Scottish Parliament Region: Lothian

Case 201302855: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Psychiatry – Psychiatry; clinical treatment; diagnosis

Overview

The complainant (Ms C) raised a number of issues about the service she received from Lothian NHS Board (the Board)'s Mental Health Services in 2011. Ms C was admitted to Meadows Ward of the Royal Edinburgh Hospital on 8 December 2011. Ms C said that, despite her sleeplessness, erratic and strange behaviour and despite her friends' concerns that she was clearly not herself, she was diagnosed with a personality disorder and discharged on 14 December 2011 without any medication.

Specific complaints and conclusions

The complaints which have been investigated are that the Board's staff:

(a) unreasonably diagnosed that Ms C was suffering from a personality disorder (*upheld*);
(b) inappropriately discharged Ms C from hospital on 14 December 2011 (*upheld*); and
(c) failed to prescribe Ms C with medication on discharge from hospital (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a formal written apology to Ms C for the failings identified in this investigation;	19 November 2014
(ii) further annotate Ms C's clinical records from Meadows Ward, to clarify that: the letters referred to in the clinical note of 9 December 2011 did not exist and no diagnosis of personality disorder had been made by the perinatal psychiatrist;	17 December 2014
(iii) raise the findings of this investigation with the relevant clinical staff for consideration as part of	17 December 2014

	their next annual performance appraisals;	
(iv)	develop a strategy for improving carer involvement and communication on Meadows Ward;	17 December 2014
(v)	develop a strategy for improving information sharing within multi-disciplinary teams on Meadows Ward;	17 December 2014
(vi)	develop a strategy for ensuring multi-disciplinary discharge planning on Meadows Ward;	17 December 2014
(vii)	review record-keeping practices on Meadows Ward, to ensure that communication with carers and family is appropriately recorded; and	17 December 2014
(viii)	meet the outstanding treatment costs Ms C incurred while in France, prior to her discharge on 13 January 2012.	17 December 2014

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant (Ms C) explained that, before her pregnancy, she had no history of mental illness. However, during her pregnancy in 2011 she experienced low mood and in May 2011 her GP referred her to St John's Perinatal Mental Health Service. She had a home assessment by a community psychiatric nurse in June 2011 and, on 19 July 2011, she was reviewed by a consultant psychiatrist (Doctor 1), who diagnosed her with 'situational stressors' and discharged her from the service.

2. Two weeks after the birth of Ms C's daughter, on 28 August 2011, Ms C was admitted to the St John's Mother and Baby Unit (M&B Unit) with a diagnosis of a possible post natal depressive episode. She was discharged on 1 September 2011, with diagnoses of '1. situational crisis' and '2. no evidence of mental illness'.

3. On 8 December 2011, Ms C called the police as she was concerned that she might harm herself or her daughter. After an initial medical assessment, she was admitted to the Royal Edinburgh Hospital (the Hospital). She was diagnosed with a personality disorder, and discharged on 14 December 2011 without any medication. Ms C explained that a friend (Friend D) who had come to visit her was concerned about her condition and took her home with her. As Friend D did not want Ms C to go back to the Hospital she contacted Ms C's mother in France and arranged for her to fly to France the next day (15 December 2011). On 20 December 2011 Ms C's mother took her to the local Accident & Emergency (A&E) where she was diagnosed with puerperal psychosis (also called Postpartum Psychosis, which is a treatable condition that can affect new mothers, with psychotic-type symptoms). Ms C was transferred to a local psychiatric hospital, where the diagnosis was confirmed. She stayed at this hospital for three weeks and received medication. Ms C was discharged on 13 January 2012 and returned to Edinburgh.

4. On 2 February 2012 Ms C, having been referred by her GP, was seen by a consultant psychiatrist (Doctor 2) at Inchkeith House (Edinburgh Community Mental Health). Doctor 2, having reviewed Ms C's notes from the Hospital, wrote to Ms C's GP on 3 February 2012. Doctor 2 considered that the diagnosis of personality disorder was 'most surprising' and commented that he 'saw nothing in the history to support such a diagnosis and clear references to

abnormalities of mental state seemed to be ignored'. Doctor 2 said that he agreed with the diagnosis of puerperal psychosis and considered the diagnosis of personality disorder to be incorrect. Doctor 2 went on to say that he would contact Ms C's daughter's social worker regarding the revised diagnosis, current treatment and prognosis as this would have an important bearing on Ms C's access to her daughter. Doctor 2 arranged to see Ms C again in seven days.

