Scottish Parliament Region: North East Scotland

Case 201003783: Tayside NHS Board

Summary of Investigation

Category

Health: Mental Health Services

Overview

The complainant (Mr C) raised a number of concerns about the standard of care and treatment provided to his son (Mr A) by Tayside NHS Board (the Board)'s Mental Health Service during the 13 months prior to his death by suicide in July 2010. Mr C also raised concerns about the communication between health staff and Mr A's family during this period.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) did not provide Mr A with appropriate care and treatment for his depression (*upheld*); and

(b) failed to communicate effectively with Mr A's parents (Mr and Mrs C) or consult with them regarding Mr A's treatment and progress (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make the use and review of the risk screening tool to complement and inform the risk assessment process mandatory for all patient assessments following a self-harm / suicide attempt;	28 February 2012
(ii) review their process for conducting RCAs to ensure a degree of independence;	28 February 2012
(iii) revise procedures in responding to Ombudsman's investigations to ensure no documents are omitted or withheld;	28 February 2012
(iv) review their practice with respect to the involvement of family and others, to ensure it is in line with the good practice contained in the NES framework;	28 February 2012

(v)	review their process for involving families in SIRs and RCAs; and	28 February 2012
(vi)	issue Mr C with a formal written apology for the failures identified in this report.	31 January 2012

Main Investigation Report

Introduction

1. Mr A (who was 20 years old when he died) was first seen in the short-stay ward in Ninewells Hospital (the Hospital) on 15 June 2009 following an intentional overdose. Mr A called for the ambulance which took him to the Hospital. He told staff that he was suicidal and suffering stress because of work and home pressures. He also told staff he had increased his use of alcohol significantly in the past months. He was reviewed by a Clinical Nurse Specialist in Liaison Psychiatry (Psychiatric Nurse 1), who arranged an out-patient appointment and contacted Mr A's GP to arrange a prescription for an anti-depressant.

2. Over the next 12 months Mr A was seen 12 times by Psychiatric Nurse 1; mostly at out-patient appointments. Mr A's mother (Mrs C) contacted Psychiatric Nurse 1 in February 2010 expressing concern about Mr A's mood and discussed the possibility that Mr A suffered from Bipolar Affective Disorder (a psychiatric illness). Mrs C attended an appointment with Mr A and Psychiatric Nurse 1 the following week. In late March 2010, following two missed appointments that month; Mr A was discharged from Psychiatric Nurse 1's caseload.

3. On 1 April 2010, Mr A was seen by another member of the Community Mental Health team (Psychiatric Nurse 2) at Wedderburn House, as he had taken a further intentional overdose. Mr A expressed concern that he might be suffering from Bipolar Affective Disorder. A review by a consultant liaison psychiatrist (the Psychiatrist) was arranged and took place on 29 April 2010. The Psychiatrist concluded that Mr A was not suffering a psychiatric illness and referred him to Tayside Alcohol Problem Service (TAPS).

4. Mr A was readmitted to the Hospital via the Accident and Emergency Department on 1 July 2010 following a third intentional overdose. He was reviewed by Psychiatric Nurse 1 (as duty psychiatric liaison) who recorded that there was no evidence of psychiatric abnormalities and that Mr A denied any current suicidal thoughts. Psychiatric Nurse 1 suggested that Mr A make contact with two organisations, both providers of independent mental health care and support, which operate in the voluntary sector. No other follow-up was arranged. Mr A was discharged from the Hospital later that day. Mr A took his own life a little over two weeks later on 16 July 2010.

5. Mr A's father (Mr C) complained to Tayside NHS Board (the Board) on 20 August 2010 and received a written response to his complaints on 6 October 2010. Following meetings with the Board and the Associate Medical Director, Mr C was not satisfied with the explanations they gave about Mr A's treatment or about the lack of involving Mr A's immediate family with his care and Mr C complained to this office.

6. The complaints from Mr C which I have investigated are that the Board:

(a) did not provide Mr A with appropriate care and treatment for his depression; and

(b) failed to communicate effectively with Mr and Mrs C or consult with them regarding Mr A's treatment and progress.

