SPSO decision report

Case: **201304582, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment he received from the board when he was admitted to prison. He said that he had consultations with two psychiatrists, but the consultations were too short for them to make reasonable decisions about his medical treatment. We found that there was evidence to show that the assessment completed by one of the psychiatrists was reasonable and that she was able to make decisions based on this. However, the evidence the board sent us had no record of the review by the second psychiatrist, so we were unable to say whether this review was reasonable, and we upheld this aspect of Mr C's complaint.

Mr C also complained that the board failed to prescribe a benzodiazepine class drug (drugs used to treat anxiety, insomnia, and a range of other conditions) that he had been receiving when he was admitted to prison. There was no evidence, however, that staff were made aware that he was receiving this medication at the time. It was also reasonable that they did not prescribe the drug when they were told about it, because there were other ways in which they could manage Mr C's symptoms. He also complained that the board had delayed in providing him with tablets that he had been prescribed to help him sleep, and that he had not received these on some of the dates the board recorded he had been given them. In addition, he complained that it was difficult to get the board's complaints forms. As we found no evidence to support these aspects of Mr C's complaint, we did not uphold them.

Finally, Mr C said that he had to wait some months for a mental health review. We upheld this aspect of his complaint, as we found that an appointment with the mental health team had been arranged, but was cancelled because he was at court that day. The appointment was not rearranged until Mr C complained about the delay more than three months later.

Recommendations

We recommended that the board:

- remind the psychiatrist of the need to ensure that appropriate records of consultations are kept in line with General Medical Council guidance;
- make prison healthcare staff aware of our finding that the delay in rearranging Mr C's appointment was unacceptable; and
- issue a written apology to Mr C.