NHS
East Midlands

An independent investigation into the care and treatment of a person using the services of Leicestershire Partnership NHS Trust

Undertaken by Consequence UK Ltd

Ref 2007/1200

January 2011

This is the report of an independent investigation commissioned by NHS East Midlands to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent investigation of adverse events in mental health services"* issued in June 2005. The guidance replaces paragraphs 33 – 36 in HSG (94)27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users (MHSUs) involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Investigation Team members were:

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- Dr Jeremy Chase, Consultant Psychiatrist in crisis and home treatment and assertive outreach, Hertfordshire Partnership NHS Foundation Trust
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Acknowledgements

The Investigation Team wishes to thank:

- the mental health service user (MHSU);
- the father of the mental health service user;
- the husband of one of the victims;
- the brother of one of the victims and his wife;
- the father of the youngest victim's daughter;
- staff employed by Leicestershire Partnership NHS Trust (LPT);
- Leicestershire Constabulary; and
- the Driver and Vehicle Licensing Agency (DVLA)

all of whom assisted in the investigation conducted.

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ACRONYMS USED IN THIS REPORT

Acronym	Full Title
A&E	Accident and emergency
GP	General practitioner
CMHT	Community mental health team
Cons P	Consultant psychiatrist
CPA	Care Programme Approach
CPN	Community psychiatric nurse
CRHT	Crisis resolution and home treatment team
DfT	Department for Transport
DLA	Disability Living Allowance
DSH	Deliberate self harm
DVLA	Driver and Vehicle Licensing Agency
EMSHA	East Midlands Strategic Health Authority
FTD	Fitness to drive
GP	General practitioner
IIT	Independent Investigation Team
LASSL	Local Authority Social Service Letter
LPT	Leicestershire Partnership NHS Trust
MDT	Multidisciplinary team
MHA	Mental Health Act (1983)
MHP	Mental health professional
MHSU	Mental health service user
NHS	National Health Service
NPSA	National Patient Safety Agency
RMO	Responsible medical officer
SHA	Strategic health authority
SW	Social worker

EXECUTIVE SUMMARY

Incident overview and intention

On 30 January 2007 a mental health service user, here referred to as the "MHSU", of the specialist mental health service provided by Leicestershire Partnership NHS Trust (LPT), lost control of her motor vehicle and killed two members of the public. The two victims were mother and daughter. The granddaughter of the older victim was present but speaking with a friend when the accident occurred. She did not witness the accident but her friend did.

On 29 January, following a significant deterioration in her mental health, the MHSU had been assessed in A&E, by LPT's Deliberate Self Harm (DSH) team and then by the city Crisis Resolution and Home Treatment team (CRHT) who determined that she was suitable for home treatment.

Following LPT's internal investigation and the subsequent trial of the MHSU East Midlands Strategic Health Authority (EMSHA) commissioned an independent investigation of the MHSU's care and management during the period leading to the accident and, in particular, on 29 January 2007.

This report sets out the Independent Investigation Team's (IIT's) findings.

Purpose of the investigation

The purpose of the investigation was to provide answers to the following questions.

- Was the overall care and management of the MHSU reasonable?
- Was the assessment of the MHSU by the DSH team reasonable on the afternoon of 29 January 2007, including its communications with the MHSU's regular care team and the CRHT?
- Was the assessment undertaken by the CRHT on 29 January 2007 of an acceptable standard?
- Was the issue of driving safety given sufficient attention by LPT mental health professionals, prior to and on 29 January 2007?
- Was the medication management of the MHSU reasonable, prior to and on the evening of 29 January 2007?
- Was the decision to accept the MHSU for home treatment a reasonable decision?

The investigation also aimed, while avoiding hindsight bias, to gauge the predictability of the MHSU's driving risk, and the potential preventability of the accident.

Outline of the review process

The team conducted:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of LPT's internal investigation report.
- Interviews with a range of mental health professionals who had direct care delivery contact with the MHSU.
- A review of relevant LPT policies and procedures.
- Communications with Leicestershire Constabulary and the DVLA.
- A semi-structured survey exploring aspects of the assessment process in crisis resolution teams in three mental health trusts unconnected with LPT.

Main conclusions

The accident in which this MHSU was involved was tragic, and its impact has been enormous for all concerned. The IIT's conclusions are based on an objective and detailed analysis of the MHSU's care and treatment in Leicestershire Partnership NHS Trust in the 12 months preceding the incident and are also cognisant of her mental health history and the precipitators to previous relapse episodes. The IIT has had access to information that was not available to the courts at the time of the MHSU's conviction. This means that it is appropriate for the IIT to state its conclusions based upon the analysis of the information it gathered, uninfluenced by any conclusions previously reported in the public press. The IIT is mindful of this in stating its conclusions. It is also mindful that the MHSU's consultant psychiatrist in January 2007 was reported in the media as having told Leicester Crown Court[1] that she thought the MHSU had needed hospital admission. However this consultant did not assess the MHSU on 29 January 2007, and based her opinion on the information provided to her by the Deliberate Self Harm (DSH) team some two hours before the Crisis Resolution and Home Treatment team (CRHT) assessed the MHSU. The CRHT's responsibility was to undertake an assessment of the MHSU's suitability for home treatment based on her presentation at the time, bearing in mind any available information from the DSH team. The CRHT was therefore carrying out its duties appropriately in attending to assess the MHSU and to determine a course of action.

With regard to the question: "Was it predictable that the MHSU would take her car out on the morning of 30 January, driving very fast and then losing control of it?" the IIT does not believe that it was predictable. There was no previous documented, or reported, history of her driving dangerously. There was only

[1] http://news.bbc.co.uk/1/hi/england/leicestershire/7363608.stm

one known incidence of her taking her car out, believing she was competent to drive when she was not. On that occasion, however, she had not been told not to drive and she had displayed responsibility some 12 days previously when she notified the DVLA about an alteration to her medication following a relapse. The more frequent clinical record is of this MHSU acknowledging that she should not drive, and not driving, when adversely affected by her medication or unwell. She, as many other drivers, had incurred fines and penalty points for speeding offences, classed as SP30 offences. She had two such offenses recorded, one in 2003 and one in 2004. In the same time period the MHSU had three significant mental health relapses.

However, in spite of her low driving risk, it is undeniable that driving risk should have been considered by MHP's between October and December 2006 and on 29 January 2007.

Unfortunately, the consideration of driving risk was not commonly at the forefront of mental health professionals' minds at this time. Although there have been few papers published on this subject, there was sufficient information in the public domain for the professionals to have been more aware about their responsibilities and MHSU's fitness to drive. However as recent DfT research shows, the lack of awareness of and thus consideration of fitness to drive was not unique to the professionals assessing the MHSU on 29 January 2007, or the MHSU's regular care team in 2006.

The IIT has considered whether paying more attention to the MHSU's fitness to drive between October and November 2006 could have prevented this tragedy. Had the MHSU been advised that she needed to report the deterioration in her mental health to the DVLA during this period, it is very possible that she would have had her driving licence revoked and that it would not have been reinstated by January 2007. However one cannot say that even had this happened, the incident would not have occurred. The incident could only have been avoided if the MHSU's father had collected the MHSU from A&E and taken his daughter home with him on 29 January 2007. He keeps his car in a locked garage so she would not have been able to access this.

With regard to the crisis assessment that occurred on 29 January 2007, although fitness to drive should have been a consideration, this on its own would not have prevented the subsequent incident. What was more important was the decision to accept the MHSU for home treatment and whether this was executed safely. The IIT's perspective based on the MHSU's presentation at the time, that the assessing CRHT mental health practitioners did not exercise the necessary caution in respect of:

- The MHSU's sleep disturbance/deprivation.
- The need for medical advice/assessment regarding the immediate management of her psychotic symptoms.

- Her lack of willingness to divulge all the information they required to complete a full assessment.
- Her home circumstances. The MHSU was living by herself. It was assumed by the assessing crisis professionals that her friend was staying with her, but this was not the case.

As a consequence, although in principle the MHSU was someone for whom home treatment may have been appropriate, she was accepted for home treatment without an adequate plan in place. This meant that the way in which she was accepted for home treatment was unsafe.

An appropriate degree of caution would have been exercised, and acceptance for home treatment would have constituted reasonable practice, had the following occurred:

- Assessment by a medical practitioner.
- Administration of an antipsychotic medication.
- A home visit to assess how the MHSU was settling at around 10.30/11pm.
- Administration of a night sedative if required at around 10.30/11pm.
- Clear instruction to advise the MHSU to contact the CRHT base if she woke during the night or early hours feeling unwell.
- Checking with the MHSU's father or her friend whether either of them could support the MHSU at home overnight, or whether she could stay with either of them until her assessment the following morning.

Because none of the above occurred and there was no interim care/treatment contract agreed prior to medical assessment the following morning, the MHSU should not have been sent home as she was. Furthermore, had the MHSU been resistant to any of the above measures, practitioners would have had to consider admitting her to hospital.

Looking at the MHSU's history, and at her expressed wish for home treatment on 29 January 2007, it is most likely that she would have agreed to an interim treatment plan if that would have enabled her to successfully achieve a home treatment outcome.

Whether or not such a treatment plan would have prevented the incident is difficult to say in retrospect. However what the IIT can say is that the incident would have been far less likely to have occurred and on the balance of probabilities would have been avoided had her father been asked to collect his daughter from the A&E department instead of allowing her to go home by taxi. That the CRHT did not contact the MHSU's father to collect his daughter from A&E does not, per se, represent a lapse in care. That no interim care package, as indicated on the previous page, was implemented does however represent a lapse in safe standards of care.

Recommendations
The IIT has eight recommendations for LPT and one for East Midlands SHA as a result of its investigation. The LPT recommendations all have a local focus. The recommendation to East Midlands SHA relates to communication between the DVLA and relevant members of the medical profession following fitness to drive assessments.

Recommendation 1: LPT needs to ensure that its crisis resolution and home treatment professionals have access to up-to-date and appropriate clinical records when conducting emergency mental health assessments.

At the time this MHSU was receiving home treatment the CRHT did not have access to core clinical information electronically, for example the most recent CPA document, the most recent risk assessment and any significant correspondence. The city CRHT's operational policy in 2006 did not address the issue of what information was required by the CRHT from a service user's regular care team when it accepted a client for home treatment. Neither did the operational policy for community mental health teams (CMHTs) address what information they will routinely provide if a service user was transferred to the care of another team such as CRHT or the Psychiatric Early Intervention Service.

It is therefore the recommendation of the IIT that the Executive Director with responsibility for quality and innovation determines with the Service Manager of the crisis resolution teams what core clinical information must be provided to them when a known patient is referred for a crisis assessment.

It is the IIT's perspective that any minimum data set should include copies of the:

- most recent CPA document;
- most recent assessment and risk management plan; and
- most recent outpatient correspondence sent to the service user's GP.

In addition to the above, because LPT does not yet have an electronic records system, it is recommended that as standard where a service user is accepted for home treatment there is a face-to-face handover involving the service user's regular care coordinator, or that the crisis team attends at the regular team's base to extract information that will enable safe and effective home treatment.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, and Service Manager for LPT crisis resolution teams.

Timescale: The IIT appreciates that this recommendation may not be easy to meet and that there may be practical issues of which it is not aware. The IIT suggests that within two months of this report being accepted, LPT needs to

determine how it is going to ensure and assure that CRHT professionals have access to core documents such as risk assessments in order to deliver an optimal service to clients.

Recommendation 2: The operational policy for LPT's crisis resolution and home treatment service must set out clear and measurable standards for how service users are discharged.

The crisis resolution and home treatment operational policy must set out clearly the standards expected when service users are discharged from the crisis resolution and home treatment service. Historically no such standards have been detailed. The draft policy tabled for presentation at the LPT senior clinical group in July 2010 does now contain discharge standards which meet the principles of the points highlighted below. These standards have been incorporated as a result of this investigation.

East Midlands SHA will need to satisfy itself that the standards remain in the final ratified policy document.

The IIT expects such standards to include the following principles:

- When discharge becomes a consideration and the service user is on a CMHT caseload, there will always be a discharge CPA meeting, or at minimum a face-to-face meeting with the service user's care coordinator.
- If a face-to-face meeting/discharge CPA meeting is not possible then the reasons for this are clearly stated in the service user's clinical records.
- When a service user is to be discharged back to the care of primary care services (i.e. there is no continuing mental health care from specialist mental health services), a formal discharge summary containing the same information as a discharge letter from community or inpatient services is faxed to the service user's GP within five working days of discharge. If the discharge is a planned discharge, there should be no reason why this is not achievable.

Target audience: LPT's Chief Operating Officer, Service Manager for LPT crisis resolution teams (city and county).

Recommendation 3: LPT's crisis resolution and home treatment service must ensure that its discharge summaries provide complete information to GPs and other relevant mental health teams and agencies.

The information provided on the discharge summaries from the CRHT to GPs and other professionals was inadequate in 2007. The management team for crisis resolution and home treatment services must ensure that, as standard, the following are addressed in all discharge correspondence:

- current diagnosis;
- problem summary (how the service user came into contact with the crisis service and a synopsis of the clinical progression);
- treatment/interventions provided;
- recovery impressions;
- current risks (self, others, safeguarding, fitness to drive, neglect, financial, engagement with services);
- medication; and
- recommendations.

The proposed discharge summary document, that will be implemented in the LPT crisis resolution and home treatment service following ratification of its revised operational policy, does require the presentation of the information tabled above.

Because the discharge summary document has been developed following feedback provided to the crisis resolution and home treatment service during this investigation, it will be East Midlands SHA's responsibility to ensure that implementation of the policy and the proposed documentation tools occurs in a timely manner. The IIT suggests that the revised operational policy should be ratified and implemented by 1 October 2010.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, and Service Manager for LPT crisis resolution teams.

Recommendation 4: LPT must ensure that up-to-date and appropriate clinical records are available to staff conducting emergency mental health assessments.

Although home treatment is for relatively short periods of time, if it subscribes to the concept of "one patient, one set of clinical records", LPT does need to ensure that this is achieved manually in the absence of functional electronic records. It is not acceptable that a service user's main clinical record does not contain a full record of all significant care interventions and the detail of care and treatment delivered.

LPT needs to set out clearly its strategy, including the financing, of how it is going to achieve the standard of "one patient, one set of clinical records". This is not the current position in LPT and each team (CMHT, CRHT, Psychiatric Early Intervention etc) is maintaining its own records relating to the service user. That these records are merged when the service user is fully discharged from the service is not sufficient. Clinical practitioners must be able to access all relevant information about a service user if they are to develop effective and safe care plans.

If providing this information electronically is not achievable for LPT then it must set out how it intends to meet the principle with its current (predominantly manual) system of clinical records. Maracis, the current LPT electronic records system, does not achieve this.

Target audience: LPT's Chief Executive, Executive Director of Quality & Innovation, Director of Risk Assurance.

Timescale: The IIT is sure that achieving a workable electronics system is already something LPT is looking at. What it needs to do is commit to a clearly defined strategy and implementation timetable, that is monitored by the SHA as part of its action implementation plan arising from this investigation. The IIT does not consider it appropriate to impose or suggest a timescale to LPT.

Recommendation 5: The LPT crisis resolution and home treatment service needs to minimise the loss of information along the communication pathway from those making referrals to the assessing mental health practitioners.

This investigation highlights the dangers of introducing too many variables in a communication pathway when service users are referred for assessment by the CRHT. In this case, information from the deliberate self harm (DSH) team was passed verbally to a triage nurse who made notes of the discussion, which were then provided to the mental health professionals (MHPs) asked to assess the service user. There was a loss of important information during this process. Consequently it is the recommendation of the IIT that:

- A faxable referral form is developed for the CRHT which provides clear headings for entering specific information. It should have an accompanying guidance sheet detailing its purpose and how it will be used. All future referrals to the CRHT should be made, or confirmed, in writing on this form.
- All faxed referrals are supplemented with telephone follow up by the CRHT triage nurse, or preferably the mental health professionals tasked with undertaking any subsequent assessment.
- For the deliberate self harm (DSH) assessment form to be extended so that greater detail about the assessment can be recorded. This should include full details of any discussions the DSH team has with a service user's regular care team and the outputs of this. If a DSH MHP believes admission to be the only option at the time of their assessment, this should be made explicit at the time of referral so that this perspective is clear to the next team, who may not be conducting their assessment until sometime later. Consequently consideration needs to be given to ensuring that a prompt for this opinion is included on any revision of the DSH assessment form.
- The DSH assessment form needs to record the contact numbers for the assessing DSH professionals, so that the assessing CRHT MHP can make proactive communication with this team. Indeed LPT could explore the practicalities of expecting the assessing CRHT MHP to have a direct conversation with the referrer prior to their assessment rather than this solely being undertaken by the CRHT triage nurse. This would reduce the opportunity for miscommunication, misinterpretation of information, and information loss.

The current draft (July 2010) of the revised crisis and home treatment team operational policy does not fully address this recommendation, and the wording over whether or not telephone referrals will be routinely accepted is less than clear. It currently implies that telephone referrals will be acceptable. It is the recommendation of the IIT that the normal standard of practice should be for faxed referrals, followed up by telephone communication, in all but exceptional circumstances.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, and Service Manager for LPT crisis teams.

Recommendation 6: All crisis resolution and home treatment professionals in LPT must recognise the increased accountability they accept when they elect not to seek the advice of the on-call psychiatric team when undertaking out of hours assessments. A culture of not using available medical input out of hours has no place in the delivery of an effective and safe crisis resolution and home treatment service.

The IIT has formed the view that it is not customary for crisis resolution and home treatment professionals to seek medical input into their out of hours crisis assessments where these are conducted on hospital premises, most usually A&E. It is essential that all crisis resolution and home treatment MHPs understand that their accountability and responsibility for a service user commences at the point they make the decision to accept this service user for home treatment, and that it is at this point that a care and treatment package, even if this is a short term package, needs to be agreed between the assessing professionals and the service user. In this case the MHPs did agree with the service user that she was to stay at home until assessed by a consultant psychiatrist the following morning. This was however an inadequate plan for this service user.

To assist MHPs in accurately recording their rationale for any treatment options instituted or not instituted, the IIT considers that it is important that the crisis team assessment tool prompts the assessing MHPs to record the immediate care and treatment agreement/contract agreed with the service user. Where this is out of hours and there is no liaison with available medical practitioners (registrar grade and above), then the reason for this should also be recorded. Similarly, where it is considered that medication is not necessary the rationale for this should also be recorded. The design of the assessment tool should reliably remind crisis resolution and home treatment professionals of the need for this information.

The IIT has formed the view that one of the reasons that CRHT MHPs may not be accessing medical advice out of hours is because of the variability of response they have received. LPT needs to explore this further, and to agree the minimum level of experience and qualification necessary in medical practitioners in order to provide crisis resolution and home treatment professionals with the calibre of assessment and advice required when making decisions regarding home treatment as an alternative to admission.

Note: Although the IIT has been advised that crisis resolution and home treatment team staff have been reminded about utilising out of hours medical staff during the assessment process, there is nothing specific in the July 2010 draft of the operational policy. If this remains absent, then LPT must make explicit its rationale for not addressing this to East Midlands SHA.

Target Audience: Executive Director of Quality & Innovation, Director of Risk Assurance, the lead clinician for the crisis resolution and home treatment service, and Service Manager for LPT crisis teams.

Recommendation 7: The managers of LPT's crisis resolution and home treatment service must map out the core and specialist knowledge, skills and competencies required of mental health professionals working within the service and ensure that all of its staff meet these competencies.

What has not been evidenced in LPT is any formal consideration of the enhanced skills and knowledge required by MHPs working in crisis resolution and home treatment, and the development of a competency framework. This gap is a national one and not limited to LPT. There is no clearly defined skill and competency framework for nursing staff working in this field.

Because HSG(94)27 investigations are intended to generate local improvements, it is the IIT's recommendation that LPT develops a clearly defined and measurable competency and skills framework for all MHPs undertaking assessments, where the output of the assessment is a decision for home treatment or hospital admission. Nurses undertaking these assessments do require an enhanced set of competencies, and LPT must satisfy itself that all staff engaged in the crisis resolution and home treatment assessments can practise to the required level of competency.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, the lead clinician for the crisis resolution and home treatment service, the crisis resolution team senior mental health practitioners and the Service Manager for LPT crisis resolution teams.

Timescale: The IIT does not believe that the development of clearly defined competencies for band five, six and seven nurses will be overly challenging for LPT. Consequently, LPT should be able to provide East Midlands SHA with a clearly defined action and implementation plan within six to eight weeks of this report's publication.

Recommendation 8: LPT must continue to ensure that all clinical staff are aware of issues that may affect a service user's fitness to drive, and ensure that they know what measures they can take to deliver their duty of care to the service user and also to the public.

LPT needs to consider developing its own practice policy document about the role and responsibility of all clinical practitioners in relation to the assessment of fitness to drive, their responsibilities in relation to the service user and the advice they should be providing to them where fitness to drive is questionable. Such a policy needs to be cognisant of the DVLA guidance on fitness to drive,

and the General Medical Council and other professional bodies' guidance which gives clear direction regarding clinical professionals' responsibilities.

Fitness to drive as a focal topic should be a component of LPT's core and update risk assessment training, and this case could be a useful case to study.

Specifically all mental health practitioners, including medical staff, must appreciate that any of the following may constitute fitness to drive issues:

- any significant and prolonged impairment of concentration;
- sleep deprivation;
- medication changes;
- hallucinations; and
- psychotic episodes.

The basic requirements for driving set out in *California Medicine* (September 1966, vol 105 (3), pages 197 – 200), as follows, may be useful pointers for staff to be mindful of:

- A basic minimum of strength and mobility.
- Ability to see and concentrate adequately on the roadway and traffic.
- Ability to interpret and make judgments about real or impending changes in the traffic situation.
- Knowledge of traffic laws.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance.

Timescale: To be agreed with East Midlands Strategic Health Authority.

Recommendation 9: East Midlands Strategic Health Authority is requested to liaise with the Department of Health to determine the best way to explore with the DVLA the issue of communication with medical practitioners following its assessment of an individual's fitness to drive. The IIT recommends that whenever fitness to drive has been assessed for medical reasons and a driving licence reinstated, that both the driver's GP and the doctor who completed the medical questionnaire for the DVLA are notified.

In this case the MHSU's consultant psychiatrist between April 2006 and January 2007 was not aware that the DVLA had reinstated her licence on an ordinary basis for one year. The letter advising that this had occurred was sent to the MHSU's GP, although the consultant had completed the DVLA's medical questionnaire and had had most contact with the MHSU. Had the MHSU's consultant psychiatrist been aware of licence reinstatement, she would have been required to notify the DVLA of the MHSU's fitness to drive issues between October and November 2006. This would have resulted in further assessment by the DVLA. Although one cannot say what the outcome

of this would have been, it would have been an opportunity to pay further attention to the MHSU's fitness to drive.

Target audience: Assistant Director, High Secure Services and Healthcare Governance, East Midlands SHA.

1.0 INTRODUCTION

This investigation was commissioned by East Midlands Strategic Health Authority to determine:

- the quality of care and management afforded the MHSU; and
- whether or not the incident on 30 January 2007 could have been prevented by different management and/or actions by the specialist mental health services in Leicester.

On 30 January 2007 the MHSU was overcome by command hallucinations that caused her to drive her car in a dangerous manner. As a consequence of this she lost control of her vehicle and it turned on to its roof. When the MHSU lost control of her vehicle two women were killed. A child was also slightly injured and a second child and a woman escaped unhurt during the incident. The deceased were mother and daughter.

The MHSU was subsequently sentenced in Leicester Crown Court. She was cleared of causing death by dangerous driving 'by reason of insanity'[2]. However she was banned from driving for life and made the subject of an order of the court under section 37 of the Mental Health Act.

1.1 Overview of the MHSU's contacts with specialist mental health services in Leicester

The MHSU had six hospital admissions and one episode of home treatment prior to the incident in 2007. Her first hospital admission was in December 1995 (11 days), followed by admissions in January 1996 (4 days), January 1996 (2 days), August 2002 (4 days), January 2004 (18 days), and May 2005 (132 days).

The MHSU had her first manic episode in 1995. All admissions until 2002 were for this. In 2002 she also experienced hypomania. In 2005 her diagnosis was quantified as bipolar affective disorder, described thus:
"Current episode mania with psychotic symptoms."

Between October 2001 and August 2004 she committed three driving offences. All of these were fixed penalty fines under code SP30 for speeding. SP30 offences do not involve dangerous driving.

In July 2004 the MHSU advised her then clinical team that she had joined a new religion, "born-again Christianity", and that she had found a new level of

[2] BBC News 28 April 2008

spirituality. The MHSU also stopped taking her medications at this time. However her total non-compliance with her medication regime was not fully recognised until her new GP wrote to mental health services in February 2005, highlighting that she had collected her last medication prescription on 22 July 2004.

