SPSO decision report

Case: **202101726, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) who had been admitted to hospital with an infection of the gallbladder. A Magnetic Resonance Cholangiopancreatography (MRCP, an MRI scan of the gall bladder) was ordered and gallstones were found to be present. However, A did not hear from the hospital for several months following the scan until they proactively chased up a response. The board later confirmed that the MRCP report had not been provided to the consultant who had ordered the test causing the delay.

A was subsequently admitted for an Endoscopic Retrograde Cholangiopancreatography (ERCP, a procedure combining an endoscopy and X-rays to examine and treat conditions of the bile and pancreatic ducts) and discharged the following day. A was admitted again a few weeks later suffering from a complication of pancreatitis and a drain was inserted. A was discharged to be seen again as an out-patient. However, a few days later A was readmitted as an emergency patient suffering from a significant infection and died shortly after. C complained about the delay between the MRCP and ERCP procedure and questioned whether this had led to A's death. C also complained about the general standard of care provided to A.

We took independent advice from a consultant general surgeon with a specialist interest in upper gastrointestinal problems. We found that there had been a failing in both the board's paper and electronic reporting systems. Despite these failings, we were of the view that the delay did not, on this occasion, lead to a worse outcome for A clinically.

However, we were critical of the care provided to A following the ERCP procedure. We also found that A was discharged too soon, despite having developed pancreatitis, against both local policies and clinical best practice. We considered that A should have been admitted for longer, under the care of the original consultant, and that better initial care for A may have facilitated earlier intervention to possibly allow for their ultimate recovery. Therefore, we upheld C's complaint.

We also commented on complaints handling noting that the complaint had not been handled in line with the board's complaints handling procedure with respect to timescales, and that the initial complaints investigation had not identified issues with post-ERCP care.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Patients receiving scans should have their scans reported to the relevant and appropriate clinicians;

reviewed, and followed up without delay.

- Patients should be under the care of the appropriate medical team during their admission. Any decision in relation to discharge should be taken by the appropriate medical team with appropriate account taken of local protocols and management pathways.
- There should be appropriate learning from serious events that ensure failings are identified and addressed and appropriate learning and practice improvements are made.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the Model Complaints Handling Procedures. They should fully investigate and address the issues raised and identify and action learning.

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.