SPSO decision report

Case: **201707487, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment her father (Mr A) received at Forth Valley Royal Hospital. Mr A had been admitted with sudden onset severe jaw pain, which was radiating to his chest and arms. He subsequently developed abdominal pain and a number of tests were carried out, including an abdominal ultrasound. On the following day, Mr A had a CT angiogram (a specialised scan using x-rays to look at the heart) of his aorta (the largest and main artery in the body). This confirmed a large aortic dissection (a tear) requiring urgent surgical intervention. Mr A was transferred to another board for this surgery. After the surgery, it was discovered that Mr A had suffered a spinal stroke. This left him paralysed and entirely reliant on carers.

We took independent advice from a GP, a radiologist (a specialist in the analysis of images of the body) and from a consultant cardiothoracic surgeon (a medical doctor who specialises in surgical procedures of the heart, lungs, oesophagus, and other organs in the chest.) We found that the ultrasound result should have been flagged up as highly significant and with greater urgency. Where a potential life-threatening abnormality emerges on a diagnostic test, every effort should be made to convey this result immediately to the clinical team involved. The failure to do so, in Mr A's case, led to a delay in definitive diagnosis and potential treatment of the aortic dissection. We, therefore, upheld this aspect of Mrs C's complaint. However, we found that earlier identification of the dissection and more timely surgery would not have necessarily changed the outcome for Mr A.

Mrs C also complained that the board had failed to comply with the relevant record-keeping guidance, as they had been unable to find some of Mr A's clinical records. We found that the board had failed to follow their 'Transportation of health records policy' and we also upheld this aspect of Mrs C's complaint.

Finally, Mrs C complained about the board's response to her complaint. We found that in their response to her initial complaint, the board had failed to identify the major failing in Mr A's treatment, which was the delay in highlighting the abdominal aortic dissection flap observed in the ultrasound examination. We also upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the delay in reporting the ultrasound result to the clinical team involved, and for the failings in relation to their handling of Mrs C's 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:

- All administrative, clerical and clinical staff who are involved in the transfer of medical records should follow the Board's Transportation of Health Records Policy.

In relation to complaints handling, we recommended:

- The board should ensure that complaints are investigated appropriately and that, when requested, they provide further information about the action they have taken in response to any potential failings identified.