

Scottish Parliament Region: North East Scotland

Case 201003482: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Psychiatry; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment provided to his son (Mr A) for mental health problems by Tayside NHS Board (the Board) prior to his death by suicide in July 2010. Mr C also raised concerns about the level of the family's involvement in the Board's Adverse Significant Incident review and their root cause analysis after Mr A's death.

Specific complaints and conclusions

The complaints which have been investigated are that:

- (a) mental health care and treatment from June 2009 until Mr A's death in July 2010 were below an acceptable standard (*upheld*); and,
- (b) the level of family involvement in the Board's Adverse Significant Incident review and their root cause analysis was below an acceptable standard (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

- | | <i>Completion date</i> |
|---|------------------------|
| (i) take steps to ensure that systems are in place in order that the care of vulnerable people is co-ordinated effectively and with due urgency, to minimise the danger of people at risk inappropriately disengaging or being lost to follow up; | 26 July 2013 |
| (ii) take steps to ensure that systems are in place in order that therapeutic engagement is planned with the patient's full participation. One-to-one therapeutic time should be negotiated and agreed on an individual basis and solitary, withdrawn and | 26 July 2013 |

- /or difficult to engage patients should have access to a range of interventions matched to their needs and wishes. They should also be consistently encouraged to engage with agreed interventions;
- (iii) ensure that clinical observation practice is in line with national guidance; 26 July 2013
 - (iv) take steps to ensure that no patient is de facto detained; 26 July 2013
 - (v) take steps to ensure that the eligibility criteria for engagement with secondary community mental health services are sufficiently flexible to allow vulnerable people to access appropriate services in situations where the person does not wish to (or does not require to) go into hospital but has complex needs which may be receptive to psycho-social interventions and which require a greater intensity of input than can reasonably be provided in the primary care setting; 26 July 2013
 - (vi) take steps to ensure that systems are in place in order that people who are vulnerable and difficult to engage are proactively followed-up by community services and all reasonable and appropriate steps are taken to minimise the risk of scheduled appointments being missed; 26 July 2013
 - (vii) ensure that the care plans of vulnerable patients, especially those who are difficult to engage or have a history of defaulting from care, include steps to be taken when scheduled appointments are missed; 26 July 2013
 - (viii) take steps to ensure that discharge letters which promote the delivery and continuity of safe and effective care are timeously received by GPs; 26 July 2013
 - (ix) take steps to ensure that up-to-date training records are maintained which enable performance against national or internal training targets to be judged; and 26 July 2013
 - (x) issue a written apology to Mr C for the failings identified in this report. 15 May 2013

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

Main Investigation Report

Introduction

1. The complainant (Mr C) raised a number of concerns about the care and treatment for mental health problems provided to his son (Mr A) by Tayside NHS Board (the Board) prior to his death by suicide in July 2010. Mr C also raised concerns about the level of the family's involvement in the Board's Adverse Significant Incident review and their root cause analysis after Mr A's death.

2. Mr A, who was 22 years old when he died, had pre-existing developmental problems, emotional difficulties and a previous diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). He had been diagnosed with Depressive Conduct Disorder in 1997 and had recently been diagnosed with Drug Induced Psychosis and Antisocial Personality Disorder. He had previously taken drug overdoses in 2004 and 2006.

3. Mr A took a further overdose of Paracetamol and other tablets in September 2009. He was admitted to Ninewells Hospital on 11 September 2009 and then to Ward 1 at the Carseview Centre mental health unit on 16 September 2009. He was discharged on 25 September 2009. On 11 January 2010, Mr A was admitted to Murray Royal Hospital due to his increased aggression and paranoid and suicidal thoughts. He was moved to the Carseview Centre on 13 January 2010 and discharged himself on 20 January 2010.

4. Mr A then took an overdose of Quetiapine (an anti-psychotic drug) and Carbamazepine (an anti-epilepsy drug with mood stabilising effects) on 6 February 2010. He declined the offer of an informal admission to the Carseview Centre whilst in general hospital care. Mr A took his own life by hanging on 10 July 2010.

5. On 8 August 2010, Mr C complained to the Board about the care and treatment Mr A had received before his death. The Board's Chief Executive responded to Mr C on 16 September 2010. He said that the Board had undertaken a thorough internal review and that this concluded that all appropriate action had been taken to support and assist Mr A. The Chief Executive said that numerous attempts had been made to encourage Mr A to work with them, but they were unable to do so.

6. The complaints from Mr C which I have investigated are that:
- (a) mental health care and treatment from June 2009 until Mr A's death in July 2010 were below an acceptable standard; and,
 - (b) the level of family involvement in the Board's Adverse Significant Incident review and their root cause analysis was below an acceptable standard.

7. The Mental Welfare Commission for Scotland (MWC) conducted a review into Mr A's death and published a report on this in February 2012. This review focussed on events from January 2010 until Mr A's death in July 2010.

Investigation

8. Investigation of the complaints involved reviewing the information received from Mr C and the Board's medical records for Mr A. My complaints reviewer also obtained advice from an independent mental health adviser (the Adviser).

