**Scottish Parliament Region: Glasgow**

**Case 200601034: Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Psychiatry; Clinical Diagnosis and treatment

***Overview***

Ms C was concerned her son (Mr A) had suffered from a deterioration in his mental illness in 2005 but that this had not been recognised by mental health professionals involved in his care. As a result, his condition had not been correctly managed. She believed that, if appropriate care and treatment had been provided, an alleged incident in June 2005 involving Mr A would not have occurred. She was further unhappy that his contact with Community Psychiatric Nurses was reduced in July 2005 in response to a perceived risk to them. Ms C was also unhappy about the response she had received from Greater Glasgow and Clyde NHS Board (the Board) following her complaints about this.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) the care and treatment given to Mr A during 2005 were inadequate (*not upheld*); and

(b) there were failures in the handling of Ms C's complaint (*upheld*).

***Redress and recommendations***

The Ombudsman recommends that the Board apologise to Ms C for the failures identified in responding to her complaint.

The Board has accepted the recommendations and will act on them accordingly.

## Main Investigation Report

### Introduction

1. In 2005 Mr A was being treated by the co-morbidity[1] evaluation and treatment team (the Team) based at Stobhill Hospital. Mr A, who had been diagnosed with bipolar affective disorder and had in the past had addiction problems, was receiving Community Psychiatric Nurse (CPN) support as well as attending regular clinic appointments.

2. In June 2005 Mr A was arrested for an attempted robbery and in July 2005 he was told he would no longer receive visits from a CPN, following a telephone call he made to NHS 24. Mr A was hospitalised for brief periods in August and September 2005.

3. Ms C has said that she felt a deterioration in Mr A's condition was clearly evident from early 2005. She said that if this deterioration had been correctly spotted and, in particular, if Mr A had been hospitalised sooner, the alleged incident in June 2005 would not have occurred. Ms C also said that no threat was made during the telephone call in July to justify the withdrawal of visits.

4. Ms C said she first complained to Greater Glasgow and Clyde NHS Board (the Board) by telephone and in December 2005 wrote to the Complaints Department in detail. Correspondence between Ms C and the Board continued throughout the first half of 2006. Ms C contacted the Ombudsman in July 2006. She complained that the Board had not responded to her concerns and that there had been significant delays in responding to her.

5. The complaints from Ms C which I have investigated are that:

(a) the care and treatment given to Mr A during 2005 were inadequate; and

(b) there were failures in the handling of Ms C's complaint.

### Investigation

6. In investigating this complaint, I obtained all the background documentation relating to the complaint and Mr A's medical records relating to his treatment by the Team. Advice was also obtained from a clinical adviser to the Ombudsman (the Adviser). The abbreviations used in the report are

[1] Co-morbidity refers to the situation where an individual has more than one illness.

explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

**(a) The care and treatment given to Mr A during 2005 were inadequate**

8. Mr A had been in contact with psychiatric services since 1995/6 and had been diagnosed with a bipolar affective disorder. He also had in the past had problems with addiction. By late 2004 Mr A was being treated by the Team.

9. Mr A had regular contact with one CPN (Nurse 1) during early 2005. The Adviser who reviewed Mr A's clinical records noted that Nurse 1 would attend with Mr A at clinic appointments; undertake assessments of Mr A's mental state, drug and alcohol use, including routine drug testing; and respond to crisis calls. Contact varied from every two to three days during a crisis to every two to three weeks.

10. The Adviser said that Mr A was largely stable through early 2005 and was reducing his prescription for diazepam with the support of his GP. In May 2005 there was an incident when it was noted Mr A said he had hit his mother by accident and he had spent a night in a police cell[2]. The police took no further action. On 1 June 2005, Nurse 1 visited Mr A following a telephone call in which Mr A said he would do something stupid. Mr A was noted to have been calmer when Nurse 1 visited him. The Adviser said that, from her review of Mr A's records, this appeared to be part of a common pattern – Mr A would ring during a crisis but be calmer when staff arrived. The Adviser said that this indicated some kind of panic disorder rather than more significant evidence of illness or deterioration.

11. On 2 June 2005 Ms C telephoned Nurse 1. In his notes of the conversation, Nurse 1 said Ms C had told him Mr A was behaving oddly and she thought he was not taking his medication[3]. She telephoned again on 3 June 2005, in some distress, to say that Mr A had left a note attached to his

[2] In commenting on the draft report Ms C said Mr A had not hit her and the police had misinterpreted this incident.

