Scottish Parliament Region: Glasgow

Case 200502382: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised concerns that the contents of a psychological report which had been completed regarding his son (Child C) contained unverified and incorrect information and included a section which was not relevant to the actual diagnosis.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board would not withdraw or correct a psychological report that it knew to contain inaccurate information *(not upheld)*; and

(b) psychological reports issued by the Board include a section which is not relevant and have no bearing on the actual diagnosis *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 28 November 2005 the Ombudsman received a complaint from the complainant (Mr C) about the contents of a psychological report which had been completed by the Department of Child and Family Psychiatry (the Department) regarding his son (Child C). Mr C complained that the report contained unverified and incorrect information and also a section which was not relevant to the actual diagnosis. Mr C had complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with the responses which he had received.

2. The complaints from Mr C which I have investigated are that:

(a) the Board would not withdraw or correct a psychological report that it knew to contain inaccurate information; and

(b) psychological reports issued by the Board contain a section which is not relevant and has no bearing on the actual diagnosis.

Investigation

3. In writing this report I have had access to correspondence between Mr C and the Board regarding the complaint and the clinical records pertaining to Child C. I sought clinical advice from one of the Ombudsman's professional medical advisers (the Adviser) who is a Psychiatric Consultant. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in the report can be found at Annex 1. Mr C and the Board have had the opportunity to comment on the draft of the report.

(a) The Board would not withdraw or correct a psychological report that it knew to contain inaccurate information

4. Mr C complained to the Board about the contents of a psychology report which was completed in respect of his son, Child C. He said that the report contained incorrect information that 'there had been no contact between [Child C] and his father until he was two and a half years old'. Mr C had attended a meeting on 12 August 2005 with the Trainee Clinical Psychologist (the Psychologist) who produced the report, and Mr C provided solicitors' letters which had set out his involvement with Child C since birth. Mr C stated that Child C no longer came for contact visits and Mr C was concerned that if, when he becomes a teenager, he was shown the original report by his mother then

this would affect his view of Mr C. The Psychologist had provided Mr C with an amended report which had the Family Background section omitted. However, if such background information was deemed necessary then Mr C felt action should be taken where the information is supplied by one parent to seek confirmation from the other parent. Mr C felt that Greater Glasgow and Clyde NHS Board – Yorkhill Division (the Division) should be taking action to protect vulnerable children and were discriminating against fathers where the mother had provided information which had not been verified. He suggested that perhaps a clause be inserted into a report that the information supplied by the mother had not been verified by the father.

5. The Board's Divisional Chief Executive (the Chief Executive) responded to the complaint and said that the information about Child C's contact with Mr C was originally obtained from Child C's mother as she had brought Child C to the clinic to be assessed. As a result of Mr C's representations an addendum had been attached to the original report which clarified the contact between Mr C and Child C to prevent future misunderstandings and to demonstrate to Child C, Mr C's desire to be an active part of his life. The Chief Executive accepted that the Division had no control of an incorrect report which had been sent to a recipient other than to issue an addendum and that is what happened in this case. The Chief Executive gave an assurance that the General Manager was liaising with the Department to ensure that all reasonable efforts are made to accurately record the involvement of parents/relatives/carers in the assessment process and that all reasonable efforts are made to involve significant persons.

6. The Adviser said that it was evident from the clinical records and papers that Mr C and his wife had lived apart for some years. Child C was referred to the Department in 2003, and referred on for a multidisciplinary assessment. When this was complete, the report, a normal clinical letter, was sent to Child C's GP and a copy to his mother, with whom he lived. Mr C obtained a copy of the report and objected to a sentence in the family background section: 'There was no contact between [Child C] and his father until he was around 2 and a half years old'. This information, from Child C's mother and grandmother, was incorrect, and Mr C produced copies of contemporary letters from solicitors to prove it. The Adviser commented that the report quite rightly lists the sources of its information, and it is an obvious inference that Child C's father was not included, and that comments about his earliest years must have come from his mother, or indeed her mother. The Adviser did not think it would be practical to have sources referenced for every fact, or even every section. Nor would it be

reasonable to be expected to produce a report that was not capable of being used selectively by someone else for his/her own purposes.

(a) Conclusion

7. Mr C had concerns that the report contained unverified and inaccurate information and that it could affect his relationship with his son. The Board have provided explanations on what action they had taken in that an addendum had been added to the records so that other clinicians or Child C could reach an informed opinion on events. I accept that it is not always possible to ensure that the information obtained from one parent is accurate when both parents are not present or the parents are either separated or divorced. However, it would not be reasonable to expect the Board to always seek confirmation from both parents where information is obtained at a consultation relating to a child. I have decided not to uphold this aspect of the complaint.

(b) Psychological reports issued by the Board include a section which is not relevant and has no bearing on the actual diagnosis

8. Mr C had concerns that the original report issued in April 2005 had a section headed 'Family Background' which he felt was not relevant. Mr C said that Division Guidelines 'Keeping and protecting information' says that except in unusual circumstances information would be restricted to those items required for the purpose of treatment or well being e.g. name and address, DOB, GP details, past medical history etc. In view of this Mr C felt the 'Family Background' section was unnecessary and would not have affected the final diagnosis.

9. The Chief Executive responded to the complaint in that Child C had been referred to the Department because of concerns regarding his emotional and behavioural functioning. He advised that in order to reach conclusions and a diagnosis it is necessary to undertake a comprehensive assessment of all factors that may contribute to the child's presentation. This routinely involves gathering information regarding early life experiences including the formation of early relationships. Documentation of information gathered in the assessment ensures a transparency of the process and indicates how a clinician has reached his conclusions. It also allows others to accept or challenge the conclusions.

10. The Adviser said that the clinical records indicated a good standard of care. The psychological report also is comprehensive, well constructed and

clear. It is typical of a communication from the Mental Health Services. Producing such letters and reports is very much part of normal practice, and psychologists and psychiatrists should be trained in this regard. Training should also emphasise the importance of factual accuracy and the inclusion of as much detail as is necessary to give a well rounded picture of the patient and his/her problems. The Adviser said some GPs would not want all this detail at the time, but it is generally accepted that the production of legible summaries such as this is of great assistance for future reference, both in GPs records and in the hospital copies. The Adviser commented that there are always concerns about the dissemination of information that is often very personal, but at present this is normal practice. The Adviser concluded that understanding the family background is an essential part of the assessment of any child and a summary of it will always be included in reports such as these.

(b) Conclusion

11. Mr C felt that the inclusion of the section 'Family Background' in psychological reports was not relevant and would not affect the final diagnosis. The advice which I have received and accept is that the family background is an essential part of the assessment of any child and should be included in reports of this type. Accordingly I do not uphold this aspect of the complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Child C	Mr C's son
The Department	Department of Child and Family Psychiatry
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional medical adviser
The Psychologist	The Trainee Clinical Psychologist who produced the psychology report
The Division	Greater Glasgow and Clyde NHS Board – Yorkhill Division
The Chief Executive	The Board's Divisional Chief Executive