An investigation into the care and treatment of Mr N

mentalwelfare commission for scotland

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Who we are

We put individuals with mental illness, learning disability and related conditions at the heart of all we do: promoting their welfare and safeguarding their rights.

There are times when people will have restrictions placed on them to provide care and treatment. When this happens, we make sure it is legal and ethical.

We draw on our knowledge and experience as health and social care staff, service users and carers.

Our Values

Individuals with mental illness, learning disability and related conditions have the same equality and human rights as all other citizens. They have the right to

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suits their needs
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health and learning disability care. Sometimes we investigate where something has gone seriously wrong with a person's care.
- We identify and promote good practice in mental health and learning disability services.
- We provide information, advice and guidance to service users, carers and service providers
- We have a strong and influential voice in service and policy development
- We promote best practice in mental health and incapacity law.

Why we conducted this investigation

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. Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 gives the Mental Welfare Commission (the Commission) the authority to carry out investigations and make related

recommendations where we believe that a person might have been ill-treated, neglected or received deficient care or treatment.

This report relates to our investigation into the care and treatment of Mr N, a man in his early forties who was subject to a CTO when he died. His death was as a result of falling from a high bridge.

We were contacted in January 2009 by Mr N's mother who felt there were learning points for services from her son's death. She told us that her son had been placed on a compulsory treatment order (CTO) following a mental health tribunal held in November 2008. The tribunal authorised his detention in hospital because it wanted a care plan to be in place before he went home. This was despite her son having argued strongly for a community order (CCTO) to be applied. The following day his detention was suspended. He died two weeks later without the community supports stated in his care plan having been put in place.

Subsequently, Mr N's case was brought to the Commission's attention by NHS Quality Improvement Scotland because of concerns emanating from the outcome of the Critical Incident Review carried out by NHS Board 1.

Mr N's mother initially contacted the Commission on 19 January 2009. She had been told there would be a critical incident review and was seeking advice on the process. We advised that she should have the opportunity to express her views to the CIR panel.

NHS Board 1's Critical Incident Review was carried out in March 2009 and the outcome reported to the Commission three months later.

A Clinical Advisor with NHS QIS referred the case to the Commission after he had considered the critical incident review undertaken by NHS Board 1. He was concerned that Mr N had been detained under a CTO and rapidly placed on Suspension of Detention.

On 14 April 2010, the Commission's Chief Executive and Chief Social Work Officer met Clinical Director 1 and Associate Medical Director 1 for Mental Health, NHS Board 1, to discuss the Commission's main concerns about the case. At that stage the Commission was concerned that the CIR was limited in its scope and that it failed to acknowledge fully and explore several significant issues pertaining to Mr N's care and treatment.

In May 2010 Clinical Director 1 confirmed that he would review the case and NHS Board 1's critical incident review into Mr N's death.

On 22 July 2010 Clinical Director 1 wrote to CE, MWC, with the outcome of his review.

The Commission welcomed Clinical Director 1's review but, while noting that some useful learning points were identified, was still sufficiently concerned about some aspects of Mr N's care, particularly in relation to interagency working and the

management of the transition between hospital and community, that it agreed to carry out an investigation under its Section 11 authority.

Our investigation focussed upon the care and treatment provided to Mr N during his final admission to hospital, which commenced on 10 October 2008 through to his death on 23 November that year. This included the decision to apply for a hospital based compulsory treatment order, the hearing for which took place on 12 November, and the subsequent decision to suspend Mr N's detention on the following day.

Chair and members of investigation team

The investigation team was chaired by the Commission's Chief Nursing Officer; the other member of the team was one of our Social Work Officers. The Commission's Chief Executive took part in the interview with Consultant Psychiatrist 1, to provide a Commission medical perspective.

Terms of reference for our investigation

1. To review Mr N's care prior to his death, with particular reference to the period between his final admission to hospital on 10 October 2008 and his death on 23 November 2008.

2. To examine the decision to suspend Mr N's detention around the same time as the granting of a hospital based compulsory treatment order.

3. To examine the factors taken into account when Mr N was placed on suspension of detention, including the communication between all parties and the community support planned and provided.

How we conducted this investigation

We reviewed case file material from medical notes, social work records and the records of the voluntary organisation which supported Mr N, focussing on the period between Mr N's final admission to hospital and his death. We also examined the pattern of Mr N's care and treatment since his diagnosis of bipolar affective disorder in 1986. Through this process we identified a group of interviewees who could provide important information about Mr N's case.

Who we interviewed

We interviewed Consultant Psychiatrist 1 who was responsible for Mr N's care and treatment during his final admission and for a period before that; Charge Nurse 1 on ward 1, where Mr N was a patient at the time of his death; MHO 1, who was Mr N's MHO over an extended period and who is based in Hospital 1, and two members of staff who were jointly responsible for delivering the voluntary organisation input to Mr N in the community. In addition, Associate Medical Director 1 attended the interview with Consultant Psychiatrist 1. We also interviewed Mr N's mother and step-father to obtain both background information on Mr N and their perspective on the care and treatment he had received over a number of years.

About Mr N

Almost without exception, everyone we met in the course of this investigation mentioned Mr N's intelligence, enthusiasm, lively mind, wit and creativity. They also described a man who could be troubled, demanding and challenging, especially when in the grip of the mental illness which plagued much of his adult life and blighted his potential.

His family told us that as a child he was full of enthusiasm and always eager to excel at anything he tried. They described a 'very bright, musical and sociable child with an infectious sense of humour'. As a boy and as a young man, he loved playing sport. He also enjoyed music, art and drama.

At the age of thirteen he suffered an episode of what was later identified as depression. He appears to have recovered gradually; however, his exam results were poorer than predicted. At the age of 18 he took an overdose of paracetamol after the end of a two year relationship. This early onset of mood disorder and episode of self harm should be understood in the context of an extensive family history of psychiatric illness and of suicide associated with affective disorder.

We understand that seven family members have died by suicide, the most recent being Mr N's cousin who died in March 2008.

By the age of twenty, according to his family, he was becoming very difficult to live with, his behaviour had become unpredictable and hostile. He was drinking heavily and had to leave home in the interests of family safety and wellbeing.

Mr N was diagnosed with 'manic depression' and spent his 21st birthday in a psychiatric hospital, having been taken there by the police who were concerned about his safety following a public incident. This incident marked the start of a long struggle between depression, mania or hypomania and twenty years of contact with mental health services characterised by a cyclical pattern of admissions to hospital interspersed with periods of independent living. In the last twenty years of his life, Mr N's erratic lifestyle was marked by heavy drinking, difficulty in managing his finances, mounting debt and sporadic low level contact with the police. From 1997 onwards he became unwell almost every year.

