Reports Protocol for Mental Health Hearings and Tribunals
# Reports Protocol for Mental Health Hearings and Tribunals

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Clinical Protocol</th>
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<tbody>
<tr>
<td>Unique Identifier</td>
<td>CL-037</td>
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<tr>
<td>Document Purpose</td>
<td>This policy provides assurance that reports being provided to Hospital Managers and Tribunals meet best practice in order to deliver the best possible high quality patient care</td>
</tr>
<tr>
<td>Document Author</td>
<td>MHA/Patient Records Manager</td>
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<tr>
<td>Target Audience</td>
<td>All Worcestershire Health and Care NHS Trust and NHS Worcestershire staff</td>
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<tr>
<td>Responsible Group</td>
<td>Mental Health Act Monitoring Group</td>
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<td>Date Ratified</td>
<td>17 04 2012</td>
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If you would like this document in other languages or formats (i.e. large print), please contact the Communications Team on 01905 760020 or email communications@hacw.nhs.uk
Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Circulation Date</th>
<th>Job Title of Person/Name of Group circulated to</th>
<th>Brief Summary of Change</th>
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<tbody>
<tr>
<td>0.1</td>
<td>02 2012</td>
<td>AMHPs, Team Leaders, MH Ward Managers, Psychiatrists, Safeguarding</td>
<td>Minor amendments</td>
</tr>
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<td>04 2012</td>
<td>Audit Department</td>
<td>Addition of monitoring statement</td>
</tr>
<tr>
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<td>04.2012</td>
<td>MHA Monitoring Group</td>
<td>Addition of sentence to nursing report template, minor amendments</td>
</tr>
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<td>Addition of information and amendment to report templates to meet First Tier Tribunal Practice Directions</td>
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</tbody>
</table>

Worcestershire Health and Care NHS Trust has a contract with Applied Language Solutions to handle all interpreting and translation needs. This service is available to all staff in the Trust via a free-phone number (0800 084 2003). Interpreters and translators are available for over 150 languages. From this number staff can arrange:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation via the Communications Manager; and
- British Sign Language interpreting.

Please note that where the visit or consultation is likely to be less than 40 minutes in duration telephone interpreting should be the preferred option. Where a lengthy consultation is expected a pre booked face-to-face interpreter would be more appropriate.
## Contents

Glossary 4

1. Introduction 5
2. Aim 5
3. Scope 5
4. Frequency of hearings 5
5. Hospital Managers 5
6. Tribunals Judiciary 6
7. Responsible Authority (RA) 6
8. Requests for reports 6
9. Timescales for hearings 7
10. Duties of Mental Health Act Administration (MHAA) 7
11. Late reports and unsuitable reports 8
12. Disclosure of information to the patient 8
13. Non disclosure of information to the patient – reporting sensitive information 8
14. Report Types 9
15. Outcomes 12
16. Patients under the age of 18 12
17. Monitoring arrangements 12

Appendix A  
Responsibility Authority Statement

Appendix B  
Responsible Clinician Report – Inpatient, Guardianship, Conditional Discharge

