SPSO decision report

Case: **202311156, Borders NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C broke their leg and underwent an operation. Following a scan the next day, C was told that the results were fine and that they could be discharged home. However, a few days later, C was contacted and told that a further review of the scan indicated that they would require further surgery, and this was performed by another surgeon a few days later.

C complained to the board about several aspects of their treatment. The board apologised that C was told two different things about their scan results and explained that there was an anomaly in the image that wasn't seen at first, but was noticed on further review. C remained dissatisfied and raised their complaints with the SPSO.

We took independent advice from an adviser specialising in orthopaedic surgery. We found that a note of a discussion between clinicians in C's medical record does not accord with another clinician's later view, and that the board's position that the discussion was wrongly recorded was the most likely explanation of what occurred. This meant that, from C's perspective, the board had unreasonably reached different conclusions following the two reviews of the scan. Given these circumstances, the complaint was upheld.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for giving them incorrect information about the scan, for the inaccurate clinical record, and for the incorrect explanation in the complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

What we said should change to put things right in future:

- Medical records should accurately record discussion outcomes.

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.