

## SPSO decision report



**Case:** 202410121, Orkney NHS Board  
**Sector:** Health  
**Subject:** Clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

C, a Patient Advice and Support Service (PASS) adviser, complained on behalf of their client (B) about the care and treatment provided to B's late spouse (A). A was under the care of two health boards for treatment of a concurrent bladder and colorectal cancer. While the bladder cancer was timeously treated, A died without having received treatment for the colorectal cancer. C also complained that the board failed to reasonably meet their obligations in accordance with Duty of Candour.

We took independent advice from a colorectal surgeon. We found that there was a failure to provide a reasonable standard of care and treatment to A, particularly in relation to a failure to mark an MRI scan request as urgent, and a failure to report the results of scopes in the normal way. We upheld this complaint. We also found that the board failed to meet their obligations in accordance with Duty of Candour. We upheld this complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/meaningful-apologies](http://www.spsso.org.uk/meaningful-apologies).

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

- Patients should receive reasonable and timeous care.