mentalwelfare commission for scotland

INVESTIGATION

Investigation into the care and treatment of Mr QR by NHS Board D

October 2017

Notes

We acknowledge and appreciate the cooperation of all of the individuals, organisations and staff who assisted us with this investigation.

The subjects of this report have been anonymised as is our practice in our published investigation reports.

Contents

The Mental Welfare Commission

Our Mission

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

Our Purpose

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

Our Priorities

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

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

Our Activity

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

Executive Summary

The case of Mr QR was brought to our attention by the Crown Office and Procurator Fiscal Service on 13 July 2015. Mr QR died on 31 December 2014 as a result of a suicidal act by putting himself under the wheels of a moving heavy goods lorry, following discharge from a psychiatric hospital on 29 December 2014.

The purpose of our investigation was to provide:

- An assessment and appraisal of Mr QR's care.
- The views of the Commission regarding:
    - The reasonableness of Mr QR's management.
    - The predictability of him carrying out a serious act of self-harm.
    - Opportunity for preventability.

The investigation looked at:

- The formulation of Mr QR's diagnosis.
- The risk assessments undertaken and the associated risk management plans.
- The discharge planning for Mr QR.
- The overall approach to his care.
- The significant event review undertaken by NHS Board D.

Findings

We believe that the process of arriving at a diagnosis of Mr QR was seriously flawed, and that this had serious implications for his care, particularly with respect to the way in which he was discharged from hospital. We do not doubt that Mr QR's consultant believed that he was diagnosing Mr QR correctly. Furthermore, we accept that Mr QR's consultant had the best interest of Mr QR's wife in mind. However, it seems the clinical focus of Mr QR's consultant was fixed in its perspective, to the exclusion of other more plausible diagnoses for Mr QR. This led to a firmly placed diagnosis of personality disorder and then factitious disorder, both of which we consider to have been misguided.

The primary contributory factors to this misguided diagnosis are considered to have been:

- The disregarding of the second opinion advice by Mr QR's consultant.
- The selective use of information provided to Mr QR's clinical team by family and friends.
- The apparent disregard of the clear correspondence submitted by Mr QR's wife that challenged the diagnosis of personality disorder.

- The lack of senior nursing presence on clinical ward rounds.

Mr QR should have been treated more rigorously for depressive symptoms. In the absence of this, the opportunity to determine whether medication may have positively impacted on his symptoms was missed.

We consider that the staff who had contact with Mr QR were genuine in their intent to help him, and to support him in achieving recovery, within the confines of the diagnostic approach. The clinical records show that Mr QR was offered an opportunity to ventilate his feelings regularly, and that staff tried to encourage Mr QR to use distraction techniques, meditation, and fitness to more constructively manage his life stressors. Unfortunately, the nurses were not afforded supervisory leadership during clinical reviews when important decisions had to be made or contested.

Mr QR's consultant undertook to seek a second opinion about Mr QR and his presentation. When the second opinion was received, it was disregarded. Although one is not bound to accept the perspective of a second opinion doctor, in circumstances where the second opinion is completely at odds with that of the treating psychiatrist, this difference requires to be taken seriously.

Good practice would be to:

- Discuss with the second opinion doctor their different perspectives.
- Seek the advice of the clinical director if the first and second opinion doctor cannot reach a consensus regarding a reasonable way forward for the patient.

We also conclude that the discharge planning and actual discharge of Mr QR in the days preceding his death fell well below the standard of what is expected.

The contributory factors as to how this happened seem to include:

- The fact that Mr QR's consultant was going on holiday.
- Staff who did not challenge the breach in good practice of discharge standards.
- A lack of senior nursing presence on clinical ward rounds.
- A belief that to provide practical discharge support for Mr QR would not benefit his mental health.

Regarding the predictability of Mr QR's death, it was known and accepted by the clinical team, and documented at discharge, that he remained a suicide risk. What was not predictable was when he might try and harm himself. From the evidence available to us we do not believe his death was an accident. What is known is that Mr QR had jumped in front of an oncoming heavy goods lorry

previously whilst an inpatient and was unhurt because of the quick actions of the heavy goods lorry driver, and because the heavy goods lorry was load free.

With regards to the prevention of Mr QR's death by different mental health management, this is a difficult question. Had Mr QR been rigorously treated with anti-depressants and then able to be positively engaged with cognitive behavioural therapy then there may have been a different outcome. There might also have been a different outcome if he had been discharged in line with good practice. This cannot be stated with certainty.

However, our serious concerns are that Mr QR was not rigorously treated, and the manner of his discharge was completely unacceptable.

The NHS Review

We acknowledge that the conclusions drawn by the NHS Significant Event Review team were appropriate, though we believe the follow up was limited in breadth and content. The conclusions were:

- that there were deficiencies in the care Mr QR received from psychiatric services; and
- that his death could have been foreseen and prevented at that time but that suicide was a likely event in the medium term.

The consultant psychiatrist responsible for Mr QR's care has acknowledged that mistakes were made and taken remedial action regarding his practice. He does, however, still stand by his diagnosis.

Our recommendations target not only the mental health service involved with Mr QR, but all mental health services throughout Scotland. We expect all such services to reflect on this case and our recommendations, and to self-assess their own service and make necessary adjustments as required.

Recommendations

Recommendation 1:

When a family, friend, or carer challenges the interpretation of information shared and conclusions drawn from it, services should make a clear record of the consideration of the challenge. The rationale for any changes, or the decision not to make changes, to the patient's management plan should be clearly recorded.

Recommendation 2:

NHS Boards should ensure there are clear guidelines for:

- Seeking a second medical opinion.
- Dealing with disagreement with the second opinion.

Recommendation 3:

NHS Boards should ensure that their teams and services adhere to good practice standards in discharge planning, including what to do should re-presentation occur a short time after discharge. On occasions where there is an extended holiday period, planned discharges should be avoided unless there is confirmed community support in place. Patients should be discharged at short notice only in exceptional circumstances and then only when their crisis plan has been agreed.

Recommendation 4:

Mental health service managers should reflect on the effectiveness of their multidisciplinary team-working. NHS Health Boards should promote this work, and specifically the use of the Patient Safety Climate tools for staff and service users is recommended to help identify issues and barriers to true multidisciplinary working.

Recommendation 5:

NHS Boards should review the way that multidisciplinary team meetings are conducted to ensure that staff of appropriate seniority attend when key decisions are being made.

Recommendation 6:

NHS Boards should advise psychiatrists that, in cases where the doctor is making an unusual diagnosis that does not correspond with a second opinion, they should treat the case as complex and seek advice from their clinical director.

1. Introduction

The investigation into the care and treatment of Mr QR has been conducted under Section 11 of the Mental Health (Care and Treatment) (Scotland) Act, by the Mental Welfare Commission for Scotland (MWC). Section 11 gives the MWC the authority to carry out investigations and make related recommendations as it considers appropriate in many circumstances, including where an individual with mental illness, learning disability or related conditions may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

The investigation seeks to identify what lessons can be learned from the experience of Mr QR and his family, not only for the health board concerned, but for all mental health services across Scotland.

We were formally informed of Mr QR's death by the Crown Office and Procurator Fiscal Service on 13 July 2015, with a copy of the local NHS Significant Adverse Event Review. We also received the latter from the NHS the next day.

On 14 May 2015, Mr QR's wife had written to NHS Board D regarding the care and management of Mr QR between August 2014 and his death on 31 December 2014.

The key points of concern raised by Mr QR's wife were:

- The recommendations in the Significant Event Review did not go far enough in ensuring that real and lasting change will happen.
- The Significant Event Review report indicates that a second opinion was requested concerning her husband's diagnosis. The second opinion, which was written into the case notes, questioned the original diagnosis.
- This information was misrepresented both verbally to family members and friends and in the discharge report. This misrepresentation resulted in the family agreeing to decisions that propelled her husband into a hurried discharge that was not adequately thought through, and failed to manage risks to his safety.
- Deliberately misrepresenting information, both verbally and in written documentation. This amounted to a breach of trust which was unacceptable.
- The consultant involved was so convinced of his diagnosis of factitious disorder that he did not act on the second opinion sought.
- The Significant Event Review report failed to highlight real concerns that she voiced around the treatment of her husband.
- Her husband's diagnosis was wrong and limited the care he received.

The concerns raised by Mr QR's wife were reiterated by his brother and sister in-law.

After considering the Significant Event Review report by the NHS Board concerned, the Crown Office referral and the concerns raised by Mr QR's wife, we decided to review Mr QR's care.

Who was Mr QR?

Mr QR had worked for many years in a registered profession and was well known in his community. There had been changes in his job responsibilities which had impacted on his mental health. At the point where he retired in December 2013, his wife felt that he found his job stressful but not overwhelming. Following his retirement, he had reservations as to whether it had been the correct decision to take early retirement. Without the structure his work provided he began to cleave to his wife's routine. He got up when she did, had a list of tasks to do while she was out, and had her dinner ready when she came home. He did fewer and fewer of the activities he used to enjoy and began to worry that he had made the wrong decision in retiring early. His anxiety about this increased to the point that it disturbed his sleep. It was not possible to reassure him. In the summer of 2014, he seemed to take a turn for the worse, although he had always really looked forward to the holidays and had lots of plans for them. His wife was struck by the contrast.

He was a spiritual person and tried many different styles of spirituality in his search for answers. Due to his spiritual beliefs he meditated every morning. He had a wide circle of friends who enjoyed his company and with whom he formed lasting relationships over many years. He valued his friends and was good at keeping in touch with long term friends, sometimes going hillwalking. One commented: 'What I like about my friendship with Mr QR was that I always ended the day feeling better and more positive about myself and my life.'

2. Chronology

16 August 2014: Mr QR had his first contact with mental health services. His wife made a call to NHS 24 as he was having suicidal thoughts. He was assessed by the community mental health assessment team. He was given a provisional diagnosis of adjustment disorder and generalised anxiety. He was prescribed the sedative Zopiclone 7.5mg at night to help him sleep and asked to see his GP on Monday, 18 August 2014. He was to be followed up by the sector team in an outpatient clinic.

18 August 2014: Mr QR was seen by his GP who prescribed the anti-depressant Fluoxetine 20 mg once daily.

21 August 2014: Mr QR attended his GP surgery for follow up. At this visit, Mr QR's GP considered admission to hospital was necessary as there was a significant deterioration in mood and suicidal ideation. Mr QR had been googling ways to end his life. His wife was reported to be exhausted and frightened. Mr QR felt 'desperate' and 'desolate', unable to see a future other than that he die or be 'looked after forever'. He was not sleeping, had no motivation, had lost weight, had thoughts of suicide and was worried about his finances.

Mr QR agreed to hospital admission and, following an assessment, was admitted to an adult inpatient ward at the local psychiatric hospital.

22 August 2014: The notes indicate Mr QR left the ward without informing nursing staff. He returned to the inpatient ward with two members of hospital staff. He had run out into a main road in front of an oncoming heavy goods lorry. The driver was so concerned that he reported the incident to the hospital. He said he had only been able to stop in time because he had not had a full load. Mr QR seemed embarrassed about the episode and said that it would not be repeated. Following assessment by the duty consultant psychiatrist, and contrary to the views of the senior ward manager, he remained an informal patient on general observations.

23 August 2014: Mr QR was reviewed by the duty consultant psychiatrist again. Mr QR's primary nurse agreed a multidisciplinary risk management plan with him.

24 August – 2 September 2014: Mr QR remained preoccupied by thoughts of his suicide attempt. He was very concerned about people (his wife, his family and people he had worked with) finding out about it and had numerous conversations with the nursing staff on the subject. He was reviewed again by the duty consultant on 24 August, when he seemed a bit more positive. He first met his consultant psychiatrist on 25 August when the notes record '? histrionic personality disorder? Also GAD' (generalised anxiety disorder).

The records show that Mr QR continued to feel he had no future, that he had made all the wrong decisions and that there was no way out of his predicament. On 29 August, Mr QR was told that the team thought that he felt much less distress than he was displaying. In consideration of information provided by Mr QR's wife, which she felt she had been pressured to provide, and Mr QR agreeing to submit an overview of his life from age five, he was given a diagnosis of histrionic personality disorder overlaid by an adjustment disorder.

