SPSO decision report

Case: **201602051, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained that her late father (Mr A) was wrongly diagnosed with metastatic cancer (a cancer which has spread from a primary site elsewhere in the body) , and then had to wait an unreasonable length of time to be informed of the mistake. Ms C said that Mr A's mental and physical health suffered as a result.

Mr A was diagnosed with prostate cancer. As part of the diagnostic process he was given a bone scan. As the results were indeterminate, a repeat scan several months later was carried out which showed some changes and was reported by the radiologist as being suggestive of possible metastatic cancer. This was communicated to Mr A at a review appointment by his consultant oncologist. A scan subsequently carried out concluded that Mr A did not have metastatic cancer.

We took independent advice from a consultant oncologist and found that it was reasonable that Mr A was initially assessed as having metastatic cancer, and that it was appropriate based on the evidence available at the time that his oncologist had communicated this to him. We also found that after it was discovered that Mr A did not have metastatic cancer, this was communicated to him within a reasonable time-frame. We did not uphold this aspect of Ms C's complaint.

Ms C also complained that Mr A was not referred to any specialist cancer support services and he was not offered additional support for pain management. Whilst we acknowledged that the board had accepted this and had apologised to Mr A's family, we were critical of these failings. We upheld this aspect of Ms C's complaint.

We also found that the board failed to respond to Ms C's complaint within a reasonable period of time and we upheld this part of her complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C and her mother for:
- failing to make Mr A aware of specialist cancer support services
- failing to offer Mr A additional support for pain management
- failing to provide an update on Ms C's complaint when it became clear that the 20 day timescale could not be met
- the unreasonable delay in arranging a meeting and providing Ms C with the minutes of this.
- These apologies should meet the standards set out in the SPSO guidelines on apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients should be informed of the specialist cancer support services that are available to them.

- Patients should be provided with additional support for pain management, where appropriate.

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.