SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 201508264, Lothian NHS Board - Acute Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr A was admitted to A&E at the Royal Infirmary of Edinburgh after being found at the bottom of a flight of stairs with a suspected head injury. He was assessed as having a reduced level of consciousness but this was attributed to intoxication. It was therefore decided that he would be observed in A&E overnight to ensure his symptoms improved.

Mr A was discharged the following morning and collected by his mother, who found him to be confused and disorientated. However, after discussion with reception staff, she was assured that he was medically fit to leave. On their return home, Mr A's mother remained concerned about his condition, so they attended A&E at Wishaw General Hospital, where a CT scan was carried out. This indicated that Mr A had suffered a brain haemorrhage. He was then transferred to the Southern General Hospital for emergency surgery.

Mr A's sister (Mrs C) complained that Mr A had failed to receive appropriate treatment for his head injury at the Royal Infirmary of Edinburgh. Mrs C felt that Mr A should not have been discharged, given his condition. The board apologised for failing to provide a correct diagnosis and accepted that they had wrongly attributed signs of disorientation and incoherence to intoxication rather than a developing bleed on the brain. The board stressed that assessing patients who have head injuries but are also intoxicated can be very difficult.

During the investigation, my complaints reviewer took independent medical advice on Mr A's treatment from consultants in both emergency medicine and neurosurgery. The advice received was that, under Scottish Intercollegiate Guidelines Network (SIGN) guidance, Mr A should have received a CT scan on admission to the Royal Infirmary of Edinburgh based on his recorded symptoms and that it was not reasonable to attribute those symptoms to intoxication in the circumstances.

My investigation also highlighted a poor level of record-keeping for Mr A's admission. According to records, Mr A appeared to have undergone

significantly fewer neurological observations than were required by the board's internal procedure for managing patients with head injuries. We also found that this procedure was not in line with SIGN guidance and that there was no record made of any assessment prior to Mr A's discharge.

Redress and recommendations

The Ombudsman recommends that the board:		*Completion date*
(i)	apologise to Mr A and Mrs C for the failings identified in this report;	20 January 2017
(ii)	review their procedure for the management of patients with a head injury to bring it in line with SIGN guidance;	21 February 2017
(iii)	carry out an audit of a sample of recent cases of this kind, to ensure they are being dealt with appropriately; and	21 February 2017
(iv)	carry out a root cause analysis to identify why the medical and nursing staff on duty did not follow the systems in place.	21 February 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to my office on behalf of her brother (Mr A) about the care and treatment he received at the Royal Infirmary of Edinburgh (the Hospital) after admission to the Emergency Department following a head injury. The complaint from Mrs C I have investigated is that Lothian NHS Board (the Board) failed to provide appropriate treatment for Mr A's head injury (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer examined all of the information provided by Mrs C. They also reviewed a copy of Mrs C's clinical records and the Board's complaint file. Finally, they considered relevant guidelines and obtained independent advice from consultant emergency medicine and neurosurgery advisers (Medical Adviser 1 and Medical Adviser 2 respectively) on the clinical aspects of the complaint. In this case, we have decided to issue a public report on Mrs C's complaint because of the failings identified in that advice, which we consider constitute a systemic failure, and because there were significant failings in the Board's investigation of the complaint.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Relevant guidelines

4. The Scottish Intercollegiate Guidelines Network (SIGN) publishes guidelines relevant to this complaint entitled 'Early management of patients with a head injury'. This guideline includes details of the Glasgow Coma Scale and the Glasgow Coma Scale Score (GCS), which provide a framework for describing the conscious state of a patient in terms of three aspects of responsiveness: eye opening, verbal response, and best motor response. A patient is scored in each of these areas, providing a useful single figure summary, ranging from three to 15, with 15 representing full consciousness. The guideline also provides criteria for brain computerised tomography (CT) scanning in head injured patients.

