Scottish Parliament Region: Lothian

Case 201203602: Lothian NHS Board - Acute Division

Summary of Investigation

Category

Health: Hospital; Accident & Emergency; clinical treatment; diagnosis

Overview

The complainants (Mr and Mrs C) raised a number of concerns about the care and treatment provided to their late son, Mr A, when he attended the Accident and Emergency (A&E) department of the Royal Infirmary of Edinburgh. Mr and Mrs C also complained that staff unreasonably failed to admit Mr A for further assessment, and that the handling of their subsequent complaint was inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Lothian NHS Board (the Board) provided inadequate care and treatment to Mr A in A&E (*upheld*);

(b) the Board unreasonably failed to admit Mr A pending further assessment (*not upheld*); and

(c) the Board's handling of Mr and Mrs C's complaint was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) consult urgently with all relevant stakeholders to formulate an appropriate protocol for dealing with patients who attend A&E with substance misuse and co-morbid mental health illness;	21 August 2014
(ii) ensure that all staff dealing with complaints are reminded of the importance of keeping complainants informed and updated during the complaints process; and	21 June 2014
(iii) issue a written apology to Mr and Mrs C for the failings identified in this report.	21 June 2014

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

Main Investigation Report

Introduction

1. Mr A was a 33-year-old man with a history of mental health problems and drug and alcohol abuse. His parents (Mr and Mrs C) described him as a 'binger' rather than an habitual drug user. Mr and Mrs C stated that Mr A had been trying to get his life 'back on track' since 2007 and had been involved in a number of agencies and departments trying to achieve this. He had worked in a supported environment with a charity for about nine months prior to commencing a rehabilitation course in England in November 2011.

2. Mr A had successfully completed the first part of the course which was a two-week detoxification programme but when he moved on to the next stage of the rehabilitation course it was not successful and he returned to Edinburgh after one week. At this point he was drug free but then, for reasons unknown to Mr and Mrs C; he relapsed on 1 December 2011.

3. On 3 December 2011 Mr A was in a distressed state and pleaded with Mr and Mrs C for help. Mr and Mrs C called the Royal Edinburgh Hospital (REH) which specialises in mental health care, and which Mr A had previously attended. They said they explained the problem Mr A was experiencing and that he had been drinking alcohol. Mr and Mrs C were advised to take Mr A to the Accident and Emergency department (A&E) at the Royal Infirmary of Edinburgh (RIE), which they did.

4. Mr A was assessed by an A&E doctor (the Doctor) and then a mental health nurse (the Nurse) who considered that Mr A was too intoxicated for a mental health assessment to be undertaken; and then discharged. Mr and Mrs C were given advice about how Mr A could self-refer to the REH when he had sobered up. Mr A was found dead in his home on 6 December 2011 from a suspected accidental overdose of heroin and alcohol.

5. The complaints from Mr & Mrs C which I have investigated are that:

(a) Lothian NHS Board (the Board) provided inadequate care and treatment to Mr A in A&E;

(b) the Board unreasonably failed to admit Mr A pending further assessment; and

(c) the Board's handling of Mr and Mrs C's complaint was inadequate.

Investigation

6. My complaints reviewer considered all the documentation provided by Mr and Mrs C and by the Board. My complaints reviewer also reviewed relevant national and local guidance and took independent advice from two of my advisers: an A&E consultant (Adviser 1) and a mental health nurse (Adviser 2).

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

(a) The Board provided inadequate care and treatment to Mr A in A&E

8. Mr A had a long history of mental health problems compounded by drug and alcohol abuse. He had been trying since 2007 to address his problems and had been involved with various agencies trying to assist him. For the nine months prior to November 2011 he had been working with a horticultural charity that provides a supportive environment for those with mental health problems. As a result of this he had been recommended for a residential rehabilitation programme lasting 18 months.

9. The programme was based in England and the first part was a detoxification course lasting two weeks, which started on 2 November 2011. Mr A successfully completed this course. He then had to move to another venue to undertake the main part of the rehabilitation programme.

