Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201917139

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201917139

Listed Authority: Western Health & Social Care Trust

SUMMARY

This complaint is about care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant between August 2017 and April 2019. The Trust diagnosed the patient with emotionally unstable personality disorder[1] (EUPD) in 2017. However, the complainant believed she also suffered from post-traumatic stress disorder (PTSD) following a personal trauma she experienced in August 2017. The complainant raised concerns about the time the Trust took to undertake a PTSD assessment. She raised further concerns that the Trust diagnosed her with PTSD but later removed the diagnosis. She also said the Trust withdrew her lamotrigine[2] prescription without prescribing an alternative medication. Furthermore, the complainant was concerned staff did not notify her of its decision to discharge her from the Primary Care Liaison Service[3] (the Service) in April 2019.

The investigation examined the details of the complaint, the Trust's response, clinical records, and relevant guidance. I also sought advice from an independent Consultant Psychiatrist and a Consultant Clinical Psychologist. The investigation found the Trust referred the complainant for the assessment within an appropriate timescale. It identified the Trust took longer than usual to undertake the assessment. However, it found the delay reasonable, as it occurred due to staff shortages and the complainant's request not to attend the only available Psychiatrist at that time.

The investigation established that staff diagnosed the complainant with PTSD in December 2018. However, it removed the diagnosis following a Consultant Psychiatrist's reassessment of the complainant in April 2019. The investigation considered this appropriate. It also found the decision not to prescribe the complainant medication following the withdrawal of lamotrigine was made in accordance with relevant guidance. The investigation could not definitively conclude

[1] EUPD describes symptoms experienced if a person is emotionally unstable, anxiety-ridden and has a pattern of self-destructive behaviour

[2] An anticonvulsant medication used to treat epilepsy and to delay or prevent the recurrence of depressive episodes in bipolar disorder.

[3] The Service acts as a single point of contact from all referrals from primary care and general hospitals including emergency and out of hours referrals.

whether or not Trust staff informed the complainant of its decision to discharge her from the Service.

The complainant also raised concerns about how the Trust handled her complaint. I found the Trust's investigation process experienced unnecessary delays. I partly upheld this issue, finding it led the complainant to experience frustration, uncertainty, and caused her the time and trouble of bringing her complaint to my office. I recommended the Trust apologise to the complainant. I also recommended action for it to take to prevent the failure recurring. The Trust accepted my findings and recommendations.

THE COMPLAINT

1. This complaint is about the actions of the Western Health and Social Care Trust (the Trust). The complainant raised concerns about care and treatment she received from the Adult Mental Health Service (AMHS) within the Trust. She also raised concerns about how the Trust handled her complaint.

Background

2. The complainant said she attended her General Practitioner (GP) in August 2017 after experiencing a personal trauma. The GP referred the complainant to the Trust's acute mental health inpatient unit. Staff in the unit diagnosed her with emotionally unstable personality disorder[4] (EUPD) and prescribed quetiapine[5]. However, Staff Grade Psychiatrist[6] (A) discontinued quetiapine in December 2017. The complainant later informed the Trust she did not wish Staff Grade Psychiatrist (A) to be involved in her ongoing care.

3. A Cognitive Behavioural Therapist[7] assessed the complainant in April 2018. She asked the Primary Care Liaison Service[8] (the Service) to review the complainant's medication. This review occurred in June 2018. The Service prescribed lamotrigine[9] and sertraline[10] for the complainant, and scheduled a review appointment for September 2018.

4. The complainant attended the Adult Psychology Therapy Service[11] (the Psychology Service) from 30 April 2018. In August 2018, the complainant asked her Psychologist to refer her to a doctor for a Post-Traumatic Stress Disorder (PTSD) assessment. The Psychologist asked the Service to consider the complainant's concerns during her review appointment in September 2018. However, the Service cancelled the assessment and rescheduled it for October

[4] EUPD describes symptoms experienced if a person is emotionally unstable, anxiety-ridden and has a pattern of self-destructive behaviour

[5] An atypical antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder.

[6] A doctor specialising in the field of psychiatry below a Consultant grade.

[7] CBT focuses on challenging and changing cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems.

[8] The Service acts as a single point of contact from all referrals from primary care and general hospitals including emergency and out of hours referrals.

[9] An anticonvulsant medication used to treat epilepsy and to delay or prevent the recurrence of depressive episodes in bipolar disorder.

[10] Sertraline is used to treat depression, panic attacks, and anxiety disorders.

[11] APTS focuses on the areas of mental and emotional disorders, and talking therapies.

