SPSO decision report

Case: **202500144, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment
Decision: upheld, recommendations

Summary

C complained that the board unreasonably failed to advise C of their immunology results or act upon these results in the following years. Over a number of years, C's liver function tests (LFT's) continued to deteriorate without clear cause. C was seen at a liver clinic where they had an MRI along with other imaging and extensive bloods. The results of these were noted as 'highly suggestive of autoimmune liver disease and more likely Autoimmune Hepatitis (a chronic liver disease where the body's immune system mistakenly attacks liver cells)'. Although C had a number of appointments after these results, C only learned of the diagnosis when they acquired copies of their medical record some years later.

The board identified and apologised for a number of failings that they had identified in C's care and treatment and took some actions with the aim of ensuring similar failings could not recur. However, the board concluded that the discussions with C during their treatment had been reasonable, stating that the focus of a more recent appointment had been on newly diagnosed intraductal papillary mucinous neoplasms (IPMNs, cystic tumours in the pancreatic ducts) on C's pancreas and that during that appointment they had touched on C's continuing liver abnormalities and the undertaking of a further liver biopsy, which was arranged but paused during the COVID-19 pandemic. C was subsequently advised that they required a liver transplant.

We took independent advice from an consultant hepatologist and gastroenterologist adviser. We found that there is no clear, objective evidence to support the board's position that the immunology results were shared with C during an appointment and that, if this had occurred a record would have been made.

We also found that the board's actions in this case were not reasonable. There should have been discussion with, and the seeking of advice from, the rheumatologists who had looked after C in the longer term. The importance of a liver biopsy to potentially clarify some of the possibilities that the immunology results had indicated should have been emphasised to C and discussed at a depth reflective of C's medical background. We uphold the complaint that the board unreasonably failed to advise C of their immunology results or act upon these in the following years.

C also complained that the board's complaint response was unreasonable. We found that given the changes in immunoglobulins and positive antibodies in C's results, it was not reasonable to suggest, as the board did, that they were no different to previous immunology results. We upheld this aspect of the complaint.

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/meaningful-apologies.

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

- When test results are available, patients are reasonably advised of these and a discussion at a depth appropriate to the patient's knowledge is undertaken and recorded. In the event that further testing, such as biopsies, would be important to clarify any possibilities the results identify, this is appropriately emphasised to patients.

In relation to complaints handling, we recommended:

- Statements in complaint responses are clear and understandable and steps are taken to ensure no unreasonable suggestions are communicated by them. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.