mental welfare commission for scotland

Investigation into the death of Mrs F

Investigations

May 2024

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Investigation into the death of Mrs F

Notes

We acknowledge and appreciate the cooperation, engagement, and reflection of all the individuals, organisations and staff who assisted us with this investigation. The subjects of this report have been anonymised.

Content warning

This report contains some details that some readers may find distressing.

Contents

Executive summary

Mrs F was a middle-aged woman who worked in a school. She experienced a rapid decline in her mental health over a short period of time following unfounded beliefs that she had caused harm to a child by providing food that they were allergic to in the course of her employment. Mrs F subsequently attempted suicide by self-poisoning and the use of a ligature. When these attempts were unsuccessful, she concealed her actions for several days. Mrs F had become overwhelmed by her distressing thoughts.

Mrs F appears not to have recognised that she was unwell and rather than seeking support from health services she wanted to go to the police to report her actions.

Mrs F's husband thought that she was unwell and supported her to go to the local emergency department (ED). Mr F was involved in the assessment at the emergency department (ED). The outcome of that assessment was that Mrs F was viewed to be at risk due to her presentation and suicidal actions and an urgent referral to the mental health assessment unit (MHAU) was made for further assessment.

Mr F drove Mrs F directly to the MHAU. He was not involved in the assessment at the MHAU, which meant that the assessment did not consider all available information.

The assessment was further limited by issues with information sharing and documentation in the MHAU that were not considered in the significant adverse event review (SAER) process undertaken by the health board following this tragic incident[1].

Mrs F was discharged from the MHAU with no further mental health appointments planned. Mr F was not involved in the discharge process. This was a missed opportunity to engage with family, share information and create a meaningful safety plan. MHAU staff reported that they felt unable to involve Mr F as when asked, Mrs F had not given consent to share her information with her husband.

Mrs F died by suicide two days after discharge from the MHAU.

Key findings

The Commission found that the level of Mrs F's distress and the description of some of her thoughts were in keeping with a mental illness.

Involvement of families and carers

There were missed opportunities to involve Mr F at the time of the MHAU assessment and when discharge and safety planning occurred. Involving families and carers should be the expectation. The Carers (Scotland) Act 2016 places a duty on health boards to involve carers. Carers have the right to be informed about discharge planning. It is essential for professionals to share information about discharge arrangements if the individual is to be discharged to or is supported by that carer in the community. The NHS charter of patient rights and

[1] Every adverse event report is an opportunity to learn and prevent or minimise harm occurring again in the future. Preventing, or minimising the chance of recurrence is dependent on a quality review of the situation. NHS Scotland owes patients or staff who have been directly affected by healthcare adverse events the assurance that the reviews of such cases are completed and that the learning will be used for prevention. Adverse event management | Turas | Learn (nhs.scot) (accessed 18 Feb 2024)

responsibilities mentions that staff making decisions about a person's care may consider the views of those close to the patient.[2]

Knowledge of confidentiality in clinical practice

Listening to the concerns of families and carers is a vital part of mental health and risk assessment and management processes. It does not require staff to break a person's confidentiality.

Our report shows that there is a training and development need for mental health staff with regards to their obligations to patients, families, and carers.

Information sharing in the MHAU

Issues with information sharing between departments were identified in the SAER process and appropriate actions taken. We found additional issues with when and how referral information was documented and shared in the MHAU that were not considered in the SAER process. This further impacted on the assessment undertaken in the MHAU and raises questions regarding the effectiveness of NHS A's (we refer to the health board, with associated health and social care partnerships, as NHS A in this report) supervision, training, and governance processes.

Mental health and risk assessment documentation and processes

The brief assessment tool and clinical risk screening and management documentation which recorded the assessment in the MHAU had incomplete sections. This was not considered in the SAER process. Supervision and clinical governance processes (including audit) should be in place to ensure that the MHAU staff are working as intended. Further work is required to ensure that the assessment tools are fit for the purpose they are designed for, including the recognition and recording of complex presentations; and how self-harm/suicidal thoughts are related to any possible mental illness.

Conclusion and recommendations

Our expectation is that families and carers should be involved wherever possible in mental health assessment and treatment processes.

Whilst it is right that consent should be sought from patients to *share* their information with others, including family members, this should not act as an impediment to *listening* to the concerns of carers and family members; and where possible involving them in care planning and safety planning.

Issues relating to information sharing between departments and in the MHAU also impacted on the MHAU staff having all the available information at the right time.

The MHAU assessment and risk management document/tools had several incomplete sections. This raises a question as to whether the MHAU documentation is usually completed as identified in the relevant service operating procedure and if not, why not and what audit processes are in place to monitor completion.

[2] The Charter of Patient Rights and Responsibilities My health, my rights, my NHS - Charter of patient rights and responsibilities - revised: June 2022 - gov.scot (www.gov.scot) (accessed 18 February 2024)

There is also evidence that clinical risk screening and management training had not been completed as detailed in the service operating procedure by all staff members at the time of Mrs F's assessment. There was uncertainty from staff regarding what was expected of them in practice. This raises additional considerations with regards the supervision training, and governance around this for MHAU staff.

Recommendations to NHS A

(To be addressed within six months)

1. **Embed guidance on confidentiality and carers into relevant operating procedures**

   NHS A must ensure that mental health staff have a clear understanding about their responsibility to listen to and involve families and carers. This guidance should be embedded in their service operating procedures and supported by supervision and training.

   Mental health staff should receive training in confidentiality, in keeping with legal duties and guiding principles. Training should include consideration about how and when it may be appropriate to meet with families where there is no or only partial consent.

2. **Review assessment and clinical risk screening and management documentation and processes**

   NHS A must review their assessment and clinical risk screening and management processes to ensure that they are in keeping with current and expected practice.

3. **Review mental health assessment unit service operating procedures and the assurance of these**

   NHS A must review their service operating procedures for the MHAU to ensure that it reflects current and expected practice. Particular attention should be paid to the supervision, training, and governance processes (including audit processes) in the MHAU to ensure that MHAU staff have the support, supervision and training to undertake their clinical duties.

