SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

# Investigation Report

UNDER SECTION 15(1)(a)

**SPSO**
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**

SPSO Information **www.spso.org.uk**

SPSO Complaints Standards **www.valuingcomplaints.org.uk**

**Scottish Parliament Region: North East Scotland**

**Case ref: 201700591, Grampian NHS Board**
**Sector:** Health
**Subject:** Hospitals / Clinical treatment / Diagnosis


**Summary**
Ms C complained about the care and treatment she received when she presented to the Neurology Department (the Department) at Aberdeen Royal Infirmary following a referral from an out-of-hours GP. Two days following her first presentation to the Department, Ms C was diagnosed with cauda equina syndrome (a rare and serious neurological condition that affects the bundle of nerves (cauda equina) at the base of the spine). Ms C raised concern that there had been a delay in carrying out an MRI scan and, following this, performing surgery for her condition. Ms C felt that if her condition had been diagnosed and treated sooner, her chance of making a more complete recovery would have increased.

We took independent advice from a consultant neurosurgeon, which we accepted.

We found that there was an unreasonable delay in providing Ms C with appropriate treatment. We noted that, under the clinical guidance in place at the time, the Board should have carried out an emergency MRI scan and then performed emergency surgery during Ms C's first admission. We considered that it was unreasonable that Ms C did not receive an MRI scan and surgery until she returned to the Department two days later. We concluded that, if the surgery had been carried out when it should have been, then it is more likely that Ms C would have maintained better urological and sexual function. However, we were unable to say that Ms C would have recovered to normal function. We also found failings with the documentation of the assessments carried out in the Department during both admissions and we were unable to conclude that the assessments were reasonable.

Ms C was also dissatisfied with the Board's response to her complaint. We found that the Board's response had referred to a timescale for providing surgery that was not relevant in this case. We considered that the Board should have considered their response more carefully and referred to relevant guidelines. We considered that the Board failed to establish all of the facts

relevant to the points Ms C raised. We concluded that the Board's response to Ms C's complaint was unreasonable.

We upheld Ms C's two complaints and made a number of recommendations to address the issues identified. The Board have accepted these recommendations and 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 dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm the recommendations have been implemented.

**Redress and Recommendations**

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms C:

| Complaint number | What we found | What the organisation should do | Evidence SPSO needs to check that this has happened and the deadline |
|---|---|---|---|
| (a) and (b) | There was an unreasonable delay in performing an MRI scan and carrying out surgical treatment on Ms C<br><br>There was a failure to adequately document Ms C's medical assessments on 14 and 16 June 2017<br><br>The Board's response to Ms C's complaint failed to establish all of the facts relevant to the points Ms C raised and was unreasonable | Apologise to Ms C for the unreasonable delay in providing her with treatment and the impact this has had upon her, the failure to adequately document medical assessments and for failing to respond to her complaint reasonably<br><br>The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance | A copy or record of the apology.<br><br>By: 20 June 2018 |

We are asking The Board to improve the way they do things:

| **Complaint number** | **What we found** | **What should change** | **Evidence SPSO needs to check that this has happened and deadline** |
|---|---|---|---|
| (a) | There was an unreasonable delay in performing an MRI scan and carrying out surgical treatment on Ms C | Neurology, Neurosurgery, Neuroradiology staff should be aware of current pathways and guidelines for the management of patients with cauda equina syndrome<br><br>Patients with suspected cauda equina syndrome should receive an emergency MRI scan | Evidence that the cauda equina pathway and guidance in place has been shared with staff who assess and investigate emergency neurosurgery admissions<br><br>Evidence that the Board, when assessing the proposal to increase access to weekend MRI scanning, have taken into account the recognised standards in place for access to emergency MRI. The Board should provide me with reasons for their decision to take action (or not do so) in relation to this matter<br><br>By: 15 August 2018 |

