

## SPSO decision report

**Case:** 201807322, Fife NHS Board  
**Sector:** Health  
**Subject:** clinical treatment / diagnosis  
**Decision:** some upheld, recommendations

### Summary

C has a family history of bowel cancer polyps (abnormal growths) on the colon and was admitted to hospital on several occasions over many months with abdominal pains and vomiting. C complained to the board that, despite their family and medical history, the board unreasonably delayed to perform a scan, which resulted in a delayed diagnosis of bowel cancer. C also complained that the board failed to accurately report on a scan, as a subsequent review identified the presence of cancer.

The board advised that a scan was not indicated when C first presented to hospital. They also advised that the initial report on the scan was adequate, and it was only when additional clinical information became available (blood test results), that a second review changed the diagnosis.

We took independent advice from a consultant colorectal (bowel) surgeon. We found that there was insufficient consideration given to C's own medical history and that an x-ray taken was not appropriately followed up or acted upon. We concluded that there were several missed opportunities to perform a scan or colonoscopy (an examination of the bowel with a camera on a flexible tube) when C had attended hospital. We upheld this aspect of the complaint.

However, we concluded that the initial report on the scan was adequate. We did not uphold this aspect of the complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to take proper account of their medical history and for failing to carry out a CT scan when they first presented to hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets).

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

- The consultant with overall care for the patient should receive feedback from the case in a supportive way and the feedback is used for reflection as part of their annual appraisal.
- This case should be discussed as a delayed diagnosis and be reported and investigated as an incident in the organisation.

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.