He was advised that the treatment for this was psychotherapy and that he would be referred to the psychologist. He was prescribed the anti-depressant Venlafaxine 75mg once a day, and informed that he would be discharged the following Wednesday, 3 September. Mr QR and, separately, his wife expressed concerns about his forthcoming discharge. Mr QR's behaviour, for example, holding his head in his hands, seemed to become more exaggerated, and yet he was still able to interact with visitors and other patients on the ward in a sociable manner. There were no references by nurses to symptoms which may have contraindicated the newly formulated diagnosis other than one comment that 'he appeared relaxed in manner, showed humour, no evidence of low mood'.

30 August 2014: Mr QR's care plan described him as struggling with his loss of role and identity since retiring; being troubled with anxiety; and being unable to regulate his emotions leading to feelings of distress and thoughts of suicide. He was to be offered information on managing anxiety; discouraged from ruminating on past events; helped to develop distraction techniques; and encouraged to rationalise his thinking processes to be more positive. Staff observing 'histrionic traits', e.g. 'over-dramaticising bodily positions' (sic) and 'loud groaning sounds', were instructed to point these out to him. The aim of this input was to equip him with coping strategies and resources to help him adjust to his new circumstances. There is no indication of how he was to be helped with suicidal thoughts.

2 September 2014: The nursing assessment at the STORM (skills based training on risk management for suicide prevention) review (http://www.chooselife.net/Training/storm.aspx) just prior to discharge, stated that he still had fleeting ideas of suicide and found it 'virtually impossible to see the future'. Daily entries in the file refer to Mr QR describing his mood getting worse, struggling with the impact of his early retirement including financial concerns and the fear his wife would leave him. He was observed to be low in mood and negative in outlook. He was noted to have poor eye contact and that his speech was slow and monotonous. However, Mr QR stated that he felt safe in hospital. There is no reference to monitoring signs or symptoms of depression in any systematic way during this admission. According to nurse B, Mr QR was not viewed as 'someone who was typically depressed'.

3 September 2014: Mr QR went on home leave with a view to discharge the following week. His prescription remained Venlafaxine 75mg once a day. A referral had been made to the clinical psychologist. The doctor recorded that the information provided by Mr QR's wife and son indicated a diagnosis of mixed personality disorder (anankastic and histrionic traits).

10 September 2014: Mr QR returned for the ward round at which he was formally discharged. The ward round notes record 'very little anxiety on MSE (mental state examination) but his dysfunctional personality traits are apparent'. His wife was asked to make a follow up appointment for two weeks' time.

23 September 2014: Mr QR attended an outpatient appointment with his psychiatrist.

31 October 2014: Mr QR attended his outpatient appointment with the clinical psychologist at the local psychiatric hospital. Following assessment, the clinical psychologist suggested that cognitive behavioural therapy may be helpful for him. Mr QR agreed to contact him within two weeks if he wished to pursue this option. The clinical psychologist offered to send him some cognitive behavioural self-help resources.

1 November – 17 November 2014: Reports from friends and family indicate that Mr QR's mental state did not improve on discharge. He was anxious, frightened, unable to see any future, and convinced he had made the wrong decision when he had retired from his job. He was also convinced that he would have nothing if his wife left him. He had written a farewell note to his wife giving her authority over his accounts. He vowed that he loved his wife and family and regretted he had let them all down. There is no indication in the notes that outpatient appointment was arranged. By mid-November Mr QR was behaving very oddly and following his wife around all the time when she was at home. Unable to cope with Mr QR's behaviour, his wife went to stay elsewhere, leaving Mr QR with a friend.

18 November 2014: Mr QR's wife made a call to NHS Direct to discuss her concerns about his mental state which had deteriorated further over the previous week. At 22:00 NHS 24 made contact with Mr QR who confirmed he had not harmed himself but was unable to say anything else on the phone.

19 November 2014: Mr QR's GP visited him at home following the contact with NHS 24. The GP was very concerned about Mr QR as he was 'quite paranoid and delusional'. The GP was so concerned about Mr QR he would have arranged for a Mental Health Act assessment if Mr QR had not agreed to go to hospital. The GP drove him there himself. After his assessment, Mr QR was no longer willing to stay. The junior doctor detained him using an Emergency Detention Certificate and he was admitted to the ward.

20 November 2014: Mr QR was assessed by the duty consultant who revoked the emergency detention as Mr QR was now willing to stay. The duty consultant requested a full physical examination and blood tests, objective assessment of his mental state and review by his own team. He did not recommend a change of medication. Risk assessment identified Mr QR as no risk of self-harm or harm to others. Mr QR stated that he felt safe in hospital. This in spite of primary reason for admission being suicidal ideation. He was, nevertheless, rated as high risk if he absconded from hospital.

21 November 2014: Mr QR was reviewed by his consultant who found his presentation much the same as on the previous admission. He decided to cease the anti-depressant Venlafaxine, and requested a CT scan. His wife told staff, however, that whereas in the past he had been obsessive and compulsive in behaviour, he was now chaotic and disorganised and that she felt intimidated by him.

23 November 2014: Mr QR informed his primary nurse that he had tried to hang himself two weeks earlier, although his account did not tally with his wife's. She had found a ladder in a room but had not interrupted a suicide attempt.

Mr QR had developed the habit of biting his lip and picking at his head and hands. He repeatedly sought the attention of staff and was then unable to speak, stuttering, or staring, or if he was able to speak he repeated information that he had already given. He informed staff and patients that everyone was dead or dying.

24 November 2014: Mr QR's consultant psychiatrist decided that Mr QR should remain on the ward for observation for a month to rule out psychiatric pathology, and that if there was no evidence of psychiatric illness a diagnosis of factitious disorder should be considered. Mr QR was heard telling other patients that they were all going to die. He continued to ruminate about past events, repeated himself, stuttered and struggled with speech, made inappropriate responses, but also had periods of agitation where he would shout and become quite intimidating.

24 November 2014: CAT scan performed at a neighbouring hospital.

25 November 2014: At 05:50 Mr QR became agitated and wanted to leave the ward. Nursing staff detained him on the ward under section 299 of the Mental Health Act, until he could be assessed by a doctor. He was shouting 'the world is ending, it is all over'. On subsequent medical assessment, he was no longer agitated and he agreed to stay on the ward voluntarily. However, he was noted to continue 'to hang about' the exit doorway causing the staff considerable concern. On the two occasions he left the ward, he was easily persuaded to return saying: 'I thought staff would come and get me'. He talked to staff about thinking that people were coming to harm by speaking with him. There was also

an incident when Mr QR expressed bizarre thoughts, including thinking he had caused a member of staff to have a miscarriage. Nevertheless, when he had visitors that day he interacted sociably with them. He later apologised to staff for his bizarre thoughts.

26 November 2014: At the ward round Mr QR was reprimanded for his remark about the pregnant nurse. The CAT scan had shown possible areas of ischemia (insufficient blood flow to the brain): the radiologist had recommended a contrast enhanced scan in view of the medical history. Later that evening Mr QR's wife requested a second opinion and was informed that the request would have to come from Mr QR himself. She was convinced that he had become a 'totally different person', and that she did not believe that his presentation was due to 'bad behaviour'.

27 November 2014: Mr QR's wife brought evidence from home which she gave to the nurses that Mr QR had been researching ways of ending his life. She felt that his doctor was treating him like 'a naughty schoolboy'. She had found letters in the bin.

28 November 2014: Mr QR refused to go for his second scan. He gave numerous reasons, in particular he was afraid of being given a lethal injection. (The procedure involved an injection of the contrast prior to the scan). Mr QR's wife wrote to his consultant and set out (again) her personal insights into her husband's behaviour, putting it into context. She mentioned stresses from reduced income and poorly performing investments; loss of status; and lack of benefit from medication. His wife's insight into this revealed that she disagreed that her husband was faking psychiatric illness, and she considered that he believed taking his own life would be a way of helping their situation. She also felt that her husband's thoughts had become disordered as a consequence of his obsessive focus on his problems, and that he had become highly critical of himself and considered himself persona non grata.

2 December 2012: Mr QR's consultant had asked another consultant psychiatrist to provide a second opinion. He began reviewing the notes.

4 December 2014: Mr QR was taken for his scan by a friend, a recently retired GP. In a letter to the consultant the friend subsequently wrote: 'Mr QR's progress has been relentlessly downhill, he has lost a considerable amount of weight, his sleep is disturbed, he is continually agitated. It is hard to imagine that Mr QR is simulating the symptoms of a psychiatric illness.'

5 December 2014: Scan result received. 'No abnormal enhancement pattern: consistent with small vessel ischaemic change. No inter-cranial mass lesion, extra-axiol collections or evidence of hemorrhage.' Mr QR met with the second opinion consultant.

8 December 2014: ACER assessment (Addenbrooke's Cognitive Examination) was performed by the GP trainee doctor to screen for evidence of dementia. Mr QR was not given the result but advised he had 'scored very well'.

The second opinion consultant concluded his assessment. He considered that Mr QR's presentation did not meet the general diagnostic criteria for personality disorder. He was unable to exclude a depressive episode, albeit with an atypical presentation. He recommended a trial of an anti-depressant. He also recommended that an organic cause be excluded and that the opinion of an older age consultant psychiatrist might be useful. This second opinion perspective was provided verbally to Mr QR's consultant psychiatrist and written in the notes on 8 December 2014.

10 December 2014: At the ward round, Mr QR was described as 'theatrical and manipulative in presentation'. A patient had died on the ward and Mr QR believed that he was responsible. The focus of the doctor continues to be on traits of histrionic or exaggerated behaviours. There is no evidence that the perspective of the second opinion doctor regarding the possibility of a depressive illness has been acknowledged.

14 December 2014: Mr QR's wife contacts the ward concerned that her husband is at 'rock bottom' and that he is in need of medication.

11 – 16 December 2014: Mr QR continued to be able to have superficial conversations but was unable to articulate his thoughts at other times. He asked staff to talk to him but was unable to finish a sentence and when they tried to terminate the conversation he would say that there was more he needed to say. He picked at his head and hands, at times causing superficial bleeding. At times he would be 'rolling in his bed and whimpering'. On a few occasions he packed his bags, saying that he was leaving, and had to be dissuaded from leaving with his wife. Mr QR's consultant told him that he felt he could control his stammer, that he could complete sentences and that he could see that his wife was 'at breaking point'.

17 December 2014: Mr QR's wife composed a letter from Mr QR requesting a change of consultant. She believed he was frightened of him. Mr QR had been agitated about the safety of the wiring in his house but she noted that he had been unusually incoherent.

Mr QR was uncommunicative and agitated in the ward round. He was offered Lorazepam and escorted to his room. He declined the medication and his agitation increased. He attempted to leave the ward and was detained under section 299 of the Mental Health Act - the nurses' power to detain. On review by the doctor he was no longer agitated or wishing to leave and, therefore, remained on the ward as a voluntary patient.

19 December 2014: Mr QR told nursing staff he no longer wanted a change of consultant and confirmed this in writing. His consultant psychiatrist requested a MRI (Magnetic Resonance Imaging) scan, further to the advice of the second opinion doctor, as the previous scans had shown signs of ischemia. Note: An MRI scan gives a more detailed image than a normal x-ray.

Mr QR continued to exhibit concerning behaviour on more than one occasion saying he couldn't breathe and becoming extremely agitated, at one point removing his top.

20 December 2014: On his return from a trip out with a friend it was observed that he had rubbed his eyes to the extent that one became bloodshot. The duty doctor was called.

21 December 2014: Mr QR was in the corridor crying out that he couldn't breathe and he was dying. He accepted 2mg Lorazepam (an anxiolytic) and calmed down.

23 December: Mr QR was very reluctant to attend the appointment for the MRI scan. He was given 2mg Lorazepam to help him relax and eventually had the scan.

24 December 2014: The old age consultant psychiatrist assessed Mr QR. She noted the result of the MRI scan was normal. Her advice was that management should be focused on the clinical presentation, and not assume an organic diagnosis. She was aware that there was a difference of opinion on diagnosis between the two consultants, both of whom had conducted thorough assessments. She focused on the possibility of an organic cause. Her assessment was written in the medical records and she confirmed that she always discussed her assessments with her colleague in person, although she could not precisely recall doing so. The diagnosis of factitious disorder was recorded in the note of the ward round.

