than three minutes. We recognise that the figure of

three minutes is an arbitrary one but the evidence we heard was conclusive that the shorter the period that a person was restrained face-down in a prone position the less risk was incurred. Professor Sheehan told us that at present “we have the most awful training system in control and restraint”. It was wrong and needed to be changed. The National Institute for Mental Health in England (NIMHE) would soon be making two appointments in training in the management of violence, which would take forward a programme of work to bring together the very best of practice. They would set out guidelines and work with the Workforce Development Confederations (WDCs) to ensure that training was delivered to a commonly high standard across the country.

Mr Rae said that there was a need for a single set of instructions for everyone which set out definitive guidance for those who deliver services. There was at present a lack of clarity in respect of the qualifications and validation of trainers and advice about good practice. The syllabus needed to be updated and induction programmes and training needed to be geared to specific client groups and their individual needs. Proposals should be developed to ensure that there was an independent system of accreditation for trainers. Training programmes with rigorous core standards should also be quality assured.

Dr Ndegwa considered that an accreditation system should be set up with some form of quality assurance. Training should take account of the patient's understanding and should appreciate the things that were important to patients. Users and decision makers were not necessarily speaking the same language. You needed a framework to understand the person you were treating.

Mr Tucker said that the ultimate responsibility for training for control and restraint was with the Department of Health. The NMC did not draft standards of care for the management of violence. At present training had fallen between different stools in terms of local and national policies. Currently nobody was really in charge of training. Each Trust organised its own. Further, nurses needed revalidation. At present they had to show proof of training only if asked to do so. As there were some 650,000 nurses on the NMC register, it was extremely difficult to check whether they had received the necessary training and to keep that check up-to-date. There should be a system that could be checked. There was, at present, no way of knowing whether they had received the training or, if they had, whether it was of an adequate quality or not.

The representatives of MIND said there was a need for specialist training in risk assessment. Professor Gournay told us that in the late 1990s the Department of Health recommended there should be further work done nationally to examine the issues of violence and training of staff in managing aggression. This had led to the commissioning of work done by him, carried out for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as one of the Standing Committees which gave

advice to the Secretary of State. This Committee published surveys. It found that a high number of staff had received no training at all. It also found enormous variation in the training people had received. Only in a minority of cases were the issues of race, culture and ethnicity mentioned at all. Professor Gournay noted that many of the training courses for nursing staff had absolutely no content regarding race, culture and ethnicity. He was staggered by that. It was not possible to reach any definitive conclusion about what training was at present being provided because of the absence of written documentation.

The range of deficiencies surprised even the experienced mental health professionals who were involved in the work. As a result of this, in early 2002, NICE had set up a Guidelines Committee, which he chaired. This Committee would produce draft guidelines in the spring of 2004. These draft guidelines would then be disseminated for consultation. Once the consultation period was over the Department of Health was likely to accept and issue them. He stressed that it was an enormous task to get the training agenda and the staff up to speed. Professor Gournay said he considered that would be a ten-year task, not a two-year task. There was difficulty in releasing people for half a day for training, let alone five to seven days, which was what was necessary.

He told us that there must be a national system for accrediting trainers. There was a need to kite-mark a training programme. When you had the opportunity to train a whole team, you delivered better training. Training nurses or doctors on their own was probably both inefficient and less effective. Dedicated control and restraint teams would not be practical. Trusts should have more of their own in-house trainers to make sure that their staff training was continually brought up-to-date. It needed money to train staff so you needed to put resources into these projects.

Professor Appleby said there should be national standards of training. There should be a curriculum approach to the training of people in the mental health services. This, he said, would eventually happen but it took time to set up. He was frustrated about how long it had already taken. An existing problem was the general issue of the variability of training. People in clinical practice at present did what appeared to be unreasonable things in restraining patients because they were not sure what to do when the emergency took place. Improved training would avoid this.

Dr Lipsedge said that patients should have educational and/or vocational training. This had already made a huge difference in the prison service and should make a huge difference to long-term patients with schizophrenia. Introducing education and training would reduce the frequency of violent incidents. Ms Tweedie said that it would be a very sensible thing for the Panel in this Inquiry to include a recommendation that there should be a national agreement on training and trainers. At present standards of training courses varied.

WE repeat our recommendation made in Part 1 of this report that there should always be a fully equipped resuscitation trolley wherever a mentally ill patient is detained, and people available at all times who are trained in the use of the equipment upon it.

Dr Cary said that wherever a mentally ill patient was detained there should be a fully equipped resuscitation trolley. There should also be people who were capable of giving the drugs on that trolley and of using all the equipment upon it, including a defibrillator.

Dr Pereira drew our attention to the use of highly automated types of defibrillators colloquially called “idiot-proof” defibrillators, which he said were extremely simple to use but expensive to buy. His own view was that automated defibrillators should be available for use in every ward which dealt with mentally ill patients and that nurses and doctors should be fully trained in their use.

AVAILABILITY OF DOCTORS

The Inquiry has already recommended that there should always be a doctor in every place where mentally ill patients are detained, or if that is not possible foolproof arrangements should be in place twenty-four hours a day to ensure that a doctor will attend within twenty minutes of any request by staff to do so.

Dr Cary said it was highly unsatisfactory for doctors to be available in an institution where mentally ill patients were treated only if they came by car or taxi in a wholly unpredictable fashion. Psychiatric units should either be close to full cardiac resuscitation units or in locations where doctors could get there quickly. In all other circumstances there should be a doctor on site. It was unsatisfactory not to be able to have a doctor at a unit until 20-30 minutes after a serious incident. But he recognised that it was difficult to provide doctors at units for twenty-four hours a day if those units were well away from a main hospital where there was 24 hour medical cover.

Professor Appleby said that if there was a diversity of in-patient units which, by definition, were in different places, it became impossible to have full on-call medical provision in the traditional sense purely logistically because doctors could not be everywhere.

SECOND OPINION APPROVED DOCTOR (SOAD)

Ms Tweedie considered that the role of second opinion approved doctors (SOADs) was to look at the prescription of the original prescribing doctor to see if he was acting reasonably. It was not necessary for a SOAD to decide whether he would have prescribed the same medication. It was a checking and balancing mechanism. The Inquiry considers that while the SOAD should always look at the prescription, it was also necessary to review the patient’s care plan.

THE witnesses who spoke of these projects, themselves came from black and minority ethnic communities. These witnesses were deeply committed. Each project has been successful. But each of these projects was relatively small and depended substantially on the personalities of those who ran them. Each operated in an inner-city area.

The common theme between these projects was the need for the project managers to establish trust between themselves and communities they served. If trust was not there, they would fail. These initiatives needed to be strongly encouraged. We were told that these projects had limited funds available, which constrained their effectiveness. We learnt that one particular project found that it was a struggle to keep going. If further resources could be found for such projects then they would be able to operate more effectively and, where appropriate, to expand. This could also enable new initiatives to start in other areas. If this happened real progress could start to be made.

