SPSO decision report

Case: **202300431, A medical practice in the Highland NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an independent advocate, complained on behalf of their client (B). B's adult child (A) died from an overdose of dihydrocodeine (opioid prescribed for pain or severe shortness of breath). A had been prescribed a number of different medicines by their GP practice including painkillers and benzodiazepines (depressants).

B complained that the practice did not appropriately manage the risks of prescribing A such medication. B questioned why prescriptions were issued to A on a monthly basis, rather than weekly or even daily. B also complained that the practice had insufficient regard to A's history of overdoses and that A should not have been given additional prescriptions on request, as had happened on multiple occasions. Lastly, B was concerned that A had remained with the practice despite having moved a significant distance away.

In their response to the complaint, the practice stated that weekly or dispensing does not necessarily prevent the hoarding of medication, and that A had been maintained as patient due to their local GP being staffed primarily by locum doctors lacking a familiarity with A's situation. They said that while they were aware of A's overdoses these were often also due to alcohol or illegal drugs. The practice said that they felt A's requests for additional medication had been genuine and that they needed to balance the risk that A would seek illicit drugs or street medication if suffering from withdrawal. The practice also stated that following this incident they had reviewed their approach to such patients and had recently refused a number of requests to keep on patients living remotely.

We took independent advice from a GP. We found that the kinds of medication prescribed to A are implicated in many drug related deaths, often in combination with other substances such as alcohol. Taking into consideration A's history, their mental health, alcohol misuse and history of multiple drug overdoses, early prescriptions should not have been given to A and instalment dispensing should have been used to reduce risk. We also found that the evidence did not suggest that A remaining as a patient with the practice had kept them safe, and had influenced the decision not to provide weekly dispending. While it was not possible to say whether this decision had contributed to A's death, overall, the practice had not provided A with reasonable care and treatment with regard to their prescription medication and on this basis, we upheld B's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the failings identified in A's care and treatment with respect to the prescription medication issued to A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

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.