SPSO decision report

Case: **202205337, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that the board provided to A, who had long-term mental health conditions. A was subject to a Community Compulsory Treatment order (CTO, a legal order that allows a person who has been detained in hospital for treatment to be discharged and receive supervised mental health care in the community). C was A's Named Person in respect of the CTO. A experienced a deterioration in their mental health over a short period of time, which concluded with them attending A&E and requesting hospital admission. A was not admitted to hospital and died later that night. The post-mortem believed that A may have completed suicide.

The board carried out a Significant Adverse Event Review (SAER) and concluded that the outcome could not have been predicted. The SAER identified areas of good practice but also some learning points. These centred on missed opportunities to refer A to addiction services and paper notes from the Forensic Community Mental Health Team (FCMHT) not being accessible by other services.

C complained to the SPSO as they felt that there were failings in the care and treatment provided to A that contributed to their death. In addition to this, C complained that the board did not communicate with them reasonably, given that they were A's Named Person.

We took independent advice from an adviser with a background in forensic psychiatric nursing. We found that the overall care and treatment provided to A in respect of their mental health was reasonable. We considered it clear that access to the FCMHT records across services would have been preferable. This would have assisted the clinical decision-making when A presented to A&E. However, we found that there are no standard guidelines or requirements for the sharing of records across NHS services in Scotland. Based on A's presentation and what was known to clinicians at the time, we found that the care and treatment provided by the board was reasonable. Therefore, we did not uphold this part of C's complaint.

In respect of C's role as A's Named Person, we found that it was unreasonable not to involve C in discussions regarding A's circumstances. Relevant Scottish Government guidance indicates that it is necessary for the board to ensure that Named Persons are given information regarding compulsory measures. We found that the board's actions and responses did not fully reflect the Scottish Government guidance regarding Named Persons. Particularly as there were discussions at the time about ending A's CTO. Under the circumstances, we found that the board did not involve or communicate with C to a reasonable level. Therefore, we upheld this part of C's complaint.

During our investigation, we found failures in the board's handling of C's complaint and made recommendations to address these.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for not involving or communicated with C to a reasonable level. 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:

- Relevant staff and services should have a firm understanding of what the Named Person role involves. Services should engage and communicate with Named Persons in line with the relevant guidance issued by the Scottish Government: Mental Health Law in Scotland: A Guide to Named Persons

In relation to complaints handling, we recommended:

- Causation/conclusion codes on adverse event review reports should accurately reflect the findings of the review.
- Documentation that is relevant to the SAER should be available to and considered by the team carrying out the review.
- In response to SPSO enquiries, every effort should be made to provide any requested information at the earliest opportunity.

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.