SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 201303790, Lothian NHS Board
Sector: Health
Subject: Hospitals: clinical treatment/diagnosis

Summary
Mr A had a history of mental illness and of self-harm, and had been in and out of hospital as a result. He was admitted to the Royal Edinburgh Hospital for treatment after an apparent suicide attempt. He was given a pass to walk unescorted in the hospital grounds, but did not return when expected. Staff decided not to contact the police to report him missing until some two hours after his expected return time. Mr A was found dead outwith the hospital a number of days later. Ms C (Mr A's fiancée and carer) complained that Mr A was not provided with appropriate care and treatment, in that the decision to allow him off the ward unescorted was inappropriate. She also complained that she was not properly involved in the decision making in Mr A's care.

The board carried out an internal review, which found that although the decision to issue the pass was high-risk, the professional judgment of staff was reasonable in the circumstances. They also said that it was reasonable not to contact police earlier, but made five recommendations, including reviews of what should happen if a patient did not return when expected, of liaison with the police and of the risk assessment tool. The board met with Ms C, who had also met the leader of the review team. Ms C remained concerned that the board had failed in its duty of care to Mr A and wanted them to admit this. She wanted a further, independent review. The board did not agree to this, and said that they had taken appropriate action through the review recommendations. They did, however, apologise to Ms C for failures in communication with her in relation to care planning.

I took independent advice on this case from a mental health nursing adviser and a consultant psychiatrist. Mr A was recognised as having unpredictable behaviour, and had returned very late from a previous pass, so both advisers were critical of the assessment of risk, and that this was not updated during treatment, as his condition appeared to be fluctuating. Poor risk recording made it difficult to understand how it had been taken into account when making decisions, there was no mention of what was done to reduce risk and there was no plan of what should happen if he did not return from a pass. Both advisers

came to the view that in the absence of a structured assessment of risk, it was unreasonable to grant Mr A an unescorted pass.

I upheld both Ms C's complaints. On the first, I accepted my advisers' view that Mr A's care fell below a reasonable standard in terms of the assessment and recording of risk. I also found that the board's review reached contradictory conclusions on whether it was reasonable for staff not to take action until two hours after Mr A failed to return. Although I cannot say whether this led directly to Mr A's death, such omissions represent a significant failing, and I criticised the board for this. As, however, the board's own review addressed many of these issues through an action plan I made limited recommendations. On the second complaint, appropriate communication with carers is a requirement of the Mental Health (Scotland) Act 2003, and it was not clear from the records whether staff viewed Ms C's as Mr A's main carer. Her status should have been documented so that staff could communicate appropriately with her.

Redress and recommendations

I recommended that the Board:		*Completion date*
(i)	provide evidence that the action plan produced following the SAER has been implemented in full;	20 May 2015
(ii)	ask the internal review team to reflect on our advisers' assessment of the care and treatment provided to Mr A;	20 May 2015
(iii)	provide evidence that they have reviewed the procedures for carer involvement in patient care and management decisions;	20 May 2015
(iv)	provide evidence that the procedural review includes a system for the timeous identification of the patient's carer or named person; and	20 May 2015
(v)	apologise for the failings identified in this report.	20 May 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints

procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002. Under the Act, the Ombudsman can publish a public report and lay this before the Parliament where he considers that there is a public interest in the matter and it is appropriate to do so. The Act says that, generally, reports of investigations should not name or identify individuals, so in the draft report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. Mr A had a life-long psychiatric history, with his first contact with mental health services being at the age of 16. He had been admitted as a psychiatric in-patient on numerous occasions and his most recent diagnosis was that he was suffering from schizophrenia.

2. Mr A was also noted to be vulnerable to acts of self-harm and suicide attempts; he was also increasingly prone to self-neglect. He also had a history of nephrogenic diabetes insipidus.

3. Mr A was admitted to the Royal Edinburgh Hospital (Hospital 1) on 23 August 2011, following a suspected deliberate overdose of a prescription medication. He absconded from Hospital 1 on 31 August 2011 and was returned by the police. He was discharged home with support from the Intensive Home Treatment Team (IHTT) on 1 September 2011.

