SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201305814, Fife NHS Board
Sector: Health
Subject: Clinical treatment; diagnosis; communication; staff attitude; dignity; confidentiality

Summary
Mr A suffered from anxiety, depression and panic attacks for many years; he attended his GP regularly and was prescribed Citalopram and, on occasion, diazepam. In March 2013, Mr A saw an out-of-hours GP, describing worsening symptoms and feeling suicidal. He was prescribed lorazepam and told to see his GP the next day; Mr A attended the out-of-hours GP again the next day and reported suicidal feelings again; he was then seen by a Duty Psychiatrist and discharged with a plan to refer for a medication review. Two days later, Mr A attended the Accident and Emergency Department at the Victoria Hospital after taking an overdose. He was discharged, and his parents (Mr and Mrs C) contacted his GP to say they felt they could not leave him alone due to his state. The following day, Mr A took his own life.

Mr and Mrs C complained to the Board and, along with Mr A's partner, met with Board staff. The Board said that, because Mr A's suicidal thoughts had been fleeting and intermittent, a decision was made that he could be treated safely in the community. He had also been declined further medication, which he had requested, due to the risk of overdose. A Significant Events Analysis was then carried out, where it was identified that benzodiazepine withdrawal may have been a factor in Mr A's mental health deterioration. It concluded that, in hindsight, Mr A's level of risk to himself had not been anticipated. A number of recommendations were made.

My investigation was mindful that we were reviewing what happened with the benefit of hindsight; nevertheless, I found that although the initial assessment by the out-of-hours GP was reasonable, the Duty Psychiatrist's assessment did not detail suicide risk factors and there was no evidence that Mr A's partner, who had attended with him, was included in discussions. Mr A was not told what to do should his condition deteriorate further. When Mr A attended A&E, staff did not know that he had already presented twice to NHS services with suicidal feelings, which he was now acting upon. Had staff known this, they would have been able to see that Mr A's condition was developing, and

different, more urgent action may have been taken. I upheld Mr C's complaint that the Board failed to provide Mr A with appropriate care, support and treatment following his visits to hospital in April 2013.

Mr C also complained that the Board unreasonably failed to provide Mr C's family with sufficient information about Mr A's health to allow them to support him, and I upheld this complaint too. The Board's SEA had already recommended that, in cases where suicide plans have been expressed and hospital admission is not taking place, it would be best practice to agree with patients that partners, family or carers are fully informed to help prevent harm. We found that Mr A's partner, who had attended all the hospital assessments, did not appear to have been involved in decisions about treatment. In addition, neither Mr A's partner nor Mr and Mrs C appeared to have been given any advice about how to deal with the on-going situation.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mr and Mrs C and Mr A's partner for the failings identified in this report;	22 June 2015
(ii) provide me with evidence of the action taken in response to the recommendations of the Significant Event Analysis;	20 August 2015
(iii) review Mr A's case with a view to improving the level and effectiveness of communication between frontline staff likely to deal with self-harm cases particularly where a patient has presented to multiple services with the same issue; and	20 August 2015
(iv) review how patient records are maintained and shared between departments to ensure that escalating levels of risk are identified at the earliest opportunity.	20 August 2015

Who we are

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

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

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainants are referred to as Mr and Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to the Ombudsman about the level of support offered to his son (Mr A) during the final weeks of his life. Mr A suffered from anxiety, depression and panic attacks over a period of 11 to 12 years. He attended his GP regularly and had been prescribed Citalopram (medication used to help the symptoms of depression and panic disorders) for around ten years. Mr A was also prescribed diazepam (anxiety medication) on some occasions when his symptoms worsened.

2. In late March 2013, Mr A experienced a worsening of his symptoms. He saw an out-of-hours GP (the Out-of-Hours GP) and explained that he was feeling suicidal. Although medication was prescribed, Mr A's symptoms did not improve. Over the following week, Mr A and his family sought further help from Fife NHS Board (the Board). His mental state was assessed and a referral made for anxiety management. In early April 2013, Mr A attended the Accident and Emergency department (A&E) at the Victoria Hospital, having taken an overdose. He was discharged with details of various support groups that he could contact should he reach 'crisis point'.

3. Mr A continued to experience worsening panic attacks and a week after his initial consultation with the Out-of-Hours GP, he took his own life. Mr C complained that the Board's staff failed to identify the seriousness of Mr A's condition and failed to provide adequate medication or counselling to help his son. He said that Mr A had been appealing for help from the Board but none had been forthcoming.