Appendix C  
Responsible Clinician Report – Community Treatment Order

Appendix D  
Nursing Report

Appendix E  
Social Circumstances Report – Inpatient, Guardianship, Conditional Discharge, CTO
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Symbol</th>
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<tbody>
<tr>
<td>Mental Health Act 1983 (amended 2007)</td>
<td>MHA</td>
</tr>
<tr>
<td>Tribunals Service</td>
<td>FTT</td>
</tr>
<tr>
<td>Associate Hospital Managers</td>
<td>AHM</td>
</tr>
<tr>
<td>Responsible Clinician</td>
<td>RC</td>
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<tr>
<td>Supervised Community Treatment</td>
<td>SCT</td>
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<tr>
<td>Community Treatment Order</td>
<td>CTO</td>
</tr>
<tr>
<td>Approved Mental Health Professional</td>
<td>AMHP</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>MOJ</td>
</tr>
<tr>
<td>Nearest Relative</td>
<td>NR</td>
</tr>
<tr>
<td>Local Authority</td>
<td>LA</td>
</tr>
<tr>
<td>Responsible Authority</td>
<td>RA</td>
</tr>
<tr>
<td>Mental Health Act Administrator</td>
<td>MHAA</td>
</tr>
</tbody>
</table>
1. **Introduction**
   a. When patients are detained under the Mental Health Act 1983 (MHA), they have the right to appeal to both the Tribunals Service and to the Hospital Managers.
   b. This right is enshrined in law and is relevant to all patients subject to the MHA, whether an inpatient in hospital, on section 17 leave, on Supervised Community Treatment or – in some cases – subject to a Conditional Discharge (forensic sections), and there are several ways in which a patient can generate a hearing.
   c. For all hearings, professionals involved in the care of the patient will be required to provide a report for the hearing and, in most cases, will be expected to attend the hearing and answer any questions.
   d. In the case of both the Tribunal and the Hospital Managers, the panel will be judging whether the criteria for detention continue to be met. The only exception to this is in the case of nearest relative “barring orders”, whereby the panel must also judge on the issue of “dangerousness”.

2. **Aim**
   a. This protocol and the templates attached are intended to provide professionals with the tools by which to maintain a consistent standard and style when generating reports.
   b. The protocol contains guidance for all staff responsible for creating reports - MHA Administrators, Responsible Clinicians, Approved Mental Health Professionals (AMHP’s)/care co-ordinators and Nursing staff.
   c. The Tribunals Service have recently updated their practice directions relating to statements and reports in mental health cases, these came into effect on 06 April 2012 and are legally binding.

3. **Scope**
   a. This protocol applies to all First Tier Tribunals (Mental Health) (FTT) and Hospital Managers (AHM) hearings for detained patients. The term “Hospital Managers” means the Trust’s Non-Executive board members who for the purposes of the MHA, delegate duties to a panel of Associate Hospital Managers (AHM’s) who are not employees of the Trust.

4. **Frequency of hearings**
   a. A patient can appeal to the FTT against their detention once in every period of detention. If they do not appeal, MHA Administration (as delegated by the Hospital Managers) are obliged to make a reference to the tribunal at the end of the initial 6 months of detention and every 3 years thereafter.
   b. A patient can appeal to the Hospital Managers more than once in each period, in addition, the AHM’s will hold a review on renewal of detention.

5. **Hospital Managers**
   a. Hospital Managers have many different responsibilities under the MHA and this includes the power of discharge. A review hearing must be held in the event that a patient’s detention is:
      * renewed by the RC, or the RC extends supervised community treatment (SCT). The AHM’s may also hold hearings at their discretion but must consider holding a hearing for the following reasons:

---

1 E-link
i. If a patient appeals to the Hospital Managers; and

ii. When a Nearest Relative (NR) is barred from discharging a detained patient.

6. Tribunals Judiciary

   a. The FTT is the statutory, independent body responsible for hearing appeals against detention and references for people detained under the Act. As part of the Ministry of Justice (MOJ), it is a court and generally hearings are held at the hospital where the patient is detained.

7. Responsible Authority (RA)

   a. For the Tribunal, generally, the RA is the Trust itself. The FTT practice directions place legal responsibility on the RA to adhere to their requirements.

   b. In the case of patients subject to Guardianship (section 7), the RA is the Local Authority (LA).

   c. For all appeals or referrals to the Tribunals Service, the RA must:
      - provide a report within the prescribed timescale;
      - ensure that all reports required for the hearing are available;
      - provide any documents specified by the Tribunals Service;
      - ensure that all reports are sent to the Tribunals Service on time (or the Ministry of Justice, in the case of restricted patients); and
      - Ensure that meeting rooms provided are suitable for the purpose.