[3] In her comments on the draft report, Ms C said she had not made these comments.

door which said 'gone but not forgotten'. Nurse 1 contacted Mr A who said that he was homeless and drinking alcohol. Mr A told Nurse 1 he would not do anything stupid and Nurse 1 advised him to go to an emergency homeless shelter. There are notes of a third telephone call from Ms C on 6 June 2005 to say that Mr A had been arrested after apparently trying to rob a local store and had been remanded in prison. Nurse 1 and a psychiatrist contacted the prison to provide details of Mr A's medication.

12. Following this incident and Mr A's release from remand, Nurse 1 visited Mr A and Ms C on 15 June 2005. Mr A and Ms C both felt that the incident had been caused by Mr A's mental health problems. Nurse 1 stated in the records that, while this was out of character, it appeared to be an impulsive action rather than due to any underlying mental illness.

13. Mr A and Ms C's concerns that the mental illness had caused him to be remanded in prison dominated contact with Nurse 1 over the next month. On 25 July 2005 Mr A contacted NHS 24 asking to be admitted to a hospital. A fax with the details of this call was sent to the Team on 26 July 2005. According to the fax, which I have seen, the call had initially been made by Ms C but Mr A had also spoken to NHS 24. The nurse receiving the call (Nurse 2) noted that Mr A had said he had seen Nurse 1 that day and wanted to be admitted to hospital but that Nurse 1 had told him he did not need to be hospitalised. Mr A was said to have made disparaging comments about Nurse 1 and the Team. Mr A was said to be due to see his psychiatrist the following morning. Nurse 2 concluded the note by saying that Mr A had denied any plans to harm Ms C but he had said that Nurse 2 would be responsible for any violence that occurred that night. Nurse 2 said further support was offered to Mr A should he feel liable to become violent and noted that Mr A had then become abusive and terminated the call. Nurse 2 said there was no evidence of psychotic features during the call.

14. In a note in Mr A's medical records, written on 26 July 2005 after Mr A had attended a clinic appointment (see paragraph 15), Nurse 1 said that the Team had contacted him to say that there had been an out-of-hours call, in which Mr A had said if he killed his mother then it would be their fault. Mr A had, though, gone on to say, when directly questioned, that he would not harm Ms C. The note also said that Mr A had described Nurse 1 as 'useless' and that undisclosed threats had been made about Nurse 1 and the service. Nurse 1 had been told the information had been faxed to the Team. Nurse 1 said he

then contacted his line manager (Nurse 3) and it was agreed that he should not meet Mr A at home, as planned, to support him in going into the clinic for his scheduled appointment that day but wait to see him when he attended the clinic. In response to my questions, Nurse 3 said he had telephoned the out-of-hours service to clarify the contents of the fax before discussing the situation with Nurse 1. In the note written on the day, Nurse 3 made no reference to a telephone call and the note largely repeated the details of the fax and confirmed the conversation with Nurse 1.

15. Mr A attended the clinic for his appointment with a psychiatrist on the morning of 26 July 2005. Nurse 1 was present and the note referred to in paragraphs 13 and 14 also contained details of this meeting. Mr A accepted he had said the service was 'useless' in the telephone call but said that he had not meant it. Mr A denied making any threats during the telephone call. The note, taken by the psychiatrist, of this meeting stated that Mr A repeated concerns that he was undergoing a relapse of his bipolar disorder. The psychiatrist noted Mr A was unhappy to be told he was responsible for his actions and that, although he said his thoughts were racing, these were fixed on the court case (paragraph 2 refers). Mr A was said to have become abusive and Ms C entered the room. Mr A said Nurse 1 was lying. The psychiatrist said he had to ask Mr A and Ms C to leave the room and end the appointment.

16. The Team's weekly meeting was held on 27 July 2005. It was decided that Nurse 1 should not have direct contact with Mr A and that advice could be given over the telephone by other CPNs in the team. Nurse 1's notes record that the decision in reference to his contact with Mr A was made because of the change in the relationship and the decision to reduce contact with other CPNs was because of an increased risk to staff.

17. In response to the concerns raised about this incident by Ms C, Nurse 3 wrote a statement in January 2006. In that statement, Nurse 1 was reported to have told Nurse 3 the risk of self harm was low and that his relationship with Mr A and Ms C had deteriorated recently. Nurse 3 added that, at the meeting the next day (on 27 July 2005, see paragraph 16), the decision had been made to reduce CPN contact because: Mr A no longer required such assertive nursing support; his mental health had been assessed as at an optimum level; and any illicit drug use had ceased some months previously. It was also noted that the relationship with Nurse 1 had deteriorated to the point where it was no longer therapeutic.

