SPSO decision report

Case: **201300582, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C, who is a prisoner, complained that the board failed to arrange for him to see the prison psychiatrist following a suicide attempt. Mr C had been treated in hospital and said that the psychiatrist there told him that he would be seen by the prison psychiatrist when he returned to prison. After taking independent advice from one of our medical advisers, our investigation found that there was no evidence that Mr C was told this, and that the hospital discharge summary said no psychiatric action was required at that time. In addition, Mr C was reviewed by the clinical manager in mental health when he returned to the prison, and this review was then discussed with the prison psychiatrist. In view of this, we found that that it was reasonable that Mr C was not seen by a psychiatrist on his return to prison.

Mr C also complained that the board failed to provide him with appropriate treatment for blood loss after he self-harmed when he returned to prison. We found that the immediate follow-up care provided to him was reasonable in many aspects. The records also showed that Mr C had refused medical treatment on at least one occasion. However, he had lost a significant amount of blood. We found that the failure to clearly state that his haemoglobin (a protein found in the red blood cells that is responsible for carrying oxygen around the body) should be monitored and to specify the timing or frequency of the monitoring in his care plan was unreasonable. Mr C's haemoglobin was not checked until two weeks later, at which time he was immediately transferred to hospital for treatment. Staff also failed to record his vital signs (signs of life including the heartbeat, breathing rate, temperature, and blood pressure) and his nutrition and fluid intake. We upheld this aspect of Mr C's complaint.

Finally, Mr C complained about the board's handling of his complaint. We upheld this complaint too, as the board had failed to respond to all the points Mr C had raised. We also found it inappropriate that in their response to his complaint the board criticised Mr C's behaviours, while noting that these were discussions that clinicians and others would clearly be entitled to have with him in another context.

Recommendations

We recommended that the board:

- issue a reminder to the staff involved in Mr C's care that care plans should clearly document the interventions planned and when/how frequently they are to be implemented;
- issue a reminder to the staff involved in Mr C's care that they should chart a patient's vital signs and nutrition/fluid when this is indicated; and
- make the staff involved in the handling of Mr C's complaint aware of our findings.