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: Lothian

Case ref: 201508849, Lothian NHS Board
Sector: Health
Subject: Hospitals (Intensive Home Treatment Team & Accident and Emergency) / Clinical treatment / Diagnosis / Discharge

Summary
Ms C complained about the care and treatment provided to her late daughter (Miss A) by the board's Intensive Home Treatment Team (IHTT), and about the way in which Miss A was discharged from their care. Miss A, who had a history of low mood and self-harm, was referred to the IHTT following an attempted overdose. She was discharged from their care after around six weeks and died at home a week later, having completed suicide.

Ms C complained about a lack of continuity of care, noting in particular the absence of a key worker for Miss A. I took independent medical advice from a consultant psychiatrist, who noted that in a crisis service such as the IHTT, it is difficult to avoid patients being seen by a number of different staff. However, the adviser considered that much more could have been done to enhance the continuity of care provided to Miss A. The IHTT policy indicates that every service user will be allocated a named worker and that complex case discussions will take place, but neither appears to have happened in Miss A's case. Ms C also complained about a lack of clarity surrounding Miss A's diagnosis. I was advised that the sharing of Miss A's diagnosis was reasonably consistent throughout, although differing terminology was used. However, I noted that there was some ongoing uncertainty surrounding the extent of Miss A's unstable personality traits, which might have benefited from a psychological opinion. The IHTT policy indicates that a psychological opinion can be sought within the IHTT but I found no evidence of this having been considered. I was also advised that the IHTT policy might benefit from being updated to define clearly the role of medical staff in diagnosing patients. I upheld this complaint.

Ms C complained about the appropriateness of Miss A's discharge from the IHTT, noting that she had ongoing suicidal thoughts. I was advised that the decision to discharge Miss A was not in itself unreasonable, as the IHTT provide short-term input to patients in crisis and that chronic risk over the long-term is not managed in this setting. However, I was advised that the process

followed in discharging Miss A was unreasonable. I found little evidence of discharge planning and no indication that plans were discussed with Miss A. I was particularly concerned that there was a lack of evidence of medical input into Miss A's discharge. Ms C also expressed unhappiness with the follow-up plan that was put in place and said that Miss A felt lost and abandoned. I agreed that the follow-up arrangements were not sufficiently robust. Miss A was discharged into the care of her GP, with the noted involvement of a private counsellor she was seeing and the provision of crisis service contacts. I concluded that Miss A should have been referred for psychiatric follow-up. I was concerned that Miss A was discharged entirely from the board's care on the basis of her private counselling, when no steps were taken to contact the private counsellor to find out what was being offered in terms of follow-up. I upheld this complaint.

Miss A attended A&E on three occasions while under the care of the IHTT, following further suicide attempts. Ms C complained that during these attendances, Miss A was not afforded sufficient privacy and dignity in her distressed states. She also complained that there was a four hour delay in Miss A receiving a mental health assessment and did not consider that enough had been done to ensure Miss A was supported following discharge from A&E.

I took independent medical advice from a consultant in emergency medicine. I was advised that Miss A had been treated in line with normal practice in a busy A&E department and I could not conclude that there was a failure to afford her adequate privacy or dignity. I was advised that a four hour wait is not unreasonable where a patient has taken an overdose and a detailed medical assessment is required prior to mental health assessment. I was critical, however, that it was not documented who was accompanying Miss A and assuming responsibility for her when she was discharged following her third attendance. In addition, I was advised that a mental health assessment form was only completed for Miss A's first attendance. While I was assured that she was appropriately assessed, and that this omission made no material difference to the care she received, I concluded that it would be good practice for this form to be completed in every instance. On balance I did not uphold this complaint but I made some recommendations.

Redress and recommendations

The Ombudsman recommends that the board: *Completion date*

(i)	support the IHTT to implement and adhere to the IHTT Operational Policy, specifically with regard to named workers and facilitating complex case discussions;	30 November 2016
(ii)	consider revising the IHTT Operational Policy to include a description of the roles of medical staff (including different grades of medical staff) within the IHTT;	30 November 2016
(iii)	apologise to Ms C for the failings identified in the care and treatment provided to Miss A;	30 September 2016
(iv)	review the discharge planning process in the IHTT, taking account of the considerations highlighted in this report;	30 November 2016
(v)	review the IHTT Operational Policy, setting out clear guidance for when patients should be seen by medical staff;	30 November 2016
(vi)	provide detailed evidence of all action taken to implement the AER (adverse event review) recommendations;	30 November 2016
(vii)	apologise to Ms C for the identified failings in the process for discharging Miss A and planning her follow-up care;	30 September 2016
(viii)	consider introducing a system whereby completion of the A&E mental health risk assessment form is mandatory for all mental health patients; and	30 November 2016
(ix)	highlight to A&E staff that it is good practice for them to document who vulnerable patients are accompanied by on discharge, and whether the accompanying persons are happy to accept responsibility for patient safety.	30 September 2016

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 Ms C and her daughter, the aggrieved, as Miss A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman about the care and treatment provided to her late daughter (Miss A) by Lothian NHS Board (the Board)'s Intensive Home Treatment Team (IHTT), and about the way in which Miss A was discharged from their care. She also complained about the care and treatment provided during attendances at the accident and emergency (A&E) department at the Royal Infirmary of Edinburgh. The complaints from Ms C I have investigated are that:

(a) the care and treatment provided by the IHTT between 29 September 2014 and 8 November 2014 was unreasonable (*upheld*);

(b) the discharge from the IHTT on 8 November 2014, and associated follow-up arrangements, were unreasonable (*upheld*); and

(c) the care and treatment provided by the A&E department at hospital on 7, 16/17 and 30 October 2014 was unreasonable (*not upheld*).

Investigation

2. In order to investigate the complaint, my complaints reviewer considered all the information received from Ms C and the Board. Independent advice was obtained from a consultant psychiatrist (Adviser 1) and a consultant in emergency medicine (Adviser 2). In this case, we have decided to issue a public report on Ms C's complaint due to the identification of potential systemic failures and also the significant personal injustice suffered by Miss A and her family.

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

Background

4. Miss A attended A&E on 28 September 2014 following an attempted overdose and was referred to the IHTT the next day. She was approaching her 21st birthday and had a history of low mood and self-harm, with a previous overdose attempt in 2013 resulting in an admission to an acute mental health ward in another health board area. She attended A&E again on 7 October 2014, having communicated an intention to jump off a bridge while out with friends, and had further attendances following overdoses on 16 and 30 October 2014. She was discharged from the IHTT on 8 November 2014. She was sadly found dead at her home on the evening of 15 November 2014, having completed suicide.

5. Ms C complained about the care and treatment provided by the IHTT, including inadequacies in communication with Miss A and her family and friends; a lack of clarity surrounding Miss A's diagnosis; and a lack of continuity of care. Ms C complained in particular about the appropriateness of Miss A's discharge from the IHTT, noting that she continued to display her presenting behaviours (including ongoing suicidal thoughts) and that no detailed follow-up plan was put in place, leaving Miss A feeling lost and abandoned. She also complained about the treatment Miss A received during her A&E attendances, including lack of privacy and dignity for Miss A in her distressed states; a delay in receiving a mental health assessment; and the adequacy of follow-up action on discharge.

6. When Ms C first wrote to the Board to indicate her intention to raise a formal complaint about Miss A's care and treatment, the Board replied advising that they would be undertaking an adverse event review (AER). They explained that the AER process was separate to the formal complaint process and, while the findings of the AER would help inform the response to any complaint issues raised, it would need to be concluded before Ms C's complaint could be responded to.

The AER

7. The AER considered the care Miss A received prior to her death and took account of Ms C's concerns in this regard. Ms C met with the clinicians carrying out the AER (the Reviewers) on two occasions and she submitted her comments in response to the draft AER report. The Reviewers also interviewed medical and nursing staff involved in Miss A's care as part of the AER process.

8. It was acknowledged by the IHTT during the AER process that there is often difficulty in maximising consistency in staff providing support/assessment. It was noted that Miss A presented in different ways to different people and her mental state changed quickly, with her described as having a strong emotional façade. It was considered difficult for different people to gain a clear view of Miss A's problems if seeing her for brief interventions. It was noted that differences between the views of individual team members in such circumstances meant that full information on which to base decisions was not available. However, it was not considered clear that the decision to discharge would have been different if there had been clear clinical ownership of decision making.

9. The final AER report highlighted that decision making within the IHTT was a key issue, noting that this was ultimately the role of medical staff and, in particular, the consultant within the team. It noted that the consultant made reasoned clinical decisions based on the views and evidence from the wider multi-disciplinary team, at times without seeing the patient, as happened in Miss A's case. It was highlighted that there was no requirement to transfer the care to another doctor when the doctor overseeing the care was absent, resulting in it being difficult for there to be a consistent decision making process based on first-hand knowledge of the patient. It was noted that, while there are agreed situations where care might be transferred to nursing staff, this did not involve a transfer of responsibility to any individual to hold decision making.

