SPSO decision report

Case: **201800058, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained that that board failed to provide his late wife (Mrs A) with reasonable care and treatment at Western General Hospital and that they did not respond reasonably to his complaint.

We took independent advice from a consultant radiologist (a specialist in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans), a consultant surgeon and a consultant oncologist (cancer specialist).

In relation to a CT scan, we found that a lymph node which was partially visible at the bottom of the CT scan, despite being enlarged and abnormal looking, was not noted by the reporting radiologist at the time. The failure to identify the abnormal lymph node was an unreasonable error. We also noted that the review of the CT scan showed concerning nodes with an increase in size in comparison with a CT scan of Mrs A's chest carried out previously. Given this and Mrs A's clinical history, this should have been noted in the scan report. We considered that, had these nodes been noted on the CT scan report, it was likely further investigation would have occurred as a result. We acknowledged that the board had accepted there was a missed potential to make a detailed diagnosis of Mrs A's condition and said they have taken action to learn from this. We asked the board to provide us with evidence of this.

We also found that a haematology consultant (a specialist in blood and bone marrow) appropriately referred Mrs A to the surgical department for an excision biopsy of the lymph node. However, due to poor communication between the haematologist and the surgeon about the exact anatomical position of the lymph node, the wrong lymph node was removed for biopsy and the diseased lymph node was left in Mrs A's groin. As a result, the pathology report of the biopsy was falsely reassuring.

We also considered that the errors identified in Mrs A's care and treatment led to a delay in the diagnosis that she had terminal metastatic lung cancer. However, it was most likely that when Mrs A first presented with the swelling in her groin, this was evidence of metastatic cancer and she was already in an incurable state. Although earlier diagnosis of the cancer could have been made, it would have made no difference to Mrs A's outcome.

We found that the palliative treatment Mrs A received was reasonable and appropriate and was consistent with national clinical guidelines. However, the delay in diagnosis of the cancer would have caused Mrs A intrusive and distressing symptoms that could have been mitigated had the excision biopsy been correctly undertaken or palliative treatment instigated at an earlier time.

We also found failings in communication concerning how the news that Mrs A had cancer had been conveyed to her. Apart from the delay in diagnosing Mrs A's cancer, there was also an unreasonable delay in informing her that she had metastatic terminal cancer. We considered that the board failed to provide Mrs A with reasonable care and treatment and upheld this aspect of Mr C's complaint.

In relation to complaint handling, we considered that the board's letter to Mr C about his complaint contained medical jargon which could have been better explained. We also considered that Mr C was not provided with all the relevant information. Given that there were a number of medical specialities involved, we considered it would have been helpful if the board's offer of a meeting to Mr C to discuss his complaint had not been restricted to the radiology service. We also noted that the board's complaint response contained factual errors in relation to dates. Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failings in the care and treatment that Mrs A received from the radiology, haematology and surgical departments in relation to the diagnosis of her cancer; for the unreasonable delay in the diagnosis; for the unreasonable delay in informing Mrs A about her diagnosis; for the poor communication with Mrs A and Mr C about her diagnosis. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients should have all relevant areas of their scan reviewed and reported. When referring a patient for surgical excision biopsy, communication between the referring clinician and the operating surgeon about the exact anatomical position of target lymph nodes should be clear. Communicating significant news, especially bad news, to a patient and/or their family should be carried out in a clear and sensitive manner and without any unreasonable delay.

In relation to complaints handling, we recommended:

- Complaint responses should be accurate, user friendly and easily understood by the complainant and include details of action taken to address failings identified.

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.