SPSO decision report

Case: **201604390, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his late father (Mr A) at Forth Valley Royal Hospital.

Mr A was referred to the board and diagnosed with prostate cancer. At a multi-disciplinary team (MDT) meeting, a decision was made to adopt a watchful waiting approach (an approach used in prostate cancer management in men with few symptoms). Mr A attended an appointment approximately six months later, then another twelve months after that. At that point, it was found that Mr A's prostate specific antigen (an indicator of prostate cancer or other prostate conditions) had risen. Following a further MDT meeting, he was seen by an oncologist who felt that he was suitable for radical radiotherapy. In the following months, Mr A's condition deteriorated and he died.

Mr C complained that staff failed to provide Mr A with appropriate clinical treatment. He questioned the decision to place Mr A on watchful waiting programme, and the level of review he received. The board partially upheld Mr C's complaint on the basis that communication could have been better. In particular, they acknowledged that it would have been appropriate for Mr A to have been seen by a consultant at the time the decision was made to put him on watchful waiting. The board advised that they had taken action as a result of Mr C's complaint, and that patients would be seen by a consultant following a decision to place them on watchful waiting.

We took independent advice from a consultant urological surgeon and an oncologist. We found that the board followed guidelines and reviewed Mr A at reasonable intervals once watchful waiting was decided on. However, we found that the watchful waiting decision should not have been made without clinical assessment by a consultant, which may have led to a decision to offer radiotherapy. We noted that Mr A's cancer followed a path that was significantly worse than could have been expected, and that a decision to offer radiotherapy would not necessarily have prevented this. On balance, we upheld Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to arrange a review with a consultant for Mr A when the decision was made to take a watchful waiting approach. The apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

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.