Scottish Parliament Region: Glasgow

Case 201103604: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Community Psychiatric Nurses; clinical Treatment; diagnosis

Overview

The complainant (Ms C) complained that Greater Glasgow and Clyde NHS Board (the Board) failed to take appropriate action when her family reported that her daughter (Miss A) was suffering from mental health problems. Miss A subsequently jumped from a window in her fourth-floor flat. She suffered serious injuries to her lower body.

Specific complaint and conclusion

The complaint which has been investigated is that Community Psychiatric Nurses (CPNs) failed to take appropriate action to safeguard Miss A when it was reported that she was suffering from mental health problems *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Ms C for the failure to carry out a reasonable telephone assessment when they spoke to Miss A and for the failure to raise concerns with a Mental Health Officer;	11 January 2013
(ii) review how risk is assessed and recorded in relation to telephone assessments in such circumstances to try to ensure as far as possible that patients assessed over the telephone receive the same quality of assessment as those spoken to face-to-face; and	22 February 2013
(iii) clarify to relevant staff the criteria or threshold regarding when concerns should be raised with a Mental Health Officer.	22 February 2013

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

Main Investigation Report

Introduction

1. The complainant (Ms C) complained that Greater Glasgow and Clyde NHS Board (the Board) failed to take appropriate action when her family reported that her daughter (Miss A) was suffering from mental health problems. Miss A subsequently jumped from a window in her fourth-floor flat. She suffered serious injuries to her lower body.

2. The complaint from Ms C which I have investigated is that Community Psychiatric Nurses (CPNs) failed to take appropriate action to safeguard Miss A when it was reported that she was suffering from mental health problems.

Investigation

3. Investigation of the complaint involved reviewing the information received from Ms C and the Board's medical records for Miss A. My complaints reviewer also obtained advice from a mental health adviser (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Community Psychiatric Nurses (CPNs) failed to take appropriate action to safeguard Miss A when it was reported that she was suffering from mental health problems

5. Miss A's family live in England. On 13 August 2011, her grandmother (Mrs D) contacted NHS 24 and then Glasgow Emergency Medical Services (an out-of-hours GP led service provided by the Board's Acute Services Division) to raise concerns about Miss A's mental health. The Board's community psychiatric out-of-hours nursing service is located with Glasgow Emergency Medical Services and they dealt with the call. Mrs D said that Miss A lived in Glasgow and had been hearing voices for some time. She said that Miss A had initially refused help, but now wanted some help. Although Miss A had been living in their area for five years, she was not known to the Board's mental health services at that time and had not had any contact with them.

6. The call was originally taken by a non-clinical call handler and triaged to a nursing adviser. It was recorded that Miss A's psychotic symptoms were worsening and that she was experiencing auditory hallucinations and 'demons'. It was also recorded that she was having visual hallucinations and seeing big spiders that were biting her. She denied alcohol or drug abuse. The call was referred to the out-of-hours community psychiatric nursing team.

7. A CPN contacted Miss A and recorded that she claimed to be hearing 'derogatory voices' and that she was being bitten by spiders. The CPN recorded that she did not appear to be overly distressed by the situation. She stated that Miss A claimed that she was not a particularly heavy drinker and only drank about twice a month. She recorded that Miss A emphatically denied that she planned to harm herself. Miss A was offered a home visit, but refused this. The CPN advised her to attend her GP and to call back if there were any changes overnight. She said that a fax would be sent to the GP. She also advised Miss A to cut back on drinking alcohol in her current state. The Board have told us that Mrs D subsequently telephoned them again and asked that they visit Miss A at home. The CPN then attempted to visit Miss A at home. She was unable to gain access and left a message on Miss A's mobile telephone, as this was switched off. She contacted Mrs D and said that they would contact Miss A at 17:00 the following day, 14 August 2011. The CPN recorded that Mrs D was happy with the outcome.

8. Miss A's aunt (Ms E) then contacted the team on 14 August 2011. She said that Miss A had been mentally unwell for a number of years and used the term bipolar or schizophrenic to describe her condition. She said that she 'actively disengages with services'. Ms E said that the family were to fly to Scotland on the following day due to their concerns about Miss A. A CPN also telephoned Miss A at 17:00 on 14 August 2011. Miss A said that she could not speak, as she had things to do. Miss A mentioned black magic and said that her ankles were very swollen. She said that she was a medium and that it was not unusual for her to hear voices. The CPN recorded that she attempted to persuade Miss A to allow them to visit her at home, but Miss A repeatedly said that she did not want anyone to visit her. She also recorded that she was unable to persuade Miss A to engage with services.

