SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201400979, A Health Board
Sector: Health
Subject: Community Nursing & Support Services; appointments; admissions (delay / cancellation / waiting lists)

Summary

Mrs C complained about how a health board responded to concerns raised by the family of her infant granddaughter (Miss A). The family were concerned about a change in Miss A's behaviour when she was around 17 months old, which they believed were due to possible abuse or maltreatment whilst Miss A was in the care of her father. The family had approached their GP, who referred them to a consultant paediatrician. The paediatrician had examined Miss A, but reported no concerns. Mrs C and Miss A's mother felt that the child had not been properly assessed and that the report produced did not provide an accurate account of the examination.

Miss A was referred to Child and Adolescent Mental Health Service (CAMHS), but the family felt that again Miss A was not appropriately assessed. The family requested a second opinion, but did not receive one. We investigated, and upheld, Mrs C's complaints that the board failed to respond appropriately to serious concerns raised about a child, and that they unreasonably failed to explain to Mrs C their role and remit in this matter.

This report concerns issues around child protection. I am conscious this is a highly complex and emotive area both for families and the professionals involved. It is important, therefore, to be clear about the remit and scope of the investigation and subsequent report. In this investigation, I have only considered the information provided by the board, in the form of Miss A's medical records. Child protection is a multi-agency responsibility and it should not be inferred from this report that the board was the lead agency with responsibility for child protection. It also should not be inferred that this report proves that abuse was perpetrated on a child. Although I accept the board did not have the lead role in child protection, however, it became clear from the advice provided that there were failings in its involvement for which it should take responsibility.

The failings identified relate primarily to the failure to record and document examination of a child to the requisite standard. Although my office can and does consider clinical judgement, that is not the area that is criticised in this report. I have taken the decision to stress this, in view of the subject matter and to forestall any misinterpretation or extrapolation from the report itself.

In order to investigate these complaints, I took independent advice from a consultant paediatrician and a consultant psychologist. I decided to issue a public report on this complaint due to the evidence that the family have suffered a significant personal injustice as a result of the board's failings. Given the sensitivity of the matters raised in the report, I also decided to anonymise the board in order to protect the identity of the family.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) carry out a review of Miss A's assessments by both the paediatric and psychology services;	8 December 2015
(ii) include the findings of these reviews in the subsequent appraisals of the doctors who carried out Miss A's appraisals;	29 February 2016
(iii) remind all staff involved in child protection work of the importance of following current guidance on examining and recording findings when assessing children;	3 November 2015
(iv) review the investigation of Mrs C's complaint in light of the failure to respond to it fully;	17 November 2015
(v) review what information is provided to families about the CAMHS service prior to referral, to ensure the reasons for referral are clear; and	17 November 2015
(vi) apologise unreservedly to the family for the failings identified in this report.	3 November 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We

normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained about the care and treatment provided to her infant granddaughter (Miss A) by a health board (the Board). Mrs C felt the Board responded inadequately to concerns raised by Miss A's family about a change in Miss A's behaviour when she was around 17 months old, which the family believed were due to possible abuse or maltreatment whilst Miss A was in the care of her father (Mr B). The family had approached their GP, who referred them to a consultant paediatrician (Doctor 1). Doctor 1 had examined Miss A, but reported no concerns. Mrs C and Miss A's mother (Ms D) felt that Miss A had not been properly assessed and that the report produced did not provide an accurate account of the examination.

2. Miss A was referred to Child and Adolescent Mental Health Service (CAMHS), but the family felt that again Miss A was not appropriately assessed. The family requested a second opinion be obtained, but did not receive one. The complaints from Mrs C I have investigated are that the Board:

(a) failed to respond appropriately to serious concerns raised about a child (*upheld*); and

(b) unreasonably failed to explain to Mrs C their role and remit in this matter *(upheld)*.

