Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health & Social Care Trust

NIPSO Reference: 17293

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

The investigation of a complaint and the production of a report are, by nature, and necessity, objective processes. With that in mind, at the outset, it is right to distinguish the heart-breaking reality that lies at the core of this case. The loss of a precious, young life cannot be measured and the pain and anguish felt by loved ones is especially difficult to bear. I wish to acknowledge the courage shown by the complainant in the face of this personal tragedy.

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SUMMARY

I received a complaint regarding the actions of the South Eastern Health and Social Care Trust (the South Eastern Trust). It related to the mental health care and treatment received by the complainant's son prior to his tragic death on 19 December 2013. The complainant's son 'the patient' had a history of alcohol and drug misuse related to depression. In the preceding months, the patient had attended the Ulster Hospital's Emergency Department (ED) on numerous occasions, usually under the influence of alcohol and drugs, and often with thoughts that life was not worth living.

The investigation considered whether the care and treatment provided to the patient by the South Eastern Trust was appropriate and reasonable. In particular, the investigation looked at: the co-ordination of the patient's care; the complainant's concern that the patient should have been detained for his own safety and; whether the complainant had been adequately included in assessments and decisions made about the patient when he presented at ED.

The investigation found the South Eastern Trust provided emergency care to the patient but as the patient was a resident of Belfast his ongoing care post discharge was the responsibility of the Belfast Health and Social Care Trust (the Belfast Trust). The actions of the Belfast Trust were not part of the complaint and were not considered as part of this investigation. The actions of the South Eastern Trust were therefore considered in the context of its role in providing emergency care to the patient and its responsibility to provide information to the patient's 'home' Trust. The investigation identified failures in care and treatment in relation to the co-ordination of approach to the patient's care; the management of the patient's safety; and the involvement of the complainant in discussions about the patient's care.

The Serious Adverse Incident (SAI) Review conducted after the patient's death addressed some of the issues described above. However, by way of remedy, I recommend that the Chief Executive should write to the complainant

acknowledging the failures highlighted in this report and offering a fulsome apology for those failures. In addition to the remedial action previously identified by the SAI Review, the Chief Executive should explain what steps will be taken to prevent the identified failings from being repeated. These steps should include the production of guidance to assist mental health practitioners in their role.

THE COMPLAINT

1. I received a complaint concerning the care and treatment provided to a patient by the South Eastern Health and Social Care Trust (the South Eastern Trust). The patient died by suicide on 19 December 2013 having gone missing from home the previous night. The complaint is essentially that the South Eastern Trust ignored the warning signs following the patient's numerous visits to ED, including previous attempts to take his own life.

Background

2. The patient was thirty-one years old when he died. In previous years, prior to his tragic death, the patient had struggled to come to terms with several traumatic life events including the death of his father and, the discovery of his uncle's body after a shooting accident. As a result, the patient had experienced long-term depression and had turned to alcohol and drugs as a means of coping. In the days immediately prior to his death, the patient had lost his job and his partner had suffered a miscarriage and taken an overdose.

3. The patient's home was located within the geographical area served by the Belfast Health and Social Care Trust (the Belfast Trust). The Belfast Trust was therefore the patient's 'home' Trust and so had overall responsibility for his care and treatment. The patient had attended the Belfast Trust's Community Addictions Team prior to 2013. However, his nearest ED was located at the Ulster Hospital, Dundonald, a hospital managed by the South Eastern Trust.

4. In the months preceding his untimely death, the patient presented to the ED at the Ulster Hospital on numerous occasions: 19, 22 September, 1/2/3 October, 4/5, 5/6, 8/9/10, 27/28 November, 15, 16/17 December 2013. His visits to the ED led to further referrals being made to the Belfast Trust's Community Addictions Team and other agencies. On 17 December 2013, the day the patient was last treated in the Ulster Hospital, Mental Health Service staff referred him to the Belfast Trust's Home Treatment Team for a same-day appointment. The patient attended this appointment. The patient was found dead on 19 December 2013.

5. The Belfast Trust conducted a Level One Serious Adverse Incident (SAI) Review[1] into the patient's untimely death and produced a report in February 2014. The South Eastern Trust offered to contribute to this audit although, ultimately, its staff were not invited to take part.

