SPSO decision report

Case: **201302796, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C complained on behalf of his daughter (Ms A) about the care and treatment she received at Perth Royal Infirmary and Ninewells Hospital. In particular, he said there was a protracted period of complacency by the staff involved in his daughter's care. At the time Mr C complained to us, Ms A had been experiencing severe and debilitating pain for over 18 months. A number of diagnoses had been suggested, and while treatments were ongoing, no single definitive cause had been found for her pain and other related symptoms. Mr C said that the medical team had ruled out endometriosis (a condition where cells similar to those that line the womb lie outside it) without adequate investigation or involving a colorectal surgeon.

In response to the complaint, the board apologised for the delays and the lack of communication between departments. They explained the reasons for and outcomes of the various tests that had been arranged, along with organising further clinical review for Ms A.

We took independent advice from three specialist clinical advisers - a gynaecologist, a gastroenterologist (a specialist in the treatment of conditions affecting the liver, intestine and pancreas) and a radiologist (a specialist in the analysis of images of the body). The radiologist said that a scan had been incorrectly interpreted, as he considered it did not show evidence of endometriosis. However, he did not consider this to be a major error of judgement requiring further action. In addition, whilst we identified that there was some confusion over referrals and some delays in arranging treatment, our advisers said that the tests and treatments offered were all appropriate in light of what was known at the time. On balance, we did not uphold Mr C's complaint as we found that although there were some errors in Ms A's care, no department had acted unreasonably and there were no serious failings. However, we did make a number of recommendations to the board.

Recommendations

We recommended that the board:

- apologise for the failings identified;
- ensure that the radiologist responsible for reporting the scan is made aware of the views of our radiology adviser on the interpretation of that scan and given an opportunity to reflect on this; and
- reflect on the potential role of multi-disciplinary team meetings in complex cases such as Ms A's and consider how this might be embedded into clinical practice, and advise us of the outcome of their consideration.