9. 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. A list of the legislation and policies considered is at Annex 3. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Mental health care and treatment from June 2009 until Mr A's death in July 2010 were below an acceptable standard

Risk assessment tool

10. Mr C raised concerns that staff from the Board had not used a risk assessment tool to assess Mr A's potential for suicide. The Adviser commented that clinicians should not rely wholly on risk assessment tools as a means of determining a person's propensity to harm themselves or others. However, he said that the traditional method, professional judgement based upon intuition and experience is, on its own, a poor predictor of outcome. He stated that professional judgement can be enhanced by using a structured approach, which systematically assesses static, stable, dynamic and future risk indicators.

11. The National Institute for Health and Clinical Excellence (NICE) guideline on deliberate self-harm states that:

'All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and

demographic features known to be associated with risk of further self-harm and /or suicide, and identification of the key psychological characteristics associated with risk ...'

12. The guideline also states that: '[T]he assessment of risk should be written clearly in the service user's notes', and that '[T]he assessment of needs is designed to identify those personal (psychological) and environmental (social) factors that might explain an act of self-harm; this assessment should lead to a formulation, based upon which a management plan can be developed.'

13. The Adviser said that a Liaison Psychiatry Nurse had addressed deliberate self-harm /suicide in her assessment of Mr A in the Short Stay Ward at Ninewells Hospital on 12 September 2009. He commented that she had recorded information pertinent to the assessment of risk, but there was no explicit formulation of risk recorded. He said that there was no evidence of a rating scale or risk assessment /screening tool being used at that time. He stated that the use of a risk assessment /screening tool based on recognised risk indicators such as that referred to in the NICE guideline would have acted as a clinical aide-memoire and provided structure to the risk screening process. It would also have enabled historical and precipitating risk factors to be considered systematically, thereby informing clinical judgement and the formulation of risk. It would have made the process more transparent and left a clear baseline in the clinical record against which future assessments of risk could be judged.

14. The Adviser stated that although there were deficiencies in the recording of the risk assessment process, the Liaison Psychiatry Nurse's management of the presenting risk was satisfactory in that she clearly felt that the level of risk warranted a period of in-patient mental health care and this was duly arranged.

15. The Adviser also reviewed the risk assessment carried out when Mr A was admitted to the Carseview Centre on 16 September 2009. He said that a comprehensive risk assessment was documented in the notes covering aggression, positional asphyxiation, suicidality and fire-raising. He also said that there were documented interventions in the care-plan to manage these identified risks.

16. The Adviser commented that the completion of the risk assessment was confirmed in the Admission Checklist when Mr A was admitted to hospital again

on 11 January 2010. He said that Mr A's suicidality was reassessed in the Carseview Centre on 14 and 19 January 2010. He said that all of this was consistent with the Board's risk management guidelines and was evidence of reasonable practice. The Adviser stated that clinical practice in the in-patient setting was reasonable in relation to the assessment of risk during both admissions.

17. The Adviser commented that a Clinical Nurse Specialist from Liaison Psychiatry saw Mr A in the Accident & Emergency short stay ward of Ninewells Hospital on 6 February 2010 following an overdose of Quetiapine and Carbamazepine. At that time, Mr A denied further active suicidal thoughts, but displayed little remorse regarding the overdose event two days previously. He did, however, admit to on-going occasional thoughts of a suicidal nature. The Clinical Nurse Specialist also noted at the time that Mr A was 'rather evasive and contradictory at times' in relation to his drug and alcohol use. No risk assessment /screening tool appears to have been used to structure the assessment and inform clinical judgement and risk management and there was no explicit formulation of risk. That said, the Clinical Nurse Specialist judged that Mr A was sufficiently vulnerable to offer him the opportunity of a further period of in-patient assessment at the Carseview Centre. The Adviser considered that under the circumstances, this judgement was reasonable.

18. Mr A declined the offer of an in-patient stay. He did not fulfil the criteria for compulsory admission and had previously been deemed to be outwith the eligibility criteria for the community mental health team (CMHT). The Adviser commented that the records state that 'various options' were discussed with Mr A, but apart from the in-patient option, it was not wholly clear what those options were. He said that Mr A appeared to be willing to seek help for his drug and alcohol problems. He was provided with the contact details for two independent sector organisations: one that supports people with drug and / or alcohol problems; and one that deals with people experiencing low mood, depression or anxiety.

19. The Adviser commented that there were a number of suicide risk indicators in Mr A's history and presentation. He said that he was a young man with a history of low mood who had made previous suicide attempts. He had: on-going thoughts of suicide; previous in-patient admissions; recently been discharged; a troubled childhood; bouts of anxiety; problems coping well with stress; access to potentially dangerous medication; expressed feelings of

hopelessness; used alcohol to excess; and had used illicit drugs. He was also impulsive, unemployed, emotionally unstable, difficult to engage and had regularly missed scheduled appointments. The Adviser said that on the basis of these factors, the risk of self-harm repetition was high.

