**Scottish Parliament Region: Glasgow**

**Case 201005160: Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; mental health

***Overview***

The complainant (Ms C) raised a number of concerns on behalf of Mr A's family that Mr A was not admitted to an in-patient facility for mental health and that there were failures in communication between the medical and mental health teams treating Mr A.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) Greater Glasgow and Clyde NHS Board (the Board) failed unreasonably to admit Mr A to hospital (*not upheld*); and

(b) there was no reasonable communication between the teams to whom Mr A was or should have been referred, including the Royal Alexandra Hospital, the intensive home treatment team, the community mental health team and the alcohol problems clinic (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
|---|---|
| (i) review the coordination of the relevant services to ensure the failures identified in this report are addressed; and | 20 September 2012 |
| (ii) apologise to the family. | 20 July 2012 |

## Main Investigation Report

### Introduction

1. Ms C complained on behalf of Mr A's family about the care and treatment provided to Mr A by Greater Glasgow and Clyde NHS Board (the Board). On 2 August 2009, Mr A attempted suicide and attended a mental health in-patient facility (Hospital 1), but he refused to be admitted and was not detained. Mr A then had contact with a number of healthcare professionals from mental health and medical services over the following months. Mr A also had numerous falls, injuries and incidents that concerned his family. He told his family that he intended to harm himself. Mr A committed suicide on 16 November 2009. Mr A's family believed that, if the healthcare professionals responsible for Mr A's care had communicated effectively with them and Mr A's GP, they would have become aware of the seriousness of Mr A's situation and admitted him for in-patient care. The family also complained about failures in communication between the various teams from medical and mental health services treating Mr A, which they considered impacted adversely on the care and treatment Mr A received.

2. On 1 March 2010, Ms C complained on behalf of Mr A's family to the Board. The Board responded by letter on 9 April 2010 and 12 October 2010 in addition to meeting Ms C and the family on 16 August 2010. The Board also held a critical clinical incident review alongside the complaints process. Mr A's family remained unhappy and Ms C brought the complaint to my office on 18 March 2011.

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

(a) the Board failed unreasonably to admit Mr A to hospital; and

(b) there was no reasonable communication between the teams to whom Mr A was or should have been referred, including the Royal Alexandra Hospital (Hospital 2), the intensive home treatment team, the community mental health team and the alcohol problems clinic.

### Investigation

4. During the course of the investigation of this complaint, my complaints reviewer obtained and examined Mr A's clinical records and a copy of the Board's complaint file. She also obtained advice from a specialist psychiatric adviser (the Adviser) on the clinical aspects of the complaint and considered the relevant legislation.

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

*Clinical background*

6. Mr A had suffered for years from the physical and psychological effects of alcohol dependency. On 2 August 2009, he attempted suicide and was taken first to Hospital 2 and then Hospital 1. Mr A was offered admission to Hospital 1, but refused and was not detained. It was documented in Mr A's records that 'though the current attempt of self harm appears serious patient is regretful, insightful and hopeful about the future. He is refusing admission and is not detainable for the above reasons'. The planned pathway of care included follow-up by the alcohol problems clinic, advice to cut down on alcohol and Mr A agreed to remain compliant with antidepressant treatment.

7. On 4 August 2009, Mr A's GP referred him to Hospital 1 and his family asked healthcare professionals to admit him. Mr A was not admitted or detained. The formal risk assessment concluded that Mr A 'needs out patient support via alcohol problems clinic and in-patient detox'. Another assessment was carried out by the intensive home treatment team on 10 August 2009 who felt that follow-up by the alcohol problems clinic was more appropriate and brought the appointment forward to 14 August 2009. When Mr A attended his appointment that day, the alcohol problems clinic referred him to the medical team at Hospital 2 because of his poor physical state and he was admitted for four days. He was still in a poor physical condition when discharged on 18 August 2009. Following a telephone conversation with Mr A's daughter, healthcare professionals at the alcohol problems clinic deemed Mr A too physically disabled to attend the clinic and discharged him on 25 August 2009. He was assessed by the community mental health team on 11 September 2009 and re-referred to the alcohol problems clinic on 23 September 2009 because alcohol abuse was considered to be the primary problem, but this referral was not received. Mr A committed suicide on 16 November 2009.