In his adult years Mr N developed a deep interest in spiritual and philosophical matters and was constantly questioning and searching for the meaning of life. After many years of study, at the age of 40 he graduated with a degree in theology from one of Scotland's most highly regarded universities. In the last few years of his life he wrote extensively on theological matters and, after his death, his family collated and published an anthology of some of his writing which gives an insight into his hopes and passions, doubts and torment.

Review of Mr N's care prior to his death

Mr N had been known to psychiatric services since 1985. His most recent Responsible Medical Officer (RMO) had involvement with him since March 2008 (8 months).

From reading medical records, detention paperwork and from accounts provided by medical staff and the family, we ascertained that all compulsory admissions were precipitated by manic episodes. Descriptions of his presentation on admission are all very similar, citing symptoms such as elation, irritability, grandiosity, over-activity and insomnia. It was the behaviour exhibited during the manic phase of his illness which brought Mr N to the attention of the police and caused the greater concern to mental health services. The recurring theme in detention documentations is that "he puts his health, safety and welfare at risk when he is manic in the community".

The family members seemed to place a far greater emphasis on the depressive element of Mr N's illness than the medical staff. According to Mr N's mother, "they never ever treated him for depression"; it was "always the mania that he got drugs for". Mr N's mother told us that his 'down periods' were 'something that the hospital hadn't picked up on so much'. She told us that he always seemed normal when he was depressed but that he had explained to her that "when people saw him as this very agreeable kind of person he was, in fact, depressed". It was his mother's view that the 'down' was always brought on by drugs prescribed by the hospital. According to Mr N's step-father, in recent years these cyclic episodes were manifesting in "sharper troughs and sharper highs". He added that "when Mr N came down, he came crashing down".

As most of Mr N's periods of depression appear to have occurred while he was out of hospital, they are less fully documented in the files; however, we did find several accounts of deliberate self harm spanning a twenty year period.

The first documented incidence of self harm occurred at the age of 18 when Mr N took an overdose of paracetamol after the end of a two year relationship.

During a period of inpatient care in March 2002, Mr N absconded and jumped into the harbour. He apparently later denied suicidal intent, describing his action as 'impulsive'.

We also learned that Mr N took an overdose of prescribed medication (Olanzapine) in February 2006. On that occasion we understand he sent a text to his sister informing her of his action. He was found unconscious and taken to A & E. The doctor assessing his mental state noted that 'he clearly remains at a long term risk of serious self harm, even complete suicide'.

The next documented references to self harm or suicidal ideation occur in late September 2008, two months before Mr N's death, when Consultant Psychiatrist 1 wrote that he complained of experiencing feelings of 'acute suicidality' after taking one 5mg tablet of Aripiprazole. We know that he contacted the out of hours medical service on 29 September 2008 with ideas of self harm. The assessing doctor, a trainee in psychiatry, noted there was no evidence of either mania or of biological features of depression present.

The family and medical staff agreed that Mr N's compliance with medication was generally inconsistent and that he challenged treatment when unwell. On the ward his behaviour was described as often very difficult; he would push boundaries, be verbally and physically aggressive and would frequently abscond.

However, it seems he generally responded very quickly to consistent treatment (within three to four weeks), helped by abstinence from alcohol. This rapid response to medication and reduction in psychotic symptoms are reflected in the pattern of frequent revocations of compulsory treatment. Each time an order was revoked it was noted that Mr N recognised that he had been unwell and that he was agreeing to continue treatment voluntarily.

Unfortunately, records show that this compliance was frequently short lived. For example, in 2006, a short term detention certificate was granted on 31 August and revoked eleven days later. Although Mr N had apparently responded well to treatment and agreed to continue accepting treatment on a voluntary basis, we understand he left hospital, failed to comply with treatment and two weeks after the revocation, another short term detention order was granted, on 25 September 2006. This certificate was again revoked before it expired as it was recorded that it was no longer necessary for Mr N to be detained in hospital. He had apparently 'elected to remain in hospital on a voluntary basis, to continue treatment with antipsychotic medication and to introduce a mood stabiliser in an attempt to offer protection against relapse of his mood disorder'.

History of offending behaviour

When he was unwell, Mr N's aggressive and threatening behaviour, exacerbated by alcohol and drug misuse, frequently brought him to the attention of the police. We heard that the police response was often to take him to hospital rather than pursue charges. Most charges were dropped because it was found that he was mentally ill at the time of the offence.

Police records show two instances of recorded convictions, one for malicious damage in 1996 and another for two counts of assault in June 2008. On both occasions, sentence was deferred, and Mr N was subsequently admonished at Sheriff Court 1. For the latter assault offences sentence was deferred to 3 February 2009, and formal notice of admonishment was given after Mr N's death.

We note that there is mention made at the tribunal and in interviews of Mr N's anxiety about an 'outstanding court appearance'; however, although we understand that Mr N was expected back in court on 3 February 2009 in relation to his deferred sentence from 9 June 2008, we have been unable to obtain any evidence from the police or Procurator Fiscal service of any new charges being brought.

No one working with Mr N seems to have made any enquiries on his behalf or to have ascertained from him exactly what his concerns may have been relating to his forthcoming court appearance. From our enquiries, it seems that there were no outstanding charges or other court appearances other than the one that had been deferred.

One of the last recorded contacts with police took place two months before his death. We understand that Mr N approached police on 21 September 2008 saying he had broken a window in a local bar where a friend of his was being held and raped. Concerned about his mental state, the police took him to Hospital 1. We understand that no further action was taken by the police.

We could find no evidence of Criminal Justice Social Work involvement at any stage in Mr N's contact with the police and courts.

Community support

Since 2006 Mr N had been living in a single person flat owned by a housing association, with support provided by a voluntary organisation. We understand that this supported accommodation is intended as a short term place for people who have been discharged from hospital or who are not yet at a stage when they can cope with their own tenancy. We heard that most of the clients using this accommodation service received services from the forensic mental health team. Usually people stay for a year or so, during which time the voluntary organisation staff will support them with housing issues such as paying bills, shopping and cleaning in preparation for managing their own tenancy. Their emphasis is on providing advice, support and assistance in order to help individuals acquire the practical and social skills required for independent living. When the person is considered by all the different agencies involved in their care as ready to move on, they apply for a permanent tenancy with the council.

