SPSO decision report

Case: **201300295, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Miss C complained about the care and treatment she received at Raigmore Hospital. Miss C said that when she arrived at the accident and emergency department (A&E) with abdominal (stomach) pain, her symptoms were not taken seriously enough and staff dismissed her view that she had an ulcer, even when she told them she had been treated for one in the past. She also said that after she was transferred to a ward, staff inappropriately gave her a drug, which she said caused her ulcer to bleed or perforate (break open the stomach wall) and her pain to treble, resulting in her needing immediate surgery. Miss C said that, as a result of the board's failings, she had to have an operation that she did not need and now has an unnecessary scar.

We obtained independent advice on this case from one of our medical advisers, a consultant surgeon specialising in gastrointestinal (digestive system) surgery. The adviser said that the consultant who initially examined Miss C in A&E mistakenly concluded that her bowel might have been obstructed. However, as the consultant was not sure of that diagnosis, he correctly sought advice from the surgical team and organised a prompt referral to the on-call senior surgical trainee for further assessment and observation.

The senior surgical trainee, however, failed to recognise that Miss C's signs and symptoms suggested peritonitis (inflammation of the lining of the abdomen) and despite these signs, placed undue reliance on the x-ray appearance of possible constipation. He failed to seek advice from the consultant gastrointestinal surgeon and/or arrange further investigations. He prescribed a drug that was advised against, given Miss C's condition, and which may have exacerbated her pain. The adviser explained that Miss C's ulcer had almost certainly perforated when she initially went to A&E and so it was highly unlikely that the treatment she received from the board influenced her need for surgical intervention. However, the senior surgical trainee's failure to make the correct diagnosis meant that Miss C's pain was prolonged unnecessarily, and we upheld her complaint.

Recommendations

We recommended that the board:

- provide Miss C with a written apology for the failings identified in this case;
- feed back our decision to all staff involved; and
- ensure that the senior surgical trainee uses our decision letter on this case as part of his training record and discusses it with his educational supervisor as part of a reflective case-based discussion.