SPSO decision report

Case: **201803767, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that there was an unreasonable delay in providing their parent (A) with a diagnosis of pancreatic cancer.

We took independent advice from a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) and a consultant gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the stomach and intestines). We found that radiology unreasonably failed to detect and report pancreatic cancer from a scan taken five months prior to diagnosis and that there was an unreasonable failure to hold a multi-disciplinary team meeting between radiology and gastroenterology with imaging. We also found that there was an unreasonable delay in investigating the cause of A's pancreatic insufficiency as it would have triggered further imaging. We considered that earlier detection may have improved A's quality of life because they would have had a management plan for palliative care sooner. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the delay in diagnosing A's pancreatic cancer at the three points detailed in the decision. 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:

- Regular multidisciplinary meetings should be arranged where difficult cases are discussed with imaging and clinical information available.
- The board should encourage the use of multiplanar reformatting facility (involves the process of converting data from an imaging modality acquired in a certain plane, usually axial, into another plane).
- The board should ensure all organs are assessed for CT reporting.
- To ensure radiological errors are reviewed with all reporting radiologists and radiographers to facilitate shared learning.
- To view this case as a learning opportunity that a lower threshold for suspicion of pancreatic cancer should be adopted by clinicians.

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.