SPSO decision report

Case: **201609186, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C was admitted to Queen Elizabeth University Hospital with severe abdominal pain. She was pregnant at that time and had been referred to the hospital with suspected appendicitis (a serious medical condition in which the appendix becomes inflamed and painful). The hospital carried out an ultrasound scan and considered it was likely that Mrs C had gastroenteritis (inflammation of the stomach and intestines). Her condition deteriorated over the next few days and it was found that her unborn baby had died. Mrs C was taken to theatre where it was identified she had appendicitis and her appendix was removed. She was then admitted to the intensive care unit at the hospital with sepsis (blood infection) and organ failure. Mrs C recovered but later had two further admissions with infections in her abdominal muscles. Mrs C complained that there was an unreasonable failure to diagnose appendicitis and sepsis.

We took independent advice from a consultant general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). We found that there had been a number of failings in Mrs C's care and treatment, including:

• a failure to adequately consider an alternative diagnosis to gastroenteritis in view of rising CRP (C-reactive protein - a blood test marker for inflammation in the body),

• a failure to give adequate consideration to carrying out a CT scan or diagnostic laparoscopy (a surgical procedure in which a fibre-optic instrument is inserted through the abdominal wall to view the organs in the abdomen or permit small-scale surgery),

• the national early warning scoring (NEWS - an aggregate of a patient's 'vital signs' such as temperature, oxygen level, blood pressure, respiratory rate and heart rate which helps alert clinicians to acute illness and deterioration) that was carried out was not done appropriately,

• a failure to interpret and actively pursue signs of sepsis on the NEWS scores,

• staff should have used maternity early warning score (MEWS) observation charts,

• there was no review by an experienced obstetrician (a doctor who specialises in pregnancy and childbirth),

• the lack of physical examination by experienced doctors,

• there was a delay in carrying out a repeat ultrasound scan and

• the delay in considering a diagnostic laparoscopy or surgery was unreasonable.

We considered that there was an unreasonable failure to diagnose Mrs C with both appendicitis and sepsis and,

therefore, upheld Mrs C's complaints. A number of failings had been identified by the board, but we made some additional recommendations for learning and improvement.

Mrs C also complained that the board's investigation into her care and treatment was inadequate. We found that there had been a delay in starting a critical incident review and that there were some failings in the report. We also upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the delay in starting the significant clinical incident investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leafletsandguidance.

What we said should change to put things right in future:

- In relevant cases, NEWS scoring should be carried out appropriately.
- Deteriorating patients should be escalated to a senior clinician especially in the presence of sepsis. Where appropriate in these cases, a senior doctor should carry out a physical examination.
- Significant clinical incident investigations should be started promptly in appropriate cases.