4. The complaints from Mr C I have investigated are that the Board:

(a) failed to provide Mr A with appropriate care, support and treatment following his visits to hospital in April 2013 (*upheld*); and

(b) unreasonably failed to provide Mr C's family with sufficient information about Mr A's health to allow the family to support him (*upheld*).

Investigation

5. In order to investigate Ms C's complaint, my complaints reviewer reviewed his correspondence with the Board and records of meetings between Mr C and the Board's staff. My complaints reviewer also reviewed additional comments provided by Mr C and copies of Mr A's clinical records. He obtained the opinion of a consultant forensic psychiatrist (the Adviser). In this case, we have

decided to issue a public report on Mr C's complaint in light of the significance of the issues highlighted during our investigation.

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

(a) The Board failed to provide Mr A with appropriate care, support and treatment following his visits to hospital in April 2013

7. Mr A attended the Out-of-Hours GP on 31 March 2013. He explained that he had been experiencing worsening low moods and increased anxiety over the preceding two weeks. He had telephoned and visited his GP who had prescribed diazepam (anxiety medication). Mr A also told the Out-of-Hours GP that he had suicidal feelings, including specific plans as to how he would end his life. The Out-of-Hours GP prescribed lorazepam (anxiety medication) and advised Mr A to see his GP the following day.

8. The lorazepam did not improve Mr A's symptoms and he returned to the Out-of-Hours GP the following day. He reported suicidal ideation again and requested stronger medication. Mr A was seen by a duty psychiatrist in the Unscheduled Care Assessment Team (the Duty Psychiatrist). They recorded that he had reportedly had a 'good spell' over the previous two years and had been able to work without feeling anxious. However, over the preceding two weeks, he had experienced increased anxiety and daily panic attacks with no particular reason. His sleep and eating patterns had been affected. Details were taken of Mr A's past medical history, medication and social circumstances. A mental state examination was carried out and it was recorded that Mr A had ongoing thoughts of suicide with a specific plan as to how he would end his life. Mr A was discharged home with a plan to refer him to a sector consultant for review of his medication. A referral was also made to the Weston Day Hospital for anxiety management.

9. On 3 April 2013, Mr A attended A&E at the Victoria Hospital, having taken an overdose. He was seen by a duty doctor (the Duty Doctor) who recorded that Mr A had fleeting ideas of suicide with details as to how he would do this, but no formal plans to take his own life. He was observed to have insight and no psychotic features. The Duty Doctor noted that Mr A had been seen by the Duty Psychiatrist on 1 April 2013 and that he had already been referred for anxiety management. Mr A requested diazepam, but this was declined. It was

recommended that he be reviewed by primary care staff regarding the ongoing management of his symptoms and that he should contact various support groups should he reach a 'crisis point'.

10. On 5 April, Mr C's wife (Mrs C) telephoned Mr A's GP concerned about his condition. Mr A's GP records state that he was staying with Mr and Mrs C at the time and that Mrs C did not feel that she could leave him alone. His panic attacks had become unbearable. The GP considered it appropriate to prescribe diazepam at that time.

11. Sadly, on 6 April 2013, Mr A took his own life.

12. Mr C complained to the Board that Mr A's mental health had clearly deteriorated in the days prior to his death. His symptoms were escalating, he expressed suicidal thoughts and had a plan in place as to how he would take his own life. Mr C complained that there had been no intervention from psychiatric staff to provide counselling or to monitor Mr A's deteriorating mental state.

13. Mr C noted that Mr A's referral for anxiety management and a medication review had not been marked as urgent. He felt that Mr A should have been admitted to hospital for further assessment of his condition. Mr C also suggested that Mr A may have been affected by having recently stopped taking diazepam.

14. Following meetings with Mr and Mrs C and Mr A's partner, the Board responded to their complaint formally on 28 May 2013. The Board explained that patients presenting with symptoms and history such as Mr A would not always be admitted to hospital. Risk factors such as the level of family support, previous history and lifestyle issues are taken into account. The Board noted that Mr A had a close, loving, family, no previous history of self-harm and no problems with illicit drugs or alcohol. This coupled with Mr A's reports that his suicidal thoughts had been fleeting and intermittent led to the decision that he could be safely treated in the community. The Duty Psychiatrist had found Mr A to be calm, displaying no signs of being depressed. Mr A would receive psychiatric support as an out-patient.

15. With regard to Mr A's requests for medication in the out-of-hours service, the Board explained that the Duty Psychiatrist had not considered this

appropriate given that Mr A was already taking Citalopram and diazepam had previously failed to reduce his panic attacks. When Mr A attended A&E on 3 April 2013, his request for additional medication was declined due to the risk of a further overdose.