This supported accommodation was arranged by Mr N's social worker. We heard that clients are often referred to this voluntary organisation if it is felt that other agencies would struggle to manage their unpredictable or risk-provoking behaviour. While their support staff have particular experience of working with people with mental disorder and offending behaviour, they have no role in supervising medication or compliance with medical treatment. Mr N received the minimum level of support required to stay in this accommodation, i.e. seven hours of support per week, spread over three visits. The voluntary organisation workers we interviewed told us that "*when he was well he would take support… but when he was unwell he just wanted to deal with it all himself".*

Chronology

- ### Admission history

Although this investigation focuses on the short period prior to Mr N's death, the approach to caring for him and decisions made about his care and treatment were to a great extent informed by the clinical team's extensive contact with him over a twenty year period and of knowledge of his pattern of presentation and his admission history. For example, since 2000, in addition to intermittent brief periods of informal admission, Mr N was subject to compulsory detention in hospital on fourteen occasions; five periods of emergency detention, eight of short term with one longer period (under section 18, 1984 legislation).

Family and clinicians agreed that there was a recurring pattern in that he would be admitted, treated, would become well, would be discharged to the community, but would not comply with the treatment plan and the cycle would start again.

- **Events preceding final admission**

Prior to Mr N's final admission to Hospital 1 on 10 October 2008, files indicate several months of chaotic behaviour, deteriorating mental health, a period subject to short term detention and several brief informal admissions.

Concerns about Mr N's deteriorating health and disturbed behaviour were raised by a number of people and agencies, namely family, police and voluntary organisation staff in the few months prior to his final admission.

According to Mr N's mother, by the end of June 2008 it was clear to the family that Mr N had become very unwell. Around the same time, the voluntary organisation alerted MHO 1 to escalating concerns about Mr N's mental state. He refused to meet with his housing support worker on 27 June. On 30 June, in advance of a planned review meeting on 3 July, his housing support worker emailed Consultant Psychiatrist 1 to raise concerns with her that Mr N appeared 'delusional… paranoid and unsettled'.

Mr N attended his out-patient appointment with Consultant Psychiatrist 1 on 3 July 2008 in the presence of MHO 1. He was assessed as 'hypomanic'… over talkative but still able to engage in two way conversation'. At interview, he did not display overt psychotic symptoms and although admission was offered to him, Consultant Psychiatrist 1 and MHO 1 did not feel he met the criteria for detention under the Mental Health Act at this stage. The preferred option was to manage Mr N's care in the community and, as he expressed a strong desire to cooperate with services, they both thought it justifiable to 'give Mr N a chance to engage on an informal basis in the community setting'. Consultant Psychiatrist 1 wrote to Mr N's GP that 'should his behaviour and mental state present serious concerns he should be admitted to inpatient unit'. They agreed a further out-patient appointment the following week; however, sadly, Mr N's grandmother died on 10 July and Mr N cancelled this appointment.

When his much loved grandmother died, Mr N was already confused and expressing bizarre thoughts. According to his mother, Mr N managed to attend the funeral on 17 July but later in the day he became "obnoxious and difficult to every family member", resulting in his being removed from the premises. We heard from his mother that he realised afterwards that he had "alienated himself from everyone".

Thereafter, Mr N did not attend his review appointment with Consultant Psychiatrist 1 on 16 July or an appointment at his GP practice on 22 July. He did, however, self-present at ward 1 on 18 July, accompanied by a staff member from the voluntary organisation. In conversation with MHO 1 he appeared to be 'extremely paranoid and … quite thought disordered at times'. MHO 1 told Mr N that the police had contacted her the previous week because of complaints about him 'harassing' a woman in pubs in town. She told him to expect a warning letter from the police about

his behaviour. He acknowledged he had been unwell for about two months, but felt he was getting better.

In her report to the NHS Quality Improvement Scotland suicide reporting officer, Consultant Psychiatrist 1 described events of this period: "it was evident that Mr N once again developed a manic episode of his illness which was manifested by exceptionally erratic behaviour with elements of verbal and physical aggression, inappropriate behaviour in public, over spending money and demanding money from the family, travelling erratically around the country, misusing alcohol… He also started expressing unrealistic concerns about safety of his female friends, he appeared to be paranoid and grossly unsettled…"

This was obviously a very chaotic time for Mr N, and there are some discrepancies in records which make it difficult to construct an accurate and unambiguous account of his movements at the end of July and early August 2008. However, there is sufficient evidence from a range of sources to indicate Mr N's mental state and behaviour were bringing him to the attention of the police and mental health services in different locations across the country.

Hospital records show that Mr N was admitted informally to ward 1 at the Hospital 1 on 22 July 2008 after being brought in by the police for assessment. Events of the following week are difficult to piece together but it seems he repeatedly left the ward without agreement. On one occasion he made his way to Edinburgh without money and attempted to book himself into one of the most expensive hotels in Edinburgh. We also heard that he spent a night in a Salvation Army Hostel in Edinburgh, and on 28 July was admitted to Hospital 2 in another Health Board area and discharged the same day.

We then understand he presented at ward 1, Hospital 1 on 31 July 2008 in a 'filthy and dishevelled state'. He was displaying signs of Bipolar Affective Disorder and was detained on a short term detention certificate (STDC). On the certificate, Consultant Psychiatrist 1 records consulting Mr N's mother as named person and notes that *'she supports the idea of using the mental health act to ensure Mr N remains in hospital'.*

On this occasion, Mr N responded well to treatment, his mental state improved and detention was revoked on 21 August 2008. The revocation certificate records that he was *'willing to comply with treatment on a voluntary basis'.*

However, this compliance appears to have been short lived. Mr N attended Consultant Psychiatrist 1's outpatient clinic two weeks later on 8 September 2008. He expressed his disagreement with available treatment. He was complaining of intolerable side effects and had been reducing and self-regulating his medication since discharge.

Throughout September 2008 Mr N's behaviour continued to cause concern. On one occasion he had apparently entered several city centre banks trying to open accounts and been threatening to staff. There were also reported concerns that he was harassing and stalking several women, including a member of staff from the voluntary organisation.

We heard that on 29 September Mr N was involved in an altercation at a local hostel, allegedly assaulting a female member of the hostel staff. Following this incident the voluntary organisation temporarily withdrew its service, to protect staff. We understand that MHO 1 and staff from the voluntary organisation made repeated attempts to meet Mr N to discuss how to reintroduce support safely, but he refused to attend meetings.

Over the next few weeks, Mr N was arrested by the police on a number of occasions in different locations but assessed by duty doctors as not meeting the criteria for detention in hospital.

As far as we can ascertain from police records, none of these incidents resulted in criminal charges.

- **Final admission**

Mr N presented himself to the Hospital 1 on 10 October 2008 and was admitted informally to ward 1. However, it was decided that he needed to be detained as his behaviour was assessed as 'erratic, grandiose and aggressive'. He was subsequently detained on a Short Term Detention Certificate. Later that day he pushed his way past nursing staff and absconded from the ward. He was reported missing and later returned by the police.

