SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

# Investigation Report

UNDER SECTION 15(1)(a)

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**Scottish Parliament Region: Mid Scotland and Fife**

**Case 201302798: Forth Valley NHS Board**

**Summary of Investigation**

***Category***

Health: Psychiatry; Community Treatment; diagnosis

***Overview***

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her daughter (Mrs A) for mental health problems by Forth Valley NHS Board (the Board) prior to her death by suicide on 11 October 2012.

***Specific complaints and conclusions***

The complaints which have been investigated are that the Board did not:

(a) offer a reasonable diagnosis (*not upheld*); and

(b) provide a reasonable standard of care and treatment (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
|---|---|
| (i) review the approach taken by the Intensive Home Treatment Team to the assessment of risk to ensure that presenting risk factors are systematically considered and recorded and that the rationale behind clinical decision making is transparent; | 18 January 2015 |
| (ii) remind medical staff of the importance of accurate and signed contemporaneous notes; | 8 December 2014 |
| (iii) review the process for communicating medical reviews of patients to IHTT staff, to ensure that all relevant information is made available timeously; | 18 January 2015 |
| (iv) review the process for discharging patients from the IHTT to ensure that medical staff's opinions are considered; and | 14 January 2015 |
| (v) apologise for the failings identified in this report. | 8 December 2014 |

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

## Main Investigation Report

### Introduction

1. The complainant (Mrs C) raised a number of concerns about the care and treatment for mental health problems provided to her daughter (Mrs A) by Forth Valley NHS Board (the Board) prior to her death by suicide in October 2012.

2. Mrs A was a 45-year-old woman with no previous psychiatric history. She attended her GP in June 2012 complaining of low mood, anxiety, fatigue, headaches, sleep disturbance, tingling and shaking in her feet and hands. It was initially suspected that she might have Multiple Sclerosis (MS) and she was referred to Glasgow Royal Infirmary's Neurological Department. MS was ruled out as a diagnosis, following neurological examination and an Magnetic Resonance Imaging (MRI) scan.

3. On 11 August 2012 following an incident, her GP referred her again to Glasgow Royal Infirmary. Although Mrs A was admitted, she was discharged without treatment or diagnosis. Mrs A's MRI scan results were sent to her by post in September. The scan results confirmed Mrs A did not have MS and that she was not suffering from any other physical conditions.

4. On 11 September Mrs A attempted suicide at the family home, although she halted the attempt. She informed her husband, who contacted her GP and she was referred as an emergency to Forth Valley Mental Health Services. On 12 September 2012 Mrs A was seen jointly by a psychiatrist (the Doctor) and a Charge Nurse (the Nurse) of the Forth Valley Intensive Home Treatment Team (IHTT). Her referral noted recent onset suicidal ideation (thoughts of, or a preoccupation with suicide) and a six week history of severe anxiety, as well as her suicide attempt. When interviewed her mood was low but it was noted she believed that her problems were physical rather than psychological in nature. It was also noted at the time that Mrs A believed that she had a severe illness such as MS or Parkinson's Disease. Mrs A said her suicidal thoughts had become more intense over the previous two days and revealed that she had been looking at suicide websites online. She stated she had tried to take her own life by attaching a hosepipe to her car exhaust but aborted the attempt because she did not believe it was working and she was concerned about the effect her actions would have on her family. Following this initial contact Mrs A was accepted onto the caseload of the IHTT with a plan to keep her situation

under daily review. She and the family were advised that she should remain in the company of family members due to her recent serious suicide attempt.

5. Over the following four weeks Mrs A saw five different IHTT nursing and medical staff who kept her mental state under review and provided her and the family with support. Mrs A's final appointment with the IHTT was scheduled for 11 October 2012, but none of the team who had been looking after her were on duty that day. The appointment was, therefore, rearranged for the 12 October 2012 because it was felt that she should be seen by a member of staff she was familiar with prior to going on a planned family holiday. Mrs A did not tell her family that the appointment had been postponed for 24 hours, which meant she was alone on the morning of 11 October 2012. Regrettably, during this period Mrs A took her own life. The family believe that in her case signs of on-going or increasing risk were missed.

