Scottish Parliament Region: South of Scotland

Case 201001620: Dumfries and Galloway NHS Board

Summary of Investigation

Category

Health: Hospitals – psychiatry; policy/administration

Overview

The complainant (Mr C) complained about the care and treatment provided to his sister-in-law (Mrs A) while she was in the care of Dumfries and Galloway NHS Board (the Board). He alleged that the Board failed to provide appropriate mental health care for Mrs A during a period when she was physically unwell.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A's anti-depressant medication, phenelzine, was stopped without reasonable psychiatric consultation in April 2010 *(upheld);*

(b) keyhole surgery was undertaken inappropriately on Mrs A in April 2010 *(not upheld);*

(c) following surgery for bowel cancer in April 2010, Mrs A was sent home without reasonable aftercare instructions, which led to further health problems and the need for her bowel to be extended *(upheld);* and

(d) Mrs A was unreasonably able to acquire the means and opportunity to self-harm in Dumfries and Galloway Infirmary and Crichton Royal Hospital *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mr C for the fact that no proper advice was given to Mrs A pre and post-operatively;	24 September 2011
(ii) when presented with patients for surgery with known mental health issues for which they take medication, ensure that the circumstances are discussed with the patient, the GP and clinicians involved;	24 October 2011

(iii)	ensure that all relevant discussions with the patient, GP and clinicians (and any subsequent outcomes) are recorded properly;	24 October 2011
(iv)	give consideration to the terms of their permission forms for operations, given the failures with regard to Mrs A;	24 October 2011
(v)	apologise to Mr C for their failure to provide Mrs A with adequate aftercare instructions in April 2010;	24 September 2011
(vi)	review their procedures to ensure that such an occurrence does not occur again;	24 October 2011
(vii)	apologise to Mr C for the insufficient care they took to prevent Mrs A from accessing the means to harm herself; and	24 September 2011
(viii)	where patients have expressed thoughts of suicide, carry out (and fully record and act on) risk assessments.	Immediately

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

Main Investigation Report

Introduction

1. Mr C complained on behalf of his sister-in-law, Mrs A, who had a history of depressive illness stretching back some 30 years. Throughout this time she had been taking anti-depressive medication (phenelzine). After her husband died in 2005, Mrs A lived alone but with ongoing support from her family. In March 2010 she was diagnosed as having bowel cancer and surgery was planned for her in early April 2010. Mrs A stopped taking her anti-depressant on 25 March 2010 in preparation for surgery, as it had a known risk of an adverse reaction with anaesthetic drugs and pain killers.

2. Mr C was of the view that Mrs A's care and treatment from that point was less than satisfactory. He maintained that she became increasingly mentally unwell after her anti-depressant medication was stopped and not restarted. He said that this, in turn, compounded her medical condition and she became extremely unwell.

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

(a) Mrs A's anti-depressant medication, phenelzine, was stopped without reasonable psychiatric consultation in April 2010;

(b) keyhole surgery was undertaken inappropriately on Mrs A in April 2010;

(c) following surgery for bowel cancer in April 2010, Mrs A was sent home without reasonable aftercare instructions, which led to further health problems and the need for her bowel to be extended; and

(d) Mrs A was unreasonably able to acquire the means and opportunity to self-harm in Dumfries and Galloway Infirmary (Hospital 1) and Crichton Royal Hospital (Hospital 2).

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C and Dumfries and Galloway NHS Board (the Board). My complaints reviewer has had sight of the Board's complaints file and all Mrs A's appropriate clinical records and the Board have made comments to this office on the complaints outlined above, by letter of 22 October 2010. Advice has been obtained from independent specialist advisers in psychiatry (both nursing and clinical) and surgery. My complaints reviewer also obtained advice from a general physician.

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

Background to the complaint

6. Mrs A's clinical records show that she had suffered from bowel symptoms for a number of years. She also suffered severe depressive symptoms for more than 30 years and for which she received treatment including ECT (electroconvulsive therapy). At the time of the investigation of her bowel symptoms, early in 2010, she was taking phenelzine, an antidepressant drug. She was not, however, under regular psychiatric review, relying on her GP for repeat prescriptions.

