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: North East Scotland

Case ref: 201507556, Tayside NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C complained to us that the board had failed to provide his wife (Ms C) with appropriate clinical treatment following a GP referral to Perth Royal Infirmary for a suspected brain aneurysm. Ms C had been referred to the hospital by a GP after becoming unwell. In the referral letter, the GP referred to, amongst other things, a suspected subarachnoid haemorrhage (an uncommon type of stroke caused by bleeding on the surface of the brain). Ms C had reported sudden onset of pain in her head and neck with some visual disturbance. She was admitted directly to the acute medical unit in the hospital where she was medically assessed by a specialist trainee doctor. She was then reviewed by a consultant physician. She was subsequently discharged home with the problem felt to be musculoskeletal.

Ms C attended her GP on several occasions over the next few weeks. She then collapsed at home and was taken to the intensive care unit with signs of acute subdural haematoma (a serious condition where blood collects between the skull and the surface of the brain). Further treatment was not deemed appropriate and Ms C died in the hospital two days later.

We took independent advice on Mr C's complaint from a consultant physician. The adviser noted that there were sufficient features to suggest that Ms C had a thunderclap headache and that a CT scan should have been performed at that time. If this was negative, a lumbar puncture (a medical procedure where a needle is inserted into the lower part of the spine to test for conditions affecting the brain, spinal cord or other parts of the nervous system) should have then been performed and, if positive for subarachnoid haemorrhage, a neurological opinion would have been essential at that point.

We found that it was unreasonable that Ms C had been diagnosed with musculoskeletal neck pain. The adviser said that a patient with no previous significant headache history who presents with sudden severe neck and occipital pain (pain at the back of the head) should be investigated as a

thunderclap headache. We also found that Ms C had not been monitored appropriately in the acute medical unit.

In view of the fact that Ms C's headache was not reasonably investigated, we upheld Mr C's complaint that the board failed to provide Ms C with appropriate clinical treatment on 7 January 2016. Whilst we cannot say that Ms C's life would definitely have been saved if these tests had been carried out, the adviser has stated that it was probable that Ms C's condition was treatable.

Mr C also complained that the board had failed to address his complaint in a timely and professional manner. We found that the board's response had not addressed all of the points Mr C had raised and that they should have provided a more detailed response to him in relation to his questions about the failure to take action in line with the relevant medical guidance. The board also delayed in issuing the minutes to Mr C after meeting him to discuss the matter. In view of these failings, we also upheld this aspect of Mr C's complaint.

Redress and Recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failure to provide reasonable treatment to Ms C when she attended the Hospital on 7 January 2016;	26 May 2017
(ii) provide evidence that steps have been taken in the Hospital to ensure that adult patients presenting with headache are investigated in line with SIGN 107 (the Scottish Intercollegiate Guidelines Network guidance on the Diagnosis and Management of Headache in Adults);	28 July 2017
(iii) provide evidence that steps have been taken in the Hospital to ensure that patients are monitored appropriately;	28 July 2017
(iv) provide evidence that steps have been taken in the Hospital to ensure that, in appropriate cases, patients are issued with a discharge note in line with SIGN 128 (the SIGN discharge document);	28 July 2017
(v) confirm that this report will be discussed at the Consultant's next appraisal; and	26 May 2017
(vi) issue a written apology to Mr C for the failure to	26 May 2017

provide a satisfactory response to his complaints.

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 Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to my office about the care and treatment provided to his late wife (Mrs C) before her death. The complaints from Mr C I have investigated are that staff from Tayside NHS Board (the Board):

(a) failed to provide Ms C with appropriate clinical treatment following a GP referral for a suspected brain aneurysm (*upheld*); and

(b) failed to address Mr C's formal complaint in a timely and professional manner (*upheld*).

2. When he made his complaint to us, Mr C said that the outcomes he wanted from his complaint were an apology; clarification if guidelines were followed; changes to procedures; and that the complaints procedure was improved.

Investigation

3. In order to investigate Mr C's complaint, my complaints reviewer examined all the information provided by both Mr C and the Board, and obtained independent clinical advice from a consultant physician (the Adviser). In this case, we have decided to issue a public report on Mr C's complaint due to the significant personal injustice he and his family have suffered.