| Complaint number | What we found | What should change | Evidence SPSO needs to check that this has happened and deadline |
|---|---|---|---|
| (a) | There was no documentation of the neurological assessments carried out on 14 and 16 January 2017, nor the discussion between the Registrar and the Neurosurgeon | Assessments of patients, referral conversations and conclusions should be fully documented in their medical records | Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in Ms C's care and that they have reflected on the Adviser's comments. (For instance, a copy of a meeting note or summary of a discussion)<br><br>By: 20 June 2018 |
| (b) | The Board failed to establish all of the facts relevant to the points Ms C raised and it was not apparent that relevant standards and guidance were considered | In line with the NHS Scotland Complaints Handling Procedure, complaints investigation should establish all the facts relevant to the points made in the complaint and give the person making the complaint a full, objective and proportionate response that represents the Board's final position | Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating and handling Ms C's complaint. (For instance, a copy of a meeting note or summary of a discussion)<br><br>By: 20 June 2018 |

**Feedback**

*Response to SPSO investigation*

The Board should ensure that all relevant evidence is provided to my office when this is first requested. In this case, the Board's failure to do this contributed to delays in the investigation.

*Points to note*

In view of the record-keeping and complaints handling issues identified, the Board should consider sharing this report more widely with staff in other services to highlight the importance of these matters.

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

## Introduction

1. Ms C complained to me about the care and treatment she received when she presented to the Neurology ward at Aberdeen Royal Infirmary (the Hospital) in January 2017 following a referral from an out-of-hours GP. Ms C was also dissatisfied with the complaint response she received from Grampian NHS Board (the Board). The complaints from Ms C I have investigated are that:

(a) there was an unreasonable delay in providing Ms C with appropriate treatment (*upheld*); and

(b) the Board's response to Ms C's complaint was unreasonable (*upheld*).

## Investigation

2. I and my complaints reviewer considered all the information provided by Ms C and the Board. This included Ms C's relevant medical records and the Board's complaints file. We also obtained independent advice from a consultant neurosurgeon (the Adviser).

3. In this case, I have decided to issue a public report on Ms C's complaint because of the significant and serious failings in this case; the personal injustice to Ms C as a result of the failings; and because I consider there may be wider learning for other health boards.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but I can confirm that all of the information provided during the course of the investigation was reviewed. Ms C and the Board were given an opportunity to comment on a draft of this report.

## (a) There was an unreasonable delay in providing Ms C with appropriate treatment

*Concerns raised by Ms C*

5. In her complaint to my office, Ms C raised concerns that, after she was assessed by a neurology registrar (the Registrar) in the Neurology department (the Department) on Saturday 14 January 2017, she was advised to return home and come back to the Hospital on Monday 16 January 2017 for an magnetic resonance imaging scan (MRI): a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Ms C said that when she returned for the MRI scan on 16 January 2017, this confirmed that she had cauda equina syndrome (a rare and serious

neurological condition that affects the bundle of nerves (cauda equina) at the base of the spine), which required emergency treatment.

6. Ms C felt that an MRI scan, and, following this, emergency treatment, should have been provided to her when she first presented to the Department on 14 January 2017. Ms C described a number of symptoms arising from cauda equina syndrome, including loss of sensation, bowel issues, sexual dysfunction, and bladder issues, which required her to use a urinary catheter (a thin tube used to drain and collect urine from the bladder). She considered that if her condition had been treated sooner, her chance of making a more complete recovery would have increased.

7. Ms C also raised more specific concerns about the Registrar who carried out the assessment on 14 January 2017. She questioned whether the Registrar had informed the on-call consultant neurosurgeon (the Neurosurgeon) that an out-of-hours GP had referred her to the Department to rule out cauda equina syndrome. Ms C further complained that, when she was advised to return home, she was given no advice about what to do if her condition worsened.

*What happened*

In the early afternoon on Saturday 14 January 2017, Ms C, who was 20 weeks pregnant at the time, called NHS 24 to report symptoms of back pain, shooting pain, numbness and altered sensation in her vagina. She was referred by NHS 24 to the local Community Hospital for an out-of-hours GP appointment.

