SPSO decision report

Case: **202001856, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment they received from the board when they were seen during pregnancy for symptoms of pain and bleeding. C had a colposcopic assessment (a simple procedure used to look at the cervix, the lower part of the womb at the top of the vagina), during which it was considered that there was no obvious cancer, but it was arranged for C to have a smear test (a test to check the health of the cervix) three months postnatally. C did not undergo the smear test and was later found to have cervical cancer. C complained that the board did not appropriately investigate their symptoms; that the postnatal follow-up was not appropriate or timely; and that the need for postnatal follow-up was not reasonably explained to them. C was concerned that earlier diagnosis and treatment would have resulted in a better outcome for them.

We took independent advice from a consultant obstetrician and gynaecologist (a doctor who specialises in pregnancy, childbirth and the female reproductive system). We found that the symptoms of pain and bleeding were appropriately investigated during C's pregnancy; however, the board should have arranged for C to have a colposcopy three months postnatally, as opposed to being invited for a smear test. We also considered that the requirement for postnatal follow-up was not reasonably explained to C. Though it was not possible to know if the cancer was present when C was three months postnatal, we accepted the advice we received that it was likely, and that had it been diagnosed and treated at that time, C probably would have had a better outcome. We upheld this aspect of C's complaint.

C also complained about the board's handling of their complaint. We found that the board had not addressed all of the issues C raised in their complaint, and that the complaint response was unclear as to the need for a postnatal colposcopy. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide them with reasonable care and treatment, and failing to respond to their complaint reasonably. 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:

- Postnatal colposcopy should be arranged in line with NHS Cervical Screening Programme: Colposcopy and Programme Management guidance.
- Requirements for follow-up care should be discussed with the patient and these discussions should be recorded.

In relation to complaints handling, we recommended:

- Complaint responses should address all relevant issues and should clearly explain the relevant clinical issues.

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.