20. The Adviser commented that careful assessment of why someone is behaving in a particular way is critical in the delivery of safe and effective mental health care. He said that the identification of what the risks actually are and the risk management decision-making must be open and transparent. He stated that there is a strong association between previous suicidal acts /self-harm events and future successful suicides. Assessment must, therefore, explore suicidal intent and the likelihood of future deliberate acts of self-harm.

21. The Adviser concluded that clinical practice in the in-patient setting was reasonable in relation to the assessment of risk. In relation to Mr A's engagement with Liaison Psychiatry in February 2010, the Adviser said that the initial conclusions of both clinicians were reasonable, ie that Mr A would benefit from a period of in-patient assessment. However, he said that the assessments of risk were not as transparent as they might have been had a standardised tool been used to inform clinical judgement. There is not a full record of all of the risk factors considered in the clinical judgement process. He said that while the question of 'suicidal intent' was clearly covered in both assessments, the overall risk assessment structure and process lacked clarity. Despite Mr A's history and presentation indicating that he was probably at high risk of future self-harm, there was no explicit formulation of risk in relation to future self-harm in either assessment.

22. In report 201003783 that I issued in December 2011, I recommended that the Board make the use and review of a risk-screening tool to complement and inform the risk assessment process mandatory for all patient assessments following a self-harm /suicide attempt. The Board have indicated that they are taking this matter forward.

Lack of co-ordination

23. Mr C also complained that Mr A's care had not been co-ordinated. Section 2.11.1 of the NICE guideline on self-harm sets out some key aims and objectives of care and treatment, which includes the need for:

- the experience of care to be acceptable to the service user and carers, especially those with psychological, social and /or alcohol /drug related problems;
- effective engagement of the service user;
- prompt and effective psychological and psychiatric treatment when necessary;
- an integrated and planned approach to the problems of people who self-harm, involving primary and secondary care, mental and physical healthcare personnel and services, and appropriate voluntary organisations.

24. I asked the Adviser if Mr A's care had been co-ordinated appropriately, including with his GP Practice. In his response, the Adviser said that Mr A's care appeared to have lacked continuity and cohesion. He commented that a number of different professionals were involved in his care during the period September 2009 to February 2010.

25. The Adviser said that Mr A was vulnerable with a high risk of further deliberate self-harm. He had a chaotic lifestyle and history of only presenting in times of crisis and of missing appointments. Despite this, maintaining on-going engagement seems to have been left to his personal motivation. When appointments were missed, there seemed to be a lack of urgency in relation to making appropriate enquiries to ensure Mr A's continued wellbeing.

26. The Adviser said that this lack of a sense of urgency was explicitly demonstrated when Mr A failed to keep his appointment on 10 February 2010. The response was to give him another appointment for 15 April 2010, more than two months later. The Adviser said that given that the appointment on 10 February 2010 was arranged as a consequence of an urgent GP referral, this seemed to be an inordinately long time.

27. The Adviser also commented that Mr A was never a patient of the CMHT. He said that had he been, he would have had a key-worker who would have had responsibility for coordinating his care across the range of professionals and agencies involved. He stated that as things stood, the principal coordinator of Mr A's care was his GP. Discharge letters to the GP were not issued promptly and communication with the GP was ineffective, especially when out-patient appointments were missed.

28. The Adviser concluded that ineffective care coordination and a lack of cohesion and sense of urgency resulted in the Board failing to deliver all aspects of care and treatment effectively. This resulted in Mr A becoming disengaged from services for a full five months before his death.

Missed opportunities for engagement

29. Mr C complained that the Board missed opportunities for engagement during Mr A's time in hospital. I asked the Adviser if the action taken by the Board in relation to engaging with Mr A whilst he was in hospital was reasonable and appropriate. In his response, the Adviser referred to Mr A's admission to hospital in January 2010 and commented that his care plan lacked detail in relation to planned interventions. He said that it seemed to be predominantly made up of formulaic pre-printed documentation. He said that it was not effectively individualised and built around Mr A's needs and wishes. He stated that evidence of Mr A's participation in the development of the care plan was scant.

30. The Adviser said that the target of providing Mr A with 15 minutes' one-to-one time per day to discuss his feelings seemed to be a very low goal for staff to be aspiring to. Despite this unambitious commitment, it appeared from the records that staff failed to deliver the planned one-to-one sessions on six of the ten days Mr A was in hospital. The Adviser commented that the purpose of one of these sessions was to 'complete the admission paperwork', which suggested that particular session took place to meet the organisation's needs and not those of the patient.

31. The Adviser said that there was little evidence in the records of staff being proactive in trying to engage with Mr A. He also said that there was no evidence of them seeking to address his problems associated with drugs and alcohol. He said that Mr A was not only in hospital for assessment and observation, he was there for care and treatment. The Adviser stated that the care plan put in place was ineffective in this regard and was not person-centred. He said that planned engagement with staff was minimal, inconsistent and lacking in therapeutic direction.

