SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **202309427, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care provided to their adult sibling (A) when they attended A&E following an accident. C also complained that the board failed to reasonably investigate A’s symptoms when they attended hospital with headaches on two further occasions the following year. A was later diagnosed with a brain tumour and C feels that there were missed opportunities in identifying this earlier.

We took independent advice from a consultant emergency physician and a GP. We found that the board undertook appropriate assessments and provided reasonable treatment to A when they attended A&E following their accident. We did not uphold this part of C’s complaint.

In relation to A’s first attendance at hospital the following year, we found that the board failed to investigate A’s symptoms. There were clear flags identified in the GP’s referral letter, indicating further investigations should have been carried out, specifically a head CT scan, and this did not occur. Therefore, we upheld this part of C’s complaint.

In relation to A’s second attendance, we found that the board reasonably investigated A’s symptoms as they presented at the time, with appropriate investigations undertaken and follow-up advice provided. Therefore, we did not uphold this part of C’s complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to undertake reasonable investigations when A attended hospital and for the poor handling of C’s complaint about this matter. 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:

- Junior doctors are aware of the importance of considering relevant clinical information from all available sources to guide clinical assessment. Clear red flags outlined in patient referrals and clinical questions resulting in patient referrals should be clearly documented in patient notes and communicated to senior reviewing clinical staff.

In relation to complaints handling, we recommended:

- Complaint responses should be accurate and based on all of the relevant evidence.

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.