SPSO decision report

Case: **202201910, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an advocate, complained on behalf of their client (A) about the care and treatment they received from the board. A had attended the board for a chest x-ray following respiratory symptoms but the x-ray was reported as normal. A had a second chest x-ray a few months later which led to them being diagnosed with lung cancer. On review of the first chest x-ray it was found that this had been abnormal and was reported incorrectly.

The board's response to C's complaint recognised a mistake had been made by the reporting radiologist (specialist in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans). The board advised that the chest x-ray had been outsourced to an external provider for reporting, and they had fed back this incident to the provider and radiologist, which had been investigated accordingly. The board apologised to A and confirmed the event met the criteria for duty of candour (a legal requirement on all health and social care providers in Scotland which seeks to ensure there is openness and transparency with the aggrieved party when something has gone wrong, and which seeks to learn from the incident). The board also advised the incident had been reviewed internally and concluded that the mistake had occurred due to human error, and that it was not considered to be indicative of a wider problem within the organisation.

We took independent advice from a lung cancer physician. We confirmed that A's diagnosis of lung cancer had been delayed by around three months due to the first chest x-ray being incorrectly reported. We found that it was reasonable for A to have expected the abnormality in their chest x-ray to be identified. However, once the mistake had been recognised, the steps taken by the board had been reasonable in alerting the external radiology company to the problem, and in terms of the board's own internal investigation into the matter. Therefore, we upheld this aspect of C's complaint but made no further recommendations due to the appropriate action taken by the board.

C also complained about the board's handling of their complaint. We found that the board had been transparent with A by alerting them to the mistake and that they had reasonably advised A of the incident meeting the criteria for duty of candour. However, we found that the board had failed to explain to A what this meant in terms of their obligations to them as the aggrieved party. It was our view that the board had not reasonably fulfilled their obligations in keeping with the duty of candour guidance. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should ensure they have met their obligations to A in respect of duty of candour. The board should offer to send A a copy of their report on the incident.

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

- Where duty of candour applies, the board should ensure they take all of the necessary steps in keeping with the guidance, and inform the aggrieved party of the organisation's obligations to them in keeping with the legislation, irrespective of whether a complaint has been made or not.

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.