SPSO decision report

Case: **201601381, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late father (Mr A). Mr A was admitted to Dr Gray's Hospital where staff identified that he had suffered a stroke. Over the course of approximately four months, he had three further admissions. During the course of the admissions, Mr A's condition deteriorated. Mrs C raised concerns about pain Mr A was experiencing in his abdomen and back, and swelling in his leg. During the fourth admission, a scan revealed cancer. Mr A died approximately one week later.

Mrs C complained that the board unreasonably delayed reaching a diagnosis that Mr A was suffering from cancer. She also complained that the board failed to appropriately diagnose a deep vein thrombosis (DVT), which was identified during one of the admissions.

The board apologised and acknowledged that they had been slow to investigate pain Mr A was experiencing in his back and abdomen. They did not consider that earlier identification of the cancer would likely have impacted on Mr A's outcome, and that treatment would have been palliative. The board considered there had not been a delay in identifying the DVT.

After receiving independent advice from a consultant in acute medicine, we upheld Mrs C's complaints. We found that the symptoms Mr A had experienced were unusual, but should have alerted the board to the possibility of cancer at an earlier stage. We noted that the cancer was aggressive in nature and early detection would not have likely altered Mr A's outcome. We found that the board did fail to recognise the DVT in this case. We were critical of the limited records regarding checks for DVT. Finally, we had some concerns about delays in the board's handling of Mrs C's complaints.

Recommendations

We recommended that the board:

- apologise for the failings this investigation has identified;
- feed back the findings of this investigation to the relevant staff;
- remind the relevant staff of the guidance surrounding assessments and checks for venous thromboembolism, including DVT;
- develop an action plan to improve assessments and checks for venous thromboembolism, including DVT; and
- apologise for the failings in complaints handling this investigation has identified.