Investigation

7. In her investigation into this complaint, my complaints reviewer obtained and examined both Mr A's clinical records relevant to this complaint and the complaint correspondence from the Board. She obtained advice from two of my professional advisers, a mental health nurse (Adviser 1) and a psychiatrist (Adviser 2). My complaints reviewer also held discussions with Adviser 1 and spoke with Adviser 2 and Mr C by telephone.

8. I have not included in this report every detail investigated but 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.

(a) The Board did not provide Mr A with appropriate care and treatment for his depression

9. Mr C was concerned that Mr A was not treated appropriately for his depression and that his condition was not taken seriously enough. He complained that, despite the numerous appointments with Psychiatric Nurse 1 and a review by the Psychiatrist, Mr A had made a number of attempts on his own life and each time was sent home to his family, with no information or support to help him best deal with his condition. In particular, Mr C felt that Mr A's deteriorating condition and continued attempts to take his own life should have made 'alarm bells' ring with his care team and made them more proactive. Mr C believed that opportunities to help Mr A were missed and these may have saved Mr A's life.

10. In their written response to Mr C's complaint and in a subsequent meeting, the Board sought to reassure Mr C about his concerns. The Board stated that both Psychiatric Nurse 1 and the Psychiatrist considered that Mr A was suffering mild to moderate depression and this was a result of various stressful factors in his life such as work and money worries and at times made worse by his heavy consumption of alcohol. The Board stated that there was no indication that Mr A required further review/assessment or in-patient treatment, however, there would have been no hesitation in providing him with such services if these had been indicated.

11. Adviser 1 and Adviser 2 reviewed Mr A's medical records and provided a number of comments on the care provided to him, from June 2009 to July 2010. Both Adviser 1 and Adviser 2 considered that the initial responses to Mr A's first overdose were appropriate and followed relevant guidance and good practice in this area. Adviser 1 noted that Psychiatric Nurse 1 was well qualified and had specialist experience in suicide prevention work. However, both Adviser 1 and Adviser 2 were concerned that there were indications of a change in Mr A's attitudes and patterns of behaviour from March 2010 onwards. They considered that these may have indicated an increased risk of suicide and his treatment plan should have been altered accordingly.

12. In particular, Adviser 1 noted these points:

- Mr A had missed two appointments with Psychiatric Nurse 1 on 9 and 23 March 2010. He stated that perhaps this was further evidence of Mr A's sense of rejection and a potential indicator of feelings of hopelessness;
- Mr A was discharged from Psychiatric Nurse 1's caseload in late March 2010. Adviser 1 stated that not being sent a further appointment may have reinforced a sense of rejection;
- Mr A's drinking remained problematic;
- Mr and Mrs C were expressing increased concerns for his ongoing safety;
- on 1 July 2010 Adviser 1 stated there was some evidence that Mr A's risk of suicide was becoming chronic. For example, it was known that he had overdosed on two previous occasions and this was the third time. The time-span between the second two events was significantly shorter than that between the first two. The amount of medication taken on each occasion appeared to have increased. Mr A's denial of ongoing suicidal intent after each overdose may have demonstrated that the acute risk had

passed; however, the chronic risk remained. Adviser 1 also stated that although acute risk may well resolve, it is important for clinicians to be alert to the person's enduring vulnerabilities and potential continued suicide risk;

- Mr A said he was the victim of an assault (immediately prior to this suicide attempt) and Adviser 1 stated that may have increased his stress levels. He had also experienced more stress about work and had recently lost his job; and
- Mr A was not given a follow-up appointment to see Psychiatric Nurse 1 after he was seen by him on 1 July 2010. He was advised to contact the two voluntary sector organisations and this may have further heightened his sense of rejection (see paragraph 4).

13. Adviser 1 concluded that he did not think that in-patient Mental Health care was indicated at any point during Mr A's contact with Mental Health Services and, even with the factors outlined in paragraph 12, there was not sufficient evidence to classify he was at high risk of suicide. He stated that Mr A did not meet the criteria for detention in hospital.