18. On 3 August 2005 Mr A was admitted to hospital, having approached a separate mental health resource centre. Clinical and nursing records said that, once admitted, it appeared that he did not require crisis intervention. Mr A was discharged on 8 August 2005. In clinical notes made during his stay Mr A was said to be unhappy about CPN reduction, following the telephone call of 25 July 2005, but that he had also said any threats made were not serious. He admitted he had said he would 'stab his mother' but that this was made in an attempt to be hospitalised.

19. Following his discharge from hospital, Mr A was reassessed. A care plan was written on 17 August 2005 which said that Mr A did not require assertive nursing and would be managed as an out-patient. There was regular contact with the Team throughout August and September 2005. Mr A was still accompanied by the members of the Team to clinic visits and was initially met by two CPNs although, on at least one occasion, a single CPN went to Mr A's home to accompany him to the clinic and he received a home visit in September 2005. Mr A and Ms C consistently raised concerns about the reduction of CPN contact. The care plan was reviewed as planned in November 2005. Mr A was again described as stable. The November care plan said that contact was to be by telephone and joint home visits made if required. In January 2006 Mr A was transferred to another team.

20. When providing clinical advice, the Adviser has said that at the time of the alleged offence the records did not suggest there were any signs of deterioration in Mr A's mental health. Mr A was showing some indication of increased arousal but there was no evidence that this should have alerted Nurse 1 to any serious risk and Nurse 1 had acted appropriately when contacted in early June 2005.

21. In considering the decision to reduce direct CPN contact, the Adviser noted that Mr A had recently been charged with a violent offence. Under these circumstances, the reduction of contact was not unreasonable.

22. The Adviser added that, although he had been admitted to hospital in August 2005 apparently suffering from hypomania, Mr A had calmed very quickly. She said it appeared there had been nothing in his presentation that would have warranted this admission and no clear signs that Mr A had been experiencing hypomania. The Adviser concluded that, on the basis of the

records, there were no significant faults in Mr A's care and nothing to suggest that either he or anyone else had been placed at risk.

*(a) Conclusion*

23. It is accepted that Mr A's actions which led to his arrest were out of character and have led to much anxiety and distress for both him and his family. Given his history of mental health problems, Mr A and Ms C believed that this was the cause of the incident. However, on the basis of the clinical records and the advice given, it is clear that Mr A's mental health problems had been stable for some time by June 2005. Mr A's behaviour did follow the pattern identified by the Adviser (see paragraph 10), where Mr A would be extremely anxious and then calm down after contact. Given this, and as Nurse 1 had spoken to Mr A in response to Ms C's concerns, there is no indication that further action was appropriate. I have also noted that, although Mr A was eventually admitted to hospital, the Adviser has said that this admission was not clinically required.

24. CPN contact was reduced following the telephone call of 25 July 2005 and through the second half of 2005 Mr A did not have the same level of support as he had during the first half. However, the care plans written in August and November 2005 show that Mr A was not regarded as having a clinical need for extra support. It is clear that the clinicians in contact with Mr A were aware that he was extremely concerned about the court case but considered his underlying mental illness remained stable. The Adviser has said there were no failures in the care provided to Mr A. On the basis of the advice I have received, I find that the decision to reduce care did not mean Mr A was receiving less support than he needed, from a clinical perspective.

25. Although I do not feel that Mr A was put at any risk by the reduction in care, Mr A and Ms C have been particularly concerned that this decision was on the basis of a threat which they say was not made and they have argued that the contents of the fax support this contention.

26. I have seen the fax sent to the Team by NHS 24 (see paragraph 13). This fax did refer to concerns Mr A had, that he might commit an act of violence if not admitted to hospital. He did, though, state he had no plans to hurt Ms C. The fax also referred to 'disparaging comments' about the Team but no note was made of a direct threat. Nurse 1 did refer to an undisclosed threat to him in his note on 26 July 2005 but when he wrote this note he had not seen the fax. Nurse 1 also wrote this note some time after he had discussed the fax by

telephone and after a clinic appointment where the telephone call had been discussed with Mr A. Nurse 1 also clearly stated in the note that Mr A denied making threats. In notes taken during his subsequent hospital admission, Mr A accepted that he had made a direct threat of violence towards Ms C but that this was not serious and was an attempt to obtain a hospital admission (see paragraph 18).

