mentalwelfare commission for scotland

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INVESTIGATION

Mr GH - listening to relatives and carers - a case study

How Mr GH became known to the Mental Welfare Commission

In February 2013 we were notified in detention papers that a 26 year-old man, Mr GH, had been admitted to hospital by police. Mr GH was not previously known to psychiatric services. The doctor noted that his partner had been trying to get him admitted for some weeks. The doctor reported Mr GH was malnourished and unkempt. He was assessed as having a psychotic illness and posing a risk to himself and other people.

We contacted his partner to look at why her efforts to alert services to her concerns were ignored, as this is a frequent complaint of relatives and carers. She said she had been worried about his mental health for 6 months. He had been drinking heavily and was finding work stressful. He would express fears that he was going to be killed and he was talking about suicide.

Mr GH's partner had called NHS 24 and also spoken to his GP. She said they had focussed primarily on his physical health (he also had long-standing physical health problems). His partner wanted to know why they had not responded to his mental distress until after there had been a crisis.

Contact with NHS 24 and follow up with his GP

Mr GH's partner told NHS 24 that Mr GH was not speaking sense and that he was saying work colleagues were doing experiments on him. When it transpired that he also had chest pain, an out of hours doctor was sent to visit him. The doctor spoke only to Mr GH. She recorded *"no chest pain or paranoia"* and referred Mr GH to community nurses and recommended he see his GP.

Following this contact Mr GH's partner spoke to his GP by telephone and the GP saw Mr GH and signed him off work. He noted "*I cannot find any obvious signs of psychosis".* An anti-depressant was prescribed. He was seen twice more by the GP and claimed to have stopped drinking, but the GP noted - *"Says the police are looking for him. He seems paranoid. Partner is concerned about his mental health; it looks booze related to me".*

The next contact with his GP was when he went to complete detention papers.

Contact with Criminal Justice Team (CJT)

Due to his contact with the police over the years, usually for breach of the peace, Mr GH was also known to the CJT. Following an event in June 2012, he was released from custody on supervised bail. Notes over several months record he was often feeling low in mood and that he was advised to see his GP regarding this.

However, in November 2012 the CJT worker wrote that he was "*talking in riddles*" and he felt everyone was *"out to get him".* Mr GH was *"strongly advised"* to visit his GP. He told her he was too embarrassed to tell the doctor anything. Over several visits the worker continued to stress he should go back to his GP.

The CJT raised concerns about his presentation with a mental health officer (MHO). Two workers, one a MHO, visited Mr GH at home. They found him animated and pacing back and forth. When they got into the kitchen it had been trashed and the floor could not be seen for rubbish. They decided Mr GH did not appear to meet the criteria for detention under the mental health act and they left advising him that they would be in touch after his court hearing.

Although the CJT obtained signed permission from Mr GH to contact his GP, no contact was ever made. There is no record of contact with his partner. The next contact with Mr GH was after his admission to the acute psychiatric ward.

The Incident

In February 2013, Mr GH destroyed his work place, and tried to take his own life, apparently because he thought people were trying to harm him. Police took him to hospital.

Follow up work by the Commission

We reviewed the GP, NHS24 and CJT case records and advised all 3 services to hold incident reviews to look at their practice and identify any learning.

Outcomes

The GP practice held a Significant Event Analysis

It recorded that Mr GH appeared coherent during interviews with the GP and denied mental health problems *"as insinuated by his partner".*

The psychiatrist commented that seeing Mr GH in general practice it would have been "difficult to pick up on a diagnosis of a severe mental illness". Although Mr GH had attended appointments with his GP, received a visit from an out of hours doctor and his family had spoken directly to the GP about their concerns, the significant event analysis concluded that the CJT had not shared their concerns about Mr GH's presentation with primary care but, had it done so, it might have "prompted earlier input from the psychiatrist".

NHS 24 held an adverse incident clinical review

The clinical review noted that assessing paranoia over the telephone is difficult as it requires engaging with someone who may not want the professional to know their thoughts. It concluded that Mr GH's mental health should have been probed further, that staff had not addressed the partner's concerns, but it did result in the appropriate outcome. Mr GH had an out of hours doctor visit.

Recommendations were made. NHS 24 integrated learning from this episode of care into their learning resources and developed a carefully anonymised case study for core induction and Public Protection eLearning updates. The "Clinical Decision Support Software" used by NHS24 call handlers was also redesigned.

The CJT conducted an investigation

The investigation identified that CJT staff in general had little experience of identifying mental health issues and knowledge of onward referral routes. Staff had left the decision to attend the GP in Mr GH's hands and accepted his reasons for not seeking treatment. The investigation felt this should have been pursued with the GP.

Their investigation made 5 recommendations. All SW staff within CJT will receive training in mental health. Where there are concerns about an individual's mental health, contact must be made with their GP or psychiatrist. If written permission is not granted by the individual then they should consider a referral via adult protection procedures. The service raised awareness with all report writing staff regarding obtaining psychological or psychiatric reports and the process to follow. When such a report is requested at court the case should remain open to a worker until after the final court outcome. There was refresher training for all MHOs within the CJT.

Conclusion

The incident could easily have proved fatal to Mr GH and his work colleagues.

With hindsight it is easy to see that together all the different agencies involved in these events had sufficient information to identify that Mr GH was struggling with his deteriorating mental health. But the CJT did not communicate with the GP, and his partner, who had all the information, was not trusted as a reliable informant.

All three services involved in his care and treatment held reviews. Two of them identified learning and development issues which they will take forward as a result of this incident. We wrote to Mr GH's partner about these outcomes. Mr GH was discharged from hospital six months later. He remains under the care of the Mental Health Team. He has responded well to depot anti-psychotic medication and he has returned to work full time.

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