7. On 19 February 2010, Mrs A had a colonoscopy which showed cancerous changes in her upper rectum. A CT scan (a computerised tomography scan) on 5 March 2010 showed no other disease or secondary spread but Mrs A was informed that she needed to have an operation. She was admitted to Hospital 1 on 1 April 2010 and, on 4 April 2010, the tumour was removed laparoscopically by a laparoscopic surgeon (the Surgeon), assisted by a consultant (the Consultant). There were no immediate complications and Mrs A was discharged home on 9 April 2010 and her GP was informed, with the suggestion that he advise about the restarting of phenelzine.

8. Soon after, Mrs A developed abdominal problems and she was admitted to Hospital 1 as an emergency with an obstructed bowel on 17 May 2010. She had a stent fitted to expand her bowel on 19 May 2010 and the next day was allowed home. However, her family said that at this time her psychiatric symptoms were recurring and reported that she was in a ‘zombie-like' state. Accordingly, they returned her to Hospital 1 on 24 May 2010 when she saw a GP trainee on psychiatric attachment, who discussed her case with the on-call psychiatric registrar. Mrs A's notes recorded that she was anxious and physically restless but ‘certainly not depressed' and she was prescribed a tranquilliser to be taken up to four times daily, ‘for 2 weeks until she's had the surgery'. She was also referred to the Community Mental Health Team (CMHT) who would contact her and discuss her case with a consultant psychiatrist about ‘re-starting an alternative anti-depressant'. Mrs A was advised to contact the CMHT if she found she could not manage her anxiety. She was discharged the same day.

9. The notes recorded that Mrs A continued to deteriorate mentally so that when the CMHT visited her at home on 1 June 2010 (Mr C said, as a result of an emergency call-out) she was admitted to Hospital 2, which provided specialist psychiatric and psychological care. However, she was admitted to Hospital 1 on 9 June 2010 where she underwent emergency surgery and a colostomy was created. On 14 June 2010, while Mrs A was an in-patient there, she self harmed by cutting her wrists. She was transferred to Hospital 2 the same day. On 1 July 2010 she again self harmed and was transferred to Glasgow Royal Infirmary (Hospital 3). She returned to Hospital 2 on 9 July 2010 but on 27 August 2010 she self harmed, a third time, by ingesting bleach. On 8 January 2011 Mrs A consumed weed killer and died as a consequence on 11 January 2011.

(a) Mrs A's anti-depressant medication, phenelzine, was stopped without reasonable psychiatric consultation in April 2010

10. Mr C complained that Mrs A was taken off phenelzine, after approximately 30 years, before her operation in April 2010. He said she was told to by the Consultant and that this happened without any psychiatric consultation. Then, he said, after the operation, she was sent home without any instructions to attend her own doctor or without any medication to allow her to lead a normal life.

11. He said this situation continued for six weeks and, as a consequence, Mrs A's general medical and mental health deteriorated enormously. He believed that the Board's care and treatment of Mrs A in this regard was totally inadequate and contributed to her decline in health.

12. When being advised of Mr C's formal complaint to us, in their letter of reply dated 22 October 2010, the Board maintained the position they had taken in responding to Mr C's direct complaint to them: that Mrs A had stopped taking phenelzine of her own accord. They said that from previous experience it appeared that she was aware that the drug needed to be discontinued prior to surgery because of the anaesthetic risks. They pointed to a note in her surgical pre-assessment care pathway which stated:

> ‘Alert details – depression/on phenelzine. Comments – previous surgery cancelled due to medication not being stopped therefore patient has already stopped for five days on her own accord.'

13. The Board also said that on admission Mrs A was considered to be of a stable mental state and there appeared to be no indication for a psychiatric consultation at that time. They also said that Mrs A's GP was informed of her discharge and received a copy of her discharge summary which recorded that her phenelzine had been stopped and also contained the statement, 'GP to revise if required as patient has not had any for three weeks now'.