2018. The Service also cancelled this appointment. Staff Grade Psychiatrist (B) undertook the review in December 2018 and diagnosed the complainant with adjustment disorder[12], PTSD, and EUPD. However, the Psychology Service disagreed with the PTSD diagnosis. Therefore, the Psychiatrist referred the complainant for a Consultant Psychiatrist assessment.

5. The complainant attended a Consultant Psychiatrist in April 2019 who disagreed with the PTSD diagnosis. She also discontinued the complainant's lamotrigine prescription and discharged her from the Service. The complainant continues to attend the Psychology Service.

6. The complainant raised concerns with the Trust in August 2019 about the treatment she received. The Trust provided its response to the complaint on 20 September 2019. The complainant raised further concerns with the Trust in October 2019. The Trust provided its final response on 1 May 2020.

Issues of complaint

7. I accepted the following issues of complaint for investigation:

Issue 1: Whether the care and treatment the Trust provided to the complainant was appropriate, reasonable, and in accordance with relevant guidance.

Issue 2: Whether the Trust handled a complaint in accordance with the relevant policy and appropriate standards.

INVESTIGATION METHODOLOGY

8. The Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's handling of the complaint.

[12] An emotional or behavioural reaction to a stressful event or change in a person's life.

Independent Professional Advice Sought

9. After further consideration of the issues, I obtained independent professional advice from the following advisors:

    - A Consultant Psychiatrist, MBChB, FRCPsych; a registered medical practitioner with experience in General Adult Psychiatry (P IPA); and
    - A Chartered Consultant Clinical & Forensic Psychologist, Psychotherapist & Group Analyst, DClinPsy; MInstGA; MSc; MSc; BSc(Hons); RMN; PgDip; PgDip; AFBPsS; CPsychol; HCPC; with experience of working with patients diagnosed with personality disorders and PTSD (CP IPA).

    The clinical advice received is enclosed at Appendix three to this report.

10. The information and advice that informed the findings and conclusions are included within the body of this report and its appendices. The IPAs provided 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

11. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[13]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

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

[13] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The British Psychological Society's (BPS) Practice Guidelines (Third Edition), August 2017 (the BPS Guidelines);
- The National Institute for Health and Care Excellence's (NICE) Borderline personality disorder: recognition and management, Clinical Guideline 78, January 2009 (NICE CG78);
- The World Health Organisation's (WHO) International Classification for Diseases and Related Health Problems, 10th Revision, 2016 (WHO ICD-10);
- The Western Health and Social Care Trust's Policy for Management of Complaints, March 2015 (the Trust's Complaints Procedure); and
- The Department of Health's (DoH) Guidance in Relation to the Health and Social Care Complaints Procedure, revised April 2019 (DoH Complaints Procedure).

Relevant sections of the guidance considered are enclosed at Appendix four to this report.

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

14. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust provided to the complainant was appropriate, reasonable, and in accordance with relevant guidance.

Detail of Complaint

15. This issue of complaint is about the Trust's care and treatment of the complainant from August 2017 to April 2019. The complainant raised the following concerns:

- It took the Psychologist two months to refer her for a PTSD assessment;
- It took the Trust 16 months to undertake the assessment;
- The Service initially diagnosed her with PTSD. However, it later removed the diagnosis;
- The Service withdrew lamotrigine and failed to prescribe appropriate medication to treat what she considered to be PTSD. The complainant said her GP had to prescribe her medication as the Service failed to do so; and
- The Service failed to appropriately notify her of her discharge in April 2019.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following guidance:
    - The BPS Guidelines;
    - NICE CG78; and
    - WHO ICD-10.

    Relevant extracts of the guidance referred to are enclosed at Appendix four to this report.

The Trust's response to investigation enquiries

Referral for a PTSD assessment

17. The Trust said the complainant did not request a PTSD assessment until 13 August 2018. It explained that at this session, the complainant asked the Psychologist '*how she could access an assessment for this diagnosis*'. The Trust said the Psychologist told the complainant she would discuss her query with a colleague during her upcoming supervision session on 15 August 2018.

18. The Trust explained the Psychologist discussed the outcome of the supervision session with the complainant on 20 August 2018. She informed the complainant that '*it was not felt that she suffered from PTSD*'. The Trust said the complainant '*insisted on a formal assessment*'. The Psychologist then

agreed to discuss it with the Service prior to the complainant's medical review appointment in September 2018.

Delay in undertaking the assessment

19. The Trust said it cancelled the review scheduled for September 2018. It also cancelled the rescheduled appointment in October 2018. It explained the delay occurred as the Locum Consultant left the service and the '*full-time consultant…was on maternity leave*'. The Trust said Staff Grade Psychiatrist (A) '*remained in the team as Acting Consultant Psychiatrist but [the complainant] did not wish to see her*'.