*Relevant legislation*

8. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) sets out the criteria of a short-term detention in hospital. It says that a patient can be detained if all of the following criteria are met:

- the patient has a mental disorder;

- the patient has significantly impaired decision-making ability with respect to medical treatment for mental disorder, as a result of his or her mental disorder;
- detention in hospital is necessary to determine what medical treatment is required and to provide treatment;
- significant risk exists to the health, safety and welfare of the patient or to the safety of others if the patient is not detained;
- there are sufficient grounds for believing that the granting of a short-term detention certificate is necessary for a patient who is refusing to accept treatment on a voluntary basis.

**(a) The Board failed unreasonably to admit Mr A to hospital**

9. Ms C said that the Board should have admitted Mr A to Hospital 1 on 2 August 2009 when he was clearly at risk of self harm. Mr A's family also said that the Board had failed to communicate with them or Mr A's GP when they decided not to admit Mr A to hospital on 4 August 2009 and, had they done so, then the seriousness of Mr A's condition would have been apparent and they would have admitted him.

*Board's response*

10. The Board said that they were sorry the family felt they had been let down by the NHS. Mr A had been seen and assessed on a number of occasions from mid-July until mid September 2009. The consensus view was that Mr A's primary problem related to his dependence on alcohol, which he acknowledged. He had serious physical health problems arising from his alcohol misuse. He was keen to reduce his alcohol consumption himself and was offered but refused admission on 17 July 2009 to a facility which provided in-patient alcohol detoxification treatment.

11. The Board went on to say that following an attempted hanging on 2 August 2009, Mr A was assessed by the duty doctor at Hospital 1. The doctor noticed that whilst the attempt of self harm appeared serious, Mr A was regretful, insightful and hopeful about the future. He refused admission and was considered not to be detainable. On 4 August 2009, Mr A's GP referred him back to Hospital 1. The duty doctor and the on-call consultant psychiatrist decided not to detain Mr A; he told the duty doctor that he was not suicidal or contemplating deliberate self harm. Moreover, there were alternative pathways of care. They established that Mr A had an appointment with the alcohol

problems clinic on 21 August 2009 and contacted the clinic to bring the appointment forward. The duty doctor also noted that Mr A was on a detoxification program via his GP. They advised Mr A to stay off alcohol and the family were given advice about support available from the RCA Trust. However, the Board accepted that Mr A's family did not feel sufficiently involved in the decision not to admit Mr A to hospital and apologised. The Board explained that good practice require that families and carers should be involved in such important decisions and that the Board had taken action to reinforce this through training and notices in waiting areas.

*Critical Clinical Incident Review*

12. A critical clinical incident review was carried out to review the circumstances leading up to Mr A's death. In particular, the review was carried out to consider the decisions not to admit Mr A, the coordination and communication between the various health care professionals and agencies dealing with Mr A, the communication with Mr A's family about decisions on his care, and to identify any lessons to be learned and possible failure of care.

13. The review found that Mr A was offered admission to hospital on 29 June 2009, 17 July 2009 and 2 August 2009 but that he refused to go and it was thought that he could not be compelled to be admitted under the Act. Mr A threatened to harm himself on several occasions when with his family, but consistently denied any suicidal thoughts or intent when assessed by mental health services. Mr A did not receive further follow-up by the alcohol problems clinic because a referral from the community mental health team did not seem to have been received. Mental health services did not learn of Mr A's death until the family contacted the hospital management team. The review said that the Board should: remind staff of the importance of taking account of the views of family and carers before making any final decision about treatment; review communication between teams especially with regard to referrals and transfers of care; and review the system for notification of deaths.

*Advice received*

14. The Adviser said that a history of impulsive suicide attempts did not necessarily meet the criteria for short-term detention under the legislation. Each case had to be individually assessed underlined by the guiding principle that less restrictive options should be considered before detention in hospital was recommended. In Mr A's case, the Adviser said appropriate risk assessments were carried out at the appointments in August 2009 and

appropriate risk management strategies (supervised detoxification and out-patient treatment) were planned. The Board's decisions not to admit Mr A to a mental health unit in August 2009 was reasonable because he did not agree to the admission and alternative pathways were available and planned. It was clear from the medical records of the consultation on 2 August 2009 that he did not meet the criteria for detention because he was insightful and agreed to treatment in the community. The community mental health team seemed initially to have liaised closely with the family and Mr A's GP. The need for medical treatment also appeared to have taken precedence (Mr A was admitted to Hospital 2 from 14 until 18 August 2009). However, when Mr A was discharged from the alcohol problems clinic on 25 August 2009, the clinic failed to put alternative support into place and did not fully consider information provided by the family. Moreover, from September until November, mental health services essentially failed to follow-up Mr A. No support was in place from them and discharge from the alcohol problems clinic on 25 August 2009 should not have occurred in those circumstances. Because of a lack of documentation about Mr A's mental state during this period (and a lack of formal requests for hospital admission), the Adviser said it was impossible to say whether he would have benefited from hospital admission for psychiatric care during this later period.

