SPSO decision report

Case: **201910708, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

C complained about the care and treatment provided to their late adult child (A) during an out-of-hours (OOH) GP visit. A had been experiencing symptoms including exhaustion, vomiting, and lack of appetite. A was examined and given anti-sickness medication, and advised that they should contact their own GP the next day for urgent follow-up review. A died the following day of acute myeloid leukaemia (an aggressive and fast progressing cancer of the white blood cells).

We took independent advice from a GP. We found that, because A was clinically stable (i.e. blood pressure, pulse and oxygen levels were normal), it was reasonable for the OOH service to advise for A to see their normal GP the following day for further investigations, particularly given that the OOH GP service cannot undertake investigations such as blood tests. We did not uphold this aspect of C's complaint.

However, we noted that the board had undertaken significant review of the events, and although the conclusion was that the OOH GP service did not act unreasonably in their appointment with A, we considered that the board had taken significant steps to ensure that all learning possible has been taken from this case.

C also complained that the board's handling of their complaint was unreasonable, as they considered that the family should have been more involved before any investigation took place. We considered the board's actions in relation to complaints handling to have been reasonable and we did not uphold this aspect of C's complaint.