5. Ms C was hospitalised again at the Hospital and discharged on 6 February 2012 to the care of her father, who took her back to France. On her return to France, Ms C was hospitalised for severe depression for three months and then attended a day hospital for a further three months. Ms C moved back to Edinburgh on 27 July 2012.

6. On 21 March 2013, with the help of the Citizen Advice Bureau and a mental health advocacy worker, Ms C complained to Lothian NHS Board (the Board) about the diagnosis of personality disorder. The Board acknowledged the complaint on 26 March 2013. In response to the concerns Ms C raised, the Board offered to meet with her on 20 May 2013. The meeting was attended by a consultant psychiatrist/clinical director (Doctor 3) and another consultant psychiatrist (Doctor 4). Following the meeting Doctor 3 wrote to Ms C on 21 May 2013 summarising the outcome of the meeting. As Ms C was dissatisfied with the Board's response, she brought her complaint to this office on 2 October 2013.

7. The complaints from Ms C which I have investigated are that the Board's staff:

(a) unreasonably diagnosed that Ms C was suffering from a personality disorder;
(b) inappropriately discharged Ms C from hospital on 14 December 2011; and
(c) failed to prescribe Ms C with medication on discharge from hospital.

Investigation

8. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Ms C's clinical records. Independent advice has been obtained from an experienced psychiatrist (the Adviser). The ICD 10 Classification of Mental and Behavioural Disorders has also been taken into account. This states that an assessment of personality disorder should be based on as many sources of information as possible.

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

(a) The Board's staff unreasonably diagnosed that Ms C was suffering from a personality disorder

10. Ms C indicated that, after her daughter's birth, she became paranoid and convinced that her ex-partner wanted to hurt her and her daughter. On 21 September 2011 she left her ex-partner's home with her daughter in very difficult circumstances, in which the police, social work and a health visitor were involved. Ms C and her daughter were allocated accommodation by the council. She described being very distressed and told social services that she felt she should return to the M&B Unit, as she felt very confused about what was real and what was not. Ms C described her separation from her ex-partner as 'acrimonious' and said she was fixated with the idea of protecting her daughter. As she would not let her ex-partner see her daughter, he took her to court for visiting rights. On 5 December 2011, a week before the hearing, Ms C's solicitor told her that she did not have enough evidence to justify supervised access. Ms C described this as the 'tipping point' and said she completely lost touch with reality and started feeling suicidal. Ms C explained that when she was asked what would happen to her daughter if she committed suicide, she replied that she would take her with her to 'a better place'.

11. Ms C said that, when she was admitted to the Hospital on 8 December 2011 she was seeing and hearing things and thought she had superpowers and a special purpose. Ms C described numerous instances of her erratic behaviour, and provided statements from friends who saw her at the time and copies of social work records, which included notes of her behaviour and conversations.

12. Ms C explained that despite her sleeplessness, erratic and strange behaviour, she was diagnosed with a personality disorder by Doctor 4 and discharged on 14 December 2011. Ms C felt this diagnosis was unfounded. She complained that, although her clinical records noted that little was known about her 'normal' personality, the Hospital staff made no attempt to find this out from her friends, or from her admission record from the M&B Unit (despite this being suggested at a medical review on 8 December 2011 and at a senior medical review on the same day). Ms C explained that several of her friends

visited her at the Hospital, and were willing, and in some cases actively attempted, to give staff background information about her but medical and nursing staff were not interested in speaking with them. Three friends (Friend A, Friend B and Friend D) provided statements detailing their attempts to speak to medical staff on different occasions. These indicated that medical staff were generally not available to talk to them and nursing staff did not show any interest in the background information they had to offer. Friend A said that when he spoke to a nurse he was not made aware that he was listed as Ms C's 'named person' for the purposes of her care as an in-patient and he was told that the nurse could not give him any information on Ms C's well-being or care.