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer has considered all the information submitted by Mrs C and by the Board. My complaints reviewer also took advice from a consultant paediatrician (Adviser 1) and a consultant psychologist (Adviser 2). In this case, we have decided to issue a public report on Mrs C's complaint due to the evidence that the family have suffered a significant personal injustice as a result of the Board's failings.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

5. This report concerns issues around child protection. I am conscious this is a highly complex and emotive area both for families and the professionals involved. It is important, therefore, to be clear about the remit and scope of the investigation and subsequent report. My complaints reviewer in their investigation has only considered the information provided by the Board, in the form of Miss A's medical records. Child Protection is a multi-agency

responsibility and it should not be inferred from this report that the Board was the lead agency with responsibility for Child Protection. It also should not be inferred that this report concludes that abuse was perpetrated on a child. Although I accept the Board did not have the lead role in Child Protection, however, it became clear from the advice provided that there were failings within its involvement for which it should take responsibility.

6. The failings identified relate primarily to the failure to record and document examination of a child to the requisite standard. Although my office can and does consider clinical judgement, that is not the area that is criticised in this report. I have taken the decision to stress this, in view of the subject matter and to forestall any misinterpretation or extrapolation from the report itself.

Background

7. Mrs C said that her daughter (Ms D), had become pregnant in early 2011, but had separated from Mr B in June 2011. Miss A was born in November 2011 and following mediation, Mr B had regular contact with her. In April 2013, Mrs C said the family had stopped Miss A's contact with Mr B, due to concerns over Miss A's safety whilst in his care.

8. On 16 May 2013, Ms D was seen by her GP (the GP). She informed the GP that Miss A's behaviour had changed following visits to her father. Miss A was reported as screaming and aggressive towards Ms D, slapping her on occasion. Miss A was displaying behaviour that Ms D considered inappropriately sexual.

9. At the appointment, Ms D expressed concern that photographs of Miss A naked in the bath had been posted on social media. Ms D also reported worries about Mr B's lifestyle and drinking, which she felt was placing Miss A at risk.

10. At this time, Mrs C also raised concerns with the GP by telephone. The GP then discussed the family's concerns with the Board and a cause for concern notification was made. On 28 May 2013, both Ms D and Mrs C raised concerns about what had happened to Miss A and asked for an update on the actions being taken.

11. On 30 May 2013, Miss A was seen by her GP. She was noted as interacting well with Ms D and Mrs C and as presenting as a happy child. Her

development was recorded as normal for her age, and an examination, including Miss A's genitals, found nothing remarkable.

12. Miss A was, however, referred to Doctor 1, given the concern expressed by Ms D and Mrs C. The referral was due to 'developed masturbatory behaviour and behavioural change following parental separation'.

13. Miss A was seen by Doctor 1 on 19 June 2013, and Doctor 1 wrote to Miss A's GP with the findings of the consultation on 3 July 2013. Doctor 1 noted she had been provided with a series of statements by members of Miss A's family regarding their concerns about the change in Miss A's behaviour. Doctor 1 said she had read all of these letters and statements following the consultation.

14. Doctor 1 noted Miss A exhibited normal behaviour at the start of the examination; however, she became irritated during it and began to cry when a vaginal examination was carried out. Although it was noted that Miss A's vagina showed some irritation, her anus appeared normal.

15. Doctor 1 said she appreciated the difficulties caused to the family and Miss A following the separation of the parents, however, she did not find any evidence that Miss A was behaving abnormally for her age. Doctor 1 said she had tried to reassure Ms D and had advised her to seek immediate medical attention should there be any bruising or lesion which was unexplained. Doctor 1 said she felt no further medical input was necessary.

16. Miss A was also referred to CAMHS on 4 July 2013 by the GP and was seen by the CAMHS locum consultant clinical psychologist (Doctor 2) on 14 August 2013, 6 November 2013 and 12 December 2013. At the second appointment Ms D was assisted by an advocate and had a prepared list of questions for Doctor 2. Doctor 2 did not feel able to answer these questions and a referral for a second opinion was requested by Miss A's family. Doctor 2 subsequently spoke with specialist colleagues in Glasgow, however, a second opinion was not considered appropriate. No other mental health intervention was considered necessary and Miss A was discharged following the appointment on 12 December 2013.

17. Mrs C complained to the Board on 9 December 2013. She said she had concerns about the reports written about Miss A by Doctor 1 following her

examination of the child. Mrs C said she felt they were overly focused on the impact on Miss A of the separation of her parents. Mrs C also felt that as a consequence, the concerning behaviours reported by Miss A's family had not been given the consideration they deserved, but had been attributed to the custody dispute. Mrs C said she and Ms D also felt the report minimised the distress Miss A had displayed during the consultation on 19 June 2013, when she had been subjected to a vaginal examination.

