Scottish Parliament Region: Lothian

Case 200800448: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Mental Health

Overview

Mr and Mrs C complained to NHS Lothian Health Board (the Board) on 24 October 2006 about the treatment and management of medical care provided to their late son (Master C) by the Board's Child and Family Mental Health Service (CAMHS) whilst he was a patient during 2000 and 2001. Mr and Mrs C also complained about the subsequent failure of the Board to provide adequate services for the treatment of his mental health in 2001.

CAMHS was governed by Lothian Primary Care NHS Trust until 31 March 2004 and was the accountable body during the period of Master C's treatment in 2000-2001. NHS Lothian Health Board (the Board) was the accountable body thereafter who considered and responded to the complaints made by Mr and Mrs C, and subsequently to this office.[1]

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed in the care and treatment of Master C during the period 2000 – 2001 (*upheld*).

Redress and recommendations

The Ombudsman has considered all the information presented to this office, together with the action taken by the Board. It is clear the service failures identified in this report demonstrate systemic failures by the Board. It is evident that the service failures were as a result of poor policy and practice.

The Ombudsman is satisfied that the Board, as a consequence of this complaint, demonstrated by the evidence presented to this office detailing improvements to CAMHS since 2001, have undertaken action to remedy the service failures identified in order to improve current services.

[1] This report will refer to the Board throughout as the accountable body.

The Ombudsman recommends that the Board:	*Completion date*
(i) provides evidence that their patient discharge process for CAMHS is clear and robust and available to patients, parents and carers; and	24 November 2011
(ii) ensures their complaints policy reflects a clear process which outlines a structured, timely approach to gathering information from key personnel involved in the complaint.	24 November 2011

Main Investigation Report

Introduction

1. Master C was first referred by his GP (the GP) to Lothian Primary Care NHS Trust (the Trust)'s Child and Family Mental Health Service (CAMHS) on 26 October 2000. He attended two out of four scheduled meetings with one of the Trust's clinical psychologists (Consultant 1) between October 2000 and July 2001. Consultant 1's note of their second meeting recorded that Aspergers syndrome may be considered. In a letter dated 9 July 2001 Consultant 1 subsequently wrote to Master C's GP, copied to Mr and Mrs C, outlining the issues and concerns raised and discussed at the meetings with Master C and his family. Consultant 1 concluded that she did not feel that Master C would necessarily need referral to Psychology or Mental Health Services and that a referral would only be indicated if he was showing signs of depression. It is not apparent that Aspergers syndrome had been followed up or communicated to the family at this time. The letter ended that on this basis Master C's case would be closed.

2. Mr and Mrs C state that they had agreed to Master C being conditionally discharged from the service at this time, on the basis that should he have a relapse he could re-access the service. A subsequent enquiry by Lothian NHS Board (the Board) in 2008 found that Mr and Mrs C never received a copy of the discharge letter dated 9 July 2001. This led Mr and Mrs C to believe that Master C had not been formally discharged from CAMHS.

3. Following re-referral by the GP to CAMHS on 1 November 2001, Mr and Mrs C claim Master C was denied access to the service because the waiting list was closed from July 2001 to all but emergency referrals. Mr and Mrs C claim that their son was not a new referral when they tried to re-access the service in November 2001. They believe that Master C was not properly assessed by the Board and Consultant 1 either during his previous visits or at this point in time and that he should in any event have been considered an emergency referral, given his presenting behaviours and the increasing difficulties they were experiencing.

4. In their letter of complaint to the Board dated 24 October 2006, Mr and Mrs C stated that the lack of effective communication by Consultant 1 during 2000 and 2001 and the failure to make a definitive diagnosis with future provision for their son, may have contributed to his suicide on 11 January 2006.

5. The Board's final consideration of the complaints raised by Mr and Mrs C was completed in December 2010; some fours years after Mr and Mrs C's concerns were first raised. On receipt of Mr and Mrs C's complaint in October 2006 the Board carried out an initial investigation and requested a case management review into Master C's care. The Board wrote to Mr and Mrs C on receipt of the report in August 2007, provided a response and a copy of the report. Thereafter the Board commissioned an independent review about the clinical decision making in 2001. It was some two years after first making their complaints that the Board traced and interviewed Consultant 1 and that Mr and Mrs C received a response about the issues they raised regarding the care and treatment provided to Master C by Consultant 1.

