SPSO decision report

Case: **201707492, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment his late father (Mr A) received at Queen Elizabeth University Hospital. Mr A was taken to A&E by ambulance as he had a severe headache, light sensitivity and was vomiting. Mr A was taken for a CT scan (a scan that uses x-rays and a computer to create detailed images of the inside of the body) and was found to have suffered a brain haemorrhage (a type of stroke caused by a blood vessel rupturing, which causes bleeding in or around the brain). Mr A's treatment options were discussed with neurosurgeons (specialists in surgery on the nervous system, especially the brain and spinal cord). They considered that treatment would not be appropriate for him and that his outlook was poor. Mr A died in the hospital several hours later. Mr C complained that there was a delay in assessing Mr A and in carrying out a CT scan. Mr C considered that an earlier diagnosis and treatment could have saved Mr A's life.

We took independent advice from a consultant in emergency medicine. We found that there was an unreasonable delay of almost an hour in a nurse initially assessing Mr A at A&E. We found that although there was a high number of patients that day, Mr A's assessment should not have been delayed, as he had a time sensitive condition. We also found that there was an unreasonable delay in carrying out Mr A's CT scan, which was partly due to the delay in initially assessing Mr A and partly due to the lack of availability of a CT scanner. Therefore, we upheld Mr C's complaint.

We also took independent advice from a consultant neurosurgeon on the impact the delay had on Mr A's treatment options and outlook. We found that the nature of Mr A's condition was so serious that it would have been terminal even with an earlier diagnosis.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the delays in assessing and triaging Mr A and in carrying out his CT scan. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance.

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

- Patients with time critical conditions should be triaged and treated timeously.
- Patients should receive CT scans within a timescale appropriate to their need.