SPSO decision report

Case: **202301151, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C's adult child (A) had been referred to the board's Community Mental Health Team (CMHT). A had some contact with both psychiatry and psychology services over the next few weeks. A later died.

The board commissioned a Significant Adverse Event Review (SAER) into the care provided to A. In the SAER it was concluded that, following an initial face-to-face assessment by Community Psychiatric Nurses (CPNs), a further face-to-face consultation should have been arranged and that not doing so compromised the care provided to A.

C complained to the board about the care and treatment provided to A, and communication during the SAER process.

We took independent advice from a psychiatry adviser. We found that the SAER conclusion regarding face-to-face consultation of A was reasonable. We also found that no evidence of a contemporaneous record of the examination carried out by a consultant psychiatrist had been provided and that the record that had been provided does not indicate a comprehensive Mental State Examination (MSE) was undertaken at this time. We found that this was unreasonable given the other evidence available of A's presentation at this time. Given this, and the conclusion of the SAER that the care and treatment of A had been compromised, we upheld C's complaint about the care and treatment provided to A.

C's concerns about the SAER process originated in the delays and lack of communication throughout the process, and the failure to provide a final copy of the SAER. We found that the SAER in itself was reasonably thorough but are concerned that no contemporaneous record of the MSE was identified by the SAER. We found that the extended timescale for completion of the SAER and the board's communication with A's family, which did not include regular or on-going communication and was subject to a lack of clarity around the status of the SAER report that continued for a period of years, was unreasonable. We also considered that during the SAER process, A's family were not provided information that they requested and there is no evidence that they were invited to meet with the review team or have engagement and involvement during the SAER processor as the report was finalised. Given this, we upheld C's complaint about the undertaking of the SAER.

We considered the way that the board communicated with C regarding the time limits for making complaints to themselves and the SPSO was overly focussed on reiterating that the complaint was out with normal timescales and unnecessarily negative. The board also stated that SPSO were "unlikely to undertake review of the complaint". We found that this was misleading as any such decision would depend on our own assessment of any special circumstances which should be taken into account when considering time restrictions. We also considered that this statement unreasonably failed to recognise how the board's own handling of communication and commitments made to C had led to the complaint being raised much later. Given this, the delay in responding to C's complaints and the failure to directly respond to a specific concern raised by C, we upheld C's complaints about how the board had handled their complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C that no comprehensive Mental State Examination of A was carried out. 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 that the board did not reasonably enable A's family to be engaged and involved during the SAER process as the report was finalised, that the board did not update A's family regarding the delays in the progress of the SAER and that there was a lack of clarity around the status of the SAER report. 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 that they reiterated on an unreasonable number of occasions that they had decided to investigate C's complaint despite it having been made out with the time limits in their Complaints Handling Procedure, and that the board unreasonably speculated that the SPSO were "unlikely to undertake a review of the complaint" if C escalated it. 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 board staff complete and record comprehensive Mental State Examinations on patients referred to psychiatry.
- The board undertake SAERs reasonably and in line with relevant guidance.

In relation to complaints handling, we recommended:

- Information in the board's complaint responses is not unreasonably negative or inaccurate.

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.