SPSO decision report

Case: **201100818, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Ms C's daughter (Miss A) was referred to hospital complaining of difficulty swallowing. She also had abdominal pain and tenderness. An endoscopy (an examination using a camera on a thin tube) was carried out but the endoscopist did not report any significant abnormalities. Miss A was seen by an ear nose and throat surgeon about two months later. He arranged for her to be admitted to another hospital where further examinations and tests were carried out. Miss A was found to have a large cancerous tumour in her throat. She was discharged from hospital with a plan to provide chemotherapy and radiotherapy. Before her scheduled treatment date, however, her condition deteriorated and she was admitted to hospital. Miss A received two courses of chemotherapy, but died shortly after her second treatment.

Ms C complained that her daughter's tumour was not diagnosed by the endoscopist. She felt that, had it been, Miss A could have commenced treatment sooner, and her prognosis might have been better. Ms C also raised concerns about the monitoring of Miss A's condition, communication with the family and mistakes made by the board in their minutes of a meeting with the family to discuss their complaints.

After taking the advice of two of our medical advisers, we did not uphold most of Ms C's complaints. We accepted that the endoscopy was not designed to examine the area of Miss A's mouth where the tumour was visible. Whilst we felt that some view of the mouth should have been taken, this would in fact have been to check for obstructions rather than a diagnostic examination. We also found that Miss A had restricted movement of her neck and jaw and that this, combined with the process of swallowing the endoscope, would have restricted the available view. Although we were satisfied with the endoscopist's actions we were, however, concerned to note that she had said that she would not examine a patient's mouth prior to the procedure. We asked the board draw her

attention to our comments about the importance of non-diagnostic oral examinations.

We were also satisfied that investigations into Miss A's condition were appropriately progressed after the endoscopy. One of our advisers noted that the tumour was so advanced that, even had it been found on the day of the endoscopy, Miss A's prognosis would not have been any different. We found the board's monitoring of Miss A's condition, and their communication with Miss A and her family while she was in hospital, to be appropriate. We did not find evidence of specific details being provided to the family when the hospital decided to discontinue treatment. However, we felt that it was not necessarily appropriate for staff to do so and were satisfied that the family had the opportunity to ask questions of the staff on duty.

The board's minutes of their meeting with Ms C stated that Miss A had been present, rather than her sister. We upheld Ms C's complaint about this and about the general accuracy of the minutes, recognising the impact that this administrative mistake would have had at a time of such distress.

Recommendations

We recommended that the board:

- draw our adviser's comments regarding non-diagnostic oral examinations to the endoscopist's attention; and
- apologise to Ms C in writing for their mistake in the meeting minutes.