25 December - 29 December 2014: Although he had been very agitated in the early hours of the morning, accepting 2mg Lorazepam at 05:00, Mr QR went home for lunch on Christmas Day. His incongruous behaviour continued, but there were still occasions when he could interact sociably with others. His wife was becoming worried at the prospect of his return home.

28 December 2014: Mr QR's primary nurse spoke to both Mr QR and his wife about the possibility of discharge the following day. Mr QR's wife was clear that she could not cope with him at home.

29 December 2014: After a lengthy meeting between the clinical team, Mr QR (not present all the time), his wife, his son, and a GP friend, Mr QR was discharged from hospital.

The notes state that, in the view of the consultant psychiatrist, the second and third opinion doctors had excluded a diagnosis of mental illness. This was clearly not the case. The diagnosis, according to the consultant, was one of factitious disorder and the treatment was psychological therapy. He made it clear that there was a high possibility that Mr QR would attempt suicide again. It was suggested that Mr QR would become more dependent the longer he remained on the ward. The family were also told that a package of care and anxiolytic medication would only validate the behaviour. Mr QR's wife, however, could not agree to a return home. At the meeting, Mr QR was also advised that he should not drive and that the DVLA would be informed of this.

After the ward round Mr QR was given a copy of the yellow pages to find accommodation. Follow up from a community mental health team could only be organised once Mr QR had registered with a GP as the mental health teams' catchment areas were based on GP registration.

Mr QR left the hospital later in the afternoon. At about 22:00 Mr QR spoke to his son on the phone and explained he was walking home. He had lost his wallet and he wanted to be picked up. Mr QR's wife ordered a taxi for him, and organised for him to stay at a B&B that night.

30 December 2014: Mr QR phoned his brother in some distress. His brother contacted his wife. She left work to find Mr QR. She organised some money for him and booked him for the week into a hostel where he could also stay during the day.

31 December 2014: 04:30 Mr QR's wife realised he had been trying to phone her. He was walking in the streets. He told her that they were torturing him at the hostel. He had already telephoned the police. His wife followed up his phone call to them. The police picked Mr QR up and took him back to the local psychiatric hospital subject to a Section 297 'place of safety' order under the Mental Health Act. This allows police to remove someone from a public place to a place of safety.

05:00 – 07:00 Mr QR was assessed by the mental health assessment team. The team had access to the mental health records. They determined that there was no indication that admission would be of benefit and suggested that he look for alternative accommodation as he was not happy in the hostel. A taxi was arranged to return him to the hostel.

In a letter from the hospital to the Procurator Fiscal it is reported that Mr QR was struck by a heavy goods lorry. Paramedics were called but he died before they could reach him.

3. Focus and key lines of enquiry

The purpose of this investigation was to provide:

- An assessment and appraisal of Mr QR's care.
- The views of the Commission regarding:
    - The reasonableness of Mr QR's management,
    - The predictability of him carrying out a serious act of self-harm, and
    - Opportunity for preventability.

The investigation looked at:

- The formulation of Mr QR's diagnosis.
- The risk assessments undertaken and the associated risk management plans.
- The discharge planning for Mr QR.
- The overall approach to his care.
- The Significant Event Review undertaken by NHS Board D.

4. Investigation process

The MWC conducted 16 interviews. These were with:

- Mr QR's wife
- Mr QR's family
- Two friends of Mr QR
- Mr QR's consultant psychiatrist
- Staff nurses on the inpatient ward
- Team leader on the inpatient ward
- Out of hours triage nurse
- Consultant in old age psychiatry
- Second opinion consultant psychiatrist
- Clinical psychologist
- Trainee GP2
- Mr QR's GP
- Trainee psychiatrist

The Commission's investigation team comprised:

- Mr Mike Diamond, Executive Director Social Work (Chair)
- Mr Douglas Seath, Nursing Officer
- Dr Steven Morgan, Medical Officer

In addition, Ms Maria Dineen, Managing Director of Consequence UK Limited and a consultant psychiatrist, Dr Mark Potter, Acting Medical Director at South West London and St George's Mental Health Trust, were asked to review the management of Mr QR and to comment on its reasonableness.

The Commission also benefitted from an expert opinion from Dr David Hall, consultant psychiatrist.

Once all interviews had been conducted, they were analysed by Maria Dineen using a qualitative research technique called content analysis. The thematic headings utilised were:

- Mr QR and his mental health decline
- Diagnosis of Mr QR
- Risk assessment and management
- Care of Mr QR
- Discharge
- Treatment of Mr QR

5. Findings

5.1 Diagnosis

Mr QR was admitted to hospital on 19 August 2014. On 1 September, a diagnosis of mixed personality disorder was made. The earliest indication that Mr QR's consultant was thinking along the lines of a non-mental illness diagnosis was on 27 August 2014 at the end of consultant ward round. The formulation of the consultant was based on:

- Information provided by Mr QR's wife at interview, and
- Staff's observations of Mr QR that had been comprehensively documented in his clinical records since admission.

However, on independently reviewing the clinical records, the independent consultant psychiatrist commissioned by the MWC said: 'It is my opinion that Mr QR's presentation was in keeping with that of an affective disorder of at least moderate severity with probable mood congruent psychotic features. I note the family history of affective disorder, Mr QR's past history of anxiety, the marked change in behaviour described in the 3-4 weeks leading up to his initial presentation, his significant depressive cognitions, the biological features of depression he exhibited, his suicidal ideation with an associated serious suicide attempt and the probable psychotic features noted. I can see nothing that would support a diagnosis of personality disorder or factitious disorder. Again, I note that there had been a distinct change in behaviour in keeping with an episode of illness rather than a longstanding personality disorder. This change had been confirmed by a GP friend, [of Mr QR's], who also confirmed a very different premorbid personality, describing [Mr QR] as funny, positive, appreciative and a pleasure to be with.' The lack of support for the diagnosis of personality disorder was also confirmed by the second opinion doctor.

This independent opinion reflected the concerns of the local NHS board's internal review around diagnosis, and the caution raised by the second opinion doctor about Mr QR's diagnosis of personality disorder, and the clinical psychologist who saw no evidence of it when he assessed Mr QR.

What the clinical records say

The progress notes made by the inpatient ward staff are comprehensive, and on every day of Mr QR's first admission the nursing staff have made substantial entries describing Mr QR's behaviours. These do describe someone who is self-absorbed, lost, and cannot think beyond his current predicaments and disappointments in life.

However, there is also information provided by family and friends that indicate that Mr QR was not normally like this, and his presentation was out of keeping with the man they knew.

Mr QR's consultant stated: 'staff have to record any behaviours in the absence of mental illness, record detailed events, behaviours and interactions thoroughly. If Mr QR wishes to leave he must sign an 'against medical advice' form.'

The nursing staff continued to have contact with Mr QR, giving him time to talk and ventilate and recording how he came across to them, which was predominantly inward looking, with some periodic episodes of commitment to problem solving.

However, as the admission proceeded, Mr QR reported feeling gradually worse and unable to face the consequences of his actions. He was worried that, since his retirement, there wouldn't be enough money to live on and that his wife would leave him. He said that he felt that he was reaching new depths and that there was something inside him 'giving up'.

His consultant was noted to have reassured him that he could help with the acute problems but he must work on the histrionic traits himself. He warned that his family would become exhausted and burnt out by his behaviour and that he should 'try and be strong and to not show his anxiety and emotions so strongly'.

The management plan was to start Venlafaxine XL 75mg (this is the minimum therapeutic dose and normally could be titrated up, according to response, to 375mg daily for severe depression). He was referred to psychology and to have cognitive behavioural therapy.

Following a two week admission, Mr QR was to be discharged to save him from becoming dependent on the hospital. He was reportedly dismissive of proactive methods to help him manage his anxiety, such as the anxiety workbook a staff member encouraged him to use. This staff member's attempts to support Mr QR in rationalising his emotions were also unsuccessful.

Mr QR was subsequently discharged on 10 September 2014. The discharge letter sent to his GP identified:

- The sense of hopelessness Mr QR had when he was first admitted.
- That he was relying on his wife for everything.
- That he considered that his steep decline had occurred over a two-week period but that he had been low for about eight or nine months.
- That Mr QR ruminated on things such as his financial affairs and past decisions he saw as bad. This rumination was a constant feature of his behaviour throughout his admission.

- When not in one to one time with staff, Mr QR was noted to appear relaxed and euthymic and was at times almost over friendly and complimentary to staff.
- Mr QR lacked insight into his condition.
- That staff considered that Mr QR showed histrionic personality traits and to further explore this Mr QR's consultant had asked his wife and son to write down features they had noticed about Mr QR's character and personality.

The final paragraph of the discharge letter said:

'These character references by family combined with the staff observations on the ward and 1:1 interaction with Mr QR allowed his consultant to reach the diagnosis of adjustment disorder and mixed personality disorder (histrionic and anankastic traits[1]).' The discharge summary did not reference any of the written information provided by Mr QR's wife contesting these diagnoses for her husband.

Second admission - November 2014

Mr QR was re-admitted to the inpatient service because of increasing concern about him, and a re-emergence of his suicidal thoughts. The admission was initiated by Mr QR's GP who, at a home visit, considered Mr QR to be psychotic. Mr QR had reported believing that people were talking about him and that this would be posted on the internet 'tomorrow'.

Mr QR's GP drove him to hospital; had Mr QR not agreed to this this he would have arranged for a Mental Health Act assessment. On admission Mr QR's presentation displayed similarities with his previous admission: a sense of hopelessness; poor sleep; reduced appetite; rumination on the past; and evasive about his thoughts including any suicidal plans.

The admitting doctor spoke with Mr QR's wife, who reported:

- Increase in bizarre behaviour over the past few weeks, not sleeping, not eating, 'obsessed' about financial issues, leaving his profession etc.
- Been constantly following her around for the past few days, doesn't feel safe with him, moved to friend's house yesterday.
- Says she feels he is not the same person anymore – can't put her finger on it, at times distracted, very forgetful, talks and talks but never says anything.

[1] Anankastic personality disorder relates to a person with obsessive compulsive behaviours

- Said Mr QR did some temp work which caused paranoid thoughts over police, due to an implied failure in him carrying out some duties. (There was no information to substantiate this prior to or after Mr QR's death.)

The formulation and differential diagnosis now was psychosis or manipulative behaviour due to personality traits. The case was discussed with Mr QR's consultant, who advised to detain Mr QR on an Emergency Detention Certificate.

Following this, he was detained on an Emergency Detention Certificate, under the Mental Health Act.

The narrative notes say:

'Level of looking after self has deteriorated. Not washing or feeding, but in last week less proactive, spending time in pyjamas, lying on bed, stuff going on (paranoia)', "living in a different reality", builds up to say something to his wife but "stutters" cannot get his words out. Bends forward rocking, look hollow saying "there's something I have to say" but wouldn't say- would lurk.'

These notes also say:

'Anti-depressants not making a difference, bumping along since August.'

The following day, and after consultant review the impression documented was:

'Doesn't appear acutely psychotic. Note previous diagnosis of PD. Evasive at interview. Now agreeable to stay in hospital and guaranteeing safety. Grounds for STDC (Short Term Detention Certificate) not met (No SIDMA (Significantly Impaired Decision-Making Ability).'

The plan following this assessment was to revoke the Emergency Detention Certificate, leave his medication unchanged and allow time out of the ward within the hospital ground (30 minutes at a time).

Mr QR was reviewed by his own consultant psychiatrist on 21 November. The notes state that the presentation remained as on his previous admission ('narcissistic, histrionic and avoidant of problems'). His low dose antidepressant was also stopped.

The narrative recorded by the nursing staff differs markedly from the records of the first admission. Staff record that they note Mr QR to be 'off balance' and 'muttering to himself'. He was also noted to stutter, which was a development since his last admission.

Because of how Mr QR was behaving at the ward round, the decision was made by his consultant to admit Mr QR for one month so that he could be observed and completely rule out psychiatric pathology.

