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 ref: 201401377, Fife NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mr C complained to the Ombudsman about the standard of care provided to his son (Mr A) in the community and in Stratheden Hospital, where he was taken by his parents in a moment of crisis. Mr A had been diagnosed several years previously with paranoid schizophrenia, and he had a history of self-harming and attempting suicide. Mr A was admitted to hospital, but absconded within hours and was found dead on a nearby railway line. Mr C believed that Mr A's suicide risk was not properly assessed on admission, and that actions were not taken that could have ensured his safety.

I obtained independent advice from a mental health nursing adviser and a consultant psychiatrist adviser. Both advisers noted the risk assessment in Mr A's medical records that was done when he was admitted to hospital. They said that the form was unsigned and that important sections were either left blank or completed without much detail. The form did, however, record Mr A's history of self-harm, suicide attempts and absconding behaviour. Both advisers said that the assessment should have been collaborative, including Mr A, his parents and all involved staff. It also should have assessed and discussed the many known factors that increased Mr A's risk of serious self-harm or suicide. As this was not the case, my advisers considered that this risk assessment was inadequate, and I agreed.

Further to this, on the day after admission, a doctor began the process to detain Mr A under a Short Term Detention Certificate. My adviser on mental health noted that this showed the doctor must have considered Mr A to be a significant risk to himself, yet did not ensure that Mr A was under constant observation from that time. Both advisers considered this to be unreasonable. They said that Mr A's detention was not recorded in his notes so it was not clear if nursing staff knew about the decision to detain him. My adviser on mental health was also concerned that Mr A was able to leave the ward and hospital without staff realising, which was unreasonable.

Given the advice received, I considered that the care and treatment provided to Mr A in the hospital was below a reasonable standard. I upheld the complaint and made several recommendations.

Mr C also complained about the medical care and treatment provided to Mr A in the community. The advice I received is that Mr A's care package was appropriately planned and delivered, and his needs were met. However, the needs of his parents, who played an essential role in supporting him, were not examined. Mr C and his wife would have been entitled to a carer's assessment, which would have explored how much choice they had in their provision of care, and the impact on them, including their health, domestic needs and relationships. I considered this to be unreasonable. I therefore upheld the complaint and made recommendations.

Redress and recommendations

The Ombudsman recommends that Fife NHS Board:		*Completion date*
(i)	review their admission procedures to ensure there is multi-disciplinary involvement in the risk assessment of emergency admissions;	20 January 2016
(ii)	remind all staff of the importance of accurate contemporaneous record-keeping;	13 January 2016
(iii)	contact Doctor 1's current employer and ask them to ensure that this report is considered and reflected on in his next appraisal;	13 January 2016
(iv)	review the risk assessment tools used by staff to ensure they include an adequate review of historical risk factors;	20 January 2016
(v)	review the procedures followed during nursing handover to ensure that patients are adequately monitored during this period;	20 January 2016
(vi)	review the procedure followed for Short Term Detention Certificates, to ensure both multi-disciplinary involvement, including carers and named persons;	20 January 2016
(vii)	review their procedures for community care provision to ensure the needs of carers are pro-actively considered; and	20 January 2016
(viii)	apologise unreservedly to Mr C and his family.	13 January 2016

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 complainant is referred to as Mr 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 standard of care provided to his son (Mr A). Mr C believed that the standard of care provided to Mr A had been inadequate, both in the community and when he had been taken to Stratheden Hospital (Hospital 1) by his parents in a moment of crisis. Mr A was admitted to Hospital 1, but absconded within hours and was found dead on a nearby railway line. The complaints from Mr C I have investigated are that:

(a) Fife NHS Board (the Board) failed to provide Mr A with appropriate medical care and treatment whilst a patient in Hospital 1 (*upheld*); and

(b) the Board failed to provide Mr A with appropriate medical care and treatment whilst in the community *(upheld).*

Investigation

2. In order to investigate Mr C's complaint, my complaints reviewer sought independent advice on the mental health nursing provided to Mr A from an adviser (Adviser 1), they also sought advice on the medical care from a consultant psychiatrist (Adviser 2). In this case, we have decided to issue a public report on Mr C's complaint due to the serious failings identified by the advice we received, the failure of the Board's own investigations to identify and correct these failings and the tragic outcome for Mr A.

3. 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.

4. In response to the comments received from the Board, I asked the advisers to review the points raised by the Board and in particular a request that my recommendation for a full apology to Mr A's family be altered to reflect the Board's view that the judgement on Mr A's level of observation was in line with good practice guidance and verified by an external medical director.

5. The advisers have reviewed the Board's comments on the reports and remain satisfied that their advice accurately reflects the evidence available. The Board did not adequately assess Mr A's risk on his final admission to Hospital 1 and as a result, he was not subject to an appropriate level of observation, which contributed significantly to his ability to leave Hospital 1 with tragic consequences.

6. The Board failed to respond in a timely fashion to my request for comments on the draft of this report. This, coupled with its refusal to accept the need for a full apology for the failings identified in this report, has delayed the report's publication.

(a) The Board failed to provide Mr A with appropriate medical care and treatment whilst a patient in Hospital 1

Concerns raised by Mr C

7. Mr C stated he believed Mr A's suicide risk was not properly assessed following his final admission and that the Board's subsequent investigation had sought to minimise the risk Mr A posed to himself in order to excuse this failing. Mr C also noted the internal review carried out by the Board had been obliged to re-issue its investigation report after he had pointed out a series of significant errors within it.

8. Mr C said that the level of inaccuracy within the Board's internal review report could have been avoided had it been cross referenced against the medical records and the family's own correspondence with the Board. Mr C also considered that the inaccuracies in the internal review had affected the conclusions reached in the Independent Review carried out for the Procurator Fiscal's Office by the Assistant Medical Director of another Scottish NHS board.

9. Mr C did not believe Mr A's risk levels were properly assessed and he felt there was insufficient evidence to underpin the clinical judgement reached that Mr A did not represent a significant risk to himself at the time of his admission on 20 June 2013.