Introduction

This investigation into the care and treatment of Mrs F was conducted under Section 11 of the Mental Health (Care and Treatment)(Scotland) Act 2003 by the Mental Welfare Commission for Scotland (the Commission). Section 11 gives the Commission the authority to carry out investigations and make recommendations to improve services across Scotland, as it considers appropriate in any circumstances, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

The Commission was first contacted by Mrs F's husband in June 2021. He told us what had happened to his wife and asked if we could help so that others would not have to go through what he and his family had experienced.

Mrs F first had contact with mental health services in April 2021 after her husband took her to the emergency department (ED) as he was concerned about her mental health. Mr F had woken that morning to find his wife sitting in their living room fully dressed, with a note in her hand, saying that she needed to go to the police station to report that she had harmed a child, in the course of her employment. Mrs F was worried that the child's parents and hit men were coming to harm her and her family and that they would lose their home to pay for legal fees.

In the emergency department Mrs F told clinicians that she had taken an overdose earlier that week and had then gone to bed. When she awoke later in the night, she was disappointed the overdose had not worked. Mrs F then attempted to use a ligature with the intent to end her life but could not complete this action and returned to bed. Mrs F had not told Mr F or anyone else about her self-harm before she was seen in the emergency department.

Mrs F was physically examined whilst in the ED and this confirmed that she did not require medical treatment for her recent overdose. Mrs F was then referred to the local mental health assessment unit; (please see box in the analysis section for more information about MHAUs page 12) and travelled there with her husband for a mental health assessment. Following this assessment Mrs F was given advice on how to contact services in an emergency and discharged to the care of her general practitioner.

Mrs F died from suicide two days later. NHS A subsequently conducted a significant adverse event review (SAER). As part of this process, a meeting took place between Mrs F's family and the SAER investigation team in August 2021. The SAER highlighted the following key areas:

- Mrs F was initially triaged[3] in the emergency department as being at 'high risk' due to her mental health and following a more in-depth assessment, was considered 'moderate risk'.
- The ED Consultant was concerned about the risk of ongoing suicidal ideation and paranoid thinking, however, after review in the mental health assessment unit, Mrs F was discharged without planned follow-up.

[3] Triage refers to conducting a preliminary assessment of patients in order to determine the urgency of their need for treatment and the nature of treatment required:

- When Mrs F was assessed in the MHAU, the electronic patient record had not been updated to include the information relating to her assessment in the ED. Only the initial triage information was therefore available to the MHAU staff.
- In addition, Mrs F had written a note detailing her overdose. This included information relating to the tablets that she took and some of her paranoid thinking. This note was given to staff at the ED but was not reviewed by the MHAU team as part of their assessment of Mrs F.
- The patient recording systems in NHS A did not allow an accurate timeline to be established regarding Mrs F's care and treatment after she left the ED and there were discrepancies between the information that was available from paper records, electronic records and the information that was provided to staff by Mr F.
- Mr F was included in the ED assessment and care planning process with Mrs F's agreement. Mr F reported that he was not given the opportunity to contribute in the MHAU, was told that his wife would tell him what had happened, and he reported that he felt rushed from the MHAU department.

There was a further meeting between Mrs F's family and senior managers in July 2022.

The Mental Welfare Commission decided to progress to investigation on 16 August 2022 having reviewed a draft version of NHS A's SAER report which we received from the family. The final SAER report and action plan were received on 23 August 2023.

Investigation terms of reference

The terms of reference for this investigation were:

1. **Engagement with services.**
   - The nature and delivery of support given to Mrs F from her first contact with services in the ED to her referral and subsequent assessment at the MHAU prior to her death.
   - The extent to which Mrs F may have accessed any community mental health support, including via her GP practice in the 24 months prior to her death.
   - The support and communication from NHS A towards and experienced by Mrs F's family prior to and following her death.

2. **Service delivery & practice**
   - The quality, substance and nature of the assessments which took place within the ED and the MHAU and the onward planning arrangements, including liaison with Mrs F and her family after each assessment.
   - All relevant NHS A policies and procedures in place at the time of Mrs F's death and all subsequent iterations of the same.

3. **To publish a report and identify learning**
   - The Commission will, as appropriate, identify, highlight and disseminate any learning for NHS A and mental health services across Scotland.

The purpose of this learning report is to:

- Examine the care, treatment and support that Mrs F received from services prior to her death.
- To identify any relevant learning for the service and wider learning for NHS Scotland and highlight and disseminate any points for learning for the health board involved, and wider mental health services across Scotland.
- And to make any recommendations as appropriate to the relevant bodies.

Investigation process

The investigation team had access to primary care (i.e., general practice held) health records from summer 2019 until the incident, and secondary care health records for the week during which the incident occurred.

The SAER report completed following Mrs F's death and the associated action plan were reviewed and we had sight of NHS A's response to the formal complaint which the family had submitted.

The following policy documents and guidance were consulted:

Local NHS A Documentation, Policies and Procedures:

- Adult Mental Health Initial Shared Assessment (IAT). Principles and Guidelines for Completion
- Crisis Service Operational Policy (Version dated 8 August 2016)
- Electronic records audit
- Mental Health Service Clinical Risk Screening & Management Policy Version 7
- Policy & Procedure Duty of Candour Compliance Process Version 2
- Provision of Mental health assessment units Standard Operating Procedure v.8
- Psychiatric Emergency Plan version dated 2019-20
- Treating Nurse Access to electronic records audit

NHS Scotland Guidance:

- Scottish Government Duty of Candour Guidance

UK Professional Bodies and other guidance:

- Nursing & Midwifery Council (NMC) Code of Practice

Having considered these records, the investigation team then conducted interviews with key individuals who were part of the process during the period identified:

- Mr F – Mrs F's husband
- Miss F - Mrs F's daughter
- Relative A
- Relative B

- Consultant C - emergency department consultant
- Staff Nurse D, mental health assessment unit
- Staff Nurse E, mental health assessment unit
- HCSW - healthcare support worker, mental health assessment unit
- Manager F, service manager for specialist services
- Manager G, head of adult services

The Commission's investigation team comprised of:

- Senior manager, nurse (Team A)
- Senior manager, nurse (Team B)
- Commission consultant psychiatrist (Team A)
- Medical director (executive lead)

Background and findings

Mrs F was in her 50s at the time of her death. She lived with her husband. They had been together for 40 years. They had an adult daughter together (Miss F), and Mrs F had one surviving sibling. We heard from relative A and B that the family were close. Mrs F worked part-time in catering and was reported to generally enjoy her job.

