SPSO decision report

Case: **201701066, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C's child (Child A) was admitted to hospital and diagnosed with hydrocephalus (a build-up of fluid on the brain). Ms C complained that the health visiting team failed to take adequate steps to identify Child A's hydrocephalus before the admission to hospital. She also considered that the board failed to investigate her complaint appropriately.

We took independent advice from a health visitor. We found that some of Child A's growth measurements were not taken properly. At the six week assessment (where a decision is taken about future monitoring of growth), we found that some of their measurements were not accurately recorded or plotted in the 'red book' (a national standard health and development record given to parents/carers at a child's birth). Therefore, there was a failure to recognise Child A's small length which would have required a plan to be put in place for further observation and measurement. We also found a failure to assess the discrepancy in the three measurements taken of Child A's weight, length and head circumference. We considered that if steps had been put in place to closely monitor growth, then the health vising team may have identified Child A's hydrocephalus. We upheld this aspect of Ms C's complaint.

In relation to the board's handling of the complaint, we found that the board did not identify or acknowledge that some growth measurements were not properly taken, recorded or plotted. It would have been reasonable to expect that the board would have looked carefully at the measurements and centiles taken and recorded in the red book. Therefore, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to correctly record Child A's measurements, analyse them and put in place steps to closely monitor their growth. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- To ensure all relevant staff understand how to use and interpret UK-WHO Growth charts in accordance with the requirements of the Royal College of Paediatric and Child health doctors.
- To ensure all relevant staff understand the importance and use of the red book so that information is accurately and consistently documented.
- There should be a review of compliance with the Universal Health Visiting Pathway and a timeline provided for this review.

In relation to complaints handling, we recommended:

- The board should ensure that in investigating complaints they scrutinise evidence carefully.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.