These projects help to eradicate the fear that we have already referred to that prevents some people with mental health problems from approaching the NHS for help. Each of these projects has a strong element of community care. Those who suffer from mental health problems, particularly those from the black and minority ethnic communities, greatly prefer treatment in the community to treatment in an institution, particularly if the institutional treatment is long-term. Treating such people in the community requires services from social workers and others who will supervise them. In some cases these people require some form of sheltered housing.

Supervisors may also be needed to ensure that these people take their medication. But if those with mental health problems can be treated in such a way that they do not lose contact with their families and/or their peer groups, they are more likely to recover. If they can be taught to build up a life for themselves and if they can form relationships and engage in education or hold down a job, then their chance of leading a satisfactory life is greatly improved.

We appreciate that the type of approach that is identified by these projects can sometimes be difficult to supervise and can put additional burdens on the NHS. But we consider them to be excellent examples of good practice and strongly recommend that they be further supported and expanded.

Dr McKenzie runs an assertive outreach team called Antenna in Haringey, London, specifically for 16 to 25 year old African and African-Caribbean clients with mental health difficulties. This project has been running for three years. There the staff team deal with a maximum of 50 people at any one time. The team aims to see people with severe mental health problems, including those who have no inter-

est whatever in using mainstream services, or have poor engagement or poor satisfaction with those same mainstream services. They see people in the community and on wards. They sort out their housing, they run various groups to engage these clients and help them and they take them out on trips. They are focused on giving them a genuine future. Some 50% of their clients at present are either in work or education. A number of their clients will refuse to take medication. They try and persuade them to do so. They tell them that their best chance of being stable is to take medication and point out that once stable they may move on and improve. But they do not insist that they take medication. They find that the majority of their clients benefit by this approach and come to take their medication.

About 70% of their clients are in regular contact with their relatives or carers and 30% in regular contact with their friends. Antenna has a 50% use of a carer support worker. The carer support worker is absolutely crucial. This worker sits down with the families of the clients and explains how the mental health system works.

During these three years they have had 187 people through their service. Dr McKenzie stressed the importance of communications between those who care for these people and the people themselves. There was a team meeting at the end of each day. All concerned sat down and talked about their clients so that everybody knew what was happening. He found that aggression in these circumstances could be coped with almost entirely by prevention.

Mr Francis was deeply involved with the Frantz Fanon Centre in Birmingham, which deals primarily with black clients and has a substantial number of black staff. It works extremely well. There is no violence. It is their policy wherever possible not to administer medication. Staff discuss all matters of concern with their clients. During the six years that the Centre has been open, no client has ever assaulted a member of staff. If clients wish for a second opinion to check either their diagnosis or their treatment, they are allowed to have one. The Centre takes the view that it is essential to give choices to clients. This builds up their confidence in the system. Mr Francis felt that there should be a better complaints process and that there should also be advocacy. He would like to see an independent advocacy service set up. He told us that the approach of this Centre does not work with everybody who comes to it but works with a very large proportion of them.

Dr Berke, in 1973, was the founder and is now the Director of the Arbours Crisis Centre. Dr Berke emphasised that the main reason for aggression and violence in psychiatric in-patients had to do with intense fear, guilt and frustration. The more that staff understood the psychiatric symptoms of their patients and the more sympathetic they were to them, the more they appreciated their problems and the better the patients responded. He would like consideration to be

given to the provision of “drug holidays” where patients could be seen and maintained in a non-drug state to see how they responded. He felt that the current problem was not too little but too much medication, given over excessive periods of time without adequate review, and said that too often medication was given for the sake of the staff and not for the sake of the patient.

Dr Pereira runs an intensive care unit at Goodmayes Hospital, which has won nine national awards from the Department of Health, the BMA and other bodies. His basic principle is to use “good common clinical sense”. He emphasised the need to talk to patients. Each week patients come into a “partnership forum”. The patients have a representative who tells the forum about what works on the unit and what does not work, what the patients like and do not like, which nurse or which doctor has an attitude problem, how they are spoken to, the quality of the bedrooms, the showers, the food etc. The unit has advocates, or user groups, at part of the meeting. They used to have some twenty complaints a year but, over the last two years, they have had not one single complaint. They have different events to cater for different ethnic communities.

Ms Spence told us that her work with the African-Caribbean Community Initiative (ACCI) stressed the importance of good communications between mental health services and the black and minority ethnic communities. At present these communities were reluctant to engage with the mental health services. They also have a sense of fear of engaging with these services. At times, the service providers appear to be almost devoid of humanity. This is largely due to their perception of people from these communities, which is as if they expect trouble or problems from them.

ACCI actively promote the improvement of mental health services. They host road shows and conferences. They have a carers’ support group. They maintain links with churches. They keep in touch with the families of those who suffer from mental health problems. They provide supported accommodation for some sufferers, mainly for those who have recently been discharged from mental health

hospitals. The staff in the supported accommodation assist the residents by helping them to develop their daily living skills, by helping with their budgeting and by offering, wherever possible, opportunities for education and training. This work has built up trust between themselves and the communities they serve. ACCI employs fourteen staff in all. They hold bi-monthly staff and members’ meetings. They have a complaints procedure, but almost no complaints. They carry out regular “users’ satisfaction evaluations”. Their aim is to “work with people not with diagnosis”.

ACCI was set up in 1987, primarily to help black people. It is now also used by people from the Asian community and also by a few white people. It is widely respected in Wolverhampton where it operates. Ms Spence is a member of the Local Implementation Team (LIT). ACCI now receive some funding from their local health trust. Ms Spence considered that if she had not been a member of LIT and thus been able to explain the nature of the work done by ACCI to a wider audience, it was unlikely that this funding would have been provided. Nevertheless, ACCI’s resources are still very limited. She made the comment that policy makers are often far removed from the reality of “what it is like to be in receipt of mental health services”. As a result, these policy makers tend to make abstract decisions, which “are not in time with the most basic human elements of what needs to be done”.

Dr Lipsedge said that there were projects of which he was aware, which did extremely useful work. He itemised work in South London carried out by Emma Balfe and Ann Benson who have analysed the verbal accounts of participants in various incidents on wards and then attempted to identify the meaning of violent incidents from the perspective of members of the medical and nursing staff and also of the patients involved in the incident. In nearly every place he had been concerned with, he found it extremely unusual for anyone to ask all the participants to give their account of what had happened, although that could be immensely helpful.

WE are encouraged by the positive evidence given by Professors Gournay, Appleby and Sheehan of the various plans to improve the mental health services nationally. But, we start this section with a note of warning.

During the past few years, a number of different initiatives have been instigated by the Department of Health, such as National Institute for Mental Health in England (NIMHE), National Institute for Clinical Excellence (NICE) and Commission for Health Improvement (CHI). Each of these initiatives has been well-intentioned and has done useful work. But the management of the individual initiatives changes and the impetus is lost.

