# SPSO decision report

**Case:** **201302406, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** upheld, recommendations


## Summary

Mrs C complained on behalf of her family about the care and treatment given to her late aunt (Mrs A) by a medical practice. She told us that there was a delay in providing a diagnosis and appropriate treatment, which affected Mrs A's prognosis and led to her consequent suffering.

We took independent advice on this complaint from one of our medical advisers, and took all the relevant documentation, including all the complaints correspondence and Mrs A's medical notes, into account. Our investigation found that the care and treatment that the practice gave Mrs A was not reasonable. After the results of a magnetic resonance imaging scan (a scan used to diagnose health conditions that affect organs, tissue and bone) raised concerns, the practice had referred Mrs A to hospital for further investigation. However, they had marked this referral as 'routine'. Our adviser said that, in the circumstances, they should have marked it as 'urgent' and the referral letter should have contained more detail, particularly about the scan's abnormal results. We also found that Mrs A's clinical notes were insufficiently detailed and it was unclear whether GPs had physically examined her.

The practice had carried out a significant event analysis (SEA) into what had happened, but our adviser pointed out that it did not reflect on what had gone wrong. There was also no recognition on the part of the practice that the abnormal findings of the scan should have been considered.


## Recommendations

We recommended that the practice:

- provide a formal apology for the shortcomings identified;
- complete a reflective SEA to address the inadequacy of the previous report;
- ensure that the GPs concerned undertake audits of the quality of information contained in referrals and advise the Ombudsman of the findings; and
- ensure that the GPs concerned audit the quality and completeness of their clinical notes and advise the Ombudsman of the findings.