In addition, his consultant asked for:

- CT head today.
- If after month there is no evidence of psychiatric illness consider factitious disorder.

The nursing records continue to be rich narrative accounts of Mr QR's behaviours and show that:

- He continued to ruminate.
- He had a habit of repeating information.
- His stutter remained, and sometimes he would stand when this happened and say nothing for a 'good few seconds'.
- Staring had become a feature of his presentation.
- He struggled to say what he wanted.
- That he remained firm in his version of events regarding attempted hanging even though staff were aware that his wife's version was different, and Mr QR knew this too.

Rumination remained a consistent feature of his presentation, going over and over events of the past.

Independent consultant psychiatrist comment:

'I'm not clear why they were considering factitious disorder. It seems to me that he is agitated and depressed. The idea of observing behaviour is reasonable but it seems to me that they are thinking that he might not have a treatable illness when depression seems to me to be the obvious possibility.'

Mr QR is again assessed by the second opinion psychiatrist. At the end of this assessment the opinion documented is:

'given history from patient and corroboration from more than one source (being consistent), and including diagnosis on CT scan along with mild cognitive impairment we need to exclude organicity. There appears to have been a gradual decline over one year with sudden change around August. His presentation does not appear to meet general diagnostic criteria for personality disorder and based on list of before/after traits. I am unable to exclude a depressive episode albeit atypical in presentation. I would consider the following:

- Fully exclude organic cause
- Consider trial of antidepressant
- ? view of old age psychiatry may be useful since ?organicity'

In the context of the diagnosis, the second opinion assessment is significant. The assessment conducted was very thorough, and the second opinion captured a very full account of Mr QR's historical and recent past. It is notable that this assessment constituted the most thorough documentation of Mr QR's recent past.

Relevant interview evidence

To explore the formulation of Mr QR's diagnosis further we met with his consultant; the second opinion consultant who became involved during Mr QR's second admission; and a range of staff working on the inpatient ward, including the team leader.

Mr QR was admitted in August 2014 with suicidal thoughts, low mood and anxiety. His primary nurse on that admission when asked if she considered Mr QR to be depressed said:

'Certainly, if you had a superficial conversation with Mr QR, he would be bright and animated and show humour, good eye contact, and quite enthusiastic about the things that he enjoyed, talking, eating and drinking. There was no sort of objective evidence of actual depression although Mr QR subjectively would describe his mood as low.'

This nurse was asked a direct question about Mr QR's diagnosis of factitious disorder and personality disorder. 'Looking at the ICD10*, I think [Mr QR] did fit those diagnoses if I'm honest, but I'm not saying that we just assumed that because he had that that we wouldn't be looking for symptoms of depression, because obviously, people with personality disorders can be depressed as well. I think Mr QR had a lot of things he needed to address but just wasn't in the place to be able to do that. He did definitely fit the criteria for personality disorder.'

However, on his second admission Mr QR's primary nurse (second admission) did demonstrate an appreciation of the success of his life to date. 'I think Mr QR has struggled most of his life, from a young age right through his life. He fitted into the criteria that way for somebody with a personality disorder, yet I think he managed his life very well with his family.' She also had an appreciation of the problems faced by Mr QR's wife. 'I think if he had changed the way he was behaving that [Mr QR's wife] would look at things differently with him. She still loved him. She just wasn't coping herself with him. It must have been difficult for her.'

She was also asked if anyone had mentioned the fact that he never really got past the low dose of anti-depressants. 'Not really. I think it was felt that they possibly weren't doing him any good at that point. I think it was decided that he should probably come off them.'

*(see page 29)

From the interviews we conducted, there also appears to be no professional insight that, for Mr QR to have had a rigorous trial of anti-depressants, he needed to be on a higher dose of medication – this was never achieved.

The care plans at that time make no reference to monitoring symptoms of depression. Neither is there reference in the nursing record to Mr QR's mood, diet, sleep, self-care, concentration or suicidality. There are, however, comments about Mr QR's behavioural traits which were observed, and appeared due to his level of agitation and anxiety.

When Mr QR's consultant psychiatrist was specifically asked about the diagnosis of adjustment disorder, he responded: 'I think [Mr QR] had been struggling with his job for a few years before he took retirement. It was not in the nature of [Mr QR] to make any decision in a hurry. He had been debating the pros and cons for a long time and discussing with his wife. He took early retirement and around the same time they bought a much bigger and older property which required a fair bit of work. The understanding was that once he retired, [Mr QR's wife] would also reduce her working hours and they would have a gradually phased retirement life. It didn't work out like that. He realised that the work they had embarked on in this property was too much and he started panicking.' (In fact, we understand that Mr & Mrs QR bought the property circa 1997 and had not just moved there around the time he retired.)

At this same time, his wife's working hours increased which expanded the time Mr QR was spending on his own. 'In my conversations with him this was a regular thing. He was beginning to get very worried that he would be ejected from his house. That is something he has said from the first day of his admission – that he would be asked to leave and it did happen. He was asked to leave. So, those were my reasons that his symptoms of anxiety and depression were not only triggered but were around the nucleus of his stressor. Therefore, I came to the view that this was an adjustment disorder and by the end of the first admission he had begun to improve.'

We noted that from time to time the nursing staff used pejorative language to describe Mr QR's behaviour. Nursing reports refer to 'histrionic behaviours' and 'over dramatic poses' as the proposed discharge date was approaching. The nurses' interpretations contrasted with their descriptions of behaviours they recorded earlier where Mr QR was observed as: 'slumping on the bed'; 'grabbing his head with his hands'; 'rolling his eyes'; and being 'emotionally labile (crying but no tears)'. Whilst later, he was observed to be interacting well with others, relaxed in manner, smiling and laughing in the company of other patients.

We also noted that staff did not balance Mr QR's presentation on the ward with his previously successful life and career. The disconnection between the two does not seem to have factored in their thinking about him, or his presentation or diagnosis.

The care plan at that time makes no reference to monitoring symptoms of depression. Neither does the nursing record make reference to Mr QR's mood, diet, sleep, self-care, concentration or suicidality. Comments about his behavioural traits dominate. Personality disorder as a diagnosis, however, very quickly became the focus for explaining any behavioural idiosyncrasies observed.

The basis for the diagnosis of personality disorder

The word personality describes deeply ingrained patterns of behaviour and the way individuals perceive, relate to, and think about themselves and their world. Personality traits are conspicuous features of personality and are not necessarily pathological, although certain styles of personality may cause interpersonal problems.

Personality disorders are rigid, inflexible and maladaptive, causing impairment in functioning or internal distress. A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment[2].

Histrionic personality disorder is defined in the ICD-10 as follows[3]:

> 'Personality disorder characterized by shallow and labile affectivity, self-dramatization, theatricality, exaggerated expression of emotions, suggestibility, egocentricity, self-indulgence, lack of consideration for others, easily hurt feelings, and continuous seeking for appreciation, excitement and attention.'

Mr QR may have been an emotional man, he may have overreacted to things in the eyes of his wife, and he may have enjoyed attention. However, this does not equate to having a personality disorder. Reading the correspondence of his family and the testimony of his friends, he does not seem to have been a man who fitted the above descriptions. He had maintained a good job, been a supportive father and a caring husband. Furthermore, he had maintained close friendships over many years.

Mr QR's consultant psychiatrist justified his diagnosis by saying:

'I asked [Mr QR's wife] and her son to provide to me written information about his personality which they did and that written information left me in no doubt that this was someone who has for a long time not just had traits of two

[2] For further detail, see ICD-10 – Classification of Mental and Behavioural Disorders (WHO), F60-69, Disorders of adult personality and behaviour

[3] ICD-10 Version 2016 F60.4 http://apps.who.int/classifications/icd10/browse/2016/en#/F60-F69

personality disorders, although not meeting syndromal criteria of either, but also has had distress and dysfunction because of it. Not just this time, even in the past.' and

'He [Mr QR] would be saying to the nurses he was very depressed, very anxious and he feels the world is going to come to an end. Then fifteen minutes later he would be chatting with other patients, having his meal and the nurses could observe this behaviour which was totally different. This happened again and again.' and

Mr QR 'had a tendency to scratch his forehead and scratch his thumb. Now I noted, [another] consultant psychiatrist noted, and multiple nurses noted that if you ignored it he would say to you – look I'm scratching myself again. I'm really anxious. He would say that to you. He would say he was greatly anxious – look I'm scratching myself again. Look there's blood. Look I'm scratching my thumb again and there's blood. He would show it to us. You could not ignore it.'

The independent psychiatrist observed that:

'We all have traits that can be exacerbated at times of stress. Part of a personality disorder diagnosis is that the traits cause problems for the patient and/or others. Mr QR appears to have had a successful career and relationship history so I don't think there is any convincing evidence of personality disorder. There were accounts from his friends that describe him in a very positive way, which do not appear to have been taken into account in the diagnostic formulation. Agitated depression with some psychotic symptoms may have been a reasonable consideration for him.'

Other clinical views

There were other clinical views. The clinical psychologist saw Mr QR as an outpatient for assessment on 31 October 2014, between his two admissions. When asked what he thought, he responded: 'I suppose what I would say is I didn't see any of the behaviours in that hour on which that diagnosis was made. If that was the first contact that he had had with the service I might have thought this is not the normal presentation of someone, it's not who you would imagine would have a personality disorder.' He offered Mr QR cognitive behavioural therapy, which is not usually helpful for someone with a diagnosis of histrionic disorder, but he intended to treat in the way he might have treated depression which might have helped with the adjustment disorder. His letter to Mr QR's consultant read: 'I would be inclined to agree with this gentleman's own assessment that his emotional difficulties are secondary to significant practical changes over the past year, […]. I did, however, suggest that the emotional

effects of these changes seem to have given rise to a different way of thinking and behaving, which in turn were making the situation worse.'

Mr QR's consultant asked a colleague to provide a second opinion. In early December, the second opinion psychiatrist conducted a thorough assessment: he reviewed the notes, spent two hours with Mr QR, an hour with his wife and spoke to a family friend. The second opinion psychiatrist noted that there was a marked change in Mr QR when he conducted the second hour of his assessment. He was more agitated, distressed and it was difficult to get information out of him. At interview, he said: 'When I saw him the second time we were talking about some of the things which we found may have precipitated a reaction which was slightly more difficult - symptomatology issues with his work, issues concerning his house, his views about his financial affairs, lots of things.'

The second opinion consultant did not feel that Mr QR's presentation met the general diagnostic criteria for personality disorder. 'The thing that stood out for me was I had a corroborative history from more than one source which were consistent in highlighting a change over the course of about a year with a more sudden change round about August, so that was consistent from more than one source in my view.[…] so I didn't think there was a pattern of behaviours which were maladaptive, principally back to early adolescence which are basically over time causing impairment in social functioning, so I didn't feel that that criteria [for personality disorder] was met based on the information that I had.'

He was not able to exclude a depressive episode, albeit with an atypical presentation. 'I think looking back, his wife came with a before and after list and what jumped out was a lack of enjoyment. Music was a consistent pleasure throughout his life but over the last year he had kind of given that up. He was previously very structured and disciplined in terms of exercise but he had given that up. They reported him previously being energetic, outgoing, and lively and this had changed. He had become more withdrawn, self-critical, really very preoccupied with his finances and I felt that probably on the face of it I wondered if he could be displaying lack of enjoyment and energy, anhedonia although there weren't other things like lack of sleep. There was also a history of change in weight. He had lost about a stone in weight I think and fairly rapidly which could fit with impaired appetite.' He recommended a trial of an anti-depressant in a structured way.

The second opinion psychiatrist considered assessment by a psychiatrist specialising in older age would be prudent owing to some possible small vessel ischaemic changes noted in a CT scan of Mr QR's brain, and 'given the history of mild cognitive impairment, possible abnormal scan it was important to exclude an atypical presentation of early onset dementia particularly.' In the event, the consultant in old age psychiatry did not consider that Mr QR had early onset

dementia. She also commented that he appeared to be psychologically upset and stressed and this would make accurate neuro-psychological measurement challenging to do accurately. Before undertaking neuro-psychological testing this consultant considered it important that his presenting psychological /psychiatric illness was attended to.