There have been many conferences, consultations and papers written during the last twenty years about the problems that the mental health services face. Some of these have dealt with the problems experienced by the black and minority ethnic communities. Time and again regrets at the existing state of affairs have been expressed. Time and again promises of improvement have been made. While it would be unfair to say that nothing has happened, it is true to say that not very much and certainly not enough has happened. Unless there are sufficient resources and sustained management, which is both dedicated and committed, these problems cannot be solved.

At present people from the black and minority ethnic communities, who are involved in the mental health services, are not getting the service they are entitled to. Putting it bluntly, this is a disgrace. The NHS is national. Final responsibility lies fairly and squarely with the Department of Health. Other institutions may advise and may contribute to what should be done. But, individually or collectively, they have little power to require that changes be made. We are told that the Department of Health is determined to carry out the necessary improvements. We very much hope that this time they will. But, in view of the history we reserve judgment about whether this time these good intentions will be translated into action and that that action will be sufficient to cure this festering abscess, which is at present a blot upon the good name of the NHS.

The witnesses expressed a unanimous view that there had been a lamentable lack of action to tackle the continuing problems relating to aggression. Although these problems have been clearly identified for many years, we consider that this question must be resolved urgently. We are encouraged by the work NICE is doing, to which we will refer in more detail. But, we still consider that it is lamentable that it has taken so long for meaningful research to be commissioned so that appropriate action can be taken.

Professor Appleby said that, in the last two years, there had been the first signs of the re-shaping of mental health services nationally. Before that these services operated in a fairly

traditional hospital-based model of care, with relatively under-resourced community services to back that up. Evidence has shown that that model was not liked by many patients who used the mental health services, particularly those from the black and minority ethnic communities. Since the year 2000, the government had committed itself to more modern models of care for mental health through the National Service Framework (NSF). This framework included home treatment, which was something that people from ethnic minorities preferred and which should be available in every service throughout the country. That was national policy but was not happening as quickly as had originally been planned. It took time – you could not simply create new home treatment teams. People had to be found to staff them and there was a staff and skills shortage across the whole system.

At present there were some 60 or so home treatment teams across the country, which did not exist three or four years ago. They were not specifically for the ethnic minority population. The national policy had also been to expand the availability of psychological therapy. But there was still a long way to go before the NHS could provide clinical psychology services by black members of staff for black patients. It was the explicit aim of the NHS to be staffed in a way which reflected the composition of the local community. He said that the system as a whole had not lost its humanity. It had a lot to learn and was under a lot of pressure. It had to learn from the voluntary sector in providing culturally appropriate services. But people in the NHS listened to patients and had concern for their cultural and other values. The Mental Health Service was way ahead of the rest of the NHS in recognising the contribution of the voluntary sector.

Professor Sheehan told us that a detailed programme of work had been developed under the auspices of the Race Relations (Amendment) Act. His view was that there was a fairer and more equal service now that it was people-orientated from the start. He said that the Commission for Racial Equality (CRE) had been tasked to help with a race-equality programme throughout the service.

There was also a special initiative with the new health and social care inspection bodies to build ethnicity into the ratings programmes for all health care with an emphasis on making sure that they worked closely with the CRE in relation to their inspection arrangements. Further, there was a key programme of work, led by the Department of Health but driven through the Primary Care Trusts (PCTs), to improve the partnership with people from the black and the minority ethnic communities.

The Department's expectation was that in all policy areas PCTs will undertake an impact assessment in relation to their work as required by the CRE. He commended the publication of

the papers "Inside Outside" and "Breaking the Circles of Fear" and other salient pieces of work. He told us that they pointed the way forward.

Professor Sheehan also told us that £3 million would be spent on a programme of activity over three years in the area of black and minority ethnic mental health. There was to be a key performance indicator for the year 2003/4, which would focus on the robustness of data in relation to ethnic monitoring in order to ensure that it was set in the proper framework of performance requirements. He said that once the Department obtained the right data, that would ensure that it could measure other indicators as it developed them. He said that CHI was committed to working with the Department. He stressed the importance of leadership. He also stressed the great importance on having more people from the black and minority ethnic communities working in the mental health system, both in the statutory and independent sectors. A major study on this was due in 2004.

The Department was also engaging with partners to research the best available knowledge and practice in relation to the delivery of services to the black and minority ethnic communities. He told us that a further key area was the issue of tackling racism between patients in in-patient settings and also in relation to staff. At present the surveys showed that only 50% of services had protocols or procedures for tackling racism in in-patient settings, which was not good enough. There should be a common standard which should be mandatory in relation to the management of violence and in relation to tranquillisation of patients when necessary. Systems of accreditation for training should be developed because inconsistency of training was a key issue.

There was a further initiative in the Department's work with the Social Exclusion Unit (SEU) to consider and tackle the determinants of mental ill health, which would concentrate on the Neighbourhood Renewal Unit (NRU) in areas of most compelling need. Ethnicity was to be a key feature of this work with the SEU.

Professor Sheehan emphasised strongly that there must be black representation on all appropriate bodies. The NIMHE was raising the profile of black representation within its own organisation. He also said that as a minimum, there would in future be nine people who would eventually take very senior positions in race equality in NIMHE.

He dealt with treatment for black and minority ethnic patients. He emphasised the importance of choice and told us that it should be possible for a black patient to be treated in a hospital that has other black patients if that was where he wished to go. But he said that it would not be appropriate to create situations where there were only black patients in a hospital. Every hospital, whatever the number of black or minority ethnic patients, must have processes in place and an understanding of ethnic matters for the staff to be able to deal with them. In certain particular places, specific black services had been set up. He instanced Tower Hamlets, where there was

a Bengali-specific service, as they comprise the majority of the population in that area.

Professor Sheehan told us that the important thing was the Department's ability to co-ordinate the efforts of many different agencies within a legal framework. The authority and power of the new commissioners to inspect and regulate health bodies was more significant than it had ever been. Their ability to bring together these various elements of programmes of work supported real change. The Department intended to support community engagement projects and to fund nine fast track workers to make this happen. The Department would invest in 80 community groups, which would give people money to generate change in the way they want to deliver. There was already in the system money for five hundred new community development workers.

For too long, he said, people have struggled locally to develop local services without support, but now there were examples in London, Birmingham, Leicester, Bradford and elsewhere. He stressed the need for co-ordination in order not to waste money. He told us that there was a meeting recently between the Secretary of State for Health and representatives from the mental health voluntary sector, which had encouraged the Department to support community groups. He said that there were twenty PCTs in this country which not only commissioned services but also managed mental health services. A network of those PCTs had been established under the Planning and Priorities Framework. There were obligations under the primary care trust ratings. These were levers for change.

Professor Sheehan said that having been around the country and been in touch with many PCTs, he felt that there was now excitement and a certain amount of panic. Community groups, he said, were going to be knocking on the door of the PCTs saying that they wanted to be involved. He genuinely believed this process would work. Next year the Department wanted to go to every single hospital in the country in the space of four or five days in order to find out the details, including the ethnic origin, of every single patient in the wards. The Department would want to know other details about the patients' background and history in terms of language and dialect and so on. It would find out where the problem areas are and would be using the data to challenge them. The Department wished to break the present cycle of "no care no treatment" once and for all. We note that in 1999 NIMHE evaluated 104 units. About 80% of these units replied commenting that the exercise was positive and requesting further help.