10. After one week of this programme Mr A decided to return to Edinburgh; at this time he was drug free.

11. Mr and Mrs C said that for some reason unknown to them, Mr A relapsed on 1 December 2011 and by 3 December 2011 he was in a distressed state; had been drinking alcohol; and in the previous days had taken street and prescription drugs. Mr A asked Mr and Mrs C for help and they contacted the REH, to whom Mr A was known. They explained the situation and were advised to take Mr A to A&E at the RIE, which they did.

12. Mr and Mrs C arrived at A&E with Mr A at about 13:15 and Mr A was reviewed by the Doctor at 14:00. Mr and Mrs C said that Mr A's blood pressure and heart rate were monitored and he was allowed to sleep. The Doctor's discharge letter to Mr A's General Practitioner stated that Mr A had taken a

mixture of illegal street drugs; a 'legal high' (drugs which have an effect similar to illegal street drugs); a prescription tranquiliser; and, alcohol. The letter continued that Mr A had also threatened suicide and although medically fit for discharge, a psychiatric review was planned. It was confirmed in a response to my office from the Board that Mr A's parents had told the Doctor of Mr A's suicidal ideation.

13. The Doctor felt that, in view of the concerns expressed by Mr and Mrs C, a psychiatric review of Mr A was needed and the Nurse from the Mental Health Assessment Service (MHAS) from the REH was contacted and asked to see Mr A in the A&E department.

14. The Nurse considered that Mr A was too intoxicated to be assessed but the Nurse spent about 30 minutes speaking to Mr and Mrs C about their concerns for Mr A's safety. Mr and Mrs C stated that they told the Nurse that they were concerned about Mr A's state of mind. Mr and Mrs C said that the Nurse had told them that he had met Mr A before and had accessed his clinical notes. Mr and Mrs C said that the notes would have revealed that Mr A had a history of overdose and self-harm.

15. Mr and Mrs C told my complaints reviewer that the Nurse said they should take Mr A home as Mr A 'would do what he is going to do'. [1] The Nurse also told Mr and Mrs C that if they had any concerns to call the emergency services, but Mr and Mrs C considered that they had already done so by bringing Mr A to A&E.

16. Mr and Mrs C said that one of the A&E nurses then came and woke Mr A up and he was discharged. Mr and Mrs C found Mr A dead in his home three days later. The post-mortem and toxicology reports put the cause of death as heroin and alcohol intoxication.

17. The Board responded to my complaints reviewer's enquiries and confirmed that the Nurse had not assessed Mr A but had spoken to his parents about their concerns. The responses stated that the Nurse had not recorded what he did to attempt to rouse Mr A, or how often he tried to do so.

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[1] In commenting on the draft report, the Board stated that the Nurse had informed Mr and Mrs C that Mr A could be seen at any time, 24 hours a day, at REH if he was sober. Due to the lack of contemporaneous notes, it has not been possible to establish exactly what the Nurse told Mr and Mrs C.

18. The Board stated that appropriate information had been given to Mr and Mrs C about how Mr A could self-refer to the Mental Health Team once he was no longer intoxicated. However, the Board acknowledged that, in view of their distress it was not clear how much of this information Mr and Mrs C took in. The information was also contained within a discharge letter sent to Mr A's GP, and the Board acknowledged that it would have been helpful to have provided Mr and Mrs C with a copy of the letter so they had the information readily available to them.

19. The Board stated that there is a gap in the wider service provision from all agencies for people who are too intoxicated to be assessed. This is recognised as a national gap. The Board stated that there have been various pilots running in two other NHS regions in Scotland to try to address this problem by providing a room to allow people to 'sober up' prior to assessment, but that this provision was not available within the Board's area.

20. The Board's response also confirmed that they do not have a specific protocol to address the problem of dealing with intoxicated patients in A&E who also have mental health issues.

Advice received

21. Adviser 1 reviewed the clinical notes from Mr A's A&E visit and was of the view that his care from the A&E staff had been reasonable. Mr A was triaged (the urgency of his condition was assessed) within five minutes of his arrival and a full set of observations were done. These observations included temperature; pulse and respiration rates; oxygen saturation (the amount of oxygen in the blood); blood pressure; and body mass index (the relationship between a person's height and weight).