4. On 5 October 2011 Mr A was readmitted to Hospital 1 following a four week period when he had refused to allow the IHTT to visit him. Access was gained to his flat by the police and Mr A was admitted to The Royal Infirmary of Edinburgh (Hospital 2), to combat dehydration. He was transferred back to Hospital 1 and, following a series of successful overnight passes, he was discharged on 22 November 2011. On 6 December 2011 he was reviewed as an out-patient and considered to be relatively well.

5. On 11 December 2011, Mr A was taken to Accident and Emergency (A&E) at Hospital 2 by the police, following an incident where he was found wandering inappropriately dressed and unaware of his surroundings in open countryside. He was transferred to Hospital 1 the same day. A nursing note on 11 December 2011 recorded Mr A self-reporting his hopes that he would die in his sleep whilst outside in the cold. On 13 December 2011 he was recorded as presenting a clear risk of self-harm. Mr A was discharged on 6 January 2012 with Community Health Team follow-up and support.

6. On 10 January 2012 Mr A was admitted to the Intensive Care Unit (ICU) at Hospital 2, suffering from carbon monoxide poisoning following a house fire. He was transferred out of ICU to another ward in Hospital 2 on 17 January 2012.

7. On 21 January 2012, Mr A was transferred back to Hospital 1. He denied on-going suicidal ideation or active thoughts of self-harm, but did complain of marked feelings of anxiety. He had concerns about his future accommodation, as he believed his sister would insist he moved out of the home owned by his recently deceased father.

8. On 23 January 2012 Mr A was diagnosed as suffering from a pulmonary embolism and transferred to Hospital 2 for treatment. Mr A was commenced on anti-coagulant therapy. Mr A also complained of pain in his urinary tract and testicles during this admission and was commenced on antibiotic therapy as well.

9. On 25 January 2012, Mr A was transferred back to Hospital 1. He was noted to be unsteady on his feet and disorientated. He was contacted on 26 January 2012 by his sister, who informed him that he could no longer stay at his father's house. By 14 February Mr A was able to go for a Valentine's meal with his fiancee (Ms C). On 24 February 2012, staff noted that Mr A had to be encouraged to use his passes to leave the ward.

10. On 29 February 2012 Mr A left the ward at 08:45. Staff called his mobile telephone at 14:45 and the decision was taken that if he did not return by 17:00, the police would be contacted. Although the police were informed at 16:50, Mr A returned to Hospital 1 of his own volition at 17:00, although he was unable to provide an explanation of his whereabouts during the course of the day, beyond saying he went to visit his home.

11. On the night of 1 March, Mr A was confused and disorganised. He was medically reviewed the next day, but was unable to offer a history and was barely able to speak. A fugue like state was suspected and it was decided that any time off the ward was to be with a nurse escort only. On the night of 3 March 2012 Mr A was recorded as describing himself as 'very anxious' and 'all over the place'.

12. Mr A was granted unescorted time off the ward to walk in the grounds of Hospital 1 on 5 March 2012, but excursions beyond the grounds were only to take place with an escort. He left the ward at 12:00 and he was noted as not having returned at 13:10. As Mr A had stated before leaving the ward that he intended to keep an appointment at 14:00, the decision was taken to give Mr A until that time to return. At 14:40, Mr A was reported missing to the police.

13. Although the police were initially informed Mr A was high risk, due to his history of impulsivity, it was recorded the following day that the police considered him to be low risk, because of his informal status as a patient (he was not detained) and the granting of unescorted passes off the ward. It was recorded on 7 March 2012 that Mr A had been re-categorised as medium risk.

14. Mr A was found dead on 19 March 2012. The cause of his death could not be established by the Procurator Fiscal and the decision was taken not to pursue matters further.

15. Lothian NHS Board (The Board) subsequently carried out a Significant Adverse Event Review (SAER) to identify any learning points from Mr A's death. Ms C remained dissatisfied with the Board's response and raised her complaints with my office in February 2014.

