SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201807854, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

Mr C complained about the follow-up care and treatment Greater Glasgow and Clyde NHS Board (the Board) provided to Mr A after he suffered a subarachnoid haemorrhage (a type of stroke caused by bleeding on the surface of the brain) which occurred when an aneurysm (a bulge in a blood vessel in the brain) ruptured.

Mr A underwent an endovascular coiling procedure (a procedure to block blood flow into an aneurysm) at Queen Elizabeth University Hospital (the Hospital) in August 2016. During his admission, he developed a perforated bowel and had colostomy surgery (a surgical procedure to divert one end of the colon (part of the bowel) through an opening in the tummy. The opening is called a stoma). He was discharged the following month.

In February 2017, Mr A attended the Hospital for a follow-up Magnetic Resonance (MR) angiogram scan (a test that provides images of the blood vessels). This showed a recurrence of the aneurysm. A further examination in the form of a Digital Subtraction Angiogram (a procedure which provides an image of blood vessels) was recommended, which was requested in July 2017.

In September 2017, the Digital Subtraction Angiogram was carried out and Mr A's case was discussed at the neurovascular Multi-Disciplinary Team (MDT) meeting. The meeting proposed that Mr A have further endovascular treatment.

In November 2017, Mr A attended an out-patient appointment with a consultant neuroradiologist (a radiologist who specializes in the use of radioactive substances, x-rays and scanning devices for the diagnosis and treatment of diseases of the nervous system) where it was recommended that the reversal of the colostomy be undertaken prior to the endovascular treatment. The colostomy reversal was to be carried out at Mr A's local hospital, which is the responsibility of a different health board.

The Board wrote to the consultant general surgeon at Mr A's local hospital in December 2017 advising that it was considered it would be better to perform the

colostomy reversal before the endovascular treatment. However, Mr A died the same month having suffered a further brain aneurysm.

Mr C complained that there were unreasonable delays, poor decision-making and poor communication by the Board, which he considered resulted in Mr A's death. In making the complaint, Mr C was representing his family (including Mrs B, Mr A's sister).

We took independent advice from a consultant neurosurgeon (a surgeon who specialised in surgery on the nervous system, especially the brain and spinal cord).

We found that when Mr A suffered a subarachnoid haemorrhage in August 2016, the care and treatment he received during his admission to the Hospital was timely and expedient and his overall management was reasonable.

A significant recurrence of the aneurysm was identified following the MR angiogram scan in February 2017 and a follow-up Digital Subtraction Angiogram was recommended. Despite this, no action appeared to have been taken for five months, until requested in July 2017. There was then a further two month delay until the Digital Subtraction Angiogram was carried out in September 2017. By this time the aneurysm had grown in size. We found that these delays were significant and unreasonable.

We also found that there was a lack of communication with Mr A subsequent to the identification of the presence of the recurrence of the aneurysm and the need for prompt further management to make him aware of this. However, communication subsequent to the Digital Subtraction Angiogram in September 2017 appeared overall to have been reasonable although the Board acknowledged that communication in relation to a letter which Mr A received about the colostomy reversal could have been better.

Mr A did not have a consultant review for a further two months until November 2017. We found that there were then further unreasonable and significant delays and poor communication in following up the need for the colostomy reversal prior to treating the aneurysm. This was further exacerbated by the fact that the general surgical team were in a different hospital. Relying solely on written communication between clinicians about this was inappropriate and insufficient in this case, which was urgent.

Whilst it is not possible to say whether earlier treatment would have led to a different outcome for Mr A and there was risks attached to surgery, we found that treating Mr A at the earliest opportunity would have minimised this possibility.

Mr C also complained about the Board's handling of their complaint, which was made to the Board by Mrs B.

We noted that the Board held a Morbidity and Mortality meeting in February 2018 to review Mr A's case which was attended by a number of consultants including Mr A's doctors. This outlined a number of contributory factors leading to Mr A's poor outcome, the reasons why, and the action to be initiated to help mitigate future occurrence and as future learning points.

However, despite this, at no point during the Board's correspondence with Mrs B or our office was any reference made to the Morbidity and Mortality meeting and its findings. While the Board acknowledged that there had been process failures in their second response to Mrs B, more could have and should have been done to identify and act transparently on the failings the Morbidity and Mortality meeting identified. It was not clear from the Board's responses to Mrs B and to our office whether all of the actions identified had been completed.