8. Requests for reports

   a. When a review of a patient's detention is required, either because of an appeal or a review of renewal, all professionals involved in the patient care will be required to provide a report. Depending on the type of detention, the report may be requested by the Ministry of Justice, the Local Authority (Guardianship) but more commonly, by Trust MHA Administration staff. Reports will usually be expected from the:

      i. Responsible Authority (RA)
         - The RA must provide a statement of information about the patient.

      ii. Responsible Clinician (RC)
         - The RC is the registered medical practitioner required to be identified under the MHA with overall responsibility for the patient’s case. If there are any disputes about the identification of the RC of a detained or community patient this would need to be resolved by the Trust Management.

      iii. Approved Mental Health Professional (AMHP) or Care Co-ordinator
         - The MHA Administration will contact the care co-ordinator (if known) or the Community Mental Health Team (CMHT) Leader local to the patient’s home address if no care co-ordinator has been appointed.
         - In the case of patients of no fixed abode, the report will be requested from the CMHT local to the ward on which the patient is detained.
iv. Nursing staff

- Nursing staff are expected to provide reports for in-patients only, (accompanied by a copy of the current nursing care plan). The named nurse for a sectioned patient should provide the report and attend the hearing, however it is accepted that this may not always be possible due to shift patterns, however it is expected that a qualified member of staff who knows the patient be present at the hearing. Ward Managers will be notified of the hearing at the same time as the named nurse.

9. Timescales for hearings

a. Section 2

Will take place within 1 week of the application. Section 2 reports must be provided to the MHA Administrator as soon as possible, and no less than two hours before the hearing is due to commence.

b. Section 3/37/Guardianship/Community Treatment Order (CTO) appeals

Timescales for these hearings are set by the FTT. Reports are due within 3 weeks of the date of the application. A hearing date may not have been set at that stage.

c. Renewal hearings – Section 3/37/Community Treatment Orders (CTO)

Timescales for these hearings are again set by the FTT. Reports are due within 3 weeks of the date of referral, regardless of whether or not a date has been organised for the hearing.

d. Hospital Managers Hearings – appeals and renewals

Timescales for these hearings are within 3-4 weeks of the date either of receipt of the appeal or form H5 (or CTO7) renewing a section, but are organised in liaison with the care team and the patient’s solicitor. Reports are required at least one week before the date of the hearing. In cases where the patient has appealed to both the FTT and the Hospital Managers, the same reports may be used for both hearings.

e. It is good practice for professionals to provide a copy of the report to the patient, and for the content to have been discussed, before the hearing if practicable.

10. Duties of Mental Health Act Administration (MHAA)

a. On behalf of the Trust, the MHAAs will:

- Send patient appeals documentation to the Tribunals Service;
- Provide a copy of the law society list of mental health solicitors to wards and patients to allow them to choose a representative, or organise a representative on a patient’s behalf if requested;
- Arrange hearing dates suitable for the RC when possible;
- Compile the RA’s report;
- Request reports from professionals involved in the patients’ care and provide a deadline for receipt of reports;
- Provide all paperwork to the FTT. This may include detention papers, previous tribunal decisions, etc;
- If the patient is a restricted patient, send copies of the documents to the Secretary of State; and
• Ensure that a suitable room is booked for the hearing to take place, with refreshments.

b. Where possible, the MHAAAs will provide reports to the Tribunals Service by way of secure email (nhs.net) to:

   TSMHnorthreportsteam@tribunals.gsi.gov.uk

c. Where it is not possible to email reports, they should be sent by first class using recorded delivery post. Fax will only be used as a last resort, or when directed by the Tribunal Judge.

d. Where reports are being provided to the Ministry of Justice, they should be emailed to:

   MHUTribunalCorrespondence@noms.gsi.gov.uk

e. Each MHAA will have an nhs.net email address and a scanner/printer to be able to facilitate these requirements.

11. Late reports and unsuitable reports

   a. If the RA fails to provide reports to the FTT within the statutory timescales, a practice direction is sent to the Trust via MHA Administration. This direction will contain details of the legal situation in respect of non-compliance.

   b. If the MHA Administration receives these, the professional will be asked to provide the report as soon as possible and their line manager will be advised of the late report. Persistent failures will result in a report to the relevant service lead.

   c. Where reports are deemed to be insufficient, a practice direction is sent to the Trust via MHA Administration. Typically, three days are allowed for the submission of a suitable report.

   d. If the Trust fails to provide reports of a suitable quality within the statutory timescales, the FTT can make a wasted costs order against the RA. In addition, the FTT can summons both reports and people to comply with hearings directions. In extreme cases, the Trust may be found to be in contempt of court if it fails to comply with these or further directions.