16. The complaints from Ms C which I have investigated are that the Board:

(a) did not provide reasonable care and treatment to Mr A between August 2011 and March 2012 (*upheld*); and

(b) did not reasonably involve Ms C in decisions about Mr A's care, treatment, transfers, discharges and risk assessments between August 2011 and March 2012 (*upheld*).

Investigation

17. In investigating this complaint my complaints reviewer had access to all the information submitted by Ms C with her complaint. They also had access to all the appropriate sections of Mr A's medical records. Additionally, my complaints reviewer took advice from a mental health nursing adviser (Adviser 1) and a consultant psychiatrist (Adviser 2).

18. 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.

(a) The Board did not provide reasonable care and treatment to Mr A between August 2011 and March 2012

Ms C's complaint

19. Ms C took part in the SAER carried out by the Board. Following this, Ms C still believed staff at Hospital 1 failed in their duty of care towards Mr A, given the high risk he was assessed as presenting, and that this had not been properly acknowledged or addressed by the Board. Ms C also believed there was a failure by staff to keep adequate records, which affected their ability to respond when Mr A went missing. She noted that the Board's SAER had concluded 'Mr A was at significant and high risk of self-harm and death, once it was known that he had significantly extended his passes'. Ms C also said that she had concerns about the Mr A's transfers between Hospital 1 and Hospital 2.

20. Ms C said that she had been Mr A's fiancée and main carer. A series of personal tragedies affecting Mr A, including life threatening injuries following a house fire, had led to a serious deterioration in his mental health. Ms C was very concerned that Mr A was at risk of self-harm prior to his death, but felt her concerns were not taken seriously by medical or nursing staff.

21. Ms C noted it had subsequently emerged that at least one member of nursing staff had felt unescorted passes should not be provided to Mr A and it was also noted senior staff had felt they had no input into the decision to grant them. Ms C also noted there had been a failure to record the reasons for the decision to issue unescorted passes properly. She felt this had affected the ability of emergency services to respond when Mr A went missing. Ms C noted the Board's own review had stated, 'The team consider that by the time the search appears to have been commenced on 7 March 2012 it is likely that he [Mr A] would not have been found alive.' Ms C said she believed Mr A was transferred too soon to Hospital 1 and that this impacted on his mental health.

22. Ms C acknowledged the Board's actions following their SAER. She felt, however, that the action plan did not recognise the essential failings in Mr A's care and treatment. She believed the decision to grant him unescorted passes was a mistake and that staff should have raised the alarm following his failure to return much sooner. Ms C also felt staff should have searched the grounds of Hospital 1 for Mr A. Had these failures not occurred, Ms C believed that Mr A might well have been found alive.

The Board's Position

SAER

23. The Board conducted an SAER of the case, which reported on 5 September 2012. The review team was made up of senior medical staff and carried out a case note review, as well as interviewing staff involved in Mr A's care. The review team concluded that Mr A's mental state placed him at significant risk of self-neglect, with the potential for fatal results. The review team felt it was clear that staff involved in Mr A's care were aware of the significant risks Mr A presented.

24. The review found there had been clear cause for concern in the days leading up to Mr A's disappearance, including significant confusion and disorganised behaviour. They also noted Mr A had disappeared for the whole day on 29 February 2012, which should also have been a cause for concern.

25. The review team found the decision to allow Mr A unescorted passes was made following a multi-disciplinary team meeting. They considered the decision to grant these passes was a question of professional judgement, although they did not believe the decision was made with the backing of the full ward team. They found that one member (not present at the meeting) stated they were strongly of the view passes should not have been issued to Mr A. There did not appear to be a clear record showing that the ward nursing team had discussed the issue of passes and the two most senior members of nursing staff did not have clearly documented input into the decisions regarding Mr A's care.

26. The review team took the view that passes should have been decided on extremely cautiously. They described the issue of passes as a 'high-risk decision' but said they were satisfied the professional judgement demonstrated was 'within the spectrum of practice that would be considered reasonable'. They found it was impossible to be certain whether nursing staff views would have made a difference to the decision. The review team considered it reasonable not to inform the police immediately of Mr A's failure to return, given his spontaneous reappearance after previously disappearing. The review team did not believe an earlier search would have found Mr A, although it noted no search of the grounds was attempted by nursing staff.

