SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201402779, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C said that although her husband (Mr C) first attended Wishaw General Hospital for investigations in February 2013, it was not until early June 2013 that he was advised that he had a terminal illness. Mr C died a few weeks later after receiving his diagnosis.

Mrs C complained about the care and treatment Mr C received and that it had taken an unreasonable time to provide him with a diagnosis. She said that communication, particularly with the family, had been poor.

We took independent advice from consultants in colorectal surgery and radiology, and also from one of our nursing advisers. We found that Mr C's medical care and nursing treatment had been reasonable so we did not uphold Mrs C's complaints about this. However, there had been a delay in making a diagnosis because a scan taken in April 2013 had shown subtle changes that had been overlooked. As a consequence, Mr C could have been diagnosed earlier (although, his outcome would have remained the same) and his palliative care started sooner. Our investigation also showed that communication with the family had been poor causing even further distress to the family at a difficult time. In light of what we found, we upheld Mrs C's complaints about the board's communication and the delay in diagnosis.

Recommendations

We recommended that the board:

- make a formal apology;
- confirm to us that as a consequence of their discrepancy meeting, they are satisfied that there is an increased liklihood of such an abnormality being detected in the future;
- make specific recognition of the failures in communication by way of a formal apology; and
- provide us with details of specific actions they have taken to show that staff have learned from the shortcomings in this case.