The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201809851, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / Diagnosis

Summary

C complained about the care and treatment provided to their spouse (A). A developed Cauda Equina Syndrome (CES, narrowing of the spinal column where all of the nerves in the lower back suddenly become severely compressed) in September 2018. C believed there were avoidable delays in diagnosing and treating A, which meant the damage A suffered was more severe and the outcome worse than it might have been.

A was originally referred to Royal Alexandra Hospital (Hospital 1) by their General Practitioner (GP). C believed that A was displaying red flag symptoms of CES at this point. A attended Hospital 1 on 20 September 2018, but was discharged without consultant review or imaging of their spine.

A continued to deteriorate and attended Hospital 1 again on 28 September 2018 at 09:00 hrs. A Magnetic Resonance Imaging (MRI) scan (a scan using power magnetic fields to generate images of the inside of the body) was carried out at 15:00 hrs. The neurosurgical team at Queen Elizabeth University Hospital (Hospital 2) were contacted, but they declined to accept A for transfer. A was discharged at around 21:00 hrs. They did not have a treatment plan and had not been reviewed by a consultant.

C took A to Hospital 2's A&E the following day. A was admitted to a neurosurgery ward and reviewed by a junior doctor. On 30 September 2018, A was referred for a further MRI by the Consultant Neurosurgeon. A underwent surgery on 1 October 2018.

A was discharged without any follow-up care being arranged. This was later arranged by their GP. They were admitted a month later as a spinal emergency, and again A was discharged without any follow-up care being arranged.

Relevant to this report was case 201608430[1]; a public report we issued about the Board previously. This investigation looked into a complaint of unreasonable delays in the treatment of CES by the Board. The investigation found that the Board failed to provide spinal surgery in a reasonable timeframe to the complainant. This was despite clear guidance that surgery needed to be performed as an emergency on an incomplete CES. This also included a failure to provide the complainant with adequate information about their condition or make the necessary referrals for postoperative care.

This report was published in January 2018. The case was closed after the Board provided evidence it had complied with our recommendations, which was largely done by April 2018. This is significant, because A's first attendance at hospital was in September 2018, after the Board was meant to have implemented changes to reduce delays for patients with CES.

We took independent advice from a consultant orthopaedic surgeon and a consultant neurosurgeon. Both advisers identified avoidable delays in A's care and treatment. The orthopaedic adviser said that A had been displaying red flag symptoms of CES when they first attended hospital on 20 September 2018. The delays in scanning A were unreasonable and A's treatment had not been in line with national guidance on the management of possible CES cases.

The neurosurgery adviser said that it was unreasonable for the Neurosurgery Department at Hospital 2 to refuse to provide diagnostic advice, or accept A for transfer on 28 September 2018. A should have been admitted as a neurosurgical emergency and undergone decompression surgery on 28 September 2018. It was also unreasonable to have delayed A's surgery further once they were admitted to a neurosurgical ward.

[1] https://www.spso.org.uk/investigation-reports/2018/january/greater-glasgow-and-clyde-nhs-board

We found that there were significant failings by the Board in the care and treatment that was provided to A. These included the failure to recognise that A was displaying red flag symptoms of CES, unreasonable delays and incorrect decisions to discharge A, as well as avoidable delays to performing surgery on A, once the severity of their condition had been grasped.

We also found that the Board had failed to investigate C's complaint appropriately or adequately. The Board did not appear to be aware of Public Report **201608430**, even though it was closely related to the issues raised by C in this case, and the Board had previously confirmed they had taken action to address the failings identified in that report.

We considered that this case raised significant concerns, given the failings in care and the failure by the Board to identify these, despite their lengthy complaint investigation. This took place within months of the Board having provided this office with assurances that they had taken action to improve the identification and treatment of patients with CES symptoms.

We upheld all of C's complaints.

Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for C and A:

Complaint number	What we found	What the organisation should do	What we need to see
a)	A's care for CES was not in line with the appropriate standards	Apologise to C and A for failing to provide care for A in line with the appropriate standards. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021
b)	The Board's actions resulted in an unreasonable delay in admitting and treating A	Apologise to A for the unreasonable delay in admitting and treating them. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

Complaint number	What we found	What the organisation should do	What we need to see
c)	The Board have not explained why A was discharged on 28 September 2018	Apologise to C and A for failing to provide an adequate explanation for the decision to discharge A. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021
d)	The Board failed to refer A to the appropriate specialisms for ongoing care, resulting in further delays to their treatment	Apologise to C and A for failing to refer A to the appropriate specialisms for ongoing care resulting in further delays to their treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

Complaint number	What we found	What the organisation should do	What we need to see
e)	The Board failed to handle C's complaint reasonably	Apologise to C and A for failing to handle their complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

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) , b) and c)	A's incomplete CES was not recognised as a neurosurgical emergency	Relevant staff understand the standard operating procedure, based on the British Association of Spine Surgeons guidelines for the care and management of CES, and provide appropriate treatment in line with it	Evidence of staff knowledge of the standard operating procedure, including guidance for staff and an explanation of how its application will be monitored. By: 19 July 2021

Complaint number	What we found	Outcome needed	What we need to see
a), b) and c)	A's referral from the Orthopaedic Department to the Neurosurgery Department was not fully documented	Document referrals to the Neurosurgery Department accurately and comprehensively by medical staff in the Orthopaedic Department	Evidence the Board are monitoring the documentation of referrals to ensure they are comprehensive and accurate. By: reporting monthly for the next six months
a), b) and c)	Orthopaedic staff were unclear what to do when A's referral to Neurosurgery was refused	Orthopaedic staff should have a clear procedure to follow when a referral is declined by the Neurosurgery Department	Evidence of a clear procedures, including an explanation of how the Orthopaedic and Neurosurgery Department have collaborated in its creation By: 19 August 2021

