SPSO decision report

Case: **201400410, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained to the board about the care and treatment that his wife (Mrs A) received. Mrs A was being investigated for lung disease when an error in interpreting a scan referral in December 2011 resulted in a delay in the diagnosis of lung cancer. Mrs A underwent surgery to remove a tumour in June 2012 but was not considered to be suitable for chemotherapy. Mrs A attended at follow-up appointments with the board where weight loss was noted. In May 2013 it was discovered that Mrs A had cancer in her right kidney. Although she was initially given a diagnosis of primary kidney cancer, tests found that it was in fact the spread of lung cancer and her treatment plan was changed accordingly. Following a stay in a hospice, Mrs A was admitted to hospital and passed away in October 2013.

Mr C complained about delays in diagnosing his wife's cancer, the incorrect diagnosis of primary kidney cancer and the standard to which the board had kept Mrs A's medical records. After taking independent advice on this case from a consultant physician and a consultant specialising in cancer care and treatment, we upheld Mr C's complaint regarding delay in diagnosis. Our cancer specialist adviser said that the initial delay could have affected Mrs A's prognosis. Issues with record-keeping around the completion of DNACPR (do not attempt cardiopulmonary resuscitation) forms were highlighted and consequently, Mr C's complaint about record-keeping was also upheld. However, we did not uphold Mr C's complaint about the diagnosis of primary kidney cancer as we were advised that this was a difficult diagnosis to make.

Recommendations

We recommended that the board:

- apologise for the delay in diagnosing Mrs A's cancer, particularly its spread in 2013;
- take steps to contact the locum consultant to ensure he is fully aware of our findings;
- ensure that this case is included for discussion at the relevant consultant's next appraisal;
- raise awareness of this case amongst staff involved in the booking of imaging to highlight the potential impact of errors;
- review how the care of patients requiring input from multiple specialities is managed and led;
- make staff aware of our findings in this case to allow reflection on the impact inaccurate diagnoses can have on patients and their families; and
- ensure that this case is included for discussion at the relevant doctor's next appraisal.