Scottish Parliament Region: Glasgow

Case 200500267: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised a number of concerns about the response he received from Greater Glasgow Health Board (the Board) following an investigation by the Mental Welfare Commission for Scotland into the care and treatment which his late son (Mr A) received at Gartnavel Hospital, Glasgow (the Hospital).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the level of medical supervision for the senior house officer who decided on Mr A's mental health state and supervision status during the period 15 March 2001 to 21 March 2001 was inadequate (*upheld*);

(b) the Board's response that a care plan was agreed by all staff was incorrect (*upheld*);

(c) the charge nurse failed to act on an instruction in Mr A's medical notes that he was not allowed to leave the ward unless accompanied by members of staff (*upheld)*; and

(d) the Board have not accepted responsibility for failing in its duty of care or offered an appropriate apology *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

[1] At the time of the events complained of Gartnavel Hospital was managed by Greater Glasgow Primary Care NHS Trust. This ceased to exist on 1 April 2004 and responsibility for management of the hospital passed to Greater Glasgow Health Board. On 1 April 2006, due to reorganisation, Greater Glasgow Health Board was renamed Greater Glasgow and Clyde Health Board. Therefore, responsibility for addressing Mr C's original complaint transferred to Greater Glasgow and Clyde NHS Board ('the Board'). For convenience I refer to the Board throughout this report although it should be noted that most of the actions complained of were those of its predecessor organisations.

(i) give consideration to amending the risk assessment tool to include issues such as impulsivity or when the patient's state of mind is unknown; and

(ii) offer Mr and Mrs C a full apology for the failings in care which have been identified in this report. The Ombudsman draws the Board's attention to the SPSO guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

Main Investigation Report

Introduction

1. On 6 June 2005 the Ombudsman received a complaint from Mr C about the response he received from Greater Glasgow and Clyde NHS Board (the Board) following an enquiry by the Mental Welfare Commission for Scotland (MWC) into the care and treatment which his late son (Mr A) received at Gartnavel Hospital, Glasgow (the Hospital) in 2001.

Background

2. The background to the complaint is that Mr A had been admitted to the Hospital on 6 March 2001 suffering from an acute psychotic illness which led him to act impulsively and to put himself at risk. Mr A was not detained in hospital under the Mental Health Act but initially was not allowed to leave the ward. On 21 March 2001 Mr A was allowed to leave the ward with his parents despite an instruction in the medical and nursing notes that leave would only be granted if he was accompanied by hospital staff. Mr A ran away from his parents and tragically died following a fall from a bridge.

3. Mr C complained to the Board on 26 April 2001 about the treatment provided to Mr A; that he was not seen by a consultant psychiatrist after he began to deteriorate from 18 March; and that he had been allowed out without the supervision of hospital staff. He also requested an independent inquiry.

4. The Procurator Fiscal had been informed of Mr A's death and conducted an investigation. This resulted in a report dated 12 June 2002 which concluded, on the basis of medical opinion, that the level of supervision was 'well within the bounds of acceptable practice' and 'I have no criticism to make of [Mr A's] assessment or management other than with regard to the supervision on the evening of his death'.

5. The MWC who were responsible for dealing with complaints about issues relating to mental health at that time carried out a subsequent investigation and produced a report. The 'Comments and Findings' section of this report consists of eight numbered paragraphs each followed by a shorter italicised paragraph. These read as follow:

> 'There were clear grounds for detaining [Mr A] under the Mental Health Act. These included his safety, the need for restraint and uncertain consent to treatment. He was not detained and there is no record of the

reasons for this. One consequence of this was that a senior psychiatrist was not required to approve the conditions of leave of absence.

An inexperienced junior doctor was left to manage a complex case because of an unexpected combination of sickness and leave. There was no direct consultant involvement for several days during which [Mr A's] mental state deteriorated significantly.

Junior doctors made decisions to reduce observation levels, which proved to be mistaken, without consulting senior doctors. There was a lack of forward planning in relation to the management of observation.

There was no detailed multidisciplinary care plan

[Mr and Mrs C] noticed a deterioration in their son's mental state but their views were ignored. Nursing staff failed to record them.

The records were inconsistent. There was inaccurate duplication and ambiguity in places. However, [Mr A's] death could have been avoided if the records had been read with appropriate care.

The Trust failed to respond to [Mr and Mrs C's] letter of complaint. Many of their concerns were not addressed in the Trust's inquiry report.'

