S.170/01-02

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

Argyll and Clyde Acute Hospitals NHS Trust

Complaint as put to the Ombudsman

1. In this report I refer to the complainant as Mr I. The account of the complaint provided by Mr I is that at about 8.30 pm on 11 December 2000 his 15 year old daughter, Miss I, collapsed in a local supermarket. Miss I was unconscious for at least 20 minutes. She was taken by ambulance to Vale of Leven District General Hospital (the hospital) where she was examined by a doctor (a senior house officer – the Senior House Officer) in the Accident and Emergency (A&E) Department at about 10.15 pm. Miss I was then discharged home, although she had complained of a sore head, and her mother had pointed out to the Senior House Officer that she had an abrasion on the left side of her temple.

2. At home Miss I continued to complain of a sore head and she started vomiting before her parents got her to bed. Mrs E then telephoned the hospital to seek advice. Mrs E told the Senior House Officer of Miss I's condition, including her drowsiness, and explained that she had previously sustained a fractured skull as a young infant. The Senior House Officer suggested that Miss I should be shaken to get a response. Shortly afterwards Mrs E made another call for advice. Miss I was complaining of a persistent headache at the left temple. Mrs E also explained that Miss I's brother, who had been present following her collapse, had said that she was jerking and fitting whilst on the floor at the scene of her collapse. The Senior House Officer suggested that Miss I take two paracetamol tablets for her headache. Later, when Mr and Mrs E were unable to rouse Miss I, Mrs E telephoned the Senior House Officer for the third time. The Senior House Officer said that if they were that concerned about Miss I's condition

they should bring her back to the A&E department, which they did with some difficulty as Miss I was not responding. About an hour after arriving at the hospital they were told that Miss I would have to be transferred to the Southern General Hospital in Glasgow as it was thought that she may have a brain haemorrhage or meningitis. Immediately on arrival at the Southern General Hospital, Miss I was given a CT scan and then taken to theatre to have an extradural haematoma removed.

3. The matters investigated were that:

(a) on her first attendance at the A&E department, Miss I was not treated in accordance with the proper procedures for head injuries; and

(b) inadequate consideration was given to the new symptoms reported by telephone after Miss I was discharged from the A&E department.

Investigation

4. The statement of complaint for the investigation was issued on 4 April 2002. Comments were obtained from the Trust and relevant documents including Miss I's clinical records were examined. Evidence was taken from Mr and Mrs E. A Professional Assessor was appointed to advise on the clinical issues in this case and his report is reproduced in its entirety in paragraph 16 below. I have not included in my report every detail investigated but I am satisfied that no matter of significance has been overlooked. The medical terms used in this report are explained in the glossary at Appendix A.

Evidence of the family

5. **Mr and Mrs E's son**, who works in the supermarket, said he was there when his sister collapsed but not with her. When he arrived on the scene his sister was lying in the recovery position and her chest and upper body were 'pulsing'. She looked as if she was trying to open her eyes but could

not. She was not communicating at all. He estimated that she was like that for about 20 minutes.

6. In correspondence about the complaint and when interviewed **Mrs E** said that her son's friend telephoned her at home to tell her what had happened. She and Mr I went to the supermarket straight away. On arrival Miss I's eyelids were closed but it looked as if her eyes were twitching underneath. Mrs E went in the ambulance with her daughter and Mr I followed by car. Miss I opened her eyes for the first time while on the trolley on the way to the ambulance but she was not aware of where she was. She appeared to be wide awake but in a trance. In the ambulance Mrs E said that her daughter eventually spoke but was clearly confused.

7. On arrival at the A&E Department of the hospital the Senior House Officer asked Miss I what had happened. Mrs E told the Senior House Officer that Miss I could not remember but, as Mrs E understood it, Miss I fell while in the supermarket. The Senior House Officer told her that Miss I had very low blood-sugar which indicated that she had not been eating properly. The Senior House Officer asked Miss I to lift her arms and legs and looked in her eyes with a light but she did not examine Miss I's head. Nobody asked if Miss I had been unconscious. Mrs E pointed out to the Senior House Officer that Miss I's glasses looked too tight on her head and also that there was a mark, like a graze, on one side of her head which turned out to be the site of the fracture. The Senior House Officer said she had examined Miss I's head and it was fine.

