Wirral Metropolitan Borough Council (23 010 463)

Category : Health > Mental health services

Decision : **Upheld**

Decision date : **17 Dec 2024**

The Ombudsman's final decision:

Summary: We uphold Mr X's complaint about his brother, Mr Y's, care and treatment. There was a short break in Mr Y's medication management. We also found Mr X was not informed about one of Mr Y's Mental Health Act assessments. However, we have not found a significant injustice arising from these actions. There was fault with the Trust and the Council's complaint handling, but sufficient steps have already been taken to address this.

The complaint

1. Mr X complains on behalf of his late brother, Mr Y. Mr X complains about the decision by Cheshire and Wirral Partnership NHS Foundation Trust (the Trust) to stop his brother's psychiatric medication in February 2022, during a hospital

admission. Mr X says this caused a deterioration in his brother's mental health, leading to his detention under section 3 of the Mental Health Act in March 2022. Shortly after, Mr X's brother became unwell and was readmitted to hospital, where he later died.

2. Mr X is unhappy with the actions of the Trust and Wirral Metropolitan Borough Council (the Council) in relation to the way his brother's detention was handled. Mr X is particularly unhappy with the way the Approved Mental Health Practitioners (AMHPs) communicated with him and did not listen to his views. Mr X also complains about lengthy delays responding to his complaint.
3. Mr X says these decisions by the Trust and the Council directly led to a deterioration in his brother's health, and ultimately his death. Mr X says he has also been caused a significant amount of distress.
4. Mr X would like to ensure this does not happen again to another family.

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The Ombudsmen's role and powers

5. The Local Government and Social Care Ombudsman and Health Service Ombudsman have the power to jointly consider complaints about health and social care. (Local Government Act 1974, section 33ZA, as amended, and Health Service Commissioners Act 1993, section 18ZA).
6. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship (Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A (1), as amended).
7. If it has, they may suggest a remedy. Our recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.
8. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. (Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)

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How I considered this complaint

9. I have considered the information Mr X provided in support of his complaint. I have also received information from the Council and the Trust including Mr Y's medical records, the Council's electronic case notes and the AMHP reports. I also considered independent clinical advice from a consultant psychiatrist. I have carefully considered all the written and oral evidence submitted, even if it is not all mentioned within this decision statement.
10. I have shared this draft decision with Mr X, the Council and the Trust and they had an opportunity to comment. I have considered the comments I received.

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What I found

Key legislation and guidance

Mental Health Act 1983: Code of Practice (the Code)

11. Under the Mental Health Act 1983 (the Act), the Approved Mental Health Practitioner (AMHP) is responsible for deciding whether to go ahead with the application to detain the person and for telling the person. They are also responsible for providing information about the proposed detention to the person's nearest relative. Any admission to hospital under the Act should be in the best interests of the person and they should not be detained if there is a less restrictive alternative. Local authorities are responsible for the actions of AMHPs.
12. The following parts of the Code are relevant to Mr X's complaint.
13. '5.11 AMHPs will need to consider making an application for displacement [of the nearest relative] if:
    - they believe that a patient should be detained in hospital under section 3 of the Act…but the nearest relative objects

14. 14.57 AMHPs are required by the Act to attempt to identify the patient's nearest relative…
15. 14.59 Before making an application for admission under section 3, AMHPs must consult the nearest relative, unless it is not reasonably practicable or would involve unreasonable delay.
16. 14.69 AMHPs should also consult wherever possible with other people who have been involved in the patient's care, including their care co-ordinator, if they are supported on the care programme approach.'

Cheshire and Wirral Partnership NHS Foundation Trust – Clozapine Prescribing and Monitoring Guidelines

17. '2.1.2 Exclusion criteria for community initiation
    - History of…unstable diabetes and paralytic ileus [a condition where the intestinal muscles do not allow food to pass, causing a blockage]
18. 2.4.3 Constipation
    - Have a low threshold for adding softening or stimulant laxatives early and review regularly. Stop other medicines that may be contributing…and reduce clozapine dose if possible.
19. 2.4.4 Common side effects [of clozapine]
    - Constipation occurs in up to 60% of patients…Constipation if left untreated can lead to paralytic ileus. When constipation is severe the fatality rate is approximately 20-30%.'