Professor Sheehan emphasised that there was a national strategy for the development of acute care for schizophrenic patients, which involved training workforce development, the development of planning locally with service user involvement. He felt that RCPsych could help in improving prescribing practices and pathways into care.

Professor Sheehan spoke of the control of aggression. He said

NICE guidelines would set the standards that would be applied. Training was needed to underpin these guidelines. He said that the Minister of Health had made a commitment that the recommendations of this Inquiry would be, "Brought directly into our Implementation Plan". That commitment remained. He told us that that commitment had been expressed in Parliament. He said:

"I did not come to the Department of Health simply to write policies. I came to make a difference. I have a real opportunity and I do not want to let people down. The focus for research within the black and minority ethnic communities should be focused on what actually works and not too much on epidemiology because we know about the facts. Research agenda has been dominated by too narrow a perspective and too narrow a set of methodologies, all concerned with the laboratory rather than the community. That has to stop."

Professor Patel told us that there needed to be a wholesale change in the mental health system in respect of patients from the black and minority ethnic communities. There were now many individual areas of practice which were good. These should be identified with clarity and drawn upon so that they become the norm throughout the service. But, despite these encouraging signs, there was at present a deficit in just about every area of work that needed to be looked at.

He said that until the Department had learnt to do ethnic monitoring and used that data intelligently, they were moving nowhere. He pointed out that the MHAC was set up in 1983, and every two years since, had said that there were disproportionate numbers of black people in psychiatric wards and that their care and treatment was far worse than that of white people. He confirmed that the MHAC had often made recommendations. In 1997 it published a Race Equality Scheme. They had produced an impact assessment with a full programme of activities. They had done a huge amount of work over the last four to five years. He drew our attention to the fact that now the number of commissioners in the MHAC who come from the black and minority ethnic communities had increased to some 24%. Professor Patel had also been working for the last eighteen months with the RCPsych to produce a Racial Equality Scheme for the College. The same process would take place with NIMHE. He expanded on the £3million programme mentioned by Professor Sheehan for activities in the area of black and minority ethnic health and explained that in the initial phase it was planned to fund at least eighty community groups in the next two years to work on mental health issues alongside service providers and commissioners.

Professor Patel felt that there had been some change in certain areas but that change had not been either good enough or fast enough and did not go far enough. It was

clear, he said, that for the last twenty years and more there had been a disproportionate lack of care and treatment for the black and minority ethnic communities in the mental health services. It had been government policy that if service users did not access services then there was no problem. But he told us that people did not access services which were inappropriate.

Mr Tucker pointed out that the work being done by NICE under the chair of Professor Gournay on guidelines on the management of violence and aggression was by no means complete. He welcomed the concept of providing a set of guidelines, which took into account all aspects of the management of disturbed behaviour.

The rationale for Professor Gournay's work was that at present the training on the management of aggression was a "bit of a mess" and it needed someone to start bringing it together. But he still had a fear that there were too many things going on at the same time. Many people, when they heard that NICE were doing this work, had stopped their work and took the view that they would wait and see what NICE found before they changed any of their policies.

Mr Rae said that the most recent Mental Health Act Code of Practice published in 1999 needed updating with particular emphasis on the chapter on restraints. He was optimistic that the NICE guidelines on the control of aggression when issued would significantly inform and influence policy and practice. He wished to see a major focus to develop proposals for an independent system of accreditation of trainers and training programmes, which would have rigorous core standards which should then be quality assessed.

Professor Gournay told us that in 2001 he was appointed as the chair of the NICE panel on the Management of Violence in Mental Health Settings. The Panel aimed to complete its report on guidance for staff working in mental health care in the NHS by March 2004. That guidance would then be subject to a wide-ranging consultation exercise, which would take several months. The guidance would be published as a NICE document. The NICE process was rigorous and systematic and, as it had considerable resources at its disposal, the work would eventually produce a much more definitive set of recommendations and guidance than was achieved with the report on the Management of Violence published by the UKCC in 2001.

NICE believed that it had made wide-ranging efforts to engage service users from a range of ethnic minority backgrounds in various ways. These included surveys, the use of the Patient Involvement Unit and consultation exercises with various service user groups representing people from minority ethnic backgrounds.

Professor Gournay said that one area that was being examined by NICE when dealing with the Management of Violence concerned culture, race and ethnicity. NICE had put in place plans to ensure additional input from African

and Caribbean users and user groups. Some recommendations regarding the management of violence had already been made implicitly and explicitly within the work that was carried out for the UKCC

Professor Gournay said that once the guidelines had been published there would still be an enormous problem. This was so because, even with definitive guidance, a situation was left where a large number of nurses, probably over one-third of the total nursing workforce, would have received little or no training in the management of violence. Dealing with the training agenda, without taking into account the need for refresher courses, would be an enormous task. That was not a two-year task but a ten-year task. There were enormous problems with releasing staff for training. There were problems with funding the training. A basic training module of five to seven days was needed for each training course, so one could imagine what would happen if a sudden decision was made that all the staff on the ward were to be trained. Wards had difficulty in releasing people for half a day for training, let alone five to seven days.

It was not just patients who were at risk. There were staff at risk because of poor training standards. It was important to

look at the perspective of the staff as well as the patient. Professor Gournay told us that he had come across incidents where patients had been permanently disabled as a result of incorrect restraint. Other patients had suffered post-traumatic stress disorder because of inappropriate restraint. These observations also applied to staff. He had a simple principle that anybody who set foot in an acute psychiatric ward, from the cleaner upwards, should be trained. Management of violence training had to include different components. It had to include theory and practice. It had to include prevention and de-escalation, breakaway techniques and control and restraint. At present there was a deficiency of training in prevention and de-escalation. The issues relating to race, culture, ethnicity and gender should be predominant throughout all training.

Trusts should do more to employ their own in-house trainers. Training people to apply pain directly to obtain compliance, rather than pain arising as a result of a hold, was an important issue which had to be resolved. Professor Gournay said that this issue presented the potential for terrible abuse of patients. He said some 4,000 violent incidents were reported at the South London and Maudsley Trust alone in 2002. These involved patient-to-staff violence, patient-to-patient violence and visitor-to-staff violence as well as verbal violence and threats of violence.

THE Inquiry found that it would be helpful to have the same system of inquiries throughout the mental health side of the NHS for serious untoward incidents (SUIs) involving detained patients with mental health problems.

They concluded that the first step should be to obtain a management report in order to find out if anything had gone wrong and to enable the management to take immediate steps to remedy any fault. There was no need for the family of the patient to be involved in this management report.

Secondly, there should be an internal inquiry. Internal inquiries should always have at least one independent member who should normally be the chair of such an inquiry. A director of the Trust should also be a member of such an inquiry. The evidence should be taken in private. There should be no legal representation allowed.

Once the inquiry has been set up it should be completed within three months. Participants who were deeply involved in the incident should always be allowed to give their own version of events. This might include the aggressor, as well as the person or people who were attacked.