Timed Observations

32. Mr C complained that staff inappropriately used the practice of timed observation to observe Mr A. The MWC had raised this matter in their report on

Mr A's death. I asked the Adviser for his comments on the matter. In his response, he said that timed observations are not recommended as a means of effectively observing vulnerable people in the national clinical observation good practice statement *Engaging People*. He said that the guidance refers to three levels of observation: general; constant; and special. Under the terms of general observation, staff are required to be aware of the general whereabouts of the person whether they are in or out of the ward. The level up from that is constant observation, when staff are expected to be within sight and /or sound of the person at all times.

33. The Adviser said that using timed checks (for example, every 15 minutes), as a raised level of observation beyond the general level is not appropriate because it is not an effective means of maintaining a safe environment for a vulnerable person. A lot can happen in 15 minutes if the person is unobserved during the period between checks. The Adviser stated that if the patient requires increased observation beyond the general level, then constant observation should apply.

34. Having said that, the Adviser also stated that it is not inappropriate to use timed checks on people subject to general observation as a means of periodically confirming their whereabouts and where a raised level of observation would be overly restrictive. He said that this is sometimes done hourly or at natural points in the clinical day such as mealtimes, medication times and shift handovers. However, he said that checking every 15 minutes in this regard would be excessive.

35. The Adviser said that it is clear from the notes that the checks on Mr A every 15 minutes were intended as a raised clinical observation level beyond the general observation level and was not as a means of delivering that level of observation. He concluded that if Mr A required a raised level of clinical observation, he should have been on constant observation. He said that to use timed checks as a form of enhanced clinical observation was misguided, inappropriate and potentially unsafe. He also stated that the practice of timed checking was not supported by the Board's Clinical Observation Policy at that time or by the national guidance.

Self-discharge

36. Mr C said that Mr A should not have been allowed to self-discharge on 25 September 2009, two weeks after he took an overdose. He also said that

the Board allowed Mr A to self-discharge against medical advice. I asked the Adviser for his comments on this matter. In his response, he said that it was clearly recorded in Mr A's notes on 17 September 2009 that the Consultant Psychiatrist considered him still to be in the high risk period for suicide and, as such, considered that he was detainable if he wished to leave. It was then recorded later that day in capital letters 'DETAINABLE IF DECIDES TO LEAVE'. The Adviser said that the records then went on to demonstrate in detail how Mr A met the Mental Health Act criteria for detention.

37. The Adviser commented that it appeared from the records that by 24 September 2009, Mr A was no longer detainable. The records note that a discussion took place regarding his status if he wished to leave and it was decided that if he wished to leave, 'he will have to go against medical advice'. The Adviser stated that if that was the case and he was not willing to be persuaded to stay, there was nothing that hospital staff could have done to compel him to do so. However, the Adviser stated that following reassurances from Mr A regarding risk-behaviours, it appeared that he was discharged on 25 September 2009 after his request to be allowed to go home was granted. He did not leave against medical advice.

38. Nevertheless, the Adviser commented that where an informal patient wishes to leave hospital against medical advice, they should not be placed in the position of feeling compelled to stay purely because of the possibility of being detained under the Mental Health Act if they try to leave. He said that sometimes statements such as 'detainable if he wishes to leave' are inappropriately written in case-notes. He stated that this type of statement is not acceptable, as it increases the risk of a person's rights being overlooked such that they become 'de facto' detained. In their response to a draft copy of this report, the Board agreed that the entries in the medical records were counter to good practice.

Mental Health Act

39. Mr C complained that staff appeared to be frightened to use the Mental Health Act to detain Mr A. The criteria for short-term detention under the Mental Health Act are that:

- the person has a mental disorder;
- the person has significantly impaired decision making capacity with respect to their need for mental health care and treatment for mental disorder;

- detention in hospital is necessary to determine what medical treatment is required or to provide that treatment;
- the person poses significant risk to their own health, safety and welfare or to the safety of others;
- granting a short-term detention certificate is necessary, for example, because a patient is refusing to accept treatment on a voluntary basis.

40. I asked the Adviser if Mr A should have been detained in hospital after his admissions in September 2009 and January 2010. In relation to the admission in September 2009, the Adviser said that it appeared from the records that by 24 September 2009, Mr A was no longer detainable. He also commented that having reviewed the records from the second admission, it was unlikely that Mr A was detainable during that period of in-patient care. The Adviser said that whilst his decision-making was frequently ill-judged, it was probably not significantly impaired because of mental disorder. He stated that during the second admission, Mr A probably did not meet all of the criteria necessary to warrant the use of compulsory measures under the Mental Health Act.

Discharged without medication

41. Mr C complained that Mr A was allowed to discharge from the Carseview Centre in January 2010 without medication. I asked the Adviser for his comments on this. In his response, the Adviser said that Mr A was prescribed medication at the point of discharge, as evidenced by the Discharge Notification and Prescription Form. Mr A would have been expected to take this notification of prescription to his GP at the earliest opportunity. However, sufficient quantities of the drugs (perhaps three to seven days' supply) would usually be dispensed by a hospital to enable patients to take the medication as prescribed until they could get supplies from a community pharmacy. The Adviser said that Mr A was prescribed medication at the point of discharge, but the Carseview Centre was unable, rather than failed, to dispense a small supply of his medication to tide him over until he could see his GP, because he would not wait for this to be done.

