SPSO decision report

Case: **202403721, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their sibling (A) in relation to the care and treatment that the board provided to A after presenting at an out of hours service with symptoms including epigastric pain, vomiting and shaking. A was sent home with treatment for dyspepsia (indigestion) but died shortly afterwards from acute haemorrhagic pancreatitis.

C complained that the board did not adequately take into account A's full presentation and relevant background information in considering a treatment plan.

We took independent advice from an experienced emergency medicine adviser. Overall, we found that the care and treatment that A received was unreasonable because A's physiological observations showed a significant degree of abnormality, and the board did not have appropriate systems in place to identify the deteriorating patient in the acute community setting. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C that it was not recognised that the physiological observations documented in A's notes were abnormal when they were seen in the OOHS. 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:

- The board should ensure that there are systems in place that identify the deteriorating patient in the acute community setting inline with SIGN 167 Care of deteriorating patients.

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.