SPSO decision report

Case: **201905779, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Communication / staff attitude / dignity / confidentiality
Decision: some upheld, recommendations

Summary

C complained on behalf of their parent (A). A was diagnosed with oesophageal cancer (tumour in the tube which connects from throat to the stomach) and later underwent chemotherapy and radiotherapy. Over a year later, A had a CT scan but the results were not reported for around three weeks. The CT scan found evidence that the cancer had spread to the liver. It was no longer possible to cure the cancer and A's care became palliative (managing pain or related symptoms, but not treating the underlying disease or condition). A was admitted to the Queen Elizabeth University Hospital where they later died.

C complained that there was an unreasonable delay in reporting and communicating the results of A's scan. We took independent advice from a consultant oncologist (a doctor who specialises in the diagnosis and treatment of cancer). The board had accepted there was a delay in formally reporting the CT scan and acknowledged it was a significant failure to report a life changing progression of disease. We upheld the complaint but as the board had already apologised for this error, we did not make any further recommendations. We also noted that the delay in issuing the report did not change the situation for A as the disease was already advanced.

C complained that the board failed to communicate reasonably with A's family during their admission to hospital. We found that there were annotations about discussions with the family in the records and it was routinely noted when family were present. However, there was little in the notes to show what was said or what individuals' concerns were. Therefore, we upheld this complaint.

C also raised a number of concerns about care provided to A during their admission. We found that there were elements of the care provided to A which were not best practice, some of which the board had already acknowledged in the complaints process. However, there were also many elements of A's treatment which were reasonable. On balance, we did not uphold this complaint.

Recommendations

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

- For staff to have the opportunity to reflect on the findings of this investigation.

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.