22. Adviser 1 considered that apart from a slightly below normal temperature of 35 degrees (normal being 37 degrees) the observations were normal. Mr A was not allocated a triage category (to indicate how soon he should be seen) but he was seen by the Doctor within 30 minutes of his arrival in A&E. Adviser 1 was of the view that based on the normal observations recorded at triage; it would have been unlikely that Mr A would have been assigned a category more urgent than 'Green' which means a patient should be seen within one hour of arrival in A&E.

23. Adviser 1 stated that the Doctor who reviewed Mr A was aware that he had been taking drugs and alcohol in the days preceding his visit to A&E and that the visit had been prompted by the concerns of his parents. The Doctor had recorded that Mr A had drunk a quantity of vodka and gin that morning.

24. Adviser 1 noted that a full medical assessment, including an Electro cardiogram (ECG a recording of the heart function) was undertaken by the Doctor. Adviser 1 was of the view that the assessment followed good practice. The results of the ECG were normal and the Doctor also recorded Mr A's Glasgow Coma Scale (GCS - a measurement of a patient's consciousness with 15 being fully conscious and alert) as 15/15.

25. Adviser 1 stated that the Doctor considered Mr A's problems were due to drug and alcohol addiction, and not deliberate self-harm at that time. However, based on the concerns expressed by Mr and Mrs C, the Doctor, therefore, requested a review by the Mental Health Service. The Doctor had noted that by the time the medical assessment was completed, Mr A was medically fit for discharge but was still intoxicated and in the care of Mr and Mrs C.

26. Adviser 1 was of the view that, from an A&E perspective, there was nothing further that could or should have been done for Mr A. Adviser 1 stated that within the NHS in the United Kingdom there are no facilities to admit a patient in order for them to sober up or for the effects of street drugs to wear off.

27. Adviser 1 continued that had Mr A been assessed by the Doctor as being medically at risk from the drugs and alcohol he had ingested, then he should have been admitted to a medical ward until that danger had passed. However, the medical assessment did not find any evidence of this so Adviser 1 was of the view that it was reasonable for the Doctor to have deemed Mr A to be medically fit for discharge.

28. Adviser 2 stated that the first priority when he arrived in A&E had been to establish Mr A's physical condition and that this was reasonable. Adviser 2 noted that all the observations and investigations were essentially normal but that due to his expression of suicidal ideation, it was appropriate to order a psychiatric review. Adviser 2 noted that there was limited evidence available on what the Nurse did to attempt to assess Mr A as he did not make any notes in Mr A's clinical records. The Nurse did, however, write a discharge letter to

Mr A's GP, which stated that Mr A had been 'asleep and unrousable' during the Nurse's discussions with Mr and Mrs C.

29. The letter also stated that Mr and Mrs C had expressed concerns for Mr A's safety in that due to his 'chaotic' use of multiple substances 'he may take an overdose'. The letter continued that 'on direct enquiry his parents did not disclose that [Mr A] had expressed suicidal thoughts or intent'.

30. The discharge letter contained advice and information to the GP on what to do for Mr A in the future and what options for assessment were available. The letter stated 'I have acknowledged the risk of accidental overdose …'.

31. Adviser 2 considered that the Nurse's statement in the discharge letter that Mr A had been 'grossly intoxicated' and 'asleep and unrousable' which prevented him assessing Mr A was at odds with the medical assessment which had been done about an hour previously. This assessment had included that Mr A's GCS was 15/15 – that is conscious and alert.

32. Adviser 2 considered that although it was acknowledged that Mr A was 'smelling strongly of alcohol' during his medical assessment, Mr A's last drink had been earlier that day, and an appropriate assessment was carried out. Adviser 2 was, therefore, of the opinion that in view of the timeline, Mr A was likely to have been less intoxicated, rather than more, when seen by the Nurse.

