SPSO decision report

Case: **201705769, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained on behalf of her child (Child A) about the care and treatment they received at Victoria Hospital. Child A was prescribed various drugs to try to manage their epilepsy (a seizure disorder), including one called phenytoin. Child A later had to be treated in hospital for an overdose of phenytoin. Ms C's main concern was that Child A was not appropriately monitored by the board, which allowed this high level of phenytoin to build up in their blood. Ms C also complained about the board's handling of her complaint.

We took independent medical advice from a consultant paediatrician (a doctor who specialises in child medicine). We found that, when Child A's dose of phenytoin was increased at their clinic review, they were appropriately referred for blood tests to monitor the impact of this increase. However, we found that the clinic review was not appropriately recorded and that there was an unreasonable delay in communicating with her GP about it. We found that the results of Child A's blood tests showed a surprising level of phenytoin in their blood, which should have prompted a clinical review. We also found that appropriate action should then have been taken, which would have been to repeat the blood tests. We upheld this aspect of Ms C's complaint.

Regarding complaints handling, we found that the board delayed in acknowledging Ms C's complaint. We also found that they failed to communicate appropriately with Ms C both during and at the conclusion of their investigation. 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 the failure to appropriately monitor child A; for the issue identified with record-keeping and GP communication; and for their communication with Ms C in relation to her complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The results of blood tests carried out to monitor phenytoin levels should be clinically reviewed and actioned appropriately.
- Clinical appointments should be recorded appropriately and actions should be shared with primary care/patients in a timely manner.

In relation to complaints handling, we recommended:

- Updates should be provided to complainants when the twenty working day timescale will not be met; and follow-up correspondence should be responded to appropriately.

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.