Complaint number	What we found	Outcome needed	What we need to see
a) and b)	A's surgery was unreasonably delayed	Surgery for CES must be performed within recommended timescales	The Board must evidence they have systems in place to ensure that patients are operated on within reasonable timescales and that these are being monitored on a monthly basis for the next twelve months. By: 19 June 2021
d)	No referrals or after care arrangements were made for A	Discharge should be planned with prompt referral to appropriate services. The Board should ensure that patients have the appropriate referrals made to community based services to support their care on discharge from hospital. This should include the transfer of care plans with the patient, where appropriate, to ensure continuity and consistency of care	Evidence the Board have taken steps to address the difficulties in providing coordinated care for CES patients and that the effectiveness of these measures is monitored on a monthly basis. By: 19 June 2021

We are asking the Board to improve their complaints handling:

Complaint number	What we found	Outcome Needed	What we need to see
e)	The Board's complaint investigation failed to identify that treatment of CES by the Board had been the subject of a public report a matter of months before A's case	To ensure the Board has effective complaint monitoring arrangements in place to identify when a new complaint concerns the same issues or clinical matters (CES in this case) as previous complaints, and that the relevance of outcomes and learning from previous cases are considered, as appropriate, in any new investigation	Evidence the Board have effective complaint handling and monitoring systems in place. By: 19 August 2021
e)	The Board's Morbidity and Mortality meeting was unreasonably delayed and did not involve all relevant staff	Morbidity and Mortality meetings should be held timeously and should involve representatives of all specialisms involved in a patient's care	Evidence that Morbidity and Mortality procedures require the involvement of all relevant specialisms. By: 19 July 2021

Complaint number	What we found	Outcome Needed	What we need to see
e)	The Board failed to properly implement their duty of candour	Appropriate implementation of the duty of candour, in line with General Medical Council guidance	Evidence that the need to apply the duty of candour has been fed back to staff in the Orthopaedic and Neurosurgery teams in a supportive manner. By: 19 June 2021

Evidence of action already taken

Complaint number	What we found	What the organisation should do	What we need to see
a)	The Board said they had already taken steps to ensure that patients with possible CES were not discharged without their case being discussed with an orthopaedic consultant first	Provide evidence that it has been monitoring the effectiveness of these measures	Evidence showing the procedural changes implemented by the Board, as well as the mechanisms in place for monitoring them. By: 19 June 2021

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

Introduction

1. C complained to my office about the standard of care and treatment provided to their spouse (A). A suffered from Cauda Equina Syndrome (CES), which developed in September 2018. Although A had undergone surgery, the CES had left them with severely restricted mobility and unable to work. C believed failings on the part of Greater Glasgow and Clyde NHS Board (the Board) meant surgery for A had been delayed and as a result A had suffered more severe damage and a worse outcome than they needed to. The complaints from C I have investigated are that:

(a) The Board failed to treat A's Cauda Equina Syndrome in line with the appropriate standards; (*upheld)*

(b) The Board's actions resulted in an unreasonable delay in admitting and treating A; *(upheld)*

(c) The Board have not explained why A was discharged on 28 September 2018; *(upheld)*

(d) The Board failed to refer A to the appropriate specialisms for ongoing care, resulting in further delays to their treatment; *(upheld)* and

(e) The Board failed to handle C's complaint reasonably. *(upheld)*

Investigation

2. In order to investigate C's complaint, my complaints reviewer took independent specialist advice on A's orthopaedic and neurosurgical care. In this case, we have decided to issue a public report on C's complaint because of the criticisms of A's care made in the advice received from these specialists. In addition, as set out in paragraphs four and five, the issue of unreasonable delay in treating CES on the part of the Board is one that had been raised in a public report issued by this office shortly before A's presentation for treatment.

3. This report includes the information that is required for me to explain my decision on this case. Please note, I have not included every detail of the information

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

Previous Ombudsman investigation

4. Relevant to this report was Scottish Public Services Ombudsman Public Report **201608430**[2]. This investigation looked into a complaint of unreasonable delays in the treatment of CES by Greater Glasgow and Clyde NHS Board. The investigation found that the Board failed to provide spinal surgery in a reasonable timeframe to the complainant (D). This was despite clear guidance that surgery needed to be performed as an emergency on an incomplete CES. The investigation also found that the standard of medical record-keeping was very poor and that D's discharge and aftercare had not been planned in a coordinated and multi-disciplinary way. This included a failure to provide D with adequate information about their condition or make the necessary referrals for postoperative care.

5. This report was published on 24 January 2018 and made a number of recommendations, as well as providing detailed feedback to the Board for important learning and improvement and to ensure as far as possible similar failings did not occur again. It should be emphasised that this case was only closed by this office after the Board had provided evidence of compliance with the recommendations and assurances they were actively implementing the important learning and improvement the report identified for them. This evidence was largely provided by 24 April 2018.

6. This is significant, as A was referred to the Board in September 2018, after the Board had provided this evidence to my office. It is of significant concern, therefore, that as the events of this report demonstrate, that the Board did not, at the time of the complaint covered by this report, appear to have taken meaningful action to apply learning from the earlier complaint to improve the standard of patient care in this area.

[2] https://www.spso.org.uk/investigation-reports/2018/january/greater-glasgow-and-clyde-nhs-board

Key events

7. As the chronology of A's care is known to all parties involved in the case, I have set out a summary of the key incidents.

8. On 19 September 2018, A was referred urgently to the Orthopaedic Department at the Royal Alexandra Hospital (Hospital 1) by their General Practitioner (GP). A was suffering from right side neuropathic pain, reduced sensation in their right thigh and bowel incontinence. C believes these were red flags for CES and A should have been treated as a neurosurgical emergency.