10. The AER report noted that a lack of clarity around diagnosis/formulation (an overall understanding of a patient's problems and needs) across services was also a key issue. It was acknowledged that Miss A would have benefited from a consistent approach to her care from individual clinicians, but stated that this was not possible within a 24/7 crisis service in which several different members of staff will be required to work with the person at different times. It was noted that the establishment and sharing of a clear diagnosis or formulation which is shared between the crisis team and the relevant community mental health team (CMHT) is of paramount importance. It was considered that, while individual practitioners who had seen Miss A on several occasions formed a clear and consistent view of her difficulties, the IHTT as a whole did not. It said it was not clear to what extent any single formulation had been shared with Miss A to allow her to have a sense of being understood and of a way forward for her. The Reviewers were unable to identify a clear shared psychological model of care, within the IHTT or shared across teams, to help practitioners understand relational difficulties. It was noted that practitioners appear to have viewed Miss A's actions solely as a 'para-suicidal' communication rather than being a potential risk factor for completed suicide. However, the Reviewers were uncertain whether this would have altered the decision to discharge Miss A from the IHTT at the time.

11. It was noted that Miss A had carried out several acts of self-harm and/or attempts on her life in the weeks preceding her death, often shortly after presenting to services, or after her mental state appeared reasonably well or improved. It was observed that Miss A completed suicide one week after discharge from the IHTT and 19 days after her last face-to-face contact with a

member of medical staff. It was noted that there had been some improvement in Miss A's mental state but this was not consistently maintained. The Reviewers did not consider it likely that, at the point of discharge, Miss A met the criteria for ongoing contact as she was not actively experiencing a crisis and her mental state appeared to have improved, although it was acknowledged that this could change rapidly.

12. The Reviewers considered that Miss A would have benefited most from a medium to long term therapeutic relationship, as well as rapid access to crisis services. It was noted that she was on a treatment dose of a second line anti-depressant and had chosen to engage with a private counsellor, with whom she stated she had a good relationship. It was acknowledged, however, that the skills and experience of the private counsellor were unknown and there were no direct lines of communication apparent. It was highlighted that Miss A was familiar with the out-of-hours mental health services, although there were no links between her counselling and crisis services. It was noted that she had used crisis lines before. Miss A was noted to have accepted being discharged from the IHTT and had an agreed plan to contact crisis services if needed. It was also noted, however, that Miss A had expressed surprise and a sense of abandonment to her flatmates following discharge.

13. The AER report noted that no decision was documented concerning whether or not a referral to the CMHT was indicated. The staff interviewed by the Reviewers considered that Miss A's future would be primarily within the psychological and social domains in the main and it was noted that this was in place. The IHTT were observed to have assessed Miss A as having always historically sought help for her suicidal actions and having been able to access help if she needed it, thus reducing the risk of completed suicide. The Reviewers were unable to draw firm conclusions regarding the impact and timing of discharge on Miss A's subsequent actions, as it was not considered clear whether she was able or willing to share her intentions with anyone who may have been able to prevent them.

14. Prior to being seen by the IHTT, Miss A was being seen by a community psychiatric nurse (the CPN), who discharged Miss A following a joint visit with IHTT staff on 29 October 2014. In relation to Miss A having begun seeing a private counsellor, the Reviewers noted that situations in which two or more professionals provide similar care simultaneously are often seen as being unhelpful due to the possibilities of conflicting advice being given. They,

therefore, considered that the decision to discharge Miss A from the CPN's caseload seemed to be appropriate. It was noted that the CPN had indicated that they were happy to take Miss A back on to their caseload at a later time, without her having to wait. The Reviewers considered that this should have formed part of an agreed discharge plan from the IHTT and should also have been indicated in a letter to the IHTT on discharge from the CPN's caseload. However, given the short timescale between Miss A's discharge from the IHTT and her taking her own life, it was not considered clear that this would have prevented her suicide. This was also considered to apply to the possibility of CMHT follow-up. It was acknowledged, however, that a much clearer and shared plan for follow-up would have been helpful, with a clear strategy for sharing this and a shared understanding of the routes back into services.

15. It was considered that there was evidence of good overall communication between and within agencies. However, it was noted that there were some issues and, in particular, that a message from medical staff to the CPN to discuss follow-up care with the private counsellor prior to discharge was not passed on to the CPN. The Reviewers could not establish whether the private counsellor would have been in a position to speak with NHS staff, however, it was noted that without communication it was not clear what was being offered in terms of follow-up. It was also noted that communication with Miss A's family was difficult due to Miss A's changing view of what could be shared. In addition, it was acknowledged that communication with Miss A's flatmates, who took her home after suicidal behaviour, would have been beneficial.

16. The Reviewers did not consider that the IHTT's overall decision making was conveyed effectively in the notes. They noted in particular that there was no clear statement of why discharge was appropriate at the time, or how the rationale for the follow-up plan was decided. It was noted that the patent's mental state on discharge is important to document. It was also noted that the staying well plan was not copied and filed, nor sent to others. It was further noted that there were difficulties in making retrospective entries due to the temporary absence of the case notes, but it was highlighted that plans in place for the service to establish a computerised clinical records system would address this.

17. In terms of the overall care and treatment, the AER report concluded that, given the relational nature of Miss A's difficulties, the key longer term protective factor would have been the formulation of a medium to long term therapeutic

relationship to promote change and also support access to crisis services. The Reviewers considered it clear that individual staff members were beginning to develop those relationships, but that Miss A did not feel able to commit to them and chose a different approach by opting to see a private counsellor. It was not considered possible to attribute Miss A's death to specific problems in care or treatment.

18. The AER report noted that the lessons learned focussed around improving the consistency of approach within and between teams, and with the patient and their relatives/carers, particularly when working with people with relational difficulties and emotional instability. The report made recommendations for areas to be improved, noting that action had already started to look at:

- Improving consistency (key worker system);
- Self-harm and links with suicide;
- Planning and preparation for discharge;
- Evidencing the rationale for decision making within records;
- Working with/involving carers; and
- Quality of record keeping.

The improvement plan was expanded and further actions for improvement included:

- adult mental health services to agree a shared model of psychological care which will enable better understanding of relational difficulties and support training, supervision and reflection to promote use of that model in front line adult mental health services;
- adult mental health services to formally agree the structure to record and share ongoing diagnosis/formulation which attends to biological, psychological and social aspects of service users across mental health services and with partner organisations;
- adult mental health services should review their support for, and information sharing with, carers, particularly with regard to crisis management, discharge plans and routes into services;
- adult mental health services should review processes to ensure that discharge information is shared systematically with other mental health services and, where possible, with non-statutory services who provide ongoing care;
- the IHTT to review their decision making processes and agree a process by which accountability for care becomes clear and enables the different

perspectives on a patient's care needs to be integrated and plans agreed. The IHTT should agree and implement a method of recording how decisions are made, and who they are made by, in the clinical record;

- the IHTT to review their use of staying well plans with the aim of early completion, appropriate sharing with others, including carers/relatives, and being filed in the clinical record and electronically.

(a) The care and treatment provided by the IHTT between 29 September 2014 and 8 November 2014 was unreasonable

Ms C's complaint

19. When Ms C wrote to the Board, she said that she felt disregarded and patronised when she called the IHTT. When she met with the Reviewers, she complained about a lack of continuity in Miss A's care, noting that over 37 professionals had been involved in her treatment between 29 September 2014 and 8 November 2014. Ms C considered this unhelpful and noted the absence of a key worker. She asked who had responsibility for the overall supervision of Miss A's case and whether multi-disciplinary reviews took place. She considered that regular case reviews or case conferences would have been helpful in Miss A's case.

20. Ms C complained further about how the IHTT communicated with Miss A and her family and friends. She described the pressures on Miss A's family and friends to keep her safe and reiterated that, when she had discussed this with the IHTT, she felt her concerns were minimised or dismissed.

21. In addition, Ms C complained about a lack of clarity surrounding Miss A's diagnosis, noting that eight different terms were used in her case notes. These were listed as severe depression; low mood and suicidal thoughts; adjustment depression; emotionally unstable personality traits; moderate depressive episode; reactive depression; mild depression without psychotic symptoms; and emotionally distressed. She asked who in the team was qualified to give a conclusive diagnosis and how appropriate and effective treatment could be offered without such a diagnosis.

22. Ms C then had a meeting with senior Board staff to discuss her complaint. Ms C noted that documentation she expected to see was missing from Miss A's records, including notes of multi-disciplinary team daily meetings; and diagnostic assessment tools. Ms C's complaint about a lack of key worker for Miss A was discussed and it was explained that the whole IHTT team had

overview of the case as they provide 24 hour care. Ms C was informed that the team included a lead nurse and two consultants, and it was agreed that arrangements would be made for her to meet the lead nurse and the lead consultant (the Consultant).