8. Mrs E said that her daughter had an eating problem. Mrs E explained to the Senior House Officer about Miss I's eating habits in some detail and stressed how concerned she was about her daughter. The eating problem started in May 2000 and seemed by September to be out of control. Miss I ate very little. She had been 10½ stone and came down to 9½ stone during that period. They had been seeing their GP for some time about the problem. Mrs E was also concerned because her daughter had suffered a skull fracture when she was two years old and Mrs E thought that might mean that she was more prone to fractures than others. Mrs E explained

her concerns to the Senior House Officer and asked her to speak to the GP who she had seen at the hospital when they arrived.

9. Mrs E said that despite her concerns Miss I was discharged. The only advice they were given by the Senior House Officer was to give Miss I tea and a biscuit to raise her blood-sugar. They arrived home at about 10.40 pm and gave Miss I a cup of tea and a biscuit. She kept complaining about pain at the side of her head and on the way to bed she was sick. She was not weight-bearing properly and in fact had not been weight-bearing properly when they left the hospital. They put her into bed and when Mrs E later checked her daughter she seemed very warm. Mrs E telephoned the A&E Department and described to the Senior House Officer how Miss I was. The Senior House Officer advised her to keep shaking Miss I to make sure that she was rousable and knew who they were.

10. Mr and Mrs E said that soon after that Miss I was copiously sick and she appeared a bit floppy and distant and was not very responsive. The volume of sickness alarmed Mrs E and she phoned the Senior House Officer again. The Senior House Officer asked Mrs E to get her son to describe again how Miss I was when she fell. He described the twitching or pulsing. The Senior House Officer advised Mrs E to give Miss I paracetamol. Mrs E explained to Miss I that she was going to give her paracetamol. She sat her forward but Miss I did not answer or open her eyes. Mrs E was not able to open her daughter's mouth to give her the paracetamol then Miss I was copiously sick again. She was not communicating at all by then. It was at that stage that Mr and Mrs E became concerned that there was something seriously wrong with their daughter. Mrs E called the hospital again. By then she was angry because she felt that no-one was listening to her. The Senior House Officer was abrupt and told her that if she was worried to bring her back. The calls to the hospital took place between 11.00 pm and 1.40 am. It took them some time to try to arrange care for their younger child and to get Miss I to the car. It was about 2.30 am when they arrived at the hospital. After an hour they were told that their daughter would have to be transferred to the Southern General Hospital. The Senior House Officer told them that Miss I may have a brain haemorrhage. On arrival at

the Southern General Hospital she was immediately given a CT scan and then taken to theatre immediately to have an extradural haematoma removed. The surgeon told them that if they had let their daughter sleep then she would have died that night.

11. Mr and Mrs E said that they had since found out that the SIGN guidelines (see paragraph 12), relating to the management of head injuries and which were issued in August 2000, say that if someone is unconscious for more than about five minutes they should be kept in hospital overnight and that a CT scan should be carried out within 4 hours. The A&E Consultant (the Consultant) later admitted that the guidance produced in August 2000 had not been circulated at the time when their daughter was seen. They felt that Miss I's head injury had been totally overlooked. In their view, if a child fell surely the obvious question was whether the child had banged her head. They also did not believe that Miss I had undergone a full physical examination as claimed in the Trust's reply to their complaint as Mrs E was with Miss I most of the time and the Senior House Officer only examined Miss I as described above.

Extracts from the SIGN guidelines

12. The Scottish Intercollegiate Guidelines Network (SIGN) objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. SIGN guidelines are not intended to be construed or to serve as a standard of medical care. They should be considered as guidelines only. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available. The SIGN guidelines on 'Early Management of Patients with a Head Injury' published in August 2000 include:

> ' … What are the indications for referral to hospital of a patient with a recent head injury?

'An apparent minor blow to the head is a common event in every day life and many patients do not require the hospital referral. The principal reasons for hospital referral are the existence or potential for brain damage or the presence of a wound that may require surgical repair.

'... CT scanning is not recommended as a routine unless there is evidence of a skull fracture.

'... Skull films should be carried out if any of the following apply and if CT is not being performed:

'(a) If the patient is alert and orientated and obeying commands (GCS 15/15)
but

...

