SPSO decision report

Case: **201004603, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, action taken by body to remedy, no recommendations

Summary

Ms C complained about what happened when she was assessed for a decision to detain her under the Mental Health Act. She said that the psychiatrist did not treat her with respect; breached confidentiality by discussing her condition in the presence of two police officers; and, after discharge and despite Ms C asking for no further contact with the psychiatrist, she was sent appointments to attend her clinic.

Our investigation, which included taking independent advice, found no evidence to show that Ms C had not been treated with respect during the assessment which took place in her flat. The notes taken by the psychiatrist and a social worker (who was present as Ms C's mental health officer (MHO)) were brief but professional. We explained to Ms C that while we did not doubt that she considered she had been treated disrespectfully, in situations where there is no independent corroborating evidence, we cannot determine which version of events is the correct one. Therefore, we were unable to uphold this aspect of her complaint.

On the matter of the discussion which took place in the presence of the police officers, our investigation found that this was reasonable. Concerns about Ms C's mental health had firstly been raised with the local mental health team by local police, who had been concerned about some aspects of Ms C's behaviour in the preceding weeks. The police officers who were present were, therefore, aware in general terms of Ms C's mental state. When the psychiatrist and the MHO needed to have a more detailed clinical discussion of Ms C's condition, they retired to Ms C's kitchen to discuss this in private. We, therefore, found no evidence of a breach of confidentiality.

In respect to the out-patient appointments sent to Ms C after her discharge, the board acknowledged and apologised for this oversight. The psychiatrist involved was the only one in the area that deals with out-patients, so the system automatically sent a follow-up appointment. This had gone out while the board were still considering Ms C's complaint as the system had not been updated. As the board had, however, already apologised for this, we made no recommendations.