SPSO decision report

Case: **201800698, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care she received at St John's Hospital. In particular, Mrs C was unhappy with delays in the identification, monitoring and diagnosis of an abnormality in her pancreas. Mrs C had a number of hospital admissions and underwent four scans. The scans showed that the abnormality had increased in size. By the time of the final scan, it was identified that the abnormality was likely to be cancer. Mrs C was subsequently diagnosed with cancer and had surgery to have part of her pancreas removed as well as chemotherapy.

We took independent advice from a radiologist (a specialist in the analysis of images of the body) and a general surgeon. We found that the management of the abnormality was reasonable until the point of the third scan. The report of this scan identified a definite increase in size of the abnormality, although inconsistently referred to it as unchanged. We considered that a referral should have been made to the surgical team to follow up the abnormality and concluded that the failure to do this was unreasonable. We upheld the complaint. However, we concluded that if follow-up had been appropriately planned, it was unlikely that the course of events would have been different in this case. This is because Mrs C received a scan to investigate abdominal pain around the same time that a scan would have been planned in line with the recommended timescales for follow-up of abnormalities.

Mrs C also had concerns about the way the board handled her complaint. We noted that the board had acknowledged and apologised to Mrs C that there had been a significant delay in responding to the complaint. We were critical that the board did not seem to have identified the cause of the delay. We also found that the board had failed to provide updates to Mrs C about the delay. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failure to make a pancreatic surgical referral after a CT scan identified a definite change in the size of a pancreatic lesion. 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:

- A definite increase in size of a pancreatic lesion should prompt a pancreatic surgical referral.

In relation to complaints handling, we recommended:

- Where there has been a significant failure follow the Complaints Handling Procedure, the board should consider whether they need to take any actions as a result of learning from this case.

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.