27. The review team also looked at the actions taken by staff and the police, following Mr A's disappearance. They said they considered Mr A 'was at significant and high risk of self-harm and death once it was known he had

significantly extended his passes'. These risks would have dramatically increased after dark, given the weather conditions at the time and Mr A's increased confusion during evening and night. They concluded it was unlikely that Mr A would have been found alive by the time the search by the police commenced in earnest on 7 March 2012. The review team felt Mr A should have been considered at high risk by the police from the outset, although they were limited in their assessment of this aspect of the review, as the police had not shared details of their investigation with the review team.

28. The review team said Mr A was found on the route of one of his favourite walks, close to where he had previously been found following his disappearance on 11 December 2011. The review team concluded an earlier, targeted search would have been more appropriate, although it could not be concluded that this would have resulted in a better outcome for Mr A, given the lack of clarity over his final movements.

29. The review concluded that the notes for Mr A were generally of a good standard. They commented, however, that the decisions on passes were often not clear, or not documented. This was particularly apparent when reviewing the notes of the ward round on 5 March 2012. The review team said Mr A's level of risk had been formally documented on 21 January 2012 on his admission to Hospital 1, but other formalised assessments of risk were subsequently documented. The review team said they believed, however, that the clinical team understood Mr A's level of risk. It was accepted during the review that the initial risk assessment was out-of-date and was not referred to during key decisions prior to his disappearance. It was also unclear to the review team how formalised risk assessment tools were utilised by the clinical team in day-to-day practice.

30. The review team made a the following recommendations:

- 'A review of the arrangements in place when patients 'extended' passes [failed to return]. The team noted that the procedures to be followed in these circumstances were unclear, with duty nurses apparently left to their own initiative.
- Nursing and other multidisciplinary staff input into patient management decisions was to be reviewed.
- The procedures for liaison with the police also required review, to ensure better sharing of information when patients absconded.

- Staff were to be reminded of the need to document reasoning behind key decisions, particularly those involving complex judgements.
- The formalised risk assessment tool was to be reviewed, to ensure it was clinically useful throughout a patient's admission.'

Subsequent investigation by the Board

31. The Board also met with Ms C on 29 April 2013. At this meeting Ms C noted that she had already met with the leader of the review team and that she had seen the action plan and report they had created. Ms C felt that the review team had not admitted that the Board had failed in its duty of care to Mr A. She wanted someone to admit this and apologise. Ms C also made it clear that she wanted an entirely independent review carried out and a number of possible methods for this were discussed.

32. In their letter to Ms C of 29 May 2013, the Board said that there were no indications that Mr A was physically unwell when he left the ward immediately prior to his death. The only concern was over his mental state and his vulnerability. The Board said they did not consider a further external review would highlight any new issues. The Board said, following their review, that they had improved procedures to be followed should a patient fail to return; including a search of the grounds; ensuring an accurate description of the patient was held on the ward; and that appropriate escalation to the police took place.

33. The Board noted that Mr A's medical records clearly showed he was stable, fit and well before he was transferred back to Hospital 1. Mr A's blood pressure medication had been resumed and his clinical observations were all normal. The Board accepted Mr A had been transferred back to Hospital 2 following development of a pulmonary embolism, but they said this condition was a new development during his admission to Hospital 1 and was unrelated to his transfer.

Advice Received

34. For clarity, I have set the advice received out under a series of sub-headings, which reflect the different areas of care considered.

Risk Assessment

35. Adviser 1 said that a risk assessment had been carried out when Mr A was admitted to Hospital 1, but was not revisited or updated. He said clinical

risk was a dynamic consideration and Mr A's presentation was noted as having marked fluctuations. Before admission he had been involved in a number of events which significantly increased his risk of self-neglect and self-harm (either accidental or deliberate). These factors should have required regular review of Mr A's vulnerability and level of risk. Mr A's medical record did not reflect this having taken place.

