SPSO decision report

Case: **201403467, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C complained that the board failed to appropriately manage her late husband (Mr C)'s adverse reactions to chemotherapy. In 2010, Mr C developed a troublesome itch and his chemotherapy was stopped half way through. In 2013 he had a severe reaction to one of his chemotherapy drugs. He later developed thrombocytopenia (a reduced platelet count), which ultimately led to his death.

We took independent advice from one of our medical advisers, who considered that there was nothing else the board could reasonably have done to treat Mr C's itch. We were advised that the cessation of chemotherapy was ultimately the only approach likely to resolve the problem. As Mr C's leukaemia had responded well to treatment, it was considered that the board's decision to stop this when they did was reasonable. We were also advised that the drug Mr C reacted to in 2013 was administered with appropriate caution and reasonable steps were taken to address the reaction when it occurred. The adviser considered that Mr C's development of thrombocytopenia could not have reasonably been predicted or avoided, noting that appropriate, but unfortunately unsuccessful, efforts were made to treat this. We concluded that Mr C's adverse reactions to chemotherapy were appropriately managed and we did not uphold the complaints.

However, we identified that the board's haematology day unit provided a poor service when Mrs C contacted them one Friday to express concern about some of the symptoms Mr C was displaying. There were no medical staff or blood analysing service available on the unit that day so they merely referred Mr C to his GP, without proper instruction. The adviser considered that this was a basic level of care that the board should have been in a position to provide. We, therefore, made some recommendations.

Recommendations

We recommended that the board:

- apologise to Mrs C for the identified failings in the care provided by the haematology day unit; and
- urgently review the identified failings, with a view to improving the service offered by the haematology day unit, and report back to us with their findings.