- consciousness has been lost.'

Extracts from Miss I's medical records

13. The following are extracts from Miss I's medical records:

Scottish Ambulance Service

'Young lady collapsed in supermarket. Unconscious for 1 to 2 minutes then very drowsy/confused. She attended GP today with flu symptoms.

Time of call:	2101
Treatment commenced:	2110
Time left scene:	2120
Time arrived hospital:	2130'

Vale of Leven District General Hospital

[Nursing notes] '11/12/00 ... Patient felt dizzy whilst shopping. Was [knocked out] for [a] short while. Patient has a headache. Still a bit dizzy. Pain behind eyes. Vision OK. [Left] side of face painful.

?Banged side of head on the ground. Has had flu like symptoms for a few days …'

[written by the Senior House Officer] '11/12/00 10.15pm Vasovagal episode. Collapsed in [supermarket], came round quickly according to parents. Felt hot/dizzy before collapse, shopping, no other symptoms, no sudden headaches, no siezure activity, no urinary incontinence reported, no weakness/slurring speech. [Complaining of] flu like illness over last 3-4 days … – advised rest and analgesia, started prelims today, feeling stressed. Underlying Anorexia Nervosa, patient has not been eating drinking/ for some months – Mum [very] anxious regarding this. Mum feels patient not drinking enough. No [history] of vasovagal episodes/collapse, feeling weak and dizzy presently, pain over [left] sided swelling. [On examination] Thin/dry mouth, BM 2.8, fully alert and orientated [Glasgow Coma Scale] 15, not postictal, ambulant. Tenderness above zygomatic arch – swelling. No other signs of head injury … Impression: Collapse – Anorexia Nervosa, low BM [due] to poor food intake and flu like symptoms … Plan: Discharge. Advised to eat tonight. Advised to attend GP in morning for further [follow up] regarding anorexia nervosa …'

[written by the Senior House Officer] '11.35 pm Mother phoned back after patient had left the department to report that [supermarket] staff said patient was rigid when she fell, making "shaky eye movements". ?fit … Also patient reported to have vomited at home and headache over site of injury. Reassured mother. Explained if patient continues to vomit continuously to return to department or if headache worsens. Also if any other concerns to come back but to go to GP in morning for bloods and full check up.'

[written by the Senior House Officer] '3.00 am Returned to department. Patient deteriorated significantly since arrival earlier. Patient now [Glasgow Coma Scale] 11/15 … Not verbalising … family reports [complaining of] headache … Impression: ?Encephalitis

?Head injury – subarachnoid – evolving neurological signs. [Right] sided weakness. Pupil changes. Transfer to [Southern General Hospital] for CT scan.'

Southern General Hospital

'… She was transferred to the Neurosurgical Unit … A CT scan showed a left temporo-parietal extradural haematoma associated with a compound fracture … On 12/12/00 through a left sided craniotomy, the haematoma was evacuated … She was discharged home on 19/12/00.'

Evidence of the Trust

14. A statement obtained from **the Senior House Officer** during the Trust's investigation included:

'Seen by triage nurse with all [observations] normal. Seen by myself at 10.15 pm. History of collapse in … supermarket. History given by [Miss I], she had felt unwell, dizzy, hot and collapsed to the ground hitting her head. On questioning of both [Miss I] and her Mother, no reports given of prolonged period of loss of consciousness, no seizure activity, no postictal behaviour. There were no clinical signs of having had a seizure … She had been feeling unwell in the preceding few days with flu-like illness and had attended her own GP. She described being under considerable stress with her prelim examinations. [Miss I] had a background of anorexia nervosa and had a very limited food and fluid intake. Again this had put her at risk of having a vasovagal attack.

'A BM performed had read 2.8 and again pointed at the above diagnosis. Her past medical history included a skull fracture aged two years of age, however, this was not clinically relevant to this presentation and did not influence my management decisions. On examination she was well, alert and orientated with normal behaviour. At all times her coma scale was top line. She looked thin and dehydrated with a dry mouth. She had no neurological deficit.

She was apyrexial with no signs of meningism. She had no visible evidence of a severe blow to the head. I assessed her tenderness to be in the region of her left zygomatic arch and below her left eye. There was minimal swelling some two hours after the event had occurred. All other examinations of head and facial bones were clinically normal.