36. Adviser 1 said that the Board's SAER had concluded staff at Hospital 1 were aware of the risks Mr A presented. Adviser 1 said that in his view, however, the risk assessment in the medical records was not clear. The rationale behind decisions could not be discerned from the information recorded and there was a lack of evidence of meaningful multi-disciplinary discussion and decision making.

37. Adviser 2 said that in the absence of Scotland specific guidance on managing mental health risk, he had benchmarked Mr A's care against current English guidance.[1] He noted this was drawn from the views of internationally recognised experts in the field and was therefore pertinent, irrespective of geography.

38. Adviser 2 said a structured risk assessment was undertaken as part of Mr A's admission on 21 January 2012 but, as noted by Adviser 1, this was not updated or revised during Mr A's treatment. Adviser 2 said there was little evidence of consideration of immediate or long-term risk. Adviser 2 said due to the lack of documented risk assessment, it was impossible to determine how this was taken into account when making decisions. He noted on 6 February 2012 the note summarising the ward round stated, 'Difficult risk assessment as history of unpredictable behaviour'. Adviser 2 said the behaviour was not specified, so no realistic assessment of risk could be drawn from it. There was no mention of consideration of factors to mitigate Mr A's risk, despite the agreement regarding passes off the ward. At the following week's ward round there was no specific mention of risk, although Adviser 2 noted 'unescorted passes should be kept to a minimum' was recorded in Mr A's notes, but 'minimum' was not defined.

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[1] Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services; Department of Health, 2007

39. Adviser 2 also pointed to 29 February 2012, when Mr A returned very late from his leave pass. No consideration was documented of updating his risk assessment at this point, consequently there was no review of the passes he was being granted. Adviser 2 added that in the week prior to Mr A's failure to return, a notable deterioration in his mental state was recorded. This deterioration was not, however, reflected in any recorded discussion of the level of risk Mr A posed. His clinical situation was reviewed again on 5 March 2012 immediately prior to his disappearance and no rationale was provided to link the decisions made around passes to any perceived risk.

40. Adviser 2 said the Board's SAER recorded that decision making about passes on 5 March 2012 involved several members of medical and nursing staff. Some of the nursing staff were noted as having held a strong view that Mr A should not be granted any leave. Adviser 2 said there was no contemporaneous record to support this, but it raised a question over whether decision making was truly multi-disciplinary and had taken into account the input of all the appropriate professionals.

41. Adviser 2's view was that overall, there was little recorded consideration of what risks were felt to exist and how they should be managed. The notes for Mr A provided no evidence explaining why specific decisions were made. It could not, therefore, be shown that these decisions were reasonable. In Adviser 2's opinion, there was insufficient evidence to show that Mr A's risk was appropriately assessed and his care, therefore, fell short of that which he could reasonably have expected.

Adequacy of the record-keeping

42. Adviser 1 said that, in general, the standard of record-keeping was both systematic and maintained to a reasonable standard. If, however, nursing staff had reservations about granting Mr A time off the ward unescorted, these should have been unambiguously recorded. The failure to do so was in Adviser 1's view unreasonable.

43. Adviser 1 said, overall, there was a failure to document assessment of risk (as previously noted); it was also unclear who had responsibility for some of the decisions and the rationale under-pinning these decisions. It was, crucially, unclear why Mr A was granted unescorted time off the ward, given his obvious vulnerability and fluctuating mental state. Additionally, the records had no

agreed contingency plan should Mr A fail to return from an unescorted pass. Adviser 1 said this should have been developed as a matter of routine, before Mr A was allowed off the ward unescorted. Adviser 1 added, however, that he felt the SAER had recognised this.

44. Adviser 1 said mental health professionals were required to discharge their function in a manner that involved the minimum restriction on the freedom of the patient necessary in the circumstances. Adviser 1 said he considered the clinical decision to allow Mr A off the ward unescorted was high risk. Adviser 1 said he felt that when the decision was considered in context, it was unreasonable. Adviser 1 highlighted the lack of evidenced multi-disciplinary involvement in the decision, the failure to record the rationale behind the assessment of Mr A's risk and the lack of a failure-to-return contingency plan as key factors in this assessment of the decision.