23. Key learning points were noted following Ms C's subsequent meeting with the lead nurse and the Consultant and these were outlined in the AER report, which indicated that work had already started to implement them. They included actions to improve the consistency of contacts with individual patients and to develop and arrange training on working with and involving carers.

24. In commenting on the draft AER report, Ms C noted the acknowledgement that different people seeing Miss A for brief interventions led to difficulties in gaining a clear view of her problems. She suggested that this highlighted the inefficacy of a poorly resourced service and stated her view that brief interventions are not appropriate for a patient with relational difficulties. She considered that, if brief interventions and visits by numerous people are inevitable due to staffing and limited resources, it is imperative that note taking and sharing of information is maintained to a high standard.

The Board's response

25. Further to completion of the AER process, Ms C met with senior Board staff to discuss her complaint and the Board followed this up with a written response. They apologised to Ms C for the failures in their actions, which they stated 'could have prevented [Miss A]'s death'. They acknowledged that, had the AER recommendations been implemented beforehand they 'may have better supported [Miss A] and prevented her death'.

26. The Board confirmed that changes were now being made so that other people with similar needs do not experience the same situation. In particular, they acknowledged that they failed to communicate with Ms C, and Miss A's flatmates, at times of diagnosis and changes to Miss A's care. They noted that the AER recommendations included plans to increase the opportunities for patients suffering similar difficulties as Miss A to be able to form helpful relationships with mental health services, both for long term therapeutic gain and to increase the likelihood they will access services when in crisis.

27. Ms C subsequently attended a further meeting with senior Board staff and clinicians to obtain an update on the actions taken by the IHTT to address the

issues identified by the AER. She informed my complaints reviewer that she was not reassured by the actions taken and she considered them to be a list of very basic requirements.

28. In writing to my complaints reviewer, the Board stated that the Reviewers found that there were problems with the care and treatment provided by the IHTT, although they could not directly relate these to Miss A's death. They said they did find a number of issues which, if addressed together, 'may have reduced the chances of [Miss A] taking her life'. They noted that these were included within the AER report.

Medical advice

29. Adviser 1 noted that Miss A's case was open to the IHTT from 29 September 2014 until she was discharged. They noted that this was a total of 40 days and, from their review of the records, observed that Miss A had a total of 32 contacts with the IHTT during that time. These consisted of 16 face-to-face contacts and 16 telephone contacts and, in addition, there were a further two unsuccessful attempts by IHTT staff to see Miss A face-to-face and a further nine unsuccessful attempts to contact her by telephone. Adviser 1 noted that, on some days, there were multiple contacts with Miss A. There were also 14 days within the 40 day period when no contact was made or attempted.

30. With regards to continuity of care, Adviser 1 observed that Miss A had contact with 17 different members of IHTT staff during her time under the team's care, including two medical staff and one support worker, with the remainder nursing staff. Some staff saw Miss A on multiple occasions whilst others saw her, or spoke to her on the telephone, only once. Adviser 1 noted that Miss A did not appear to have a key worker. They observed from the Reviewers' interview note with the Consultant during the AER process that 'in theory there are key worker groups' in the IHTT but that 'these do not operate as they are intended to resulting in difficulties ensuring consistency in staff attending appointments'.

31. Adviser 1 noted that the IHTT Operational Policy sets out the role and responsibilities of the 'Named Worker' and states that 'Every IHTT service user will be allocated a named worker when accepted for home treatment'. Adviser 1 observed from this policy that the responsibilities of the named worker include: accepting responsibility for coordinating and updating assessments and care

plans; leading on communication with other agencies; and discharge planning. Adviser 1 could see no mention in the records of a named worker for Miss A.

32. Adviser 1 said there was reference in the records to team meetings within the IHTT where Miss A's case was discussed, however, they could see no detailed record or minute of these meetings, or any list of those in attendance. They said there did not appear to be any other documented system of multi-disciplinary case discussion or review. The IHTT Operational Policy sets out the structure of Team Clinical Meetings. These include three shift handover meetings per day and one multi-disciplinary team (MDT) handover meeting per day (weekdays only). The policy also states that:

> 'A multi-disciplinary team clinical meeting will take place fortnightly (Tuesdays at 1.30pm) to provide an opportunity for in-depth discussion and reflection of complex clinical cases. A brief summary of the case and potential learning outcomes will be documented'.

Adviser 1 noted that there were three 'MDT' entries in Miss A's case record. These were on 23 October 2014, 30 October 2014 and 4 November 2014. The entries in the records associated with these meetings are all brief notes to schedule appointments and do not appear to relate to a more detailed review of Miss A's case. Adviser 1, therefore, assumed that the IHTT did not hold one of the fortnightly case discussions for Miss A, or if they did it was not documented.

33. Adviser 1 considered that the number, frequency and method of contacts made by the IHTT was reasonable and, while they acknowledged that the high number of different staff seeing Miss A was not ideal, they considered that this was largely unavoidable in a service like the IHTT. They noted that the purpose of the IHTT, as stated in their Operational Policy, is 'to provide short term intensive community based care as a viable alternative to admission to hospital'. In order to provide a 24 hour per day, 7 day per week service, Adviser 1 envisaged that the IHTT requires a high number of staff, many of whom will work shifts. Much of their work will involve responding to acute situations and crises and so will be unpredictable. In these circumstances, Adviser 1 considered that it would be impossible for patients to always see the same member, or members, of staff. They considered that reasonable steps were taken in the circumstances to offer continuity of care to Miss A. Adviser 1 noted that the IHTT also involved the CPN in Miss A's ongoing care, which offered the opportunity to improve continuity.

34. Adviser 1 considered, however, that the problems caused by having to see a high number of different staff could be minimised or mitigated by optimising communication between staff members and by having a key worker type system in place. They said it would also help to have an agreed formulation and a clearly documented care plan that is easily accessible to staff, however, they noted that establishing these in the first place is made more difficult when a number of staff are involved. They observed that this was clearly highlighted in the AER.

35. In relation to Miss A's diagnosis, Adviser 1 noted that there is no specific statement in the IHTT Operational Policy regarding how they approach the issue of diagnosis. The policy states that the IHTT will 'Formulate a holistic care plan which meets all identified assessed needs including mental health …' and that they will 'Formulate a comprehensive risk management plan'. When interviewed for the AER process, the IHTT nursing staff stated that a diagnosis was the role of medical staff. Adviser 1 noted that, while the policy sets out arrangements for access to medical staff, it does not specifically set out the role of medical staff. Adviser 1 observed that there have been significant developments in terms of enhancing nursing roles across health care in recent years but said it remains standard practice within psychiatry for medical staff to formally diagnose patients. They, therefore, considered it reasonable for the IHTT nursing staff to have stated this when interviewed.

36. Adviser 1 noted that Miss A was seen on four occasions by medical staff, three times by a specialty doctor (Doctor 1) and once by a core trainee (Doctor 2). They observed that Doctor 1's documented impression, following assessment of Miss A on 29 September 2014, was that she had a 'Moderate depressive disorder. Probably longstanding anxiety or/? Some emotional instability'. Doctor 1 saw Miss A again on 9 October 2014 and documented their impression that Miss A had 'Longstanding emotional problems and compulsion to overachieve. Currently moderately depressed'. Doctor 2 assessed Miss A on 17 October 2014 and documented their impression that Miss A 'remains depressed but has future plans. Ongoing risk of DSH [deliberate self-harm]/suicide'. In Miss A's fourth and final review by medical staff on 20 October 2014, Doctor 1 did not document a clinical impression or diagnosis. Adviser 1 noted that the Discharge Summary from the IHTT detailed Miss A's diagnosis as 'Moderate depressive episode. Emotionally unstable personality traits'.

37. It was also noted by Adviser 1 that, when interviewed for the purposes of the AER, Doctor 2 was asked if they had 'been able to identify any kind of formulation' and responded that they 'felt the picture appears to be that of emotional instability'. When the CPN was interviewed for the AER, they stated their view that Miss A had a 'diagnosis of depression with emotional instability but no formal diagnosis of EUPD [emotionally unstable personality disorder]'.

38. In Adviser 1's opinion, the diagnostic labels attached to Miss A during her time with the IHTT were reasonable. Adviser 1 noted that these labels were based upon clinical interviews with medical staff and, to some extent, these were informed by previous records and third party information from Ms C. It was observed by Adviser 1 that medical staff took the view that Miss A's mood (depressive) symptoms were the primary diagnosis but it was also recognised that she was likely to have had a number of more longstanding psychological issues related to her underlying personality (the 'emotional instability' referred to throughout her records).

39. Adviser 1 considered that the diagnostic terminology used in Miss A's records was reasonably consistent. They expressed awareness, however, that Ms C had a number of contacts with IHTT staff and considered it entirely possible that she heard a number of different terms or diagnoses used in relation to Miss A during these discussions. They did not consider it likely that any inconsistency in terminology reflected diagnostic disagreement within the IHTT, but rather that there are a number of different terms or labels in psychiatry that can be used to describe the same disorder or diagnosis, which can be unhelpful. Adviser 1 noted that this can be particularly problematic when describing abnormal personality traits (as in Miss A's case) or personality disorders, and said it is widely acknowledged that there are significant shortcomings in the way these traits or disorders are defined and categorised.