We consider that this second opinion doctor was meticulous in his assessment and consideration of Mr QR's presentation, recognising that his former life and current presentation were at odds with a diagnosis of personality disorder. His desire to exclude other less obvious causes of the change in Mr QR was commendable.

Asked whether the second opinion psychiatrist had made clear to Mr QR's psychiatrist that he did not support his diagnosis of Mr QR, he replied: 'I spoke with [Mr QR's psychiatrist] because I felt I couldn't support his diagnosis at this point because he asked about a differential diagnosis of personality disorder and factitious disorder. I felt given my assessment I couldn't support that diagnosis at that time so I went and told [him], listen I can't support and I've written documentation in the notes.'

The diagnosis of factitious personality disorder

During Mr QR's second admission to hospital, 19 November 2014 – 29 December 2014, his consultant psychiatrist started to consider a diagnosis of factitious disorder.

His rationale, described at interview, for this was: 'The key symptoms noted in depression are that it will be low mood most hours of the day most days of the week. Along with associated symptoms of anergia, anhedonia and anything else that comes with it but it is most hours of the day, most days of the week. It is not an appearing and disappearing phenomenon. In Mr QR's case I did not see that. Mr QR voiced a number of times psychotic symptoms in the form of delusions. The very definition of delusion is that it is a fixed false belief. It is not appearing and disappearing. A man cannot be deluded for five minutes and that would happen with Mr QR again and again. Because of the variation in the presentation it got me suspicious.'

Factious disorder is also referred to as Munchausen's syndrome. Persons with this syndrome will act as though they have a disorder, or disease or disability when in fact they do not. Importantly they know they do not have the disorder but repeatedly and consistently feign symptoms[4].

[4] Factitious disorder is listed in ICD-10 at F68.1 as 'Intentional production or feigning of symptoms or disabilities, either physical or psychological'.

Common features of people presenting with this disorder are:

- Dramatic but inconsistent medical history.
- Unclear symptoms that are not controllable and that become more severe or change once treatment has begun.
- Predictable relapses following improvement in the condition.
- Extensive knowledge of hospitals and/or medical terminology, as well as the textbook descriptions of illnesses.
- Presence of multiple surgical scars.
- Appearance of new or additional symptoms following negative test results.
- Presence of symptoms only when the patient is with others or being observed.
- Willingness or eagerness to have medical tests, operations or other procedures.
- History of seeking treatment at numerous hospitals, clinics and doctor's surgeries, possibly even in different cities.
- Reluctance by the patient to allow doctors to meet with or talk to family, friends or prior doctors.
- Problems with identity and self-esteem.

It is an unusual diagnosis, which should only be made after full consideration of alternative possibilities.

Mr QR's psychiatrist said:

'As a psychiatrist, I don't make a diagnosis in isolation. My own reading of a person's mental health or mental state examination is a part of the other package that comes with it and that is information from the other people who have been observing, especially the nurses and junior doctors. No-one believes that his symptoms were genuinely psychotic or genuinely depressive. I couldn't ignore it.'

With regard to factitious disorder the second opinion doctor said: 'I've never made the diagnosis myself. It's something which I think is much much more uncommon. I think it's something which is very much more a diagnosis of exclusion; you need to rule out everything else and be very confident that this is a factitious disorder before I would consider making that diagnosis.'

The opinion of the Commission's independent psychiatrist is:

'Patients with factitious disorder deliberately create or exaggerate symptoms. As this diagnosis had been assigned to [Mr QR] it appears that the care team looking after him viewed all and any of his symptoms in this context, although it appears to me extremely likely that [Mr QR's] symptoms were in fact indicative of major mental disorder.'

The views of family and friends

At interview, when asked about the collateral history he had obtained Mr QR's consultant psychiatrist reported:

'Collecting collateral history in writing is normal for me because I have learned from bitter experience that very often if you note down what you gather verbatim, very often people will forget what they said and sometimes backtrack. The collateral history that I got, in the first instance from [Mr QR's wife] and [his] son, clearly suggested to me traits of personality dysfunction. Later on [Mr QR's wife] went and checked the diagnostic criteria and she agreed and disagreed with some of them. [Mr QR's friend] a very senior GP also flagged up concerns that [Mr QR's] behaviour was very different from what he had known him to be. To ask was I absolutely certain midway through the second admission that this was factitious disorder – no I wasn't. I was getting all the information and that was the time I felt maybe I should get a second opinion. It was also apparent by that time that [Mr QR's wife and his son] were not liking my approach.'

The nursing and trainee medical staff working on the ward held opinions that reflected that of Mr QR's consultant psychiatrist. There was no dissent in the team. They all considered that:

- Mr QR met the diagnostic criteria for personality disorder.
- The diagnosis of factitious disorder was reasonable.
- Mr QR's presentation was not all that believable.

The information shared with us by Mr QR's wife and by his friend makes clear that they did not agree with the doctor's diagnosis of Mr QR.

The letter written to the ward team by Mr QR's friend (the retired GP) stated:

'I really wanted to say that this wasn't the Mr QR I knew because that was set against the diagnosis that [Mr QR's wife] and I had been given of a factitious disorder which wasn't a term I knew but when I looked it up it essentially implied that Mr QR was putting it on. There was no way in my mind, my view that that was true. He didn't want what was happening. He wasn't gaining anything by what was happening.'

This same friend said about his meeting with Mr QR's consultant psychiatrist:

'I did express again the difficulty I had in believing that Mr QR was putting this on, that this could have been factitious or that he was trying to get anything out of the illness. My understanding was that Mr QR was in a desperate position and the more ill he got the less able his wife was to look after him, and the less able she was to have him back home.'

Mr QR's wife expressed regret for what she had said during the first meeting/ward round with his consultant psychiatrist. 'I was really angry and distressed and I would have thought, in that circumstance, that what I said would have been understood within that context but at the end of that meeting I remember the psychiatrist's comment was – do not worry this man will never trouble you again. I remember thinking what have I said and what are they going to do, what's happened and he said he already had a very strong idea of Mr QR's diagnosis, as if that was what I wanted, the diagnosis that I was longing for but before that. This felt like being asked to be an informer, I needed to take on this responsibility of going round friends and family and extracting accounts from them as to how they viewed Mr QR.'

She also said: 'The second time that Mr QR was in there were lots of other things going on. I can't remember the name that they gave him, but on top of that there was this thing that he just made everything up which was part of this, which was really frightening. This became part of Mr QR's illness because he had no reference point other than what they said to him, so when they saw him do things like having meals and actually chatting to people, it was evidence that the rest was just making things up, not evidence that maybe it might be good for Mr QR to have some activity, just he's making things up and it felt like being spied on the whole time in a very negative way.'

We asked Mr QR's wife what he had thought of his diagnosis. Her response was: 'When he looked at it, he said that he could see some things about the obsessive compulsive but not the histrionic; that didn't mean anything to him but it lay really heavily on him. He felt a huge amount of shame, I think, having been in hospital and about that. That was the kind of overlay but the second time that he went in he felt that he was having a really negative effect on people – there was a woman opposite whose curtains were kept shut. He felt that she was dying as a result of him and there was a man who actually did die. I think he had dementia and [Mr QR] thought that was his bad influence.'

We asked Mr QR's wife if her impression was that when staff said Mr QR was making up his symptoms because he can talk quite normally that the reverse was the case. He was distressed but was still able to engage with people because that was what was expected of him. Mr QR's wife responded: 'and… I think that's what [Mr QR] did the whole of his life in a way. He was very bright and he was a survivor and given the right sets of conditions he was able to function and function

really well and begin to take them away. Until that time when he had that crisis at twenty-five he seems to have been able to keep it together but at that point something opened up that never fully went away and I think he was quite right, he did need me as part of that and in a sense he did need his work, although he hated all the routine in some way, but that routine was very good for him. What they saw as acting, I would say it was him unwell and what he was doing when he was with other people was doing that acting that he was very good at doing.'

Given that Mr QR's wife, his family and his friends had such valuable insights into him, it is unfortunate that the clinical team did not engage with them more in the formulation of their diagnosis and in testing out its veracity. It is clear from the testimonies of friends and family that the features the team were basing their diagnosis on were all features of Mr QR's known and understood personality – this is not being contested. However, the way the team processed this information, and the diagnosis they arrived at as a consequence is strongly contested by friends and family. Their concerns are echoed by the health board's own internal review, the second opinion psychiatrist who reviewed Mr QR on 2 – 8 December, and a clinical psychologist who interviewed Mr QR.

Given all the information presented to Mr QR's consultant psychiatrist and the ward team, we cannot understand how they failed to reconsider their perspectives and diagnoses.

Observation by the Commission

The clinical records of Mr QR's inpatient episodes show that the nursing staff maintained regular and well documented records of Mr QR's interactions and behaviours. The quality and focus of these records did not alter particularly following the instruction of Mr QR's consultant that they must record everything they considered to be non-mental health initiated in terms of Mr QR's behaviours. The staff simply seemed to record their experience of Mr QR, and their efforts to try to assist him in addressing his pessimistic outlook and sense of hopelessness.

The interviews with ward staff confirmed this, and that their interpretation of Mr QR's behaviour was consistent with a diagnosis of personality disorder. Our concern is that many of the staff who attended the ward rounds with Mr QR were relatively junior and no senior team member was present, such as the team leader, who may have provided staff with the confidence to challenge the working diagnosis of personality disorder. The ward manager stated that she didn't attend ward rounds and considered that this duty could be delegated to key workers. From accounts given by the staff we interviewed, they seemed content to accept the decisions of the senior doctor without question.

However, no staff member was able to articulate why greater attention was not given to the many occasions Mr QR's wife phoned to raise her concern about diagnosis, or why greater attention was not given to the concerns raised by Mr QR's friend (of over 5 years), the retired GP.

The records of Mr QR's consultant are also detailed. However, information that supported his thinking about Mr QR's diagnosis was accepted. Any information that challenged or ran counter to the consultant's thinking about Mr QR appears to have been either rejected, or not given the same weight.

For example, the information provided by Mr QR's wife that supported a diagnosis of mixed personality disorder was referred to on more than one occasion in the clinical records, and featured as a key influencer in the September 2014 discharge letter.

However, the subsequent correspondence provided to Mr QR's consultant, by Mr QR's wife where she set out logical challenges to his diagnosis, based on over 27 years of marriage to Mr QR, is not referred to at all. Similarly, information provided by Mr QR's GP friend challenging the later diagnosis of factitious disorder, appears to have not been heard.

Observation by the Commission (continued from last page)

Not only was Mr QR's consultant selective about what he 'heard' and utilised from family and friend testimony in coming to Mr QR's diagnosis, he also completely disregarded the opinion of the second opinion consultant psychiatrist who said:

- Consideration should be given to a trial of anti-depressants
- Depressive illness could not be ruled out

This second opinion consultant also stated that Mr QR did not meet the diagnostic criteria for personality disorder. The diagnosis of factitious disorder had not been assigned to Mr QR at the time the second opinion assessment was conducted. There is no evidence in the clinical records, or from the interviews we conducted that justify why the opinion of the second consultant was not acted on.

In written evidence supplied to the MWC, Mr QR's consultant psychiatrist stated that he had sought advice and believed that he was not obliged to follow the advice of a second opinion doctor. However, he said that that he would act differently if a similar situation arose: 'Even if I disagree with the diagnosis I would now prefer to have a full trial with an anti-depressant.'

What can be taken from this section of the report to benefit mental health service users across Scotland?

There are several powerful lessons emerging from this case which adult inpatient units need to reflect on as part of their own self-assessment and local improvements to the way in which they work.

Where a service user has family and friends who are willing to engage with the service and provide information about and experiences of the service user, how the information is used and the interpretation of it by NHS staff must be checked out with the family / friends. Mental health teams cannot assume that they have interpreted accounts given by family/friends correctly without going through a validation process

Where an unusual diagnosis is arrived at in a person's later life, as happened to Mr QR, the multidisciplinary team should consider how the diagnosis sits with the person's life up to this point. If there is incongruity, a second opinion should be sought and acknowledged. If it differs markedly from the team's opinion and the team elects to reject it, the views of the clinical director should be sought.