8. The GP assessed Ms C and documented symptoms including pain in her lower back, pelvis and left leg, as well as numbness around her vagina and perineum. The GP made a referral to the Department at the Hospital to rule out the possibility of cauda equina syndrome. The GP informed Ms C that she should go to the Hospital for further assessment in the Department.

9. Ms C arrived at the Neurology ward later that evening (Saturday) and was assessed by the Registrar, who reviewed Ms C before discussing her case with the Neurosurgeon. The Neurosurgeon recommended that Ms C could be discharged and should return on Monday 16 January 2017 for an MRI scan. The Registrar communicated this to Ms C.

10. Ms C returned to the Neurology ward as planned on Monday 16 January 2017. An assessment was carried out, which noted that Ms C had no bladder

sensation and was finding it more difficult to pass urine. An MRI scan was performed at 15:00, and this was interpreted as showing a large central canal zone disc herniation at L5/S1 (where the soft cushion of tissue between the vertebrae separating the lumbar spinal region from the sacrum is pushed out) which was causing cauda equina compression. Ms C consented to surgery and a Microdiscectomy (a surgical procedure to remove a section of disc from the spine in order to relieve the pressure on the nerves) at L5/S1 was carried out at 19:00.

11. Following the operation, Ms C experienced urinary retention and was catheterised. Follow-up care in the Urology department was arranged and Ms C was discharged home on Wednesday 18 January 2017. Following the operation, Ms C continued to experience loss of perineal sensation, bowel issues and required to self-catheterise to pass urine.

*The Board's response*

12. In response to Ms C's complaint, the Board said the prognosis of cauda equina syndrome is difficult to predict based on presenting symptoms, and even if a patient is operated on early, they may be left with urinary or bowel problems. The Board noted that even if cauda equina syndrome is detected on an MRI, it may not be practicable or safe to operate on a patient immediately. The Board said that surgery is ideally performed within 48 hours if possible, and Ms C's medical notes confirmed that an MRI scan and surgery were performed within 48 hours.

13. The Board said that the Radiology department had an on-call system in place on Saturday and Sunday mornings for urgent queries for cord compression and cauda equina syndrome. The Board explained that if a patient is referred for an MRI scan on Saturday evening, they would be scanned on Sunday morning, whilst if a patient was referred on a Sunday evening they would be scanned on Monday morning. The Board noted that many patients are referred each week for investigation into suspected cauda equina syndrome and the vast majority of cases show no disc herniation. The Board said that it was unrealistic to request urgent imaging for all patients, and clinical judgement had to be exercised regarding whether or not imaging is required, and when it should be performed.

14. The Board said that if an MRI scan had been carried out on Sunday 15 January 2017, then it was possible that surgery would have been

performed earlier. However, the Board said that there was no guarantee that earlier surgery would have improved the outcome in the long term.

15. In response to further enquiries made by my office in respect of access to emergency MRI scanning, the Board said that they did not presently have capacity to run an MRI service 24 hours a day, seven days a week. The Board said that the existing commitment was challenging due to staffing capacity, and the service would be reviewing the impact of a proposal to extend the on-call MRI availability at weekends.

*Neurosurgery advice*

16. We sought the advice of a neurosurgeon (the Adviser) on Ms C's complaint that there was an unreasonable delay in the Board providing her with treatment.

*Relevant Guidance*

17. The Adviser referred to the following guidance in providing advice on Ms C's complaint:

- Managed Service Network for Neurosurgery (Scotland) Adult Cauda Equina Syndrome Pathway.
- Society of British Neurological Surgeons (SBNS), Standards of Care for Established and Suspected Cauda Equina Syndrome (2009).
- Society of British Neurological Surgeons (SBNS) and British Association of Spine Surgeons (BASS) guidance on Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome (2016).