9. On 20 September 2018, A was telephoned and asked to attend the fracture clinic at Hospital 1. They were reviewed by a junior doctor (Doctor 1), who then discussed the case with an orthopaedic registrar (Doctor 2). It was decided that A should not be admitted, but referred for a Magnetic Resonance Imaging (MRI) scan as an out-patient. The waiting time for a non-urgent MRI at this point was six weeks. A's condition was not discussed with an orthopaedic consultant during this attendance.

10. C was very concerned by A's condition, which continued to deteriorate and on 28 September 2018 A returned to Hospital 1 around 09:00 hrs. A's symptoms included being unable to drive, saddle paraesthesia (numbness and tingling along the inner thighs and lower groin), bilateral leg pain and urinary incontinence. A was examined by a junior doctor (Doctor 3) and referred for an MRI. This was carried out at 15:00 hrs.

11. At 17:00 hrs, attempts were made to contact the Neurosurgery Department at Queen Elizabeth University Hospital (Hospital 2) by the Orthopaedic Department at Hospital 1 to discuss A's diagnosis and possible transfer. A was told at 21:00 hrs that Hospital 2 would not accept them as a neurosurgical emergency and A was discharged to be referred for treatment as an out-patient. They were not provided with significant pain relief and, because they had not been admitted, no discharge letter was provided.

12. By 29 September 2018 A was in severe pain, doubly incontinent, and suffering erectile dysfunction. C said A's pain was such that they were unable to sleep or

remain in one position for any length of time. C took A to Hospital 2's A&E department. A was incontinent of urine on arrival. Whilst at Hospital 2, A was telephoned by the consultant in charge of the Orthopaedic Department at Hospital 1, who expressed concern at A's discharge the previous evening and said the Neurosurgery Department at Hospital 2 had agreed to accept A as a patient.

13. A was transferred to a Neurosurgery ward and was reviewed by a neurosurgical registrar (Doctor 4) at 21:00 hrs. A was told an operation might be performed on 30 September 2018, but the Consultant Neurosurgeon (Doctor 5) would decide the following morning. Doctor 5 referred A for a further MRI on 30 September 2018 and spinal decompression surgery was performed on 1 October 2018.

14. A was discharged without follow-up care being arranged. They were readmitted as a spinal emergency a month later. A did not see Doctor 5 during this admission and was again discharged without follow-up care being arranged. A's follow-up care was arranged by their GP, and A was informed there would be a 20-week wait before an appointment at the pain clinic could be arranged.

Complaints

15. Complaints (a), (b) and (c) are closely related so I have set out the concerns raised by C, the Board's responses to them and to this office, as well as the medical advice I obtained for all three complaints together. The decisions are then set out separately for each complaint.

(a) The Board failed to treat A's Cauda Equina Syndrome in line with the appropriate standards

(b) The Board's actions resulted in an unreasonable delay in admitting and treating A

(c) The Board have not explained why A was discharged on 28 September 2018

Concerns raised by C

16. C believed that A's condition should have been treated as a neurosurgical emergency from 20 September 2018 onwards. They said that the Board had apologised for failing to admit A when they had attended Hospital 1, but they had failed to acknowledge the consequences of this decision, or to investigate fully all the failings C believed had taken place in A's care.

17. C's specific concerns can be summarised as follows:

- The Board failed to treat A's CES in line with recognised national standards, despite A's clear red flag symptoms of CES.
- Multiple opportunities to diagnose and treat A were missed by discharging A twice when they should have been admitted. There were also unnecessary delays in performing surgery once A was admitted.
- The Board had failed to take into account earlier reports from the SPSO relating to CES. C suggested that the Board had not learnt and improved from previous complaints.
- The Board had acknowledged some errors, but had blamed junior members of staff. They had not acknowledged other failings in A's treatment or the responsibility of senior staff for A's care.
- The Board continued to follow the practice of using junior members of medical staff to request and discuss transfers between departments in different hospitals. This meant the referring consultant was not involved and the discussions were not documented.
- There had been no detailed explanation of how the decision to discharge A had been reached following A's attendance at Hospital 1 on 28 September 2018.
- A had not seen an orthopaedic consultant at any point at Hospital 1. They had also been discharged without adequate pain relief.

The Board's response

18. The contents of the Board's complaint responses to C are known to all parties so I will not repeat them in detail. I have summarised the key points of their responses to C:

- A should have been admitted as an in-patient for an MRI on 20 September 2018. This error had been discussed with Doctor 1 and Doctor 2.
- It was unreasonable to have discharged A on 20 September 2018 solely on the grounds that they were still mobilising.
- The Orthopaedic Consultant in charge of the Fracture Clinic at Hospital 1 on 20 September 2018 had not been aware of A's presentation at the clinic, or of the decision to allocate them for MRI scanning as an out-patient.
- On 28 September 2018 the request for an MRI for A had been placed at 14:21. A had been scanned at 15:46 and the report had been issued at 17:31.
- After the MRI had been reviewed, the Neurosurgery Department had been contacted for advice. This would be done by a junior doctor for speed, but senior input from a registrar or consultant was always available.
- The Neurosurgery Department had advised that A's condition had been extant for two weeks, and their view was that transfer for out-of-hours surgery would not have improved the prognosis, whilst carrying an unacceptable level of risk.
- The Orthopaedic Consultant from Hospital 1 had contacted the Neurosurgery Department at Hospital 2 and made arrangements for A's admission on 29 September 2018. They had then telephoned A to tell them about this arrangement. In fact, A had by this time presented at A&E and so the Neurosurgery Department were contacted again to inform them of this.
- A's surgery was delayed in Hospital 2 because of the gradual onset of their symptoms and the findings of the examination on 29 September 2018, which suggested that CES was not the only possible explanation. The Board did not accept the delay affected A's prognosis.

