SPSO decision report

Case: **201003393, South Lanarkshire Council**
Sector: local government
Subject: complaints handling (incl social work complaints procedures)
Outcome: some upheld, no recommendations

Summary

Ms C complained to the council about their handling of an incident involving her late brother (Mr A). Mr A had severe learning difficulties and at the time of the incident was receiving 24-hour support at home from a care provider. He fell down a flight of stairs and was seriously injured, after the carer administered a drug with a sedative effect. Mr A died some time later.

We acknowledged that the council's communication with Ms C could have been clearer in relation to who was actually investigating the incident but did not consider that they had intentionally misled her. Neither did we consider it unreasonable that the council did not hold a further complaints hearing after Ms C provided them with a report from the Health and Safety Executive (HSE), as the report contained little information that was not already available to the council. We also determined that the council provided a reasonable explanation about why they did not follow procedures laid out in the Adult Support and Protection (Scotland) Act 2007 and associated code of practice issued by the Scottish Government.

We noted, however, that the Scottish Government introduced guidance two months after the incident, clarifying the role of the chief social work officer (CSWO). This outlined that the CSWO should ensure that significant case reviews are carried out into all critical incidents either resulting in, or which could have resulted in, death or serious harm. Although the guidance was not in place at the time of the incident involving Ms C's brother, it came into effect less than two months later, and the council received the care provider's report into the investigation after the guidance had been published. Given the seriousness of the incident, therefore, and the fact that the HSE only recently disclosed more of their report, we concluded that it would have been reasonable for the council to have conducted a significant case review. This would have enabled them to look at all aspects of Mr A's care, to properly establish whether any lessons had to be learned or improvements in practice were needed. As, however, the independent chair of the council's adult support and protection committee had since agreed to conduct such a review, we made no recommendations about this.