SPSO decision report

Case: **201000633, Lothian NHS Board - Royal Edinburgh and Associated Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, no recommendations

Summary

Mrs C complained about the care and treatment that her son (Mr A) received when he was admitted to hospital as a voluntary psychiatric patient, after being taken there by the police. He was examined on admission and a care plan was completed. He was reviewed again the following morning by a doctor who had treated him when he had previously been admitted. The doctor gave him a pass to leave the hospital for two hours. Mr A did not return to the hospital and was found dead a number of days later.

We were able to investigate only limited elements of Mrs C's complaint, because the main aspects of it had already been investigated by the Crown Office and Procurator Fiscal Service when deciding whether to hold a Fatal Accident Inquiry. We found that the care and treatment provided to Mr A during the short time he was in the hospital was reasonable and appropriate. Communication between the doctors who saw Mr A had also been satisfactory, and it was reasonable for a doctor to previously diagnose Mr A with schizophrenia.

That said, we found that no one from the hospital had phoned Mrs C back after she contacted them the morning after Mr A was admitted, asking to speak to the doctor who had previously treated him. Our investigation found that they were not required to call her back immediately, but should have done so at some stage, as it is good practice to involve family and carers when assessing and managing patients. We, therefore, found that communication with Mr A's family during his short admission was not reasonable. However, in view of the fact that a doctor had written to Mrs C to apologise for this, we did not make any recommendations.