Background

10. In June 2011, Mr A sustained a fall from a walk way leading to a Dundee swimming pool. It was never determined conclusively whether this was a suicide attempt or an accident. Mr A sustained serious injuries in this incident, including injuries to his brain.

11. In January 2013, Mr A was an informal patient at Hospital 1, but on 16 January 2013 Mr A impulsively discharged himself, against medical advice. He was informally readmitted (ie not detained) five days later on 21 January 2013, he remained an in-patient until a planned discharge took place on 15 March 2013. It was noted at the point of admission that Mr A had informed Mr C that he intended to commit suicide by jumping from a tall

building. During this admission, on 27 January 2013, Mr A left Hospital 1 without permission and made his way to the swimming pool in Dundee where his previous accident had occurred. When he became aware Mr A had absconded, Mr C managed to contact Mr A by telephone. During the conversation, Mr A stated he intended to kill himself. Mr C was able to locate Mr A and with the assistance of the police Mr A returned to hospital.

12. On 8 February 2013 Mr A was detained under a Mental Health Act Short-term Detention Certificate (STDC), which was valid for twenty eight days. An application was then made to the Mental Health Tribunal Scotland (MHTS) for a Compulsory Treatment Order (CTO).

13. On 14 March 2013 a MHTS hearing granted a CTO for six months, with Mr A's treatment to be provided within the community. The records of the hearing and its formal findings, both contain the tribunal's concerns about the robustness of Mr A's community care plan. The order was granted subject to the care plan being enhanced. The MHTS indicated that the care plan should be shared with Mr C.

14. Mr A's care was managed by Weston House Day Hospital (Hospital 2). Staff at Hospital 2 considered Mr A to have been generally well over the first eight to ten weeks following his discharge. By the end of May, however, his persecutory ideas had resurfaced and Mr A was noted to be speaking about suicidal impulses.

15. On 12 June 2013 it was agreed Mr A should be readmitted informally to Hospital 1 for a one week period. On admission he was noted to be disturbed, Mr A was talking about Satan and the Anti-Christ and responding vocally to distressing auditory hallucinations. It was noted that his use of cannabis had recently increased. During Mr A's admission he was reported to have come into conflict with another patient and to have responded violently to auditory hallucinations by kicking patio furniture around.

16. Mr A left Hospital 1 on the evening of 16 June 2013 against medical advice according to his medical records. This is disputed by Mr C, who has stated he left on 15 June 2013 and it was subsequently acknowledged by the Board that this was an error in Mr A's medical records. It is documented that Mr A refused to see a member of nursing staff before leaving, however, nursing staff did not believe use of their holding power was justified in the

circumstances. Transport was arranged to take Mr A home, but there is no record that Mr C was informed of the discharge.

17. On 20 June 2013 Mr A was informally re-admitted following a suicide attempt in which he had cut his arm, causing himself a serious injury. Mr C also reported that Mr A had intended to throw himself under a train, but had been unable to access the platform, due to the ticket barriers. On admission Mr A was noted to be hallucinating and distressed. He required Haloperidol, an antipsychotic drug twice to help him cope with distressing persecutory auditory hallucinations. Mr C emailed Mr A's Mental Health Officer (MHO) informing him Mr C had been readmitted and included a detailed account of events.

18. On 21 June 2013, following a clinical interview, Mr A was assessed as requiring detention under an STDC. This was due to concerns for his safety, his overall mental state and his previous impulsive departures from Hospital 1, against medical advice. Mr C had informed the interviewing doctor (Doctor 1) that Mr A had left what they considered to be a suicide note in his flat and gave Doctor 1 a copy of the note prior to Doctor 1 examining Mr A.

19. Doctor 1 had completed the Approved Medical Practitioner section of the STDC, however, he had not signed or dated it. The STDC had been left for the MHO to complete and Doctor 1 left the ward at approximately 12:45. The expectation was that the MHO would visit the ward around 15:45 to interview Mr A and complete the appropriate section of the STDC documentation.

20. In the intervening period, it was considered appropriate to nurse Mr A under general observation. Prior to the arrival of the MHO, however, Mr A left the ward and ended his life. The last recorded observation of Mr A was at 12:55 on the patio area. Hospital 1 was informed by police at 13:40 that a man's body had been found on the railway line at a nearby station.

The Board's Response

21. The family met with the Board on 8 August 2013 to discuss the on-going internal review by the Board. The first draft of this review was produced on 11 September 2013, and a response to Mr C's complaint to the Board was produced on 29 October 2013, which included a copy of the completed internal review. The Board set out a brief chronology of the events leading up to Mr A's admission. They acknowledged that Mr A had been spoken to by Doctor 1 on 20 June 2013 at Hospital 2, when receiving treatment for self-inflicted cuts to his

arms. Doctor 1 did not consider Mr A had been significantly distracted by aural hallucinations during this meeting. On arrival at Hospital 1 Mr A was acknowledged to have been distressed whilst in the car park. Following his assessment, the treatment plan advised an informal admission.

22. The Board said staff did not believe Mr A posed an increased risk to himself on 21 June 2013, although the STDC was started. The Board believed there was nothing significant in Mr A's presentation, symptoms or behaviour which suggested imminent self-harm.

23. Mr C responded to the Board, noting there were a substantial numbers of errors in the Board's internal review report. He considered that Mr A's behaviour was not adequately described, and that the presentation of the events was inaccurate. Mr C noted they were not informed Mr A was admitted as an informal patient, he also noted inaccuracies relating to a suicide note from Mr A found in his flat. Had Mr C been aware Mr A was an informal patient who was effectively free to leave the ward, he would have complained at the time and he would not have left until the issue had been resolved to his satisfaction.

Meeting with Mr C on 14 November 2013

24. Mr C and his wife met with the Board. Mr C explained the complaint response and internal review had only been received the previous week. Mr C said they now understood Mr A had been an informal patient on admission on 20 June 2013. They had assumed since aspects of his treatment were being conducted under the Mental Health Act, he was not an informal patient. Present at the meeting were a number of Board staff, including the consultant psychiatrist responsible for Mr A's care (Doctor 2).

