SPSO decision report

Case: **201405558, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C's daughter (Miss A) was born with hydrocephalus (a build-up of fluid on the brain causing pressure), and from the age of about two years old, she began to suffer multiple infections and seizures. She was admitted to hospital on many occasions and Ms C was informed that her daughter was likely to have epilepsy. Miss A was diagnosed as having gastroenteritis (inflammation of the stomach and intestines) when she was three. Meanwhile, her seizures continued and Ms C was advised that they were probably due to her underlying fever and gastroenteritis. Ms C was unhappy as she considered that no progress was being made to establish the cause of her daughter's symptoms or to treat her properly. In the circumstances, she took Miss A to a children's hospital in another board area where she was diagnosed with a cerebral abscess and where she remained for five months.

Ms C complained of the delay in diagnosing her daughter and of the board's failure to refer her to the children's hospital in another board area for treatment. She was unhappy with the way they responded to her complaint.

We investigated the complaint and took independent advice from one of our medical advisers, who is a consultant paediatrician (doctor dealing with the medical care of infants, children and young people). We found that there had been a delay in diagnosing Miss A and that there may have been a missed opportunity to do this sooner. We also found that, while the board had intended to refer Miss A to the children's hospital in another board area, for reasons unknown, no appointment was made. We also found that there had been undue delay in providing a response to Ms C's concerns and that although a detailed letter was drafted, it was not sent. A meeting arranged to replace the letter took place months later. The complaint was upheld.

Recommendations

We recommended that the board:

- make a formal apology to recognise the delay in diagnosis;
- advise us what actions have been taken since the meeting to improve the two-way flow of communication between the hospitals identified;
- make a formal apology for their failure to respond adequately to the complaint; and
- emphasise to the staff concerned the importance of adhering to their complaints process and of the necessity for good, clear and timely communication.