Background

5. On 31 March 2015, Mr A was found at the bottom of a flight of stairs after attending a wine-tasting event. It is assumed that he had fallen, but this was

not witnessed and Mr A has no recollection of the events leading to the presumed fall.

6. An ambulance was called and, on arrival, the ambulance crew recorded that Mr A was combative and uncooperative. He was noted to have a GCS of 14. The ambulance crew documented that he had been drinking during the afternoon but that a friend of Mr A had reported that he was not intoxicated prior to the fall.

7. Mr A arrived at the emergency department at the Hospital at 18:58 and was triaged around 90 minutes later at 20:30. The triage nurse who assessed him noted that he was bleeding from his nose but that there were no signs of a head injury, that he had been incontinent of urine, and that he had been reported to have froth around his mouth. The nurse also noted '?seizure' and '?HI [head injury]'.

8. At 20:40, the triage nurse assessed Mr A as having a GCS of 12. He was noted to be responding inappropriately to questions and only opening his eyes when he was spoken to.

9. Mr A was then seen by a doctor (Doctor 1) at 22:51. Doctor 1's record of the assessment notes the assumed mechanism of injury, that Mr A had been reported to be combative, and that he had been incontinent of urine. No further record was made of his nose bleed or the reported froth at his mouth. Doctor 1 recorded that his GCS at this time was 'rousable to 15'.

10. A third set of neurological observations were recorded at around 01:00 on 1 April 2015. Mr A's GCS was assessed as 15. It does not appear that any further neurological observations were recorded.

11. Doctor 1's record of the admission notes: 'Observed in department for 6 hours, neurological observations normal throughout'. Doctor 1's diagnosis was that Mr A was drunk and incapable with no significant injuries.

12. The Board's non-clinical records show that Mr A was discharged at 07:28, when the Board have advised that he was reviewed by a registrar, who they say assessed him as being orientated and encouraged him to be picked up by an adult who would be able to observe him further at home that day. However, there are no clinical records relating to the discharge.

13. Mrs C has advised that their mother (Mrs B) received a call from Mr A following his discharge, and found him to be extremely disorientated and incoherent. On arrival at the Hospital, Mrs B reportedly found Mr A only partially dressed. She has stated that his speech was badly impaired and that he was complaining of a sore head. Mrs C states that Mrs B then approached the administration desk as she did not feel Mr A was fit to be discharged, but staff assured her that he was medically fit to leave.

14. Mrs B then took Mr A to her home to monitor him, arriving around 12:00. She reports that his condition continued to deteriorate and she called NHS 24 in the late afternoon. She was advised to take Mr A to hospital immediately and they attended Wishaw General Hospital shortly after.

15. Mr A was triaged at Wishaw General at 18:00 that day, and his GCS was recorded as 14, as his verbal responses were confused. A CT scan was ordered and carried out which showed a large brain haemorrhage.

16. Mr A was then transferred to the Neurosurgical Department at the Southern General Hospital, where he underwent emergency surgery. Mr A was discharged nine days later.

17. During his subsequent recovery, Mr A has continued to experience some problems with his memory and speech, which have affected his employment. He has also suffered a number of fits, which have required further emergency admissions and necessitated a referral for further neurological treatment.

May 2015 formal complaint

18. On 13 May 2015, Mrs C submitted a letter of complaint to the Board. The letter explained that Mrs C held serious concerns that the Board had failed to follow the proper clinical processes and that this had impacted on Mr A's subsequent recovery.

The Board's formal response

19. The Board responded in writing in a letter dated 10 July 2015. The Board began by apologising for the delay in providing a response to Mrs C's complaint. They explained that her complaint was investigated by a consultant in emergency medicine (Doctor 2), who was on duty at the time of Mr A's

admission. The Board offered Doctor 2's sincere apology for Mr A's experience and wished him a full and speedy recovery.