40. Adviser 1 concluded that the treatment Miss A received by the IHTT was not adversely affected by the use of different diagnostic language or terminology. Miss A was receiving treatment with anti-depressant and anxiolytic (anti-anxiety) medications, and was in regular contact with clinical staff, and Adviser 1 considered that this was a reasonable approach. That said, Adviser 1 did not consider it reasonable for Miss A to have been discharged whilst there remained uncertainty about the extent and significance of abnormal personality traits. This has been addressed under complaint (b).

41. With regards to communication, Adviser 1 reiterated that there were multiple occasions when Ms C was in contact with IHTT staff, either face-to-face or via the telephone. Adviser 1 said there was nothing in the records which would suggest any significant problem with the nature of these communications. They observed that, during Doctor 2's interview for the purposes of the AER, they described their meeting with Ms C on 17 October 2014 as a 'difficult interview'. Adviser 1 noted that this would not be unusual or unexpected given the circumstances in which they met ie following a further overdose of medication by Miss A. Adviser 1 pointed out that how one perceives the communications from another is in large part a subjective judgement and, whilst Ms C felt her concerns were minimised or dismissed, they could find nothing in the records to substantiate this.

42. Overall, Adviser 1 agreed with the findings of the AER that the absence of an agreed, documented and accessible formulation was a significant omission in Miss A's care. It was also not consistent with the IHTT's Operational Policy. Similarly, Adviser 1 considered that the lack of a named worker for Miss A may have contributed to some of the consistency and communication issues raised by Ms C, and may have meant that no one individual was taking responsibility for formulating and managing Miss A's case.

43. Adviser 1 noted that the IHTT does have a mechanism for facilitating multi-disciplinary team discussion of complex cases but this does not seem to have been used in Miss A's case. They also noted that the IHTT Operational Policy indicates that there is a half-time psychologist on the team, yet no reference to the seeking of a psychological opinion on Miss A is evident. Adviser 1 said there may have been valid reasons for both these omissions but they are not evident from the records. Adviser 1 considered that, had such action been taken, it could have helped formulate some of Miss A's presenting difficulties.

44. Adviser 1 considered that the findings of the AER relating to decision making and lines of responsibility within the IHTT were also important. However, they agreed with the AER finding that none of these things would necessarily have altered the outcome of Miss A's case. While Adviser 1 considered that the remedial action taken by the Board addressed the majority of the issues identified, they suggested further remedial steps that could be considered and this has been reflected in my recommendations.

(a) Decision

45. In considering the overall care and treatment Miss A received while she was under the care of the IHTT, I have focussed on the three main areas raised by Ms C in her complaint. Namely that of communication, diagnosis and continuity of care.

46. I acknowledge that difficult conversations between IHTT staff and family members caring for someone in a crisis situation would not be an uncommon occurrence. However, I have found no evidence of any particular instances where Ms C contacted IHTT staff and had her concerns dismissed or minimised. I am, therefore, unable to substantiate Ms C's complaint in this regard.

47. In terms of Miss A's diagnosis, I acknowledge that various different diagnostic labels were used and it is understandable that this might have caused confusion or suggested uncertainty within the team. However, I am assured that, whilst different terminology was used, the diagnosis given to Miss A was reasonably consistent and her treatment was not adversely impacted in this respect. I am advised that it is the role of medical staff to diagnose patients and I accept that it would be helpful if this role was clearly defined in the IHTT Operational Policy. While it appears that there are well-recognised shortcomings in the way psychiatrists define certain conditions, it would also seem that Miss A being seen by a high number of different staff would have contributed to some extent to any inconsistencies in terminology used.

48. This leads me on to continuity of care. The fact that Miss A was seen by a number of different staff is not the subject of dispute. I am advised that this is difficult to avoid in a crisis service such as the IHTT, with round the clock shift working and the requirement to respond to unpredictable events. I note that steps were taken to involve the CPN in Miss A's care and that this could have contributed towards improving consistency. However, I consider that much more could have been done to enhance the continuity and consistency of care provided to Miss A. In particular, the IHTT Operational Policy indicates that every service user will be allocated a named worker but this did not happen in Miss A's case. The policy also indicates that MDT discussion of complex cases will take place and be documented but there is little evidence of detailed multi-disciplinary discussion of Miss A's case having taken place. Further, I am advised that the policy suggests that a psychological opinion can be sought

within the IHTT but there is no evidence of this having been considered for Miss A. Had these things been a feature in Miss A's care, the acknowledged absence of an agreed, documented and accessible formulation could potentially have been avoided. In the circumstances, I uphold this complaint. I am advised that the lack of an agreed formulation was a significant omission in this case and I have addressed this further, as it relates to Miss A's discharge, in complaint (b). I note that the Board have already acknowledged some of the identified failings relating to continuity of care, and the AER made recommendations to address these. However, I have the following additional recommendations to make.

(a) Recommendations

49. I recommend that the Board:	*Completion date*
(i) should support the IHTT to implement and adhere to the IHTT Operational Policy, specifically with regard to named workers and facilitating complex case discussion;	30 November 2016
(ii) should consider revising the IHTT Operational Policy to include a description of the roles of medical staff (including different grades of medical staff) within the IHTT; and	30 November 2016
(iii) should apologise to Ms C for the failings identified in the care and treatment provided to Miss A.	30 September 2016

(b) The discharge from the IHTT on 8 November 2014, and associated follow-up arrangements, were unreasonable

Ms C's complaint

50. When Ms C first wrote to the Board to indicate her wish to make a formal complaint, she stated that her main question was why Miss A was left to die alone with only four telephone numbers as a safety net. Ms C wrote further indicating that she had serious concerns about the reasons given for Miss A's discharge, given that she continued to display her presenting behaviours. In complaining about the IHTT's communication with her, Ms C stated that she felt they sought only to tick boxes and move Miss A on. Ms C expressed concern that Miss A had no detailed follow-up plan and felt lost and utterly abandoned when the decision to discharge was communicated to her. In a letter to the Reviewers, Ms C stated that she remained harassed, disgruntled and distressed, and unable to understand how her daughter killed herself a mere

week after her discharge, while the final notes state clearly that she still had suicidal thoughts.

51. When Ms C subsequently met with the Reviewers, she questioned how the decision to discharge Miss A was reached and who had taken the decision. She highlighted again that Miss A had continued to express suicidal thoughts to the team and noted that this was included in the Discharge Summary. Ms C questioned why Miss A was discharged despite the fact that her presentation had not changed and she noted that there was no record of improvement in her case notes. She also questioned whether Miss A's previous suicide attempts were taken seriously and interpreted appropriately. She considered there to be a lack of clarity regarding previous suicide attempts and acts of self-harm and queried whether the differences in links were apparent to the team.

52. Ms C complained that Miss A had not felt there had been preparation for discharge and she felt surprised and abandoned when she was discharged. Ms C considered that it would have been helpful for both her and Miss A to have been involved in a discharge planning meeting prior to discharge.

53. Ms C also complained about Miss A's follow-up care, noting that there had been no ongoing psychiatric follow-up. It was noted that Miss A had ongoing contact with a private counsellor, whom the family had sourced and paid for, but that she was discharged from the Board's care. Ms C said it was unclear who she or Miss A could contact for help post-discharge, noting that there had been no signposting to future services and the crisis services documented on the Discharge Summary were not accompanied by contact numbers.

54. Ms C highlighted that Miss A's previous suicide attempts had occurred after IHTT visits and noted that Miss A had not accessed crisis services when she had thoughts of suicide. Ms C questioned how this was understood by the team when, in particular, Miss A had been advised to make use of crisis services when experiencing suicidal thoughts.

55. Ms C noted that she had contacted the IHTT following Miss A's discharge and was told that Miss A could seek re-referral from her GP if she was struggling and could be put on the waiting list for further psychological services. Ms C complained that no information was provided about the waiting list time. She considered that a more holistic approach involving medication and talking therapies, with access to further support, would have been helpful.

56. When Ms C subsequently met with senior Board staff to discuss her complaint, she noted that the documentation she considered to be missing from Miss A's records included a discharge follow-up plan; notes of the Consultant having met with Miss A; and assessment tools at discharge. It was also noted that there was no record of a team meeting having been held to discuss Miss A's discharge. Assuming such a meeting took place, Ms C questioned who was present; who contributed to the information about Miss A; and who made the decision to discharge her. Board staff acknowledged that Ms C was seeking evidence that there was a decision making process with regard to Miss A's discharge.

57. The key learning points documented from Ms C's subsequent meeting with the lead nurse and the Consultant included actions to develop and arrange training for IHTT staff on the links between self-harm and suicide; to review the paperwork for planning and preparation for discharge from the IHTT; and to improve the recording of the evidence and rationale for decision making within the IHTT.