In May 2005 the MHSU was referred by her GP to the city Crisis Resolution and Home Treatment Team (CRHT), as she was very unwell. At the CRHT assessment it was noted:

- "unable to engage with the MHSU - no insight and appears to be very disturbed;
- refused CRHT treatment;
- refused offer of admission;
- unable to engage for full assessment as appears to be responding to hallucinations, unable to answer or concentrate on questions; [and]
- requires MHA".

The MHSU was subsequently admitted under the Mental Health Act and remained in hospital until October 2005. The clinical records show that once medicated she made an excellent recovery though her preoccupation with religious themes continued. This did not settle until she was commenced on risperidone towards the end of her inpatient period.

Following her discharge from hospital the MHSU was followed up appropriately at outpatients. It was noted early on (November 2005) that the she suffered from significant side effects as a result of her risperidone, including amenorrhoea (absence of menstrual periods). She was therefore advised to reduce the dose of this to 4mg.

Care Programme Approach (CPA) reviews in November 2005 and January 2006 correctly identified the MHSU's relapse indicators as medication non-compliance, reducing insight and an increase in religious fervour.

At the CPA review in January 2006, because the MHSU had been stable for three months since discharge from hospital, and on the basis of positive feedback from her father regarding her progress and mental health, it was agreed that her consultant psychiatrist (Cons P1) would write to the Driver and Vehicle Licensing Agency (DVLA) and her insurance company advising that in his view she was now fit to drive. Following correspondence with the DVLA, on 16 February 2006, Cons P1 received a request from the DVLA to complete the fitness to drive medical questionnaire. The correspondence that accompanied this request stated that:
"The above named driver may be entitled to drive whilst we are awaiting your reply and this may have an impact on road safety."

On 8 April 2006 the DVLA confirmed by letter that the MHSU had been provided with a restricted licence for one year. The letter to Cons P1 said that should the MHSU's mental health relapse in this 12 month period, the DVLA

must be informed[3]. The letter also said that if the patient was unable or unwilling to take advice about her suitability to drive, then the medical advisor at the DVLA must be informed.

By 19 April 2006 a change of care team had occurred and responsibility for the MHSU had transferred to Consultant Psychiatrist 2 (Cons P2) and her team. The handover was conducted effectively with an appropriate CPA meeting attended by all relevant professionals. At this time the MHSU was reporting herself to be medication compliant. The dosage of risperidone was at this time 1mg per day.

On 24 April 2006 the MHSU was referred to the city CRHT by a senior house officer (SHO) in A&E. She had been seen shouting and praying in the street. On assessment it was noted that she believed that she had done something wrong and had gone against the Bible, and as a consequence was asking God to forgive her. The records note that the MHSU herself felt she was becoming unwell but did not consider herself to be elated as she had not been spending lots of money. The records note that she had been hearing voices of a derogatory nature calling her names. Following the CRHT assessment the MHSU was accepted for home treatment.

The following day she was assessed by the consultant for the CRHT. This individual set out for the MHSU the boundaries including compliance with medication. Non-compliance would, the MHSU was advised, result in compulsory admission to hospital. Consequently the MHSU agreed to an immediate increase in her medication from 1mg to 4mg a day of risperidone. Once on this dosage it was noted that her sleep improved immediately. However her auditory hallucinations persisted as did her religious concerns for the duration of CRHT input.

Between 25 April and 17 May the clinical records and the recollections of the CRHT staff suggest that the MHSU was not driving and did not feel able to drive owing to reduced concentration levels. However, on 18 May it is clearly recorded in the clinical record that the MHSU advised the visiting mental health professional (MHP) that she had driven her car. The records state that: "… she feels alert enough to drive. Although challenged due to experiencing voices/plus her medication, the MHSU appeared adamant that she was competent."

After this the issue of the MHSU driving was discussed at the CRHT multi-disciplinary team meeting the same day, and as a result the MHSU was advised that she must not drive until further notice.

[3] Note: it is the licence holder's duty to inform the DVLA, not the medical practitioner. The medical practitioner can only inform the DVLA if the service user ignores medical advice not to drive and thus presents a tangible safety risk to other road users and self.

The MHSU complied with this advice from the CRHT consultant.

By 1 June 2006 the CRHT began to plan for the MHSU's discharge back to her community mental health team (CMHT). At this time she again raised the driving issue. She was noted to be concerned at not being able to drive when she felt OK to do so. The medical advice about not driving was reiterated. The MHSU was also advised to contact her insurance company to see if her insurance could be frozen.

On this same day the CRHT MHP discussed the prevailing situation with the MHSU's regular community psychiatric nurse (CPN). Also discussed were the MHSU's financial concerns around her eligibility for Disability Living Allowance. The CPN was noted as having not been aware that the MHSU had been advised not to drive.

On 5 June 2006 the MHSU was discharged from the CRHT back to the care of Cons P2 and the community mental health team.

On 13 June 2006 a CPA meeting was held. Unfortunately, no representative of the CRHT was able to attend.

The record of this CPA meeting notes that the MHSU was advised to tell the DVLA of her change in clinical circumstance.

It was also noted that the MHSU lived alone.

Relapse and/or increasing risk indicators were noted as:

- pressure of speech;
- thought disorder;
- being easily distracted;
- religious delusional ideation;
- thoughts of wanting to harm herself (kill);
- verbal aggression;
- irritability; and
- paranoid thoughts about her food being poisoned.

Risk reduction factors were noted as:

- medication compliance;
- engagement with the CMHT; and
- stability at home.

The contingency plan was detailed as:

- contact GP and responsible medical officer (RMO);
- increase in CPN contact; and
- consider referral to CRHT.

The immediate plan of care was for:

- Welfare Rights to assist with the Disability Living Allowance review;
- the social worker (SW) to assist with the MHSU's housing and benefits dispute;
- the CPN to visit every other week and assist with activities; and
- an outpatient appointment in one month.

The MHSU progressed well in the community and by 12 July 2006 Cons P2 noted in her outpatient record that the MHSU was the "best I have seen her since taking over her care in March".

The clinical record noted that the MHSU "was calm, displayed no inappropriate giggling, her speech was normal in form rate and volume, there was no over religious content at all. Her mood seemed fine and euthymic[4] and she reported no depression." She was noted to be sleeping well. She was also noted to continue to experience infrequent and faint auditory hallucinations but was not troubled by these.

The records also stated that the MHSU remained reluctant to take her medication as she was troubled by side effects. She had amenorrhoea, some hair loss, some postural hypotension, and a feeling of cloudiness in her brain in the morning. However, the records noted that she was agreeable to continue on her current doses of medication for a month or two longer.

On 20 July the DVLA sent a confidential medical questionnaire to Cons P2 asking that she complete and return this within 21 days.

On 2 August Cons P2 completed the questionnaire regarding the MHSU's fitness to drive, as requested by the DVLA. This was received by the DVLA on 3 August 2006.

On 15 August at an outpatient appointment some evidence of hypermania was noted. The MHSU was noted to be laughing loudly, her speech was a little pressured at times, and she was talking quite a lot about what she described as "spiritual warfare". Auditory hallucinations were noted to remain faint and she continued to sleep well. The MHSU was noted to be slightly chaotic in functioning but managing things reasonably well with help. About medication, Cons P2 wrote: "A decrease in medication would be foolish but the MHSU would be unlikely to accept an increase in medication as she only takes what she is on currently with some reluctance." A plan was made to assess the MHSU in six weeks.

On 15 August 2006 the DVLA wrote to the MHSU advising her that: "Medical investigations have now been completed and I can confirm that the Medical

[4] Euthymic is a word used to describe a psychological state that is statistically or otherwise normal, neither elated nor depressed, or somebody in such a psychological state.

Adviser has recommended a regular review of your fitness to drive. This means that you will be issued with a new photo-card licence valid for one year." The letter also stated: "If during the course of your current licence, there is either a deterioration in your condition or your doctors advise you not to drive, the law requires you to notify the DVLA again."

Cons P2 received no communication from the DVLA about this because they could not read her signature at the time. Consequently the notification was, according to DVLA records, sent to the MHSU's general practitioner.

On 22 August the DVLA received back from the MHSU her acceptance of "ordinary entitlement lasting for a period of one year".

On 25 August the MHSU fractured her foot and could not drive.

By 25 September the MHSU was again becoming unwell. The CPN record noted that the MHSU immediately burst into tears on her arrival. She was noted to have told the CPN that she felt lonely and troubled. She reported hearing persecutory voices saying derogatory things about her, and violent things to her, for example, "chop off your arms". She was also hearing swear words and the voices were telling her not to tell her CPN.

The MHSU was reported to put the voices down to spiritual warfare and not her mental illness. She believed she could "pray her way out of them".

Between this date and 4 October the MHSU's mood improved. She also received support from her friend.

On 5 October the MHSU was seen by Cons P2. Her diagnosis was changed to "bipolar currently mixed affective state".
At this outpatient appointment the MHSU was noted to be reasonably well and not posing a risk to self or others. She was being monitored for signs of neglect.
Her mental state was however noted to have been "somewhat unsteady recently" and she continued to experience hallucinations. The MHSU attributed her lack of concentration to spiritual warfare but her consultant psychiatrist considered it to be more related to her mania.

By 19 October the MHSU was noted to be flat in mood. She was preoccupied and responding to auditory hallucinations. She was noted to be feeling low and had not been able to pray owing to poor concentration. It was also noted that the MHSU was experiencing physical anxiety. Consequently the CPN arranged to visit again the following day.

Between 23 October and 21 November the MHSU was considered to be at risk of neglect. She was not well. However on 21 November it was noted by Cons P2 that the MHSU was not as low as she had been during the preceding three weeks. She was however noted to be hypomanic.

By 12 December an increase in CPN follow up was requested by Cons P2 as the MHSU's hypomanic state continued. CPN follow up was to occur at least weekly.

On 19 December when the CPN visited the MHSU at home she noted that there were no hallucinations evident and that the MHSU remained non-compliant with her medications, taking them at night only rather than twice a day.

On 27 December at the CPN home visit there was no evidence of thought disorder and no hallucinations. However the MHSU's flat remained chaotic. The MHSU was noted to be running against the clock all of the time. Her behaviour was quite impulsive.

On 5 January 2007 the MHSU did not answer the door when her CPN called for a planned appointment. It transpired that the MHSU had not gone to sleep until the early hours of the morning.

On 8 January 2007 the SW for the CMHT took over the contact with the MHSU as the CPN was on annual leave. The clinical records show that the SW had contact with the MHSU on 10 and 11 January by phone and 17 January 2007 at her home. She advised him that she was taking her medications. The SW also called the MHSU on 24 January to remind her to take her medication.

On 29 January the MHSU was admitted to accident and emergency (A&E) having taken too many quetiapine tablets.

On 30 January the incident occurred.

Please go to Appendix 1, page 94, for a more detailed chronology of the MHSU's contacts with the statutory mental health service in Leicester.

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by East Midlands Strategic Health Authority (the SHA) were as follows.

"To undertake a systematic review of the care and treatment provided to the MHSU by Leicestershire Partnership NHS Trust (LPT) to identify whether there was any aspect of care and management that could have altered or prevented the events of 30 January 2007.

The IIT is asked to pay particular attention to the following:

- The care and treatment the MHSU was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector if appropriate) and in the 6-12 months preceding this.
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
  - In particular to examine the reasonableness of the CRHT decision not to admit the MHSU on 29 January 2007.
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
  - To examine the operational policy for the Leicester City CRHT.
  - To explore particularly the clarity of roles and responsibilities in relation to determining an in-patient admission.
  - The routes of redress if a patient is not admitted and the service user's consultant believes that they need admitting.
- The adequacy of the risk assessment and care plan and their use in practice.
  - In particular to explore staff awareness of the appropriateness or inappropriateness of the MHSU holding a driving licence in the 12 months preceding the incident.
  - The training provided to CRHT staff in risk assessment.
  - The exercise of professional judgment and clinical decision making.
  - The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs.
- If appropriate, the extent of services' engagement with carers and the impact of this.
- Quality of internal investigation and review.

3.0 CONTACT WITH THE FAMILIES OF THE DECEASED, THE FAMILY OF THE MHSU AND THE MHSU HERSELF

The IIT made initial contact with the MHSU in March 2009 to seek consent from her to access her clinical records and also those held by the Leicestershire Constabulary and the DVLA. Subsequent to this there was a delay in the commencement of the investigation process whilst all relevant information was gathered. During this time the MHSU provided the requested consent.

In October 2009 the IIT had email and telephone communication with the husband of one of the deceased women (V1). At the time this individual was not sure whether he wanted to meet the IIT, or to read a copy of the investigation report. It was therefore agreed that when the report was nearing completion the IIT would contact him so further discussions could take place. This communication occurred on 13 February 2010. As a result of this it was agreed between the IIT and this individual that a time would be arranged to speak on the phone once the report was fully complete.

On 11 November 2009 the IIT wrote to the brother of the other deceased woman (V2), and the father of the child whose mother (V1) was killed. No response was received. A second letter was sent to both on 15 February 2010, and the husband of V1 was asked if he could verify that the IIT had the right addresses for the brother of V2 and also the previous partner of V1. He confirmed that the IIT did. Successful contact was subsequently made with these individuals and a meeting date agreed for 15 June 2010.

The IIT also met the father of the MHSU on 6 January 2010. This visit was originally planned for December but had to be rearranged owing to poor weather conditions. The MHSU's father asked the IIT not to make further contact with his daughter because it was too distressing for her. The IIT empathised with his position but were mindful that the MHSU had a right to make this decision for herself. Consequently contact was made with her via her current clinical team. The MHSU told her current care team that she did not want to meet the IIT.

Further meetings were held with all families on 27 July 2010. A meeting between the sister-in-law of V1 and LPT was facilitated on 20 August 2010.

Subsequent to the family meetings the IIT has maintained contact with the families by telephone and letter.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the independent Investigation Team's (IIT's) findings in relation to the following questions:

4.1 Was the overall care and management of the MHSU reasonable?

4.2 Was the assessment of the MHSU by the deliberate self harm (DSH) team reasonable on the afternoon of 29 January 2007, including its communications with the MHSU's regular care team and the city crisis resolution and home treatment team (CRHT)?

4.3 Was the assessment undertaken by the city CRHT on 29 January 2007 of an acceptable standard?

4.4 Was the decision to accept the MHSU for home treatment a reasonable decision?

4.5 Was the issue of fitness to drive and the MHSU given sufficient attention by LPT mental health professionals prior to 29 January 2007?

In setting out its findings the IIT is very mindful of the tragic outcome when the MHSU set out in her car on the morning of 30 January 2007. The MHSU lost control of her car and two members of the public died as a result. The accident was witnessed by schoolchildren, one of whom was the daughter of one of the victims; this girl was not injured in the incident. At the time of the incident the MHSU was very unwell and beset by command hallucinations. She had the night before been assessed by two sets of mental health professionals. The outcome of the last of these assessments was a decision to accept the MHSU for home treatment in the community.

It is incontestable that had the MHSU been admitted to hospital the accident would not have happened. However, this statement is made with the benefit of hindsight. All NHS mental health trusts have crisis resolution teams and all such teams are required to be gatekeepers where admissions to hospital are concerned. It is their task to undertake assessments that enable a decision to be made regarding admission or an alternative. The alternative to admission is termed "home treatment". This delivers intensive community support (often several times a day) to mental health service users in their home during a period of crisis in their mental health.

Therefore on 29 January 2007 the crisis resolution team was doing what it should do. The question is whether its task was carried out appropriately and whether it's decision-making was sound.

In assessing this, it is the responsibility of the IIT to avoid hindsight bias[5] and to analyse the appropriateness of decisions made on the basis of the information available to clinicians at the time, and the circumstances in which they acted. It is also the responsibility of the IIT to consider what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency (NPSA) refers to as the "substitution test" in its incident decision tree.[6]

[5] Hindsight bias: this is the inclination to see events that have occurred as more predictable than they in fact were before they took place. Hindsight bias has been demonstrated experimentally in a variety of settings, including politics, games and medicine. In psychological experiments of hindsight bias, subjects also tend to remember their predictions of future events as having been stronger than they actually were, in those cases where those predictions turn out correct. This inaccurate assessment of reality after it has occurred is also referred to as "creeping determinism".

[6] http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx

4.1 Was the overall care and management of the MHSU reasonable?

The time period over which the IIT analysed the MHSU's care and management was between March 2006 and January 2007. This period was of greatest significance in enabling the IIT to make judgments about the reasonableness of the clinical decisions made on the evening of 29 January 2007.

It is the opinion of the IIT that between March 2006 and the last face-to-face contact with the MHSU on 17 January 2007, the MHSU's care and management was reasonable, as evidenced by the following.

- There was an appropriate handover of care between the MHSU's care team until 17 March 2006, and the care team that took over the clinical responsibility for her care and management from then on.
- Following the handover between professionals on 17 March 2006 there was a CPA review, which the MHSU and her father attended.
- The incoming care coordinator, who was a community psychiatric nurse (CPN2), undertook a detailed and thorough assessment of the MHSU at her home with a social work colleague.
- When the MHSU was first seen at outpatients by her new consultant Cons P2, a very detailed assessment was undertaken by this individual and her then senior house officer. Cons P2 paid particular attention to the MHSU's religious beliefs. She was a "born-again Christian"[7] and therefore her religious expression would be different to that expressed by more mainstream Christian churches such as the Church of England. Because religious fervour was a persistent feature of the MHSU's psychosis it was essential that Cons P2 and CPN2 tried to properly understand her faith, and to gain a perspective regarding when this was expressed psychotically and when her expression was culturally appropriate for someone who practises evangelical Christianity.
- When she relapsed on 24 April 2006, the MHSU was appropriately assessed in A&E by the city Crisis Resolution and Home Treatment team (CRHT) and appropriately accepted for home treatment.

[7] In Christianity, being born again represents a spiritual and metaphorical rebirth, accepting Jesus as the Messiah and receiving the Holy Spirit. The origin of the term "born again"[1] is the New Testament: "Jesus replied, 'Very truly I tell you, no one can see the kingdom of God without being born again.'"[John 3:3] It is a term associated with salvation in Christianity. In recent history, "born again" is a term that has been widely associated with the Evangelical Christian renewal since the late 1960s, first in the United States and then later around the world. Associated perhaps initially with Jesus People and the Christian counterculture, "born again" came to refer to an intense conversion.

- The consultant psychiatrist for the city CRHT (Cons P3) assessed the MHSU on 25 April 2006. This was very good practice. At the time the CRHT was not well staffed from a medical perspective, and its consultant strove to see all new patients accepted for home treatment the day after assessment by the CRHT mental health professionals (MHPs). This demonstrated a high level of commitment to the role and purpose of the crisis team.
- At the first assessment by Cons P3 the MHSU indicated that she was not keen to take any increase in medication. Cons P3 set out for the MHSU very clearly the importance of taking the medication at the dose he prescribed. It was also impressed upon the MHSU that if she was not willing to comply with the prescribed treatment, that admission to hospital would be the only alternative and consideration would have to be given to admission under the Mental Health Act (1983).
- The CRHT visited the MHSU twice a day between 25 April and 2 May 2006. Thereafter it had contact with her on a daily basis, the vast majority of these contacts being home visits. During these contacts the CRHT's clinical records evidence vigilance regarding the MHSU's medication. The records also evidence that communication did occur with the MHSU's CPN, albeit the framework for this was informal. The notes also evidenced appropriate medical input to the MHSU's management.
- On 18 May 2006 the MHSU informed the MHP who visited her at home that she had taken her car out the day before, and felt competent to drive again. The MHP immediately advised her not to drive and raised the issue at their daily team meeting. A further telephone call was made to the MHSU later that same day to reiterate the same "do not drive" advice until she had been seen and assessed by Cons P3.
- In spite of a number of assertions by the MHSU that she was safe to drive the CRHT maintained its stance of no driving, and the MHSU was advised to contact her insurer to see if her policy could be frozen until she was told by a medical doctor that she could drive again.
- Following the MHSU's discharge from the CRHT, her home community mental health team (CMHT) including Cons P2 held a Care Programme Approach meeting on 16 June 2006. This was within 10 days of her discharge back to this team. At this meeting the MHSU was advised to notify the DVLA of her current circumstances and not to drive again until she had heard the outcome of its assessment regarding her fitness to drive (Cons P2 and CPN2 were unaware at this time that the MHSU had already been in touch with the DVLA).

- The care plan agreed between Cons P2, CPN2 and the MHSU was very reasonable. It included:
  - Regular follow up of the MHSU by her care coordinator.
  - Regular attendance at outpatients to see her consultant psychiatrist. It is notable that this MHSU saw Cons P2 at every outpatient appointment. This was very good practice. Cons P2 did have concerns about the MHSU, she did not feel that her symptoms were fully controlled, and there were persistent issues with maintaining medication compliance. This was a service user who required senior medical input.
  - There was a clear appreciation of the need for the involvement of a social worker (SW) to provide support and advice with resolution of the MHSU's financial issues. The MHSU's care team showed diligence about this and the clinical records clearly evidence the SW's input.
- The frequency of visits to the MHSU's home between the end of September 2006 and the end November 2006 by CPN2 was good. This was a period of marked instability in the MHSU. CMHTs are generally very busy and to make weekly visits would have been challenging. However in some instances CPN2 visited the MHSU very frequently when concern was high about her. For example home visits were undertaken on 19, 20, and 23 October followed by telephone contact on 24 October. Visits also occurred on 8, 10, 14, and 17 November. This represents good practice. The IIT did question whether support from the CRHT could have been sought. CPN2 told the IIT that at this time the CRHT would have taken over the MHSU's care completely rather than co-work with her. This, she believed, would have compromised the consistency she was trying to establish with medication concordance.
- Consideration was given to admission of the MHSU on 21 November 2006. However, Cons P2 did not believe that the MHSU could be detained under the Mental Health Act at this time. This was expressed clearly to the MHSU's general practitioner (GP) in a detailed letter on the 24 November 2006. The quality of the correspondence between Cons P2 and the MHSU's GP was consistently good.
- When the MHSU's care coordinator went on holiday in December 2006 she made provision for the social worker known to the MHSU to keep in contact with the MHSU. The MHSU had been seen by Cons P2 on 21 December and she was considered to be well at this time. Cons P2 recalled that that the MHSU was better than she had been, the best she had seen her in fact. She was taking her quetiapine regularly at night, according to the MHSU's account to her (Cons P2) and to the CPN. The MHSU also said she was getting a good night's sleep, that she was not hearing God's voice, and had

no troubling spirits, she was also learning the keyboard, and learning the recorder.

- Although the SW who provided cover for the MHSU's CPN in January 2007 did not visit the MHSU every week, he did have frequent telephone contact with her to discuss medication and to remind her to take her medication. Furthermore there was a substantial home visit at the home of the MHSU on 17 January. Telephone contacts occurred on 10, 11 and 17 January.

4.1.1 Medication management

Although this MHSU was considered to be willing to work with her mental health teams, she was not an individual who could be considered as compliant with the medication treatment prescribed for her. She was always trying to negotiate a reduction in dosage and was never particularly willing to consider an increase in it.

Her last admission under the Mental Health Act in 2005 was precipitated by many months of medication non-compliance. This aspect of the MHSU's behaviour was a known and recognised risk for her and made relapse a foreseeable possibility.

It is the IIT's perspective that all of the mental health professionals involved in the support, care and management of the MHSU between March 2006 and January 2007 did their reasonable best to encourage the MHSU to take her medication. They also tried to alter her medication to minimise the impact of its side effects on her without compromising her mental health, and were willing to try alternative medications to see if these suited the MHSU better.

The mental health professionals were also robust with the MHSU in spelling out to her the risks of medication non-compliance. Cons P2 in particular worked hard to help the MHSU understand that taking her medication did not diminish her spiritual beliefs or God's healing power. The MHSU's firmly held beliefs, that prayer and meditation would heal her, were a constant impediment to her medication compliance. Also an impediment was her belief that she was beset by evil spirits, so that when she believed voices to be telling her to take her medication, she would not do so because she could not identify the message as a good thing.

When the MHSU was transferred to the care of Cons P2 she was on the following medicines:

- risperidone[8] 1mg once a day; and
- Epilim Chrono (sodium valproate) 900mg once a day.

When the MHSU was accepted by the city CRHT for home treatment, Cons P3 immediately increased her medication to:

- risperidone 4mg; and
- Epilim Chrono 900mg.

This had an immediate positive impact on her psychotic symptoms and her sleep.
As previously noted in this chapter, the CRHT was diligent in the provision of intensive home treatment to the MHSU, a major focus of which was medication compliance.

When the MHSU was discharged back to her regular care team on 5 June 2006 she again immediately sought a review of her medication. However, in spite of the side effects such as amenorrhoea, Cons P2 kept the medication regime unchanged and she and CPN2 constantly encouraged the MHSU to take her medication as prescribed to try and achieve stabilisation in her mental state.