6. Subsequently, following intervention from the complainant via the Coroner's Office and the then Minister for Health, the South Eastern Trust agreed to conduct a Level Two SAI Review[2]. The resultant report was produced in February 2016.

7. The Coroner held an inquest into the patient's death in October 2016.

Issue of complaint

8. The following issue of complaint was accepted for investigation:
Whether the care and treatment provided to the patient by the Trust was appropriate and reasonable.

[1] When a serious incident occurs, such as in this case, the purpose of an SAI review is to understand what occurred and to share learning across the relevant services. A Level One SAI review (called a Significant Event Audit) will assess what happened, why it happened, what has been / or will be changed and identify local or regional learning.
[2] A Level Two SAI review (called a Root Cause Analysis) identifies any underlying system and process issues that may have caused or contributed to the serious incident.

INVESTIGATION METHODOLOGY

9. In order to investigate the complaint, all relevant documentation was obtained from the Trust, as well as the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of this complaint. An Investigating Officer also met with the complainant.

Independent Professional Advice Sought

10. After further consideration of the issues, independent professional advice was obtained from the following independent professional advisor (IPA):

- Mental Health Nurse RGN, RMN, BA (Hons) Community Mental Health Nursing and Diploma of Applied Science Advances psychiatric nursing practice. Twenty eight years' experience of working in mental health services in the UK

11. The IPA provided advice on 20 May 2018. This was shared with the South Eastern Trust who provided written comments on 30 August 2018. The IPA subsequently provided updated advice on 18 October 2018. Later in the investigation, the IPA provided further advice dated 5 May 2020 which appears under the heading 'Additional Question'. Finally, on 26 May and 1 June 2020, the IPA provided other supplementary advice.

12. The information and advice which have informed the findings and conclusions are included within the body of this report. The IPA has provided 'advice'; how that advice has been weighed, within the context of the specific issues which I have decided to investigate, is a matter for my discretion.

Relevant Standards

13. In order to investigate complaints, this office must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

14. The general standards are the Ombudsman's Principles[3]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Principles for Remedy

15. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional-judgement functions of the Trust whose actions are the subject of this complaint.

16. The specific standards relevant to this complaint are:

- Royal College of Psychiatrists Better Services for People who Self Harm (2006);
- Crisis Resolution and Home Treatment A Practical Guide (2006) – The Sainsbury Centre for Mental Health;
- Best Practice in Managing Risk – Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services (March 2009) – Department of Health Guidelines;
- South Eastern Health and Social Care Trust Involving Families / Carers in the Assessment, Care Planning, Review and Discharge Processes (2011);
- National Institute for Health and Care Excellence (NICE) Service user experience in adult mental health - CG136 (2011); and

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- Joint Protocol for the Transfer of Adult Mental Health Patients between Belfast HSC Trust and South Eastern HSC Trust[4] (March 2013).

17. All of the information obtained in the course of the investigation has not been included in this report but everything that is considered to be relevant and important has been taken into account in reaching the findings.

18. In accordance with the NIPSO process, a draft copy of this report was shared with the complainant and the South Eastern Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant offered no comment. The Trust's comments are referred to at paragraph 65 of this report.

INVESTIGATION

Whether the care and treatment provided to the complainant by the Trust was appropriate and reasonable.

19. Within the broad area of complaint outlined above, the complainant highlighted several areas where she had particular concern. Having considered these areas, the Director of Investigations decided the investigation should focus on three specific issues:

Co-ordination with Belfast Trust

- The complainant stated that, given the escalation of the patient's behaviour in the weeks leading to his death, a co-ordination of approach with Belfast Trust should have been apparent and, a multi-disciplinary meeting involving professionals from both Trusts should have been convened to address the patient's needs.

[4] Referred to hereafter as the Joint Protocol

Detainment

- It was complained that the patient should have been 'detained' due to the significant risk which he posed to himself in the days before his death. The complainant referred particularly to the events of 16/17 December 2013, the patient's last presentation to the ED.

Involvement of the patient's mother (the complainant)

- The complainant claimed that her views as the patient's mother were not taken into account, or, were relegated in importance to those of the patient's partner who was his next of kin. The complainant claimed that, given his partner's own mental health problems, she, as the patient's mother, should have been involved in any mental health assessments or decisions being made, irrespective of the fact that the patient's partner was named as his next of kin.