12. Disclosure of information to the patient

   a. The CQC consider it good practice to provide the patient with a copy of their report and for the contents of the report to have been discussed with the patient by the relevant professional before the hearing.

13. Non disclosure of information to the patient – reporting of sensitive information

   a. The FTT can give a direction to prohibit disclosure to the patient (or anyone else) of information, statements, reports or other documents. They will only do that if they are satisfied that the disclosure would cause harm to the patient, or any other person and that this is a proportionate response, bearing the interests of justice in mind.

   b. If the Trust, or any person making a report to the FTT, feels that a non-disclosure order is necessary, they must:

      • Extract the relevant information from the other material provided and provide it to the FTT separately, ensuring that it is clearly marked:
“NOT TO BE DISCLOSED TO THE PATIENT WITHOUT THE EXPRESS PERMISSION OF THE TRIBUNAL”

- Provide full written reasons on the prescribed Tribunals Service Form (CMR1) for the proposed exclusion so that the Tribunal can make the decision as to whether grounds for non-disclosure are met. The MHAA will assist with the preparation of this form if all the relevant information is provided to them.

c. If the Tribunal agree, then all parties to the hearing must respect the non-disclosure rule.

d. If the patient has a representative, the Tribunal may allow disclosure to that representative, if it is the interests of the patient, and as long as they are satisfied that the representative will act in accordance with the exclusion.

e. Excluded documents must not be disclosed to anyone without the Tribunal’s consent.

14. Report Types

a. The care team should meet before a hearing to construct a care plan that could be put into place if the patient were discharged. This should form part of the reports.

14.1 Responsible Authority report

a. Appendix A meets the Tribunal criteria and is used by the Trust MHA Administration. The Trust must complete an Administration Statement for all hearings involving in-patients and community patients.

b. Reports must include:
   - Patients full name (including any alternative names used in their records);
   - Date of birth, age and usual place of residence;
   - Patients first language and if not English, whether an interpreter is required and for which language;
   - If patient is deaf, whether a British Sign Language interpreter or Relay interpreter is required;
   - Date of admission or transfer to Trust, details of the initial application for detention, along with any subsequent renewals or changes in the authority for detention;
   - Details of the detaining hospital;
   - Details of any transfers;
   - Name of the RC and the date that the patient came under care of RC;
   - Name of the local Social Services Authority and the NHS body which would have the duty to provide s117 aftercare;
   - Name of the care co-ordinator;
   - Address of the Nearest Relative (NR) or person fulfilling that function, along with any specific requests that the NR should not be consulted. If that is the case, confirmation that the RA believes the patient has capacity to make that request;
   - Name and address of anyone who plays a significant part in the care of the patient, but not professionally;
• Name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;
• Details of any registered lasting or enduring power or attorney made by the patient; and
• Details of any advance decisions to refuse treatment made by the patient.

14.2 Clinician’s report

a. Appendix B, suitable for in-patients, patients subject to guardianship, or subject to conditional discharge.

b. Reports must include the following:

• Full details of the patient’s mental state, behaviour and treatment for mental disorder

• So far as the report author is aware, a statement as to whether the patient (when mentally disordered) has ever:
  i. threatened to, or actually harmed or neglected themselves;
  ii. harmed or been threatening to other people; or
  iii. damaged or threatened to damage property;

• An assessment of the risks posed to the patient or others if the patient were discharged at the hearing and how those risks could be managed effectively

• An assessment of the patient’s strengths and any other positive factors that the panel should be aware of when making a decision whether the patient should be discharged

• Whether the patient has a learning disability or cognitive impairment which may undermine their understanding or ability to cope with the hearing and whether any approaches or adjustments that the panel can make to deal with the case fairly

c. Appendix C, suitable for s17(a) Supervised Community Treatment, (Community Treatment Order) reports must include the following:

• An assessment of the patient’s capacity to decide whether or not to attend, or be represented at a hearing

• Details of the circumstances leading up to the underlying s3 order and why the patient was then made subject to a CTO.

