SPSO decision report

Case: **201601026, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained on behalf of her late father (Mr A) about the failure to provide him with an appropriate scan following his presentation with significant weight loss over a short period of time. Ms C said Mr A had not been contacted about an appointment. Mr A was then phoned by a doctor who took the decision, without seeing Mr A, that a scan was unnecessary. Ms C said she believed that had Mr A been scanned, then the lung cancer he had would have been discovered and treated. Mr A had died suddenly of heart failure, and Ms C believed his heart had been under strain due to the untreated condition.

The board said that Mr A had been phoned on several occasions without success. He had then been written to, offering him an appointment. When the doctor had phoned Mr A it had been to ascertain if a scan was still necessary. The doctor's recollection was that Mr A had not wished to proceed with a scan and that he had stated that he had regained a small amount of weight. The board did not feel that Mr A's medical outcome was affected by the decision not to give him a scan.

We took independent medical advice and found that it would have been appropriate to review Mr A in clinic, given his symptoms. We noted that there was a significant gap between the phone conversation and the doctor writing to Mr A's GP, which meant that there were not appropriate records kept of the phone call. The advice we received was that this was in breach of General Medical Council guidelines on communication with patients. We found that there was evidence that the board made reasonable efforts to contact Mr A about his appointments, and so we did not uphold this aspect of Ms C's complaint. However, we considered it a failing that the doctor was unable to access Mr A's appointment schedule when he phoned him, and as such he could not advise him of the length of time Mr A would wait before his next appointment. We therefore upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to contact Mr A's GP in a reasonable amount of time and for failing to arrange a scan.

What we said should change to put things right in future:

- The staff involved should reflect on the advice we received in relation to Mr A's need for an appointment for a scan.
- Staff should adhere to reasonable timescales when dictating clinical correspondence. At a minimum, these timescales should be in line with General Medical Council guidance.
- Clinical staff should be able to access the in-patient appointment viewing system to check appointments.

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.