Investigation of a complaint against the Southern Health & Social Care Trust

Report Reference: 202001941

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

This complaint is about the care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's late sister (the patient). The complaint concerns the Trust's Home Treatment Crisis Response Service (HTCR) actions from 22 August 2018 to 13 February 2019. The patient's sister (the complainant) brought this complaint to my Office on behalf of the patient's mother. I upheld elements of the complaint.

The patient attended the Emergency Department (ED) at Daisy Hill Hospital on 22 August 2018 following an overdose of paracetamol tablets. HTCR assessed the patient and referred her to the care of the Trust's Community Addictions Team (CAT), and to the Self-Harm Intervention Programme (SHIP).

The patient's sister (Sister A) contacted the patient's GP on 17 January 2019 with concerns about the patient's mental health. The patient was admitted to the care of HTCR on 18 January 2019 until her passing on 13 February 2019.

The complainant raised concerns about HTCR's mental health assessment on 22 August 2018, and its decision to refer the patient to CAT and SHIP. She also raised concerns about the appropriateness of HTCR's actions in response to Sister A's safeguarding concern, and the role of the patient's ex-partner in her care and treatment from 18 January 2019 to 13 February 2019. The complainant also raised concerns about the quality of the HTCR's recovery care plans and risk assessments.

The investigation established a number of failings which included a failure to obtain appropriate consent from the patient to allow for input from those close to her into her HTCR assessment and a failure to include the patient and her sister's input into her subsequent care plans.

The investigation highlighted there were 19 recorded HTCR visits within the patient's 27 day admission. Of the nineteen visits, only three members of staff offered consistency by attending 12 of these visits. It also highlighted that the Trust staff who had not recently reviewed the patient completed the patient's care plans. This caused the patient a loss of opportunity to establish a routine and rapport with the professionals involved in her care.

The failings identified in the patient's care and treatment are of great concern to me. I consider those public bodies which provide care for vulnerable people have an enhanced responsibility to be vigilant in ensuring a patient's needs are met. I acknowledge the failures identified in this report caused the family to experience continuing uncertainty about whether Sister A's input could have had any impact on the patient's clinical pathway.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failure in the patient's care and treatment. I made further recommendations for the Trust to address via an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. This complaint is about the actions of the Southern Health and Social Care Trust (the Trust). The complaint concerns the care and treatment the Trust's Home Treatment Crisis Response Service (HTCR) provided to the complainant's sister (the patient) from 22 August 2018 to 13 February 2019. The complainant brought this complaint to my Office on behalf of the patient's mother.

Background

2. On 22 August 2018, the patient self-referred herself to the Emergency Department (ED) at Daisy Hill Hospital, having taken an overdose of six 500mg paracetamol tablets. During her attendance at ED, HTCR conducted a mental health assessment of the patient. Following this assessment, on the same day, HTCR referred the patient to the Trust's Community Addictions Team (CAT), and to the Self-Harm Intervention Programme (SHIP).

3. The patient attended five appointments with SHIP from 18 September 2018 to 11 December 2018. SHIP discharged the patient on 13 December 2018. The patient declined an appointment with CAT which was scheduled for 26 November 2018. Following discussion at a CAT case management review meeting on 27 November 2018, CAT discharged the patient back to her GP's care.

4. On 17 January 2019, another of the patient's sisters (Sister A) contacted the patient's GP following concerns about the patient's mental health. The GP reviewed the patient on 18 January 2019 and made an urgent referral on behalf of the patient to HTCR. HTCR assessed the patient on the same day and admitted her to its care for a mental health assessment. The patient remained under the care of HTCR until 13 February 2019 when she sadly took her own life at her home.

Issue of complaint

5. I accepted the following issue of complaint for investigation:

   Whether the care and treatment HTCR provided to the patient from 22 August 2018 to 13 February 2019 was appropriate, reasonable and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

1. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

2. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

   - A Mental Health Nurse with over 30 years' experience in mental health, and has worked with inpatient wards, community mental health teams and crisis teams (N IPA); and
   - A Consultant in General Adult Psychiatry with over 30 years' experience dealing with the conditions relevant to this investigation (P IPA).

   I enclose the clinical advice received at Appendix two to this report.

3. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this complaint, is a matter for my discretion.

Relevant Standards and Guidance

4. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration

5. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The Mental Health (NI) Order 1986 (the Mental Health Order);
   - Mental Capacity Act (Northern Ireland) 2016 (the Mental Capacity Act);
   - National Institute for Care and Excellence (NICE) CG 136 – Service User Experience in Adult Mental Health: improving the experience of care for people using adult NHS mental health services, December 2011 (NICE Guidance);
   - NICE Psychosis and Schizophrenia in adults: prevention and management Clinical Guideline [CG178] March 2014 (NICE Psychosis Guidance);
   - Southern Health and Social Care Trust Operational Policy and Procedures for Home Treatment Crisis Response Service June 2018 (HTCR Procedures);
   - Southern Health and Social Care Trust Confidentiality and Information Sharing with Service User and Carers – Good Practice Guide August 2016 (Trust Confidentiality Guidance);
   - Northern Ireland Adult Safeguarding[2] Partnership Adult Safeguarding Operational Procedures Adults at Risk of Harm and Adults in Need of Protection September 2016 (Adult Safeguarding Procedures);

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[2] An 'Adult Safeguarding Concern' describes the process where someone is first alerted to a concern or incident that indicates an adult with care and support needs is experiencing or is at risk of abuse or neglect, and as a result of their care and support needs, are unable to protect themselves against abuse or neglect, or the risk of it.

