SPSO decision report

Case: **202308194, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board's mental health services did not communicate information regarding C's adult child (A) reasonably. A, who had experienced various mental health issues, was taken to hospital after taking an unknown quantity of tablets. C and another family member were concerned about A's mental health. A did not wish to remain in the hospital and clinicians assessed that A had capacity to make this decision. A few days later, A agreed to go to the hospital for a mental health assessment. The board referred A to the community mental health team (CMHT) and did not admit them to hospital. A few weeks later, A took their own life.

C complained about the board's actions in the lead up to A's death. The board's complaint response indicated that they had no concerns about the actions taken in relation to A's care. A significant adverse event review (SAER) concluded that communication between agencies (including within the board) could have been improved and an action plan based on the SAER recommendations was developed. The board acknowledged that A had died while in their care and apologised for this. C remained dissatisfied and raised their complaints with SPSO.

We took independent advice from a consultant psychiatrist. We found that, as the SAER concluded, there were failures in communication involving the mental health team, including failures to update risk assessments, failures to use the electronic case notes system and inconsistency in referral criteria across CMHTs. We concluded that the board did not take a partnership approach when communicating with Ass family and did not adequately take into account their concerns when assessing risk. Therefore, we upheld C's complaint.

During our consideration of the complaint, we gave the board the opportunity to comment on the adviser's views on the SAER Action Plan. The board reviewed and rewrote the SAER Action Plan and the proposed actions now relate directly to the recommendations in the report. However, we also noted that the board do not have the resources to undertake the proposed actions due to funding decisions. We noted that the revised SAER Action Plan could have included alternative actions that were not reliant on funding decisions. We have taken all of the above into consideration when making our recommendations.

Recommendations

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

- Board staff are mindful of the importance of communication with the family members of neurodiverse patients and adequately take the concerns of family members into account when assessing risk.
- The board develop a contingency plan to address failings in communication through training and team development of relevant staff that does not rely on external new funding, which could include building in awareness-raising and training within the development of revised CMHTs; and developing "Neurodiversity champions" within each team as sources of greater expertise to spread information and awareness.

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.