SPSO decision report

Case: **201808160, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained to us about the care and treatment she received from the board when she was diagnosed with lung cancer. Ms C was told that the tumour in her lung had been visible in a CT scan she had several years earlier, which was taken to plan her radiotherapy treatment (a treatment using high-energy radiation) for breast cancer. Ms C complained that the lung tumour was not identified at that time or if it was, she was not offered any treatment. We took independent medical advice from an oncologist (cancer specialist). We found that CT scans for planning radiotherapy are not taken with enough detail to be used for diagnostic purposes. We also found Ms C's lung tumour was small and it could have easily been missed by a clinician who was not reviewing her CT scan for diagnostic purposes. We found it was reasonable that Ms C's lung lesion was not identified at that time and we did not uphold this aspect of her complaint.

Ms C also complained about the communication with her about her condition and treatment, leading up to her diagnosis of lung cancer. In particular, that Ms C was sent an appointment letter for a chest CT scan without being told the reason why she was being referred for a CT scan. We took independent medical advice from an acute medical consultant. We found that Ms C and her GP were not appropriately informed about the outcomes of investigations that had been carried out; and why there was a need to carry out further investigations into her condition. We upheld this aspect of Ms C's complaint.

Ms C also complained about the board's complaints handling. We found that the board did not keep Ms C appropriately updated during their investigation. We found that the board had failed to identify and respond to all aspects of Ms C's complaint; it was unclear what the conclusions of their complaints investigation had been; and they did not apologise to Ms C for failings they had identified. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failings in their communication with her; and for failing to handle her complaint in a reasonable manner. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- Patients and their GPs should be appropriately informed about the outcomes of investigations and the need to carry out any further investigations.

In relation to complaints handling, we recommended:

- In line with the NHS complaints handling procedure, complaint responses should address all the issues

raised and demonstrate that each element has been fully and fairly investigated; include the conclusions of the investigation; and include an apology where things have gone wrong. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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.