SPSO decision report

Case: **201508116, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about a delay in diagnosing her late mother (Mrs A)'s brain tumour. Mrs A attended A&E on six separate occasions over a six month period (five attendances at Hairmyres Hospital and one at Wishaw General Hospital), with symptoms of dizziness, fainting and disorientation. Her third attendance resulted in a hospital admission, where abnormalities with her heart were identified and a pacemaker was fitted. When her symptoms continued and she attended A&E for a fourth time, she was referred to neurology for a routine out-patient appointment. She had two further A&E attendances while she waited for this, with the second resulting in a brain scan, which diagnosed a brain tumour. She was transferred to a hospital in another health board area for urgent surgery but unfortunately this was unsuccessful and she did not regain consciousness. She died ten months later.

Mrs C considered that a brain scan should have been carried out earlier. We took independent medical advice from a consultant in emergency medicine and a consultant physician. We were advised that it was reasonable for a cardiac cause of Mrs A's symptoms to have been pursued initially. However, it was noted that she had new symptoms when she attended A&E for the fourth time, having had her heart problem addressed. We concluded that a brain scan should have been considered at this point. We also identified that there was a further opportunity to diagnose the brain tumour earlier, at Mrs A's penultimate A&E attendance. On this occasion, A&E staff considered that admission was warranted, but the on-call physician decided to discharge her, pending pre-planned follow-up, without seeing her. We were critical of this. We upheld the complaint and made a number of recommendations, including one about record-keeping as the board could not locate the records from one of Mrs A's A&E attendances.

Recommendations

We recommended that the board:

- provide Mrs C with a written apology for the failings identified in this investigation;
- ensure that all relevant staff are made aware of the outcome of this investigation, including those no longer employed by the board;
- take steps to have this complaint included for discussion at the annual appraisals for all relevant staff, including those no longer employed by the board, to ensure learning opportunities are captured; and
- take steps to ensure that Hairmyres Hospital is complying with 'Records Management: NHS Code of Practice (Scotland)' following the missing A&E attendance records.