'I did not carry out any radiological imaging, as I had no evidence to suggest a significant head injury from either the history or the examination. My diagnosis was one of a viral and metabolic upset as a cause of collapse without significant head injury. Bloods were taken to exclude an electrolyte disturbance …

'Following discharge [Miss I]'s mother had telephoned the Department at 11.35 pm. She described how [Miss I] had pain when biting. I attributed this to pain locally at the site of the injury and explained it was relatively common to experience pain and that simple analgesia would be appropriate. She also raised concern that [Miss I] was feeling sick and vomited … I advised her to rest but to be observed.

'The next 'phonecall was received at approximately 12.15 am. [Miss I]'s mother had phoned with new information given by [Miss I]'s brother who worked within [the supermarket]. He reported that she had been reported as being rigid "with shaky eye movements" … The reports given were unclear as to being unconscious or seizuring. There had been no evidence of seizure activity at the time of examination or reports of being postictal at the time of the initial assessment.

'There was a further 'phonecall. This time [Miss I]'s mother described how the vomiting had continued and she seemed worse than earlier. There was no clear indication that there had been any drop in her conscious levels or that she was drowsy and unresponsive. I said if she was concerned that she should return to the Department for

further assessment. I asked if they required transport and [Miss I]'s mum has said they had their own. I did not suggest a 999 ambulance, as I had not been under the impression that there was a substantial deterioration in [Miss I]'s condition from the telephone description.

'On arrival at the hospital the father had requested for a chair to get [Miss I] from the [car] to the Department. I was obviously very concerned when I heard that [Miss I] could not walk. On seeing [Miss I] there was a marked deterioration in her condition. She was drowsy although still obeying commands but she was no longer able to talk in a coherent manner. She was clammy and bradycardic compared to earlier observations. There was swelling in the left temporal area and the possibility of dried blood in her left nostril although again the swelling appeared minimal. We checked a BM, which was in the normal range. She was moved into the [resuscitation] room. Although apyrexial she appeared to possibly have some neck stiffness. I had contacted the medic on call to assess the patient. After another further examination still there were no localising signs, the left pupil was marginally bigger than the [right] although at this stage this was very subtle and not entirely convincing. The medic and myself felt in view of her recent flu-like illness and collapse with nothing on examination to suggest a significant blow to the head, that meningitis was high on the differential diagnosis. Therefore she was given appropriate antibiotics. I think at this point the Southern General Neurological Institute was contacted re CT scan via the medic on call. I had contacted my A&E Consultant for guidance. Again the effects of a head injury were on the differential but an infective cause seemed likely.

'I called a senior anaesthetist for maintenance of the patient's airway. Again further assessment of the patient was carried out by the anaesthetist. It was during this time that the left pupil became clearly larger than the right. [Miss I] was developing increased tone with a decrease in power of her right lower limb. It was clear at this

point that there was raised intracranial pressure due to an intracranial bleed. The Southern were again contacted and there was emergency transfer to the institute within 45 minutes of readmission to the Department. It was confirmed as an extradural bleed and emergency surgery was carried out.

15. In his written response to the Ombudsman's statement of complaint the **Chief Executive** included:

'[Miss I] was brought to the A&E Department, Vale of Leven Hospital by ambulance at 2130 hours on 11 December 2000. She was seen initially by the triage nurse who carried out routine observations, and was subsequently examined by [the Senior House Officer] at 10.15pm. The history given to [the Senior House Officer] was that [Miss I] had collapsed but had come round quickly according to her parents. She had apparently felt hot and dizzy before the collapse. There was no evidence of sudden onset of headache or seizure activity. There had been no urinary incontinence and since the incident there had been no weakness or slurring of speech. [Miss I] had complained of a flu-like illness over the previous 3-4 days. She had apparently started her preliminary examinations that day and had been feeling stressed. Her parents gave a history of underlying anorexia nervosa and it was noted that [Miss I] had not been eating or drinking properly for some months. The parents were exceedingly anxious regarding this. There had been no previous episodes of vasovagal collapse. She was feeling weak and she complained of pain in relation to a left-sided scalp swelling. [The Senior House Officer] has noted that on examination she appeared thin and had a dry mouth. She was fully alert and orientated. The Glasgow Coma Scale was 15 and she did not appear postictal. Blood glucose as measured by BM Stix was 2.8. There was no focal neurological deficit. Minimal swelling with tenderness above the left zygomatic arch. There was no other sign of head injury. There was no abnormality on examination within the ears. [The Senior House Officer] then carried out a full physical examination and her final opinion was that [Miss I] had

