SPSO decision report

Case: **201204150, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment that his father (Mr A) received during his stay in hospital, and particularly during the final three days of his life. Mr A was diagnosed with myasthenia gravis (a medical condition where muscles become easily tired and weak) while he was on a neurology ward (for disorders of nerves and the nervous system) and was then transferred to a cardiology ward (for heart disorders) due to the deterioration of a long standing heart condition. While he was in the cardiology ward, the consultant neurologist remained in contact and reviewed him regularly. When Mr A was about to be discharged, he contracted a norovirus (winter vomiting) infection, and was not well enough to leave. His family asked for assurances that the consultant neurologist was consulted about the delayed discharge, but medical notes indicate that he was not told about the delay until late on the third day after. He then reviewed Mr A promptly.

That night Mr A's heart condition deteriorated, and he became weak and tired. He had difficulty swallowing his pills the next morning, and his family said that he choked on his food at lunchtime, although the board did not provide any information about that incident. After lunch, Mr A's condition deteriorated rapidly. A chest x-ray indicated that he had an infection, with possible signs of aspiration (when material from the stomach or throat is taken into the lungs), and although staff tried to stabilise his condition, Mr A died.

We obtained independent advice on this complaint from a medical adviser. They said that the neurologist should have been told earlier about Mr A's delayed discharge. They also said that Mr A should have been given a swallowing assessment to ensure he would not choke on food. They concluded that there was evidence that aspiration had led to an infection (pneumonia), which contributed to Mr A's deterioration, although this evidence was not completely conclusive. We upheld Mr C's complaint about his father's care and treatment, on the basis that communication between specialist teams was inadequate and that a swallowing assessment should have been conducted.

Mr C also complained about the board's handling of his complaint. Our investigation found that the board had given Mr C conflicting information. We also found evidence that their initial investigation was not sufficiently robust. We upheld this complaint, and highlighted that it took a full eight months for Mr C to get a final response to all the issues he raised, which was far too long.

Recommendations

We recommended that the board:

- ensure that, where a review is requested from another specialist, adequate notes are taken in enough detail for staff to carry out appropriate tests and monitoring;
- raise staff awareness to ensure that all complaints are handled in line with their complaints procedure, and in particular, that investigations are thorough and responses adequately address all the issues raised; and
- apologise to the family of Mr A for the failures identified.