- Department of Health, Social Services and Public Safety The Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS March 2006 (Quality Standards);
- Nursing and Midwifery Council (NMC) The Code January 2015 (the 2015 NMC Code); and
- NMC The Code October 2018 (the 2018 NMC Code).

I enclosed relevant sections of the guidance considered at Appendix three to this report.

6. I did not include all information obtained during the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

7. I shared a draft of this report with the complainant, the Trust, and the clinicians whose actions are the subject of the complaint to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. My staff also met with the complainant and her representative from the Patient Client Council. Both the complainant and the Trust submitted extensive comments in response to the draft Investigation Report. I gave careful consideration to all the comments I received and where appropriate I have included these comments within the body of this report.

THE INVESTIGATION

Whether the care and treatment HTCR provided to the patient during the period 22 August 2018 to 13 February 2019 was appropriate, reasonable and in accordance with relevant standards.

In particular, the investigation of this issue of complaint considered:

- The mental health assessment HTCR conducted for the patient in ED on 22 August 2018, and the related decision to refer the patient to CAT and SHIP;
- HTCR's actions in response to Sister A's safeguarding concerns from 18 January 2019 to 13 February 2019; and
- HTCR's actions in relation to the recovery care plans and the risk assessments that HTCR completed during its involvement with the patient from 18 January 2019 to 13 February 2019.

Mental health assessment 22 August 2018

Detail of Complaint

8. The complainant believed it is '*impossible to determine the absence or otherwise of mental illness on the basis of a single assessment'*. She also considered HTCR ought to have obtained collateral information[3] from the patient's family to inform the assessment and the related decision to refer the patient to SHIP.

Evidence Considered

Legislation/Policies/Guidance

9. I considered the following policies/guidance:
    - NICE guidance;
    - HTCR procedures;
    - NMC Code; and
    - Trust Confidentiality Guidance.

[3] Information about the patient obtained from the patient's contacts.

Trust's response to investigation enquiries

10. The Trust stated *'on 22 August 2018, the patient explained to the Home Treatment/Crisis Response (HTCR) team that she had been estranged from her family so no collateral history was obtained'*.

11. The Trust stated HTCR's ED assessment *'was of an acceptable standard in the circumstances'*, and *'the onward referral to the [CAT] and SHIP was, in any event, the appropriate course of action'*. In response to the draft Investigation Report the Trust stated *'even if practitioners had spoken to her fiancé [on 22 August], the outcome of the assessment would not have changed'*. This is because the Trust is of the view that it's staff's actions *'at that time were appropriate'*.

Relevant Trust records

12. The Trust provided this Office with the relevant records for the patient's ED attendance and assessment. I enclose a summary of the records provided at Appendix four to this report.

Relevant Independent Professional Advice

13. The N IPA advised HTCR's mental health assessment was appropriate and reasonable in the circumstances. She advised HTCR's assessment included the patient's present situation, stressors in her life and *'a mental state examination was conducted by the HTCR which included a safety plan'*.

14. In response to the draft Investigation Report the complainant highlighted that the patient's mental health assessment on 22 August 2018 stated *'only has contact with younger sister* [Sister A]*'* and under 'associated people[4]' it listed Sister A as a contact. The N IPA advised *'there are no guidelines to recommend that the Trust should have contacted associated people'*.

15. The N IPA also advised there is no evidence or documentation within the clinical records to suggest HTCR asked the patient if it could speak to her [then]

[4] An associated person can be anyone who the patient has given permission to speak with including friends, family members, colleagues etc. It is a record of other social supports apart from the next of kin, but also provides a list of contact details for staff involved in the care of the patient.

fiancé[5]. She advised HTCR *'should have asked [the patient] if they could contact her [fiancé] for information because he was still living in [her] home'*. She advised this consent would have allowed HTCR an *'opportunity to explore collateral information to inform [the patient's] mental health assessment on 22 August 2018 with her consent'*.

16. However, in response to the draft Investigation Report the Trust stated *'even if practitioners had spoken to her fiancé, the outcome of the assessment would not have changed'*. The N IPA advised she *'concur[ed] with the Trust…because the Trust carried out an [HTCR] assessment of her needs at the time'.*

17. The N IPA advised HTCR's assessment *'identified that counselling (Self-Harm Intervention Programme (SHIP)) and help with her drug and alcohol intake (Addictions Team (CAT)) would be of benefit'*. The N IPA advised *'this decision was based on the assessment of her needs and the clinical judgement of the HTCR and an admission to hospital was not required'*. The N IPA advised *'HTCR's decision on 22 August to refer [the patient] to [CAT] and [SHIP] was reasonable and appropriate in the circumstances'*.

Analysis and Findings

Assessment and Collateral information

18. The NICE guidance states *'Assessment in crisis should be undertaken by experienced health and social care professionals competent in crisis working and should include an assessment of the service user's relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis, and current treatment'*.