On 15 August the MHSU again pushed for a reduction in her medication. Cons P2 wrote in her letter to the MHSU's GP that it "would be foolish" to reduce her medication at this time. She also noted that the MHSU was "unlikely to accept an increase either". However, Cons P2 noted that a change in medication might ease the MHSU's side effects and enable her (Cons P2) to increase the amount of medication. This was the plan.

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[8] Risperidone is an atypical antipsychotic drug that is used for treating schizophrenia, bipolar mania and autism. Other atypical antipsychotic drugs include olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), aripiprazole (Abilify) and paliperidone (Invega). Atypical antipsychotics differ from typical antipsychotics due to the lesser degree of extrapyramidal (movement) side effects and constipation. Risperdal Consta is an injectable, long-acting form of risperidone.

The exact mechanism of action of risperidone is not known, but, like other antipsychotics, it is believed that risperidone affects the way the brain works by interfering with communication among the brain's nerves. Nerves communicate with each other by making and releasing chemicals called neurotransmitters. The neurotransmitters travel to other nearby nerves where they attach to receptors on the nerves. The attachment of the neurotransmitters either stimulates or inhibits the function of the nearby nerves. Risperidone blocks several of the receptors on nerves including dopamine type 2, serotonin type 2, and alpha 2 adrenergic receptors. It is believed that many psychotic illnesses are caused by abnormal communication among nerves in the brain and that by altering communication through neurotransmitters, risperidone can alter the psychotic state. Risperidone was approved in the USA in December 1993.

Consequently on 29 September 2006 Cons P2 agreed with the MHSU that she would change her medication from risperidone to quetiapine. Cons P2 contacted CPN2 on 6 October to advise her that 7 October would be the MHSU's last day on risperidone and that from then on she should be taking 150mg quetiapine twice a day and Epilim Chrono 900mg once a day.

By 19 October CPN2 became aware that the MHSU had not been taking the quetiapine as prescribed. She had been taking 225mg nocte rather than the 150mg bd (twice a day) as prescribed. The MHSU was advised by CPN2 about taking the quetiapine at 12 hour intervals and why she should do this.

CPN2 visited the MHSU on 20 October to check that she was OK and also to ascertain whether she was taking her medication correctly. The MHSU reported that she was and that her concentration was better, she was able to pray and able to go out with a friend.

CPN2 visited the MHSU again on 23 October. On this occasion the MHSU had not taken her medication but did so in the presence of the CPN.

By 8 November CPN2 had introduced a dosette box to enable her to better monitor whether the MHSU was taking her medications as prescribed. The CPN believed that not only did the MHSU's religious beliefs interfere with her medication compliance, but also her somewhat chaotic lifestyle. The idea of the dosette box was to enable some order to be introduced to the medication regime and to make it much easier for her to assess whether the MHSU had been taking her medication. The implementation of this system for the MHSU represents good practice.

However, CPN2 had to collect the box from the pharmacist on 14 November as the MHSU forgot to do this herself.

The MHSU never attained the full therapeutic dose of quetiapine. On 21 November 2006 Cons P2 noted in her letter to the MHSU's GP that "she is not fully compliant with what is being prescribed for her but she is perhaps taking her medication much more regularly than she was a week ago. We will continue to monitor things closely."

At the final outpatient appointment prior to the incident which was on 12 December, Cons P2 wrote: "The MHSU is now consistently taking medication...we would like her to be taking a little more quetiapine but are pleased that she is on regular doses even if at a level which is perhaps too low… Taking it regularly has improved her mental state." At this time the MHSU was taking 150mg of quetiapine at night and 900mg Epilim Chrono once a day.

CPN2's last home visit to the MHSU, prior to her annual leave, was on 5 January 2007. At this visit CPN2 encouraged the MHSU to take her

medication at an earlier time that evening (10pm). She also encouraged her to try and establish a regular pattern regarding the time she took her medication.

While she was on annual leave CPN2 asked her social work colleague to maintain contact with the MHSU, and to ensure that she was collecting her medication and to monitor concordance. The social worker shared an office with the CPN and was very aware of the MHSU's medication compliance issue. The CPN clearly told the IIT that when she asked for her colleague to monitor the MHSU she expected it to be mainly on a face-to-face basis.

4.1.2 Risk assessment and risk management

In June 2007 the Department of Health (DH) produced a document entitled "*Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*".

This document sets out 16 best practice points for effective risk management. These points are set out in appendix 2 (page 130) of this report.

The DH document makes clear that the risk assessment and management process needs to achieve a balance between risk avoidance and risk taking. The points that are of most significance to this case are points 6-11, detailed on pages 7 and 8 of the DH publication. These are:

- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
- Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
- Knowledge and understanding of mental health legislation is an important component of risk management.
- The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and action to be taken by practitioners and the service user in response to crisis.
- Where suitable tools are available, risk management should be based on assessment using the structured clinical judgment approach.
- Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

The LPT CMHT operational policy makes clear that all service users will have a dedicated risk assessment and risk management plan. Although the IIT

cannot fault the mental health professionals' adherence to the CPA policy, what is not in the MHSU's records is any detailed risk assessment document after January 2006 other than the risk assessment conducted by the CRHT in April 2006. This is an unfortunate documentary omission.

However, the care plan for the MHSU during 2006 states:

"Risk indicators:

- pressure of speech;
- thought disorder;
- preoccupation with religious beliefs;
- hallucinations often of a distressing nature i.e. the devil issuing commands to which she responds;
- verbal aggression to carers;
- irritability and impulsivity;
- withdrawal from main carers – father and S; [and]
- previous relapses have occurred with non-concordance with medication."

The "*Interagency Care Programme Approach assessment and outline care plan*" (22 March 2006) under risk factors says:

"The MHSU has in the past been vulnerable to exploitation and as a consequence has incurred debts. When the MHSU has periods of elation, she has behaved in a disinhibited way, which may leave her vulnerable."

The IIT also undertook a review of the medical correspondence between 1994 and 2004. The information detailed in the MHSU's 2006 care and risk plans reflected her long standing relapse behaviours and also her vulnerabilities.

There was nothing in this woman's past history to suggest that she posed a risk of harm to others in any way. Her risk of harm was almost entirely to herself in terms of neglect and vulnerability to impulsive behaviours, of over-generosity and inviting "needy" people into her home.

Consequently the following crisis plan was appropriate:

- "Arranging immediate assessment to ascertain level of risk.
- Liaise with father and S to get up-to-date information.
- Consider crisis resolution team if the MHSU is insightful and supported to engage by family.
- If the MHSU lacks insight, consider Mental Health Act assessment in view of risk to self or others as history indicates."

Furthermore Cons P2 and the MHSU's care coordinator (17 March 2006 to incident date) were both able to describe the MHSU's risk vulnerabilities and her behaviour around these in detail.

Therefore although there was no up-to-date documented risk assessment or risk management plan, the IIT is confident that this MHSU's risks were well understood and that her regular care team were very mindful of these.

In addition to the above a significant factor for the MHSU was financial risk. When the MHSU's care was transferred from Cons P1 to Cons P2 her financial situation was dire and there had been a number of efforts made to ensure that the MHSU received the Disability Living Allowance (DLA) to which she was entitled. Her care team from March 2006 picked this issue up vigorously, liaising with Welfare Rights[9] to achieve resolution of this issue.

The issues surrounding medication risk have already been addressed in section 4.1.1 (page 33).

The only risk issue that is not adequately addressed is the MHSU's driving risk when unwell, or when her concentration was impaired. However in LPT it was not, and in many trusts was and is not, usual practice to notate issues relating to driving as an integral component of the assessment and risk assessment process. The issues of driving risk and fitness to drive are addressed in detail in section 4.5 of this report (page 67).

Overall, therefore, the IIT is satisfied that the MHSU's care team from 17 March 2006 did pay appropriate attention to the MHSU's risk vulnerabilities and did all it could to monitor these and to ensure that an appropriate plan was in place to mitigate their impact, as far as it was possible to do so.

[9] Welfare Rights had been involved with the MHSU since 2003.

4.1.3 Information transfer between the care teams engaged with the MHSU

This issue is mostly dealt with under the next two headings:

- Care Programme Approach (4.1.4); and
- discharge planning (4.1.5).

There is however one element that is not addressed and this is the information provided to the CRHT when it takes a service user on for home treatment.

When this MHSU was receiving home treatment, in May and June 2006, the CRHT did not have access to core clinical information electronically, for example the most recent CPA document, the most recent risk assessment and any significant correspondence. The CRHT's operational policy in 2006 did not address the issue of what information is required by the CRHT from a service user's regular care team when it accepts a client for home treatment. Neither does the operational policy for community mental health teams (CMHTs) address what information they will routinely provide if a service user is transferred to the care of another team such as the CRHT or the Psychiatric Early Intervention Service (PIER).

If the CRHT is to be integral to the delivery of safe and effective mental health services in Leicester, then it needs to be able to access all relevant clinical information.

Furthermore between April 25 and 5 June 2006, although the MHSU's CPN remained in contact with her, and the clinical records do evidence a number of occasions where there was communication between the CRHT and the MHSU's regular CPN, there was no joint care planning meeting or exchange of essential information that the IIT has become aware of, including informing the CRHT that the MHSU had had her driving licence reinstated on 8 April 2006. The DVLA's letter contained within the MHSU's medical records clearly says:
"Should the patient's medical condition relapse in the ensuing 12 months the patient must inform the DVLA".
Although the clinical records and the records provided by the DVLA suggest that the MHSU was not driving between 25 April and 16 May, subsequent to 18 May it would have been useful for the CRHT to have known about this so that they could have supported the MHSU in notifying the DVLA that she had suffered a relapse. This notification did not occur until June 2006, some eight weeks after her initial relapse.

4.1.4 Care Programme Approach

There was very good adherence to the Care Programme Approach process in the care and management of this MHSU.
Furthermore there is clear evidence that the MHSU attended CPA review meetings, as did her father on some occasions. The records show that the views and opinions of the MHSU and her father, when he was present, were sought and that these did have a bearing on the decisions made by the relevant care team.

CPA reviews were held on:

- 23 March 2006; and
- 13 June 2006.

The plan was for a further CPA review meeting some six months later. However, because the MHSU's father was due to be on holiday on the date the CPA was planned for, it was postponed until a date could be discussed and agreed with him.

The only CPA meeting that was not as information rich as it could have been was that held on 16 June 2006, following the CRHT's discharge of the MHSU back to Cons P2 and her CPN care coordinator. Although the CRHT was invited to attend this CPA meeting it was unable to do so. This was not altogether surprising given the nature of work a crisis team undertakes. However, there was no face-to-face handover between the two teams. There was exchange of information by telephone but this is not a substitute for a full handover of care. At the time, and at the time of this investigation, there were no standards in the CRHT operational policy regarding how handovers of care following a period of home treatment were to be effected (see "Discharge planning" section below). This was and is unacceptable.

That the CRHT was not able to attend the CPA meeting on 16 June, and the lack of formalised handover of care between the two teams, does not appear to have materially impacted the subsequent care and management of the MHSU, except that the CMHT was left unaware of the MHSU's displayed lack of insight about her driving competency.

4.1.5 Discharge planning

Following on from the above, the IIT was interested in what the usual discharge planning process is within the CRHT. The IIT was informed that the local standard was for a copy of the CRHT discharge care plan to be sent to the referring team. Furthermore this standard remained in situ at the time of this investigation. There was no formal requirement for a face-to-face handover meeting to occur. The IIT tested what other CRHTs do via a simple survey questionnaire to which mental health professionals from three crisis and home treatment teams outside Leicestershire responded.

There were 35 respondents in total. Of these 27 answered the question about how service users are discharged, as follows:

- Fourteen (51.9%) said that their operational policy required a face-to-face discharge meeting.
- Five (18.5%) said that their policy required a CPA discharge planning meeting.
- Three (11.1%) said that their operational policy required a telephone handover only.
- Five (18.5%) said that their operational policy gave no guidance.
- No respondents said that their operational policy required a discharge summary/letter only.

These responses highlight that there is variety of practice in the field of crisis and home treatment, and that for most of the professionals who responded to the questionnaire there is an expectation that a face-to-face meeting or CPA discharge planning meeting will occur. However, the respondents also highlighted the difficulties in meeting this expectation in practice with only six of them (22.2%) saying they achieved this 100% of the time. 13 professionals (48.1%) said they achieved it more than 50% of the time but less than 100% of the time. If LPT were to adopt a face-to-face or CPA discharge meeting as its practice standard, the trust would need to audit percentage compliance over time and ascertain the reasons for non-compliance.

In the case of this MHSU, there was a telephone handover conversation between one of the CRHT MHPs and the MHSU's CPN care coordinator approximately one week prior to discharge. The CPN care coordinator also contacted the CRHT on the planned discharge day to find out whether discharge had occurred. However, it is the perspective of the IIT that this cannot constitute an acceptable handover of care.

The IIT also reviewed the discharge summary/care plan produced by the CRHT at the time of her discharge in June 2006. The discharge summary says:

"The MHSU was referred to CRHT by Dr X (SHO) after she was taken to A&E by ambulance. The MHSU's neighbour called the ambulance when the MHSU was seen shouting and praying in the street.

On assessment the MHSU reported that she felt she had done something wrong and had gone against the Bible and as a consequence was asking God to forgive her. Her neighbour heard her and called the ambulance. The MHSU however felt she was becoming unwell. She did not feel she was elated because she was not spending a lot of money. The MHSU was also complaining of hearing voices of a derogatory nature calling her names.

The MHSU was accepted for home treatment by the consultant to the CRHT on 25 April 2006 and her risperidone was increased to 4mg from 1mg. The consultant also recommended that the MHSU should stop driving until the situation was reviewed by the CRHT or her own treatment team.

During the MHSU's contact with CRHT it was felt that the therapeutic dose for her risperidone during the acute phase of her illness was 4mg. It appears with the present dose her sleep improved immediately. However auditory hallucinations and religious concerns persisted for the duration of her treatment.

The MHSU was discharged on 05/06/2006 when she felt that her symptoms were much reduced and less intense."

Medication was noted as: risperidone 4mg daily, procyclidine 5mg[10] daily and Epilim Chrono 900mg daily.

Although the discharge summary clearly highlights that the MHSU was not to not drive until advised that she was safe to do so by her regular community consultant psychiatrist, the level of detail in the discharge summary was not adequate after eight weeks of home treatment. Because home treatment is an alternative to admission, it is not unreasonable to expect discharge information to be of a similar standard to that expected for inpatient discharges, and the discharge letters sent to GPs following outpatient assessments.

[10] Procyclidine is used to counteract the particular side effects of risperidone. It was not continued by the MHSU's CMHT consultant psychiatrist because the side effects she reported were not side effects procyclidine would counteract.

Information under the following headings would therefore have been useful:

- diagnosis;
- problem summary;
- treatment/interventions provided;
- recovery impressions;
- current risks;
- medication; and
- recommendations.

With regard to the MHSU's risk factors, although the issue of driving was clearly addressed in the discharge summary there was no other risk information provided to her regular care team.

The most significant pieces of information that were not included were:

- The MHSU's lack of insight regarding her competence to drive. It would have been very useful for her regular care team to have known that in spite of the MHSU's well described self policing regarding not driving, there was one episode in June where she perceived herself to be competent and did go out in her car. The CRHT immediately asked the MHSU not to drive and she did comply with its advice. Nevertheless the lack of insight displayed by the MHSU would have been an important factor for Cons P2 and the CPN care coordinator to have been made aware of.
- The continual requests by the MHSU for medication review, and staff concern that at one point she seemed to want to avoid CRHT visits when her medication was due. Although the MHSU's regular team were aware of the MHSU's tendency to medication non-compliance, it had only taken over her care in March, some six weeks before home treatment started. As the CMHTs do not have access to the home treatment records, the communication of all identified risk factors should have occurred.

The IIT found it notable that it is not customary for the regular care team to be provided with a copy of, or access to, the CRHT records so that all salient information could be copied and placed within the MHSU's main records. Although home treatment is for relatively short periods of time, if it subscribes to the concept of "one patient, one set of records", LPT does need to ensure that this is achieved manually in the absence of functional electronic records. It is not acceptable that a service user's main clinical record does not contain a full record of all significant care interventions and the detail of care and treatment delivered.

4.1.6 Overall comment by IIT

The care and management of the MHSU was mostly of a good standard. The areas that could have been improved relate to systems of work rather than to individual practitioners. The systems issues are:

- The lack of formalised and robust standards for handover of a service user from the CRHT back to the regular care team.
- The inadequate design of the city CRHT discharge care plan summary.
- The lack of easy access by the CRHT to essential documentation for existing service users, such as the most up-to-date CPA documents and the most up-to-date risk assessment and risk management plan.
- The lack of any formalised policy regarding assessing fitness to drive, and/or any reference to fitness to drive as an integral component of the risk assessment and CPA assessment tools. (Note: a formalised approach to fitness to drive would not have been commonplace in many mental health trusts in 2006. However the IIT found, via a Google search, one such policy in use in Dorset Healthcare University NHS Foundation Trust, reference number CP-025-06)[11].

[11] Dorset Healthcare University NHS Foundation Trust Policy: http://www.dorsethealthcare.nhs.uk/Portals/3/Policies/CP-025-06.pdf

4.2 Was the assessment of the MHSU by the deliberate self harm (DSH) team reasonable on the afternoon of 29 January 2007, including its communications with the MHSU's regular care team and the city CRHT?[12]

The MHSU was referred by A&E for assessment by the deliberate self harm (DSH) team because she had taken six quetiapine tablets that morning and the motivation for this was uncertain.

The assessment that was undertaken by this team was as good as it could be in view of the MHSU's inability to communicate with them. The IIT finds no aspect of it that could or should have been improved at the time. However the IIT does have concerns relating to the receipt and interpretation of information provided to the CRHT triage nurse by the DSH team. These are detailed in section 4.2.2 (page 47).

4.2.1 The DSH team assessment

Unusually, because two DSH MHPs were available at the time A&E referred the MHSU to the DSH, they both assessed the MHSU. Normally the MHPs undertake these assessments on their own.

Their assessment comprised the following:

"Background / precipitating factors: Difficulty obtaining any information from pt due to deterioration in mental state. The MHSU unable to answer questions due to preoccupation with religious beliefs. Currently sitting on bed in EDU. Communicating overtly to God. Says she is repenting to God for her sins. Appears to be pressure of speech, religious delusions. Pt is born again Christian. Appears distracted and angry at self.

Mental state exam: Difficulty engaging in conversation due to being thought disordered.

Opinion: A 40 year old lady presenting with a probable psychotic episode. No evidence of suicidal tendencies. Appears to be some query regarding her number of seizures. MSE-difficult to carry out due to patient inability to engage and preoccupation with religious beliefs. Thought disordered, Patient remains vulnerable and at risk. Would benefit from further assessment or probable in-patient admission."

The outcome of the assessment was that a discussion was held with the MHSU's social worker, who told them that Cons P2 advised them to refer the

[12] In this section there are references to the actions taken by the MHSU's care coordinator and the triage documentation in the crisis team. It is not possible to properly respond to this question without reference to the information exchanges that occurred between the DSH team, the MHSU's regular care team and the CRHT.

MHSU to the CRHT. This advice was followed. The CRHT agreed to assess the MHSU later that day.

In keeping with good practice the DSH MHPs communicated their findings and concerns to the MHSU's consultant psychiatrist Cons P2, and her social worker. Both professionals agreed that the MHSU was behaving in a way that was unusual for her, on the basis of their experience. The two behaviours that caused them to think this were:

- her lack of communication[13]; and
- the excessive dose of quetiapine taken that morning.

As a result of these discussions a decision was made to refer the MHSU for a crisis assessment. National policy[14], at the time, was that all hospital admissions were to be "gate kept" by the crisis team.

The LPT "*Crisis and home treatment policy*" at the time stated:

"Gatekeeping The CRHT has a responsibility for gatekeeping access to the adult inpatient beds for the City ... the only exceptions are to be:

1. Through the outpatients clinic where the consultant has decided that admission is the only option. In this instance a courtesy call from the consultant to the CRHT to inform them of the decision.
2. Those patients who are on fast-track. Again a courtesy call will be made to the CRHT.
3. From CMHT's liaison/DSH and other mental health services where appropriate when admission is indicated as the only option. In this instance a courtesy call from the mental health professionals to the CRHT to inform them of the decision."

At the time Cons P2 believed that there was a management drive for all patients requiring admission to be assessed by the crisis team and she told the IIT that she felt she should adhere to this, even though from what she had been told it was her opinion that the MHSU would require admission and the inpatient ward was alerted to the possibility of this. The MHSU's social worker told the IIT that his understanding at the time was that hospital management
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might be required, but that as the MHSU had received home treatment successfully in the spring/early summer of the previous year, then a crisis

[13] A review of the MHSU's historical records showed that the last time she had relapsed and been incommunicative was in December 1995. On this occasion she was found lying in the road, screaming at the top of her voice quoting passages from the bible "trying to exorcise the devil". Interview of her was impossible. All conversation was dominated by her need to listen and respond to apparent auditory hallucinations, or God or Satan.

[14] This was in keeping with national policy as detailed in the Department of Health's "*Mental health policy implementation guide*", chapter 3, "Crisis resolution/home treatment teams".

assessment was required to determine what would be most appropriate now. He also told the IIT that he did contact the CRHT triage nurse to advise that Cons P2 was willing to admit and that the inpatient ward was aware that the MHSU might be admitted.

When the IIT discussed the decision for a crisis assessment with the DSH MHPs, it is clear that they expected the outcome of this assessment to be an inpatient admission. From their perspective all the conversations they had had with the MHSU's regular care team indicated that this is what she required at the time their assessment was undertaken.

The DSH MHPs told the IIT that they contacted the CRHT triage nurse in the normal manner and communicated to this individual a summary of the MHSU's presentation. The MHP who undertook this communication believes that the responses made by the triage nurse at CRHT to her statements clearly indicated to her that the triage nurse did understand the information communicated. It was not, and is not, the system for Leicester CRHT to ask a referrer to complete a faxable referral pro forma. Referrals are always undertaken via the telephone.

In its survey questionnaire sent to crisis teams outside Leicestershire, the IIT sought to find out whether other teams used a system of written referral. Of the CRHT professionals who responded to the questionnaire, 60.7% (17 out of 28) said that a faxed referral form supplemented by telephone conversation was the usual method for referring individuals to the crisis team.

A copy of the DSH assessment form is not provided to the CRHT at the time of the referral but is left in A&E for the assessing crisis professionals to read before meeting with a service user.

4.2.2 Issue of concern

It became very apparent during the interviews conducted with the DSH and CRHT staff that something had been lost in the communication exchanges between:

- the DSH team and the CRHT triage nurse; and
- the CRHT triage nurse and the MHPs asked to attend at A&E to assess the MHSU.

The DSH staff are adamant that they communicated that they believed that the MHSU would "probably" require in-patient admission and that her regular care team also thought this.

The two CRHT MHPs are equally adamant that no one ever communicated anything that suggested that an inpatient admission was the regular care team's preference.

Because the DSH team does not make a record of the information communicated to the crisis team, relying on the premise that the assessment form details this, it is very difficult to be certain precisely what information was exchanged.

The record made by the social worker to the MHSU said:

"T/C to CRHT. Discussed referral. Asked CRHT to contact the base and leave a message to inform me of the outcome of the assessment. Also highlighted that Cons P2 would consent to admission if necessary."

This record does not say that Cons P2 feels that the MHSU needs to be admitted and that a bed had been arranged for her. It clearly indicates that in the mind of the professional who wrote it that home treatment was a possibility. The IIT has spoken with this individual who confirmed that this was his understanding at the time. He also confirmed that CRHT had a gatekeeping function and that if admission was to occur then it needed to go through the crisis assessment process.

There is nothing recorded on the triage form that conveys in any way at all the level of concern the DSH MHPs, or the MHSU's regular care team said they communicated to the CRHT triage nurse.

Unfortunately the IIT was not able to interview the triage nurse on duty at the time as she was on long term sick leave. However as four individual members of staff consistently and independently related their concerns to the IIT and two of these had direct communication with the CRHT triage nurse, the IIT can say that the CRHT triage records cannot represent a full and accurate record of what was told to the CRHT on 29 January 2007. This is not acceptable.

4.2.3 Comment by IIT

It has not been possible to completely clarify what information was received by the CRHT triage nurse. However what is clear is that:

- The DSH team believes that it communicated very clearly to the crisis team the view that the MHSU would probably need admitting.
- The social worker for the MHSU also told the CRHT triage nurse that the MHSU's consultant psychiatrist was willing to admit her and that the availability of a bed in the inpatient unit had been confirmed.
- The information about the probable need for admission was not communicated to the two CRHT professionals tasked with undertaking the crisis assessment for the MHSU.

Because it is clear that there was a loss of important information to the assessing CRHT professionals, the IIT has considered how requests for a crisis assessment can more reliably be communicated to the CRHT, and

consequently how complete information can be provided to the CRHT professionals tasked with undertaking crisis assessments.