5.2 Risk Assessment and Risk Plan

Mr QR's first risk assessment was performed between the 21 and 23 August 2014.

The STORM approach to assessing risk was utilised which is the national standard for Scotland[5].

The STORM approach requires consideration of the following:

- Suicidal intent
- Any suicide plan
- The background to the suicidal thoughts and increased risk of harm behaviour
- Protective factors (i.e. risk reduction factors) / risk increase factors
- Coping mechanisms
- What to do in crisis

The initial assessment conducted on 21 August revealed:

- Constant thoughts of suicide
- Bleak thoughts about his future
- A sense of hopelessness

However, Mr QR reported not having any active plans, though he had been researching ways of committing suicide, including hanging, swimming out to sea, and jumping from a local bridge.

With regards to any specific triggers for his thoughts Mr QR was not able to describe any. He also reported that they were new for him, starting only two weeks previously.

Protective factors were identified as his wife and sons, and increased risk factors as his gender, and that he was recently retired. The risk plan was to admit Mr QR to an inpatient adult psychiatric ward for assessment.

What did staff say about Mr QR and his risks?

We asked about risk when we interviewed medical and nursing staff, and the hospital chaplain.

The day following his first admission Mr QR had left the ward. According to the notes made following the heavy goods lorry driver's report, he had hidden in the bushes and jumped in front of an oncoming heavy goods lorry. Initially, staff were under the impression that he had lain down in the road in front of the heavy goods

[5] http://www.chooselife.net/Training/storm.aspx

lorry. Immediately after the incident, a member of staff remained with Mr QR until he could be assessed by the duty consultant.

Mr QR's primary nurse was asked if the incident was a serious incident. 'Yes. It wasn't taken lightly by any means, and the level of distress that Mr QR was in certainly wasn't taken lightly, nobody dismissed that. From our point of view it showed just how unhappy he was and how desperate he was. It wasn't taken lightly. I think it was taken very seriously by everybody.' The nursing ward manager described the action she took when she discovered that Mr QR had jumped out in front of the heavy goods lorry.

She also said: 'The consultant, I don't believe, thought that he needed to be on increased levels of care, however I worried that he may need to be because he was alone. It was the second day of admission and what he had done had been quite considerable. So, I noted that I got the consultant back, and he said he felt that after doing a STORM assessment, then the risk wasn't as high and he was okay on general levels of care. He was on call during that weekend and was happy to review him daily.'

The hospital chaplain, who happened to be a friend of Mr QR's, recounted how he had described the incident with the heavy goods lorry. 'His intention behind that – he did say that he had intended in the moment to take his life, to end his life but on reflection he was glad that he hadn't so that was the gist of what he was saying.'

Mr QR's consultant psychiatrist told us 'That happened on the watch of the on-call consultant. When I discussed that with Mr QR he was remorseful about what had happened. This is all in the context of ward rounds.

The feeling of the nurses was, and these are my words, that they were not entirely convinced that it was a genuine attempt. They were not entirely convinced. As I said when I discussed with him so much else had happened and there were doubts coming up about his presentation.' 'I am convinced that if my consultant colleague, who was on duty at that time of the day, who was a far more experienced psychiatrist than I am, was convinced that this was a genuine attempt and there was a high risk of this happening again he would have without a shadow of a doubt put Mr QR on constant obs. The fact was that he didn't and if you see from his notes, he was not overly concerned.'

Sometime after Mr QR's readmission in November, he talked about having attempted to hang himself. His primary nurse during that admission was asked if she was aware of the incident.

'I know that when he was in hospital he certainly spoke to me about a hanging. What he had told me didn't confirm with [what I heard] when I spoke to his wife. I don't know if he was talking about the same incident or not. He told me he got

a ladder and his wife and friend had come in and they had stopped him. When I spoke to his wife she didn't confirm what Mr QR had said about the incident. She did say there was a ladder at the loft but her or the friend didn't come in and stop him from actually doing it. I don't know if that was the same incident that he is speaking of or not.'

On two occasions during the second admission (19 November – 29 December 2014) nurse's power to detain was used. Mr QR's primary nurse (first admission) was asked whether there were general concerns about Mr QR being at risk of self-harm on the occasions that the nurse's power to detain was used. She said: 'I think it was because Mr QR was so agitated. Certainly, when I used my holding powers on him it was on night shift and he was getting more and more agitated, more and more distressed. You could see he was distressed. Trying to speak to him, trying to de-escalate wasn't really working. He was becoming more and more insistent that he was going to leave. Tried to offer him medication. Offered him one to one and he wasn't really accepting of that. I think he just got himself to a point that he couldn't come down again so the decision was made to use nurse holding powers until we could get his doctor to assess him.' And then on these occasions the doctors decided there was no need to detain him further?' 'Yes.'

The nursing ward manager was asked about the second time in December when Mr QR left the ward after a visit from his wife. He had been brought back to the ward and the nurse's power to detain had been used. She was asked if Mr QR had been considered a suicide risk at that point. 'I think he was considered.

He was obviously anxious to go and the way he presented would have posed a risk of some sort. So that was why the nursing holding powers were used to allow assessment. You wouldn't have let him go in the state that he presented in.'

When we asked whether Mr QR was considered at risk of suicide when he was discharged we received conflicting answers from staff.

Mr QR's friend had rung the ward when he heard Mr QR being discharged. He spoke to a senior nurse: 'I said did you consider that there would be a risk of suicide and she said yes, there is a risk of suicide.'

Mr QR's primary nurse (first admission) said: 'I think we were all really shocked when we found out what had happened. I don't think we had expected [Mr QR] to do that at all. It was a shock. We were all very shocked and upset.'

His primary nurse (second admission) had a similar response. 'No, I don't think anybody thought he was. I certainly didn't and when I heard I was quite surprised.'

When Mr QR's consultant psychiatrist was asked about risk assessment and risk management he explained that he would assess risk each time he saw Mr QR; any changes would be noted in a form completed by the nursing staff. He said: 'I think in Mr QR's case there was an awareness from all staff members that there was a risk. He had attempted it before and there was a high risk he would attempt it again. In a way if Mr QR had a mental illness I could have treated it and it wouldn't have happened but because I still believe that he did not, and as you can imagine I have reflected on it and reflected on it some more, I am still convinced that at that time with the only information I had I took the right judgement call.'

The junior doctor who, with the triage nurse, saw Mr QR in the early hours of Hogmanay explained what he was assessing for in the interview on 31 December. 'I was looking for major changes in his mental state, that we might have seen over the last few days that would be in keeping with something else having happened that would mean that we would need to change the plan.' He did ask about thoughts of suicide: 'I recall him saying that he wouldn't do anything like that and that he, through other parts of the discussion, was talking about seeing his family later on – he had that future orientation – that he was going to see his wife and family on Hogmanay'. 'He talked quite convincingly.' 'I remember it being quite a quick response as well and him not appearing that he was hiding that or trying to trick us.'

Observation by the Commission

It is clear from his records and the interviews with staff that everyone knew that Mr QR was frequently assessed as being at increased risk of suicide. However, whereas Mr QR's family believed that there must be a therapeutic approach, including medication, which would alleviate this, or at least reduce it, his care team did not. They saw treating Mr QR as endorsing his beliefs, which the staff saw as 'wrong' beliefs.

The ward staff took appropriate action when they were concerned that Mr QR might leave the ward, using their powers of detention and seeking medical assessment of Mr QR. They had from the point of his first admission been alert to this specific aspect of his risk.

Staff were risk aware. However, they saw Mr QR as having complete control over his risks, and that if he attempted and completed suicide then it would be his 'choice'. We are less convinced, and wonder how Mr QR would have responded differently had he received medication at a higher dose. It seems that opportunity or chance of recovery was denied to him, because he was not treated rigorously.

The risk assessment identified protective factors as his wife and sons, which highlights the importance of treating the family as an asset and a positive factor in therapeutic engagement with the patient.

As we go on to discuss, the known risks do not appear to have been properly factored into discharge planning.

5.3 Discharge from Hospital

Mr QR had two discharges from hospital, one in September 2014 and one on 29 December 2014. The discharge episode we investigated is the one that occurred on 29 December 2014.

The records show that

- 28 December 2014 was the first time discharge was mentioned in the clinical records in relation to his second admission[6]. At this point the records say: 'spoke to Mr QR explaining the fact that he may be discharged tomorrow. He was not surprised and said he did know that it was coming. He said that his wife wouldn't come and get him and he was aware that his wife doesn't really want him home at present.'
- At this stage there is no prior evidence of discharge planning for Mr QR, or preparation of his family for discharge.
- Once aware of the plan, Mr QR's wife phoned the ward and told the staff that she did not think Mr QR was safe or fit for discharge. The notes say 'she feels he is a risk to himself and others and that [Mr QR's consultant] said he [Mr QR] would have input at home such as psychology. She believes as does [Mr QR's GP friend] that Mr QR should have a package of care.' The GP friend asked the ward staff if he/she considered Mr QR a risk of suicide; the staff is reported as answering that Mr QR was a risk of suicide but that 'ultimately that was Mr QR's choice'.
- 29 December, there was a dedicated meeting between Mr QR's family and his consultant psychiatrist on the day of discharge. It is clear during this meeting that Mr QR's wife:
    - Would like sufficient planning time to be able to organise taking time off work to support her husband.
    - Would like a CPN to be in place before Mr QR came home.
- Mr QR's consultant explained that the longer Mr QR stayed the more entrenched the behaviour would become.
- A date of 7 January was suggested (i.e. one week later). The clinical response to this was 'the problem is Mr QR will escalate his behaviour when the discharge is set'. However this date would allow Mr QR's wife to plan for his discharge.
- Mr QR's consultant is noted to re-iterate:
    - Three psychiatric opinions that confirm no psychiatric illness. In fact, as discussed above, the second opinion doctor clearly notes in the

[6] The ward notes for 3 December contain a reference to discharge the following week, but Mr QR was still undergoing assessment at the time, and this suggestion does not appear to have been followed up

clinical record that he is unable to exclude a depressive episode, albeit atypical in presentation, and suggested further investigation to exclude organic cause, a trial of anti-depressant, and seeking the views of an older adult psychiatrist. The older adult psychiatrist simply ruled out any organic cause but gave no opinion on diagnosis.
    - Nursing observations.
    - Clinical psychology opinion sought. The letter to Mr QR's consultant said: 'I would be inclined to agree with this gentleman's own assessment that his emotional difficulties are secondary to significant practical changes over the past year, […]. I did, however, suggest that the emotional effects of these changes seem to have given rise to a different way of thinking and behaving, which in turn were making the situation worse.'
    - That Mr QR sees the distress he causes but does not change his behaviour, and this causes him much pessimism.
    - That Mr QR should only be at home if his behaviour is OK.
- Mr QR's consultant also suggested:
    - Mr QR goes out on day passes.
    - That his driving licence is revoked.
    - Mr QR applies for his driving licence back when he is better.

While the above was being discussed Mr QR was not present, but was invited to re-join the meeting afterwards. When Mr QR re-joined the meeting, his consultant advised him that:

- The CT results and MRI scan show nothing that might be causing his behaviours.
- That two other consultant psychiatrists had confirmed no psychiatric illness.
- That Mr QR has factitious disorder – psychological distress resulting in his behaviour exhibited.
- That Mr QR will see occupational therapy, clinical psychologist and CPN in the community.
- Date of discharge to be 7 January 2015, but can have day leave passes 9am – 5pm in the interim.
- Advised not to drive. Mr QR was not happy with this and reported intending to drive regardless. Mr QR's consultant then advises Mr QR that he will inform DVLA of his clinical advice.

Mr QR's response to this plan is:

- It is not possible to discharge him. This is because he can't manage his house.

- His wife explains she is happy to manage the house and doesn't want to spend the future at the house.
- Mr QR expresses that it is 'all rubbish' and 'all a story'.
- Wife advises that she cannot have him home in the way he has behaved until now.
- Mr QR turns his chair away from his consultant.

The records say: 'Mr QR put out of room'.

The clinical record also says that Mr QR's escalating behaviour through the meeting is evidence of his manipulation, and that this is just the beginning. Mr QR's wife is noted to reiterate that she cannot have him home like this.

