SPSO decision report

Case: **201402090, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained on behalf of Mrs A, the widow of Mr A. Following a referral by his GP, Mr A was seen in Ninewells Hospital for advice and investigation in May 2013. He was given a computerised tomography (CT) scan (which uses

x-rays and a computer to create detailed images of the inside of the body) which showed an abnormality on one of his ribs which was suspected to be sinister. In July 2013, a biopsy was attempted but this failed because it was too uncomfortable for Mr A. The following month, a further CT scan was taken as was a biopsy under general anaesthetic. The results confirmed that Mr A had cancer. Mr A had further investigations the following month and a treatment plan for him was discussed by a multi-disciplinary team. Mr A was advised of his diagnosis and plan in October 2013. Regrettably, Mr A's condition continued to deteriorate and he died in May 2014.

Mr C questioned why early tests and investigations given to Mr A failed to show evidence of his illness and said that there had been delays in providing him with treatment. Mr C said that as a consequence, Mr A had lost time with his family. Mr C also complained that there had been delay in issuing correspondence to Mr A. On behalf of the hospital, the board said that it had been very difficult to diagnose Mr A's illness and that while tests showed that something was wrong, this could have been for a number of reasons; there had been a delay in getting biopsy results but this had been unavoidable. Similarly, they said that there had been a delay in sending out letters because of administrative problems but that this had not affected Mr A's treatment overall.

We took independent advice from a consultant clinical oncologist and found that it had been very difficult to diagnose Mr A's cancer and to establish information by biopsy to determine the type of treatment he needed. This was not unreasonable in the circumstances. However, it had not been reasonable not to have treated Mr A as a suspected case of cancer from the outset and thus provide him with this care and treatment at an earlier date. Because of this delay and confusion in correspondence sent to Mr A, we upheld Mr C's complaint.

Recommendations

We recommended that the board:

- provide a formal apology to Mrs A;
- provide a formal apology for the delays in correspondence;
- inform us of the outcome of their administrative review and the steps taken to avoid a similar situation; and
- ensure that the advice provided for this complaint is brought to the attention of those clinicians involved in the case.