SPSO decision report

Case: **201400324, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the mental health care and treatment provided to her late son, as well as the lack of support for her and her family, the lack of family involvement in the critical incident review (CIR) following her son's death, and the delay in providing her with a copy of the CIR report. Mrs C also complained to the General Medical Council (GMC) about the psychiatrist involved in her son's care. The GMC investigated, and decided to take no action.

We decided not to re-investigate those matters which had already been considered by the GMC. However, we agreed to investigate some issues which had not been looked at by the GMC, including the conduct of a mental health assessment, the support provided to the family, and the complaints about the CIR.

After taking independent mental health advice, we upheld three of Mrs C's complaints. We found that the board unreasonably failed to include Mrs C in the CIR process and that the delay of over six months in providing Mrs C with a copy of the CIR report was unreasonable. However, we accepted that the board had apologised for this delay and taken appropriate steps to improve their CIR process.

We also found the board had not provided reasonable support for Mrs C and her family as carers. While the board had since amended their paperwork to improve involvement of carers at the assessment stage, we did not consider this was sufficient to prevent a recurrence, as the meaningful involvement of a person's relatives should be on-going, rather than completed as a one-off exercise.

In relation to the mental health assessment of April 2011, we found this had been conducted reasonably, and we did not uphold this complaint. However, we were concerned that there had been a delay in arranging a referral to a psychiatrist following this assessment, and we raised our concerns about this with the board.

Recommendations

We recommended that the board:

- apologise to Mrs C for the failings our investigation found; and
- advise us how they will ensure on-going carer involvement, in light of our adviser's comments.