Despite being nursed on what was described as 'constant observation', he absconded on multiple occasions (five instances recorded). Staff found him difficult to manage in an open ward, and on 14 October 2008 he was transferred to the intensive psychiatric care unit (IPCU).

On 21 October 2008 Consultant Psychiatrist 1 examined Mr N and completed the medical report for a Compulsory Treatment Order application. At that time his behaviour was described as 'significantly disturbed, agitated and aggressive'.

Following review by Consultant Psychiatrist 1 on 28 October, Mr N commenced 'supervised passes' to ward 1.

On 30 October 2008 the CTO application was completed and signed by MHO 1. On 31 October 2008, Mr N was settled enough to be transferred back to ward 1. By 1 November, he was complying with escorting restrictions and by 3 November, it was recorded that his mental state was much improved compared to admission but agreed that the CTO application should proceed. Short day passes (up to 3 hours unescorted) were approved.

On 5 November 2008 day passes were extended up to 6 hrs and on 6 November Mr N spent a few hours in his flat, escorted by a nurse.

We understand Mr N was given an 'overnight pass' on 11 November 2008 (the day before the tribunal hearing) to his home address.

At the tribunal hearing on 12 November 2008 a hospital based CTO was granted. The application was not contested.

- **The Mental Health Tribunal for Scotland**

The Mental Health Tribunal for Scotland ("the Tribunal") is the body in Scotland charged with making, approving and reviewing decisions imposing compulsory measures for the detention, care and treatment of people in Scotland who have a mental disorder. The Tribunal exercises a judicial function and brings its specialist knowledge to bear on the cases before it.

In exercising its judicial function it is an independent, impartial body making decisions on the facts and applying the relevant law. All parties appearing before a Tribunal must be aware of its judicial authority and the consequent obligation to provide full and transparent evidence.

The tribunal on 12 November 2008 was a very significant event in this investigation. We asked all our interviewees who were present at the tribunal to give an account of their recollection of what was proposed, discussed and agreed at the hearing. We also listened to a recording of the tribunal hearing and are grateful to the MHTS President for facilitating access to the recording.

As there appears to have been a significant discrepancy between what was discussed and agreed at the tribunal and what happened afterwards, we are taking the unusual step of including a fairly full and detailed account of the tribunal hearing.

We examined the decision to apply for a hospital based compulsory treatment order. The MHO confirmed that the order she had applied for continued to be what she was applying for and that there were no procedural changes to note.

The RMO input to the tribunal

When Mr N is in hospital, he regains insight and consents to continue taking medication when he leaves hospital, but he 'falls to pieces' very rapidly. The RMO described Mr N as 'intellectually able' and said that even when unwell, he can present in a plausible way. So, treatment is not consistent. He is also a risk to himself and others when unwell. She described his compliance with medication and his attendance at the clinic as erratic. Though his current insight was described as reasonable, the RMO confirmed that she was still applying for a hospital based order on the basis it was premature to make him informal, based on massive historical evidence of non-compliance with medication, propensity for fast relapse and the severity of his illness. She added that, therefore, the criteria for compulsory treatment were met and that the order was needed for consistency of treatment. The RMO said that the voluntary options for treatment had been exhausted. He was given the opportunity of engaging with treatment, trying to choose medication that would agree with him, but this did not work.

Mr N's mother's input to the tribunal

Mr N's mother said that she felt her son was always discharged too soon, though she acknowledged the pressure he puts on services for this to happen. She also

raised the issue of a need for Community Psychiatric Nurse (CPN) involvement which the RMO confirmed could be arranged.

The MHO input to the tribunal

MHO 1 confirmed that she agreed the grounds for detention continued to be met, that Mr N's behaviour presented significant risks for him, that he was vulnerable, loses insight very quickly and that a number of recent life events had been significant for him. She said that they had been trying on an informal basis to work with him for a long time but that this was not working.

She explained that the voluntary organisation input involved general housing support, covering matters such as budgeting and keeping the flat tidy.

Tribunal proceedings

The tribunal convener sought confirmation that engaging a CPN would be something for the future, suggesting that, otherwise, they would be looking at a CCTO. Consultant Psychiatrist 1 said that the CPN could still be introduced to start exploring the relationship with Mr N. Mr N's mother sought confirmation that a hospital based order was still being sought. Consultant Psychiatrist 1 confirmed that it was, but added that the order could be suspended to allow passes home, though the suspensions could end if there were any issues of non-compliance or any deterioration in Mr N's mental health.

The legal member asked if the plan was to use suspension at some stage. Consultant Psychiatrist 1 explained that over the next 2 months suspension would be used to give Mr N freedom off the ward but that he would be closely monitored. The legal member asked if the plan was to go for a CCTO in the future. Consultant Psychiatrist 1 confirmed that it was.

The convener asked for clarification of the main purpose of the hospital based part of the order. Consultant Psychiatrist 1 explained that Mr N had a propensity to relapse very quickly, often only a few weeks after discharge. She said that she wanted safeguards in place in the event of relapse, in order to provide adequate care and re-entry into the system straight away. If non-compliant at this stage, the depot option is considered as the next step. The hospital based order would also give an opportunity to keep a very close eye on Mr N; also that support packages needed to be discussed and were not in place yet. The convener asked if it was also to monitor how the new medication works. Consultant Psychiatrist 1 confirmed that it was, that they had introduced the new medication 4 weeks before and were pleased to have seen the response to date, but that they wanted to see sustained remission over the next 2 weeks. The convener went on to seek confirmation that Consultant Psychiatrist 1 felt that because Mr N relapses so quickly, his ability to make informed choices about his treatment is affected. Consultant Psychiatrist 1 confirmed this to be correct, that because he relapses so quickly and so unpredictably, he cannot fully comprehend the level of care he needs and the treatment he requires at that stage. Mr N's mother also mentioned his outstanding court appearance, which put him under a lot of stress, adding that he had become ill after his court appearance in June. Mr N mentioned that he had felt suicidal after his cousin's suicide in March saying that he felt somehow responsible. He reflected upon his inability to put matters in perspective.

The convener sought confirmation that MHO 1 wanted her application granted. Confirming that she did, MHO 1 explained that they had been in this position so many times before and that while Mr N commits to taking his medication and abstaining from alcohol, in reality this does not last. She said that he does not stay well for long enough to allow further education or work opportunities to be taken forward for him. She said that he 'needs to be in hospital for a bit longer' so that they can get a proper plan in place, and to see that his medication is working and that he is happy with it. Consultant Psychiatrist 1 added that it is a hospital based order but that it can be suspended, though he would be brought back into hospital if there was any evidence of non-compliance. She said that passes can be flexible and can allow him time off the ward to see how he progresses. Mr N's mother pointed out that he was not being discharged, as he had hoped. Asked by the convener, both Mr N and his mother confirmed that they had no opposition to the order.