16. The Board carried out a significant event analysis (SEA) of the events leading to Mr A's death. The SEA expanded on comments made in their Board's response to Mr C's complaint. In particular it noted that Mr A's lorazepam prescription would have ended in early February 2013 and that benzodiazepine (the name for the group of medications to which lorazepam and diazepam belong) withdrawal may have been a factor in the deterioration of Mr A's mental health.

17. The SEA stated that a further prescription for diazepam had at no time been actively refused or denied. My complaints reviewer noted that records taken by the out-of-hours service and Duty Psychiatrist clearly record Mr A's request for diazepam. The records indicate that the Out-of-Hours GP who saw him on 1 April 2013 refused to prescribe medication, however, she referred Mr A on to the Duty Psychiatrist who would make the ultimate decision in this respect. The Duty Psychiatrist did not prescribe diazepam, but made a referral for a review of Mr A's medication. A&E staff who saw Mr A on 3 April 2013 recorded that diazepam had been refused. The SEA noted that staff had been concerned that securing a further diazepam prescription had been a driving factor behind Mr A's attendance at the hospital.

18. The SEA acknowledged that Mr A had presented to the different services in an acutely distressed state. However, his anxiety had lessened when he was seen by staff and it was recorded that he was calm during conversations with staff. The SEA recognised that, with hindsight, the actions and responses of services to Mr A's presentations failed to anticipate the degree of risk that he posed himself. However, the SEA concluded that staff had considered his circumstances carefully and the clinical judgement was deemed proper and adequate at the time based on his presentation and background.

19. The SEA considered whether A&E staff should have referred Mr A for a further psychiatric assessment on 3 April 2013. The report concluded that it was not possible to speculate whether such a referral would have resulted in Mr A being admitted to hospital. It found, however, that A&E staff did not have access to the notes made by the Unscheduled Care Assessment Team and the

Duty Psychiatrist. It was accepted that, had these been available, staff may have recognised the severity of Mr A's symptoms and a different care plan may have been instigated.

20. The SEA recommended that the A&E department consider whether, in all cases where suicidal intent is expressed clearly, a psychiatric assessment should be indicated, even if the patient has been seen recently by psychiatric services. It also recommended that, in cases where multiple departments are involved in the emergency care and assessment of an individual, accurate records should be maintained on discussions undertaken and the rationale for discharge. Specifically, it was recommended that letters sent from the Unscheduled Care Assessment Team to the patient's GP should be available to A&E staff.

21. In a subsequent letter to Mr C, the Board stated that they had taken action in accordance with the SEA report's recommendations. The Board apologised to Mr and Mrs C for the failings highlighted by the SEA.

22. My complaints reviewer sought the Adviser's opinion on the Board's care and treatment of Mr A. He asked the Adviser whether he considered Mr A's condition was adequately assessed at each of his presentations. The Adviser noted that, when Mr A was first seen by the Unscheduled Care Assessment Team on 1 April 2013, he was initially seen by a nurse. Relevant risk factors were identified and documented appropriately. Mr A was passed on for further evaluation by the Duty Psychiatrist. The Adviser noted that the Duty Psychiatrist was a junior psychiatrist (a fully qualified doctor, but one acting under the supervision of a more senior specialist). Based on the clinical records, the Adviser considered that the Duty Psychiatrist appropriately recorded Mr A's thoughts of suicide and allowed a reasonable amount of time to assess Mr A's condition. The Adviser noted Mr C's concerns that Mr A's partner was not consulted. He also highlighted that there was no explicit recording of the consideration of the risk factors for suicide or self-harm. By the time of this consultation, Mr A had presented twice with suicidal ideation as the immediate problem. Other than his lack of response to the lorazepam that the Out-of-Hours GP had prescribed, little had changed.

23. The Adviser noted that the Duty Psychiatrist did not seek advice from a more senior specialist. Whilst the Adviser considered the discharge plan for Mr A to be appropriate, there was no evidence of advice being given to Mr A's

partner who was with him, as to what to do should his condition worsen, or how to safeguard against self-harm. While the records note that Mr A and his partner were happy for him to be discharged, there is no record of any other options being considered. The Adviser did not find the Duty Psychiatrist's assessment, as described in the records, to be sufficiently detailed.