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

(a) The Board failed to provide Ms C with appropriate clinical treatment following a GP referral for a suspected brain aneurysm

Background

5. Ms C was referred to Perth Royal Infirmary (the Hospital) by a GP on 7 January 2016 after becoming unwell earlier that day. In the referral letter, the GP referred to, amongst other things, a suspected subarachnoid haemorrhage (an uncommon type of stroke caused by bleeding on the surface of the brain). Ms C had reported sudden onset of pain in her head and neck with some visual disturbance. She was admitted directly to the Acute Medical Unit in the Hospital where she was medically assessed by a specialist trainee doctor (year 1/2) at 16:45. She was then reviewed by a consultant physician (the Consultant) at 17:50. She was subsequently discharged home with the problem felt to be musculoskeletal.

6. Ms C again attended her GP with neck pain and other issues on 11 January, 18 January and 22 January 2016. She collapsed at home on 24 January 2016 and was taken to the Intensive Care Unit with signs of acute subdural haematoma (a serious condition where blood collects between the skull and the surface of the brain). Further treatment was not deemed appropriate and Ms C died on 26 January 2016. On 1 March 2016, the Consultant wrote to Ms C's GP. They said that they had considered the merits of a CT scan on 7 January 2016, but based on their clinical judgement, they considered that a subarachnoid haemorrhage was unlikely and the most likely explanation of Ms C's symptoms was that they were muscular in origin.

7. Mr C complained to the Board that staff should have acted on the GP's concerns on 7 January 2016. He said that had they arranged a CT scan etc. then they might have identified the condition earlier.

The Board's response

8. A local adverse incident review of Ms C's care was carried out on 10 February 2016. This said it was not possible from the CT scan carried out on 24 January 2016 to suggest what would have been seen if a CT scan had been carried out when Ms C first attended the Hospital on 7 January 2016. The report said that it may have been that it would have demonstrated an aneurysmal subarachnoid haemorrhage.

9. On 15 February 2016, Mr C wrote to the Board to complain about the treatment Ms C had received at the Hospital on 7 January 2016. He asked why the GP's diagnosis had been dismissed and what procedures were in place for diagnosing patients who present with acute head pain without any sign of trauma. He also set out the action that he wanted the Board to take. The Board wrote to Mr C on 17 February 2016 and said that they had asked a senior member of staff to review his complaint. They stated that he would then receive a written response and that their aim was to issue this within 20 working days.

10. Mr C wrote to the Board again on 19 February 2016 and said that the Consultant had contacted him to arrange a meeting. He asked if the meeting was being arranged as part of the complaints process or as part of the adverse incident review. The Board responded to Mr C on 23 February 2016, stating that the meeting was in addition to the local incident review recently undertaken.

11. On 29 February 2016, Mr C, along with other member of Ms C's family, met the Board to discuss his complaint. The minutes of the meeting state that they asked why the GP's comments about a possible subarachnoid haemorrhage had been dismissed. In response, the Board said that the admitting unit doctors were not under the instruction of GPs. They said that although GPs often raise possible diagnoses for varying symptoms, the admitting unit have the role of clinically examining and testing patients to try to ascertain the final diagnosis.

12. Mr C asked the Board why the Scottish Intercollegiate Guidelines Network (SIGN) and European guidelines for subarachnoid haemorrhage, which state that a CT scan and lumbar puncture were carried out, had not been adhered to on this occasion. The minutes of the meeting state that it was explained that many patients present with headache and not all have a CT scan. The Board said that the guidelines are there for guidance only and that it is for the admitting doctor to use their clinical judgement to decide what further tests were necessary. They said that that Ms C had a very unusual presentation, as the initial pain had started after she turned her head. They said that this suggested that it was a muscular problem and that she had presented with neck pain rather than a headache. They stated that the fact that Ms C had experienced pain in the right side of her neck was difficult to explain, as her subsequent bleed had been on the left side.