The convener confirmed that the order being applied for would be granted, acknowledging that there is an underlying problem with his illness which causes Mr N's insight to fluctuate very rapidly and needs to be viewed over a longer period of time to make sure that it lasts. They thought about making the appointment of a CPN a recorded matter but did not feel it necessary to do so as it will happen anyway. The tribunal felt that the order was necessary on the basis that the care team had to monitor what was happening at that time; particularly as new medication had been introduced. They acknowledged that there were a lot of potential stressors outwith hospital and that the safety network in place would help them to monitor any problems and to ensure that Mr N gets better and stays better.

The tribunal accepted that Mr N required close monitoring of his recovery as his new medication had only been introduced four weeks earlier. They agreed that Mr N needed a planned discharge into the community on gradually extended passes to monitor the effects and compliance with this new medication regime. It was further noted that as Mr N relapsed so rapidly, his recovery had to be consolidated before he could be discharged from hospital to avoid rapid relapse and readmissions. The tribunal agreed that an allocated CPN would be a desirable part of the treatment plan and it was confirmed by both the RMO and MHO that this would be introduced.

To summarise, the plan agreed at the tribunal was:

- To keep Mr N in hospital until his mental health stabilised
- To put safeguards in place in the event of relapse
- To discuss and put in place a community support package
- To monitor closely any periods of suspension
- To monitor compliance with and effectiveness of new medication

The well argued justification for the plan was that Mr N lacks insight, becomes unwell very quickly, that when unwell he poses a risk to himself and others; that he was on new medication and that they required time to put a support plan in place.

The investigation team is of the opinion that this was a well conducted hearing, with all parties given a full and fair opportunity to discuss the care and treatment appropriate to meet Mr N's needs. The proposed plan was sound and well reasoned.

- **After the tribunal**

Mr N again stayed overnight at his flat on 12 November, and on 13 November attended ward 1 for review. We heard that he reported no complaints or any ongoing problems.

On 13 November, the day following the tribunal, the hospital based measures of the CTO were suspended at 1500 hrs for a period of six months, with the following conditions attached:

1. *To continue taking prescribed medication*
2. *To abstain from alcohol*
3. *To attend for regular reviews on the ward*
4. *To reside at home address*

Effectively, Mr N was out of hospital from 11 November, the day before the tribunal hearing.

We understand from the account given in NHS Board 1's critical incident review that during the ward review on 13 November a request was made for CPN involvement. Files show a referral letter to the same CPN dated 4 December 2008 (eleven days after Mr N's death) thanking him for agreeing to provide CPN input and care management. It notes that the introduction of CPN support was recommended by the tribunal. No contact was established by the CPN prior to Mr N's death.

Nursing notes made on 16 November indicate Mr N remains on pass and has had no contact. The nursing care plan indicates an intention to have a '*well prepared and organised discharge following extended passes'.*

- **Final week before death**

On 20 November, Mr N attended ward 1 for review with Consultant Psychiatrist 1. He apparently reported coping well at home, spending lots of time at home, cleaning his flat which he described as being in a 'ruined state'. Although he talked of going back to college and taking control of his life, there is no mention of any of the *'structured daily activities'* which were stipulated as necessary in the care plan submitted with the Suspension of Detention.

According to Consultant Psychiatrist 1, Mr N did talk about feeling *'slightly on the down side'* but denied being depressed. In response to direct questions he did not express suicidal thoughts or intent. We heard from both his mother and step-father that Mr N *"was very good at masking his symptoms".* Indeed, his mother told us that *"he always seemed most 'normal' when he said he felt depressed"* but that he had explained to her that "*when people saw him as this very agreeable kind of person he was, in fact, depressed".*

Consultant Psychiatrist 1 reported that there was no evidence of psychotic features at interview. While on the ward, Mr N provided written consent to medical treatment and agreed to take medication as advised/prescribed. The plan agreed at review was that he would have another 'pass' home from 20-27 November. He would return

to the ward on the afternoon of 27 November for review and continue with the same medication.

Nursing notes indicate that Mr N was also attending the ward between reviews to socialise with patients and to *'have a chat with'* nursing staff'.

On 21 November, Mr N contacted MHO 1 to discuss restarting his community support package. We take this as an acknowledgement that there were no supports in place for him at home while on suspension. We understand that a meeting to make these arrangements was planned for 24 November.

Mr N spent Saturday, 22 November with his mother and bought new clothes for himself in town. His mother told us that on the day before he died, Mr N told her that he felt '*locked up inside and couldn't express himself'.* We do not know if Mr N shared this perception with staff.

We heard from Mr N's mother that on the night before his death, her son had spent the evening with his friend from upstairs, talking, laughing and joking about different ways he could commit suicide. His friend decided that Mr N was just joking because he was always joking, even when he was really low. Although we do not know if Mr N was planning his death at this time, it would appear that thoughts of suicide were present.

- **Death**

On the day of his death, Sunday 23 November, Mr N attended the ward around lunch time. We understand he spent some time talking to the Chaplain, having lunch with other patients and chatting to nursing staff on ward 1.

He was noted to be *'slightly low in mood'* by a Staff Nurse.

Later that day, Mr N took his own life by jumping from a prominent high bridge.

We heard from Charge Nurse 1 that it must have taken a considerable effort as the bridge has substantial barriers around five feet high at the point from which he jumped.

Charge Nurse 1 told us that there were *"no warning signals"* and that he *"didn't see his suicide coming'"* Given the difficulty of accessing the bridge, he suspected that Mr N was *"under the influence";* however, toxicology results obtained post mortem show that there was no presence of opiates and that alcohol levels were within the UK legal limit for driving.

Positive feedback

In the course of reviewing files and interviewing key people involved in caring for Mr N, we identified several examples of notable practice.

1. The voluntary organisation support workers showed a considerable degree of tolerance in supporting Mr N, even when his behaviour was difficult and

abusive. In addition, they made every effort to communicate concerns about his deteriorating mental health to the social work department and to his clinical team.
2. The RMO clearly respected Mr N's autonomy and made admirable efforts to involve him in decisions about his own care and treatment.
3. The care plan proposed to the tribunal was appropriate and clearly articulated.
4. The tribunal hearing was well conducted, with all parties afforded the opportunity to contribute.