suffered a vasovagal collapse, possibly secondary to anorexia nervosa, low food intake and recent flu-like illness. She was allowed home, but advised to attend her general practitioner the following morning for follow-up and management of anorexia nervosa.

'[Mrs E] telephoned [the Senior House Officer] at 11.35pm to report that [Miss I] had had an episode of vomiting. As far as [the Senior House Officer] was aware, this was the first episode of vomiting. [The Senior House Officer] obtained the impression that [Miss I] had local pain at the site of injury rather than a headache. She therefore did not connect this to a possible complication of a head injury. [The Senior House Officer] advised that if there were any other concerns that she might come back, otherwise she should attend her general practitioner in the morning. In the meantime, [Miss I] should be allowed to sleep.

'[Mrs E] telephoned again at 12.15am. [The Senior House Officer] appreciated that [Miss I] did complain of headache, but as [Miss I] had had no pain relieving medication up till that point, she advised that [Miss I] should be given two Paracetamol. [Mrs E] reported [Miss I]'s brother's description which might have been consistent with a seizure, however previous notes show that during her initial assessment within the A&E department, [the Senior House Officer] had considered the possibility of a seizure as the cause of [Miss I]'s initial collapse, but had noted that there had been no tongue biting and no incontinence. This is why [the Senior House Officer] did not consider advising [Miss I] to return to the Accident and Emergency Department for reassessment or admission at that time …

'The Trust accepts that [the Senior House Officer] did not apply head injury protocols, did not obtain an x-ray of the skull and did not consider admitting [Miss I] to hospital on her first admission to the department. This was due to an initial error in attributing [Miss I]'s symptoms to an episode of collapse or faint. This judgement was made in light of the clinical history detailed [above] …

'The Trust accepts that [the Senior House Officer] did not fully appreciate the significance of the head injury or she would have managed [Miss I] differently. A full apology was offered to the family through [the MP] … The Trust accepts that [Mr I] was justified in making the complaint …'.

Report of the Ombudsman's Professional Assessor

16. I now set out the Assessor's report:

(i) *My comments below are based entirely on the review of the medical records and letters regarding Miss I's care provided by the Ombudsman's office.*

(ii) *I have tried to summarise below, what happened to Miss I on the night of 11 December 2000, as far as I can from the records and letters supplied to me.*

Contemporaneous Scottish Ambulance Service report sheet

(iii) *The Scottish Ambulance Service received a call of 'collapse' on 11 December 2000 at 9.01 pm. They arrived on scene and commenced treatment at 9.10 pm, left the scene at 9.20 pm, and arrived at the Vale of Leven Hospital at 9.30 pm. They have recorded that a young lady had collapsed in the supermarket. She had been unconscious for one to two minutes, and was then very drowsy and confused. She had attended her GP that day with 'flu symptoms'. She had a past medical history of a skull fracture 13 years previously.*

Contemporaneous notes of the nursing staff at the Vale of Leven A&E Department

(iv) *A nurse has recorded that Miss I had collapsed. She felt dizzy whilst shopping and ?fainted. She was 'ko'd' for a short while. She had a headache and still felt a bit dizzy. The left side of her face was painful and she had ?banged*

the side of her head on the ground. She had 'flu-like symptoms' for a few days and had been seen by a GP from an out-of-hours service the previous night.