13. In the minutes of the meeting, it was recorded that the family expressed their concern that red flag warnings were missed and that this was discussed further. The Board highlighted the lack of any meningeal irritation (inflammation of the meninges) or other typical clinical symptoms or signs of subarachnoid haemorrhage at the time of Ms C's assessment. Mr C asked if there would be any change in practice at the Hospital for patients presenting with headache. The Consultant said that having reviewed the notes, they would not have done anything differently at the time. They said that they would not change their clinical practice in this situation, although they understood that the family might find this difficult to accept. They said that they were content at the time of Ms C's discharge that a CT angiogram was not necessary and explained that they would not have discharged Ms C if they felt this should have been performed. They also confirmed that their diagnosis at that time was musculoskeletal pain.

14. The minutes state that clinical staff apologised that Ms C was not discharged with a hand-written discharge script to give to the GP. The Consultant explained that immediate electronic discharge summaries are not possible for patients attending the Acute Medical Unit, but that patients should be given hand-written summaries with a follow-up subsequent electronic discharge, completed by middle grade staff and signed off by a consultant at a later date. The Board said that an electronic discharge was not completed in Ms C's case and the family said that they thought that there was a lack of communication between the hospital and the GP.

15. The minutes also state that staff said they would speak to the Board's Medical Director about an independent review of the case. They state that if permission was given for this, an independent reviewer from outwith the Board would be asked to review the case and provide an opinion, which would be shared with the family.

16. On 10 March 2016, Mr C wrote to the Board again. He said that guidance from SIGN on the Diagnosis and Management of Headaches in Adults (107) made explicit the urgency of diagnosis, but Ms C had been left for several hours before she was examined. Mr C wrote to the Board again on 31 March 2016 and said that both the minutes and the response to his complaint were late.

17. The Board sent a copy of the minutes to the family on the same day. They said that they would contact them again once a decision had been made about whether an independent review should be carried out. They also enclosed a copy of the local adverse incident review report.

18. On 19 April 2016, Mr C referred his complaint to us. He said that he believed that the Board had failed to act on the concerns of the GP and had failed to follow guidance from SIGN and the National Institute for Health and Care Excellence. He said that staff should have carried out a CT scan on 7 January 2016, especially as the GP had reported concerns about a possible subarachnoid haemorrhage.

19. The Board wrote to Mr C again on 21 April 2016. They said that their Medical Director had agreed there was merit in getting a further opinion on the difficulties associated with diagnosis. They said that a request had been made to another Board for a suitable clinician to undertake the external review and that they would provide further information and updates on this.

Medical advice

20. We asked the Adviser if they considered that there had been unreasonable delays in Ms C being assessed when she attended the Hospital on 7 January 2016. In their response, the Adviser said that Ms C had been triaged by nursing staff in the Acute Medical Unit at 14:00. A medical assessment was then carried out at 16:45. The Adviser said that this was not unreasonable and would depend on other clinical priorities and cases at that time. The Adviser said that a consultant review was then carried out at 17:50 and that this was within the accepted time standards. They stated that they did not consider that time delay to assessment was a significant factor in this case.

21. We then asked the Adviser if they considered that staff in the Acute Medical Unit took reasonable account of the information in the letter from Ms C's GP. In their response, the Adviser said that it appeared that both the junior and senior doctors who attended Ms C in the Acute Medical Unit were aware of, and understood the GP's clinical reasoning. However, they also stated that they did not consider that the possibility of subarachnoid haemorrhage was considered carefully enough and discounted. They stated that it did not appear in the junior doctor's differential diagnosis list, despite it being top of the concerns raised by the GP.

22. The Adviser went on to say that the fundamental issue here was the assessment and investigation of headache. They said that Ms C's symptoms had been identified as a neck pain but occipital head pain (pain in the back of the head) was also a component as in the GP's referral letter. They stated that the headache history taken in the Acute Medical Unit was not adequate and did not specify exact location and time to peak intensity. The Adviser referred to the guidance from SIGN on the Diagnosis and Management of Headaches in Adults (107), which states that:

> '3.1 Introduction. The individual patient's history is of prime importance in the evaluation of headache. The aim of the history is to classify the headache type(s) and screen for secondary headache using 'red flag' features. An inadequate history is the probable cause of most misdiagnosis of the headache type.'