20. The Board said that, since 2014, all patients arriving at the Emergency Department are seen by a triage team consisting of nursing and medical personnel including a senior emergency medicine doctor. The Board recognised that Mrs C had raised concerns that Mr A was left alone in a corridor on admission but offered reassurance that he was under the care of their triage team during this time.

21. The Board advised that routine observations were carried out at 20:40 which, apart from a reduced level of consciousness, were normal. They said that this was attributed to intoxication and it was decided he should undergo a period of observation to ensure this improved. If it did not, their intention was to carry out a CT scan of the brain.

22. The Board explained that, according to Scottish Government guidelines, patients should be seen by a doctor within two hours. They said that Mr A had already been seen by a doctor on arrival but that a formal, more thorough, assessment was carried out by Doctor 1 at 22:51. Doctor 1's assessment was that he had sustained a head injury and was intoxicated with alcohol but did not require any brain scanning or further investigation at that time, as his condition had improved, which is characteristic of a patient with intoxication. The Board said that, based on Doctor 1's assessment, Mr A was to have repeat observations every two hours for a six hour period, as per protocol. If these observations indicated any deterioration of his condition, he would have then received a CT scan of his brain.

23. The Board advised that a registrar reviewed Mr A at this time and agreed that he did not require brain imaging. They state that the registrar agreed that he should be monitored to ensure his condition continued to improve and that he was safe to be discharged in the care of an adult who would be able to observe him further at home.

24. The Board said that, at 00:41, Mr A was moved to the minor injuries area of the department and, at 01:30, his vital signs were all recorded as being normal. They advised that he was further observed in an area where there were many members of staff and where he could be seen at all times until 07:28, when he was reviewed once again by a registrar.

25. The Board stated that, at this time, Mr A was noted to be walking, talking, and wanted to go home. They said that he was mobilising well around the department and said that he would either catch a taxi or ask someone to pick him up. They explained that he was assessed, found to be orientated, and was able to give his name, date of birth, and address. The Board said that he was encouraged to make arrangements to be picked up to ensure he was cared for by an adult who would be able to observe him further at home that day.

26. The Board advised that Mr A and Mrs B were given verbal and written information regarding symptoms to be concerned about after a head injury. They said that it was well recognised that not all patients fit the criteria for a CT brain scan after six hours' observation in the Emergency Department and it is for this reason that patients and their relatives are given written and verbal advice, along with clear instructions to return to the Emergency Department should the patient develop further symptoms.

27. The Board then advised that Doctor 2 was pleased that Mrs B was able to later recognise that Mr A's condition had deteriorated and was able to take him to an Emergency Department for further assessment. The Board said that whilst they were able to detect the majority of traumatic brain haemorrhages during a patient's time in the Emergency Department, it is well recognised that this is not always the case, which is the reason for strong discharge advice. They said that it was possible that Mr A had some early bleeding on his brain when he was discharged from the Emergency Department and apologised that this was not detected. They advised that Doctor 2 was aware that patients who have a head injury and are also intoxicated are very difficult to assess. They said that Doctor 2 believed that any disorientation and incoherence shown by Mr A was incorrectly attributed to intoxication rather than developing bleeding on the brain and that Doctor 2 apologised most profusely for this.

28. The Board explained that Doctor 2 had spoken at length to the medical and nursing staff involved in Mr A's care and had re-emphasized the difficulty in detecting brain haemorrhage in such patients. They advised that they had 'reinforced the management of patients with head injuries and the management of patients with intoxication, into [their] junior doctor induction programme'.

Complaint: The Board failed to provide appropriate treatment for Mr A's head injury.

Concerns raised by Mrs C

29. Mrs C explained that she was extremely disappointed with the response she had received from the Board. She said that the letter included statements that were factually incorrect and that she felt the letter was heavily weighted with clinical terminology, leading to a lack of transparency.

30. Mrs C said that she felt there appeared to be long gaps between the assessments Mr A received. In particular, she mentioned that he had been admitted at 18:58 but was not observed until 20:40, and then did not receive a formal assessment until 22:51. She questioned whether these were reasonable delays to assess someone with a head injury.