6. The complaint from Mr and Mrs C which I have investigated is that the Board failed in the care and treatment of Master C during the period 2000–2001.

Investigation

7. Investigation of this complaint involved reviewing the Board's medical records, complaints information and correspondence, together with information provided by Mr and Mrs C. My complaints reviewer also obtained advice from a professional medical adviser (Adviser 2).

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. Mr and Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed in the care and treatment of Master C during the period 2000-2001

9. Mr and Mrs C complained to the Board following the death of their son on 11 January 2006 about the level of care provided to Master C during his involvement with CAMHS between October 2000 and November 2001. Mr and Mrs C believed that following Master C's discharge in July 2001 that they had been left without adequate support services following the closure of the CAMHS patient list to anything other than emergency cases. Mr and Mrs C claim that they had not previously been informed that Master C had been discharged from the service.

10. Following a meeting between Mr and Mrs C and Consultant 1 on the 4 July 2001, a record completed on 5 July by Consultant 1 details matters discussed at the meeting and notes an action at the end 'Discharge'. There is no evidence to suggest this action or information was communicated to Mr and Mrs C at this time.

11. On 5 September 2001 the Board informed all GP practices that they had imposed a Temporary Restriction of Access to the Child and Adolescent Mental Health Service. The letter stated that patients already on the waiting list would be seen, but that no new referrals would be accepted.

12. The Board advised GP practices that, where emergencies arose, the criteria for children and young people to be considered, and seen, were:

- children and adolescents with severe depression;
- children and adolescents at risk from serious harm;
- children and adolescents with possible psychosis;
- children and adolescents where severe trauma / abuse has resulted in major disturbance; and
- children and adolescents with life threatening loss of weight.

13. Mr and Mrs C made several attempts (approximately 14) to contact Consultant 1 during this time, requesting access to CAMHS on behalf of Master C. Ongoing concerns about his behaviour at home and at school, which at times resulted in violent outbursts and rage, heightened their concerns about their son's mental health and wellbeing. Master C was also becoming increasingly withdrawn and agitated.

14. Consultant 1 wrote to Master C's GP on 25 October 2001 advising that she had been contacted by Mrs C regarding Master C's intermittent refusal to attend school, and frequent emotional outbursts, resulting in aggressive behaviour. Consultant 1 advised the GP that she had confirmed to Mrs C the case was closed to CAMHS and that she had encouraged her to liaise with the school's Educational Psychologist (the Educational Psychologist). Consultant 1 advised the GP that he may wish to refer Master C back to the service when the waiting lists re-opened.

15. It is clear from the correspondence on file that Mr and Mrs C collectively left several messages for Consultant 1 from 23 October onwards, including one on 25 October that suggested looking again at the option to refer to a specialist school, and three telephone messages on 29 October 2001. The first telephone call note on 29 October from Mrs C requested an urgent referral to the specialist day centre for Master C due to his persistent non attendance at school.

16. The record of the second call from Mr C noted:

> 'Please call, Mum and Dad quite desperate now …'

17. A record of the third call on 29 October noted that Mr C asked if the referral to the specialist school had been actioned. It recorded Mr C advising that:

> 'He is having his worst crisis yet and they need him to be seen. Dad said they were not informed that his case was being closed.'

18. Consultant 1 recorded that on 31 October 2001 she discussed the messages and Master C's case with the Locum Consultant Psychiatrist (Consultant 2). Following this discussion Consultant 1 contacted Mrs C by telephone on the same day and left a message that the case was closed and involvement by the specialist day centre may be requested via a written referral from Master C's GP. Consultant 1 followed these calls with a letter to Mr and Mrs C on 1 November 2001, and in that response re-stated that the CAMHS list was closed and in order for Master C to be re-referred he would need to meet the emergency criteria. In her letter dated 1 November 2001, Consultant 1 expressed surprise that Mrs C had not been aware of the case closure. It was also her understanding that Master C's discharge from CAMHS had been discussed at the 4 July meeting. Consultant 1 concluded that Master C's GP would need to re-refer him in order for his case to be considered.

