SPSO decision report

Case: **201302422, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained on behalf of her client (Mr A) who suffers from a delusional disorder (a mental health disorder where sufferers hold irrational beliefs). Mr A went to A&E in Lorn and Islands Hospital as he wanted them to check a mark on his leg. Staff were concerned about his mental wellbeing and spoke to the duty psychiatrist at another hospital who decided that he should be transferred and admitted there. In the event that Mr A was unwilling to go, it was agreed that his admission be facilitated with the use of an Emergency Detention Certificate (EDC). Documentation had to be completed for this and, before arrangements could be made for transfer, Mr A left Lorn and Islands Hospital. He was later brought back, handcuffed, by the police, sedated and transferred.

Ms C complained that Mr A was not adequately assessed at A&E. She also said that staff did not follow the correct process/procedures in relation to the EDC and there was unreasonable delay in transferring Mr A between hospitals. She subsequently complained of the delay in responding to her complaint about this.

We took independent medical advice from one of our psychiatric advisers. We found that, while it had been reasonable to prioritise Mr A's mental health over his concerns about his leg, the board had not first tried to establish whether he was a risk to others or himself, nor attempted to discuss his condition with his usual psychiatrist and review his records before deciding that he needed to be tranquilised. They also failed to follow the correct procedures (in terms of assessment and proper completion of the appropriate forms) for issuing an EDC. This led to Mr A being sedated against his will. Furthermore, the board delayed in dealing with Ms C's complaints. We, therefore, upheld these complaints.

Ms C had also complained that the board delayed in transferring Mr A between hospitals, but we did not find evidence to confirm this, and did not uphold her complaint.

Recommendations

We recommended that the board:

- apologise to Mr A for the shortcomings in assessing him;
- ensure that the circumstances of the complaint are brought to the attention of the on-call psychiatrist and ensure that it is considered at his next formal appraisal;
- make a formal apology to Mr A for failing to follow correct procedures;
- review the training given to medical staff working in A&E to ensure that they understand what is required before detaining people under an EDC and how to complete the appropriate paperwork;
- should formally apologise to Ms C and Mr A for their failure to respond in a timely manner; and
- should emphasise to the staff involved in this complaint the importance of responding to complaints in accordance with the board's stated response times.