## **SPSO decision report**



Case:	202100730, Fife NHS Board
Sector:	Health
Subject:	Clinical treatment / diagnosis
Decision:	upheld, recommendations

## Summary

C complained about the care and treatment provided by the board to their partner (A). A had a seizure and was admitted to hospital for further assessment. C reported their concern to staff that A had dislocated their jaw during the seizure, and advised that this had happened to A before.

A underwent x-rays and was referred to oral and maxillofacial surgery (OMFS, specialists in the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck) for review. OMFS concluded that no further treatment was required for A. C continued to report their concern about A's jaw and an urgent referral was made to ear nose and throat (ENT) for further assessment. This was later re-directed on vetting to OMFS, however no follow-up review by OMFS took place by the time of A's discharge some weeks later.

On discharge, C contacted A's GP who arranged for A to be seen by another health board. A was diagnosed as having a dislocated jaw and underwent emergency surgery.

The board said that there had been evidence of dislocation in the right jaw joint. They said that due to A's dementia and reduced mobility, they were unable to fully cooperate during their assessment and would not have been able to manage further x-ray procedures. They noted that A did not appear to be experiencing any pain and appeared to have a good range of movement of their jaw.

We took independent advice from an oral and maxillofacial surgeon. We found that A's initial assessment on arrival at the hospital and the decision to wait until the x-rays had been reported before referring A to OMFS for further assessment was reasonable. However, we found that the assessment of A's jaw by OMFS failed to elicit the clinical features of the dislocation and failed to consider other types of scan after concluding the diagnosis was unclear.

On the matter of the urgent referral to ENT which was later redirected to OMFS, we were critical that no follow-up review by OMFS took place prior to A's discharge. We considered that the board failed to provide A with reasonable care and treatment and upheld C's complaints.

We also noted that, at the point of C complaining to the board, it was known that A had in fact dislocated their jaw during their admission. The board confirmed in their response to our enquiries that no internal processes for reporting or learning or improvement had been followed on becoming aware of this harm. While the board had responded to C's complaint, we were critical that they failed to initiate or follow other processes to record the event, or to elicit learning and improvement outcomes at the point of becoming aware of it. Therefore, we made a recommendation to the board on this matter.

## Recommendations

What we asked the organisation to do in this case:

 Apologise to C for failing to reasonably assess and diagnose A's dislocated jaw, the referral to ENT being inappropriately accepted, and the unreasonable delay by ENT in reviewing A which did not take place during their admission. 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:

- The findings of this investigation should be fed back to relevant clinical staff in a supportive way for reflection and learning, and to inform future decision making regarding assessment processes.
- Referrals to other specialties for review should be made appropriately and accepted only when it is reasonable to do so. Referrals should be seen within a reasonable timescale.
- When the board becomes aware of a harm through the complaint process, processes should be followed to ensure reporting and learning and improvement takes place. This should be in line with both statutory duties and in keeping with any additional internal processes relevant to the incident type.

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.