13. Ms C was also concerned that her clinical records were incomplete and incorrect in relation to her personal history. In addition, she was concerned that her clinical records did not fully detail her irrational behaviour and that, although there were some notes in her clinical records describing her behaviour as 'manic' and 'psychotic', these appeared to have been ignored in making the diagnosis of personality disorder. Further Ms C was concerned that there was an inconsistency between her clinical records and the information given to her by the Board, in relation to whether she had previously been diagnosed with personality disorder. When she met with Doctor 3 and Doctor 4 to discuss her complaint, they told her that her diagnosis dated back to the time when she was in the M&B Unit. However, the clinical records from the M&B Unit do not reveal any such diagnosis and when Ms C wrote to Doctor 3 to clarify this, he told her that this information was given to Doctor 4 verbally. This conflicted with the clinical note that Doctor 4 made at the time, which stated 'see letters from perinatal psychiatrist, who felt she had a florid personality disorder and shared this with her'.

14. Ms C explained that the diagnosis of personality disorder had had a severe impact on her life, irretrievably affecting her relationship with her daughter, as she was separated from her when she was only four months old, and she did not have any reasonable contact with her daughter for almost 20 months. Ms C also lost all custody rights. She said that the diagnosis and its consequences had also slowed her recovery from puerperal psychosis. At the time of her complaint to this office, she were still recovering and being treated at Inchkeith House. Finally, she had suffered financial losses, as her French hospital bills, after discretionary financial help, amounted to 503.50 Euros.

Board's response to Ms C's complaint

15. In response to Ms C's initial complaint, the Board invited her to meet with Doctor 3 and Doctor 4 on 20 May 2013. At the meeting, they told her the diagnosis of personality disorder was made following a thorough assessment on Meadows Ward by doctors and nursing staff, which did not provide evidence for a diagnosis of a psychotic illness or mood disorder. They said that the working diagnosis of personality disorder seemed correct at the time, although subsequent events pointed to a diagnosis of puerperal psychosis. The Board said that because this was not a factual error, they would not be able to redact the diagnosis from the clinical notes. However, they said it would be possible to annotate the notes to reflect the updated diagnosis.

16. Doctor 3 sent Ms C a letter following the meeting, to summarise the discussion. Ms C responded on 4 June 2013, requesting additional information on several points. In particular, she noted that the doctors had advised her during the meeting that the diagnosis of personality disorder predated her time on the Meadows Ward in the Hospital, and went back to her admission to the M&B Unit. In a subsequent letter of 22 July 2013, Doctor 3, explained that he had received and reviewed Ms C's clinical notes from the M&B Unit and had again reviewed her clinical records from the Hospital. He went on to clarify that there was an entry in the Hospital case notes (on 9 December 2011) which stated that Doctor 1 had felt Ms C 'had a personality disorder and shared this with her'. However, Doctor 3 explained that this information was given to Doctor 4 verbally and there was no written record in the M&B Unit case notes.

17. The Board said that they had clarified the rationale for the personality disorder during the meeting with Ms C. Doctor 3 had explained that the ward assessment was thorough and did not provide evidence for a diagnosis of psychotic illness or mood disorder and that, based on a review of available records and discussion with Doctor 4, the working diagnosis of personality disorder seemed correct at the time. The Board noted that events further to Ms C's discharge pointed to a diagnosis of puerperal psychosis.

