SPSO decision report

Case: **202101351, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late child (A) received from the board about symptoms of productive cough, breathlessness and occasional wheeze. A was referred by their GP to the board and received two outpatient chest x-rays. Separately, A also self-presented at the A&E owing to their symptoms, where they were discharged with a trial of steroids and inhaler. A's first of the two outpatient chest x-rays was reported as normal and their GP routinely referred them to the respiratory department for further investigation of their symptoms. The second of the two outpatient chest x-rays was considered to show changes suggestive of pulmonary oedema (a condition in which too much fluid accumulates in the lungs, interfering with a person's ability to breathe normally). At this point, A's GP upgraded the respiratory referral to urgent. On vetting by a respiratory consultant, A's GP was contacted with advice to commence a diuretic (drugs that enable the body to get rid of excess fluids) straight away and urgently refer A to cardiology, on suspicion of heart failure.

A was seen at the cardiac function clinic, with the plan being made to see them at the heart failure clinic. A's condition deteriorated before being seen at the heart failure clinic and the GP arranged for their immediate admission to the coronary care unit (CCU). A suffered a cardiac arrest shortly after admission requiring resuscitation, and they were subsequently transferred to another health board for surgery where they died.

C complained about the delays by the board to assess, diagnose and treat A's condition, especially as A had presented to the A&E, and after the follow-up x-ray showed significant deterioration within a 4 week period. Having been referred to cardiology, C complained that the board failed to treat A's condition with the urgency it required. C also complained that A had been transferred to another health board for surgery when it was known A's condition was such that this intervention would have been futile.

The board's response to C's complaint advised that the treatment A received at the A&E was appropriate to their presenting condition at the time. The board did not comment on the timings of the cardiology appointments or assessments, however they explained the immediacy of A's condition was understood at the time of the admission to CCU, with appropriate treatment being provided at the time, including in relation to A's transfer to another health board for surgery.

We took independent advice from three clinical advisers, a consultant radiologist, a respiratory and general medical consultant and a consultant cardiologist (specialist dealing with disorders of the heart). We found that the treatment provided to A at the A&E was reasonable, based on what was known at the time.

We found that the first of the outpatient chest x-rays which had been reported as normal was in fact abnormal and required clinical correlation in respect of A's presenting symptoms. Had this happened, a cardiac cause for A's symptoms could potentially have been made sooner. With regards to the second chest x-ray, we found that the board failed to use the radiology alert system in place to flag urgent and/or unexpected findings.

We also found that the vetting process by the respiratory consultant had been reasonable, as was the advice to

urgently redirect to cardiology and immediately commence A on a diuretic. On the matter of the timing of A's cardiology review, we found that this was unreasonable in light of them having significant indicators of heart failure, known to date back. We found that A received reasonable care and treatment on being admitted to CCU and ICU. On balance of the above, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delays in assessing and treating A's condition. 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:

- Patients presenting with signs of heart failure should be appropriately assessed including in relation to deciding to manage patients in an inpatient or outpatient setting.
- Abnormal findings on x-rays should be appropriately identified and reported.
- X-rays which are considered critical, urgent and/or where unexpected significant findings are identified should be flagged to the referrer using the significant finding alert system.

In relation to complaints handling, we recommended:

- The board should ensure SPSO requests for documentation and evidence are responded to in line with the time frames requested and that they are fully compliant with their complaints handling guidance when responding to SPSO enquiries.

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.