23. The Adviser said that all of the indicators were that Ms C's headache peaked almost immediately and was described as severe, overwhelming and later rated as 10/10 for severity. They added that importantly, Ms C had not

suffered with frequent headaches and had never had migraine in the past. They also referred to section 2.1 of the SIGN guidance on the Diagnosis and Management of Headaches in Adults:

> 'Patients who present with headache and red flag features for potential secondary headache should be referred to a specialist appropriate to their symptoms for further assessment. Most patients have primary headache and do not require further investigation. Red flag warning features highlight which patients require further investigation for potential secondary headache. Patients with a first presentation of thunderclap headache should be referred immediately to hospital for same day specialist assessment. Thunderclap headache is a medical emergency as it may be caused by subarachnoid haemorrhage.'

24. The Adviser stated that the red flag features that were present in Ms C's case included the rapid severe nature of the pain (thunderclap) and the non-focal features, for example, blurred vision and unsteadiness/dizziness. They referred to section 3.3 of the SIGN guidance:

> 'Secondary headache (i.e. headache caused by another condition) should be considered in patients presenting with new onset headache or headache that differs from their usual headache. Observational studies have highlighted the following warning signs or red flags for potential secondary headache which requires further investigation:'

The red flag features listed below this then include:

- 'thunderclap: rapid time to peak headache intensity'; and
- 'non-focal neurological symptoms'. …

25. The Adviser said that they did not consider that SIGN 108 (Management of Patients with Stroke or TIA) was relevant in Ms C's case, as there were no focal features that could not be explained by the severe pain and probable low blood pressure. They said that, in summary, there were sufficient features here to suggest a thunderclap headache. They commented that the minority of cases of thunderclap headache are due to subarachnoid haemorrhage (25 percent) in one prospective study in the Lancet in 1994). In addition, they commented that it is important to note that a sentinel (early warning) headache occurs in some patients in the days and weeks before a more significant subarachnoid haemorrhage is finally diagnosed. They stated that a subarachnoid haemorrhage is a life-threatening condition and that investigation is indicated in all cases when it is suspected. They added that recurrence might

be prevented by detecting and treating cerebral aneurysm (weak point in the blood vessels, causing them to bulge or balloon out) if that is the cause. They said that the majority of aneurysms are now treated using relatively non-invasive techniques. This includes using catheters to insert coils into the aneurysm to stop it enlarging and rupturing, as occurred in Ms C's case. The Adviser has stated that whilst it was not definite, it was probable that Ms C's condition was treatable.

26. Next, I asked the Adviser if they considered that the appropriate assessments and tests had been carried out in Ms C's case. In response, the Adviser said that a thorough history and history and examination had been recorded. However, they added that the clinical picture was of a thunderclap headache. They commented that there may be no underlying serious cause found for this, but a minority are due to underlying subarachnoid haemorrhage. They stated that a non-contrast CT headscan should have been performed immediately. If this was negative for subarachnoid haemorrhage, a lumbar puncture (a medical procedure where a needle is inserted into the lower part of the spine to test for conditions affecting the brain, spinal cord or other parts of the nervous system) should have been performed. The Adviser referred to SIGN 107 2.3:

> 'In patients with thunderclap headache, unenhanced CT of the brain should be performed as soon as possible and preferably within 12 hours of onset. Patients with thunderclap headache and a normal CT should have a lumbar puncture.'

27. Next, I asked the Adviser if it was reasonable that staff did not seek advice from neurosurgery or neurology on 7 January 2016. In their response, they said that this had been reasonable. They stated that this is a common presentation to Emergency and Acute Physicians. They said that initial tests should have been completed by the Acute Medical Unit team on the basis of a thunderclap headache, requiring exclusion of a secondary cause such as subarachnoid haemorrhage. The Adviser commented that if they were uncertain about the management plan, they could have consulted the specialist neurology team but this should not have been necessary in this case until the CT head scan and lumber puncture had been completed. They said that if Ms C had tested positive for subarachnoid haemorrhage, a neurosurgical opinion would have been essential at that point.

