SPSO decision report

Case: **202106315, Western Isles NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an advocacy worker, complained on behalf of the family of A, about a failure to appropriately investigate A's symptoms, and a consequent delay in diagnosing and treating their cancer.

We took independent medical advice from a radiology consultant (specialist in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans), an Ear, Nose and Throat (ENT) consultant and a general medical consultant. We found that the initial scans A received were reported reasonably and did not show any malignancy. When A's GP later referred them to ENT, we noted that consideration should have been given to upgrading this to urgent. It remained routine and A was not seen until nine weeks after the referral, at which point their cancer was diagnosed.

In the meantime, A had been admitted to hospital under the care of the general medical team. We found that the medical team did not place sufficient emphasis on A's physical symptoms, which were 'red flags' for the possibility of cancer. There was a failure to scan A's neck, which is where their symptoms were. We also found that A should have been referred to ENT more urgently, preferably as an inpatient. The general medical team wrote to ENT asking for the earlier ENT referral to be expedited, but the letter did not sufficiently emphasise the physical concerns and placed undue emphasis on the likelihood of the problems being of a psychological nature. Had an ENT review been arranged while A was an inpatient, it is likely that their cancer would have been diagnosed at this point.

We concluded that the board failed to reasonably investigate A's symptoms and upheld the complaint. We noted that an earlier diagnosis around the time A was an inpatient would have been unlikely to have affected the outcome for A. However, we recognised it would have given A and their family more time to come to terms with the diagnosis.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the issues identified. 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:

- Patients' physical symptoms should be thoroughly assessed and they should be appropriately referred for review and scanning/x-ray as required in accordance with their presenting symptoms.
- Referrals to ENT should be appropriately triaged and upgraded as required.

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.