18. The Adviser summarised that if there is clinical suspicion of cauda equina syndrome then a patient should be treated in accordance with the SBNS and BASS guidance (2016), which states that:

> 'A patient presenting with acute (de-novo or as an exacerbation of pre-existing symptoms) back pain and/or leg pain, with a suggestion of a disturbance of their bladder or bowel function and/or saddle sensory disturbance, should be suspected of having a cauda equina syndrome. Most of these patients will not have critical compression of the cauda equina. However, in the absence of reliably predictive symptoms and signs, there should be a low threshold for investigation with an EMERGENCY scan. The reasons for not requesting a scan should be clearly documented.'

'The appropriate investigation of these patients is an MRI scan except where specifically contraindicated. The investigation should be undertaken as an emergency. It is very difficult to justify waiting until the end of an elective MRI list. The spinal societies (BASS and SBNS) strongly recommend that MRI scanning should be undertaken urgently at the hospital receiving the patient in order to ensure timely diagnosis and, when appropriate, immediate referral and transfer to a spinal unit.'

'[where] cauda equina compression is confirmed [this] should precipitate an urgent referral to the appropriate surgical service.'

'Nothing is to be gained by delaying surgery and potentially much to be lost. Decompressive surgery should be undertaken at the earliest opportunity, taking into consideration the duration of pre-existing symptoms and the potential for increased morbidity whilst operating in the small hours. We recommend reasons for any delay in surgery be documented.'

19. The Cauda Equina Syndrome Pathway states that:
'All acute hospitals should have arrangements in place for urgent imaging of patient with suspected Cauda Equina syndrome. The hospital where the patient presents should carry out the scan prior to referral.'

*Clinical Advice*

20. The Adviser said that the examination for saddle sensory disturbance (reduced sensation in the saddle (perineal) area) should include a test for sensation using a small pin around the vagina and anal region, and anal sphincter tone and contraction. The Adviser said that where cauda equina syndrome is suspected following examination, an urgent MRI should then be performed, not left to the next day, or even the end of the imaging list that day. The Adviser noted that where cauda equina compression is demonstrated on the MRI scan, and is compatible with the patient's clinical history and the clinical findings, then emergency surgery should be performed.

21. The Adviser noted that the Board did not hold a record of the assessment carried out by the Registrar on 14 January 2017, and they were unable to establish what information the Registrar passed onto the Neurosurgeon as they found the record of their conversation was brief. The Adviser said that the Neurology assessment was insufficient, or at least recorded insufficiently,

because no record of perineal sensory function was documented. The Adviser said that this information was crucial in light of the out-of-hours GP's earlier assessment which documented 'vaginal and perineal tingling'. The Adviser considered that the absence of the record of the Registrar's assessment was an unreasonable failing.

22. As part of their investigation of the complaint, the Board had obtained staff statements. Based on these statements, the Adviser said they were able to infer that the Registrar informed the Neurosurgeon of leg pain and numbness. However, the Adviser was unable to determine whether the Registrar informed the Neurosurgeon of Ms C's perineal sensory loss, as this was not documented.

23. In any event, the Adviser said they would expect the Neurosurgeon to have asked the Registrar whether Ms C's perineal sensation was intact before a decision was made about whether an emergency MRI scan was necessary, or whether it could be left to Monday 16 January 2017. To the extent that it was evident that the out-of-hours GP's referral to the Department was to rule out suspected cauda equina syndrome, the Adviser considered it likely that the Registrar would have conveyed this information to the Neurosurgeon when discussing the case. The Adviser added that if this information was not initially conveyed by the Registrar then they would expect the Neurosurgeon to have asked for the reason for Ms C's referral, which would have led the Neurosurgeon to derive this information.

24. Staff statements indicated that the Neurosurgeon made the decision that Ms C should return for an MRI on Monday 16 January 2017, and that this was communicated to Ms C by the Registrar. The Adviser considered that it was not reasonable to delay the MRI scan until 16 January 2017, according to guidelines, as detailed above.

25. The Adviser also said that they were unable to find evidence that the Registrar provided Ms C advice about what she should do if her condition worsened. They acknowledged that while it was possible that advice was given but not recorded it would be usual practice to record such information and advice if it was given. They explained that this might consist of confirming that an information sheet has been provided, and sometimes a very brief comment such as 'advice given'.

