AGENDA ITEM No. 3

NORTH LANARKSHIRE COUNCIL

REPORT

To: SOCIAL WORK COMMITTEE (OPERATIONS AND SERVICES) SUB COMMITTEE	Subject: SAFE CARE: CONSIDERATION OF THE RECOMMENDATIONS FROM THE INQUIRY OF THE DEATH OF DAVID BENNETT
From: DIRECTOR OF SOCIAL WORK	
Date: 4 OCTOBER 2005 Ref: MW	

1. Purpose of report

This Report is to advise Committee of the Inquiry into the Death of David Bennett and the Scottish Executive's publication in December 2004 of Safe Care: Consideration of the Recommendations from the Inquiry of the Death of David Bennett.

2. Background

2.1. David Bennett was a man of 38 years and of African–Caribbean origin. He had schizophrenia and had been receiving treatment for this for some eighteen years before his death in October 1998.

At the time of his death David Bennet was an in patient at the Norvic Clinic, a medium secure psychiatric unit run by Norfolk, Suffolk and Cambridge Strategic Health Authority.

2.2 On the evening of his death David Bennett had been involved in an incident with another patient who was white. He had been the recipient of repeated racist abuse from this patient. After the incident David Bennett was moved to another ward, where he subsequently hit a nurse. He was then restrained by a number of nurses and a struggle developed. During the prolonged struggle that continued he collapsed and died.

2.3 In response to David Bennett's death an inquiry was established. The terms of reference for this included investigation of his care and treatment at the time of his death, the history of David Bennett's care, and broader mental health issues such as the developing black and ethnic minority mental health strategy, the use of restraint, and strategies for the care and management of people with schizophrenia who do not appear to be responding to medication

2.4 The Inquiry reported in December 2003. Contained in its report were 22 recommendations for action to improve mental health services. In January 2005 the Department of Health published its Action Plan Delivering Race Equality in Mental Health Care, drawing upon the Inquiry's report and recommendations.

3. Proposals/Considerations

3.1. The Inquiry report concluded with 22 recommendations for action. These included:

- the need for training in cultural awareness and sensitivity (including mandatory training for managers and clinical staff)
- the acknowledgement of institutional racism within the NHS
- the need for mandatory training around the use of restraint, and the recording of restraint
- the need for mental health services to have written policies about racist abuse which were publicly displayed and closely monitored
- Care Programme care plans to include details of a person's ethnic origin and cultural needs.

3.2. In December 2004 the Scottish Executive issued Safe Care: Consideration of the Recommendations from the Inquiry into the Death of David Bennett. While the locus of the Inquiry into the death had not extended to Scotland, the Scottish Executive subsequently reviewed the positions in Scotland against the recommendations (22) of the Inquiry.

3.3. In Scotland Fair for All guidance for health was published in 2002. This provides a strategic framework to combat inequality and to recognise the diversity of people using services. The National Resource Centre for Ethnic Minority Health is monitoring and supporting the progress in achieving the standards required through Fair for All. The establishment in 2004 for the Scottish Transcultural Mental Health Network also seeks to promote the development of culturally appropriate and responsive mental health services for people from diverse backgrounds.

4. Financial/Personnel/Legal/Policy Implications

4.1. There are no Financial/Personnel/Legal/Policy Implications at this time.

5. Recommendation

5.1. Committee is asked to:

(i) note the contents of this report.

Jim Dickie
Director of Social Work
21 September, 2005

For further information on this report please contact Mary Wilson, Service Manager, Community Care (Adults) on telephone 01698- 332172