SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201405800, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained that the board failed to provide him with the necessary preparation in advance of a procedure to examine his bowel (colonoscopy). The board acknowledged that Mr C was not given the necessary preparation, which he should have received three days in advance of the procedure, and they apologised to him. We took independent medical advice from a GP. They noted that the hospital had sent clear instructions to the prison health centre regarding the preparation for the procedure and the adviser therefore considered it unreasonable that this was not carried out.

The hospital subsequently recorded that Mr C had refused to attend his appointment and he complained about this as he did not consider that the fault for this lay with him. The board apologised to Mr C for inaccurately recording that he had refused to attend. The GP adviser considered that this incorrect recording was unreasonable as it could have resulted in Mr C not receiving a follow-up appointment when the investigation was important to rule out a potential underlying cancer diagnosis.

As it happened, the prison doctor re-referred Mr C for a colonoscopy but this was vetted by the hospital and the procedure was changed to an examination of only the lower part of his bowel (flexible sigmoidoscopy). Mr C complained that this change of procedure was not explained to him. We were advised that it would have been reasonable for the sigmoidoscopy procedure to be explained to Mr C on the day of the procedure and the records indicated that this happened. However, we could not see any evidence of the reasons for the change in procedure being explained to him.

Mr C also complained about the time the board took to respond to his complaint and for their failure to answer his questions. The board acknowledged that there were inconsistencies in their responses and that they had not answered all of Mr C's specific questions. They also acknowledged that they had taken too long to respond to Mr C's final letter. It had taken them six months to respond to this and we concluded that this was an unreasonable timescale.

We upheld all the complaints.

Recommendations

We recommended that the board:

- reflect on the process failings that have occurred in this case and inform us of the steps they have taken to ensure that similar future failings do not occur;
- remind staff to ensure that relevant information is shared with a patient when a procedure is changed and that this is documented;
- remind complaints handling staff of the importance of responding to complaints in a full, accurate and timely manner; and
- apologise to Mr C for the failings this investigation identified in their handling of his complaint.