- There was a history of difficult communications around acute referrals for suspected CES. The Board agreed deputising these referrals to junior staff was not best practice, although it was widespread and long established.

19. In response to my enquiries, I would summarise the Board's response as follows:

- They recognised that there had been individual errors in A's care, but did not accept there were systemic problems, or that staff did not recognise the importance of senior involvement in cases of CES.

- An electronic referral process was being trialled, which it was hoped would ensure clear and documented communication between the Emergency Department and the Neurosurgery Department.

- The Board's referral form had compulsory fields which required the referrer to specify their seniority and identify the responsible consultant to encourage appropriate senior input into referrals.

- Contact had first been made with the Neurosurgery Department at Hospital 2 on 28 September 2018. The Neurosurgery Department had felt A might need an MRI and their case should be discussed with members of the referring department.

- At this point the Neurosurgery Department's view was that A had the symptoms of an incomplete CES, of roughly two weeks duration. The Neurosurgery Department had requested that emergency MRI scanning be escalated within Hospital 1 in the first instance as this was their responsibility. The Neurosurgery Department did not provide diagnostic advice.

- Out-of-hours surgery carried risks that were not balanced by the prospect of improvement given the duration of A's symptoms. Transfer was not advised as the Neurosurgery Department were aware A had an existing referral for orthopaedic surgery. Once it became clear that A had been referred for orthopaedic spinal surgery, but this had not been vetted, Doctor 5 had instructed A should be transferred to the Neurosurgery Department.

- The Neurosurgery Department felt the opportunity for early intervention had passed and that although an urgent decompression was required, this should take place at the next available elective timeslot.
- The referring team at Hospital 1 were informed of the decision not to transfer on the evening of 28 September 2018. The Orthopaedic Consultant at Hospital 1 was informed on the morning of 29 September 2018 at the trauma meeting.
- The Board accepted that A should not have been discharged on 28 September 2018, but they felt it was difficult to determine the exact impact this had on them in terms of actual avoidable harm. The Board said this was because of A's existing spinal history which may have had an impact on their condition.

Relevant policies and procedures

20. British Association of Spinal Surgeons (BASS) guidelines on management of Cauda Equina

http://www.spinesurgeons.ac.uk/wp-content/uploads/2019/01/Cauda_Equina_Syndrome_Standards_SBNS_BASS-Dec-2018.pdf

21. Low back pain and sciatica in over 16s: assessment and management

https://www.nice.org.uk/guidance/ng59

Medical advice

22. I sought advice from an orthopaedic consultant (Adviser 1), and a consultant neurosurgeon (Adviser 2). Both confirmed they had the necessary expertise to comment on these cases and that they had no conflict of interest. The advice from each is set out under separate headings

Orthopaedic advice

23. Adviser 1 provided the following comments on A's care and treatment:

- A was displaying red flag symptoms of possible CES on 20 September 2018 when they first attended Hospital 1.

- On 20 September 2018 Doctor 1 had reached a provisional diagnosis of CES and discussed the case with Doctor 2. Doctor 2 had advised that A should be discharged and provided with an MRI scan as an out-patient. This was unreasonable as A should have been scanned as an emergency.

- A patient presenting with back pain and/or sciatic pain with any disturbance of their bladder or bowel function and/or saddle or genital sensory disturbance or bilateral leg pain should be suspected of having threatened or actual CES as per BASS guidance. A was recorded as displaying all of these symptoms on 20 September 2018.

- Moreover the reliability of clinical diagnosis of threatened or actual CES was low and there should have been a low threshold for investigation with an emergency MRI scan.

- When A attended the A&E Department at Hospital 1 on 28 September 2018, they were still presenting with red flag symptoms of CES. The decision to perform an urgent MRI at this point was reasonable.

- On 28 September 2018 the advice provided by the Neurosurgery Department at Hospital 2 was unreasonable. A's MRI showed compression of their spinal column without CES being excluded, and they should have been transferred for surgery as an emergency.

- It was, therefore, entirely unreasonable for A to have been discharged with only pain relief on 28 September 2018.

- A was telephoned by the Orthopaedic Department at Hospital 1 on 29 September 2018 at 16:00 hrs, because they were concerned about the refusal by the Neurosurgery Department at Hospital 2 to accept A for transfer the previous day. This was also unreasonable: if there had been concerns about A's condition, then the Orthopaedic Department should have addressed these prior to A's discharge.

Neurosurgical advice

24. Adviser 2 was asked to consider A's care from 28 September 2018 onwards. I would summarise their comments as follows:

- A's medical records showed the Neurosurgery Department had told the Orthopaedic Department they did not give advice on investigations for CES. The reasoning for this was unclear, as in most Neurosurgical Departments, an on-call registrar should at least advise the referring clinician to obtain an urgent MRI scan if there was clinical suspicion of CES.

- A should have been admitted as a neurosurgical emergency on 28 September 2018, as they had all the features of an unresolved CES. A should have been transferred and undergone spinal decompression surgery on 28 September.

- Hospital 2's statement that A did not have CES red flag symptoms on 28 September 2018 was incorrect. At this point A had most of the red flag symptoms of CES.

- The examination of A on 29 September 2018 was reasonable, as was the explanation that it was preferable to perform the operation in daylight hours.

- However, A was admitted at circa 16:00 and the neurosurgical examination was not carried out until 21:42, thus losing more than five valuable hours when a whole-spine MRI could easily have been performed, with a plan for surgery either that evening (before night time) or first thing the next morning.

- It was reasonable to have requested a whole-spine MRI scan on 29 September 2018, but, in the context of a single contradictory sign from A's examination, this should have been expedited in order to facilitate emergency surgery on the morning of 30 September 2018.

- It was not reasonable to delay surgery until 1 October 2018.