20. These issues were communicated to both the complainant and the South Eastern Trust, by letter, on 1 December 2017.

21. The complainant has not complained about the actions of the Belfast Trust and so this complaint is concerned solely with the actions of the South Eastern Trust.

Listed Authority's Response

Co-ordination with Belfast Trust

22. The Trust stated: *'On each occasion that [the patient] was seen and assessed in SET[5], staff within Belfast Trust were subsequently informed of the outcome of assessment or through the Card Before Your Leave[6] [CBYL] referral process.'*

[5] South Eastern Trust

[6] *Under the CBYL scheme where it has been assessed that the patient poses no immediate risk to themselves or others, the patient is given a next day appointment with a member of the mental health team who will check how they are doing and arrange any on-going care and support that may be required.* Source: HSCB 24/04/2013

23. With particular reference to the patient's attendances at the ED on 15 and 16 December 2013, the Trust was clear that appropriate procedure was followed which gave the patient next-day access to Belfast Trust's mental health services in relation to his attendance on 15th, and same-day access in relation to his attendance on 16th.

24. The Trust stated that the *'support and assistance'* provided to the patient was *'comprehensively addressed within the original SET SAI report'*.

25. *'The [SAI] Review Team identified deficits in communication between the two Trusts during some of [the patient's] presentations. As a result, the Review Team recommended that improvements should be made to ensure improved communication at times of case transfers in terms of discussion following each assessment and follow up arrangements.'*

26. *'Additionally, the Review Team recommended that transfer of care must be centrally coordinated to ensure information, both written and verbal, is shared. A further aspect to this recommendation sought to ensure that the then draft Trust policy on 'Initiating a Multidisciplinary Case Discussion in Response to a High Referral Rate for an Individual Service User, Including those with Self-Harm/Self Harm Ideation' should be reviewed to include practice guidance at times of transfer of care.'*

Detainment

27. The Trust stated: *'It is the presentation at the time of assessment which ultimately determines the legality of the need for detention under the Mental Health (NI) Order 1986.'*
'[The patient] was assessed by a number of practitioners at the times of his presentations within South Eastern Trust and was not deemed to require assessment for detention under the Mental Health Order.'
'During his mental health assessments, on each occasion, [the patient] denied that he had thoughts that life was not worth living, that he was not experiencing suicidal ideation and he had no suicidal plan or intent. [The

patient] therefore did not meet the legal threshold for assessment under the Mental Health Order.'

28. Referring to the 17 December 2013, the Trust stated: *'There is evidence in the records that on this occasion, given [the patient's] previous and numerous presentations, the assessing practitioner liaised with colleagues who had assessed [the patient] previously. A number of key areas were identified and considered, i.e. there was deterioration in [the patient's] mood from previous assessments and, as highlighted by his mother, there was an exacerbation of risky behaviours, and his mother was fearful that [the patient's] ability to keep himself safe was diminishing. The assessing practitioner contacted the Belfast Trust Home Treatment Team, which is [the patient's] home Trust, and discussed his presentation. The Home Treatment team is part of the acute care service which facilitates admission to hospital and alternatives to admission based on assessed need.*
Following this discussion, [the patient] was offered an appointment with the Belfast Home Treatment Team later that afternoon. [The patient] attended this appointment accompanied by his fiancée.'

Involvement of the patient's mother (the complainant)

29. The South Eastern Trust stated that its SAI Review Team had considered the complainant's view that *'she was not adequately involved in the aftercare arrangements on each occasion her son attended [the] Emergency Department.'*
The SAI Review Team *'noted that at the times of assessment, [the patient's] partner was the identified next of kin, and thus was consulted in relation to a collaborative history. The Review Team also considered the complainant's role in providing additional information in relation to her son and concurred that practitioners should consider input from other family members in the provision of aftercare. Subsequently, a recommendation was made that all relevant Senior Managers should ensure this practice within their teams.'*

30. In terms of the Mental Health Assessment conducted on 17 December 2013, the South Eastern Trust explained how an attempt was made to contact the complainant by phone for the purpose of taking a corroborative history. Although she could not then be reached, contact was made through a phone call from the patient. The South Eastern Trust stated: *'The assessing practitioner's practice in relation to contacting [the complainant], following her son's assessment was in accordance with Trust policy.'*

Records

31. The investigation considered medical records and mental health case notes related to the patient's ED visits for the period 22 September to 17 December 2013. The South Eastern Trust's SAI Review Report was also considered.