Contemporaneous notes of the Senior House Officer

(v) *The Senior House Officer has recorded in her notes that Miss I had collapsed in a supermarket, and according to her parents had come round quickly. There was no seizure activity or urinary incontinence reported. She had a 'flu-like' illness for the past three to four days, had started her prelim examinations that day, and was feeling stressed. She had an underlying problem with anorexia nervosa and she had not been eating or drinking properly for some months. Her mother was very anxious regarding this. She had no previous history of faints or collapse but she had a history of sustaining a skull fracture when aged two years old.*

(vi) *The Senior House Officer has then gone on to record an examination noting that Miss I was fully conscious. Her BM Stix reading was 2.8 (very low). She had some swelling and tenderness above her left zygomatic arch. Both her eardrums were intact and there were no other signs of a head injury. The rest of her examination was unremarkable.*

(vii) *The Senior House Officer came to the conclusion that Miss I had collapsed probably secondary to a low blood sugar caused by her poor food intake, and also her 'flu-like symptoms'. She decided Miss I could be allowed home but advised her to attend her GP the following morning for further follow-up of her anorexia nervosa, and Miss I seemed to be in agreement with this as she felt she needed help.*

(viii) *The Senior House Officer has then made a record of the first telephone conversation with Miss I's mother following discharge at 11.35 pm. The Senior House Officer has*

recorded that Miss I's mother phoned back reporting that the supermarket staff had said Miss I was rigid when she fell, making shaky eye movements and ?jerking movements of her arms and legs. She also reported that Miss I had vomited at home and was complaining of a headache over the site of her injury. The Senior House Officer has recorded that she reassured Miss I's mother but explained to her that if she continued to vomit continuously or her headache worsened to return to the Department. She also told her to return if she had any other concerns and in any case to see her GP in the morning for blood tests and a full check-up.

(ix) *The Senior House Officer's next record is documented at 3.00 am and states that Miss I had returned to the Department and had deteriorated significantly since her arrival earlier. Her Glasgow Coma Scale was now 11 out of 15. She looked pale and was not talking, and the family reported that she was complaining of a headache. Her examination at this stage records that Miss I's left pupil was greater than her right, and there was some blood visible in her left nostril. There was some swelling over her left temple area. Her BM Stix measure was now 9.6 (normal range). On examination of her limbs she has recorded that Miss I had reduced power in her right lower limb. The Senior House Officer has then gone on to record her impression of ?encephalitis, ?head injury, ?subarachnoid. She arranged transfer to the Southern General Hospital for a CT scan.*

<u>Mrs E's recollection of the three telephone calls</u>

(x) *At a meeting on 5 October 2001 during the Trust's investigation of the complaint it was recorded that Mrs E said that she had telephoned the A&E Department at 11.35 pm and spoke to the Senior House Officer. The Senior House Officer had instructed that Miss I should have tea and biscuits when she went home but Mrs E explained to the*

Senior House Officer that Miss I could not bite the biscuit because of the pain in her head and that she had vomited. Apparently the Senior House Officer had told her to allow Miss I to go to sleep.

(xi) *It was recorded that Mrs E said she telephoned the Department a second time at 12.15 am and again spoke to the Senior House Officer. She explained that Miss I was still complaining of a headache and the Senior House Officer asked what Miss I had been like when she had been found in the supermarket. Mrs E said Miss I's brother worked in the supermarket and was with his sister shortly after her fall. He described her condition as 'was moving and her legs and arms were shuddering'. Mrs E asked if she could give Miss I pain relief and was told 'of course, give her two paracetamol'.*

(xii) *Mrs E telephoned the Department a third time at 1.30 am and explained that Miss I had not been able to take the paracetamol as she was unable to open her mouth. The Senior House Officer told her that if she was concerned she should bring her to the A&E Department. The Senior House Officer asked if she needed transport. It then took Mr and Mrs E 25 minutes to get Miss I into the car because of her condition.*

<u>The Senior House Officer's recollection of the second and third telephone calls</u>

(xiii) *The Senior House Officer recorded in a statement obtained during the Trust's investigation of the complaint that the second phone call was received at approximately 12.15 am. Miss I's mother phoned with new information given by Miss I's brother who worked within the supermarket. Apparently he reported that she had been rigid and shaky with eye movements. The reports given were unclear as to being unconscious or having a seizure.*

(xiv) *A third phone call was received from Miss I's mother this time describing that Miss I's vomiting had continued and that she seemed worse than earlier. There was no clear indication that there had been any drop in her conscious levels or that she was drowsy and unresponsive. The Senior House Officer said that if Miss I's mother was concerned she should return to the Department for further assessment. The Senior House Officer asked if they required transport and Miss I's mother said that they had their own.*