6. The MWC reported on the follow-up of this investigation in their Annual Reports for 2003-04 and 2004-05. The MWC's Annual Report for 2006-07 included the following passage in relation to the case:

'Whilst the level of cover and supervision offered was of a very good standard in the circumstances, the investigation report highlighted that Mr A had not been seen face to face by a consultant in the period immediately before his death. The report highlighted that no covering consultant would be able to offer the level of input normally afforded to patients if their own consultant was present. Unfortunately, when reporting on the follow up of this investigation in the Annual Reports … the Commission incorrectly summarised this finding saying that 'an inexperienced junior doctor was left to manage a complex case' and 'during a significant period of time there was no experienced psychiatrist to supervise his care'. The consultant concerned complained to the Commission that these comments significantly under-estimated the input

and supervision that had been provided. The Commission investigated and found in favour of the complainant.

The Commission apologises for these errors and would like to stress that any assumed criticism of individual clinical practice was neither meant, nor justified.'

I have also seen that in correspondence with Mr and Mrs C subsequent to the publication of that apology the MWC have stated '… the Commission's intended position was that no consultant should be expected to cover the clinical work of three people as this would make it almost inevitable that the patients involved would not receive the level of face to face assessment in decision making that would ordinarily be afforded'; and '… there was no problem with the original investigation report. The findings and recommendations of that report stand and are in no way altered by the apology issued. … The Commission's position remains clear; that no individual in these circumstances would have the time to offer the highest possible standard of care and treatment to all the patients for whom they have suddenly assumed responsibility'.

7. On 22 February 2005 the Board wrote to Mr C with their response to the MWC investigation report and an apology for the distress and upset which he had experienced over the last four years following Mr A's death.

8. Mr C wrote to the Board on 19 April 2005 asking for further information and saying that he did not accept their apology as it did not cover the failings in Mr A's care which had been identified. The Board sent a further response to Mr C on 25 May 2005 and addressed the issues which were raised. They stated they were sorry Mr C found the apology inadequate but that they were mindful that the MWC report said that they should consider making an apology which had been done. Mr C subsequently complained to the Ombudsman.

9. It was established that the MWC were considering the Board's response to their report and a meeting was planned with the Board for October 2005. The meeting took place on 9 December 2005 and although further action was agreed there was no objection from the MWC to the Ombudsman considering Mr C's complaint. On 2 March 2006, Mr C and the Board were formally advised that the Ombudsman would investigate Mr C's complaint.

10. The complaints from Mr C which I have investigated are that:

(a) the level of medical supervision for the Senior House Officer (SHO) who decided on Mr A's mental health state and supervision status during the period 15 March 2001 to 21 March 2001 was inadequate;
(b) the Board's response that a care plan was agreed by all staff was incorrect;
(c) the charge nurse failed to act on an instruction in Mr A's medical notes that he was not allowed to leave the ward unless accompanied by members of staff; and
(d) the Board have not accepted responsibility for failing in its duty of care or offered an appropriate apology.

Investigation

11. In writing this report I have had access to Mr A's clinical records and complaints correspondence from the Board. I should make it clear that the scope of this investigation does not include the actions of MWC staff and I have referred in paragraphs 5 and 6 to actions taken by the MWC merely as background to the matters which have been investigated. Nor have I considered whether Mr A should have been detained under the Mental Health Act: that is not a matter for the Ombudsman. However, it is relevant to record that Mr and Mrs C's complaint is substantially rooted in a concern that their son's safety was not appropriately safeguarded at a time when he was critically ill. In that context it is relevant to note that the MWC report concluded that 'There were clear grounds for detaining [Mr A] under the Mental Health Act. These included his safety, the need for restraint and uncertain consent to treatment. He was not detained and there is no record of the reason for this'. In investigating Mr and Mrs C's complaint I obtained clinical advice from one of the Ombudsman's professional medical advisers, who is a consultant psychiatrist (Adviser 1) and one of the Ombudsman's professional nursing advisers, who is a psychiatric nurse (Adviser 2). I also made written enquiries of the Board and met Board staff and Mr and Mrs C.

12. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in the report is contained at Annex 1. Mr C and the Board were given an opportunity to comment on drafts of this report.