25. Doctor 2 explained that detention had not been approved by the Mental Health Tribunal, so any in-patient stay would be voluntary. As Mr A had not breached his CTO measures, the only option that could have been considered was the STDC, which Mr A was to be assessed for. The MHO was to visit the ward later in the afternoon, after discussion with Doctor 1 it was agreed they would attend mid-afternoon as Mr A appeared to be co-operative.

26. Mr C said the expectation the family had had was that Mr A was in a safe place, where he would be monitored. Mr C said he was clear Mr A was in a state of crisis when he was admitted on 20 June 2013. Doctor 2 stated a

patient cannot be detained if they accept the treatment being offered, which Mr A had done. They believed Mr A was being co-operative.

27. It was accepted in Mr C's view at this meeting that Mr A had posed a serious suicide risk on many occasions and had a history of suicide attempts. Mr C also said it was accepted that the repeated references to self-harm, rather than suicide appeared to minimise the risk of Mr A's actions, although Mr C acknowledged this had not been deliberate.

28. The meeting did not discuss the complaint which was to be considered further at a later date. It was agreed the Board's internal review report would be re-drafted in respect of Mr C's comments and that identified inaccuracies would be corrected.

The Board's Internal Review Report Findings

29. The Board conducted an internal incident review on 14 August 2013, with the final version produced on 30 January 2014. The Board acknowledged Community Psychiatric Nursing (CPN) staff were not notified of Mr A's discharge on 15 June 2013. The Board also noted that cannabis use was a likely factor in the varying nature of his presentation in the period prior to his final admission. The Board's review stated there was nothing significant in his presentation or behaviour which suggested an increased or imminent risk of self-harm. Additionally the Board took the view that even had Mr A been seen leaving the ward, there was no certainty that nursing staff would have felt it appropriate to stop him. A copy of the Board's internal review report was sent to the Mental Welfare Commission for Scotland (MWC) by the Board.

Medical Report

30. A medical report was compiled for the Procurator Fiscal's office, by the Associate Medical Director of another NHS board. The medical report stated Mr A was at high risk of suicide in both the short and long term and that every effort had been made to reduce the risk. The medical report also considered the decision to place Mr A under general observation only and concluded this was clinically reasonable, and a decision which would probably have been taken by the majority of competent and conscientious practitioners.

Mental Welfare Commission Involvement

31. Mr C wrote to the MWC expressing concerns about aspects of Mr A's treatment. In response the MWC stated they shared concerns that Mr A's

observation was not considered fully on 21 June 2013. The MWC said, however, they had to accept the team responsible for Mr A's care did not believe his presentation merited him being placed on a higher level of observation. The MWC noted the system for monitoring patients' movements on and off the ward had failed, thereby enabling Mr A to leave the ward unnoticed. Although the MWC informed Mr C they were in discussion with Health Improvement Scotland regarding the supervision of patients in hospital generally, they were taking no further action against the Board in this case.

Mental Health Tribunal Involvement

32. Mr C wrote to the Mental Health Tribunal for Scotland (MHTS). He expressed a number of concerns about Mr A's care and their dissatisfaction that their complaints remained unresolved. Mr C noted there were in his view, significant inaccuracies within the Board's incident review and he felt Mr A's potential for suicide was minimised by this document.

33. The MHTS reviewed the case, but asked Mr C to note they were limited to considering the operation of the mental health tribunal. Mr C wrote back to the MHTS expressing concerns at the absence of key stakeholders from Mr A's tribunal hearing. Mr C also expressed concerns about a lack of clarity within the early warning signs plan which the tribunal had instructed to be compiled, particularly over the persons responsible for initiating agreed actions.

Further Comment from Mr C

34. Mr C noted he had discussed Mr A's illness with Doctor 1 on 20 June 2013, as noted in the family's complaint to the Board. Mr C had discussed the case again with Doctor 1 and Doctor 2 in August 2013, prior to the completion of the Internal Clinical Review.

35. Mr C said during the conversation with Doctor 2, it had been stressed that Mr A's illness was severe and his prognosis was poor. Mr C was informed that Electro Convulsive Therapy had been considered, but Mr A had declined this. Doctor 2 had then asked how long Mr C had thought Mr A would live, Mr C said this was a surprising question which had never been mentioned whilst Mr A was alive. Mr C's understanding had been Mr A's medication could take up to two years to have the maximum effect on Mr A's schizophrenic symptoms. Mr C said they had told Doctor 2 they did not consider Mr A's death on 21 June 2013 had been inevitable and that his death had been preventable. I note that

Doctor 2 disagrees with Mr C's recollection of the conversation and denies having spoken to the family like this.

Advice Received

36. Due to the multiple facets of care and treatment considered by the advisers, I have summarised their views under separate headings to make clear the issues considered by each piece of advice.

Risk Assessment of Mr A

37. Adviser 1 noted a previous risk assessment document was present in Mr A's notes completed on 23 January 2013. A subsequent risk assessment document on 20 June 2013, was completed in a very similar manner. This recorded his history, including self-harm, suicide attempts and absconding behaviour. Drug and alcohol misuse was identified as a service challenge, but his variable compliance with medication and other treatment strategies was not noted.

38. Adviser 1 said the summary recorded Mr A as known to the ward and that his admission was due to a deterioration in his mental state and an act of deliberate self-harm. No formulation was carried out of the current risk, or of any balancing factors that might offset this. The document was not signed and the section for recording whether more detailed risk assessment was required had been left blank. Adviser 1 highlighted that there was no evidence to show how the findings of this assessment were discussed in a multi-disciplinary context or how they were used to inform the risk management plan.