Analysis and Findings

It was never the intention of this investigation to apportion blame for Mr N's death, but rather that, by reviewing his care, the care management decisions and service delivery, learning points might be identified by the services involved and by the wider mental health care community in Scotland.

Also, we acknowledge that Mr N had not expressed suicidal ideas during this episode of illness. This makes this investigation even more important. There is a well documented increased risk of suicide after discharge from mental health care. We wanted to look into the process of transition from hospital to community care to see if lessons could be learned from Mr N's death.

Suspension of Detention

We found compelling evidence that there was a contradiction between the plan proposed at the tribunal hearing and what then happened.

On the basis of the evidence presented to it, the tribunal panel granted a hospital based CTO. Although the issue of suspension of detention was raised at the tribunal, it was clear that this was being discussed as a future option, to be considered once Mr N's health was stabilised, after gradual extension of time allowed out of the ward and a community support package put in place.

We find it difficult to understand what had changed in the circumstances between the day of the tribunal, when the tribunal heard and accepted the convincing case made by the RMO and MHO in support of a hospital based CTO, and the following day when the suspension certificate was signed.

The reasons given for suspending detention were perfectly legitimate i.e. *to facilitate reintegration into community living, to allow contact with family members and to promote structured daily activities.*

In addition, conditions were set out in suspension certificate, namely:

1. *To continue taking prescribed medication*
2. *To abstain from alcohol*
3. *To attend for regular reviews on the ward*
4. *To reside at home address*

Although the legal purpose of a suspension certificate is to suspend compulsory measures authorising detention in hospital for a specified time, (in this instance from 13 November for a period of 6 months to 11 May 2009), we heard from the RMO that this was not in fact her intention. She explained that there was some confusion in the early years after the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003 around the suspension process and she believed at that time that any period of leave or 'pass' for a patient subject to a CTO needed to be covered by such a suspension certificate. In her view, she was using the suspension process to allow Mr N to have time away from the hospital, in line with his wishes, with the security of the hospital staff and hospital bed as a back-up, knowing that she could recall him to hospital at any time if he failed to comply with the conditions set. The clinical team's perception was that Mr N was an in-patient with sanctioned time at home. This is confirmed in Clinical Director 1's review.

This confusion aside, it was clear from discussion at tribunal and from our interviews and records examined that the community support package was not in place, that CPN support was not in situ, and that apart from being escorted on a visit home by a nurse on 6 November, no health or social care practitioner or support worker visited Mr N at home prior to suspension of detention, nor in the period between the tribunal hearing and his death 11 days later.

The weakness in the suspension plan was that it failed to learn from past unsuccessful attempts at re-integrating Mr N into the community. Despite arguing robustly at the tribunal that things would have to be done differently this time to monitor his compliance and sustain his wellbeing in the community, Mr N was out in his flat, on new medication, without preparation or measures in place to support him at this time of peak vulnerability.[1]

Any measures to monitor how he was coping during this period appear to have been hospital based, relying on his attendance at ward 1, although it is not clear whether this was done in any systematic way.

Relying on Mr N's self-reports of how he was managing at home at such a vulnerable time in his recovery was a poor substitute for visiting him to assess how well he was coping, particularly given that non compliance with medication while in the community is a recurrent theme in medical reports recommending compulsory treatment.

Communication between all parties

Although suspension and eventual variation to a community compulsory treatment order were discussed as future options, MHO 1 and Mr N's mother left the tribunal confident that Mr N would be detained in hospital until his mental health was stabilised and safeguards were put in place to support his recovery and monitor his medication. This view was confirmed in interviews with Mr N's mother and with MHO

[1] Safety First : Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001)

1. Mr N's mother stressed that her understanding was that her son would not leave hospital until he was ready to go and "everything had been put in place because he wouldn't have managed without support". Mr N's mother confirmed that Mr N had phoned her on 13 November and said he was out of hospital. Her reaction had been that "he couldn't be", but she then received a letter from Consultant Psychiatrist 1, two days after the hearing, confirming that Mr N had been placed on suspension of detention from 13 November through to 11 May 2009. Mr N's mother told us that she could not understand it and expressed her shock at hearing her son was out of hospital immediately following the tribunal hearing. It gave her no time to try to help him get his flat in order and she was aware that the community supports discussed at the tribunal were not yet in place.

We also heard from MHO 1 that on leaving the hearing her understanding was that a hospital based order was granted and that Mr N would remain an in-patient, to engage with nursing and medical care and treatment until an appropriate support package was put in place. The first she knew that Mr N was out of hospital was when she returned from holiday on 18 November and received a letter from Consultant Psychiatrist 1.

We heard from Mr N's mother that she was "very rarely informed" when Mr N had left hospital, "had his section lifted" or was out in the community. They would always get a letter afterwards but, generally, the first they knew he was out of hospital was when he phoned.

We also learned in the course of the investigation that communication and joint working between Social Work Department 1 and NHS Board 1 could be inconsistent and ad hoc. For example, social work officers were not routinely involved in NHS Board 1's critical incident reviews and NHS clinical managers did not have access to relevant social work files. There were also different perceptions of the purpose of the meeting planned for the 24 November. We heard from the social work department and Mr N's mother that the meeting was arranged to review and discuss reinstatement of the community support package, while the NHS staff thought that was the date when support services would be in place. We think that such apparently minor but significant differences of understanding may be indicative of a lack of 'joined up thinking' between the social work and health care partners.

Assessment and management of risk

"Prevention is difficult and prediction- identifying the highest risk patient from the many who are at risk to some degree – unreliable, but, the management of risk can always be improved." [2]

Much has been made by the clinical team of the fact that Mr N was not discharged, but 'on pass'; however, Mr N's mother told us that from her son's perspective, this

[2] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Lessons for mental health care in Scotland (2008)

was a technical distinction. From Mr N's point of view, as soon as he was out of hospital, he was free to do what he wanted.

We make this point as we think that although the clinical team understood that a bed was still available on the ward, from Mr N's perspective he was to all intents and purposes 'discharged'. It is worth noting that the Safety First Report (2001) from the Confidential Inquiry into Suicide and Homicide by People with Mental Illness[3] highlights the risk of self harm during leave of absence as well as in the immediate period after discharge. It recommends, therefore, that clinical monitoring should be targeted at both groups, and similar effort put into providing community support.

We noted earlier the notion that there was still 'confusion' about the use of the suspension provision within the 2003 Act, some three years after its implementation in 2005. We also note that both in patient records and at interview, staff frequently used the terms 'pass' and 'suspension' interchangeably. We think there was a lack of clarity and understanding of the term 'pass'. In addition, we think this may have led to a lack of clarity about the expectations of all parties when patients were 'on pass'. We could not find any systematic recording of the expected nature or frequency of contact with ward staff, which makes it difficult to have confidence in monitoring this condition of suspension.