Consequently LPT is recommended to consider and implement the following:

- The development of a faxable referral form for the crisis team which provides clear headings for entering specific information. There should also be an accompanying guidance sheet detailing its purpose and how it will be used. This then is to be supplemented with telephone follow up by the CRHT triage nurse.
- For the DSH team assessment form to be extended so that greater detail about its assessment can be recorded. This should include full detail of any discussions it has with a service user's regular care team and the outputs of this. If the DSH MHPs believe admission to be the only option at the time of their assessment, this should be made explicit at the time they make a referral so that this perspective is clear to the next team which may not be conducting its assessment until sometime later.
- The DSH team assessment form needs to record the contact numbers for the assessing DSH professionals so that the assessing CRHT MHPs can make proactive communication with this team. Indeed LPT could explore the practicalities of expecting the assessing CRHT MHPs to have a direct conversation with the referrer prior to their assessment, rather than this solely being undertaken by the CRHT triage nurse. This would reduce the opportunity for miscommunication, misinterpretation of information, and information loss.

4.3 Was the assessment undertaken by the city Crisis Resolution and Home Treatment team (CRHT) on 29 January 2007 of an acceptable standard?

The assessment undertaken by the CRHT on 29 January fell below the robustness one expects of a crisis assessment. Although aspects of it were adequate, there were some significant factors that were inadequately explored or not explored at all.

In its interviews with the staff involved, and their managerial and clinical leaders, the IIT determined to establish why this was.

The IIT asked MHPs involved in the assessment of the MHSU to individually describe the assessment process they normally undertake. The process described was then compared to the assessment undertaken.

The assessment process described was:

"It is important to know what the patient would like and why they are at the attention of services.
Other key issues to explore/consider are:

- What made the person go to GP (for example) today – what was their motivation?
- What can be done to help?
- What does the person feel about their illness, family troubles, social troubles – do they feel they have an illness?
- What is the person like normally?
- What do they do for a living, what family, what support network – helps gauge whether home treatment is appropriate?
- If someone is engaged in risky behaviour – are they suicidal, threats to harm others?
- To explore any self harm behaviour – intent – location – desired outcome. Have to look at risk in context of what individual is actually doing.
- The same if there is expressed risk to others – in what context is this displaying – more aggressive behaviour for example?
- Looking at an increase in alcohol and or drug use and whether or not the person sees it as a problem. Is it usual usage – is it unusual?
- Is it a well known patient – what factors are normally present when they are ill - are they present at the moment? Do they hear voices and are they now, if yes do these match with what has been heard previously – are they manageable? Is it something, with increased support, that they can work through safely or is this something that needs more intensive support in hospital?
- Have there been incidents with police – usual/unusual/ increased incidence?
- How is the person getting on with neighbours?"

With regard to the essential information the MHP needs to try and capture to assess the risks if an individual is psychotic, the MHPs reported the following:

- "The person's understanding of their illness – are they saying yes I am hearing voices.
- [Are they saying] I can do other things, they (the voices) are bothering me but I can manage.
- If they are command hallucinations - do I feel I have to do what they say – what will happen if I don't. How can I avoid being consumed by the voices – can I resist. What level of control does the individual still have?
- How able is the person to get help – can they overcome the voices in order to do this?
- Is there a risk of non-engagement for this person?
- Will they take the medication?
- Frequency of attendance of the voices – do they have relief – or not?"

The descriptions provided by the MHPs clearly demonstrate that both professionals involved did know what they were doing, and had an appropriate level of understanding to competently determine the service user's mental state and appropriately assess her risks of harm to self, vulnerability risk, and risk of harm to others.

An analysis of the MHSU's assessment record revealed:

- It was known that she was prescribed quetiapine and Epilim Chrono however, dosage and compliance were recorded as not known.*[15]
- With regard to the MHSU's perception of her situation it is recorded that: "I have lost my voice because I was singing so loudly to God. Can CRHT come and see me. I know I am not well."*
- Family carers: no family present.*
- Communication historical: previously very talkative when last with CRHT.
- Communication current: softly spoken due to very loud singing to God. Slightly guarded, good eye contact, open posture – sitting eating dinner. Unable to follow full conversation at times.*
- Adjustment reaction: states she has been under stress recently. Did not want to discuss further.
- Mood disorder/depression: none on assessment.

[15] The focus of the discussions between the IIT and the MHPs was around the assessment features identified with an asterisk (*).

- Mood disorder/manic: known bipolar disorder, previously under CRHT when high in April 2006. Now liability of mood, excessive religious ideas, recognises she is unwell and asking for home treatment.
- Thought disorder: past history noted. Now excessive pre-occupation with God. Hearing God's voice. Unable to follow full conversation at times.*
- Anxiety: none at assessment.
- Personality issues: none known.
- Physical issues: oedema in her legs.*
- Miscellaneous: none identified.
- Social: lives with friend/partner. On benefits, has CPN and SW, lives in council flat, "born-again Christian".*

The risk assessment revealed:

- Aggression: no evidence on assessment.
- Suicide: took an overdose of 6 quetiapine this morning but denies any suicidality. She felt it would help her mental state.*
- Deliberate self harm: denies any thoughts.
- Illicit drugs: denies.
- Alcohol: denies.
- Forensic: denies any police involvement.
- Self neglect: reduced sleep and non-compliance with medication*.
- Arson/fire setting: none identified.
- Child protection/vulnerable adult: none known.

The completed "initial risk screening tool" utilised by LPT indicated that no fuller risk assessment was required; however, it was appropriate that the full risk assessment form was completed anyway.

The completed assessment form and risk assessment did not convey to the IIT what level of understanding the assessing MHPs had regarding what was happening with the MHSU. The documentation was sparse. The MHP who was responsible for documenting the assessment was very aware when we interviewed her that her documentation was inadequate. This issue had already been addressed with her soon after the incident with the manager for the CRHT. This professional was keen to assure the IIT that she was much more comprehensive with her record keeping now. The IIT had also seen the quality of this MHP's record keeping when she visited the home of the MHSU during the periods of home treatment between April and June 2006. On these occasions the quality of her documentation was good.

During interviews with both MHPs, the IIT set out to gain a better insight to what the CRHT MHPs really understood about the MHSU on the night of 29 January 2007. The focus of the discussions was around the assessment features identified with an asterisk above. Namely:

- the medication situation;
- the MHSU's sleep deprivation;
- the fact that the MHSU could not follow the conversation at all times (this is mentioned twice on the assessment form); and
- the MHSU's home situation.

The following became apparent to the IIT.

Risk

The MHSU's risks were seen as vulnerability and neglect. One of the MHPs recalled from previous experience of the MHSU that: "She wouldn't do any social activities, she would neglect herself, she was not able to focus on normal aspects of life ... at times excitable, over friendly also therefore vulnerability in social situations."

Medication

With regard to her medication the MHPs told the IIT that the MHSU "knew she was on quetiapine but couldn't tell them the dose or frequency – she (the MHSU) knew she had to have it to get better and knew she'd been better before which is why she took several tablets".

The IIT's consultant psychiatrist asked whether they had any recollection about the MHSU's pattern of taking tablets prior to her A&E attendance. The assessing MHP responded that as far as he recalled she had been taking them erratically. He did not think that she was completely non-compliant.

The MHP making the record of the assessment recalled:
"The OPA letters indicated what medications the MHSU was on, that she wasn't particularly stable and hadn't been for a while but that she didn't want more meds. However, up until this point she was not unwell enough to need hospital treatment. She was being constantly reviewed at OPA."

The MHSU's thoughts, beliefs and hallucinations, and her inability to follow the conversation consistently

Both MHPs recalled that at times the MHSU appeared preoccupied with something, and the MHP taking the lead with the assessment had to repeat his questions. However this MHP is clear that he was not seeing the presentation the DSH team had seen earlier. He told the IIT that the MHSU was holding a conversation and she said she was managing OK. However, because he and his colleague knew the MHSU from her previous home treatment episode, and also because of the DSH experience, he knew there was more to it and she may be more unwell than she was coming across. Both MHPs were adamant that they did not disregard the information on the

DSH team assessment form. However they did need to temper what that team had found with how the MHSU was presenting to them some two hours later.

The assessing MHP did tell the IIT that he got a sense that the MHSU did not want to discuss everything that was happening to her that night. He thought she was trying to project an image that she was better than she was. He thought this would come to light over time.

This MHP was asked how significant such withholding of information is, when making decisions about home treatment versus admission.
He told the IIT that in his experience service users often take some time to be able to discuss what is happening to them, for many reasons. However, if he thought that a patient was withholding information that would raise a question about their safety or the safety of others, then this would be strongly considered. He did not feel that the MHSU was doing this. He felt able to gauge this as he did have contact with her during her last home treatment episode. Also, in his experience, although psychotic patients may not describe their problems in detail, 99% of the time the CRHT could manage this. It was also his experience that a more complete understanding of a service user's psychotic features is achieved over a period of time, not during the initial assessment.

This MHP also told the IIT that his previous experience of the MHSU in relapse was that when very unwell things would just pour out of her – this time she was much more contained. This further gave rise to the suspicion that there was more depth to what she was saying. This was something they hoped to get more insight into during the home treatment period.

With regard to understanding her voices, the assessing MHP told the IIT that "past presentation is a good indicator of what you might expect to find on current assessment. However, it is also important to understand that a full and accurate assessment may not be possible on one occasion. Assessment starts well before we arrive and continues throughout the period of home treatment."

Sleep disturbance/deprivation

The MHP who undertook the record keeping responsibility recalled that the MHSU said her sleep was OK. She was having a couple of hours but she was very busy. Her colleague recalled that he knew the MHSU had had a lack of sleep for several days. She looked very tired; she was in his view not far off crashing. He was aware from before that she did not have a good sleep-wake pattern. This was an issue that he felt would need to be monitored over the following days.
With regard to sleep medication both professionals were mindful of the excessive dosage of quetiapine the MHSU had taken at least nine hours prior to their assessment. Furthermore the assessing MHP told the IIT that normally, if he felt it appropriate, he would instigate medication in advance of

the CRHT medical assessment. He suggested that examples of when he might do this are if a service user was agitated or distressed, and needed containment. On the whole however his experience is that they (the CRHT MHPs) try and keep involvement with medication limited as they will ask one of the medics to be involved at an early stage.

The lack of attention to the MHSU's sleep disruption was a significant issue in the minds of the IIT. It did leave the MHSU vulnerable. With the benefit of hindsight, the assessing MHP believes that having had prescribed or having administered a sedative to the MHSU to have assisted her sleep would have been a good idea. However he also stated that the doses they can administer result in a short term effect only and would not have assured that the MHSU would have slept until the morning. This of course would have been directly linked to the time of administration. Administration in A&E at the end of the assessment process at approximately 6.45/7pm would have been of little value. However administration at a time closer to 10.30/11pm would have been more useful. This would have required a night visit to the MHSU's home to assess whether she had settled or not.

The IIT also asked Cons P3 and the manager for the CRHT about their perspectives on the medication issue. Both professionals advised the IIT that more attention should have been given to medication, especially in view of the MHSU's sleep deprivation. A medical consultation should have occurred.

Support at home

The MHSU's home circumstances were not explored at all during the assessment. The MHPs assumed, based on their prior recollections, that the MHSU's friend was staying/living with her. This was not the case and this assumption meant that the MHPs did not give appropriate consideration to the risks of the MHSU going home to an empty house and whether or not, given her clinical presentation, this was appropriate. The IIT understands that at the time this assessment was undertaken, the CRHT did not routinely consider the home circumstances of an individual when making a decision to accept them for home treatment. However it is the perspective of a senior member of the CRHT that they "would not let someone go home on their own if psychotic".

Transportation home

In this case A&E was asked to arrange for a taxi to take the MHSU home. The IIT found this surprising given her presentation and the instability in this. It is the perspective of the IIT's nurse advisor that this MHSU should have been taken home by the MHPs. This would have provided an opportunity to have made a more accurate assessment of the home situation and the support available to the MHSU overnight.

4.3.1 Comment by IIT

The issue of whether this MHSU should have been accepted for home treatment is addressed in section 4.4 (page 64).

Our comments here are targeted at the crisis assessment undertaken, and its completeness.

Although the interviews with the CRHT MHPs show that they did give more consideration to what was going on for the MHSU than their clinical records suggest, the leaders of the CRHT themselves found the assessment undertaken inadequate. They thought it should have been more thorough in respect of:

- medication management;
- the increased risks associated with the MHSU being at home alone;
- exploration of the MHSU's hallucinations and voices; and
- the assessment of risk associated with an individual who does not want to speak about what is happening.

The IIT agrees with this. However the IIT believed that it was important to gather the perspective of a broader range of professionals, about what issues they would consider if they went to assess a patient in A&E with a similar presentation to this MHSU. Consequently the IIT elected to issue a semi-structured survey questionnaire to a range of crisis resolution and home treatment professionals working in specialist mental health services outside Leicestershire. The IIT did not present the scenario to crisis resolution and home treatment professionals working in Leicestershire because it was aware that the incident involving this MHSU had deeply affected the Leicestershire crisis resolution and home treatment services and it was therefore inappropriate to do so.

The question asked was[16]:

[16] Note: Respondents were not informed of the nature of the incident that had occurred, nor of the location of the crisis resolution and home treatment service involved or the incident date and time. Furthermore although the survey was conducted in 2010, the IIT does not believe that practice is remarkably different now from what it was in 2007, or that the expected actions and standards of practice would have been any different.

"If you are assessing a service user in the evening who has a diagnosis of hypomania and your assessment has revealed that they are:

- Sleep deprived
- Distracted
- Experiencing hallucinations
- Willing to engage with HT but would prefer not to be admitted

How might you manage this situation?"

Twenty nine (82%) out of the 35 professionals who completed the questionnaire[17] responded.

The following reflects the general content of the responses provided:

Table 1: sample of responses to question 12 of the IIT's survey questionnaire

- 1) Get medication written up and preferably reviewed by a medic.
  2) Administer meds.
  3) Liaise with family/friends if applicable.
  4) Promote sleep.
  5) Give details of CRHT and how to contact.
  6) Give appointment for early next day.

- 1) Phone duty doctor to discuss medication options for overnight and request they attend to assess jointly.
  2) Take into account carer's views if there is a carer as to whether home treatment is appropriate.
  3) Assess risks and consider whether these can be managed on home treatment, if not consider requesting Mental Health Act assessment.
  4) Use any previous information available if they have previous history to inform decisions e.g. risk assessment, relapse plans, care plans, recent contacts from staff (not direct input on EPEX yet so may not be able to access these if file cannot be accessed).

- 1) Consider patient group direction[18] (PGD) medication (Zopiclone and or Lorazepam).
  2) Consider a review with the on-call SHO.
  3) Arrange further home visit that evening if the client is

[17] Please note that some questions were not answered by all 35 respondents. In some cases the number of respondents to an individual question was 31.
[18] Patient Group Direction medications are medicines that authorised nursing staff can prescribe.

Table 1 continued

agreeable.
4) Arrange further home visits the next day.
5) Arrange medical review with a CR/HT medic ASAP.
6) Access existing CPA, if known and available.
7) Seek support from family members if appropriate.
8) Encourage contact from the client over night via telephone.
9) If the client is not agreeable to all of the above and refused informal admission to hospital then a Mental Health Act assessment would be requested.

- 1) The interventions would be dependent on the service user's abilities to cope with the hallucinations and to what degree these are impairing their ability to function independently. I would have to be assured that they were able to independently maintain a safe environment or that there were resources able to assist relatives or professional carers. The service user's preference for home treatment would need to be considered along with their capacity, safety and ability to comply with any plan of treatment.

  2) Given the above brief it is likely I would use an antipsychotic PGD if they were not on any other medication or get a medic to prescribe if I could not use our PGD pathway. Hopefully this would make some immediate impact on sleep deprivation and dampen down any psychotic features.

  3) I would explore what coping strategies they could utilise to manage the hallucinatory experiences and encourage these. Likely to make some suggestions to distract themselves from the hallucinatory experiences (commonly they are of a derogatory auditory nature) or sometimes where service users have a "relationship" with their voices use well versed techniques they may have.

  4) The distraction issue is a little more complex as it would need to be considered when does it happen, is it an absence or distraction by positive symptomology or negative. Most important is how does it affect the service user's behaviour and does it compromise or diminish their safety.

Nineteen of the 29 responders to this question also identified that they would:

- Seek medical input into the assessment and/or for medication purposes.
- Ensure that the service user was supported at home and that the carer/relative felt able to cope with the situation at home.

Only three responders said that they would simply arrange for medical and medication review the following day, or soon after the assessment.

The IIT is satisfied that the information it gathered via the survey questionnaire supports its perspective regarding the adequacy of assessment and management of the MHSU on the night of 29 January 2007 by the LPT CRHT. The IIT is of the opinion that a greater depth of assessment should have occurred with this MHSU, in relation to her:

- medication;
- hallucinations;
- sleep pattern;
- current home situation;
- risk exposure in relation to the above; and
- suitability to be managed at home overnight (i.e. in the period prior to the planned CRHT consultant assessment)

before the LPT crisis and home treatment MHPs arranged to send her home on her own.

4.3.2 Other issues relevant to the MHPs' assessment of the MHSU

Although touched on earlier, the IIT believes it is appropriate to restate here that both CRHT MHPs told the IIT that they were not at all aware at any stage that the MHSU's usual mental health team, and in particular Cons P2, believed that an inpatient admission was the most prudent course of action.

The assessing MHP told the IIT that "all referrals to CRHT should be considered for hospital admission. The fact that the patient is then being referred for home treatment assessment indicates that the referrer believed that to some degree home treatment may be an option. If we had known that admission had been arranged then we would not have taken things any further.[19]"

[19] The interviews with a range of staff revealed some differences of opinion regarding whether the CRHT always undertook an assessment even where admission was requested. Referring professionals had experienced a variety of responses where home treatment was not considered an option. Although the party line from the CRHT was that they did not assess if home treatment was not considered an option, referrers' experience showed that there was an inconsistency in this. Although the IIT can understand why the CRHT might take the position it did, it was not in keeping with the gatekeeping function of CRHT. Furthermore the interviews revealed to the IIT a lack of appreciation in

Review of previous documentation

The MHPs told the IIT that they did review the DSH team assessment record before assessing the MHSU. They also had access to her last home treatment records, the CRHT discharge summary and the two last outpatient appointment letters written by Cons P2. They were therefore fully aware that the MHSU was psychotic and had been unstable for some time. With regard to the extent to which they reviewed the records provided, they read all bar the previous home treatment progress notes. The MHPs advised that it was not their practice to always read through all previous home treatment progress notes; often they relied on the CRHT discharge summary. Time and the volume of the record were influencing factors in this. The consultant psychiatrist for the CRHT and the CRHT team leader both told the IIT that they expect CRHT MHPs to re-familiarise themselves with the whole record, not simply the discharge summary.

Access to out of hours medical advice

Although out of hours psychiatric advice is available to the crisis team, the impression conveyed by both MHPs is that their preference is to utilise the triage nurse back at base and request medication review from the CRHT consultant psychiatrist as soon as practicable following assessment (in this case the following morning). The practice of the CRHT was that the consultant psychiatrist to the CRHT (Cons P3) undertook an in-depth assessment of service users accepted for home treatment the day after the initial assessment. This was the common standard of practice for the LPT CRHT. It is also the common standard of practice reported by the CRHT professionals who completed the IIT's survey questionnaire[20]. Of the 35 professionals who completed the survey, 22 answered the question relating to medical input. Of these 12 (54.5%) said that MHPs usually do the initial assessment with the CRHT medical staff visiting a service user within 24 hours to make a more in-depth assessment.

The IIT also sensed that there may be some over-reliance on the expectation that all individuals who are referred via A&E have been assessed by a psychiatric SHO. However this may be a good number of hours before the CRHT undertakes its assessment. Consequently all MHPs must consider very carefully any decision they make not to seek out of hours medical advice, especially when there is any question about medication or clinical risk. It is the MHP's responsibility to ensure that the assessment they undertake is robust and complete.

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non-CRHT professionals regarding what CRHT could manage in the home situation. Consequently referrers may not have the correct judgment if they dismiss home treatment as an option without CRHT involvement in the assessment process.

[20] Seven mental health trusts were asked to issue the survey questionnaire to 4-5 professionals working in their crisis and home treatment teams.

4.3.3 Systems issues

Training and education

When the LPT crisis resolution teams were created the city team undertook a four to five week orientation programme during which a wide range of subjects was covered, including the assessment of service users and the mental state exam. However, with the benefit of hindsight the team leader for the CRHT, and Cons P3, feel that the assessment process required more attention than it received. However, it would not have been possible when the team was being pulled together to have accommodated more training and orientation than was provided. The team manager was under pressure to have the team up and running by 1 April 2004. Leicester, as with all other mental health trusts, were aiming to fully implement the NHS Plan target for crisis resolution teams in 335 mental health trusts by December 2004.

The IIT is of the opinion that the city CRHT team leader and its clinical leader undertook with diligence their task of appointing team members and trying to ensure that they all had an appropriate knowledge framework for working in this very new service. Appropriate research was undertaken as to what would make a successful CRHT and both leaders undertook field visits to already established crisis teams.

What appears to have been lacking was any formal consideration of the enhanced skills and knowledge required by MHPs working in crisis resolution and home treatment and the development of a competency framework. What also appears to have been lacking in the education framework was a vehicle for underlining to MHPs (generally nursing staff) that in taking a post in a crisis resolution team, they were accepting a level of responsibility for clinical decision making that hitherto had not resided with nursing staff.

CRHT MHPs in Leicester were expected to make a decision about the suitability of an individual for home treatment without the automatic involvement of a medical practitioner. We already know that if such an assessment occurred out of hours, the medical assessment would occur the following day. However, home treatment commences at the point the decision is made to accept an individual on to it. It is at this point that MHPs have to be absolutely certain that intensive home treatment is a viable and safe option for the individual they are assessing, regardless of what other professionals think, who may have seen the service user prior to them. Furthermore, if MHPs make a decision not to institute any active interventions between the time of their assessment and the time the individual is likely to be assessed by a medical practitioner, then it is their responsibility to satisfy themselves that there is no foreseeable increased risk to the individual that could be mitigated by a treatment intervention. In this case these interventions could have included medication, seeking agreement from the individual that they would make contact with the CRHT between “now and X o’clock”, an interim visit to the individual’s home between X and Y o’clock, taking the individual home to

conduct a further assessment, seeking the opinion of an on-call psychiatrist, or utilising a crisis bed or a crisis house.

The IIT is not confident that this responsibility is fully appreciated by the LPT CRHT MHPs it interviewed.

Clinical supervision

Clinical supervision was problematic for the CRHT at the time this incident occurred. The current senior MHP has, since his employment in 2007, implemented a number of strategies to improve the process and adherence to clinical supervision. However, he reports that he has not considered himself to be especially successful at achieving full team engagement with this. Consequently he, the CRHT manager and the individual team leaders, have implemented a more traditional model where measurement of compliance is easier. This seems to have been beneficial and clinical supervision is more robust within the team.

Documentation tools and documentation management

The manager for the CRHT told the IIT that he and the team leaders did review and audit MHPs' documentation. However, he found that the lack of depth/detail could at times cause concern. He advised that staff were informed of shortfalls and reminded to ensure these were not repeated. Some staff were consistently good whereas others were less so – this in itself was not unusual and remains so today. However, partly as a result of this incident and also because it is difficult to impose a standard of record keeping, he reached the conclusion that what was needed was extra training and a complete overhaul of the assessment format to make it more formulaic/prescriptive. This would, as far as it was possible to do so, force MHPs to notate their findings in more detail. The form in use in 2006, although addressing all key areas one would expect at this time, was not overly directive and relied on practitioners recording their findings as a narrative. The IIT undertook an assessment of the quality of documentation using the form that replaced it, and consistently found the quality of documentation to be good. Also, the new form clearly took an MHP through the assessment process in a structured manner.

4.3.4 Root causes

The IIT does not believe there was any specific, single "root cause" to the lack of robustness in the CRHT MHPs' assessment of the MHSU on 29 January 2007. However, there were a range of factors that the IIT believes were significant in influencing the way in which the MHPs conducted their assessment. These include a combination of proximal factors, i.e. those directly relating to the individual practitioners involved, and system factors, i.e. those relating to the systems and processes designed to deliver a consistently high service in the CRHT.

These were the following.

- The MHPs' prior knowledge of the MHSU and their perspective that her presentation was not remarkably different to what they had experienced before. They were very familiar with her religious over zealousness when unwell and had also experienced her distracted by her need to communicate with God. When they assessed the MHSU although she was clearly unwell, she was not presenting in the way she had to the previous assessment team. She greeted the CRHT MHPs by name and made clear her wish for home treatment. The MHPs also placed too much significance on their prior knowledge of the MHSU, rather than pursuing a more detailed assessment at the time. (Proximal cause – error of omission.)
- The lack of appreciation in the assessing MHPs regarding the degree of risk they accepted as individual practitioners, when they determined that no active treatment was required between the time of assessment and the MHSU being seen the following day. The risk of no active treatment coupled with the MHSU's diagnosis and sleep disturbance was not fully appreciated. (SKR[21] error.)
- It was not the culture in the CRHT at the time to routinely seek the input of the duty psychiatrist on call when assessing service users out of hours in A&E. (Custom and practice.)
- A lack of robustness in the governance framework for the CRHT, in respect of clinical supervision, the audit of practice and robust measurable clinical standards. (Organisational factors.)
- The lack of a clear skills and knowledge framework for MHPs at the time and the lack of any formalised ongoing enhanced skills training, to ensure that all MHPs had the enhanced assessment skills required to conduct assessments so as to consistently fulfil the crisis resolution and home treatment function. (Organisational factors.)