18. When questioned about the reference in the clinical notes to letters from Doctor 1, the Board explained that there was no record of any letters as mentioned in Doctor 4's clinical note for 9 December 2011 and concluded that the information was probably given verbally, rather than in writing. The Board provided statements from both Doctor 4 and Doctor 1. Doctor 4 recalled that Doctor 1 had told her she thought Ms C had personality dysfunction, based on

her contact with her prior to the birth of her daughter. Doctor 4 could not remember if she spoke with Doctor 1 on the telephone or face to face, and had expected that this diagnosis would be recorded in Ms C's M&B Unit clinical notes but had no access to them at the time. In relation to her note in Ms C's clinical records about 'letters from the perinatal psychiatrist', Doctor 4 said she believed she made some record based on her conversation with Doctor 1 in good faith. Doctor 1 stated that she had not made a formal diagnosis at any time of personality disorder. She said that it was possible she had commented to colleagues, in an informal situation, that she felt there were key contributing issues related to her personality. However, she said she would 'be regretful if such informal comments were translated into a diagnostic label', given that she had avoided this in her official communications.

Advice received

19. My complaints reviewer asked the Adviser to consider Ms C's clinical records and to confirm whether the diagnose that Ms C was suffering from a personality disorder was reasonable. The Adviser observed that a working diagnosis of 'psychotic episode' was given during Ms C's initial medical review on 8 December 2011 and in a senior medical review on the same day. The Adviser explained that the term psychotic refers to mental states where there is some departure from normal reality, although it does not in itself imply a particular cause or specific diagnosis. He said that, as part of a working diagnosis, it is useful in indicating a general area of interest or enquiry; although, as with any diagnosis, it may be subject to revision. He said that it would be unusual for the diagnosis to change to a different group, without positive evidence, in less than a week. The Adviser noted that 'manic episode' (an episode of pathological elevation of mood with over-activity, that may also show irritability) remained on the list of possible diagnoses after review on 9 December 2011. However, Doctor 4's note for the same day included a reference to 'letters from the perinatal psychiatrist who felt she had a florid personality disorder and shared this with her'.

20. The Adviser pointed to a number of records throughout Ms C's clinical notes which he said suggested an abnormal mental state, including being restless, with manic speech or 'overtalkative', acting 'bizarre', having changeable mood, laughing loudly and hysterically, and behaving oddly, such as showering twice, walking around in strange clothes, and collecting various objects and taking them to her room. The Adviser also noted that Ms C's history on admission included not sleeping for a week and being more active

than usual. He also said that throughout her admission Ms C received doses of tranquillisers, including on her own request.

21. The Adviser explained that a multi-disciplinary team meeting on 13 December 2011 noted Ms C's odd behaviours, but recorded that these were not thought to be genuine mania symptoms. Her changeable mood and paranoia about name badges and one to one recordings were noted but not explored further. Ms C's discharge was planned for the next day. The Adviser said that when Ms C was examined on 14 December 2011, she was felt to be deliberately denying various things that she would otherwise know. Discharge took place with a diagnosis of 'personality disorder, unspecified' and 'no evidence of mental illness'. The Adviser noted that social work records for this day included records of a telephone call in which Ms C exhibited a type of disorder in the form of thought that may be seen in many episodes of mania (including jumping from topic to topic with no connection or with unusual associations), which would be difficult to mimic or feign.

22. In view of Ms C's clinical records, the Adviser considered there was not sufficient evidence or information to conclude that the primary diagnosis was of personality disorder, as it was not clearly demonstrated that the behaviours and interactions she showed were habitual, enduring or longstanding, nor was there any history consistent with personality disorder dating back to childhood or adolescence. The Adviser observed that, in Ms C's clinical records, trained staff continued to make observations regarding a potentially abnormal mental state up to the point of discharge, which were largely unexplored.

23. The Adviser said that the personality disorder declared was 'unspecified' and there was no attempt to clarify any particular dimension or trait and no comparison with clinical thresholds on these dimensions. Although the clinical records were relatively well kept on the whole, the Adviser considered that there was insufficient documentation of the thinking behind the preferred and emerging diagnosis of personality disorder. The Adviser considered that, based on Ms C's clinical notes, it was likely she was suffering from puerperal psychosis prior to her discharge from the Hospital.

24. Overall, the Adviser considered that the ward assessment of Ms C was deficient in terms of obtaining collateral history. Although the need for background information was identified, there were no documented efforts to obtain this, despite references to visitors who, as Ms C's evidence had shown,

would have been co-operative in giving this information. The Adviser explained that the ICD 10 suggests that assessment of personality and personality disorder should be based on as many sources of information as possible. In this case, over-reliance was placed on a previous diagnosis which had not been justified or documented. The Adviser further commented that communication with carers (friends), both in obtaining history and communicating treatment plans, was poor.