Our investigation identified significant failings and, accordingly, we upheld both of Mr C's complaints.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C and his family:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board failed to provide Mr A with a reasonable standard of care and treatment There was failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was failings in communication between staff involved in Mr A's care and treatment There were failings in the Board's handling of the complaint	Apologise to Mr C, Mrs B and Mr A's family for: • the failings in care and treatment and communication identified in the report; and • the failings in complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology By: 18 December 2020

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	There were unreasonable delays in Mr A's care and treatment after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication between staff involved in Mr A's care and treatment	There should be in place a streamlined and efficient system for highlighting reports of an aneurysm and acting upon its findings Communication with patients and/or their families should be proactive and timely, especially in relation to a serious diagnosis Communication between staff should be appropriate and timely especially where a patient has had a serious diagnosis and requires treatment	Evidence that the Board have reflected on the failings identified in Mr A's case and reviewed their processes and guidance for highlighting reports of an aneurysm Details of the review and any changes, including how any changes will be shared with relevant staff, to be provided to this office Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions) By: 18 February 2020

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	What we need to see
(a)	There were unreasonable delays in Mr A's care and treatment after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication between staff involved in Mr A's care and treatment	The Board convened a Morbidity and Mortality Meeting in February 2018 in which they recommended action points Action included: • a more robust system for MDT referral; • improved team working and communication between the neurosurgery and neuroradiology departments; • better safety netting to ensure that a patient diagnosed with a recurrent aneurysm is tracked for	Confirmation of the action the Board say they have taken (evidence of guidelines circulated and training sessions attended, such as emails; memos minutes) By: 18 February 2020

Complaint number	What we found	What the organisation say they have done	What we need to see
		urgent review; • at least one vascular neurosurgeon is present at a Morbidity and Mortality meeting; and • standard operating procedure for Digital Subtraction Angiogram views for coil embolisation	

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 about the follow-up care and treatment Greater Glasgow and Clyde NHS Board (the Board) provided to Mr A after he suffered a subarachnoid haemorrhage (a type of stroke caused by bleeding on the surface of the brain) which occurred when an aneurysm (a bulge in a blood vessel in the brain) ruptured. In making the complaint, Mr C was representing his family (including Mrs B, Mr A's sister). In particular, Mr C complained that there were unreasonable delays, poor decision-making and poor communication by the Board, which he considered resulted in Mr A's death.

2. Mr C also complained about the Board's handling of the complaint made by Mrs B on behalf of Mr A's family.

3. The complaints from Mr C I have investigated are that:

(a) The Board failed to provide Mr A with reasonable care and treatment (*upheld*); and

(b) The Board's handling of Mrs B's complaint was unreasonable (*upheld*).

4. This report is likely to be distressing for Mr C and his family to read. I acknowledge the very difficult time they have experienced and they have my, and my complaints reviewer's, sincere sympathy.

Investigation

5. With my complaints reviewer, I have considered carefully all the information provided by Mr C and the Board. This included Mr A's relevant medical records and the Board's complaint file. We also obtained independent professional advice from a consultant neurosurgeon (the Adviser). In considering the case, the Adviser had sight of Mr A's relevant medical records and the Board's complaint file.

6. I appreciate that at this time, the whole of the NHS is under considerable pressure due to the impact of COVID-19, and that the Board has experienced a high number of positively diagnosed cases. Like others, I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) is making. However, much as I recognise this, I also recognise that patient safety, personal redress, and learning from complaints are as relevant as ever and it is important that we do not miss opportunities to learn for the future.

7. I recognise that the events under consideration happened some time ago, nevertheless, in this case, I have decided to issue a public report on Mr C's

complaint. This reflects my concern about the serious failings identified in Mr A's care and treatment; the significant personal injustice to Mr A's family and the potential for wider learning from the complaint.

8. 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. My complaints reviewer has reviewed all of the information provided during the course of the investigation. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

9. This section contains a summarised chronology of Mr A's care and treatment, which is the subject of Mr C's complaint.

10. On 4 August 2016, Mr A suffered a subarachnoid haemorrhage. Mr A was initially admitted to his local hospital and then transferred to the Queen Elizabeth University Hospital (the Hospital) the same day. On 5 August 2016, Mr A underwent an endovascular coiling procedure.

11. On 25 August 2016, Mr A developed a perforated bowel and had colostomy surgery.

12. On 9 September 2016, Mr A was discharged from the Hospital.

13. On 14 February 2017, Mr A attended the Hospital for a follow-up Magnetic Resonance (MR) Angiogram scan. This showed a recurrence of the aneurysm. A further examination in the form of a Digital Subtraction Angiogram was recommended.