6. Mrs C complained to the Board on 6 June 2013 about the care and treatment Mrs A had received and asked that it be reviewed. The Board responded in full on 16 August 2013. The Board said staff who had cared for Mrs A were shocked and saddened by her death. The Board emphasised that all staff took risk assessment very seriously and the Board believed the IHTT had over time built up a level of experience, which enabled them to appropriately assess the risk posed by patients with suicidal thoughts. The Board confirmed that a review had been undertaken of the care Mrs A had received. The Board also set out the diagnosis Mrs A had received as well as an explanation of the medication she had been prescribed and the rationale behind her treatment.

7. The complaints from Mrs C which I have investigated are that the Board did not:

(a) offer a reasonable diagnosis; and

(b) provide a reasonable standard of care and treatment.

**Investigation**

8. Investigation of the complaints involved reviewing the information received from Mrs C and the Board's medical records for Mrs A. My complaints reviewer also obtained independent advice from an mental health nursing adviser (Adviser 1) and a consultant psychiatrist (Adviser 2).

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. Mrs C and the Board were given an opportunity to comment on a draft of this report.

**(a) The Board did not offer a reasonable diagnosis**

10. Mrs C said she believed mistakes had been made in the way Mrs A's treatment had been provided. She said the family remained unclear about Mrs A's final diagnosis. They were unsure whether she had been suffering from depression or psychosis. Mrs C said the family also now believed that Mrs A had been delusional during her illness. They noted that she had talked about parts of her brain 'flying off'. Mrs C said Mrs A was obsessed with this thought, and the idea that she had some serious type of physical illness, even after she received the all clear from her MRI scan.

*The Board's Position*

11. The Board said that following thorough investigations for a medical cause of Mrs A's symptoms, she had been diagnosed as suffering from a severe depressive episode without psychosis. The Board said the diagnosis was based upon Mrs A exhibiting at least four symptoms of depression (although they did not specify what these were). The Board said that Mrs A's remarks about part of her brain 'having died' were made to the Doctor assessing her in the context of a discussion about stroke. The Board said given the context of the remarks, the Doctor's clinical judgement was that Mrs A did not hold this belief to a delusional intensity and she could not, therefore, be considered to be psychotic.

*Advice Received*

12. Adviser 1 said Mrs A was jointly assessed by medical and nursing staff following her referral from the GP on 12 September 2012 and she was accepted onto the IHTT caseload. A detailed letter summarising the assessment and conclusions was sent to Mrs A's GP on 14 September 2012. The assessment was preceded by a detailed Triage Assessment and a completed Risk Profile.

13. Adviser 1 said Mrs A's assessment revealed her to be anxious, low in mood, recently tearful, with frequent suicidal thoughts, particularly so over the preceding two weeks and becoming more intense over the previous two days.

She had been exploring suicide websites on the internet and had attempted carbon monoxide self-poisoning the previous day, by attaching a hosepipe to her car exhaust. She aborted the attempt because she was concerned that it was not working and was worried that someone would find out what she was doing. She was also concerned about the effects of her actions on her family. The Doctor was of the view that Mrs A had intended to kill herself at the time and only failed because the method she used is no longer an effective method of suicide.

14. He noted that the record showed Mrs A self-reported sleep disturbance, early morning wakening, fatigue, loss of interest in previously enjoyed activities, difficulty socialising, impaired concentration and memory in addition to a preoccupation with her physical health. She believed that she had MS or some other type of neurological disorder rather than a mental health problem. She denied having on-going suicidal thoughts or plans and stated that her family were supportive and a protective factor in this regard. On-going high suicidal intent and explicit planning would have heightened the perceived level of risk.

15. Adviser 1 said Mrs A had been diagnosed with moderate depressive illness with associated anxiety. This diagnosis was in keeping with her presentation. He noted the assessment was conducted in an appropriate manner, which respected Mrs A's dignity.