58. In commenting on the draft AER report, Ms C noted that the Reviewers had not been able to clearly identify any care or service delivery problems that led to the adverse event. Ms C questioned whether Miss A being discharged whilst clearly voicing suicidal intent was an example of good care. She also asked whether the lack of follow-up care plan, lack of telephone numbers for crisis services and lack of advice for family and friends on keeping Miss A safe were examples of good care.

59. Ms C considered that Miss A's documented longstanding relational/attachment issues, with powerful sense of abandonment, was a very powerful but completely ignored diagnosis throughout her care. She questioned why the team would treat a person who had abandonment issues with further rejection, noting that on the day of Miss A's discharge she felt completely abandoned by the IHTT.

60. In responding to the indication that the IHTT works in crisis only, Ms C questioned what the criteria is for defining crisis and she asked whether the presence of ongoing thoughts of suicide was thought to be a crisis situation. She also questioned why Miss A was left to her own devices and did not receive an onward referral to another team for ongoing work.

61. Ms C noted that there was no staying well plan or minutes of a team meeting prior to discharge. She asked what the Board's input was into the provision of psycho-social care. She questioned whether the latter element referred to the private counsellor and, if so, she asked what evidence there was of the counsellor's actual existence; contact details; place of work; accreditation; theoretical framework and counselling approach. In relation to the noted potential for simultaneous input by the CPN and private counsellor being unhelpful, Ms C questioned why short-term solution focussed work could not run concurrently with long-term therapy. She queried how this view could be reached given the fact that the Board had made no contact with the private counsellor and had no information about the therapy being offered

62. In respect of the corresponding indication that Miss A did not feel able to commit to developing relationships with individual staff members (and had chosen private counselling instead), Ms C stated that Miss A was not given the opportunity to commit to this as she was discharged. She asked whether it was acceptable practice for NHS care and treatment to be withdrawn if a private counsellor is employed and she questioned the appropriateness of discharging patients to an external, costly service, which provides one hour contact on a weekly basis, when they are continuing to voice thoughts of self-harm and suicide.

63. Ms C expressed overall disappointment with the draft AER report, which she considered watered down the issues raised and place undue focus on looking for examples of good care, rather than asking fundamental questions surrounding the appropriateness of Miss A's discharge and adequacy of follow-up arrangements.

The Board's response

64. As noted previously, when the Board wrote to Ms C, further to having met with her to discuss her complaint, they acknowledged that they 'may have better supported [Miss A] and prevented her death' if the AER recommendations had been implemented beforehand. In particular, they acknowledged that they failed to communicate with Ms C and Miss A's flatmates at the time of her discharge.

65. In writing to my complaints reviewer, the Board indicated that the Reviewers considered Miss A to have fitted the criteria for discharge from the

IHTT and that prolonged contact with a crisis team was considered unlikely to have provided increased benefit for her. They said the Reviewers considered that an appropriate follow-up plan for Miss A would have involved a medium to long term therapeutic relationship with a person with suitable training and a clear route of access back into crisis services.

66. The Board said the Reviewers had noted that Miss A and Ms C had strongly expressed a preference for Miss A to continue with her private counsellor and she had decided against further contact with the CPN, which the Reviewers considered would have provided a more robust follow-up arrangement. They noted that Miss A was aware of crisis services and had used them in the past. However, it was acknowledged that greater efforts should have been made to communicate discharge plans, risks and contingency planning with the private counsellor. It was noted that the private counsellor's involvement was unclear as they had declined to participate in the AER process.

67. The Board highlighted that, although aspects of the discharge were found to be unsatisfactory, it was difficult for the Reviewers to draw conclusions as to whether acting differently would have prevented Miss A's death.

Medical advice

68. From Adviser 1's review of the records, they considered that Miss A's ongoing high risk of further suicide attempts or acts of deliberate self-harm was well recognised by IHTT staff. A handwritten note dated 29 September 2014 stated 'No concrete plans but high risk of impulsive acts against self'. On 17 October 2014, Doctor 2 noted there was an 'Ongoing risk of DSH/suicide'. On 20 October 2014, an IHTT nurse documented that Doctor 1 had 'highlighted risk of completed suicide'. On 6 November 2014, an IHTT nurse reviewed Miss A and reported that she was 'low' and was 'struggling to cope'. Miss A was tearful at times but, in the same interview, appeared 'reactive and bright' at other times. Adviser 1 observed that Miss A's Discharge Summary from the IHTT, dated 10 November 2014, noted that she had 'Ongoing thoughts of suicide and self-harm'.

69. Adviser 1 considered that Miss A's records were reflective of her fluctuating mental state and the fact that she could appear bright and reactive at times, but at other times was low. They advised that this changeable presentation could have been a result of a resolving depressive episode or

underlying emotional instability, or indeed both. It was also reported that, at times, Miss A could 'put a brave face on' to staff and appear better than she was (Ms C highlighted this to staff as one of her concerns). At her last appointment with medical staff on 20 October 2014, Doctor 1 noted that Miss A appeared 'brighter' but still reported feeling generally low in mood. Frequent ongoing 'suicidal ruminations' were also noted.

70. Adviser 1 noted that a Clinical Global Impression scale (a psychiatric assessment tool used to measure severity of illness and treatment response) was completed by IHTT nursing staff, presumably shortly before Miss A's discharge but it was not dated. Although this rated Miss A as 'much improved', Adviser 1 noted that there was no further detail about the rationale for this rating. In the opinion of Adviser 1, while there were signs of improvement in Miss A at times, there was no convincing evidence of a pattern of sustained or consistent improvement over time.

71. It was noted by Adviser 1 that Miss A's discharge was discussed early on in her care with IHTT. The records first mention discharge in an 'AM Handover' note dated 3 October 2014, which stated 'Discuss d/c [discharge] plan for next week?'. Adviser 1 noted that this may well be standard practice for the IHTT, which is a short term service. The possibility of discharge was raised again on 6 October 2014 at the 'MDT'. The case note entry stated 'Next visit to be a joint visit with [the CPN] and to be discharged from IHTT caseload'. On 13 October 2014, the case note entry from the 'MDT' stated 'H/V [home visit] planned for this evening. Plan discharge'. The 'AM Handover' note from 16 October 2014 stated 'H/V today at 10.30. Start discharge plan'. Adviser 1 could see no clear documentation of these discharge plans having been discussed with Miss A.

72. A case note entry from 6 November 2014 stated 'For discharge today as discussed with [the Consultant]. Provide details on crisis contacts. If unable to, offer one further visit'. Adviser 1 noted that Miss A was reviewed by an IHTT nurse on 6 November 2014 and it was noted that Miss A was 'unaware' that she was to be discharged that day, but that she 'knew it would happen at some point'. Miss A was provided with leaflets for Samaritans, Edinburgh Crisis Centre and Breathing Space. It was agreed that Miss A would be seen one more time and would complete a staying well plan. Adviser 1 noted that this took place on 8 November 2014 and Miss A was discharged thereafter.

73. Adviser 1 said that, other than the brief case note entries mentioned above, they could see no documentation of a discharge planning meeting in the records. They noted that Miss A appeared to have been aware the input from the IHTT was a short term measure, but she was not aware she was to be discharged until the day it was to happen (two days before it actually happened). Adviser 1 noted that efforts were made to provide Miss A with crisis contacts and complete a staying well plan but said it was not clear from the records what Miss A's view of these sources of support was.

74. Adviser 1 reiterated that there were frequent mentions of discharge in the case records but said there was no detailed documentation of the decision making process the team went through in planning this. It was noted by Adviser 1 that Miss A was not seen by a consultant psychiatrist. The Consultant attempted to see Miss A on 5 November 2014 but she was not at home. Miss A's case then appears to have been discussed with the Consultant on 6 November 2014 but the details of this discussion were not documented.

75. With regards to Ms C's concerns that Miss A's previous suicide attempts were not taken seriously or interpreted correctly, Adviser 1 did not consider there to be anything in the records to substantiate this. They noted that Miss A's initial referral to the IHTT was precipitated by a suicide attempt, and that her discharge from the IHTT was delayed on several occasions partly due to further episodes of attempted suicide or deliberate self-harm. At the point of discharge from the IHTT, it was recognised that Miss A continued to pose a high risk of future suicide or deliberate self-harm attempts. In the opinion of Adviser 1, the IHTT proceeded with the discharge, not because they did not take Miss A seriously, but because they assessed the risk as chronic and they felt the measures they had put in place were adequate.

76. Adviser 1 concluded that the decision to discharge Miss A from the IHTT was not in and of itself unreasonable, however, the manner in which she was discharged was unreasonable. It was noted by Adviser 1 that the IHTT is a short term service used as an alternative to hospital admission, and that the IHTT had supported Miss A through a number of crises and provided her with treatment for her depression. Adviser 1 presumed that the IHTT viewed Miss A's risk to herself as chronic and to be manageable by her GP with additional input from a private counsellor, whom she had started seeing, as well as from crisis services, such as Samaritans, when required. On that basis, they took the decision to discharge Miss A.