28. I also asked the Adviser if they considered that staff had monitored Ms C appropriately whilst she was in the Acute Medical Unit. In their response, they said that they did not consider that she had been monitored appropriately. They said that the initial SEWS (Scottish Early Warning system) score was 2 and that Ms C was meant to be observed hourly at that point, but the next set of observations were not recorded until 16:45. Although the SEWS score had reduced at that point, this could not have been predicted at that time. The Adviser stated that although this was a technical failure of care, it had no adverse impact on Ms C.

29. I asked the Adviser if they considered it was unreasonable that Ms C was diagnosed with musculoskeletal neck pain. In response, they said that they considered this was unreasonable. They stated that a patient with no previous significant headache history who presents with sudden severe neck and occipital pain should be investigated as a thunderclap headache. They commented that there were some features that distracted attention here including the mode of onset, dizziness, blurred vision and relatively rapid resolution, but added that the latter is not uncommon with sentinel headache events.

30. Finally, I asked the Adviser if they considered that it was unreasonable that a discharge note was not issued. The Adviser stated that this was unreasonable and that a discharge note should have been issued which conformed with SIGN 128 (the SIGN discharge document) and should have included:

- patient demographics
- primary and secondary diagnoses
- treating clinician and contact details
- clinical complaint
- investigation results
- medication
- follow up arrangements.

31. The Adviser said that this should have been sent to the primary care team and would have allowed them to evaluate what action had taken place and what, if any, investigations had been performed. It would also have provided the treating team's contact details if further information was required.

External Review arranged by Board

32. In response to our enquiries on Mr C's complaint, the Board told us that they were satisfied that the care and treatment provided to Ms C was appropriate given her presentation. However, they also said that they had approached another Board to identify a suitable clinician to undertake an external review. They subsequently sent us a copy of the external review, which was carried out in November 2016 by a consultant physician (the External Reviewer) from another Board who had recently retired. In their report, they said that they considered the letter from Ms C's GP on 7 January 2016 to be an excellent referral letter. They also commented that they had carried out a highly commendable assessment.

33. That said, the External Reviewer stated that they considered that the decision to discharge Ms C from the Hospital without a CT scan was an error of judgement. They commented that subarachnoid haemorrhage was a real and present danger from the time of presentation. They commented that the GP had referred to 'SAH' (subarachnoid haemorrhage) and had requested that they ensure that there was nothing more serious going on. They stated that given that concern had been so explicitly raised, the only way to exclude subarachnoid haemorrhage was by urgent CT scan, which at up to six hours after onset, would have had a greater than 98 percent chance of revealing that diagnosis.

34. The External Reviewer stated that a CT head scan is quick, non-invasive, accurate, readily accessible and relatively inexpensive. They said that they would not advocate that a CT head scan should be undertaken in every patient presenting with either neck pain or headache. However, they considered that in this case, there were enough 'red flag' symptoms to warrant the investigation. The External Reviewer also commented that the GP's observation of elevated blood pressure appeared to have been ignored and that there was no sense of urgency. They said that the doctor had not provided a convincing argument about why they had dismissed the GP's concerns and, in particular, for rejecting the diagnosis of subarachnoid haemorrhage.

35. The External Reviewer also said that although they would be very confident that a CT head scan on 7 January 2016 would have revealed the presence of a sentinel (early warning) subarachnoid haemorrhage, it would be wrong to say that this in itself would have been life-saving. They stated that Ms C might still have died even if the diagnosis had been made on

7 January 2016, although the opportunity for effective intervention would have been greatly increased.

The Board's response to the draft report

36. In line with our normal practice, we sent a copy of our draft report on the complaint to Mr C and the Board for comment. In the Board's response to us, they said that while subarachnoid haemorrhage was listed as a potential diagnosis by the GP, this is usual practice for many GPs referring patients with headaches, as they are entirely appropriately seeking a second opinion to investigate the possibility of a serious cause for a common presentation. They stated that the text of the GP letter indicates their thought that this was most likely to be a musculoskeletal problem, which would have had as much, if not more, influence on the attending physician as the list of potential diagnoses. They stated that the text of the letter reflected the thoughts of the GP more accurately than the list at the top of the page. They added that the interaction between the GP and hospital in these types of referrals is to seek an opinion.