18. Mrs C also complained Miss A had not been properly assessed by CAMHS. She noted Doctor 2 had said on 6 November 2013 she was not qualified to answer the family's questions about Miss A's behaviour. Although the family had requested a second opinion be sought, Doctor 2 had informed them she was unable to refer them elsewhere for this. Mrs C asked why Doctor 2 had been unable to refer Miss A within the NHS for a second opinion, despite this being her right.

19. The Board responded to the complaint on 16 January 2014. They said the referral to CAMHS by Miss A's GP was routine, rather than urgent. The GP had also stated that Miss A had been examined in her surgery, without any concerns being identified. The Board said the purpose of the referral had been to enable Mrs C and Ms D to gain insight into Miss A's behaviour and help them to manage it.

20. The Board said Doctor 2 had been presented with a list of questions by Ms D during their meeting. The Board said these questions required responses that would either confirm or rule out sexual abuse, as a cause for Miss A's behaviours. Doctor 2 felt that the subsequent request for a second opinion was related to her inability to provide answers to the submitted questions, due to the lack of any evidence that abuse had taken place. Doctor 2 had informed the family that she had discussed the case with colleagues in another Health Board's Specialist Children Services, but she had been advised that the concerns expressed by the family would be best raised with social services.

21. Doctor 2 felt referral for a second opinion was difficult given the concerns expressed related to Miss A's safety. She was unable to suggest a specific service to which Miss A could be referred. Doctor 2 had advised the family to contact the Child Law Centre for further advice.

22. Mrs C was not satisfied with this response, and wrote to the Board on 7 February 2014. She said she felt aspects of the response were inaccurate. The family were not given a clear explanation of the reason for the CAMHS referral at the time, as suggested by the Board. The family had understood Miss A would be assessed by an appropriately qualified specialist, with a view to identifying the cause of Miss A's concerning behaviour.

23. Mrs C noted the family's concerns about Miss A's behaviour at the time of her paediatric examination had not been addressed. She emphasised that a second opinion for Miss A had been sought because of the concerns about the root cause of her change in behaviour.

24. The Board responded on 19 March 2014. They said there was no indication that a specialist child protection assessment was required in the referral received by CAMHS. When Ms D had attended the appointment on 14 August 2013, she had reported the concerning behaviours were no longer occurring. The Board said as a result of this disclosure, Doctor 2 considered the reason for Miss A's referral no longer applied.

25. The Board said Doctor 2 had been aware during her discussions with Ms D that her expectations of the consultation were at odds with the referral. Doctor 2's recollection was that Ms D was extremely upset during the consultation. Doctor 2 had explained it was not the role of CAMHS to address the possible causes of Miss A's behaviour, as these should have been addressed already through the child protection system, prior to Miss A's referral.

26. Although Doctor 2 had felt CAMHS had no role to play, in acknowledgement of the distress displayed by Ms D, a follow up appointment had been offered to the family. At the second appointment on 6 November 2013, the family had been accompanied by an advocate, who had suggested a referral for a second opinion, as Doctor 2 had stated child protection was not her area of expertise. Doctor 2 had told the family she was not aware of any service that would provide what they were requesting, but she undertook to consult with colleagues.

27. Doctor 2 had met with the family again on 12 December 2013, following these consultations. Doctor 2's colleagues had not been able to provide further information about the route for the requested referral. It had been suggested to Doctor 2 that either social services or the Child Law Centre might be

appropriate. Doctor 2 had explained this to the family and signposted them as suggested.

28. The Board added that referrals were the responsibility of the family's GP. Doctor 2 had, therefore, been looking for suggested referral routes, but these would have been the responsibility of the GP to implement.

29. Mrs C remained dissatisfied with the Board's response and brought her complaint to my office.

(a) The Board failed to respond appropriately to serious concerns raised about a child

Concerns raised by Mrs C

30. Mrs C said the family were very distressed as they remained uncertain what had happened to cause Miss A's behaviour to change so suddenly. The family did not feel that Doctor 1's record of Miss A's examination was accurate. Mrs C said they were especially concerned by what they felt was a minimising of Miss A's response to being vaginally examined. Mrs C said that Miss A had been happy to be held by Mrs C up to that point. Mrs C said Doctor 1 had not acknowledged that Miss A had become extremely agitated at the point the examination had started and had screamed uncontrollably throughout the rest of the consultation, until she was taken home.