39. Adviser 1 said Mr A's clinical notes highlighted a number of historical and contemporaneous factors that elevated his risk of serious self-harm or suicide on 20 June 2013. These included the following historical risk factors:

- persecutory delusions;
- derogatory auditory hallucinations, including commands;
- past history of acting on delusions;
- a history of deliberate self-harm;
- significant suicide attempts involving violence, including an attempt to inject air into his chest, attempting to gain access to a railway line with suicidal intent;
- previous non-compliance with treatment;

- impulsivity, impaired self-control, and unpredictable decision making – history of acting recklessly without thinking;
- previous absconding and absenting from hospital without informing staff
- drug and alcohol abuse; and
- record of self-discharge against medical advice.

Factors at time of admission:

- fluctuating suicidal ideation;
- agitation and significant distress at the point of admission caused by suicidal thoughts and increased derogatory hallucinations to the point that his behaviour was distressing other patients;
- fluctuating decision making;
- significant act of self-harm on day prior to admission, when he cut his forearm deeply with a knife or razor and attempted to gain access to a railway line with the intention of killing himself;
- significantly increased use of cannabis in period leading up to admission; and
- an apparent suicide note divesting care of his cat (a loved pet) to others.

40. Adviser 1 added that the initiation of the detention process could only have taken place if Doctor 1 considered Mr A presented a significant risk to self or others. As Doctor 1 had completed the AMP section of the STDC, he must have considered Mr A a significant risk to himself.

41. Adviser 1 said risk assessment was an estimation of an individual's potential risk based on a balance between historic and precipitating risk factors, weighed against factors which could be considered protective. A systematic assessment of risk was a crucial component of managing risk in individuals at risk of harming themselves.

42. Adviser 1 found no evidence of meaningful involvement of Mr A or Mr C, which he described as an important aspect of risk assessment. Adviser 1 also found no formulation of risk, which was part of a structured professional judgement as endorsed by the Department of Health and the Scottish Risk Management Authority. Adviser 1 said best practice would have involved a formulation of risk that looked at whether there were general or specific risks to Mr A, his volatility, assess any known early warning signs and what treatment or

actions could diminish the risk. Formulation provided the link between assessment of risk and its management.

43. Adviser 1 concluded the risk assessment of Mr A fell below what could be considered a reasonable standard. There was no evidence of multi-disciplinary discussion about the level of risk observed, no discussion around short term detention and no evidence that risk factors were assessed or discussed, including the apparent writing of a suicide note.

44. Adviser 1 said Mr A's presentation showed clear evidence of a number of significant risk factors. Although Mr A reportedly denied suicidal intent, this had to be weighed against his history of impulsivity in this regard. Adviser 1 said that patients on general observation were under national guidance considered to be those who:

> 'do not pose a serious risk of harm to self or others and are unlikely to leave the ward area or other treatment departments without prior permission, escort, or at least informing staff of their planned destination.'

Mr A had a history of absconding and was a significant risk to himself.

45. Adviser 1 noted that significant weight had been given to Mr A's statement that he felt safe in Hospital 1 when his level of risk was determined. Adviser 1 said no single factor either of risk or protection could be considered to mitigate against possible suicidal behaviour. In Adviser 1's view, not enough weight was given to the evident risk factors present. As a result, although a risk assessment document had been used, it was inadequate because it had not been effectively completed, and no proper formulation of risk had been done from it.

The Response to Mr A's Abscondment

46. Adviser 1 noted his previous comments about the level of risk considered appropriate for patients on general observation. Mr A had a history of self-harm, suicide attempts and impulsivity, including a recent impulsive self-discharge and a significant suicide attempt which had precipitated his re-admission.

47. Adviser 1 said the national guidance previously referred to stated that constant observation should be used for patients who posed a significant risk to themselves or others. Under this, an allocated member of staff should be

aware through visual observation, or hearing of the location of the individual at all times.

48. Doctor 1 who was responsible for designating Mr A as suitable for general observation had said in retrospect that his view was that constant observation was unnecessary as Mr A had said he would be 'okay' staying on the ward. Adviser 1 said that Mr A's recent actions and historic risk factors did not appear to have been a consideration in this decision. No time-out care plan had been drawn up, although 'nil time out until reviewed by medical staff' was recorded on his observation care plan.

49. The admission information sheet identified risks related to aggression and self-harm and the nursing and medical admission records noted Mr A had been feeling 'suicidal for the past few days'. Adviser 1 said as noted, Mr A presented with a number of suicide risks. The STDC indicated fluctuating suicidal ideation, had written a suicide note and was prone to impulsive and unpredictable decision making. The STDC clearly recorded that Mr A's health and safety were at significant risk if he was not detained.

50. Adviser 1 noted that whilst the medical report compiled by the Assistant Medical Director of a different NHS board acknowledged Mr A was at high risk of suicide in both the short and long term, it had taken the view every effort was made to reduce that risk. This independent review concluded placing Mr A under general observation was clinically reasonable and a decision which would probably have been taken by the majority of practitioners.

51. Adviser 1's view was that the incident reviews had attempted to establish what had happened when Mr A absconded. They had not, however, examined the more complex nature of why events had unfolded in the manner in which they did. Adviser 1 accepted Mr A's fluctuating behaviour would have made on-going assessment challenging. He said, however it was concerning that despite Mr A being placed on nil time out (pending review) he was allowed to go to Hospital 1's shop on several occasions unescorted. Adviser 1 noted there was no evidence this requirement was reviewed or relaxed.

52. The Board stated Doctor 1 did not believe Mr A presented an increased risk when he interviewed him on 21 June 2013 and there was nothing in his behaviour, presentation or symptoms, which suggested an increased or imminent risk of serious self-harm. Adviser 1 said there were, however, a

number of risk factors in his history and presentation on admission which should have given cause for concern. Adviser 1 noted that commencing the STDC meant Mr A must have been considered a significant risk. To detain, or attempt to detain someone who was not a significant risk to self and / or others would have been illegal.