When we examine known patterns of suicide, we find that most patient suicides happen without obvious warning and when risk appears to be low.

Recent evidence indicates that the most risky time for death by suicide is the post-discharge period. In 2001 the National Confidential Inquiry into suicide and homicide by People with mental Illness reported that[3]

- Twenty six percent of suicide cases in Scotland died within three months of discharge from in-patient care
- Post-discharge suicides were at a peak in the first 1-2 weeks following discharge
- Around a third of in-patient suicides in Scotland were on agreed leave at the time of death.
- 35% of post-discharge suicides in Scotland occurred before the first follow up appointment.
- Just under one third of suicides in the community missed their final appointment with services (29% in Scotland).

We cite these findings because they provide a salutary reminder of the particular risks present in the period after leaving hospital care and we believe that responsible mental health professionals have a duty to keep up to date with contemporary evidence and incorporate it into their clinical practice and service design. We found little evidence of application of this knowledge into risk assessment or management of Mr N's care.

[3] Safety First : Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001)

Scotland's national strategy on suicide prevention 'Choose Life' 2002[4] recommended the focus of action and efforts on a number of priority groups. Mr N matches many of the criteria of these priority groups in that he was a relatively young, unemployed man with a history of severe mental illness and substance abuse, affected by the aftermath of recent family suicide and, in addition, was recently bereaved.

We have referred earlier to Mr N's documented history of self harm, resulting from both impulsive and premeditated acts over a twenty year period. In 2006 it was noted by the doctor assessing his mental state after an overdose of prescribed medication that '*he clearly remains at a long term risk of serious self harm even complete suicide'.*

These episodes of self harm should be understood in the context of an extensive family history of psychiatric illness and of suicide associated with affective disorder.

We understand that seven family members have died by suicide, the most recent being Mr N's cousin who died in March 2008.

In this case, clinical management appears to have been based on the team believing they knew Mr N well and could predict his behaviour and his response to treatment. However, we are not confident that Mr N's history of self harm, his family history of suicide and recent stressors were fully taken into account when making decisions.

The only formal risk assessment we found in the files we examined was a single sheet titled 'self harm risk assessment', partially completed on admission to ward 1 on 10 October 2008. It appears to have been used as a means of deciding upon the appropriate level of observation (at this time, 'general'[5]). It was, however, superficial, incomplete, and unsigned.

We could find no evidence of an effective risk management plan in place to underpin the decision to suspend detention.

Dr Harry Burns, writing his foreword to the Scottish summary of the 2001 National Confidential Inquiry, notes that mental health services can strengthen their management of risk in a number of ways. Most of the measures that can be taken to reduce risk are not about a long list of instructions or protocols for clinical staff but are concerned with the quality of care more broadly, for example closer follow up or contact with patients' families.

In addition to the well established clinical risk indicators for suicide, there is a growing body of evidence showing a positive link between improvements in mental

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[4] *Choose Life:*
A National Strategy and Action Plan to Prevent Suicide in Scotland 2002

[5] For full description of observation levels see CRAG guidelines "Nursing Observation of Acutely Ill Psychiatric Patients in Hospital" (1995), revised 2002

health services and a reduction in suicide rates[6]. Professor Louis Appleby, Director of the National Confidential Inquiry writes *'the community care reforms of the last decade seem to have had a positive impact on patient suicide - providing more intensive support to the most vulnerable patients appear to have improved their survival'"*[7].

We turn now to factors which we believe may have minimised the risk in Mr N's case, namely the assessment of his home circumstances, the provision of an adequate support package before suspension of detention including visiting him at home while on suspension to check how well he was coping and communicating with Mr N's family.

Assessment of home circumstances

The nurse accompanying Mr N home on 6 November recorded that his home environment was chaotic and disorganised and that there was no electricity available. Although there was a multidisciplinary team meeting held that same day, we could find no reference made to social work, family or any other community agency to help assist Mr N in tackling the condition of his flat to make it habitable.

Five days later, with no apparent measures put in place to improve his living conditions, Mr N was granted an overnight pass to this flat. We established during the course of our investigation that Mr N's flat had a power card meter so the electricity supply was relatively easily restored. It is not clear, however, that ward staff were aware of this and, in the event, power was only restored when Mr N's mother gave him money for a power card.

We heard from MHO 1 that social work or ward staff usually go home with people when they are going 'on pass', to ensure that their home is habitable. She added that "all this is usually organised before the person is officially discharged". We accept that Mr N was not 'officially discharged'; however, we would suggest that the same steps should be taken to ensure the safety and comfort of all patients recovering from serious mental illness who are leaving the comparative safety of the hospital environment. Whereas it may be acceptable for a patient to spend a short part of the day at home in such circumstances to get his home in order, it is hard to justify sanctioning overnight 'passes' to a property which lacks basic amenities.

It would appear that the hospital's priority was keeping a bed available/open as opposed to ensuring effective community support was in place prior to the decision to suspend detention. In our view, the provision of a 'bed' does not equate to 'treatment'. It could be argued that this practice, rather than fostering recovery and optimising self management, was creating dependency and reinforcing a pattern of hospital based support.

Management of transition from in-patient care to community

[6] Full citation to be inserted : Kapur N et al the Lancet 02.02 2012
[7] ibid

The quality of care provided by modern mental health and social services depends as much on how professionals work together as on their individual competence within their own field of expertise. For the purposes of this investigation we have adopted the definition of inter-professional working as 'how two or more people from different professions communicate and co-operate to achieve a common goal'. [8]

We think in this case that one element of the 'common goal' ought to have been the co-ordination of services and support to ensure continuity and a seamless transition of care from one setting to another.

In our view, a multi agency co-ordinated approach such as the Care Programme Approach (CPA), originally adopted in Scotland in 1992, would have provided an appropriate framework for co-ordinating Mr N's care given the complexity of his problems and his history of non-compliance and offending; however, this does not appear to have been considered.

We heard different accounts of the format and effectiveness of communication between individuals and organisations providing care for Mr N.

While we heard in interview that health and social work staff shared space in the hospital and met regularly at ward rounds and Community Mental Health Team meetings, there appears to have been a lack of communication between the ward staff and social work staff as the social worker/MHO appears not to have been informed of the issues concerning the state of Mr N's flat. We also heard that there were no arrangements made with the social work staff to support Mr N while he was out on suspension.

It appears that Mr N was allowed to return home without a documented rationale for the decision, without consultation with the social work service and without a plan for his support in place.

Support in the community

We agree with the recommendation of the National Confidential Inquiry 2008 that there is a strong case for more intensive community support for patients at highest risk and greatest need.