• Details of the original authority for SCT (contained on the CTO1)

• The name of the RC and the length of time the patient has been under their care

• Full details of the patient’s mental state, behaviour, treatment for medical disorder and relevant medical history

• So far as the report author is aware, a statement as to whether the patient (when mentally disordered) has ever:
  i. threatened to, or actually harmed or neglected themselves;
  ii. harmed or been threatening to other people; or
  iii. damaged or threatened to damage property;
along with details of the neglect, harm, damage or threats.

- An assessment of the risks posed to the patient or others if the patient were discharged at the hearing and how those risks could be managed effectively.
- An assessment of the patient’s strengths and any other positive factors that the panel should be aware of when making a decision whether the patient should be discharged.
- Reasons why the patient can be treated in the community without detention in hospital and why it is necessary that the power to recall the patient to hospital under s17(e) remains in place.
- Details of any specific conditions in place.

14.3 Nursing Report
a. Appendix D, only required for in-patients (including patients on s17 leave).

b. Reports must include the following as a minimum:
   - The patient’s understanding of and willingness to accept the current treatment for mental disorder provided or offered;
   - The level of observation that the patient is subject to;
   - Details of any episodes of seclusion or restraint, along with reasons why this was necessary;
   - Details of any episodes of absence without leave (AWOL), or failure to return when required after being granted leave of absence (s17); and
   - Details of self harm or harm to others, damage to property etc., or threats along these lines.

c. A copy of the current nursing care plan and risk assessments must be attached to the report.

d. The template at Appendix d, allows for more information to be provided.

14.4 Social Circumstances Report (AMHP or Care Co-ordinator)
a. Appendix E, suitable for in-patients, patients subject to guardianship, or subject to conditional discharge.

b. Reports must include the following:
   - The patient’s home and family circumstances;
   - If under 18, the names and addresses of any individuals with parental responsibility (and how that was acquired);
   - If practicable, a summary of the nearest relative’s views, unless – in consultation with the patient – this is considered inappropriate. *NOT IN RESTRICTED CASES*;
   - If practicable, the views of people who play a significant role in the care of the patient, but who are not professionally concerned;
   - The patient’s views, concerns, hopes and beliefs about the tribunal and their expectations of the outcome;
   - Opportunities for employment and housing available to the patient;
• If the patient is discharged, the community support or after care which would be available to the patient and its likely effectiveness;
• Financial circumstances, including benefits;
• An assessment of the patient’s strengths and any other positive factors that the panel should be aware of when making a decision whether the patient should be discharged; and
• An assessment of the risks posed to the patient or others if the patient were discharged at the hearing and how those risks could be managed. (If the patient has children who are subject to child protection plans the children’s social worker must be contacted if there is a change to the patients section and /or leave arrangements).

c. Additional – for CTO’s only:
• An account of patient progress under the CTO, conditions of the CTO and details of any behaviour that has put the patient or others are risk of harm; and
• An assessment of any likely risks which the patient or other persons would be subject if the order were discharged.

15. Outcomes

a. The care team should meet before a hearing to construct a care plan that could be put into place if the patient were discharged. This should form part of the reports.

i. Tribunals Service
The Tribunals Service can choose to uphold the section, discharge the section immediately or defer the discharge to a future date. They can also adjourn the hearing.

ii. AHM Panel
The AHM’s can uphold the section or discharge the section. Unless there are unusual circumstances which demand that the hearing is adjourned, eg a legal challenge or the need for additional reports, a decision will be made on the day.

16. Patients under the age of 18

a. It is not anticipated that this Trust will be required to hold hearings for patients under the age of 18. The FTT makes special provision for them and specific guidance is available for professionals who may be asked to contribute to a hearing. The booklet is called “Reports for Mental Health Tribunals” and is available via www.tribunals.gov.uk or from the Trust MHA Administration.