20. The Trust explained it rearranged the appointment for December 2018 when another Psychiatrist (Staff Grade Psychiatrist (B)) joined the service. It further explained it '*was always the intention that [the Service] would offer [the complainant] a medical review when appropriate medical staff were available, due to [the complainant] not wishing to be seen by [Staff Grade Psychiatrist (A) / Acting Consultant]*'.

21. The Trust explained it did not initially refer the complainant to the Service for a PTSD assessment. It said it referred the complainant for a medical review. The Trust said the complainant's Psychologist requested a PTSD assessment for her following their appointment on 20 August 2018. It explained it agreed to undertake the assessment '*as part of her upcoming medical review appointment*'.

22. The Trust referred to the complainant's follow up assessment in April 2019. It said the complainant previously expressed she did not wish to attend Staff Grade Psychiatrist (A). Therefore, the Trust added the complainant to the Consultant Psychiatrist's waiting list when she [the Consultant] returned from maternity leave at the end of January 2019.

23. The Trust explained that waiting times for outpatient appointments '*vary depending on various factors'.* This includes *'medical cover availability and complainant choice, if an issue about seeing the medical staff that are available has been highlighted'.*

PTSD diagnosis and onward referral

24. The Trust said the Consultant Psychiatrist (who the complainant attended in April 2019) '*did not think there was sufficient evidence to make an ICD 10 diagnosis of PTSD*'. It explained the Consultant discharged the complainant from the service and referred her back to the Psychology Service. The Trust said mental health professionals assessed the complainant. However, the complainant '*disagrees with their conclusions regarding her diagnosis'*.

Medication

25. The Trust explained the complainant informed the Consultant Psychiatrist in April 2019 that lamotrigine '*was of no real benefit but has caused her side effects'*. It said the Psychiatrist asked the complainant's GP to withdraw the medication. The Trust referred to NICE CG78, which outlines treatment for EUPD, and explained the Psychiatrist did not prescribe the complainant alternative medication based on the guidance.

26. In relation to the complainant's concern that the service did not prescribe her appropriate medication, the Trust said it was the complainant's '*opinion*' and she is '*currently undergoing therapy with the [the Psychology Service]*'.

Discharge from the Service

27. The Trust explained the Consultant Psychiatrist discharged the complainant from the Service on 2 April 2019 as she did not require further input. It provided contemporaneous notes the Consultant took during the complainant's appointment. It said that under '*Plan*', the notes document '*DC [discharge]*'.

Relevant Trust records

28. A summary of the Trust's records relevant to this investigation is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

Referral for a PTSD assessment - CP IPA

29. The CP IPA advised the complainant first raised concerns she may be suffering from PTSD during her session with the Psychologist on 13 August 2018. He advised '*there are no signs reported that [the complainant's] response is*

indicative of having PTSD in earlier sessions'. Therefore, he advised he did not consider the Psychologist ought to have referred the complainant for a PTSD assessment earlier than this date. The CP IPA advised the Psychologist informed the complainant she would need to consult with a senior colleague who had clinical experience in this area. He said it was '*entirely clinically appropriate*' for the Psychologist to do so.

30. The CP IPA advised that during their next session on 20 August 2018, the Psychologist told the complainant that '*the opinion is that she does not have PTSD*'. He further advised, '*my understanding of the records is that the complainant is requesting a specialist assessment at just over three months into her treatment'*.

31. The CP IPA advised he did not consider it took two months for the Psychology Service to request a PTSD assessment for the complainant. He advised that on 20 August 2018, the Psychologist referred to the complainant's review arranged for 12 September 2018, and asked the Service to undertake a PTSD assessment at that time. However, the Trust cancelled both that appointment and a subsequent appointment in October 2018. The CP IPA said he '*can see that it may have contributed to some frustration on the part of the complainant*'. However, he said it was '*out of the Psychologist's control*'. The CP IPA advised he considered the Psychologist's actions '*timely, appropriate and commensurate with relevant BPS guidance*'.

Delay in undertaking the assessment – P IPA

32. I referred the P IPA to the complainant's concern about delays in the process. The P IPA advised there is '*no national guidance for assessment times in psychiatric services*'. He further advised that many services '*set a target of 12 weeks' maximum wait for routine new appointments*'. However, this can be '*difficult to meet*' given the '*difficulties all services have experienced in the last few years*'.

