SPSO decision report

Case: **201600267, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of Mrs B about the care and treatment of her late husband (Mr A). Mr A was admitted to Queen Elizabeth University Hospital with symptoms including severe abdominal pain and weight loss. He underwent tests, including a CT scan, but nothing was found to explain his symptoms. His GP later contacted the hospital as they remained concerned about Mr A's pain, and the CT scan was reviewed. Abnormalities in Mr A's liver and abdomen were suspected, and a further CT scan and liver biopsy confirmed that he had secondary liver cancer. He was referred to oncology and died after two sessions of chemotherapy. Ms C complained that Mr A's cancer was not diagnosed earlier and that there were signs on the first CT scan that were initially overlooked.

The board accepted that there was a delay in diagnosing Mr A's cancer but said the original CT scan report was falsely reassuring. They did not consider that this delay had any bearing on Mr A's prognosis, as Mr A's cancer was advanced and would have been regarded as terminal at the time of the first scan. They noted that the missed diagnosis on the first scan had been discussed at a radiology review meeting and also fed back to the radiologist concerned.

We took independent advice from a consultant radiologist who noted that interpreting the first scan was not straightforward and that the abnormalities were subtle. Nonetheless, they confirmed that these were overlooked, leading to delay in diagnosis. We also took advice from a consultant clinical oncologist, who confirmed that the delayed diagnosis would not have altered Mr A's life expectancy but acknowledged that it would have delayed his access to palliative care services. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should issue a written apology to Mrs B regarding the delay in diagnosing Mr A's cancer, and consequently the delay in him accessing palliative care services.

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.