The investigation found that Mrs F had not had any prior contact with mental health services before this episode and had one GP involvement many years previously during a period of grief, following the death of a close family member.

In early April, whilst on annual leave from her work, Mrs F took an overdose of medication without telling anyone and then went to bed. When she awoke later in the night, she tried to apply a ligature with the intent of ending her life but could not complete this action and returned to bed, again without telling anyone.

Three days later, Mrs F was up and dressed when her husband awoke, which was unusual behaviour for her. Mrs F told Mr F that she was worried that she had mixed up food bags for the children at her work and believed that she had harmed one of the children who had food allergies. Mrs F had written a scribbled note with her name, address, date of birth and the name of her GP. It also had a list of her physical symptoms ("shaking, pains in stomach, head"), the details of tablets that she had taken three days previously and a few lines of text. It said, "stressed out over a matter", "just take the note, do not say anything to husband", "nothing to do with husband" and "he knows nothing".

Mrs F asked her husband to take her to the police station. She did not tell him about her self-harm. Mr F was worried about his wife's mental health and rather than taking her to the police station he decided to take her to the local emergency department (ED). Mr F took the note with them, although did not open the envelope so was not aware of its content. Mr F had not had any concerns about Mrs F's mental health before then. Mr F stated that Mrs F did not react adversely to being taken to the emergency department rather than the police station. Mr F said that Mrs F did not appear to realise they had instead travelled to the hospital until they

entered the building. Mrs F was taken straight into the ED on arrival. Due to Covid-19 restrictions Mrs F was taken into the department alone and her husband waited in the reception area. Mrs F was triaged (triage is a process to assess how unwell a person is to determine next steps in care) by a member of nursing staff and found to be highly distressed and expressing suicidal thoughts. The triage nursing assessment concluded that Mrs F was at 'high risk', due to her recent actions and active suicidal thoughts.

Mrs F was then seen by Consultant C. Mrs F reported some physical symptoms including abdominal discomfort that may have related to her overdose. Mrs F told Consultant C about the overdose and ligature use. Mrs F spoke at length about her concerns that she had given a child at school the wrong food and her belief that the child had come to harm due to an allergic reaction. Mrs F could not give any objective evidence regarding this, nor could she be reassured that it was unlikely anyone had come to harm. She presented with poor eye contact during her time in the ED and was described as agitated and withdrawn. Consultant C was concerned about the level of agitation and what she believed to be ongoing suicidal thoughts and intent. Consultant C considered Mrs F to be at 'moderate' risk.

Approximately 40 minutes after arrival at the emergency department Mr F was asked to come into the department by one of the nursing staff. Mr F handed the note that Mrs F had written to them. He had not read the note.

Whilst Mrs F was in the ED, physical investigations were completed including physical examination, physical observations, blood tests and an electrocardiogram (ECG)[4]. These were all within normal ranges; there was no evidence of any harm caused by the recent overdose.

Consultant C spoke to Mr and Mrs F together. Mrs F had no concerns about Mr F being involved in her care and treatment. Consultant C said that she had concerns about Mrs F's mental health. Mr F agreed with this because of her unusual behaviour and the beliefs she held about having harmed a child. The need for a mental health assessment was also discussed and agreed. Due to the expected wait for an ambulance to take Mrs F to the MHAU, which was on another site, Mrs F agreed with Mr F driving her there. Mr F reported to the investigation team that he was fully prepared for his wife to be admitted to a psychiatric ward.

Consultant C made a telephone referral to the local MHAU to request an urgent mental health assessment. The call was taken by a staff nurse at the MHAU. Consultant C informed the staff nurse that Mrs F had presented following an overdose and that she was concerned about ongoing suicidal thinking, and Mrs F's overwhelming worries and distress. The staff nurse asked if Mrs F could go home, instead of attending the MHAU, but accepted that she could not, due to Consultant C's concerns about Mrs F's presentation.

Mr and Mrs F left the emergency department together and drove to the MHAU. The MHAU was reported to have been quiet that morning and Mrs F was seen quickly after her arrival by two staff nurses (Staff Nurse D and Staff Nurse E). Staff Nurse D had taken the initial referral call from Consultant C.

Staff Nurse D and Staff Nurse E reported that Mrs F engaged with them, and they did not have concerns that she was experiencing psychotic symptoms or at risk of further harm to herself.

[4] An ECG is a test that records the electrical activity of the heart, which includes it's rate and rhythm.

Mrs F reported to them that she had started to become anxious about mixing up food bags when she was at work around a week before she took an overdose. She had been worried about this since then and it had affected her sleep. She reported having taken an impulsive overdose at home. She said that she just wanted to end things. She narrated the incident with the ligature to the nursing staff. When Staff Nurse E asked Mrs F if she wanted to die, she said no. When asked why she had not spoken about her overdose sooner, Mrs F advised that she had felt ashamed of her actions.

As Staff Nurse D and Staff Nurse E did not see the ED documentation prior to seeing Mrs F, they did not see the note that Mrs F had written. Whilst the note had remained in the ED a scanned copy of it was appended to the ED documentation when it was uploaded on to the electronic system. When Staff Nurse D and Staff Nurse E asked Mrs F about the note that had been provided to ED, she said that it was a letter about which tablets she had taken, written after the overdose, and denied that this was a suicide note.

Staff Nurse D and Staff Nurse E spoke to Mrs F about her concerns about the food bags being mixed up at her work and felt that Mrs F was reassured that it was unlikely that any harm had come to the children.

Mrs F was described as calm and appropriate throughout the MHAU assessment. She reportedly did not present as agitated or distressed. During our investigation we were told that Mrs F was: "facially bright, engaging, pleasant and jovial throughout". However, the clinical records from the MHAU assessment state that Mrs F's "mood appeared low, blunted affect[5]" and that rapport was "established with some prompting". Mrs F denied ongoing thoughts of suicide. She talked about her daughter who was considered by the assessing nurses to be an important protective factor.

Staff Nurse D and Staff Nurse E spoke to Mrs F about relaxation techniques and safety planning. Mrs F was given an emergency pocket information card (EPIC) which details emergency contact details and Mrs F said she would use this if needed. Mrs F told the nursing staff that she had plans to return to work in a few days. She agreed to attend her GP should her symptoms worsen.