33. The P IPA advised the Service cancelled the reviews scheduled for September and October 2018 '*due to a shortage of medical staff*'. He said it had one acting Consultant Psychiatrist at that time [Staff Grade Psychiatrist (A)], who the

complainant '*stated she did not want to see*'. The P IPA said '*such difficulties are common in practice*' due to a '*national shortage*' of Consultant Psychiatrists.

34. The P IPA advised the Trust reviewed the complainant in December 2018. He said it is '*important to note that during this time the complainant continued to receive some input from [the Psychology Service]*'. Therefore, the Trust did not leave the complainant '*without any treatment or review by the service as a whole*'. He advised the Trust's reasons for the delay were '*consistent with what is known nationally and are reasonable*'.

35. I referred the P IPA to the complainant's review appointment in April 2019, which occurred four months after her assessment in December 2018. He advised the complainant indicated she did not wish to see the acting Consultant Psychiatrist. Therefore, the Trust added her to the (substantive) Consultant Psychiatrist's routine waiting list following her return from maternity leave in late January 2019. The P IPA advised it was his opinion the Trust could not '*have done anything to prevent the wait for assessment*'. Therefore, he advised the Trust's approach was '*appropriate and reasonable*'.

36. The P IPA advised '*it is clear'* the process incurred delays *'which were doubtless frustrating for the complainant*'. However, he considered the Trust's reasons for the delays '*reasonable*'. He further advised he did not '*identify any clear detrimental impact on the complainant's overall mental health*'.

PTSD diagnosis and onward referral

37. I referred the P IPA to the complainant's assessment in December 2018. The P IPA advised the '*issue of diagnosis is uncertain*'. He said the diagnosis documented on the head of Staff Grade Psychiatrist (B)'s letter is EUPD. However, she listed two additional diagnoses in the section titled 'diagnosis' (adjustment disorder, EUPD and PTSD). The P IPA advised he reads this as a '*differential diagnosis*[14]'. He referred to the handwritten notes of the consultation, and said it documents '*?PTSD*'. He also advised Staff Grade

[14] A list of possible conditions that could be causing the symptoms. When making a diagnosis, a doctor may have a single theory as to the cause of a person's symptoms. They may then order tests to confirm their suspected diagnosis.

Psychiatrist (B)'s letter suggests that a more experienced clinician ought to review the proposed diagnosis.

38. The P IPA advised it is not unusual for this to occur when there is an '*overlap of symptoms between possible diagnoses*'. He further advised that in his opinion, the letter and notes of the consultation suggest that Staff Grade Psychiatrist (B) considered EUPD the '*preferred diagnosis*'. However, she also considered PTSD '*a possible issue*'. The P IPA advised the Trust's approach to the assessment was '*reasonable*'.

39. I asked the P IPA if in his professional opinion he agreed with the diagnoses outlined in Staff Grade Psychiatrist (B)'s letter. He advised that in his view, the complainant '*did not present with symptoms and clinical history that would strongly suggest PTSD*'. He further advised the complainant's symptoms were '*long standing features of the complainant's EUPD such as anxiety, obsessional thoughts and disturbed sleep'*. The P IPA said the complainant's presentation at her appointment in April 2019 was '*consistent with the existing diagnosis of EUPD enabling PTSD to be excluded as a possible diagnosis*'.

40. I asked the P IPA if the decision to refer the complainant to a Consultant Psychiatrist was reasonable and appropriate. He advised it was '*appropriate'* for the Trust *'to look for further assessment and clarification from a more senior and experienced clinician'*. He further advised this was '*routine practice'*.

41. I referred the P IPA to the outcome of the Consultant Psychiatrist's assessment in April 2019 and asked if he considered it appropriate. The P IPA said he considered the complainant's symptoms and known history. He advised the Consultant Psychiatrist's EUPD diagnosis with anxiety and obsessional symptoms and previous trauma was '*reasonable*'. He also advised the treatment plan the Consultant Psychiatrist provided was '*reasonable*'.

Medication

42. The P IPA advised a locum Consultant Psychiatrist prescribed lamotrigine for the complainant in June 2018. He also advised the (substantive) Consultant Psychiatrist withdrew this medication following her review in April 2019. The P

IPA said the records document the Consultant Psychiatrist did so '*because neither the complainant nor [the] doctor felt it was effective'*.

43. I asked the P IPA if the Consultant Psychiatrist ought to have prescribed an alternative medication. He advised doctors do not always prescribe alternative medication in this situation. The P IPA referred to NICE CG78 and advised the Consultant Psychiatrist's record of the consultation documents '*there was no clear indication for any additional medications given both the complainant's presenting symptoms and diagnostic formulation of EUPD, anxiety/obsessional symptoms and trauma'*.

