SPSO decision report

Case: **201600626, A Medical Practice in the Grampian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A). Over the course of a number of years Mr A attended the practice with anxiety and depression. During this time, the practice treated Mr A in primary care, and did not refer him to mental health services. Subsequently, Mr A did not attend the practice with these problems for approximately 18 months. Mr A then contacted the practice and reported persistent thoughts about suicide to the GP who saw him. The GP developed a plan of management, including referring Mr A to psychiatric services. However, the referral was not processed. Mr A committed suicide approximately ten days after his attendance at the practice. Mrs C complained that the practice failed to appropriately refer Mr A to mental health services in view of his presenting symptoms.

The practice said they provided appropriate treatment based on Mr A's symptoms during his earlier attendances. They did not consider a referral was appropriate at that stage. When Mr A returned and described persistent thoughts about suicide, they said a referral was appropriate. The practice acknowledged there was an error in processing the referral, although they noted that it was unlikely Mr A would have received an appointment before his death.

After receiving independent advice from a GP, we upheld Mrs C's complaint. We found there was an administrative failing in not making the referral (as the practice acknowledged). We also found the practice should have scheduled an earlier review when Mr A re-attended the practice. However, we did not consider the practice should have made a referral at any of Mr A's earlier attendances, and we found that the care and treatment provided during this time had been reasonable.

Recommendations

We recommended that the practice:

- confirm that the GP will review the relevant National Institute for Health and Care Excellence guidance and consider identifying this as a learning need in their personal development plan;
- confirm the GP will discuss this case as part of their annual appraisal; and
- apologise for the failings identified in this investigation.