SPSO decision report

Case: **201802026, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained on behalf of her daughter (Miss A) that, when Miss A attended the Queen Elizabeth University Hospital on several occasions with groin pain and leg swelling, she did not receive appropriate treatment. Miss A was eventually admitted to hospital and was later diagnosed with secondary cancer.

Mrs C said the board unreasonably misdiagnosed Miss A's condition during her initial visit to A&E at the hospital. She said that they told Miss A she had strained her groin, when in fact she had a large blood clot there.

We took independent medical advice from a consultant in emergency medicine and from a consultant in general medicine. We found that although the diagnosis given at the time was incorrect, it was consistent with Miss A's recorded history and examination findings and was not unreasonable. We did not uphold this aspect of the complaint.

Mrs C said that the board unreasonably delayed in reaching a diagnosis of Miss A's condition. Her concerns included that it took several months of visits to the hospital before Miss A was admitted. We found that the clinicians who saw Miss A at the hospital could, and should, have exercised discretion and carried out further investigations of Miss A's condition at an earlier stage. We also found that the delay in Miss A being admitted to hospital and given a diagnosis, was unreasonable. Earlier investigation would almost certainly have identified the abnormal tissue causing Miss A's problem and led to the subsequent diagnosis of an underlying secondary cancer. While further early investigation might not have resulted in a different outcome, Miss A could have been spared the pain and anxiety caused by the delay in diagnosis of secondary cancer. Therefore, we upheld this aspect of the complaint.

Mrs C also said that the board failed to deal with her complaint about Miss A's care and treatment appropriately. We found that the board had delayed in responding to Mrs C's complaint, failed to provide her with any updates and that, following repeated contact by Mrs C's MSP's office, a full response was eventually forthcoming. This was contrary to the board's complaint handling procedure and we, therefore, upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and Miss A for the delay in admitting Miss A to Queen Elizabeth University Hospital and investigating and diagnosing her condition at an earlier stage; and for failing to provide Mrs C with appropriate updates on her complaints. 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:

- In future cases of this type, staff should admit patients to Queen Elizabeth University Hospital and carry

out further investigations at an earlier stage, in order to reach a diagnose within a reasonable timeframe.

In relation to complaints handling, we recommended:

- Where the board needs longer than the 20-day timescale to issue a full response, they must explain the reasons to the complainant, and agree with them a revised timescale whenever possible, in accordance with the board's complaints policy and procedure.

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.