19. The records document the ED staff made a request for HTCR to assess the patient during her attendance at ED on 22 August 2018. The HTCR assessment records included information on the patient's personal circumstances, her current situation, recent events in her life, her employment status, a mental examination, and a safety plan. The assessment also indicated Sister A was an 'associated person'. I accept the N IPA's advice *'the mental*

[5] At the time of the ED visit (August 2018) the ex-partner was the patient's fiancé.

health assessment conducted by the HTCR on 22 August 2018, was appropriate and reasonable'. Therefore I am satisfied the HTCR's mental health assessment was appropriate. I do not uphold this element of the complaint.

20. However I note the HTCR procedures state an assessment of a patient '*Wherever possible it should include the service users relative, carer or significant other within their social system and network'*. I also refer to the Trust Confidentiality guidance which states *'Consent will be sought from service users about the sharing of information with others deemed appropriate by the Home Treatment Team'*. This guidance also states the consent *'should normally be as part of the initial assessment or admission process. A clear record of this discussion and the decision made by the Service User should be documented in the Service User's notes'*.

21. In response to this Office's enquires the Trust stated *'on 22 August 2018* [date of assessment]*, the patient explained to the Home Treatment/Crisis Response (HTCR) team that she had been estranged from her family so no collateral history was obtained'*. However I note there is a discrepancy in this statement as the HTCR's assessment documents *'associated people contact name [Sister A]* …*only has contact with younger sister [Sister A]'*. Therefore it is evident the patient was not estranged from all members of her family. I note the N IPA advised *'there are no guidelines to recommend that the Trust should have contacted associated people'* and therefore I accept the Trust was not obligated to contact Sister A. However, I consider it important to highlight to the Trust that the information provided to my Office was inaccurate and that it is clear there was an opportunity to ask for the patient's consent to seek collateral information from Sister A.

22. The records also document the patient's [then] fiancé lived with the patient. The N IPA advised *'there is no evidence or documentation in the clinical records to suggest that information about [the patient's] [fiancé] was explored, or that consent was sought to obtain collateral information to inform the mental health assessment on 22 August 2018'*. Further she advised *'there is nothing documented in the records that the staff asked [the patient] if they could contact her [fiancé] who was still living in [her] house'*.

23. I cannot conclude whether the patient would have consented to input from her fiancé. Nevertheless I accept the N IPA's advice it was inappropriate for HTCR not to ask the patient if it could contact her fiancé as *'she was being discharged back to the home'* where her fiancé was living with her. I am satisfied HTCR's failure to speak to the patient and to subsequently ask the patient if HTCR could contact her fiancé for collateral input a failure in care and treatment. I uphold this element of the complaint.

24. The N IPA advised this failing in care and treatment did not impact the outcome of the patient's assessment *'because the Trust carried out an assessment of her needs at the time'*. Nevertheless I consider this failure in care and treatment caused the patient to sustain an injustice of a loss of opportunity to receive potential collateral input into her care and treatment from her fiancé. In response to the draft Investigation Report, the complainant said HTCR's failure to obtain collateral history resulted in HTCR's assumption *'that [the patient's] attendance at ED on 22 Aug 2018 was therefore a situational crisis as a result of very recent events, rather than the longer term events coming to a head following a prolonged period of ill health'*. I acknowledge the complainant's clear view that the assessment was based on information solely from the patient without wider input from her loved ones. I consider this failure in the patient's care and treatment caused the complainant to experience continuing uncertainty about the difference collateral input may have had on the patient's clinical pathway.

Referral to CAT and SHIP

25. I refer to the HTCR procedures which state *'ensure that service users have timely access to the psychological, psychosocial and pharmacological interventions'*. The 2015 NMC Code requires nursing staff to *'act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it'*.

26. After consideration of all the evidence available to me, I accept the N IPA's advice and I am satisfied that HTCR's decision to refer the patient to CAT and SHIP *'was reasonable and appropriate in the circumstances, and in keeping*

with the Trust's policies, procedures, and guidelines'. I do not uphold this element of the complaint.

Safeguarding concerns from 18 January to 13 February 2019

Detail of Complaint

27. The complainant said HTCR failed to '*carry out a safeguarding assessment despite concerns raised by [Sister A] concerning [the patient's ex-partner's] behaviour and influence'* on the patient. The complainant also said HTCR allowed the patient's ex-partner to sit in on two of the patient's HTCR assessments from 18 January to 13 February 2019. She said HTCR allowed the ex-partner to answer questions on the patient's behalf.

28. In response to the draft Investigation Report the complainant said HTCR should have sought consent from the patient on every occasion the HTCR team wanted to speak to the patient's ex-partner. She said the patient's health varied day to day *'therefore consent given on one day should not have been presumed to be on-going consent…it is not difficult to expect that consent should be reconfirmed at every interaction especially as a patient's health changes over the course of treatment'*. The complainant said the patient provided consent for the HTCR to obtain collateral information which is different from consent to sit in on a HTCR visit.

29. The complainant also said HTCR failed to recognise the patient's ex-partner's role in her care during two HTCR assessments *'as an overall pattern of concerning and controlling behaviour'*. The complainant said the HTCR failed to question the ex-partner's motives for giving information and his reluctance for the patient to go to hospital.

Evidence Considered

Legislation/Policies/Guidance

30. I considered the following legalisation/policies/guidance:
    - The Mental Health Order
    - Mental Capacity Act;
    - NICE Guidance;

- NICE Psychosis Guidance;
- Trust Confidentiality Guidance; and
- Adult Safeguarding Procedure.

