SPSO decision report

Case: **201600787, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment given to her father (Mr A) on four occasions he attended A&E at Wishaw General Hospital. She further complained that the board failed to deal with her subsequent complaint in a reasonable and timely way. The board took the view that Mr A had been treated appropriately and that they had dealt quickly and reasonably with the complaint.

We took independent advice from a nurse and from a consultant in emergency medicine. Mr A first attended A&E on three occasions over the course of a month. We found that Mr A had largely been treated appropriately but that when he unexpectedly attended on the second occasion, his case should have been discussed with a consultant and he should have undergone a scan.

On his fourth attendance around a month later, we found that while there were delays in treating Mr A, these were unavoidable as the A&E department was at full capacity. However, we found shortcomings in his triage and that he was not reviewed by the intensive care team. We found this to have been unreasonable as Mr A's diagnosis was unclear and he was seriously deteriorating. Mr A died the day after this admission. We upheld these aspects of Mrs C's complaint.

Although Mrs C also complained about the way her complaint to the board was dealt with, we found that it had been considered in a timely and appropriate way. Staff also met with her family on four occasions. We therefore did not uphold this aspect of Mrs C's complaint.

Recommendations

We recommended that the board:

- make a formal apology for the shortcomings identified;
- ensure that staff are made aware of the findings of this investigation so that they may consider these further with a view to preventing similar occurences;
- make a formal apology referencing the identified failures in dealing with Mr A's care and treatment;
- advise us of the action taken and confirm that this would prevent a similar occurrence; and
- carry out an internal review of this case which should be presented and discussed at a morbidity and mortality meeting with peer review.