Decision to allow Mr A to leave the ward on an unescorted pass

45. Adviser 1 said that it had to be taken into account that there was a need for clinicians to use the least restrictive option necessary to effectively manage prevailing risks. Additionally, the intention was that time off the ward should be relatively short and restricted to the grounds. He felt, however, that on balance the lack of transparency in the decision to grant an unescorted pass, coupled with the lack of recorded multi-disciplinary involvement and the absence of a failure-to-return contingency plan were sufficient to render the decision unreasonable.

46. Adviser 2 said there was no contemporaneous evidence that staff had voiced objections to Mr A receiving unescorted passes. Adviser 2 said that the guidance on best practice supported the concept of 'positive' risk-taking. Adviser 2 said that this essentially meant that some risks had to be accepted in order to mitigate other risks.

47. In Mr A's case, Adviser 2 said these risks were due to his dissociative difficulties, which were underpinned by anxiety. Mr A's anxiety would have become worse the longer he hid away from real world stressors. Restricting him to the ward would, in the long-term, have left him increasingly 'institutionalised' as he became socially de-skilled. There was a case, therefore, for arguing that granting short passes within the grounds would reduce the risk of this institutionalisation developing.

48. Adviser 2 said in this case, however, the decision around leave appeared divorced from a structured assessment of risk and its mitigation. He could not, therefore, consider the decision to grant unescorted passes to Mr A reasonable. Adviser 2 said to make a decision on whether it was appropriate to grant an unescorted pass to Mr A would have required a critical assessment of all the information available on the level of risk he posed. There was no objective evidence of a coherent decision, which took into account Mr A's risk and clinical factors and included a risk mitigation strategy.

Was the response by medical staff to Mr A absconding reasonable?

49. Adviser 1 said the evidence showed that the clinical team had been slow to react to Mr A's failure to return. There was no contingency plan drawn up for this eventuality when the time off the ward was granted. Adviser 1 said there was an element of risk in all unescorted passes and the risk Mr A posed was obvious, given his recent presentation.

50. Adviser 1 said the failure to document a comprehensive contingency plan was clearly unreasonable. He also noted that staff appeared to be unable to provide police with an accurate contemporaneous description; he considered this too to be unreasonable.

51. Adviser 2 said whilst most organisations who had missing patient policies included a requirement to advise a member of medical staff, there were no specific tasks for a doctor when a patient went missing, which could not be carried out by nursing staff. Adviser 2 said in his view, the failings had occurred prior to Mr A's disappearance, when Mr A's risk was not properly assessed. He said it should have been agreed what action would be taken should Mr A fail to return. Adviser 2 noted this was not a hypothetical situation in the case of Mr A, as he had failed to return previously. Adviser 2 said that as staff had not formed a risk management plan for Mr A, when he failed to return, they did not have an action plan for staff to follow.

(a) Decision

52. Mr A had a history of mental health problems, which had fluctuated severely since 2011. He had previously acknowledged one passive attempt at suicide in December 2011, when he was found wandering hypothermic in the open countryside. Ms C has complained that Mr A was not provided with an appropriate level of care and treatment.

53. I note that the Board's SAER concluded that the decision to allow Mr A unescorted passes fell within the bounds of acceptable professional judgement. Although they noted the failure to evidence the reasoning behind this decision in Mr A's notes, they considered the decision to grant these passes to be reasonable. The SAER also found that the clinical team were aware of the risk Mr A posed to himself, although they again noted that no dynamic risk assessment was recorded and there was no risk assessment for Mr A other than that carried out on his admission on 21 January 2012. The Board's review further concluded that the decision not to carry out a search for Mr A was reasonable, given the lack of clear guidance to staff on what procedures to follow, and his previous reappearance after an unauthorised absence.

