SPSO decision report

Case: **202000655, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, the parent of A, complained about a delay in diagnosing A's thyroid cancer. A had an emergency admission to Dumfries and Galloway Royal Infirmary with acute tonsillitis and a lump was found on their neck. This lump was subsequently excised four months later, and cancer was diagnosed the following month. C complained that no prior indication had been given that cancer was suspected, and that the delay in diagnosing this led to unnecessary operations. They also complained about a subsequent delay in informing them about identified nodules on A's lung that were being monitored.

The board told us that they recognised that an earlier biopsy could have led directly to definitive surgery, without the need for further investigations or procedures and ultimately to a quicker resolution for A. They confirmed that they developed a new neck lump clinic as a result of this complaint. We took independent advice from a head and neck surgeon. We noted that A should have had an urgent needle biopsy at an earlier point in time. This would have led to an earlier diagnosis and less surgery. We noted that an excision should only have been considered if a diagnosis was not possible from the needle biopsy. Therefore, we upheld the complaint that there was an unreasonable delay in diagnosing A's cancer. We considered that the new neck lump clinic was the best way to avoid this happening again. While we were assured that the delay did not have an impact on A's prognosis, we noted that it will have added to the distress for A and the family.

In relation to C's concerns about not being advised sooner that cancer was suspected, we noted that cancer did not appear to have been considered earlier. We were, therefore, unable to conclude that there was a failure to communicate a suspicion of cancer. We noted that the board had already acknowledged that they did not make A aware of the lung nodules when they were identified. Therefore, on balance, we upheld the complaint that communication was unreasonable. The board had already apologised for this and they told us that they had revised their process to require clinicians to copy GP letters to patients.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and C for the unreasonable delay in diagnosing A's cancer. 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:

- Neck lumps should be investigated with a needle biopsy in the first instance, and an excision should only be considered if a diagnosis is not possible from the needle biopsy. This should be undertaken urgently until cancer is excluded. This case should be discussed at the department's morbidity meeting and the findings of this investigation fed back to relevant staff in a supportive manner for reflection and learning.

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.