(a) Decision

25. C complained that A's care and treatment from the Orthopaedic Department at Hospital 1 and the Neurosurgery Department at Hospital 2 was not in line with the

relevant guidelines and standards. C believes that A was significantly impacted by the delays in recognising and treating their CES.

26. The advice I received and accepted from Adviser 1 was that A's orthopaedic care was not in line with the relevant BASS standards. A presented to Hospital 1 with red flag symptoms of CES, but these were not acted on and A was inappropriately discharged on 20 September 2018 without an MRI having been carried out.

27. A was then brought back to Hospital 1, on 28 September 2018 with red flag symptoms of CES which were not properly recognised by either the Orthopaedic or Neurosurgery teams. It was a further significant failing on the part of both Hospital 1 and Hospital 2 that A was not transferred as a neurosurgical emergency on 28 September 2018.

28. Adviser 2's neurosurgical advice was also highly critical of the Board. It was incorrect for the Board to state A did not have CES red flags at the time their transfer was refused by the Neurosurgery Department at Hospital 2.

29. When A was admitted to Hospital 2, Adviser 2 was critical of the standard of care they received there. Again they noted delays in A's care, in particular the decision to delay their surgery until 1 October 2018 which Adviser 2 considered unreasonable. Adviser 2 noted that A was not examined for a protracted period following admission and no effort was made to expedite their MRI scan so that they could be operated on as quickly as possible.

30. It is clear from the advice I have received and accepted that A's care and treatment repeatedly fell below a reasonable standard. This is particularly concerning given the previous findings by this office of the importance of minimising delays when treating cases of suspected CES. It does not appear that the actions the Board told us they had taken to improve the recognition and treatment of CES as a neurosurgical emergency have been effective. As a consequence the treatment A was provided with did not comply with the appropriate standards.

31. I uphold this complaint.

(b) The Board's actions resulted in an unreasonable delay in admitting and treating A

(b) Decision

32. The findings for complaint **(a)** also apply to complaint **(b)**. The advice I have received is clear that there were a series of unreasonable and avoidable delays in admitting and treating A. The Board's statement that A was not a neurosurgical emergency, because they were not displaying red flag symptoms of CES is incorrect. A was displaying the red flag symptoms of CES from 20 September 2018 onwards. A's examination when they were admitted was unreasonably delayed. Although it was reasonable to request a whole-spine MRI, no attempt was made to expedite this to enable surgery to be performed.

33. I note that Adviser 2 did not conclude it was possible to be certain of the impact the delays to A's surgery had on the outcome of the surgery. While I accept this, I have no doubt that the delays contributed significantly to A's pain and distress and that the surgery should have been carried out much sooner than it was. This again confirms to me that the Board still does not have an adequate system in place for identifying and treating suspected CES.

34. I uphold this complaint.

(c) The Board have not explained why A was discharged on 28 September 2018

(c) Decision

35. Although the Board's responses have provided some insight into the events taking place on 28 September 2018, it is still not clear why A was discharged. It would appear this was the result of a combination of:

- an incorrect assessment of A's symptoms from the Neurosurgery Department at Hospital 2 as not suitable for emergency transfer, and
- a failure within the Orthopaedic Department at Hospital 1 to discuss the case with an orthopaedic consultant prior to the decision being reached to discharge A.

36. It does appear, however, that the Orthopaedic Consultant was aware of A's attendance, unlike the visit on 20 September 2018.

37. The Board have not answered C's question as to why the Orthopaedic Department allowed A to leave Hospital 1 without establishing a safe care pathway for them. They have maintained the designation of A by the Neurosurgical Department as not suitable for transfer was appropriate, although the advice I have received from both advisers is that this is incorrect.

38. As summarised in this report, A's medical records do not contain details of the discussion between Orthopaedics and Neurosurgery, nor the reason why A was not transferred as a surgical emergency. The Board's subsequent responses suggest the duration of A's CES was a factor, but this was not recorded at the time. As the advice I have received and accepted makes clear, A had red flag symptoms of CES and qualified as a neurosurgical emergency; the Board's responses and investigations have failed to acknowledge or accept this.

39. I uphold this complaint.

(d) The Board failed to refer A to the appropriate specialisms for ongoing care, resulting in further delays to their treatment

40. C said that A was discharged without being referred to the appropriate specialisms for ongoing care, despite the very obvious care needs they had. C pointed out that these general issues had already been highlighted to the Board following the public report issued in 2018. C said A's postoperative care was organised entirely by their GP, even though A had been readmitted to Hospital 2 in October 2018 as a spinal emergency due to their ongoing issues.

The Board's response

41. I would summarise the Board's response as follows:

- A had declined nursing advice prior to discharge. The Board had difficulties managing patients with CES as a group, as some of the services that provided advice and assistance were district, or local, rather than regional services. For

this reason, the nursing advice A had declined regarding continence and actions to take in the event of symptom recurrence was important.

- It was accepted there were problems post-discharge for A. In addition to gaps in service, A's decision to pursue a complaints route rather than to approach clinical services with post-discharge concerns made it difficult for the Board to make best use of the resources they could offer.

Advice received

42. Adviser 2 provided the following comments on the follow-up care provided to C:

- There was no evidence from the records supplied of any robust follow-up arrangements. The Immediate Discharge Summary from A's September admission and their subsequent one in October 2018 stated 'routine neurosurgical follow up' and 'as above' respectively.

- The notes did mention that A 'declined nursing advice prior to discharge'. This had to be viewed in the context of a previously well individual in significant pain, discomfort and indignity from CES (from incontinence of bladder and bowel, and erectile dysfunction), who was then discharged from the initial hospital only to be readmitted in a worse state eight days later, and whose surgery on a Sunday then had been delayed unnecessarily for want of an MRI scan. It was completely understandable that A did not wait for nursing advice before discharge.

