SPSO decision report

Case: **201905893, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from Greater Glasgow and Clyde NHS Board. C was referred to the Early Pregnancy Unit (EPAS) by a private clinic on two occasions. C complained that EPAS took too long to declare the pregnancy non-continuing, that C was required to attend an unnecessary number of scans and that their care was not escalated to a doctor. C also complained that the advice and care that they received by phone, and the fact that they were contacted and invited to a reassurance scan, was unreasonable. C further complained that EPAS asked them for distressing information rather than gathering this from the private clinic and that EPAS did not gather consent from C for surgical management as they ought to have done. C also complained that the care and treatment that they received as an inpatient was unreasonable.

The board noted that they apologised for the delay in the time C waited to be seen, that during their admission C fainted and was lowered to the floor by a nurse who then called a doctor, that all options were not discussed and that on reflection there was a missed opportunity to obtain a second opinion. The board also noted, however, that this would not have changed C's management plan.

We took independent advice from a consultant obstetrician (the medical specialism for pregnancy, child birth etc) and gynaecologist (medicine of the female genital tract and its disorders). We found that a second opinion should have been sought, which may have allowed miscarriage to be diagnosed earlier. We also found that C should not have had to relay findings or be subjected to repeated examination when diagnosis had already been made by the private clinic and that the necessary documentation ought to have been obtained from the private clinic. We further found that during C's fainting episode, appropriate observations and actions were taken and the faint was well managed.

In light of the above, we found that whilst it was reasonable for EPAS to repeat some scans, a second opinion was not sought when it should have been. If this happened, C's miscarriage could have been diagnosed earlier, and therefore, the care and treatment provided to C was unreasonable. Additionally, the actions of EPAS asking C to relay findings and requiring C to undergo a further scan was unreasonable. We found that C's faint was well managed and the care and treatment provided to C during this time was reasonable.

We also considered the way in which the board handled C's complaint. We found that it does not appear that the board's complaint investigation took account of the clinical notes made by the doctor to ensure a full and accurate response was provided.

We partially upheld C's complaint and made recommendations to the board as a result.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO

guidelines on apology available at www.spso.org.uk/informationleaflets.

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

- Patients attending EPAS should not be required to undergo unnecessary scans.

In relation to complaints handling, we recommended:

- When carrying out an investigation, consideration should be given to ensuring the response takes into account any relevant clinical notes so that the complainant receives a full and accurate response.

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.