(a) The level of medical supervision for the SHO who decided on Mr A's mental health state and supervision status during the period 15 March 2001 to 21 March 2001 was inadequate

13. As noted in paragraph 2, Mr A was admitted to the Hospital on 6 March 2001. He was under the care of a consultant psychiatrist (Consultant 1) with day to day responsibility for his treatment lying with a more junior doctor (the SHO). To place in context Mr C's complaint about the level of medical supervision available for the SHO from 15 March I now summarise relevant events in the period 15-21 March 2001:

- Thursday 15 March - Consultant 1 (who had seen Mr A on 13 March) went on leave. From that date cover for her patients was provided by another consultant, Consultant 2. The SHO saw and reviewed Mr A and noted he was 'doing well' and was to go home with his parents for three or four hours on Saturday.
- Friday 16 March - The SHO saw Mr A again and again recorded that he was doing well.
- Saturday 17 March - There are no entries in Mr A's medical or nursing notes. He made a visit home, which his parents say was in the afternoon and lasted three hours (and they also say that he made another home visit, also of three hours, on Sunday).
- Sunday 18 March - In an entry made in the medical notes at 20.15 the SHO recorded that Mr A's visit home had gone well but that he had felt some apprehension about events while at home. An entry in the nursing notes records that Mr A settled early in the evening but that he approached staff at around 01.00 saying that 'he felt like he was dead' and this was similar to how he had felt the previous week.
- Monday 19 March - Consultant 2 reported sick (the Board have told me that Consultant 2 was ill for three days – 19-21 March and that another consultant – Consultant 3 – provided cover on 20 and 21 March). There is no entry in Mr A's medical records for 19 March but an entry in the nursing notes that day records that the SHO saw Mr A in the morning and granted him a short time out of the ward. The entry in the nursing notes records that later a telephone call had been received from Mrs C who said that Mr A had turned up at home and seemed unwell. After Mr A returned to the ward it was recorded that he 'feels unwell again and doesn't understand why he was able to leave the ward'. He was advised to stay in the ward for the remainder of the day and his medication was increased again. An

entry made that night reads 'Appearing pre-occupied and perplexed at times this evening'.

- Tuesday 20 March - The SHO noted that she had reviewed Mr A who felt anxious. Among other things she recorded that she planned to review his medication and intended to discuss his condition with Consultant 2. However, her note recording that intention is immediately followed by one stating that she had instead had a discussion with Consultant 3. A six-line entry in Mr A's nursing notes includes the statement that he 'spent time with his parents tonight who are concerned there is underlying problems [Mr A] is not willing to discuss'.
- Wednesday 21 March - The circumstances of Mr A's departure from the ward this day and his subsequent sad death are summarised in paragraph 2 and considered more fully below.

14. Mr C said that it was clear that his son was left in the hands of a trainee doctor who had the responsibility to determine his mental state and to make judgements about the level of surveillance necessary. Mr C complained that Mr A, who had serious mental health problems, was not seen by a consultant from 15 March 2001 to 21 March 2001, the night of his death. Mr C said that he and his wife had attempted to impress on staff the seriousness of Mr A's condition on a number of occasions between 18 March 2001 and 21 March 2001 but that he was not seen by a consultant. Mr C explained that when Mr A was at home on the weekend of 17 – 18 March 2001 they were very concerned about his mental state. On 18 March they were concerned that they would not be able to persuade him to return to hospital. They informed nursing staff of their concerns as they believed Mr A should have been assessed by a consultant at that time. On 19 March 2001 Mr A returned home without warning. Mr C was very concerned about how ill he looked and angry that he had been allowed so much freedom at the Hospital. Mr C said he and his wife took Mr A back to the Hospital and it appeared the staff were unconcerned and in fact had not noticed he had left the hospital. Mr C thought that at that time Mr A was as ill as when he was first admitted to hospital and that he should have been fully assessed. They had a meeting with a staff nurse who agreed that Mr A appeared to be psychotic. They pressed her to get his levels of medication reinstated, which was done. They also asked that the consultant be alerted and the meeting recorded but the MWC could subsequently find no record of that being done.

15. Mr C said it was found by the MWC that the consultant (that is, Consultant 2), who was covering for Mr A's consultant, did not provide proactive help to the SHO or ask to see the most seriously ill patients. The contact between the consultant (Consultant 3) and the SHO was a telephone call made by the SHO on 21 March 2001 (the day Mr A was allowed to leave the ward with his parents – paragraph 2) although Mr C had reported concerns since 18 March 2001. The telephone call related to the SHO's concerns about Mr A's demeanour and advice that his medication should be increased.