14. The specialist mental heath nurse adviser (Adviser 1) consulted in this matter confirmed that the records showed Mrs A had stopped taking phenelzine of her own accord on 25 March 2010 in preparation for her surgery. He said that the drug concerned was of a type which should normally be stopped two weeks before any planned surgery because of known adverse reactions. He said that it was recommended that any discontinuation was gradual to avoid any potential withdrawal symptoms.

15. My complaints reviewer also took advice from a specialist in surgery (Adviser 2), who said that Mrs A's clinical notes failed to show that there had been a full discussion between the surgical team and Mrs A's GP, psychiatrist or anaesthetic team. He said discussions should have taken place to ensure a slow withdrawal of the drug to avoid the complications of sudden withdrawal. He said there should have been full advice from Mrs A's psychiatric team about her management before, during and after her surgery and decisions recorded about the type of anaesthesia to be used and avoided. Adviser 2 also informed me that the surgery on 19 May 2010 had failed and that further specialist dilators were ordered for a further operation.

16. A specialist in psychiatry (Adviser 3) confirmed that it was correct for Mrs A not be taking phenelzine when she had her operation on 4 April 2010, in order to increase the safety of the anaesthesia and analgesia she would require. He said that, in his view, it was not absolutely essential that a psychiatric assessment was made prior to her operation but that it would have been good practice for one of the doctors on the surgical team to have discussed the case directly with Mrs A's GP. However, he said that on 24 May 2010, when Mrs A was readmitted to Hospital 1 from home after her operation, the GP trainee (see paragraph 8) recorded an adequate history and examination of her mental state. He said that the GP trainee's assessment of the situation was reasonable and that, furthermore, in his opinion it would not have been practical at this stage to restart the drug because it appeared that more surgery was going to be required (see paragraph 14). He said that the

unreasonable practice on the part of the surgical team was that they did not make proper arrangements for considering restarting phenelzine after the initial surgery (on 4 April 2010), as Mrs A was left exposed for six weeks without it. He said by chance, by 24 May 2010, Mrs A was better placed when the need for surgery arose. However, generally, Adviser 3 said that the post-operative management concerning the re-starting of phenelzine fell well below the standard that should have been expected. This view was echoed by the general physician adviser (Adviser 4) who said that although the Board did advise Mrs A's GP that the drug had been stopped (see paragraph 13), there was no evidence in the clinical notes of any other communication or discussion with Mrs A, her family or any other service. In his view too, this was well below a standard that could be reasonably expected.

(a) Conclusion

17. While Mr C thought that Mrs A had been taken off the drug phenelzine by medical staff, this was not the case. The notes recorded that Mrs A had done this herself as a result of her previous experience (see paragraph 12). All four specialist advisers agreed this was the case. However, they were all critical about the lack of proper advice given to Mrs A before her operation. She had been taking this particular drug for 30 years and it was known that an abrupt cessation could cause withdrawal symptoms. The situation did not improve post-operatively. She was left exposed without the drug for six weeks with little advice. In all the circumstances, I uphold the complaint and I recommend that the Board should apologise.

18. It is important that patients are treated holistically. Accordingly, the Board should seek to avoid a similar recurrence. When patients present for surgery and it is known that they have mental health issues for which they take medication, the Board should ensure that the circumstances are fully discussed with the patient, the GP and other clinicians directly involved. Further, the Board should ensure that these discussions and subsequent outcomes are appropriately recorded.

