SPSO decision report

Case: **201802737, Tayside NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment her late child (Child A) received from the board before their death. Child A had been diagnosed with a rare disorder that affected their development. Child A had a CT scan (a scan which creates detailed images of the inside of the body) of their brain, which identified cerebellar tonsillar descent (the lower part of the brain pushes down into the spinal canal). Ms C found out about this after Child A died. She said that Child A's behaviour had changed around that time, and she complained that the board had failed to tell her about this.

We took independent advice from a consultant neuroradiologist (a specialist who uses scans to diagnose and characterise abnormalities of the central and peripheral nervous system, spine, and head and neck). We found that it had been unreasonable not to discuss the findings and the clinical implications with Ms C and, therefore, upheld this aspect of the complaint.

Ms C also complained that the board had failed to provide reasonable care and treatment to Child A in relation to this. We found that it had been unreasonable not to carry out further investigations, and specifically an MRI scan, to evaluate this. We upheld this aspect of the complaint. However, the evidence suggests that it would not have been possible to prevent Child A's death.

Finally, Ms C complained that the board delayed in responding to her complaint. The board had acknowledged that there were delays in responding to Ms C's complaint and that she was not kept updated on the delays. We also upheld this aspect of the complaint, although we noted that the board had apologised to Ms C for this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to discuss the findings and implications of the CT scan and for failing to carry out further investigations to evaluate Child A's condition. 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:

- In cases of this nature, the imaging findings should be shared with patients and their carers.
- Radiology staff reporting head CT scans should be aware of the clinical implications of cerebellar tonsillar descent (congenital or acquired) and appropriate imaging confirmation and evaluation should be undertaken where clinically relevant.

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.