SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201608106, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C's late partner (Ms A) was given drug treatment for multiple sclerosis (a condition which can affect the brain and/or spinal cord). During the treatment, Ms A experienced stomach pain. After this she was referred for tests and she was diagnosed with cancer. Ms A underwent surgery to treat the cancer, however her condition deteriorated after the surgery and she later died.

Ms C complained that Ms A was not appropriately monitored during her multiple sclerosis treatment. Ms C considered there was a delay in diagnosing the cancer and that cancer treatment options were not fully discussed with Ms A. In addition, Ms C complained that the risk of surgery was not fully explained to Ms A and that the decision to go ahead with the surgery was unreasonable. Ms C also had concerns about the nursing care Ms A received after the surgery and about how the board dealt with her complaint.

We took independent advice from a consultant neurologist, a consultant gynaecologist and a nurse. We found that Ms A was appropriately monitored during her multiple sclerosis treatment. We found that there was no unreasonable delay in diagnosing Ms A's cancer. We also found that the decision to proceed with surgery was appropriate and that the nursing care Ms A received afterwards was of a reasonable standard. Therefore, we did not uphold these aspects of Ms C's complaint.

However, we did find that the discussions with Ms A about the cancer treatment options available to her were not properly recorded. We found that the consent form she signed for the surgery did not document all of the risks. We also found that the board did not respond appropriately to all of the concerns that Ms A raised and that there were delays in investigating the complaint, which the board had acknowledged. Therefore, we upheld these aspects of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to properly document any discussions with Ms A about the cancer treatment options available. Also apologise that the consent form Ms A signed for the surgery did not document all of the risks. Also apologise for failing to appropriately address all of Ms C's concerns in their response to her complaint. These apologies should comply with the SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- Every discussion with a patient about treatment options should be documented in the medical records.
- The risks of surgery discussed with a patient should be documented, in order to reduce the likelihood of a miscommunication or misunderstanding.

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.