SPSO decision report

Case: **201905257, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, an advocate, complained on behalf of their client (B). B's partner (A) was diagnosed and treated for a frozen shoulder (a condition affecting the shoulder, making it painful and stiff with loss of mobility) by the board after attending the emergency department. A's pain and symptoms did not improve so they continued to attend health services. B considered it was unreasonable for A to have been diagnosed with a frozen shoulder based on their level of pain and the board failed to provide reasonable treatment. A's health deteriorated and they were diagnosed with cancer. B said this diagnosis and A's prognosis were not appropriately communicated.

We took independent advice in relation to the complaints.

C complained that the board unreasonably administered a steroid injection to A. We found that A's symptoms were atypical for a frozen shoulder and there were red flag symptoms present. Therefore, the case should have been discussed with the responsible consultant at the clinic and further investigations carried out, prior to a decision on whether the injection should be administered. Therefore, we upheld the complaint.

C also complained that the board failed to diagnose A's cancer in a reasonable timescale. We found that there was a short but unreasonable delay in diagnosing A's cancer. We considered that the actions during most of A's attendances were reasonable. However, they raised concerns regarding no consultant opinion being sought when A attended the emergency department and that there was a missed opportunity to investigate A's atypical symptoms during one of the appointments. We found that there was a lack of clinical ownership for A's case. Therefore, we upheld the complaint.

C also complained the board failed to communicate A's cancer diagnosis in a reasonable manner. There was limited information to consider as the records were not a verbatim account of conversations. We found that there was no evidence to suggest the doctor communicated with A and B in a cold or uncaring manner. Therefore, we did not uphold the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for administering the steroid injection to A and for the delay in diagnosing A with cancer. 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:

- Cases involving multiple specialties should be appropriately managed and atypical signs of frozen shoulder appropriately investigated.
- Registrars should consult with senior clinicians prior to administering steroid injections where there are

atypical signs for frozen shoulder.
- Relevant records should be available to clinicians.

In relation to complaints handling, we recommended:

- Complaint responses should respond to all key points raised by the complainant.

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.