31. Mrs C questioned whether the Board's decision not to carry out a CT scan was reasonable in the circumstances. She said that both doctors at Wishaw General and the Southern General had expressed concerns to the family around the lack of a scan.

32. Mrs C also questioned the Board's assessment that Mr A was intoxicated, given the length of time that had passed between admission and discharge. She expressed that she felt it was unreasonable to believe someone was still suffering from intoxication in the circumstances.

33. Mrs C disputed that Mr A and Mrs B were given verbal and written advice on discharge. She advised that Mrs B arrived at 11:00 to collect Mr A and found him in the waiting room. Concerned about his condition, Mrs B then returned to admissions and emphasised Mr A's poor colour, incoherence, and headache. Mrs C advised that the only advice Mrs B claims to have received was that Mr A was medically fit to leave.

34. Mrs C provided photographic evidence of a cut Mrs B had found on Mr A's head after returning home, and questioned why this did not appear to have been identified by medical staff.

The Board's response

35. The Board's response to Mrs C's complaint has been summarised in detail in the background section of the report. The Board repeatedly apologised for failing to correctly diagnose Mr A, but it is not clear whether they found this

failure to be unreasonable, as the response does not state whether or not the complaint was upheld.

Medical advice

36. Medical Adviser 1 noted that it is common for patients to present to emergency departments with both head injuries and alcohol intoxication and stated that it can be difficult to judge whether a reduced level of consciousness or altered behaviour is due to alcohol or due to the head injury. They advised that it is common practice to observe intoxicated patients for a period of time with regular neurological assessments being carried out to ensure that their level of consciousness and behaviour normalises as the effects of the alcohol wear off.

37. Medical Adviser 1 advised that it was not reasonable to assume that alcohol was the cause of Mr A's reduced level of consciousness for the following reasons:

- his level of consciousness was significantly reduced (GCS 12) at 20:40, two and a half hours after his injury;
- there was a considerable possibility that he had sustained a significant mechanism of injury by falling down stairs;
- the ambulance crew recorded that a friend had advised that he had not been intoxicated prior to being found;
- his incontinence and the froth around his mouth should have raised the possibility that he had suffered a seizure; and
- the fact that his nose was bleeding should have raised the possibility of a head injury.

38. Medical Adviser 1 said that, according to SIGN guidelines and the Hospital's head injury protocol, Mr A should have undergone a CT scan shortly after triage. They advised that although, in some circumstances, a decision could be made by an experienced emergency physician to closely observe a patient with intoxication and a GCS of 12 and make a decision with regard to the need for a scan an hour or so later, the factors listed above should have prompted the decision to proceed to a scan. Medical Adviser 1 said that the failure to undertake a scan at this stage was unreasonable.

39. Medical Adviser 1 also said that the quality of nursing and medical records relating to Mr A's admission were not of a reasonable standard. They noted

that Mr A was in the emergency department for over 12 hours but there was only one entry in the nursing record and one relatively brief record in the medical notes. In particular, Medical Adviser 1 was critical that the registrar's reviews of Mr A referred to in the Board's complaint response were not documented.

40. Medical Adviser 1 said that, when discharging a patient with this type of injury it is important to document that their level of consciousness was normal and that they were not experiencing a headache or nausea. They advised that the failure to record these pieces of information at the time of Mr A's discharge was unreasonable.

41. Medical Adviser 1 explained that, according to SIGN guidelines, and the Hospital's own guidelines, neurological observations should have been carried out every 30 minutes for the first two hours. They considered that only documenting three sets of neurological observations for Mr A in a 12-hour period was unreasonable.

