SPSO decision report

Case: **201601675, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, no recommendations

Summary

Mrs C complained on behalf of her husband (Mr A) about the care and treatment he received at the Institute of Neurological Sciences at the former Southern General Hospital. Mr A was treated for spontaneous intracranial hypotension (low fluid pressure inside the head) which is a condition that can be caused by the development of a leak of cerebrospinal fluid (a fluid found in the brain and spine that provides protection for the brain). Mrs C submitted three separate complaint letters to the board over a number of months. Her complaints related to the investigative procedures that were carried out in an attempt to locate the site of the leak, the care and treatment provided to Mr A, and the board's handling of her complaint.

We took independent advice from a consultant neurologist and a consultant neuro-radiologist. We found that an initial scan was not accurately reported which the board had identified themselves and apologised for. They also took steps to address the matter to prevent recurrence. Whilst we noted that this error caused some delay in Mr A's treatment, we did not consider that it had significantly affected his outcome given that the scan had not shown the actual site of the leak. In addition, we did not consider that a neuro-surgery referral was indicated because no definite site of a leak had been identified. We also considered that the type of scanning machine used was appropriate. We did not uphold this aspect of the complaint.

We did not identify any significant failings in obtaining Mr A's consent to another investigative procedure but considered that there should have been a record of a discussion with Mr A that there was a risk it could cause worsening headaches. We did not identify any concerns about the way in which the procedure was carried out and considered it was accurately reported. A further scan carried out a week later was also properly reported and Mr A received reasonable care and treatment afterwards. We did not uphold this aspect of the complaint.

In terms of the board's handling of Mrs C's complaints correspondence, we identified that there was undue delay in their final response which the board accepted and had apologised for. We found that the board had regularly updated Mrs C about the delays and explained the reasons for this. We identified that the board had given inaccurate information to Mrs C about requesting and agreeing extensions to the 20-working-day target for responding to complaints. We also found that the board should have explained in an earlier letter to Mrs C that Mr A's initial scan was inaccurately reported, although they addressed this in later correspondence. We upheld this aspect of the complaint. The board explained that they had already taken action to prevent these issues from arising again in the future, and we requested that they send us evidence of this.