32. I note the complainant's view that services should have been alert to the fact that the patient's partner (and next of kin) was herself experiencing mental health concerns. The SAI Review Report made reference to this as follows: *'The Review Team . . . would concur that in a situation where practitioners are aware that there is more than one member of the family experiencing mental health concerns, this should alert practitioners to whom the individual/s present, to consider input from other members in the provision of* aftercare*.'*

33. I also note the following comments contained in the SAI Review:
'On the assessment of 17 December 2013 undertaken by Nurse A, [the complainant] was contacted and discussed her concerns with the assessing nurse, which both corroborated the history taken from [the patient] and added to the agreed outcome of the assessment.'
The record of the assessment has been examined and supports this account.

Independent Professional Advice

Co-ordination with Belfast Trust

34. The IPA was aware that the South Eastern Trust, the Belfast Trust and

various groups from the voluntary sector had been involved in the patient's care.

35. The IPA stated: *'A multi-agency approach should have been adopted because of [the patient's] increased attendance to A&E[7] and his increased level of risks (he had a history of overdosing on medication, he attempted to hang himself and he had a history of carrying a shotgun in his car). His history was enough to trigger a multiagency safety plan for [the patient].'* In support of this view, the IPA referred to national guidelines entitled *Better Services for People who Self Harm*, published by the Royal College of Psychiatrists in 2006: *'31. Joint protocols should be agreed between the services that treat people who self harm'.*

36. The IPA stated: *'The Belfast mental health services would be responsible for setting up the meeting taking a multiagency / multidisciplinary approach.'*

Detainment

37. The IPA stated: *'[The patient] would need to have met certain criteria to be detained under the Order. The criteria is that a person must be suffering from a mental disorder of a nature or degree that warrants detention in a hospital for assessment or treatment and that he/she ought to be detained in the interests of his/her own health, safety or with a view to the protection of others. . . . The decision is usually made by two doctors and an ASW[8] whether that person should be detained or not under the Order. The three people involved in the Mental Health Order assessment must all agree that the person needs to be detained in hospital and meets the criteria for detention. During the assessment [the patient's] history would be looked at overall. However, the decision to detain a person under the Order is based on the clinical judgement of the professionals at the time.'*

[7] Accident and Emergency
[8] Approved Social worker

38. Initially, the IPA stated: *'[The patient's] risks had increased and it would have been standard practice to discuss the case with a senior team member and or with a doctor / consultant psychiatrist.'*

39. In response, the South Eastern Trust did not accept that its mental health practitioner should have consulted a senior colleague / consultant. According to the Trust it is *'not standard practice in this Trust or elsewhere in Northern Ireland.'*
'The mental health professionals who undertake crisis assessments are highly skilled and experienced professionals who undertake such assessments on a daily basis. The assessing practitioners do at times liaise with other senior colleagues and psychiatrists as the need arises, however, the need to do so in [the patient's] case was not evident.'

40. The IPA's further advice refers specifically to this point. Contrary to the South Eastern Trust's position, the IPA was clear that the need to do so <u>was</u> evident in this case. In particular the IPA highlighted that the patient was brought to the ED because *'he expressed suicidal ideas about hanging himself',* and, the assessor found *'he could not guarantee his safety.'* The IPA stated that the risk factors with which the patient had presented *'should have alerted the [assessor] that he was moderate to high risk'* and, this *'should have prompted or triggered a request to a senior clinician / psychiatrist from the [assessor] to review [the patient].'*

41. The IPA found no record that a safety plan had been produced on that occasion. The IPA was concerned by this because the patient did not say he could keep himself safe. The IPA stated the assessor did not '*assess and identify [the patient's] risks'* which the IPA regarded as *'crucial and fundamental'*. The IPA considered the apparent risk to the patient's safety to be such that the assessor should have raised the possibility of the patient's admission with a more senior colleague. The IPA also highlighted the necessity for the case to be discussed with colleagues.