Trust's response to investigation enquiries

31. The Trust stated the SAI[6] review panel *'considered that matters pertaining to safeguarding were appropriately managed by the HTCR team'*. The Trust also stated the Peer Review report[7] found evidence to *'demonstrate that safeguarding concerns were identified and discussed by the [HTCR]'*.

32. In response to the draft Investigation Report the Trust stated the Regional Safeguarding Procedure does not stipulate a requirement to complete a safeguarding referral (APP1 form) to show that the Trust has considered a concern. It stated the records document *'HTCR did proactively seek the facts; the patient was asked directly by the Consultant Psychiatrist about safeguarding concerns whilst alone at the home and she denied any concerns'*. The Trust further stated the Multi-Disciplinary Team (MDT) meeting records contained a plan to continue to be mindful and monitor any concerns raised by Sister A regarding the patient. *'On this basis a judgement was made that this was not a safeguarding matter. It would therefore have been inappropriate to raise a safeguarding referral based on the information at that time'*.

Relevant Trust records

33. The Trust records contain HTCR's visitation records, care plans and risk assessments for the patient from 18 January 2019 to 13 February 2019. The Trust also provided this Office with its MDT meeting notes where it considered Sister A's concerns. I enclose a summary of the records provided at Appendix four to this report.

[6] Serious Adverse Incident reviews are initiated following unexpected or unintended incidents of harm. Their objective is to ensure service providers learn from the harm and make improvements to services. The Trust carried out an SAI on 28 September 2019.
[7] Peer Review of Serious Adverse Incident. The Trust made the decision to commission an independent peer review of the SAI process as the family did not agree to the findings of the SAI.

Relevant Independent Professional Advice

Mental Health Nurse IPA

34. The N IPA advised it was appropriate that HTCR permitted the patient's ex-partner to be present during some home visits and to answer questions on the patient's behalf, *'because the clinical records show that consent was sought from [the patient] that staff could speak to her ex-partner'*. In relation to the complainant's comments on consent, the N IPA advised *'there are no guidelines to suggest that the Trust or the HTCR should request consent daily from service users who are under their care and treatment'*. She advised the 'literature' states staff should obtain consent on a '*regular basis*'. She also advised *'there is no difference in obtaining consent during a home visit and collateral information. Consent is consent, no matter what the environment/situation is'*.

35. The N IPA advised the clinical records document on 22 January 2019 HCTR spoke to her ex-partner and the Trust staff noted concerns about him. The records also document HTCR sought collateral information from Sister A the day before. The N IPA advised there is evidence in the records that the ex-partner did not want the patient to go to hospital and the records also document the patient did not want HTCR to admit her to hospital. She advised HTCR considered the patient was not suitable for a Mental Health[8] assessment as she did not meet its criteria for detention. The N IPA advised this is in keeping with the Mental Health Code of Practice[9] as the patient *'was deemed to have capacity and made the decision for herself'*.

36. Initially the N IPA advised the HTCR *'did not respond appropriately'* to Sister A's safeguarding concerns during the period 18 January to 13 February 2019. The N IPA advised *'the records show that the HTCR were not proactive in establishing the facts and did not take the appropriate action of raising a safeguarding alert which would have been appropriate'*. However in response to the draft Investigation Report the Trust refuted this finding and provided additional evidence to support that it did consider Sister A's concerns. On

[8] An assessment under Mental Health (NI) Order 1986
[9] Mental Health (NI) Order 1986 Code of Practice.

receipt of this additional evidence I sought further N IPA advice in relation to this matter. The N IPA advised upon a review of the additional clinical records *'there is evidence to suggest that discussions took place, and a plan was agreed to continue to monitor any concerns raised regarding [the patient] and clinical decisions made that this was not a safeguarding matter'*. The N IPA further advised HTCR asked the patient on many occasions if there was any abuse, which she denied.

Psychiatrist IPA

37. The P IPA provided advice on the care and treatment the HTCR Psychiatrist provided to the patient and his response to Sister A's safeguarding concerns. I enclose the P IPA's full advice at Appendix two to this report.

38. The P IPA advised HTCR's *'management of the patient was in line with NICE guidance for assessment and treatment'*. He advised HTCR made an effort to confirm the suspicion that illicit drugs may have been involved in her mental illness and *'there was insufficient evidence to justify a referral to Safeguarding'*.

Analysis and Findings

39. The Trust Confidentiality guidance states *'The service user will be encouraged in a positive way to allow information to be sought and shared'.* This guidance also states *'Consent will be sought from service users about the sharing of information with others deemed appropriate by the Home Treatment Team'.*

40. The clinical records document HTCR sought consent from the patient to obtain collateral information from her ex-partner on 19 January 2019. I also note the records document HTCR also obtained consent from the patient on 26 January 2019 to obtain information from her ex-partner. The N IPA advised there are no guidelines on how often HTCR should obtain consent from a patient, and *'there is no difference in obtaining consent during a home visit and collateral information'*.

41. As HTCR recorded it had the patient's consent to discuss collateral information with her ex-partner, I accept the N IPA's advice that it was appropriate for

HTCR to allow the patient's ex-partner to be present during some home visits and to answer questions on the patient's behalf.