- A was reviewed in separate out-patient settings by Physiotherapy, Pain Management, Orthopaedics and Urology, yet there was no mention of this being arranged by Neurosurgery. The discharge letters do not mention any specific follow-up plans. It had to be concluded that Neurosurgery had no role in facilitating A's postoperative care.

(d) Decision

43. The advice upon which I have relied is that A's postoperative care was not arranged by the Board. The Board's response implies that this was contributed to by A's decision to leave the ward without receiving guidance from nursing staff. The

Board also suggested that C and A's decision to complain about the care A received prevented them from accessing clinical services effectively.

44. It is unacceptable in my view, to place the responsibility for this failure on decisions made by A, after they had received substandard care over a period of several days, causing them significant pain and distress.

45. The Board stated they had difficulty with patients suffering from CES as a group because of the lack of integration between the various services required to provide support and care to these individuals. There is no evidence that the nature of the services A required was a factor, as the Board did not make any attempt to liaise with other services. It also suggests to me a lack of focus on A as an individual, and it is difficult to see how this approach is consistent with the values of NHS Scotland, particularly in respect of dignity and respect.

46. This again highlights the failure of the Board to embed the learning and changes required, following this office's previous public report, despite the assurances we were given at that time.

47. I uphold this complaint.

(e) The Board failed to handle C's complaint reasonably

48. C felt that the Board's handling of their complaint had been very poor. The complaints process had been extremely protracted, and the final response they had received had not answered their questions satisfactorily.

49. Their view was that the Board had looked to place all the responsibility for the errors on A's care on the most junior staff involved. The Board had not properly acknowledged the devastating impact of the failings on A, and they had denied being aware of any similar cases.

50. C believed the Board had failed to properly identify learning from the case. They noted there had been no Serious Clinical Incident (SCI) review, and the Morbidity and Mortality meeting that had been held had been significantly delayed and did not include the Neurosurgery Department. C felt the Board had not properly

examined the case to see if there were systemic failings. As a result, the failings that had affected A's care could happen again.

51. C also raised the issue of whether duty of candour should have applied in this case. They believed it should have applied but the Board had not responded on this.

The Board's response

52. I would summarise the Board's response as follows:

- The Board accepted they had not complied with the appropriate timescales for handling the complaint. This was because the complaint was complex and had required input from multiple staff members from different specialisms.

- No SCI was carried out because the errors were due to individual decision-making rather than a system or process issue. The individuals concerned had been spoken to and the investigation of the complaint had provided the Board's Senior Team with information about the case.

- An SCI would have triggered duty of candour, but as one had not taken place, duty of candour did not apply.

- There was no written record of the feedback provided to staff.

- The Board suggested the case had been discussed at an earlier Morbidity and Mortality meeting, but no record existed of this discussion. The decision had been taken to discuss it again in September 2019, but the Board did not believe this delay had had any impact on the learning for the Board.

- The case had been discussed at a Morbidity and Mortality meeting on 13 September 2019. This resulted in the Orthopaedic Department altering their procedures to ensure patients were discussed with the consultant on call, and presented at the next trauma meeting.

- The Board recognised that referral for imaging as a non-urgent out-patient was not an appropriate method of referral.

- No review of the actions of the Neurosurgery Department had taken place. A had been treated on the first available elective neurosurgery list, which was appropriate.

Advice received.

53. Adviser 1's comments were as follows:

- The delay in investigating A's care through the Morbidity and Mortality process was unreasonable.
- The outcome of that process was didactic, and it was not possible to ascertain if appropriate learning had taken place from A's experience. There should have been a presentation and a discussion with both Orthopaedic and Neurosurgery Departments present.
- There should have been a Standard Operating Procedure (SOP), covering the roles of both Orthopaedic and Neurosurgery Departments, to cover actions and responsibilities when managing and transferring patients with suspected CES, based on BASS guidelines. This should have formed part of staff induction and been displayed in a visible position in both Neurology, Orthopaedic and A&E departments.
- Adviser 1 would have expected written feedback to be given to Doctor 2 that could be included in their training portfolio.
- The advice given by Doctor 2 on 20 September 2018 was certainly unreasonable. However, the advice given by the Neurosurgery Department on 28 September 2018 was also unreasonable. It was also unreasonable for A to be told operating on a Sunday was not possible. There was no evidence the Board's complaint investigation had identified or addressed these failings.
- The lack of joined-up cross-specialty working in resolving the complaint was unreasonable. The lack of shared learning and a SOP for the management of patients with suspected CES was also unreasonable.
- Duty of candour should have applied in this case.

54. Adviser 2's comments on the Board's internal investigation and complaint responses were as follows:

- The records of contributions to the Morbidity and Mortality meeting appeared to be solely from the Orthopaedic Department; this was unreasonable.
- There was little evidence from the records to suggest any sustainable learning had come from this incident. No SCI investigation had been conducted, which was a missed opportunity for the Board to formally challenge itself and facilitate learning. There was no evidence of communication with the junior doctors involved in the beginning of A's journey.
- There was no evidence of learning or modification of practice from the Neurosurgery Department, despite clear failings.
- Neurosurgery failed to recognise that A had presented with red flags for CES on 28 September 2018 although these were described to them by the Orthopaedic Department. The Neurosurgery Department had also stated they would not provide advice on the assessment of CES. The rationale behind this statement was difficult to understand, as it would be normal practice for neurosurgery staff to provide this type of advice.
- The Board had denied throughout that A presented with a neurosurgical emergency, which was incorrect.
- The Board did not quantify or qualify what they meant by actual avoidable harm from the acknowledged delays and missed opportunities. They also referred erroneously to A's previous spinal history as a factor in their decision-making, which was not a factor in this case.
- The Board acknowledged that A's CES was 'not complete' at the point at which their operation was delayed. It was this very presentation of incomplete CES that was known to benefit from emergency surgery. By the time someone presented with a complete CES it was usually too late to intervene meaningfully. The Board's responses had not acknowledged or addressed this.