19. Master C's GP wrote to Consultant 1 on 1 November 2001. The GP referred to discussions during a telephone call from the school that had highlighted Master C's behavioural issues and a call from Mr C requesting that his case be re-opened as his violent outbursts and behaviour had become a concern and the family were becoming desperate. Consultant 2 responded to the GP on 14 November advising that Master C's case had been considered at an allocation meeting on 7 November 2001 and, following discussion, it was felt that it did not meet the criteria for an emergency referral. Consultant 2 advised that, in the interim, staff at Master C's school, together with [the] Educational

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20. Following the death of Master C in January 2006, and their subsequent complaint to the Board in October 2006, Mr and Mrs C were in correspondence with the Board over the following five year period.

21. The Board's Associate Medical Director (Doctor 1) initially considered the complaint on receipt in October 2006 and advised Mr and Mrs C that as he had prior involvement in the decision to close the patient list in September 2001; it would be appropriate for a clinician outwith the (local) services to review Master C's case.

22. An interim report detailing the facts of the case and a conclusion into the case management was then produced by Acting Clinical Director and Consultant Psychiatrist (Doctor 2) in recognition of the complaints raised by Mr and Mrs C. Doctor 2 provided a copy of his report to Mr and Mrs C on 16 August 2007.

23. This report noted from the records that Master C had become increasingly distant from his parents. It said:

> 'A few months after starting school, he lost interest in his usual activities, appeared anxious, was losing weight and spoke of killing himself by jumping from a window.'

24. The report also identified a record of a meeting held on the 4 December 2001 at Master C's school between Consultant 2, a psychologist, a third person identified only by initials, and Master C's teacher. The meeting note provided by Master C's school, notes their collective frustration that the waiting lists were closed and that they planned to move Master C to the top of the list when the list re-opened. The note also suggested that Consultant 2 wanted to exclude Aspergers syndrome or some other condition. It is unclear from the correspondence on file that this suggestion was followed up or acted upon.

25. The report acknowledged that the Board had been unable to discuss Master C's case with Consultant 1, as she had left the Board in 2002, and noted

that whilst Master C's case was dealt with according to the guidelines at that time, the nature and style of communication between CAMHS and the family was unacceptable. The Board apologised to Mr and Mrs C for the standard of communication, and confirmed that, despite their best efforts, they had been unable to locate or contact Consultant 1. Doctor 2 concluded that it was possible, with hindsight, that Master C had been thinking of suicide prior to his death but there was no evidence that his death could or should have been predicted. Doctor 2's report made recommendations that a further review be undertaken to review the clinical decision making in 2001.

26. The Board then commissioned an independent report from a consultant in Child and Adolescent Psychiatry (Consultant 3) to review the issues identified in Doctor 2's report. A copy of this report was provided to Mr and Mrs C in April 2008.

27. This report identified failings in record-keeping and communication with the family. Consultant 3 noted that the letter detailing Master C's discharge from CAMHS, dated 9 July to Master C's GP had not been sent to Mr and Mrs C, but as a result of clerical error, two copies had been sent to the GP. She also noted that there was no record of Mr and Mrs C's agreement with the discharge of Master C from CAMHS during the meeting on 4 July 2001.

28. Consultant 3 highlighted the poor quality of records and meeting notes during Master C's time as a patient with the service. She noted that there was a lack of information recorded regarding Master C's refusal to attend CAMHS following his two individual appointments. She concluded that no information about diagnosis had been recorded by Consultant 1 at the time. Consultant 3 reported that based on her own knowledge of Scottish CAMHS at that time, Consultant 1's style and method of communication was consistent with other clinical psychologists. Consultant 3 also reported inconsistencies between meeting records from the school and the Board.

29. Consultant 3 recorded that the re-referral to CAMHS in November 2001 contained insufficient information despite Consultant 1's attempt to augment the information by phoning Master C's GP and the Educational Psychologist. She noted that brief hand written notes about referral to the weekly allocation meeting were contained within the records; however no minute of the allocation meeting existed. The letter of response provided to the GP on

14 November 2001 explained the reasons for rejection of Master C's case and the list closure. Consultant 3 recorded:

> 'it is noteworthy that this is the first correspondence to the GP throughout the case file where the letter was not copied to [Mr and Mrs C].'

30. Consultant 3 noted that the time of re-referral coincided with a period of difficulty within CAMHS, which included issues around resourcing and closure of patient lists across the country. Consultant 1 had spoken with the GP but it appeared that no additional information was available, and as such she concluded that the decision not to accept Master C as an emergency referral was made in good faith and appropriate at that time. Consultant 3 concluded that, had more detailed information been available at that time then the result of the referral may have been different.