9. On 18 October 2011, Ms C telephoned the Board to make a complaint. She said that she had arrived at Miss A's flat on 15 August 2011 to be met by the Police who told her that Miss A had jumped from a window and had suffered

serious injuries to her lower body. Ms C has stated that the CPN should have alerted social workers or the Police.

The Board's response

10. In their response to Ms C's complaint, the Board said that calls to their out-of-hours service are recorded and they had listened to the recordings. They said that a CPN had telephoned Miss A in response to the call from Mrs D. Miss A told her that spiders were biting her. They said that the CPN explored this further and offered to visit her to carry out a face-to-face mental health assessment. The Board said that Miss A refused to allow staff to visit despite several attempts to advise her otherwise. They said that Miss A was clear that she had no plans to harm herself and that she had never attempted to do so in the past. The CPN suggested that she should call them back if her situation deteriorated or if she changed her mind about allowing staff to visit. She also suggested that Miss A contact her GP in the near future.

11. In the response to the complaint, the Board said that Mrs D subsequently telephoned them again and asked staff to visit Miss A at home. Staff agreed to do so, but on arrival, there was no answer. They telephoned Miss A, but her mobile telephone was switched off and a message was left. A CPN telephoned Mrs D to inform her of this and it was agreed that staff would try to contact Miss A again the next evening around 17:00 when they came back on duty. The Board said that on the following day, a CPN telephoned Miss A at 17:00, but she refused to see anyone.

12. The Board said that the Service Manager for their out-of-hours service was satisfied that staff had consistently tried to see Miss A and had communicated regularly with the family about her refusal to do so. They said that the Service Manager was satisfied that it could not have been foreseen that Miss A would jump from the window. They stated that it would seem that Miss A had been experiencing mental health problems for many years and, until then, had managed to avoid contact with mental health services in Glasgow. They said that nursing staff were sorry about what had happened to Miss A.

13. Ms C wrote to the Board again on 12 December 2011. She said that the CPN should have gained access to Miss A's flat and spoken to her face-to-face to assess her mental state. She said that Miss A had been screaming down the telephone when she spoke to her. She also stated that Miss A's buzzer had not

been working. She said that the Police had told them they would have forced entry to Miss A's flat if they had been contacted.

14. The Board responded to this letter on 5 January 2012. They said that the CPN had not been working with the Police on the matter and that she did not discuss it with a social worker. They said that staff did try to gain access to the building and were unaware that the buzzer was not working. They said that Miss A was adamant that she had no plans to harm herself. They said that they were sorry Miss A suffered injuries from her fall and that they hoped she was making a speedy recovery.

Advice obtained

15. I asked the Adviser if the actions of the CPNs in relation to taking action to safeguard Miss A were reasonable and appropriate. In his response, he said that he had listened to recordings of the telephone conversations with Miss A. He stated that it appeared to him that the assessment by the CPN who telephoned Miss A on 13 August 2011 was generally in the right direction in that she established rapport and tried to establish the nature and cause of the presenting problems. However, he said that he considered that the CPN should have done more to clarify and act on the symptoms Miss A described. He said that the main symptoms of concern described by Miss A were visual, tactile and auditory hallucinations. He said that Miss A was also in some emotional distress in response to them.

16. The Adviser also commented that it appeared that the CPN had established that there were two possible causes for the hallucinations. Firstly, an organic cause, such as withdrawal from alcohol or another physical condition such as head injury or infection; and secondly, a psychosis. He said that the CPN had tried to establish whether Miss A was drinking heavily. He said that although there was no evidence of slurred speech or confusion, the CPN pursued and returned to this line of questioning several times. He stated that it appeared that the CPN considered that the problem was alcohol related. The Adviser said that when alcohol withdrawal reaches the stage of Delirium Tremens (DTs), it is a medical emergency and there is a significant mortality rate for this. He stated that if Miss A was hallucinating because she was in withdrawal from alcohol, then the CPN should have raised the matter with the local Mental Health Officer.

17. The Adviser also stated that if it was assumed that the other possible cause of Miss A's hallucinations was psychosis, then it appeared that the question as to what extent she was able to act rationally and take responsibility for her behaviour was not adequately considered. He said that it appeared that insufficient weight was given to the risk factors involved in leaving someone who was hallucinating, distressed and experiencing persecutory delusions alone in a flat.

