SPSO decision report

Case: **201906045, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) who died from an aggressive and complicated form of cancer. C considered that there was a lack of urgency in the board's actions and there was no clear plan for A's treatment.

The board confirmed that they carried out a number of investigations and referred A's case to the National Sarcoma Team in order to seek their view. Further tests were requested and a referral was made to the Acute Pain Service. The board said that while no definitive diagnosis was reached, there had been a plan to pursue radiotherapy; however, A's condition quickly deteriorated and they died.

We took independent advice from a consultant gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the stomach and intestines). We found that the treatment plan of A's condition was reasonable and we did not consider there was a lack of urgency. However, we concluded that, at the point when significant changes were observed in a scan compared to a scan performed some months prior, the board should have held a local multi-disciplinary team (MDT) discussion and/or referred to a cancer of unknown primary (CUP) (where the place cancer began is not known) MDT to discuss A's case. This may have resulted in a more faster and possibly would have led clinicians to concentrate more on pain relief. On balance, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to hold a local MDT and/or refer to a CUP MDT at the point the significant changes were observed in the scan. 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:

- Clinical managers should reflect on this case with regard to whether there was a missed learning opportunity at the point the significant changes were observed in the scan.
- The board should give consideration to how they could strengthen their multi-disciplinary teams to enable them to meet more regularly to discuss cases with different specialists.

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.