SPSO decision report

Case: **201704684, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the in-patient care she received at Ninewells Hospital. In particular, that there was a delay in diagnosing diverticulitis (where small pouches from the wall of the gut become inflamed or infected). She also complained that a consultant surgeon had not examined her when she attended an out-patient clinic appointment at Perth Royal Infirmary and that the care that she received from the out-of-hours service was unreasonable.

We took independent advice from a consultant colorectal surgeon (a specialist in the medical and surgical treatment of conditions that affect the lower digestive tract) in relation to Mrs C's concerns about a delay in diagnosing diverticulitis. We found that a computer tomography (CT) scan should have been carried out rather than an magnetic resonance imaging (MRI) scan because it would have provided a more complete examination of Mrs C's abdomen and pelvis. In addition, we considered that a CT scan should have been performed within a few days after Mrs C's discharge from Ninewells Hospital. We were also critical of the length of time it took for staff at Ninewells Hospital to contact the consultant surgeon at Perth Royal Infirmary to inform them about the results of the MRI scan. We also found that the letter to the consultant surgeon had not referred to Mrs C's earlier hospital admission. In terms of the clinic appointment at Perth Royal Infirmary, we considered that the consultant surgeon should have examined Mrs C given there was no evidence of her symptoms having settled. We considered that the time taken to diagnose diverticulitis was unreasonable and upheld this aspect of Mrs C's complaint.

In relation to Mrs C's out-of-hours appointment, we considered that the treatment she received was reasonable and appropriate. We did not uphold this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the unreasonable delay in performing the MRI scan, for not ensuring that an urgent CT scan was performed, the unreasonable delay in the consultant surgeon being informed about Mrs C's hospital admission and MRI results, and for not conducting a physical examination at Mrs C's clinical appointment. 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:

- Staff should ensure that urgent CT scanning is performed when recommended.
- Staff should ensure timely and appropriate communication with other specialities where relevant.
- Staff should ensure that relevant information is clearly recorded and physical examinations carried out where appropriate.