Scottish Parliament Region: North East Scotland

Case 200702047: Tayside NHS Board

Summary of Investigation

Category

Health: Adolescent Mental Health Services; psychology and eating disorders

Overview

The complainant (Mrs C) raised a number of concerns about the lack of psychology and other adolescent mental health services available to her daughter (Miss A) by Tayside NHS Board (the Board). In particular Mrs C was concerned that a failure to provide Miss A with appropriate services led to an escalation of Miss A's depression and subsequent eating disorder which ultimately contributed to her death by suicide in 2007. Mrs C also complained that her attempts to raise her concerns with the Board received a patchy and slow response that did not recognise the ongoing importance of the concerns she was raising.

Specific complaints and conclusions

The complaints which have been investigated are that the Board failed to:

(a) provide Miss A with access to appropriate psychology services (*upheld*);
(b) provide Miss A with access to appropriate eating disorder services (*upheld*); and
(c) handle Mrs C's complaint in a timely and appropriate manner (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise in writing to Mrs C for all the failures identified in this report;
(ii) review the current service provision of family therapy to adolescents with eating disorders; and
(iii) consider the introduction of an Integrated Care Pathway designed around the NHS Quality Improvement Scotland and NICE guidelines on the management of anorexia.

Main Investigation Report

Introduction

1. On 5 November 2007, the Ombudsman received a complaint from the complainant (Mrs C) about the mental health treatments available in the Tayside NHS Board (the Board) area and in particular how this had impacted on the treatments available to her daughter (Miss A) between March 2005 and her death, by suicide, in April 2007, aged 18-years-old. Mrs C made several attempts to raise the matter with the Board, and although her complaints had been acknowledged and some responses received, she was concerned that all her concerns had not been addressed. Following receipt of the complaint by the Ombudsman's office our consideration of the matter was suspended pending further responses and a meeting with the staff, which did not resolve matters for Mrs C and the case was reopened by the Ombudsman's office.

2. The complaints from Mrs C which I have investigated are that the Board failed to:

(a) provide Miss A with access to appropriate psychology services;
(b) provide Miss A with access to appropriate eating disorder services; and
(c) handle Mrs C's complaint in a timely and appropriate manner.

Investigation

3. Investigation of this complaint involved reviewing Miss A's clinical records and the Board's complaint records relating to this complaint. I have also sought the opinion of a psychiatric adviser to the Ombudsman (Adviser 1) and a mental health adviser to the Ombudsman (Adviser 2) and discussed matters with Mrs C by telephone. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to provide Miss A with access to appropriate psychology services

4. Miss A was reviewed by the Child and Adolescent Mental Health Service (CAMHS) in early 2005 (she was then aged 16-years-old) at which time she was expressing suicidal feelings. She did not return for follow-up later that year. Miss A returned to CAMHS in 2006 as her mood declined. She was admitted to the Young People's Unit (YPU) in 2006 for a period of ten weeks.

5. Mrs C was concerned that Miss A was not offered adequate clinical psychology services in 2005 and 2006 as she only attended four Cognitive Behaviour Therapy (CBT) sessions with a clinical nurse specialist. Mrs C did not consider that Miss A had found these positive or helpful and noted she was placed on a waiting list for group therapy but this was several months long. Mrs C told me that there had been no discussion with members of Miss A's family about how her family might work together with Miss A to help her. Mrs C was most concerned that there were no clinical psychologists in post during 2005/2006 but it also appeared to be an ongoing issue of lack of psychology support for young people in the area and that Miss A's experience would be repeated.

6. Mrs C also noted that once Miss A was admitted to the YPU under the care of a psychiatrist (Doctor 1) she self harmed and took an overdose and again did not find her admission helpful. Mrs C noted that there were no clinical psychologists attached to the YPU and told me that she felt Miss A's condition deteriorated at this time. Miss A continued to see Doctor 1 through the summer of 2006 following her discharge from the YPU but refused to continue these appointments as she did not find them helpful. Mrs C told me that she felt there was no real help to manage Miss A's recurring low moods.

7. In their responses the Board noted that there was an issue of shortage of psychology services in 2005 and 2006 but that by 2007 a part-time consultant clinical psychologist had been appointed to the CAMHS team. The Board also advised Mrs C in July 2008 that there were plans in progress to provide a 12 bedded in-patient unit for young people in the North of Scotland with the more serious mental health problems, which would offer a comprehensive range of therapies and specialist support staff. The Board invited Mrs C to be involved in the development work for this.

