SPSO decision report

Case: **201303259, A Medical Practice in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained on behalf of her late brother-in-law (Mr A) that the medical practice delayed twice in referring him to hospital. Mr A visited his GP nine times between September 2011 and November 2012, with various symptoms, including a sore throat. He was finally referred to the ear, nose and throat (ENT) department in November 2012, and was diagnosed with throat cancer, for which he had surgery and radiotherapy.

When he then reported ear pain to the ENT surgeons he was told that this was likely nerve damage following his treatment. He continued to experience pain and in May 2013 went to his GP. The GP found evidence of inflammation, prescribed various drops, and told Mr A to come back if the pain did not resolve. Mr A went back to the practice the next week and saw a locum (temporary) GP who diagnosed nerve damage and prescribed a drug for nerve pain. He also advised Mr A to come back if the pain did not stop. Mr A contacted the practice by phone a week later and told another GP that he was still in pain. The GP made an urgent referral to ENT that day, and Mr A was seen by an ENT consultant some four days later. After further investigations he was diagnosed with inoperable throat cancer in July 2013 and he died in January 2014.

Our investigation included taking independent advice from one of our medical advisers, who is a GP. We did not uphold the first complaint as the adviser said that there was no unavoidable delay in making the first referral to ENT. The clinical records showed that although Mr A reported throat pain on some occasions, this was not a constant feature and there was evidence that at times certain treatments resolved or improved this. When, however, Mr A reported a 'red flag' symptom (a symptom especially likely to indicate a particular serious illness) in November 2012, the GP had spoken to an ENT specialist and urgently referred Mr A that day.

On the second complaint, the adviser found that there was a delay of one week between Mr A being seen by the locum GP, who appeared to have considered making an urgent referral, and the referral actually being made after Mr A's phone call. The adviser said that in view of Mr A's recent medical history, the locum should have referred him immediately. It was not clear from the records whether the locum prepared the referral but it was not sent, or if the referral was not made until later. Either way, there was an avoidable delay of one week on the part of the practice and we upheld this complaint.

Recommendations

We recommended that the practice:

- take steps to ensure that such delays in urgent referrals do not occur again.