16. Mr C summarised his concerns as being that the SHO, who had no experience in psychiatry, was put in the position where she had to manage the case-load of a consultant from 15 March to 21 March 2001. Mr C noted that when the Procurator Fiscal made a preliminary enquiry into a Fatal Accident Inquiry the doctors interviewed did not include a consultant providing cover between 15 and 19 March and Mr C concluded that there was in fact no consultant cover in this period. On 20 and 21 March the SHO had a covering consultant who was responsible for the workload of three consultants. She was concerned about her patient but he was not seen by the consultant who was clearly overloaded. She was not involved in any meeting of the multi-disciplinary care group and the care plan was seriously flawed. The SHO was put in an impossible position and was not provided with the support she needed because of a range of systemic failures.

17. During this investigation the Board advised me that when Consultant 1 was on scheduled annual leave from 15 to 21 March 2001 inclusive medical and nursing staff were informed of the cover arrangements, which were that cover was to be provided by Consultant 2.

18. Consultant 3 has said that her recollection is that on the day that she was first consulted about Mr A (20 March) she was about to leave the ward when staff asked if they could discuss his case with her as they had become aware that the covering consultant had telephoned in sick. She understood that to have happened just on that day. She did not consider it necessary to see Mr A herself as she was satisfied that both the nursing team and the SHO who had been in daily contact with him had presented her with a clear summary of the clinical picture including particular areas of concern and were delivering an appropriate treatment plan. She had worked on the ward for four and a half years and was confident in the staff's ability to assess, supervise and manage acutely ill patients and had ensured that they were content with the

arrangements she had put in place for ongoing input until Consultant 1's return from leave on 22 March. Consultant 3 informed staff of her whereabouts and how she could be contacted. The SHO was asked to telephone Consultant 3 and they discussed Mr A's treatment plan which Consultant 3 agreed (the SHO's entry in the medical notes records this happening on 20 March).

19. In reflecting on the whole sequence of events the Board referred to the Procurator Fiscal report quoted in paragraph 4 and said that this mirrored their own view that Mr A's death was a tragic accident for which responsibility could not be attributed to any individual member of staff. However, the Board had learned a stark lesson from the events and had done all they could to avoid any such event occurring in the future. The Board have provided me with a copy of their current Consultant Absence Cover policy. It states that all inpatients should be seen by the deputising consultant at least weekly whether the leave being covered is planned or unplanned.

20. Adviser 1 said it is obviously inevitable that consultants took leave and when that happened it was entirely usual for junior doctors, even as inexperienced as the SHO, to be responsible for patients under supervision from a consultant providing cover. What is at issue is the extent to which the consultant covering the absence of a colleague should participate in the management of his/her patients. Adviser 1 agreed that the covering consultant should take steps to ask the SHO and ward staff about his/her colleagues' patients and ask if there is anyone they would like seen. In his view Consultant 2 should have visited the ward or spoken to the SHO and he felt it would have been best to have done so on Friday 16 March to anticipate any problems over the weekend. Adviser 1 considered that the actions of the SHO and nurses on 19 March were adequate and in particular that it was reasonable not to try to contact a consultant that day. Adviser 1 also considered that the actions of the nurses, the SHO and Consultant 3 on 20 March were reasonable. On balance, he considered that the level of consultant cover was adequate, with the proviso that covering consultants should take steps to ask about patients for whom they have assumed responsibility; but he expressed concerns about the adequacy of the administrative arrangements for providing cover.

(a) Conclusion

21. Consultant 1 went on leave on 15 March 2001, nine days after Mr A's admission to the Hospital. Mr C suspects that there was no consultant cover in the period between 15 and 20 March but I accept the Board's evidence that

initially cover was provided by Consultant 2 but he was absent due to sickness from 19 March. Consultant 3 assumed Consultant 2's responsibilities from 20 March.