16. Adviser 1 said a detailed care plan had then been developed to address Mrs A's needs, with jointly agreed goals of care. These included initial daily monitoring of her mental state, and on-going supervision by members of the family. Citalopram (an antidepressant also helpful in panic disorders) which had been originally prescribed by her GP was increased to 20 milligrams daily and she was advised to continue with her Zoplicone (a drug to aid sleeping) at night and use Diazepam (a minor tranquilliser) for anxiety. Adviser 1 said he believed the drug therapy prescribed was appropriate for Mrs A's condition.

17. Adviser 1 said the structure and quality of the initial assessment carried out by the Doctor and the Nurse and the subsequent care plan were reasonable and in line with the Scottish national standards for crisis services. Adviser 1 felt that the initial diagnosis of Mrs A was also reasonable. The record of the assessment was comprehensive, and a detailed care plan was produced as a result. The assessment considered and identified Mrs A's symptoms accurately.

18. Adviser 2 noted the medical input into Mrs A's case was provided by the Doctor who assessed Mrs A in conjunction with a nurse from the IHTT. Adviser 2 said the Doctor's first assessment detailed the presenting complaints along with a personal history of Mrs A. Adviser 2 said the assessment was detailed and captured a comprehensive history of the patient.

19. Adviser 2 said the diagnosis given was in line with the criteria set out in national guidance. Mrs A was exhibiting all three of the most typical symptoms of depressive illness. These were a low or depressed mood, a general loss of interest and enjoyment and reduced energy levels, leading to increased fatigue and decreased activity. Alongside these she also had additional symptoms, including reduced concentration, ideas or acts of self-harm or suicide and disturbed sleep. These symptoms were noted to have been present for more than two weeks.

20. Adviser 2 said the level of risk was captured by the Doctor in her assessment of Mrs A on 12 September 2012, as she noted 'it was clear at this time this lady had intended to kill herself'. Adviser 1 said the Doctor clearly felt Mrs A posed a serious risk to herself and advised it was important for her to remain in the company of family members.

21. Adviser 2 said overall in her view the diagnosis and risk assessment by medical staff was within reasonable standards.

*(a) Conclusion*

22. Mrs C has questioned the adequacy and accuracy of the diagnosis of Mrs A's condition as she was concerned that a lack of clarity in the diagnosis may have contributed to Mrs A's death. The advice I have received is that Mrs A's initial assessment was thorough, with a comprehensive history taken of the patient and a clear identification of the symptoms of depression. Although I appreciate Mrs A's family feel this diagnosis was not clearly communicated to them, there is no evidence that the diagnosis of her condition was inadequate. Nor is there any evidence that elements of her condition were not diagnosed, which subsequently contributed to her suicide.

23. I do not uphold this complaint.

**(b) The Board did not provide a reasonable standard of care and treatment**

*Risk Assessment*

24. Mrs C said the family felt the care and treatment provided to Mrs A had not been 'intensive'. She also felt Mrs A had been able to dictate the level of treatment she had received, to her detriment. In particular Mrs C felt Mrs A should not have been left without cover from IHTT staff over the weekend. Mrs C also felt strongly the IHTT had been mistaken when they advised the family that Mrs A did not pose a risk. As a result the IHTT had said that Mrs A should be given more time on her own. Mrs C noted that prior to receiving this advice the family had ensured that Mrs A had not been left on her own. She felt had the family not received this advice Mrs A would not have had the opportunity to take her own life.

*The Board's Position*

25. The Board said the report produced by the IHTT following Mrs A's death detailed the input Mrs A had received in the weeks leading up to her death. Mrs A had been seen on a daily basis by the IHTT for the first three days following her referral. Mrs A had then been seen twice a week until the time of her death. The Board said Mrs A had been deemed to be at level 2 (medium risk) and this was then reduced to level 1 (low risk) as she appeared to be improving and responded well when staff attended her home. The Board added that during their last visit, the IHTT noted that Mrs A denied having suicidal thoughts. The IHTT had also noted Mrs A had good support from family and friends and had been able to discuss plans for the future, including an impending family holiday.

