SPSO decision report

Case: **201201553, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C's wife (Mrs C) became unwell and visited her GP who arranged for tests, which showed she had kidney stones. Mrs A continued to suffer abdominal pain but a CT scan (a special scan using a computer to produce an image of the body) and various other gastrointestinal investigations (investigations of the stomach and intestine) did not show any significant abnormality. Mrs C's GP referred her to a hospital accident and emergency unit (A&E) surgical team for further assessment. An urgent out-patient CT scan was requested and she was discharged the same day.

Nine days later, Mrs C went to A&E again because she continued to suffer severe pain, and was reviewed by the medical and surgical teams. Further tests were carried out and although she could have been admitted at this time, Mrs C preferred to go home and prepare herself for being admitted in two days' time. However, as Mrs C could no longer tolerate the pain, she returned to A&E the next day and was admitted to hospital. A CT scan and biopsies (tissue samples) confirmed that Mrs C had cancer of the pancreas that had spread to her liver, and she died a few weeks later.

Mr C complained that the consultant did not examine his wife and that she was only prescribed painkillers and advised to take laxatives. We took independent advice from one of our medical advisers, who said that Mrs C was appropriately assessed and examined by the junior A&E doctor and that although laxatives had been recommended, there was evidence that the staff were also considering other causes of the pain. We also noted that relevant tests were organised, including x-rays and blood tests and Mrs A was appropriately given morphine for pain relief.

However, we upheld Mr C's complaint, as we identified that it would have been reasonable and appropriate for the consultant, as the senior A&E doctor in attendance, to have examined Mrs C to confirm the junior doctor's assessment and findings. In doing so, we noted our adviser's view that such an examination was unlikely to have resulted in an earlier diagnosis of cancer. We also considered that the consultant should have pro-actively consulted with the surgical team, rather than having done so at Mrs C's request. Finally, we were critical that the consultant did not document his consultation with Mrs C. The General Medical Council provides guidance, which says that it is good medical practice to make such a record.

Recommendation

We recommended that the board:

- inform the consultant of our findings in relation to matters related to Mrs C's examination and the documenting of his consultation.

When it was originally published on 27 March 2013, this case was wrongly categorised as 'not upheld'. The correct category is 'upheld' and it was amended on 8 May 2013.