*(a) Conclusion*

15. Ms C complained that the Board's failure to admit Mr A to hospital in August 2009 was unreasonable and the decision was not informed by information from the family and Mr A's GP, particularly on 4 August 2009. The Board accepted that the family should have felt more involved in the decision not to detain Mr A to hospital on 4 August 2009 and have taken steps to address this. However, even if the family had been more involved, the advice I have accepted is that Mr A did not agree to admission on 2 and 4 August 2009, he did not meet the criteria for detention, and appropriate risk assessments were carried out. Moreover, there were alternative pathways of care planned at that time. In the circumstances, I do not uphold the complaint. However, I am concerned about the lack of support for Mr A when he was discharged from the alcohol problems clinic and I go on to address this matter further.

**(b) There was no reasonable communication between the teams to whom Mr A was or should have been referred, including Hospital 1, the intensive home treatment team, the community mental health team and the alcohol problems clinic**

16. Ms C complained about the lack of communication between the teams treating Mr A and that this impacted adversely on the care and treatment he received. There was information about Mr A's condition that did not seem to be available to the mental health service. For example, the family said that on 14 August 2009, Mr A told staff at Hospital 2 that his injuries were due to falling from an attempted suicide. Ms C said there were further failures in that the alcohol problems clinic failed to contact Mr A when he was re-referred by another team.

*Board's response*

17. The Board said that on 10 August 2009, the intensive home treatment team assessed Mr A. The assessment recorded that Mr A denied any suicidal ideation, he regretted the attempted hanging which had been an impulsive act and had no intention of carrying out any form of self harm. The team did not feel that Mr A required hospital admission at that time or that their involvement was appropriate. They advised Mr A to seek medical help as he appeared to be in physical pain, which Mr A said was as a result of a fall. The Board said they could not establish whether a nurse at a medical ward at Hospital 2 said that Mr A sustained an injury because he tried to hang himself. The team told Mr A and his GP that they were able to bring Mr A's appointment with the alcohol problems clinic forward to 14 August 2009 and provided information about support groups.

18. The Board said that on 14 August 2009, Mr A attended the alcohol problems clinic and was referred to Hospital 2 because of his frailty. He was admitted that day, and discharged from Hospital 2 on 18 August 2009. On 25 August 2009, the clinic dictated a letter to Mr A's GP saying he had been discharged from the clinic because of his deteriorating physical health but they would be willing to see him in the future if his physical health improved.[1] The Board noted telephone contact between the alcohol problems clinic and the consultant psychiatrist confirming that the clinic would not be following up Mr A. Mr A was referred to the community mental health team and the referral was

[1] The records show that this letter was dictated on 28 August 2009 and typed and dated on 8 September 2009.

screened on 1 September 2009. The team assessed Mr A on 11 September 2009, the assessment was discussed at a multi-disciplinary review meeting on 22 September, and the team referred him to the alcohol problems clinic on 23 September 2009. The Board said the critical incident review found no evidence that the alcohol problems clinic had received the referral letter. Nonetheless, Mr A had some contact with the community mental health team and had managed to stop drinking.

19. On 9 October 2009, a member of the community mental health team telephoned Mr A who told them that he had dislocated his shoulder and fractured his arm, had been hospitalised for a week and might require further surgery. They told Mr A he had been referred to the alcohol problems clinic and Mr A said he had not had any contact from them.

20. The Board acknowledged that the service relating to the referral to the alcohol problems clinic could have been improved. This fell short of the standards expected of staff and the Board had acted to minimise the chances of any re-occurrence.

