SPSO decision report

Case: **201302529, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, action taken by body to remedy, recommendations

Summary

Mrs C complained that psychiatric staff in Stratheden Hospital treated her son (Mr A) unreasonably while he was a patient there. Our investigation considered a number of individual issues that she raised in relation to this, and in doing so we took independent advice from our mental health adviser.

Mrs C said that staff had failed to check whether Mr A had any dangerous items in his possession when he was being admitted to the hospital, which meant that he was able to start a fire in a room. We found, however, that he had not been formally admitted to the hospital at this point. Staff had not completed his admission assessment, as they had been called away to deal with a medical emergency involving another patient. Had this assessment (which would have included a risk assessment and a plan to minimise risk) been completed, any potentially dangerous articles would have been removed from Mr A's possession. In the circumstances, we did not consider that staff acted unreasonably, but we said that the board should treat this as a learning point.

Mrs C also said that staff delayed in arranging for an injury to Mr A's hand to be treated. We found that Mr A had initially refused to allow staff to carry out an examination, and that once he had consented to being examined and treated, staff had acted appropriately. Mrs C also complained to the board that Mr A was assaulted and molested by staff in the hospital. We found, however, that an adult protection investigation had been carried out into these matters, led by the local council, and that the board had also satisfactorily considered and investigated these allegations. In addition, we found that staff had acted reasonably in relation to getting Mr A an advocate, and were entitled to decide that Mrs C could not use a camera in the hospital to take photos. We also found that Mr A had been prescribed medication in line with the relevant guidelines and that staff had acted reasonably in relation to this.

That said, we found that Mr A had been transferred to another ward in his underwear and without shoes, which we found inappropriate. We also found that staff had failed to adequately observe or supervise him when he was moved into a seclusion room, and there was no evidence of a plan to ensure that he had appropriate access to food, fluids and a toilet during seclusion. This was not acceptable and, in view of these specific failings, we upheld Mrs C's complaint. However, we noted that the board had apologised to her for what happened when her son was transferred, and had acknowledged that there were failings when he was put in the seclusion room. This had prompted a review of seclusion practice and procedures in the hospital. The board sent us evidence of this review and we were satisfied that they had taken action to address these failings. We did, however, draw their attention to some failings in relation to a significant event review carried out in relation to the matter.

Recommendations

We recommended that the board:

- issue a written apology to Mrs C for the failings identified in relation to putting her son in a seclusion room.