SPSO decision report

Case: **202105743, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, an MSP, complained on behalf of their constituent (B) about the care and treatment of their adult child (A). A had awoken with a cut and bruised face and no memory of how the injuries had been sustained. A attended a minor injuries unit before being sent by taxi to A&E for further assessment. A was assessed and discharged without further treatment or follow-up. A few months later, A died suddenly.

B believed that A had suffered a seizure on both occasions and that A's assessment had been inadequate. B felt staff had failed to consider whether A had suffered a seizure nor had they considered prescribing medication which could have prevented further seizures. B was also unhappy with the way their complaint was handled.

We took independent advice from a consultant in emergency medicine. We found that the examination of A was thorough. However, given the uncertainty over the cause of A's injuries and the symptoms they described, further investigation should have been carried out. We did not find that A's death could have been predicted, or that there was any definitive evidence that A had suffered a seizure. However, given that further investigations were justified and were not carried out, we found that the standard of care provided to A was unreasonable and that the cause of A's injuries was not adequately investigated or followed up. Therefore, we upheld these parts of C's complaint.

In relation to complaint handling, we found the board's investigation to be reasonable. We did not uphold this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the failings identified in this decision. 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:

- The board should share this decision with the departments involved for discussion at a team review with a view to identifying any points of learning and improvement.
- The emergency department should review their practices regarding the assessment of causes of head/facial injury and subsequent investigation of underlying conditions.

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.