SPSO decision report

Case: **201606542, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about treatment he received at the Royal Infirmary Edinburgh after suffering a head injury. He raised concerns that the board had failed to identify a fracture to his skull on his first attendance, as they did not carry out a CT scan until he was referred back to hospital by his GP two days after being discharged.

This case was very similar to a complaint we had recently upheld (201508264). In that case, we recommended that the board carry out an audit of similar head injury cases treated at the hospital. As the audit was still in progress at the time of Mr C's complaint, we asked the board to include his case in their consideration. They did so, and repeated what they had told Mr C in their response to his complaint - that they considered the treatment he received was appropriate. They also maintained this position in response to enquiries we made throughout our investigation.

We took independent advice from a consultant in emergency medicine. The adviser told us that the board's failure to carry out a CT scan on Mr C's first admission was unreasonable as the board had recorded that Mr C had a severe and persisting headache and Mr C had suffered a fall from a height greater than one metre. Under guidance from the Scottish Intercollegiate Guidelines Network (SIGN) and the board's protocol in place at that time, this should have led to a CT scan being arranged. We also found that the board had failed to carry out enough observations of Mr C's level of consciousness. In particular, the board had failed to record that Mr C was reviewed by an experienced doctor before being discharged. SIGN guidelines specify that an experienced doctor should review all head injury patients before they are discharged to ensure that six specific criteria are met. However, this failling had since been remedied by a new procedure implemented following case 201508264.

We were also concerned that, despite a number of these failings being a repetition of those highlighted in case 201508264, the board had failed to identify the failings, either in response to Mr C's complaint, as part of the audit they carried out into his care or when responding to our enquiries. For these reasons, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to provide appropriate treatment for his head injury. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/leaflets-and-guidance" www.spso.org.uk/leaflets-and-guidance .

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

- All staff should follow the protocols in place with regards to patients with head injuries.

In relation to complaints handling, we recommended:

- The board's investigations at all stages should identify failures in care and, where failings are identified, make proportionate changes to avoid similar mistakes in future.

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.