26. In relation to Ms C's presentation to the Department on Monday 16 January 2017, the Adviser noted that, again, no record of the neurological assessment was made by (different members of) the Neurology team at this time. The Adviser stressed the importance of documenting clinical findings following the examination of a patient. In this case, the Adviser said that there was no clear documentation of Ms C's clinical state, including perineal sensation, despite this being prior to an operation to treat sensory loss.

27. The Board informed my office that the Radiology department had an on-call system in place on Saturday and Sunday mornings for urgent queries. However, the Adviser said that the SBNS's Standards of Care for Established and Suspected Cauda Equina Syndrome (2009) stated that 'Access to a 24 hour MRI scanning service must be available for patients with suspected cauda equina syndrome'.

28. The Adviser concluded that there was an unreasonable delay in the diagnosis and treatment of Ms C. They advised that it would have been reasonable to perform an MRI scan on the evening of 14 January 2017, and, given the subsequent finding of a large disc prolapse, it would then be appropriate for emergency surgery to have been carried out that same night. They said if surgery had been carried out at this time, then it was more likely that Ms C would have maintained better urological and sexual function. However, the Adviser was unable to say that Ms C would have recovered to normal function.

29. The Adviser was satisfied that, following the MRI scan at 15:00 on 16 January 2017, the care and treatment provided to Ms C was appropriate.

**(a) Decision**

30. The basis on which I reach decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question.

31. Ms C complained that there was an unreasonable delay in the Board providing her with treatment. In their investigation of Ms C's complaint, the Board did not identify evidence of an unreasonable delay in providing surgical treatment. The Board have stated that an MRI scan and surgery were both carried out within 48 hours.

32. The advice I have received and accept is that under the guidance in place at the time, Ms C should have had an emergency MRI scan on the evening of Saturday 14 January 2017 for suspected cauda equina syndrome, and then received emergency surgery the same evening. Rather than performing an emergency MRI scan, it was deferred until Monday 16 January 2017. I am clear, from the advice I have received, that this was unreasonable.

33. In addition, the advice I have received is that there was inadequate documentation of assessments carried out in the Department on 14 and 16 January 2017. The Adviser highlighted the importance of documenting clinical findings following examination; particularly in relation to perineal sensation. Yet in this case there was no clear documentation of Ms C's clinical state, including perineal sensation, even prior to an operation to treat sensory loss. Nor is it clear that Ms C was advised what to do if her condition worsened. As a result, I am unable to conclude with any certainty that Ms C was adequately examined on each occasion she attended the hospital.

34. Taking into account that Ms C was, at that time, 20 weeks pregnant, I consider these are significant failings in care.

35. Ms C considered that if her condition had been treated sooner, her chance of making a more complete recovery would have increased. The advice I have received and accept is that if the surgery had been carried out when it should have been, on 14 January 2017, then it is more likely that Ms C would have maintained better urological and sexual function. However, the Adviser was unable to say that Ms C would have recovered to normal function.

36. While I am unable to reach a definitive conclusion about the impact of the delay on Ms C's outcome, I recognise that any reduction to Ms C's likelihood of recovery is a significant one, and I appreciate how difficult this episode has been for her.

37. Based on the information the Board and Mrs C have provided, and the advice I have received and accepted, I uphold this complaint.

38. These are significant failings and the Board should fully and properly reflect on this case to ensure there is appropriate learning and improvement for the future.

39. I am also mindful of the advice I have received that SBNS standards require that 24 hour MRI scanning is available to patients with suspected cauda equina syndrome. Given this is a standard that has been set by a recognised national body, my expectation is that the Board should ensure it now takes this standard into account when assessing the impact of the proposal to extend weekend on call MRI scanning. I have made recommendations to address all the failings identified at the end of this report.