44. The P IPA advised the complainant's prescription for sertraline continued. He said this was '*appropriate*'. The P IPA also advised the Consultant Psychiatrist arranged for the complainant to withdraw from lamotrigine gradually. He said this was '*consistent with routine practice*'. The P IPA advised the Trust's management of the complainant's medication was in accordance with NICE CG78, and was '*appropriate and reasonable'* given her clinical presentation.

45. I referred the P IPA to the complainant's GP records. I asked if the complainant's GP prescribed her alternative medication following the decision to withdraw lamotrigine. The P IPA advised the GP prescribed the complainant buspirone[15] in August 2019. He said this was more than four months after the Consultant Psychiatrist withdrew lamotrigine. He further advised he could not identify any medication the GP prescribed that is considered an alternative to lamotrigine.

Discharge from the Service

46. The P IPA advised the Consultant Psychiatrist discharged the complainant from the Service following her appointment in April 2019. He said the decision is *'clearly recorded in the contemporaneous record and the outpatient letter*'.

47. I asked the P IPA if the Consultant Psychiatrist informed the complainant of the decision to discharge. The P IPA acknowledged the Consultant Psychiatrist's and the complainant's differing recollections of this part of the consultation. He

[15] A medication primarily used to treat anxiety disorders, particularly generalized anxiety disorder.

advised the decision to discharge was part of the treatment plan, which '*appears to have been discussed with the complainant*'.

48. I asked the P IPA if the Trust notified the complainant in writing of her discharge. He advised that there was no evidence to suggest the Trust provided written confirmation to the complainant of her discharge. However, he said to do so is '*a little unusual*' if it was discussed during a consultation. The P IPA advised that '*verbal communication of the management plan was appropriate and reasonable*'.

49. The P IPA advised the decision to discharge the complainant was *'both appropriate and reasonable given the complainant's presentation as described'*. He also advised the Consultant Psychiatrist excluded the PTSD diagnosis. Therefore, there was no '*clear indication for referral to any other service other than [the Psychology Service] given the complainant's presentation at that time'.*

Other information considered

The complainant's GP records

50. The complainant's GP Practice provided records documenting the medication it prescribed to her following her appointment with the Service in April 2019. The records document it last prescribed lamotrigine for the complainant on 26 April 2019. The records also document the Practice continued the complainant's sertraline and amitriptyline[16] prescriptions. The Practice commenced a prescription for buspirone on 26 August 2019.

Analysis and Findings

Referral for a PTSD assessment

51. The complainant said the Psychologist took two months to refer her for a PTSD assessment. I note the complainant first raised concerns about PTSD to the Psychologist on 13 August 2018. I also note the Psychologist informed the complainant she would consult with her colleague who specialises in the condition.

[16] An antidepressant primarily used to treat major depressive disorders.

52. I note at their next session the Psychologist explained to the complainant her colleague did not consider she had PTSD. However, the complainant requested a formal assessment. I note from the records the Psychologist told the complainant she would ask the Service to undertake an assessment during her review appointment planned for September 2018, which she did. The BPS Guidelines state that in this situation, psychologists ought to '*refer to another professional with the appropriate skills and experience'*. I consider by referring the complainant, the Psychologist acted in accordance with the BPS Guidelines. I also consider the Psychologist acted on the complainant's request soon after she raised it in her session on 13 August 2018.

53. I note the complainant first queried a PTSD diagnosis three months after she started attending the Psychologist. I considered if the Psychologist ought to have referred the complainant before she raised it during her session in August 2018. I note the CP IPA's advice that the complainant's responses in earlier sessions were not *'indicative of having PTSD*'. I accept his advice. Therefore, I do not consider the Psychologist ought to have referred the patient for a PTSD diagnosis earlier.

54. I note the complainant's appointment with the Service, planned for September 2018, did not occur until early December 2018. I acknowledge therefore, that the Trust delayed the complainant's assessment for two months. However, I accept the CP IPA's advice that the delay was '*out of the Psychologist's control*'. Based on the evidence available to me, I do not consider it took the Psychologist two months to refer the complainant for a PTSD assessment.

55. I recognise the complainant was keen for staff to refer her for a PTSD assessment given the concerns she had at that time. I also recognise that any perceived delay would have caused her concern. However, I can only find evidence to suggest the Psychologist referred the complainant at the earliest opportunity. Therefore, I do not uphold this element of the complaint.