77. However, in Adviser 1's opinion, the manner of Miss A's discharge was not reasonable. They noted that there is no record of detailed discharge planning or of Miss A having had input into the discharge process. They noted that this is of particular significance in individuals with emotionally unstable personality traits, as Miss A had, who can have powerful negative reactions to the withdrawal of services. The records state that the main member of medical staff involved in Miss A's care, Doctor 1, was away for one week at the point of Miss A's discharge. Adviser 1 said it was not clear if Doctor 1 had any input into the decision to discharge Miss A, or if they were even aware of the decision, but said they would have expected Doctor 1 to have had a key role in developing discharge plans, especially as they were responsible for prescribing Miss A's pharmacological treatment and had documented their own concerns about Miss A's risk of completed suicide.

78. Adviser 1 said there was presumably a decision that Miss A required review by a member of IHTT medical staff prior to her discharge, explaining why the Consultant attempted to see Miss A on 5 November 2016. They did not consider it clear as to what changed in the three days after the Consultant had attempted to see Miss A that meant it was felt appropriate to proceed with the discharge without Miss A having been reviewed by medical staff. Ultimately, Adviser 1 was led to conclude that it was not reasonable to discharge Miss A without her having been reviewed by medical staff.

79. Adviser 1 noted that the AER could not draw any firm conclusions regarding the impact and timing of Miss A's discharge from the IHTT on her subsequent actions. Adviser 1 agreed that this was the case but, notwithstanding the absence of any clear causal link, they still regarded the manner of Miss A's discharge as unreasonable.

80. With regards to follow-up arrangements, Adviser 1 noted that the IHTT Operational Policy states that the 'IHTT will endeavour to ensure that robust follow-up arrangements are in place prior to discharge from IHTT'. At the point of Miss A's discharge, a standard Discharge Summary was completed, which detailed follow-up plans as '… Private Counsellor for person centred therapy' and 'Samaritans, Breathing Space, MHAS [Mental Health Assessment Service], Crisis Centre NHS 24'. Adviser 1 said it was not clear who the Discharge Summary was distributed to but presumed that it would have went to Miss A's

GP and Miss A herself. They could see no other documentation of discussion with Miss A's GP.

81. Adviser 1 observed that emphasis on Miss A having begun seeing a private counsellor and appearing positive about this input. It was decided that having more than one person providing psychological therapy would be counterproductive for Miss A, so the NHS input (at that point being provided by the CPN) was withdrawn. Adviser 1 could see no documentation of any contact between the IHTT and private counsellor to discuss Miss A's case. The AER highlighted that IHTT medical staff had requested that the CPN discuss Miss A's follow-up care with the private counsellor prior to discharge, but this message was not passed on to the CPN. In relation to Ms C's complaint about the appropriateness of including details of a non-NHS service in the follow-up plan, Adviser 1 said that there was nothing inappropriate about this and that it was not uncommon for private or third sector agencies to be involved in patient care and formally recognised in care plans. That said, they considered that it would have been more professional to have included the full name and contacted details of the private counsellor on the Discharge Summary (only a shortened, colloquial version of the counsellor's first name was quoted).

82. With regards to Ms C's complaint that no actual telephone numbers for the crisis services were included on the Discharge Summary, Adviser 1 noted that these would have been included on the leaflets provided to Miss A.

83. Adviser 1 concluded that the follow-up arrangements put in place for Miss A following her discharge from the IHTT on 8 November 2014 were not reasonable. It was noted by Adviser 1 that Miss A had been diagnosed with a mental illness (moderate depressive episode) by IHTT medical staff and had been started on treatment with a second line anti-depressant medication ie she had not responded adequately to the first anti-depressant she had received from her GP). Assuming Miss A was taking her first anti-depressant as prescribed, then Adviser 1 considered that her failure to benefit from it suggested a degree of treatment resistance in Miss A's condition, or that her condition was not a 'straight forward' depression but was complicated by comorbid issues (in Miss A's case emotionally unstable personality traits). Adviser 1 noted that Miss A's dose of anti-depressant was increased at her last appointment with a psychiatrist on 20 October 2014, in an effort to treat her ongoing symptoms. At the point of her discharge from the IHTT, it was

recognised that Miss A's mental health continued to fluctuate and that she was at ongoing risk of future deliberate self-harm and suicide attempts.

84. Adviser 1 noted that Miss A was discharged from the IHTT with no medical or psychiatric follow-up and she had not been reviewed by a psychiatrist for 19 days prior to her discharge. In Adviser 1's opinion, Miss A's case should have remained open to secondary care mental health services, including to a psychiatrist who would have continued to monitor her response to medication. Adviser 1 said this would most likely have been via a referral back to the CMHT.

85. Given the view of the IHTT that Miss A most likely had emotionally unstable personality traits, Adviser 1 considered that it would also have been reasonable to make further efforts to assess the extent and significance of these traits, including whether Miss A warranted a diagnosis of EUPD. They advised that this was also a piece of work that could have been taken forward by a CMHT, possibly with the input of psychology staff. They said the possibility of a referral to a psychotherapy department for further assessment or treatment could also have been considered.

86. Adviser 1 observed that, as it was, the only arranged follow-up in place for Miss A was with a private therapist, with whom no one from the Board appeared to have had any contact. They said it was not clear if the private therapist was fully aware of the extent or seriousness of Miss A's risk to herself, or indeed whether this therapist had the skills and competencies to manage Miss A's condition. Adviser 1 said it was not, therefore, possible for Board staff to conclude that Miss A did not require further psychological therapy. Furthermore, Adviser 1 could see no documentation of any contact with Miss A's GP, other than a copy of the Discharge Summary being sent. In Adviser 1's view, these were not robust follow-up arrangements and they were not reasonable.

87. While Adviser 1 noted that the recommendations of the AER went some way to addressing the issues raised by Miss A's discharge, they did not consider these sufficient and suggested that the Board should consider taking further remedial action. In particular, it was suggested by Adviser 1 that the Board should review the discharge planning process in the IHTT to ensure it is adequate and fit for purpose in meeting the IHTT's stated aim of putting in place robust follow-up arrangements. They suggested that any such review should include the following considerations:

- ensuring adequate consultation with, and involvement of, the patient; relatives/carers; CMHTs; primary care services; and third sector or private sector agencies;
- in cases where emotionally unstable traits or personality disorder is diagnosed or suspected (or relational difficulties, which is the term used by the AER), the IHTT should be particularly mindful of the possibility of ambivalence towards services by the patient and of the possibility of powerful negative responses to the withdrawal of services (Adviser 1 noted that this aspect may have already been addressed by the Board's recommendation regarding services adopting an approach to care that is consistent with an appropriate psychologically informed model);
- ensuring that adequate review by medical staff has been carried out prior to discharge from the IHTT. If medical review is not felt to be necessary, the reasons for this should be clearly documented as part of the discharge planning process;
- ensuring that, in cases where there are recognised ongoing mental health needs and/or ongoing prescription of psychotropic medications (particularly if these are commenced by the IHTT) at the point of discharge/transfer from the IHTT, adequate arrangements are in place for medical follow-up and review of medications. If medical follow-up is not felt to be necessary, the reasons for this should be clearly documented as part of the discharge planning process; and
- ensuring that, in cases where there are outstanding diagnostic issues (such as the possibility of emotionally unstable personality traits in Miss A's case) at the point of discharge/transfer from the IHTT, adequate consideration has been given to whether or not further assessment and/or treatment is indicated. If it is felt that this is not indicated, this should be clearly documented as part of the discharge planning process.

(b) Decision

88. I accept that the IHTT are designed to provide short-term input and that chronic risk over the long-term would not be managed in this setting. I am satisfied that the evidence suggests that the IHTT recognised the on-going risk of Miss A attempting suicide and I do not consider that the decision to discharge her was as a result of a failure to appreciate this. Whilst I cannot, therefore, conclude that the decision in itself was unreasonable, I am advised that the process followed in discharging Miss A was unreasonable. The discharge planning process was not clearly documented, there is no evidence of a

discharge planning meeting having taken place and no indication that discharge plans were discussed with Miss A. Of particular concern to me is the lack of evidence of medical input into Miss A's discharge. She had not been seen by a doctor for 19 days prior to discharge, with no evidence of the medical staff who had seen Miss A up to that point having had any involvement in, or awareness of, the decision to discharge. The decision appears to have been discussed with the Consultant but the detail of that discussion was not recorded. Miss A was not at home when the Consultant tried to visit her prior to discharge and the Consultant did not personally see her at any time. I do not consider it reasonable for the discharge to have proceeded without an appropriate member of medical staff having reviewed Miss A.