**(b) The Board's response to Ms C's complaint was unreasonable**

*Concerns raised by Ms C*

40. In her complaint to my office, Ms C expressed concern about the complaint response she received from the Board. Ms C noted that the Board had claimed that her surgery was performed within 48 hours, yet she disagreed that this accurately represented the events. Ms C said she understood that the 48 hour target applied to the period from symptom onset to treatment. Ms C said that since it was documented that she had presented to the out-of-hours GP on Saturday 14 January with a one day history of symptoms, and since she received treatment on Monday 16 January, she was, therefore, not treated within 48 hours.

*Relevant guidance*

41. At the time Ms C made her complaint to the Board, the Scottish Government's 'Can I Help You?' Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services was in place.[1] This guidance described a number of timescales for acknowledging and responding to complaints, and detailed the best practice approach for investigating and responding to complaints. Paragraph 3.10.1 of the guidance states that:

> 3.10.1 Complaints handled by full investigation are typically those that are complex or require a certain amount of examination to establish the relevant facts before a response can be provided. At the investigation stage, staff should also be aiming to 'get it right first time'. Their goal is to establish all of the facts relevant to the points raised and provide a full,

[1] In April 2017 a new two stage model Complaints Handling Procedure was introduced for all Health Boards in Scotland. The second stage being a thorough investigation to be carried out within 20 working days.

objective and proportionate response that represents the definitive position.

*Neurosurgery advice*

42. My complaints reviewer sought comments from the Adviser in relation to Ms C's complaint that the Board's response to her complaint was unreasonable.

43. In relation to the point at which the 48 hour timescale starts (ie at point of symptom onset or admission), the Adviser said that the point when the clock starts is debated, as it is different in different studies. The Adviser explained that the 48 hour measurement has been used in the argument as to whether, once continence has been lost (partially or fully) , there is any value in operating as an emergency, as the prognosis may not be improved. The Adviser added that, in that context, 48 hours starts from the moment of first loss of continence, and this is often taken as the time a urinary catheter is passed.

44. The Adviser said that the 48 hour target was not particularly relevant to this case, because Ms C had not become incontinent. The Adviser said that this meant that it was especially important to carry out the operation as an emergency on 14 January 2017, as this could have prevented Ms C from becoming incontinent. The Adviser concluded that the Board's explanation of the timing showed little understanding of the details of what this timescale refers to. The Adviser said that the 48 hour timing was not relevant to this case, and they reiterated their advice that Ms C should have been operated on as an emergency on Saturday 14 January 2017, according to contemporary guidance.

45. It is clear that the Board's complaint response had been based upon the comments received from the staff involved, and the Adviser considered that these comments could have been given greater scrutiny.

**(b) Decision**

46. In this case, it is evident that the Board satisfactorily acknowledged Ms C's complaint in writing within the appropriate timescale. It is also apparent that a report of the Board's investigation (a complaint response) was issued to Ms C within 20 working days of the Board's receipt of her complaint. The evidence provided further indicates that the investigating officer appropriately sought comments on the complaint from staff involved.

47. In response to Ms C's complaint, the Board said that an MRI scan and surgery were performed within 48 hours. The Board did not specify from which point this timescale started, or how the timescale was relevant in Ms C's case. The Adviser said that the 48 hour timescale was not relevant to this case, and they considered that the Board's explanation of the timing showed little understanding of the details of what this timescale referred to.

48. Given a central point of Ms C's complaint related to the 48 hour timescale for operating, I consider the Board should have given this point more careful and detailed consideration, including making reference to relevant guidelines. Had the Board done so, this would have provided a fuller response that properly assessed whether the Board had acted in line with recognised standards and guidance. To the extent that it appears the Board took neither of these steps, I consider that they failed to establish all of the facts relevant to the points Ms C raised. For this reason, I consider that the Board's response was unreasonable, and I uphold this complaint.

49. The Board have accepted the recommendations and will act on them accordingly. 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.

