SPSO decision report

Case: **201901872, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the standard of medical care and treatment provided to their parent (A). A received a likely diagnosis of metastatic lung and liver cancer. They were placed on palliative care, however, after approximately a year, A remained in good health. C sought a further review, A received subsequent scans, and it was ultimately established that they did not have cancer (approximately two years after the original diagnosis).

C raised concerns about the basis for the initial diagnosis that A had cancer. They also complained about the subsequent management of A. C said there was no appropriate follow-up or subsequent communication after the diagnosis. Ultimately, C requested a review, but said it took significant time for the board to establish there was no cancer.

We took independent advice from a consultant 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 a consultant geriatrician (a doctor who specialises in medicine of the elderly). We found that the diagnosis that A likely had cancer was reasonable. It was based on a reasonable radiological opinion given the findings on A's CT scan. We did not uphold C's complaint in that regard.

In relation to A's subsequent management, we found that there were unreasonable failings. The standard of care and attention the board provided to A following discharge was not reasonable, and we found evidence that follow-up was proposed for A and then not acted on. We also found that there was a failure to respond within a reasonable time to the referral for an oncology review. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for the failings identified in this investigation and include recognition of the impact the failings have had on them. The apology should meet the standards set out in the SPSO guidelines on apology at www.spso.org.uk/information-leaflets.

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

- Ensure effective systems are in place for review on hospital discharge and communication is effective especially where there is diagnostic uncertainty.

In relation to complaints handling, we recommended:

- Ensure board investigations identify and address incidents covered by the Duty of Candour with the relevant Scottish Government guidance.

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.