89. I am also led to conclude that the follow-up arrangements put in place for Miss A's discharge were unreasonable. It appears that Miss A was not on a settled medication regime and it would, therefore, have been appropriate for a referral to the CMHT, for psychiatric follow-up, to have been arranged to allow her response to anti-depressant medication to be monitored. It was not appropriate for this to be left to Miss A's GP given the level of risk involved. Also, given the acknowledged lack of agreed formulation for Miss A and, in particular, the uncertainty surrounding the extent and significance of her emotionally unstable personality traits, a referral to the CMHT would have allowed the consideration of psychology input, or onward referral for psychotherapy input. The discharge plan merely noted that Miss A was seeing a private counsellor but no steps were taking by Board staff to get in touch with this external therapist, despite IHTT medical staff having advised this course of action. This meant that Miss A was discharged with no planned follow-up care from the Board in place, due at least in part to the unverified involvement of a private therapist. I also find this particularly concerning.

90. I conclude that the process followed in discharging Miss A was inadequate and the follow-up arrangements put in place were not sufficiently robust. I, therefore, uphold this complaint. I note that the Board, via their AER process, have already acknowledged failings surrounding these aspects of Miss A's care and they have made some recommendations to try to address these. When Ms C brought her complaint to this office, she acknowledged that the Board had made recommendations which sought to address her specific criticisms. However, she indicated that she required reassurance that the proposed action would actually be taken. Given the significance of the issues raised, it was agreed that Ms C's complaint would be fully investigated and that careful

consideration would be given to the sufficiency of the Board's planned remedial steps.

91. I have had sight of the Board's updated action plan, as at December 2015, which indicated that some steps have been taken to address the acknowledged failings in Miss A's care. However, I do not consider that this sufficiently addresses all the failings this investigation has identified. I remain particularly concerned about the lack of medical input into Miss A's discharge. Further to my recommendation for the roles of IHTT medical staff to be more clearly defined, I consider that this could be expanded to specifically include when patients should be seen by medical staff. This could factor in whether consultant review should be a feature in cases where there is deemed to be a certain level of risk. I also remain concerned about the lack of planned further Board input into Miss A's care when her response to medication was still being monitored and the extent and appropriateness of her private therapy was undetermined. I make the following additional recommendations.

(b) Recommendations

92. I recommend that the Board:	*Completion date*
(i) should review the discharge planning process in the IHTT, taking account of the considerations highlighted in this report;	30 November 2016
(ii) should review the IHTT Operational Policy, setting out clear guidance for when patients should be seen by medical staff;	30 November 2016
(iii) should provide detailed evidence of all action taken to implement the AER recommendations; and	30 November 2016
(iv) should apologise to Ms C for the identified failings in the process for discharging Miss A and planning her follow-up care.	30 September 2016

(c) The care and treatment provided by the A&E department at hospital on 7, 16/17 and 30 October 2014 was unreasonable

Ms C's complaint

93. When Ms C met with the Reviewers, she complained about the treatment Miss A received in A&E following her suicide attempts. She indicated that the attitude of staff was brusque and dismissive and she noted that, on one occasion, Miss A was left waiting in a corridor with police officers. She noted that, on another occasion, Miss A was left in a corridor and crowded waiting

room in a drowsy state with exposed bleeding arms, and was later left alone in a cubicle feeling isolated. Ms C considered that a designated waiting area, providing privacy and dignity for patients in such circumstances, would be helpful.

94. Ms C also complained about the access to mental health care and assessment in A&E. She noted that, on one occasion, Miss A waited four hours for review by the IHTT. She was told that the team were in another hospital and questioned why Miss A could not, therefore, have been assessed by the MHAS. Ms C questioned the links between services involved in Miss A's care and asked what had led to this delay.

95. Ms C also complained about how Miss A was discharged from A&E. She stated her view that staff needed to be more proactive in ensuring that the person taking responsibility for Miss A following discharge was able to accept the role. She did not consider that enough had been done to explain aftercare and provide contacts for those supporting Miss A. She questioned the training provided to staff on suicide prevention and risk assessment. When Ms C then met with senior Board staff to discuss her complaint, she noted that the way Miss A was treated at A&E impacted on her because of the dismissive attitude of staff.

The Board's response

96. When the Board wrote to Ms C to update her on actions taken following her complaint meeting with senior Board staff, they stated that their records did not indicate why Miss A could not have been seen by the MHAS on 16 October 2014, rather than have to wait for the IHTT staff who were unavailable. However, they noted that the A&E doctor had established that Miss A had ongoing input from the IHTT and that the IHTT would review her.

97. The Board noted that, when Miss A was seen by the IHTT, following a wait for their arrival, it was recorded that she had expressed frustration over seeing different CPNs each time. The Board said they might conclude from this that, once the A&E doctor established that Miss A was on the IHTT caseload, referral to the MHAS was not deemed necessary, especially in the context of Miss A not being happy seeing so many different staff.

98. The AER report noted that Ms C's complaints regarding the treatment of Miss A in A&E had been passed to A&E for their review. In the report covering

letter, one of the Reviewers noted that there had been a delay in receiving recommendations from A&E and, in light of this, the report's recommendations related to mental health services only. It was indicated that a response from A&E would follow separately but there was no mention of this when the Board subsequently wrote to Ms C, having met with her to discuss her complaint.

99. My complaints reviewer, therefore, asked the Board to provide me with their comments directly. They apologised that no formal response had been issued from A&E and they expressed regret that the issues about A&E were not covered in their final response to Ms C.

100. The Board apologised if it was Miss A and Ms C's experience that staff displayed a brusque, dismissive attitude. They noted that patients who are intoxicated (with alcohol or drugs), and patients with self-harm, present commonly to A&E. They said their staff are experienced in supporting and assessing patients presenting in these situations and that this is provided in a caring and sympathetic manner. They said they were sorry that Ms C did not find this to be the case during Miss A's presentations.

101. The Board noted that, when patients are brought to A&E by the police due to a concern for their safety, then it is up to the police officers to decide at which stage in the assessment they leave. They said the primary concern for all parties is the safety of their patients and they find that the police are generally a calming presence, and their patients are more likely to stay for the complete assessment if police officers remain with them. They explained that, due to the nature of the service they provide, there are various reasons for the presence of police officers in A&E. They noted that there are occasions when there are large numbers of officers present but they said this is not within the control of the unit.

102. The Board also noted that they are constrained by the number of cubicles they have available and, at times when A&E is busy, they have to keep patients in the corridor both before and after their assessment. They acknowledged that this is less than ideal but said they should absolutely preserve their patients' dignity at all times. They apologised that they clearly did not attain this with Miss A's care and they noted that her wounds should have been dressed and covered at all times.

103. In relation to Miss A being left along in a cubicle, the Board noted that, due to the size and activity in A&E, they do not have the resources to provide one to one care. They advised that nurses perform regular care rounds and patients who are felt to be at risk are placed in cubicles closest to the nurses' station. They noted that they operate an open curtain policy when direct patient care is not being delivered, which assists in the observation of patients but also allows patients visual contact with the staff looking after them.

104. With regards to Miss A's four hour wait until the IHTT arrived, the Board said they strive to provide timely and appropriate care for all their patients. However, they noted that they have no influence over the timings in cases such as this where specialist input from another service is required. They explained that they report daily on delays waiting for specialist intervention at a hospital level and report back to the specialty team with a request for an explanation.

105. The Board stated that a designated area providing some privacy and dignity is a gold standard of care and one they strive to achieve. They appreciated that they do not always achieve this due to the current limitations on space and volume of patients seen daily in A&E. They advised that they are trialling ways to free up space in the clinical areas so they can attain this standard of care regularly.

106. The Board further advised that some of the nursing staff have undertaken additional training in mental health and each nursing team had a lead for mental health. In terms of mental health assessment, they said they were fortunate to have the support of the MHAS team on site, who can undertake the initial assessments relatively quickly.

Medical advice

107. Adviser 2 noted that it is common for patients with mental health problems to present to emergency departments accompanied by the police. They advised that this is often due to the nature of the initial presentation, for example the police being called by relatives, friends or bystanders when the patient is attempting self-harm. It was noted that this appears to have been the case when Miss A presented on 7 October 2014, when she stated an intent to jump off a bridge while in the presence of her friends. Adviser 2 said it is common for the police to stay with patients in A&E until they are assessed by medical staff. They considered this reasonable practice.

108. Adviser 2 observed that, due to the number of patients in A&E frequently exceeding the number of clinical rooms, patients unfortunately often have to wait in corridors prior to their assessment. Although not ideal, Adviser 2 considered this reasonable when compared to practice in other A&E departments.

109. Adviser 2 noted that Miss A arrived by ambulance on 16 October 2014 and would have been on an ambulance trolley prior to triage. They observed that she was triaged 18 minutes after arrival and was triaged to the intensive care area rather than the waiting room. Adviser 2 considered that this would suggest that the time she had to spend in the waiting room and the corridor was kept as minimal as possible. Again Adviser 2 noted that patients often have to wait in corridors in busy A&E departments, prior to being assessed, and while acknowledging that this is not ideal, they did not consider it unreasonable.