**Recommendations**

**Learning from complaints**

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Ms C:

| Complaint number | What we found | What the organisation should do | Evidence SPSO needs to check that this has happened and the deadline |
| --- | --- | --- | --- |
| (a) and (b) | There was an unreasonable delay in performing an MRI scan and carrying out surgical treatment on Ms C.<br><br>There was a failure to adequately document Ms C's medical assessments on 14 and 16 June 2017.<br><br>The Board's response to Ms C's complaint failed to establish all of the facts relevant to the points Ms C raised and was unreasonable | Apologise to Ms C for the unreasonable delay in providing her with treatment and the impact this has had upon her, the failure to adequately document medical assessments and for failing to respond to her complaint reasonably<br><br>The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance | A copy or record of the apology.<br><br>By: 20 June 2018 |

We are asking The Board to improve the way they do things:

| Complaint number | What we found | What should change | Evidence SPSO needs to check that this has happened and deadline |
|---|---|---|---|
| (a) | There was an unreasonable delay in performing an MRI scan and carrying out surgical treatment on Ms C | Neurology, Neurosurgery, Neuroradiology staff should be aware of current pathways and guidelines for the management of patients with cauda equina syndrome<br><br>Patients with suspected cauda equina syndrome should receive an emergency MRI scan | Evidence that the cauda equina pathway and guidance in place has been shared with staff who assess and investigate emergency neurosurgery admissions<br><br>Evidence that the Board, when assessing the proposal to increase access to weekend MRI scanning, have taken into account the recognised standards in place for access to emergency MRI. The Board should provide me with reasons for their decision to take action (or not do so) in relation to this matter<br><br>By: 15 August 2018 |

| Complaint number | What we found | What should change | Evidence SPSO needs to check that this has happened and deadline |
|---|---|---|---|
| (a) | There was no documentation of the neurological assessments carried out on 14 and 16 January 2017, nor the discussion between the Registrar and the Neurosurgeon | Assessments of patients, referral conversations and conclusions should be fully documented in their medical records | Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in Ms C's care and that they have reflected on the Adviser's comments. (For instance, a copy of a meeting note or summary of a discussion)<br><br>By: 20 June 2018 |
| (b) | The Board failed to establish all of the facts relevant to the points Ms C raised and it was not apparent that relevant standards and guidance were considered | In line with the NHS Scotland Complaints Handling Procedure, complaints investigation should establish all the facts relevant to the points made in the complaint and give the person making the complaint a full, objective and proportionate response that represents the Board's final position | Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating and handling Ms C's complaint. (For instance, a copy of a meeting note or summary of a discussion)<br><br>By: 20 June 2018 |

**Feedback**

*Response to SPSO investigation*

The Board should ensure that all relevant evidence is provided to my office when this is first requested. In this case, the Board's failure to do this contributed to delays in the investigation.

*Points to note*

In view of the record-keeping and complaints handling issues identified, the Board should consider sharing this report more widely with staff in other services to highlight the importance of these matters.

**Terms used in the report** **Annex 1**

| | |
|---|---|
| BASS | British Association of Spine Surgeons |
| cauda equina syndrome | rare and serious neurological condition that affects the bundle of nerves (cauda equina) at the base of the spine |
| magnetic resonance imaging (MRI) | a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body |
| Ms C | the complainant |
| saddle sensory disturbance | reduced sensation in the saddle (perineal) area. |
| BNS | Society of British Neurological Surgeons |
| the Adviser | a consultant neurosurgeon |
| the Board | Grampian NHS Board |
| the Department | the Neurology Department |
| the Hospital | Aberdeen Royal Infirmary |
| the Neurosurgeon | an on-call consultant neurosurgeon |
| the Registrar | a neurology registrar |
| urinary catheter | a thin tube used to drain and collect urine from the bladder |

## List of legislation and policies considered — Annex 2

The Managed Service Network (MSN) for Neurosurgery Adult Cauda Equina Syndrome Pathway

Society of British Neurological Surgeons, Standards of Care for Established and Suspected Cauda Equina Syndrome (October 2009)

Society of British Neurological Surgeons and British Association of Spine Surgeons, Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome (January 2016)