Staff Nurse D and Staff Nurse E reported that Mrs F had made it clear that she did not want her husband to be involved in the assessment or discharge planning process. They said that they felt Mrs F had the capacity to make this decision and they did not have clear reasons to breach her confidentiality. When Staff Nurse D offered to speak to Mr F on her behalf Mrs F replied that she would rather tell him herself in the car.

Mr F noted that the time that Mrs F spent in the MHAU was short and that he had not had time to complete the paperwork (this was administrative paperwork with regards patient general demographic details etc.,) in that time. He does not recall seeing any information or card that was given to Mrs F.

When staff escorted Mrs F out of the unit, they said to Mr F that Mrs F would tell him what had happened in the car. He did not feel that he had the opportunity to ask what happened or what

[5] 'Blunted Affect' refers to a lack of emotional sensitivity (Symptoms in the Mind, Sims, Third Edition (2003), p 306

the follow-up plans were. He was not asked for his views, and he reports when he asked to speak to the nurses this was refused. Mr F stated that he felt rushed out of the unit.

Mr F reported that Mrs F did not speak to him in the car and so he had no idea what was discussed during the assessment. When they arrived home Mrs F went to bed to sleep for a few hours. When she got up, she told him that she did not want to talk about what had happened. They ordered take away food and watched television.

The next day, Mrs F spoke to her daughter for a long time on the telephone as normal. Mrs F had been out in the garden with her husband, which she did not frequently do, was making plans to visit her daughter and undertake changes in the garden and had made her husband his favourite dinner. Mrs F did not tell her daughter anything about the events of the day before and her daughter had no indication that anything was wrong. In retrospect, Miss F felt that her mum had made a real effort to make this a perfect last day.

The following day, Mr F went to work at 6am as usual. Mrs F was still in bed as she had another week off before returning to work. Mr F phoned her at 9am and she spoke about plans for a hair appointment later in the day. When Mr F got home at 1:45pm he found letters lying everywhere in their bedroom. He noticed a kitchen knife was missing and he called the police to report Mrs F missing. Mr F also called Mrs F's brother to tell him what had happened over the weekend and that Mrs F was missing. When Mr F went into the bathroom, he discovered Mrs F's body. Mrs F died from self-inflicted knife wounds.

Communication

Communication between the emergency department and mental health assessment unit

Mental health assessment units

Mental health assessment units (MHAUs) have functioned in Scotland for a number of years. They were rolled out more widely across Scotland at the outbreak of the Covid-19 pandemic to minimise attendance of mental health patients in emergency departments whilst ensuring people in a mental health crisis were able to access the help they needed without unnecessary delay. Prior to the setting up of MHAU services mental health assessments would have been carried out in the EDs when required. Scottish Government intimated to health boards in 2020 its expectations for the assessment of unscheduled mental health presentations. The following criteria were put forward:

1. Provide the assessment of unscheduled mental health needs for anyone presenting in mental health crisis/distress.
2. Only require referrals via the emergency department (ED) where physical medical attention is required first or where people present in the emergency department under self-referral.
3. Provide assessment separate to the emergency department.
4. Be staffed by mental health professionals.

As these departments were deemed more appropriate settings for mental health assessments many units set up during this time have remained in place post Covid-19.

Referrals to the MHAU are by telephone. The standard operating procedure for NHS A's MHAU requires that all patients referred to the MHAU by the ED must have a completed Mental Health Triage and Risk Assessment Tool (MHTRAT) which should be scanned and emailed to the nurse in charge of the MHAU unit prior to the person attending there. We were informed during our investigation that referral calls are usually taken by a healthcare support worker who records initial details. The referral is then passed to one of the registered nurses to contact the referrer for more information to establish if the referral will be accepted by the MHAU or whether alternative arrangements such as referral to the person's GP might be more suitable.

On this occasion, one of the staff nurses on duty (Staff Nurse D) took the initial call, rather than the healthcare support worker. We note from our interview with Consultant C, and from the SAER, that Consultant C felt frustrated by the call and that she had to justify the need for referral to the MHAU. She also felt that a less experienced doctor may have had the referral refused by the receiving nurse. It was Consultant C's opinion that Mrs F's presentation met criteria for a specialist mental health assessment due to the ongoing concerns about her suicidal thoughts.

We reviewed the documentation from the ED and found that it had been completed as expected.

From the SAER documentation and from our interviews with NHS A staff, we know that the ED assessment documentation was not uploaded to the electronic record system until later on the day of Mrs F's presentation, by which time Mrs F was at home.

The SAER identified that the delay in uploading the ED clinical notes on to the electronic record system meant that MHAU clinicians only had the verbal referral information at the time of their assessment. They did not have the written documentation from the ED which included the note that Mrs F had written. Staff Nurses D and E told us that they did not contact the ED to request their documentation before they saw Mrs F or check the electronic record system afterwards to see if the information had been uploaded. Neither staff nurse saw that Consultant C had documented that Mrs F may be presenting with 'paranoia[6]'. It was however, stated in the SAER that Staff Nurse E did check later to see what tablets Mrs F had taken as an overdose.

Staff Nurse E reported that prior to assessing Mrs F the only information available was the verbal handover from Staff Nurse D and that they did not fully appreciate the level of concern raised in the ED assessment about Mrs F's suicidal actions.

The SAER also highlights that prior to the establishment of MHAUs, the mental health assessment would have been carried out by mental health staff in the ED which may have allowed face-to-face discussion between the ED and MHAU staff before and after Mrs F's assessment. The SAER recommended that MHAU staff do not carry out assessments until all documentation from the referring site has been uploaded, to ensure all risk assessment information is accessible to assessing staff.

The action plan from the SAER clearly states that assessments should not be finalised until staff are sure all relevant information has been gathered. It also highlighted the difficulties resulting from the MHAU moving to a different site in NHS A. The SAER recommended that referrers are asked whether they want feedback following the MHAU assessment and that the outcome of this discussion is recorded on the referral form with the intention that this feedback loop would "improve communication between cross site partners, allow the creation of a safe discharge plan and provide a safety net for decisions to be challenged where appropriate".