Discharged without follow-up

42. Mr C said that Mr A was discharged from hospital without follow-up. I asked the Adviser if additional follow-up action should have been taken when Mr A was discharged from hospital in September 2009 and January 2010. In his response, he said that due to the diversity of underlying causes of self-harming behaviour, there is no widely accepted or standardised method to

enable clinicians to identify accurately those individuals who need further assessment and care following hospital admission. The overall aim, however, should be to minimise harm.

43. The NICE guidelines on deliberate self-harm at section 4.11.1.4 refer specifically to people who have self-harmed and are at risk of repetition, they state:

'... consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow frequent access to a therapist, when needed, home treatment when necessary, and telephone contact; and outreach should include following up the service user actively when an appointment has been missed to ensure that the service user is not lost from the service. The therapeutic intervention plus outreach should continue for at least 3 months.'

44. As previously stated, there were a number of suicide risk indicators in Mr A's history and presentation. On the basis of these factors, the risk of self-harm repetition was high. On 29 December 2009, the intention to make a referral to the CMHT was documented, but this does not appear to have been followed up. The CMHT had previously assessed Mr A as being unsuitable for their service because he did not have a severe and enduring mental illness. However, the Adviser said that he did have a range of social and psychological problems, which increased his risk of further self-harm and they may have been able to offer him some help.

45. The Adviser said that Mr A was due to commence counselling with a charitable organisation on 19 January 2010. However, he was an in-patient in the Carseview Centre at that time and the opportunity was missed. Nothing seems to have been done after his discharge to rearrange this.

46. The Adviser commented that the plan was for Mr A to be followed up via out-patient appointments when he was discharged in September 2009 and January 2010. He said that referral for more intensive support would probably have been appropriate on both occasions given Mr A's presentation. The Adviser stated that periodic out-patient appointments, even if he had attended regularly, would probably have lacked the frequency and intensity of approach required to meet Mr A's psychological and social needs. Management in secondary care with input from external agencies may have been more beneficial. However, due to the CMHT's strict eligibility criteria, had Mr A been

referred there, the likelihood is that they would have seen him once and considered that he was not suffering from a severe and enduring mental illness. He probably would have been referred back to his GP or onto an addiction service.

Referred to external agencies rather than being treated by the Board

47. Mr C said that Mr A was passed to external agencies rather than being treated by the Board. I asked the Adviser if it was appropriate to refer Mr A to external agencies or back to his GP and not to provide treatment direct to him. In his response, the Adviser said that on the basis of the assessment carried out in the Accident & Emergency ward on 6 February 2010, the Clinical Nurse Specialist offered Mr A an in-patient admission for a period of assessment. Mr A declined this offer and was given information regarding respected independent providers of mental health support. The Adviser said that it was often appropriate for clinicians to refer people to them. However, the difference between what they provide and what in-patient services can provide in terms of intensity of care and support is marked.

48. The Adviser said that if the Clinical Nurse Specialist believed that Mr A was vulnerable enough to warrant a period of in-patient assessment, then the step down in terms of intensity of support from that option to the option of using external agencies seemed a precarious step to take. He also stated that it was not clear from the records if a CMHT referral was considered. However, there was further evidence that indicated that the Clinical Nurse Specialist considered that a CMHT referral would not be helpful. He said that it was likely that this option was rejected because Mr A would not have met the eligibility criteria for on-going engagement with the CMHT.

49. The Adviser commented that Liaison Psychiatry Services rarely follow-up the people they see. Their role tends to be to undertake a psycho-social assessment and refer onward to appropriate services. He commented that due to the strict and potentially overly rigid eligibility criteria for CMHT, the Clinical Nurse Specialist probably had very limited options in relation to Mr A's follow-up after he declined in-patient care. Mr A's risk of further self-harm was high and he probably required more intensive input than the external agencies could provide.

50. The Adviser commented that expecting Mr A, a person with a chaotic lifestyle and significant track record of failing to keep appointments, to self-refer

to the suggested external agencies was probably overly optimistic and ill-judged. He said that integrated management in secondary care from the CMHT with input from external agencies may have been more beneficial, but the notes are not wholly clear in relation to why this option was not favoured. He said that it was likely that it was because Mr A was judged not to be living with a severe and enduring mental illness.

Letters to GP

51. Mr C also said that letters had not been sent to Mr A's GP until more than two weeks after he had been discharged. I asked the Adviser if the Board had delayed unreasonably in sending discharge letters to Mr A's GP. In his response, he said that detailed and timeous communication between hospital departments and GPs improves continuity of care and clinical outcomes. He commented that if GPs are to ensure continuity and /or to implement changes in care following admission then they require information, accurately and promptly, following a patient's discharge. Poor communication is a common source of dissatisfaction among GPs. Incomplete or delayed discharge letters compromise care quality and continuity. Such deficits in communication and information transfer at hospital discharge adversely affect follow-up patient care.

