SPSO decision report

Case: **201305443, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained on behalf of her daughter (Ms A) about the treatment Ms A received at the Western General Hospital. She said that the reporting of a scan was unreasonable, and that the arrangements for follow-up appointments after this scan and an operation carried out some nine months later were unreasonable. Finally Ms C was unhappy with the board's handling of her representations.

During our investigation, we took independent advice from a consultant neurosurgeon and a consultant neuroradiologist, after which we upheld Ms C's complaints. In responding to the complaints, the board had accepted that the written report prepared after the scan failed show that there was a significant abnormality and they had apologised for this error. They had suggested improvements as a result, and our adviser said that these should be implemented.

We also found there was a delay in Ms A receiving a follow-up appointment after the scan, for which the board had also apologised. The advice we received was that Ms A's clinical pathway had not changed as a result of this, but it did lead to a considerable delay in telling her about her new diagnosis. The adviser also said that there was no delay in the follow-up appointment after Ms A's operation but we were concerned that she was not provided with the findings reported at the time of her operation during her in-patient stay in hospital. We were satisfied that there was no delay in arranging a further scan after her operation.

The board had apologised that Ms A had not received details of the oncology (cancer) team including the clinical nurse specialist in a timely manner. As a result of these communication problems the board had taken action to improve coordination of neurology patients and their care by establishing a new multi-disciplinary team. Finally, they had accepted failings in their handling of Ms C's complaints and had taken action as a result.

Recommendations

We recommended that the board:

- report back to us on the action taken to implement the improvements proposed; and
- ensure the staff involved in this case are made aware of the importance of ensuring findings reported at the time of the operation are appropriately reported to patients and/or their relatives.