42. Medical Adviser 1 was also critical of the assessment recorded by Doctor 1. They noted that no record was made by Doctor 1 that it had been previously documented that froth had been observed around Mr A's mouth, or that a friend had reported that he had not been intoxicated prior to his presumed fall. Medical Adviser 1 also noted that Doctor 1 recorded that Mr A's neurological observations were normal throughout his admission despite a GCS of 12 (indicating reduced consciousness) being recorded at 20:40.

43. My complaints reviewer sought advice from Medical Adviser 2 on how the delay in diagnosis and subsequent treatment may have impacted on Mr A's condition and recovery.

44. Medical Adviser 2 agreed with Medical Adviser 1 in their view that Mr A should have undergone a CT scan according to SIGN guidelines. They also agreed that the documentation of Mr A's admission was not of a reasonable standard.

45. Medical Adviser 2 expressed that, as it was reasonable to expect a CT scan to have taken place during Mr A's admission, this should have allowed surgery to be carried out 24 hours sooner than it was. However, they advised that it was difficult to say if and how this delay may have affected his recovery.

46. Medical Adviser 2 said that, from the records available, Mr A's condition did not appear to deteriorate significantly between discharge and his presentation to Wishaw General. They did, however, accept that there was some disparity between the Board's stated assessment and Mrs B's opinion of his condition on discharge. The Board advised that Mr A was orientated, whereas Mrs B reported that he appeared confused, with badly impaired speech. Medical Adviser 2 said that they were unable to adjudicate between these varying accounts and this affected their ability to form a clear representation of how Mr A's condition progressed.

47. However, Medical Adviser 2 said that, based on the information available, they felt it was unlikely that earlier treatment would have led to a different post-operative course. They said that if it could have been evidenced that Mr A's dysphasia (difficulty with speech) had worsened between discharge and readmission, then their opinion may have been different, but this was not clear from the records available.

Decision

48. The advice I have received is that, based on his presentation, it was unreasonable that Mr A did not undergo a CT scan on admission to the emergency department. As his GCS was recorded as 12 at 20:40, this should have indicated an immediate CT scan under both SIGN and hospital guidelines but no scan took place.

49. SIGN guidelines also state that a CT scan should be performed within eight hours for any patient showing signs of any seizure activity or who suffered a dangerous mechanism of injury. The advice I have received is that there was sufficient evidence available that Mr A met both of these criteria. This further indicates that the Board's failure to perform a CT scan was unreasonable. I am also critical that the Board's internal procedure does not reflect SIGN guidance in this respect, only recommending that patients who meet these criteria are admitted for six hours of neurological observation.

50. With regards to the neurological observations carried out, both SIGN and hospital guidelines indicate that these should be performed every 30 minutes for the first two hours, every hour until six hours, and then every two hours until 12 hours. This should have resulted in Mr A being observed at least 11 times

during his roughly 12 hour stay in the emergency department. However, only three observations were documented.

51. The advice I have received is that Doctor 1's diagnosis – that Mr A was drunk and incapable – was unreasonable. Medical Adviser 1 has stated that it would have been reasonable to expect Doctor 1 to question the possibility of another cause for Mr A's behaviour and reduced level of consciousness, given the length of time that had passed since he last had alcohol and the symptomatic suggestions of seizure activity. Doctor 1 failed to document that these factors were fully considered and also incorrectly recorded that Mr A's neurological observations had been normal throughout his admission. It would also appear that Doctor 1 incorrectly assessed that there was no external evidence of a head injury, as this is contradicted by the photographic evidence supplied by Mrs C.

52. The advice I have received is that the failure to record an assessment of Mr A prior to discharge was unreasonable following a prolonged stay in the emergency department. Medical Adviser 1 noted that it was important to document that Mr A's level of consciousness was normal and that he had no headache and no nausea. The Board's internal procedure also specifies that a head injury proforma must be completed prior to discharge but I have seen no evidence of this. I am particularly critical of these failings, given that Mrs B maintains that Mr A was presenting with all of these symptoms when she arrived to collect him from the emergency department.

