# SPSO decision report

**Case:** **202008806, Lothian NHS Board - Acute Division**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

C complained on behalf of their client (B) about the care and treatment provided to B's late sibling (A). A had attended the A&E in mental distress, had attended their GP the same day, and had a hospital appointment with the crisis team a few days later. At this appointment it was considered that hospital admission was not required. A completed suicide a short time later. B felt that the board had failed to provide reasonable care and treatment to A.

We took independent advice from a mental health nursing adviser. We found that the board had carried out a detailed review of A's care and had taken some action which was reasonable. However, we found that the risk assessment carried out by the board when A presented at A&E lacked transparency and rigour. The assessment carried out a few days later provided more detail, however, it lacked a structured risk assessment and the clinical reasoning behind not offering any ongoing planned follow-up and the weighing of current and historical risk indicators against protective factors was not fully transparent. The record keeping of the risk management decisions was also not sufficient to show the way in which risks factors and protective factors were balanced. We also found that it was unreasonable that the board's administrative systems resulted in an erroneous early diagnosis of borderline personality disorder being recorded. We found that the Adverse Event Review process did not appear to attempt to establish why things occurred as they did, rather than simply establishing what occurred. Therefore, we upheld the complaint


## Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for failing to provide reasonable care and treatment to A. 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:

- Processes for risk assessments should ensure that information is gathered from all professional and non-professional sources, and that decision-making is a transparent, structured process based upon best possible evidence.
- The AER process should explore the influence of factors such as systems and processes, supervision, team-working, management decision-making, patient factors, resources, training, and policies / protocols in order to establish why things occurred as they did.

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.