52. In the case of Mr A's first admission to hospital, the discharge took place on 25 September 2009, but the discharge letter was not dictated until 5 November and not typed until 9 November 2009 - 45 days after discharge. The Adviser stated that this was unsatisfactory and unjustifiable. In the case of Mr A's second admission, he left hospital on 20 January 2010. The discharge letter was dictated on 28 January 2010 and typed on 3 February - 14 days after Mr A left hospital. The Adviser said that although there did not appear to be any national benchmark, anything in excess of two weeks would be unreasonable in relation to ensuring continuity of care.

Missed appointments

53. Mr C complained that the Board did not take action when Mr A missed appointments, despite the nature of the referral. He said that they should have contacted his GP. I asked the Adviser if the Board should have contacted Mr A's GP or taken any other action when he failed to attend appointments. In his response, he said that some people are difficult to clinically manage because of their chaotic lifestyles, impulsivity and erratic compliance with care and treatment initiatives. In such cases, communication between professionals

is important to ensure that everyone in the wider care-team is aware of current developments, particularly missed appointments and failures to engage.

54. The Adviser stated that the NICE guidelines on deliberate self-harm refer specifically to people who have self-harmed and are at risk of repetition (see paragraph 46). He stated that Mr A's GP had specific concerns in relation to his propensity for self-harm and that Mr A had a history of turning to the GP for support in times of crisis. The Adviser commented that it would have been good practice for the Board to have contacted the GP when Mr A failed to keep appointments. I have seen evidence that they did so in February and April 2010.

55. Mr C also stated that the Board could have contacted Mr A direct after he missed appointments. The Adviser commented that the care team had Mr A's mobile telephone number and, therefore, had the means of contacting him when he missed appointments. He said that clinically managing people who are difficult to engage requires perseverance, assertiveness of approach and flexibility. Vulnerable people with a history of significant self-harm who miss appointments are a cause for concern. He said that the NICE guidelines on deliberate self-harm record the importance of telephone contact and active follow-up after a missed appointment.

56. The Adviser concluded that given Mr A's vulnerability and chaotic and disorganised lifestyle, it would have been reasonable to expect that services might contact him directly. This would have been to both remind him of appointments and to make appropriate enquiries in relation to his welfare and agree future contact arrangements when he missed appointments.

Commitment 13

57. Mr C also said that the Board had not implemented Commitment 13 of the Scottish Government's mental health delivery plan, *Delivering for Mental Health*. This was Scotland's national mental health strategy covering the period 2006-2011. Mr C felt that if the Board had met the commitment by the end of 2007, some or all of what happened with his son might have been avoided.

58. Commitment 13 stated that:

'We will translate the principles of *'Mind the Gaps'* and a *'A Fuller Life'* into practical measures and advice on what action needs to be taken to move

the joint agenda forward and support joined-up local delivery by the end of 2007.'

The Adviser said that each NHS Board was duty-bound to develop and implement a Local Delivery Plan. This should set out explicitly their priorities, timescales, associated constraints, risks, and challenges related to the implementation of the targets within *Delivering for Mental Health*.

59. The Adviser said that the responsibility to deliver Commitment 13 fell to the Scottish Government and not individual NHS Boards. The *Mind the Gaps* report on meeting the needs of people with co-existing substance misuse and mental health problems sought to identify gaps in the provision of services for this, often complex, care group. The *A Fuller Life* report on alcohol related brain damage (ARBD) sought to explore the care needs, issues and challenges faced by those with ARBD, their families and carers and how services can best address these.

60. A Mental Health and Substance Misuse Group was set up by the Scottish Government to translate the principles and recommendations of *Mind the Gaps* and *A Fuller Life* into a series of practical measures. These measures were aimed at helping to improve the awareness, support and service provision for people who have both mental health and substance misuse problems. This culminated in the *Closing the Gaps* report in late 2007. There were six practical recommendations in the report, which focused on actions to deliver change and improvement in the prevention, care and recovery services for this care group, their carers and families. The Scottish Government committed to ensuring the monitoring of the implementation process via the Implementation Review work plan.

61. The Adviser said that the Board should have developed an action plan to deliver on these aims and progress should have been monitored by the Scottish Government. We asked the Board for further evidence in relation to this matter. The report that they sent us indicated that the Scottish Government's 50 percent suicide training target was indeed met by the Board and the Adviser said that this was commendable. However, the remainder of the report related to work in progress and provided little detail regarding the amount of progress made or any constraints experienced by the Board in this regard.

62. The Board also sent us an Alcohol Brief Interventions Training Delivery Report. The Adviser said that there was sufficient evidence in this to indicate that a significant number of staff from a range of professions and clinical contexts, including nurses in training, had undergone appropriate training and that the training was being delivered as an on-going commitment.

