SPSO decision report

Case: **201508582, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the mental health care and treatment of his late wife (Mrs C) in the weeks prior to her suicide. Mrs C had a history of mental illness, and was referred urgently to psychiatry by her GP due to returning symptoms. Mrs C was assessed and a plan was made to treat her at home with support from the Intensive Home Treatment Team (IHTT). After four weeks, the IHTT referred Mrs C to her local team (Rehabilitation and Enablement Services Mental Health Team (RES MHT)) for further care. However, due to problems with the referral process there was a delay in transferring care and a ten day gap between appointments. Mrs C completed suicide the day after her first RES MHT appointment.

The board conducted a Significant Clinical Incident investigation into Mrs C's death. While the review team concluded the care was appropriate, they identified problems with the transfer process, and a lack of documentation about the role Mrs C's family had in her care planning. In response to Mr C's complaint, the board acknowledged failings in involving Mrs C's family in her care planning and in the referral process. The board apologised to Mr C and provided information on a number of actions underway to improve the RES MHT service.

After taking independent mental health and psychiatry advice, we upheld Mr C's complaint. We agreed with the board's findings that there was a lack of involvement of Mrs C's family in her care planning, and failings in the referral process. We also found that, while a comprehensive risk assessment was carried out, the management plan did not include a summary formulation of risk (as required by the local policy). While we considered the board had already taken appropriate action to address the issues found in relation to the RES MHT, we asked that they provide details of action taken in relation to the IHTT.

Recommendations

We recommended that the board:

- remind staff of the requirement to implement a summary formulation of risk (as well as a risk management plan) under the Clinical Risk Screening and Management Policy; and
- demonstrate that action has been taken to improve documentation of carer involvement (and patient consent to this) by IHTT staff in care planning and risk management.