SPSO decision report

Case: **201400321, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about care and treatment provided to his late mother (Mrs A) by the board. Mrs A attended the A&E department at University Hospital Ayr and was admitted to the hospital, where she was diagnosed with a urinary tract infection. Mrs A had a number of longstanding conditions including spinal curvature and lymphoma (a type of cancer). An x-ray was taken which showed a large abnormality at the top of the right lung. This was reviewed by a doctor who considered the progression of Mrs A's lymphoma as a possible diagnosis. After being advised that Mrs A's x-ray showed deterioration, Mr C and his family decided to take her home and she was discharged the following day. The doctor's reading of the x-ray was incorrect as the abnormality was caused by Mrs A's head resting against her chest. The family were advised of this after her discharge and she was readmitted two days after returning home. Mrs A died several weeks later.

Mr C complained that Mrs A had not been given appropriate medication for her infection due to the misdiagnosis and that this had hastened her death. Mr C also complained that the response to his complaint was inadequate.

After taking independent advice from our medical adviser, we found that there had been a major error in the doctor's interpretation of the x-ray and that Mr C and his family should not have been advised that there was a deterioration in her condition. Although we did not find any evidence that Mrs A had been given inappropriate medication or that the incident had hastened her death, we upheld Mr C's complaints due to the significance of the error in reading the x-ray. We also found that the board's investigation of Mr C's complaints did not fully address the doctor's error and that the responses provided were inconsistent. We upheld both Mr C's complaints and made a number of recommendations.

Recommendations

We recommended that the board:

- make staff aware of our adviser's comments on the incorrect diagnosis and determine if there are lessons that can be learned from this incident;
- remind staff of the importance of keeping accurate contemporary records in line with the relevant General Medical Council guidance;
- provide a copy of our decision to the doctor to ensure he is fully aware of the outcome of this investigation and allow any learning points to be discussed at his next appraisal; and
- carry out a review to determine if the doctor's misinterpretation of the x-ray was an isolated incident and provide appropriate training if required.