*Advice Received*

26. Adviser 1 said that he had concerns about the way the risk that Mrs A presented to herself had been assessed and monitored during the period under the IHTT's care. He noted that Mrs A displayed a number of factors associated with risk of suicide and suicide attempts.

27. Adviser 1 said that while not uniformly predictive of suicidal ideation and behaviour, these factors are warning signs of psychological vulnerability. No single risk factor on its own increases or decreases risk. He said that feelings of hopelessness, helplessness, worthlessness and despair are more closely associated with suicidal intent than any other aspects of depression. He went on to say that the risk for suicide increases with an increase in the number of

risk factors present, such that when more risk factors are present at any one time the more likely it is that they indicate an increased risk for suicidality at that time.

28. Adviser 1 noted that it was also accepted there were a range of factors which were considered to lower the risk of suicide. These were usually described as protective factors. Adviser 1 said it was important to note that no single protective factor, or set of protective factors, ensured protection against suicidal thoughts. He said risk and protective factors were neither stable nor equally weighted. It was not, therefore, possible to 'balance' factors against each in order to derive a sum total score of relative suicidal risk.

29. Adviser 1 said suicidal ideation is believed to precede the onset of suicidal planning and action. Suicidal ideation can be associated with a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). It was, therefore, essential to explore the presence or absence of ideation – currently, in the recent past, and concurrent with any change in physical health or other major psychosocial life stress when assessing a patient's level of risk.

30. Adviser 1 went on to say it was important for the assessing clinician to bear in mind suicidal ideation could be denied by the patient for a number of reasons. A comparison, therefore, had to be made between any denials on the part of the patient against their clinically observable presentation. Adviser 1 said that of particular importance was evidence of suicide planning, which showed intent and preparation for death.

31. Adviser 1 said that at the point of initial contact with the IHTT at 15:00 on 12 September 2012, a brief risk assessment was carried out. It categorised Mrs A to be at level 3 risk of suicide under the IHTT's categorisation tool, 'a serious apparent risks. On the same day at 17:00 her level of risk was reported to be level 2 – 'at significant risk'. He said the Triage Assessment carried out on the same day recorded that suicidality was 'a mild problem' but the following day the risk level was recorded as still being at level 2 'significant'. Adviser 1 said that on 14 September 2012 the assessment of risk was reduced to level 1 'low apparent risk'. The assessment of risk remained at level 1 for the remainder of Mrs A's period of engagement with the IHTT.

32. Adviser 1 said on-going assessment of Mrs A's level of risk and suicidal intent would have been difficult. It was clear from the clinical records she had

regularly denied current suicidal thoughts when she was seen by members of the IHTT. Adviser 1 noted that as previously stated an on-going high suicidal intent would have heightened the perceived level of risk. However, Adviser 1 said there were occasions when Mrs A was recorded as admitting to encroaching suicidal ideation, such as the medical review on 25 September 2012 and during a home visit on 4 October 2012.

33. Adviser 1 said that throughout her period of engagement with the IHTT Mrs A continued to self-report symptoms consistent with her diagnosis of depression, for example, low mood, reduced appetite, disturbed sleep with early morning wakening, headache, impaired concentration and impaired memory, attaining little pleasure from previously enjoyed pursuits and preoccupation with physical health concerns. On 4 October 2012 she was noted to be weeping frequently and wondering why she was not feeling any better. However, on 8 October 2012 her mother and husband reported they had observed some improvement in her mood, although Mrs A herself did not acknowledge this progress. Her family continued to be appropriately viewed as a protective factor by the IHTT, she appeared to be engaging positively with her care plan and she was apparently showing signs of 'future focus' by planning to go away on holiday.

