SPSO decision report

Case: **201809079, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care provided to a family member (A) at Woodend Hospital and Aberdeen Royal Infirmary. Immediately prior to the episode of care we considered, medical investigations had been performed which indicated that A had metastatic cancer (cancer which has spread from one part of the body to another). A was then referred to the urology department (specialists in the male and female urinary tract, and the male reproductive organs).

We took independent advice from a urology adviser. In response to C's complaint, the board acknowledged that there had been a failure to request a CT scan as planned and apologised for this. We found that there was a failure to expedite a flexible cystoscopy (bladder examination using a narrow tube-like telescopic camera) and keep A informed about their care. In addition, we found that A should have been referred to oncology (specialists in the diagnosis and treatment of cancer). In view of these findings, we concluded that the care and treatment was unreasonable and we upheld C's complaint.

C also complained about the board's actions leading up to the decision whether or not to carry out a full post-mortem examination following A's death. C considered that the board had failed to follow the procedure that applied in the circumstances that the nearest family members did not agree about a post-mortem. C was also unhappy with the lack of communication about this matter. We considered a number of pieces of relevant legislation and guidance and took into account comments from the adviser. The circumstances leading to the decision about post-mortem were complex. On balance, we found that the board acted reasonably in this instance and we did not uphold the complaint. We provided feedback about good practice for the board to consider.

Finally, we found that the board's response to C's complaints could have been clearer in one respect. We also found that the board did not respond to a related complaint (about A's treatment a number of years prior) and inform C whether they would extend the timescale for accepting a complaint or not. We made a recommendation to address this finding.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable delay in performing an urgent CT scan; the failure to ensure that A was adequately informed about the plans for a CT scan; and the lack of referral to oncology. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Inform C of their decision whether or not they are extending the timescale (in relation to their complaint about A's historical treatment), and provide a reason for this.

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

- Care plans agreed at multi-disciplinary meetings should be implemented and followed up to ensure appropriate communication takes place with the patient/patient's representative and that timely investigations and referrals take place where relevant.

In relation to complaints handling, we recommended:

- Complaint responses should be comprehensive and transparent. In line with the NHS Model Complaints Handling Procedure, the timescale for acceptance of a complaint may be extended if the Feedback and Complaints Officer considers it would be reasonable in the circumstances. Where a decision is taken not to extend the timescales a clear explanation of the basis for the decision should be provided to the person making the complaint, and the person should be advised that they may ask this office to consider the decision.

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.