# SPSO decision report

**Case:** **201700001, Borders NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Mrs C complained about the care her late son (Mr A) received from the board's mental health team. Mr A was discharged home on a community based compulsory treatment order but completed suicide around 18 weeks later. Specifically, Mrs C complained that the conditions of the compulsory treatment order were not adhered to by staff, that there was insufficient communication with Mrs C as Mr A's named person, and the board's review of Mr A's death did not include certain information which Mrs C considered relevant.

The board carried out a significant adverse event review (SAER, a structured approach to learning from an adverse event) and in their response to Mrs C, they concluded that the care Mr A received was person-centred. The board also identified some learning points in relation to managing the expectations of the named person. Mrs C was unhappy with this response and brought her complaint to us.

We took independent advice from a mental health nurse and a consultant psychiatrist (a specialist in the diagnosis and treatment of mental illness). We found that there were significant gaps and numerous retrospective entries in Mr A's medical records which were unreasonable and not in line with national guidance on record-keeping. We considered that this likely impacted on the team's ability to fully understand Mr A's health and wellbeing. There was evidence to show that Mr A did not receive the planned number of weekly visits from the team, either because he missed appointments or because the visits were not carried out. Given Mr A's complex care package, we also considered that escalation to the responsible medical officer should have taken place when there had been a nine day gap in contact or when there was a significant deviation from his care plan (only one visit a week instead of three). Therefore, we upheld this aspect of Mrs C's complaint.

In relation to communication with Mrs C, we noted that the rights of the named person are limited and there was no requirement for the team to have shared all aspects of Mr A's care with her. However, we considered it is generally good practice to communicate with the named person/family which had been part of Mr A's care plan. We found that the mental health team did not communicate reasonably with Mrs C and upheld this aspect of her complaint. However, we noted that the board had acknowledged these failings.

In relation the the SAER, we did not have significant concerns about the information Mrs C felt was missing. However, we were critical that she had not been provided with the opportunity to raise such concerns. We were also concerned that the SAER should have identified the failings in record-keeping as part of the review of Mr A's care. We upheld this aspect of Mrs C's complaint.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in Mr A's agreed care plan and poor record-keeping. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- When significant deviation from an agreed care plans occurs, this should be escalated to the responsible medical officer for discussion and a record made of what the response to this should be.

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.