25. My complaints reviewer also asked the Adviser whether the Board had adequately explained to Ms C the rationale for the diagnosis of personality disorder. The Adviser said that there was no clear explanation of the rationale in the documentation available. It appeared to have been explained as the apparent absence of treatable mental illness. The Adviser also noted that the account which the Board gave Ms C of the perinatal assessment of personality disorder was inconsistent with the documents.

(a) Conclusion

26. This investigation has taken into account what Ms C said and how the Board replied. I am also mindful that Ms C explained the serious consequences which her misdiagnosis has had for her life, by impacting on her recovery and on-going health and her relationship with her daughter.

27. The Board explained that, based on a review of available records and discussion with Doctor 4, the working diagnosis of personality disorder seemed correct at the time, but my Adviser did not agree with this.

28. The advice I have received and accept, is that the ward assessment of Ms C was deficient in terms of obtaining collateral history and that there was not sufficient evidence or information to conclude that the primary diagnosis was of personality disorder. I also note the Adviser's comment that over-reliance was placed on a previous diagnosis which had not been justified or documented. In addition, the Board confirmed that there was no record in Ms C's clinical notes from the M&B Unit about personality disorder.

29. I am critical of the failures by staff to seek collateral history about Ms C from her friends, carers or from her previous admission notes from the M&B Unit. I am also critical of the failure to explore Ms C's odd behaviours, or to seek to clarify any particular dimension or trait of her 'unspecified' personality disorder, including comparison with clinical thresholds.

30. In addition, I am concerned that the clinical note of 9 December 2011 prepared by Doctor 4, which recorded incorrect information about Ms C's previous diagnosis, appears to be based on a recollection of an informal conversation, unsubstantiated by any formal correspondence. This note referred specifically to 'letters from the perinatal psychiatrist' although I am satisfied, based on the Board's information, that Doctor 4 had not received any such letters. The note is also inaccurate in stating that Doctor 1 thought Ms C had a personality disorder. Doctor 1 confirmed that she did not make a diagnosis of personality disorder at any time and, although she may have made informal comments about contributing factors relating to Ms C's personality, she did not expect these to be translated into a diagnostic label, given that she had avoided this in her official communications. Therefore, I consider that this note was inaccurate and misleading.

31. I am also concerned that the Board failed to investigate and acknowledge this error, when Ms C complained to them about her diagnosis. Although the Board identified that the reference in Doctor 4's note was not substantiated by Ms C's clinical records from the M&B Unit, it appears nothing was done to investigate this discrepancy or establish whether the information about the previous diagnosis was correct. I am concerned that Doctor 3 felt it was appropriate to rely on Doctor 4's recollection of her conversation with Doctor 1 without further investigation, although this account conflicted with the medical records and Doctor 1's evidence was readily available.

32. In view of the failures described above, I uphold the complaint.

(a) Recommendations

33. I recommend that the Board:

		Completion date
(i)	issue a formal written apology to Ms C, for the failings identified in this complaint;	19 November 2014
(ii)	further annotate Ms C's clinical records from Meadows Ward, to clarify that: the letters referred to in the note of 9 December 2011 did not exist, and no diagnosis of personality disorder had been made by Doctor 1;	17 December 2014
(iii)	raise the findings of this investigation with the relevant clinical staff for consideration as part of	17 December 2014

	their next annual performance appraisals;	
(iv)	develop a strategy for improving carer involvement and communication on Meadows Ward; and	17 December 2014
(v)	develop a strategy for improving information sharing within multi-disciplinary teams on Meadows Ward.	17 December 2014

(b) The Board's staff inappropriately discharged Ms C from hospital on 14 December 2011

34. Ms C described her continued erratic behaviour on the day of discharge on 14 December 2011. She refused to leave the Hospital and stood with her back against the door to prevent staff from getting in her room. She said that she also had conversations with a social worker and her father, in which she was not speaking rationally.

