# SPSO decision report

**Case:** **201802908, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Ms C was suffering from, amongst other symptoms, back pain and was referred to a physiotherapist. Shortly after, a magnetic resonance imaging (MRI) scan of her back was taken. Months later Ms C was referred to a gynaecologist (medical specialism of the female genital tract and its disorders) who ordered a further MRI scan as her symptoms continued. When the radiologist reviewed this request, Ms C's previous MRI scan was also reviewed. This second review noted the abnormalities in Ms C's pelvis and documentation was added to their records at that point. A subsequent CT scan confirmed that Ms C had ovarian cancer, and she had an operation to remove two large tumours. However, it was only during an appointment with her consultant oncologist (cancer specialist) a year later that she learned that these tumours had been detected in the MRI scan taken years earlier.

We took independent advice from a medical adviser who specialises in radiology (the analysis of images of the body). We found that the report of the first MRI was unreasonable, because it failed to mention abnormalities in the pelvis and advise further investigations. This meant that there was, at the least, a missed opportunity to diagnose Ms C with ovarian cancer earlier. We also found that it would have been reasonable for the gynaecologist to have informed Ms C earlier about what happened. Instead, Ms C only found out after asking specifically how long the tumours had been present. Therefore, we upheld the complaint.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failings in the initial review of the scan and communication identified in this investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Review what happened in light of the medical adviser's comments and address any systemic or training issues.
- Share the results of this investigation with the radiologist.
- Discuss the imaging at a learning discrepancy meeting.
- Share the results of this investigation with all relevant clinicians including the gynaecologist.

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.