[21] SKR: This represents a skill, rule and knowledge based error.

4.4 Was the decision to accept the MHSU for home treatment a reasonable decision?

This question is the one that will be of most interest to the MHSU, the families of the women who died, and the mental health professionals involved.

On the basis of all of the information the IIT has reviewed and heard, on the balance of probabilities home treatment was a reasonable option for the MHSU on the evening of 29 January 2007 in every respect, except for the fact she was going home to an empty house. This is not to say that had this been known it would have prevented a home treatment option, but that how she was taken on for home treatment would have been more cautious.

In addition to the lack of up-to-date knowledge about the service user's home circumstances, the following were not reasonable:

- the lack of any treatment of the MHSU that evening;
- the way the MHSU was transported home (i.e. via taxi); and
- the lack of any further contact between the MHSU and the CRHT that evening or night.

The absence of these interventions meant that whilst in principle home treatment was reasonable, it was not implemented safely. The CRHT had continuing responsibility for the MHSU from six o'clock on the evening of the 29 January 2007. This responsibility was inadequately discharged.

The IIT has given very careful consideration as to what may have happened if:

- Medical advice had been sought on 29 January 2007 regarding the MHSU's medication.
- The MHSU had been taken home by the MHPs so that they could properly assess her home circumstance.
- CRHT MHPs had made a second visit to the MHSU at around 10.30/11pm that night to determine whether or not she was settled.

It considers that it is probable that:

- The MHSU would have been treated with an antipsychotic medication.
- That the MHPs would have become aware that the MHSU was at home on her own. This would have provided the opportunity for a revision of their treatment plan. Serious consideration then would have had to be given to the wisdom of allowing an individual who was psychotic to be at home on her own untreated.
- That the MHPs would have had the opportunity to administer a sedative to assist the MHSU with her sleep/rest.

4.4.1 Had any one of these actions been taken, is it possible that the incident would not have occurred?

With regard to the administration of an antipsychotic medication and a sedative at an appropriate time of the evening/night, there are no absolute guarantees that the MHSU would not still have been overcome by command hallucinations and driven her car as she did on the morning of 30 January 2007. However, the IIT believes that the chances of this occurring may have been reduced.

If the MHPs had known that the MHSU would be at home alone, this might have altered what happened.
Although a diagnosis of bipolar disorder does not prohibit the option of home treatment, it is recognised that it is one of the more challenging diagnoses to manage in the community and that relapse when it occurs can be very sudden and very florid. Furthermore sleep disturbance is a recognised precursor to mania.

With the presentation features of:

- sleep disturbance;
- medication non-compliance;
- hallucinations/psychosis;
- reluctance to divulge what is going on, especially when prior experience of the service user highlights this behaviour as different; and
- impulsivity – (taking six tablets of quetiapine when getting the MHSU to take a regular amount has been a persistent challenge),

one would need to think extremely carefully about the safety of this individual being at home on their own untreated. This MHSU did have a supportive family living nearby and it would have been possible to negotiate support at home for her. However this is not what happened. She was sent home, on her own, with no active treatment instigated. The IIT understands that had the MHSU's father been contacted he would have attended at A&E to collect his daughter. Following discussions with the MHSU's father the IIT considers that had this occurred it is more than likely that the MHSU's father would have taken her to his home on the evening of 29 January 2007.

The consultant psychiatrist to the LPT CRHT is clear he would not send a psychotic patient home to be on their own. However, the IIT consultant psychiatrist does not see this as a barrier per se to having accepted the MHSU for home treatment providing that:

- She had been seen by a psychiatrist and medicated.
- A home visit occurred at around 10.30/11pm to administer a night sedative if required.
- It was agreed with the MHSU that if she awoke and felt disturbed/ unwell then she would contact the CRHT.

- It was agreed with the MHSU that she would remain at home until the planned assessment in the morning.

If the MHSU would not agree to such a treatment plan then hospital admission, via a Mental Health Act assessment if this could not be achieved voluntarily, would have been the right course of action.

Because there was no plan to deliver any of the above, this MHSU should not have been sent home on the night of 29 January 2007. Provision should have been made for an overnight crisis admission and further assessment conducted the following morning with a view to early discharge and the continuance of home treatment.

The IIT wishes to make very clear that:

- Finding that the MHSU should not have been sent home has absolutely nothing to do with the perspective of the professionals who previously assessed the MHSU, nor that of her regular consultant psychiatrist. Its finding is completely focused on the delivery of safe and effective decision making within crisis resolution and home treatment. Had all four actions detailed above been taken, then it is the perspective of this IIT that the MHSU could have been safely accepted for home treatment.
- Had the MHSU been accepted for home treatment within the parameters described above, there are no guarantees that the driving incident that occurred on 30 January would not have occurred anyway. However, the risk of it occurring would realistically have been much reduced.
- The risk of the MHSU taking her car out on the morning of 30 January 2007 was not at all predictable or foreseeable by the CRHT MHPs. There was nothing in the MHSU's past history to demonstrate that she drove recklessly in response to command hallucinations. To the contrary this MHSU was largely responsible and did not drive when unwell or adversely affected by her medication. There was only one recorded instance of the MHSU having lack of insight into her driving competency. She told the CRHT that she had driven her car and that she believed she was competent, and then stopped driving immediately when the CRHT advised her not to drive again until advised by her clinical team that she could.

4.5 Was the issue of driving safety given sufficient attention by LPT mental health professionals prior to and on 29 January 2007?

The issue of driving safety and the MHSU was given variable degrees of attention between 2006 and 2007. Consequently there is no straightforward response to the question posed.

There are some key national guidelines and legislation that all clinicians have access to. The most important is it is the duty of the licence holder or licence applicant to notify the Driver and Vehicle Licensing Agency (DVLA) of any medical condition which may affect safe driving. Failure to do so is an offence under the Road Traffic Act (RTA) 1988.

However the RTA and DVLA highlight that for a number of illnesses individuals may not recognise that they are unfit to drive and/or may not wish to notify the DVLA. Mental health disorder falls into this category. Consequently it is essential that all mental health professionals, including nurses, social workers and occupational therapists as well as medical practitioners, are mindful of driving safety issues when they conduct their assessments of mental health service users.

The IIT undertook an internet search and found one policy entitled "*Policy for the management of driving and mental health problems*"[22] dated October 2006 that was operational in Dorset Healthcare University NHS Foundation Trust. Section 2.1(p2) of this policy states:

"Asking about driving should be an integral part of any assessment as the medical condition or any resulting medication may impact on the patient's driving performance. This responsibility lies with all members of the clinical team. The result of this assessment must be documented at each new assessment".

The DVLA publication "*For medical practitioners – at a glance guide to the medical standards fitness to drive*" says: "The information in this booklet is intended to assist doctors in advising their patients whether or not they should inform the DVLA of their medical condition and what the outcome of medical enquiries is likely to be." The DVLA's booklet also sets out for medical practitioners the legal basis of fitness to drive, and makes clear the General Medical Council (GMC) guidelines for medical practitioners where a patient either cannot or will not follow medical advice given in relation to fitness to drive.

[22] http://www.dorsethealthcare.nhs.uk/Portals/3/Policies/CP-025-06.pdf

The GMC guideline "*Confidentiality: Reporting concerns about patients to the DVLA or DVA*[23]" states:

"3. You should seek the advice of an experienced colleague or the DVLA or DVA's medical adviser if you are not sure whether a patient may be unfit to drive. You should keep under review any decision that they are fit, particularly if the patient's condition or treatments change. The DVLA's publication *For medical practitioners – at a glance guide to the current medical standards of fitness to drive* includes information about a variety of disorders and conditions that can impair a patient's fitness to drive.

4. The driver is legally responsible for informing the DVLA or DVA about such a condition or treatment. However, if a patient has such a condition, you should explain to the patient:

(a) that the condition may affect their ability to drive (if the patient is incapable of understanding this advice, for example, because of dementia, you should inform the DVLA or DVA immediately), and

(b) that they have a legal duty to inform the DVLA or DVA about the condition.

5. If a patient refuses to accept the diagnosis, or the effect of the condition on their ability to drive, you can suggest that they seek a second opinion, and help arrange for them to do so. You should advise the patient not to drive in the meantime."

In addition to the above, in September 2006 the Department for Transport (DfT) published a booklet entitled "*Fitness to drive – a guide for health professionals*". This booklet is available as a PDF download on the DfT website[24]. This publication was endorsed by the British Medical Association and its Board of Professional Activities and Board of Science.

This booklet says that safe driving requires:

- Effective and reliable control of the vehicle.
- The capacity to respond to the road, traffic and other external clues.
- Knowledge of and a willingness to follow the rules of the road.

It also says that "any condition that impairs perception cognition (including alertness, attitude to risk, recall) or motor function has the potential to interfere with the whole information processing loop critical to safe driving".

[23] http://www.gmc-uk.org/static/documents/content/Confidentiality_reporting_concerns_DVLA_2009.pdf
[24] Fitness to drive – a guide for health professionals http://www.dft.gov.uk/adobepdf/164386/fitnesstodrive

In *California Medicine* (September 1966, vol 105 (3), pages 197 – 200) it is suggested that the requirements for operating a motor vehicle are:

- A basic minimum of strength and mobility.
- Ability to see and concentrate adequately on the roadway and traffic.
- Ability to interpret and make judgments about real or impending changes in the traffic situation.
- Knowledge of traffic laws.
- Knowledge of the mechanics and, to a lesser extent, physics of driving.

The information detailed above shows that there has been information on driving safety available to clinical practitioners for quite some time. However, recent research conducted by the DfT across all 32 UK medical schools exploring education of trainee doctors and fitness to drive showed that a significant number of schools do not provide specific teaching on this topic. The findings of this research were published on the DfT website on 13 January 2010[25]. Furthermore the research report revealed that in many of the schools where such tuition is offered, the subject is not covered in depth. Given the central importance of the car to modern living, and the foreseeable risks to driving safety that a range of medical conditions can cause or contribute to, the IIT suggests that the education of clinical practitioners in this area is inadequate and that it should be more comprehensive and universal.

The IIT wanted to obtain a broader understanding of the perspective of mental health professionals about their contemporary understanding of their responsibilities in relation to driving safety. Consequently information was sought from a small number of mental health nurses and consultant psychiatrists in differing geographical localities in England. The questions posed were as follows:

"1. Are you aware of the following DVLA guidance?

2. If you identify that a service user presents a driving risk what do you see as the boundaries of your responsibility?

3. If you advise a service user to voluntarily surrender their driving licence to the DVLA would you feel you have a responsibility to find out if your advice has been followed?

4. If you were the Consultant Psychiatrist or care coordinator to a patient with a schizoaffective disorder or a service user with hypomania, what attention would you give to driving safety risk if the patient was compliant with medication in that they "took some" but non-compliant in that they only ever took half your prescribed dosage and were constantly trying to negotiate a reduction in this?"

[25] http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme6/report91/

Six professionals (two consultant psychiatrists and four mental health practitioners) responded to the questions asked. All were aware of the DVLA guidelines, and all provided responses to the remaining three questions that suggested a reasonable insight to the balance of responsibility between the mental health service and the service user in relation to driving safety.

The following is indicative of all professionals' responses to question 4:

"I would see the issue less about meds compliance and more about mental state stability. If the latter was prone to fluctuations that affected their ability to drive then I would see driving as a key factor in their overall risk assessment. I would also throw in there, if they had side effects from meds that affected their ability to drive, that would also need considering."

Because this case involved crisis resolution and home treatment, a number of questions were also included in the semi-structured questionnaire sent to crisis teams. One of these was the frequency with which they currently assess fitness to drive as an integral component of their current assessments. 31 respondents answered this question. Of these, 22 said they always consider vulnerability to pose a driving risk as part of the crisis assessment. Five said they usually consider it, and only four said that they sometimes consider it. No respondents said that they never consider it. At least one of the crisis team managers working for a responding trust told the IIT that their attention to detail about driving safety had arisen because of clear issues emerging with some of their client group rather than because it was automatically included in their assessment from the start. The IIT is also aware of another mental health trust in northern England where increased awareness of driving safety has followed a serious driving incident involving a service user of the trust.
It seems to the IIT that questions relating to driving safety should be a core component of risk assessment training and that risk assessment documentation tools should also specifically ask questions about fitness to drive. A car becomes a potential weapon of destruction if the person behind the wheel has impaired capacity including impaired concentration.

4.5.1 What happened with this MHSU with regard to her driving situation?

In May 2005 the MHSU had a significant relapse in her mental health that required five months of inpatient care. She was discharged back home in October 2005. Between this date and January 2006 she was not driving.

On 4 January 2006 she is noted to have expressed a desire to drive again. She had been stable for three months since her discharge from hospital and her father also believed her to be well enough to again hold a driving license. Consequently it was agreed that her then consultant psychiatrist (Cons P1) would write to the DVLA advising them that he considered the MHSU fit to drive.

On 13 January 2006 the DVLA sent correspondence to Cons P1. This correspondence requested that he complete the DVLA's medical assessment questionnaire. The letter to Cons P1 clearly stated:

"The above named driver may be entitled to drive whilst we are awaiting your reply and this may have an impact on road safety."

On 8 April the DVLA informed Cons P1[26] that they had reinstated the MHSU's driving licence. She was granted an ordinary driving licence to be reviewed in 12 months' time. This letter also stated that should the MHSU's mental health relapse in this 12 month period the DVLA must be informed[27]. The letter also said that if the patient is unable or unwilling to take advice then the medical advisor at the DVLA must be informed by the doctor treating the patient at the time.

On 12 April the MHSU was reviewed by the SHO to Cons P2. She was also reviewed by Cons P2. This was the first time that Cons P2 had met the MHSU since accepting her on to her caseload on 17 March 2006. The case notes reveal very through assessments by the SHO and Cons P2.

On 24 April the MHSU relapsed again and is accepted for home treatment by the city Crisis Resolution and Home Treatment (CRHT) team.

On 3 May the MHSU telephoned the DVLA to advise that her medication (risperidone) had been increased as her mental health had deteriorated. The MHSU undertook this herself without any prompting from mental health professionals. The DVLA sent the MHSU a letter and medical questionnaire.

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[26] This letter would have in fact been forwarded to Cons P2 as she was the consultant to the MHSU by 12 April.

[27] Note: it is the service user's responsibility to do this. It would be a clinical professional's responsibility to highlight the issue to the patient and to encourage them to notify the DVLA.

Note: There is no direct reference to the issue of driving in the MHSU's records until 5 May 2006 where the CRHT progress notes say that the MHSU was concerned about driving due to her lack of concentration and sedation. The impression drawn from the notes, and validated at interview, was that the MHSU was not driving at this time[28].

On 8 May 2006 the MHSU was noted as reporting to the CRHT that she could not drive owing to the effects of her medication and that she had to rely on friends to transport her.

On 18 May it appears that the MHSU did drive her car (which she was legally entitled to do). She reported to the CRHT MHPs that she was feeling better and believed she was competent to drive. The CRHT notes show that she was immediately told not to drive. The clinical records also reveal that the issue was discussed at the CRHT team meeting that day and a subsequent phone call was made to the MHSU, reiterating the earlier advice not to drive. The MHSU was noted not to be happy about this but the data in the records suggests that she did adhere to the guidance given.

On 1 June the issue of driving was again raised by the MHSU. She continued to feel that she was competent to drive, but the medical advice continued that she must not. She was also advised to contact her insurance company to find out if her insurance policy could be frozen. She continued to follow the advice not to drive.

On 5 June the MHSU was discharged from the CRHT back to the care of Cons P2 and the CMHT. The issue of driving and the advice provided was clearly stated on the CRHT discharge summary. What is not made clear is that although the MHSU appeared to be adhering to the advice she continued to believe that she was competent to drive.

On 5 June the DVLA sent the MHSU a reminder letter and further questionnaire as it had not received a response from the information sent on 3 May. The MHSU was informed at this time that the DVLA was revoking her licence because of her failure to return the required documents.

On 7 June the MHSU telephoned the DVLA to advise that she had been unaware that she needed to complete the questionnaire. She told the DVLA that she would do so as soon as possible. As a consequence of this the MHSU's license was not revoked.

On 8 June the DVLA received the completed questionnaire from the MHSU. Unfortunately her consent to approach her doctors was not enclosed.

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[28] Note: readers of this report must remember that while the DVLA undertakes its medical assessment a license holder remains permitted to drive. Consequently it is incumbent upon clinical professionals to advise a patient if there are any features that pose a driving risk, such as poor concentration.

On 13 June there was a CPA review which the MHSU attended. At this meeting the MHSU told Cons P2 that she had been told not to drive by the CRHT until she had spoken to her. This consultant reports that the MHSU asked her for permission to drive. She also reports that she told her that she should not do so. This consultant also told the MHSU to notify the DVLA of her current circumstances and that she must not drive again until it had made a decision regarding her fitness to drive. As far as the IIT has been able to ascertain, the MHSU did not tell anyone she had already notified the DVLA.

On 23 June the DVLA wrote again to the MHSU asking her to complete the consent form to enable it to contact her doctor.

On 10 July the DVLA received the MHSU's consent form.

On 20 July the DVLA wrote to the MHSU's consultant psychiatrist (Cons P2) requesting completion of a medical questionnaire.

On 3 August the DVLA asked Cons P2 to complete and return the medical assessment questionnaire upon which the DVLA medical advisors base their decisions regarding fitness to drive.

On 9 August the medical assessment questionnaire was received by the DVLA. The form was fully completed. However, there was one error of documentation. The form stated that the MHSU had been stable for four months whereas she had only been stable for two. Cons P2 was unaware of her error until this investigation. On reflection she agreed that the MHSU had only been stable for two months at the time she completed the form. At the time she had used the commencement of home treatment as the period where stability had commenced and not the point at which she was discharged back into her care. The DVLA guidelines are specific. A service user must have achieved a minimum of three months' stability for a driving license to be reinstated.

On 15 August the DVLA notified the MHSU that she had again been granted an ordinary licence, to be reviewed in one year. She was asked to sign a declaration of acceptance and to return her existing driving licence. The IIT did ask the DVLA if they would have reinstated the MHSU's licence had they been aware that she had in fact only achieved two months of stability. A medical advisor to the DVLA told the IIT that the MHSU would have had her driving licence revoked if the information on the medical questionnaire had been correct.

On 22 August the DVLA received the signed declaration from the MHSU.

Between 25 August and 25 September the MHSU had a fractured foot that was in plaster. She was not driving during this time. Her mental health was reasonable during this period.

On 5 September the DVLA sent letters to the MHSU and to her GP advising that a licence had been issued, subject to a medical review in 12 months' time. At this time the MHSU was also issued with a new licence.

Between 4 and 31 October the MHSU experienced deterioration in her mental health. Her concentration was poor, she was experiencing auditory hallucinations and she was noted to be distracted. Over this period no guidance was given to the MHSU regarding driving. Both Cons P2 and the MHSU's CPN told the IIT that they were unaware that she had her driving licence back and that as far as they were aware, she was not driving. The assumption of Cons P2 was that as she had received no information from the DVLA that the MHSU had not yet had her driving licence reinstated. The information contained in her medical records about her mental state during this period was such that notification to the DVLA of the deterioration should have occurred. This requirement would have been made clear to the MHSU in the letter she received from the DVLA, confirming its decision that she could continue to drive on a restricted ordinary license. Although there were a number of indicators to MHSU's CMHT that she was not driving during this period, had the DVLA been notified as it should have been, and the DVLA's medical questionnaire been completed and returned, it is possible that the MHSU's licence would have been revoked until she had achieved three months' stability in her mental state.

The MHSU's variable mental state continued during November 2006. It was not until 12 December that the clinical records show that improvement was notable although evidence of hypomania remained present until 19 December.

In the first two weeks of January 2007 the medical records and staff recollections suggest that the MHSU was more settled, although she continued to complain of poor concentration due to her medication.

On 17 January she had a home visit by her social worker. She was noted to be in good spirits. At this visit it was noted that the social worker would collect the MHSU for her next outpatient appointment with Cons P2 on 30 January. It is this social worker's recollection that the MHSU was not driving at this time, hence the fact that he was collecting her to take her to her appointment.

On 24 January the social worker had telephone contact with the MHSU. She was going shopping and reported no problems.

On 29 January the MHSU was admitted to A&E having taken an excessive dose of quetiapine. She was initially assessed by the DSH team and then the CRHT before being discharged home, having been accepted for home treatment. The issue of driving safety, as previously noted in section 4.3 (page 50), was not addressed during the CRHT assessment.

4.5.2 Information gathered from Cons P2 and the MHSU's CPN about the MHSU's fitness to drive

The IIT is very mindful of the lack of clarity for health professionals generally around their responsibilities regarding a patient's fitness to drive. There is today a greater awareness of this, but as DfT research highlights (Department for Transport (2010) *Road safety research report no. 91, sub-report 3,National survey of health professionals' knowledge and attitudes to fitness to drive*) it continues to be an area where there is a lack of clarity and confusion about when patients should be advised not to drive.

In the case of this MHSU, the correspondence from the DVLA to Cons P1 on 8 April 2006 made the position clear. This was, if there was further relapse (deterioration in mental state) then the patient had a responsibility to notify the DVLA. The letter to the medical practitioner highlighted that during any subsequent medical assessment process a patient is entitled to drive, and there may therefore be risks associated with this. It implies that the medical practitioner should advise the patient accordingly and tell the DVLA if the patient does not heed medical advice.

Apart from 18 May, 1 June and 5 June (discharge summary) and the CPA document of 16 June 2006, there are no other references to the MHSU's fitness to drive or advice about driving given to her. This reflected the lack of appreciation in Leicester and elsewhere of the need to make judicious records about clinical observations and advice in respect of fitness to drive at the time.

The first time information about the MHSU's fitness to drive should have been documented was on 25 April 2006 when she was assessed at home by the home treatment team. However, the lack of proactive documentation is in some way mitigated by the actions of the MHSU herself such as her notification to the DVLA on 3 May 2006 that she was unwell. There are a number of references in the MHSU's records, after this date, to her not driving.

The records of 18 May and 1 June say clearly that the MHSU was told not to drive because she was unfit to do so. The IIT has been unable to find out if the CRHT MHPs were aware that the MHSU had notified the DVLA at this stage. However, it is at this point that the MHSU should definitely have been told to notify the DVLA. The incident on 18 May highlighted the MHSU's lack of awareness that she was not competent to drive and consequently increased her dangerousness on the road.

There is reasonable communication of the "not to drive" advice in the CRHT discharge summary and a completely appropriate action at the MHSU's CPA meeting of 16 June, where the MHSU was advised to notify the DVLA of the deterioration in her mental health. Furthermore the response of Cons P2 to the DVLA's request that she complete a medical assessment questionnaire was timely. What would have made the CRHT discharge document more

robust was if the MHSU's lack of awareness about competence to drive had been documented. This was a critical piece of clinical information that the MHSU's regular care team needed to be made aware of.

What, retrospectively, will be concerning for all the mental health professionals caring for the MHSU over this time is that she did not tell any of them that she had contacted the DVLA on 3 May, and that it was in contact with her on 5 June. This was a service user that was thought to be very open and communicative.

After August 2006 there should have been reference to the MHSU's fitness to drive in the clinical records between October and 12 December 2006. The content of the outpatient appointment assessments clearly notate behaviour that could affect fitness to drive. However there is no reference anywhere in the clinical notes (medical or community CPN) about this.

The IIT asked Cons P2: "Had you been aware that the MHSU had her driving licence back in November and December, would it (at the time) have been a concern?" She told the IIT that if she had been aware:

"It should have been; her lapses in concentration evidenced by overflowing the bath, and her intermittent attention to auditory hallucinations rather than reality should raise concerns that she might not be fit to drive. I can't say whether I would have paid attention to it or not, but think I didn't have a very high awareness of driving issues *at the time*. This was obviously of huge concern to me after the incident, and I did literature searches, discussed it with my peers, with a DVLA medical advisor and the internal inquiry team."

The MHSU's CPN told the IIT that she didn't know when the MHSU got her licence back. She recalled that the MHSU broke her foot in August and that she said "now I can drive again I have broken my foot". The other conversations the CPN can recall were around medications and driving. To her recollection the MHSU demonstrated awareness that she couldn't drive if sleepy as a result of medication. The CPN believed that the MHSU when relatively well was aware of when she could and could not drive.