The delays in uploading the ED documentation and in completing the telephone triage form (discussed in the next section of the report) meant that Mrs F's mental health assessment took place without all the information being available.

The separation of the ED and MHAU may also have impacted on the communication between the two services as they are no longer on one site and able to discuss as freely and quickly any queries that may have arisen during the referral and assessment process.

Communication at the mental health assessment unit

Staff Nurse D took the initial telephone referral from Consultant C. The MHAU was quiet that morning and Staff Nurse D happened to be at the front desk, so answered the call. Usually, it would be the healthcare support worker who would answer the phone.

[6] Paranoia: 'Thinking and feeling like you are being threatened, even if there is no evidence or very little evidence that you are' (Mind website, accessed 5 January 2024)

NHS A's MHAU standard operating procedure states that all MHAU staff will complete a telephone referral form to gather information and risk assess the situation prior to patients attending the MHAU. We found that the telephone referral form was not completed as expected at the time of the referral and instead completed with the assessment paperwork after Mrs F left the department by a different member of staff.

We heard from Service Manager F and Service Manager G that there is an expectation that all staff will record notes on patients' files timeously. Service Manager F said the expectation is that the form completed for a telephone referral to the MHAU should be completed at the time of the call by the person who takes the call. Staff Nurse D told us she was unaware of guidance as to when such documentation should be completed.

That the telephone referral form was not completed at the time by the nurse who took the referral and that it was completed later by a different nurse was not identified in the SAER process.

Whilst some flexibility will often be required in busy departments there is a possibility that a change from the usual practice of the health care support worker taking the initial telephone referral contributed to the triage form not being completed at the time of the call as normal.

This change may have inadvertently removed a layer of safety that results from two clinicians being able to review the information from the initial assessment in the ED prior to undertaking their own review. It also raises an issue relating to MHAU staff knowledge and understanding of service operating processes that we will return to later in this report.

Communication with family

In the emergency department

The SAER states that Mrs F had voiced to both sites (ED and MHAU) that she did not wish her husband to be part of the assessment process.

Consultant C told us that Mrs F agreed and gave consent for Mr F to be involved. Consultant C did not withhold any information from Mr F. She felt that there was no notion of secrecy between Mr and Mrs F.

Mr F described the communication in the ED as positive. Whilst there, he spoke with nursing and medical staff. He was able to give them some background history and discuss his concerns about his wife. Mr F reported that he felt included, informed, and listened to. When he left the department with his wife, he was clear on the assessment outcome and onward plan.

In the mental health assessment unit

Staff Nurse D and Staff Nurse E were clear when we spoke to them that Mrs F did not want her husband to be involved at the MHAU. This meant that Mr F was not included in the mental health and risk assessments. He did not have the same opportunity to share his concerns as he had in the ED and this, in conjunction with the issues relating to information sharing between the departments, meant that the opportunity to obtain important information about Mrs F was missed.

The local clinical risk screening and management policy states that "all members of the multi-disciplinary team involved in the service user's care need to contribute and the involvement of the service user and carer or family should be actively sought, where possible" and requires the active involvement of service users and carers/ family in risk management planning whenever possible and appropriate.

We reviewed the information recorded in the MHAU assessment tool and found that the section regarding "carers/ next of kin/ others' views, concerns and expectations from services" was not completed.

The SAER concluded that the communication between MHAU staff and Mrs F's family was a concern stating, "the family did not feel there was an opportunity to raise concerns, share their views on the patient's presentation and/or receive feedback on the discharge plan".

Staff Nurses D and E felt that they were unable to speak with Mr F, as they did not have the explicit consent of Mrs F. Furthermore, there was specific information relating to her use of a ligature that Mrs F said that she did not want Mr F to be told.

During our interviews with the MHAU staff, one of the staff nurses reflected on the information that might have become available to them had they spoken to Mr F, noting that "they would have gotten a totally different picture", about the "kind of delusional things" Mrs F had been saying to him. They went on to say this would have "changed obviously (sic) the outcome".

We acknowledge the openness of this reflection.

There is a need for greater understanding about how meeting with families and carers to listen to their concerns differs from sharing information without consent and breaching confidentiality. Clinicians can, and should, meet with families and carers, wherever possible, to ensure that they have all available information to support their assessment and treatment. The involvement of families and carers is especially important when individuals are being discharged home to ensure robust safety planning.

We acknowledge that decisions about breaching a patient's wish to involve relevant others, even where an assurance is provided that confidential information will not be disclosed, can be complicated. The personal experience and unique knowledge of a carer can be invaluable to professionals. Working together and including carers in the treatment plan can help achieve better outcomes for the individual. Our good practice guidance *Carers and Confidentiality* is available here.

The SAER recommended that "there must be clear communication given to the family or made available to the family of patients in (MHAU) regarding confidentiality. This may include a poster or a leaflet which highlights that families and carers can share their concerns to staff and we are always there to listen".

We were informed by the senior managers that posters have since been placed in the MHAUs informing families to contact staff to inform them of the concerns that they may have whilst acknowledging that due to confidentiality issues staff are not always able to feed back. Leaflets have been developed to give to carers to inform them of their ability to discuss their concerns with staff.

Whilst we agree with the SAER recommendation and note the action, we feel that this information must also be shared with mental health staff so that they can fully understand their responsibilities to engage with families and carers when undertaking mental health assessment and in planning treatment and follow-up.

Recommendations to NHS A

NHS A must ensure that mental health staff have a clear understanding about their responsibility to listen to and involve families and carers. This guidance should be embedded in their service operating procedures and supported by supervision and training.

Mental health staff should receive training in confidentiality, in keeping with legal duties and guiding principles. Training should include consideration about how and when it may be appropriate to meet with families where there is no or only partial consent.

Mental health and risk assessment

Assessment at the emergency department

Mrs F was seen quickly on arrival at the emergency department. Mr F was not able to go into the department with Mrs F due to Covid-19 restrictions. Because of this, the emergency department had put in place a system whereby mental health patients, who may be at risk if alone, were treated in cubicles where department staff could easily see them.