If one of the participants had died, their family should always be allowed to submit their views in person if that was what they wished to do. Families of participants should always be given sufficient information about the SUI as soon as possible and always at an early stage so that they were as fully informed as was reasonable before they gave their views to the inquiry. The inquiry should always produce a written report, which should be available to all participants and their families where appropriate.

The third step would be to hold an independent inquiry. But this should only be done in the most serious cases.

On every occasion when a death had taken place and on any other occasion when it was considered necessary by the Health Authority to be desirable to do so, there should be an independent inquiry under the provision of NHS Executive HSG(94)27. Paragraph 36 stated:

In setting up an independent inquiry the following points should be taken into account:

i. **the remit of the inquiry** should encompass at least:

- ☐ the care the patient was receiving at the time of the incident
- ☐ the suitability of that care in view of the patient's history and assessed health and social care needs
- ☐ the extent to which that care corresponded with statu-

tory obligations, relevant guidance from the Department of Health and local operational policies

☐ the exercise of professional judgement

☐ the adequacy of the care plan and its monitoring by the key worker

ii. **composition of the inquiry panel**

Consideration should be given to appointing a lawyer as chairman. Other members should include a psychiatrist and a senior social services manager and/or a senior nurse. No member of the panel should be employed by bodies responsible for the care of the patient;

iii. **distribution of the inquiry report**

Although it will not always be desirable for the final report to be made public, an undertaking should be given at the start of the inquiry that its main findings will be made available to interested parties.

These guidelines have not been altered since this document was issued in 1994. We consider that the time has come for it to be looked at again. We appreciate that inquiries under HSG(94)27 are fairly infrequent. Members of any such inquiry are unlikely to have experience of other similar inquiries. They need more guidance than is available at present. This guidance could be given by a re-drafting of the existing paragraph 36 or by issuing guidelines to assist those who take part in such an inquiry. We consider that it should be made clear that, where there is a death, the family of that person has a right to give evidence on all relevant matters. The inquiry should also be directed to consider and report on all relevant ethnic issues. We are concerned that under the existing HSG(94)27 no sanction is at present available to the inquiry if a witness declines to give evidence to them. Consideration should be given to imposing some sanction, particularly to staff employed in the NHS. We suggest that staff should be reminded that if they fail to co-operate they may face disciplinary procedures.

Ms Tweedie said there were some extremely good internal inquiries but also others which did not address the basic issues that arose after any serious untoward incident. There needed to be rigour in the terms of reference for these inquiries. She recommended that there should always be an independent element to any inquiry. She would also wish that action should be taken which would ensure that the findings of inquiries were drawn together in one place so that lessons can be learnt. At present the findings from one inquiry were not normally fed into other inquiries, nor were they recorded centrally.

INQUIRY REPORTS INTO OTHER DEATHS

The Panel has read a number of reports from inquiries that have been set up after deaths of patients in mental hospitals. Many of them made specific recommendations, which

primarily related to the facts of the case that they were investigating.

It is not appropriate for us to make comments about those reports. There is, however, one report, namely the report of the Committee of Inquiry into the deaths in Broadmoor Hospital of Orville Blackwood and of two other African-Caribbean patients, Michael Martin and Joseph Watts, which is of relevance.

That report was issued in 1993. Orville Blackwood died while in seclusion. Many of the recommendations made in that report are disturbingly similar to recommendations that we include in this report but it is disturbing to find that little action has been taken upon them. For example, it is recommended at (c)(i):

"That urgent action should be taken by the Director of Nursing Services to introduce training in the control of violent incidents without resorting, in the first instance, to physical restraint".

Further, they recommended at (d)(ii):

"That the Special Hospitals Service Authority (SHSA) in conjunction with other relevant bodies, should give consideration to the commissioning of further research into the diagnosis of schizophrenia in Afro-Caribbeans."

and (d)(iii):

"That the SHSA monitor patterns of diagnosis among minority ethnic groups in the special hospital system."

and (f)(i):

"That all staff be given adequate training in all forms of resuscitation techniques appropriate to their discipline, and such training should be regularly updated."

That Inquiry also wrote a chapter on the problems of racism which contains information on many of the general matters that we have heard during the course of this Inquiry and set out in this report.

While we recognise that it takes time to implement reforms and to act upon recommendations, we express our grave concern at the apparent lack of reaction by anybody in authority to attempt to implement these and other recommendations made in that report.

When further recommendations from other reports are made

in future we recommend that there is a system which ensures that they are carefully collated and considered by the Department of Health so that, where appropriate, they can be acted upon without undue delay.

SUDDEN DEATH IN PSYCHIATRIC HOSPITALS

The Inquiry found the evidence relating to sudden deaths in psychiatric hospitals to be unclear. The statistics were unsatisfactory so it was difficult to draw clear conclusions from them. We recommend that more detailed statistics are kept so that it can be known how many patients in mental health institutions die when being restrained or within a short time thereafter with details of their ethnic grouping..

Professor Appleby said that his research had not found that there was an over-representation of people from minority ethnic communities in cases of sudden death in mental hospitals. But, he said that results that have not been found do not necessarily mean that they are not there.

Ms Tweedie said there had been a reduction in the number of deaths where control and restraint had been employed shortly before death. In the period 1997-2002 statistics indicate that one hundred and eight deaths in which restraint had been used within the preceding seven days had occurred, of which twelve were from the black and minority ethnic communities. We received a letter from the Commission saying that statistics were not collated to indicate that restraint was being used at the time of death. But Ms Tweedie said that in the last two years the Commission considered that there were only three cases where the use of control and restraint were closely associated with the time of death. The Commission remained deeply concerned about the apparently discriminatory attitudes to black and minority ethnic patients.

INQUEST told us that since 1996 there had been monitoring of the ethnic origin of people who die in custody but this did not include deaths of detained patients. There was a gap in information, not only about who was dying but why they were dying.

The Inquiry notes that coroners make recommendations from time to time and proposes that those recommendations should be monitored and collated centrally.

INQUEST told us that the failure by the NHS to provide information and support to families after a death had a highly detrimental effect on families' mental health. It affected their ability to grieve properly, their ability to continue with their own lives and to cope with their emotional distress. There should be the same procedures in respect of people who die in mental health hospitals as for those who die in general hospitals. The family of anyone who dies should have a right to have a pathologist present on their behalf at the post-mortem unless there are exceptional circumstances. At present, by the time the family had been told about the death in a mental health institution, the post-

mortem had either already taken place or would take place before the families could arrange for a pathologist to be present on their behalf.

Families should have access to information about where to go for help after a death of a family member who was in a mental health institution. So many families found themselves lost in the system where they did not understand what was happening and did not have anybody to advocate for them. A further key point was that families should be informed of the death immediately. If there was an investigation after the death, families should have an effective access to that investigation process from the beginning to the end. The investigative body should be an independent body. One was left with the feeling that some people's lives did not have equal worth with others.

