SPSO decision report

Case: **201908658, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C had been in contact with a number of specialists at the health board as C suspected they were symptomatic of lung cancer. C said that a tumour in their lung was visible from a number of tests carried out by hospital specialists, but that this was unreasonably missed. C also said that treatment decisions and management were not reasonable and that the failure to diagnose them with lung cancer within a reasonable time had catastrophic consequences for their prognosis. C was also concerned about the way the health board dealt with their complaint.

We took independent advice from three advisers: 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), a respiratory physician (a doctor who specialises in treating and managing patients with conditions affecting their lungs) and from an orthopaedic specialist (a specialist in the treatment of diseases and injuries of the musculoskeletal system). We found that C's treatment was reasonable. C was regularly reviewed and their antibiotics were changed in order to try and improve their outcome.

However, we found that there was a significant delay in the diagnosis of lung cancer resulting from an unreasonable failure of radiological interpretation which lead to significant injustice to C; this failure would shorten C's life. We also found an unreasonable failure to follow up test results or to carry out a further scan, although we concluded that in themselves this would not have changed the outcome for C.

In relation to the standard of respiratory care and treatment provided, we found that the diagnostic process and treatment decisions were reasonable.

Finally, we found significant failings in the health board's investigation of C's complaint. While the health board identified radiological errors, they did not apologise for these or explain how they occurred and what action the health board were taking to ensure they did not happen again, nor was there any consideration of the impact of these errors on C's prognosis and treatment decisions. We upheld three complaints out of four.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this investigation and inform C of what and how actions will be taken to stop a future reoccurrence. 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:

- Carry out an audit of x-rays and scans taken between a specified time-period to ensure there is no systemic issue which may have affected other patients.

- Ensure that test results are followed up appropriately.
- Feedback the findings of our investigation in relation to the complaint handling failures to relevant staff for them to reflect on.
- Feedback the findings of our investigation in relation to the failure of radiological interpretation to relevant staff for them to reflect on.
- Review the complaint handling failures to ascertain: how and why the failures occurred; any training needs; and what actions will be taken to stop a future reoccurrence.
- Review the failure of radiological interpretation to ascertain how and why the failures occurred and what actions will be taken to stop a future reoccurrence and inform this office of the results.

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.