SPSO decision report

Case: **201906320, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C developed an infection following a wisdom tooth extraction, which was not diagnosed and subsequently spread to their brain. C was reviewed in hospital on several occasions, including out-patient reviews by oral and maxillofacial (OMF) surgeons (specialists in treating diseases and injuries of the mouth and face) and an in-patient admission to Victoria Hospital. C questioned how the infection was missed on so many different occasions by so many different people.

The board indicated in their response that there were no clinical signs which led them to suspect bacterial infection, and jaw joint problems were being considered as the cause of C's symptoms. C was then suspected, during their in-patient admission, to have viral encephalitis (inflammation of the brain). A plan to carry out an MRI wasn't pursued due to noted improvement in C's condition. The responsible consultant reflected that an MRI should have been performed during the admission, and that not doing so may have delayed the identification and treatment of the infection in C's brain.

We took independent medical advice from a consultant OMF surgeon and a consultant physician. While it was noted that C's infection presented atypically and was difficult to diagnose, their C-reactive protein (CRP, inflammation marker) was raised when they initially presented and this wasn't acted upon. A CT scan also showed subtle signs of infection but this wasn't picked up at the time. An urgent out-patient MRI was requested to look for joint problems and not to exclude infection, otherwise it may have been carried out sooner. We also found that the subsequent in-patient assessment didn't give due care and attention to C's recent wisdom tooth extraction and hospital attendances. It was agreed that the failure to pursue an in-patient MRI contributed to the failure to correctly diagnose and appropriately treat C's infection. We considered that the decision to discharge C with a persistent headache was unreasonable. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to diagnose and treat their infection earlier. 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:

- This case should have joint Mortality & Morbidity review. The findings of this investigation should be presented, to ensure relevant learning for staff from the OMF service, radiology and medicine.

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.