SPSO decision report

Case: **201403602, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care his father (Mr A) received at the Royal Alexandra Hospital's A&E department after attending there with a severe headache. Specifically, Mr C complained that Mr A was not reviewed by a doctor for several hours and there was a delay in taking a CT scan of his head (computerised tomography scan: a specialised x-ray). Mr A had a subarachnoid haemorrhage (SAH: a bleed on the brain). He was transferred to a hospital with specialised services where he suffered a seizure and died.

The board said that Mr A was seen by a doctor within ten minutes of arriving at A&E and that an immediate CT scan had not been performed as Mr A's neurological examination was normal. However, he was admitted to a medical ward with the intention of carrying out a CT scan. The board considered whether there were any lessons to be learned. Consequently, the department have lowered the threshold for when a CT scan should be arranged if a SAH is suspected when neurological examination is normal.

We took independent advice from two of our medical advisers and found that Mr A was assessed promptly by an emergency doctor who had suspected a SAH. However, we were critical that the board would normally only arrange a scan if there was a neurological decline. We considered a scan should have been arranged as soon as the doctor suspected a SAH in line with national guidance. In any case, when Mr A's condition declined in A&E, a CT scan was not arranged until a further decline happened several hours later on the ward.

We were also critical that there was no record to show that the doctor had discussed the merits of arranging a CT scan with the on-call consultant. This was not in line with the General Medical Council's good practice guidance on record-keeping.

Recommendations

We recommended that the board:

- apologise to the family for failing to arrange a timeous CT scan in line with national guidance;
- review their local protocol on the management of headaches to ensure it is in accordance with national guidance; and
- draw to the attention of the emergency doctor the importance of recording discussions about the management of patients in line with good practice.