53. Adviser 1 said given the available evidence, he considered the decision to nurse Mr A under general observation was unreasonable. Adviser 1 referred to the national guidance on the provision of clinical observation. As the STDC form had been completed, Mr A must have been considered a risk to himself or others. Adviser 1 said that he agreed with this assessment, which showed that at the time Mr A was considered to have significantly impaired decision making. The decision to pursue an STDC suggested Doctor 1 did not have confidence Mr A would remain as an in-patient. In the Board's internal review report, Doctor 1 had subsequently stated he considered general observation appropriate as Mr A had stated he would not leave the ward.

54. Of further concern for Adviser 1 was Mr A's ability to leave the ward and Hospital 1 without the knowledge of staff. It was also of concern that his absence was not then noted until staff were informed of a body on the railway line by the Police. Adviser 1 acknowledged that staff levels were below optimum that day, which presented a challenge, however, even under general observation, staff should have been aware of Mr A's whereabouts at all times, but it was evident they did not.

55. Adviser 1 also accepted that staff handover periods were busy and occupied staff attention, however, this could not be given as a justification for leaving patients without an effective means of observation. Adviser 1 said the failures of staff on the ward contributed to Mr A's ability to leave Hospital 1 and end his life on the nearby railway line, which was clearly unreasonable.

56. The Board had stated that even had Mr A been seen leaving, staff may not have felt it necessary to stop him, as he had left the ward earlier unescorted and returned without incident. Adviser 1 considered this position unreasonable. Mr A was a patient who was in the process of being detained, due to his deteriorating mental state and the risk he posed to himself. He had been on the ward less than twenty four hours after a significant act of self-harm, which could be considered an attempt at suicide and with a history of serious self-harm and suicide attempts. His time out status was 'nil' and had not been subject to

medical review. Adviser 1 said he would, therefore, have expected staff to prevent Mr A from leaving Hospital 1 had he been seen attempting to do so.

57. Adviser 1 added that it was also a source of concern that Mr A's detention was not recorded in the nursing notes. It was not, therefore, clear if staff were aware that Mr A was in the process of being detained.

Risk Assessment of Mr A

58. Adviser 2 identified a 'Working with Risk' document within the submission of documents from the Board. This was dated 20 June 2013 and identified self-harm as a risk along with a history of absconding. There was a brief summary of Mr A's presentation, however, the form was not complete and had not been signed. There was no consideration of further detailed risk assessment. The initial care plan was signed, but consisted of the highlighting of standard items, with no individual nursing actions noted. The observation plan noted 'no time out' until medical review.

59. The medical clerking form was completed, but was not detailed and indicated the plan was to admit Mr A, continue administering his prescribed medication and place him on general observations. Adviser 2 noted this clerking was done by a junior doctor who had seen Mr A during a previous admission when he had impulsively discharged himself against medical advice. The handwritten notes indicated it was recognised as an emergency admission, but that Mr A was an informal patient and that he was to be placed on general observations. He was noted to have required and received tranquilising and sedative medicine on two occasions. Adviser 2 noted that the prescription of emergency medication to Mr A occurred prior to the medical clerking, but there was no evidence this had been discussed by medical staff.

60. Adviser 2 said a retrospective summary of contact had been provided by Doctor 1. He noted a brief contact, prior to admission to Hospital 1 on 20 June 2013. A review was arranged for Mr A the following day. A conversation with Mr C was recorded by Doctor 1 in Hospital 1's car park, but although he recorded that a suicide note was handed over by Mr C, the record of the conversation did not appear to refer to the events leading up to Mr A's admission. Doctor 1 then reviewed the patient, following Mr C's departure and agreed to the proposed treatment plan. Mr A was noted as having limited response to Clozapine and the plan was to augment this therapy.

61. Adviser 2 also noted that Doctor 1 informed the patient he intended to apply for a STDC. The observation levels were unchanged, but an MHO was called to pursue an STDC. Doctor 1 completed the certificate, noting the recent suicide attempt, the suicide note, fluctuating suicidal ideation and unpredictable decision making, but did not date or sign it.

62. Adviser 2 said the assessment should have considered various risks, been continuous and have led to a specific and individual plan. It needed to take into account past history, related factors as well as current events and circumstances. It should also have been collaborative, involving the patient, carers and all involved staff. There was no evidence the views of Mr C or Mr A had been sought. Adviser 2 said he considered the risk assessment carried out on 20 June 2013 had been inadequate.

63. Adviser 2 said the risk of suicide was constantly present, although it was likely to have fluctuated. Mr A also presented with clear and significant historical risk factors. Adviser 2 acknowledged treatment resistant schizophrenia conferred an increased risk of suicide itself and that Mr A's condition was further complicated by substance abuse and head injury. Mr A had previously left hospital impulsively with the intent to kill himself by violent means and there had been a recent documented deterioration in his mental state. Adviser 2 said the evidence justified the decision to apply short term detention on Mr A. The decision to continue general observation was inconsistent with the decision to seek an STDC and was in Adviser 2's view unreasonable.

Absconding and Hospital 1's response

64. Adviser 1 said that the national guidance was clear that patients under general observation had to be considered not to pose a risk to themselves or of leaving without permission or escort. Mr A had a history of significant self-harm and suicide attempts as well of impulsively absconding or discharging himself from hospital. He had also made a significant suicide attempt, which had led to his readmission. Adviser 1 stated that in his view, Mr A met the criteria for constant observation, which the guidance stated was applicable to patients who posed a significant risk of harm to themselves or others.

65. Adviser 1 said the admitting doctor had designated Mr A as general observation. Doctor 1 in reviewing him the following day did not refer to clinical observation levels. He stated retrospectively that he did not consider constant

observation necessary, as Mr A had clearly stated he was happy to stay on the ward. This did not appear to take into account Mr A's history of impulsivity and unpredictable decision making, or his past absconding behaviour.

66. There was no evidence that Mr A's 'no time-out' status had been reviewed by medical staff, or that it had been discussed with Mr A himself. There was no time out care plan in place, in contrast with Mr A's admission earlier in the year.