My comments

(xv) *Can I commence by saying that one has complete sympathy for both parties in this difficult case as on the one hand Mr and Mrs E nearly lost their daughter and on the other hand the Senior House Officer will live with the memory of this difficult case for the rest of her professional life.*

(xvi) *In reviewing such a case it is likely that the most accurate information is that recorded in the contemporaneous notes made by the clinical staff, as at the time they have no vested interest other than recording the facts as they perceive them. The statements made at a later date will, by necessity, be clouded by memory and emotion. This obviously applies to both parties.*

(xvii) *The contemporaneous notes of the Scottish Ambulance Service give the initial impression that Miss I simply collapsed in the supermarket, was unconscious for a short period, and then was drowsy and confused for a period. They do not appear to suggest that Miss I was suffering from a head injury at all. By the time Miss I arrived at hospital the impression recorded in the nurses' notes was that Miss I had collapsed presumably due to a faint, which would be entirely in keeping with having had a 'flu-like' illness for a*

few days. Although she was unconscious for a short while only she had a headache and felt a bit dizzy. This would be entirely in keeping with such a faint. They have, however, also noted that she may have banged the side of her head on the ground.

(xviii) *The Senior House Officer's notes suggest again that Miss I collapsed in the supermarket and according to her parents came round quickly. She has recorded making enquiry as to whether Miss I had had a fit and there was no suggestion of this. She has also recorded that Miss I was suffering from anorexia nervosa, had not been eating or drinking well for some months, had a 'flu-like' illness for three or four days, and was feeling stressed having commenced her prelim examinations that day. These were all very good reasons why Miss I might have fainted and were backed up by the fact that she had a very low blood sugar level of 2.8 on testing. The Senior House Officer has recorded in her examination that Miss I had some swelling and bruising over her left temple region, but was fully conscious and had no other evidence of a significant head injury.*

(xix) *The Senior House Officer's notes are in fact extremely good and are well written, logical and record her having asked all the appropriate questions and performed an appropriate examination given the history of a young girl collapsing in a supermarket. It is obvious, however, that all the clinical staff have interpreted Miss I to have suffered a faint for which there are a number of good reasons why she might have fainted, causing her to collapse and suffer a relatively insignificant bang to the left side of her head when she fell. All the staff obviously misinterpreted the significance of this head injury given that Miss I appeared fully recovered by the time she arrived in hospital, and that there were no clinical signs to suggest a more serious head injury. Given this I*

feel that the Senior House Officer's management of this case was entirely appropriate.

(xx) *The Senior House Officer has made a contemporaneous record of the first telephone call with Miss I's mother and has recorded the discussion about Miss I possibly having had a fit whilst at the supermarket, vomited at home, and having a headache over the site of the injury. The Senior House Officer's instructions to return if the vomiting continues, if the headache worsens, or if she had any other concerns were entirely appropriate. Even if Miss I did have a fit in the supermarket causing her to collapse it would not in itself indicate that Miss I should have been detained in hospital. It would have been different, however, if Miss I had sustained a significant head injury and fitted subsequently to this.*

(xxi) *There is some discrepancy in the Senior House Officer and Mrs E's recollection of the second and third telephone calls but in any event both agree that during a third telephone call the Senior House Officer suggested they return to the hospital if they were concerned about Miss I and asked if they had transport. Again I found this to be entirely appropriate. Many members of the public do not appreciate that the ambulance service is a completely separate organisation from the hospital service and hospitals cannot order 999 ambulances, rather 999 ambulances can only be requested by the public.*

(xxii) *In summary therefore Miss I presented as a patient who appeared to have fainted and in falling sustained what initially appeared to be a trivial head injury. Given this she was managed entirely appropriately. Obviously with hindsight it is apparent that she had in fact suffered a very significant head injury which the clinical staff failed to appreciate. Given the information provided to the staff and*

the clinical findings on examination this is entirely understandable. If Miss I had presented as somebody with an obvious significant head injury her management would have been entirely different.