42. In response to the draft Investigation Report the complainant said HTCR failed to consider the ex-partner's motives for giving information about the patient to the HTCR team during the period 18 January to 13 February 2019. She also said HTCR did not consider his reluctance for the patient to go to hospital and his lack of concern for how unwell she was.

43. The clinical records document on 28 January 2019 the nursing staff *'are aware collateral given by ex-partner is not marrying up with our daily observations…well aware of dynamics within relationships'*. I note the MDT records document on 29 January and 5 February 2019 HTCR staff were fully aware of the ex-partner's role in the patient's care and treatment. In response to the draft Investigation Report the complainant said she disagreed with HTCR's assessment on this matter. However I note the clinical records document Sister A provided collateral information to HTCR on a regular basis and raised concerns to HTCR regarding the patient's appearance. In particular I note HTCR were in contact with Sister A on the following dates: 18 January, 22 January, 25 January, 28 January, 30 January, 31 January, 1 February, 4 February, 8 February, and 12 February.

44. The N IPA advised there is also evidence in the clinical records to suggest the ex-partner was reluctant for the patient to go to hospital *'however there is evidence in the clinical records to show that [the patient] when asked did not want to go to hospital'*. The N IPA advised the patient was *'deemed to have capacity and made the decision for herself*[10]*'*. I accept the N IPA's advice for that reason a detention under the Mental Health Order would not be applicable.

45. I acknowledge the complainant's concerns about the ex-partner, and I can appreciate his involvement in her care was distressing for her family. Nevertheless, based on the available evidence I am satisfied HTCR was fully aware of the ex-partner's role in the patient's care. I note HTCR was also in

[10] Mental Capacity Act (Northern Ireland) 2016 states *'a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'*

regular contact with Sister A who was providing HTCR with reliable updates on the patient's wellbeing.

46. The complainant also said HTCR *'failed to carry out a safeguarding assessment despite concerns raised by [Sister A] concerning [the patient's ex-partner's behaviour and influence'* on the patient. I refer to the Adult Safeguarding procedure which provides actions for Trust upon receipt of an 'Adult Safeguarding Concern'. This procedure states the *'Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met'*. The procedure requires the Trust to inform the *'referrer of the outcome of their decision'*.

47. The clinical records document on 28 January 2019 Sister A contacted HTCR as she had safeguarding concerns regarding the patient's ex-partner. This record documents Sister A contacted HTCR via telephone and *'is really concerned for her sister…she also reports that [the patient's] ex-partner (they have officially split 29/12/2019) is a bad influence in that he told [Sister A] magic mushrooms[11] are normal psychedelic experiences are good'*. This record also states Sister A *'is worried about the influence of her sisters ex [-partner] and certainly would question what he says'*. The record further states that during this telephone conversation HTCR's nurse reassured Sister A that HTCR were *'aware that collateral given by ex-partner is not marrying up with our daily observations at present and as a team are well aware of dynamics within relationship'*.

48. The records document following this telephone conversation Sister A provided collateral information to HTCR on 30 January 2019 and HTCR nurses directly asked the patient if she had any further issues or concerns which she denied. The records document on 1 February 2019 a Consultant Psychiatrist along with the patient's support worker visited the patient. During this visitation the records document the Consultant Psychiatrist asked the patient about the ex-partner and the records state *'denies any concerns re [ex-partner] – denies exploitation or abuse of any sort. Denies that [ex-partner] introduced her to drugs or has*

[11] Psilocybin mushroom, commonly known as magic mushrooms or shrooms, are a polyphyletic informal group of fungi.

influenced her in any way. States she feels 'OK' about their current living situation & plans to continue to work with him'. The records document *'no indication at present for APP1 but continue to monitor'*.

49. I note the MDM records on 1 February 2019 document Sister A provided HTCR with collateral on the patient (on the same day) and felt that she sees *'slight improvement'* in the patient. The records document the clinicians had concerns that the patient was vulnerable however *'-no direct cause for concern, denies any abuse or exploitation'*. This record further documents *'no clear risks identified to consider APP1 at present but to be kept in mind as possibility'*.

50. In response to the draft Investigation Report the Trust provided further records which document *'HTCR did proactively seek the facts; the patient was asked directly by the Consultant Psychiatrist about safeguarding concerns whilst alone at the home and she denied any concerns'*. This is documented within the MDT meeting notes on 5 February 2019. The Trust further stated the MDT meeting records contained a plan to continue to be mindful and monitor Sister A's concerns regarding the patient. It stated *'on this basis a judgement was made that this was not a safeguarding matter. It would therefore have been inappropriate to raise a safeguarding referral based on the information at that time'*.

51. Following the draft Investigation Report I sought advice from P IPA. This is because a Consultant Psychiatrist was involved in the decision making in relation to Sister A's concerns during the MDT meeting on 5 February 2019. The clinical records also document that on occasion a Consultant Psychiatrist visited with the patient in her home. The advice sought from the P IPA was specifically in relation to safeguarding concerns that Sister A raised during the period 18 January 2019 to 13 February 2019. The P IPA advised the records document Sister A contacted HTCR with concerns about the ex-partner, and that *'he put hemp in her tea. And he is advising [the patient] to take magic mushrooms'*. He advised the HTCR's management of the patient was in line with the NICE guidance and *'efforts were made to confirm the suspicion that illicit drugs might have been involved in producing her mental illness, but they did not confirm it and so there was insufficient evidence to justify a referral to*

Safeguarding'. I accept this advice. also consider the records document that HTCR were actively engaging with Sister A I also accept the P IPA's advice that HTCR's management of the patient was in line with the NICE guidance.

