SPSO decision report

Case: **201902863, Fife NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to us about the board regarding treatment of their child (A). A became unwell and was referred to Victoria Hospital, where they were diagnosed as having gastroenteritis (inflammation of the stomach and intestines) by a paediatric nurse practitioner and discharged home. Three days later, A suffered a seizure and was readmitted to the hospital. They were transferred to a hospital in another health board area and diagnosed as having pneumococcal meningitis (a life-threatening infectious disease that causes inflammation of the layers that surround the brain and spinal cord). They remained in hospital where they later died.

C complained to the board about their initial assessment and treatment of A. They complained that A was misdiagnosed and that staff did not follow the correct procedures when reviewing their condition. C also felt that A should have been seen by a doctor before the decision was made to discharge them.

The board arranged for a Significant Adverse Event Review (SAER) to be carried out by doctors not involved in A's care. The SAER identified a number of areas where the board could have acted differently in A's case. However, C still had a number of concerns and asked that we conduct a further review of the case.

We took independent advice from a consultant paediatrician. We found that, overall, the SAER had appropriately identified the key failings in the board's care, including that the original diagnosis of gastroenteritis was unreasonable based on A's symptoms. However, we found some additional failings in record-keeping, and highlighted that we would have expected the misdiagnosis to have been identified when the nurse practitioner discussed A's case with a doctor before discharge. We also considered there had been failings in the handling of C's subsequent complaints.

For these reasons, we upheld all of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with reasonable treatment, failing to reasonably diagnose A, failing to keep reasonable records about A's treatment, and failing to reasonably communicate with them. 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:

- When being consulted by nurse practitioners, doctors should be able to identify potential misdiagnosis.
- When the content of a telephone call is relevant to the care record of a patient, the clinical record should be updated with details of this.

In relation to complaints handling, we recommended:

- When comments or input is required from multiple clinicians, this should be clearly coordinated and organised to avoid unnecessary delay.
- Where complaints investigations are delayed, complainants should be kept up to date on progress and given detailed reasons for the delays when requested, particularly in sensitive cases involving a death.

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.