34. Adviser 1 said in this type of situation risk was dynamic and subject to fluctuations in line with a person's mental state and social circumstances. Risk factors such as suicidal ideation and intent, hopelessness, psychosocial stress and active psychological symptoms tended to be present for an uncertain length of time. Adviser 1 also said they could fluctuate markedly in both duration and intensity. In this case, Adviser 1 said the rationale for the reduction in the level of perceived risk from level 3 (serious apparent risk) to level 1 (low apparent risk) over a period of 48 hours was not evident. A previous suicide attempt is an extremely serious warning sign in people with significant depression. Mrs A had been referred to mental health services as an emergency, her suicide attempt was serious, and her intent was lethal at the time (it was stated in the Doctor's assessment on 12 September 2012 that it was clear Mrs A intended to kill herself). Adviser 1 said in view of these factors, 48 hours was too short a period in which to conclude Mrs A's level of risk had reduced from 'serious' to 'low'.

35. Adviser 1 also noted the change in assessment was at odds with the view the Doctor expressed following her assessment of Mrs A on

25 September 2012, that Mrs A should remain in the company of her family at all times given her on going low mood and continued suicidal ideation. Adviser 1 said this medical advice was not commensurate with the needs of a person assessed as being at low risk.

36. Adviser 1 said in this case the approach to the review of risk lacked structure and transparency and there was no evidence in the notes of the level of risk being discussed between the professionals involved in Mrs A's care prior to it being reduced. Adviser 1 said the presence of feelings of hopelessness or helplessness were critical factors in the assessment of risk of suicide, but he could find no reference in the notes to show these were issues considered by the IHTT or discussed with Mrs A. He could also find no evidence of her sense of self-esteem / self-worth being considered, despite the importance of this being assessed as part of a balanced judgement of risk.

37. Adviser 1 said for the majority of the four weeks (the first 48 hours excepted) that Mrs A was being seen by the IHTT her risk level was considered to be 'low'. Adviser 1 said that although she had a supportive family, was willing to engage with the IHTT and had shown some progress and future focus, she still showed signs and symptoms of depression such as low mood, diurnal variation[1], periods of weeping, impaired concentration, impaired memory, marked sleep disturbance with early morning wakening, anxiety, nihilistic thoughts, somatic ruminations[2] and lack of pleasure from previously enjoyed activities. She also had recently made a serious suicide attempt and had on going periodic suicidal ideation. He said that in light of these factors it was a matter of concern that her level of risk was considered to be low.

38. Adviser 1 said it was also a matter of concern that on 20 September 2012 nursing staff recommended that the family give Mrs A more time on her own, yet five days later the Doctor responsible for her care believed she should remain in the company of the family at all times because of her on-going low mood and continued suicidal ideation.

39. Adviser 2 commented that the Doctor considered Mrs A to present a significant risk on both the occasions that she (the Doctor) reviewed her. Adviser 2 said that based on the symptoms elicited with on-going depression,

[1] A pattern of feeling worse during a particular part of the day. Depressed patients often exhibit this symptom, and typically report feeling more depressed in the morning.
[2] Compulsively focussed attention on the symptoms of distress or depression

anxiety and fluctuating suicidal thoughts, in her view the Doctor had made the correct assessment about the risks posed by Mrs A.

40. Adviser 2 noted, however, that the hand written case notes produced by the Doctor did not refer to advice being provided to Mrs A's family that she should not be left on her own at any time. This was referred to instead on a document entitled 'Report summarising contact with patient', dated 29 September 2012. Adviser 2 noted that it was not clear who this document was intended for, as it contained more information than the hand written notes, or the letter subsequently sent to the GP.

41. Adviser 1 said as previously set out, of particular concern was the reduction in the level of perceived risk from 'serious' to 'low' over the initial 48 hour period of engagement with the IHTT following a serious suicide attempt.

*Monitoring of Mrs A*

42. Mrs C questioned whether Mrs A had been appropriately monitored by medical and nursing staff. In particular Mrs C felt Mrs A had not been taking her medication consistently, but that staff had not monitored this appropriately. Mrs C also said she was now aware that patients in the early stages of treatment with anti-depressant drugs could present an increased suicide risk. Mrs C felt that Mrs A should have been more closely monitored by medical and nursing staff during this period.

