SPSO decision report

Case: **201901266, Ayrshire and Arran 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). A had surgery to remove their gallbladder. A's recovery from surgery was difficult but they were deemed fit enough to be discharged.

However, A had to be readmitted four days later after becoming unwell, and was discharged again two days later. A deteriorated at home and was readmitted two days later and was diagnosed as suffering from a significant bleed. A was taken to the operating theatre but died later that day.

C complained to the board that A's symptoms indicated severe illness, that they were not fit enough to be discharged from hospital and that had treatment been provided sooner, they may have survived.

The board explained to C the complications with the initial surgery, why they considered discharge was appropriate on each occasion and that the source of the bleed could only be identified during the post mortem. The board acknowledged that there had been delays in A being assessed and treated on their final admission. They apologised for the delays and explained they identified learning as a result. The board's view was that given that the type of bleed was very rare, earlier intervention was unlikely to have resulted in a different outcome for A.

We took independent advice from an appropriately qualified clinical adviser. We found that whilst there was complications with the initial surgery, and A's recovery was difficult, the care and treatment provided, including the decisions to discharge A on both accounts, was reasonable.

However, on A's final readmission, there was an unreasonable delay in assessing A, diagnosing that their symptoms were caused by a significant bleed and subsequently moving A to theatre for investigations.

Whilst earlier treatment was unlikely to have altered the outcome for A, this delay was so serious that we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable delay between A's diagnosis and in A being moved to theatre for further investigations to take place. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Relevant clinicians and clinical managers should reflect on this case and give consideration as to whether there are aspects of their provision for gastrointestinal bleeds and major haemorrhage pathway which may reduce the likelihood of delays between diagnosis and intervention.

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.