42. The IPA raised the question of the patient's capacity noting that a *'mental capacity assessment does not appear to have been completed periodically in the interaction with [the patient] especially at times of heightened risk'.* In response, the South Eastern Trust stated that *'during [the patient's] assessments, there was no indication that he lacked capacity (an individual is deemed to have capacity unless he is assessed otherwise).'*

Involvement of the patient's mother (the complainant)

43. The IPA referred to the South Eastern Trust's guidelines: *Involving families/carers in the assessment, care planning, review and discharge processes (December 2011)*. The IPA stated: *'Family involvement is strongly recommended in these guidelines.'*

44. The IPA referred to the advice contained in Nice Guidance CG136, paragraphs 1.1.14 to 1.1.17 which relates to involving the family and carers of a person using mental health services. The IPA quoted from paragraph 1.1.15 including the following wording: *'If the person using mental health services wants their family or carers to be involved, encourage this involvement . . . '*

45. Referring to family members, other than the patient's named next of kin, the IPA advised: *'it is not clear from the clinical records'* whether *'any requirement to involve other family members'* was met.

46. In response, the South Eastern Trust stated that: *'[The patient's] next of kin was recorded as his partner . . . It was she with whom, in the main, the assessing practitioners spoke. However, the SET SAI Review Team acknowledged the value of [the patient's] mother's input also and as such identified this within the report. As such there are two recommendations which reference this issue, (i) in relation to the mental well-being of the next of kin, and (ii) ensuring that staff should listen to the concerns of significant others.'*

Analysis and Findings

Co-ordination with Belfast Trust

47. The first principle of good administration, Getting it Right, requires that *'public bodies . . . should follow their own policy and procedural guidance . . .'*

48. I note that both the IPA and the South Eastern Trust agree that more should have been done for the patient by way of the co-ordination of a multiagency approach to address his needs. The patient's attendances at the ED in the latter half of 2013 presented numerous opportunities for a more co-ordinated approach to be developed, not least between the two Trusts. I note that the SAI Review conducted by the South Eastern Trust found *'little evidence in the records of conversations between the South Eastern and Belfast Trusts regarding [the patient's] presentations or his aftercare. There was no evidence in the records that a co-ordinated approach was taken in the care and treatment of [the patient] by either Trust.'* The Trust acknowledged there was a need to improve *'overall communication . . . in cases of frequent presentations'* as in this patient's case.

49. I note the South Eastern Trust's SAI Review reinforced the need for staff to adhere to section 10 of the Joint Protocol. Section 10 specifically highlights communication requirements with the Belfast Trust. One of the principles listed in the Joint Protocol states: *'There will be good communication between practitioners and services to ensure smooth transfer and continuity of care.'* I note the SAI Review referred to *'non adherence to the extant policy and inadequate recording of referral documentation between Trusts.'* With the first principle of good administration in mind, I am satisfied this is indicative of a failure to do so in the patient's case and is therefore a failure in care and treatment.

50. The Chief Executive of the Trust advised this office: *'This policy has been reissued to all Mental Health Staff.'* I also note the South Eastern Trust's SAI Review contributed to the drafting of a new policy: *Procedure for Initiating a*

Multidisciplinary Case Discussion in Response to a Higher Referral Rate for an Individual Service User, including those with self-harm/self harm ideation. The Chief Executive provided my office with the *'reviewed version (2017) of this policy'* and advised that it has been *'circulated and implemented within the South Eastern Trust Mental Health Services.'* I note paragraph 4.2.2 of that policy refers specifically to the inclusion of other Trust's in the Multidisciplinary Case Discussion – *'in the case of service users who present out of catchment to South Eastern Trust services . . . '*

51. The South Eastern Trust has therefore sought to improve inter-agency communication as a result of this complaint. However, whilst the Trust has identified areas for its own improvement as a direct result of this case, the primary responsibility for co-ordination of approach was with the patient's *'home Trust'* or *'Trust of origin'*. Other than ensuring the patient's immediate needs were met each time he presented to the ED and that appropriate information was shared, I am satisfied the South Eastern Trust could not have directed the patient's longer term care needs as this was not his home Trust. The South Eastern Trust ensured that the patient was directed to his home Trust on each occasion he visited its ED in the Ulster Hospital.