33. The Nurse had access to Mr A's clinical notes made by the Doctor during the medical assessment and Adviser 2 commented that the Nurse appeared to have disregarded the information, which came from Mr and Mrs C, that Mr A had expressed suicidal ideation earlier that day. Adviser 2 noted that due to the lack of an assessment by the Nurse, there was insufficient evidence to conclude with any degree of certainty that Mr A was at on-going risk of suicide or deliberate self-harm. There was also nothing within the evidence available that Mr A met the criteria for detention under the Mental Health Act (MHA).

34. The MHA allows a person who is thought to be a danger to themselves and/or others to be detained in psychiatric care against their will. There are strict guidelines on the type of condition(s) or symptom(s) the person is displaying and the assessment and consultation required before they can be detained.

35. Adviser 2 considered that it would have been possible that Mr A had fallen into a deep alcohol-induced sleep while waiting for the Nurse to arrive in the A&E department. However, Adviser 2 was of the view that every reasonable effort should have been made to awaken him to allow an assessment of his mental health condition to have taken place. Adviser 2 noted that the Nurse had not recorded what efforts, and how often, he had made to rouse Mr A.

36. Adviser 2 was of the view that the Nurse's statement that Mr A was 'unrousable' is not supported by any clinical records completed by the Nurse. It also conflicts with the evidence that an hour before the Nurse's arrival Mr A had been sufficiently alert to have been medically assessed, and half an hour after the Nurse's arrival and subsequent departure, staff in the A&E department were able to rouse Mr A to send him home with Mr and Mrs C.

37. Adviser 2 commented that intoxication may influence a person's mental state presentation and may imitate or mask symptoms of an underlying mental or physical disorder. This could result in an increased risk of harm to self or others and exacerbate the risk of suicide. Adviser 2 stated that if a patient is believed to be at on-going risk of significant self-harm or suicide then it is not appropriate for mental health staff to refuse to make an assessment and send the person away.

38. Adviser 2 noted that a report from the Royal College of Psychiatrists (RCP) CR118 published in January 2004, addressed the provision of psychiatric liaison services to A&E departments. The report stated that 'There should be locally agreed protocols for the management of patients with alcohol dependency which depend upon available services and resources.' This report was replaced by CR 183 published in December 2013, after the events complained of. CR 183 confirmed the need for such provision. As referred to above, no such protocol exists within the Board. Adviser 2 commented that had such a protocol been in place at the time of these events, the Nurse may have been clearer on what was expected in the circumstances of 3 December 2011.

39. On the matter of the follow-up advice given by the Nurse, verbally to Mr and Mrs C on the day, and in writing to the GP in the discharge letter, Adviser 2 stated that because of the lack of an assessment, it was not possible to say whether the advice given was appropriate or not.

(a) Conclusion

40. Mr A was in a distressed state and Mr and Mrs C were concerned for his safety due to his chaotic use of illegal and prescription drugs and alcohol. Their fear was that he would accidentally overdose, and this appears to be what happened on 6 December 2011, some three days after his discharge from A&E.

41. It is clear from the clinical records available that a full and appropriate assessment of Mr A's physical condition was undertaken and Adviser 1 stated that the care and treatment provided by the A&E Doctor was reasonable. I note in particular that the A&E Doctor rated Mr A's GCS as being 15/15 – conscious and alert.

42. This appears to be at odds with the Nurse's view that Mr A was 'unrousable'. Adviser 2 considered that due to the passage of time since Mr A's last alcoholic drink or drugs and the fact that he had been allowed to sleep while waiting for the Nurse to attend, Mr A would have been likely to have been less intoxicated, rather than more, than when he was assessed by the Doctor.

43. On the matter of his discharge, Adviser 1's view was that, physically, Mr A was fit for discharge on 3 December 2011. However, due to the lack of an assessment of his mental health, there is no way to know whether he was mentally fit for discharge on that day. The fact that Mr and Mrs Cs' fears were realised three days later suggests that he may not have been.

44. The main concern was that Mr A was discharged without an appropriate assessment of his mental health having taken place. The Nurse says that he was unable to do an assessment, but there is no evidence to support this.

45. Therefore, based on all the evidence and advice available to me, and to the extent that I have identified, I uphold this complaint.