24. Having reviewed the records for Mr A's attendance at A&E following his overdose, the Adviser highlighted that there were no notes of his earlier attendances at the out-of-hours services with suicidal thoughts. The A&E doctor telephoned colleagues in the Unscheduled Care Assessment Team and was reassured by their advice that Mr A was already in contact with psychiatric services. However, no information was exchanged as to the extent of the previous assessment or whether it remained valid in the changed circumstances. The Adviser was critical that psychiatric input was not sought. He considered the assessment of Mr A to have been insufficient. He explained that acts of apparent attempted suicide can be impulsive and later regretted. This may be especially true if the individual is intoxicated. In this case, Mr A was not considered to be intoxicated. No account was taken of the fact Mr A had presented twice before with thoughts of suicide before settling but then progressing to an overdose. The Adviser said that, had Mr A declined further examination it is unlikely he would have been detained against his will, but no offer of further examination was made. He considered that the decision to discharge Mr A was made based on inadequate information and was, therefore, unreasonable.

25. My complaints reviewer asked the Adviser whether it was reasonable for Mr A to have been discharged home by the Duty Psychiatrist and A&E staff. The Adviser noted that Mr A had given assurances regarding his changed thoughts and these were taken at face value by the staff assessing him. The Adviser commented that hospital admission is not always the best plan and allowing Mr A to go home was not inappropriate.

26. With regard to Mr A's requests for diazepam, the Adviser explained that diazepam is an anxiolytic or sedative drug of the benzodiazepine type. Drugs from this group can produce both physical and psychological dependence and are, therefore, recommended for short-term use. Mr A had been prescribed diazepam intermittently over a number of years. On 7 August 2012 he was given 28 tablets to be used as necessary and it was not until 12 March 2013 that he received a similar supply. However, on 27 March 2013 he was noted to

have been taking the tablets three times a day and to have run out of supplies four or five days previously. A further supply of 14 tablets (one to be taken per night) was provided.

27. When Mr A saw the Out-of-Hours GP on 31 March 2013, he had again run out of diazepam. lorazepam (another benzodiazepine type drug) was prescribed. When Mr A returned to the out-of-hours service the following day, he is recorded as feeling that neither the diazepam nor the lorazepam had been helpful.

28. The Adviser said that the pattern of diazepam use does not suggest that Mr A was likely to be physically dependent on the drug. He had been taking it regularly for approximately three weeks. Although Mr A had been using diazepam more frequently than prescribed, he had come to think it was not helpful. The Adviser explained that it would be usual to be cautious when prescribing diazepam in cases where a risk of self-harm has been identified, particularly if a patient has used greater than prescribed quantities. The Adviser noted that the records for Mr A's A&E attendance indicated a positive decision not to supply more diazepam. He considered this to be appropriate in the circumstances.

29. The Adviser also considered it appropriate for lorazepam to be prescribed instead of diazepam on 31 March 2013. He noted that they are similar drugs with similar effects. lorazepam is sometimes preferred for short-term management of panic attacks.

30. The Adviser commented that it is not always possible to predict whether an individual will act on their thoughts of suicide. He said that different interventions from the Board's staff may not have altered the outcome for Mr A.

(a) Decision

31. The advice that I have accepted is that it is not always possible to predict whether an individual will act on their thoughts of suicide. I am mindful of the fact that I am reviewing this case with the benefit of hindsight and that, had things been handled differently, the outcome may still have been the same for Mr A.

32. That said, I consider there to have been some clear and significant failings in the Board's handling of Mr A's case.

33. I found that Mr A's initial presentation to the Out-of-Hours GP on 31 March 2013 was handled reasonably. Appropriate medication was prescribed and advice given to return to his GP should his condition fail to improve.

34. I accept the Adviser's comments regarding the Duty Psychiatrist's assessment of Mr A on 1 April 2013. The corresponding notes do not suggest a detailed consideration of Mr A's suicide risk factors and his partner was not included in discussions about his condition. Whilst the decision to discharge Mr A was not unreasonable, and a suitable onward referral was made, insufficient information was provided to Mr A as to what he should do should his condition deteriorate further.

35. When Mr A subsequently attended A&E on 3 April 2013, there had clearly been a development in his condition, as he had taken an overdose. I was particularly concerned by the level of information available to A&E staff at this point. They did not have access to records that would have shown that Mr A had presented twice already with thoughts of suicide and that he had now acted on these thoughts. Although A&E staff telephoned the Unscheduled Care Assessment Team and were able to confirm that there was already a treatment plan in place for Mr A, no details were provided regarding Mr A's previous attendances that would highlight that his condition was escalating.

36. At each presentation, staff were reassured by apparent improvements in Mr A's mental state. I consider that, had an overview or summary been available, staff would have been able to easily see the development of Mr A's condition and different decisions may have been made. Similarly, different and more urgent action may have been taken had the communication between the different frontline services been more effective.

