SPSO decision report

Case: **202400103, Lanarkshire NHS Board**
Sector: Health
Subject: Communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their adult child (A) by the board. A had received care from mental health services for several years prior to their death by suicide. C complained that the board failed to reasonably share information with A's family and failed to involve family in A's care. C also complained about the board's adverse event review process, and their complaint handling.

We took independent advice from a consultant psychiatrist. We found that the board had failed to evidence that there was any discussion with A about sharing information with their family or involving family in care and treatment, including risk assessment. We considered that not to have had this discussion, or to have had the discussion and failed to document it, was unreasonable.

The board told us that records were kept briefer than they would normally, because A was an employee of the NHS and was concerned about their records being kept confidential. We did not consider this to be a reasonable position to take, as all patients, including those who are NHS staff, should be confident that their records will be kept confidential. We considered it unreasonable that the board had not addressed this concern. We upheld C's complaint about information sharing and involvement of family.

In relation to the adverse event review process, we found that the board had not appropriately taken account of C's view on the scope of, and information to be contained within the review, and because it did not identify the failings in care. We upheld this aspect of the complaint.

Finally, we considered the board's handling of C's complaint to be unreasonable. This was because answers to multiple questions about care and treatment were responded to using generic and repetitive phrasing, the complaint response contained several inaccuracies and C was not made aware that some aspects of the complaint could only be responded to by another organisation until the final complaint response,. We upheld this aspect of the complaint.

Recommendations

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What we asked the organisation to do in this case:

- Apologise to C for the failings with regard to information sharing and involvement of A's family, the adverse event review process and the complaint handling and response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Adverse event review teams should be open to the requests of family when making decisions about scope

and information contained in the final report. Adverse Event Reviews should be a reflective and learning process that appropriately consider events in sufficient detail to ensure failings and any appropriate learning and practice improvements are identified.
- Patients who are also employees of the NHS should have confidence that records will be confidential.
- Records should be comprehensive and completed in line with professional standards. In particular, mental health services should seek to discuss involving family in care planning and risk assessment. These discussions and outcomes of such should be documented and revisited regularly.

In relation to complaints handling, we recommended:

- Where some aspects of a complaint cannot be responded to by the board, the board should coordinate responses or make the complainant aware that they need to approach another organisation at the earliest possible point. Complaint responses should attempt to address individual concerns, or explain why that is not possible. Complaint responses should be accurate.

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.