When asked if fitness to drive was a feature of the clinical risk assessment and risk management plan the CPN advised that it was not. However, she was unaware that this was a risk issue for the MHSU. She was not aware that there had been any incidents of unsafe behaviour around driving. She was aware that the MHSU had been medically advised not to drive following her relapse in 2005, and again at the CPA review of 16 June 2006 and that she had complied with this advice. However, at the time fitness to drive was not required to be commented on in the care plan or risk management plan.

This being said the CPN is quite clear that between October and December had the MHSU mentioned anything about driving then she would have acted on this. This sentiment was also echoed by Cons P2 who said that she can

"state with absolute certainty that had the MHSU's CPN had any suspicion that she was driving at a time when her mental state or medication made this dangerous, she would have raised it with the MHSU and alerted *me* to it".

Furthermore Cons P2 also told the IIT that although there was no specific focus on driving in the team's contacts with the MHSU, the following would have influenced this:

- Cons P2 had not received any notification from the DVLA advising that the driving licence had been reinstated.
- The MHSU broke her foot in August 2006 and was in plaster until late September so could not drive.
- From October 2006 the MHSU's CPN was in close contact with her because her mental health state had deteriorated. No information was shared during these clinical contacts that suggested that the MHSU was driving.
- The MHSU was taken to outpatients appointments by the CPN or her social worker. She did not drive herself.

4.5.3 Comment by IIT

It is very easy to be wise after the event. However the IIT can identify with the MHSU's regular care team and the lack of specific attention paid to fitness to drive. It is not a routine factor on risk assessment forms, and in the experience of the IIT there is variability to the extent to which it is addressed in trust risk assessment workshops. The guidance provided by the DVLA, although improved, is not as clear and accessible[29] as it could be. Furthermore the standardised letter the DVLA sends to an individual's medical practitioner could be more explicit in guiding medical staff about the general issues that call fitness to drive into question. This correspondence could also refer to DVLA guidance for medical practitioners and provide the internet address for this.

The above being said, given the information provided to the IIT by all clinical professionals that driving was a significant issue for the MHSU, it was somewhat surprising that no enquiry was made by the MHSU's clinical team at any stage as to whether she had heard from the DVLA regarding her application to have her driving licence reinstated. The team should have established what the outcome of the DVLA's enquiries were.

However, it is difficult to be overly critical when a research report commissioned by the DfT[30] published in January 2010 says:

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[29] Accessible: this refers to simplicity of advice rather than accessibility of the DVLA and DfT documents which are available on their respective websites.
[30] Department for Transport (2010) *Road safety research report no. 91, sub-report 3,*

“A growing body of evidence suggests that health care professionals’ (HCPs') knowledge of the guidelines on medical aspects of fitness to drive (FTD) is less than satisfactory and that HCPs often fail to advise patients about their FTD (Frampton, 2007; Ormerod and Heafield, 2007; Steier et al., 2003).”

The IIT did ask the DVLA why it did not send notification of its reassessment of the MHSU’s fitness to drive to Cons P2. The medical advisor who responded to the IIT’s query did not know why notification had been sent to the MHSU’s GP and not Cons P2. The usual process is for the doctor who has completed the medical questionnaire to be sent the notification. The DVLA medical advisor suggested to the IIT that one reason why the GP may have been notified was because the psychiatrist’s name and/or signature was not legible. Further inquiry with Cons P2 revealed that her signature was not legible.

What the DVLA did tell the IIT was that in August 2006 the MHSU would have had her driving licence revoked, had it been aware that she only had two months’ stability at this time and not four months as was stated on the medical questionnaire. The IIT did make further enquiry of the DVLA about how long the MHSU would have had to wait before again applying to have her driving licence reinstated. The IIT was advised that as soon as the MHSU had achieved three months’ stability then she could have reapplied for the reinstatement of her driving licence. The IIT can see no reason why this would not have occurred in September 2006.

National survey of health professionals’ knowledge and attitudes to fitness to drive. (http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme6/report91/)

4.5.4 Potential impact on the incident had the MHSU's clinical team been aware that the DVLA allowed the MHSU to keep her ordinary licence in August 2006

This is a very difficult question to answer. However, had the MHSU's clinical team been notified, as Cons P1 was, that the MHSU had been granted an ordinary driving licence with a review period in 12 months' time, it is probable that Cons P2 would have addressed fitness to drive with the MHSU when she experienced further deterioration in her mental health in October and November 2006. The information in the clinical records and shared with the IIT at interview strongly suggests that the MHSU should have been advised not to drive over this time. It is also possible that the DVLA would have suspended the MHSU's driving license until three consecutive months' stability were again achieved. Had this occurred, the MHSU would not have been in possession of a valid driving licence on 30 January 2007.

Whether this would have had any impact on the incident that subsequently occurred is difficult to say. What we do know is that the psychotic episode that the MHSU experienced on this day was so severe that she was not capable of exercising her normal judgment about not driving when unwell. Cons P2 told the IIT that she discussed the incident with the MHSU and her understanding is that even had the MHSU not had a licence, given that the car and car keys at home, she would have driven her car as she was so overcome by the command hallucinations telling her to do so.

Had her father taken custody of her car as he had done previously when his daughter was not driving, then the MHSU would not have been able to respond to the command hallucinations. However, there are no guarantees that this would have been the situation in January 2007.

5.0 Actions taken by Leicestershire Partnership NHS Trust following its own recommendations in 2008

Following the incident involving the MHSU, LPT undertook its own internal investigation to identify what lessons it could learn and to make recommendations for improving its internal systems and processes. The following recommendations were made as a consequence of the internal investigation:

1. "That the CMHTs and the CRHT (city) should undertake some joint work to agree standards of practice around communication.
2. It is recommended that all clinical teams within the Trust should ensure that fitness to drive forms a key element of initial and ongoing assessments.
3. An audit project into CRHT communication pathway and discharge communication should be undertaken.
4. The panel recommends that the findings of this investigation are brought to the attention of the executive team and that careful consideration is given to the risk issues around further bed reductions.
5. The panel recommends that the caseload size and availability of administrative support should be considered in the job planning process.
6. The Trust should enter into correspondence with the DVLA about the identification of medical professionals to whom correspondence should be copied (when a licence is reinstated).
7. The Trust should consider feeding information from this investigation back to the DVLA for discussion.
8. It is recommended that the Trust should look at developing a half-day training programme for doctors and other clinicians to support the implementation of a fitness to drive policy.
9. It is recommended that an audit is undertaken to enable doctors within the Trust to identify where their knowledge gaps are in their knowledge and training.
10. All clinical areas should be reminded that supervision is a mandatory requirement for all nurses and allied professionals and it is not an elective process."

LPT was asked what progress had been made against its recommendations. The IIT is pleased to report that LPT has fully addressed, and/or is nearing completion on a number of work streams that will achieve this. LPT specifically advised that:

- Recommendations one and three have been addressed by a new Crisis Resolution and Home Treatment team operational policy that has

recently been ratified. Standards for communication have been included in the development of more robust operational working arrangements.

- Fitness to drive (recommendation two) has been addressed in the trust's interagency CPA risk assessment initial screening document which is used on a trust-wide basis.
- Recommendation four was not addressed specifically by the trust as there was already a specific piece of work being undertaken to reconfigure the adult services. Consequently the trust has established a work programme relating to inpatients and centres of excellence, and this has addressed the risks around bed configuration.
- Recommendation five has been superseded by LPT developing a Business Unit Model which picked up the resource and service needs across trust services.
- The Executive Director of Quality and Innovation advised the IIT that the previous medical director did liaise with the DVLA about fitness to drive and as a consequence a decision was made to adopt the DVLA guidance. A targeted piece of work was undertaken within the trust to ensure that all relevant staff were aware of the DVLA guidance and of fitness to drive as a core issue when assessing risk.
- Recommendations eight and nine: in the aftermath of this incident, awareness training was implemented for medical staff. This was undertaken by the former medical director. Subsequent to this an audit was conducted in 2009, the results of which will inform trust management of the current level of knowledge in staff so that further training can be delivered if necessary.
- Recommendation ten: supervision is a mandatory requirement across the trust and a revised supervision policy was launched in 2009. The IIT is informed that supervision forms a regular component of the trust's annual audit programme via the personal development process. The current target for supervision is an 80% uptake of personal development plans.

In addition to the above the Executive Director of Quality and Innovation was able to confirm to the IIT that:

- The current system of referral to the Crisis Resolution and Home Treatment team has been reviewed as part of the revised operational plan which includes convergence of City and County crisis resolution and home treatment services.
- The triage document that is used to document referrals has been recently been revised. In combination with information that should be available on Maracis, this should provide adequate information for any circumstances.

- With regard to out-of-hours medical advice, both CRHT teams have recently been reminded of the need to routinely consider out of hours medical input for all new assessments or any other challenging situations. They all have access to the on-call SHO and consultant. Staff have also been reminded of the need to ensure they seek appropriate advice, on either medical or operational management, outside office hours from across the trust rather than from colleagues within the team who are not on duty. In addition, they need to clearly record any discussions they have with on-call doctors. The additional document LPT plans to produce, "*User's guide to the operational policy*", will make this completely clear to staff.

6.0 Conclusions

The accident in which this MHSU was involved was tragic, and its impact has been enormous for all concerned. The IIT's conclusions are based on an objective and detailed analysis of the MHSU's care and treatment in Leicestershire Partnership NHS Trust in the 12 months preceding the incident and are also cognisant of her mental health history and the precipitators to previous relapse episodes. The IIT has had access to information that was not available to the courts at the time of the MHSU's conviction. This means that it is appropriate for the IIT to state its conclusions based upon the analysis of the information it gathered, uninfluenced by any conclusions previously reported in the public press. The IIT is mindful of this in stating its conclusions. It is also mindful that the MHSU's consultant psychiatrist in January 2007 was reported in the media as having told Leicester Crown Court[31] that she thought the MHSU had needed hospital admission. However this consultant did not assess the MHSU on 29 January 2007, and based her opinion on the information provided to her by the Deliberate Self Harm (DSH) team some two hours before the Crisis Resolution and Home Treatment team (CRHT) assessed the MHSU. The CRHT's responsibility was to undertake an assessment of the MHSU's suitability for home treatment based on her presentation at the time, bearing in mind any available information from the DSH team. The CRHT was therefore carrying out its duties appropriately in attending to assess the MHSU and to determine a course of action.

With regard to the question: "Was it predictable that the MHSU would take her car out on the morning of 30 January, driving very fast and then losing control of it?" the IIT does not believe that it was predictable. There was no previous documented, or reported, history of her driving dangerously. There was only one known incidence of her taking her car out, believing she was competent to drive when she was not. On that occasion, however, she had not been told not to drive and she had displayed responsibility some 12 days previously when she notified the DVLA about an alteration to her medication following a relapse. The more frequent clinical record is of this MHSU acknowledging that she should not drive, and not driving, when adversely affected by her medication or unwell. She, as many other drivers, had incurred fines and penalty points for speeding offences, classed as SP30 offences. She had two such offenses recorded, one in 2003 and one in 2004. In the same time period the MHSU had three significant mental health relapses.

[31] http://news.bbc.co.uk/1/hi/england/leicestershire/7363608.stm

However, in spite of her low driving risk, it is undeniable that driving risk should have been considered by MHP's between October and December 2006 and on 29 January 2007.

Unfortunately, the consideration of driving risk was not commonly at the forefront of mental health professionals' minds at this time. Although there have been few papers published on this subject, there was sufficient information in the public domain for the professionals to have been more aware about their responsibilities and MHSU's fitness to drive. However as recent DfT research shows, the lack of awareness of and thus consideration of fitness to drive was not unique to the professionals assessing the MHSU on 29 January 2007, or the MHSU's regular care team in 2006.

The IIT has considered whether paying more attention to the MHSU's fitness to drive between October and November 2006 could have prevented this tragedy. Had the MHSU been advised that she needed to report the deterioration in her mental health to the DVLA during this period, it is very possible that she would have had her driving licence revoked and that it would not have been reinstated by January 2007. However one cannot say that even had this happened, the incident would not have occurred. The incident could only have been avoided if the MHSU's father had collected the MHSU from A&E and taken his daughter home with him on 29 January 2007. He keeps his car in a locked garage so she would not have been able to access this.

With regard to the crisis assessment that occurred on 29 January 2007, although fitness to drive should have been a consideration, this on its own would not have prevented the subsequent incident. What was more important was the decision to accept the MHSU for home treatment and whether this was executed safely. The IIT's perspective based on the MHSU's presentation at the time, that the assessing CRHT mental health practitioners did not exercise the necessary caution in respect of:

- The MHSU's sleep disturbance/deprivation.
- The need for medical advice/assessment regarding the immediate management of her psychotic symptoms.
- Her lack of willingness to divulge all the information they required to complete a full assessment.
- Her home circumstances. The MHSU was living by herself. It was assumed by the assessing crisis professionals that her friend was staying with her, but this was not the case.

As a consequence, although in principle the MHSU was someone for whom home treatment may have been appropriate, she was accepted for home treatment without an adequate plan in place. This meant that the way in which she was accepted for home treatment was unsafe.

An appropriate degree of caution would have been exercised, and acceptance for home treatment would have constituted reasonable practice, had the following occurred:

- Assessment by a medical practitioner.
- Administration of an antipsychotic medication.
- A home visit to assess how the MHSU was settling at around 10.30/11pm.
- Administration of a night sedative if required at around 10.30/11pm.
- Clear instruction to advise the MHSU to contact the CRHT base if she woke during the night or early hours feeling unwell.
- Checking with the MHSU's father or her friend whether either of them could support the MHSU at home overnight, or whether she could stay with either of them until her assessment the following morning.

Because none of the above occurred and there was no interim care/treatment contract agreed prior to medical assessment the following morning, the MHSU should not have been sent home as she was. Furthermore, had the MHSU been resistant to any of the above measures, practitioners would have had to consider admitting her to hospital.

Looking at the MHSU's history, and at her expressed wish for home treatment on 29 January 2007, it is most likely that she would have agreed to an interim treatment plan if that would have enabled her to successfully achieve a home treatment outcome.

Whether or not such a treatment plan would have prevented the incident is difficult to say in retrospect. However what the IIT can say is that the incident would have been far less likely to have occurred and on the balance of probabilities would have been avoided had her father been asked to collect his daughter from the A&E department instead of allowing her to go home by taxi. That the CRHT did not contact the MHSU's father to collect his daughter from A&E does not represent a lapse in care. That no interim care package, as indicated on the previous page, was implemented does however represent a lapse in safe standards of care.

7.0 RECOMMENDATIONS

The IIT has eight recommendations for LPT and one for East Midlands SHA as a result of its investigation. The LPT recommendations all have a local focus. The recommendation to East Midlands SHA relates to communication between the DVLA and relevant members of the medical profession following fitness to drive assessments.

Recommendation 1: LPT needs to ensure that its crisis resolution and home treatment professionals have access to of up-to-date and appropriate clinical records when conducting emergency mental health assessments.

At the time this MHSU was receiving home treatment the CRHT did not have access to core clinical information electronically, for example the most recent CPA document, the most recent risk assessment and any significant correspondence. The city CRHT's operational policy in 2006 did not address the issue of what information is required by the CRHT from a service user's regular care team when it accepts a client for home treatment. Neither does the operational policy for community mental health teams (CMHTs) address what information they will routinely provide if a service user is transferred to the care of another team such as CRHT or the Psychiatric Early Intervention Service.

It is therefore the recommendation of the IIT that the Executive Director with responsibility for quality and patient safety determines with the Service Manager of the crisis resolution teams what core clinical information must be provided to them, when a known patient is referred for a crisis assessment.

It is the IIT's perspective that any minimum data set should include copies of the:

- most recent CPA document;
- most recent risk assessment and risk management plan; and
- most recent outpatient correspondence sent to the service user's GP.

In addition to the above, because LPT does not yet have an electronic records system, it is recommended that as standard where a service user is accepted for home treatment there is a face-to-face handover involving the service user's regular care coordinator, or that the crisis team attends at the regular team's base to extract information that will enable safe and effective home treatment.

Target audience: Chief Operation Officer, Executive Director of Quality & Innovation, and Service Manager for LPT crisis resolution teams.

Timescale: The IIT appreciates that this recommendation may not be easy to meet and that they may be practical issues that it is not aware of. The IIT suggests that within two months of this report being accepted, LPT needs to determine how it is going to ensure and assure that its CRHT professionals have access to core documents such as risk assessment in order to deliver an optimal service to clients.

Recommendation 2: The operational policy for LPT's crisis resolution and home treatment service must set out clear and measurable standards for how service users are discharged.

The crisis resolution and home treatment operational policy must set out clearly the standards expected when service users are discharged from the CRHT service. Historically no such standards have been detailed. The draft policy tabled for presentation at the LPT senior clinical group in July 2010 does now contain discharge standards which meet the principles highlighted below. These standards have been incorporated as a result of this investigation.

East Midlands SHA will need to satisfy itself that the standards remain in the final ratified policy document.

The IIT expects such standards to include the following principles:

- When discharge becomes a consideration and the service user is on a CMHT caseload, there will always be a discharge CPA meeting, or at minimum a face-to-face meeting with the service user's care coordinator.
- If a face-to-face meeting/discharge CPA meeting is not possible then the reasons for this are clearly stated in the service user's clinical records.
- When a service user is to be discharged back to the care of primary care services, (i.e. there is no continuing care from specialist mental health services), a formal discharge summary containing the same information as a discharge letter from community or inpatient services is faxed to the service user's GP within 5 working days of discharge. If the discharge is a planned discharge, there should be no reason why this is not achievable.

Target audience: LPT's Chief Operating Officer, Service Manager for LPT crisis resolution teams (city and county).

Recommendation 3: LPT's crisis resolution and home treatment service must ensure that its discharge summaries provide complete information to GPs and other relevant mental health teams and agencies.
The information provided on discharge summaries from the CRHT to GPs and other professionals was inadequate in 2007. The management team for crisis resolution and home treatment services must ensure that, as standard, the following are addressed in all discharge correspondence:

- current diagnosis;
- problem summary (how the service user came into contact with the crisis service and a synopsis of the clinical progression);
- treatment/interventions provided;
- recovery impressions;
- current risks (self, others, safeguarding, fitness to drive, neglect, financial, engagement with services);
- medication; and
- recommendations.

The proposed discharge summary document, that will be implemented in the LPT crisis resolution and home treatment service following ratification of its revised operational policy, does require the presentation of the information tabled above.

Because the discharge summary document has been developed following feedback provided to the crisis resolution and home treatment service during this investigation, it will be East Midlands SHA's responsibility to ensure that implementation of the policy and the proposed documentation tools occurs in a timely manner. The IIT suggests that the revised operational policy should be ratified and implemented by 1 October 2010.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, and Service Manager for LPT crisis resolution teams.

Recommendation 4: LPT must ensure that up-to-date and appropriate clinical records are available to staff conducting emergency mental health assessments
Although home treatment is for relatively short periods of time, if it subscribes to the concept of "one patient, one set of records", LPT does need to ensure that this is achieved manually in the absence of functional electronic records. It is not acceptable that a service user's main clinical record does not contain a full record of all significant care interventions and the detail of care and treatment delivered.

LPT needs to set out clearly its strategy, including the financing, of how it is going to achieve the standard of "one patient, one set of clinical records". This is not the current position in LPT and each team (CMHT, CRHT, Psychiatric Early Intervention etc) is maintaining its own records relating to the service user. That these records are merged when the service user is fully discharged

from the service is not sufficient. Clinical practitioners must be able to access all relevant information about a service user if they are to develop effective and safe care plans.

If providing this information electronically is not achievable for LPT then it must set out how it intends to meet the principle with its current (predominantly manual) system of clinical records. Maracis, the current LPT electronic records system, does not achieve this.

Target audience: LPT's Chief Executive, Executive Director of Quality & Innovation, Director of Risk Assurance.

Timescale: The IIT is sure that achieving a workable electronics system is already something LPT is looking at. What it needs to do is commit to a clearly defined strategy and implementation timetable that is monitored by the SHA as part of its action implementation plan arising from this investigation. The IIT does not consider it appropriate to impose or suggest a timescale to LPT.

Recommendation 5: The LPT crisis resolution and home treatment service needs to minimise the loss of information along the communication pathway from those making referrals to the assessing mental health practitioners.

This investigation highlights the dangers of introducing too many variables in a communication pathway when service users are referred for assessment by the CRHT. In this case, the information from the deliberate self harm (DSH) team was passed verbally to a triage nurse who made notes of the discussion, which were then provided to the mental health professionals (MHPs) asked to assess the service user. There was a loss of important information during this process. Consequently it is the recommendation of the IIT that:

- A faxable referral form is developed for the CRHT which provides clear headings for entering specific information. It should have an accompanying guidance sheet detailing its purpose and how it will be used. All future referrals to the CRHT should be made in writing on this form.
- All faxed referrals are supplemented with telephone follow up by the CRHT triage nurse, or preferably the mental health professionals tasked with undertaking any subsequent assessment.
- For the DSH assessment form to be extended so that greater detail about the assessment can be recorded. This should include full details of any discussions the DSH team has with a service user's regular care team and the outputs of this. If a DSH MHP believes admission to be the only option at the time of their assessment, this should be made explicit at the time of referral so that this perspective is clear to the next team, who may not be conducting their assessment until sometime later. Consequently consideration needs

to be given to ensuring that a prompt for this opinion is included on any revision of the DSH assessment form.

- The DSH assessment form needs to record the contact numbers for the assessing DSH professionals, so that the assessing CRHT MHPs can make proactive communication with this team where necessary. LPT could explore the practicalities of expecting the assessing CRHT MHP to have a direct conversation with the referrer prior to commencing their assessment, rather than this solely being undertaken by the CRHT triage nurse. This would reduce the opportunity for miscommunication, misinterpretation of information and information loss.

The current draft (July 2010) of the revised crisis and home treatment team operational policy does not fully address this recommendation, and the wording over whether or not telephone referrals will be routinely accepted is less than clear. It currently implies that telephone referrals will be acceptable. It is the recommendation of the IIT that the normal standard of practice should be for faxed referrals, followed up by telephone communication, in all but exceptional circumstances.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, and Service Manager for LPT crisis resolution teams.

Recommendation 6: All crisis resolution and home treatment professionals in LPT must recognise the increased accountability they accept when they elect not to seek the advice of the on-call psychiatric team when undertaking out of hours assessments. A culture of not using available medical input out of hours has no place in the delivery of an effective and safe crisis and home treatment service.

The IIT has formed the view that it is not customary for crisis resolution and home treatment professionals to seek medical input into their out of hours crisis assessments where these are conducted on hospital premises, most usually A&E. It is essential that all CRHT MHPs understand that their accountability and responsibility for a service user commences at the point they make the decision to accept this service user for home treatment, and that it is at this point that a care and treatment package, even if this is a short term package, needs to be agreed between the assessing professionals and the service user. In this case the MHPs did agree with the service user that she was to stay at home until assessed by a consultant psychiatrist the following morning. This was however an inadequate plan for this service user.

To assist MHPs in accurately recording their rationale for any treatment options instituted or not instituted the IIT considers that it is important that the crisis team assessment tool prompts the assessing MHPs to record the immediate care and treatment agreement/contract agreed with the service user. Where this is out of hours and there is no liaison with available medical

practitioners (registrar grade and above) then the reason for this should also be recorded. Similarly, where it is considered that medication is not necessary the rationale for this should also be recorded. The design of the assessment tool should reliably remind crisis resolution and home treatment professionals of the need for this information.

The IIT has formed the view that one of the reasons that CRHT MHPs may not be accessing medical advice out of hours is because of the variability of response they have received. LPT needs to explore this further, and to agree the minimum level of experience and qualification necessary in medical practitioners in order to provide crisis and home treatment professionals with the calibre of assessment and advice required when making decisions regarding home treatment as an alternative to admission.

Note: Although the IIT has been advised that crisis and home treatment team staff have been reminded about utilising out of hours medical staff during the assessment process, there is nothing specific in the July 2010 draft of the operational policy. If this remains absent, then LPT must make explicit its rationale for not addressing this to East Midlands SHA.

Target Audience: Executive Director of Quality & Innovation, Director of Risk Assurance, the lead clinician for the crisis resolution and home treatment service, and Service Manager for LPT crisis resolution teams.

Recommendation 7: The managers of LPT's crisis resolution and home treatment service must map out the core and specialist knowledge, skills and competencies required of mental health professionals working within the service and ensure that all of its staff meet these competencies.

What has not been evidenced in LPT is any formal consideration of the enhanced skills and knowledge required by MHPs working in crisis resolution and home treatment, and the development of a competency framework. This gap is a national one and not limited to LPT. There is no clearly defined skill and competency framework for nursing staff working in this field.