The initial triage was undertaken by a nurse and the corresponding section of the department's mental health triage and risk assessment tool was completed. This includes a range of questions about the person's initial presentation, appearance, and behaviour and those felt to be relevant to Mrs F were 'is the patient obviously distressed, markedly anxious or highly aroused' and 'is the patient currently expressing suicidal ideation?'. Mrs F was considered high risk following this triage. Mrs F was then reviewed by Consultant C who undertook the initial mental health assessment in the ED and completed the corresponding section on the assessment tool. Consultant C recorded that Mrs F's mood was low and that she "did not want to be here anymore." Consultant C considered Mrs F to be at moderate risk. In the section relating to risk factors, ongoing suicidal thoughts and intent and family concern about risk were recorded. That Mrs F had concealed her overdose was not selected in the additional risk factors section of the form. Consultant C made a note in the section relating to Mrs F's thoughts about a "possible paranoia".

Consultant C then, with Mrs F's agreement, invited Mr F into the department. They discussed their concerns about Mrs F's presentation and reached agreement that further psychiatric assessment was required.

It is evident that consideration had been given to Mrs F's presentation including relevant risk factors and that the mental health triage and risk assessment tools were completed.

Mr F was involved in the assessment process, and this ensured that the information and concerns that he had as a key person in Mrs F's life were included within the assessment and subsequent risk management process. This is good practice.

Assessment at the mental health assessment unit

The standard operating procedure for the service says that "the service aims to provide patients with a full psychiatric evaluation including mental health risk assessment with appropriate treatment and follow-up arrangements".

The MHAU has specific tools that are to be completed at the time of a crisis presentation. The assessment tool records the psychiatric assessment and mental state of the person being seen and forms the basis of the letter to the person's GP. There is a separate risk screening and management tool to identify any potential harm to the person, staff or to the public. A summary of this is included in the final documentation to the GP.

Mental health assessment

The process of assessment begins with the telephone referral. Information about the person's presentation and the reason for referral is gathered and summarised in the telephone referral form setting the scene for the subsequent mental health assessment. We know that this form was not completed by MHAU staff until after Mrs F's assessment.

We know that Mrs F's assessment in the MHAU was limited from the outset as the MHAU did not have the information from the ED, which included the note that she had written.

We reviewed the assessment documentation that was completed after Mrs F was seen in the MHAU. In that Mrs F is described as having new anxiety symptoms, low mood, and blunted affect. Additional 'biological' symptoms including reduced appetite and a change in her sleep pattern were also noted.

It is documented in the assessment that Mrs F described catastrophic thinking about having harmed a child with "no evidence to support these thoughts". Mrs F also said she was "worried about what people at work think about her".

Whilst the combination of symptoms described are suggestive of an episode of mental illness, a record of the possibility of a mental illness is not documented in the assessment tool and the relevant sections for primary and other diagnoses are incomplete.

An additional section about Mrs F's functioning before the current difficulties was also incomplete.

Consultant C had documented that Mrs F was presenting with a possible paranoia, but the MHAU staff nurses did not see this information which may have prompted them to explore Mrs F's mental state in more detail.

Mr F was not given the opportunity to talk to the staff nurses about his concerns regarding his wife's presentation and was therefore unable to share highly relevant information about his concerns for her mental health, her significant and unfounded worries about her work and her beliefs that she and her family would come to harm that could have been considered during Mrs F's assessment.

The SAER process noted that "the mental health risk assessment was completed and uploaded that day and GP electronic letter sent" but did not comment on the incomplete sections of the form noted here and earlier in the report. We will return to this issue later in our report.

We agree with the SAER findings that Mrs F's assessment was limited by lack of availability of information from ED.

If information from the ED and from Mr F had been sought and considered during the assessment process, then the possibility of a major mental illness contributing to Mrs F's self-harm could have been explored and the increased risk to Mrs F resulting from any mental illness considered in the subsequent management planning.

Recommendation to NHS A

NHS A must review their assessment and clinical risk screening and management processes to ensure that they are in keeping with current and expected practice.

Risk assessment

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCSIH)[7] reports that risk is often individual and suggests an approach to risk management that is personal and individualised. The guidelines suggest the focus of risk assessment should be on the person's needs and how to support their immediate and long-term psychological and physical safety.

The local risk assessment and management policy states "clinical risk assessment can be defined as a part of clinical care in which the link between the presence of certain risk factors, aspects of a service user's behaviour and adverse outcomes are explicitly identified and acknowledged by clinicians. Clinical risk management is a process in which clinicians, service users and carers work towards a realistic, shared view of risk and then decide together how best to manage it".

We reviewed the clinical risk screening and management documentation with regards to the information gathered in the MHAU.

We found that the section relating to medication was not completed and it is a concern that this information was not considered at the time of the assessment. It is important to explore whether someone who has self-harmed has access to medications (and/or other means) that could be used to self-harm with again. Any medication that Mrs F is prescribed, in addition to other medications she may have at home, are important details and these should have been discussed and documented at the time of the assessment.

The MHAU assessment identified a number of protective factors which included Mrs F's disclosure of her self-harm, her relationships with her husband and her daughter, her enjoyment of her work and her agreement to make contact with mental health services or her GP if she had further worries, low mood or increasing anxiety.

Mrs F had acted on her thoughts when they overwhelmed her. Mrs F had not been able to prevent herself from acting on these thoughts in the preceding days. Her regret that her overdose was unsuccessful, her use of a ligature thereafter and her ability to conceal these actions from her husband at the time and for a few days after, when considered with the shame that she reported, suggests that she had great difficulty speaking about her suicidal thoughts and this limited her ability to ensure her health and well-being. This also limited her ability to seek help from others.

Whilst it is important to consider positive and protective factors, we did not find that the same weight was given to some of the conflicting information that was documented that may have led to a more balanced view of the risk to Mrs F after she left the MHAU.

[7] Personalised risk management from NCISH NCISH | The University of Manchester (accessed 26 April 2024)

Risk management and follow-up

The MHAU staff nurses told us that they provided Mrs F with crisis contact information before she left the department. She was given a crisis card and emergency contact numbers which she told them she would use. She also told them that she would tell her husband what they had talked about and what they had agreed. Mr F was not given any safety card or emergency contact information by the MHAU staff. Mrs F did not tell her husband what was agreed at the MHAU as she said she would.

Mr F told us that he would have brought Mrs F back for a review if he had been asked. He said that Mrs F could have had a visit the next day at home or been told to go to see her GP. Mr F spoke of his guilt about going to work on the day that his wife died. He said that no one had told him that his wife might harm herself again and that if he had been told this he would never have left her.

