SPSO decision report

Case: **201808444, Glasgow City Health and Social Care Partnership**
Sector: Health and Social Care
Subject: clinical treatment / diagnosis
Decision: upheld, no recommendations

Summary

C complained to us that the partnership had failed to provide reasonable psychiatric care and treatment to their parent (A) before they completed suicide. We took independent advice from a psychiatric adviser. We found that there had been a number of failings in A's care:

There was no specific action taken to either address or mitigate the risks identified on A's care plan beyond continuation of the current treatment plan and referral to psychotherapy.

It was not clear from the record to what extent there was direct communication between the psychiatrist and the community psychiatric nurse (CPN), specifically with respect to A's management following an overdose.

The fact that A was neither reviewed medically or from a nursing perspective over a six-week period in the aftermath of their overdose was a significant shortcoming.

The lack of development of shared risk management plans within the community mental health team (CMHT) was not reasonable.

The fact that there was not a scheduled regular meeting to discuss complex cases was not reasonable.

There was neither a clearly understood protocol within the CMHT to annually review longer-term cases or a robust facility to provide the psychiatrist with regular consultant supervision for cases under their care.

It was not apparent from the case record exactly which consultant was responsible for A.

A did not receive appropriate annual review from the CMHT and that this was not reasonable.

In view of these failings, we upheld C's complaint. However, we considered that the action the partnership had decided to take in response to these failings had been reasonable, but asked for evidence that this had been completed. There was also no clear evidence that A's death could have been prevented.

C also complained that an officer from the partnership had failed to meet them in response to their complaint as previously agreed. Whilst it was not entirely clear if the officer had offered to meet C, overall, the handling of the matter was unacceptable given the nature of C's complaints. We also upheld this complaint, although we were satisfied with the action the partnership had subsequently taken in response to these failings and made no recommendations.