SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201303143, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment of her late husband (Mr C). Mr C was diagnosed with lung cancer and over a five-month period had six appointments with five different consultants. At most of the appointments, which were at both the Beatson Cancer Centre and Royal Alexandra Hospital, Mr and Mrs C had to wait around one and a half hours beyond the appointment time, which was extremely stressful for them. Mr and Mrs C also attended one of the appointments expecting to receive the results of a scan. However, this was not available until 17 days after it was taken, when Mr C began to develop increasing weakness in his legs. He was admitted to hospital the following day and developed complete paralysis of his legs and lack of sensation up to his abdomen. The cancer was found to have spread to his spine, leading to spinal cord compression, and Mr C died shortly after. Mrs C complained that if the results of the scan been available earlier, there might have been a better outcome for her husband, had treatment been administered sooner.

After taking independent advice on Mr C's case from two of our medical advisers, we found that there was a delay in making the scan available, and that the radiologist failed to flag the risk of spinal cord compression when reporting the scan. While there was only a slight possibility that earlier information would have meant that the outcome would have been different for Mr C, these failings led to a significant personal injustice as the delay caused a great deal of distress and there was a missed potential opportunity to diagnose and treat Mr C's spinal compression earlier. We also found an error in the reporting of a previous scan, which might have affected treatment decisions relating to Mr C's pain. Finally, in relation to Mrs C's complaint about the board's appointment handling, we found that there was a lack of continuity of care because of poor record-keeping and the involvement of multiple consultants. This adversely affected the information available to the consultant at each appointment, potentially impacted on Mr C's care and was particularly distressing for both Mr and Mrs C, given the ongoing situation.

Recommendations

We recommended that the board:

- take account of our medical adviser's comments about reviewing report turnaround times and reporting radiology errors, and provide us with evidence on how they intend to avoid a recurrence;
- provide evidence that multi-disciplinary team meetings play a role in the management of patients with lung cancer, in line with the relevant guidelines;
- raise the failures our investigation identified with relevant staff, and ensure it forms part of their annual appraisal;
- provide us with evidence on how they intend to avoid a recurrence of the failures that our investigation identified in the complaint about appointment handling; and
- apologise to Mrs C for the failures our investigation identified.