18. The Adviser said that although the CPN was warm and empathetic towards Miss A, she did not thoroughly investigate either possible cause and did not recognise the dangers inherent in the situation. He stated that too much weight was given to Miss A's ability to manage her own affairs and take responsibility for herself. He also considered that too much emphasis was placed on Miss A's assertion that she would not harm herself without any consideration being given to her capacity to make such a decision. He stated that the CPN could clearly be heard in one of the recordings of the telephone conversations asking Miss A if she felt safe. Despite Miss A crying out in fear in response to hallucinating that she was being bitten by spiders, the CPN accepted her word that she would not harm herself.

19. The Adviser commented that staff attempted to visit Miss A following a request from Mrs D. This was unsuccessful and staff reported that there was no response when they rang the buzzer to her flat and called her mobile telephone. They reported back to Mrs D that they thought she was asleep. They also raised concerns about breaching Miss A's confidentiality if they called at her neighbours' doors.

20. The Adviser said that there were insufficient attempts to use the information supplied by relatives to corroborate evidence with regard to Miss A's past psychiatric history. He said that staff could have tried to find out where Miss A had last been treated and then made telephone calls to try to locate any previous notes.

21. The Adviser also commented that it was unclear as to whether Miss A intended to harm herself or whether she jumped from the window on the basis of her hallucinations (being commanded to jump or feeling so frightened that she decided to risk jumping). He said that these possibilities did not appear to have been considered.

22. The Adviser said that there was sufficient information about Miss A's mental health from both telephone conversations and from relatives to form an opinion that she was experiencing either an acute organic confusional state or an acute episode of psychosis. He said that both carry considerable risk and the individual cannot be expected to be able to exercise responsibility for their safety. Their ability to think rationally and critically would obviously be impaired. The Adviser stated that the level of telephone assessment fell below what he considered to be reasonable. He also commented that concerns about Miss A could have been raised with a local Mental Health Officer. They could have exercised their powers under sections 33 and 35 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to gain entry to Miss A's flat.

23. During our investigation, we asked the Board for any guidance that is issued to staff who work in the out-of-hours service about the questions that need to be asked to complete a telephone-based assessment in such circumstances. In their response, the Board referred to 'Assessment Guidelines Documentation'. They confirmed that this would be used as a guide and as part of any mental state examination, which was used to assess risk. However, there was no evidence that this had been completed in Miss A's case. The Board told us that all telephone contacts are recorded on an electronic patient record. The Board said that in the case of face-to-face assessments, additional paper documentation would be completed along with the Mental Health Partnership Clinical Risk Screen and Management Tool.

24. In his response to me, the Adviser said that although telephone assessment is never a substitute for face-to-face assessment, there was no reason why staff could not ask relevant questions over the telephone. He considered that it would be reasonable for staff to try to assess people over the telephone with the same thoroughness as they do face-to-face, although this can take longer. He said that he could see nothing in the Board's response that indicated that telephone based assessments were as rigorous as they could be. He said that risk assessment and documentation relating to Miss A's history and her mental state examination had not been completed. He also commented that although the Board had interviewed the relevant staff, they had not asked them for statements.

Conclusion

25. In view of the advice I have received, I consider that the level of telephone assessment fell below a reasonable standard. There was also a failure to raise

concerns with a Mental Health Officer, who could have gained entry to Miss A's flat if they considered this appropriate. In view of all of this, I have upheld Ms C's complaint that the Board failed to take appropriate action when her family reported that Miss A was suffering from mental health problems.

Recommendations

26. I recommend that the Board:	*Completion date*
(i) issue a written apology to Ms C for the failure to carry out a reasonable telephone assessment when they spoke to Miss A and for the failure to raise concerns with a Mental Health Officer;	11 January 2013
(ii) review how risk is assessed and recorded in relation to telephone assessments to try to ensure as far as possible that patients assessed over the telephone receive the same quality of assessment as those spoken to face-to-face; and	22 February 2013
(iii) clarify to staff the criteria or threshold regarding when concerns should be raised with a Mental Health Officer.	22 February 2013

27. 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.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Miss A	The aggrieved (Ms C's daughter)
CPNs	Community Psychiatric Nurses
The Adviser	The Ombudsman's mental health adviser
Mrs D	Miss A's grandmother
Ms E	Miss A's aunt

Annex 2

Glossary of terms

Delirium Tremens (DTs)	A severe withdrawal reaction after stopping alcohol. Symptoms include: marked tremor (the shakes) and delirium (agitation, confusion, and seeing and hearing things that are not there). Some people have convulsions. Complications can develop such as dehydration and other serious physical problems. It is fatal in some cases