SPSO decision report

Case: **201802857, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the treatment her husband (Mr A) received during his admission to Wishaw General Hospital. Mr A was admitted with abdominal pain and a temperature and was discharged the same day with a principal diagnosis of gastritis (inflammation of the lining of the stomach). Mr A latter suffered a ruptured appendix and damaged bowel which required emergency surgery. Mrs C complained that if Mr A had received the correct diagnosis in his initial admission, with reasonable investigations carried out, the rupture could have been avoided.

We took independent advice from a general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). We found that the treatment provided to Mr A was unreasonable. Insufficient notice was taken of Mr A's raised temperature, white cell count and CRP (inflammatory marker) as objective evidence together with lower abdominal pain. We considered that appendicitis should have been considered as a possible diagnosis. We also found that Mr A was discharged too early without a second examination and on discharge the wrong diagnosis was recorded and advice on what to do next was unclear. We upheld this aspect of Mrs C's complaint.

Mrs C also complained about the board's response to her complaint. Mrs C raised a number of questions about the treatment Mr A received. The board explained the actions taken and why they considered this was reasonable.

We sought advice about the accuracy of the board's response in terms of Mr A's presentation and treatment. We found that the board failed to provide a reasonable response to Mrs C's complaint. While the board responded to the questions Mrs C raised, the medical records did not evidence the board's outline of the treatment provided, including that appendicitis was considered in Mr A's initial admission and the advice provided when discharging Mr A. We also upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide a reasonable complaint response.
- Apologise to Mr A for failing to provide reasonable treatment to him. The apologies should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "https://www.spso.org.uk/information-leaflets" https://www.spso.org.uk/information-leaflets .

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

- Documentation, including discharge summaries, needs to be clear, including who saw, when and what.
- Formal discharge summaries should be completed in a timely manner.
- Learning should be taken from the complaint and reflected upon in a morbidity review to highlight the importance of high index of suspicion of appendicitis in young adults with abnormal tests and atypical

history.
- Relevant staff should be reminded of the importance of difficult cases being re-assessed by more senior clinicians.

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.