8. Adviser 1 told me that the general practice in CAMHS units is to work with families in developing the care and treatment plans for a young person. Adviser 1 commented that her review of Miss A's notes did not reveal such a partnership or suggest a working relationship between Miss A's family and staff. Adviser 1 told me that she considered that during her initial contacts with CAMHS, Miss A did not receive timely treatment for her depression and that such treatment could have prevented Miss A later developing anorexia. Adviser 1 concluded that there was a lack of specialist psychology services available to Miss A which meant she was only given limited psychology input

and this had meant there was no alternative offered when the CBT services had not worked for Miss A.

(a) Conclusion

9. The Board have acknowledged that there was a shortage of psychology services available in 2005 and 2006. Adviser 1 has told me that the lack of services meant Miss A did not receive the timely treatment which could have prevented her developing the further problems as she did. I acknowledge that there have been developments in this area since the events of this complaint. However, these services were not available for Miss A when she was in need of them and I uphold this aspect of the complaint.

(a) Recommendation

10. In view of the actions already undertaken by the Board to provide psychology services within the CAMHS, the Ombudsman has no further clinical recommendation to make on this aspect of the complaint. The Ombudsman does recommend that the Board apologise in writing to Mrs C for all the failures identified in this report

(b) The Board failed to provide Miss A with access to appropriate eating disorder services

11. In 2006 following her admission to the YPU, Miss A developed anorexia and in January 2007 (now aged 18) she was assessed, at the arrangement of Mrs C, at a privately run eating disorders unit (the Unit). The assessment recommended an in-patient admission to the Unit, but this was not taken up by the Board who offered out-patient services in Tayside from both eating disorder and psychology services, with input from a dietician at the Unit.

12. Mrs C told me that the offer of out-patient services was insufficient for Miss A's needs. Miss A had not successfully engaged with CAMHS staff in the past and her developing anorexia had gone untreated and unremarked upon because of the lack of dietician or psychology support within the CAMHS. Miss A had, however, interacted well with the psychologist in the Unit during assessment and had wanted to be admitted. Mrs C also noted that the psychologist who was intended to provide the out-patient support to Miss A was known to be going on maternity leave a few weeks after, but this lack of continuity was not considered by the Board when deciding not to admit Miss A to the Unit. Mrs C considered that the decision not to admit was seriously influenced by financial concerns.

13. In response to a draft of this report the Board commented that the decision not to admit was not based on any financial constraint as the spending was discussed independently of any clinical decision. In Miss A's case it was agreed that any funding up to and including admission, if indicated, would have been allocated.

14. The Board responses noted that Miss A had declined further appointments with Doctor 1 in 2006 and did not meet the criteria for an eating disorder at that time. Mrs C has disputed this point as she notes that Miss A's menstrual cycle had ceased at this time but that she had not been asked any questions about this until she presented to her GP late in 2006. The Board also noted that Miss A was coming round to the idea of treatment and that Miss A had fully supported the decision not to be admitted to the Unit. This does not accord with Mrs C's views that Miss A had been expecting and was agreeable to, treatment in the Unit. Mrs C also noted that she was not kept informed by the Board of what was happening during this period.

15. Adviser 1 told me that the National Institute for Health and Clinical Excellence in England and Wales (NICE) produced guidelines in January 2004 for the management and treatment of eating disorders. These guidelines are not mandatory in Scotland but offer examples of good practice which are worthy of consideration. In addition, in November 2006, NHS Quality Improvement Scotland (NHS QIS) produced Recommendations for Management and Treatment of Eating Disorders. In this instance Adviser 1 told me that there appeared to have been a lack of family therapy offered to Miss A and Mrs C which was contrary to the NICE guidelines, particularly as this related to care of an adolescent. This was the case despite recognition by staff working with Miss A that management of family conflicts was a central issue for Miss A. The decision not to pursue in-patient treatment at the Unit was tempered by the suggestion that family therapy at the Unit might be needed a few months in the future, but Adviser 1 told me that good practice would have suggested a much earlier intervention was needed. Adviser 1 told me that she considered that the decisions not to admit Miss A as an in-patient to the Unit or to offer family therapy and support to Miss A and her family over time amounted to an unreasonable level of care and treatment.

