SPSO decision report

Case: **201204612, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who is an advocacy worker, complained on behalf of her client (Mrs A) about the care and treatment provided to Mrs A's late husband (Mr A) before he committed suicide. Mr A had a history of depressive illness. He was referred to a community psychiatric nurse (CPN). He saw both the CPN and the board's mental health assessment service before he was admitted to hospital after presenting with suicidal thoughts. He took his own life two days after being discharged from hospital.

In considering this complaint, we took independent advice from our psychiatric adviser, after which we upheld only one of Ms C's four complaints. Ms C had complained that the CPN delayed in referring Mr A to hospital. Our investigation found, however, that the CPN had not delayed in referring him to a consultant psychiatrist at the hospital. We were also satisfied that there were reasonable attempts to manage Mr A with other treatments, and noted that there was contact with other parts of psychiatric services at an early stage.

Ms C also complained that the board failed to make a reasonable diagnosis or offer reasonable treatment and medication to Mr A when he was admitted to hospital. Our investigation found that Mr A's case was complex and he had diagnoses of personality disorder and depression. The risks he presented were considered and assessed, but it was concluded that he did not meet the criteria for detention. We found that attempts had been made to manage his case with appropriate drug and psychological treatments and our adviser said that his treatment and medication were reasonable.

Ms C also complained that the board failed to carry out an appropriate risk assessment. She said that they failed to properly assess the risk of suicide and child protection issues. She also said that they had failed to involve Mrs A when deciding to discharge Mr A. We found that the hospital had carried out frequent risk assessments on Mr A in a satisfactory manner. He did not show impaired decision-making and so could not be detained in hospital. We also found that Mrs A was involved as far as possible in her husband's care, and that child protection issues were taken into account. However, we upheld the complaint about the assessment of risk, as we found that Mr A had been discharged to his brother's home. We considered that the hospital should have asked Mr A for consent to contact his brother in order to involve him in the discharge plan, and to check if there were children at his address. We noted that the standard documentation around discharge had not been completed and had this been done, it could have acted as a prompt to contact Mr A's brother.

Recommendations

We recommended that the board:

- make the staff involved in Mr A's care and treatment aware of our findings.