37. The Board also stated that the GP and the two doctors in the Hospital who saw Ms C had not used the term 'thunderclap headache'. They stated that CT scans are readily available in the Hospital and that the admitting team could have easily arranged this if they thought that Ms C needed one. They stated that there had been a detailed assessment of Ms C and that a reasoned clinical decision was then made, which they recognised in retrospect was wrong with tragic consequences. They added that the GP saw Ms C several times after she was discharged.

38. I discussed the Board's comments with the Adviser. They stated that they said that the GP had offered a differential diagnosis of subarachnoid haemorrhage and there was enough evidence to warrant adequate consideration of this. They stated that it was clear that Ms C had a thunderclap headache, as she did not normally have headaches, but said that it was overwhelming and it was rated as 10/10 for severity at onset.

(a) Decision

39. The complaint I have considered is that the Board failed to provide Ms C with appropriate clinical treatment following a GP referral for a suspected brain aneurysm. The advice I have received is that there were sufficient features to suggest that Ms C had a thunderclap headache and that a non-contrast CT scan should have been performed at that time. If this was negative, a

lumbar puncture should have then been performed and, if positive for subarachnoid haemorrhage, a neurological opinion would have been essential at that point. In view of the fact that Ms C's headache was not reasonably investigated, I have upheld Mr C's complaint that the Board failed to provide Ms C with appropriate clinical treatment on 7 January 2016.

40. Whilst we cannot say that Ms C's life would definitely have been saved if these tests had been carried out, the Adviser has stated that it was probable that Ms C's condition was treatable.

(a) Recommendations

41. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failure to provide reasonable treatment to Ms C when she attended the Hospital on 7 January 2016;	26 May 2017
(ii) provide evidence that steps have been taken in the Hospital to ensure that adult patients presenting with headache are investigated in line with SIGN 107 (the Scottish Intercollegiate Guidelines Network guidance on the Diagnosis and Management of Headache in Adults);	28 July 2017
(iii) provide evidence that steps have been taken in the Hospital to ensure that patients are monitored appropriately;	28 July 2017
(iv) provide evidence that steps have been taken in the Hospital to ensure that, in appropriate cases, patients are issued with a discharge note in line with SIGN 128 (the SIGN discharge document); and	28 July 2017
(v) confirm that this report will be discussed at the Consultant's next appraisal.	26 May 2017

(b) The Board failed to address Mr C's formal complaint in a timely and professional manner

42. Mr C wrote to the Board on 7 April 2016 and said the response to his complaint was shamefully inadequate. He said that the points he had made in his complaint dated 16 February 2016 had been ignored and that the meeting minutes and local adverse incident review did not constitute a response to his complaint. He also said that the response was late. He asked that the Board examine his complaint letter and address each of the points outlined within it.

43. The Board wrote to Mr C again on 21 April 2016. They said that they were genuinely sorry that he believed his initial complaint had been ignored. They stated that the meeting had been part of the complaints process with a member of the complaints and feedback team being present. They stated that they often meet with complainants in response to a complaint and this provides an opportunity to raise concerns and questions directly with the clinicians involved and receive information in relation to these. They stated that a note of the meeting is taken which then provides a written record of the verbal complaint response. They added that they were extremely sorry if this was not clearly explained to him at the time. They also said that he could submit any amendments to the note of the meeting.

44. In their response to our enquiries, the Board said that a verbal complaints response was provided in a meeting and a written note of the meeting was then issued to Mr C in line with their normal process. They said that they considered that the complaint had been handled correctly and appropriately.

The Board's Complaints Management Procedure

45. This states that:

> 'To assist in the investigation and resolve issues, NHS Tayside welcomes the opportunity to speak directly with complainants and their families. Complainants may therefore be contacted by a senior manager to discuss the issues raised over the telephone or face-to-face.'

Can I help you?