52. I accept the IPA advice which stated the *'Belfast mental health services would be responsible for . . . taking a multiagency / multidisciplinary approach.'* I do not consider the South Eastern Trust had ultimate responsibility to take on the necessary co-ordination role. Therefore, on this basis, I do not uphold this element of the complaint.

Detainment

53. I have treated the word 'detained' as a reference to particular powers under the Mental Health (NI) Order 1986 where a person can be detained to undergo a psychiatric assessment. I note the complainant's strong belief that, by 17 December 2013, given the traumatic events of the previous night, the patient had adopted a *'massive change in tactic'* and could not be trusted with his own safety. Whilst this is acknowledged, there is no reason to suggest

that the patient would have refused admission to hospital had the South Eastern Trust taken this step; the record indicates the patient's consistent predisposition to seeking help for his difficulties.

54. The ED was made aware of the patient's life threatening actions by the PSNI. I noted the following ED record made at 23.40 on 16 December 2013: *'PSNI telephoned to say they had gone to site of attempted hanging and found a rope and . . . board pinned to a tree . . . to write a message on.'* I am satisfied this information was available to the mental health assessor.

55. However, on this the last occasion that the patient presented to the ED, the CPN[9] who conducted his mental health assessment decided upon an *'acute'* referral to the Belfast Trust's Home Treatment Team (HTT) for a same-day appointment. According to the complainant, it was only through her insistence that the CPN was persuaded to make a same-day referral. I note the complainant had '*insisted that [the patient] was not coming home*'.

56. Had she not intervened, the complainant was clear the CPN's intention had been to send the patient home with a less urgent Belfast Trust referral. I understand this conflicts with an account given by the CPN. Whilst it is therefore not possible to establish this fact, there is evidence that, by 17 December 2013, the risk to the patient's safety had significantly increased. It is clear from her complaint that, despite this fact, the complainant believed decision-making, on that occasion, continued to be influenced by the fact that the patient *'did not belong'* to the South Eastern Trust.

57. I note the IPA advised that the CPN should have sought advice from a senior colleague. In light of the clarification of process set out by the IPA (and helpfully commented upon by the Trust[10]) I am satisfied that such a step would have been in line with the action necessary to decide whether the patient should be admitted for psychiatric assessment. I note paragraph 10.6

[9] Community Psychiatric Nurse
[10] South Eastern Trust letter to NIPSO dated 30 August 2018

of the Joint Protocol (March 2013) would have facilitated a decision to admit the patient and his subsequent transfer to Belfast Trust accommodation. The question of the patient's mental health capacity could also have been addressed by a psychiatric assessment, although I am aware that mental incapacity is not a requirement for detention under the Mental Health Order[11].

58. Despite the increased risk, I note the Trust did not accept the IPA's view that input from a senior colleague was necessary. The Trust claimed that, on 17 December 2013, *'the assessing practitioner liaised with colleagues who had assessed [the patient] previously.*' This would have been in line with the independent advice I have received. However I have found no evidence, among the contemporaneous records, to substantiate this claim. Against this, I am mindful of the complainant's concern that the patient was *'given permission to go home'* despite the very worrying intensification in his actions.

59. In relation to the patient's *'current and recent mental health presentation'* as of that date, I note the mental health assessment records include the wording: *'No current plan of suicide but ambivalent re same.'* A typed portion of the assessment papers noted that the patient had been *'expressing suicidal ideation and had ideas of hanging himself'* while reportedly being *'intoxicated with alcohol and cocaine.'*

60. The IPA identified a shortfall in relation to an assessment of the risk posed to the patient's safety on 17 December 2013. Also, having highlighted the need for a safety plan given the patient's ambivalence and inability to guarantee his own safety, I am concerned to note the IPA's advice that such a safety plan was absent. I accept the IPA advice in this regard.

61. I note the mental health assessment records for 17 December 2013 included the note: *'Risk assessment updated'*. However, there is no evidence that the appropriate document was updated on that date; the last entry is dated

[11] Article 4(2) provides the grounds for detention under the Order.

10 November 2013 at 10:45. I note the SAI Review also found that the patient's risk assessment had not been updated.

62. Having reflected on the escalation that had occurred in the patient's behaviour, I accept the IPA advice that there was a shortfall in the mental health assessment. I consider there was a failure to assess the risk the patient posed to himself and a failure to document a safety plan. I also accept the IPA advice that there was a need for the matter to be referred to a more senior clinician in this case. I consider it was a failure not to have done so.