53. Mrs B also disputes the Board's assertion that she was provided with verbal and written advice on how to monitor Mr A's condition after discharge. In their complaint response, the Board have recognised the importance of such advice. Despite this, they have been unable to evidence that any advice was given to Mrs B.

54. I am also concerned about the Board's investigation of this complaint. The poor record-keeping during Mr A's admission appears to have been repeated during their subsequent investigation of Mrs C's complaint. From the evidence I have seen it does not appear that statements were requested from any of the staff involved, despite the response clearly stating that Doctor 2 spoke to all staff members involved in Mr A's care.

55. I am also critical that the Board's investigation failed to identify any of the issues highlighted in this report. In particular, I would have considered that it should have been immediately evident to any reasonable investigation that the level of documentation available was less than should be expected. I would also have expected the Board's investigation to identify the failures to follow SIGN and hospital guidelines and suggest suitable steps to address these mistakes.

56. It is particularly concerning that the Board's response, having failed to identify the procedural errors described above, appears to suggest that the primary reason for their misdiagnosis was that Mr A was intoxicated. Despite repeatedly apologising for failing to correctly diagnose Mr A's condition, the Board do not appear to have reached a view on whether or not the treatment he received was reasonable in the circumstances and it is not clear from the response whether the Board upheld Mrs C's complaint. I consider this to be unreasonable.

57. The advice I have received, and which I accept, is that the standard of clinical care and treatment Mr A received was unreasonable. Therefore, I uphold the complaint.

58. I consider the repeated failures by multiple staff to follow the procedures in place, or sufficiently document the care and treatment they provided, to constitute a systemic failure. I also consider that the Board's failure to appropriately record their investigation of Mrs C's complaint, or identify any of the failings highlighted in this report, to be significant.

59. Had the Board followed the correct procedures and provided appropriate treatment, Mr A would have likely undergone surgery around 24 hours earlier than he did. The advice I have received is that it is not possible to say with certainty whether this delay impacted on his condition and subsequent recovery. However, this uncertainty has been increased by the poor documentation of Mr A's admission and discharge, which has meant it has not been possible to form a clear representation of how his condition progressed. Had this documentation been available, Medical Adviser 2 may have reached a different conclusion and the possibility remains that earlier treatment may have improved Mr A's recovery. Regardless, it is clear that this avoidable delay in treating a life-threatening injury placed Mr A at increased risk and resulted in prolonged stress and suffering for him and his family.

Recommendations

60.	I recommend that the Board:	*Completion date*
(i)	apologise to Mr A and Mrs C for the failings identified in this report;	20 January 2017
(ii)	review their procedure for the management of patients with a head injury to bring it in line with SIGN guidance;	21 February 2017
(iii)	carry out an audit of a sample of recent cases of this kind, to ensure they are being dealt with appropriately; and	21 February 2017
(iv)	carry out a root cause analysis to identify why the medical and nursing staff on duty did not follow the systems in place.	21 February 2017

61. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations by the date specified. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved, Mrs C's brother
the Hospital	the Royal Infirmary of Edinburgh
the Board	Lothian NHS Board
Medical Adviser 1	a consultant in emergency medicine who provided medical advice on the treatment provided to Mr A
Medical Adviser 2	a consultant neurosurgeon who provided medical advice on the treatment provided to Mr A
SIGN	Scottish Intercollegiate Guidelines Network
GCS	the Glasgow Coma Scale Score
Doctor 1	a doctor who assessed Mr A and provided the diagnosis
Mrs B	Mr A and Mrs C's mother
Doctor 2	a consultant in emergency medicine who investigated Mrs C's complaint for the Board

Annex 2

Glossary of terms

brain haemorrhage	a burst blood vessel that causes bleeding in the brain
computerised tomography (CT) scan	a scan that combines a number of x rays to produce detailed internal imaging
triage	an initial medical assessment to determine the urgency of the need for care