SPSO decision report

Case: **202308046, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A). C complained that A had an infected toe which remained unresolved despite undergoing several months of treatment. A was diagnosed with oesophageal cancer but was unable to start chemotherapy treatment because of the ongoing infection. C said that A experienced significant pain during this time and that there was a failure to reasonably coordinate A's care needs.

We took independent advice from a consultant orthopaedic surgeon (specialist in treatment of diseases and injuries of the musculoskeletal system) and a consultant clinical oncologist (specialist in the diagnosis and treatment of cancer). We found that the board had provided reasonable care and treatment to A over several admissions when each one was considered in isolation.

However, on one occasion, we found that an MRI scan result was not correctly reported at the time. This resulted in A receiving lesser surgery than they would otherwise have received.

We also found that the board had failed to report the incident in line with Duty of Candour legislation, or undertake an internal review process to learn from the event. We found that a more coordinated approach to A's care may have provided a proper overview of their care needs (including pain) which were known to be complex given the number of specialties involved in A's care. Therefore, we upheld this part of C's complaint.

C complained that the board's handling of their complaint was unreasonable. We found that the board kept C reasonably informed of delays.However, they did not accurately describe the failing with the MRI scan or acknowledge the impact this had on A's surgery and treatment plan. There was also a failure during the complaint process to initiate relevant reporting and investigation processes in relation to the MRI scan reporting when this became known. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- When an incident or harm occurs, processes should be followed to ensure reporting and learning and improvement takes place. This should be in line with both statutory duties and in keeping with any additional internal processes relevant to the incident type.
- The board should reflect on whether A's care could have been managed differently.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with HYPERLINK "https://www.spso.org.uk/the-model-complaints-handling-procedures" The Model Complaints Handling Procedures | SPSO .

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.