Hampshire County Council

Adults' Services Sub-Committee - Social Services Committee

1 December 2000

Report of The Independent Inquiry into The Treatment and Care of Phillip John Craigie

Report of the Director of Social Services

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1 Summary

1.1 This report advises Members of the findings, recommendations and action plan of the Independent Inquiry into the Treatment and Care of Phillip John Craigie. The Inquiry concerned the killing of a man in a driving accident. Mr Craigie was subsequently convicted of causing death by reckless driving and detained in hospital with a restriction order under the Mental Health Act 1983.

1.2 The Inquiry concluded that that the events resulting in the death of another car driver could not have been foreseen. The Inquiry made five recommendations concerning risk assessment and the need to provide a satisfactory place of safety in a hospital for people detained by the police under the Mental Health Act. An action plan has been agreed by Portsmouth and South East Hampshire Health Authority, Portsmouth Community Health Care Trust and Hampshire County Council Social Services Department.

2 Introduction

2.1 On 28 January 2000 at Winchester Crown Court Phillip John Craigie pleaded guilty to a charge of causing death by reckless driving and two charges of dangerous driving. He was made the subject of a hospital order under section 37 of the Mental Health Act 1983 and to a restriction order without limit of time under section 41 of that Act. The charges arose out of events on 18 March 1999, which resulted in the death of another car driver.

2.2 Members were advised of the outcome of a confidential inquiry into the case on 7 April 2000, and that an Independent Inquiry according to Department of Health guidelines was required, now that Mr Craigie had been dealt with by the Courts. The current report is the outcome of that Inquiry. It was jointly commissioned by Portsmouth and South East Hampshire Health Authority and Hampshire County Council and published 18 October 2000.

3 The Inquiry Report

3.1 A copy of the Inquiry report has been placed in the Members Library. The Action Plan is enclosed with this Committee Report as an appendix.

3.2 The brief facts of the case are as follows:

On 17 March 1999 Mr Craigie was assessed under the Mental Health Act 1983 by a Consultant Psychiatrist, Dr Caesar, and a Hampshire Social Services Department Approved Social Worker (ASW) Mr Glenn. The assessment took place at the Central Police Station in Portsmouth, where Mr Craigie was being held under section 136 Mental Health Act 1983. This section provides the police with the power to remove a person to a place of safety if they find in a public place a person who appears to be suffering from a mental disorder and is in immediate need of care of control.

3.3 Mr Craigie was not previously known to the specialist mental health services. The conclusion of the assessment by Dr Caesar and Mr Glenn was that Mr Craigie did not need to be detained under the Mental Health Act, but did need to be engaged into treatment. The plan included medication, psychiatric follow up and support from the social services department. Mr Craigie returned to his family home with his parents.

3.4 On 18 March, following a series of events detailed in the Inquiry report, Mr Craigie drove his car at high speed and crashed into a stationary car at traffic lights. The driver of the stationary car, Mr David Close, was killed. Mr Craigie was taken to hospital, and on 19 March was re-assessed by Dr Caesar, a police surgeon and the ASW, Mr Glenn. Mr Glenn made an application for Mr Craigie to be compulsorily detained in hospital under section 3 Mental Health Act 1983.

4 Findings

The findings of the Inquiry included the following:
(The full findings are found in Section 12 of the Inquiry Report)

i. The decision not to detain Mr Craigie under the Mental Health Act on 17 March 1999 cannot reasonably be criticised.

ii. If warnings were given to Mr Craigie and his family about driving or using dangerous machinery they were insufficient.

iii.Mr Craigie's needs were treated suitably, and that "on the evidence available on 17 March nobody could have foreseen the alarming, disastrous and tragic events of the following evening".

iv. There were minor criticisms of the failure to successfully contact the GP after the assessment on 17 March, although it is recognised that this would have added little to the assessment.

v. Advice from the DVLA was issued in July 1999 after the current incident, recommending that a person is advised to stop driving immediately and to notify the DVLA if their mental state is seriously

unstable, medication is likely to impair safe driving, or if the patient is not compliant with essential medication.

vi. Dr Caesar or Mr Glenn cannot be reasonably criticised for not having given clear advice to Mr Craigie or his parents.

vii. The place of safety arrangements under which Mr Craigie was detained on 17 March were profoundly unsatisfactory. The Mental Health Act Commission(and the Home Office, though not specifically noted in the report) recommend that a place of safety should be provided in a hospital rather than police station.

5 Inquiry recommendations and action plan

5.1 The Inquiry makes five recommendations. The appendix describes these and the action plan agreed jointly by Portsmouth and South East Hampshire Health Authority, Portsmouth Community Health Care Trust, and Hampshire County Council Social Services Department. The recommendations relate to:

i. Risk assessment

ii. DVLA guidance on fitness to drive

iii.Provision of an adequate place of safety

iv. Warnings to patients about the side effects of medication

v. The need in certain circumstances to take steps to require a person with a mental illness to comply with a treatment plan.