16. In response to a draft of this report the Board expressed the view that it was not clear that Miss A wanted to be admitted as an inpatient to the Unit as

she was (as is common with patients with anorexia nervosa) extremely ambivalent about any treatment. The Board noted further that Miss A gave an extremely negative account of past in-patient experiences, and did not wish to repeat that. The Board told me that the advice from the Unit was that Miss A's reluctance to engage had to be handled with great care or she would not be amenable to any help. The Board commented that specialist in-patient treatment was one of the options, however, the Board noted this was not immediately necessary and noted that in their view Miss A did not meet the NHS QIS criteria for admission. Miss A was not considered by an adult psychiatric services doctor (Doctor 2) to be detainable under the mental health legislation. The Board told me that Miss A did have access to a specialist eating disorder service and staff made extensive effort to develop a creative care plan which was to be shared between local and specialist services at a pace which it was hoped Miss A could cope with.

17. I asked Adviser 1 and Adviser 2 to review the Board's comments. Both advisers noted that while there was a clear difference in view between Mrs C and the Board as to Miss A's willingness to be admitted as an in-patient, there was a lack of monitoring of Miss A's physical condition between her Unit assessment in February 2007 and her death in April 2007. Both advisers considered this to be an unacceptable level of care as it meant that the Board were not able to consider whether Miss A was continuing to lose weight and if so the need to further consider dehydration, electrolyte disturbance, hypoglycaemia and other serious consequences of anorexia not least of which is serious risk of self harm or suicide. This in turn could have necessitated the need to consider whether compulsory treatment was necessary.

18. Adviser 1 specifically noted that:

> 'The NHS QIS Guidelines refer to care and treatment tailored to the needs of the anorexic individual. Integrative care pathways need to include 'access to assertive outreach, day hospital care, inpatient care intensive treatment'… in the month between 22 March 2007 and 22 April 2007, when Miss A died, the care she received could not be described as assertive outreach. It was left to Miss A to determine her choices but her capacity to make appropriate choices as an adult was not being monitored, and should have been.'

19. Adviser 2 noted that Miss A's anorexia was probably not taken seriously enough with the primary focus being on her depression. Adviser 2 told me that

when admission to the Unit was decided to be unnecessary by Doctor 2 a structured and assertive package of care should have been put in place to promote and monitor Miss A's mental health and physical wellbeing. The decision to refer Miss A to a psychologist about to go on maternity leave demonstrates a lack of effective coordination of her care. Adviser 2 concluded that good practice suggests that, in the absence of a dedicated local NHS Eating Disorder Service, an Integrated Care Pathway designed around the NHS Quality Improvement Scotland and NICE guidelines should have been in place. Adviser 2 expressed his view that an in-depth critical incident review would have been the most effective way to review Miss A's care as clinical records and complaints correspondence can never give a complete picture (see also complaint (c)).

(b) Conclusion

20. Both Adviser 1 and Adviser 2 told me that the level of support offered to Miss A and her family over time was inadequate. Adviser 1 also told me that it was her view that ultimately the decision not to admit Miss A as an in-patient to the Unit was incorrect. Such an admission would have provided access to the family therapy which the NICE guidelines refer to as being needed to help patients with an eating disorder, and which was not otherwise available to Miss A. Moreover the advisers were of the view that given the decision was taken not to admit, the care offered to Miss A in the community was uncoordinated and inadequate. In view of this I uphold this aspect of the complaint that the Board failed to provide access to appropriate eating disorder services.

(b) Recommendations

21. The Ombudsman recommends that the Board:

(i) review the current service provision of family therapy to adolescents with eating disorders; and

(ii) consider the introduction of an Integrated Care Pathway designed around the NHS Quality Improvement Scotland and NICE guidelines on the management of anorexia.

The Ombudsman also notes that the apology referred to in paragraph 10 is relevant here.