14. Adviser 1 noted that Mr A's suicide would have been difficult to predict as he had stable periods, and previous suicide attempts were impulsive and associated with heavy drinking episodes. However, he did not feel it was sufficient to send Mr A home on 1 July 2010 with only a hand-written note and contact details for the two voluntary sector organisations but suggested that, at a minimum, a follow-up appointment with Psychiatric Nurse 1 should have been offered. Adviser 1 also noted that Psychiatric Nurse 1 had not used the Clinical Risk Assessment and Management Tool provided to this office by the Board as the tool used by their staff to assist in the identification of suicide risk. Adviser 1 commented that such tools, used on a needs led basis, can aid the formulation of risk and make the risk assessment process more transparent. Completion of the risk assessment may not have alerted staff to an increased risk of suicide on Mr A's part, however, using the tool initially and then reviewing the findings at each consultation may have assisted Psychiatric Nurse 1 to identify gradual changes in Mr A's presentation over time (see paragraph 12). Use of this tool could also have supported the development of a care plan which Mr A would have been aware of and would have been able to share with his family (see complaint b).

15. Adviser 2 concluded that, while he considered Mr A had received appropriate and reasonable care, he was concerned this was based on inadequate assessment and that a more comprehensive assessment may have led to more intensive treatment. Adviser 2 also stated that within Mr A's clinical records, there was no record of an assessment completed by Psychiatric Nurse 1 or the Psychiatrist.

16. Adviser 1 and Adviser 2 noted that both Psychiatric Nurse 1 and the Psychiatrist had each written individually to Mr A's GP with details of their findings regarding Mr A's pathway of care.

Significant Incident Review/Root Cause Analysis

17. At the conclusion of the investigation and as part of our normal process the Board and Mr A were provided with a copy of the draft report to comment on any factual inaccuracy. It was only at this stage that the Board provided my complaints reviewer with copies of both the Significant Incident Review (SIR) held on 30 August 2010 and the Root Cause Analysis (RCA) undertaken on 10 August 2011. In this report I express my serious concern that the SIR and the RCA were not provided to my office during the course of the investigation and were only provided after the draft report was issued (paragraphs 30, 31 and 33 refer).

18. Having considered both documents carefully I have concluded that:

- there was no written care or treatment plan for Mr A and none of this is reflected in the SIR or RCA; this calls into question the rigour with which these reviews were carried out;
- the RCA we have seen is at best superficial, it is not independent and is conducted by those involved in the care of Mr A;
- the RCA appears to have been conducted only after three other suicides had taken place; and
- in the case of Mr A only 22 lines in the two page RCA document are devoted to his circumstances.

Given my significant concerns in relation to the SIR and RCA I have made reference to them in my conclusions on complaints (a) and (b) and make recommendations related to both reviews.

(a) Conclusion

19. Adviser 1 and Adviser 2 were satisfied with Mr A's initial care and treatment; however, they felt that more thorough assessments would have assisted in identifying changes in his behaviour. This would have helped identify increased risk, which could have led to more treatment being offered to him.

20. It is clear from the medical records that at no point in Mr A's care was an explicit assessment made of risk either in terms of the potential for future self-harm or suicidality. Despite seeing Mr A on 13 separate occasions, Psychiatric Nurse 1's records consist of notes of meetings with Mr A and record some of Mr A's comments on his views of his feelings and intentions. They do not contain an adequate professional assessment of risk of suicide or repetition of self-harm by Psychiatric Nurse 1. Nor is there any such assessment recorded by the Psychiatrist.

21. In addition, nowhere in the medical records is there a written care and treatment plan for Mr A. Adviser 1 has expressed concern that no formal tool was used to support the assessment and management of Mr A's risk of suicide. A Risk Tool was included in the medical notes sent to me by the Board and both Adviser 1 and Adviser 2 thought the tool provided was in line with good practice. It was unused in Mr A's case. The Board explained that this tool is an aid to assessment and would not replace the need for diagnosis by an appropriate professional and would only be used in cases where a person is designated as a Mental Health patient, which Mr A was not. Nonetheless it does show that options on Risk Assessment were available at that time.

22. National Institute for Health and Clinical Excellence Guideline Number 16, 2004 (NICE guideline) provides guidance on how patients presenting with deliberate self-harm should be managed.

23. Section 8.8.1.9 states:

> 'All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and / or suicide, and identification of the key psychological charecteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent'.