54. The advice I have received concluded that Mr A's level of risk was not properly assessed, or recorded. It cannot, therefore, be shown that this level of risk was considered as part of the decision to grant Mr A unescorted passes. Both advisers considered Mr A's care fell below a reasonable standard in this regard.

55. The Board's SAER also concluded that the decision not to take any action for two hours following Mr A's failure to return was reasonable, as was the decision by nursing staff not to conduct a search of the grounds. They also concluded it was unlikely Mr A would have been found earlier, had a search been initiated sooner.

56. I note the Board's SAER also concluded, however, that due to the climatic conditions in early March and Mr A's confusion during the evening and night, the risk to Mr A increased dramatically with nightfall. Additionally, the review team commented that Mr A's body was eventually found at a spot which was well known to be a favourite walking route of his. They suggested that a targeted search for Mr A would have been an appropriate response to his disappearance.

57. The Board's SAER appeared to have reached conclusions which are contradictory. If Mr A's level of risk increased dramatically as night fell, to the extent that the risk to Mr A's survival increased significantly, then the failure to have a clearly defined procedure for his failure to return, which led to a delay of some two hours before his disappearance was reported to the police, cannot be considered reasonable. Equally, the failure of staff to search the grounds of Hospital 1, along with the apparent failure to provide information to the police

about Mr A's previous disappearances, was also unreasonable, given the recognised to risk to his well-being as described in the Board's own SAER.

58. I conclude, therefore, on the basis of the advice I have received that there was inadequate assessment and recording of risk in Mr A's care. Additionally, and significantly in this case, the failure to adequately assess Mr A's risk means the decision to grant him unescorted passes cannot be considered reasonable. I am also critical of the failure by staff to act with sufficient urgency when Mr A disappeared, despite the acknowledged and significant increase in the risk to him of being absent from Hospital 1 overnight.

59. Although it cannot be concluded that these failures led directly to Mr A's death, they represent a significant failing on the part of the Board. I am critical that the Board's internal SAER, although it acknowledged a number of failings and made a series of significant recommendations, avoided criticism of staff in these areas.

60. I have noted Ms C's comments on the transfer of Mr A between Hospital 1 and Hospital 2. I will address the communication issues raised under complaint (b). Neither of my advisers considered that there was any evidence to suggest that Mr A was transferred prematurely, or that the transfer impacted on his treatment or well-being.

61. I uphold this complaint. In my view, the Board's SAER made appropriate and significant recommendations to address the failings identified. I have, therefore, limited my recommendations to ensuring that the action plan produced by the Board has been implemented.

(a) Recommendations

62. I recommend that the Board:	*Completion date*
(i) provide evidence that the action plan produced following the SAER has been implemented in full; and	20 May 2015
(ii) ask the internal review team to reflect on our advisers' assessment of the care and treatment provided to Mr A.	20 May 2015

(b) The Board did not reasonably involve Ms C in decisions about Mr A's care, treatment, transfers, discharges and risk assessments between August 2011 and March 2012

63. Ms C complained that she had not been properly involved in the decisions around Mr A's care. She said that she was not consulted or informed of changes to Mr A's treatment, nor was she informed when he was transferred between hospitals. This resulted in her travelling to visit Mr A at Hospital 2, when he had in fact been transferred back to Hospital 1.

64. Ms C said this was, in her view, poor practice on the part of the Board and was at odds with recommendations on the involvement of the main carer / named person as set out in the Mental Health (Scotland) Act 2003.

65. Ms C said it was difficult for her to identify who was in charge of Mr A's care and she was not, therefore, clear about who she should be attempting to contact, or who could provide her with information about Mr A's treatment. Ms C felt excluded and uninvolved in Mr A's care.

The Board's position

66. The Board's internal review identified Ms C's concerns; they noted that she was not accurately recorded in Mr A's notes as his significant carer or named person. Additionally, her telephone calls to the ward seeking information were not adequately documented.

67. In their letter to Ms C of 29 May 2013, the Board said they were sorry for the poor communication with her. They said they had improved their involvement with relatives and carers and clarified the immediate actions to be carried out should a patient not return to the ward within the time agreed.