52. In her original advice the N IPA advised HTCR *'did not take the appropriate action of raising a safeguarding alert which would have been appropriate'*. However following the additional information the Trust provided in response to the draft Investigation Report, the N IPA advised that upon her review of the clinical records *'there is evidence to suggest that discussions took place, and a plan was agreed to continue to monitor any concerns raised regarding [the patient] and clinical decisions was made that this was not a safeguarding matter'*. The N IPA also advised this information changes her original advice regarding this element of complaint. I accept the N IPA's amended advice.

53. Overall, based on the available evidence including the records and the IPA advice I am satisfied the Trust acted in accordance with its Adult Safeguarding procedure. I am also satisfied the records document HTCR staff asked the patient about the ex-partner's role in her care, and she denied any abuse. I consider the records document HTCR were actively engaging with Sister A and relied on the information Sister A provided to them on the patient.

54. I am in no doubt the issues in this complaint are of serious concern for the complainant and her family. However my investigation found no evidence of a failing by the Trust in relation to this matter and I do not uphold this element of the complaint. It is unfortunate that the additional records provided to my Office by the Trust after the draft Investigation Report was issued had not been made available to the Investigating Officer at the outset. This would have allowed the N IPA to have earlier consideration of all relevant information. However, I hope the N IPA's review of this new information and her advice, along with the Consultant Psychiatrist's advice that the Trust took appropriate action after discussions offers the complainant some reassurance.

Care plans and risk assessments

Detail of Complaint

55. The complainant said HTCR's care plans for the patient were *'not uniquely appropriate to [the patient]'*. The complainant said the *'information recorded in [recovery] care plans under 'what is important to you now and in the future' and 'what needs to happen to meet identified needs' is nonsensical'*. The complainant also believed the patient's risk assessment *'underestimated the impact of financial issues and guilt as medication allowed [the patient] to gain insight into her circumstances'*.

56. The complainant said there is no evidence the patient or Sister A were involved in the completion of the patient's risk assessments or care plans, and HTCR staff members who had not reviewed the patient in person completed her risk assessments and care plans.

Evidence Considered

Legislation/Policies/Guidance

57. I considered the following policies/guidance:
    - NICE guidance;
    - HTCR Procedures; and
    - Trust Confidentiality guidance.

Trust's response to investigation enquiries

58. In response to the complainant's concerns that information recorded in the patient's recovery care plans was *'nonsensical,'* the Trust stated the "What needs to happen to meet identified needs" section of the care plan document *'identifies what actions both the service user and professional will take to aid in their recovery.'* The Trust explained its review of the patient's case had *'identified areas of learning regarding the completion of [recovery care plan] documents'*. It also explained HTCR *'introduced a Recovery Care Plan Audit as part of its Nursing Quality Indicators to improve practice.'* I enclose this audit at Appendix five to this report.

59. In response to the draft Investigation Report the Trust stated their *'HTCR Team have acknowledged that care plans should be co-produced and care plans are now developed with patients on a weekly basis... Care plans are reviewed at the weekly ward round to ensure regular updates and continuity'*.

60. The Trust stated the HTCR records showed '*the initial assessments [on 18 January 2019] were completed by staff with [the patient] and her sister.'* The Trust further stated the patient's *'view of her treatment was directly quoted within her care plan … [the patient] was kept updated on her treatment plan and treatment changes'*.

61. The Trust stated, in response to the draft Investigation Report, that there are multiple entries in the patient's HTCR notes of the HTCR team seeking collateral information from Sister A. In relation to Sister A's involvement, it stated HTCR *'clearly documented'* this consent from the patient in the initial assessment, and *'continued engagement is evidence of implied consent'*. The Trust also stated the notes document the HTCR team was in regular contact with Sister A.

62. In relation to the complainant's concern HTCR members who had not reviewed the patient in person completed the patient's recovery care plans and risk assessments, the Trust stated both the SAI and Peer Review addressed *'the issue of consistency of staff within HTCR'*. The Trust informed this Office it has taken forward learning as a result. This learning includes a review of the Mental Health Directorate's structure and the population of additional staffing.

Relevant Trust records

63. The Trust provided this Office with the patient's care plans and risk assessments from 18 January 2019 to 13 February 2019 inclusive. The Trust also provided this Office with HTCR's records which included the patient's progress notes and minutes of the multi-disciplinary team (MDT) meetings where it discussed the patient's care and treatment. I enclose a summary at Appendix four to this report.

Relevant Independent Professional Advice

64. The N IPA advised although *'there were different clinicians visiting [the patient] at home the HTCR staff members who had most recently seen/assessed [the patient] during home visits had prepared the recovery care plans'*.

65. The N IPA advised the recovery care plans *'were appropriate'* for the patient and her circumstances. However, she advised *'the quality of documentation in the patient's care plans are insufficient'*. The N IPA advised this is because the patient's care plans are *'static and not dynamic',* and *'there is no evidence that [the patient] was involved in developing her care plan…this is not in keeping with national guidelines'*.