31. Consultant 3 also noted that Mr C had expressed concern that Master C's difficulties had not been diagnosed. Mr and Mrs C had been informed by Consultant 1 that Master C showed features of adjustment reaction but this was not stated in writing in correspondence with the GP or on the medical records, and no formal diagnosis was made. Consultant 3 concluded her review of Master C's case file, and through discussions with senior CAMHS staff in April 2008, confirmed that records were taken appropriately by Consultant 1 and that her practice of not recording a diagnosis was in line with normal practice for clinical psychologists working within CAMHS at the time.

32. Consultant 3 was of the view that it would subsequently be difficult, in the absence of direct evidence from clinicians involved in Master C's care, to make a definitive diagnosis almost seven years after Master C's initial contact with CAMHS. Consultant 3 concluded the point by noting the information provided by the GP in the second referral of Master C was 'similarly insufficient to make a full and accurate diagnosis'.

33. Consultant 3 noted that as a result of the Board's inability to trace Consultant 1, she was unable to discuss Mr and Mrs C's concerns with Consultant 1 as part of her investigation.

34. Consultant 3 concluded that:

> 'CAMHS clinicians acted in good faith and in line with normal practice during a period of extreme shortfall of resources. The information provided to the CAMHS Clinicians by the parents and by the GP led to his

discharge in July 2001 and the non acceptance of his re-referral in November 2001.

Re-referral to CAMHS in November 2001 contained insufficient information despite [Consultant 1's] attempt to augment the information by phoning [Master C's GP] and [Educational Psychologist].'

35. Mr and Mrs C remained dissatisfied and had a number of outstanding concerns following receipt of the report. Their concerns were primarily regarding the care, treatment and practice provided by Consultant 1.

36. Following continuing discussions between Mr and Mrs C and the Board, attempts to trace Consultant 1 were successful. In September 2008 Consultant 3 had two telephone interviews with Consultant 1 where the complaints and concerns raised by Mr and Mrs C in 2006 were discussed.

37. Consultant 3 asked for specific responses regarding the issues of record-keeping and referral to the specialist day school. Consultant 1 was of the view that it was normal practice at that time to hand-write notes as there was no administrative support to provide typed notes. In reviewing the notes she commented that she had recorded a developmental history and in regards to the reference to Aspergers:

'[This] may have meant that a fuller assessment, possibly at [the specialist school] would have been helpful. This was not pursued as [Master C] failed to engage.'

38. Consultant 1 advised that it was normal practice at that time to record thoughts about possible formulations as a hypothesis. She commented on the lack of diagnosis by stating that at that time the British Psychological Society had advised that it was not the psychologist's role to make a diagnosis and that formulation of behavioural difficulties was the preferred option. Consultant 1 continued that whilst she may have discussed adjustment disorder in a general sense, it would not have been her practice to make a formal diagnosis.

39. With regards to the referral meeting where Master C's case had been discussed and rejected, Consultant 1 advised she was not in attendance, and that during that time all referrals were discussed with CAMHS senior clinicians, which included psychiatrists and heads of disciplines. She stated there were strict referral criteria in place because of the closure of the waiting list.

Consultant 1 also advised that the letter written following the allocation meeting was routinely written by the consultant, no minute was taken at the meeting and again that this was normal practice.

40. Consultant 3 acknowledged Consultant 1's helpful and co-operative approach, and stated she had answered all her questions fully. She noted that:

> 'Consultant 1 has expressed 'profound regret about the outcome but stated that on perusing the case files there was no way that this event could have been predicted.'

41. Consultant 3 concluded that following a full and frank discussion with Consultant 1 she was of the view that her involvement in Master C's care was appropriate and in line with practice at that time. The additional report dated 2 October 2008 was issued to Mr and Mrs C.

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42. Mr and Mrs C remained dissatisfied and complained to my office on 15 October 2008 about the care and treatment provided to Master C by the Board.

43. They specifically requested that my complaints reviewer:

> undertake a full review of the facts and formal judgement made of the clinical practice, communication and professional responsibility of the treatment and management of their son who was rejected by the CAMHS service in 2001, and who went on to commit suicide in January 2006.