(a) Recommendations

19. I recommend that the Board:	*Completion date*
(i) apologise to Mr C for the fact that no proper advice was given to Mrs A pre and post-operatively;	24 September 2011

(ii)	when presented with patients for surgery with known mental health issues for which they take medication, ensure that the circumstances are discussed with the patient, the GP and other clinicians involved; and	24 October 2011
(iii)	ensure that all relevant discussions with the patient, GP and clinicians (and any subsequent outcomes) are recorded properly.	24 October 2011

(b) Keyhole surgery was undertaken inappropriately on Mrs A in April 2010

20. It is Mr C's contention that Mrs A had no choice about the type of operation she had and that she was strongly recommended to have keyhole surgery rather than a 'full' operation. He said this was inappropriate given her poor overall health (including her mental health) and he maintained that this type of operation contributed to her worsening mental health situation.

21. In writing to us about this particular aspect of the complaint the Board, in their letter of 22 October 2010, said that both options, open surgery and laparoscopic (keyhole), were discussed with Mrs A. They maintained that laparoscopic was her preference because it meant that she would have a shorter stay in hospital afterwards. They said that laparoscopic surgery was considered appropriate by the Consultant who had performed the surgery with the Surgeon (see paragraph 7). The Board advised that the Surgeon was one of the leading laparoscopic surgeons in the UK and, had he had any doubts about this type of surgery, he would have acted upon them. They also said that laparoscopic surgery was deemed by all clinicians involved to have been entirely appropriate.

22. Adviser 2 confirmed to my complaints reviewer that laparoscopic surgery is appropriate for upper rectal cancer and is a safe and reliable technique. However, he said that if a full discussion (see paragraph 15) had taken place with Mrs A about the cessation of phenelzine prior to the operation, this might have led to a discussion as to whether a general anaesthetic or spinal/epidural anaesthetic was the safest for Mrs A. He said that if regional anaesthesia was advised, open surgery would have had to have been performed and explained to Mrs A. It was, however, recorded that surgical technique only (as opposed to anaesthesia) was discussed with Mrs A, whose preference was laparoscopic as it might lead to a shorter stay in hospital. Adviser 2 said that both techniques

were reliable and well tested but a final decision should have taken into account Mrs A's psychiatric medication and the problems relating to her depressive state. He also said the permission form for the operation was inadequate, in that it did not include reference to possible stoma or conversion to open surgery if needed. He went on to say that both techniques (laparoscopic and open surgery) involved a bowel joining procedure and the risk of this leaking or narrowing after surgery was present however the operation was performed. Therefore, early introduction of a proper diet and its maintenance were essential. He pointed out to me that Mrs A's clinical records on 3 August 2010 noted that she had lost 20 kilograms in weight and said she was probably not eating properly due to her psychiatric condition. He said that in his view, the failure to properly supervise her diet (mental state and medication needs) during the post operative period led to complications of the operation. This led to bowel obstruction and further emergency surgery.

23. Notwithstanding, Adviser 2 was of the view that laparoscopic surgery was appropriate for Mrs A but that there were failures identified with this in that there could have been implications of not having a full discussion about the cessation of phenelzine. He considered her aftercare to have been poor (this is addressed in complaint (c), below).

(b) Conclusion

24. I have taken into account what Mr C has said on this matter and the Board's view that laparoscopy was what Mrs A preferred, given that it meant a shorter stay in hospital. Adviser 2 also reviewed Mrs A's medical notes and was of the opinion that laparoscopic surgery was appropriate for Mrs A. In the circumstances, I do not uphold Mr C's complaint that keyhole surgery was undertaken inappropriately. Nevertheless, I have concerns about what appears to have been a lack of post operative monitoring of Mrs A's physical and mental condition and, in the circumstances, I recommend that the Board reconsider the terms of their permission forms for operations, to take into account the concerns raised by Adviser 2 (that it did not include reference to the possibility of a stoma or conversion to open surgery given Mrs A's past surgical history).

(b) Recommendation

25. I recommend that the Board:	*Completion date*
(i) give consideration to the terms of their permission forms for operations, given the failures with regard	24 October 2011

to Mrs A.

