SPSO decision report

Case: **202101651, Highland NHS Board**
Sector: Health
Subject: Adult Social Work Services (Highland NHS Only)
Decision: some upheld, recommendations

Summary

C and B complained about the board's handling of reports of alleged elder abuse in relation to a family member (A). They also complained that the board had failed to handle appropriately a referral made to the District Care Panel (DCP) for residential care for A, and had failed to give sufficient consideration to A's circumstances and that they were at risk of harm when rejecting the request. They also complained that following concerns for A's welfare, A had been removed from their place of residence, but the board had failed to properly assess A's care needs or to provide A with a reasonable level of support. In pursuing these matters, C and B said that the board's communication with them had fallen below a reasonable standard.

We took independent advice from a social worker. We found that although the Adult Support and Protection (ASP) investigation was procedurally sound, it had been lacking in quality. The board's analysis of A's circumstances and the Personal Outcome Plans were lacking, and were not persuasive in assessing a care need. As such, we found that the board had failed to safeguard A. We upheld this aspect of the complaint.

We also found that although the DCP handled A's referral for residential care appropriately, the information provided to the DCP was lacking in terms of the quality of the ASP investigation and the robustness of the case presented regarding A's situation. As such there was a failure by the board to prioritise securing urgent short-term accommodation that took account of A's circumstances. We upheld this aspect of the complaint.

We found that following A's removal from their place of residency, the board had followed up with A reasonably. We did not identify any further shortcomings in the board's assessments of A's care or living needs. We did not uphold this aspect of the complaint.

Finally, we found that the board had, at times, failed to respond to C and B's questions and requests for information regarding their concerns about A. We also found that there had been occasions where the board's correspondence with C and B had been unreasonably slow. We therefore upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and B for the poor handling of their correspondence. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C, B and A for the issues identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- The board should (i) share this decision notice with the staff involved in A's case with a view to reflecting on how the ASP investigation could have better identified the nature and extent of their situation and

pushed for an outcome that would have better protected A; and (ii) use this case as a reflective exercise to consider the effect of undue pressure and trauma on decision-making in ASP cases.
- The board should review how they track and respond to general correspondence to ensure all points are responded to fully and within a reasonable timescale.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.