SPSO decision report

Case: **202004502, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained of a delay in diagnosing their late partner (A)'s cancer by medical staff in University Hospital Monklands. A was diagnosed with a rare cancer and died three weeks later. They had been unwell for around five months and had multiple hospital attendances and admissions. C complained that appropriate tests weren't carried out in a timely manner, and that A was misdiagnosed and treated for potential illnesses they did not have.

We took independent medical advice from a consultant in respiratory and general medicine. We found that A's case was complex and unusual and that it was reasonable to consider other diagnoses more likely than cancer, and to treat these accordingly while investigations continued. However, we found that reasonable action was not taken to manage the pleural effusions (fluid around the lung) that A initially presented with. Guidelines indicate that a fluid aspiration (removal of a small amount of fluid for testing) should have been arranged to rule out infection in the pleural space (cavity between lungs and chest wall). This was not arranged until almost eight weeks later. When this was done and the result was inconclusive, guidelines recommended that a biopsy be carried out and this wasn't done either. In addition, an ultrasound scan the following day reported ascites (fluid within the abdomen), and again a fluid aspiration was indicated but wasn't carried out.

A biopsy via thoracoscopy (keyhole camera into the pleural space) was not carried out until a further 14 weeks later. A's cancer was diagnosed thereafter. We found that there were earlier indications for a thoracoscopy and missed opportunities to diagnose A's cancer from the time of their initial presentation. While we acknowledged that an earlier diagnosis was unlikely to have altered A's prognosis, we noted it would have enabled palliative care to commence and allowed the family time to prepare and make the most of the time they had left together. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to carry out appropriate investigations in a timely manner, and for the consequent delayed diagnosis and impact of this on A and the family. 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:

- Adherence to relevant national guidelines on managing pleural disease and managing ascites. Appropriate investigations carried out as and when indicated, leading to timely diagnosis.

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.