Mrs F was due to return to work in a week's time. Her enjoyment of her job was considered at the MHAU assessment to be a protective factor, however the significant distress Mrs F reported relating to her work was a key factor in her self-harm. Mrs F's return to work should have been considered as a significant stressor and risk factor for further self-harm.

In our meetings with service managers, we were told that there are a range of follow-up options when people present to MHAUs which include hospital admissions, or referral to crisis teams, community mental health teams and community support services. We were told by the MHAU nursing staff that crisis follow-up was considered for Mrs F, but they did not feel that Mrs F met criteria for referral due to her remorse about the overdose, and the assumption that her attendance at health services was evidence of her seeking help.

The service operational policy for the local crisis services states that the purpose of the service is to provide short-term intensive community-based care as a credible alternative to admission to hospital. The service provides home assessment, treatment, intervention, or support as an alternative to hospital admission for people experiencing an acute mental health crisis.

Criteria for referral to the CMHT are "any mental disorder where there is a risk of self-harm or harm to others where the level of support required exceed that which a primary care mental health team could offer".

Treatment and follow-up arrangements were not considered in detail during the SAER process as might be expected.

Manager F told us during our investigation that Mrs F may not have required admission to hospital, but mental health follow-up in the community was appropriate. She said that she had followed this issue up with staff as part of the SAER action plan to ensure firstly that the crisis team referrals guidance was clear and understandable and secondly that the crisis team were fully aware of how to deal with referrals from the MHAU staff.

The nature of Mrs F's presentation suggests that Mrs F was at risk due to the recent deterioration in her mental health and would benefit from follow-up by mental health services.

Clinical governance

Supervision

NHS A's MHAU service operating procedure at the time of Mrs F's assessment states that the unit will have four members of staff working at all times. This includes three mental health nurses, one of whom should be a Band 6 senior staff nurse. In this case, both Staff Nurse D and Staff Nurse E are Band 6 senior staff nurses.

Manager G told us that "there should be appropriate levels of supervision across the MHAU for the team".

We have highlighted through this report issues regarding recording and sharing of information and incomplete sections of assessment tools relating to Mrs F's assessment in the MHAU. We asked Manager F and Manager G about this. They told us that if clinicians are unable to complete required documentation and in situations where there is any diagnostic uncertainty, these should act as prompts to seek support from a senior colleague.

Staff Nurses D and E told us that they did not consider that Mrs F's case was complex at the time of their assessment therefore they did not consider support from a senior colleague was required.

The guidance states that "medical input to the MHAU will be provided by a rota populated by dedicated medical staff resident in the unit. Senior advice will be provided by the consultant on call for each site".

We were also told by Staff Nurse E that there would normally be a Band 7 senior charge nurse (a senior nurse) covering the MHAU. On some days, the Band 7 would be present in the MHAU. At other times they would be based on another site and could be contacted by telephone. On the day of Mrs F's assessment, the Band 7 nurse was based elsewhere.

We reviewed the MHAU service operating procedure and the Adult Mental Health Initial Shared Assessment Principles and Guidelines for completion. We found that it did not contain any information about supervision arrangements for MHAU staff or guidance as to when MHAU staff may wish to seek advice from the duty psychiatrist or psychiatrist on call. The position of the Band 7 nurse and their availability to MHAU nurses is not mentioned.

Training

Senior managers informed us of the expectation that mental health staff keep their training up to date. The service managers thought that the MHAU staff had completed their clinical risk screening and management training[8]. Staff Nurse E informed us that at the time of Mrs F's assessment she had not yet undergone the required risk management training and Staff Nurse D told us that she thought she had competed the risk management training.

[8] The incident took place during the Covid-19 pandemic and a half-day in-person risk training was not available however the electronic module on risk assessment remained so.

Clinical governance

The NHS A Mental Health Service Clinical Risk Screening & Management Policy says that all staff will undertake three yearly risk management training and that all clinical staff within the organisation will undertake clinical risk management training at the appropriate level on appointment. Registered nurses are required to complete both the foundation and specialist training. The policy states that the responsibility for monitoring, adherence to policy and associated mandatory training lies with the lead associate medical director and nurse director partnerships.

During our investigation, and as detailed throughout this report, we found that MHAU staff did not act in accordance with the MHAU risk screening and management service operating procedures. We identified issues relating to record keeping, information sharing and documentation at the time of Mrs F's assessment in the MHAU. We found that supervision arrangements were not considered in the service operating procedures. We could find no guidance relating to when MHAU staff should consider seeking a senior opinion. We found that one staff nurse had not completed their training as was expected by service managers and the other was unsure if they had.

These issues indicate that the expected supervision, training, and associated governance processes are not functioning as intended.

Recommendation for NHS A

NHS A must review their service operating processes for the MHAU to ensure that it reflects current and expected practice. Particular attention should be paid to the supervision, training and governance processes (including audit) in the MHAU to ensure that MHAU staff have the support, supervision and training to undertake their clinical duties.

Communication with Mrs F's family following the incident

Mrs F's family told us that they felt that the contact that they had with NHS A after Mrs F's death was inadequate and increased their distress following this incident. The family told us they had to repeatedly ask for information. They said that some of their questions had not been answered, despite assurances from senior managers that they would be. They told us they received no offer of post incident support or bereavement counselling. They told us that there was no sense of what the service would do differently as a result of this tragic incident.

That there were no pre-existing relationships between the family and the mental health service may have contributed to the difficulties Mr F and family described in their communication with NHS A, particularly at a time when they were distressed by events and struggling to understand what had happened. In situations where there are established relationships between individuals, their families and clinical teams it may be clearer to families who they can contact and a corresponding sense of responsibility from the clinicians involved.

We expect services to meet their professional obligations to families following traumatic incidents and promote a sense of confidence by delivering what they say they will timeously and ensuring a clear point of contact following a serious incident.

Duty of candour

The Scottish Government Organisational Duty of Candour came into effect on 1 April 2018. It confers legal duties on health and social care providers where there has been an unexpected event or incident that has or could have resulted in death or harm to a person. Organisations are required to apologise and meaningfully involve individuals and their families in a review.