63. In addition, the Board told us that Tayside Substance Misuse Services had developed training in behavioural approaches for non-psychology staff. However, they said that it would require a significant amount of work to produce further evidence in relation to the number of people who had undergone this training. In response to this, the Adviser said that in any situation where a measurable training target has been set, either internally by a Board or externally by a national body, it is essential that the Board maintain accurate records in order to demonstrate progress or identify slippage against the training benchmark. He said that if electronic systems do not allow retrospective reports to be collated and extracted, then the statistics should be recorded by those involved in either authorising the training for individual practitioners or those involved in delivering it.

64. The Adviser commented that without such record-keeping, the setting of national targets became meaningless because local services will be unable to state with any degree of confidence whether or not a target has been met. He said that accurate and up-to-date training records should be maintained in the future, especially where training is linked to the Board's performance. In their response to a draft copy of this report, the Board said that the training in behavioural approaches for non-psychology staff did not relate to a national or local target. However, it was the Board who had provided the above information as evidence of their progress in relation to Commitment 13. The Adviser said that when Boards have an internally or externally set training target, it is helpful for any training that contributes to the meeting of that target to be quantified, whether the impetus for the training comes from a training initiative aimed at large groups, or an individual's professional development plan.

(a) Conclusion

65. I have highlighted a number of failings in relation to the care and treatment provided to Mr A above. I do not consider that the care and treatment provided to Mr A from June 2009 until his death was of a reasonable standard. I have, therefore, upheld the complaint.

(a) *Recommendations*

	<i>Completion date</i>
66. I recommend that the Board:	
(i) take steps to ensure that systems are in place in order that the care of vulnerable people is co-ordinated effectively and with due urgency, to minimise the danger of people at risk inappropriately disengaging or being lost to follow up;	26 July 2013
(ii) take steps to ensure that systems are in place in order that therapeutic engagement is planned with the patient's full participation. One-to-one therapeutic time should be negotiated and agreed on an individual basis and solitary, withdrawn and /or difficult to engage patients should have access to a range of interventions matched to their needs and wishes. They should also be consistently encouraged to engage with agreed interventions;	26 July 2013
(iii) ensure that clinical observation practice is in line with national guidance;	26 July 2013
(iv) take steps to ensure that no patient is de facto detained;	26 July 2013
(v) take steps to ensure that the eligibility criteria for engagement with secondary community mental health services are sufficiently flexible to allow vulnerable people to access appropriate services in situations where the person does not wish to (or does not require to) go into hospital but has complex needs which may be receptive to psycho-social interventions and which require a greater intensity of input than can reasonably be provided in the primary care setting;	26 July 2013
(vi) take steps to ensure that systems are in place in order that people who are vulnerable and difficult to engage are proactively followed-up by community services and all reasonable and appropriate steps are taken to minimise the risk of scheduled appointments being missed;	26 July 2013

- (vii) ensure that the care plans of vulnerable patients, especially those who are difficult to engage or have a history of defaulting from care, include steps to be taken when scheduled appointments are missed; 26 July 2013
- (viii) take steps to ensure that discharge letters which promote the delivery and continuity of safe and effective care are timeously received by GPs; and 26 July 2013
- (ix) take steps to ensure that up-to-date training records are maintained which enable performance against national or internal training targets to be judged. 26 July 2013

(b) The level of family involvement in the Board's Adverse Significant Incident review and their root cause analysis was below an acceptable standard

67. Mr C said that he had not been involved in either the Adverse Significant Incident review or the root cause analysis and had not been able to see the reports. The Board told Mr C that they could not send him a copy of the Adverse Significant Incident review note, as it was written for internal use only, but would summarise the main issues.

68. I asked the Adviser if the family should have been involved in the Board's Adverse Significant Incident review and the root cause analysis. In his response, the Adviser said that one of the principles under-pinning the Mental Health Act is 'Respect for Carers'. This means that those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account. The Adviser stated that unless there are specific reasons for not doing so, it is good practice to involve relatives in incident reviews. The nature and degree of involvement is likely to vary from case to case depending upon: the wishes of relatives; their capacity to understand and participate in the process; and, any potential risks associated with their direct or indirect involvement. The Adviser commented that participating in a review is often therapeutic for relatives. However, some may not wish to participate and it must be remembered that where a patient has died, the relatives are going through a grieving process.

69. The Adviser stated that once a review team is established, it would be good practice for the lead reviewer to contact the named relative of the deceased to:

- write to offer to meet to discuss the incident;
- explain that the purpose of the review is to examine the sequence of events leading up to the incident; and
- explain how the relative can take part in the review process.

70. The Adviser said that clearly there will be situations in some cases where strong feelings and views held by relatives could result in hostility towards staff, especially if everyone involved was in the same room at the same time. He said that one of the aims of the root cause analysis approach is to move things away from a blame culture towards a learning culture. He said that if a review was being conducted by appropriately independent professionals from outwith the person's care-team or geographical location, the risk of conflict can be significantly diminished. In some instances, if relatives choose to participate in the review, for safety, it might be considered necessary for two members of the review team to meet with them.

71. The Adviser said that a minimum reasonable expectation would be for relatives to be asked face-to-face, in writing or by telephone (as deemed appropriate) for their views and if they have any specific questions or concerns they wish the review to address. He said that if relatives are not to be involved, the reasons for this should be clearly stipulated.

