SPSO decision report

Case: **201300332, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that the board provided to her late mother (Mrs A) before she committed suicide. Mrs A had been admitted to hospital with low mood and worsening anxiety. She had a diagnosis of recurrent depressive disorder and a history of drug overdoses dating back a number of years. When it was initially proposed that Mrs A would be discharged from hospital, both she and Mrs C had concerns that she was being discharged too early. After taking independent advice from one of our medical advisers, we found that that staff had taken these concerns on board and had postponed the discharge by five days, which we found showed evidence of reasonable patient and carer involvement. We found that Mrs A's subsequent discharge was appropriately planned and phased. Risk assessments had been carried out and she had three successful overnight passes before her discharge. In view of all of this, we considered that it had been reasonable for the board to discharge Mrs A.

Mrs C also complained that staff had failed to ensure that there was an adequate support package in place when Mrs A was discharged. It had been agreed that she would be followed up by a community psychiatric nurse (CPN) and would attend an out-patient psychiatric clinic. We found that the planned follow-up care at the time of Mrs A's discharge was reasonable, in that it was adequate to meet her needs and her level of assessed risk. However, Mrs A's consultant in hospital had recorded that she would receive CPN input for as long as was indicated after she was discharged, and in the weeks after her first appointment with a CPN, Mrs A's anxiety levels had increased. Mrs C, Mrs A and her GP had all contacted the board to say that she was struggling with increased anxiety. Despite this, after a second CPN visit, it was decided that the visits would stop. Although it was decided that she would be referred to a mental health day service, Mrs A had concerns about this. The CPN also told Mrs A that she was moving to another job. We found that, on balance, in view of Mrs A's increased anxiety it was unreasonable to discontinue the CPN follow-up after only two visits and so we upheld this complaint. We did, however, consider that it was appropriate for the CPN to tell Mrs A that she was moving to another job. Mrs A took her own life just two days after the second appointment. Had the CPN input been continued, the next visit would probably not have been for another few weeks. We took the view that it would, therefore, be unreasonable to say that the withdrawal of CPN support was a significant factor in Mrs A's decision to take her own life.

Recommendations

We recommended that the board:

- issue a written apology to Mrs C for the premature decision that Mrs A no longer needed to see a CPN; and
- make the relevant staff aware of our finding on this complaint.