SPSO decision report

Case: **202306728, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) who was diagnosed with lung cancer. C considered that there had been missed opportunities to diagnose A earlier, and that as a result A was denied appropriate care which may have affected their outcome. C also complained that the cause of death determined by the board was inconsistent with A's diagnosis. Additionally, C complained that the cause of death was amended at a later date, which caused them to doubt the accuracy of the board's conclusions.

In their complaints response, the board stated that X-rays conducted earlier in the year had been reviewed and that radiologists were in agreement that A's disease could not have been identified earlier. The board had also apologised that the cause of death had initially been determined to be hospital acquired pneumonia, and that this had now been corrected to community acquired pneumonia with lung cancer as the major contributing cause.

We took independent advice from an experienced respiratory consultant. We found that it was not unreasonable that A's cancer had not been detected on earlier X-rays. However, a decision to downgrade a GP's referral from 'urgent suspicion of lung cancer' to 'new urgent' created delays in investigations of approximately four weeks, and likely longer had A not been admitted to hospital unrelated to the referral. Further delays of around three weeks were also apparent between the final investigation and the final multidisciplinary team (MDT) discussion. We also found that it was unlikely that there would have been a different outcome for A due to the nature of A's illness. As such. we upheld C's complaint.

Regarding the cause of death, we found that the cause of death had been correctly identified in line with the available information and that whether the pneumonia had been hospital or community acquired was a technicality that was less significant than the overall conclusions. Based on this, on balance, we did not uphold this aspect of the complaint that there had been inaccurate or misleading information provided.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- There should be a robust system in place for triaging respiratory referrals, which should only be downgraded when there is a clear clinical reason to do so. All patients with suspected cancer undergoing investigations should be appropriately tracked to prevent delays.

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.