31. Mrs C said the family were then referred to Doctor 2, who had told them she could not provide an assessment of Miss A's behaviour. The family had not received the specialist assessment they had requested for Miss A. Mrs C stated the family had found the experience very distressing and traumatic.

The Board's response

32. The Board stated they considered their responses to Mrs C of 16 January 2014 and 19 March 2014 had adequately addressed all the issues she raised in her complaint.

Medical advice

33. As noted advice was received on both the paediatric and psychological services provided to the family. For clarity, these have been set out under separate sub-headings.

Paediatric Advice

34. Adviser 1 said the record of the consultation on 19 June 2013 by Doctor 1 documented the concerns of Mrs C and other family members about Miss A's change in behaviour. The examples given included:

- a fear of men;
- periods of unexplained distress and clinginess to her mother and Mrs C;
- a loss of appetite;
- rubbing her genitals on a toy duck in a manner the family found disturbing;
- touching her genitals whilst saying 'Dada'; and
- aggressive behaviour towards others after weekends with her father.

35. Adviser 1 said the National Institute for Clinical Excellence (NICE) guidance 'When to suspect child mistreatment' stated that child mistreatment should be considered if a child or young person displayed, or was reported to display a marked change in behaviour or emotional state that was a departure from what would be expected for the age or developmental stage and was not explained by a known stressful situation, that was not part of child mistreatment.

36. Adviser 1 noted that Miss A's history as reported to Doctor 1 suggested a number of the listed factors which could indicate child mistreatment were present. This included Miss A becoming withdrawn and fearful, aggressive, excessive comforting behaviour when witnessing parental distress, withdrawal of communication, periods of extreme distress and inconsolable crying. Adviser 1 added that the guidance stated that past or current child mistreatment should be suspected if a pre-pubertal child displayed, or was reported to display unusual sexualised behaviours. One of the examples given was of genital contact with a doll, which was a concern explicitly raised by Miss A's family.

37. Adviser 1 said in addition to the NICE guidance, the Royal College of Paediatrics and Child Health (RCPCH) Child Protection Companion (2006) noted sexually abused children presented in many ways. It said there were few absolute diagnostic signs and the aim of any assessment was to build up a picture of the child, including their history and presentation. Adviser 1 also noted that as well as the RCPCH, the Scottish Government's guidance 'National Guidance for Child Protection in Scotland' (2010) contained a pro-forma for use when assessing a child who had possibly been sexually abused.

38. Adviser 1 said the history recorded by Doctor 1 was short, and the Scottish Government pro-forma had not been used. Adviser 1 did not believe the assessment adequately covered the areas it should have considered. The history taken from Ms D did not explore the information reported by the family, the assessment of the family history and its composition was brief, no past medical history was recorded, symptomatology was limited and there was no summary of Miss A's developmental progress.

39. The documentation of Miss A's physical examination was also inadequate and Adviser 1 said what was recorded was concerning. Adviser 1 said the RCPCH Child Protection Companion, provided guidance on what should be documented when performing a physical examination of a child suspected of maltreatment. Adviser 1 said Doctor 1's examination did not record the majority of observations set out in this guidance. Adviser 1 said Doctor 1 did record Miss A's height and weight, but did not carry out a systemic examination and the genital examination performed appeared incomplete.

40. Adviser 1 said the guidance said the record of the genital examination should make it clear the position the child was in when they were examined. The method of examination should be recorded, as should any use of a colposcope. All areas of the genitalia, labia majora, labia minora, vestibule, posterior fourchette, hymen and vagina should have separate examinations recorded. The examination of the anus should be similarly detailed. All findings should be illustrated on body diagrams. Adviser 1 said that Doctor 1's notes of the examination commented on an absence of bruising between the legs, some irritation in the vagina, but made no mention of the condition of the areas listed by the guidance.

41. Adviser 1 said of particular concern from the record of the genital examination, was Doctor 1's recorded finding that 'her [Miss A's] vagina showed a little bit of irritation'. Adviser 1 said that in pre-pubertal children, it was unusual to be able to see through the hymen into the vagina. Adviser 1 said no mention was made of the hymen and no record was made of its condition in the clinical notes or the formal report from the consultation.