STAFF SUPPORT

The Inquiry considers that staff support in mental health institutions is a subject which requires sensitivity and flexibility. There should be an emphasis on developing a supportive atmosphere after any incident where serious injury or death has taken place, where staff can express their thoughts and feelings about what has happened. Some staff may be in a state of shock, or suffering from post-traumatic stress disorder. It should be borne in mind that:

“When considering whether time off is needed, it is important to be aware that, whilst this may be important, anxieties can increase whilst away from the workplace. It is generally advisable to get back to work as soon as possible to prevent what has been described as “the incubation of fear”. Obviously, there are exceptions to this if staff are particularly distressed by an incident, or if they have sustained any physical injury.”

The above is contained in paragraph 7.3.8 of the Norfolk Mental Health Care NHS Trust's "Good Practice Guidelines

for the Prevention and Management of Aggression". It is in our view not possible to set out more detailed guidelines that can be generally applicable to staff who have suffered some degree of physical or mental harm or stress as a result of a violent incident in any hospital setting. Practice varies enormously. Extraneous circumstances sometimes exacerbate the distress caused to a particular person. Sympathetic consideration should always be given to members of staff.

In the first part of this Inquiry we found out that at least one member of the staff of The Norvic Clinic involved in the restraint of David Bennett suffered considerable mental stress and showed signs of post-traumatic stress disorder. In addition to that member of staff we were also fully aware of the serious injuries suffered by the nurse who was assaulted by David Bennett.

The view was expressed by some of the witnesses in that part of our Inquiry that the management team at The Norvic Clinic and in the Trust had not expressed sufficient sympathy with their plight, nor done enough to alleviate their distress. The evidence emphasised the need to have in place appropriate procedures to deal with this type of problem. In the mental health services there is always a risk of a violent incident. In any individual violent incident there is always the possibility that either members of the staff or the patient may be injured, physically or mentally. Nothing we can suggest in this report can prevent that.

We have concentrated in this report on how to prevent injury to the patient because, in the case of David Bennett, he died while under restraint. More research is needed to discover how staff can best be protected. This is a subject that was brought to our attention by the RCN. It is also a matter that will be dealt with by NICE in their inquiry on the management of violence in mental health settings. It is a subject that will have to be carefully considered when setting out proper training and proper control and restraint procedures for the management of aggression.

Recommendations

RECOMMENDATIONS

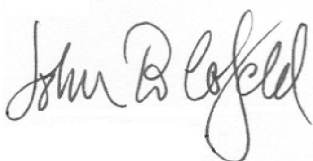
The Inquiry has made a number of recommendations in the report. Here we highlight the main ones.

- 1 All who work in mental health services should receive training in cultural awareness and sensitivity.
- 2 All managers and clinical staff, however senior or junior, should receive mandatory training in all aspects of cultural competency, awareness and sensitivity. This should include training to tackle overt and covert racism and institutional racism.
- 3 All training referred to in 1 and 2 above should be regularly updated.
- 4 There should be Ministerial acknowledgment of the presence of institutional racism in the mental health services and a commitment to eliminate it.
- 5 There should be a National Director for Mental Health and Ethnicity similar to the appointment of other National Directors, appointed by the Secretary of State for Health to oversee the improvement of all aspects of mental health services in relation to the black and minority ethnic communities.
- 6 All mental health services should set out a written policy dealing with racist abuse, which should be disseminated to all members of staff and displayed prominently in all public areas under their control. This policy should be strictly monitored and a written record kept of all incidents in breach of the policy. If any racist abuse takes place by anyone, including patients in a mental health setting, it should be addressed forthwith and appropriate sanctions applied.
- 7 Every CPA care plan should have a mandatory requirement to include appropriate details of each patient's ethnic origin and cultural needs.
- 8 The workforce in mental health services should be ethnically diverse. Where appropriate, active steps should be taken to recruit, retain and promote black and minority ethnic staff.
- 9 Under no circumstances should any patient be restrained in a prone position for a longer period than three minutes.
- 10 A national system of training in restraint and control should be established as soon as possible and, at any rate, within twelve months of the publication of this report.
- 11 The Department of Health should collate and publish annually statistics on the deaths of all psychiatric in-patients, which should include ethnicity.
- 12 All medical staff and registered nurses working in the mental health services should have mandatory first-aid training, including CPR training.
- 13 Records should be kept of all psychiatric units' use of control and restraint on patients. The Department of Health should audit the use of control and restraint.
- 14 There is an urgent need for a wide and informed debate on strategies for the care and management of patients suffering from schizophrenia who do not appear to be responding positively to medication and we recommend that the Department of Health monitor this debate in order to ensure that such strategies are translated into action at the earliest possible moment. (See term of reference 10).
- 15 All medical staff in mental health services should have training in the assessment of people from

the black and minority ethnic communities with special reference to the effects of racism upon their mental well being.

- 16 All patients in the mental health services should be entitled to an independent NHS opinion from a second doctor of their choice, in order to review their diagnosis and/or care plan. If a patient, by reason of mental incapacity, is unable to make an informed decision, their family should be entitled to make it for them.
- 17 The question of detention in and treatment of patients in secure accommodation should be reconsidered in order to ensure that no patient is detained in such accommodation unless it is necessary, and that the period of each detention and the treatment be kept constantly under review.
- 18 The Department of Health should examine, with the Department of Social Security, possible modifications to State financial assistance so that patients do not leave resident hospital care in order to obtain adequate financial assistance from the State.
- 19 All psychiatric patients and their families should be made aware that patients can apply to move from one hospital to another for good reason, which would include such matters as easier access by their family, a greater ethnic mix, or a reasoned application to be treated by other doctors. All such applications should be recorded. They should not be refused without providing the applicant and their family with written reasons.
- 20 There is a need to review the procedures for internal inquiries by hospital trusts following the death of psychiatric patients with emphasis on the need to provide appropriate care and support principally for the family of the deceased, but also for staff members. (See term of reference 9).
- 21 There is a need for medical personnel caring for detained patients to be made aware, through appropriate training, of the importance of not medicating patients outside the limits prescribed by law and the need for more regular and effective monitoring to support the work undertaken by the Mental Health Act Commission in this field. (See term of reference 11).
- 22 It is vital to ensure that the findings and recommendations of this Inquiry inform all relevant parties, including the developing black and minority ethnic mental health strategy. (See term of reference 12).

This report, together with its findings and recommendations, was presented by the Inquiry to the Secretary of State for Health and the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority on Wednesday, 17 December 2003.



Sir John Blofeld, Chairman of the Inquiry Panel

Appendices

WITNESSES REFERRED TO IN PART 2 OF THE REPORT

Mr. Chris Allen and Mr. Ian Gallon represented the Royal College of Nursing. Mr. Allen is the RCN's mental health adviser and Mr Gallon is Chair, RCN Mental Health Nursing Forum.

Professor Louis Appleby, National Director for Mental Health and a Professor of Psychiatry at the University of Manchester. He is leading research on sudden deaths among mental health in-patients.