(e) Decision

55. The Board's investigation and response to both A's care and C's complaint was inadequate. The Board seemed to be unaware of Public Report **201608430,** issued at the start of 2018, which had previously identified as problems many of the issues that affected the quality of care provided to A. The Board also seemed to be unaware of the actions it said it had taken to address issues around delay in diagnosing and treating CES, and issues arranging follow-up care.

56. In fact, C had asked specifically about incidents of CES which had occurred at the Board. In response to those questions the Board said that they did not have records of incidents like A's in the preceding two years. It is true that some aspects of the care provided in case **201608430** are different, however, it is a case of CES and there are significant thematic similarities between the two cases.

57. I note the Board's response to C appeared to be on the basis of checking the DATIX records. A's case was not apparently recorded as a serious incident on the DATIX system, because no SCI was triggered as a result. If this is common practice, then checking the DATIX records would not necessarily alert the Board to similar failures, if like A's case, they were not recorded as serious incidents at the time.

58. In my view, the tone of parts of the Board's response are defensive and display little empathy for someone who had gone from being fit and active with a young family, to an individual with significant care needs and unable to work. I found it extremely surprising and very disappointing that so little concern was expressed for A and the devastating outcome they suffered. In fact, the Board's responses minimise this in my view, in their failure to acknowledge it clearly and unambiguously. This is also concerning, not least because this was highlighted specifically in case **201608430** and detailed feedback and recommendations were provided to the Board, which it said it had taken our findings on board and as noted previously provided evidence and assurances it had acted on them.

59. As C pointed out in their complaint to this office, where the Board did accept failings, these were placed on the most junior staff involved. The Board could provide no evidence showing they had discussed A's case with those staff. More senior members of staff, and the organisation as a whole, did not appear to accept

responsibility for A's care. As the advice notes, there is no evidence the Neurosurgery Department participated at all in the Morbidity and Mortality meeting.

60. In fact, at points in the Board's internal correspondence, which was then reflected in the response to C, A's discharge from Hospital 2 without nursing advice was presented as A contributing to their own difficulties. I must also note the Board suggested that C's decision to make a formal complaint had negatively impacted on the information the Board was able to provide them with, and possibly on A's care.

61. Both of these aspects are very concerning. It is entirely unreasonable for the Board to effectively blame A for contributing to their own difficulties, when they subsequently acknowledged they struggled to provide services which met the needs of this type of patient. Nor is it reasonable or appropriate to suggest that accessing the complaint process should in some way impede a patient's care. This is compounded by the fact that as this investigation found, C and A's concerns about the standard of care provided were entirely justified. This calls into question the culture of the governance and leadership of an organisation which not only makes these points, but makes them in the context of a complaint process.

62. I also have to note that parts of the Board's complaint response are not supported by the available evidence. It is unclear how the Board were able to make their statements about the events surrounding A's discharge on 28 September 2018, for example. Those statements were not supported by the medical records and it is not clear how the Board reached the conclusion that A did not have red flag symptoms of CES, something both advisers considered to be incorrect.

63. I accept that the Board held a Morbidity and Mortality meeting, but the advice I have received is that this was unreasonably delayed and inadequate, as it failed to review A's care in its totality, because the Neurosurgery Department did not contribute directly.

64. The advice I received also commented on the failure of the Board to recognise their failings and identify the appropriate learning from this case. It also noted that the Board's response was based on an inaccurate assessment of A's condition, which the complaint investigation had failed to identify. This then led, incorrectly, to the conclusion that the Neurosurgery Department did not need to learn from the

experience. I accept this advice and am greatly concerned that, again, this calls into question the culture and governance of an organisation that failed to prevent a basic tenet of good complaint handling, learning and improvement, to be acted on effectively.

65. The advice also noted that duty of candour should have applied in this case. The Board deny this, but I note the General Medical Council (GMC) guidance on duty of candour.

> "Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress."

66. I do not believe that it is appropriate or credible for the Board to suggest this did not apply to A's care and treatment, even before the findings of this investigation. I consider that their failure to accept that duty of candour should have applied in A's case, given that C specifically asked them this question in their complaint, is unreasonable.

67. I uphold this complaint.

Conclusion

68. This is an extremely concerning case. The Board, within months of having provided evidence and assurances that they had complied with the findings of a Public Report by this office intended to improve care for patients with CES, failed to provide adequate care, and recognise the condition as a neurosurgical emergency.

69. A's care and treatment was shambolic, characterised by poor communication between different hospital teams, and lengthy waits for examination and treatment. These waits were compounded by inappropriate decisions to discharge A on the part of the Orthopaedic Department at Hospital 1, and a refusal by the Neurosurgery Department at Hospital 2 to provide diagnostic advice, as well as an incorrect assessment of A as not having red flag symptoms of CES.

70. It is especially concerning that some of these findings echo those of the earlier Public Report and that, despite a lengthy internal complaint investigation, the Board

failed to identify significant failures in A's care and treatment. For this reason, the recommendations go further than previously, requiring a period of monitoring from the Board to ensure that compliance and learning have been shared, implemented and embedded. This also recognises that CES cases are rare, and the Board may go periods without treating any, which underscores the importance of having clear, visible and well understood standard operating procedures for staff to refer to across the organisation.