66. In relation to the patient's risk assessments the N IPA advised HTCR's clinical records document *'[the patient] and [Sister A] were involved and participated in the risk assessments'*. She advised the risk assessments were *'appropriate regarding the issues ['financial issues', 'family relationships' and 'guilt at false accusations'] because [the patient's] risks were considered at that time'*.

67. The N IPA advised the clinical records document Sister A reported information about the patient. In her initial advice the N IPA advised there *'is no evidence regarding [the patient's] views or those of [Sister A] recorded in the notes'*. The N IPA advised HTCR should have sought consent from the patient whether she wanted Sister A to be involved in her care and treatment. If this consent was obtained *'then her sister's views would have been involved/recorded in [the patient's] care plan'*.

68. However following the Trust's response to the draft Investigation Report the N IPA clarified *'consent for collateral history was documented on the initial assessment in January 2019 and it is correct to say that continued engagement is evidence of implied consent.'* She further advised *'there is evidence to suggest […] the patient wanted her sister involved'*.

Analysis and Findings

Care Plans

(i) Clinicians Involved.

69. The Quality Standards requires HTCR to have *'effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes'*.

70. The complainant said the patient's *'risk assessment and care plans were compiled by people who had not seen [the patient]'*. I note the records document there were 19 recorded HTCR visits within the patient's 27 day admission. Of the nineteen visits, only three members of staff offered consistency by attending 12 of these visits. I note the Trust acknowledged different clinicians had visited the patient who subsequently prepared the patient's care plans.

71. However I remain concerned about the number of different clinicians that visited the patient from 18 January 2019 to 13 February 2019. I would have expected HTCR to endeavour to deploy a small number of clinicians to visit and treat the patient throughout this period of care to allow the patient to establish a routine and build rapport with the clinicians who visited her. I consider this routine may have allowed the patient to build trust and familiarity with the staff members.

72. I am also concerned some clinicians who had not visited the patient subsequently prepared the patient's care plan. I am critical the senior HTCR staff members considered this appropriate at the time. I would have expected HTCR would have only permitted those clinicians who visited the patient to complete her care plan. I consider this to be a failure in the patient's care and treatment. I uphold this element of the complaint.

73. I consider this failure in care and treatment caused the patient a loss of opportunity to establish a routine in her care and to benefit from building a level of trust with a set number of clinicians. I also consider this failure in care and treatment caused the complainant and her family uncertainty about the Trust's ability to provide care and treatment to the patient.

(ii) Patient's Involvement.

74. The complainant said the information recorded in the patient's care plans were *'non sensical'*. The N IPA advised HTCR developed the patient's recovery plans based on HTCR's assessment of her needs. I noted with concern the N IPA's advice that *'the quality of documentation in the care plans are insufficient'*. The N IPA advised the patient's care plans were a repeat of what is recorded in the clinical record *'and are not based on a comprehensive assessment of her needs'*.

75. I refer to the HTCR procedures which require *'Home treatment staff work to collaboratively with service users, carers and significant others from their network to develop a strength based recovery care plan'*. I note the NICE guidance also states *'people using mental health services jointly agree a care plan with health and social care professionals'*.

76. The N IPA advised *'there is no evidence that [the patient] was involved in developing her care plan'* and advised *'there is nothing recorded in the clinical records to show that [the patient] was involved'*. The complainant has understandably raised concerns that there is no evidence the patient was involved in the completion of her care plans. I am critical the care plans do not document the patient's personal input, and I accept the N IPA's advice *'this is not in keeping with national guidelines'*. I consider HTCR clinicians ought to have acted in accordance with national guidelines to involve the patient in the formulation of her care plans. I am satisfied the HTCR's failure to include the patient in the completion of her care plans is a failure in her care and treatment. I uphold this element of the complaint.

77. I consider HTCR's failure to include the patient when developing her care plans caused the patient to sustain an injustice of a loss of opportunity. I accept the N IPA's advice had the patient being involved in the completion of her care plans, she *'would have had a better understand[ing] on how to maintain her health and wellbeing. She would have also learned about the steps to take if her condition deteriorated and where to go for treatment or support, if necessary'*.

(iii) Sister A's Involvement.

78. The complainant said HTCR did not involve Sister A in the completion of the patient's care plans. I refer to the Trust Confidentiality guidance which states *'The service user will be encouraged in a positive way to allow information to be sought and shared'.* This guidance also states *'Consent will be sought from service users about the sharing of information with others deemed appropriate by the Home Treatment Team'.* I note the HTCR procedures require HTCR to work collaboratively with *'significant others [..] to develop a strength based recovery care plan'*.

79. HTCR's initial assessment on 18 January 2019 documents the patient's consent to allow Sister A to provide collateral information. I note HTCR's records document Sister A was in frequent contact with HTCR from 18 January 2019 to 13 February 2019 and regularly provided her views on the patient's care and treatment. I also note the records document HTCR requested the patient's collateral information from Sister A on four occasions from 18 January 2019 to 13 February 2019. The records also document Sister A regularly spoke and visited with the patient outside of HTCR visits and assisted the patient with her financial issues.

