SPSO decision report

Case: **201508140, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her mother (Mrs A) when she was a patient at the Royal Infirmary of Edinburgh. Mrs A suffered from breathlessness and collapse and had three admissions to hospital.

During her first admission to hospital, tests showed that Mrs A had pulmonary oedema (fluid on the lungs that can indicate heart failure). After Mrs A's second admission to hospital several months later, she was followed up by the respiratory clinic and referred to the cardiology team after further tests showed a heart condition. Mrs A continued to suffer from breathlessness and episodes of collapse. Shortly after her third admission to hospital, Mrs A suffered a heart attack and died.

Mrs C said that staff unreasonably failed to notice the problems with Mrs A's heart and provide appropriate treatment within a reasonable time and that the failure to treat Mrs A led to her death.

We took independent advice from a specialist in cardiology. We found that the board missed an opportunity to diagnose the cause of pulmonary oedema, which had been identified during Mrs A's first admission to hospital, and that as a result Mrs A's heart condition was not diagnosed within a reasonable time. This in turn meant that there was an unreasonable delay in referring Mrs A to the cardiology team for further assessment and treatment. However, it was unclear whether an earlier diagnosis would have led to a different outcome, due to Mrs A's medical history. It was our view that a potential opportunity for further treatment was missed and we therefore upheld Mrs C's complaint.

Recommendations

We recommended that the board:

- provide a plan detailing the changes they have made to ensure that appropriate tests and referrals to cardiology are undertaken within a reasonable time;
- confirm the learning gained as a consequence of this complaint and provide details of how this has been passed to and considered by relevant staff; and
- apologise to Mrs C for the failures this investigation identified.