Because HSG(94)27 investigations are intended to generate local improvements, it is the IIT's recommendation that LPT develops a clearly defined and measurable competency and skills framework for all MHP's undertaking assessments, where the output of the assessment is a decision for home treatment or hospital admission. Nurses undertaking these assessments do require an enhanced set of competencies and LPT must satisfy itself that all staff engaged in the crisis resolution and home treatment assessments can practise to the required level of competency.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance, the lead clinician for the crisis resolution and home treatment service, the crisis resolution team senior mental health practitioners and the Service Manager for LPT crisis resolution teams.

Timescale: The IIT does not believe that the development of clearly defined competencies for band five, six and seven nurses will be overly challenging for LPT. Consequently LPT should be able to provide East Midlands SHA with a clearly defined action and implementation plan within six to eight weeks of this report's publication.

Recommendation 8: LPT must continue to ensure that all clinical staff are aware of issues that may affect a service user's fitness to drive, and ensure that they know what measures they can take to deliver their duty of care to the service user and also to the public.

LPT needs to consider developing its own practice policy document about the role and responsibility of all clinical practitioners in relation to the assessment of fitness to drive, their responsibilities in relation to the service user and the advice they should be providing to them where fitness to drive is questionable. Such a policy needs to be cognisant of the DVLA guidance on fitness to drive, and the General Medical Council and other professional bodies' guidance which gives clear direction regarding clinical professionals' responsibilities.

Fitness to drive as a focal topic should be a component of LPT's core and update risk assessment training, and this case could be a useful case to study.

Specifically all mental health practitioners, including medical staff, need to appreciate that any of the following may constitute fitness to drive issues:

- any significant and prolonged impairment of concentration;
- sleep deprivation;
- medication changes;
- hallucinations; and
- psychotic episodes.

The basic requirements for driving set out in *California Medicine* (September 1966, vol 105 (3), pages 197 – 200), as follows, may be useful pointers for staff to be mindful of:

- A basic minimum of strength and mobility.
- Ability to see and concentrate adequately on the roadway and traffic.
- Ability to interpret and make judgments about real or impending changes in the traffic situation.
- Knowledge of traffic laws.

Target audience: Executive Director of Quality & Innovation, Director of Risk Assurance.

Timescale: To be agreed with East Midlands Strategic Health Authority.

Recommendation 9: East Midlands Strategic Health Authority is requested to liaise with the Department of Health to determine the best way to explore with the DVLA the issue of communication with medical practitioners following its assessment of an individual's fitness to drive. The IIT recommends that whenever fitness to drive has been assessed for medical reasons and a driving licence reinstated, that both the driver's GP and the doctor who completed the medical questionnaire for the DVLA are notified.

In this case the MHSU's consultant psychiatrist between April 2006 and January 2007 was not aware that the DVLA had reinstated her licence on an ordinary basis for one year. The letter advising that this had occurred was sent to the MHSU's GP, although the consultant had completed the DVLA's medical questionnaire and had had most contact with the MHSU. Had the MHSU's consultant psychiatrist been aware of licence reinstatement, she would have been required to notify the DVLA of the MHSU's fitness to drive issues between October and November 2006. This would have resulted in further assessment by the DVLA. Although one cannot say what the outcome of this would have been, it would have been an opportunity to pay further attention to the MHSU's fitness to drive.

Target audience: Assistant Director, High Secure Services and Healthcare Governance, East Midlands SHA.

APPENDIX 1: DETAILED CHRONOLOGY OF CONTACTS BETWEEN THE MHSU AND LPT

Date	Key event	Contextual information	Risky behaviour
Background		The MHSU had 6 hospital admissions and one episode of home treatment prior to the incident in 2007. Her first hospital admission was in December 1995 (11 days), followed by admissions in January 1996 (4 days), January 1996 (2 days), August 2002 (4 days), January 2004 (18 days), and May 2005 (132 days). The MHSU had her first manic episode in 1995. All admissions until 2002 were for this. In 2002 she also experienced hypomania. In 2005 her diagnosis was quantified as bipolar affective disorder: "Current episode mania with psychotic symptoms."	The MHSU had three driving offences between October 2001 and August 2004. All were fixed penalty fines under code SP30 for speeding. Note: SP30 means that there would have been no element of dangerous driving. The fines were simple speeding fines.
27-Jan-04	Discharge from ward	`The MHSU was discharged following admission for a hypomanic episode. The admission had been for 18 days. Medications on discharge were: ❒ haloperidol 3mg tds; ❒ procyclidine 2.5mg tds; and ❒ Epilim Chrono (sodium valproate) 700mg nocte.	

Date	Key event	Contextual information	Risky behaviour
24-Feb-04	The MHSU reduced her medication	The MHSU attended her outpatient appointment (OPA). She was noted to be well with no evidence of mental illness. Her rationale for reducing her medication was because of excessive sleeping. Consequently a medication decrease of haloperidol was advised. Medication was now procyclidine 2.5mg tds, and Epilim 700mg at night, with haloperidol 1.5mg mane, 3mg afternoon and 3mg at night. The MHSU was advised to drop the afternoon dose.	
20-Apr-04	OPA on 19 April	The MHSU attended her OPA. She reported herself to be well but was noted to be over talkative and a little circumstantial. The MHSU admitted to being snappy with family and friends. The consultant psychiatrist (Cons P1) noted that her serum levels of sodium valproate were less than desired (24mmol rather than 40-120mmol per litre). Consequently the Epilim Chrono was increased to 900mg. The plan was to review the situation in 2 months.	
12-Jun-04	OPA	The MHSU attended her OPA. She was noted to be more settled in mood, not over talkative and not snappy. The MHSU admitted to having smoked a bit of weed (“a few drags”) but felt ill on it so did not want to smoke it again. Her consultant supported this thought. She was advised to have her sodium valproate levels checked and to attend at outpatients in 2-3 months’ time.	

Date	Key event	Contextual information	Risky behaviour
30-Jun-04	GP expressed concern about the MHSU	The GP made contact with Cons P1. The GP reported that the MHSU has gone rapidly downhill since moving to a larger flat 2 weeks previously. The GP also reported that the MHSU was hearing voices whispering her name in her ear. She was also noted to be suffering from acute anxiety. The MHSU also admitted to missing one dose of Epilim. The GP encouraged the MHSU to stay on her Epilim. The GP requested an urgent assessment of the MHSU. An appointment was offered for 5 July (1 week later).	The MHSU was reported to be reducing her Epilim Chrono to 700mg. She also wanted to stop her haloperidol.
07-Jul-04	OPA assessment by SHO	At the OPA the senior house officer (SHO) noted that the MHSU had not had her sodium valproate levels done as she had a fear of needles. The SHO asked her to provide a serum sample but she refused. The SHO suggested perhaps the GP could do it, again the MHSU refused and then admitted to not taking her medications for the past week. The MHSU did not believe she needed medication - she felt much better without it. The SHO noted that the MHSU justified this by telling him she had joined a new religion ("born again Christianity"). The MHSU reported experiencing a high level of spirituality. She was sleeping well and this had not happened before. A friend, was noted to be her carer. The plan was for review in 4 weeks. It is also agreed that the MHSU could stop the haloperidol but was to continue with the Epilim Chrono and also olanzapine 10mg.	Lack of insight regarding the value of her medication to maintaining mental health. Some ambivalence regarding medication: "It depends on how I am feeling and whether I take it or not."

Date	Key event	Contextual information	Risky behaviour
26-Jul-04	GP assessment	The GP assessed the MHSU on 26 July and also on 3 August. The GP noted that the MHSU had stopped her medication and did not want to start it again. The MHSU said she felt fine. The GP highlighted that the MHSU was a new patient at the practice. The GP perceived that the MHSU did have insight and believed that her behaviour might be heralding a relapse or might simply be normal optimism. The GP noted that the MHSU preferred to believe the latter. S was noted to have attended with the MHSU though the GP noted that he was not sure of the dynamics of their relationship.	
03-Nov-04	OPA	The MHSU was accompanied to her OPA by S. She was noted to be "overtly cheerful and dressed in bright jeans". Her thought content was reported to have wandered around spirituality and Jesus. Her mood subjectively was OK but objectively appeared to be high. The MHSU reported that she was fine since converting to Christianity. She admitted to not taking her medication for the last four months. The SHO tried to persuade the MHSU to take her medication but she was not to be persuaded.	The MHSU had now stopped her medication for 4 months.
03-Dec-04	GP assessment	The GP reported that the MHSU's sister called on 2 December because she was concerned about her. She reported that the MHSU believed that Jesus was in her house all of the time talking to her. She was bringing strangers into her home that she believed needed help. She was also reported to be hearing voices all the time. She had also written scriptures all over her walls and was reported to have said that "the devil killed her brother" (he died aged 13). The GP stated that he had seen the MHSU on 30 November for a foot sprain, where she seemed to be behaving appropriately but the GP did not assess her mental state during this appointment. The GP requested a domiciliary visit or community psychiatric nurse (CPN) home visit.	

Date	Key event	Contextual information	Risky behaviour
03-Dec-04	Urgent OPA	The MHSU was accompanied by S, who shared a flat with the MHSU. He also shared the same religious beliefs. The MHSU's manner was assessed as normal, and she reported doing normal activities and not consuming alcohol or illicit substances. Her sleep had been reduced over the last few weeks but she reported no ill effects from this. She was attending church three times a week. Her friend reported that the MHSU did not have any deterioration in her behaviour, mood, temper or thoughts. At assessment she was preoccupied with religious thoughts, but there was no pressure of speech or flight of ideas, and no grandiosity. S agreed to alert the GP if he noticed any deterioration in the MHSU's behaviour. The CRHT number was given in case of emergency.	
31-Jan-05	OPA	At this appointment the MHSU was found to be well. "Behaviour, mood, thoughts, perception, and cognitive functions all within normal limits. She appears realistic about her plans." The plan was to review her in two months' time.	
17-Feb-05	GP appointment	The MHSU had had a viral infection and it was noted that she had not been requesting any repeat prescriptions. The GP was writing to confirm that the MHSU had stopped her olanzapine 10mg daily and her Epilim 900mg nocte. Her mood however was noted to be stable. The last time she had ordered any medications was 22 July 2004. Consequently she had been without medication since this time.	
25-Apr-05	OPA	The MHSU was considered to have stable mental health at this assessment. "Her sleep, appetite mood and behaviour all are normal."	

Date	Key event	Contextual information	Risky behaviour
24-May-05	CRHT assessment	The MHSU was referred by her GP to the CRHT as she was very unwell. At the CRHT assessment it was noted: - “unable to engage with the MHSU - no insight and appears to be very disturbed; - refused CRHT treatment; - refused offer of admission; - unable to engage for full assessment as appears to be responding to hallucinations, unable to answer or concentrate on questions; - requires MHA (i.e. a Mental Health Act assessment)”.	
04-Oct-05	Discharged from inpatient care following 132 days of hospital admission	The MHSU had been admitted following breach of the peace. She had been behaving oddly one week prior to admission. She had threatened to kill herself and was saying on admission that God would kill her. She had also been verbally aggressive to a friend. **Note:** The MHSU's father believed she had been ill for 2 weeks prior to admission. He had witnessed her talking when no-one was present. Her friend also said the MHSU believed she was being attacked by “evil spirits and that God was going to kill her because she had not been living up to Christian standards”. The records note that the MHSU did not believe she needed her medication now that she was a born again Christian.	Verbal aggression was noted as a probable relapse indicator. The MHSU was noted to have been arrested on a number of occasions due to her illness but did not admit to any convictions.

Date	Key event	Contextual information	Risky behaviour
04-Oct-05 continued	Discharged from inpatient care following 132 days of hospital admission	Once re-medicated the MHSU made excellent progress. Her psychotic symptoms were reduced, although thoughts of the devil and being poisoned persisted. Her sleep improved and the voices faded. Her thoughts remained obsessed with religious themes. The pattern of her beliefs did not settle in the early part of her admission. Following the introduction of risperidone there was a gradual improvement in the MHSU's presentation. She stopped reporting voices and her religious beliefs became more appropriate. She remained preoccupied by religion. Following successful home leave, including two periods of one week's leave, the decision was made for discharge. On discharge from inpatient services the MHSU's medications were: ❒ Epilim Chrono - 900mg nocte; ❒ risperidone 6mg once a day; and ❒ procyclidine 2.5mg nocte. Note: the procyclidine was to be stopped in two weeks' time.	

Date	Key event	Contextual information	Risky behaviour
11-Nov-05	OPA	The MHSU was accompanied by her CPN and a student nurse. She was noted to be experiencing problems with excessive sleep and lethargy, weight gain and amenorrhoea. She was noted as not being in any relationship. She was attending a university course, was comfortable with her church activities and had been able to maintain all her functions. On examination she was "comfortable, pleasant and cheerful". It was also noted that she engaged well. There was no over- talkativeness or any pressure of speech or elation. The MHSU was noted to have amenorrhoea. Because of this and the weight gain, the consultant decided to asses her serum prolactin levels and serum valproate levels. The MHSU was advised to reduce her risperidone to 4mg per day. The next follow up was to be in 4-6 weeks.	
11-Nov-05	CPA review	See above. The next CPA review was planned for 17 February 2006. The care plan recorded was reasonably detailed and gave a clear picture of the plan of care and interventions. The risk indicators were also clearly identified along with the contingency plan. Non-compliance with medication regime. Reduced insight.	
07-Dec-05	Challenge to refusal of DLA	There was supportive communication between the MHSU's care team and the relevant council department regarding the MHSU's eligibility for Disability Living Allowance (DLA).	

Date	Key event	Contextual information	Risky behaviour
04-Jan-06	CPA review	The CPA review was brought forward as there had been some initial concerns regarding the MHSU's mental state. Three weeks prior to the CPA review, the MHSU had been experiencing high anxiety states, palpitations and sleep disturbance. She also had significant concerns regarding the loss of her Disability Living Allowance and income support. She could no longer access free medication. By time the CPA review took place, most stressors had been dealt with. The MHSU's sleep had improved, and she was flat sharing with friends. Her main concern was the amenorrhoea that continued; consequently she was requesting further reductions in her risperidone. The MHSU also highlighted that she wanted to drive again; she did not want to be dependent on others. The MHSU's father gave a positive account of his daughter's progress and he was noted to feel that she was safe to drive again at the time of this CPA. As it was now three months since the MHSU's discharge from hospital, it was agreed that Cons P1 would write to the DVLA and her insurance company advising that in his view she was now deemed fit to drive.	
13-Jan-06	Letter to DVLA	Cons P1 wrote to the DVLA.	
17-Jan-06	Letter of invite re CPA	The social worker (SW), the MHSU's father, Consultant Psychiatrist 1, the GP and the MHSU were invited to the CPA meeting on 24 March (this date was then changed to 17 March).	
03-Feb-06	Risperidone reduced to 1mg	Letter to GP from Cons P1.	

Date	Key event	Contextual information	Risky behaviour
13-Feb-06	DVLA request for completion of medical assessment form	Note: the DVLA form says: “The above named driver may be entitled to drive whilst we are awaiting your reply and this may have an impact on road safety”.	
08-Apr-06	Letter from DVLA confirming that the MHSU has a restricted licence for one year	The letter from the DVLA states that should the MHSU's mental health relapse in this 12 month period, the DVLA must be informed. The letter also says that if the patient is unable or unwilling to take advice then the medical advisor must be informed.	
18-Apr-06	First home visit by the new CPN	The MHSU had forgotten about the CPN's visit; however she was noted to be welcoming. The MHSU was also noted to be slow in her thinking and easily distracted. The MHSU advised that her friend would contact the CMHT to update them on how she was coping and to ensure consistent support. It was also noted that the MHSU was to attend the housing office with the SW. The MHSU advised the CPN that she was taking her medication but was waiting for it to be altered as discussed at the last OPA.	

Date	Key event	Contextual information	Risky behaviour
19-Apr-06	Care plan sent to GP following transfer of care from Cons P1 to Cons P2	A detailed care plan was sent to the GP. It was noted that on 12 April at the CPA handover meeting, the MHSU reported that she was drowsy during the day and needed coffee to stay awake. Her sleep was noted to be OK but she sometimes stayed up late with Bible study, and praying. She might sleep from midnight through to 10am. She also reported her eating pattern to be personal and did not wish to elaborate. The MHSU did not think she had any special religious powers such as healing powers. The MHSU believed that she was going through a trial by God. The impressions of Cons P2 at this time were that the MHSU was hypomanic but that she was "currently only just taking 1mg of risperidone as she attributes this to her over sedation in the daytime". The plan was to try and find an alternative antipsychotic whilst continuing the Epilim. The plan was also to speak with the MHSU's friend.	

Date	Key event	Contextual information	Risky behaviour
24-Apr-06 and 25-Apr-06	CRHT assessment - taken on for home treatment	The MHSU was referred to the Crisis Resolution and Home Treatment team (CRHT) by an SHO in A&E. The MHSU had been seen shouting and praying in the street. On assessment the MHSU believed that she had done something wrong and had gone against the Bible and as a consequence was asking God to forgive her. The MHSU felt she was becoming unwell but was not elated as she was not spending lots of money. She was also hearing voices of a derogatory nature calling her names. Following this initial assessment the MHSU was assessed on 25 April by the consultant for CRHT (Cons P3) and accepted for home treatment. During CRHT contact it was felt that the therapeutic dose of risperidone was 4mg for the MHSU. It is noted that on this dose her sleep improved immediately, however her auditory hallucinations persisted as did her religious concerns for the duration of CRHT input. The plan was to have contact with the MHSU twice a day to establish medication compliance. Medications were: - risperidone 4mg; - procyclidine 5mg; and - Epilim Chrono 900mg.	Disinhibited behaviour when unwell.

Date	Key event	Contextual information	Risky behaviour
25-Apr-06 (cont)	Home visit	When the MHSU was seen at home by Cons P3 the records note that she said she didn't know if she had slept at all the previous night, and that she had shouted out of the window yesterday due to being “on trial as a born again Christian”. The next visit from the CRHT was planned for the same day between six and seven o’clock in the evening. When medication was discussed the MHSU was not keen on taking more risperidone. The MHSU shared with the CRHT that she was worried about the sedative effects of medication and losing concentration which meant she could not drive. The issue of admission was highlighted if she was non-compliant with medication. The MHSU then agreed to take the 4mg dose of risperidone rather than be admitted.	
26-Apr-06	CPN notified about referral to CRHT	The MHSU’s CPN received notification from the CRHT that the MHSU had been referred to them from A&E.	
26-Apr-06	Home visit by CRHT mental health professional (MHP)	At the time of this CRHT MHP's visit, the MHSU's father was present. He confirmed that he had noticed deterioration in his daughter's mental health. The MHP noted that there was significant religious iconography present in the MHSU's flat. The MHP noted a preoccupation with religion and that the MHSU asked him if he was a Christian. The MHSU was noted to have taken her medication at this visit.	

Date	Key event	Contextual information	Risky behaviour
27-Apr-06	Home visits by CRHT MHP	At the first home visit the MHSU could not locate her risperidone. However she said she was willing to take it. She advised that her friend had put her medication somewhere. At the evening visit one risperidone tablet was located and the visiting MHP was advised by the MHSU that her friend had the rest at his house and would bring them around tomorrow.	
28-Apr-06	Telephone call from the CPN	The MHSU's CPN alerted the CRHT to concerns raised by the MHSU's friend. He was worried that the MHSU was not engaging with the CRHT. The CPN also advised the CRHT that during her conversation with S, the MHSU retracted her prior consent that she (the CPN) could speak with S.	The MHSU was present during the call and became irritated and cross stating that she did not want S to talk with the CPN. (One week previously the MHSU had stated that she did.) She was also displaying a lack of insight as to how unwell she was.
29-Apr-06	Home visit by CRHT MHP	The CRHT noted that the friend of the MHSU had contacted the CPN. He had expressed concern about the MHSU and her preoccupation with the scriptures. Both he and the church elders felt that the MHSU's preoccupation was excessive and detrimental. S also was reported to have advised the CPN that he did not believe that the MHSU was taking advice from anyone at present. S also advised that the MHSU was not getting any rest. The CRHT were advised of the MHSU's response during the telephone call to the CPN. **Note:** There is a discrepancy by one day in the dates recorded by the CMHT and the CRHT regarding this. The IIT does not consider this to be significant.	

Date	Key event	Contextual information	Risky behaviour
29-Apr-06 to 01-May-06	Home visits by CRHT MHPs	CRHT visits had continued twice a day until 29 April. They were to be once a day from 30 April. The MHSU was variable in her attitude to her medication over this time. On 1 May she advised that when she next saw Cons P2 she would ask for a medication review as the risperidone was making her drowsy. The MHSU reported that in the morning she struggled, and continued to feel tired and drowsy throughout the day. The MHSU was advised why her medication was important, and that it would be reviewed towards the end of the week. The records note that the MHSU was actively responding to voices during the assessment. The MHSU asked for two visits the following day because she was "scared of the content of the voices. The voices are telling her they will kill her, she is going to die, telling her not to listen to CRHT, challenging her in a derogatory manner."	The MHSU again talked of having her risperidone reviewed by Cons P2 when she next saw her.
02-May-06	Home visit by CRHT MHP	The MHSU was noted to be calmer with a reduction in the voices. It was also noted that she believed the risperidone was helping. The voices she heard however continued to be distressing. The next visit was agreed for 6.30pm. The MHSU's CPN also made contact with the CRHT for an update on the MHSU's situation. In particular the CPN was anxious to know if the MHSU was again sleeping in her bed.	

Date	Key event	Contextual information	Risky behaviour
05-May-06	CRHT multi disciplinary review at home	The plan was to continue to visit the MHSU daily and to monitor her levels of drowsiness. Note: on 6 May it was noted that the MHSU seemed to be trying to avoid visits at the time her medicines were due. Medication was discussed including the use of other anti-psychotics. It was agreed that the MHSU would split her risperidone into two 2mg doses to see if this helped alleviate the morning drowsiness.	The MHSU was concerned about driving due to sedation and lack of concentration. The impression given in the clinical records is that the MHSU was not driving at this time, as the CRHT gave her a lift to her church after the meeting at her request.
06-May-06 to 08-May-06	Home visit by CRHT MHP	Lethargy and lack of concentration were reported themes for the MHSU even when she did not appear drowsy to the CRHT team. On 8 May the MHSU reported continuing to hear voices, not as loud as before but they "told her that he is going to kill her by squeezing her heart out". She says she did not recognise any of the voices. She was advised to call CRHT overnight if she heard voices that frightened her. The purpose of calling CRHT was to provide distraction from the voices. On the evening of 8 May the MHSU contacted CRHT with tightness in her chest. She was concerned that it was the risperidone that was causing it and did not want to take it anymore, but would try something else.	The MHSU told the MHP on 8 May that she could not drive due to her medication effects. She was concerned about this. She had to rely on her friends to drive her.

Date	Key event	Contextual information	Risky behaviour
09–May-06 to 17-May-06		The CRHT continued with daily visits. The MHSU continued to complain of the sedative effects of her medication, and her experiences of voices.	
18-May-06	Home visit by CRHT MHP and MDT review	The plan now was for visits every other day. The MHSU advised the MHP that she had driven her car. The MHSU stated that “she feels alert enough to drive. Although challenged due to experiencing voices / plus her medication, the MHSU appeared adamant that she was competent”. The issue of driving was highlighted at the multidisciplinary team (MDT) review. The MHSU was advised by phone that she must not drive until further notice. (Note: between then and the visit on 1 June, there is no documentation around confirmation being sought that the MHSU was not driving.) The MHSU was informed by phone of the advice to not to drive again. She was noted not to be happy about this. She spoke with Cons P3 about it who reiterated the advice that she was not to drive at all until he had assessed her.	The MHSU believed herself to be competent to drive even though it was apparent to the CRHT professionals that she was not.
20-May-06	Home visit	The MHSU was seen at home in the morning. She did not appear distracted or bothered by voices. She appeared bright in mood. The next visit was planned for 22 May.	

Date	Key event	Contextual information	Risky behaviour
26-May-06	Telephone contact with MHSU by CPN	The MHSU was concerned regarding her eligibility for refunded charges for her prescriptions. She told her CPN that “she had been told by someone at the CRHT that she should not have to pay for prescriptions”. However she was also advised that until she had an exemption certificate she must pay. Welfare Rights was sending her this form. The CRHT was informed of the correct position by the CPN.	
01-Jun-06	Home visit by CRHT	The CRHT was beginning to plan for discharging the MHSU back to her CMHT, and the care of her CPN and Cons P2. It was clear that the MHSU had financial concerns at this time and the CRHT MHP advised that she would liaise with the CPN to see what, if any, extra assistance was needed. The MHSU again raised the driving issue. She was concerned at not being able to drive when she felt OK to do so. The advice was reiterated about not driving. The MHSU was also advised to contact her insurance company to see if her insurance could be frozen. The MHP's plan was to discuss the MHSU with her CPN. She did so that afternoon. The MHP discussed with the CPN the MHSU's financial concerns and also the issue of her not driving but wanting to. The CPN advised that she was unaware that the MHSU had been advised not to drive. It was noted by the CPN that the only person who could advise whether the MHSU can commence driving again was a consultant psychiatrist. The records show that the MHP agreed to raise this point with Cons P3.	

