SPSO decision report

Case: **201508819, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late relative (Miss A). Miss A attended her GP practice with an abdominal swelling, which led to an urgent referral to the gynaecology service at Glasgow Royal Infirmary. Tests showed that Miss A had an ovarian cyst and arrangements were made for her to have it surgically removed. She was then discharged from the gynaecology service. Over the course of the following year Miss A attended her GP with various symptoms and ultimately attended the emergency department at Glasgow Royal Infirmary. After several attendances at hospital, tests identified that she had advanced cancer. Miss A was then transferred to the Beatson West of Scotland Cancer Centre for treatment and she died a short time later.

Mrs C complained that there was an initial failure to diagnosis that Miss A had cancer when she was referred to gynaecology and the ovarian cyst was removed. Mrs C also complained that there was a delay in diagnosing Miss A with cancer after she attended the emergency department the following year, and that appropriate treatment had not been given to Miss A.

We took independent advice from consultants in pathology, gynaecology and surgery. We found that appropriate tests and investigations were initially carried out when Miss A attended the gynaecology service. However, we found that there should have been a record to show that family history of ovarian or breast cancer had been enquired into, in line with relevant guidance. In addition, we found that there was evidence to indicate that the ovarian cyst had burst during surgery, but that the records did not contain clear information about this having occurred. We also found that there was a failure to accurately report the pathology specimens after the cyst was removed. We considered that, had these been reported in a timely manner, this would have altered Miss A's clinical management and she would not have been discharged from the gynaecology service with no follow-up. We upheld Mrs C's complaint about an initial failure to diagnose Miss A.

Regarding the delay in diagnosing Miss A the following year, we found that biopsies taken at the time of a sigmoidoscopy (a procedure to visualise the rectum and lower colon) showed evidence of cancer, but that there was a two week delay in this being recognised by the clinical team and Miss A being informed of the results. We upheld this aspect of Mrs C's complaint.

We found that the appropriate option of palliative chemotherapy was decided upon and that reasonable surgical care had been provided to Miss A. However, we concluded that there may have been a lost opportunity to halt the progression of the cancer because of the time taken to communicate the findings of the sigmoidoscopy and also because of a delay in arranging treatment for blocked kidneys which Miss A had also developed. On balance, we concluded that Miss A had not been provided with appropriate treatment, and we upheld this part of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and the family for the inaccurate reporting of the pathology specimens, the delays in communicating the cancer diagnosis and a delay in treating blocked kidneys. The apology should comply with the SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- Staff should follow the guidance about enquiring into family history of ovarian or breast cancer, as recommended in the Royal College of Obstetricians and Gynaecologists' Green-top guideline No.62.
- Consideration should be given to amending the proforma to include a subheading for family history.
- Staff should record whether a cyst has been removed intact or has burst during surgery.
- Staff should ensure that pathology specimens are sampled and correlated in accordance with the Royal College of Pathologists' guidelines on ovarian tumours.
- Staff should ensure they are aware of the Royal College of Pathologists' guidelines on the examination of ovarian tumours.
- Pathology staff should ensure that new cancer diagnoses are communicated promptly to the clinical team.
- Staff should ensure in similar cases that appropriate treatment for blocked kidneys is commenced in a timely manner. An appropriate care pathway should be in place.

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.