44. Mr and Mrs C also requested that a professional opinion from the Ombudsman service be provided, on how safe it was to close a medical referral list for vulnerable children with mental health problems.

45. Following initial consideration of the issues and complaints raised by Mr and Mrs C, my complaints reviewer requested an assessment of the complaint case papers and medical notes from a specialist adviser in adult psychiatry (Adviser 1) in November 2008. Adviser 1 noted that the service provided by the Board from first referral of Master C by his GP in 2000 through to discharge from the service in 2001 was '… reasonable although it was also thoroughly unsatisfactory.' Adviser 1 noted that the practice of closing waiting lists was not uncommon at this time and he was aware of other instances of this practice.

46. Adviser 1 stated that in the circumstances and based on the information he had reviewed, it would not be possible to link the events of 2000-2001 and Master C's death in 2006.

47. Following a series of discussions and meetings with and between my complaints reviewer, the Board and Mr and Mrs C, the Board agreed to consider and address the remaining outstanding concerns. My office closed the complaint in January 2009 on this basis.

48. Correspondence continued between my complaints reviewer, Mrs C and the Board in the subsequent period. Following a meeting between Mr and Mrs C and the Board on 15 December 2008, Consultant 3 issued a third report on 11 February 2009 in which she acknowledged the disappointment felt by Mr and Mrs C regarding the CAMHS input into Master C's care and that they were unclear about the diagnosis and discharge process relating to Master C. The decision to discharge Master C was revisited in this report. Consultant 3 recorded that Consultant 1 confirmed (and she had previously advised Mr and Mrs C) that:

> 'a child would not be discharged without the consent of the family, ie consensual discharge. It was [Mr and Mrs C]'s view that discharge was not consensual but that they reluctantly agreed to it on the basis that [Consultant 1] advised that [Master C] could be re-referred / seen again should he have further/additional problems.'

49. Consultant 3 noted the Board had recognised Consultant 1's commitment to accept Master C again into the service prior to the closure of the waiting list, however, she acknowledged that there were events following the closure of the waiting list that had the potential to affect Consultant 1's ability to facilitate this.

50. Consultant 3 continued that the closure of the waiting list in 2001:

> 'proved an insurmountable barrier to [Master C]'s re-referral to CAMHS … despite [Mr and Mrs C]'s attempts to provide further information to CAMHS workers … there is no evidence in the CAMHS case file that [Mr and Mrs C]'s concerns were heard by CAMHS staff. [Mr and Mrs C] were left with the view that [Master C] would have no further access to CAMHS and no further attempts were made by them to have [Master C] re-referred to the service prior to his tragic death despite their ongoing concerns for his mental health.'

51. In conclusion Consultant 3 commended Mr and Mrs C for their strength and endurance during a very difficult time.

52. The Board reconsidered further aspects of Mr and Mrs C's complaint, provided a further response and on 23 June 2009 confirmed their complaints process had been exhausted.

53. Mr and Mrs C remained dissatisfied and my complaints reviewer agreed to re-open the case and consider the complaints which they presented on 4 August 2009. Two main areas of complaint were reviewed which centred on the provision and access to services from 2000 to 2006 and the present CAMHS provision.

54. Following a number of enquiries made to the Board and further meetings with Mr and Mrs C, my complaints reviewer determined the complaint on 30 October 2009. Mr and Mrs C were then advised that no further action could be taken by this office and concluded that the investigation into the complaints could not determine a causal link between the decisions taken by the Board to close the list in 2001 and Master C's subsequent suicide in 2006.

New Evidence and Investigation

55. On 18 February 2011, I decided to re-open consideration of Mr and Mrs C's complaint about the Board on the basis of their challenge to decisions previously taken. Mr and Mrs C presented new and material evidence and I took the decision to re-open their complaint.

56. I have taken into account, as part of my consideration of Mr and Mrs C's complaint, a letter received by them from a representative of the Board dated the 9 August 2010. In this letter the Board's representative acknowledged that:

> 'The closure of the waiting list was wrong, and I'm relieved to understand that that practice has been banned and will never occur again. I also believe that the service understands the importance of agreeing a working diagnosis and communicating that clearly to the patient, their GP and to the parents and carers of that patient with their consent … there has been a failure of understanding between the service and yourselves about [Master C]'s diagnosis, prognosis and treatment plan.'