When Mr QR is brought back into the room, his wife is reported as telling him that he needed to leave hospital and that he needed to live independently in a local town. Mr QR was noted to protest that he didn't have the means, to which both his wife and son told him that 'you absolutely do have the means'.

Following these exchanges his consultant suggested discharging Mr QR on 6 January, and asked would his family prefer it if Mr QR was discharged while the consultant was still at work, before he went on holiday on 4 January.

Then Mr QR's consultant decided that he should discharge Mr QR the same day. The record of the meeting says: 'Family happy with plan, believe it is the correct thing to do.'

Mr QR was then brought back into the room (again) and told:

- To be discharged today.
- Advised he needs to find accommodation.
- Son will bring in his bank card and new PIN.
- Advised to register with a GP.
- Advised not to drive.
- His consultant advised him that he had pushed his family away and advised he find his accommodation himself. Also advised if he doesn't leave by 5pm the police will be asked to remove him from the hospital.
- Advised to start packing up and ringing around.

Mr QR eventually leaves the hospital at 21.25pm with no accommodation organised. He told a staff member he had nowhere to go. The notes say: 'I reminded him that he has been given ample opportunity to deal with his accommodation issue.'

When his wife called at a later point, the staff member advised her that her husband had left and he/she did not know where to.

What the staff said when asked about the discharge episode

Mr QR's primary nurse (first admission) believed that the date for discharge was brought forward because it was felt that being in hospital was no longer of benefit to Mr QR. 'There wasn't really any need for Mr QR to be in hospital anymore.' The junior doctor accepted that the discharge occurred at a difficult time of year, but 'It was time to discharge him'. 'Keeping him for longer - his behaviour was getting worse. It was as good as it was going to be.'

Mr QR's consultant was going on holiday on 4th January. When asked about discharge he said: 'So I said to them I could discharge him on 7 January. Every passing day Mr QR's presentation was becoming more and more difficult, attention seeking and the altercations they were having were becoming more frequent.'

As Mr QR's wife was not willing to have Mr QR at home, even on 'day passes' that meant he would have to find somewhere else to stay, probably not in the same catchment area.

The consultant also advised Mr QR would need to register with a GP to determine the catchment area in order to refer to the appropriate community mental health team (CMHT). And, 'The second thing that occurred to me was that the covering consultant had his own patient load. If I had been here on 7 January all I needed Mr QR to give me was the name of the GP. I would have walked across, knocked on the door of the appropriate consultant and said this is the patient, this is the background, can you please give the gentleman an appointment and even if you are not able to give an urgent appointment I will give an urgent appointment for follow-up after discharge. Can you please ask your CPN, your clinical psychologist, your social worker to get involved?' 'I thought personally I could get a much better package of care around him rather than leave it to somebody else who is not around. Because of his deterioration what we were seeing as symptoms I didn't even have the option that I could come back and discharge him.'

The second opinion consultant confirmed that as covering consultant: 'I think it would be a very difficult discharge to do.'

At interview Mr QR's consultant acknowledged that he now regretted the timing of the discharge: 'I wish I had not discharged him that day.'

Mr QR's consultant was also asked what was safe and supported about Mr QR's discharge. He said:

'Mr QR had been informed several times that he is not wanted back in his house, he had to find alternative accommodation. Until the last day he had not done anything about it despite being informed. Then on the last day the nurses actually gave him the book (Yellow Pages) and said look these are the potential

B&Bs which you can go to. He said he does not have money which is not correct. He actually lost his wallet. Mr QR told me that he actually threw it away. Regarding the safety of the discharge, bearing in mind the diagnosis that I had made at that time and yes as I said to you earlier I wish I had not discharged him that day, the idea was that he would reside in a place in the local area and be quickly picked up by the CMHT. So in my view Mr QR was well enough to keep himself safe in the community while the CMHT picked him up with some speed.'

The clinical psychologist was asked if he had been consulted about the possibility of providing psychological therapy after Mr QR was discharged. He said: '[Mr QR's consultant] didn't specifically with regards to discharge but I think there was an understanding that this had been offered.'

We consider it is noteworthy that the clinical psychologist had seen Mr QR in passing on the ward just before, and just after Christmas, and had made a record of his observations: 'Mr QR was apparently unable to speak in sentences - latent responses'. 'Ward staff had observed these behaviours consistently although there are occasional episodes where they appear to resolve. No plans to initiate psychological therapy at present.'

The psychologist recalled: 'That was the occasion when I had asked Mr QR "remember we've still got this as a possibility on the table", but he just kind of looked at me.' 'I wasn't able to get any words out of him unfortunately, which creates a difficulty when we're doing a talking therapy.'

What had been agreed at the discharge meeting, according to the hospital chaplain, was not what actually occurred. 'At the end of the meeting it was about supporting Mr QR to make that move from the hospital into the community and what I'm told happened was that Mr QR had to make his own arrangements and to get himself out of the hospital to find himself somewhere to stay which I could actually allow myself just now to be quite distressed about when I think about a friend of mine being put through that. It's grim actually given his condition.'

The junior doctor described the meeting to discuss Mr QR's discharge. She recalled it was an extended meeting with two family members, a friend, Mr QR and more than one member of nursing staff. 'It was quite a difficult interaction with Mr QR because we wanted to get him discharged and he was quite comfortable being an inpatient so we always knew that that was going to be a difficult time and I remember it was.' When asked about her entry in the notes that said 'Mr QR was put out of the room', she replied: 'I think it was just in case – Mr QR's consultant asked him to step outside for a minute and the nurse took him outside, the rest of us had a chat and then he was brought back in.'

The hospital chaplain, a friend of Mr QR's, confirmed how difficult the meeting was. 'He (Mr QR's consultant) made Mr QR wait outside while we talked about him which I have to say I was uncomfortable with, but Mr QR agreed to do that,

and Mr QR's consultant's rationale behind that was that if Mr QR was in the room he would keep cutting in, keep interrupting, wanting to go over old ground again.' 'I suppose it was the being summoned and dismissed aspect of it that I was least comfortable with.'

Mr QR's consultant did not recall saying that the police would be called if Mr QR did not leave by 5pm, but confirmed 'that it is a fairly regular occurrence in our hospital now that we have to ask the police or tell the patient that if they do not leave by 5pm we will have to ask them to leave.' However, the nursing ward manager acknowledged that she had only witnessed patients being told that the police would be called if they did not leave the ward once or twice in twenty years. And Mr QR's primary nurse (first admission) concurred, saying: 'It doesn't happen all that often I must say.'

Mr QR's primary care nurse for the duration of his second admission was asked if there were things that on reflection she might have done differently. She replied: 'Probably. Certainly, on the day of his discharge, […] Although I did sit with Mr QR for a while that day of his discharge, and wished him all the best and hoped he would be fine but reading back the notes I thought – that was harsh, handing him the Yellow Pages. I could have sat with him and maybe looked at some accommodation with him, things like that you know.'

The junior doctor who assessed Mr QR on the morning of the 31 December said: 'The thing that has struck me in reflecting on it is whether, when the police had brought him up, we should have made contact or offered whether he wanted us to contact his wife or someone.'

The perspective of family and friends

Mr QR's wife had agreed to the discharge: 'I was persuaded that, out of all the bad options, that that was the best solution at that moment and so was [our son]. I can remember going back and saying there was a way forward. Once I thought thank goodness Mr QR is out of there but I certainly wasn't thinking straight.'

His wife described what it felt like for her in the discharge meeting: 'I didn't have a clue what to do. I was really frightened for myself, for my son and for Mr QR and I was trying to manage that fear. I didn't have any plan forward from there.

I had been told by [Mr QR's consultant] that three psychiatrists had concluded that Mr QR did not have a psychiatric illness. That there was nothing more for him in [the hospital] that they could offer and that was that.'

Mrs QR talked about the discharge meeting: 'We were called in and he [Mr QR's consultant] did say that Mr QR could stay in up to the following week but he would have this diagnosis of factitious disorder. He would expect his behaviour to get much, much more difficult and he was going to be sent out at that point anyway and his advice was that Mr QR should be sent out, leave the hospital as quickly as possible. I said that I really wanted him to have an occupational therapist (OT) and to have a CPN and he finally agreed to that

and he said they would help him to get accommodation and if they hadn't managed to do that on the Monday then he might have to stay over until the Tuesday.'

Mr QR's wife talked about Mr QR's discharge plan: 'I said I don't feel safe with Mr QR coming home. He said could he maybe go to that place that you spoke about and I said no. That's not going to work. There was no discussion of appropriate care for Mr QR at all. I wasn't involved in that.'

During the discharge meeting Mr QR's consultant, as Mr QR's son understood it, explained that Mr QR was adopting the symptoms of a patient with mental illness although he didn't have one. 'He would just get locked into this way of thinking if he was kept in there for any longer.'

Mr QR's son had initially not wanted his father discharged but had changed his mind during the meeting. 'It was like well okay, he's the doctor he knows what he's saying. If he says, if we don't discharge him now he'll be sick forever, I'll take his word for it.'

Mr QR's son was asked if any other staff spoke during the meeting: 'I don't think so. I think it was just me, my mum, my dad and his consultant psychiatrist who spoke during the meeting.'

Observation by the Commission

Having read the clinical records and interviewed the staff we consider that Mr QR's discharge was not adequately planned. Even though the second opinion did not support Mr QR's consultant's diagnosis, and the old age psychiatrist did not give an opinion on diagnosis at all, a decision was taken to discharge Mr QR. The multidisciplinary team do not appear to have discussed the second opinion provided, they merely proceeded on the basis that the diagnosis of factitious disorder was the correct one. We do not understand how these two assessments by fellow consultants (that did not support Mr QR's consultant) became incorporated into the rationale for discharge, quoted by Mr QR's consultant during the course of that final meeting and referred to in the discharge summary.

Although the option of cognitive behavioural therapy was still open to Mr QR, Mr QR's consultant does not appear to have discussed the diagnosis of factitious disorder with the clinical psychologist and considered with him what psychological treatments might be possible.

Mr QR's condition was deteriorating and the consensus of the team was that this was exacerbated by being in hospital. Mr QR's wife could not have him home because she could not cope with the behaviours which the team believed he was manufacturing. There is no doubt that the team believed that Mr QR was displaying what the discharge summary calls pseudo-psychotic symptoms. However, they knew that it would soon be Hogmanay, they knew he had nowhere to stay, and they knew that they were asking a man, who had become very dependent, to find accommodation and register with a GP before any community support would be offered to him.

The motivation was to discharge Mr QR before his consultant went on holiday. The team were aware it would be a difficult process and they were firm about it, to the point of saying that if he did not leave the premises they would call the police. They had to be firm because Mr QR did not want to leave, he did not think he could manage. The family were persuaded by the arguments in the meeting but it is difficult to see what they could have done if they had not been persuaded. Mr QR's wife said she could not look after him, she said she did not think the spiritual retreat could support him. She could not have been clearer.

When Mr QR finally left, staff did not know where he was going. The follow up appeared to depend on Mr QR letting the team know that he had found accommodation and registered with a GP. We consider this unacceptable practice, irrespective of diagnosis and especially in view of the time of year.

5.4 Overall impression

It is clear from reading Mr QR's clinical records that the nursing staff spent considerable amounts of time with him, and encouraged Mr QR to try to look constructively at his situation and life challenges. There is evidence, however, that staff had a sense of frustration with Mr QR: his seeming inability to take responsibility for his life; his persistence in looking backwards; and berating himself about past decisions that had not worked out as he had hoped. Mr QR also tended to have a 'doom and gloom' forward looking perspective, that staff and his family found difficult to manage.

Although Mr QR's wife and his close friend, a retired GP, could see that he was unwell, and that there was more to his illness than self-indulgence, the staff caring for Mr QR could only see Mr QR in terms of disordered personality and attributed all of his reported and displayed symptoms to this. Any suggestions made by Mr QR's wife, son and friend, that they considered the picture to be more complex, that Mr QR was in fact very unwell and bore little resemblance to the man they knew, appeared not to have been listened to. Our impression was of an inflexible perspective in the ward staff and in Mr QR's primary consultant psychiatrist that did not allow for the contemplation of an alternative explanation for Mr QR's presentation.