35. Ms C provided statements from her friends, who described their attempts to raise concerns about her discharge with medical staff. Friend B said she was unable to speak to a doctor but managed to speak to one of the nurses. However, she felt that the nurse was simply allowing her to 'ventilate her concerns' and that what she said would have no impact on the decision to discharge Ms C. Friend D said she also tried to speak to a doctor about Ms C's discharge but, after waiting over four and a half hours, eventually gave up and took Ms C home. Friend D felt that Ms C was in no fit state to look after herself and was concerned that she had been discharged.

36. Ms C also provided a number of social work records, in which conversations were noted between social work officers and the Hospital staff noting her friends' concerns, and social workers' own concerns about her discharge. These notes suggest that the Hospital staff were considering calling security to evict Ms C from the building.

37. Ms C explained that she was seriously ill and incapable of looking after herself at the time of her discharge. She could not pack or orient herself. She was very frightened and would have been removed by security if her friend had not been there to take her home. She felt that her delusions and hallucinations were such that she was a danger to herself and others.

38. The Board explained that there was 'no evidence of treatable mental illness or risk during her in-patient stay which would have warranted delaying

the discharge further'. The Board said that this was discussed with Ms C at the meeting with Doctor 3 and Doctor 4 on 20 May 2013, although there does not appear to be any minutes from this meeting, and the letter Doctor 3 sent Ms C on 21 May 2013 summarising the meeting does not mention this aspect.

39. In relation to Friend B's attempts to raise her concerns with the nurse, and Ms C's erratic behaviour following discharge, a letter from Doctor 3 of 22 July 2013 confirmed that there was 'no record of her behaviour following the discharge on 14 December 2011, nor of [Friend B]'s conversation with one of the nurses'. Without such a record, Doctor 3 explained that it would not be possible to clarify or confirm these events.

Advice received

40. The Adviser noted that discharge occurred on 14 December 2011 with no psychiatric follow-up, although Ms C's GP was informed of the discharge by telephone that day. The Adviser also said that there was a record of an email to Ms C's social worker from an occupational therapist, which indicated that her friend of ten years standing had said that she was not in her own mind and felt strongly that she should not be discharged home.

41. The Adviser considered that the decision to discharge Ms C on 14 December 2011 was not reasonable. The Adviser said that Ms C continued to display evidence of an abnormal mental state; there had been no effective communication with her identified carer or her friends; and there did not appear to have been a proper assessment of her needs. The Adviser went on to say that the discharge appeared to be relatively unmanaged.

42. The Adviser said that he considered the comment in the discharge letter that her 'friends had come to pick her up after discharge. They understood the situation well and were very supportive of her' was disingenuous at best. He said that little or no account was taken of available collateral information.

43. My complaints reviewer asked the Adviser to comment on the lack of records of Ms C's behaviour following discharge and Friend B's conversation with the nurse that day. The Adviser confirmed that it would be difficult for the Board to comment on Ms C's behaviour post-discharge, as they did not have contemporaneous notes. However, in relation to Friend B's conversation with the nurse, the Adviser was critical that there was a relative absence of notes

relating to contact with carers and friends overall, which he felt, in itself, should have been of concern to the Board.

(b) Conclusion

44. The Board said that there was no evidence of treatable mental illness or risk during Ms C's in-patient stay which would have warranted delaying her discharge on 14 December 2011. However, I am mindful of the Adviser's comments about Ms C's continuing signs of a disturbed mental state and I am critical of the Board's failure to effectively communicate with her carer or friends, or to properly assess her needs before discharging her. I am also critical of the decision to discharge Ms C without appropriate support.

45. I have taken into account the information provided by Friend B and Friend D, about the day of her discharge, which is supported by the social work notes Ms C provided. I am concerned about the Board's record keeping in this regard, including the lack of records about the nurses' conversations with Ms C's friends and social workers. I am also mindful of the Adviser's comments about the statement in the discharge papers that her friends had come 'to pick her up' and 'understood the situation well.' Based on the reasons detailed above, I uphold this complaint.

