SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201303844, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained to us about the care and treatment of her son (Mr A) at the Royal Edinburgh Hospital. Mr A was admitted to hospital under a short-term detention certificate when he was having an acute reaction to stress. He was discharged nine days later, but had ongoing contact with psychiatric services. He was readmitted to hospital the following month, and was an in-patient for a month. After he was discharged he continued to be in the care of psychiatric services, and engaged to varying levels with community based staff. Around ten weeks after his discharge Mr A committed suicide.

Mrs C complained that her son's care was not sufficiently coordinated between professionals and teams. She was also concerned that her son had been discharged without a care plan in place and with no support, and said that staff were unwilling to provide her with enough information for her to be able to support her son.

We took independent advice from two of our advisers - a psychiatric nurse and a psychiatrist. The advisers reviewed Mr A's care and treatment and said that Mr A's care had been appropriately coordinated. They said that information about a patient's care and treatment could not always be shared with all family members, but that information was passed on appropriately during Mr A's care. Mr A was given appropriate medication, but at times he had been reluctant to take this. The advisers also explained that, while the medication prescribed may have slowed Mr A down, it would not have lowered his mood. In relation to Mr A's discharge, the advisers said that the discharge process was properly planned and cohesive. On the basis of this advice, we did not uphold the complaint about Mr A's care and treatment.

Mrs C also complained that she had not received a full response to her complaints within a reasonable timescale. She had chased the board for responses, and felt that her concerns were not addressed honestly. She also met with board staff in an effort to get answers. It was nearly two years from when Mrs C first wrote to the board when they finally told her she could contact us. The NHS complaints procedures says that complainants should be told that they can approach us after 40 business days, even if the board have not provided a final response to the complaint by then. We upheld this complaint, as the timescales were not in line with the NHS complaints procedures. We also found that the responses lacked the detail that Mrs C was expecting and did not address all her concerns, which was not in line with good complaints handling.

Recommendations

We recommended that the board:

- apologise to Mrs C for their failure to address her complaints in a timely and appropriate manner.