46. This was a difficult situation, and it is recognised by both advisers and by national bodies such as the Royal College of Psychiatrists that there is a gap in provision for patients who present to NHS services with both substance misuse and mental health problems.

47. Adviser 2 endorsed the RCP view that an agreed protocol, involving all stakeholders, should be in place in all acute hospitals to deal with such patients. The Board acknowledged that they have no such protocol, despite the original

report from the RCP being issued some ten years ago. I have, therefore, made recommendations below.

(a) Recommendations

48. I recommend that the Board:	*Completion date*
(i) consult urgently with all relevant stakeholders to formulate an appropriate protocol for dealing with patients who attend A&E with substance misuse and co-morbid mental health illness; and	21 August 2014
(ii) issue a written apology to Mr and Mrs C for the failing identified.	21 June 2014

(b) The Board unreasonably failed to admit Mr A pending further assessment

49. The Board stated that Mr A was considered to be physically fit for discharge and there was no indication that he met the criteria for detention under the MHA. Although considered to be still intoxicated, their view was that he was conscious, alert and in the care of responsible persons – Mr and Mrs C. In the absence of facilities to allow Mr A to sober up until he could undergo a mental health assessment, the Board stated that the A&E staff considered it appropriate to discharge him.

50. The Board did, however, acknowledge, as referred to in paragraph 18, that it would have been appropriate to have provided Mr and Mrs C with a copy of the discharge letter from the Nurse to Mr A's GP so that they had written advice on the assessment and treatment options available for Mr A.

Advice obtained

51. Adviser 1 stated that the assessment of Mr A's physical condition was reasonable, appropriate and timely. Adviser 1, therefore, considered that there was no medical reason not to discharge Mr A on 3 December 2011.

52. Adviser 2 commented that allowing patients to remain in A&E until they are sober enough to co-operate with a psychiatric assessment has implications for resources as the person could not be left unobserved and unsupervised.

53. Adviser 2 stated that one of the difficulties would be that each person would take a differing period of time to sober up depending on their own

tolerance and the substance(s) ingested. Some could be assessable within an hour or two and some may take eight hours or more

54. However, Adviser 2 stated that all A&E departments should, as recommended by the RCP and referred to at complaint (a) above, have an agreed protocol for dealing with patients who present with both mental health problems and alcohol and/or drug intoxication. The Board did not at the time have such a protocol.

(b) Conclusion

55. As I have referred to in complaint (a) and above, there was no medical reason to admit Mr A to hospital. The difficulty I have is that without the benefit of a mental health assessment I have no way of knowing whether there was a psychiatric reason to admit Mr A. I have addressed this issue at complaint (a).

56. The Board have acknowledged they do not have an agreed protocol in place to deal with patients such as Mr A, and that the information provided to Mr and Mrs C could have been better. Therefore, the care provided to Mr A was not best practice, but the basis upon which I base my decisions is 'reasonableness'. That is, were the actions taken, or not taken, reasonable in the circumstances at the time and in light of the information available to those involved?

57. There is a recognised and acknowledged gap within the NHS in the provision of facilities to allow patients to recover from intoxication in order for meaningful assessment to take place. It would, therefore, be inappropriate to criticise the Board for not being able to provide facilities that are not generally available within the NHS.

58. Therefore, based on all the evidence and advice available to me, I do not uphold this complaint.

(c) The Board's handling of Mr and Mrs C's complaint was inadequate

59. Mr and Mrs C first complained to the Board in a letter dated 6 May 2012 which was received at the Board on 15 May 2012. The letter was acknowledged the following day. A written statement was obtained from the Doctor and the Clinical Nurse Manager spoke to the Nurse, but no formal written statement was obtained.

60. A holding letter was sent to Mr and Mrs C on 26 June 2012 explaining that the investigation of their complaints was on-going and indicated that a full response would be sent to them 'within the next three weeks'. Mr and Mrs C then wrote to the Board on 14 July 2012 to request a meeting to discuss their concerns.

61. A response letter was then issued on 24 July 2012 about which Mr and Mrs C raised several points of concern. A meeting between Board staff and Mr and Mrs C was then arranged for 12 November 2012.