Maudsley Prescribing Guidelines in Psychiatry – Schizophrenia and Related Psychoses

20. Clozapine – Adverse affects: Constipation
    - 'Stop other medication that may be contributing and reduce clozapine dose if possible. Effective treatment or prevention of constipation is essential as death may result.'
21. Management of suspected acute Clozapine-Induced Gastrointestinal Hypomobilitiy (CIGH)
    - [CIGH is the severe slowing of digestion in a person's gut.] 'Signs and symptoms that warrant immediate medical attention [include] vomiting. There have been case reports of fatalities occurring only hours after first symptoms present, and this emphasises the urgency for prompt assessment and management (including cessation of clozapine).'

NHS Cheshire and Merseyside – Clozapine: Reducing the risk of harm

22. ‘A break in treatment of more than 48 hours…will require re-titration.’

What happened

23. Mr Y lived in a nursing home. He had a history of complex physical and mental health needs including paranoid schizophrenia, mild learning disabilities and type 1 diabetes. Mr Y took an antipsychotic medication (clozapine) to manage his schizophrenia.
24. In early February 2022, Mr Y was taken to Arrowe Park Hospital due to unexplained vomiting. Mr Y had experienced similar incidents of vomiting previously.
25. An abdominal x-ray showed Mr Y was severely constipated. Constipation is a common side effect of clozapine. Mr Y was treated with laxatives and an enema.
26. Mr Y’s inpatient care included psychiatric input from the Trust’s Liaison Psychiatry team, who provided mental health services at the hospital. During ward discussions with the hospital pharmacy, the pharmacist advised withholding Mr Y’s clozapine if faecal impaction was suspected.
27. The Trust’s psychiatrist decided to stop Mr Y’s clozapine until the constipation had resolved. A plan was put in place then to slowly re-introduce the clozapine. Mr Y was prescribed haloperidol as an alternative antipsychotic medication in the interim, although there was a short delay implementing this due to availability problems.
28. In mid-February, Mr Y began taking clozapine again. After a break from clozapine, a person needs to be slowly weaned back onto it with carefully managed dose increases over a period of time. This process is known as re-titration. A Multi-Disciplinary Team meeting agreed Mr Y should complete this process in an inpatient mental health setting, where he could be properly monitored. Mr Y’s medical history, including recent constipation due to clozapine and type 1 diabetes. This meant community based re-titration, for example at his nursing home, was considered too risky for him.
29. A mental capacity assessment found Mr Y lacked mental capacity to make decisions about his psychiatric medication. Following this, a Mental Health Act assessment was completed. This assessment recommended Mr Y be detained under section 3 of the Act to complete the clozapine re-titration process.

There were no local mental health beds available but a placement was found outside of the area.