67. Adviser 1 said the admission information sheets identified the presence of risks related to aggression and self-harm. The nursing and medical admission records also made reference to Mr A reporting 'feeling suicidal for the past few days'. As detailed already there were a number of suicide risk factors evident in Mr A's history and presentation.

68. The STDC indicated fluctuating suicidal ideation, had written a suicide note and was prone to impulsive and unpredictable decisions regarding his treatment. In this regard his decision making was considered significantly impaired. The STDC is clear that not detaining Mr A was a significant risk to his health, safety or welfare.

69. Adviser 1 noted the Board had a medical report, carried out by the Assistant Medical Director of a neighbouring NHS board which concluded that although Mr A was at a high risk of suicide, every effort was made to reduce the risk. The decision to nurse him under general observation was reasonable and was a decision which would probably have been taken by a majority of competent and conscientious practitioners.

70. Adviser 1 said that he considered the Board's internal review report sought to establish what had happened, but he did not see any evidence it had sought to establish why events had unfolded as they did. Although Mr A's impulsiveness, cannabis use and fluctuating suicidal ideation would have made on-going assessment challenging, there were concerning factors in the way his care and treatment was planned and administered.

71. Adviser 1 again highlighted Mr A's unescorted visits to the hospital shop. He noted this appeared to ignore the 'nil time-out' recorded for him until medical review and this assessment had not been reviewed or relaxed.

72. Additionally the Board had stated Doctor 1 did not believe Mr A posed an increased risk when he interviewed him on 21 June 2013. Nor was there anything significant in Mr A's presentation, symptoms or behaviour, particularly on the morning of 21 June 2013 which suggested an increased or imminent risk of self-harm. Adviser 1 said there were, however, a number of historical risk factors and risk factors in his presentation at the time, which should have given cause for concern. Adviser 1 said that for Doctor 1 to have initiated the detention process, he must have considered Mr A to be at significant risk. To have sought Mr A's detention without this belief would have been illegal.

73. Adviser 1 said he agreed with the subsequent independent review's conclusion that Mr A was at high suicide risk in the short and long-term. He did not agree, however, that the decision to nurse him under general observation was reasonable, or that every effort was made to reduce this risk. Adviser 1 referred again to the national guidance on clinical observation; general observation is only appropriate for individuals who are not considered to be at serious risk of self-harm or absconding.

74. Adviser 1 noted the STDC clearly set out the risks Mr A posed to himself including impulsivity and absconding and impaired decision making. The Board's internal review report also stated that Doctor 1 did not have confidence that Mr A would remain as an in-patient, which was key to the decision to detain Mr A. Doctor 1 had suggested retrospectively that he felt it acceptable to place Mr A on general observation, since Mr A had said he would remain on the ward. Adviser 1 said the evidence showed, in his view, that the decision to nurse Mr A under general observation was unreasonable.

75. Adviser 1 also said Mr A's ability to leave the ward unremarked whilst undergoing the detention process was concerning, especially as his absence was not noted until Police contacted staff. Although staff numbers presented a challenge on the day in question, even under general observation, Adviser 1 said a knowledge of Mr A's whereabouts should have been held by staff at all times, but clearly was not. Adviser 1 said whilst Mr A may have left during shift handover, which was always a busy time, failures in clinical observation practice and staff deployment contributed to Mr A being able to leave the ward and end his life.

Use of Holding Power

76. Adviser 1 noted the Board's internal review report concluded staff were unlikely to have used their holding powers, even had they noticed Mr A absconding. The reasoning for this was that he had previously left the ward unescorted and returned. Adviser 1 considered this unreasonable, Mr A was being detained due to his deteriorating mental state, a significant risk to self and impaired and impulsive decision making. Mr A had been on the ward for less than twenty four hours, after a significant self-harming event had a long history of serious self-harm and suicide attempts and was prone to absconding. His time out status was nil, and had not been medically reviewed. In light of these factors Adviser 1 said contrary to the Board's view, he would have expected nursing staff to prevent Mr A from leaving the ward had he been seen attempting to do so. Adviser 1 added it was concerning the nursing notes did not refer to the detention process having commenced, and it was unclear if staff were aware Mr A was to be detained.

77. Adviser 1 said that risk assessment documents were not completed properly. The opportunity of taking detailed history from Mr A's parents was not used. There was no evidence of discussion between staff from different disciplines at the hospital or between hospital and community staff.

78. Adviser 2 said that the decision that short term detention was appropriate should have led to consideration of Mr A's observation levels being increased. He noted that Doctor 1's retrospective summary indicated nursing staff had been informed of the decision to initiate the short term detention process. There was no documentation of this or of an appropriate observation level, but Adviser 2 said he would have expected staff to apply the holding power, where staff were aware of the decision to detain having been taken, but the process was not complete.

(a) Decision

79. Mr C's belief is that Mr A, his son, was failed by the Board at time when he was extremely vulnerable. He said that Mr A was not cared for appropriately and actions which could have ensured his safety were not taken.

80. The Board's position is that staff acted reasonably. Mr A was appropriately assessed and his suicide could not have been anticipated, nor was there a clear indication from Mr A's presentation on 20 June 2013 and 21 June 2013 that the risk he posed to himself or others was significant, or likely

to lead to imminent serious self-harm. The Board have noted they have already conducted an Internal Review and that the incident was reviewed externally for the Procurator Fiscal's Office.

81. The advice I have received is that Mr A's risk assessment was inadequate. There is no evidence of multi-disciplinary involvement in Mr A's assessment or discussion of the appropriate level of observation or short term detention. The advice also noted no evidence of discussion or adequate record of the risk factors at the time of Mr A's presentation, including his apparent suicide note.

82. The advice noted Mr A's history and immediate presentation contained clear factors indicative of an elevated risk of self-harm or suicide. The advice also noted Mr A's history of impulsivity both in regard to absconding or self-discharging from treatment and self-harm. The advice did not consider adequate weight was given to Mr A's evident risk factors.

