mentalwelfare
commission for scotland

# Loss of focus

**Report from our investigation into the care and treatment of Ms Z**

# Contents

## Who we are

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits his or her needs; and
- Be enabled to lead as fulfilling a life as possible.

## What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

## Introduction

We have the legal authority to investigate cases where there have been problems with the care and treatment of an individual who has a mental illness, learning disability or other mental disorder. Our duties are set out in the Mental Health (Care & Treatment) (Scotland) Act 2003. Under the Act we have the power to carry out investigations and make recommendations where we believe that a person might have been ill-treated, neglected or received deficient care or treatment. Our Investigations and Inquiries Group decided to conduct this investigation because of particular concerns we had about Ms Z's care and treatment, her risk assessment and the NHS Board's Adverse Significant Incident Review (ASIR).

This report is from our investigation into the care and treatment of Ms Z, a woman in her thirties who was receiving inpatient psychiatric care when she died. A social worker reported the death to us. Ms Z had died as a result of a serious self-injury having walked out of the hospital where she was being detained and treated under mental health law. She left hospital on 8 February 2007 without permission and was found dead by police two days later. The postmortem reports that the cause of death was either by exsanguination, or air embolism, or both, as a result of incisions she made to her neck. The postmortem report also recorded her as having schizophrenia. There was alcohol in her body, but no evidence of hypothermia.

Ms Z's parents were dissatisfied with the care and treatment their daughter received, by the ASIR and with the NHS Board's response to their complaint. They complained first to the NHS Board and then, in December 2007, to the Scottish Public Services Ombudsman (SPSO) citing inadequate care and an inadequate response to their original complaint. The SPSO dealt with the issue of the NHS Board's response to Ms Z's parents' complaint.

Our team met with the SPSO representative on 30 April 2008 and decided that the SPSO would deal with the issue of the NHS Board's response to Ms Z's parents' complaint and we would investigate her care and treatment. If anything in Ms Z's parents' complaint regarding her care and treatment was not covered by our investigation they would be able to ask the SPSO to look into the matter.

Initially the main focus of our investigation was on the period from October 2006 to February 2007. We also took account of longer-term decisions about treatment because we found that past events appeared to have a bearing on her more recent care and treatment.

Our investigation was carried out by members of our practitioner team and was chaired by one of our part-time Commissioners. The team was assisted by members of our casework and corporate services team.

Our investigation team looked at:

Diagnostic, treatment and clinical issues
- diagnosis and treatment
- medical leadership
- professional and personal relationships

Coordination and communication
- structure of the service
- record keeping
- joint working
- involvement of relatives

Management of Risk
- risk assessment
- history of overdose and self injury
- abrupt discharge 31 December 2006

Social support

Incident review

# Ms Z's problems were among the most complex and challenging that any clinician could expect to meet.

### How we conducted the investigation

Our investigation began with a detailed examination of all relevant health, social work and other related files and correspondence. A timeline of key information was developed from the notes. Through this process we identified a group of interviewees who could provide important information about Ms Z's case.

Members of the investigation team also held a meeting with Ms Z's parents to help us to understand Ms Z as an individual, as well as to hear their concerns about her care and treatment.

Fifteen interviewees were selected from the relevant services involved in Ms Z's care and treatment. Each interview was recorded and written notes were made from each recording. These written notes were sent to the interviewee to check for factual accuracy.

A draft Statement of Fact was then sent to the Medical Director and Director of Social Work in those services responsible for Ms Z's care and treatment. They were asked to comment and suggest factual changes or corrections which we considered in drafting the final statement.

All available information was analysed to identify key areas of concern. From this the investigation team produced findings and recommendations that we have directed to the organisations involved in Ms Z's care.

### Summary of Ms Z's circumstances

Ms Z had a decade of contact with psychiatric services and for much of this time had many problems, including a chaotic lifestyle, mental ill health and alcohol problems. Over the years she had contact with a number of psychiatric teams and there were several previous episodes when treatment was under compulsory measures. Although she was initially thought to have a primary psychotic illness (schizophrenia or schizoaffective disorder), in the last years of her life there was less clarity about her diagnosis.

Latterly more weight was given to her alcohol problems, personality factors and her social circumstances. From August 2005, when she was discharged from the care of the Community Mental Health Team (CMHT), her only contact with psychiatric services was at times of crisis although she continued to have some contact with social work staff. Between October 2006 and her death in February 2007 she was admitted to three different hospitals on four occasions and as a result she had input from three different clinical teams. There was also an unplanned discharge on Hogmanay and a serious episode of serious self-harm. At the time of her death she was subject to a short-term detention certificate.

