SPSO decision report

Case: **201507589, Grampian NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: some upheld, recommendations

Summary

Mrs C, who is an advocacy worker, complained on behalf of Mrs A about the care and treatment provided to her husband (Mr A). An abnormality was noted on a brain scan Mr A received and he was not informed of this until five years later, when he was told he had a tumour. A biopsy was then carried out but Mr A suffered a bleed in his brain as a result of the biopsy operation and was left significantly incapacitated and in need of residential care.

Mrs C complained that Mr and Mrs A were not informed about the existence of the brain tumour when it was first noted and that no follow-up action had been taken. The board noted that the abnormality was first thought to have been a stroke and it had not been confirmed as a tumour until more recently. We obtained independent medical advice from a consultant neurosurgeon and a general medical consultant. It was considered that the tumour could have been diagnosed much earlier had prompt follow-up been arranged. However, we were assured that treatment would only have been proposed if the tumour had grown in size or Mr A's condition deteriorated, meaning that this would have happened around the time treatment was ultimately considered anyway. We noted that Mr A was not informed of the findings of the initial scan and we concluded that this should have happened. We also concluded that these findings should have been followed up to allow a confirmed diagnosis to be made and communicated to Mr A. While we were satisfied that this delayed diagnosis did not significantly impact on his treatment, we upheld this complaint.

Mrs C also complained that the board had failed to explain to Mr A the risks attaching to the biopsy procedure. We observed that discussions surrounding the risks, including bleeding and brain damage, were documented in a clinic appointment note prior to the biopsy, and also on the consent form which Mr A had signed. We did not uphold this complaint.

Mrs C also complained about the board's handling of the complaint, including the timeliness and comprehensiveness of their response. We considered that the board's replies were unreasonably delayed and that they failed to adequately address all of the issues raised. We also noted that their complaint file did not appear to contain a full account of their investigation. We upheld this complaint.

Recommendations

We recommended that the board:

- ask the relevant clinicians to reflect on the findings of this investigation and ensure that appropriate action is taken in future to follow up on unexplained abnormalities, particularly when the clinical signs do not support the suspected diagnosis;
- ask the relevant clinicians to ensure that any unusual scan results are shared with the patient;
- apologise to Mr and Mrs A for the failure to share with them the findings of the initial scan, for the failure to follow this up, and for the consequent delay in confirming, and informing them of, Mr A's tumour diagnosis;
- ask complaints staff to reflect on the complaints handling failings this investigation has identified and take steps to ensure that their feedback and complaints handling procedures are fully adhered to;

- ask complaints staff to ensure that all correspondence relevant to their investigation of a complaint, including internal correspondence, is filed on their complaint file; and
- apologise to Mr and Mrs A for the failure to provide a clear, comprehensive and timely response to their complaint.