SPSO decision report

Case: **201800637, Lothian NHS Board - Royal Edinburgh and Associated Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the failure of emergency mental health services to treat them during crisis admissions. C stated that they had been brought to the hospital on multiple occasions by police but that an assessment was not always carried out. C also complained that they had not been allocated a psychiatrist (a medical practitioner who specialises in the diagnosis and treatment of mental illness) or a community psychiatric nurse.

The board responded by advising that services treated C appropriately when they attended and completed assessments when required. They also stated that C previously was supported by a psychiatrist but disengaged from this service and did not re-engage with services in the intervening period. C was unhappy with this response and brought their complaint to us.

We took independent advice from a psychiatric adviser and a mental health nurse. We found that the medical records showed that the board had acted reasonably and occasions where full assessments were not completed were appropriate and in keeping with strategies put in place to treat C. We considered that the plan to manage C's crisis contacts was in their best interests and we found no evidence of mental health assessment's being unreasonably withheld. Therefore, we did not uphold this aspect of C's complaint.

In relation to the allocation of a psychiatrist, we found that C had disengaged with services. However, proposed actions suggested by a psychiatrist to re-engage and support C did not appear to be actioned and records showed an unexplained gap in contact between C and services of around 18 months. Therefore, we upheld this aspect of C's complaint.

C requested a review of our decision and the case was reopened for further consideration. Details of this are explained below.

C was admitted to A&E at the Royal Infirmary of Edinburgh (RIE). After being transferred to an acute medical unit (AMU) from A&E, they left the ward and returned to their home. The police were contacted and they visited C at their home. C was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) and returned to the RIE the following morning. C complained that the assessment carried out following C being detained and taken to hospital was unreasonable.

We took independent clinical advice from a consultant psychiatrist. We found that, while the board met the minimum requirement of the Act in terms of undertaking a medical assessment, there was no clear documentation detailing the mental state examination. We considered, given the complexity of the case, the lack of recent review and the presentation of C at the time, a formal assessment undertaken by an appropriately trained clinician from psychiatric services would have been reasonable and this did not take place. As such, we upheld this aspect of C's complaint.

C also complained that the assessment that was undertaken into their capacity was unreasonable. We found that

there was no evidence to suggest that C did not have capacity to make their own decisions at the time. We noted that informal assessments are undertaken in every clinical interaction and we would not expect a formal capacity assessment to have been undertaken when clinicians considered C retained capacity. The psychiatric team had advised that in terms of C's mental health they considered C had capacity to make decisions on their care. The focus was then on whether C's physical injuries required care but C had consented to treatment for the same. Therefore, it was determined that there was no reason to detain C or undertake a formal capacity assessment. As such, we did not consider the lack of a capacity assessment to be unreasonable in these circumstances. We did not uphold this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to undertake a formal assessment of them by an appropriately trained clinician from psychiatric services. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C that the agreed actions and proposed strategies were not pursued. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Individual clinicians will reflect on the outcome of this investigation as required within their annual appraisal process.
- The board should take steps to ensure that treatment plans devised are effectively followed through, in order to try and foster trusting relationships, minimise a sense of rejection, demonstrate service consistency and reliability and show a willingness to work in an open, engaging and non-judgemental manner.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.