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: Glasgow

Case ref: 201507587, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mrs C complained about the care and treatment given to her young son (Master A) when he attended a hospital Emergency Department (ED) over a period of two days after he suffered a head injury at nursery. Master A has hydrocephalus and had had a shunt fitted a few months after he was born to relieve the pressure caused by fluid accumulation. Because of this, Mrs C said that as well as the usual checks and examination, he should also have been given a precautionary CT scan. He was not and was discharged home.

A month later, Master A and his family went abroad on holiday and he became very ill and was taken to hospital. A CT scan taken there showed that his shunt had become dislodged and he had suffered a bleed. He remained in hospital for four days before being returned home.

Mrs A complained to the board who took the view that the care and treatment given to Master A on the two occasions he attended the ED was reasonable. Our investigation showed that Master A's examination in the ED had been good, specific and relevant. However, as he had attended again for the same problem within a short time, caution needed to be taken; on the second occasion his head injury should have been discussed with a senior member of staff and as there was reason to question a shunt malfunction, staff should have had a low threshold of suspicion and considered a CT head scan. Alternatively, as his parents felt that Master A's condition had not returned to normal, he should at least have been admitted for observation. For these reasons, we upheld the complaint.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make Mrs C a formal apology recognising the identified shortcomings identified in this report; and	26 May 2017
(ii) ensure that the clinical staff involved in Master A's	26 June 2017

case make themselves fully aware of the relevant Scottish Intercollegiate Guidelines Network guidance ('Early management of children with a head injury', May 2009) to ensure that the same situation does not recur.

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 about the care and treatment given by Greater Glasgow and Clyde NHS Board (the Board) to her young son (Master A) when he presented at the Emergency Department (ED) of Yorkhill Hospital, Glasgow on 5 and 6 July 2015. Master A has hydrocephalus (an abnormal build–up of fluid on the brain) and had a shunt (a medical device to relieve pressure caused by fluid accumulation) fitted in 2012 a few months after he was born.

2. The complaint I have investigated from Mrs C is that the Board did not provide a reasonable standard of treatment for Master A on 5 and 6 June 2015 by failing to carry out a computerised tomography (CT) scan (*upheld*).

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer carefully considered all the information provided by Mrs C and the Board (including the complaints correspondence and Master A's relevant clinical records). They also obtained independent clinical advice from consultants in paediatrics (Adviser 1) and in paediatric neurosurgery (Adviser 2) and this has also been taken into account.

4. In this case, we have decided to issue a public report on Mrs C's complaint as it raises important and significant issues of interest to the wider public.

5. This report does not include 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.

Complaint: The Board did not provide a reasonable standard of treatment for Master A on 5 and 6 June 2015 by failing to carry out a CT scan

Background

6. On 5 June 2015, Master A fell at nursery hitting his head. He was sick and very sleepy. Accordingly, Mrs C took him to the ED and advised of his background (including his shunt). He was checked over and was discharged later that day. However, Mrs C said that he continued to be sick and was complaining of a sore head and she was, therefore, advised to take him back to the ED. After he had been re-examined and his shunt was checked to be working, he was discharged. Mrs C complained that despite requests, on

neither occasion was a precautionary CT scan (a scan that uses a computer to produce an image of the body) taken.

7. In July 2015, Master A and his family went abroad on holiday but after arrival he became very ill and was admitted to hospital. I understand that after a CT scan, x rays and blood tests, Master A was operated upon because his shunt drainage tubing had become dislodged and he had suffered a bleed. He remained in hospital for four days and was then returned to Scotland.

8. Mrs C was aggrieved that although she had twice taken Master A to the ED in June 2015, he had not been seen by a neurosurgeon despite his known medical history. Mrs C further believed he should have been given a CT scan. She complained to the Board on 20 July 2015 but essentially, they replied that he had been appropriately examined and assessed and that he had not displayed any features which would have triggered investigation by CT scan. Nonetheless, the Board also reported that the consultant paediatric surgeon who normally cared for Master A had expressed the view that at the time he presented at the ED, a neurosurgeon should have been consulted and a CT scan performed.

9. Mrs C maintained her complaint to the Board which resulted in further investigation. A reply was sent in February 2016. This said that despite the consultant paediatric surgeon's view (see paragraph 8), the matter had been further discussed and another opinion had been taken from a consultant neurologist. Their view was that there were no published guidelines for such circumstances as those experienced by Master A and, as he had not reported headaches or abnormal neurological symptoms, a CT scan had not been justified. The Board were satisfied that Master A's treatment had been reasonable.

10. Mrs C remained unhappy with this and so complained to me. She expressed the view that the Board appeared to be resistant to change and she wanted to be assured that steps were now taken to improve the handling of patients like Master A and that a proper investigation (CT scanning) was always carried out.

