SPSO decision report

Case: **201302424, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C's daughter (Miss A) woke with an inflamed eye. She bought eye drops, but the symptoms got much worse overnight, and she woke the following day with pain, swelling and blurred vision. She went to A&E at Monklands Hospital, where anaesthetic was applied. A doctor examined her, identified a lesion (an area of damage) and said that as Miss A normally wore contact lenses, this would be treated with antibiotics not routinely stocked in A&E. The doctor spoke by phone to the junior ophthalmologist (eye doctor) on call, who said that Miss A should start using an ointment similar to the drops, but stronger, and arranged her an ophthalmology clinic appointment for the next morning.

When the anaesthetic wore off, the pain returned and Miss A contacted her father, who took her to an eye infirmary, where it was confirmed that she had bacterial keratitis (infection of the cornea - the transparent front part of the eye), and she was admitted for intensive antibiotic therapy. Mr C said hospital staff told his daughter that the delay in starting treatment had badly damaged her eye. Her treatment was continuing and if this failed to improve her vision, she might need a corneal transplant. Mr C complained about the care and treatment his daughter received at Monklands and about the way the board handled his complaint, saying they did not fully address it and blamed Miss A for the outcome of inappropriate treatment.

We took independent advice on this case from two of our medical advisers, specialists in emergency medicine and opthalmology, and upheld both complaints. Our advisers said that Miss A's symptoms and history should have triggered an immediate review by the on-call ophthalmologist, and that the decision to change her medication from drops to similar, stronger ointment and review her in 24 hours was not reasonable. We were critical that, given the information the doctor provided on the phone, the on-call ophthalmologist did not see Miss A as a matter of urgency, and that they advised her to use the ointment when the drops had not been effective. This led to a significant injustice to Miss A, who now has a degree of irreversible damage to her vision.

We found that the board completed their investigation and drafted a response without input from the relevant clinical expert. The investigation was not in line with the NHS complaints procedure, and they failed to address the main issues. There was an inference in the response that Miss A should bear some responsibility for what happened. We did not consider it reasonable for the board to suggest that, having been assessed in A&E and told to come back for a review, she should have returned a few hours later with the same symptoms and expected different treatment. The board in fact failed to consider whether the initial treatment was adequate, and we took the view that it was lack of ophthalmic care that led to the sequence of events. Miss A, quite reasonably, did not go to A&E the next day because when she discussed the problem with her family, they appropriately decided that her condition was not being adequately managed and reasonably sought medical care elsewhere.

Recommendations

We recommended that the board:

- ensure this complaint is raised with relevant staff as part of their annual appraisal and address any training

needs;

- review their complaints process to establish when a complaint should trigger a significant event analysis in light of our adviser's comments;
- review the out-of-hours ophthalmic care at the hospital to ensure an adequate level of care is provided;
- ensure that the failings in complaints handling are raised with relevant staff; and
- apologise to Mr C for the failings our investigation identified.