14. On 10 July 2017, the Digital Subtraction Angiogram was requested.

15. On 7 September 2017, the Digital Subtraction Angiogram was carried out.

16. On 20 September 2017, Mr A attended an out-patient appointment where he was reviewed by a consultant neurosurgeon (Doctor 1).

17. On 21 September 2017, Mr A's case was discussed at the Neurovascular Multi-Disciplinary Team (MDT) meeting. The meeting proposed that Mr A have further endovascular treatment.

18. On 16 November 2017, Mr A attended an out-patient appointment with a consultant neuroradiologist (Doctor 2) where it was recommended that the reversal of the colostomy be undertaken prior to the endovascular treatment. The colostomy

reversal was to be carried out at Mr A's local hospital, which is the responsibility of a different health board.

19. On 5 December 2017, Doctor 1 wrote to the consultant general surgeon at Mr A's local hospital (Doctor 3) advising that it was considered it would be better to perform the colostomy reversal before the endovascular treatment.

20. On 31 December 2017, Mr A died having suffered a further brain aneurysm.

(a) The Board failed to provide Mr A with reasonable care and treatment

Concerns raised by Mr C

21. Mr C said that there were unreasonable delays, poor decision-making and poor communication by hospital staff which resulted in Mr A's death.

22. He said that Mr A died in December 2017 following a brain aneurysm, despite being advised in February 2017 that it required attention following the insertion of a coil. Mr C said the coil was leaking and above the tolerance level deemed safe. He noted the Board had commented the standard timescale was two months for an endovascular procedure. He said a full year passed with Mr A having neither the necessary endovascular treatment nor the colostomy reversed.

23. Mr C considered that there had been failures in decision-making on how best to proceed with Mr A, in particular, whether the concerns about the recurrence of the aneurysm or the colostomy reversal should be addressed first.

24. Mr C considered that there was a lack of communication and ownership of Mr A's wellbeing, which meant no procedures were scheduled. He considered a simple telephone call, meeting, or better coordination would have avoided this.

25. Mr C said that Mr A's death had devastated their family and they were looking for answers about Mr A's care and treatment.

26. Mr C also complained about how the Board dealt with the family's complaint, which was made to the Board by Mrs B. I have addressed this in detail at complaint (b).

The Board's response

27. I have set out below the main points of the Board's response.

The Board's initial response to Mrs B

28. The Board said that they were sorry that Mr A had a lengthy wait between the time when the MR Angiogram was carried out in February 2017 until he was advised of the results. They said it was standard practice that patients were not given a time frame of when they would receive their scan results.

29. They were sorry that Mr A's follow-up appointment was not arranged until September 2017. However, there was no expression of urgency in his results or in any documentation that suggested the appointment should be arranged sooner and the subsequent management of Mr A's aneurysm supported this.

30. Doctor 2, whom Mr A saw in November 2017, would have required Mr A's colostomy to be reversed first unless Doctor 3, who was to carry out the colostomy reversal, was happy to carry out the surgery whilst Mr A was on dual antiplatelets. Doctor 2 was waiting to hear from Doctor 1 about how Doctor 3 wished to proceed. The Board said that Doctor 1 wrote to Doctor 3 on 5 December 2017. The Board also said that it had not been Mr A's responsibility to contact Doctor 3 about this and they were sorry if Mr A perceived this to be the case.

31. They said they were genuinely sorry that Mr A's family did not feel that he received a high standard of care from the Board.

The Board's follow-up response to Mrs B

32. The Board said that based on the scans performed in February 2017, it was Doctor 1's initial priority that the aneurysm be investigated. The MR Angiogram performed on 14 February and reported on 17 February 2017 recommended a Digital Subtraction Angiogram should be performed. This was not indicated as urgent. It was requested on 10 July 2017, which led to the out-patient appointment that Mr A attended on 7 September 2017.

33. Staff considered the colostomy reversal needed to be performed first due to the risks to Mr A of antiplatelet therapy, which would be required following the endovascular treatment. They were of the view that had the endovascular treatment been performed first, there would have been a significant increase in risk for Mr A during the colostomy reversal such as bleeding or a stroke.

34. The decisions were made based on clinical information, perceived risks and diagnostic information.

35. The Board acknowledged that treatment ideally should have been carried out within two months from the identification of the aneurysm.

36. The Board also acknowledged that correspondence was not delivered in the most effective manner, and said they were currently reviewing their MDT processes.

37. The Board further acknowledged there were delays in processes being in place, leading to a delay in identifying the preferred treatment option. They apologised for this. They could not say if the outcome for Mr A would have been different if treatment had been undertaken earlier.

