SPSO decision report

Case: **201806705, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C made a number of complaints to us about care and treatment he had received after he attended the Royal Alexandra Hospital with back pain. He was subsequently diagnosed with metastatic prostate cancer. He was transferred to the Beatson West of Scotland Cancer Centre and was given radiotherapy (a treatment using high-energy radiation). Mr C considered that the primary treatment at that time should have been surgical.

We took independent advice on the complaints from an emergency medicine consultant, an orthopaedic consultant (a specialist in the treatment of diseases and injuries of the musculoskeletal system), a consultant oncologist (a doctor who specialises in the diagnosis and treatment of cancer) and a neurosurgery consultant (a specialist in the diagnosis and treatment of disorders of the nervous system, especially the brain and spinal cord).

Firstly, Mr C complained that there was a delay in carrying out an MRI scan. We found that he should have had an MRI scan within 24 hours, but there was a delay in carrying this out. We upheld this complaint.

Mr C also complained that when he attended A&E at the Royal Alexandra Hospital, he was inappropriately referred to the orthopaedics team. We found that it had been reasonable to refer him to the orthopaedics team and we did not uphold this complaint.

Mr C complained that there had been a failure to communicate effectively and to discuss the result of the MRI scan with the neurosurgery team. We did not find any failings in relation to this and we did not uphold the complaint.

Mr C complained that he was unreasonably given radiotherapy without consent being obtained for this appropriately. We found that it had been appropriate to give him radiotherapy at that time, given his deteriorating neurological symptom. We did not find any failings in relation to this matter and we did not uphold the complaint.

Mr C also complained that staff failed to communicate reasonably with him. We found that staff had not met his needs in relation to communication and upheld this complaint. However, we noted that the board had acknowledged and apologised for this failing.

Mr C complained that medical staff failed to adequately communicate to nursing staff that he should have been given Clexane (medication that helps to reduce the risk of blood clots) before an operation. We found that it was unreasonable that medical staff failed to communicate this adequately and upheld this complaint. The board said that they had already taken action in relation this complaint and we asked them for evidence of this.

Finally, Mr C complained that there was an unreasonable delay in deciding that surgery should be carried out after the MRI scan was reviewed by a spinal surgeon. We found that the timescale was reasonable and did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the unreasonable delay in carrying out an MRI scan. 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:

- The board should consider developing a standardised pathway for the management of Malignant Spinal Cord compression based on NICE Guidance and including access to urgent MRI scans within 24 hours. This should also take bank holidays into account.

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.