# SPSO decision report

**Case:** **202008128, Lothian NHS Board - Acute Division**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** some upheld, no recommendations


## Summary

C complained about the care and treatment provided to their late parent (A) when they were admitted to hospital for investigations of lung cancer. A had an out-patient appointment for a CT scan, however, the day before this appointment, A was admitted to hospital due to increased haemoptysis (coughing up of blood). There was a delay in performing the CT scan due to miscommunication between the clinical team and radiology, which the board have acknowledged. When A was taken for the scan, they suffered a massive haemoptysis and a subsequent cardiac arrest and died.

C complained about the communication failures which led to a delay in arranging the CT scan and that insufficient efforts were made to resuscitate A. To investigate C's complaint, we reviewed the clinical records and sought independent advice from a consultant radiologist (a specialist in the analysis of images of the body).

Our investigation found that while there were communication failures in arranging A's CT scan on an in-patient basis, we did not consider the delay caused to be unreasonable as A's condition was stable and there were no further episodes of haemoptysis. We did however, uphold the complaint on the basis that there were communication failings. We made no recommendations due to action already taken by the board.

Our investigation also found that reasonable attempts were made at resuscitation when A suffered the cardiac arrest. We did not uphold this aspect of the complaint.