38. The Board concluded by saying that in relation to clinical decision-making, they said each decision was taken appropriately in light of the information available and taking into consideration Mr A's presenting conditions and the risks they represented.

Medical advice

39. The Adviser said that the transfer of Mr A from the local hospital with a subarachnoid haemorrhage to the Hospital on 4 August 2016 was timely and expedient.

40. The Adviser explained that on 5 August 2016, Mr A underwent coil embolisation of an anterior communicating aneurysm (a brain aneurysm), which was the source of his subarachnoid haemorrhage. In the Adviser's view, this again was carried out in a timely and expedient fashion. The Adviser said that from their review of the medical records, the coil embolisation procedure appeared to have been uneventful and it was noted that the interventional radiologist (a medical doctor who performs minimally-invasive procedures using medical imaging guidance) felt that the aneurysm was 'completely obliterated'.

41. The Adviser noted that on 25 August 2016, Mr A suffered a perforated bowel and underwent an emergency laparotomy bowel resection (a surgical procedure for removal of part of the bowel) and creation of a stoma (an opening on the abdomen). In the Adviser's view, this proceeded expediently and uneventfully.

42. The Adviser noted that on 14 February 2017, Mr A underwent an MR Angiogram, which the Adviser said was a routine follow-up scan. This was reported on 17 February 2017. The Adviser said the report noted that Mr A had a significant, 9 x 6mm, recurrence of the aneurysm. A further examination in the form of a Digital Subtraction Angiogram was suggested. However, the Digital Subtraction Angiogram was not requested by the neurosurgical team until 10 July 2017 and did not take place until 7 September 2017. This reported the aneurysm was now measuring 13 x 7.5mm and suggested that Mr A's case be discussed at the 'next possible MDT'. The Adviser noted the outcome of the MDT discussion, which took place on 21 September 2017, recommended that Mr A have further endovascular treatment.

43. The Adviser said that there was clear evidence that Mr A had suffered a significant and early recurrence of an aneurysm in February 2017. The Adviser explained that there are no published guidelines on timescales but that standard practice in a situation like this was to treat the patient at the earliest possible opportunity. The Adviser commented that although the Board's complaint response referred to a two month time scale for treating an aneurysm, they were not aware of any such evidence or guidelines. In the Adviser's view, there was an unreasonable delay in acting upon this. Once the aneurysm had been identified there was a five month delay before the Digital Subtraction Angiogram was requested and a subsequent further two months delay before the Digital Subtraction Angiogram was carried out. In the Adviser's view, the Board should have a more streamlined and efficient system for highlighting such reports and acting upon their findings.

44. The Adviser considered that once the decision for further endovascular treatment had been reached at the MDT meeting on 21 September 2017, it would have been optimal for the decision regarding what should take priority, the endovascular treatment or the colostomy reversal, to have been taken at the same time. However, the Adviser said that the MDT may not have been aware of the existence of Mr A's colostomy at that point, as there did not appear to be evidence from the medical records that any such discussion about this took place.

45. The Adviser noted that Doctor 2 discussed the recommendation of the MDT, for further endovascular treatment, with Mr A at an out-patient clinic on 16 November 2017. The Adviser said that it was clear that once Doctor 2 realised the existence of Mr A's colostomy on 16 November 2017, a decision had to be reached about which procedure was to be carried out first. The outcome being that Doctor 2 recommended Mr A undergo reversal of the colostomy prior to proceeding with the endovascular treatment.

46. The Adviser considered the decision-making surrounding the proposed treatment of Mr A was reasonable and did not disagree with the decision that the reversal of the colostomy should occur first. However, the Adviser said that once this decision had been made, efforts should have been concentrated on achieving this as expediently as possible so as to allow the endovascular treatment to be completed as early as possible thereafter. Yet, the Adviser noted, there was a further three week delay between Doctor 2 making this recommendation to Doctor 1 and Doctor 1 then writing to Doctor 3 with this advice on 5 December 2017. The Adviser noted that no further action or correspondence took place subsequent to this. In the Adviser's view, this further delay was significant and unreasonable.

47. The Adviser noted that before any treatment could be carried out Mr A, sadly, had died on 31 December 2017 from further aneurysm rupture.

48. The Adviser also commented on communication with Mr A.

49. The Adviser considered that there was a lack of communication with Mr A subsequent to the follow-up MR Angiogram being arranged. The Adviser said there was no suggestion of the Board informing Mr A at that time of the presence of a significant and early recurrence of the aneurysm and the need for prompt further management.