Advice

11. Adviser 1 commented that on both the occasions Master A attended the ED, he received thoughtful and careful assessments in the ED. They

considered that the history taking and examination by the triage nurses was good, specific and relevant. The correct observations were taken including general cardiovascular examinations and specific neurological examination of Master A's conscious state and his pupils. On both occasions he attended, Adviser 1 said that his shunt was considered and, the second time, a paediatric trainee performed extra neurological examinations on Master A that were reassuring. They added that staff had been careful to look for signs of raised intracranial pressure but found none; he was kept for extra observations on both dates to ensure that he did not deteriorate further and discharge advice was given.

12. Adviser 1 confirmed that there was no specific SIGN (Scottish Inter Collegiate Guidelines Network) advice for head injury in children with shunts but they added that when a child re-presented to hospital for the same problem, caution needed to be taken to consider whether the problem had progressed or whether the initial diagnosis was incorrect. However, a SIGN general head injury guideline for children Early management of children with a head injury, May 2009 stated that the management of patients who returned to hospital unexpectedly following a head injury should be discussed with senior members of staff. It was Adviser 1's view that while Master A had been assessed very carefully on his second presentation, he had not been discussed with a senior member of staff as he should have been. They went on to say that given the persistence of his vomiting, his second attendance for the same condition and the addition complication of his shunt, Master A should have been discussed with the neurological team for their advice regarding a CT scan.

13. Adviser 2 similarly confirmed that there were no specific SIGN guidelines for the management of children with a shunt who presented with a minor head injury but they added that the general advice referred to above contained a flowchart on 'indications for head CT' which stated that 'consider ED discharge if child has no comorbidities and has social support at home, otherwise admit to hospital'. It was Adviser 2's view that the fact that Master A had a ventricular-peritoneal shunt was a morbidity which could have malfunctioned at any time. Based on this, they said that they would have expected Master A to have been admitted when he attended the ED on 6 June 2015, even although his observations were normal. They went further and said that if parents were sufficiently concerned about their child to bring him back to the ED within 24 hours of him being seen previously, they considered that something could

have been wrong. They believed that at the time, Mrs C's views and concerns should have been taken more seriously.

14. Adviser 2 said that in cases where there was reason to question a shunt malfunction, as in Master A's case on his second presentation, there should have been a low threshold of suspicion. If he had been admitted at this time (as they believed he should have been) there would have been a number of available options to consider:

- a CT head scan as this was his second presentation and Mrs C as his parent was concerned that he was not back to his normal self. This was irrespective of his normal presentation; and
- admission for 24 to 48 hours because Mrs C felt that Master A was not back to normal or if he had been symptomatic, then they would have recommended a CT head scan even if the observations were normal.

15. They added that the issue of testing the shunt by depressing the reservoir or valve to see if the shunt was working was not fool proof (see paragraph 6). They said that the sensitivity and specificity of this test was low and that it was only relevant if the reservoir or valve did not depress or refill. They said that this would indicate a shunt malfunction but it would not rule out any shunt malfunction.

Decision

16. The circumstances of Master A's illness must have been extremely distressing for Mrs C and while both advisers were content with the way he was treated on 5 June 2015 both expressed reservations about his treatment and care the following day. Adviser 1 said they would have expected Master A's case to have been discussed with the neurological team for their advice concerning a CT scan, while Adviser 2 went further and said that they would have expected that he would have either been given a CT scan or admitted for 24 to 48 hours. None of these things happened and, accordingly, I uphold the complaint. The Board should now make Mrs C a formal apology recognising these identified shortcomings. They should also ensure that the clinical staff involved in Master A's case make themselves fully aware of the relevant SIGN guidance Early management of children with a head injury, May 2009 to ensure that the same situation does not recur.

Recommendations

17. I recommend that the Board:	*Completion date*
(i) make Mrs C a formal apology recognising the identified shortcomings identified in this report; and	26 May 2017
(ii) ensure that the clinical staff involved in Master A's case make themselves fully aware of the relevant SIGN guidance Early management of children with a head injury, May 2009 to ensure that the same situation does not recur.	26 June 2017

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

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
the Board	Greater Glasgow and Clyde NHS Board – Acute Services Division
Master A	the complainant's son
ED	Emergency Department
Adviser 1	a consultant paediatrician
Adviser 2	a consultant in paediatric neurosurgery
SIGN	Scottish Inter Collegiate Guidelines Network

Annex 2

Glossary of terms

computerised tomography (CT) scan	a scan that uses a computer to produce an image of the body
hydrocephalus	an abnormal build-up of fluid on the brain
shunt	a medical device to relieve pressure caused by fluid accumulation