*The Board's Position*

43. The Board said it was the IHTT's view that there was no evidence Mrs A was not taking her medication and it was not considered appropriate to supervise her to ensure she did so. The Board said the view of their Lead Pharmacist was that it was not usual practice to supervise medicine compliance. However, the Board acknowledged that generally patients should be reviewed every one to two weeks at the start of antidepressant treatment to assess any side effects from medication and the patient's response to their therapy. There could be a delay of two to four weeks before antidepressant action took place and during the first weeks of treatment there was an increased potential for agitation, anxiety and suicidal ideation. The Board said close monitoring was therefore advised.

*Advice Received*

44. Adviser 1 said that he did not believe there was any evidence that Mrs A was not compliant with her prescribed medication regime. He added it was not normal practice to supervise an individual without cognitive impairment in the taking of their medication, unless there were grounds for believing they were deliberately non-compliant.

45. Adviser 1 went on to say that for those recovering from depressive illness, the early stages can be the most dangerous. At this stage the person may still be symptomatic and sad, but mentally more focussed with improved energy and motivation. They may, therefore, be more able to plan and complete their suicide. Vigilance was required on the part of the care team until the recovery is well established. The feelings of sadness and the person's energy levels might not respond to treatment at a similar rate. Adviser 1 said that he found no evidence in the records that the IHTT took into account any potential for Mrs A to present an increased suicide risk as a consequence of being in the early stage of recovery from depression.

46. Adviser 1 also noted it was impossible to state if the number of staff involved in Mrs A's care could have been reduced. He said it was clear, however, that the number of people involved in providing care for Mrs A had been unsettling for her family and had led to their impression that this had had a negative impact on the quality of the care provided to her.

47. Adviser 2 said the National Institute for Clinical Excellence (NICE) guidelines for treating depression state that a person suffering from depression, starting a course of anti-depressant treatment, should normally be seen within a week and frequently thereafter as appropriate, until the risk is no longer considered clinically important.

48. Adviser 2 said Mrs A was someone with serious risk of suicide and was already one week into treatment with anti-depressants when she was first assessed by the IHTT. Throughout the four to five week period of antidepressant treatment, Mrs A received regular face-to-face contact with members of the IHTT. Adviser 2 said although this regular monitoring was important, there was no evidence in the records of discussions with Mrs A or her family around the increased suicide risk in the early stages of treatment.

*Record-keeping*

49. Adviser 2 also noted that the hand written case notes produced on 25 September 2012 by the Doctor did not refer to advice being provided to Mrs A's family, that she should not be left on her own at any time. The notes did record that Mrs A was not doing as well in the days leading up to the assessment, having had an episode of panic. The assessment elicited the on-going symptoms of depression from Mrs A, as well as an admission of occasional suicidal thoughts.

50. Adviser 2 said the issue of whether the family should ensure Mrs A was not left alone was referred to in a document entitled 'Report summarising contact with patient', dated 29 September 2012. Adviser 2 noted that it was not clear who this document was intended for, as it contained more information than the hand written notes, or the letter subsequently sent to the GP.

51. Adviser 2 said that this report was the most detailed record of the Doctor's assessment of Mrs A's. In this the Doctor said she was asked to review Mrs A to discuss discharge and follow up. Adviser 2 said the Doctor's assessment was well presented, with details of Mrs A's symptoms, her preoccupation with physical illness and continuing experience of suicidal thoughts. Adviser 2 said the Doctor noted some factors, which could be considered to reduce Mrs A's level of risk, but the Doctor continued to consider the risk to be present, prompting her to advise that Mrs A should not be discharged from the IHTT and for her to suggest that the family should stay in the company of Mrs A.

52. Adviser 2 said it was important to note that the advice to give Mrs A more time on her own was given by IHTT nursing staff on 20 September 2012. It was, therefore, possible that when Mrs A was reviewed on 25 September 2012, she presented with more severe symptoms, including admitting to occasional suicidal thoughts.