50. The Adviser considered that communication subsequent to the Digital Subtraction Angiogram on 7 September 2017 appeared to have been reasonable. However, the Adviser noted that Mr A's family felt that the responsibility for contacting Doctor 3 about the colostomy reversal was left to Mr A. While the Adviser is of the view that the letter that Doctor 2 wrote to Mr A does not suggest this, they noted that the Board in their complaint response had acknowledged that communication in this regard could have been better.

51. The Adviser also considered how the Board's staff communicated with each other about Mr A's care and treatment and with Doctor 3 who was to carry out the colostomy reversal. The Adviser noted that over a three week period Doctor 2 wrote to Doctor 1 who then wrote to Doctor 3. In the Adviser's view, this method of communication was inappropriate and relying solely on written communication was insufficient for such an urgent case and had led to significant delay. This had further been exacerbated by the fact that Doctor 3 and the general surgical team was based in a different hospital.

52. In the Adviser's view, it is not possible to say whether earlier treatment would have led to a different outcome for Mr A as he could have succumbed to an aneurysm recurrence at any time. The Adviser explained that intervention itself carries significant morbidity, and even mortality, and therefore complications of the endovascular procedure itself could have resulted in a poor outcome for Mr A. Nevertheless, given the size and early nature of the aneurysm recurrence, it was reasonable to recommend that Mr A be treated as early as possible to avoid the risk of such an outcome and minimise the possibilities of aneurysm rupture.

(a) Decision

53. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigations look at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time. I do not apply hindsight when determining a complaint.

54. The advice I have received and I accept from the Adviser is that:

- When Mr A suffered a subarachnoid haemorrhage on 4 August 2016, the care and treatment he received during his admission to the Hospital was timely and expedient and his overall management was reasonable.

- A significant recurrence of the aneurysm was identified following an MR Angiogram in February 2017 and a follow-up Digital Subtraction Angiogram was recommended. Despite this, no action appears to have been taken for five months, until requested in July 2017. There was then a further two month delay until the Digital Subtraction Angiogram was carried out in September 2017. By this time the aneurysm had grown in size. These delays were significant and unreasonable.

- There was a lack of communication with Mr A subsequent to the identification of the presence of the recurrence of the aneurysm and the need for prompt further management to make him aware of this.

- Communication subsequent to the Digital Subtraction Angiogram on 7 September 2017 appeared to have been reasonable. While the letter which Doctor 2 wrote to Mr A does not suggest that responsibility for contacting Doctor 3 about the colostomy reversal was left to him, the Board have acknowledged that communication in this regard could have been better.

- Although an MDT meeting took place in September 2017, where the decision that Mr A needed further endovascular treatment was made, it would have been beneficial for the decision regarding which treatment should take priority, the endovascular treatment or the colostomy reversal, to have also been taken at this time. However, there is no evidence that the MDT were aware of the existence of Mr A's colostomy or of any such discussion taking place.

- Mr A did not have a consultant review, with Doctor 2, for a further two months until November 2017. There were then further unreasonable and significant delays and poor communication in following up the need for the colostomy reversal prior to treating the aneurysm. This was further exacerbated by the fact that Doctor 3 and the general surgical team were in a different hospital. Relying solely on written communication was inappropriate and insufficient in this case, which was urgent.

- During this period the aneurysm ruptured and, sadly, Mr A died. Whilst it is not possible to say whether earlier treatment would have led to a different outcome for Mr A and there was risks attached to surgery, treating him at the earliest opportunity would have minimised this possibility.

- I acknowledge that the Board in their complaint response to Mrs B accepted there were delays in Mr A's treatment and that ideally Mr A's treatment should have been within two months from the point the recurrence of the aneurysm was identified. However notwithstanding this, the Adviser has said that the standard practice is that treatment in a case such as Mr A's should take place at the earliest opportunity.

55. I note that a Morbidity and Mortality meeting was held in February 2018 to review Mr A's case which was attended by a number of consultants including Mr A's doctors. This outlined a number of contributory factors leading to Mr A's 'poor outcome', the reasons why, and the action to be initiated to help mitigate future occurrence and as future learning points. Action included a more robust system for MDT referral, improved team working and communication between the neurosurgery and neuroradiology departments, better safety netting to ensure that a patient diagnosed with a recurrent aneurysm is tracked for urgent review, at least one vascular neurosurgeon attends a Morbidity and Mortality meeting and standard operating procedure for Digital Subtraction Angiogram views for coil embolisation.

56. Despite identifying these actions, at no point during the Board's correspondence with Mrs B or my office was any reference made to this meeting and its findings. It is also not clear from the Board's responses to Mrs B and to my office whether all of these actions have been completed.