(c) The Board failed to handle Mrs C's complaint in a timely and appropriate manner

22. Mrs C first raised a complaint with the Board in June 2007. The response letter sent on 29 June 2007 indicated a written response to her issues would be provided by the Chief Operating Officer or his deputy within four weeks. A holding letter was sent in early August explaining there would be a short delay and a response was sent on 16 August 2007 from the Director of Finance. Mrs C wrote to the Chief Executive of the Board on 9 September 2007 expressing concern that the response had come from someone with no mental health background and not the Chief Executive as she had been led to believe it would. Mrs C also raised a number of concerns about the response she had received as she felt this had not reassured her that her concerns had been recognised or that matters would be improved for other young people in the future. Mrs C was advised by letter of 17 September 2007 that the Chief Executive would undertake to respond to her concerns following a reinvestigation of the matter. Mrs C contacted the Ombudsman's office in June 2008 advising she had not yet received this response. It emerged that a response had been sent from the Associate Director of Mental Health directly to Mrs C in March 2008 but this was never received. A copy was forwarded to Mrs C in July 2008. Mrs C was distressed at the apparent lack of urgency in the response and the fact that again it did not come from the Chief Executive and moreover it did not address her specific concerns about Miss A's care but was of a far more general nature. At my suggestion a meeting was to be arranged by the Board in autumn 2008 to discuss Mrs C's concerns with her. There was a delay in organising this meeting which did not occur until May 2009 but during that time a further written response to the issues identified in Mrs C's previous correspondence was provided to Mrs C from the Chief Executive on 4 March 2009.

23. The Board apologised to Mrs C that the response to her letter of 9 September 2007 had been significantly delayed, did not respond to all the issues she had raised and had not come from the Chief Executive as she had expected. The Board has also apologised that she did not receive a copy of the response letter when it was originally sent in March 2008 and that these problems were not identified by complaints staff at the time.

24. In relation to another complaint to the Ombudsman's office I am aware that the Board has undertaken a review of the role played by complaints staff in progressing and monitoring complaints and that a number of changes to the

complaints system have occurred in late 2008 which would help to prevent the delays and confusions experienced by Mrs C in pursuing her complaint.

25. Adviser 2 noted that the handling of this complaint from the outset was ineffective. The delays in the process would have communicated a lack of understanding and compassion for Mrs C's situation - regardless of how upset or sorry the individual practitioners might have felt personally. Adviser 2 was emphatic that a full root-cause-analysis style critical incident review should have been conducted – perhaps two months after Miss A's death. He told me that a fully inclusive review of this nature involving all stakeholders, including family members, would have drilled down to the, undoubtedly complex, truths underlying this tragedy and resulted in meaningful service improvement recommendations. Such an approach would have clearly demonstrated a willingness to learn on the part of the Board. If properly conducted, the staff involved in Miss A's care would have felt supported. It would also have prevented Mrs C from becoming embroiled in a protracted complaints process which can only have contributed to her personal grief and stress.

(c) Conclusion

26. There were significant delays in responding to Mrs C's complaint following the initial response. There appears to have been a failure to ensure that the clinical staff asked to respond did so in a timely manner or to ensure that their responses adequately answered the questions raised. The response itself did not come from the Chief Executive, or an identified deputy as set out in the Board's complaints process.

27. For all these reasons I uphold this aspect of the complaint that the Board failed to respond to Mrs C's complaint in a timely and appropriate manner.

(c) Recommendation

28. In light of the changes already implemented by the Board the Ombudsman has no further recommendations to make beyond the apology identified in paragraph 10. However, the Ombudsman draws particular attention to the opinion of Adviser 2 that a Critical Incident Review was the appropriate course of action in a case such as this.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Tayside NHS Board
Miss A	Mrs C's daughter
Adviser 1	A psychiatric adviser
Adviser 2	A mental health adviser
CAMHS	Child and Adolescent Mental Health Service
YPU	Young People's Unit
The Doctor	The doctor responsible for Miss A's care in 2006
CBT	Cognitive Behaviour Therapy
The Unit	A privately operated eating disorders unit
NHS QIS	NHS Quality Improvement Scotland
NICE	National Institute for Health and Clinical Excellence in England and Wales
Doctor 2	Adult psychiatric services doctor

Annex 2

List of legislation and policies considered

National Institute for Health and Clinical Excellence in England and Wales (NICE) guidelines for the management and treatment of Eating Disorders. January 2004

NHS Quality improvement Scotland 2006
Eating Disorders in Scotland: Recommendations for Management and Treatment