Delay in undertaking the assessment

56. The complainant said it took the Trust 16 months to undertake the assessment. I note the Trust explained it arranged to review the complainant's medication in

September 2018. I also note it did not initially intend to undertake a PTSD assessment during its review. As outlined previously, the Service only agreed to undertake the assessment at that time following the complainant's request to her Psychologist in August 2018.

57. I note the Service cancelled both this appointment and the one rescheduled for October 2018 due to staff shortages. I also note that once the Trust appointed a second Staff Grade Psychiatrist, the review (and PTSD assessment) took place in December 2018. I acknowledge the Trust delayed this review appointment for two months. However, I note staff shortages caused the delay. I also note the Trust could have arranged an earlier review. However, it only had one psychiatrist available at that time, and the complainant informed the Trust she did not wish her to be involved in her care.

58. I note that following the PTSD assessment in December 2018, the Service requested a second opinion from a Consultant Psychiatrist. However, the process experienced a further delay due to the staff shortages referred to previously. I note the Trust added the complainant to the Consultant Psychiatrist's routine waiting list when she returned from maternity leave in late January 2019. I also note the complainant attended for reassessment fewer than 12 weeks later, in early April 2019.

59. I acknowledge and understand the complainant's frustration with the delays in the process. However, I note the P IPA's advice that '*such difficulties are common in practice*' due to a '*national shortage*' of Consultant Psychiatrists. While this is doubtless frustrating for both the Trust and its patients, I accept the P IPA's advice that the Trust could not '*have done anything to prevent the wait for assessment'*. I also accept the P IPA's advice that he did not '*identify any clear detrimental impact on the complainant's overall mental health'*. Therefore, I do not uphold this element of the complaint.

PTSD diagnosis and onward referral

60. The complainant said the Trust diagnosed her with PTSD in December 2018. However, it removed the diagnosis in April 2019. I refer to Staff Grade Psychiatrist (B)'s notes of the assessment, and the letter she sent to the

complainant's GP in December 2018. I note the Psychiatrist's opinion that based on her assessment, the complainant '*met the criteria ICD 10 for PTSD*'. However, due to a difference of opinion with the Psychology Service, Staff Grade Psychiatrist (B) referred the complainant to the Consultant Psychiatrist for reassessment. I note the P IPA advised this situation is common where there is an '*overlap of symptoms between possible diagnoses'*. I accept his advice that the Trust's decision to obtain a Consultant Psychiatrist's opinion was '*reasonable*' and '*routine practice*'.

61. I note that following the second assessment, the Consultant Psychiatrist did not consider there was '*sufficient evidence to make an ICD-10 diagnosis of PTSD*'. I note the P IPA's advice that based on his own review of the records, he considered the complainant '*did not present with symptoms and clinical history that would strongly suggest PTSD'*. I accept the P IPA's advice that while it was correct to consider PTSD, the complainant's presentation in April 2019 was '*consistent with the existing diagnosis of EUPD'*.

62. I recognise that the removal of the diagnosis understandably caused the complainant frustration and uncertainty. However, I can find no evidence to suggest that in removing the diagnosis, staff acted unreasonably or inappropriately. Therefore, I consider the Trust's decision to remove the PTSD diagnosis appropriate. I do not uphold this element of the complaint.

Medication

63. The complainant said the Trust instructed her GP to withdraw lamotrigine. I refer to the Consultant Psychiatrist's notes of the assessment in April 2019. In relation to lamotrigine, the notes document, '*no real benefit, feels has had side effects'*. I note NICE CG78 states that before starting treatment for EUPD, doctors ought to review '*the effectiveness and tolerability of previous and current treatments'*. I consider the Consultant Psychiatrist followed this guidance and established the treatment was ineffective. It also states that doctors should discontinue ineffective treatment. Therefore, I consider in deciding to withdraw lamotrigine at that time, the Consultant Psychiatrist acted in accordance with NICE CG78.

64. The complainant also said the Trust failed to prescribe appropriate alternative medication to treat what she considered to be PTSD. I note the Consultant Psychiatrist reaffirmed the complainant's EUPD diagnosis and removed the PTSD diagnosis. In relation to the EUPD diagnosis, I again refer to NICE CG78. It states '*Drug treatment should not [my emphasis] be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder*'. I note the guidance also refers to medication for comorbid conditions[17]. However, I note the P IPA's advice that the complainant's records did not clearly indicate a need *'for any additional medication'* given the complainant's presentation and diagnosis.

65. The complainant explained her GP had to prescribe her alternative medication as the Trust failed to do so. The Practice records document the complainant's GP continued her prescription for sertraline and amitriptyline. I also note he prescribed buspirone for the complainant four months after the Consultant Psychiatrist withdrew lamotrigine. While these medications are commonly used for anxiety, I note the P IPA advised he could not identify any medications the GP prescribed that are '*considered an alternative to lamotrigine*'.

