SPSO decision report

Case: **201404761, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained to us on behalf of his daughter (Mrs A) in relation to two assessments she had at Forth Valley Royal Hospital's psychiatric services. Mrs A's mental health was deteriorating, and her family initially sought help for her from a GP, who referred her for a psychiatric assessment. She was subsequently sent home, so her family sought GP assistance again. Following a home visit, Mrs A was again referred for a psychiatric assessment, with a very similar outcome. Mr C complained that the family were only given the opportunity to explain why they were so concerned about Mrs A after her second psychiatric assessment, when they insisted on speaking to the doctor.

We took independent advice on this complaint from one of our advisers in psychiatry. The adviser was critical that Mrs A's family were not expressly involved in either of the assessments. He said that this should be a standard part of such assessments. He also noted that insufficient weight was given to the GP's concerns and findings. He noted that the first GP had done a detailed assessment and history, and this was not fully considered during either of Mrs A's psychiatric assessments. The adviser noted that both doctors who assessed Mrs A were trainees, and expressed concern that there was insufficient documentation as to why Mrs A did not meet the criteria for detention at hospital. He also found that the plan for future follow-up was not practical and did not sufficiently involve her carers.

We considered the advice we received, and found that the psychiatric assessments had not been sufficiently robust. We therefore concluded that she was not given a reasonable standard of treatment. We also noted that the failings in this case potentially put Mrs A at significant risk, as her family no longer felt able to keep her safe.

Recommendations

We recommended that the board:

- review the training for those involved in emergency assessments to ensure it highlights the importance of a corroborative history from relatives and carers; the concerns and findings of GPs; full documentation of consideration of a patient for detention in hospital, including clear links to the legal criteria for that detention; and a practical plan when a patient is not detained, involving carers, and including advice and guidance on potential future action;
- remind existing staff involved in emergency assessments of the requirements specified above; and
- apologise to Mr C and to Mrs A for the failings identified, for the distress they caused, and for the risks that these led to for Mrs A.