SPSO decision report

Case: **201810148, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C told us that their spouse (A) had been under the care of a cardiologist (a specialist that deals with diseases and abnormalities of the heart) who saw them at least once a year for review appointments following surgery, until their death twenty years later. A scan taken six years before their death showed a chronic dissection of the descending thoracic aorta (a serious condition in which there is a tear in the wall of the major artery carrying blood out of the heart). Clinicians decided to manage A's condition conservatively, but C told us neither they nor A were aware of this or the findings of the scan. C was also concerned that clinicians failed to carry out regular scans to monitor A's condition until shortly before their death and that communication between different specialists had been poor.

We took independent advice from a consultant cardiologist. We found a number of failings that had an impact on the board's ability to monitor A's condition which in turn meant that their treatment plan was not fully informed. These failings included: lack of records relating to A's operation and x-rays which made interpretation of later scans more difficult; lack of follow-up on whether additional imaging and/or cardiac opinion was needed following the scan showing the dissection; results of a CT colonoscopy (a procedure that uses a CT scanner to produce detailed images of the colon and rectum) were not shared or acted upon. We also found that communication between the relevant healthcare professionals was not as effective as it should have been given A's complex clinical condition. We upheld both of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this investigation. 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:

- Ensure communication between clinicians from different specialisms is effective.
- Ensure record-keeping by healthcare professionals is of a reasonable standard.
- Ensure that significant test results are followed up appropriately.
- Feedback the findings of our investigation in relation to further tests and referrals to other specialists to relevant staff for them to reflect on.

In relation to complaints handling, we recommended:

- Ensure board investigations identify and address incidents covered by the duty of candour with the relevant Scottish Government guidance.

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.