(xxiii) *The crux of this particular case is that the staff at the Vale of Leven Hospital assessed Miss I as a patient who had suffered a faint and in doing so had a small graze over her left temple region. The period of unconsciousness was assumed to be due to the faint rather than any subsequent head injury. As such therefore the management of Miss I was entirely appropriate, and the SIGN Head Injury Guidelines did not apply.*

(xxiv) *Hindsight has shown, however, that Miss I suffered a significant head injury, rather than a simple graze, and her period of unconsciousness was at least in part a result of this head injury. As such the SIGN Guidelines would indicate that she should have had a skull x-ray and dependent on the result of that been admitted or had a subsequent CT scan performed. Neither of these points however affects my conclusion that Miss I was managed entirely appropriately.*

(xxv) *As far as staffing in the A&E Department is concerned, in an ideal world there would be a senior experienced A&E doctor in all A&E departments at all times. However, many departments are staffed overnight by a junior doctor with an A&E consultant on-call for back up as was the case at Vale of Leven Hospital on the night in question.*

Findings

17. In reaching my findings I have been guided by the advice provided by the Ombudsman's Professional Assessor. Mr and Mrs E complained that when their daughter attended at the A&E department, she was not treated in accordance with the SIGN guidelines for head injuries which had been

published two months before; and that inadequate consideration was given to the new symptoms reported by Mrs E to the Senior House Officer by telephone after Miss I's discharge. Had Mrs E not persisted in obtaining further treatment for her daughter that night it is probable that Miss I would have died. The Trust said that the Senior House Officer did not apply the head injury guidelines or obtain a skull x-ray or consider admitting Miss I to hospital at her first attendance due to an initial error in attributing her symptoms to an episode of collapse or faint. The Senior House Officer did not fully appreciate the significance of the head injury or she would have managed Miss I differently. The Trust accepts that Mr I was justified in making the complaint.

18. The Ombudsman's Professional Assessor considers that Miss I presented as a patient who appeared to have fainted given the history of a flu like illness, stress and limited food and fluid intake. In falling she had sustained what initially appeared to be a very trivial head injury in the form of a graze and minimal swelling on the side of the head. The Assessor said that the Senior House Officer asked all the appropriate questions and performed an appropriate examination. He said that although in hindsight it was apparent that Miss I had suffered a very significant head injury, given the information provided to the staff and the clinical findings on examination, the Senior House Officer's conclusion was understandable and her management of Miss I was appropriate. He also states that the advice given by the Senior House Officer in relation to the new symptoms reported by Mrs E after Miss I's discharge was appropriate. I accept that advice.

19. I fully understand and sympathise with the concerns of Mr and Mrs E about the treatment their daughter received at the hospital given the events that followed and the knowledge of the likely consequences had Mrs E not persisted and secured further treatment for her daughter. I also appreciate why they continued to pursue their complaint having discovered the SIGN guidelines on the management of patients with a head injury which were published two months before their daughter's attendance at the hospital. However, I must consider whether the Senior House Officer's actions were based on a reasonable and responsible exercise of clinical

judgement in the circumstances at the time. It is evident that the Senior House Officer was aware that Miss I banged her head and noted a graze on the side of her head. The question is whether the Senior House Officer should have managed Miss I as a patient with a potentially serious head injury. Given the advice of the Assessor, I accept that the Senior House Officer acted correctly in light of the history and the clinical findings and that it was reasonable not to apply head injury guidelines. I therefore do not uphold the complaint.

Conclusions

20. I have set out my findings in paragraphs 17 to 19.

Gillian Stewart
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services
Ombudsman Act 2002

18 March 2003

Appendix A

Glossary of medical terms

apyrexial	not feverish
B.M. Stix	measure of blood sugar level
bradycardic	slow pulse rate
compound fracture	association of a fracture with a break in the skin
craniotomy	removal (temporary) of part of the skull to carry out an operation on the brain
encephalitis	an inflammation of the substance of the brain
focal neurological deficit	a localised neurological sign
meningism	neck stiffness
Glasgow Coma Scale	a measurement of level of consciousness
postictal	clinical state following a fit
subarachnoid haemorrhage	bleeding into the membranes surrounding the brain
temporo-parietal extradural haematoma	bleeding into the space between the inner surface of the skull and the outer surface of the covering of the brain
vasovagal episode	an episode of fainting
zygomatic arch	temple region