83. Although Mr A's fluctuating behaviour would have been challenging to deal with his assessment is described as concerning, Mr A was allowed to leave the ward unescorted, despite having a 'nil time-out' designation until medically reviewed. This medical review did not take place and Mr A should not, therefore, have been allowed to do this. The Board stated following Mr A's death that he was not considered to present a risk, however the advice is clear that for the short term detention process to have been commenced, he must have been considered to pose a significant risk to himself or others.

84. Given that the decision to pursue an STDC was reasonable, the advice is clear that the decision to leave Mr A on general observations was unsupportable. Given his history of impulsivity and the reason for his admission, which was due to an impulsive suicidal act immediately previously, Mr A should have been considered a significant risk to himself. There is no evidence nursing staff were aware of the decision to detain Mr A. The advice I have received is that had Mr A not been on general observation and had nursing staff been involved in the discussions around his imminent detention, it would have been reasonable to expect them to exercise their holding power to ensure Mr A remained within the confines of the ward.

85. On the basis of the advice received I consider the care and treatment provided to Mr A fell below a reasonable standard. Although it is impossible to be certain whether Mr A would have succeeded in taking his own life at a later

date, the inescapable conclusion from the advice I have received is that if his treatment had met a reasonable standard, there is the possibility that he would not have been able to abscond from the ward and take his own life on 21 June 2013. I uphold this complaint and make the following recommendations. I note that Doctor 1 no longer works for the Board, but continues to be employed within NHS Scotland.

(a) Recommendations

86. I recommend that the Board:	*Completion date*
(i) review their admission procedures to ensure there is multi-disciplinary involvement in the risk assessment of emergency admissions;	20 January 2016
(ii) remind all staff of the importance of accurate contemporaneous record keeping;	13 January 2016
(iii) contact Doctor 1's current employer and ask them to ensure that this report is considered and reflected on in his next appraisal;	13 January 2016
(iv) review the risk assessment tools used by staff to ensure they include an adequate review of historical risk factors;	20 January 2016
(v) review the procedures followed during nursing handover to ensure that patients are adequately monitored during this period; and	20 January 2016
(vi) review the procedure followed for Short Term Detention Certificates, to ensure both multi-disciplinary involvement, including carers and named persons.	20 January 2016

(b) The Board failed to provide Mr A with appropriate medical care and treatment whilst in the community

87. Mr C said Mr A had been diagnosed in 2008 with paranoid schizophrenia and he set out a brief chronology of the impact this had had on Mr A. This included episodes of self-harm and self-medication with cannabis and alcohol. From February 2013, Mr C and his wife had taken over Mr A's personal finances, due to his regular inability to manage them properly and a spell during which Mr A was financially exploited by individuals within the community.

88. Mr C highlighted his frustrations with the care provided to Mr A. He noted a number of instances of crisis, when he felt the responses provided by the

CPN team had been inadequate. Mr C noted that Mr A's CPN did not attend the MHTS hearing on 14 March 2013. Following this, Mr C had asked to be written into Mr A's warning system. Mr C also listed a series of communication failings, where he felt the CPN team had continued to be unresponsive to requests for assistance from Mr A. Mr C said that in the twelve months prior to Mr A's death, he had been unable to speak to his CPN.

89. Mr C said his impression was that there was a lack of focussed, co-ordinated care in the community. This had adversely affected Mr A's quality of care and Mr C's ability along with his wife to support their son. Mr C said both he and his wife were elderly and suffered from variable health which affected their energy levels. Mr C said they were required to provide Mr A with a level of care which severely restricted their ability to spend quality time with him.

The Board's Response

90. The Board acknowledged that Mr C had not been informed when Mr A's CPN had gone on annual leave, but said this was not something that happened routinely. They could not identify evidence to support all the examples provided, however, and could not confirm these had taken place as described. The Board agreed, however, that at times of crisis the CPN should have been more pro-active in keeping Mr C informed of their actions and that they should have engaged more pro-actively with Mr C generally, given the level of involvement in Mr A's treatment.

91. I note the Board apologised for this at the time of their investigation into Mr C's complaint.

Mental Health Nursing Advice

92. Adviser 1 said he had considered the Community Careplan put in place following Mr A's discharge from Hospital 1 under a Community Compulsory Treatment Order (CCTO) on 14 March 2013. Adviser 1 noted this CCTO had been the source of some concern to the MHTS who directed explicit relapse management plans be put in place and a sound risk assessment be carried out.

Risk Assessment

93. On 15 March 2013, Adviser 1 considered a reasonable and robust risk assessment was carried out. The involvement of Mr A and Mr C in the process was evidenced. The assessment was also circulated to all the stakeholders in the health and social care team, Mr A and Mr C.

94. A traffic light system was put in place to ensure signs of relapse were timeously responded to when identified. The various warning signs were specifically related to Mr A's mental state and behaviour.

95. Other aspects of the care plan complied with the framework set out in the Care Programme Approach, a framework for people with severe mental disorder and complex health and social care needs. This included regular multi-disciplinary review and meaningful engagement with the care recipient and the appointment of a named individual to co-ordinate, monitor and oversee care plan delivery and progress.

96. Adviser 1 did note Mr C was not invited to attend Mr A's CPA meeting on 27 March 2013. He described the failure to invite him as unreasonable, given the level of involvement he had in Mr A's care. The meeting did clearly identify Mr A's needs and the individuals responsible for responding to them. On 29 April 2013 it was noted Mr A had been in touch with his GP complaining of breakthrough psychotic symptoms. Mr A and Mr C were invited to attend the CPA review on 13 May 2013 and Mr A's GP updated on the outcome of the meeting by letter. It was noted Mr A was engaging appropriately with staff from a charitable foundation and was compliant with his medication. He was requesting input to help with psychotic phenomena. It was also noted he continued to use cannabis, which appeared to be the source of his residual psychotic symptoms.

97. Adviser 1 said the home visit records showed Mr A was seen on the following dates: 22 March 2013, 27 March 2013, 5 April 2013, 19 April 2013, 22 April 2013 (an urgent unscheduled visit), 26 April 2013, 3 May 2013, 10 May 2013, 26 May 2013 and 7 June. This showed a pattern and frequency in keeping with the plan agreed at the CPA meeting.

