SPSO decision report

Case: **202000833, Highland NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). A attended Raigmore Hospital with symptoms including lethargy, bruising and weight loss. A was found to be severely anaemic (a low level of red blood cells) and had a very low platelet count (small cells that help the blood to clot). A was asked to attend Caithness General Hospital for regular platelet treatment and further investigations into their condition.

Around a month later, A became unwell and they attended A&E at Caithness General Hospital. A was discharged home the same morning. Two days later, C became concerned about A as they looked 'black and blue'. C phoned the consultant haematologist (a specialist in diseases of the blood and bone marrow) for advice. They told C to contact A's GP if they were concerned about A's condition. By the next morning, A had become very unwell and they were taken to Caithness General Hospital by ambulance. A was found to have intracranial bleeding (bleeding within the skull). A was airlifted to Aberdeen Royal Infirmary that evening for platelet treatment. A's condition continued to worsen and they died the next day.

We took independent advice from a consultant haematologist. We found that there was no evidence A was told about the possible complications they could develop from their low platelet count, such as the risk of internal bleeding. We found A was unreasonably discharged home from Caithness General Hospital, as they should have been referred for emergency platelet treatment. In relation to C's phone call to the consultant haematologist, we acknowledged a GP should normally be the first point of contact. However, we considered appropriate action was not taken in response to the phone call, given C had described signs of A having internal bleeding. For these reasons, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- If a patient/family member contacts a clinician with information that indicates they are seriously unwell, this should be recognised and appropriate action should be taken.
- Patients at risk of developing serious complications should be given clear information about that, and it should be appropriately documented in their medical records.
- Patients, who are found to have low platelet levels, should be referred for timely and appropriate platelet treatment.
- The board’s complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement.

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.