66. I acknowledge the Consultant Psychiatrist instructed the complainant's GP to withdraw lamotrigine, and did not recommend an alternative medication. I do not doubt this caused the complainant an element of uncertainty regarding her treatment. However, based on the evidence available to me and advice from the P IPA, I consider the Consultant Psychiatrist acted in accordance with NICE CG78. I do not uphold this element of the complaint.

Discharge from the service

67. The complainant said the Service did not inform her it discharged her in April 2019. I am aware that most, if not all, healthcare providers usually inform patients of their discharge during their face to face consultation, and only notify their GP (rather than the patient) in writing. I note the P IPA also advised that '*verbal communication of the management plan was appropriate and*

[17] The presence of one or more additional conditions often co-occurring with a primary condition.

reasonable'. Therefore, I consider it appropriate for the Service to inform the complainant of her discharge verbally.

68. I considered if the records contained sufficient evidence to suggest the Consultant Psychiatrist informed the complainant of her discharge. I note the P IPA's advice that the plan to discharge is clearly documented in the Consultant Psychiatrist's handwritten note of the assessment. While I am satisfied the note evidences the Psychiatrist's intention to discharge the complainant, I do not consider it sufficiently evidences that she communicated her decision to the complainant. Therefore, in the absence of this evidence, I am unable to conclude if the Consultant Psychiatrist informed the complainant of the decision to discharge her from the Service. I would ask the Trust to remind staff in similar situations to inform patients of the decision to discharge, and to clearly document in the record they did so.

Issue 2: Whether the Trust handled a complaint in accordance with the relevant policy and appropriate standards.

Detail of Complaint

69. The complainant raised concerns about the time the Trust took to respond to her complaint. She also said the Trust did not admit fault in its first letter of response. However, it made two admissions of fault in the second written response.

Evidence Considered

Legislation/Policies/Guidance

70. I considered the following policies and guidance:
    - The Trust's Complaints Procedure; and
    - DOH Complaints Procedure.

The Trust's response to investigation enquiries

Delay in response

71. The Trust explained it initially responded to the complainant's concerns on 20 September 2019. It said it received further correspondence from the complainant on 17 October 2019. The Trust explained it offered the

complainant dates for a meeting to discuss her complaint in February 2020. However, the complainant requested a written response before agreeing to a meeting. The Trust said it provided its response on 1 May 2020. It explained the complainant did not agree to meet with the Trust following her receipt of its response, and instead submitted her complaint to NIPSO.

Conflicting information in responses

72. The Trust explained the complainant asked two questions in her first written complaint it received in September 2019. It said she asked further questions in her second piece of correspondence it received in October 2019. The Trust explained that in its second written response, issued in May 2020, it apologised for '*a delay in responding and making an appointment with [the Consultant Psychiatrist*]'. It said its responses did not admit '*faults regarding diagnosis, treatment, or care*'.

Relevant Trust records

73. A summary of the relevant records relating to this issue of complaint is enclosed at Appendix five to this report.

Analysis and Findings

74. The complainant raised concerns with delays experienced during the complaints process. I note the complainant first submitted concerns in August 2019. Both the Trust's Complaints Procedure and the DoH Complaints Procedures states, *'a full investigation of a complaint should normally be completed within 20 working days'*. I note the Trust provided its first response to the complaint on 20 September 2019. Therefore, I am satisfied the Trust issued its first response in accordance with relevant guidance.

75. I note the complainant submitted further concerns in October 2019. On this occasion, the Trust did not respond to the complainant until 1 May 2020. This is more than 130 working days after the Trust received the second letter. I find this delay significant and unacceptable.

76. In accounting for the delay, the Trust explained it asked the complainant to meet to discuss her concerns. It also explained that while the complainant

initially accepted the request, she later declined in favour of a written response. However, I note it was February 2020 before the Trust suggested to hold a meeting. This was four months after the Trust received the complainant's second complaint. I do not consider this accounts for the extensive delay.

77. I note the Trust's complaints department regularly sent holding letters to the complainant from October 2019 to April 2020. I also note that from March 2020, the Trust informed the complainant that pressures experienced due to the Covid-19 pandemic delayed the process. I acknowledge the significant and unprecedented pressure the pandemic placed on the Trusts. However, the Trust did not experience these pressures until March 2020. This was five months after it received the complainant's second letter. Therefore, I do not consider the pressures the Trust experienced account for the extensive delay.