37. I found the Board's management of Mr A's requests for diazepam to be reasonable.

38. Whilst acknowledging the action already taken by the Board following the SEA, with all of the above in mind, I uphold this complaint.

(a) Recommendations

39. I recommend that the Board:	*Completion date*
(i) apologise to Mr and Mrs C and Mr A's partner for the failings identified in this report;	22 June 2015
(ii) provide me with evidence of the action taken in response to the recommendations of the SEA;	20 August 2015
(iii) review Mr A's case with a view to improving the level and effectiveness of communication between frontline staff likely to deal with self-harm cases particularly where a patient has presented to multiple services with the same issue; and	20 August 2015
(iv) review how patient records are maintained and shared between departments to ensure that escalating levels of risk are identified at the earliest opportunity.	20 August 2015

(b) The Board unreasonably failed to provide Mr C's family with sufficient information about Mr A's health to allow the family to support him

40. Mr C complained to the Board that staff had not shared information about Mr A's condition with Mr A's partner and other family members. He explained that family members had not been aware of Mr A's thoughts of suicide or the severity of his condition. Had they been aware of this, they would have been able to monitor him more closely and identify any changes in his condition.

41. The SEA acknowledged that, given Mr A's stated plans for suicide, it may have been beneficial to share information with his relatives if it was established that he was happy for such information to be shared. The SEA commented that it was impossible to say whether sharing this information with relatives would have guaranteed Mr A's safety.

42. The SEA recommended that, in cases where detailed suicide plans have been expressed, and admission to hospital is not being considered, it should be best practice to agree with the patient that partners, family or carers are fully informed of the situation in order to maximise the opportunities to prevent harm. It was also recommended that the plans for treatment and support should also include clear details on what to do should the patient's condition deteriorate.

43. In a letter to Mr C, the Board confirmed that they would take action in line with the SEA's recommendation. They accepted that Mr A's partner and other family members could have been given information regarding his risk factors when he was discharged from the out-of-hours service. They apologised to Mr C for not doing so and for failing to provide adequate information as to what to do should Mr A's condition deteriorate.

44. The Adviser commented that, generally, relatives and carers should be a useful source of information and corroboration. This may be by separate interviews, or during discussions with the patient and relatives present. The Adviser said that relatives views about managing the patient should be taken into account, but are not the only determining factor. Decisions must be made that are clinically appropriate and in accordance with the patient's wishes. The Adviser said that care must be taken not to disclose confidential information against the patient's wishes but this is generally not a problem in practice. He said that relatives and carers should be given enough information to allow them to take up a supportive and collaborative role, with guidance given on what to expect and what to do in emergencies.

45. The Adviser noted that there was little evidence of a conversation with the carer who attended the hospital assessments (Mr A's partner). Her account is not recorded on one occasion and on the other the corresponding notes are insufficiently detailed.

(b) Decision

46. It is clear from the SEA's conclusions and the Adviser's comments that relatives and carers have a recognised role in monitoring and supporting individuals struggling with anxiety and expressing thoughts of self-harm.

47. In Mr A's case, whilst there is evidence of Mr A's mother and partner being present at the hospital, or talking to staff on the telephone, decisions about his potential for self-harm and treatment plan were made without their involvement.

48. There were no detailed accounts of relatives' view of the changes in Mr A's condition. Nor is there any evidence of Mr A being asked whether staff could share details of his condition with his family. Most disappointing of all, when Mr A was discharged, there is nothing to suggest staff provided any advice to family members in terms of keeping an eye on him, what to look out for, and what to do in an emergency.

49. I found that the Board failed to adequately communicate with, and involve, Mr A's partner and family. I uphold this complaint.

(b) Recommendations

Under Complaint (a) I asked the Board to provide me with details of the action taken in response to the SEA's recommendations. I have no further recommendations to make.

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

Annex 1

Explanation of abbreviations used

Mr and Mrs C	The complainants
Mr A	Mr and Mrs C's son
the Out-of-Hours GP	an out-of-hours GP who saw Mr A
the Board	Fife NHS Board
A&E	Victoria Hospital's Accident and Emergency department
the Adviser	a consultant forensic psychiatrist providing professional medical advice to the Ombudsman
the Duty Psychiatrist	a junior psychiatrist in the Unscheduled Care Assessment Team
the Duty Doctor	a doctor on duty in A&E
SEA	Significant Event Analysis

Annex 2

Glossary of terms

Benzodiazepine	the name for a group of medications to which diazepam and lorazepam belong
Citalopram	medication used to help the symptoms of depression and panic disorders
Diazepam	anxiety medication
Lorazepam	anxiety medication