SPSO decision report

Case: **201801784, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment she received from the board for her ongoing health problems. She said that the board initially failed to appropriately diagnose and treat her health condition and then failed to provide her with appropriate care and treatment for her condition. Ms C said she was advised by the board that she had multiple sclerosis (MS) and she never had any reason to doubt the diagnosis, until ten years later she discovered she had a condition which inhibited the absorption of vitamin B12, when she found that supplementing her diet with liquid vitamin B12 resulted in her experiencing improvements in many of her symptoms.

We took independent medical advice from a consultant neurologist (a specialist in the diagnosis and treatment of disorders of the nervous system). We found that Ms C's initial diagnosis of probable MS was appropriate. The evidence suggested that the description given to Ms C of the level of certainty of her MS was reasonable and in line with the actual status of her diagnosis at that time. We found that vitamin B12 deficiency would not be expected to have presented with the pattern of relapsing–remitting disease in Ms C's case. We considered that there was no indication to have administered vitamin B12 injections in the early stage of Ms C's illness, as there was no evidence that her condition related to vitamin B12 deficiency. Therefore, we did not uphold this part of the complaint.

In terms of Ms C's subsequent treatment, Ms C raised a number of issues, including that the board did not order a further spinal MRI to compare with the spinal MRI done at the time of her diagnosis. We found that the main purpose of MRI scans in a case such as this was to secure the diagnosis, rather than to monitor progress and there was, therefore, no clear indication to repeat the scans any more regularly than was actually done. We considered that the board provided Ms C with appropriate subsequent care and treatment and did not uphold this part of the complaint.

Ms C also complained that the board failed to respond to her complaint about her diagnosis and treatment appropriately. We found that the board's responses to Ms C's complaint failed to address all the issues raised; the responses were issued outwith the timelines set out in the NHS Model Complaints Handling Procedure; and the board failed to keep Ms C updated on the reason for the delays and give her revised timescales for completion. We, therefore, upheld this part of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to address all the issues raised in their responses to her complaint; for issuing the responses outwith the timelines set out in the NHS Model Complaints Handling Procedure and for failing to keep her updated on the reason for the delays and give her revised timescales for completion. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The board’s responses to complaints should address all the issues raised, be issued within the timelines set out in the NHS Model Complaints Handling Procedure and keep the complainant updated on the reason for the delays and give revised timescales for completion.

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.