SPSO decision report

Case: **202107945, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their adult child (A) by the board. A had an extensive history of epilepsy and was diagnosed with ictal asystole (a rare but potentially devastating complication of epileptic seizures). A was referred by the board's neurology service (specialists in disorders of the nervous system) to the cardiology service due to ongoing seizures with loss of consciousness which could not be controlled with medication. A was fitted with a pacemaker but later developed severe headaches and a rash. A was advised to stop taking recently prescribed tablets and that the rash was likely caused by the ointment used when the pacemaker was fitted.

A few days later, A was finding it difficult to breathe and called NHS 24. Paramedics attended A at home but A was not admitted to hospital. A phoned NHS 24 again the following day and when paramedics attended, they took advice from an emergency medical consultant at the hospital who advised that A should take paracetamol and see the GP the following morning.

A was advised by the GP to attend the COVID-19 hub where A collapsed and was taken to hospital. A was admitted to hospital and died the following day from sepsis (a life-threatening reaction to an infection).

C complained that the board's cardiology service failed to provide reasonable care and treatment to A. We took independent advice from a consultant cardiologist. We found that there was a failure to provide a clear timeframe on the day of the pacemaker implantation and a failure to take reasonable action when A developed a rash following the procedure. We also found that the board failed to identify the asystole earlier but had already acknowledged this in their complaint response to C. Given these failings, we upheld this part of C's complaint.

C complained that an emergency medical consultant unreasonably told the paramedic that A should take paracetamol and see the GP the following morning. We took independent advice from a consultant in emergency medicine. We found that there were failings in the assessment of A and that given the deranged physiology (disturbance of normal bodily functioning), repeated presentation and symptoms, the advice provided by the emergency medical consultant was unreasonable. Therefore, we upheld this part of C's complaint.

Finally, C complained that a doctor in the COVID-19 assessment centre unreasonably told C to take A home and put them to bed. We found no evidence to support this. Therefore, in the absence of any supporting records, we did not uphold this part of C's complaint.

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:

- Full and complete information should be obtained during any virtual assessment of a patient so that advice is appropriately provided and recorded on the basis of that information.

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.