(c) Following surgery for bowel cancer in April 2010, Mrs A was sent home without reasonable aftercare instructions, which led to further health problems and the need for her bowel to be extended

26. Mr C said that, after her operation on 9 June 2010, Mrs A was sent home without any instruction to attend her own doctor and without any medication to allow her to return to a normal life. He said her general and medical health were declining rapidly and he attributed this to the Board's failure to monitor her aftercare properly.

27. In relation to this aspect of the complaint, the Board maintained that Mrs A was sent home with reasonable aftercare instructions. They said that at the point of discharge her wound was clean and healing well; she was eating and drinking and her bowels were working satisfactorily; Mrs A's discharge summary noted that she had been prescribed a painkiller (paracetamol) and something to treat any vomiting or nausea (domperidone); and her GP was made aware of her surgery outcome and her medicines and of a possible requirement regarding phenelzine. The Board also mentioned that the stricture from which she suffered was a known complication of both open and laparoscopic surgery (but see Adviser 2's concerns about the consent form, paragraph 22).

28. Adviser 2 has expressed his reservations about the quality of the aftercare given to Mrs A (see paragraph 22). In connection with this complaint he told my complaints reviewer that there were failures after the operation to properly monitor Mrs A's condition (for instance, her diet) which, in his view, led to her deteriorating condition. He said Mrs A's aftercare was not recorded clearly in her notes and, in view of her depressive state, she should have been checked frequently by her GP and district nurses liaising with psychiatric services in the community. He considered her aftercare to be inadequate. He, like Mr C, considered that the failure to monitor Mrs A properly after her operation led to complications. In his view, this, in turn, led to bowel obstruction and further emergency surgery. He said that Mrs A reacted badly after her colostomy and stated that it was like a bereavement. This worsened her psychiatric state.

(c) Conclusion

29. Notwithstanding the Board's view, I cannot ignore the advice given by Adviser 2. He was definite in his opinion about the aftercare given to Mrs A and its subsequent repercussions. In consideration of all the circumstances, I

uphold this complaint. I recommend that the Board apologise to Mr C in relation to their failures in this regard and also that they undertake a review of their procedures to ensure that such an occurrence does not occur again.

(c) Recommendations

30. I recommend that the Board:	*Completion date*
(i) apologise to Mr C for their failure to provide Mrs A with adequate aftercare instructions in April 2010; and	24 September 2011
(ii) review their procedures to ensure that such an occurrence does not occur again.	24 October 2011

(d) Mrs A was unreasonably able to acquire the means and opportunity to self-harm in Hospital 1 and Hospital 2

31. Mr C said that after her second operation on 9 June 2010 (when she had a colostomy), Mrs A's depression got worse and this resulted in her self harming. On 14 June she cut her wrists with scissors and on 1 July 2010 she used a knife on her arms resulting in life threatening injuries, which required that she be admitted to Hospital 3. Mr C said that after a week she was returned to Hospital 2 and investigation took place into how she obtained a knife while she was in a ward there. Mr C said Mrs A told them this was where she had obtained the knife but he said that staff refused to accept this. Mrs A was placed on a short-term detention certificate under the Mental Health Act (from 27 July to 23 August 2010), that is, without any home visits. Then, on 27 August 2010, she ingested bleach and was taken from Hospital 2 to Hospital 1 as an emergency. She was readmitted to Hospital 2 on release. Mr C said he found it hard to believe that Mrs A was able to self harm three times while supposedly in a safe environment.

32. In response, the Board said that while Mrs A was in Hospital 1, on 14 June 2010, she cut her wrists with the nail scissors from her manicure set. They said that a risk assessment had been in place at the time and no increased risk of self harm had been identified prior to this incident. On the second occasion (1 July 2010), the Board stated that a significant incident review took place after the event and all possible avenues were explored to identify how Mrs A had acquired the knife but that she would not disclose that information. A further significant incident review took place regarding the incident on 27 August 2010.

