SPSO decision report

Case: **201706006, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, no recommendations

Summary

Ms C complained about the care and treatment her late mother (Ms A) had received at Glasgow Royal Infirmary. Ms A had been admitted to the hospital after taking a mixed overdose, including opiate-based painkilling medication. She was given naloxone (a drug that can reverse the effects of opioids). On the following morning, Ms A had a respiratory arrest and was transferred to the high-dependency unit, where her naloxone was increased. She was reviewed by the liaison psychiatry department several days later and was discharged home.

We took independent advice from a consultant psychiatrist. We found that, although the hospital had delayed in issuing the final discharge letter, the care and treatment provided to Ms A had been reasonable. We did not uphold this aspect of the complaint.

Ms C also complained that the board's communication with her family had been unreasonable. We found that there was a lack of consistency in Ms A's records in relation to communication with her family. It was not recorded who was present, who had a discussion with the family or what was discussed. We found that this was unreasonable and we upheld this complaint.

Ms C further complained that the board had provided inaccurate information to her about their review of Ms A's treatment. We did not consider that the response from the board to Ms C had been inaccurate or that that it misinformed her. We did not uphold this aspect of the complaint.

Finally, Ms C complained that the board's response to her complaint had been unreasonable. After the board had issued their initial response to Ms C's complaint, an MSP wrote to them again on behalf of Ms C. In response to this, the board agreed that a further review by a clinician in a separate part of the board would be carried out. However, they delayed in informing Ms C of this and in then carrying out the further review. In view of this, we also upheld this aspect of Ms C's complaint.

The board said they had taken action to address these failings, so we asked for evidence of this, but made no further recommendations.