SPSO decision report

Case: **201502006, A Medical Practice in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mr C complained about the care and treatment given to his son (Mr A) in the month before he died. Mr A had two consultations at the practice during this period. During the consultations he expressed concern about his mental health. At his second appointment he saw a locum GP, who noted that his mood was lower. They discussed whether he should be off work, and he was prescribed anti-depressants. He also completed two questionnaires in a public place within the practice. He later reported to Mr C that he had found it difficult to complete these in such a public place. Nine days later Mr A took his own life. The GPs involved both met with Mr C and his family in the weeks after his death, and a significant event analysis (SEA) was conducted four months later.

Mr C complained that Mr A was not given enough support when he needed it, that he should have been signed off work, and that the locum GP should have had greater involvement in the SEA.

We sought independent advice from one of our GP advisers, who reviewed Mr A's notes. She said that, on the basis of these notes, the discussions at both appointments had been reasonable, that due consideration had been given to Mr A's symptoms, and that his subsequent death could not have been predicted. The adviser was also satisfied that the SEA was in line with NHS guidance.

We considered that, while Mr A's death was tragic and a sad loss for his family, the care and treatment he had from the practice was reasonable, and the GPs involved could not have predicted that his mental health would decline as it did. We were satisfied that the SEA had been conducted in a reasonable manner, and appropriately took into consideration a report provided by the locum GP.