*Advice received*

21. The Adviser said there seemed to have been little if any direct communication between the medical and the mental health service in August 2009 and most of the information about Mr A's physical condition seemed to have reached the community mental health team through the family and GP. The alcohol problems clinic should have received a copy of the discharge letter from Hospital 2 (about Mr A's discharge on 18 August 2009) which would have enabled them to assess fully the degree of Mr A's physical impairment and plan their potential involvement accordingly. There is no evidence in their records the alcohol problems clinic received a formal discharge letter. The interaction between the alcohol problems clinic and the community mental health team was also characterised by a process of referrals and re-referrals without direct liaison between the services on whether these referrals were actually received and would result in provision of services. This process resulted in unnecessary expectations and delays, and did not constitute 'joined up' care. The alcohol problems clinic informed the community mental health team on 28 August 2009 that they would not be following Mr A up. However, they did not ascertain whether the community mental health team would take over his care. The Adviser said that a referral for assessment, which can always be declined (as it was in this case) is not an alternative

support mechanism. It was known to the alcohol problems clinic that Mr A's recent suicide attempt occurred under the influence of alcohol, which was matched by the community mental health team's assessment on 11 September 2009 that his difficulties appeared to be related directly to his use of alcohol. The community mental health team concluded that there was no role for it and re-referred Mr A to the alcohol problems clinic on 23 September 2009. Because the community mental health team did not accept the referral and the alcohol problems clinic did not act on the re-referral of 23 September 2009, Mr A was essentially lost to follow-up by the mental health or addiction services after 11 September 2009 and he had only one telephone contact, on 9 October 2009.

22. Turning to the alcohol problems clinic's decision to discharge Mr A on 25 August 2009 because he was too physically ill to attend, the Adviser said that the alcohol problems clinic should have tried to establish adequate support through liaison with the family, GP and social services. Informing Mr A's GP two weeks after discharge from the alcohol problems clinic was insufficient. He said that discharge should not have occurred without the arrangement of alternative support mechanisms. The Adviser added that the lack of coordination between the alcohol problems clinic, the community mental health team and other relevant services and a lack of follow up following discharge from the alcohol problems clinic on 25 August 2009 were not covered in the critical incident review held by the Board.

23. My complaints reviewer asked the Adviser what effect the lack of follow up from the alcohol problems clinic (because of the lost referral from the community mental health team on 23 September 2009) had on the outcome. The Adviser responded that it was impossible to quantify the contribution that the lack of support from the mental health services during the final two months of Mr A's life may have had to his final mental breakdown and suicide. Mr A was at high risk of mental and physical illness on the basis of his long-standing use of hazardous quantities of alcohol and alcohol-dependence, which had relapsed after several courses of treatment. This was compounded by the breakdown of his support network. It was impossible to say whether follow-up by the alcohol problems clinic could have made a positive impact in this situation.

*(b) Conclusion*

24. Ms C complained that the communication between the various healthcare professionals and agencies dealing with Mr A was not reasonable and that this had an adverse impact on the standard of care Mr A received. The advice I have accepted is that there was a lack of coordination characterised by poor communication between the alcohol problems clinic, the community mental health team and other relevant services including general hospital services and that the Board failed to put alternative support into place when Mr A was discharged from the alcohol problems clinic on 25 August 2009. It is impossible to know if proper support from mental health services during the final two months of Mr A's life would have had a positive impact on the outcome in the circumstances. However, it is clear that the standard of care Mr A received following discharge from the alcohol problems clinic was not reasonable and that he and his family were let down by the Board during an extremely difficult and distressing period. I am also critical that the failures in coordination and communication between the teams dealing with Mr A and lack of follow-up from 25 August 2009 was not referred to and addressed by the critical incident review given the seriousness of the failures. I uphold the complaint.

*(b) Recommendations*

| 25. I recommend that the Board: | *Completion date* |
|---|---|
| (i) review the coordination of the relevant services to ensure the failures identified in this report are addressed; and | 20 September 2012 |
| (ii) apologise to the family. | 20 July 2012 |

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

**Annex 1**

## Explanation of abbreviations used

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|---|---|
| Ms C | The complainant |
| Mr A | The aggrieved |
| The Board | Greater Glasgow and Clyde NHS Board |
| Hospital 1 | Dykebar Hospital |
| Hospital 2 | Royal Alexandra Hospital |
| The Adviser | A specialist psychiatric adviser to the Ombudsman |
| The Act | The Mental Health (Care and Treatment) (Scotland) Act 2003 |

**Annex 2**

## List of legislation and policies considered

The Mental Health (Care and Treatment) (Scotland) Act 203