22. The MWC's investigation report (paragraph 5) found that 'An inexperienced junior doctor was left to manage a complex case because of an unexpected combination of sickness and leave. There was no direct consultant involvement for several days during which [Mr A's] mental state deteriorated significantly'. This office's investigation has confirmed that conclusion. In recent correspondence with Mr and Mrs C (paragraph 6) the MWC have said 'no consultant should be expected to cover the clinical work of three people as this would make it almost inevitable that the patients involved would not receive the level of face to face assessment in decision making that would ordinarily be afforded' and 'no individual in these circumstances would have the time to offer the highest possible standard of care and treatment to all the patients for whom they have suddenly assumed responsibility'. Again, I see no reason to differ from those judgements. However, the issue I have to consider is whether, in all the circumstances, the care and treatment provided fell within the range of what was acceptable. In other words in assessing whether the medical supervision the SHO received in the period 15-21 March 2001 was adequate I have to reach a view on whether the supervision was such as to enable her to deliver care and treatment of an acceptable standard.

23. I accept the advice I have received (paragraph 20) that in circumstances such as this the covering consultant should take steps to ask the SHO and ward staff about his or her colleagues' patients and ask if there is anyone they would like seen. I record as a matter of fact that there is nothing in the clinical notes to suggest any contact by Consultant 2 with the SHO or her patients and I note Adviser 1's view that it would have been desirable for Consultant 2 to visit the ward or speak to the SHO on Friday 16 March. I am also concerned that although Consultant 2 was ill from 19 March the evidence suggests that neither the SHO nor Consultant 3 was aware of that until the next day. Consultant 3, who became involved on 20 March, reviewed Mr A's treatment plan and discussed matters with the SHO that day. Consultant 3 chose not to see Mr A and I am satisfied that she made that decision after discussion with staff who had been in contact with Mr A and who were aware of, and made records referring to aspects of, his parents' concerns about his mental state. I see no grounds to criticise the level of supervision which Consultant 3 provided in respect of Mr A. As to the period between 15 and 19 March, it is important to

note that Mr A was recorded to be doing well on 15 and 16 March; was at home for periods on 17 and 18 March; and that on 19 March, when a deterioration in his condition was recorded, the action taken by the SHO and nurses was, in the view of Adviser 1, adequate. Having said all that, I am concerned at the lack of evidence of any involvement by Consultant 2 and the clear indications that for up to a day neither the SHO nor Consultant 3 was aware that the latter had assumed cover responsibilities. Mr C has explained (paragraph 17) that part of the context for his concern at the level of medical supervision for the SHO is that he considers the care plan was 'seriously flawed'. I deal with Mr C's specific complaint relating to the care plan in the next section of this report. Here I will simply say that I consider that there were grounds for concern about the adequacy of the care plan and some other aspects of the records and that these are relevant to reaching a view on whether the SHO had the support she needed to provide an appropriate level of care and treatment for Mr A. Taking everything into account, I conclude that for a period the level of medical supervision for the SHO was not adequate. On that basis I uphold the complaint.

24. Given the standard of cover prescribed by the Board's current Consultant Absence Cover policy (paragraph 19) the Ombudsman has no recommendation to make.

25. I must record here that the Board have told me they do not accept this finding. In their view, there was adequate supervision of the SHO throughout the period by a consultant. They acknowledged that it may not have been an optimum level of supervision but it was there and in the Board's view it is incorrect to say it was inadequate. The Board said that it would not be practical to construct rotas on the basis that there are always two consultants available to provide full cover when one is on leave just in case another goes off sick. The cost to the health service of doing this would be prohibitive and would only serve to diminish the level of care the NHS was able to provide to the population as a whole. The Board felt that the conclusion reached was based on an unrealistic expectation and was not supported by comments elsewhere in the report that the Ombudsman supported the Board's current Consultant Absence Policy. I must also record that I consider this view suggests a misunderstanding of the basis on which I have reached my finding – which relates particularly to the period before Consultant 3 assumed responsibility for Mr A's care – and is not predicated on a view that there should always be two consultants available to provide full cover. My conclusion in respect of this

complaint therefore remains unchanged. That said, I accept that the Board's view is honestly and conscientiously reached and that there are valid grounds for differing views on these issues. In all the circumstances, the Ombudsman proposes to take no further action in respect of this aspect of Mr C's complaint.

(b) The Board's response that a care plan was agreed by all staff was incorrect

26. Mr C complained about the Board's response to the MWC report which was that a care plan which included (a) a change of medication, (b) stop passes home, and (c) accompanied time out 'was discussed with [the SHO] and the nursing staff. All agreed the plan'. Mr C felt that this contradicted the MWC report which stated 'there was a lack of forward planning in deciding observation levels in relation to the risks of harm to Mr A' and 'There was no detailed multi-disciplinary care plan'.