63. On 4 August 2020, in its written response[12] to the draft report, the South Eastern Trust stated it *'accepts the investigation's findings with the exception of one failing'* – the Trust disagreed there was a need for the matter to be referred to a more senior clinician. *'We do not believe that this was necessary in this case, as the practitioner followed the only course of action open to her in escalating the case to the Belfast Home Treatment Team for reassessment.'* The Trust's comments were carefully considered, in full. However, I do not agree that the only course available was discharge and referral to the Belfast Trust.

64. Noting the Joint Protocol, it is clear the difference between referral of the patient to the Belfast Trust, or, immediate admission of the patient locally, came down to the interpretation of the terms '*acute'* and '*very acute'* as highlighted in paragraphs 10.2 and 10.6 of the Joint Protocol respectively. The investigation found no guidance to help practitioners distinguish between these terms. Neither has guidance been found to help practitioners decide when an acute mental health patient should be referred to a senor clinician. I consider both these factors to be particularly relevant to this case.

65. I acknowledge that it cannot be known whether matters would have developed any differently had the patient been referred to a senior clinician before discharge from the Ulster Hospital was considered.

[12] Apart from this one exception, the South Eastern Trust accepted the investigation's findings.

66. The written record indicates that the mental health assessment was completed and a referral made to the HTT by 12.25pm on 17 December 2013. I note the HTT appointment was for 2pm in the Belfast Trust's Mater Hospital, one hour and 35 minutes later. The patient attended this appointment. From that time I am satisfied the Belfast Trust had responsibility for the patient's safety.

67. Given the tragic turn of events very soon after the patient's contact with both Trusts, it is clear from her complaint that the complainant felt the decision should have been to detain the patient for his own safety. With the benefit of hindsight, I have every sympathy with this viewpoint. However, it is relevant to have regard for the Coroner's verdict at inquest. In particular, the Coroner found *'[The patient's] condition did not meet the criteria for admission under the mental health legislation . . .'*

Involvement of the patient's mother (the complainant)

68. The first principle of good administration, Getting it Right, requires that *'public bodies . . . should follow their own policy and procedural guidance . . .'*

69. I note the South Eastern Trust's account of why the complainant was not contacted directly prior to the assessment conducted on 17 December 2013. Notwithstanding this, there is evidence that the complainant's input, concerning the patient, was obtained by the Trust's Mental Health Team on that occasion; I refer, in particular, to the following extract from the record of the mental health assessment: *'I spoke with [the patient's] mother . . . who reported that she has become increasingly concerned about [the patient's] wellbeing and feels his risk behaviours and thoughts of self-harm have escalated. [His mother] reports that she is supportive of [the patient] and feels that he has not addressed issues from his past.'*

70. I note the complainant believed the next-of-kin's personal crises were not taken into account when the patient's needs were being considered by the

Trust. There is no doubt the complainant cared deeply for the patient and was ready and able to play a central role in supporting the patient, especially given the next-of-kin's mental health difficulties. Whilst emphasising the primacy of next of kin, the South Eastern Trust has acknowledged that more could have been done to involve the complainant, generally, during the preceding months when the patient was making numerous visits to the ED. I also note the Trust has taken steps to ensure the involvement of other family members where more than one member of the family is experiencing mental health concerns.

71. The Trust's policy on involving family members (2011) made clear at paragraph 4.2.2 that staff *'will ordinarily seek to involve family members / carers as a routine part of the assessment, care planning, review and discharge processes . . . This involvement is particularly important in a situation where a carer/family member has expressed a concern for the patient/service user.'* With the probable exception of 17 December 2013, it is clear from the clinical records that this was not the complainant's experience. Being mindful of the first principle of good administration, I accept the IPA advice in relation to this matter. According to paragraph 4.2.9 of the policy: *'Where the views of family members/carers have not been sought . . . staff must ensure the reason for this is clarified and documented.'* If this applied in relation to any of the patient's visits to the ED, I have not found evidence that it was documented. I agree that more should have been done to involve the complainant and, in view of the policy requirements, I am satisfied this is indicative of a failure in care and treatment by the South Eastern Trust.