33. Adviser 1 said from his review of Mrs A's clinical records there was little to suggest to him that there was evidence of proper liaison between Hospital 1 and Hospital 2 concerning her mental health. Adviser 3 confirmed this (see paragraph 15) and said that the parties involved must have been aware of her mental frailty because, on 24 May 2010, Mr C's family brought her back to Hospital 1 saying that she was in a zombie-like condition (see paragraph 8). The notes also confirmed that on 1 June 2010, the community based Crisis Assessment and Treatment Service (CATS), who had been asked by the CMHT to drop off medication for Mrs A, found her to be ‘zonked' and agitated. She was admitted to Hospital 2. The referral proforma CATS completed referred to her expressing suicide ideation, as does the nursing admission checklist, although the medical assessment records noted that she was not suicidal. Hospital 2 nursed Mrs A on 10 minute observations.

34. Mrs A was readmitted to Hospital 1 on 7 June 2010 with post-operative complications and had a second operation (colostomy) on 9 June 2010. Although her history of depression was acknowledged when she was checked in, Adviser 1 said that there was nothing to suggest from her records that her mental state was being monitored. Yet, by this time, it must have been clear from the foregoing that there were question marks surrounding her mental health but Adviser 1 said that there was nothing in her notes to suggest that this was considered in June 2010. In the meantime, Mrs A self harmed with scissors and, given that she had a long history of depression, Adviser 1 was firmly of the opinion that staff should have been more vigilant regarding her access to potentially harmful instruments. He suggested that if greater regard had been paid to her mental health needs, staff may have been more alert, more aware of the risks and put safety measures in place.

35. There was a more serious incident of self harm on I July 2010 when Mrs A was detained in Hospital 2, which ultimately required Mrs A's admission to Hospital 3. Mrs A then drank bleach on 27 August 2010 when she was once again a patient in Hospital 2. The critical incident report into these incidents (dated 14 September 2010) concluded that the cutting incident was ‘unpredictable'. Adviser 1 said that he could see no evidence in this critical incident report that, prior to either of the incidents concerned, appropriate risk assessment had been done. He said that there was a report completed on 8 October 2010 but this was long after both incidents and after the critical incident review.

36. In his view, Adviser 1 said the fact that Mrs A was able to access a knife and bleach while she was in Hospital 2 (a hospital providing specialist psychiatric and psychological care) pointed to a systems failure. He said that the critical incident report failed to recognise this or to get to the root causes of events.

(d) Conclusion

37. It appears to me that there were sufficient indications in Mrs A's clinical records to show that she was in an extremely parlous state and had expressed thoughts of suicide (see paragraph 33). She had also been detained under the Mental Health Act (see paragraph 31). Accordingly, I believe greater care should have been taken concerning her safety and her ability to access the means to harm herself. I uphold the complaint.

(d) Recommendations

38. I recommend that the Board:

		Completion date
(i)	apologise to Mr C for the insufficient care they took to prevent Mrs A from accessing the means to harm herself; and	24 September 2011
(ii)	where patients have expressed thoughts of suicide, carry out (and fully record and act on) risk assessments.	Immediately

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

40. During the progress of this investigation, on 8 January 2011, Mrs A consumed weed killer while she was at her mother's home. She died as a consequence on 11 January 2011.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	The aggrieved
Hospital 1	Dumfries and Galloway Royal Infirmary
Hospital 2	Crichton Royal Hospital
The Board	Dumfries and Galloway NHS Board
The Surgeon	A laparoscopic surgeon
The Consultant	The consultant who assisted the Surgeon on 4 April 2011
CMHT	Community Mental Health Team
Hospital 3	Glasgow Royal Infirmary
Adviser 1	A specialist mental health nurse
Adviser 2	A specialist in surgery
Adviser 3	A specialist in psychiatry
Adviser 4	A general physician
CATS	Crisis Assessment and Treatment Service

Annex 2

Glossary of terms

Colonoscopy	The examination of the colon using a camera
Colostomy	A surgical procedure to form an opening in the large intestine
Laparoscopic	Minimally invasive/keyhole
Phenelzine	An antidepressant drug
Stoma	An opening in the large intestine
Stricture	Abnormal narrowing