27. Adviser 1 said that there was no written detailed multi-disciplinary care plan or evidence of forward planning to cover observation levels in the case of fluctuating mental state and the risks of harm. However, Adviser 1 said that it was equally true that there was a care plan in the sense of brief notes of management decisions and these were made in a multi-disciplinary fashion between doctors and nurses and possibly other disciplines.

28. Adviser 2 said that although nursing staff made a reasonable assessment and produced a relevant care plan there was no comprehensive risk assessment by the team. Despite the presence of a number of risk factors (such as impulsivity, evidence of psychosis, dangerous and delusional beliefs translating into risky behaviour, fragile and changeable mental state), there was no overall plan to address these, although individual decisions and actions were in the main reasonable up to 18/19 March 2001. Adviser 2 could find no clear prescription of the level of observation required for Mr A, nor the reason for it, nor any indicators for changes in the level of observation. Adviser 2 said that there was a failure to carry out a multi-disciplinary risk assessment which could have clearly informed decisions about leave and observation.

(b) Conclusion

29. Mr C felt the Board's response regarding the care plan was at odds with the findings of the MWC report. It is clear from the MWC report and the comments from the Advisers that there was a lack of a detailed multi-disciplinary care plan or comprehensive risk assessment which would inform

decisions about future care and treatment. However, it is acknowledged that there were brief notes which alluded to plans for Mr A's management by staff. I have taken the view that the Board's response was referring to the brief notes and, therefore, to that extent, was accurate. However, I do not consider that those notes can be regarded as a care plan in the sense that the term is normally understood. I am concerned at the Advisers' comments about the lack of a detailed multi-disciplinary care plan and comprehensive risk assessment. These are documents that are fundamental to the overall care and treatment of a patient and accordingly I uphold this aspect of the complaint. The MWC recommended that the Board should review its care plan documentation and nursing observation policy. In the course of this investigation the Board have sent me copies of revised documentation now in use and have assured me that formalised care plans are now prepared for all patients. Given this, the Ombudsman has no further recommendations to make.

(c) The charge nurse failed to act on an instruction in Mr A's medical notes that he was not allowed to leave the ward unless accompanied by members of staff

30. Mr C complained about the Board's response which was that 'The charge nurse made the decision to allow [Mr A] out with [Mr and Mrs C] as she had read the entry in the medical notes and interpreted these as being accompanied time out which meant with staff or [Mr and Mrs C]'. I have seen that on 21 March the SHO wrote in the medical notes 'withhold home visits for now' and 'still allowed passes to the grounds, shops, either with parents, staff or girlfriend'. Below this is another entry by the SHO which reads 'Allowed 30 minutes to 40 minutes accompanied by nursing staff today, probably unaccompanied by tomorrow'. An entry made in the nursing notes on 21 March reads 'Reviewed by [the SHO] see medical notes. To have accompanied time out with staff only'.

31. Adviser 1 said that the records concerning leave arrangements on 21 March 2001 were inconsistent. It was hard to understand why Mr and Mrs C were allowed to take Mr A off the ward and were recorded as doing so immediately below an entry to the effect that he should only leave if escorted by staff. Adviser 1 continued that if Mr A had not been allowed to leave the ward, he would not have died as a consequence of his behaviour having left it. Equally Adviser 1 said it is by no means certain that had Mr A left the ward accompanied by nursing staff they would have been able to prevent his running away. However, it would be fair to say that the risk would have been reduced.

Adviser 1 said that it would be unlikely that further explanations about the decision to allow Mr A to leave with his parents could be found after such a time since the event.

32. Adviser 2 commented that the entry in the medical records for 21 March 2001 clearly state that Mr A's passes out (leave) may be taken with his parents, staff or friends. The entry below it (apparently written at the same time) states that he was 'allowed 30-40 minutes accompanied by nursing staff'. Adviser 2 said that this could either mean that the nursing staff should accompany Mr A or that the nursing staff could allow him to leave the ward accompanied – this is a lack of clarity in the record. The entry in the nursing records (presumably) later that day states that he should only go out accompanied by staff. Adviser 2 could understand why a nurse might take the second reading of the medical entry (ie that nursing staff allowed him accompanied leave) and to think it was appropriate for him to be allowed out with his parents as this had happened before. Adviser 2 felt that it would have been wise for the nurse to have clarified the situation in view of the discrepancy in the medical record.

