

## SPSO decision report

**Case:** 201806552, Forth Valley NHS Board  
**Sector:** Health  
**Subject:** clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

Ms C complained to us about the care and treatment provided to her father (Mr A) before his death from suicide. Mr A was admitted to Forth Valley Royal Hospital after expressing suicidal thoughts. He was discharged on the following day. Ms C complained that it was unreasonable to discharge Mr A at that time.

We took independent advice from a psychiatric adviser. We found that there was no evidence that Mr A had been adequately assessed and we upheld the complaint that he was discharged unreasonably.

Mr A returned to the hospital on the day he was discharged and asked to be readmitted. However, it was decided that he would not be readmitted. Ms C complained that this decision was unreasonable. We found that it was unreasonable that the nursing staff did not consult a doctor and carry out an assessment when Mr A returned to the hospital. We also upheld this complaint.

Ms C complained that Mr A's medical records were inadequate. We found that there were failings in relation to describing the assessment of risk, the clinical rationale for the management of Mr A, discharge planning, changes in his mental state and information available from his family. We upheld this complaint.

Finally, Ms C complained that the board had delayed in completing a significant adverse event review. The board had accepted that there were delays in this and had apologised for this. We upheld this complaint.

We were satisfied, however, that the board had taken reasonable and appropriate action to try to prevent all of these failings recurring. They had also apologised to the family for most of the failings, although we recommended that they issue a further apology for the delay in completing the significant adverse event review.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the delay in completing a significant adverse event review. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsos.org.uk/information-leaflets](http://www.spsos.org.uk/information-leaflets)

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.