Mrs F's family told us that they asked questions in their meetings with NHS A, and were told they would be answered, but they had to keep asking for the information over several months and when they did receive a reply not all of their questions were answered.

Mrs F's family told us that they do not think that the verbal apology they received in their meetings with NHS A was genuine or sufficient.

The SAER concluded that there were issues identified that may have caused or contributed to the event however the organisation did not record this event as a duty of candour event.

NHS A did meet with Mrs F's family to discuss the SAER and the family's concerns about Mrs F's care and treatment. The SAER indicates that an apology was given in writing and verbally, however, Mrs F's family dispute this.

We asked senior managers how the decision was made that Mrs F's death was not a duty of candour event when they recognised issues that may have caused or contributed to the event outcome. They advised us that this decision resulted from conversations with their governance team.

We have highlighted issues in other Commission investigations relating to duty of candour and have made a previous recommendation to all health boards that local policies fully reflect Scottish Government's guidance[9]. Please see report into Mr D linked here.

In our meetings with Mrs F's family, and particularly from speaking to Mr F, we are aware of their concern about the recording of the time when Mrs F was seen, when they left the MHAU and the duration of the MHAU assessment. Mr F reported feeling rushed and not given the opportunity to speak to the staff. We are aware that the timelines are also considered and commented on in the SAER and in response to the complaint lodged by Mr F.

Our investigation has highlighted aspects of the assessment process that may not have been available to the SAER team. We have written to the relevant managers who commissioned the SAER to provide this information and the timelines that we have been informed of. We have asked how the information from this report might impact on any further actions that the health board intends to take.

[9] We recommended: All health boards must raise awareness among staff of the organisation's obligations under duty of candour and related local policies. This should include a focus on organisational duty of candour when training staff to undertake SAERs and especially the requirement for a full apology (which is not the same as an admission of liability or blame)

Conclusion and recommendations

Our expectation is that families and carers should be involved wherever possible in mental health assessment and treatment processes. Whilst it is right that consent should be sought from patients to *share* information with others, including family members, this should not act as an impediment to *listening* to their concerns; and where possible involving them in care planning and safety planning.

We found that, issues relating to information sharing between departments and within the MHAU also impacted on the MHAU staff having all the available information at the right time.

The MHAU assessment and risk management document/tools had several incomplete sections. This raises a question as to whether the MHAU documentation is usually completed as identified in the relevant service operating procedure, and if not, whether the tools are fit for purpose and what audit processes are in place to monitor completion.

There is evidence that clinical risk screening and management training had not been completed as detailed in the service operating procedure by all staff members at the time of Mrs F's assessment and uncertainty from staff regarding what was expected of them in practice. This raises additional considerations with regards the supervision, training, audit processes and governance around this for MHAU staff.

Recommendations to NHS A

(To be addressed within six months)

1. **Embed guidance on confidentiality and carers into relevant operating procedures**
   NHS A must ensure that mental health staff have a clear understanding about their responsibility to listen to and involve families and carers. This guidance should be embedded in their service operating procedures and supported by supervision and training. Mental health staff should receive training in confidentiality, in keeping with legal duties and guiding principles. Training should include consideration about how and when it may be appropriate to meet with families where there is no or only partial consent.

2. **Review assessment and clinical risk screening and management documentation and processes**
   NHS A must review their assessment and clinical risk screening and management processes to ensure that they are in keeping with current and expected practice.

3. **Review MHAU service operating procedures and the assurance of these**
   NHS A must review their service operating procedures for the MHAU to ensure that it reflects current and expected practice. Particular attention should be paid to the supervision, training and governance processes (including audit processes) in the MHAU to ensure that MHAU staff have the support, supervision and training to undertake their clinical duties.

Appendix: glossary

Briefing note – a briefing note is a short document, usually one to three pages long, that informs a decision-maker about an issue and, if applicable, possible actions they can take and often includes a recommendation of action to address the issue.

Clinician – any health care professional who works directly with patients.

Consultant – a consultant is the most senior grade of doctor who has completed full medical training in a specialised area of medicine and has clinical and administrative responsibilities in leading a team of junior doctors and other healthcare staff.

ED – an **emergency department**, also known as an accident and emergency department (A&E), or casualty department, is a medical treatment facility specialising in emergency medicine, the acute, unplanned care of patients who present without prior appointment; either by their own means or by that of an ambulance.

Health and social care partnership (HSCP) – organisation formed as part of the integration of health and social care services provided by NHS boards and local authorities; jointly run by the NHS and local authority.

Healthcare support worker – NHS healthcare support workers are staff who assist healthcare professionals in providing care to patients. They work as part of wider health or social care teams, under the supervision of registered healthcare professionals.

Mental health assessment unit – these units were rolled out across Scotland at the outbreak of the Covid-19 pandemic to minimise attendance of mental health patients at emergency departments.

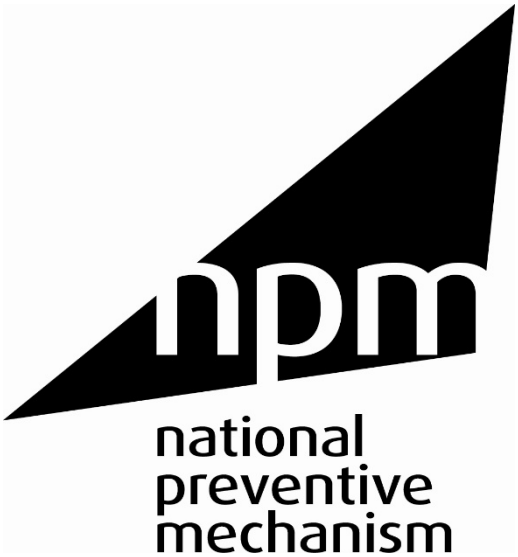
Practitioners – professionals such as nurses, social workers, occupational therapist, physiotherapists etc.

Service manager – senior member of HSCP staff who has responsibility for a particular part of HSCP service.

Significant Adverse Event Review (SAER) – reviews which are aimed at supporting health boards improve services by learning from adverse events, reducing the risk of these events happening again and providing public assurance that NHS boards are effectively managing adverse events.

Staff nurse – a nurse who is registered to practice with the Nursing and Midwifery Council who provides patient care across a range of healthcare settings.

Team leader – senior member of HSCP staff, who would usually report to service manager.



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