33. Adviser 2 felt that it would be unlikely that so far after the event that additional information would be obtained about what happened or why staff took the actions they did. A request was made to the Board for copies of policies or guidance which would show that the failings which had been identified had been or were being addressed. The Board supplied copies of policies and procedures relating to discussing and recording time out which should ensure confusion about accompanied visits does not arise in the future; clinical risk assessment supported by guidance and training; observation policy; standards for ward management; care planning and record-keeping. Adviser 2 felt the current policies and procedures were excellent. Her only concern was the risk assessment tool which did not address the issue of impulsivity or when the patient's state of mind was unknown and she suggested that the Board may wish to consider these issues in a future review.

(c) Conclusion

34. Clearly there was confusion in Mr A's medical and nursing documentation with regards to whether he was allowed out of the ward only if accompanied by nursing staff or his parents. The nurse who allowed Mr A to leave the ward with Mr and Mrs C interpreted the notes to mean that this was allowed. The clinical advice which I have received and accept is that, based on Mr A's recent history,

he should only have been allowed out if accompanied by nursing staff. I too feel that in view of the apparently conflicting information in the records the nurse should have sought clarification from medical staff. Accordingly I uphold this complaint.

(c) Recommendation

35. The Ombudsman recommends that at the next review of their forms, the Board give consideration to amending the risk assessment tool to include issues such as impulsivity or when the patient's state of mind is unknown.

(d) The Board have not accepted responsibility for failing in its duty of care or offered an appropriate apology

36. Mr C complained that despite the MWC report the Board did not hold themselves in any way responsible for the death of Mr A. The MWC report said 'the Trust should reply to [Mr and Mrs C's] letter and consider whether an apology would be appropriate'. Mr C believed that the Hospital failed in its duty of care and that Mr A lost his life as a result, and that he and his wife were due a proper apology. The apology which had been given was for the distress and upset that Mr and Mrs C had experienced over the four years following the death of their son.

37. Adviser 1 said that in his view, taking together the issues identified in the MWC report, there was a failure of care in relation to the final decision to let Mr A out on leave with his parents.

(d) Conclusion

38. The MWC report could be read as saying that the Board should consider offering an apology to Mr and Mrs C for not replying to Mr C's original letter of complaint or for the failings which had been identified in the MWC report. I accept there are differing clinical views as to whether the overall treatment provided to Mr A was adequate. However, a number of failings have been identified in this report. These include shortcomings in medical supervision of the SHO; the interpretation and lack of clarity of medical and nursing records; whether Mr A should have been accompanied by nursing staff; and failure to complete a detailed multi-disciplinary care plan and risk assessment. I am of the view that these constitute failings in care to Mr A which have not been explicitly recognised by the Board and on that basis I uphold this complaint. The Board have told me whilst offers have been made previously to meet with the family and these have been declined, they feel that only by engaging

directly with them will it be possible to achieve some sense of closure of their tragic loss. They are willing to repeat the offer they have previously made to meet with the family either alone, or in a facilitated discussion, or with formal mediation.

(d) Recommendation

39. The Ombudsman recommends that the Board offer Mr and Mrs C a full apology for the failings in care which have been identified in this report. The Ombudsman draws the Board's attention to the SPSO guidance note on 'apology' (which sets out what is meant and what is required in a meaningful apology). The Board have acknowledged inadequacies in the apologies previously given to Mr and Mrs C and repeated their willingness to meet Mr and Mrs C to offer a face to face apology for the failings they have acknowledged. For their part, Mr and Mrs C have told me they have carefully considered this offer and will be happy to meet once they have received a full and meaningful apology for all the failings in care identified in this report including the aspect of lack of consultant cover. The Ombudsman encourages both parties to consider whether there is a basis on which, together, they can bring closure on this matter and this office is happy to work with them to facilitate that, should it be helpful to do so.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Mr A	The complainant's son
MWC	Mental Welfare Commission for Scotland
The Hospital	Gartnavel Hospital
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
Consultant 1	Consultant responsible for Mr A's treatment
Consultant 2	Consultant who was scheduled to be responsible for Consultant 1's patients while she was on leave
Consultant 3	Consultant who covered for Consultant 2 who went on sick leave
SHO	Senior House Officer who treated Mr A