80. I consider due to Sister A's level of involvement; it would have been vitally important for HTCR to include Sister A's views in the patient's care plan. Again, it is concerning to note the N IPA's advice that the patient *'was not best supported and involved in decision-making about essential information for continuity of care and for use in emergencies'*. I also accept the N IPA's advice Sister A's involvement in the patient's care plan *'would give a fresh perspective on how [the patient] particular needs for care and support can best be met'*. I consider the absence of Sister A's views in the patient's care plan a failure in the patient's care and treatment.

81. Overall I am critical HTCR did not follow the national guidelines when completing the patient's care plans. I would expect the Trust and its staff to learn from the failures identified in this report. I uphold this element of complaint.

82. I consider this failure caused the patient a loss of opportunity to receive Sister A's input into her care plans. I consider the identified failures caused the complainant and her family to experience upset and uncertainty on HTCR's ability to provide the most appropriate care and treatment to the patient. I acknowledge the complainant and her family will always question if the care plans been appropriate would the outcome have been different.

Risk Assessments

83. The complainant said the patient's risk assessment from 22 January to 13 February 2019 *'underestimated the impact of financial issues and guilt as medication allowed [the patient] to gain insight into her circumstances'*. The N IPA advised *'the clinical records show that [the patient]'s risks were screened and assessed by the HTCR in accordance with the Trust template on their electronic clinical records system'.* On review of the evidence, I accept the N IPA's advice the patient's risk assessments from 18 January 2019 to 13 February 2019 *'was appropriate regarding the issues* ['financial issues', 'family relationships' and 'guilt at false accusations'] *because* [the patient's] *risks were considered at the time'.*

84. The complainant also said the patient was not involved in the completion of her risk assessments from 22 January to 13 February 2019. I note the risk assessments provided to my Office document the patient's input. I accept the N IPA's advice *'the documents show that on each occasion from 22 January to 13 February 2019 the [patient] […] [was] involved and participated in the risk assessments'*. On review of the evidence I am satisfied the patient had input into her risk assessments.

85. The complainant also said Sister A did not have an input into the patient's risk assessments. I note the risk assessments document Sister A was present with the patient during the completion of her risk assessments. The risk assessments document HTCR obtained consent from the patient to receive collateral information from Sister A. The N IPA advised, *'the documents show that on each occasion from 22 January to 13 February 2019 that [the patient] and [Sister A] were involved and participated in the risk assessments'*. I am

satisfied Sister A was involved in the completion of the patient's risk assessments. I do not uphold this element of the complaint.

86. Since the complainant raised this issue of complaint to my Office the NI Assembly enacted the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021. As the period of investigation is 2018/2019, I am unable to consider this legislation in the context of this complaint. However I consider this legislation represents a crucial development in Northern Ireland's response to domestic abuse, and criminalises coercive and controlling behaviour.

CONCLUSION

87. I received a complaint about the care and treatment HTCR provided to the patient from 22 August 2018 to 13 February 2019. I upheld elements of the complaint for the reasons outlined in this report.

88. I found HTCR appropriately referred the patient to the care of SHIP and CAT on 22 August 2018, and it was appropriate for HTCR to allow the patient's ex-partner to sit in her HTCR's visits and speak on her behalf. I am satisfied HTCR responded appropriately to Sister A's safeguarding concerns. I also found the patient and Sister A had input into the patient's risk assessments.

89. However the investigation found the following failures in care and treatment:
    i) HTCR did not ask the patient's consent to obtain collateral information for its assessment on 22 August 2018;
    ii) HTCR deployed 14 different clinicians to visit the patient over a 27 day period;
    iii) HTCR clinicians who had not recently reviewed the patient in person completed her care plans;
    iv) HTCR failed to involve the patient during the formulation of her care plans; and
    v) HTCR failed to involve Sister A during the formulation of the patient's care plans.

90. The failures identified in this report are of significant concern to me. I would expect the Trust and HTCR clinicians to learn from the failures identified in the

report. I particularly note how the complainant described how the Trust's care and treatment of her sister has affected her and her family saying *'the family have been completely and utterly let down and have lost all faith in the ability of public bodies such as the [the Trust] to follow their procedures'*. I consider the complainant and her family will always have an element of doubt about the care and treatment the Trust provided to the patient and wonder if things would have been different had the identified failings not occurred. I offer through this report my condolences to the complainant for the loss of her sister.

Recommendations

91. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused because of the failures identified (within **one month** of the date of this report).

92. I further recommend the Trust brings the failures identified in this report to the attention of HTCR staff, highlighting the importance of the following: obtaining collateral information from the patient's loved ones when completing a mental health assessment, developing care plans with a patient and incorporating their views and developing care plans with a patient's loved one and incorporating their views. HTCR staff involved in this case should evidence a reasonable level of reflection of findings in the complaint including discussion of the matter in their next appraisal.

93. I recommend HTCR reviews its process to ensure those staff reviewing a patient's care plans include at least one individual that has met with a patient in person.

94. I recommend the Trust undertakes an audit using a random sampling of HTCR clinical records over the last six months. The audit should assess if the records contain the following: a patient's involvement in the development of their care plans, and whether HTCR involved a patient's loved one during the creation of care plans and incorporated their views within the care plans. Take action to address any identified trends or shortcomings. The Trust should report its

findings to this Office, and ought to include any recommendations identified in its update to this Office.

95. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

Margaret Kelly
Ombudsman

2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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