SPSO decision report

Case: **201800406, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late mother (Ms A) at the Royal Infirmary of Edinburgh. Ms A had undergone treatment for early stage lung cancer, and was followed up at six-monthly intervals. Mrs C complained that at a follow-up appointment, Ms A had been told there were no signs of cancer, but a few weeks later was found to have liver cancer. Mrs C said that there was a failure to identify the spread of lung cancer and that Ms A had been given false hope.

We took independent advice from a radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) and an oncologist (a doctor who specialises in the diagnosis and treatment of cancer). We found that there had been a failure to identify a mass near Ms A's spine on a scan, and that this was unreasonable. However, we noted that it was unlikely that earlier identification of this would have altered Ms A's outcome. We also found that at a follow-up appointment, the clinical examination done was incomplete as it did not include examination of the abdomen. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failure to identify a mass and the failure to carry out a full clinical examination at the oncology appointment. 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:

- Radiological findings should be accurately reported.
- Full clinical examination should be performed and documented during oncology follow-up appointments in cases of radical lung cancer treatment.