24. Section 8.8.1.10 states:

'The assessment of risk should be written clearly in the service user's notes. The assessment should also be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.'

This is a serious failing

25. Section 8.8.1.15 states:

'Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed on to the service user's GP and to any relevant mental health services as soon as possible to enable follow-up.'

26. I am concerned that the assessments of Mr A did not include a formulation of risk and Mr A's care was left, in the main, to the discretion of Psychiatric Nurse 1. I am also concerned that, apart from an early request for a prescription for antidepressant, Psychiatric Nurse 1, despite many meetings with Mr A, does not appear to have a documented and detailed plan for his treatment. As stated above, I have not seen evidence of a professional assessment of risks for Mr A in the case notes as set out in the relevant guidelines. I am extremely critical of this and regard it as a failing in care.

27. Turning to the decision to discharge Mr A, when Psychiatric Nurse 1 referred Mr A to a voluntary body, it is not clear from the records why Mr A was discharged, what the motivation of the referral was and how it met Mr A's needs (see paragraphs 1, 2 and 12).

28. NICE guideline 16 section 8.8.1.17 states:

'in particular the decision to discharge a person without follow up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.'

29. I have not seen evidence that the decision to discharge Mr A took all these factors into account. While I accept NICE are discretionary guidelines provided

to health boards and clinicians, I am critical that more cognisance was not apparently given to these guidelines during Mr A's care and treatment.

30. I also have significant concerns over both the late submission of the SIR and the RCA and the quality of these reviews.

31. It is disturbing that the SIR carried out by the Board did not pick up on the points made in paragraphs 14, 15 and 18 about the lack of an assessment of risk, the lack of care and treatment plans, or the circumstances of Mr A's discharge.

32. As stated at paragraph 18 I am disturbed by the fact that the RCA into Mr 's death only runs to 22 lines as part of a two page document looking at the deaths of four people. I consider that the analysis appears to consist of a reiteration of actions taken with at best perfunctory analysis of cause and lacks a degree of independence I would expect to see when reviewing such serious events.

33. Both the SIR and RCA were crucial to Mr C's complaint and to my office's investigation. The Board is experienced in dealing with my office's request for information during an investigation and the lack of access to two key documents is an extremely worrying development. More importantly these documents are critical not just to Mr C in pursuing his complaint, they are vital elements in helping all Mr A's family understand and come to terms with his death.

34. In conclusion, taking all these factors into account, including the advice I have received, I have significant concerns over the care and treatment afforded to Mr A. and I uphold this element of Mr C's complaint.

(a) Recommendation

35. I recommend that the Board:	*Completion date*
(i) make the use and review of the risk screening tool to complement and inform the risk assessment process mandatory for all patient assessments following a self-harm / suicide attempt;	28 February 2012
(ii) review their process for conducting RCAs to ensure a degree of independence; and	28 February 2012
(iii) revise procedures in responding to Ombudsman's	28 February 2012

investigations to ensure no documents are omitted or withheld.

(b) The Board failed to communicate effectively with Mr and Mrs C or consult with them regarding Mr A's treatment and progress

36. Mr C was concerned that he, Mrs C and his family had found it difficult to obtain any information about Mr A's progress or treatment because he was an adult. He felt that they should have been involved in his treatment plan as Mr A was sent home with no immediate support other than his family and they did not have the information they needed to help him. Mr C said he and the family felt excluded from discussions and appointments and felt that their perspective was not really listened to.

37. Adviser 1 stated that, in relation to the involvement of relatives in the care of an adult, the principles of confidentiality are clear. Where possible, the patient's consent should always be sought before sharing personal health information with anyone including next-of-kin, carers and other relatives. However, where such consent is withheld, the clinician still has the ability to speak to the relatives to elicit relevant information from them which may be important in the delivery of safe and effective care. It is the flow of information about the patient to the relatives which requires consent. Adviser 1 commented that the default position should always be to involve the relatives wherever practicable, whilst respecting the rules on consent and confidentiality. Relatives can have vast experience of the person and their behaviours outwith the clinical setting which may be critical to the care-planning and/or risk assessment processes.