72. In terms of outcome, I note the complainant had wanted the South Eastern Trust: *'to at least acknowledge . . . that they could have done more'*. These comments obviously relate to the entirety of the complaint, nonetheless, the Trust has provided an acknowledgement in relation to this aspect. In addition, I note the Trust has given an undertaking that its practitioners will *'consider input from other family members in the provision of aftercare.'* – Recommendation 2, SAI report. In that regard the South Eastern Trust has

provided a notice dated 10 July 2017 which was given to staff and included the following wording specific to this SAI recommendation: *If staff are made aware during the assessment process that there is more than one family member experiencing mental health concerns – staff should consider input from other family members in the provision of aftercare – E.g. Risk management & Safety planning.*

Record keeping

73. I note the IPA raised concerns regarding the standard of record keeping. The IPA criticised the standard of clinical notes made in relation to the patient's visit to the ED on 15 December 2013. This is not a matter that I considered as part of the investigation however I note the Trust did not accept the advice of the IPA and provided a detailed response in relation to this. In particular the Trust stated: *'The nursing documentation is of a high standard with clear reason for attendance documented, correct language used and no abbreviations. The signature is legible and clear, as well as an electronic signature from triage. These notes clearly demonstrate keeping with the NMC[13] guidelines on record keeping.'*
'The comment regarding abbreviation and illegible signature is in relation to medical staff and not nursing staff. It should be noted that when a patient is transferred onto the integrated care pathway for adults who have self-harmed (which happens at triage), this document becomes the clinical record instead of the ED clinical notes and any clinical information is obtained from it rather than the ED record.'
'It is clearly documented on the ED clinical record that bloods were requested and taken at triage.'
'With regards to the documentation of the medical notes in December 2013 it is the Trust's view that these notes are legible. Emergency Physicians use directed examinations which are determined by the patient's presentation. No detailed physical examination was required on this visit and would not have changed the decision to refer for crisis response assessment.'

[13] Nursing and Midwifery Council

74. I do not intend to make a finding on this issue as I am satisfied that it did not have any impact on the analysis and findings in relation to the issues of complaint accepted for investigation set out above. I would ask the Trust to consider the IPA's comments with a view to identifying if there are any opportunities to improve practice.

75. I have taken account of the IPA's comments concerning the standard of record keeping in relation to the mental health assessment conducted on 17 December 2013 in the context of their relevance to the risk to the patient's safety on that occasion.

CONCLUSION

76. The complainant submitted a complaint to me about the actions of the South Eastern Health & Social Care Trust.

77. The investigation found the following:

- Primary responsibility for co-ordinating the patient's care belonged to the patient's home Trust and not the South Eastern Trust. However, the South Eastern Trust did not adhere to the policy relating to its role in that process. This constitutes a failure in care and treatment.
- There was a failure to document a safety plan for the patient during his mental health assessment on 17 December 2013.
- There was a failure to conduct a risk assessment for the patient during his mental health assessment on 17 December 2013.
- There was a failure to refer the patient to a more senior professional during his mental health assessment on 17 December 2013.
- More should have been done to include the complainant in discussions around the patient's care and to have identified the clear escalation in the patient's self-harming behaviour. The policy relating to the involvement of families/carers was not adequately followed which constitutes a failure in care and treatment.

78. Ultimately, the patient was delivered into the care of the Belfast Trust before he died by suicide. However, I consider the complainant has suffered the injustice of distress and uncertainty given her knowledge that, had the above failures in his care and treatment not occurred, perhaps an alternative outcome to the one that transpired may have been a possibility.

79. I note the SAI Review conducted by the South Eastern Trust has not identified and addressed all of the failures described above. By way of remedy the Chief Executive should write to the complainant accepting the failures highlighted in this report and offering a fulsome apology for those failures, acknowledging that more could have been done for the patient by the South Eastern Trust. In addition to the remedial action previously identified by the SAI Review, the Chief Executive should explain what steps have been taken to ensure risk assessments and safety plans are completed during mental health assessments.

80. Finally, I recommend that guidance be produced which helps mental health practitioners:

- distinguish between the terms '*acute'* and '*very acute'* as used in section 10 of the Joint Protocol; and
- decide when referral to a senior clinician is necessary in acute mental health cases.

MARGARET KELLY

Ombudsman **21 September 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.

- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.