Date	Key event	Contextual information	Risky behaviour
05-Jun-06	CRHT discharge to the CMHT	See above. The discharge form completed identified: - why the MHSU was taken on for home treatment; - why the MHSU was behaving in the way she was; - the increase in her medication to risperidone 4mg; - that the MHSU had been advised to stop driving until the situation was reviewed by CRHT or her own treatment team; -that the CRHT considered the therapeutic dose of her medication was 4mg of risperidone; - that the MHSU's sleep improved immediately with this dose; - that auditory hallucinations and religious concerns persisted; and that - on discharge that the MHSU's condition was less intense and her symptoms reduced	
06-Jun-06 and 08-Jun-06		The CMHT CPN made a telephone call to the CRHT checking that the MHSU had been discharged and invited the CRHT to attend the planned CPA review on 13 June. This was further followed up with a formal invitation to Cons P3 on 8 June, where the letter states "a representative from the Crisis Resolution Team is welcome to attend this meeting".	

Date	Key event	Contextual information	Risky behaviour
13-Jun-06	CPA review - Enhanced CPA	The CPA review document notes that the MHSU had been asked to notify the DVLA about the change in her mental health and that she was not to drive again until it reached a decision. It was noted that although the MHSU had experienced a reduction in persecutory ideas since commencing 4mg risperidone, she did feel fatigued with some difficulty in her concentration. It was noted that the MHSU found home treatment helpful, especially as it had avoided admission which had occurred on previous occasions. The plan was: ❒ for Welfare Rights to assist with DLA review; ❒ for the SW to assist with the housing and benefits dispute; ❒ for the CPN to visit every other week and assist with activities; and ❒ for the next OPA to take place in one month. At the time of this CPA review the MHSU was noted to be “concordant” with her medication. The review also highlighted that the MHSU lived alone. **Relapse/increasing risk indicators were noted as:** -pressure of speech; -thought disorder; - easily distracted; - religious delusional ideation; - thoughts of wanting to harm herself (kill); - verbal aggression; - irritability; and - paranoid thoughts about her food being poisoned.	

Date	Key event	Contextual information	Risky behaviour
13-Jun-06 continued		**Risk reduction factors:** - medication compliance; - engagement with the CMHT; and - stability at home. **Contingency plan:** - contact GP and responsible medical officer (RMO); -increase in CPN contact; and -consider referral to CRHT. **Crisis plan:** - Fast track admission or CRHT; and - Mental Health Act assessment if necessary.	
23-Jun-06	Home visit	The MHSU was noted to be eating and sleeping well. She was taking her medications as prescribed. However, she was complaining of some dizziness and over sedation. It was also noted that she had an outpatient appointment with Cons P2), for review of her medication. It was also noted that she was going on holiday to Devon with her father and her friend.	
06-Jul-06	Telephone contact with MHSU	The MHSU was not in for her planned home visit on 5 July. During a telephone call the MHSU shared her belief that Cons P2 would consent to her driving again. This was in spite of it being explained a number of times to the MHSU that she must wait for the DVLA's decision regarding her licence.	

Date	Key event	Contextual information	Risky behaviour
12-Jul-06	Letter to welfare officer and MHSU seen by CPN	Cons P2 confirmed that the MHSU had a bi-polar disorder and was at risk of impulsive behaviour and self harm. The letter noted that she could be unstable and that she had required a hospital admission and home treatment in the last 12 months. The letter noted that the MHSU was not aware when her mental health deteriorated. She could have disruptive behaviour when suffering from mania. Cons P2 confirmed that the MHSU required constant supervision. The CPN saw the MHSU immediately prior to an OPA. The CPN noted that the MHSU was more settled, and more able to articulate her concerns. There was no reference to religious beliefs. The CPN noted that the MHSU had completed her first distance learning module in computing. The CPN also noted that the MHSU was troubled by side effects of her medication, namely amenorrhoea, light-headedness and hair loss. This was discussed with Cons P2 who advised that the MHSU would be compromising her mental health if changes in medication were insisted upon at this time. However, if the MHSU remained stable then they might be able to review the medications at a later date.	Impulsive behaviour and self harm. Unaware when her mental health deteriorated.

Date	Key event	Contextual information	Risky behaviour
12-Jul-06	OPA	A letter from Cons P2 to the GP after this OPA noted that the MHSU was the “best I have seen her since taking over her care in March”. The clinical records also note that the MHSU was calm, displayed no inappropriate giggling, and her speech was normal in form, rate and volume, with no over-religious content. Her mood seemed fine and euthymic and she reported no depression. She was noted to be sleeping well. It was noted that she did experience infrequent and faint auditory hallucinations and was not troubled by these. The MHSU was also noted to remain reluctant to take medication as she was troubled by side effects. She had amenorrhoea, some hair loss, some postural hypotension, and a feeling of “cloudiness in her brain” in the morning. However she was agreeable to continue on her current doses of medication for a month or two longer.	Self neglect, lack of insight, verbal aggression, impulsivity, no risk of harm to others.
09-Aug-06	The CPN chased up the MHSU's Disability Living Allowance appeal.	The MHSU’s CPN underlined to Welfare Rights the gravity of the situation for the MHSU as she was in dire financial straits.	

Date	Key event	Contextual information	Risky behaviour
15-Aug-06	OPA	Some evidence of hypermania was noted at this OPA. The MHSU was noted to be laughing loudly, her speech was a little pressured at times, and she was talking quite a lot about issues to do with spiritual warfare. Auditory hallucinations remained faint and she continued to sleep well. The MHSU was noted to be slightly chaotic in functioning but managing things reasonably well with help. "A decrease in medication would be foolish but the MHSU would be unlikely to accept an increase in medication as she only takes what she is on currently with some reluctance. " Next appointment was planned for 6 weeks.	
25-Aug-06	The MHSU fractured her left foot	The MHSU was well supported by family and friends. The CPN was going to collect a supply of medication for the MHSU.	
21-Sep-06	Home visit	The CPN noted at the visit that the MHSU was stable in mood and functioning. It was also noted that the MHSU reported some drowsiness and poor concentration. It was also noted that the MHSU was troubled by a council tax letter which was difficult to understand. Social worker support was to be provided with this.	

Date	Key event	Contextual information	Risky behaviour
25-Sep-06	Home Visit	The CPN noted that the MHSU immediately burst into tears on her arrival. The MHSU said she felt lonely and troubled. She reported hearing persecutory voices saying derogatory things about her, and violent things to her e.g. “chop off your arms”. She was also hearing swear words and the voices were telling her not to tell her CPN. It was noted that the MHSU would be seen by the SW on the Tuesday and the Friday. It is also noted that her plaster cast was now off. The MHSU said she was compliant with her medication.	The MHSU had experienced an increase in the hearing of voices, and these were violent and derogatory in nature. Also the voices were telling her not to disclose to her CPN. The MHSU admitted hearing voices for a while but put the voices down to spiritual warfare and not her mental illness. She believed she could “pray her way out of” this.
29-Sep-06	OPA	The MHSU was accompanied by her CPN. It was noted that the MHSU's mood had improved since 25 September. However the MHSU expressed a wish to change her medication, owing to her amenorrhoea and the ongoing sedation with risperidone. A decision was made to commence the MHSU on quetiapine with a gradual increasing dosage with a view to stopping the risperidone in the week following commencement.	
04-Oct-06	Home visit	The MHSU's friend was present. Due to ongoing problems with medication it was agreed that the CPN would liaise with Cons P2. It was noted that the MHSU was not able to increase her quetiapine as instructed due to over-sedation (the MHSU reported).	

Date	Key event	Contextual information	Risky behaviour
05-Oct-06	OPA	The diagnosis at this time had changed to “bipolar currently mixed affective state”. Medications had changed. Risperidone had been changed to quetiapine 150mg twice a day. Epilim Chrono remained at 900mg once a day. The MHSU was noted to be reasonably well and not posing a risk to self or others. She was being monitored for signs of neglect. Her mental state was noted to have been “somewhat unsteady recently”. Dips in her mood had been accompanied by second person auditory hallucinations of a distressing nature. The MHSU asked about the change in medication. The MHSU voiced concerns about the increase in hallucinations she experienced and also the amenorrhoea she had on risperidone. The MHSU also attributed a lack of concentration to risperidone but her consultant considered that this was more a feature of hypomania rather than the medication. Risperidone was to stop from 7 October. Quetiapine 150mg was to continue twice a day from this date. The MHSU agreed to contact the SW if there were any problems as the CPN would be away the following week.	

Date	Key event	Contextual information	Risky behaviour
19-Oct-06	Home visit	The MHSU was noted to be flat in mood. She was preoccupied and responding to auditory hallucinations. She was noted to be feeling low and had not been able to pray owing to poor concentration. It was also noted that the MHSU was experiencing physical anxiety. The CPN also noted that the MHSU had not been taking the quetiapine as prescribed. She had been taking 225mg nocte rather than the 150mg bd as prescribed. The MHSU was advised about taking the quetiapine at 12 hour intervals and why she should do this. The CPN arranged to visit again the following day.	Very poor concentration that interfered with every day activities.
20-Oct-06	Home visit	The MHSU's mood was noted to be much better and the MHSU reported taking the medication as instructed. Her concentration was noted to be better, she was able to pray, and was able to go out with a friend. The MHSU continued to be troubled by a voice which she interpreted as the devil.	

Date	Key event	Contextual information	Risky behaviour
23–Oct-06 to 31-Oct-06	Home visit, telephone call and accompaniment to OPA	The CPN records note that the MHSU remained preoccupied with voices. The records also note that the MHSU responded to them by praying out loud. The MHSU was noted to continue with feelings of persecution. The CPN planned enhanced contact to establish a pattern of regular medication. The MHSU had not taken her medications as prescribed on 23 October, but took them in the presence of the CPN.	Praying out loud when troubled by voices.
31-Oct-06	OPA	At this assessment it was noted that the MHSU was at some increased risk of neglect if her mental state deteriorated further. Close monitoring was being undertaken by the CPN. There were no suicidal thoughts or thoughts of harm to others. The MHSU reported occasionally hearing a third person auditory hallucination and Cons P2 noted that the MHSU's mood was neither high or low, which raised the possibility of a schizoaffective process. However, the consultant also noted that this would not have made a difference to her clinical management. The plan was to gently persuade the MHSU to increase her quetiapine over time. The letter from Cons P2 to the GP notes that the MHSU was in the process of changing over her medication from risperidone to quetiapine, however it was also noted that she was not taking anything approaching a full dose of quetiapine. Consequently she was troubled by hallucinations and when the consultant spoke with her, the hallucinations disrupted the	Deterioration in mental state and at risk of neglect if further deterioration occurred.

		MHSU's conversation with her.	
Date	**Key event**	**Contextual information**	**Risky behaviour**
01-Nov-06	DLA awarded	Welfare Rights confirmed that the MHSU had been awarded high rate DLA care and low rate mobility allowances. Housing, council tax and income support forms had been completed.	
09-Nov-06 (date in records appears to be wrong. The date should be 3 Nov)	Telephone contact	The original appointment was on 3 November but the MHSU had made a mistake with her calendar and was not available. The CPN tried to call and left the MHSU a message to make contact. The CPN's notes say “if attempts to contact the MHSU fail [the CPN] will put her on alert with the CRHT”. That evening the MHSU is placed on alert with CRHT. The MHSU's father did not know where she was. The MHSU's friend was not available.	There was no evidence that the MHSU was collecting her prescriptions from her GP surgery.
08-Nov-06	Home visit	The MHSU was noted to continue to be troubled by voices but maintained that church was helpful to her. Her home was noted to be chaotic. The MHSU was offered CRHT input but declined this at this time. The MHSU's father was in Italy for three weeks, consequently the CPN suggested an additional home visit that week which the MHSU agreed to. The MHSU suggested to her CPN that she may have been better on risperidone, however, she was not taking the prescribed amount of quetiapine. The MHSU agreed to a blister pack system to be set up to assist in the organisation of her medications.	

Date	Key event	Contextual information	Risky behaviour
10-Nov-06	Home visit	The MHSU was in bed when the CPN called. She reported not having got to bed until about 1am. She looked perplexed and distracted. The CPN discussed attending a study day for voice hearers with the MHSU. The MHSU gave the impression of being keen. She also asked the CPN if she would go with her. The next visit was planned for 14 November.	
14-Nov-06	Home visit - unsuccessful	The MHSU was not at home for the scheduled visit. A visiting card was left by the CPN advising that she would call again on 17 November. On this day the CPN arranged for blister pack collection for Thursday with the pharmacy.	
17-Nov-06	Home visit	The MHSU was woken up by the visit (11.30am). She appeared less preoccupied and more able to concentrate. Although religious preoccupation was evident, its content was more in context with the conversation. The MHSU had not collected her medications as instructed. The CPN therefore assisted in this to try and establish a more regular pattern with the MHSU.	

Date	Key event	Contextual information	Risky behaviour
21-Nov-06	OPA	The MHSU was noted to be hypomanic at this time. Recommended medication was sodium valproate (Epilim Chrono) 900mg and quetiapine 150mg twice a day. However it was also noted that the MHSU was only taking 100-150mg of quetiapine at night. The MHSU was noted to be slightly less chaotic and less self neglecting at this assessment. The consultant also noted that the MHSU was not as low in mood as she had been approximately three weeks previously. The MHSU's speech was fluent and elevated. She was saying things like: "I am blessed and favoured". She was "laughing loudly". The MHSU was noted, as usual, to attribute her improvement to praying and meditating on God's word. The consultant noted that the MHSU was talking a lot about religious things and her religious interpretation of events. **Note**: This reduced when she was more well. The consultant noted that the MHSU was not fully compliant with her medication but "perhaps is taking medication more regularly than she was three weeks ago". The consultant also noted that at this time "she is not ill enough to be compulsorily treated at present".	

Date	Key event	Contextual information	Risky behaviour
12-Dec-06	OPA	The MHSU was noted to remain hypomanic. Interventions noted were an increase in CPN follow up to weekly and also attendance at the Hearing Voices Network group. The MHSU was noted to be “hardly” experiencing auditory hallucinations at all. Neither was she troubled by “evil spirits” or hearing God's voice. She was noted to appear quite relaxed in clinic. Cons P2 noted that the MHSU had said she was willing to reconsider her medication regime after Christmas. It was also noted that the MHSU's view was “still that the root of her problem is spiritual warfare”. The letter to the GP noted that the MHSU was consistently taking quetiapine 150mg nocte and sodium valproate 900mg nocte. It was also noted that her consultant psychiatrist would like her to take a higher dose of quetiapine but was pleased that the MHSU was at least taking a regular dose, even if this was lower than the optimal dose.	There was a noted lapse of concentration where the MHSU overfilled her bath.
28-Nov-06	Home visit - unsuccessful	The MHSU was not available for the scheduled visit. The CPN left a calling card asking the MHSU to make telephone contact.	

Date	Key event	Contextual information	Risky behaviour
19-Dec-06	Home visit	The MHSU was noted to be tired. She was not sleeping until the early hours. Her flat was noted to be chaotic. The MHSU put this down to the pressure of Christmas. The CPN noted that no hallucinations were evident and that the MHSU remained non-compliant with her medications. The MHSU was only taking her medication at night.	
27-Dec-06	Home visit	No evidence of thought disorder noted, nor of hallucinations. The MHSU's flat remained chaotic. The MHSU was noted to be running against the clock all of the time. Her behaviour was quite impulsive at present. The CPN would collect the MHSU's medication as she had not done so.	
05-Jan-07	Home visit - unsuccessful	The CPN had contacted the MHSU 30 minutes prior to her arrival to check that she was in, but received no response when she knocked on the door. The CPN then tried to call her but was not able to elicit a response on the MHSU's phone. When she called later that day, the MHSU said that she had fallen asleep as she had not gone to sleep until the early hours of the morning. She slept through the CPN's knocking. The MHSU acknowledged the return of her voices and told the CPN that she was going to church to deal with it that evening. It was agreed that the SW would make telephone contact on Monday. The MHSU was encouraged to take her medication at an earlier time that evening (10pm). She was encouraged to try and establish a regular pattern of the time she took her medication.	

Date	Key event	Contextual information	Risky behaviour
08-Jan-07	Telephone contact (SW)	The SW noted that the CPN had requested telephone contact with the MHSU on Wednesday to ensure that the MHSU was taking her medications. The SW agreed to do this and to visit her the following week.	
10-Jan-07	Telephone contact	The SW asked the MHSU whether she had collected her medication. The MHSU told the SW that she had forgotten and that she had only just woken up (12pm). She told the SW that she would get ready and collect her medication that afternoon. The SW recorded that he asked the MHSU whether she was having trouble with her sleep. The MHSU was noted to have denied this and said that she had been up late studying. She was noted to say that she was well and denied hearing voices. She did however complain that the medication was affecting her concentration. The SW reminded the MHSU of their appointment to meet the following week.	
11-Jan-07	Telephone contact	The SW called the MHSU to check whether she had collected her medication. The MHSU confirmed that she had and that she would see the SW the following week.	

Date	Key event	Contextual information	Risky behaviour
17-Jan-07	Home visit	The SW noted that the MHSU was in good spirits. She had forgotten his visit and had just woken up when he arrived. It was noted that the MHSU told the SW that she had been up late the night before celebrating her birthday with friends. She was reported to have enjoyed the celebration and was pleased with her presents. The MHSU revealed that she was planning to go to her niece's birthday and she and the SW discussed an appropriate present for her. The SW checked the medication blister pack. This showed that medications were being taken. The MHSU said that she heard the odd voice but it was only a whisper so she was not distressed by it. The SW asked the MHSU whether she wanted to meet with him next week. She advised that she would prefer a telephone call as she had a busy week. The SW also arranged to collect her to take her to her planned OPA with Cons P2 on 30 January.	
24-Jan-07	Telephone call	The MHSU was on her way out when the SW called. He reminded her to collect her medication. The MHSU advised that she was going to do this on her way into town as she was going shopping. It was also noted that the MHSU "stated that she was well and had no problems". The SW reminded her that he would pick her up at 10am on 30 January for her OPA.	

Date	Key event	Contextual information	Risky behaviour
29-Jan-07	Telephone call to SW from Deliberate Self Harm (DSH) team	The SW noted that the DSH tried to contact him in the CPN's absence (she was on holiday). He was however on a ward round with Cons P2. He therefore called the DSH MHP after this had finished. The DSH MHP advised the SW that the MHSU had presented in A&E after taking six quetiapine. She also advised that the MHSU was not talking coherently and did not appear mentally well. The SW discussed the situation with Cons P2. Consequently the SW relayed to the DSH team that it needed to refer the MHSU to the CRHT for assessment. He told the DSH MHP that they were very concerned as it was unusual for the MHSU to present in the manner described (i.e. not talking and taking too many tablets). The SW also contacted the CRHT triage nurse and asked her to leave a message for him at the CMHT base regarding the outcome of the referral. The records also note that he advised CRHT that Consultant Psychiatrist 2 would consent to admission if necessary.	
29-Jan-07	Triage for CRHT	The CRHT was contacted by the DSH team regarding the MHSU and assessment with a view to "probable admission". The data on the triage form is unremarkable and conveys no level of concern at all about the MHSU.	

APPENDIX 2 16 BEST PRACTICE POINTS FOR EFFECTIVE RISK MANAGEMENT[32]

1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgment.

Fundamentals

2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.

3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.

4. Risk management must be built on recognition of the service user's strengths and should emphasise recovery.

5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.

Basic ideas in risk management

6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

8. Knowledge and understanding of mental health legislation is an important component of risk management.

9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

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[32] Department of Health (2007) "*Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*."

Best practice in managing risk
10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgment approach.

11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

Working with service users and carers
12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

Individual practice and team working
14. Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.

15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.

16. A risk management plan is only as good as the time and effort put into communicating its findings to others.

APPENDIX 3 THE GENERAL MEDICAL COUNCIL'S SUPPLEMENTARY GUIDANCE "*CONFIDENTIALITY: REPORTING CONCERNS ABOUT PATIENTS TO THE DVLA OR DVA".*

"1 In our *Confidentiality* guidance, we advise that:
36 There is a clear public good in having a confidential medical service. The fact that people are encouraged to seek advice and treatment, including for communicable diseases, benefits society as a whole as well as the individual. Confidential medical care is recognised in law as being in the public interest. However, there can also be a public interest in disclosing information:
to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime; or to enable medical research, education or other secondary uses of information that will benefit society over time.

37 Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm, both to the patient and to the overall trust between doctors and patients, arising from the release of that information.

53 Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.

2 The Driver and Vehicle and Licensing Agency (DVLA) and Driver and Vehicle Agency (DVA) are legally responsible for deciding if a person is medically unfit to drive. This means they need to know if a driving licence holder has a condition or is undergoing treatment that may now, or in the future, affect their safety as a driver.

3 You should seek the advice of an experienced colleague or the DVLA or DVA's medical adviser if you are not sure whether a patient may be unfit to drive. You should keep under review any decision that they are fit, particularly if the patient's condition or treatments change. The DVLA's publication "*For medical practitioners – at a glance guide to the current medical standards of fitness to drive*" includes information about a variety of disorders and conditions that can impair a patient's fitness to drive.

4 The driver is legally responsible for informing the DVLA or DVA about such a condition or treatment. However, if a patient has such a condition, you should explain to the patient:

(a) that the condition may affect their ability to drive (if the patient is incapable of understanding this advice, for example, because of dementia, you should inform the DVLA or DVA immediately), and

(b) that they have a legal duty to inform the DVLA or DVA about the condition.

5 If a patient refuses to accept the diagnosis, or the effect of the condition on their ability to drive, you can suggest that they seek a second opinion, and help arrange for them to do so. You should advise the patient not to drive in the meantime.

6 If a patient continues to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. As long as the patient agrees, you may discuss your concerns with their relatives, friends or carers.

7 If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should contact the DVLA or DVA immediately and disclose any relevant medical information, in confidence, to the medical adviser.

8 Before contacting the DVLA or DVA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing once you have done so.

APPENDIX 4: INVESTIGATION METHODOLOGY

The investigation methodology was structured and embraced the key phases detailed in the National Patient Safety Agency's root cause analysis e-learning toolkit. Key activities were:

- Critical appraisal of the MHSU's clinical records and the identification of areas that the IIT needed to understand better.
- Document analysis.
- Face-to-face and telephone interviews and discussions with staff working in LPT and the local housing association.
- Obtaining written information relating to the provision of information to carers.
- Liaison with Leicestershire Constabulary.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

APPENDIX 5 SOURCES OF INFORMATION USED TO INFORM THE INVESTIGATION'S FINDINGS

The sources of information used to inform the investigation's findings were:

- The MHSU's mental health records.
- The original internal investigation report commissioned by LPT.
- A meeting with the author of the LPT's internal investigation report.
- A meeting with the MHSU's father.
- A meeting with the family of the victims.
- Email and written correspondence from Leicestershire Constabulary.
- Relevant press coverage at the time.

The IIT also conducted one-to-one interviews with:

- The MHSU's consultant psychiatrist (Cons P2).
- The consultant psychiatrist and the manager of the Psychiatric Liaison Team.
- The MHSU's community psychiatric nurse from 2006 – 2007.
- The MHPs who undertook the DSH assessment.
- The MHPs who conducted the crisis resolution and home treatment assessment.
- The investigating officer for Leicestershire Constabulary.

It had telephone communication with:

- The MHSU's social worker from 2006 – 2007.

It obtained written information from:

- The DVLA.

It viewed LMHTT policy documents relating to:

- the Care Programme Approach
- incident investigation
- "*Being open*"
- CMHT operational policy
- Crisis Resolution and Home Treatment Team operational policy.

APPENDIX 6 GLOSSARY

The Care Programme Approach (CPA)[33]

CPA is the framework for good practice in the delivery of mental health services. In early 2008 the "*Refocusing the Care Programme Approach: policy and positive practice*" document was published[34]. This made changes to the existing Care Programme Approach.

One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, the principles and values do. CPA still aims to ensure that services will work closely together to meet your identified needs and support you in your recovery. If you have a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When your needs have been identified and agreed a plan for how to meet them will be drawn up and a care coordinator will be appointed. You and your views will be central throughout the care and recovery process.

There are four elements to the Care Programme Approach:

- Assessment – this is how your health and social care needs are identified.
- Care co-ordinator – someone is appointed to oversee the production and delivery of your care plan, keep in contact with you, and ensure good communication between all those involved in your care.
- Care plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of your care and support.
- Evaluation and review – your care plan will be regularly reviewed with you to ensure that the intended outcomes are being achieved and if not that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as "enhanced CPA".

Risk Assessment

Risk assessment and risk management should be part of the routine care provided to a mental health service user. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However the general principles of risk assessment and risk management rely on undertaking an assessment and identifying aspects of an individual's behaviour and lifestyle that might pose a risk to self, or to others,

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[33] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php

[34] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

and to the qualification of that risk where possible. Once risks are identified it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

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