38. Adviser 1 noted that Mr and Mrs C made contact with his GP as a consequence of their concerns and they also accompanied Mr A to at least one of his appointments. There is no evidence that this prompted Psychiatric Nurse 1 to arrange a focused discussion with Mr and Mrs C to determine their views and concerns and perhaps gain valuable historical or current information about how Mr A was behaving at home, or how his current behaviours compared with previous behaviour. According to Adviser 1, there is nothing in the notes to indicate that Psychiatric Nurse 1 approached Mr A formally to seek his consent to involve his parents in his care. Had he done so, the position regarding the appropriateness of their involvement, and what that involvement may have looked like, would have been much clearer. Adviser 1

concluded that Mr and Mrs C should have been enabled to participate in Mr A's care, as far as his consent and the principles of clinical effectiveness allowed.

39. Adviser 2 expressed the view that information about Mr A from Mr and Mrs C should have been sought at an early stage. In particular, he noted that independent evidence or corroboration should have been sought from Mr and Mrs C about Mr A's drinking habits and the problems he was experiencing at work.

40. Relevant guidance was issued by NHS Education Scotland (NES) in 2008 - A capability framework for working in acute mental health care (the NES Framework) which expects nurses to:

- gather, exchange and act on information to help make early assessment and care planning possible, including any immediate needs, risks, and concerns service users and families may have;
- demonstrate a values base that recognises the key role of relatives and carers in the recovery of service users, values their involvement in the recovery process and is able to provide appropriate information and support while respecting confidentiality and the choices of the individual; and
- form relationships with service users, carers and others, which support people to explore and make sense of their distress and their experiences of acute mental health services.

(b) Conclusion

41. Both Adviser 1 and Adviser 2 and the relevant guidance all indicate that involvement of family and carers is good practice in assessing and managing patients. In Mr A's case Adviser 1 and Adviser 2 felt that Mr and Mrs C should have been involved in providing background information about aspects of Mr A's life (see paragraphs 37 and 38), Good practice and the advice I have received indicate that Mr and Mrs C should have been more involved in Mr A's assessment, treatment and care.

42. When commenting on the draft report Mr C asserted to my complaints reviewer that in late 2010 he was told when contacting the Board by telephone that a SIR report was not available as it had not been done. While there is no record of this telephone call in the papers provided to my office, it is clear that Mr C and his family were not involved in the SIR or RCA, nor were they provided with copies of the review documentation. These documents were

crucial not only to Mr C in pursuing his complaint but they were vital elements in helping Mr C and his family through their grieving process. Mr A's family should have been involved in the Board's enquiries into their care of Mr A, following his death and I am critical they were not. Taking all these factors into account I uphold this aspect of Mr C's complaint.

(b) Recommendation

43. I recommend that the Board:	*Completion date*
(i) review their practice with respect to the involvement of family and others, to ensure it is in line with the good practice contained in the NES framework; and	28 February 2012
(ii) review their process for involving families in SIRs and RCAs.	28 February 2012

General recommendation

44. I recommend that the Board:	*Completion date*
(i) issue Mr C with a formal written apology for the failures identified in this report.	31 January 2012

45. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	The aggrieved, Mr C's son
The Hospital	Ninewells Hospital
Psychiatric Nurse 1	A clinical specialist nurse working for the psychiatric liaison service
Mrs C	Mr A's mother
Psychiatric Nurse 2	A clinical specialist nurse working for the psychiatric liaison service
The Psychiatrist	A consultant liaison psychiatrist
TAPS	Tayside Alcohol Problem Service
Mr C	The complainant
The Board	Tayside NHS Board
Adviser 1	A mental health nurse specialist
Adviser 2	A consultant psychiatrist
SIR	Significant Events Review
RCA	Root Cause Analysis
NICE	National Institute for Health and Clinical Excellence
NES	NHS Education Scotland

Annex 2

Glossary of terms

Bipolar Affective Disorder	Bipolar affective disorder is a serious, long-term condition where the sufferer has periods of depression and periods of mania or hypomania

Annex 3

List of legislation and policies considered

NHS Education Scotland (2008) - A capability framework for working in acute mental health care

National Patient Safety Agency – Root Cause Analysis

NICE: National Clinical Practice Guideline NO 16; the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care