# SPSO decision report

**Case:** **201205325, Lothian NHS Board**
**Sector:** health
**Subject:** complaints handling
**Outcome:** some upheld, recommendations


## Summary

Ms C's late father (Mr A) had a complex medical history including heart disease. He had a chest x-ray, which showed a mass on the lung but was wrongly reported as normal. After further tests and body imaging Mr A was diagnosed with advanced lung cancer. Ms C said Mr A was told that his tumour was inoperable, and it was decided to treat him with chemotherapy and radiotherapy. Mr A developed kidney disease after the first cycle of chemotherapy, which was stopped, and he was then treated with radiotherapy. However, he became more unwell and was diagnosed with radiation pneumonitis (lung damage arising from radiotherapy). A scan the next month showed lung changes that were reported as relating to emphysema (lung disease that causes shortness of breath). Shortly afterwards, however, an underlying lung condition was detected. Mr A continued to deteriorate and he was admitted to the Western General Hospital where, despite treatment, he died.

Ms C complained that the hospital did not detect her father's underlying lung condition quickly enough. She said that, had it been spotted earlier, Mr A could have had surgery instead of radiotherapy, which she believed would have led to a more positive outcome. She was concerned about a consultant's communication with her family about her father's treatment options, and said that the board failed to treat his heart condition. She was also unhappy with the way they handled her complaint.

We took independent advice from two of our medical advisers, who specialise in oncology (treatment of patients who have cancer) and radiology (the analysis of images of the body). They said that it was reasonable that Mr A's underlying lung condition was not detected earlier and, while knowing about it might have made radiotherapy a more risky option, surgery was also a high risk option with no guarantee of a cure. The oncologist said that the management of Mr A's conditions was appropriate based on information available at the time of treatment (including for his heart condition). We appreciated that, for the family, learning about Mr A's underlying lung condition was extremely distressing and clearly caused them a great deal of uncertainty about the potential outcome. However, our adviser said that it was very unlikely that Mr A's life expectancy would have been different had treatment changed. Our radiology adviser criticised the radiologist's interpretation of the x-ray, although they also said that the failure to identify the mass would not have affected the outcome. Although a number of aspects of Mr A's care and treatment were reasonable, we upheld the complaint as there was an unreasonable delay in identifying the mass, which was a significant failure and led to a delay in diagnosis.

We did not uphold Ms C's complaint that the consultant did not discuss surgery or heart treatment. The advice we accepted was that communication was reasonable and there was evidence that treatments were fully discussed. This was on the basis of the information available to board staff at the time and, as already noted, it was reasonable that they did not pick up Mr A's underlying lung condition earlier. Our oncology adviser also said that there was evidence that the consultant had explained the issues and obtained Mr A's consent for treatment.

On the complaints handling, we were satisfied that the board fully addressed the complaint and that the time they took to respond was reasonable as there were delays in obtaining consent from the family. However, it was clear after further contact from Ms C that she wanted clarification and a further response to the issues raised, and the

board should have taken earlier steps to provide this.

### Recommendations

We recommended that the board:

- raise the failures identified with relevant staff; and
- apologise to Ms C for the failures identified.