SPSO decision report

Case: **201905498, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment they received from Inverclyde Royal Hospital. C underwent colorectal surgery during which it was identified that they had rectal cancer which had spread into the vascular system. Prior to the surgery, a lesion on C's lung was noted but was not thought to be typical of cancer and a plan was made to keep it under review. C raised a number of concerns regarding the reasonableness of the management plan for their cancer and delays to their treatment. They considered that treatment decisions were made without their involvement and they were given misleading information about their treatment options.

We took advice from a general and colorectal surgeon who noted that the monitoring of C's lung lesion was unstructured. We were advised that a CT PET scan was not carried out in a timely manner; there was no referral to a lung multi-disciplinary team (MDT) when scans subsequently showed an increase in lesions; and there was a delay in referring to oncology for discussion of treatment options. As such, C was not provided with a clear picture of their condition and management plan, and treatment was not instigated as soon as it might have been. While it was accepted that treatment options were limited and earlier treatment may not have altered C's prognosis, earlier discussion with oncology could have cleared up some of the uncertainty and alleviated C's associated distress. We accepted the advice and upheld this complaint. Whilst not raised in the complaint, the adviser also observed a failure during the colorectal surgery to check for a tattoo marker that had previously been placed to mark the tumour. While this did not result in a failure to fully remove the tumour, the adviser described it as a 'near miss'.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C's next-of-kin for the lack of clarity in follow-up monitoring; the failure to refer C to the lung MDT and carry out a CT PET scan in a timely manner; the delay in referring to oncology; and the failure to check for the tattoo marker during surgery. 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 colorectal MDT should reflect on C's care and treatment and review its processes for referrals to oncology or other MDTs, to ensure appropriate input is received and acted upon.
- The colorectal MDT should review its processes in respect of ensuring there is a clear pathway for monitoring specific issues separate to standard post-surgical follow-up.
- The board should tell the Ombudsman what their process is for reporting and reviewing 'near miss' events, and why there was an apparent failure to identify this one.
- The colorectal team should discuss the failure to check for the tattoo marker during surgery, and how a similar future error can be avoided.

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.