17. Monitoring arrangements

a. The templates attached to this protocol are for guidance only. The suitability of reports being created for Hospital Managers and Tribunal hearings will be monitored via the Mental Health Act Monitoring Group.
### STATEMENT BY THE RESPONSIBLE AUTHORITY

**INFORMATION RELATING TO PATIENTS**

<table>
<thead>
<tr>
<th>Tribunal reference no:</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Full name of the patient:</td>
<td></td>
</tr>
<tr>
<td>Also known as:</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Age:</td>
</tr>
<tr>
<td>Usual place of residence:</td>
<td></td>
</tr>
<tr>
<td>Patient’s first language:</td>
<td>Interpreter required:</td>
</tr>
<tr>
<td>Is patient deaf?</td>
<td>BSL/Relay required:</td>
</tr>
<tr>
<td>The hospital or unit at which the patient is currently detained under the Act (including ward):</td>
<td>Date of Admission:</td>
</tr>
<tr>
<td>Details of the application, order or direction to which these proceedings relate:</td>
<td></td>
</tr>
<tr>
<td>Details of any transfers under Section 19 or Section 123 of the Act:</td>
<td></td>
</tr>
<tr>
<td>Local authority responsible for providing patient with after-care under Section 117:</td>
<td></td>
</tr>
<tr>
<td>The name of the Responsible Clinician:</td>
<td></td>
</tr>
<tr>
<td>Responsible Clinician for this patient since:</td>
<td></td>
</tr>
<tr>
<td>Care Co-ordinator appointed for the patient:</td>
<td></td>
</tr>
<tr>
<td>Name and address of nearest relative (or person exercising that function):</td>
<td></td>
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<tr>
<td>Has patient requested that this person is not consulted or kept informed:</td>
<td></td>
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</tbody>
</table>
Is the patient considered to have the capacity to make this request:

Name and address of anyone who plays a substantial part in the care of the patient but is not professionally concerned with it:

Name and address of any deputy or attorney appointed under the Mental Capacity Act 2005.

Details of any existing lasting power of attorney made by the patient relating to personal welfare:

Details of any existing enduring or lasting power of attorney made by the patient regarding property and affairs:

Details of any existing advance decisions to refuse treatment for mental disorder made by the patient:

Details of any other existing applications, orders or directions made under the act:

Signed: 

<table>
<thead>
<tr>
<th>Name:</th>
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<tr>
<td>Date:</td>
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| Designation: |

Documents attached:

<p>| | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Copies of original application, order or direction</td>
</tr>
<tr>
<td>2.</td>
<td>Copies of supporting recommendations, reports and records</td>
</tr>
<tr>
<td>3.</td>
<td>Consent documents</td>
</tr>
<tr>
<td>4.</td>
<td>Renewal reports</td>
</tr>
<tr>
<td>5.</td>
<td>Transfer documents</td>
</tr>
<tr>
<td>6.</td>
<td>Certificates authorising treatment</td>
</tr>
<tr>
<td>7.</td>
<td>Details of any hospital managers hearings</td>
</tr>
<tr>
<td>8.</td>
<td>Copies of tribunal decisions</td>
</tr>
<tr>
<td>9.</td>
<td>Copies of applications in force immediately prior to this Section</td>
</tr>
</tbody>
</table>
RESPONSIBLE CLINICIAN’S REPORT FOR HEARING

In respect of

As stated in the Tribunals Judiciary Practice Direction, the statement provided to the Tribunal Service or Hospital Managers must include an up-to-date clinical report. Unless it is not reasonably practicable, this report must be written or counter-signed by the patient's responsible clinician.

