SPSO decision report

Case: **201911276, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about a failure to diagnose their late partner (A)'s spinal cord cancer when they attended Wishaw General Hospital. They attended the Accident & Emergency Department and were referred on to the medical team for an urgent MRI scan for a suspected malignant spinal cord compression (MSSC, MSCC can happen when cancer grows in the bones of the spine or in the tissues around the spinal cord). However, this was subsequently changed to a CT scan, the result of which was normal, and A was discharged. A attended a private neurology (the science of the nerves and the nervoussystem, especially of the diseases affecting them) appointment the following week, where arrangements were made for an urgent hospital admission and a tumour in the spinal cord was diagnosed. A was left confined to a wheelchair following surgery and died around ten months later. C complained that, in not carrying out an MRI scan, the board failed to adhere to national guidance on MSCC management.

We took independent medical advice from a consultant radiologist (a specialist in the analysis of images of the body), who advised that it is normal practice to initially investigate any patient with a history of prior malignancy and suspected MSCC with an MRI of the whole spine. We, therefore, considered that it was unreasonable in A's case for the board to have carried out a CT rather than an MRI scan. It was noted that there was limited MRI scanner availability the day A presented, however, guidance allows for an MRI scan to take place within 24 hours. We found that an MRI scan should have been undertaken the following day and this omission was unreasonable. Had the MRI scan taken place, the spinal tumour would have been detected earlier. We were unable to say whether this would have had an impact on A's overall prognosis. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to conduct an MRI scan prior to discharging A. 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:

- NHS Lanarkshire's guidance on the management of MSCC should be reviewed to ensure that it is in line with NICE guidance. The findings of this investigation should be shared to ensure relevant learning for staff.

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.