78. The Trust's Complaints Procedure states that in the event of a delay, '*it is important that the relevant Investigating Officer, or Assistant Director notify complaints staff of the likely length of any delay and the reason/s for this'*. Furthermore, the DOH Complaints Procedure states complaints will be dealt with '*as promptly as possible'*. I note in its earlier holding letters, the complaints department informed the complainant it had not received the investigating officer's response. Therefore, there is no evidence to suggest the investigating officer informed the complaints department of the reasons for the delay. I accept it may not always be possible for a Trust to fully respond to a complaint within the stated 20 day timeframe. However, I expect bodies to take immediate and appropriate action to investigate and respond to issues raised. Having reviewed the records, I do not consider those involved in the investigation process demonstrated sufficient urgency to respond to the complaint within an acceptable timescale. I acknowledge this also made it difficult for the complaints team to provide sufficient updates to the complainant.

79. The complainant also raised concerns about the content of the Trust's written responses to her complaint. In particular, she said the Trust did not admit fault in its first letter of response. However, it made two admissions of fault in the second written response. I note in her first letter the complainant provided a detailed chronology of events leading to her complaint. I also note she referred

to several concerns within her chronology. However, at the end of her letter, the complainant asked just two questions of the Trust. Having reviewed the Trust's response, I am satisfied it responded to both questions the complainant raised. However, I consider the Trust's response could have set out more clearly the reasons why it did not uphold her complaint. In particular, why the Consultant Psychiatrist did not consider the complainant's symptoms met with the WHO ICD 10's diagnosis for PTSD, rather than simply quoting from the notes of the assessment. I would ask the Trust to ensure that in future, it provides full and clear responses to each issue of complaint raised.

80. I note the complainant raised additional questions in her second letter of complaint. In its response, I note the Trust apologised for the time taken to respond to the complaint. It also apologised for its staff's error in booking an assessment with Staff Grade Psychiatrist (A) despite the complainant previously informing the Trust she did not wish to see this Psychiatrist. Furthermore, I note the letter documented that staff did not intend to cause the complainant any distress. This was in response to the complainant's concern that the Consultant Psychiatrist '*lied*' in the Trust's response to her first complaint.

81. This letter makes two apologies the Trust did not make in its first response, and referred to distress it may have caused the complainant. I note the first apology relates to the delay experienced during the second part of the complaints process. I also note the reference to '*distress*' the Trust said the complainant may have felt referred to the Consultant Psychiatrist's response to her first complaint. As both apologies relate to events that occurred after the Trust provided its first response, I do not consider it was possible for it to refer to them in its first letter.

82. I also note the Trust's second letter apologises for a staff member booking an appointment for the complainant with Staff Grade Psychiatrist A. While I note the complainant referred to this concern in her first letter, she did not include it in the two issues she asked the Trust to investigate. Therefore, I am satisfied the Trust did not consider it necessary to respond to this concern in its first letter.

83. I consider the failing identified in paragraph 76 of this report amounts to maladministration. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with complaints promptly and avoid unnecessary delays. I consider the Trust failed to act in accordance with these Principles in its handling of the complaint. I do not doubt the Trust's failure to address the complainant's concerns with sufficient urgency caused her frustration and uncertainty. Furthermore, had the Trust managed the complaint appropriately, the complainant may not have felt it necessary to take the time and trouble to bring her concerns to my office.

CONCLUSION

84. The complainant raised concerns about care and treatment the Trust provided to her between August 2017 and April 2019. I acknowledge the frustration the complainant must have felt given the delays experienced and the uncertainty surrounding the PTSD diagnosis. However, my investigation found no evidence of failing on the part of the Trust regarding the care and treatment it provided. Given these findings, I do not uphold this issue of complaint. I hope, however, this report addresses the complainant's concerns and goes some way towards reassuring her that she received appropriate care and treatment.

85. The complainant also raised concerns about how the Trust handled her complaint. I partly uphold this issue of complaint for the reasons outlined previously in this report. I consider this caused the complainant frustration, uncertainty, and time and trouble in bringing her complaint to my office.

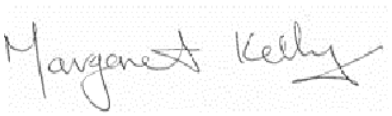
Recommendations

86. I recommend within **one** month of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration identified; and

ii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to do so within a reasonable timeframe. This will enable the Trust to meet the target timeframe set out in relevant guidance.

87. The Trust accepted my findings and recommendations.



MARGARET KELLY
Ombudsman **15 December 2021**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.
- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.