Dr. Hadrian Ball, Consultant Forensic Psychiatrist, Medical Director of the Norfolk Mental Health Care NHS Trust since July 2000 and previously Clinical Director of the Norvic Clinic.

Dr. Joseph Berke, Co-Founder and Director of the Arbours Communities, 1973-2000; Founder and Director of the Arbours Crisis Centre established in 1973 to provide intensive personal, psychotherapeutic intervention and support within the context of a non-institutionalised home environment.

Mr. Richard Brook, Chief Executive, MIND; **Ms Lisa Haywood**, Director of City and Hackney MIND; and **Mr. Jahid Sardar** of Diverse Minds (MIND'S specific initiative for black and minority ethnic communities) represented MIND (The National Association for Mental Health) which works for a better life for everyone with experience of mental distress.

Dr. Nat Cary, Consultant Home Office accredited Forensic Pathologist, who carried out a post-mortem on David Bennett at the family's request. He has a particular interest in deaths in custody and deaths during restraint.

Dr. Suman Fernando, Consultant Psychiatrist and writer on race and culture in mental health and psychiatry. Honorary Professor in Department of Applied Social Sciences at London Metropolitan University.

Mr. Dominic Ford, Mental Health Development Manager, Commission for Health Improvement (CHI).

Mr. Errol Francis, Sainsbury Centre for Mental Health, co-author of 'Breaking the Circles of Fear' which was a review of the relationship between mental health services and African and Caribbean communities published in 2002.

Dr. Chandra Ghosh, a Consultant Forensic Psychiatrist with many years' experience working in NHS Special Hospitals and now working in a medium secure unit in the independent sector.

Professor Kevin Gournay, CBE, Professor of Psychiatric Nursing, Institute of Psychiatry, King's College, University of London. Professor Gournay led the research team which produced a report on the Management of Violence published by the UKCC in 2001. He is Chair of the NICE Panel on the Management of Violence in Mental Health Settings which aims to produce guidance for staff working in mental health care in the NHS in England and Wales by March 2004.

Dr. Maurice Lipsedge, Emeritus Consultant Psychiatrist, The South London and Maudsley NHS Trust; Honorary Senior Lecturer in the Department of Psychological Medicine within Guy's, King's and St. Thomas' School of Medicine and Course Adviser for Diploma in Occupational Psychiatry and Psychology; Approved for purposes of Section 12(2) of the Mental Health Act 1983.

Dr. Kwame McKenzie, Senior lecturer in psychiatry at the Royal Free and University College Medical School; Honorary Consultant Psychiatrist to Barnet, Enfield and Haringey NHS Mental Health Trust. RMO to Antenna, an assertive outreach team for 16 to 25 year old African and African-Caribbean origin clients with mental health difficulties from 2000-2003.

Dr. David Ndegwa, Consultant Forensic Psychiatrist and Clinical Director of Forensic Psychiatry for the Borough of Lambeth within South London and Maudsley NHS Trust. He was a member of the reference group chaired by Professor Sashidharan, which produced 'Inside Outside'.

Professor Kamlesh Patel, Chairman of the Mental Health Act Commission. Professor and Head of Centre for Ethnicity and Health at the University of Central Lancashire. Currently seconded to the National Institute for Mental Health in England (NIMHE) as national strategic director to lead the black and minority ethnic mental health programme.

Dr. Stephen Pereira, Consultant Psychiatrist, who represented the Royal College of Psychiatrists.

Mr. Malcolm Rae, OBE, previously Nursing Officer for Mental Health/Forensic Psychiatry at the Department of Health and joint lead of the Acute In-patient Care programme of the National Institute of Mental Health in England (NIMHE).

Ms Helen Shaw and Ms Deborah Coles, Co-Directors of INQUEST, which was launched in 1981 and is the only non-governmental organisation in England and Wales which works directly with the families and friends of those who die in custody to provide an

independent free legal and advice service on inquest procedures and their rights in the Coroner's Court. It provides specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation.

Professor Antony Sheehan, *Group Head for Mental Health and Chief Executive of the National Institute for Mental Health in England (NIMHE).*

Dr. Richard Shepherd, *Consultant Forensic Pathologist, Home Office Pathologist, Senior Lecturer in Forensic Medicine.*

Ms Alicia Spence, *Director of the African-Caribbean Community Initiative (ACCI) established in Wolverhampton in 1987 to support local African and African-Caribbean people within the mental health system.*

Mrs. Mary Teasdale, *Head of the National Advice Service, Rethink (formerly the National Schizophrenia*

Fellowship). Rethink was established in 1972 to provide mutual support to families coping with severe mental illness and is now one of the largest providers of services. Other activities include advice, lobbying, campaigning to influence government policy, research and practical support.

Mr. Paul Thain, *Director of Strategic Development, Norfolk Mental Health Care NHS Trust.*

Mr. Rick Tucker, *a Professional Adviser for Mental Health and Learning Disabilities to the Nursing & Midwifery Council (formerly the UKCC) who takes the lead in nursing in secure environments (including prisons) and the management of violence.*

Ms June Tweedie, *is a legal member of the Mental Health Act Commission and a non-executive director on the Board. She is the Chair of the Equality and Diversity Committee and is one of a small team from the Commission which looks into the circumstances of deaths in psychiatric institutions.*

APPENDIX II

WITNESSES REFERRED TO IN PART 1 OF THE REPORT

**Please note some of the positions held by staff
reflect where they worked at the time of the inquiry.**

Family:

Dr. Joanna Bennett (sister)
Mrs. Winifred Bennett (sister)

North West Anglia Healthcare Trust:

Dr. Feggetter, Consultant Psychiatrist (now retired)

Cambridgeshire & Peterborough Mental Health Partnership NHS Trust:

Dr. Sagovsky, Consultant Psychiatrist

St. Andrew's Hospital, Northampton:

Dr. Comish, Consultant Psychiatrist
Dr. Holding, Consultant Psychiatrist

Rampton Hospital:

Dr. Murphy, Consultant Psychiatrist

Norfolk Mental Health Care NHS Trust:

Miss Kant, Chair
Mr. Shelton, Chief Executive
Dr. Hughes, Medical Director
Mr. Thain, Director of Strategic Development

Hellesdon Hospital:

Dr. Ward, Consultant Forensic Psychiatrist

Norvic Clinic:

Mr. Bailes, Consultant Forensic & Clinical Psychologist
Dr. Ball, Consultant Forensic Psychiatrist
Mr. Bartlett, Nursing Assistant
Dr. Bishram, Senior House Officer
Mrs. Chambers, General Manager
Mr. Clapham, Nursing Assistant
Mr. Corbould, Social Worker
Mr. Deeks, Staff Nurse

