SPSO decision report

Case: **201508840, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C complained that staff at University Hospital Crosshouse failed to provide her father (Mr A) with appropriate clinical treatment following his admission with abdominal pain. Mr A was diagnosed with cholangitis (an infection of the tube connecting the liver to the duodenum, the first part of the small intestine immediately beyond the stomach) and an ERCP (endoscopic retrograde cholangiopancreatography, a procedure where a flexible tube is passed into the small intestine) was performed on Mr A four days later. Mr A suffered a retroperitoneal perforation (a small tear in the upper bowel) during the ERCP. Mr A's condition deteriorated and he died.

We obtained independent advice from a consultant gastroenterologist and a consultant general surgeon.

The consultant gastroenterologist explained that an ERCP was the appropriate procedure in Mr A's case, as verified by the British Society of Gastroenterology and National Institute for Health and Care Excellence guidelines. They explained that the procedure was carried out appropriately, was documented as being relatively straightforward and was well tolerated by Mr A. However, they said Mr A suffered a recognised complication of an ERCP. Both advisers said that although Mr A's perforation was not detected as soon as it could have been, the management of Mr A's condition would not have changed with an earlier diagnosis. The consultant general surgeon confirmed that the time taken to diagnose the perforation was not due to poor practice. We therefore did not uphold Mrs C's complaint.