Conclusion

57. My investigation has identified significant failings as set out above. I am deeply troubled that the Board, in their first response to Mrs B, did not identify these failings for themselves, and that there had been a lack of urgency with Mr A's case (I consider complaint handling in more detail under complaint (b) below). This is despite the fact that by the time of the Board's responses to Mrs B, a Morbidity and Mortality meeting had been held which identified failings in care.

58. While the Board acknowledged there had been process failures in their second response to Mrs B, more could have and should have been done to identify and act transparently on the failings the Board's Morbidity and Mortality meeting identified. Given the significance for future patient care I would have expected, at the very least, to see evidence of an urgent action plan being fully implemented at that time. Not to have done so, is in my view a further serious failure in care.

59. Taking account of the advice I have received and in view of the failings identified, I uphold this complaint. My recommendations for action are set out below.

(b) The Board's handling of Mrs B's complaint was unreasonable

Mr C's concerns

60. Mr C said that he and his family were dissatisfied about how the Board investigated and responded to their complaint, which was made to the Board by Mrs B. Mr C considered the Board's investigation of and response to the complaint was inadequate.

Background

61. On 12 February 2018, Mrs B complained to the Board via email setting out her and her family's concerns about Mr A's care and treatment.

62. The Board acknowledged Mrs B's complaint by email the same day, 12 February 2018, and stated that they would be in contact in the next few days and asked for a contact telephone number. They enclosed a copy of the Board's complaint leaflet.

63. The Board acknowledged Mrs B's complaint dated 15 February 2018 and stated that it was their aim to respond within 20 working days. They enclosed a copy of the Board's complaint procedure leaflet.

64. Mrs B acknowledged the Board's reply by email dated 19 February 2018 and confirmed that she wished future responses from the Board to be sent in hard copy to her. This was acknowledged by the Board by email on the same day.

65. On 16 March 2018, the Board wrote to Mrs B informing her that their investigation was not yet complete as they were awaiting further clinical information for which they apologised.

66. On 20 March 2018, Mrs B (having not received the Board's letter of 16 March 2018) emailed the Board referring to their letter of 15 February 2020 and requested an explanation why she had not heard from them. She said she had sent an email as she wanted no further delay in correspondence. However, she would expect the Board's detailed response by hard copy as previously agreed.

67. On 21 March 2018, the Board sent Mrs B by email a copy of their letter of 16 March 2018 which they said had been sent by post. On the same day Mrs B emailed a response saying she had not yet received the Board's letter. Later that evening Mrs B emailed the Board stating she had now received the Board's letter and asked for some indication how long it would take to complete their enquiries.

68. On 22 March 2018, the Board emailed Mrs B stating they were not in a position to provide her with a response time and apologised that they could not be more specific regarding timescales.

69. The Board wrote to Mrs B on 13 April 2018 informing her that they had not completed their investigation. They explained that as their investigation had exceeded more than 40 working days they were required to ask for her agreement to a further extension to complete their investigation. If she was unhappy about this she could take her complaint to my office.

70. Mrs B wrote to the Board on 28 April 2018, having contacted my office in the interim for advice, agreeing to their extension request and asking for an expected date for their response.

71. The Board wrote to Mrs B on 4 May 2018 informing her that their investigation was complete and they aimed to provide her with a response to her complaint within the next ten to fourteen working days. They apologised for the distress caused to her and her family by the delay.

72. On 22 May 2018, a Board complaint manager emailed Mrs B to provide her with an update. They expressed their condolences on the death of Mr A and said they appreciated this had been a difficult time for her and her family and they were sorry for the delay and the length of time it was taking to provide her with a response to her complaint. They said they were still investigating the concerns she had raised in order to provide her with a full response and said they would be happy to discuss this further on the telephone if she provided a contact number.

73. On 24 May 2018, Mrs B replied saying that she was slightly confused as the Board's letter to her dated 4 May 2018 was signed by a different complaints manager who had said their investigation was complete and they aimed to provide her with a response to her complaint within the next ten to fourteen working days. She asked what exactly was happening.

74. On 25 May 2018, the manager who had sent the email dated 22 May 2018 emailed Mrs B. They said they were sorry for the confusion and explained they had recently taken over the complaint due to the absence of the manager who had been dealing with her complaint. They said there were a few points in relation to the investigation that they felt were not fully complete and they should have explained this previously and offered to speak on the telephone with Mrs B if she provided a contact number.