30. The AMHP contacted Mr X, as Mr Y's nearest relative. Nearest relative is a term used in the Act for a family member who has certain rights and responsibilities when a person is detained under the Act. Mr X was unhappy about the location of the bed and exercised his right, as nearest relative, to object. Mr Y's discharge was then delayed as his physical health deteriorated and he was no longer fit for discharge.
31. In early March 2022, a fresh Mental Health Act assessment was completed as the previous one had expired. It decided the option to continue re-titration at Mr Y's nursing home should be explored further before another recommendation to detain.
32. On 7 March, following discussions with the nursing home, a Multi-Disciplinary Team meeting agreed that an inpatient mental health bed under section 3 was the only safe option. A third Mental health Act assessment was completed. A local bed in a specialist learning disabilities unit had been found for Mr Y. Mr X objected again, as he wanted re-titration to continue at the nursing home. However, following discussion with the nursing home manager, Mr X withdrew his objection.
33. The next day, Mr Y moved to Eastway, a Trust run inpatient unit for people with learning disabilities, under section 3 of the Act.
34. Within a week, Mr Y completed his re-titration back onto clozapine, although it took a few attempts due to medication refusal causing gaps in his treatment plan. However, Mr Y's mood had begun to deteriorate. He began to display an increase in erratic and aggressive behaviour and started declining food, drink and oral medication. Mr Y's diabetes was also unstable.
35. On 13 March, Mr Y was taken to A&E at the Countess of Chester Hospital due to concerns he may have diabetic ketoacidosis (DKA), a potentially life-threatening condition where ketones increase in the blood. Mr Y did not have DKA and returned to Eastway.
36. On 18 March, following a further deterioration in Mr Y's diabetes and physical health, he was taken back to A&E. Shortly after, a Multi-Disciplinary Team meeting decided Mr Y would stay in hospital to focus on stabilising his physical health under the care of the endocrinology team. The clozapine re-titration could be continued while doing this. The section 3 detention was discharged.
37. Mr Y had some further vomiting episodes in hospital. His medical records show that his mood and behaviour deteriorated further and he continued to regularly refuse food, drink and oral medication. The re-titration onto clozapine, an oral

medication, could not continue and was discontinued. Mr Y was prescribed haloperidol injections instead.

38. While in hospital, Mr Y caught COVID-19 and was treated for sepsis. In late April 2022, Mr Y developed pneumonia. Shortly after, Mr Y died in hospital.

Analysis

Constipation management

39. Mr X complains about the Trust's decision to stop Mr Y's clozapine as part of the treatment for his constipation. Mr X says the nursing home sent instructions to the hospital for managing Mr Y's bowels with laxatives and not to stop his clozapine, which the hospital did not follow. Mr X says the decision to stop Mr Y's psychiatric medication was wrong. Mr X says this caused Mr Y to have a mental health relapse, leading to his detention under section 3. Mr X says his brother became extremely distressed at being detained, causing him to stop eating and drinking, which impacted on his diabetes. Following this, Mr Y was readmitted to an acute hospital where he later died. Mr X says the Trust's decision to stop clozapine triggered these events and he believes his brother would not have died if his medication had continued.
40. I have reviewed Mr Y's medical records which record that he arrived at hospital already constipated and had sometimes been declining his daily laxative at the nursing home. I have seen nothing to suggest Mr Y developed constipation in hospital or that his constipation occurred due to the actions of the Trust. Mr Y was treated promptly for constipation with laxatives and an enema, in line with the Trust's Clozapine Prescribing and Monitoring Guidelines (the Trust's Clozapine Guidance). The Trust's medical professionals felt Mr Y's constipation was a side effect of his clozapine.
41. Constipation is a well-known and common side effect in patients on clozapine. I have reviewed several guidance documents for clozapine, all of which strongly state that constipation must be taken seriously and treated aggressively. Severe constipation can cause serious complications which, left untreated, can result in death. The Trust's Clozapine Guidance notes 'when constipation is severe, the fatality rate is approximately 20-30%'. It was clinically appropriate for the Trust to robustly treat Mr Y's constipation.
42. I have reviewed the Trust's Clozapine Guidance which outlines laxative and stool softener steps for treating constipation. It also refers to stopping other medications which may be contributing to constipation and considering

reducing the clozapine dose. However, it does not directly address the option to discontinue clozapine as part of the treatment.

