SPSO decision report

Case: **202001745, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about their adult child's (A) treatment in the months prior to their death. A completed suicide soon after they had been assessed by nurses from the Crisis Assessment and Treatment Service (CATS) and Specialist Drug and Alcohol Service (SDAS). C complained that the risk to A's life wasn't properly assessed, and that the family weren't appropriately involved. C also complained that board staff failed to take follow-up action when A had communicated suicidal thoughts in previous months, and that there was no follow-up plan in place following discharge from a hospital admission.

We took independent advice from a mental health nurse and a psychiatrist. We found that the assessment prior to A's death did not explain how it was concluded that there was no immediate risk when A was exhibiting a number of risk factors. There was no evidence of these risk factors being effectively weighed against protective factors, and no evidence of hospital admission having been considered and ruled out. There was also no evidence of C and A's sibling (B) having been appropriately involved in the assessment. We found that the post-assessment care plan was not sufficiently robust, and that the notes were not clear as to the level of the family's agreement with this. B contacted CATS out of hours service post-assessment to express concern about A and complained that no help was provided. We found that there was an unreasonable failure to arrange a follow-up telephone consultation.

With regards to a lack of follow-up further to A's previous report of suicidal thoughts, the board said that they could find no record of this having been reported to them. We found that there was evidence in the GP record of the GP having contacted SDAS about this. We found that there was a failure to record or act upon this communication from the GP. It was noted that this may not have had a material impact on the eventual outcome, as A was later admitted for assessment and stabilisation, though, we found that there was an unreasonable delay in A receiving any follow-up following their discharge from this admission. The board had already acknowledged this and taken steps to address it.

C also complained about a reduction in dosage of A's anti-psychotic medication during the aforementioned admission. We found that A was appropriately involved in this, but that there was no evidence of proactive involvement of family members in these discussions. We also found that there was a lack of clarity surrounding the prescribing of Pregabalin (an anticonvulsant and nerve-pain relief drug). The board had already undertaken to establish good practice guidelines to ensure medication safety in polypharmacy (the simultaneous use of multiple medicines by a patient). The board also acknowledged a number of issues relating to communication with the family and a failure to involve them in care planning. We found that there was an overall failure to involve family members as partners in the care process. We, therefore, upheld all aspects of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and B for the identified shortcomings in the crisis assessment, and failures to involve and

communicate with them regarding A's care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

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

- Approaches to risk assessment should be systematic and evidence-based, and clinical judgements effectively reasoned in clinical records.
- Families' views should be respected and they should be involved as partners in the care process as far as confidentiality imperatives allow. Working with families should be central to recovery-focussed mental health care, and should be governed by agreed guidelines/standards for practice and regular monitoring.
- Risk management should explore all available options for keeping people safe within the context of placing the minimal necessary restrictions upon their freedoms. In the interests of transparency, clinical records should demonstrate the options considered for keeping people safe and why chosen courses of action were preferred over other available alternatives.
- There should be more robust approaches to risk assessment, record-keeping and family participation. Families' views should be respected, and they should be involved as partners in the care process as far as confidentiality imperatives allow.
- To be effective in preventing recurrences of serious incidents, investigations should be carried out with due thoroughness to get to the root causes underlying tragic events. SAER processes should be robust and allow critical information to be gathered from all stakeholders.
- Systems and processes for monitoring the effectiveness of record-keeping should be robust, and clinical record-keeping practice should form part of each practitioner's clinical supervision activity.

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.

When this report was first published on 21 December 2022, it referred to A as the 'child' of C. This was in reference to their familial relationship however the summary was amended to read 'adult child' on 22 December 2022 for clarification. We apologise for any confusion caused.