72. The Adviser also commented that Healthcare Improvement Scotland (HIS) provide guidance on suicide reporting. This guidance contains a suicide review template which includes sections to record:

- relative /informal carer involvement in both the care process and in the suicide review;
- views of relatives and responses to specific questions asked; and
- support required for relatives /carers.

73. The guidance also includes a 'Best Practice Checklist', which asks if all relevant people are involved in the review process and that this may include relatives and informal carers. It also asks if all necessary information is available to the review team, including third party information from relatives.

74. The Adviser said that although the HIS suicide review guidance does not specifically mention relatives' involvement in root cause analysis exercises per se, it is the usual methodology for conducting these reviews. He stated that the spirit of the message regarding the involvement of relatives is clear, as is the principle of 'Respect for Carers' under-pinning the Mental Health Act.

75. I also asked the Adviser if the Board should have sent Mr C a copy of the review and the root cause analysis documents. In his response, the Adviser said that the HIS checklist asked if all of the people affected by the death had appropriate information about the conclusions and outcome of the suicide review. He said that bearing in mind the 'Respect for Carers' principle and the fact that the deceased's family are likely to have been traumatised by their death, it was reasonable to conclude that the 'people affected by the death' referred to in the checklist should, first and foremost, include the relatives of the deceased.

76. That said, the Adviser said that he did not believe that Mr C should have been sent a full copy of the root cause analysis report automatically. He stated that relatives can sometimes find the level of detail in these documents distressing and stressful to read. However, he said that it was good practice, and should be the default position, to inform relatives of the conclusions of a root cause analysis exercise. He also said that root cause analysis exercises are generally internal procedures and reports are not automatically made public. However, unless there are specific and recorded reasons for not doing so, relatives may, on request, be provided with a copy of a root cause analysis report, which has been suitably anonymised in the interests of confidentiality and safety. The Adviser stated that clearly any report which mentioned staff members, other patients or third parties by name would have to be redacted in this regard. He also said that Health Boards should have procedures in place for dealing openly and transparently with external requests for copies of root cause analysis reports.

(b) Conclusion

77. The Board's Significant Event Management Policy states that relatives must be given the opportunity to contribute to and receive feedback following a Significant Clinical Event Analysis (SCEA) but not necessarily be asked to attend. Relatives should be involved in an Adverse Significant Incident review and a root cause analysis unless there are compelling reasons that make this inadvisable or impracticable. The level of involvement is likely to vary on a case

by case basis, but at the very least, they should be asked for their views and for any specific questions or concerns they might have which they wish the review to address. I also consider that it is reasonable that, as a minimum requirement, the family should be privy to the conclusions of the report including learning points and planned actions designed to minimise the risk of recurrence.

78. I have not seen evidence that Mr C was adequately involved in the reviews or that he was asked for his views and for any specific questions or concerns he might have that he wished the review to address. I, therefore, uphold the complaint.

79. In report 201003783 that I issued in December 2011, I recommended that the Board review their process for involving families in Significant Incident Reviews and root cause analysis. I am satisfied that the Board have now implemented this recommendation and have addressed this issue.

General Recommendation

80. I recommend that the Board:	<i>Completion date</i>
(i) issue a written apology to Mr C for the failings identified in this report.	15 May 2013

81. 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.

Explanation of abbreviations used

Mr C	The complainant
Mr A	The aggrieved (Mr C's son)
The Board	Tayside NHS Board
ADHD	Attention Deficit Hyperactivity Disorder
MWC	The Mental Welfare Commission for Scotland
The Adviser	The Ombudsman's mental health adviser
NICE	The National Institute for Health and Clinical Excellence
CMHT	Community Mental Health Team
ARBD	Alcohol related brain damage
HIS	Healthcare Improvement Scotland
SCEA	Significant Clinical Event Analysis

Glossary of terms

Carbamazepine	An anti-epilepsy drug with mood stabilising effects
Quetiapine	An anti-psychotic drug
Secondary care	Care from a specialist

List of legislation and policies considered

The National Institute for Clinical Excellence /The National Collaborating Centre for Mental Health. *Self-Harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. National Clinical Practice Guideline No. 16. London. 2004

The Scottish Executive. *The Mental Health (Care and Treatment) (Scotland) Act 2003*. Edinburgh. 2003

The Scottish Executive. *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems*. Edinburgh. 2003

The Scottish Executive. *A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage*. Edinburgh. 2004

The Scottish Government. *Mental Health in Scotland: Closing the Gaps – Making a Difference: Commitment 13*. Edinburgh. 2007

The Scottish Executive Health Department, Clinical Resource and Audit Group (CRAG). *Engaging People: Observation of People with Acute Mental Health Problems. A Good Practice Statement*. Edinburgh. 2002

The Scottish Executive. *Delivering for Mental Health. The Mental Health Delivery Plan for Scotland*. Edinburgh 2006

The Mental Welfare Commission for Scotland. *Hard to Help: The Mental Welfare Commission review of the death of Mr O*. Edinburgh. 2012