42. Adviser 1 said if the vagina was clearly visible, then the hymen may not have been present, or the hymeneal aperture could have been enlarged. Adviser 1 said these would have been significant findings, requiring further investigation. Adviser 1 said that the presence of visible vaginal irritation should

also have been a concerning sign. Adviser 1 said it was possible that Doctor 1 was using the term 'vagina' more loosely, to refer to the entire genital area. She said this would have been a misleading use of the term, but in even if this were the case, the presence of redness or inflammation, which was the implication of the use of the term 'vaginal irritation' could be significant as this had been reported as a finding in sexually abused pre-pubertal girls as referenced in the RCPCH guidance. Adviser 1 stressed that further examination should have been carried out to determine the significance of this symptom.

43. Adviser 1 said that it was also unusual for a child Miss A's age to become distressed during genital examination, as they generally tolerated gentle examination of this area well. She acknowledged there was a variance between Doctor 1's note of the extent of Miss A's distress and Mrs C's recollection. It was, however, clear Miss A had become upset and Adviser 1 said this could have been significant and should have been included as part of the assessment of symptoms.

44. Adviser 1 said she concluded the clinical record did not show an appropriately thorough examination was carried out of Miss A, given the seriousness of the reported concerns.

45. Adviser 1 also commented on the conclusion reached by Doctor 1, that there was no evidence that Miss A was not demonstrating normal behaviour for a child her age. Adviser 1 said that as the NICE guidance showed; Miss A had reportedly demonstrated a number of behaviours which could have been a cause for concern. The RCPCH guidance stated that any major change in a child's behaviour should prompt a search for cause and that abuse should be considered if no obvious explanation could be found.

46. Adviser 1 said the reported change in Miss A's behaviour as detailed by Mrs C and Ms D, as well as other family members in correspondence appeared to be major and had clearly caused the family significant concern. Adviser 1 said the acute nature of the change, coupled with the context, in which Miss A's behaviour improved after unsupervised contact with her father had ceased, should have raised a concern that the change may have been triggered by an abusive event.

47. Adviser 1 said that in her own practice she would have been concerned when faced with the history as presented to Doctor 1 and would not consider

Miss A's multiple behaviours as normal. Adviser 1 said the rocking or rubbing described could be considered childhood masturbation or gratification disorder. This was recognised as a common variant to normal behaviour; however, the possibility of child sexual abuse had to be excluded first, especially as suspicions of child sexual abuse had been reported by the family and some unusual findings were documented following the physical examination.

48. Adviser 1 said overall, she did not consider it had been reasonable for Doctor 1 to conclude there was no evidence to suggest Miss A's behaviour was abnormal.

49. It was noted by Adviser 1 that the Board had not addressed the issues raised by the family regarding the paediatric consultation in their response to either of Mrs C's complaints. Adviser 1 said Mrs C's concerns along with those of Ms D had been dismissed by Doctor 1. This ignored the family's request for a second opinion. Adviser 1 considered that this failed to meet the requirements of the 'National Guidance for Child Protection in Scotland' (2010), which required partnership working between agencies, actively considering potential risks to the child. It also required agencies to work collaboratively with the family. Adviser 1 considered the dismissal of the family's concerns was inappropriate and the communication regarding the paediatric examination fell below the standard the family could reasonably have expected.

Psychology Advice

50. Adviser 2 said Miss A had been referred to CAMHS due to masturbatory behaviour, with a request for clinical insight into this behaviour, coupled with support for Ms D and techniques for dealing with it. The referral letter contained details of the masturbatory behaviour, as well as Miss A's newly developed fear of men, parental separation and maternal family concern of sexual abuse.

51. Adviser 2 said the British Psychological Society generic professional good practice guidelines stated that the main tasks expected from a psychologist were:

- Assessment
- Formulation
- Intervention
- Communication.

52. Adviser 2 said that the NICE guidelines (as there are no Scottish Inter Collegiate Guidance Network (SIGN) guidelines for this specific area) on child maltreatment state that 'consider, suspect or exclude maltreatment' was a necessary task for health professionals, if presented with symptoms of possible abuse. Adviser 2 said the record of the appointment with Miss A on 14 August 2013 did not contain a complete assessment of Miss A's behaviour over time. The notes did not record any exploration of the frequency and intensity of the episodes of the behaviour, together with the triggers, whether cessation through distraction techniques was achieved and context, including parental responses. Adviser 2 said that building such a timeline would have allowed a clinical judgement to be made of whether the history contained any indication of child maltreatment or sexual abuse.

