SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201609661, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, recommendations

Summary

Mr C complained that staff at Ninewells Hospital failed to consider a diagnosis of brugada syndrome when he was being investigated for fainting episodes. Brugada syndrome is a condition associated with blackouts, serious arrhythmias (where the heart can beat too slow, too fast or irregularly) and sudden death. The syndrome is characterised by a particular electrocardiogram (ECG - a test to check the heart's rhythm) abnormality, either spontaneously or after a drug test.

During investigation of his fainting episodes, Mr C was advised not to work or drive. Mr C experienced a further fainting episode when a cannula was being inserted into his vein prior to an ajmaline challenge (a drug test to identify the characteristic ECG pattern changes associated with brugada syndrome) being carried out. The ajmaline challenge did not go ahead and Mr C was dissatisfied that it was not rescheduled prior to being discharged from the cardiology service. Mr C moved and said that he was diagnosed with brugada syndrome following an ajmaline challenge at a different hospital.

We took independent advice from a consultant cardiologist. We found that there was evidence to demonstrate that hospital staff had considered the possibility of brugada syndrome. We considered that from the various tests carried out there was no evidence to support a diagnosis of brugada syndrome. We found that it was reasonable for staff to diagnose Mr C with vasovagal syncope (the temporary loss of consciousness due to a neurologically induced drop in blood pressure) and not to have rescheduled the ajmaline challenge. We did not uphold the complaint. However, we were critical of the time it took the board to investigate Mr C's fainting episodes. We also found that there was no evidence to clearly show that Mr C's diagnosis and the reasons for not rescheduling the ajmaline challenge had been fully explained to him. We made three recommendations to address these shortcomings.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for not ensuring that he was fully informed about his diagnosis. Also apologise for the time taken to investigate his fainting episodes. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Staff should ensure that, in similar cases, patients are fully informed about their diagnosis, including any decisions made in relation to further investigations, and clearly document when this has been done.
- Staff should ensure that investigations are carried out in a timely manner, particularly when patients are unable to work or drive.

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.