53. Adviser 2 said the third record of the assessment of 25 September 2012 was provided by the letter written by the Doctor to Mrs A's GP, which was also dated 29 September 2012. This mentions continuing Mrs A on Citalopram, self-help cognitive behaviour therapy and continued input from IHTT.

54. Overall Adviser 2 said whilst it was common practice to do hand written notes at the time of an assessment and then write a letter summarising these to a patient's GP, it was unclear whether the letter to the GP or the report

summarising contact with the patient were final versions, as both were unsigned. Adviser 2 said it was good practice to ensure that all copies of medical records which were to be relied on later were signed.

*Hospitalisation*

55. Mrs C asked whether Mrs A should have been treated in hospital, and questioned whether it was appropriate for someone whose mental health had deteriorated so quickly to be treated solely at home. Mrs C also asked if the care and treatment Mrs A had received at home could be characterised as 'intensive'.

*The Board's Position*

56. The Board said that Mrs A was seen on a regular basis by the IHTT. They did not believe that during this period Mrs A was thinking of ending her life and this had been reflected in her risk review. The IHTT's clinical view throughout Mrs A's treatment had been that she could safely be treated at home and that there was no need for her to be admitted to hospital. The Board noted that hospital admission was considered for all patients assessed by the IHTT.

*Advice Received*

57. Adviser 1 said that it was increasingly common for care to be offered in the least restrictive environment commensurate with safe and effective practice. This included alternatives to psychiatric admission. Adviser 2 said treating an individual in the community reduced the stigma of mental illness and protected the integrity of the family unit. For mothers with dependent children, it was generally felt that intensive home treatment was preferable to in-patient admission and the inevitable separation this caused.

58. Additionally Adviser 1 said observing the patient in their home environment gave the IHTT a better grasp of what constituted normal behaviour for the patient. Hospital treatment tended to focus on controlling behaviours and treating symptoms. Consequently the underlying symptoms remained, only to surface later and trigger further mental health crises.

59. Adviser 1 said Mrs A had willingly sought help and appeared to be participating in the on-going assessment of her needs and engaging appropriately with the clinical team. She also had the support of her family and Adviser 1 felt it unlikely she would have willingly acceded to hospital admission, as her focus was on finding a physical cause for her symptoms, rather than

accepting they were psychological. Adviser 2 went on to say that he did not believe Mrs A could have been compelled to accept admission as an in-patient under the Mental Health Act, as she was cooperating with a viable alternative form of treatment and her capacity to make treatment decisions did not appear diminished. Adviser 1 said the decision to treat Mrs A at home, rather than admit her to hospital was reasonable.

60. Adviser 1 went on to say that the goal of crisis intervention was to lessen the intensity and duration of any period of crisis, by attempting to shift the patient's focus onto a plan of action that was coherent and achievable. It was essential to ensure the patient had a safe and supportive environment, drawing on existing family and social networks, if appropriate.

61. Adviser 1 said there was clear evidence that the IHTT had attempted to use the least restrictive means to treat and support Mrs A, in line with the principles underpinning the Mental Health Act and National Crisis Service standards. He said the level of family participation was appropriate and in line with good practice and there was evidence of appropriate psychological therapy being used in conjunction with Mrs A's prescribed medication.

*(b) Conclusion*

62. The advice I have received is that although the initial assessment of Mrs A was reasonable, as was the care plan developed from it, there were a number of failings in the care and treatment provided to Mrs A. There is no evidence that Mrs A's risk of suicide was comprehensively assessed, before the level of risk assigned to her was substantially reduced.

63. The advice has also highlighted inconsistencies in the record of the second medical assessment of Mrs A on 25 September 2012. From the records available, it appears that medical staff took a different view to the nursing staff on Mrs A's condition and it is unclear why this was not communicated to the IHTT team and Mrs A's family. It is also unclear why the decision was taken to discharge Mrs A, despite reservations being expressed by the Doctor who had assessed her on 25 September 2012.