53. Adviser 2 said there was not a sufficiently detailed behavioural analysis of past or present behaviour and the reason for the subsequent referral to conclude there was no cause for concern.

54. Adviser 2 also said that there only a partial developmental history, but it was not reasonable to have concluded that Miss A's masturbatory behaviour was part of normal development, or a gratification disorder. Information about the pregnancy, crawling, walking, verbal and non-verbal development of Miss A should have been documented as this would have allowed a clinical judgement to be formed on whether child maltreatment could be excluded.

55. Adviser 2 said there was no evidence of formulation or working in the notes which gave insight in to Doctor 2's assessment of the historical presences of Miss A's masturbatory behaviour, or any hypothesis to explain its subsequent cessation. Adviser 2 said the clinical judgement that there was no cause for concern, appeared to have been reached due to the masturbatory behaviour having ceased. This was also the reason given for not providing further intervention. Adviser 2 also said the letter provided by Doctor 2 to the referring doctor did not set out clearly how maltreatment of Miss A had been excluded by the assessment.

(a) Decision

56. The advice received is that both the paediatric and psychological assessments of Miss A were inadequate. The records of these assessments do not comply with NICE guidelines or the guidance provided by the Scottish Government for recording findings when investigating possible abuse or

mistreatment. The advice also notes that the guidance provided by the RCPCH for assessing children in these circumstances has not been followed. Furthermore, the advice states the conclusions reached following the assessments of Miss A were not reasonable. The paediatric advice in particular, has identified several findings which should have been a cause for concern and prompted either further investigation, or clarification of their findings by Doctor 1. The advice I have received is that Miss A's behaviour should have been a cause for concern and that it was not reasonable to conclude from the information recorded that her behaviour was not abnormal. Furthermore insufficient steps were taken to exclude the possibility of abuse or maltreatment before the family's concerns were dismissed.

57. I also note the Board failed to address the paediatric element of Mrs C's complaint in either of their response letters. The advice I have received is that the family's concerns were unreasonably dismissed by the Board without adequate explanation. Given the concerns related to the possible sexual abuse of an eighteen-month-old child, I consider this to be a serious failing on the part of the Board. I am highly critical of the fact that the Board did not address these concerns and that no scrutiny appears to have been carried out of the paediatric service provided, despite the family's clearly stated view there was the possibility Miss A had been sexually abused.

58. I consider, given the advice received, that the Board failed to respond appropriately to the concerns of Miss A's family. It must, however, be emphasised this does not mean there is evidence Miss A was sexually abused and my office cannot reach any findings on this. It is rather that the level of care provided to her fell substantially below the standard which she and her family could have expected. This failure by the Board has contributed significantly to the distress the family has experienced.

59. I uphold this complaint and make the following recommendations.

(a) Recommendations

60. I recommend that the Board:	*Completion date*
(i) carry out a review of Miss A's assessments by both the paediatric and psychology services;	8 December 2015
(ii) include the findings of these reviews in the subsequent appraisals of the doctors who carried	25 February 2016

	out Miss A's appraisals;	
(iii)	remind all staff involved in child protection work of the importance of following current guidance on examining and recording findings when assessing children; and	3 November 2015
(iv)	review the investigation of Mrs C's complaint in light of the failure to respond to it fully.	17 November 2015

(b) The Board unreasonably failed to explain to Mrs A their role and remit in this matter

Concerns raised by Mrs C

61. Mrs C said that she and Ms D felt that they had been unsupported by the Board, and they had not been appropriately provided with support or guidance at any stage. Of particular concern to Mrs C was the failure to explain properly to the family why they were referred to Doctor 2 and why a second opinion could not be obtained for Miss A, despite their formally documented misgivings about the assessment carried out by Doctor 2. Mrs C felt this decision had not been explained to the family properly.

The Board's Position

62. The Board's position is expressed in their letter of 19 March 2014. The appointment Miss A received with CAMHS was a routine one, with no indication a specialist child protection assessment was required. The referral from Ms D's GP had indicated that Ms D required assistance with managing Miss A's behaviour. It was apparent that Miss A's family had different expectations and Doctor 2 had explained that child protection assessment was not her role, as this should have been picked up in the child protection process.

