

## SPSO decision report

**Case:** 201508147, Ayrshire and Arran NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Outcome:** some upheld, recommendations

### Summary

Mrs C complained about the care and treatment received by her husband (Mr A) at Ayr Hospital for a rare type of bladder cancer. Specifically, Mrs C was dissatisfied with surgery performed, the communication with her and Mr A, and the board's response to her complaint.

We took independent advice from a consultant urological surgeon and a consultant radiologist. We found that the surgical treatment and follow-up review were both of a reasonable standard. Whilst we did not uphold the complaint about Mr A's treatment, we identified unreasonable failings in the reporting of a scan which had shown Mr A's cancer had worsened. We found that even had the scan had been reported accurately, it would not have changed Mr A's treatment or outcome. However, Mrs C and Mr A would have known about this much sooner. We also noted that although there was no specific indication for it at the time, it would have been preferable for Mr A's particular case to have been reviewed by the urology multi-disciplinary team and we made a recommendation in relation to this.

In addition, we were critical that the board had not identified the error in the reporting of the scan after Mrs C complained about the matter.

We also considered that the communication with Mr A and Mrs C fell below a reasonable standard.

### Recommendations

We recommended that the board:

- apologise to Mrs C for the inaccurate reporting of the scan;
- reflect on the reporting of the scan and take steps to identify learning and improvement;
- consider routine review by the multi-disciplinary team of follow-up imaging for those patients with bladder cancer at high risk of recurrence;
- share these findings with the staff involved in Mr A's care; and
- share these findings with the staff involved in the investigation of the complaint for shared learning.