46. The Scottish Government have produced guidance, 'Can I Help You?', for the NHS and their health service providers to assist them in handling and responding to feedback, comments, concerns and complaints raised in relation to health care in accordance with the Patient Rights (Scotland) Act 2011. In relation to meetings, this states that:

> '3.10.3 The investigation team may consider:
>
> a. face-to-face meetings;
> b. written statements which can be helpful where staff have left the organisation or are on extended leave; and
> c. alternative dispute resolution services in the form of mediation or conciliation …'

47. This guidance also states that:

'Complaints must be acknowledged in writing within three days and investigated within 20 working days or as soon as reasonably practicable'.

(b) Decision

48. The Board have stated in their response to us that they consider that the complaint was handled correctly and appropriately. I consider that it was reasonable for the Board to arrange a meeting with the family to discuss the complaint. That said, I have noted that when Mr C asked the Board to clarify whether the meeting was being arranged as part of the complaints process, the Board said that it was in addition to the local incident review recently undertaken.

49. However, I do not consider that the correspondence issued by the Board on 31 March 2016 was an adequate response to the complaints Mr C had submitted on 15 February 2016 or 10 March 2016. In the Board's covering letter, they said that they hoped that the meeting offered Mr C an opportunity to fully discuss his concerns and seek the answers he required. Mr C's email of 10 March 2016 was a clear indication that he was not satisfied with the response he had received to his questions at the meeting.

50. I consider that the Board should have ensured that all of the points Mr C had raised had been addressed in either the cover letter or the minutes and should have provided a more detailed response to Mr C in relation to his questions about SIGN guidance and the failure to take action in line with this. The complaints team had in fact obtained additional information from the Consultant in relation to Mr C's email of 10 March 2016, but did not include this in their cover letter. In addition, the Board's investigation failed to identify that Ms C had not received reasonable care and treatment when she attended the Hospital on 7 January 2016. Whilst it is recommended in guidance that the Board's investigation is completed within twenty working days, despite arranging the meeting with Mr C fairly quickly, the Board them took more than 20 working days to issue the minutes. In view of these failings, I have also upheld this aspect of Mr C's complaint.

51. From April 2017, a standard approach to handling complaints will be introduced across the NHS in Scotland. The procedure has been developed by NHS complaints handling experts working closely with my staff. It complies with the SPSO's guidance on a model complaints handling procedure, meets all of the requirements of the Patient Rights (Scotland) Act 2011, and accords with

the Healthcare Principles introduced by the Act. The new procedure aims to provide quicker, simpler and more streamlined complaints handling. I have taken this into account in considering what recommendations to make to the Board in relation to this aspect of Mr C's complaint.

(b) Recommendation

52. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failure to provide a satisfactory response to his complaints.	26 May 2017

53. We will follow-up on these recommendations. 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

Mr C	the complainant
Ms C	the aggrieved (Mr C's wife)
the Board	Tayside NHS Board
the Adviser	the Consultant Physician who provided medical advice on the treatment provided to Ms C
the Hospital	Perth Royal Infirmary
the Consultant	the Consultant Physician who reviewed Ms C on 7 January 2016
SIGN	Scottish Intercollegiate Guidelines Network
SEWS	Scottish Early Warning system
the External Reviewer	the Consultant Physician from another Board who reviewed the case

Annex 2

Glossary of terms

aneurysm	weak point in the blood vessels, causing them to bulge or balloon out
computerised tomography (CT) scan	scan uses x-rays and a computer to create detailed images of the inside of the body
lumbar puncture	a medical procedure where a needle is inserted into the lower part of the spine
occipital	at the back of the head
Scottish Early Warning system (SEWS)	a set of patient observations to assist in the early detection and treatment of serious cases and support staff in making clinical assessments
sentinel	early warning
subarachnoid haemorrhage	an uncommon type of stroke caused by bleeding on the surface of the brain

Annex 3

List of legislation and policies considered

SIGN (Scottish Intercollegiate Guidelines Network) 107: Diagnosis and Management of Headaches in Adults (107)

SIGN 128 (The SIGN discharge document)

Can I help you? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care. The Scottish Government, Edinburgh 2012

NHS Tayside: Complaints Management Procedure