SPSO decision report

Case: **201604122, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about events following an incident when he became ill at home and was taken by ambulance to Monklands Hospital. He said that the board incorrectly recorded that he underwent a loss of consciousness at home and then unreasonably assessed that he was unfit to drive. He said they failed to follow health guidelines on loss of consciousness in over 16s and that their actions resulted in an unnecessary ban on driving for him. Mr C also said that the board unreasonably failed to respond to his complaint.

Mr C said the board failed to communicate the basis of their diagnosis of his illness to him and how this affected his fitness to drive. He said they also provided him with incorrect information regarding the relevant Driver and Vehicle Licensing Agency (DVLA) regulations and his future prospects of driving. Mr C subsequently saw a cardiac consultant who said there was nothing clinically wrong with his heart and that he had undergone a simple faint and was fit to drive.

We took independent medical advice from a consultant in general medicine, who said it was not clear from the records whether Mr C did or did not lose consciousness. However, the adviser noted that there was no evidence that staff had asked for any witness accounts of what occurred from Mr C's wife or daughter, which they considered to be crucial in such cases. The failure by staff to gather this information before assessing that Mr C was unfit to drive meant that their decision was based on incomplete information. We upheld this part of Mr C's complaint.

We also found that the evidence available did not demonstrate that staff gave Mr C reasonable information about the basis for his diagnosis and how this affected his ability to drive. We upheld this part of the complaint. We asked the board to provide evidence of remedial action that they said they had taken and also made recommendations to address the remaining failings. We did not have sufficient evidence to say with certainty that Mr C was incorrectly advised of the relevant DVLA regulations and his future prospects of driving. Therefore, we did not uphold this part of his complaint.

We also found failings in the board's handling of Mr C's complaint and, therefore, upheld this part of his complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to follow National Institute for Health and Care Excellence guidelines, the failings in communication about the assessment that he was unfit to drive and the failings in their complaint responses. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Where a transient loss of consciousness (TLoc) is suspected, staff should question the person involved and any witnesses, and use this information in determining whether the person had TLoC.
- Patients found to be unfit to drive should be given clear information about the basis for this.

In relation to complaints handling, we recommended:

- Complaint responses should address the issues raised, clearly explain any areas of disagreement and give adequate apologies where things have gone wrong.

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.