## Our findings

### Diagnostic, treatment and clinical issues

In terms of both diagnosis and management, Ms Z's problems were among the most complex and challenging that any clinician could expect to meet in a career. She was in contact with a number of teams over the decade who despite considerable efforts struggled to help her address her problems. For any team working with a person with such complex problems there is a tension between the need to support the person's autonomy and help them take responsibility for their life, and at other times the need to take control of the situation by the use of mental health legislation. It is often difficult to decide which strategy is appropriate in a given situation, but consistency in approach across teams is key.

The clinical difficulties were apparent from the notes and discharge letters of the various clinicians working with Ms Z. From 2005 the weight given to mental illness, personality problems, or alcohol problems differed depending on who was working with her. There was no systematic overview of her symptoms and treatment and after 2005 no doctor regarded themselves as having ongoing responsibility for Ms Z's psychiatric care.

Given that attempts to help Ms Z with her alcohol problem were continually undermined by her mental health problems, we find it surprising that joint work between the drug and alcohol team and mental health services was not proposed. Where specialist referrals were made we found that they were not followed up robustly. The Scottish Government policy document "Mental Health in Scotland: Closing the Gaps – making a difference" refers to the need for careful joint working for people with mental health and alcohol problems and suggests that, in most cases of significant mental illness, mental health services should take the lead in ensuring a co-ordinated approach. In addition we cannot say with hindsight whether Ms Z had suffered impairment of brain function as a result of her drinking but there were many indications that this might be the case. Given Ms Z's history of alcohol abuse, the clinicians working with her should have considered the possibility that cognitive impairment had limited her ability to comply with advice or look after her own welfare.

Initially we had thought that this case might illustrate the alienation a person with a diagnosis of personality disorder may experience from services that feel defeated by the demands and complexity of the person's circumstances. But after interviewing all the people involved, we realised this was not the case for Ms Z. Everyone spoke warmly of her and did not perceive her as making impossible demands. Workers, particularly the nursing staff in the admission wards, seemed beguiled by Ms Z's pleasant nature and intelligence, going along with her wishes even in the face of her deteriorating physical state, acute distress, and the escalating severity of her repeated self injuries and overdoses.

Community staff may have overlooked the possibility that the psychosis was relapsing because they focussed mainly on personality and alcohol problems.

# Good record keeping and communication underpin effective risk assessment and management.

## Coordination and communication

The way the NHS Board organised its mental health services led to significant fragmentation of care for Ms Z. Specialist referrals were not progressed when Ms Z was in 'out of sector'[1] wards. Bed management decisions were not responsive to her particular needs. Although there have been changes in the way the NHS Board organises its mental health services since the period of this investigation, we heard from staff of all three hospitals that the problem of frequent "out of sector" admissions persists.

It is clear that there were failures to communicate between clinical teams and that these resulted in Ms Z receiving unfocussed and uncoordinated treatment and care. Poor records and poor transfer of information between teams meant relevant information was not considered when making assessments. Information from GPs, accident and emergency liaison psychiatry and social work agencies was not either accessible to, or reviewed by, the mental health service. In addition, health staff were misinformed about the structure of addiction services in this area. They confused the services offered by the NHS and the local authority. As a result they made incorrect assumptions about the involvement of the NHS alcohol services in Ms Z's care.

A robust method for coordinating care is essential for someone like Ms Z who has complex needs and receives services from a number of agencies. We found a lack of systematic multidisciplinary review which led to an unfocussed approach to her care. The Care Programme Approach (CPA) might have resolved some of the problems identified in this case. The team believed that they could not use the CPA because she would not cooperate. In our view, this was an incorrect assumption.

Good coordination of her care by CPA could have ensured that there were multidisciplinary meetings to share information and review the appropriateness of the care plan, including arrangements for crisis management. Adherence to CPA principles would have ensured that Ms Z's parents were appropriately involved in care planning.

While it is impossible to say that CPA would have led to a different outcome for Ms Z and her family, it is clear that if this approach had been used many of the problems associated with fragmented care, poor record keeping, poor risk assessments and overall lack of direction in treatment and care, would have been addressed.

[1] "Out of sector" means a ward other than the one that people from a particular catchment area would usually be admitted to. This meant that Ms Z was not looked after by a team that was familiar with her case and the services in her area.

## Management of risk

The need to identify and try to manage risk for Ms Z was essential. Her case was complex and difficult, given the conflicting views from different practitioners. Good record keeping and communication underpin effective risk assessment and management and there was a lack of good record keeping or review. The teams involved with Ms Z, although aware of the significant number of risk factors throughout this period, did not appear to recognise the importance of risk assessment and the development of a risk management plan.