Name of Patient:

Date of Birth:

Home Address:

Date of Admission:

Current Legal Status:

Date of Section:

Detaining Hospital:

Responsible Clinician:

AMHP/Care Co-ordinator:

Nearest Relative
Full details of the patient’s mental state, behaviour and treatment for mental disorder, including medical history

Statement regarding neglect, self harm and/or harm or threaten of harm to others, together with details

Risk assessment and management of risk if the patient were discharged, and how these could be managed effectively

An assessment of the patient’s strengths and relevant positive factors

Whether the patient has a learning disability or other disorder that may affect their understanding or ability to cope with the hearing and any amendments that the panel can consider to deal with the case fairly

SIGNED:

__________________________________________________

PRINT NAME: ______________________

DATE: ______________________
Appendix C

RESPONSIBLE CLINICIAN’S REPORT FOR HEARING

In respect of

As stated in the Tribunals Judiciary Practice Direction, the statement provided to the Tribunal Service or Hospital Managers must include an up-to-date clinical report. Unless it is not reasonably practicable, this report must be written or counter-signed by the patient's responsible clinician.

Name of Patient:

Date of Birth:

Home Address:

Date of CTO:

Extension date of CTO (if applicable):

Responsible Authority:

Responsible Clinician:

Period of care under RC:

AMHP/Care Co-ordinator:

Nearest Relative
Details of the underlying s3; including the circumstances which lead to the original CTO

Details of the patient’s mental state, behaviour and treatment; relevant medical history

An assessment of the patient’s capacity to decide whether or not to attend, or be represented at a hearing

Whether the patient has a learning disability or other medical disorder that might affect their ability to understand or cope with the hearing and any alterations that the panel can make to deal with the case fairly

Statement regarding neglect, self harm and/or harm or threaten of harm to others, together with details

Risk assessment and management of risk if the patient were discharged, and how such risks could be effectively managed

An assessment of the patient’s strengths and relevant positive factors

The rationale for the CTO, including why it is necessary to be able to recall the patient to hospital

Details of any specific conditions of the CTO

SIGNED:

__________________________________________________________________________

PRINT NAME: ___________________________ DATE: ___________________________

__________________________________________________________________________
NURSING REPORT FOR HEARING

In respect of

The report must be up-to-date and specifically prepared for the hearing. In relation to the patient's current in-patient episode, it should contain full details of the following:

Name of Patient:

Date of Birth:

Home Address:

Date of Admission:

Current Legal Status:

Date of Section:

Detaining Hospital:

Named Nurse:

Responsible Clinician:

AMHP/Care Co-ordinator:

Nearest Relative
The patient’s understanding of and willingness to accept treatment for mental disorder

The level of observation

Any occasions on which the patient has been secluded or restrained, including reasons why this was necessary

Any occasions on which the patient has been absent without leave, or has failed to return following leave

Any incidents where the patient has harmed themselves or others, or has threatened other persons with violence, or has damaged property

An assessment of the patient’s strengths and relevant positive factors

A copy of the patient’s current nursing plan is attached

SIGNED:

__________________________________________________

PRINT NAME: DATE:

_________________________________________ _______________
Appendix E

Worcestershire Health and Care NHS Trust

SOCIAL CIRCUMSTANCES REPORT FOR HEARING

In respect of

Reports should be concise and up-to-date. Medical and social work terminology and medical opinions should be avoided wherever possible.

Name of Patient:

Date of Birth:

Home Address:

Date of Admission:

Current Legal Status:

Date of Section:

Detaining Hospital:

Responsible Clinician:

AMHP/Care Co-ordinator:

Nearest Relative

The patient’s home and family circumstances (To include any children with ages or adults who may be vulnerable) (Details of any ongoing Children’s social care involvement if applicable)

If under 18, the names and addresses of any individuals with parental responsibility
for the patient and how that was acquired

Views of the nearest relative (except in restricted cases), unless inappropriate to consult

Views of others with substantial part in the care of the patient

Views of the patient including hopes and beliefs in relation to the hearing

Opportunities for employment and housing available

What community support is available if patient is discharged, and its effectiveness

Patient’s financial circumstances, including entitlement to benefits

An assessment of the patient’s strengths and relevant positive factors

An assessment of the extent to which the patient or other persons would be put at risk if patient discharged and management plan (particularly any mentioned in Family circumstances above)

Other relevant factors

SIGNED:

_________________________________________________________________________