SPSO decision report

Case: **201604207, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained to us about the care and treatment provided to her late father (Mr A) at Wishaw General Hospital after he was diagnosed with cancer of the oesophagus (the tube that carries food from the throat to the stomach). Mr A had been admitted to hospital for an operation. During the operation a hole in one of his air passages was identified and he was transferred to another hospital outwith the board area. It was decided there that his cancer had spread and was inoperable. Mr A died four days later.

Mrs C complained that there had been delays in carrying out tests and in providing treatment to Mr A. We took independent advice from a consultant upper gastrointestinal surgeon and from a consultant radiologist. We found that, in general, the board had provided reasonable care and treatment to Mr A. However, there had been delays in carrying out two scans that Mr A needed. The board did not have the facilities to carry out these scans and had referred Mr A to another board. There was no evidence that the board had taken any action to escalate the matter when there were delays in carrying out the scans. In view of this, we upheld Mrs C's complaint, although we did not consider that the delays in carrying out the scans would have influenced the ultimate clinical outcome for Mr A.

Mrs C also complained that the board did not take reasonable action to investigate the possibility of Mr A's cancer spreading before the operation. We found that the investigations the board had carried out before the operation were appropriate and in line with standard practice. It had also been reasonable for them to carry out the operation. We did not uphold this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failure to act on the delays in the scans being carried out. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Ensure that there are adequate mechanisms in place to prevent delays in having scans carried out outwith the board.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.