Scottish Parliament Region: South of Scotland

Case 200600199: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Mental Health Services; communication

Overview

The complainant (Mr C) and his sister raised a number of concerns about the care and treatment provided to their sister (Ms A) by Mental Health Services within Ailsa Hospital (Hospital 1), Ayrshire and Arran NHS Board (the Board) in February 2006. Ms A sustained a major spinal injury as a result of a fall from a window after her discharge from Ayr Hospital (Hospital 2) on 14 February 2006. Ms A never recovered, her condition deteriorated and she died in January 2007. Following the submission of Mr C's complaint to the Ombudsman's office the Board undertook a further review of Mr C's concerns and at a meeting with Mr C a number of issues were explained and apologies given for the failings in communication with Ms A's family which had been identified. Mr C was satisfied with much of this but remain concerned about the treatment provided to his sister. These are the issues investigated in this report.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms A's treatment at Hospital 1 during January and February 2006 was ineffective and she was discharged inappropriately (*not upheld*); and

(b) Ms A was treated and discharged inappropriately from Hospital 2 following her attendances at the Accident and Emergency Department on 10 and 13 February 2006 (*not upheld*).

Redress and recommendations

Because of the action already taken by the Board to address failures in communication since the complaint was submitted to the Ombudsman's office, the Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 19 April 2006, the Ombudsman received a complaint from Mr C about the care and treatment provided to his sister (Ms A) for bipolar affective disorder (BPD), by Mental Health Services within Ayrshire and Arran NHS Board (the Board) in January and February 2006. Mr C is supported in his complaint by his sister (Mrs D). In particular Mr C complained about the actions of Ms A's psychiatric consultant (Consultant 1) during her admission to Ailsa Hospital (Hospital 1) from 13 January to 9 February 2006 and following her admissions to the Accident and Emergency Department (A&E) in Ayr Hospital (Hospital 2) on 10 and 13 February 2006. Mr C complained to the Board on 26 February 2006 and received a response on 6 April 2006. Mr C remained dissatisfied with the response and approached the Ombudsman's office.

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

(a) Ms A's treatment at Hospital 1 during January and February 2006 was ineffective and she was discharged inappropriately; and

(b) Ms A was treated and discharged inappropriately from Hospital 2 following her attendances at A&E on 10 and 13 February 2006.

3. Following the submission of Mr C's complaint to the Ombudsman's office the Board undertook a further review of Mr C's concerns and at a meeting with Mr C a number of issues were explained and apologies given for failings identified. Mr C was satisfied with much of this but remain concerned about the treatment provided to his sister and communication with her family about this treatment. These are the issues investigated in this report.

Investigation

4. Investigation of this complaint involved obtaining and conducting a detailed review of Ms A's relevant clinical records, reviewing papers submitted by Mr C, obtaining the views of a clinical (psychiatric) adviser to the Ombudsman (the Adviser) who also reviewed the records, and reviewing the complaints correspondence of the Board. Ombudsman staff approached the Board having conducted the initial review and this prompted a further detailed review by the Board. The Board review highlighted a number of failings which had previously given the Ombudsman's office cause for concern and sought to address these with revised and new procedures. Mr C continued to have serious concerns after the review about the clinical issues in his complaint and

Ombudsman staff directly interviewed Consultant 1 to obtain the further information needed to reach a conclusion on this complaint. A transcript of that interview has been reviewed by the Adviser. I have also considered the Board's report of their own review of this complaint and Mr C's comments on that review.

5. 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) Ms A's treatment at Hospital 1 during January and February 2006 was ineffective and she was discharged inappropriately

6. Mr C told me that Mrs D had expressed concern directly to staff about Ms A's suicidal frame of mind but nothing appeared to be done about this and Ms A was discharged from hospital in a more depressed state than when she had been admitted, and had been discharged without any of her family being informed. Mrs D had tried to contact Consultant 1 to discuss her concerns but he had declined to speak to her.

7. During the Board's investigation of this complaint they explained that the concerns expressed to staff were noted but that staff did not note any suicidal intent and considered Ms A as safe to discharge. The Board apologised that no one had explained to Mr C or Mrs D that their concerns had been followed up by staff. The Board also noted that there was an important learning point in this case for staff who had to recognise that relatives were an important source of information and should be listened to even though patient confidentiality may demand that information held by staff cannot be shared with relatives. The Board also explained that Ms A's voluntary admission was for rationalisation of her current medication. They noted that Ms A was not in agreement that her medication should be fully stopped before discharge but that this was in line with best evidence for the treatment of BPD, but again information about treatment plans should have been offered at an earlier stage and the Board apologised that this was not the case. The Board explained the sequence of events around Ms A's discharge and again apologised that a communication plan should have been discussed and agreed in advance to ensure that the appropriate person was aware of Ms A's discharge.