98. Adviser 1 also considered the clinical records kept by the CPN and Hospital 2. He noted there was evidence that Mr A was troubled at times by voices and his self-organisation was clearly impaired. There was in his view, however, nothing to suggest his mental health had significantly deteriorated to the point of causing him substantial distress. The observations of the CPN and hospital staff were broadly consistent and there was no evidence that action was not taken in response to Mr A's position on the traffic light system in place.

99. The care plan for Hospital 2 was also, in Adviser 1's view reasonable. The monitoring of Mr A's medication was acceptable and the associated blood tests were properly recorded. Adviser 1 said the community care package was reasonable. It was effectively planned, co-ordinated and documented. There were no disquieting acts of omissions in relation to care planning or implementation.

The demands placed on Mr A's parents

100. Adviser 1 said there was a consensus that family involvement in care for relatives was important, and it was known family members often felt excluded or undervalued. He noted that family members often developed expertise and knowledge of the patient and there was a desire for them to be seen as part of the multi-disciplinary team. Adviser 1 said Mr A's parents clearly played a vital role in supporting him both practically and emotionally as he was dependent on them for a number of life skills. Adviser 1 said it was recognised that support of this type placed a significant burden on carers, especially when dealing with an individual like Mr A, whose mental state fluctuated significantly.

101. Adviser 1 said there was no evidence in the contemporaneous clinical records indicating Mr C was considered to be unduly burdened. There was, however, no indication that the pressures upon Mr A's family were explored by the health or social-care team. Due to their significant role in Mr A's care, Mr C and his wife would have been entitled to a carer's assessment. This would have explored how much choice they had in their provision of care, the impact on them, including their health, domestic needs and relationships. Adviser 1 said whilst the Care Programme Approach (CPA) process produced a reasonable package of care for Mr A, it was silent on the needs of his parents.

102. Adviser 1 said that the pressures of caring for Mr A did not appear to have been taken into account by the Health and Social Care team. A carer's assessment should have been offered. The Board and its partner agencies should, in Adviser 1's view become more proactive in assessing and addressing the emotional and practical needs of carers.

Psychiatric Advice

103. Adviser 2 noted the involvement of Mr C in the CPA process was appropriate. There were examples of inefficient communication, as noted by Adviser 1 and he felt it would have been appropriate for a carer's assessment to have been offered to Mr C and his wife.

(b) Decision

104. The Board believe the actions of the CPN team complied with their policies and procedures and that they responded appropriately when Mr A was suffering periods of crisis. They accepted the CPN team could have communicated with Mr C more pro-actively.

105. The advice I have received is that whilst there is no evidence that Mr C was placed under an unreasonable burden, there is no evidence that this was explored at any point. Mr C and his wife should have been provided with a carer's assessment, but one was not offered. As a result, although Mr A's needs were reasonably addressed, there is no evidence any consideration was given to the pressures placed upon Mr C and his wife and the negative impact this might have been having on them. I consider this to be unreasonable, Mr C and his wife provided an invaluable support to Mr A and made significant efforts which contributed to his ability to live in a community setting and participate in treatment. This should have been recognised by the Board and an appropriate level of support offered.

106. I uphold this complaint

(b) Recommendation

107. I recommend that the Board:	*Completion date*
(i) review their procedures for community care provision to ensure the needs of carers are pro-actively considered.	20 January 2016

Additional Recommendation

108. Although the Board have expressed their condolences to Mr C, this has been tempered by the fact that they have not accepted Mr A's risk was not properly assessed and that had it been, his death may have been preventable on 21 June 2013. I am, therefore, recommending the Board provide a further unqualified apology to Mr C and his family for the failings identified in this report.

109. I recommend that the Board:	*Completion date*
(i) apologise unreservedly to Mr C and his family.	13 January 2016

110. 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 C	the complainant
Mr A	Mr C's son
Hospital 1	Stratheden Hospital
The Board	Fife NHS Board
Adviser 1	a mental health nursing adviser
Adviser 2	a consultant psychiatrist
STDC	Short Term Detention Certificate
MHTS	Mental Health Tribunal Scotland
CTO	Compulsory Treatment Order
Hospital 2	Weston House Day Hospital
Doctor 1	a psychiatrist responsible for Mr A's care and assessment on his final admission to Hospital 1
MHO	Mental Mealth Officer
Doctor 2	a consultant psychiatrist responsible for overseeing Mr A's care
CPN	community psychiatric nurse
MWC	Mental Welfare Commission

CCTO	Community Compulsory Treatment Order
CPA	Care Programme Approach

Annex 2

Glossary of terms

auditory hallucination	the perception of sounds or voices, without any actual auditory stimulus
carer's assessment	assessment of the needs of the individual providing care for someone, this is a statutory right under the Community Care and Health (Scotland) Act 2002
Compulsory Treatment Order (CTO)	an order authorising the detention and treatment in hospital of a person, granted by a mental health tribunal
Haloperidol	an anti-psychotic medication
persecutory ideas	a delusional condition in which the affected person believes they are being persecuted, either
schizophrenia	a long term mental health condition, causing symptoms including hallucinations, delusions and changes in behaviour
Short Term Detention Certificate	certificate allowing the detention of an individual at short notice if they pose a risk of harm to themselves or others. Must be agreed by a Doctor an MHO

Annex 3

List of legislation and policies considered

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

The Scottish Executive Social Work Inspectorate. Implementing the Care programme Approach, Edinburgh, 1998

The Scottish Executive Health Department Clinical Resource and Audit Group. Engaging People: Observation of People with Acute Mental Health Problems. Edinburgh. 2001

Department of Health. Best Practice in Managing Risk (2007)

Risk Assessment Tools Evaluation Directory Version 2. The Risk Management Authority Scotland. (2007)

Community Care and Health (Scotland) Act 2002