It seemed clear to the investigation team that there were times Ms Z might have required a higher level of observation, or more intensive input from nursing staff. For example, she did not cope with telephone calls to and from her family with good or bad news. An increase in observation levels for a temporary period might have acted as a barrier to her impulsive departures from the ward, when she was likely to buy alcohol, become a management problem and/or self-harm.

Ms Z was discharged abruptly from hospital on Hogmanay because she had consumed alcohol. There was no aftercare in place and no concern for her ongoing welfare. For any patient we would expect plans to have been put in place in preparation for discharge. For someone with Ms Z's history and where sudden discharge could be anticipated, a good discharge and aftercare plan was even more important. In our view the decision to discharge her in this way was extraordinary and unacceptable.

## Social support

The practical, social and emotional help given to Ms Z by the social work department during this time was considerable. They attempted, but in the event were not successful in their aims to improve and stabilise Ms Z's social circumstances. In particular they tried to help her gain access to health care, for both physical and mental illness. Her care manager had frequent contacts with her GP, but both were frustrated to some extent by the lack of consistent specialist mental health care.

An inexperienced care manager was left to fill the gaps left by the mental health service. He was left to work with someone with very complex needs and received minimal support or guidance from the mental health service. Although this is not an area we explored in depth, it would appear that, as a front line worker, he needed more robust support and supervision from within the social work department. This might have enabled him to be more proactive in passing on information to the mental health teams and more confident to challenge their approach and strengthen decision-making in the multidisciplinary forum.

## Incident review

There is no doubt that the ASIR was inadequate because of limitations of scope. It was also held a long time after the event. The Mental Health Reference Group (MHRG) recommends that reviews are held within four weeks of the incident and that a meeting to discuss the findings is held within six weeks.

The failure of the review to look at the months prior to Ms Z's death meant there was no consideration of the history and contribution of fragmented care. An opportunity to learn from this was missed. There would also appear to have been no plans to review the 'near misses' which took place shortly before Ms Z's death, notably the serious self-harm which occurred less than a month prior to her death. This was so serious that she required two days treatment in a medical ward before she was stable enough to be transferred to the psychiatric ward.

## Summary of our recommendations

The majority of our recommendations are directed to the NHS Board and local authorities that provided care for Ms Z. Other NHS Boards and local authorities may wish to take note of our recommendations and consider whether their organisation could avoid similar incidents in their service. We also make two recommendations to the Scottish Government.

Many of our recommendations relate to the need for improved coordination and focus for treatment and care.

## Recommendations with regard to diagnosis, treatment and clinical issues

### Recommendation 1

The NHS Board along with local authority partners should ensure that patients with complex mental health problems (including borderline personality disorder) have a multidisciplinary assessment of all their needs including mental health, cognitive function, capacity and physical health.

### Recommendation 2

The NHS Board should ensure that there is continuity and clarity of medical leadership as patients move between CMHTs, in-patient psychiatric services and primary care. If responsibility for a complex case is passed back to the GP this should be absolutely clear as should the plan of action if circumstances change.

### Recommendation 3

The NHS Board along with local authority partners should review the interface between their mental health service and specialist alcohol services (those within the health service, and those provided by the local authority) to improve knowledge and practice in the assessment and treatment of people who have both mental illness and alcohol problems.

### Recommendations with regard to coordination and communication

Recommendation 4

The NHS Board should hold an urgent review of procedure for “out of sector but within the NHS Board area” admissions in general adult psychiatry and should review the location of acute adult admission beds.

Recommendation 5

The NHS Board should review the quality and organisation of case notes with particular regard to case note summaries and information available to anyone who is new to the case.

Recommendation 6

The NHS Board should develop a system to coordinate the distribution of information about patient contacts with A&E departments, out of hours services and liaison services to ensure CMHT staff, consultants and GPs are aware of multiple contacts by the same patient.

Recommendation 7

The NHS Board and local authority should jointly ensure the implementation of the Care Programme Approach to facilitate multidisciplinary planning of care and treatment of people who are vulnerable because of their complex needs.

### Recommendations with regard to management of risk

Recommendation 8

The NHS Board should ensure that all inpatient and other relevant staff receive training in risk assessment and risk management.

Recommendation 9

The NHS Board, along with local authority partners, should develop a policy for abrupt discharges from psychiatric inpatient units.

### Recommendations with regard to incident review

Recommendation 10

The NHS Board should review how it examines adverse significant incidents and ensure that they involve relatives, carers and relevant local authority and voluntary sector staff. They should also ensure they review and examine “near-miss” events.

### Our recommendations for the Scottish Government

Recommendation 11

The Scottish Government should ensure that there is updated guidance on management of complex cases via the Care Programme Approach within general adult mental health services.

Recommendation 12

The Scottish Government should ensure that there is updated guidance on policies and procedures for investigation of adverse significant incidents within mental health services.

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