At the tribunal, Consultant Psychiatrist 1 had explained that she wanted safeguards in place in the event of relapse, in order to provide adequate care and re-entry into the system straight away. She also stated that a hospital based order would give an opportunity to keep a very close eye on Mr N; that support packages needed to be discussed and were not yet in place. It was also argued that the CTO was necessary in order to monitor the effectiveness of the new medication.

No systems were put in place in the community to keep this 'close eye' on Mr N or to monitor his compliance with and response to medication.

[8] Ovretveit, Mathias & Thompson (eds) (1997) Interprofessional Working for Health and Social Care

We also note that the voluntary organisation's organisational policy is to withdraw home support while clients are in hospital. Because Mr N was not discharged, his home support had not been reinstated.

We heard that the tribunal believed CPN support and intervention so crucial to the success of the care plan that they considered making its provision a recorded matter. However, they did not feel it necessary to do so as they had been told it would be put in place.

We acknowledge that there are contrasting views held about the utility of separate home treatment/crisis support teams. The view expressed to us by Associate Medical Director 1 was that he did not consider such a structure appropriate. He considered that crisis support and intervention should be a function of community mental health teams. Such a model can be effective, providing there is adequate provision and flexibility to respond quickly to a referral. However, in this service and on this occasion we heard that a heavy workload and backlog may have impacted upon the CPNs' capacity to prioritise and respond.

As we noted previously, files show a referral letter to the CPN dated 4 December 2008 (eleven days after Mr N's death) thanking him for agreeing to provide CPN input and care management. However, no contact was established by the CPN prior to Mr N's death.

Consultant Psychiatrist 1's explanation was that Mr N was not assessed as needing immediate CPN intervention as he was not discharged, and he had free and full access to the support provided by the ward. Consultant Psychiatrist 1 also told us that there were long delays in getting letters typed.

We disagree that CPN intervention was not needed. In our view, at a time of peak vulnerability, Mr N had, in effect, less support at home than he had prior to his admission

Conclusion

'Every death under mental health care is a tragedy, inevitably raising the question of whether more could have been done'.[9] It is not the intention of this investigation to apportion blame but rather to highlight key areas of clinical practice where improvement is needed and suggest what changes could be made.

As the National Confidential Inquiry (2008) acknowledges, anyone who has been in clinical practice knows how difficult it can be to get the balance right between respecting patient autonomy and active intervention. This dilemma was not only clearly recognised by the clinicians caring for Mr N but, to some extent, grappling with this dilemma characterised the decision making by the RMO immediately before, during and after the tribunal hearing.

We recognise that caring for a man such as Mr N, with his fluctuating perception of his need for support and ambivalence towards engaging with treatment, could be difficult and frustrating.

We also think it possible that Mr N's intelligence and persuasive eloquence may have masked his vulnerability and contributed to a less proactive approach to the management of his care.

We do not know what was in Mr N's mind at the time he took his own life. He does not appear to have shared his thoughts or suicidal intentions with those caring for him prior to his death; however, it is well documented that his mood could deteriorate rapidly and that he was capable of impulsive acts of self harm.

Despite knowledge of this well documented clinical pattern and agreement at the tribunal that he needed to be in hospital for a bit longer, to ensure ongoing compliance with medication and to get a proper plan in place, Mr N was sent home from hospital without a community support package in place, without prior communication with his family or MHO, and with no means of validating his self-reports of how well he was managing at home.

We think there was over reliance on using the hospital as the 'safety net' and because Mr N was not formally discharged from the hospital, the community supports had not been triggered.

This hospital based service model and practice of 'keeping a bed open' as the principal means of providing support during transition is unsatisfactory in the absence of other supports. We consider that it was far more important to offer support at home to help Mr N's recovery and carefully monitor his mental health.

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[9] The National Confidential Inquiry into suicide and homicide by people with mental illness June 2008

We noted an apparent lack of an integrated approach to the transition from in-patient to community care. Had this been in place, it would have provided a more flexible and effective means of managing Mr N's care in these circumstances.

In our view, this was a serious omission which must be addressed by the RMO and service managers as a matter of urgency to ensure the safe transition from in-patient to community care for vulnerable individuals.

Having reviewed the case files, interviewed key informants and examined the tribunal findings it is the conclusion of the investigation team that while Mr N's death may not have been preventable, there were several factors that may have reduced the probability of his suicide and increased the family's confidence that the people providing care for Mr N were listening to them and responding appropriately to keep him safe. Our recommendations address these factors and suggest further learning points to be considered by the agencies involved in providing care for Mr N.

Though it is impossible to say if Mr N's death could have been prevented in the longer term, if the plan argued for and agreed at the tribunal had been implemented there is, in our view, a stronger probability that he would not have had the opportunity to carry out his suicide at that time and in that manner.

The tribunal does not appear to have been fully informed of the intentions of the RMO to suspend detention immediately and therefore did not have the opportunity to satisfy itself of the robustness of the community supports available.

In light of the growing evidence that adopting the recommendations made by the National Confidential Inquiry correlates with a reduction in suicide rates, we would urge NHS boards and partner agencies to review their service provision, in particular to consider the introduction of 24 hour crisis teams and assertive outreach services designed to keep in touch with patients who have a history of erratic compliance and missed contact with services.

Recommendations

NHS Board 1 should:

1. Review the function of community mental health teams to ensure that they assess the needs of people in transition from hospital to community care.
2. Provide practitioners with guidance on management and review of periods of leave from hospital, with particular reference to communication with carers and the importance of feedback from a third party on how successful the period of leave was.
3. Ensure that there is a process for communication of proposed long episodes of suspension to the designated mental health officers.

NHS Board 1 and local authority partners should:

4. Review the criteria for, and use of, the care programme approach to ensure that it is targeted at vulnerable people with complex needs and multi-agency involvement.
5. Review the arrangements for support for people on leave from hospital to ensure that, during significant spells of leave, supports from all providers are available based on individual need, prior to the period of leave.

We also wish to draw the attention of Scottish Ministers to recommendation 5.

In the context of the integration of health and social care, Scottish Ministers should consider the recommendation we have made to review the arrangements for support for people on leave from hospital to ensure that, during significant periods of leave, supports from all providers are available based on individual need.

Other learning points for NHS Board 1. The Board should:

- Review the process for documentation and management of clinical risk within mental health services and audit compliance with policy on this.
- Audit compliance with targets for typing and sending clinical letters and take action to address delays.
- Remind all approved medical practitioners of the judicial authority of the tribunal, the importance of providing clear information on current and proposed plans of treatment to the tribunal and explaining any intention to change those plans.