43. I have also reviewed the Maudsley Prescribing Guidelines in Psychiatry (the Maudsley's Guidelines) – Schizophrenia and Related Psychoses - Management of suspected acute Clozapine-Induced Gastrointestinal Hypomobilitiy (CIGH). CIGH is the slowing of digestion in a person's gut.
44. The Maudsley Guidelines for managing CIGH state 'signs and symptoms that warrant immediate medical attention [include] vomiting. There have been case reports of fatalities occurring only hours after first symptoms present, and this emphasises the urgency for prompt assessment and management (including cessation of clozapine).'
45. Mr Y was constipated and had unexplained vomiting, which are symptoms of potentially serious complications which require prompt and aggressive treatment. I reviewed various clozapine related guidelines and, aside from the Maudsley Guidelines, there is little which explicitly addresses the option to stop clozapine as part of constipation treatment. Without clear guidelines to follow, this decision would ultimately have been a matter of clinical judgment for the psychiatrist managing Mr Y's care.
46. The Trust's complaint response of 6 September 2022 says a clinical decision was made to stop Mr Y's clozapine as his physical health was a priority. Despite treatment with laxatives and an enema, Mr Y's bowel remained impacted with faeces. The Trust explained that continuing to take clozapine with constipation risks it becoming toxic in the bloodstream with serious side effects. The Trust apologised if this was not properly explained to Mr X.
47. I have not found fault with the Trust's decision to stop Mr Y's clozapine. If left unresolved, Mr Y's constipation risked developing into a potentially fatal complication. The clinical decision was made by weighing up the risk to Mr Y's mental health versus the risk to his physical health. This decision was taken with input from other professionals including the hospital pharmacist. At that time, Mr Y's physical health needed to be prioritised.
48. While it is possible that the decision to stop Mr Y's clozapine had some negative impact on his mental health, this was unavoidable due to the urgent need to treat his constipation promptly. The risk of continuing his clozapine was higher than stopping.
49. The Trust prescribed haloperidol to Mr Y as an alternative antipsychotic medication when the clozapine was suspended. There was a delay of a few days due to lack of availability on the ward. This caused a gap in Mr Y's mental health treatment. This is fault. However, the clinical records show that Mr Y's

psychotic symptoms were relatively well controlled during his initial hospital admission. As such, I have not found a significant injustice arising from this short delay.

Location of bed for clozapine re-titration

50. Mr X objected to the initial recommendation to detain Mr Y under section 3 of the Act. This was primarily due to the mental health bed being located over an hour away from where he lived. Mr X felt it would be detrimental to his brother if he was not able to visit regularly.
51. There was a difficult balance to be struck between ensuring Mr Y's clozapine was reintroduced as soon as possible, pressures on local mental health bed placements and location.
52. The Trust and Council records show that finding a mental health bed for Mr Y was challenging as all the local beds were full at that time. It was important for Mr Y to recommence his clozapine treatment as soon as possible, therefore it was appropriate for the Trust to consider out-of-area beds.
53. It is clear the Trust was listening to Mr X's concerns, as it explored local placements in the first instance. This included considering the options for Mr Y to continue his treatment at his nursing home and the local learning disability unit bed at Eastway.
54. Mr Y's clozapine management was discussed at several Multi-Disciplinary Team meetings including Trust health professionals, Council staff and other professionals who knew him well. This included the consultant psychiatrist from Mr Y's local learning disabilities team and the nursing home manager. Consideration was also given to whether any less restrictive options could be appropriate.
55. The decision that community-based re-titration would not be appropriate was in line with the Trust's clozapine guidance. This states '2.1.2 Exclusion criteria for community initiation - History of...unstable diabetes and paralytic ileus [a condition where the intestinal muscles do not allow food to pass, causing a blockage]'. Mr Y had just experienced clozapine induced constipation, unexplained vomiting and was type 1 diabetic. These risk factors excluded him for community-based re-titration. The matter was discussed with the nursing home manager who had initially hoped to be able to support Mr Y but ultimately agreed they could not provide the required support.
56. The Trust and the Council decided Mr Y's complex medical needs meant an inpatient mental health bed was the only safe option to provide the required level of monitoring. A local mental health bed at Eastway was found for Mr Y. Mr

Y was found to lack mental capacity to make decisions about his clozapine care and could not consent to a voluntary admission. Therefore, an application under the Act was the only remaining option. I have not found fault with the way this decision was made.