5.2 Members should note that a Risk Policy was agreed by Adults' Services Sub-Committee on 28 January 2000 and all mental health staff have received training on this. The Department has a Mental Health Practice Handbook which has been revised and is to be published shortly. This provides practical guidance on the application of the Mental Health Act and matters related to it such as risk assessment. Mental health staff have been advised of the findings and recommendations of the Inquiry.

6 Recommendations

(1) That Members note the findings of the Independent Inquiry into the Treatment and Case of Phillip John Craigie, the recommendations and action plan, and are invited to comment accordingly.

Background Papers

Section 100D - Local Government Act 1972 – Background Documents

The following documents disclose facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of this report.

NB: the list excludes:

1. Published works

2. Documents which disclose exempt or confidential information as defined in the Act.

None

Adults Sub - Craigie (GC)

24/11/00

Adults Sub - Craigie (GC)

24/11/00

Appendix

REPORT OF THE INDEPENDENT INQUIRY INTO THE TREATMENT AND CARE OF PHILLIP JOHN CRAIGIE

RECOMMENDATIONS AND ACTION PLAN

1. Introduction

1.1 In June 2000 Portsmouth and South East Hampshire Health Authority in conjunction with Hampshire Social Services commissioned an independent inquiry into the care and treatment of Mr. Phillip Craigie prior to the events of 18th March 1999 which resulted in the death of Mr David Close.

1.2 The Health Authority recognises the profound effects of this tragedy on everyone involved but especially Mrs Close and her daughter Mrs Norman and offers them its deepest sympathy.

1.3 The inquiry team presented its findings at a joint press conference with the Health Authority, Hampshire Social Services and Portsmouth Community Healthcare Trust on 18th October 2000.

2. Recommendations and Action Plan

2.1 In examining the events leading up to 18th March, the panel looked at the suitability of Mr Craigie's treatment in the context of the actual and assessed risk of harm to himself or others. They found that "On the evidence available on the 17th March nobody could have foreseen the alarming, disastrous and tragic events of the following evening." However, the panel did make a number of recommendations. These have been considered by

the relevant organisations, and the following action plan agreed:

Recommendation 1

"The Trust's Risk Assessment Policy should require consideration as to whether:

(a) the individual concerned is a driver with access to a car
(b) driving in that individual's current mental state would give rise to a greater than usual risk to the safety of self or others
(c) the risk of such degree that the individual should be given explicit advice not to drive or to operate machinery
(d) relatives, friends or carers (if present) should be advised to discourage the individual from driving or operating machinery
(e) proposed medication might have significant sedative or side effects
(f) any other steps to reduce risk can reasonably be taken in the circumstances"

Recommendation 2

"Medical staff should be aware of DVLA guidance on fitness to drive".

A "patient's fitness to drive" policy had already been implemented in the Trust's adult mental health services. This policy will be reviewed in the light of this recommendation. The Risk Assessment Policy will also be reviewed in the light of the recommendations. Hampshire social services staff will be advised of the DVLA guidance and these details will be incorporated in the department's revised Mental Health Practice Handbook, to be republished this Autumn. In addition, the Health Authority Chief Executive has written to the Chief Medical Officer raising concerns as to the adequacy of the DVLA guidance and the importance of including consideration of fitness to drive in NHS Trust and social services risk assessment policies.

Recommendation 3

"As a matter of urgency steps should be taken, in collaboration with the Police and Social Services, to provide a satisfactory place of safety in a hospital setting".

A multi-agency group is being convened to determine how to provide more appropriate places of safety and tasked with making recommendations by January 2001.

Recommendation 4

"Medical staff should understand that they have primary obligation to warn patients (or those attending with them) about the possible sedative or side effects of medication or about risks associated with the supposed condition of the individual concerned".

This is clearly understood and accepted by Trust medical staff to be a key element of best practice. The AMH Clinical Governance Group will review this issue.

Recommendation 5

"Health Service and Social Services staff should be aware that where a person is unwilling or unable to accept a diagnosis of mental illness it may be necessary to take particular care to ensure compliance with any proposed treatment plan".

This will be incorporated in the review of the Trust's Risk Assessment Policy as referred to in 1 above and will also be discussed at the Mental Health Clinical Governance Group.
Adults Sub - Craigie (GC)

24/11/00

2.2 Action on all the above will be reviewed at a meeting attended by the Health Authority and Trust Chief Executives and the Social Services Department Assistant Director in January 2001. All appropriate action will be undertaken to address the recommendations contained in the report.

2.3 Finally, as required by Department of Health guidance, copies of the report will be circulated to all health authorities, NHS Trusts with mental health services and social services departments in order to ensure the development of best practice.

Brendan Ward
Director of Strategic and Service Development
1 November 2000

Adults Sub - Craigie (GC)

24/11/00