SPSO decision report

Case: **201804281, A Medical Practice in an NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained that the practice unreasonably failed to assess her child (Child A) before prescribing antidepressants; unreasonably failed to assess Child A before referring her to child and adolescent mental health services; unreasonably failed to include relevant information in the referral to child and adolescent mental health services; and unreasonably failed to give Ms C the appropriate information when she raised concerns about Child A.

In investigating Ms C's complaints, we took independent advice from a GP. We found that in relation to the prescription of antidepressants, this was a repeat prescription that should not have been issued. We found that Child A should have had a face-to-face assessment prior to antidepressants being re-prescribed. We found that this was an administration error as it should have been noted by the administrative staff who printed the repeat prescription that there had been a lengthy period of time since the last repeat prescription. We upheld this aspect of Ms C's complaint, however we considered that the actions already taken by the practice would address this issue.

In relation to the referral to child and adolescent mental health services, we found that this should not have been made without Child A's consent, and without a face-to-face assessment of Child A. Therefore, we upheld the complaints that there was an unreasonable failure to assess Child A and that the referral was unreasonable. However, in relation to the information that was included in the referral, we considered this to be reasonable. We found that appropriate action had been taken by the practice to address the failure to assess Child A in person prior to the referral being made, however, we made a recommendation to the practice in relation to consent.

We found that when Ms C raised concerns about Child A with the practice, they failed to tell her that Child A would need to be assessed in person. We upheld this aspect of Ms C's complaint.

Finally, we found that the practice's significant event review of the matters relating to this complaint was of a poor standard and lacked reflection. We made a recommendation to the practice to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for; failing to assess Child A before prescribing antidepressants; failing to assess Child A before referring them to the Young People's Department at Child and Adolescent Mental Health; making an unreasonable referral to the Young People's Department; failing to give Ms C the appropriate information when she raised concerns about Child A. 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:

- Patients should be informed of referrals and given the opportunity to object to any disclosure of information. This should be in line with General Medical Council guidance relating to consent and sharing information about young people, and ethical practice.
- Information should be given to parents/carers about the need to assess young people prior to referral where appropriate.

In relation to complaints handling, we recommended:

- Significant event reviews should be robust and reflective.