SPSO decision report

Case: **201807681, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained on behalf of his mother-in-law (Ms B) about the care and treatment Ms B's late husband (Mr A) received during his admission to University Hospital Ayr with suspected renal colic (a type of pain experienced when urinary stones block part of the urinary tract). After Mr A collapsed in the hospital he was assessed by a consultant vascular surgeon (a specialist in the treatment of diseases affecting the vascular system including diseases of the arteries, veins and lymphatic vessels) who suspected a ruptured abdominal aortic aneurysm (a bulge or swelling in the main blood vessel from the heart that has burst). This was confirmed on an urgent CT scan. Mr A was taken to theatre where he died.

Mr C told us that he considered the care and treatment Mr A received was unreasonable because the aneurysm was misdiagnosed for the vast majority of Mr A's time in the hospital; that no urine test was ever performed and as a result nitrites (nitrites can be a sign of infection) in Mr A's urine could not have pointed towards the diagnosis of renal colic; no effort was made to investigate or test for an aneurysm prior to Mr A's collapse; no ultrasound or CT scan was performed prior to Mr A's collapse; and there was delay in starting the operation once the suspected ruptured abdominal aortic aneurysm was identified.

We took independent advice from a consultant vascular and general surgeon. We found that aspects of Mr A's care and treatment were reasonable. In particular, that the initial diagnosis of renal colic was reasonable. We noted that once the diagnosis of an aneurysm was made there was no delay in getting Mr A to theatre. However, we found that there was an unreasonable delay in carrying out a CT scan which would have identified the presence of an aneurysm. As such, there was an unreasonable delay in making the diagnosis of a ruptured aneurysm. The board have accepted that the diagnosis should have been considered earlier than it was and have taken action to prevent a similar incident happening again.

We upheld Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and the family for the unreasonable delay in carrying out a CT scan and as a result, an unreasonable delay in making the diagnosis of a ruptured aneurysm. 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:

- Patients presenting with apparent renal colic should have differential diagnosis considered and also be considered for urgent CT scanning.

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.