75. On 28 May 2018, the letter setting out the Board's response to the complaint was sent to Mrs B by a Board Director.

76. On 23 June 2018, Mrs B wrote to the Board with comments on the Board's response and said she was surprised at the lack of detail in their response despite asking very specific questions and felt their response to her complaint had lacked a personal touch. Mrs B said that copies of Mr A's medical records that she had requested previously had arrived incomplete with many blank pages and she found it 'abysmal' that the Board had requested payment for providing this. Mrs B requested copies of all relevant correspondence relating to Mr A's care and treatment.

77. On 5 July 2018, the Board responded, informing Mrs B they had referred her letter to their Health Records Manager. They apologised about how Mrs B felt there was a lack of a personal response and offered their sincere condolences to her and her family and again advised her of her right to take her complaint to my office.

78. On 6 July 2018, the Board's Health Records Manager, said in an internal email that they would cancel the invoice issued to Mrs B for the copies of Mr A's medical records and would write to Mrs B to apologise.

79. Mrs B wrote to the Board on 6 August 2018 in which she set out a list of detailed questions about Mr A's care and treatment which she felt remained unanswered and asked for her complaint to be reopened or for the Board to treat her letter as a new complaint.

80. On 25 August 2018, Mrs B emailed the Board seeking a response to her letter of 6 August 2018. She said the distress she and her family were experiencing was being exacerbated by the delays they had encountered due to poor communication.

81. On 28 August 2018, a Board complaints manager (who had not previously been in contact with Mrs B) emailed Mrs B apologising for the delay in responding to her. They explained they had taken over the handling of her complaint and the matters she had raised in her letter of 6 August 2018 were under investigation.

82. On 30 August 2018, Mrs B replied by email asking when she could expect a response.

83. On 3 September 2018, the Board replied that they were awaiting further information from staff and a response would be provided at the earliest opportunity.

84. On 5 October 2018, Mrs B emailed asking for an update on the Board's investigation.

85. On 9 October 2018, the Board emailed Mrs B in response. They apologised that she had not been kept informed and explained their investigation was still ongoing.

86. On 30 October 2018, the Board's Interim Director of Diagnostics, wrote to Mrs B in response to the issues raised by Mrs B in her letter of 6 August 2018. They acknowledged there were delays in Mr A's treatment and learning from their investigation of Mrs B's concerns would be used to inform future practice. They said they were sorry the first response had failed to resolve her complaint. They said if she had any remaining concerns to contact the Board, alternatively she was informed of her option to complain to my office.

87. On 21 November 2018, Mrs B wrote to the Board and thanked them for their response and their acknowledgment that there were delays in the treatment of Mr A and said she intended to pursue further action.

Relevant policies, procedures, legislation

88. In reviewing the case, I have had sight of relevant guidance, including:

a. The Board's Complaints Policy and Procedure (2017).

b. NHS Scotland Model Complaints Handling Procedure (MCHP) (2017)

89. The Complaints Policy and Procedure gives organisations considerable discretion as to how to investigate a complaint, although it notes:

> 'An investigation aims to establish all the facts relevant to the points made in the complaint and to give the person making the complaint a full, objective and proportionate response that represents our final position.'

90. The MCHP sets out complaint handling standards and procedures.

(b) Decision

91. In considering this complaint, my role is not to reconsider the substantive issues of Mrs B's complaint to the Board. These concerns have been addressed in my consideration of complaint (a) above. What I have considered here is how the Board handled Mrs B's complaint. In doing so, I have reviewed the correspondence between Mrs B and the Board and taken into account the requirements of the Board's Complaints Policy and Procedure (2017) and the MCHP.

92. The Board have acknowledged that the complaint response to Mrs B was not issued within the 20 working day period set out in the Board's complaint handling

guidance. I note there was a significant delay in the Board issuing their initial complaint response to Mrs B, a period of three months. However, given the complexity of the complaint, the detailed correspondence, and as it involved a number of issues including asking relevant staff and different departments (diagnostics and neurosurgery) to comment on the complaint and also a change in the member of the Board's staff handling the complaint, I consider the delay in providing a response to the complaint was, on balance, reasonable in the circumstances.

93. Nevertheless, given the additional time taken to investigate I would have expected a full response to the points raised. I consider the Board's response letter was unduly brief and does not fully reflect the detailed comments provided by clinical staff involved in Mr A's care nor the outcome of the Morbidity and Mortality meeting held in February 2018. I understand Mrs B's disappointment and her concerns about the brevity of the letter and the lack of detail which was exacerbated by the length of time that she had waited for a response to her complaint. I also consider that given the circumstances of this case, it would have been appropriate, when responding, to have offered Mrs B a meeting. In my view, an opportunity to respond to the complaint and to give a full and open response to Mrs B was missed. Furthermore, at this stage I consider this was also a missed opportunity to learn from the complaint.