AMHP actions

57. Mr X is unhappy with the way the AMHPs handled Mr Y's Mental Health Act assessments. Mr X says his views were not listened to and the AMHP was determined to 'get her way'. Mr X also says he, as nearest relative, was not informed of all of Mr Y's Mental Health Act assessments.
58. I have not been able to make a finding about the AMHPs attitude to Mr X. I have reviewed the AMHPs assessments, which includes notes of telephone calls with Mr X. These records do not align with Mr X's recollection of being pressured into the AMHPs opinion. The assessments record Mr X's concerns and where he exercised his right to object to the recommendation for detention. The records consider Mr X's views and record why the AMHPs did not agree.
59. Mr X says he felt that he had no option but to agree to the recommendation to detain on 8 March 2022. The AMHP notes record Mr X willingly agreed after he spoke with the nursing home manager, who also supported the decision to detain.
60. I have no reason to doubt Mr X's account, however people can have different recollections of the same conversation. Too much time has passed to ask the AMHPs for further recollections and this would be unlikely resolve the issue. With no independent evidence, such a recording of the telephone calls, to confirm either view, I am faced with two conflicting accounts. As such, I have not been able to make a finding on this point.
61. Mr X complains that he was not informed of all the Mental Health Act assessments carried out. It is clear that Mr X was informed of the first and third assessments, where recommendation to detain are made. The AMHP assessments include records of conversations with Mr X, including his objections.
62. I am not satisfied that Mr X was informed of the second assessment, where it was decided to first explore community options before further consideration of detention. The 'nearest relative consulted' box is ticked, however there is no record of any conversation with Mr X and the information on the AMHP assessment is generally sparse. This is contrary to the Code, which states

multiple times that nearest relatives must be consulted on all assessments. Failure to inform Mr X is fault.

63. I acknowledge Mr X is frustrated that he was not informed of an assessment, as he should have been. However, this is an unusual case where there were multiple assessments and Mr X has been consulted regularly throughout the process. Indeed, the third and final assessment was completed just a few days later and Mr X was involved with this. The assessment Mr X was not informed about led to further exploration of less restrictive options to detention, which is something Mr X would likely have supported. Overall, I have not found sufficient injustice arising from this point.
64. Mr X complains that an AMHP contacted the nursing home to find out whether there were any other family members. Mr X felt this was an attempt to 'usurp' him after he had objected, by finding the views of another relative.
65. Under part 14.57 of the Code, AMHP are required by the Act to attempt to identify a patient's nearest relative. Nearest relative is different to Next of Kin. The role of nearest relative is defined in law, with a strictly ordered list. The relative highest up the list is the nearest relative. There are several relatives on the list who are above sibling. Where two people fall into the same category, such as siblings, the eldest person would take priority. Strictly speaking, Mr X and Mr Y's older sister would have been considered nearest relative.
66. I have not found fault with the AMHP exploring whether the correct nearest relative had been identified. The AMHP was obliged to do so by law. I note the AMHP decided Mr X was the appropriate nearest relative, recognising that he was closely involved in his brother's care. Mr X's concerns were recognised and action was taken in response by exploring alternative options and locations.
67. Mr X is also unhappy that the AMHP mentioned legal action to potentially displace him as Nearest Relative if he did not agree to the detention. I can appreciate why Mr X found this upsetting. However, whether the professionals felt there was no alternative to detention and the Nearest Relative disagrees and an agreement cannot be reached, the only way to resolve the matter is through the Mental Health Tribunal. Part 5.11 of the Code states AMHPs will need to consider making an application for displacement if they believe a patient should be detained in hospital under Section 3 of the Act but the Nearest Relative disagrees. While Mr X perceived this as a threat, the AMHP was explaining the correct process.
68. Mr X complains that Mr Y's care co-ordinator, a learning disabilities nurse, was not contacted prior to the decision to detain Mr Y as part of the assessment

process. Part 14.69 of the Code says 'AMHPs should also consult wherever possible with other people who have been involved in the patient's care, including their care co-ordinator, if they are support on the care programmes approach.'