The nursing STORM (skills-based training on risk management for suicide prevention) assessment following his first admission described him having constant thoughts of suicide; bleak thoughts about the future; and hopelessness. His primary nurse recalled that he was admitted 'with low mood and suicidal ideation'. She described him as 'more sad than depressed', but then stated she had been 'monitoring for evidence of low mood and anxiety'.

Nursing staff were aware that, on initial assessment on his second admission, Mr QR had reported poor sleep; poor appetite; agitation; thoughts of suicide; problems with his memory and attention; and lack of confidence. In spite of this, there was no care plan to monitor and report on these symptoms, nor is there any clear record of a formal review of his mood. Nevertheless, the nursing narrative was extensive, and the records came across as though the nursing staff were making honest contemporaneous accounts of their interactions and impressions of Mr QR as they went along. It is clear from the records that despite challenges in developing a rapport with Mr QR, staff did make themselves available to him to talk for good periods of time, and in the main daily. However, there is no real evidence of systematic recording of nursing care, from the initial assessment to care planning and evaluation, which demonstrate any impact of nursing interventions.

Mr QR was not always appreciative of nursing input and was often noted to have rejected ideas offered by the staff as to how he could think more constructively about his stressors, and help himself recover.

We also read information provided to the NHS staff by Mr QR's wife. This information and information recorded in the clinical records, made clear that Mr QR's wife cared about him very deeply and was not intending to leave him as Mr QR consistently thought. The records set out information provided by Mr QR's wife at the request of Mr QR's consultant, and her efforts to instil balance in how this was interpreted and used by Mr QR's consultant. We do not believe that Mr QR's consultant listened sufficiently to Mr QR's wife. He appears to have taken the information that fitted his own narrow perspective about Mr QR, even though objectively Mr QR did not meet the diagnostic criteria for the diagnosis assigned to him of personality disorder.

The records also show that Mr QR's wife was exhausted and at her wits end to know how to support her husband and that Mr QR's behaviour patterns made returning home untenable without an improvement in them. However, even though Mr QR's wife provided constructive ideas to his care team about a centre where he might be able to live and work while he got better, this was not followed up, and in the event Mr QR was discharged at very short notice without any accommodation arranged. Despite what was written in the records about the family supporting 'immediate discharge' on the 29 December 2014, looking at the records in context, we do not believe this to be true. We believe that Mr QR's wife and his family deferred to medical opinion that discharge was in his best interests.

With regard to the medical management of Mr QR, we have serious reservations about the accuracy of the diagnosis of mixed personality disorder and factitious disorder. We can appreciate why there was consideration of a personality disorder based on the way Mr QR behaved on the ward with staff, his persistence in not seeming to take responsibility for himself, and his perpetual ruminations on constant themes of money, retirement, his wife, and his 'unmanageable house'. We accept and acknowledge that Mr QR's consultant accessed a second opinion regarding Mr QR's presentation, and sought access to tests that would confirm or rule out an organic cause for Mr QR's presentation. His consultant also asked for him to be reviewed by older people's services in case there was any cognitive impairment affecting his behaviour. However, Mr QR's consultant did not act fully on the advice of the second opinion consultant, and neither did he record any rationale for not doing this.

Mr QR's consultant appears to have disregarded Mr QR's past successes in life, and his social popularity. The Commission does not challenge the fact that Mr QR displayed certain traits associated with histrionic personality disorder and OCD. Mr QR himself agreed with this assessment, as did his wife. However, to have attributed his symptoms entirely to a disordered personality in a man who had a successful family life, a successful career, and who engaged socially with many long term, close friends was misguided.

To have ignored all the information that argued against such a diagnosis, was in the opinion of the Commission, an omission. It denied Mr QR a rigorous trial of antidepressant medication.

The Commission's view is reinforced by the independent consultant psychiatrist, who reviewed Mr QR's case notes on behalf of the Commission, and said:

'I feel that there are serious failings in this case with regard to assessment, diagnosis, management and discharge planning. I feel the care falls well below the standard that I would consider acceptable.'

5.5 The Significant Event Review

A Significant Event Review was conducted by NHS Board D on 9 February 2015. It concluded:

'It is the opinion of the panel that there were significant deficiencies in the care that [Mr QR] received from the psychiatric services. These deficiencies cause us concern. It is our hope that our recommendations, when implemented, will address these concerns and improve the care that patients with similar problems to [Mr QR] receive in the future.

We believe that Mr QR's death on 31 December 2014 could have been foreseen and prevented at that time. It is our view, however, that he had very complex problems and that suicide in the medium term would have been, even if the psychiatric care he received had been better, a very likely event.'

The review findings included (alongside aspects of the case which it concluded went well):

- Criticisms of some of the nursing notes, including an excess use of terms that could be viewed as pejorative.
- A discrepancy between the opinion of the second opinion doctor as expressed by him and as subsequently quoted by other clinicians.
- A lack of a care plan during the second admission.
- That the care programme approach should have been considered.
- That the discharge was 'precipitate'.

Actions to be taken included:

- Writing to all clinical staff reminding them of the need to accurately record clinically important information and of the danger of using pejorative language.
- Writing to local clinical staff stressing the importance and value of consultant second opinions.
- That consultant second opinions should be in the form of a typed letter in the clinical notes that would be shared with other care givers.

- Reminding local clinicians that all professionals who participate in a multi-disciplinary round should record information shared and their opinion.
- A multidisciplinary workshop to look at discharge procedures for vulnerable patients.

We agree with the conclusions of the review regarding the significant deficiencies in the care received by Mr QR, but do not believe that the follow up action was sufficiently wide-ranging or auditable.

The consultant psychiatrist responsible for Mr QR's care has acknowledged that mistakes were made in relation to the discharge arrangements. Also, that when Mr and Mrs QR were unhappy with his approach, he should have transferred care to another consultant. The consultant also acknowledges that documentation should have been much better. He has acknowledged these errors and taken remedial action regarding his practice. He does, however, still stand by his diagnosis.

We are aware that significant changes have occurred within the NHS provider since Mr QR's death. These include the introduction of a care pathway for people with a diagnosis of personality disorder, and training for nursing staff in the appropriate and inappropriate use of language in the clinical record.

We expect the NHS Board to review their actions in the light of this report and our recommendations, to ensure that there is an enduring change to practice and to the culture of this service.

6. Overall conclusions

The Commission considers that the nursing staff who had contact with Mr QR at the time of his first and second admission to hospital were genuine in their intent to help him, and to support him in achieving recovery. The clinical records show that Mr QR was offered at least daily, and sometimes more frequently than this, opportunity to ventilate his feelings on a one to one basis with staff. The documentation of these sessions also show that staff did try and encourage Mr QR to use distraction techniques, meditation, and fitness to more constructively manage his life stressors. Unfortunately, the nurses were not afforded supervisory leadership during clinical reviews when important decisions had to be made or contested.

With regards to medication management, Mr QR was never on a rigorous medication regime. Therefore, there was never the opportunity to determine whether medication may have positively impacted on his symptoms. The reason why this did not happen seems linked to the medical assessment and diagnosis of him.

With regards to diagnosis, the medical staff who assessed Mr QR also made mostly comprehensive records, which enabled a sense of quality to be assessed. We have no concerns about the amount of attention Mr QR received from the psychiatric professionals involved. We do, however, have concerns about the fixed perspective of Mr QR's primary consultant and the trainee doctors working with him. The Commission does not doubt that Mr QR's consultant believed that he was diagnosing Mr QR correctly. Furthermore, the Commission accepts that he had the best interest of Mr QR's wife as a focus of his attention. However, it seems the clinical focus of Mr QR's consultant was fixed in its perspective, to the exclusion of other more plausible diagnoses for Mr QR. This led to a firmly placed diagnosis of personality disorder and then factitious disorder which the Commission considered to have been misguided.

The primary contributory factors to this are considered to have been:

- The selective response to the second opinion advice by Mr QR's consultant.
- The selective use of information family members provided to Mr QR's clinical team.
- The non-utilisation of information provided to Mr QR's clinical team that counterbalanced information provided by family members.
- The apparent disregard of the carefully constructed correspondence submitted by Mr QR's wife that challenged the diagnosis of personality disorder.
- The lack of senior nursing presence on clinical ward rounds.

- A fixed perspective across all staff groups about Mr QR, coupled with a lack of professional questioning by the nursing staff of the medical approach.

In relation to the views of family and friends, this case has highlighted a narrow interpretation of information provided by Mr QR's family, and a selective use of the information. Such an approach does not enhance confidence in family members and friends to be forthcoming with mental health teams. Families must trust that services will use information provided respectfully and check out with families and friends that the professional interpretation of what they have been told is reasonable.

One way of achieving this might be to allow families / friends to read the record made following the giving of information so that they can confirm accuracy of interpretation.

In this case, Mr QR's consultant undertook to seek a second opinion about Mr QR and his presentation. When the second opinion was received, it was disregarded. Although one is not bound to accept the perspective of a second opinion doctor, in circumstances where the second opinion is completely at odds with that of the treating psychiatrist, prudence must prevail, which it did not for Mr QR.

Good practice would be to:

- Discuss with the second opinion doctor their different perspectives.
- Seek the advice of the clinical director if the first and second opinion doctor cannot reach a consensus regarding a reasonable way forward for the patient.

The discharge planning and actual discharge of Mr QR in the days preceding his death fell well below an acceptable standard.

The contributory factors as to how this happened are not clear, but seem to include:

- The fact that Mr QR's consultant was going on holiday.
- Staff who did not challenge the breach in good practice of discharge standards.
- A lack of senior nursing presence on clinical ward rounds.
- A belief that to provide practical discharge support for Mr QR would not benefit his mental health.

Regarding the predictability of Mr QR's death, it was known and accepted by the clinical team, and documented at discharge, that he remained a suicide risk. What was not predictable was when he might try and harm himself.

What is also known is that Mr QR had previously dived in front of an oncoming heavy goods lorry and was unhurt because of the quick actions of the heavy goods lorry driver, and because the heavy goods lorry was load free. It is also known that in the hour prior to his death Mr QR told a doctor that he had no plan to end his life.

With regard to the prevention of Mr QR's death by different mental health management, this is a difficult question. We cannot definitely conclude that, had Mr QR been:

- treated with anti-depressants,
- positively engaged with cognitive behavioural therapy, and
- discharged in line with good practice standards,

then his death would not have occurred.

What can be concluded is that the opportunity for a different outcome and the possible reduction in Mr QR's suicide risk was removed because he was not actively treated, and because the manner of his discharge was unacceptable.

7. Recommendations

The recommendations below target not only the mental health service involved with Mr QR but all mental health services throughout Scotland. The Commission expects NHS Boards to reflect on this case and the recommendations, and to self-assess their own service and to make necessary adjustments as required.

Recommendation 1:

When a family, friend, or carer challenges the interpretation of information shared and conclusions drawn from it, services should make a clear record of the consideration of the challenge. The rationale for any changes, or the decision not to make changes, to the patient's management plan should be clearly recorded.

Recommendation 2:

NHS Boards should ensure there are clear guidelines for:

- Seeking a second medical opinion.
- Dealing with disagreement with the second opinion.

Recommendation 3:

NHS Boards should ensure that their teams and services adhere to good practice standards in discharge planning, including what to do should re-presentation occur a short time after discharge. On occasions where there is an extended holiday period, planned discharges should be avoided unless there is confirmed community support in place. Patients should be discharged at short notice only in exceptional circumstances and then only when their crisis plan has been agreed.

Recommendation 4:

Mental health service managers should reflect on the effectiveness of their multidisciplinary team-working. NHS Boards should promote this work and specifically the use of the Patient Safety Climate tools for staff and service users is recommended to help identify issues and barriers to true multidisciplinary working.

Recommendation 5:

NHS Boards should review the way that multidisciplinary team meetings are conducted to ensure that staff of appropriate seniority attend when key decisions are being made.

Recommendation 6:

NHS Boards should advise psychiatrists that, in cases where the doctor is making an unusual diagnosis which does not correspond with a second opinion, they should treat the case as complex and seek advice from their clinical director.


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Mental Welfare Commission (Oct 17)