SPSO decision report

Case: **202303356, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, recommendations

Summary

C complained about the care and treatment that their adult grandchild (A) received from the board.

A received regular anti-psychotic medication from the board's mental health service. Separately, A suffered from episodes of paralysis, for which they attended A&E on numerous occasions. A died suddenly at home.

C complained that the board failed to recognise A was seriously unwell, with their episodes of paralysis wrongly being attributed to their mental health condition. On the day of A's death, A had fainted at the health centre after receiving their injection. C said that A attended A&E for assessment but was discharged without treatment.

The board's response to C's complaint advised that A had been fully assessed during each of their A&E attendances, with appropriate referral being made to neurology (specialists in the diagnosis and treatment of disorders of the nervous system) and advice sought from the mental health service. The board said that there was no evidence of A attending A&E on the day of their death so were unable to account for the hospital ID band that they had been wearing at the time. The board completed a Significant Adverse Event Review (SAER) in response to C's complaint.

We took independent advice from an A&E consultant and a consultant psychiatrist. We found that A received reasonable care from the board during their A&E attendances and confirmed that there was no record of A having attended A&E on the day of their death. We found that the management and review of A's mental health was both reasonable and appropriate. Therefore, we did not uphold C's complaint.

We found that the board's complaint response was delayed following the conclusion of the SAER. Therefore, we made a recommendation on complaint handling in keeping with our powers to monitor and promote best practice.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to respond timeously to their complaint following completion of the SAER. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- In relation to complaints handling, we recommended
- Complaint responses should be issued in keeping with the timeframe given by the complaints handling procedure. Where a delay is necessary such as to allow completion of other review processes, the final complaint response should be issued as soon as it is practicably possible on conclusion of the other review process.

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.