69. I have not found any evidence to confirm that Mr Y's care co-ordinator was directly involved, prior to the decision to detain. There is some evidence that the Trust liaised with Mr Y's local Learning Disabilities team but no records relating specifically to the care co-ordinator being contacted. There is no reference to the care co-ordinator being contacted by the AMHPs as part of any of the assessments. This is fault.
70. However, it appears Mr Y's local consultant psychiatrist was part of the Multi-Disciplinary Team meetings, along with the nursing home manager. While the care co-ordinator should have been contacted, other professionals closely involved in Mr Y's community care were consulted. As explained above, the Multi-Disciplinary Team ultimately decided the only safe option for Mr Y's re-titration was to recommend an inpatient mental health bed. Even if Mr Y's care co-ordinator had been contacted, it is unlikely the outcome of the assessments would have been any different. I have not found a significant injustice arising from the failure to involve Mr Y's care co-ordinator.

Complaint handling

71. There was significant delay by the Trust and the Council when handling Mr X's complaint, lasting several months. This was primarily due to confusion over which organisation should be responding to him and lengthy gaps in communication between the organisations. The AMHPs were acting in the Council's capacity and this responsibility cannot be delegated. However, this was complicated by the AMHP staff being based with the Trust, and the Trust holding most of the records. In the end, the Council responded to Mr X but had to do so without access to key records. The way Mr X's complaint was handled is fault.
72. In the circumstances, the practical approach would have been for the Trust and the Council to work together and issue a joint response. This did not happen.
73. The Council has acknowledged the delay and apologised to Mr X. As a result of Mr X's complaint, the Council met with the Trust in July 2023 to review processes for complaints which overlap both organisations. A new complaint process was put in place to clarify responsibilities including the option for the Trust to feed into the Council complaints process, where appropriate.

74. The Council and Trust's complaint handling caused Mr X frustration and inconvenience. However, I am satisfied that the Council and the Trust have taken adequate steps to put things right.

Injustice

75. Mr X says the actions of the Trust and the Council led to Mr Y's death. Mr X believes Mr Y's death would not have happened if he had not been detained under section3.
76. Mr X says Mr Y was very distressed once he realised he was in a mental health bed but improved significantly once he was back in an acute hospital setting. Having reviewed Mr Y's medical records, I can see Mr Y's mental health was deteriorating before he moved to Eastway, despite his clozapine being re-introduced. While Mr Y deteriorated rapidly following his admission to Eastway, there is nothing in his clinical records which confirm that this was directly due to unhappiness at his location. It is unclear why Mr Y's health deteriorated. Mr Y's clinical records show that, despite a small improvement in his demeanour, he continued to regularly refuse of food, drink and oral medication when he returned to an acute hospital bed.
77. Mr Y's hospital admissions were handled differently, depending on his health needs. The first admission was initially about resolving his constipation and then prioritising his clozapine re-titration. The second admission was about stabilising Mr Y's diabetes as the priority need. Even if Mr Y had completed his re-titration in the acute hospital bed, rather than detention, we cannot know whether he may have still become unwell with COVID-19, sepsis or pneumonia. I understand Mr X's strength of feeling on this point. However, I cannot know what would have happened if Mr Y had not been detained and I am unable to speculate as to whether to outcome would have been any different.

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Final decision

78. I have not found fault with the Trust's decision to stop Mr Y's clozapine as part of his constipation treatment. There was a short delay providing an alternative antipsychotic medication for Mr Y, however there is no evidence that this caused a significant injustice.

79. I also did not find fault with the overall handling of Mr Y's Mental Health Act assessments. An AMHP failed to consult with Mr X about the second assessment, but again there is no evidence of a significant injustice arising from this.
80. I found fault with the Trust and the Council's complaint handling, including lengthy delays due to lack of joined up working between the organisations. This caused Mr X frustration and inconvenience. However, Mr X has received an apology and there have been improvements to the relevant policies. As such, I consider sufficient steps have already been taken to put things right.
81. I have now completed my investigation.

Investigator's decision on behalf of the Ombudsmen

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Investigator's decision on behalf of the Ombudsman

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