SPSO decision report

Case: **201805988, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained that her partner (Mr A) had been misdiagnosed with brain cancer.

We took independent advice form a consultant clinical oncologist. We found that it was unreasonable for the board to have given Mr A the wrong information by misdiagnosing him with brain cancer. We accepted that this was likely a mistake or human error as a result of misreading Mr A's scan report. Following the discovery of the error, most of the action taken by the board was reasonable. We noted that the board apologised to Mr A and the consultant involved had reflected on this matter. However, we also found that the board failed to record on Datix (incident reporting system) or another similar reporting system that Mr A had been misdiagnosed with brain metastases. They also failed to carry out a serious adverse event review to consider whether there were any contributory factors that could be mitigated. We upheld Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to appropriately record and carry out an appropriate review to ensure that there were no other contributory factors that could be mitigated. The apology 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:

- Near misses and errors should be reported via Datix or another similar reporting mechanism and, if indicated, a Serious Adverse Event Analysis should be carried out.