8. The Adviser reviewed Ms A's clinical records and the interview with Consultant 1 and told me that overall Consultant 1's diagnosis and treatment of

Ms A's presenting problems represented good practice. The Adviser considered that the care provided and management strategy while Ms A was an in-patient in Hospital 1 were reasonable although he noted they did not correspond with Ms A's own wishes – a fact that was recognised by staff. The Adviser told me that he did believed that it was reasonable not to interpret the intensification of tension, distress and anger Ms A exhibited during her admission as a relapse of her BPD (which might require hospitalisation) but rather an indication of her unhappiness (where hospitalisation was not appropriate). The Adviser told me that the clinical decision to discharge Ms A (or rather allow her to take her own discharge) on 9 February 2006 was adequate. The Adviser was critical of the early complaint handling in this case and the overall communication with Mr C and Mrs D throughout Ms A's admissions. He did consider that even if Mrs D had been able to talk directly with Consultant 1 the actions taken by staff would not have been different. The Adviser noted that a number of procedural changes have occurred as a result of this complaint including communication about discharge arrangements.

(a) Conclusion

9. The Adviser told me that Consultant 1 should have responded to Ms A's family in the early days after she was discharged from Hospital 1. He considered that the clinical decisions Consultant 1 took regarding Ms A's treatment and discharge from Hospital 1 were reasonable and would not have changed even if he had spoken with the family directly. Based on the clinical advice I have received from the Adviser I conclude that Ms A's treatment and the decision to discharge were clinically appropriate and I do not uphold this aspect of the complaint.

(a) Recommendation

10. Because of the action already taken by the Board to address failures in communication since the complaint was submitted to the Ombudsman's office the Ombudsman has no recommendations to make.

(b) Ms A was treated and discharged inappropriately from Hospital 2 following her attendances at A&E on 10 and 13 February 2006

11. Mr C and Mrs D were concerned that although Ms A was admitted to A&E on 10 February 2006 following a drug overdose and again on 13 February 2006 following a distressed call for help, she was discharged almost immediately. They were further concerned that information about Ms A's admissions was not being passed on to Consultant 1 and/or the team back at Hospital 1. Mrs D had

tried to contact Consultant 1 by telephone on 13 and 14 February 2006 to discuss her concerns but he had not returned her call. Overall they were concerned that despite Ms A expressing suicidal thoughts and intentions (including an intention to jump from a window as she later did) staff permitted her discharge and seemingly ignored all these warning signs.

12. During the Board's investigation of this complaint they explained that Ms A was assessed by the Liaison Psychiatric Service on 11 February 2006 who had access to Ms A's electronic health records. Following Ms A's discharge from Hospital 1 she had been reviewed by the Community Mental Health Team and her care had been transferred to another consultant (Consultant 2) with her agreement. The Board noted that the telephone messages had been left for Consultant 1 but as he was not in work until 15 February 2006 he had not received them until then. The Board apologised that action had not been taken to ensure an urgent message was acted on immediately and that Consultant 1 had not returned the call as he should have done on 15 February 2006 following his return. By then Ms A's care had passed to Consultant 2 who would have been aware of Ms A's admissions on 14 February 2006 when these were discussed at the Community Team meeting. The Board apologised that Consultant 1 had not dealt adequately with Mr C or Mrs D's concerns and should have met with them directly or arranged a meeting for them with Consultant 2 to discuss their views.

13. The Board noted that staff had recorded Ms A's suicidal feelings and extreme agitation and distress but had concluded that she had no current suicidal intent and was capable of reaching her own decisions.

14. The Adviser told me that he considered that the clinical assessment of Ms A's mental state during her A&E admissions were reasonable although he recognised that Mr C did not agree with these assessments. The Adviser told me that the explanations of the difference between suicidal ideas and intent given during the second complaints investigation by the Board were reasonable. The Adviser further considered that the decisions to discharge Ms A on 11 and 13 February 2006 were reasonable in spite of the outcome.

(b) Conclusion

15. It is understandable that Ms A's family should be concerned that despite expressly giving voice to the thought that she would throw herself from a window, Ms A was discharged from hospital and immediately carried out this

action. Ms A's family believe this could and should have been prevented. The Adviser has told me that, in his opinion, staff recognised Ms A's suicidal ideas but were reasonable in concluding she did not have suicidal intent at that time. The Adviser was critical of aspects of the communication and complaint handling in this case but recognised that the Board had taken sensible steps to address this matter but concluded that overall the care and treatment provided was reasonable in spite of the outcome. Taking all this into account I conclude there was no clinical failure in the treatment or discharge of Ms A on 10 or 13 February 2006 and I do not uphold this aspect of the complaint.

(b) Recommendation

16. Because of the action already taken by the Board to address failures in communication since the complaint was submitted to the Ombudsman's office the Ombudsman has no recommendations to make.

Annex 1

Explanation of abbreviations used

Mr C	The complainant, Ms A's brother
Ms A	The aggrieved
BPD	Bipolar depressive disorder
The Board	Ayrshire and Arran NHS Board
Mrs D	Ms A's sister
Consultant 1	The consultant psychiatrist responsible for Ms A's care until shortly after her discharge from Hospital 1
Hospital 1	Ailsa Hospital
A&E	Accident and Emergency Department
Hospital 2	Ayr Hospital
The Adviser	A psychiatric adviser to the Ombudsman
Consultant 2	The consultant psychiatrist responsible for Ms A's care from shortly after her discharge from Hospital 1