SPSO decision report

Case: **201101118, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: upheld, recommendations

Summary

Mr and Mrs C complained about the care and treatment that their eleven year old son (Master A) received for chest problems at a hospital's emergency department assessment unit. They said that it was unacceptable that the board took the time they did to diagnose Master A's tuberculosis (an infectious lung disease). Master A had four visits to the hospital in about six months, the last of which was a review appointment at a clinic, which was scheduled at his second visit to the emergency department.

We found from looking at the medical records, and taking advice from one of our medical advisers that in their own review of this case the board found that a consultant's comment on an x-ray report should have raised the possibility of a diagnosis of tuberculosis. However, due to administrative problems within the hospital this was not followed up. Although the review said that the administrative problems were being addressed, we found that the board's response to Mr and Mrs C's complaint said the same thing, eighteen months later. We saw no evidence that the matter had yet been satisfactorily resolved.

The board said they regretted that a diagnosis of tuberculosis was not reached earlier. Our medical adviser took the view that Master A's review appointment at the clinic should have been arranged sooner. Our adviser also said that tuberculosis should have been excluded or diagnosed around the time of Master A's third visit to the emergency department, and certainly by the time of the review appointment at the clinic. The delay led to a progression in Master A's condition. As the evidence indicated that it was unacceptable that the board took the time they did to diagnose Master A's illness, we upheld the complaint.

Recommendations

We recommended that the board:

- apologise to Master A and his family for the delay in diagnosing his illness;
- review the August 2009 emergency department assessment unit visit, in the light of the Ombudsman's adviser's comments, to ensure that a differential diagnosis of tuberculosis is considered in children with symptoms and examination/investigation results such as those present in Master A; and
- provide the Ombudsman with a copy of their action plan to take forward the learning points from Master A's case. The action plan should address the issues raised in 2009 and 2011 about the problems with filing timeously the emergency department assessment unit records in a child's hospital case records.