64. The advice I have received is clear that Mrs A's suicide would have been difficult to predict and that the decision not to treat her as an in-patient was also appropriate. Additionally the level and intensity of treatment was generally considered to be appropriate. I do not consider, however, given the failings

highlighted above, that the standard of care and treatment provided to Mrs A was of a reasonable standard. I have, therefore, upheld the complaint.

*(b) Recommendations*

65. I recommend that the Board:

| | | *Completion date* |
|---|---|---|
| (i) | review the approach taken by the IHTT to the assessment of risk to ensure that all presenting risk factors are considered and recorded appropriately and that the rationale behind clinical decision making is transparent; | 18 January 2015 |
| (ii) | remind medical staff of the importance of accurate and signed contemporaneous notes; | 17 December 2014 |
| (iii) | review the process for communicating medical reviews of patients to IHTT staff, to ensure that all relevant information is made available timeously; | 18 January 2015 |
| (iv) | review the process for discharging patients from the IHTT to ensure that medical staff's opinions are considered; and | 14 January 2015 |
| (v) | apologise for the failings in care and treatment identified in this report. | 17 December 2014 |

66. 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**

| | |
|---|---|
| Mrs C | the complainant |
| Mrs A | the complainant's daughter |
| the Board | Forth Valley NHS Board |
| GP | General Practitioner |
| MS | Multiple Sclerosis |
| MRI | Magnetic Resonance Imaging - scan used to diagnose health conditions that affect organs, tissue and bone |
| the Doctor | the consultant psychatrist who assessed Mrs A initially |
| the Nurse | the charge nurse who assessed Mrs A initially |
| IHTT | Intensive Home Treatment Team- A service providing intensive treatment for mentally ill patients at home, as an alternative to in patient admission |
| Adviser 1 | A mental health nursing adviser |
| Adviser 2 | A consultant psychiatrist adviser |
| NICE | National Institute for Clinical Excellence |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Citalopram | a medicine used to treat depression and panic disorders |
| cognitive behaviour therapy | treatment to help a patient manage their problems by changing the way they think and behave |
| depression | an illness characterized by a low mood and by low self-esteem and a loss of interest or pleasure in normally enjoyable activities |
| Diazepam | a medicine used to control feelings of anxiety |
| Multiple Sclerosis | a condition damaging the central nervous system |
| neurological disorder | a condition affecting the nervous system |
| nihilistic thoughts | feelings that life is without objective meaning, purpose, or intrinsic value |
| Parkinson's Disease | a condition affecting the brain, which impairs the sufferers movements |
| psychosocial | a psychological factor influenced by interaction with the social environment |
| somatic rumination | constant thoughts or worry about physical illness |
| suicidal ideation | thoughts of, or a preoccupation with suicide, including planning, and unsuccessful attempts. |
| Zoplicone | a medicine used to treat sleeping problems |

**Annex 3**

## List of legislation and policies considered

The Scottish Government; Mental Health in Scotland, National Standards for Crisis Services, A Workbook; Edinburgh 2008

The Royal College of Psychiatrists; Self Harm, Suicide and Risk: A Summary Position Statement; PS3/2010; RPSYCH London 2010

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

The Mental Welfare Commission for Scotland; Intensive not Intrusive. Our visits and telephone interviews with individuals and carers who have had contact with Intensive Home Treatment Services and the service providers; pages 5 and 6; Edinburgh. 2012

The National Institute for Clinical Excellence (NICE) National Clinical Practice Guideline No.16; Self-harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care. The British Psychological Society and Royal College of Psychiatrists. London, 2004.

NHS Education for Scotland, The 10 Essential Shared Capabilities for Mental Health Practice in Scotland, The Scottish Government, Edinburgh, 2011.

ICD-10; Classification of Mental and Behavioural Disorders

NICE Guidelines [CG90] Depression in Adults: The Treatment and Management of Depression in adults