SPSO decision report

Case: **201607812, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that the board provided to her late brother (Mr A).

Mr A attended the emergency department at Forth Valley Royal Hospital. After performing an examination and taking blood tests, staff considered that he had gastroenteritis (inflammation of the stomach and intestines). Mr A returned the next day, and staff continued to feel he was suffering from a viral illness. Mr A was seen the following day by an out-of-hours GP. He was then admitted to the board's acute assessment unit, who performed a range of further tests. The tests were normal, and Mr A returned home. He was seen the next day by a further out-of-hours GP. Mr A returned to the board's emergency department the following day, and was again admitted to the acute assessment unit. Over the subsequent days, Mr A's condition deteriorated and he was diagnosed with carcinomatous meningitis (a type of cancer). Mr A died a number of days after his second admission to the acute assessment unit.

Mrs C complained that the board unreasonably delayed in diagnosing Mr A with carcinomatous meningitis. She also said that staff unreasonably discharged Mr A from the hospital on several occasions. Finally, she said that staff unreasonably failed to provide effective pain relief.

We took independent advice from a consultant in emergency medicine, an out-of-hours GP, and a consultant in acute medicine. We found that carcinomatous meningitis is a rare form of cancer that is aggressive and that it presented atypically in this case. We found that staff carried out appropriate investigations, and that it was not unreasonable for them not to identify the cancer at an earlier stage. We identified one delay in reporting an x-ray, although this did not appear to impact on the timescale for diagnosis. As such, we did not uphold Mrs C's complaint about an unreasonable delay in diagnosing Mr A.

Regarding Mrs C's complaint about the discharges, we found that staff had a reasonable basis for considering Mr A was suffering from gastroenteritis, and therefore, it was appropriate to discharge him. We did not uphold this aspect of Mrs C's complaint.

In relation to Mr A's pain relief, we found that this could have been managed better during Mr A's final admission. While we noted the board's concern to balance pain control with consciousness level, we considered that the dosage could have been adjusted to a more appropriate level. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A's family for the failings in pain control and the delay in reporting the x-ray. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- X-rays should be reported promptly, to minimise the danger that results are missed.
- In similar cases, staff should effectively balance pain control with level of consciousness.

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.