68. The Board said they were sorry Ms C was not informed that Mr A had been discharged from Hospital 2, which had resulted in her making a fruitless journey to that hospital. They accepted there was no evidence staff at Hospital 2 had attempted to contact her to inform her of the transfer and the Board apologised for the distress this had caused Ms C. The Board said that staff had been reminded of the importance of informing the named person of transfers and patient relocations.

Advice received

69. Adviser 1 said the Mental Health (Scotland) Act 2003 was underpinned by a set of principles, including a requirement for a professional making a care and treatment decision to take the views of the person's named carer, named person, guardian or welfare attorney into account. There was also an expectation that the needs of carers would be taken into account and that the professional should ensure that they got the information and support they needed.

70. Adviser 1 said it was not clear from the records whether Ms C had been viewed by staff as Mr A's carer. Her status should have been identified at the point of admission, which would have allowed staff to ascertain what Mr A's views were on staff communication with her.

71. Adviser 1 said there should have been a systematic process for identifying the communication wishes and expectations of both patient and carer, but there was no evidence of this in the medical record. Significant carers should be identified as part of the admission process, or as soon as practicably possible afterwards. The patient's consent for staff communication with others should also have been recorded. All subsequent dialogue between staff and carers should have been recorded with sufficient detail for reference as necessary.

(b) Decision

72. The Board identified during their SAER that they had not communicated well with Ms C. They accepted that this had led to Ms C making a trip to the wrong hospital, following Mr A's transfer, and they have apologised for any distress this caused her. The SAER recommended that the procedures for involving carers in care planning should be reviewed and that the outcome of this review should be documented.

73. The advice I have received is clear that this should already have been taking place, as it is a requirement of the Mental Health (Scotland) Act 2003. I note that Mr A's sister was listed as his next of kin, although there was no evidence that she had been communicated with instead of Ms C. Ms C clearly was Mr A's main carer and was in communication with staff about his care. Her status should, therefore, have been documented to ensure that this was appropriate.

74. I uphold this complaint.

(b) Recommendations

75. I recommend that the Board:	*Completion date*
(i) provide evidence that they have reviewed the procedures for carer involvement in patient care and management decisions;	20 May 2015
(ii) provide evidence that the procedural review includes a system for the timeous identification of the patient's carer or named person; and	20 May 2015

General Recommendations

76. I recommend that the Board:	*Completion date*
(i) apologise for the failings identified in this report.	20 May 2015

77. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the complainant's fiancé
Hospital 1	the Royal Edinburgh Hospital
IHTT	Intensive Home Treatment Team
Hospital 2	The Royal Infirmary of Edinburgh
A&E	Accident and Emergency
ICU	Intensive Care Unit
Ms C	the complainant
the Board	NHS Lothian Health Board
SAER	Significant Adverse Event Review
Adviser 1	an independent mental health nursing adviser
Adviser 2	an independent consultant psychiatrist

Annex 2

Glossary of terms

Accident and Emergency	medical facility specialising in emergency medicine
anti-coagulant therapy	treatment with medication to prevent blood clots
fugue state	a state of reversible short-lived memory loss
hypothermic	a fall in core body temperature, which can be fatal
institutionalised	deficits in social and life skills developed following a period in hospital
Intensive Care Unit (ICU)	a hospital department specialising in care for critically ill patients
Intensive Home Treatment Team (IHTT)	mental health team providing intensive intervention in the community, aimed at avoiding hospitalisation for individuals
nephrogenic diabetes inspidus	a condition which causes excessive thirst and the consequent passing of large amounts of dilute urine, which can lead to dehydration or electrolyte imbalance because of the body's impaired ability to retain water
Procurator Fiscal	the public prosecutor in Scotland
pulmonary embolism	a blockage of the main artery of the lung or one of its branches by a substance in the bloodstream
schizophrenia	mental disorder categorised by abnormal

	social behaviour and failure to recognise what is real
Significant Adverse Event Review (SEAR)	a review carried out when an individual suffers unintended serious harm
suicidal ideation	thoughts of suicide, or a preoccupation with suicide