SPSO decision report

Case: **201805598, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C's father (Mr A) was referred by his GP to the Royal Alexandra Hospital for investigation of breathlessness. Two chest x-rays and a CT scan were performed over the following months. Mr A attended A&E seven months after his initial referral with severe pain in his side and back and a further x-ray was carried out. Mr A was admitted to hospital later that month following a fall, and a further x-ray and CT scan were carried out. Further to a biopsy (tissue sample) of an identified mass, Mr A was told he had incurable cancer. He died the following month.

Mr C complained about a failure to diagnose the cancer from the first CT scan. We took independent advice from a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques). We found that an abnormality on the CT scan was not reported. This resulted in an avoidable delay of approximately three months in the diagnosis of Mr A's cancer. Therefore, we upheld this aspect of the complaint. The board have already apologised to Mr C for not picking up the cancer on the CT scan, and have undertook to discuss this at a learning meeting.

Mr C also complained about a delay in notifying Mr A of the results of this CT scan. We took independent advice from a consultant physician. We found that the scan result had been left on a consultant's desk awaiting dictation, and the consultant had retired. It took Mr A's prompting before a secretary arranged for another consultant to review and share the result. Mr A received the result ten weeks after it had been reported. We considered this delay was unreasonable and that a more robust system was required. We also noted that the board had not addressed this aspect of Mr C's complaint. Therefore, we upheld this aspect of the complaint.

Mr C also complained that there was a failure to diagnose Mr A's cancer from the x-ray taken during his admission to A&E. We found that the x-ray raised the possibility of an abnormality and suggested a repeat CT scan which was later carried out. We considered that this was appropriate and there was no unreasonable failure to diagnose the cancer directly from the x-ray. We did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the unreasonable delay in informing Mr A of the result of his CT scan, and for failing to address Mr C's complaint about this. 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:

- There needs to be a robust system in place for reviewing and communicating imaging results. The board should review their system and provide this office with an assurance that mechanisms are in place to avoid a repeat of the circumstances which contributed to the delay in this case.
- The board should reflect on the adviser's comments in relation to minimising any systems deficiencies

which might contribute to perceptual errors when reporting imaging studies, unless such reflection occurred as part of the Learning from Discrepancies me

In relation to complaints handling, we recommended:

- The board should adhere to their Complaints Policy and Procedure, and aim ‘to establish all the facts relevant to the points made in the complaint and to give the person making the complaint a full, objective and proportionate response’.