46. I consider that the Board acted unreasonably in discharging Ms C when they did. Ms C explained how this discharge left her without formal support, when she was not in a position to look after herself and could have been a danger to herself and others. I am also mindful of the advice I have received and accept that there did not appear to have been any proper assessment of Ms C's needs and that her discharge appeared to be unmanaged.

47. I have also taken into account that, as a result of how she felt Ms C had been treated in the Hospital, her friend who collected her from the Hospital decided to send her to France to be with her family. While there, Ms C was taken to a local A&E where she was diagnosed with puerperal psychosis. This diagnosis was later confirmed by a local psychiatric hospital and treatment was given. As a result of this treatment, Ms C incurred medical costs.

48. In all the circumstances, I consider that the costs of treatment Ms C incurred while in France prior to her discharge on 13 January 2012 arose as a result of the Board's decision to discharge her from the Hospital which, for the reasons detailed above, I have found to be unreasonable. I have made a

number of recommendations to address the failings identified in this complaint, including that the Board should, on submission of receipts meet the medical costs Ms C incurred while in France prior to her discharge on 13 January 2012.

(b) Recommendations

49. I recommend that the Board:	*Completion date*
(i) develop a strategy for ensuring multi-disciplinary discharge planning on Meadows Ward;	17 December 2014
(ii) review record-keeping practices on Meadows Ward, to ensure that communication with carers and family is appropriately recorded; and	17 December 2014
(iii) meet the outstanding treatment costs Ms C incurred while in France, prior to her discharge on 13 January 2012.	17 December 2014

(c) The Board's staff failed to prescribe Ms C with medication on discharge from hospital

50. Ms C complained that she was discharged on 14 December 2011 without any medication.

51. The Board explained that the clinical team considered there was no evidence of treatable mental illness during Ms C's in-patient stay which would have warranted treating her with medication at the time of her discharge. The Board noted that this was discussed at her meeting with Doctor 3 and Doctor 4 on 20 May 2013.

Advice received

52. The Adviser said that the non-prescription of medication was related to the diagnosis which had been made. In this sense, the non-prescription of anti-psychotic or mood stabilising medication was consistent with Ms C's diagnosis of personality disorder. The Adviser commented that it may have been considered safer to give no prescription on discharge, although it had been thought appropriate to administer sedation as required while Ms C was in the Hospital. The Adviser noted that there was no recorded discussion of the considerations. Given that it had been found appropriate to give Ms C sedative medication on Meadows Ward, the Adviser was critical of the lack of discussion surrounding the decision to discharge without medication.

(c) Conclusion

53. Based on the advice given, I am satisfied that the Board's decision not to prescribe medication was consistent with the diagnosis of personality disorder. However, I note the Adviser's criticism of the lack of discussion surrounding this decision, particularly in view of the fact that medical staff had found it appropriate to administer sedation on occasion while Ms C was on Meadows Ward. In view of the advice I have received, and because the decision about medication was based on a diagnosis which I have found was unreasonable as detailed above, I consider that the decision to discharge Ms C without medication was unreasonable. Therefore, I uphold this complaint.

54. However, I consider that the failings identified in relation to this complaint will be addressed by my recommendation above and, therefore, I do not consider that additional recommendations are required.

55. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
Doctor 1	consultant psychiatrist, St John's Hospital
M&B Unit	St John's Mother and Baby Unit
the Hospital	Royal Edinburgh Hospital
Friend D	the complainant's friend
A&E	Accident and Emergency
Doctor 2	consultant psychiatrist, Inchkeith House
the Board	Lothian NHS Board
Doctor 3	consultant psychiatrist/clinical director
Doctor 4	consultant psychiatrist, Royal Edinburgh Hospital
the Adviser	psychiatrist
Friend A	the complainant's friend, who is a GP
Friend B	the complainant's friend, who is a GP

Annex 2

Glossary of terms

ICD 10	the ICD – 10 Classification of Mental and Behaviour Disorders – Clinical descriptions and diagnostic guidelines – World Health Organisation