94. Understandably, Mrs B felt the concerns she had about Mr A's care and treatment were still unanswered and that she had no alternative but to ask the Board to look at her complaint again. This resulted in more delay while the Board carried out further investigations and I note that on occasions Mrs B had to chase the Board for an update on what was happening. While the Board eventually acknowledged there were delays in Mr A's treatment, this could, and should, have been addressed in the initial complaint. This clearly added to the distress of Mrs B and her family. I also consider at this stage that a further opportunity was lost to offer Mrs B a meeting with the Board.

95. Accordingly, I have found that the Board's complaint handling investigation was unreasonable. Given this, I uphold this aspect of the complaint.

96. I recognise that the complaint handling in this case was some time ago. I have not recommended action in relation to complaint handling. This is because the Board have implemented improvements over recent months with training, support and input from my office. As a result I am satisfied that wider action, leading to improvement, is being taken.

97. 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 Mr C and his family:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board failed to provide Mr A with a reasonable standard of care and treatment There was failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was failings in communication between staff involved in Mr A's care and treatment There were failings in the Board's handling of the complaint	Apologise to Mr C, Mrs B and Mr A's family for: • the failings in care and treatment and communication identified in the report; and • the failings in complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology By: 18 December 2020

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	There were unreasonable delays in Mr A's care and treatment after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication between staff involved in Mr A's care and treatment	There should be in place a streamlined and efficient system for highlighting reports of an aneurysm and acting upon its findings Communication with patients and/or their families should be proactive and timely, especially in relation to a serious diagnosis Communication between staff should be appropriate and timely especially where a patient has had a serious diagnosis and requires treatment	Evidence that the Board have reflected on the failings identified in Mr A's case and reviewed their processes and guidance for highlighting reports of an aneurysm. Details of the review and any changes, including how any changes will be shared with relevant staff, to be provided this office Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions) By: 18 February 2020

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	What we need to see
(a)	There were unreasonable delays in Mr A's care and treatment after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication with Mr A after he suffered a recurrence of a brain aneurysm There was unreasonable failings in communication between staff involved in Mr A's care and treatment	The Board convened a Morbidity and Mortality Meeting in February 2018 in which they recommended action points. Action included: • a more robust system for MDT referral; • improved team working and communication between the neurosurgery and neuroradiology departments; • better safety netting to ensure that a patient diagnosed with a recurrent aneurysm is tracked for urgent review; • at least one vascular	Confirmation of the action the Board say they have taken (evidence of guidelines circulated and training sessions attended, such as emails; memos minutes) By: 18 February 2020.

Complaint number	What we found	What the organisation say they have done	What we need to see
		neurosurgeon is present at a Morbidity and Mortality meeting; and • standard operating procedure for Digital Subtraction Angiogram views for coil embolisation	

Terms used in the report **Annex 1**

aneurysm	a bulge in a blood vessel in the brain
antiplatelets	a group of medicines that stops blood cells (platelets) from sticking together and forming a blood clot
coil embolisation	a procedure to block blood flow into an aneurysm
colostomy	a surgical procedure to divert one end of the colon (part of the bowel) through an opening in the tummy. The opening is called a stoma
Digital Subtraction Angiogram	a procedure which provides an image of blood vessels
Doctor 1	a consultant neurosurgeon (a surgeon who specialised in surgery on the nervous system, especially the brain and spinal cord)
Doctor 2	a consultant neuroradiologist (a radiologist who specialises in the use of radioactive substances, x-rays and scanning devices for the diagnosis and treatment of diseases of the nervous system)
Doctor 3	a consultant general surgeon
endovascular treatment	a procedure to treat problems affecting the blood vessels, such as an aneurysm
MDT	multi-disciplinary team
Magnetic Resonance (MR) Angiogram	a test that provides images of the blood vessels
Mr A	the aggrieved

Mr C	the complainant and a relative of the family
Mrs B	Mr A's sister
subarachnoid haemorrhage	a type of stroke caused by bleeding on the surface of the brain
the Adviser	a consultant neurosurgeon who provided advice on the complaint
the Board	Greater Glasgow and Clyde NHS Board
the Hospital	Queen Elizabeth University Hospital

List of legislation and policies considered **Annex 2**

Greater Glasgow and Clyde NHS Board, Complaints Policy and Procedure (2017)

NHS Scotland Model Complaints Handling Procedure (MCHP) (2017)