SPSO decision report

Case: **201501832, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, action taken by body to remedy, no recommendations

Summary

Miss C took her young son to A&E at Crosshouse Hospital as he was suffering from breathing problems and chest pain. A doctor arranged for a chest x-ray. He said there was no infection and discharged Miss C's son. Nearly a month later, Miss C's GP contacted her about a letter from the hospital stating that her son's x-ray had been misread. It said that he had pneumonia and required antibiotics. Miss C complained to the board about the delay in being told the x-ray had been misread. She said that her son's health had suffered as a result of this.

The board wrote to Miss C and apologised for the delay in notifying the GP of the x-ray report. While the x-ray had been interpreted initially by a doctor in A&E, this interpretation was incorrect. This was only found when the x-ray was formally reported on some 25 days later. A letter was then sent to the GP with the accurate report. The board offered an unreserved apology for the delay in reporting the x-ray, which was due to a combination of staff vacancies and demand on the service at that time. The board have since obtained additional support in an effort to reduce waiting times for imaging reports. The board said that the doctor who incorrectly interpreted the x-ray would be spoken to about their actions. They also said that the case would be discussed at clinical governance and audit meetings in order that lessons could be learned.

We took independent advice from a medical adviser who is a specialist in emergency medicine. The adviser confirmed that the time taken to formally report the x-ray was unacceptable even if there were staffing issues. We upheld the complaint. As the board had already apologised for the delay and had taken action to prevent a repeat occurrence, no recommendations were made.