Mrs. Egmore, Administrator
Mr. Evans, Staff Nurse
Miss Farrow, Nursing Assistant
Mr. Fixter, Staff Nurse
Mrs. Hadley, Staff Nurse
Mr. Loudon, Charge Nurse
Miss Marris, Nursing Assistant
Mr. McMahon, Senior Charge Nurse
Mrs. Moore, Student Nurse
Mr. Ncube, Charge Nurse
Mr. Parr, Senior Social Worker
Mrs. Robson, Staff Nurse
Dr. Rudzinski, Specialist Registrar in Forensic
Psychiatry
Dr. Sedgwick, Consultant Clinical Psychologist
Dr. Shetty, Consultant Forensic Psychiatrist
Dr. Solomka, Consultant Forensic Psychiatrist
Dr. Stanley, Consultant Forensic Psychiatrist
GC; GH; DS, DW - patients in the Clinic

Expert witnesses:

Dr. Cary, Consultant Forensic Pathologist
Professor Forrest, Professor of Toxicological Medicine
Dr. Harrison, Consultant Pathologist
Dr. Lipsedge, Consultant Psychiatrist
Dr. Wood, Consultant Forensic Psychiatrist

East Anglian Ambulance NHS Trust

Mr. Holdsworth - Paramedic
Mrs. Holdsworth - Paramedic
Mr. Rogers - Paramedic

ABC Taxis:

Mr. Hall - Taxi driver

Police:

Detective Inspector Deacon
Detective Superintendent Swain

MPs

Mrs. Clark
Dr. Gibson

APPENDIX III

ABBREVIATIONS USED IN BOTH PARTS OF THE REPORT

ACHCEW – Association of Community Health Councils of England & Wales

BMA – British Medical Association

BNF – British National Formulary

CBT – Cognitive Behaviour Therapy

CHC – Community Health Council

CHI – Commission for Health Improvement

CN – Charge Nurse

CPA – Care Programme Approach

CPN – Community Psychiatric Nurse

CPR – Cardio-Pulmonary Resuscitation

CPS – Crown Prosecution Service

CRE – Commission for Racial Equality

DI – Detective Inspector

DSS – Department of Social Security

D. SUPT – Detective Superintendent

ECG – Electrocardiogram

HMP – Her Majesty's Prison

Mg - Milligrams

MHAC – Mental Health Act Commission

MHRT – Mental Health Review Tribunal

NA – Nursing Assistant

NHS – National Health Service

NICE – National Institute for Clinical Excellence

NIMHE – National Institute for Mental Health in England

NMC – Nursing & Midwifery Council

NMHCT – Norfolk Mental Health Care NHS Trust

NRU – Neighbourhood Renewal Unit

PCT(s) – Primary Care Trust(s)

PIU – Patient Involvement Unit

PMA – Prevention and Management of Aggression

RCN – Royal College of Nursing

RCPsych – Royal College of Psychiatrists

RMO – Responsible Medical Officer

SEU – Social Exclusion Unit

SN – Staff Nurse

SOAD(s) – Second Opinion Approved Doctor(s)

SUI – Serious Untoward Incident

UKCC – United Kingdom Central Council for Nursing, Midwifery and Health Visiting (now the Nursing & Midwifery Council)

WDC – Workforce Development Confederation

DOCUMENTS/PAPERS STUDIED BY THE INQUIRY PANEL

'Big, Black and Dangerous?' – the Report of The Committee of Inquiry into the death in Broadmoor Hospital of Orville Blackwood and a Review of the deaths of two other Afro-Caribbean Patients. Published in 1993.

'Breaking the Circles of Fear' – a review of the relationship between mental health services and African and Caribbean communities. Published by The Sainsbury Centre for Mental Health in 2002

Commission for Health Improvement (CHI):
CHI's statutory functions
CHI's approach to ethnic diversity in clinical governance reviews

Clinical Governance Review of the Norfolk Mental Health Care NHS Trust: December 2002
Race Equality Schemes, 2002 and 2003

Commission for Racial Equality's: 'Code of Practice on the Duty to Promote Race Equality' and 'Ethnic Monitoring – A guide for public authorities'

'Dangerous stereotypes': Maurice Lipsedge – Journal of Forensic Psychiatry, May 1994

Deaths of Detained Patients in England and Wales: A Report by the Mental Health Act Commission on Information Collected from 1 February 1997 to 31 January 2000. Published in February 2001.

Delivering Race Equality: A framework for action – mental health services. Consultation document published by the Department of Health in October 2003.

Engaging and Changing – Developing effective policy for the care and treatment of black and minority ethnic detained patients. Published by the National Institute for Mental Health in England (NIMHE) in 2003

INQUEST's: Annual Report 2002
Reports on deaths in custody
Response to the Fundamental Review of Coroner Services
Memorandum to Health Select Committee Inquiry into the provision of NHS mental health services

'Inside Outside' – Improving Mental Health Services for Black and Minority Ethnic Communities in England. Published by the National Institute for Mental Health in England (NIMHE) in 2003.

Mental Health Act Commission's:
Biennial Reports Guidance Note: 'Nurses, the Administration of Medicine for Mental Disorder and the Mental Health Act 1983'
'Improving Care for Detained Patients from Black and Minority Ethnic Communities', 2000

National Institute for Clinical Excellence (NICE):
Guidelines on Schizophrenia

Nursing & Midwifery Council: Code of Professional Conduct

Police Complaints Authority (PCA):
Policing Acute Behavioural Disturbance: Revised Edition, March 2002
Safer Restraint Conference, April 2002

Race Relations (Amendment) Act 2000

Rethink Policy Statements:
2 - Police Involvement in the control and restraint of people with a severe mental illness
11 - Meeting the needs of informal carers of people with a severe mental illness
27 - Confidentiality and Information Sharing

Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Published by the Department of Health in 1999.

The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care' – a consultation document prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) by a team led by Professor Kevin Gournay, CBE. Published in 2001.

The Royal College of Psychiatrists':
Management of Imminent Violence: clinical practice guidelines to support mental health services
Strategies for the management of disturbed and violent patients in psychiatric services
Curriculum for basic specialist training and the MRCPsych examination
Report of the Ethnic Issues Project Group
Consensus Statement on the Use of High Dose Anti-psychotic Medication
Race Equality Scheme

The Stephen Lawrence Inquiry – Chapter Six – Racism. Published in 1999.

'Violence by psychiatric in-patients. Management by medication, restraint and seclusion and ethnic influence'. Gisli Gudjonsson, Sophia Rabe-Hesketh and George Szmukler

Violent incidents on a medium secure unit over a 17-year period': Gisli Gudjonsson, Sophia Rabe-Hesketh and Claire Wilson – Journal of Forensic Psychiatry, September 1999

Working Towards Eradicating Racism in the Norfolk NHS': The ERINN Report published in May 2001

Written submissions were received from:
Ms. Pauline Abbott-Butler, Footprints (UK)
Dr. Joseph H. Berke, Arbours Crisis Centre
Dr. Suman Fernando, Consultant Psychiatrist

NOTES

NOTES

NOTES

NOTES

NOTES

NOTES

NOTES

**Published by the
Norfolk, Suffolk and Cambridgeshire
Strategic Health Authority**

**Victoria House
Capital Park
Fulbourn
Cambridge
CB1 5XB**

**Tel: 01223 597500
Fax: 01223 597555
Web: www.nscstha.nhs.uk**