SPSO decision report

Case: **201306129, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the delay in diagnosing her late husband (Mr C)'s cancer. Mr C suffered intermittent pain over about two years, following a fall. Mrs C said Mr C attended A&E at Glasgow Royal Infirmary on numerous occasions, as well as being seen by colorectal (bowel) and gastroenterology (digestive system) specialists. Mr C's cancer was first diagnosed over two years after his fall, following a scan which showed possible cancer in his liver. Mrs C raised concerns that Mr C should have been given this scan earlier.

The board considered that Mr C received appropriate treatment and investigations. They said they only had records of Mr C attending A&E on two occasions, although Mrs C said he attended numerous times.

After taking independent medical advice from A&E, colorectal and gastroenterology specialists, we upheld Mrs C's complaint. We did not find any evidence that Mr C attended A&E on more than two occasions, and we found that the care and treatment at A&E was mostly reasonable. However, on one occasion the A&E doctor did not specifically record checking whether Mr C was losing weight (which would have been a 'red flag' symptom), and we were critical of this. We found the investigations carried out by the colorectal service were reasonable and timely, and there would have been no reason for them to arrange a scan, based on Mr C's symptoms and the results of other tests and examinations at that time. We also found the gastroenterology clinic arranged appropriate investigations. However, we found there was a delay of several weeks in performing the initial investigations (including the scan) and reviewing the results, which meant that Mr C's care did not meet the Scottish Government's standards for cancer waiting times (HEAT targets).

Recommendations

We recommended that the board:

- issue a written apology to Mrs C for the failings our investigation found;
- raise our findings about the A&E review with the doctor involved for reflection and learning; and
- review their processes for scheduling investigations arising from suspected cancer referrals, taking into account the 62-day HEAT standard.