71. 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 C and A:

Complaint number	What we found	What the organisation should do	What we need to see
a)	A's care for CES was not in line with the appropriate standards	Apologise to C and A for failing to provide care for A in line with the appropriate standards. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

Complaint number	What we found	What the organisation should do	What we need to see
b)	The Board's actions resulted in an unreasonable delay in admitting and treating A	Apologise to A for the unreasonable delay in admitting and treating them. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021
c)	The Board have not explained why A was discharged on 28 September 2018	Apologise to C and A for failing to provide an adequate explanation for the decision to discharge A. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

Complaint number	What we found	What the organisation should do	What we need to see
d)	The Board failed to refer A to the appropriate specialisms for ongoing care, resulting in further delays to their treatment	Apologise to C and A for failing to refer A to the appropriate specialisms for ongoing care resulting in further delays to their treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021
e)	The Board failed to handle C's complaint reasonably	Apologise to C and A for failing to handle their complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets	A copy or evidence of the apology. By: 19 June 2021

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) , b) and c)	A's incomplete CES was not recognised as a neurosurgical emergency	Relevant staff understand the standard operating procedure, based on the British Association of Spine Surgeons guidelines for the care and management of CES, and provide appropriate treatment in line with it	Evidence of staff knowledge of the standard operating procedure, including guidance for staff and an explanation of how its application will be monitored. By: 19 July 2021
a), b) and c)	A's referral from the Orthopaedic Department to Neurosurgery Department was not fully documented	Document referrals to the Neurosurgery Department accurately and comprehensively by medical staff in the Orthopaedic Department	Evidence the Board are monitoring the documentation of referrals to ensure they are comprehensive and accurate. By: reporting monthly for the next six months.

Complaint number	What we found	Outcome needed	What we need to see
a), b) and c)	Orthopaedic staff were unclear what to do when A's referral to Neurosurgery was refused	Orthopaedic staff should have a clear procedure to follow when a referral is declined by the Neurosurgery Department	Evidence of a clear procedures, including an explanation of how the Orthopaedic and Neurosurgery Department have collaborated in its creation By: 19 August 2021
a) and b)	A's surgery was unreasonably delayed	Surgery for CES must be performed within recommended timescales	The Board must evidence they have systems in place to ensure that patients are operated on within reasonable timescales and that these are being monitored on a monthly basis for the next twelve months. By: 19 June 2021

Complaint number	What we found	Outcome needed	What we need to see
d)	No referrals or after care arrangements were made for A	Discharge should be planned with prompt referral to appropriate services. The Board should ensure that patients have the appropriate referrals made to community based services to support their care on discharge from hospital. This should include the transfer of care plans with the patient, where appropriate, to ensure continuity and consistency of care	Evidence the Board have taken steps to address the difficulties in providing coordinated care for CES patients and that the effectiveness of these measures is monitored on a monthly basis. By: 19 June 2021.

We are asking the Board to improve their complaints handling:

Complaint number	What we found	Outcome Needed	What we need to see
e)	The Board's complaint investigation failed to identify that treatment of CES by the Board had been the subject of a Public Report a matter of months before A's case	To ensure the Board has effective complaint monitoring arrangements in place to identify when a new complaint concerns the same issues or clinical matters (CES in this case) as previous complaints, and that the relevance of outcomes and learning from previous cases are considered, as appropriate, in any new investigation	Evidence the Board have effective complaint handling and monitoring systems in place. By: 19 August 2021
e)	The Board's Morbidity and Mortality meeting was unreasonably delayed and did not involve all relevant staff	Morbidity and Mortality meetings should be held timeously and should involve representatives of all specialisms involved in a patient's care	Evidence that Morbidity and Mortality procedures require the involvement of all relevant specialisms. By: 19 July 2021

Complaint number	What we found	Outcome Needed	What we need to see
e)	The Board failed to properly implement their duty of candour	Appropriate implementation of the duty of candour, in line with General Medical Council guidance	Evidence that the need to apply the duty of candour has been fed back to staff in the Orthopaedic and Neurosurgery teams in a supportive manner. By: 19 June 2021

Evidence of action already taken

Complaint number	What we found	What the organisation should do	What we need to see
a)	The Board said they had already taken steps to ensure that patients with possible CES were not discharged without their case being discussed with an orthopaedic consultant first	Provide evidence that it has been monitoring the effectiveness of these measures	Evidence showing the procedural changes implemented by the Board, as well as the mechanisms in place for monitoring them. By: 19 June 2021

Terms used in the report

Annex 1

'A'	the aggrieved
Adviser 1	an orthopaedic consultant, medical adviser to the SPSO
Adviser 2	a consultant neurosurgeon, medical adviser to the SPSO
bilateral leg pain	pain on both sides of the body at the same time
the Board	Greater Glasgow and Clyde NHS Board
'C'	the complainant and the spouse of the aggrieved
Cauda Equina Syndrome (CES)	severe type of narrowing of the spinal column where all of the nerves in the lower back suddenly become severely compressed
'D'	the complainant in case 201608430
DATIX	electronic incident reporting system
Doctor 1	junior doctor
Doctor 2	orthopaedic registrar
Doctor 3	junior doctor
Doctor 4	neurology registrar
Doctor 5	consultant neurosurgeon
General Medical Council (GMC)	public body that regulates medical practitioners in the United Kingdom

Hospital 1	Royal Alexandra Hospital
Hospital 2	Queen Elizabeth University Hospital
Magnetic Resonance Imaging (MRI)	scan using power magnetic fields to generate images of the inside of the body
neuropathic	nerve pain
orthopaedics	medicine focusing on the muscles and skeleton
neurology	medicine focusing on the nervous system, including the spinal cord
saddle parathesia	numbness of the buttocks, inner thighs and the area between the legs

Legislation and guidance referred to in the report Annex 2

British Association of Spinal Surgeons (BASS): *Guidelines on the management of Cauda Equina Syndrome*, (2018)

NICE Guidance: *Lower Back Pain in over 16's assessment and management*

https://www.nice.org.uk/guidance/ng59

General Medical Council: *Professional Duty of Candour;*

The professional duty of candour - GMC (gmc-uk.org)