62. Following the meeting, the General Manager (the general manager) of the Edinburgh Community Health Partnership (part of the Mental Health Services of the Board), wrote to Mr and Mrs C on 3 December 2012 to clarify some points that had been discussed at the meeting. Mr and Mrs C complained again to the Board in a letter dated 20 January 2013. The general manager responded to Mr and Mrs C on 25 March 2013.

63. Mr and Mrs C remained dissatisfied with the responses they had received from the Board as they considered that not all of the issues they had raised, in particular why Mr A had not been kept in hospital until he could be assessed, had been answered. Mr and Mrs C, therefore, asked my office to review their complaints on 26 April 2013.

64. The national guidance on handling NHS complaints (the Guidance) states that letters of complaint should be acknowledged within three working days and where possible full responses should be sent within 20 working days. Where it is not possible to meet this deadline, the Guidance states that the complainant should be kept informed of the reason(s) for any delay and they should be given an idea of when to expect the full response.

65. The Board's own local complaints policy, a copy of which was supplied to my complaints reviewer during the investigation, mirrors the Guidance.

(c) Conclusion

66. Mr and Mrs C's original complaint letter was acknowledged the day after receipt and this complies with the Guidance. The next letter they received was dated 26 June 2012, some 28 working days later. This was a holding letter, which explained that the General Manager was seeking further information to

be able to fully answer all Mr and Mrs C's questions. The letter did not indicate when they could expect a full response.

67. The General Manager then sent a full response dated 24 July 2012, a further 20 working days after his holding letter, and by which time Mr and Mrs C had already requested a meeting. This meeting eventually took place in November 2012 but it is not clear from the copy complaints file seen by my complaints reviewer why this took so long to organise.

68. Similarly, there is no evidence as to why it took the General Manager over two months to respond to the issues Mr and Mrs C raised following the meeting in November 2012 and his letter of December 2012.

69. I appreciate that this was a difficult case involving staff based at two different sites. The Guidance makes it clear that although a full response within 20 working days is desirable, this is a merely a guideline and there will be times when it is not possible to meet this. However, complainants should be kept informed of the reasons for the delay and given an expectation of when they will receive a response. This did not happen in this case and demonstrates a lack of empathy towards bereaved parents.

70. On the matter of the time taken to arrange the meeting with Mr and Mrs C, I am aware of the difficulties of co-ordinating the diaries of clinicians to facilitate such meetings. However, the complaints file seen by my complaints reviewer did not make it clear why it took from the receipt of Mr and Mrs C's original request for meeting, which was received by the Board on 16 July 2012, until a follow-up call from Mrs C on 18 October 2012 to begin taking action to arrange a meeting.

71. Therefore, based on the evidence available to me, and to the extent I have identified, I uphold this complaint.

(c) Recommendation

		Completion date
72.	I recommend that the Board:	
(i)	ensure that all staff dealing with complaints are reminded of the importance of keeping complainants informed and updated during the complaints process.	21 June 2014

73. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the aggrieved, the late son of the complainants
Mr and Mrs C	the complainants
REH	Royal Edinburgh Hospital
A&E	Accident and Emergency
RIE	Royal Infirmary Edinburgh
the Doctor	A&E doctor
the Nurse	an on-call nurse from the Mental Health Assessment Service
the Board	Lothian NHS Board
Adviser 1	an A&E consultant
Adviser 2	a mental health nurse
MHAS	Mental Health Assessment Service
GP	general practitioner
ECG	Electro cardiogram
GCS	Glasgow Coma Scale
MHA	Mental Health Act
RCP	Royal College of Psychiatrists
the General Manager	the general manager of the Edinburgh

Community Health Partnership (part of the Mental Health Services of the Board)

Annex 2

Glossary of terms

Body mass index	the relationship between a person's height and weight
Electro cardiogram (ECG)	a recording of the heart function
Glasgow Coma Scale (GCS)	a measurement of a patient's consciousness with 15 being fully conscious and alert
Oxygen saturation	the amount of oxygen in the blood
Triaged	the urgency of his condition was assessed
Triage category	to indicate how soon a patient should be seen