# SPSO decision report

**Case:** **201902266, Western Isles NHS Board**
**Sector:** Health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Mr C, an advocate, complained on behalf of his client (Mr A) about the care and treatment Mr A received from the board when he attended hospital after his GP sent for an ambulance for him. The GP sent for an ambulance after a phone consultation with Mr A's wife, as they suspected that Mr A was having a stroke.

When Mr A was admitted to A&E, he was treated for fast atrial fibrillation (an irregular heart beat) and possible alcohol related issues. Mr A was discharged from the hospital on the day after he was admitted. However, he was admitted to hospital again the following day. A CT scan was carried out and this confirmed that Mr A had suffered a stroke.

Mr C said that medical staff within A&E did not act appropriately when Mr A was originally admitted to hospital and that medical staff unreasonably failed to investigate the possibility that Mr A had suffered a stroke, despite symptoms being identified in his admittance notes.

We took independent advice from an appropriately qualified adviser. We found that there was nothing contained in Mr A records when he was originally admitted that indicated he had suffered a stroke. Based on the evidence and Mr A's presentation, we concluded that it was reasonable for medical professionals to exclude a stroke at that time. However, we noted that Mr A symptoms were suggestive of a transient ischaemic attack (TIA; a stroke lasting for a shorter period, less than 24 hours). The records suggested appropriate consideration was not given to the possibility and symptoms of a TIA. If a TIA had been diagnosed, then the management of Mr A's atrial fibrillation may have been different. This may not have prevented Mr A's readmission or stroke, but could have changed the overall clinical management.

We concluded that medical professionals did not unreasonably fail to identify a stroke when Mr A was originally admitted. However, we concluded that the board did not give appropriate consideration to whether Mr A had suffered a TIA. In light of this, our view was that the board unreasonably failed to provide appropriate care and treatment to Mr A when he was originally admitted to hospital. Therefore, we upheld Mr C's complaint.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for failing to give appropriate consideration to the possibility he had suffered a TIA and as a result, did not include this as part of their atrial fibrillation workup and decision-making with respect to out-patient follow-up and anticoagulation. 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:

- A&E staff should be aware of the signs of a TIA and the links between TIAs and arterial fibrillation.

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.