SPSO decision report

Case: **201602166, A Medical Practice in the Orkney NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Miss A). Ms C said that Miss A's medical practice failed to follow up her abnormal blood results, and that as a result she was subsequently diagnosed with hepatitis C (a virus that can infect and damage the liver, and can be transmitted to others through contact with infected blood) a number of years later. Miss A believed that had the practice kept the blood results under review, the diagnosis of hepatitis C would have been made earlier and that she would therefore not have suffered from other medical conditions.

We took independent medical advice and found that although there was an improvement in Miss A's condition initially, her blood results were still abnormal and further tests should have been arranged. As a result, this had contributed to the delayed diagnosis of hepatitis C. We therefore upheld Ms C's complaint. We also found that the practice procedure for the reporting of blood results had subsequently been updated and that the current process is appropriate and would highlight that action is required when abnormal results are identified.

Recommendations

We recommended that the practice:

- apologise to Miss A for the failure to arrange follow-up blood tests.