57. The representative apologised on behalf of the Board for the failures and advised that the service had taken steps to ensure that the risk of a similar incident occurring again had been minimised.

58. At a meeting in my office on 18 February 2011 with Mr and Mrs C, they re-stated that the administration of the Board's emergency referral system to CAMHS was incorrectly applied and their understanding was that Master C was not a new referral. They believed that as Master C had been a patient of CAMHS previously, he would be considered as an existing case and up to three approaches could be made to access the service at that time. It remains their belief that he should have been considered as an emergency referral not a new referral.

59. Mr and Mrs C restated their belief that their son was depressed and this had not been recognised by Consultant 1 as part of his referral and subsequent consultations in 2000-2001. They recalled that during what was to be their last meeting with Consultant 1 on 4 July 2001, she advised that Master C was not depressed but had an 'adjustment reaction'. Consultant 1 advised that a referral would be indicated if he 'was showing signs of depression'.

60. On the basis of my discussions with Mr and Mrs C, and as a result of the new evidence presented to this office, I requested further specialist advice from a Consultant Child and Adolescent Psychiatrist (Adviser 2). I specifically requested that Adviser 2 consider the new information provided and asked if the advice this office received in November 2008 from Adviser 1 was appropriate and relevant to the provision of child psychiatric services, based on the complaints and information presented to my office.

61. The advice I received from Adviser 2 on 23 March 2011 concluded that not only was the overall service provided at the time unreasonable, but it was also extremely unsafe.

62. Adviser 2 continued that the behaviours identified in the Board's interim report of August 2007 showed a clear description of a boy who was clinically depressed with the move to secondary school attributed as the triggering factor. At the time of the GP referral to CAMHS in October 2000, Mr C's main concern was that his son had threatened suicide.

63. Adviser 2 concluded her point by stating:

'I consider that there is a link between the service provided in 2000-2001 and [Master C] taking his own life in 2006'.

64. Adviser 2 noted that the response provided by the Board's representative was comprehensive. In addition she acknowledged that the practice of clinical psychologists at the time was not to make formal diagnoses. It was Adviser 2's view that Consultant 1 had worked with a behavioural formulation of the difficulties Master C posed. She was critical that there had been no consideration of the gravity of the emotional and behavioural difficulties presented by Master C, which in her view amounted to clinical depression. Adviser 2 stated that a member of the medical team should have been directly involved in Master C's care, and had that happened the likelihood of a diagnosis being made and conveyed to the GP would have increased.

65. Adviser 2 concluded that:

'The provision and practice of the emergency referral service came across as inadequate, unsafe and thoroughly unsatisfactory.'

The Board's response 2011

66. I met with the Board's representative on 31 March 2011 to discuss the specifics of the case and the new information presented by Mr and Mrs C. During my discussions I specifically asked to be provided with further information and details around the improvements, if any, that had been made to CAMHS within the Board to date.

67. The response I received on 26 April 2011 from the Board has confirmed that CAMHS has undergone a significant change since 2001 and indeed since the death of Master C in 2006. The Board confirmed a number of key points relating to the service provided by CAMHS now and in comparison to the service provided ten years ago.

68. In regards to Master C's care and treatment and the Board's investigations into Mr and Mrs C's complaints, the Board's letter noted that the decision to discharge Master C was 'consensual' and that this was recorded in the discharge letter of 9 July 2001. The Board confirmed that it was Consultant 1's belief that this had been copied to Mr and Mrs C and reaffirmed in her letter of 1 November 2001 to Mr and Mrs C. It was noted by Consultant 3 in her report of April 2008 that due to a clerical error, Mr and Mrs C did not receive a copy of the 9 July letter, and instead two copies had been forwarded to the GP in error.

The letter of 1 November 2001 from Consultant 1 noted surprise that Mr and Mrs C had not been aware of Master C's discharge from the clinic and that a request for re-referral needed to be made through Master C's GP.

69. The Board concluded that in relation to Master C's care it was clear the interaction between CAMHS and the school demonstrated that there was ongoing discussion and review of Master C's case from a psychiatric perspective. The Board concluded that Consultant 3's report was that '[Master C]'s care was appropriate and in line with usual practice at the time'.