110. Adviser 2 also noted that it is widely regarded as good practice to assess mental health patients in single cubicles. They said that this means patients are in a calm and quiet area and are not upset by other patients. It also means that they can discuss symptoms and problems in privacy, out of the earshot of other patients. Adviser 2 noted that Miss A was kept in the triage area from 01:30 to 02:30 on 30 October 2014 and was then moved to the high dependency area. They said it was, therefore, less likely that she would have been kept in a cubicle on this occasion.

111. Adviser 2 said there is no evidence in the clinical notes to support the concerns raised by Ms C that A&E staff displayed a brusque attitude and were dismissive of suicide attempts.

112. Adviser 2 noted that Miss A was seen by the MHAS at 04:50 on 7 October 2015, which was one hour and four minutes after she presented. Adviser 2 considered that this was reasonable.

113. Adviser 2 then observed that Miss A was assessed by the IHTT at 23:15 on 16 October 2015, which was four hours and three minutes after she presented. They noted that, on this occasion, Miss A needed to be assessed by an A&E doctor prior to IHTT referral as she had ingested tablets and had cut herself. They explained that blood tests for paracetamol needed to be taken, and that these can only be taken four hours after the time of drug ingestion. It was noted that Miss A had taken the overdose at 16:30 and, therefore, the

earliest time that a blood sample could be taken was 20:30. Adviser 2 explained that, following this, it takes time for the laboratory to analyse the sample and, only when the results have come back excluding a significant paracetamol overdose, can the patient be referred to the mental health team. Taking into account the time for triage, medical assessment, the wait for blood tests and the wait for analysis prior to mental health referral, Adviser 2 considered that a wait of four hours was not unreasonable. They also observed that, on this occasion, the IHTT were with another patient in another hospital.

114. Similarly, Adviser 2 noted that Miss A was seen by the MHAS at 05:40 on 30 October 2014, which was four hours and 25 minutes after she presented. They advised that blood tests for paracetamol were again required on this occasion, four hours after drug ingestion, and an A&E doctor's assessment was required prior to referral. The blood tests were taken at 04:30, with ingestion of alcohol and drugs noted as having been between 23:00 and 00:20. Adviser 2, therefore, considered that this was the earliest possible time that blood tests could have been taken and, in the circumstances, they did not consider that a wait of four hours and 25 minutes for mental health referral was unreasonable.

115. With regards to actions taken on discharge, Adviser 2 observed that a note on the discharge letter of 7 October 2014 states 'Discussion held with friend present and able to keep herself safe at home with no further attempts at self-harm until IHTT can see her in the morning. Friend agreeable to this also'. Adviser 2 said it, therefore, appeared that efforts were made to ensure that Miss A's friend was willing to take responsibility for Miss A on this occasion. Adviser 2 considered this reasonable.

116. Adviser 2 also considered the documented actions on 16/17 October 2014 reasonable, when the IHTT noted that '[Miss A] will go home with parents tonight. Agrees to call IHTT if needed'.

117. In relation to Miss A's attendance on 30 October 2014, Adviser 2 could see no record regarding who accompanied her and who she was discharged with. They considered it unreasonable to have failed to document who Miss A was discharged with on this occasion.

118. Adviser 2 explained that all nursing and medical staff working in A&E departments will have had training and experience in dealing with mental health patients. It was noted that all A&E staff deal with mental health patients and

patients complaining of suicidal ideation on a regular basis. Adviser 2 said that, on each of the occasions Miss A presented to A&E, she was assessed by A&E staff to be appropriate for urgent referral to an on-call mental health team. They considered that this demonstrated that appropriate mental health assessments were being carried out by A&E staff. Once referred to and seen by the on-call mental health team, Adviser 2 confirmed that responsibility for suicide prevention and risk management is passed from A&E staff to the specialist mental health staff.

119. Adviser 2 noted that A&E has a detailed mental health assessment form, which they said this demonstrates good practice in terms of mental health assessment by staff. They noted, however, that this was only completed for Miss A's presentation on 7 October 2014. They said that a system to ensure this is mandatory for all mental health patients should be considered. However, they did not consider that the failure to complete the form for Miss A in every instance would have made any material difference, as she was referred on all occasions for a specialist mental health assessment by an on-call mental health team.

120. Adviser 2 also observed that there appears to be a system in place for directing patients from triage directly to the MHAS, without them having to wait for an initial assessment by A&E medical staff before onward referral. Adviser 2 noted that this occurred for Miss A on the 7 October 2014, which was the occasion when there was no drug ingestion or physical self-harm that would have required treatment by an A&E doctor prior to psychiatric assessment. Adviser 2 considered that this is an excellent system which minimises unnecessary waits for patients presenting with mental health complaints.

121. Adviser 2 concluded that there was no evidence of unreasonable practice by A&E staff involved in Miss A's care. They suggested, however, that the Board should consider implementing a system which mandates completion of A&E's mental health form for all mental health patients presenting with suicidal ideation or following self-harm.

(c) Decision

122. I understand how distressing the occasions of Miss A's A&E attendances must have been for her and her family and friends, and I appreciate that the presence of police and lack of privacy would have added to this distress. However, I am advised that this is difficult to avoid and that waits in corridors or

busy waiting rooms, while far from ideal, are common in busy A&E departments. Equally, I am advised that it is seen as good practice to assess mental health patients in single cubicles. I am, therefore, unable to conclude that A&E staff acted unreasonably in either regard. Neither can I evidence that they displayed a brusque attitude or dismissed Ms C's concerns. I note that Miss A was referred for urgent specialist mental health assessment each time she attended and I am advised that this demonstrated that A&E staff carried out appropriate mental health assessments. However, the dedicated mental health assessment form was only completed for Miss A's first attendance. While I am assured that this made no material difference to the care Miss A received, it would be a matter of good practice for this form to be completed in every instance. I am also advised that it is good practice to always document who a patient is accompanied by, particularly on discharge when the responsibility for the patient's safety is being passed on. This was documented for Miss A's first two A&E attendances but not the last attendance and I am critical of this.

123. With regards to Miss A's specialist mental health assessments, I note that such a review would normally be carried out in this setting by the MHAS. This was the case for Miss A on her first and third attendances. On her second attendance she was assessed by the IHTT. It is not clear to me why this differed on this occasion but I note that Miss A was already a patient of the IHTT and it was reasonable for them to have assessed her, rather than the MHAS, if they were in a position to do so.

124. Miss A waited over four hours for specialist mental health assessment on both her second and third attendances. Ms C complained about this delay, particularly in relation to the second attendance when it was felt that the wait for IHTT staff to arrive had contributed to the delay, and that an earlier assessment by MHAS should have been considered. However, while it was noted that IHTT staff were at another hospital and could not attend immediately, this does not appear to have delayed things significantly beyond the time it took for Miss A to be assessed by A&E medical staff. I am advised that, as Miss A had taken an overdose on each of her second and third attendances, in contrast to her first attendance, the medical assessments necessarily took longer on these occasions. I am assured that, in such circumstances, a wait of over four hours was not unreasonable.

125. I conclude that the overall care and treatment Miss A received in the A&E department was reasonable and I do not uphold this complaint. However, I have the following recommendations to make.

(c) Recommendations

126. I recommend that the Board:	*Completion date*
(i) should consider introducing a system whereby completion of the A&E mental health risk assessment form is mandatory for all mental health patients; and	30 November 2016
(ii) should highlight to A&E staff that it is good practice for them to document who vulnerable patients are accompanied by on discharge, and whether the accompanying persons are happy to accept responsibility for patient safety.	30 September 2016

127. 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 dates 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

Ms C	the complainant
Miss A	the aggrieved
the Board	Lothian NHS Board
the IHTT	the Board's Intensive Home Treatment Team
A&E	the Accident and Emergency department at the Royal Infirmary of Edinburgh
Adviser 1	the Ombudsman's psychiatric adviser
Adviser 2	the Ombudsman's emergency medicine adviser
the AER	the Board's Adverse Event Review of the care provided to Miss A prior to her death
the Reviewers	the clinicians from the Board who carried out the AER
CMHT	the Board's Community Mental Health Team
the CPN	the Board's Community Psychiatric Nurse who Miss A was seeing at the time of her referral to the IHTT
the Consultant	the lead consultant psychiatrist within the IHTT

MDT	multi-disciplinary team
Doctor 1	specialty doctor within the IHTT and the main member of medical staff involved in Miss A's care
Doctor 2	trainee doctor within the IHTT
EUPD	emotionally unstable personality disorder
DSH	deliberate self-harm
MHAS	the Board's Mental Health Assessment Service

Annex 2

Glossary of terms

formulation	an overall understanding of a patient's problems and needs

Annex 3

List of legislation and policies considered

Edinburgh's Intensive Home Treatment Team Operational Policy, Lothian NHS Board 2012