27. The reduction of contact with CPNs in general was said to have been made because of an 'increased risk'. While the fax did not refer to a direct threat, it is possible more information was available about the telephone call (Nurse 3 referred to a telephone call to the out-of-hours service). This was, though, not noted at the time. However, even although the fax did not contain a direct threat, it is clear from the notes prior to this meeting that Mr A was increasingly upset, not only with Nurse 1 but with the service he was receiving in general and his clinic appointment that morning had been cut short as a result of his and Ms C's behaviour. The Adviser has pointed out that the offence with which Mr A was charged referred to an act of violence. In the circumstances, the decision to reduce contact on the basis of a perceived increased risk to staff was reasonable even if no direct threat had been made during the telephone call on 25 July 2005. There is also evidence that there was a significant breakdown in the relationship with Nurse 1 and the decision to end contact between Mr A and Nurse 1 was also reasonable in the circumstances.

28. While I have no concerns about the decision made on 27 July 2005, I was concerned that the statement made by Nurse 3 in January 2006 indicated that risk was not a factor, when the notes at the time referred to this as the key factor. The reasons referred to in that statement were the basis for decisions made following Mr A's discharge from hospital (see paragraph 19) but there is no evidence that these were discussed at the meeting on 27 July 2005. While it is useful for NHS staff to provide additional information based on their recollections, as well as what was written at the time in response to complaints, they should be particularly careful to clarify when they are doing so and that what they say is supported by the notes. As indicated in paragraph 43, the Board have undertaken reviews of their complaints procedure and, given this, the Ombudsman makes no direct recommendation on this point but would draw this to the Board's attention.

29. In conclusion, on the basis of the clinical records and the advice given, I do not uphold this complaint.

**(b) There were failures in the handling of Ms C's complaint**

30. Ms C first complained about Mr A's care by telephone in December 2005 and then by letter in January 2006. She called to say another letter would be forthcoming and asked the Board not to respond until they received it. This letter arrived on 16 February 2006.

31. A Nurse Team Leader (Nurse 4) responded on behalf of the Board on 9 March 2006. This reply detailed Mr A's treatment throughout 2005 and concluded that Mr A had received appropriate care. In explaining the reduction of CPN contact in July 2005, Nurse 4 said that a fax had been received that raised concerns and that, specifically, there appeared to have been a threat to Ms C and an undisclosed threat to Nurse 1. The letter said that it was decided Nurse 1 should not have contact with Mr A because of the deterioration in their relationship and that Mr A should only be reviewed at an out-patient clinic. The letter continued that, following further contact with Mr A and Ms C, Nurse 3 had explained to them that, although there had been concerns about Nurse 1's safety, the reason for the reduction in CPN contact was because Mr A was assessed as not requiring assertive nursing. At the end of the letter, Ms C was informed she could contact Nurse 4 or the complaints manager to discuss this.

32. Following a telephone conversation with Ms C on 4 April 2006, Nurse 4 wrote on 6 April 2006 to Ms C with a list of issues that Ms C had said were unresolved: this included an inaccuracy regarding a date; that Mr A had been described as bipolar in a disability allowance form; and the input of Nurse 3 in Mr A's care. The letter said these would be reviewed.

33. Ms C wrote on 16 May 2006 repeating her concerns and saying she was unhappy with the way her complaint had been answered.[4] On 8 June 2006 she received a letter from a complaints administrator with the Board apologising for the delay and explaining that on Nurse 4's return from annual leave there had been a high sickness level in his team. She said Ms C could come to the Ombudsman's office with her complaint if she was unhappy with the continuing delay.

[4] The Board have said they never received the two letters written by Ms C on 16 May 2006. All other correspondence from Ms C was present in the Board's complaint file.

34. Ms C wrote again on 14 June 2006 saying that the issues in the letter of 6 April 2006 were not the ones that she had wanted addressed and a further letter would be sent about this. Ms C also said that Mr A was still not stable and she wished her complaint to be dealt with thoroughly. She was also concerned that she had been given the wrong telephone number for Nurse 4. Ms C also telephoned on a number of occasions in June 2006 seeking further comment on her complaints. She wrote on 22 June 2006 and referred again to the events of 2005 and added that Mr A was still not receiving the care he needed and that she felt last year was repeating again. On 30 June 2006 she received a letter from the Board apologising for their failure to respond and saying the telephone number given for Nurse 4 was correct.

35. On 3 July 2006 Ms C received a letter from Nurse 4. Nurse 4 apologised for the delay in responding to Ms C. He explained this had been as a result firstly of his annual leave and, on his return, the Team had had a period of high sick leave. Nurse 4 provided Ms C with further information about the points he had listed in his letter of 6 April 2006. He apologised for an error in a date. Nurse 4 suggested if Ms C had outstanding issues they should meet to discuss these.

