

## SPSO decision report

**Case:** 202408872, Glasgow City Health and Social Care Partnership  
**Sector:** Health and Social Care  
**Subject:** Other  
**Decision:** not upheld, no recommendations

### Summary

C complained about the care and treatment provided to their adult child (A). A experienced a decline in mental health and was referred to their local community mental health team by their GP. A was in contact with mental health services for a period of approximately three months before dying by suicide.

C complained that the board had not reasonably listened to their concerns about A. C also complained about the board's assessment and management of risk for A, A's diagnosis and medications.

The board completed a Significant Adverse Event Review (SAER) of the care and treatment provided in the six months prior to A's death. The review concluded that, overall, appropriate care was provided by mental health services. The review identified some improvements and recognised that communication between A's family and the consultant psychiatrist was poor. The review found that the issues identified did not contribute to A's death.

We took independent advice from a consultant psychiatrist. We found that the care and treatment provided to A was reasonable, including the assessment and management of risk for A, A's diagnosis, the prescription of medications and the board's handling of concerns from A's family. We found some shortcomings in documentation. We found that the Board's SAER was reasonable, as the standard of the review was good and the recommendations made by the review were appropriate, however, the review process took significantly longer than timescales stated in the guidance for SAERs, for which the board apologised. On balance, we did not uphold C's complaint.