SPSO decision report

Case: **201809826, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the clinical care provided to their child (A) by the board, specifically, that a Chiari malformation (where the lower part of the brain pushes down into the spinal cord) was visible on a magnetic resonance imaging (MRI) scan performed by the board and that the abnormality was not noted until they insisted on a further MRI scan.

A suffered from a number of symptoms including headaches, tinnitus (ringing or buzzing in the ears), vertigo (a sensation of loss of balance or that objects around you are spinning) and drop attacks (sudden falls to the ground) for a number of years.

In relation to the reporting of the MRI scan, the board considered it was a miss of an incidental finding and apologised for the matter in retrospect.

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 such as x-rays and other scans). Whilst we found that it was reasonable to ask only about a possible tumour, we considered that it was unreasonable that the radiology report did not report on the cerebellar tonsillar protrusion (a type of brain herniation) or indicate the presence of Chiari malformation. We also noted that the type of Chiari malformation A had (Chiari I) does not necessarily produce symptoms, but good practice would have been to record this finding and suggest review by a neurosurgeon, which did not happen in this case. We upheld this aspect of C's complaint.

C also complained about the communication that occurred with an ear, nose and throat (ENT) consultant. We took independent advice from an ENT consultant. We found that it would not be reasonable to expect an ENT clinician to recognise the Chiari malformation when the radiologist did not. However, we found that it was unreasonable that there was no record of discussions with A or C about the third scan being arranged, or discussions about medications. The board accepted that there had been failings in communication with the family and they took steps to address the matter. We upheld this aspect of the complaint, but made no further recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for not having referred in the radiology report to the cerebellar tonsillar protrusion, or indicate the presence of a Chiari malformation. 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:

- Radiological reports should be accurate and reasonable.

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.