70. The Board also confirmed in their letter of response on 28 April 2011, that the criteria for an emergency referral in 2001 were the same as they are now:

- evidence of mental health problems;
- risk assessment – risk of self harm / life threatening behaviour;
- symptom severity; and
- degree of psychosocial impairment.

71. The Board went on to say that information provided shows that access to services has been delivering a local maximum waiting time of 18 weeks from referral to assessment. The interaction between medical professionals and GPs is cohesive and patient centred, and that criteria and guidelines for referral into the service are available to referrers electronically and over the telephone. This service is now monitored daily. In line with a Scottish Government Delivering for Mental Health initiative, a named linked worker is also in place for schools in the Lothian area.

Conclusion

72. I have taken account of all the information presented to this office, together with the action taken by the Board. I am clear that the delays experienced by Mr and Mrs C in receiving an adequate and timeous response to the complaints, and the service failures identified in this report demonstrate systemic failure by the Board. It is evident that service failure was as a result of poor policy and practice. That it took almost two years to trace the whereabouts of Consultant 1, a clinician central to the care and treatment of Master C and to the complaints raised by Mr and Mrs C is at least disappointing. It is my view that it was incumbent on the Board to undertake a robust review and subsequent investigation into Mr and Mrs C's complaints professionally and timeously.

73. The Board commissioned three reviews by an independent clinical consultant in adult and child psychiatry in an attempt to address the complaints and ongoing concerns of Mr and Mrs C. It is evident that the reports produced identified a number of failures relating to the care and management of Master C. These related to record-keeping, communication, a lack of cohesive working, insufficient information communicated to relevant parties relating to Master C's referral and a failure to make a definitive diagnosis of Master C. Fundamentally the report acknowledged that these failures were accepted practice during the time of Master C's involvement with CAMHS and the Board.

74. Responses provided by the Board attempted to address and acknowledge the failures relating to the treatment and medical care provided to Master C. During my consideration of this complaint it is apparent that two opportunities were missed by the clinicians involved in Master C's care to pursue their suspicion of Aspergers syndrome. That combined with the inadequate communication and record-keeping identified by Consultant 3 and the failings identified in the report commissioned by my office from Adviser 2, despite being consistent with practice at that time, leave no doubt that the Board failed in its care and treatment of Master C. In considering this case and all the relevant information presented to this office, I am minded to accept the advice I received from Adviser 2 on 23 March 2011. I uphold the complaint that the Board failed in the care and treatment of Master C during the period 2000 – 2001.

75. Whilst these concerns have now been addressed, and the Board's representative has acknowledged the closure of the waiting list was wrong, has been banned, and will never occur again, this admission is much too late in the day for Master C and his family. I anticipate that Mr and Mrs C will continue to seek answers to the failures identified in this report, but given the passage of time it is doubtful these questions will ever be fully answered. I commend Mr and Mrs C for their perseverance.

76. Notwithstanding the systemic failures, I am satisfied that the Board has sought to learn lessons from this case, specifically and generally to improve the service from CAMHS.

Recommendations

77. I recommend that the Board:	*Completion date*
(i) provides evidence that its patient discharge process for CAMHS is clear and robust and available to patients, parents and carers; and	24 November 2011
(ii) ensures its complaints policy reflects a clear, timeous process which outlines a structured, timely approach to gathering information from key personnel involved in the complaint.	24 November 2011

78. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Master C	Mr and Mrs C's son
The GP	Master C's GP
The Trust	Lothian Primary Care NHS Trust
CAMHS	The Board's Child and Family Mental Health Services
Consultant 1	The Board's Clinical Psychologist responsible for Master C's care
Mr and Mrs C	The complainants
The Board	Lothian NHS Board
Adviser 2	A consultant child and adolescent psychiatrist
The Educational Psychologist	Master C's School Educational Psychologist
Consultant 2	The Board's locum consultant psychiatrist
Doctor 1	The Board's Associate Medical Director
Doctor 2	The Board's Acting Clinical Director and consultant psychiatrist
Consultant 3	A consultant in child and adolescent psychiatry

Adviser 1	A specialist adviser in adult psychiatry
Adviser 2	a consultant child and adolescent psychiatrist

Annex 2

Glossary of terms

Asperger syndrome	Asperger's syndrome is a developmental disorder that affects a person's ability to socialize and communicate effectively with others