63. Doctor 2 had sought specialist advice from her colleagues regarding a second referral, however this had not been considered feasible. She had subsequently explained this to the family on 12 December 2013.

Advice received - Psychology Advice

64. Adviser 2 said it was clear from the questions Miss A's family had posed to Doctor 2 their perception was that Miss A's behavioural changes could be explained by her suffering some form of abuse. Adviser 2 said in her view the request by the family to receive a second opinion was not appropriately handled, as there was no evidence of an attempt to work collaboratively with Miss A's family to resolve why they felt a second opinion would be helpful.

Adviser 2 said as Doctor 2 felt the case did not raise safeguarding concerns, a clear statement should have been provided by her explaining why sexual abuse was excluded as a hypothesis.

65. Adviser 2 said it was not always helpful for long lists of pre-prepared questions to be brought to assessment appointments. It was, however, within a patient's rights to do this and the content of the questions could provide a shared understanding of the presenting problem, as well as insight into the family's goals, level of anxiety and trust in the support systems available to them. Adviser 2 said that not responding to the questions posed by the family on the basis that Doctor 2 lacked the specialist expertise had created confusion, leading to the request for a second opinion. If CAMHS believed the family's questions could only be answered by social services, then this should have been explained to them at this juncture.

66. Adviser 2 noted that had Doctor 2 felt that she lacked sufficient expertise to progress intervention for Miss A, it would have been reasonable to expect the relevant expertise to be identified and provided.

(b) Decision

67. I consider that the Board failed to explain clearly to Miss A's family why they were referred to CAMHS. It is clear from the evidence provided that the family's expectation was that the assessment carried out by Doctor 2 would deal with the concerns they had raised about the possible sexual abuse of Miss A. Doctor 2 has stated that a second appointment was only offered to Miss A's family due to the level of distress Ms D exhibited at the first appointment she attended. In Doctor 2's recollection, this appointment was only offered to Ms D, to ensure she had understood their conversation at the first appointment.

68. The advice received is clear that the assessment carried out at the appointment on 14 August 2013 by Doctor 2 was inadequately documented. The advice also notes the clinical judgement of there being no cause for concern was generated by the masturbatory behaviour no longer being present, rather than an understanding developed through the assessment of Miss A. The advice also notes there is insufficient evidence the role and remit of the Board were clearly explained to the family.

69. I consider that given the seriousness of the issues raised by Miss A's family, and the advice received, the Board's communication with the family fell

below the standard they could reasonably expect and failed to explain the Board's role and remit when dealing with their request for a psychological assessment for Miss A.

70. I uphold this complaint.

(b) Recommendation

71. I recommend that the Board:	*Completion date*
(i) review what information is provided to families about the CAMHS service prior to referral, to ensure the reasons for referral are clear.	17 November 2015

General Recommendation

72. I recommend that the Board:	*Completion date*
(i) apologise unreservedly to the family for the failings identified in this report.	3 November 2015

73. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Miss A	Mrs C's infant granddaughter
the Board	a Scottish National Health Board
Mr B	Miss A's father
Doctor 1	a consultant paediatrician
Ms D	Miss A's mother
CAMHS	Child and Adolescent Mental Health Services
Adviser 1	an consultant paediatrician
Adviser 2	an consultant psychologist
GP	General Practitioner
Doctor 2	a consultant clinical psychologist
NICE	National Institute of Clinical Excellence
RCPCH	Royal College of Paediatrics and Child Health
SIGN	Scottish Inter Collegiate Guidance Network

Annex 2

Glossary of terms

colposcope	instrument used to illuminate and examine the vagina
formulation	the development of an explanation for the problem the patient presents with, from the clinical assessment
hymen	a membrane surrounding or partly covering the external vaginal opening

Annex 3

List of legislation and policies considered

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National Guidance for Child Protection in Scotland 2010

Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse. The Royal College of Paediatrics and Child Health and the Faculty of Forensic and Legal Medicine, October 2012

The Physical Signs of Child Sexual Abuse – An evidence based review and guidance for best practice; Royal College of Paediatrics and Child Health, March 2008