36. In a telephone call on 9 July 2006 Ms C agreed to a meeting but later decided that she would gain nothing further from this and on 20 July 2006 wrote to the Ombudsman's office.

37. In her letter of complaint Ms C indicated that she still remained unhappy about the delay in the response (see paragraph 4); she was concerned about the error in the date; and, in her view, the fax contained no threat. She also said that, when she telephoned, she had discovered that Nurse 4 was a colleague of a psychiatrist directly involved in Mr A's care.

*(b) Conclusion*

38. The Board have accepted there was a significant delay in responding to Ms C's complaint and apologised to her for this throughout the process. They were in contact with her regularly and kept her informed of progress. However, I have noted that advice given to Ms C about the procedure was inaccurate. The NHS complaints procedure changed in April 2005. Following this, once a complainant had received a response from the NHS they were entitled to come directly to the Ombudsman's office if they remained unhappy. Ms C should

have been informed of this option in the letter to her of 9 March 2006. She was only informed of this on 8 June 2006, when further delays occurred in response to her concerns about the letter of 9 March 2006 (see paragraph 33). When responding to a draft of this report the Board have commented that it was not the intention of staff dealing with Ms C's complaint to conceal her right to approach this office and that she had been sent an information leaflet which included contact details of this office on three separate occasions. Nevertheless, Ms C should have been informed of this option in the Board's response and I am concerned about this.

39. I also have concerns about the details of the responses received. I do not dispute Nurse 4's findings that the care given was appropriate. However, in his letter of 9 March 2006 he stated that the reduction of care was because of the breakdown in relationship with Nurse 1 and then, in the following paragraph, stated that Ms C was told that the reason for this was that Mr A did not require this level of care. No comment was made on this apparent contradiction or the source of this information. Nurse 4 also did not directly address Ms C's concerns on the content of the fax itself. Instead, Nurse 4 related the information contained in Nurse 1's note (see paragraphs 14 and 31) which referred to an undisclosed threat to Nurse 1. I have already noted that Nurse 1 made it clear he was reporting the contents of the fax third hand. While I appreciate that Nurse 4 was not able to have direct contact with Nurse 1, who was on sick leave at the time, and that Ms C had provided detailed complaints, the letter sent did not properly respond to the issues raised.

40. The next letter of 30 June 2006 was clear in its conclusions but it explicitly addressed matters that Nurse 4 set out in his letter to Ms C of 6 April 2006. Ms C had made it clear she did not want these matters addressed. A short reference was made to recent contact but there was no attempt to explain what Nurse 4 had taken from this or how this was reflected in the answers given.

41. I, therefore, uphold this complaint on the basis that Ms C was not correctly informed of her right to come to this office in March 2006, in line with NHS procedure and also that the responses she received were not adequate.

42. I have noted that Ms C was confused as she had addressed her complaint to the complaints department but the complaint was dealt with by Nurse 4, who was a colleague of one of the psychiatrists involved in Mr A's care. Complaints made to an NHS Board are normally dealt with through a complaints

department. However, there is no evidence that Nurse 4 had any previous involvement in Mr A's care and the initial stage of the NHS complaints procedure does require an internal response. This was, therefore, not inappropriate. Although Ms C remains concerned about the error in a date she has received an apology for this and this appears to have been a genuine oversight.

43. Since this complaint was made, the Board have undergone reorganisation. The Board have also accepted previous recommendations made by the Ombudsman that they review the complaints procedure (report number 200500103) and audit this to ensure that responses are dealt with in line with NHS guidance (report number 200503649). Therefore, while the Ombudsman recommends that an apology be made to Ms C, no more detailed recommendations are being made.

*(b) Recommendation*

44. The Ombudsman recommends that the Board apologise to Ms C for the failures identified in responding to her complaint.

45. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

21 November 2007

**Annex 1**

## Explanation of abbreviations used

| | |
|---|---|
| Mr A | The aggrieved and Ms C's son |
| The Team | The Co-morbidity team |
| CPN | Community Psychiatric Nurse |
| Ms C | The complainant |
| The Board | Greater Glasgow and Clyde NHS Board |
| The Adviser | Clinical adviser to the Ombudsman |
| Nurse 1 | The CPN who had regular contact with Mr A during early 2005 |
| Nurse 2 | The Nurse who received Mr A's out-of-hours call at NHS 24 on 25 July 2005 |
| Nurse 3 | Nurse 1's manager |
| Nurse 4 | The Nursing Team Leader who responded to Ms C on behalf of the Board |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Bipolar affective disorder | a psychiatric condition defined by periods of extreme mood; it used to be described as manic depression |
| Co-morbidity | Refers to a person who has more than one disease |