SPSO decision report

Case: **202305315, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a Patient Advice and Support Service (PASS) adviser, complained on behalf of their client (B) about the care and treatment provided to B's late spouse (A). A was under the care of two health boards for treatment of a concurrent bladder and colorectal cancer. C complained about the care and treatment received for their colorectal cancer. They also complained about the adequacy and conclusions reached by a Level 2 Adverse Event Review and a Level 1 Significant Adverse Event Review carried out by board A, as well as a lack of transparency under the Duty of Candour and the way that they had handled the complaint. While the bladder cancer was timeously treated, A died without having received treatment for the colorectal cancer.

In responding to the complaint, the board outlined their management of A's colorectal cancer through the regional multi disciplinary team process, having reviewed the care and treatment as a Level 2 adverse event review and a Level 1 significant adverse event review.

We took independent advice from a colorectal surgeon. We found that there was a failure to provide a reasonable standard of care and treatment to A, particularly in relation to delays in initiating treatment for their colorectal cancer. We upheld this complaint. We found that the Adverse Event Review and the Significant Adverse Event Review (SAER) conducted by the board were inadequate, with inaccuracies in the timeline and unsupported conclusions. We upheld this complaint. We found that there was a failure by the board to meet their Duty of Candour obligations, and we upheld this complaint. We also found that the board's handling of the complaint was unreasonable, and we upheld this 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/meaningful-apologies.

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

- Patients should receive reasonable and timeous care.
- When an unexpected or unintended incident occurs, processes should be followed to ensure reporting and learning and improvement takes place. This should be in line with both statutory duties and in keeping with any additional internal processes relevant to the incident type, including but not limited to adverse event reviews and Duty of Candour.

In relation to complaints handling, we recommended:

- Complaint investigations should be managed in accordance with HYPERLINK "https://www.spso.org.uk/the-model-complaints-handling-procedures" The Model Complaints Handling

Procedures | SPSO. Complaint investigations should fully investigate the matters of complaint made and identify actions for learning and improvement.