SPSO decision report

Case: **201801445, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment her late mother (Ms A) had received from the practice before Ms A completed suicide.

She complained that the practice failed to identify that her mother had a personality disorder. We took independent advice from a GP adviser. We found that it had been reasonable for the practice not to diagnose that Ms A had a personality disorder. We did not uphold this aspect of the complaint.

Ms C also complained that the practice failed to manage Ms A's anti-depressants and that they had failed to take appropriate action when she stockpiled medication. We found that the practice had acted reasonably in relation to these matters and did not uphold these aspects of the complaint.

Ms C then complained that the practice had failed to call her back, after she had contacted them to raise concerns about her mother's behaviour. We found that there was no evidence that Ms C requested or was promised a follow-up call by the practice. In view of this, we found that it was reasonable that the practice did not call her back. We did not uphold this aspect of the complaint.

Ms C complained that the practice had failed to take action when Ms A reported abuse of her children. We did not find any evidence in the practice's records that Ms A had reported physical abuse of her children. However, we considered that there was evidence of emotional abuse by Ms A to her children and that social work input should have been arranged in relation to this. We upheld this aspect of Ms C's complaint.

Finally, Ms C complained that the practice had unreasonably failed to deal with her complaint appropriately. We found that the practice had made a reasonable attempt to respond to the issues raised. It was also reasonable that one of the GPs named in the complaint carried out the investigation, given the size of the practice. That said, we found that the practice had unreasonably failed to provide updates on the investigation or information about when they expected to issue a final response. In view of these failings, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for their failure to ensure that social work input was arranged and for failing to keep her updated on the complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- GPs should be familiar with the indications of emotional abuse in children and the referral mechanisms in place for social work assessment.

In relation to complaints handling, we recommended:

- When there is a delay in responding to a complaint, the practice should tell the person making the complaint about the reasons for the delay and when they can expect a response.

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.