

## SPSO decision report

**Case:** 201508225, Ayrshire and Arran NHS Board

**Sector:** health

**Subject:** clinical treatment / diagnosis

**Outcome:** not upheld, recommendations

### Summary

Mr C complained about the care received by his sister (Miss A) at University Hospital Ayr, in particular that there was a delay in her being scanned and a delay in transferring her to the Beatson West of Scotland Cancer Centre, which is in another board area. Miss A had a history of Crohn's disease (a long-term condition that causes inflammation of the lining of the digestive system) and became unwell. Further tests showed that Miss A had tumours in her liver and bone marrow. She died two days after being transferred to the centre.

We took independent medical advice and found that Miss A had been reviewed urgently when abnormalities were identified. We found that she was offered admission to hospital to undergo further tests including a specialist scan. However, it appears Miss A opted to wait for an out-patient appointment. Whilst cancer was not initially suspected we found that the time taken to carry out a specialist scan was reasonable. We concluded that Miss A's care was reasonable and did not uphold Mr C's complaint.

However, we were critical of the board's communication about Miss A's transfer to the centre, which caused Miss A and her family additional distress. The board apologised for this and we made a recommendation to identify any further learning and improvement.

### Recommendations

We recommended that the board:

- evidence that they have liaised with Greater Glasgow and Clyde NHS Board to identify any possible learning and improvements in relation to the delayed transfer to the centre.