SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201507648 and 201508652, A Medical Practice in the Highland NHS Board area and Highland NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis / GP & GP Practices

Summary
Ms A, who suffered from a number of physical disabilities and other conditions, began to complain of headaches in December 2013. She had surgery to remove a nasal ulcer, and a CT scan revealed no abnormality of her sinuses.

Subsequently, Ms A attended the practice on a number of occasions complaining of vomiting and headaches. At the same time, Ms A's mother contacted NHS 24 with concerns about Ms A and she was seen by the board's out-of-hours service. Ms A's medical practice prepared a referral letter to neurology. In the meantime, Ms A was admitted to the surgical service at Raigmore Hospital with abdominal pain. Ms A was seen by a neurologist on the ward and diagnosed with occipital nerve compression. Following her discharge, Ms A was seen by GPs from the practice, again with headaches and other symptoms. Ms A was given an appointment for an MRI scan. Ms A died at home before this could be carried out. A post-mortem found that the cause of death was a haemangioblastoma (a tumour of the central nervous system within the brain).

During the investigation, my complaints reviewer sought advice from a GP, a nurse, a neurologist, a neuroradiologist, and a neurosurgeon.

I found the practice did not provide a reasonable standard of care in relation to the examination and referral of Ms A's headache symptoms. I also found the board's out-of-hours service failed to provide Ms A with appropriate care and treatment. Regarding Ms A's admission to hospital, I found failings in relation to the neurological examination recorded and a failure to review a CT scan of Ms A's sinuses.

I am also particularly critical of the way the board handled this complaint and their lack of focus on their failings and ways to improve their services.

Redress and recommendations

The Ombudsman recommends that the practice:	*Completion date*
(i) apologise to the family for the failings this investigation has identified;	23 December 2016
(ii) conduct a significant event analysis for review by this office; and	23 January 2017
(iii) confirm that the staff involved will discuss this issue as part of their annual appraisal, including identifying the relevant Scottish Intercollegiate Guidelines Network (SIGN) and Scottish Cancer referral guidance as a learning.	23 December 2016

The Ombudsman recommends that the board:	*Completion date*
(i) apologise to the family for the failings this investigation has identified;	23 December 2016
(ii) confirm the out-of-hours staff identified will discuss this case as part of their annual appraisal, including identifying the relevant SIGN and Scottish Cancer referral guidance as a learning point;	23 December 2016
(iii) assess the performance of the out-of-hours staff involved, and identify any training needs;	23 December 2016
(iv) confirm the neurologist will discuss this case as part of their annual appraisal;	23 December 2016
(v) should review arrangements for ward consultations (including considering the availability of previous scans for review and encouraging consultants to dictate letters as if it were an out-patient consultation);	23 January 2016
(vi) conduct a significant event analysis for review by this office, given the seriousness of this case, and my findings;	23 February 2016
(vii) provide my office with an explanation of why a serious incident review was not undertaken in this case; and	23 January 2016
(viii) review complaints handling in this case to establish why the failings in care were not identified.	23 January 2016

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman on behalf of the parents of the late Ms A. Ms C complained about the care and treatment provided by Highland NHS Board (the Board) and a medical practice in the Highland NHS Board area (the Practice). The complaints from Ms C I have investigated are that:

(a) the Practice failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported (*upheld*); and

(b) the Board failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported (*upheld*).

Investigation

2. In order to investigate Ms C's complaint, my complaints reviewer sought independent advice from a GP (Adviser 1), a nurse (Adviser 2), a neurologist (Adviser 3), a neuroradiologist (Adviser 4), and a neurosurgeon (Adviser 5).

3. In this case, we have decided to issue a public report on Ms C's complaint because of the significant personal injustice Ms A suffered.

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

Background

5. Ms A lived at home, and was cared for by her mother. She had several conditions including physical disabilities, learning difficulties, autism, chronic fatigue syndrome and asthma.

6. Ms A started to complain of headaches in December 2013. She had surgery to remove a nasal ulcer on 12 February 2014. She was reviewed by an ear, nose and throat (ENT) consultant twice after this, once as a routine post-operative review (19 March 2014), and once following a further GP referral (1 July 2014). At the appointment on 1 July 2014, the ENT consultant found no ENT problems, but requested a computerised tomography (CT) scan of Ms A's sinuses, and suggested possibly obtaining a neurology opinion. Subsequently, the CT scan was performed and reported as showing no abnormality of Ms A's sinuses on 14 July 2014.

7. On 30 July 2014, Ms A attended the Practice complaining of vomiting and headache. She further attended the Practice on 8 August 2014, and a home

visit was made on 11 August 2014. The Practice prepared a referral letter to neurology on 11 August 2014 and submitted this on 13 August 2014, requesting assessment of Ms A's ongoing headache and loss of balance.

8. During this period, Ms A's mother contacted NHS 24 with concerns about her headaches and vomiting. She was in contact with NHS 24 on 2, 10 and 11 August, when Ms A was still vomiting and had persistent headaches. Ms A was seen by the out-of-hours service on 2, 10, 11 and 12 August 2014 (the later following a self-referral). Two of these were consultations with nurse practitioners (2 and 10 August 2014), and two were consultations with GPs.

9. Ms A was admitted to the surgical service at Raigmore Hospital (the Hospital) with abdominal pain on 12 August 2014. She was taken in by her parents, who remained with her through the admissions process and consultations.

10. The first reference to Ms A's headaches during her admission was at 02:30 on 13 August 2014. After a day or so Ms A's abdominal pain subsided, but her headaches persisted, and she was seen by a neurologist (the Neurologist) on the ward on 15 August 2014. There is a disagreement about how long Ms A was seen on the ward. Ms A's family said the attendance was brief and limited, with no interaction with Ms A's mother (her main carer). The Board said the Neurologist recalled that he was with Ms A and her mother for at least 20 minutes. The Neurologist diagnosed Ms A with occipital nerve compression. The Board have said her symptoms subsided, though this is at odds with her parents, who have said she was still very unwell. Ms A was discharged on 18 August 2014.

11. Following her discharge from the Hospital, Ms A was seen by GPs from the Practice on 21, 25 and 29 August 2014 with a range of symptoms, including headaches, a shaking episode, and was having difficulty walking.

12. Ms A was given an appointment for an magnetic resonance imaging (MRI) scan on 10 September 2014; and at her mother's request this was brought forward to 8 September 2014. Sadly, however, Ms A died at home on 2 September 2014.

13. A post mortem found that the cause of death was a haemangioblastoma, a tumour of the central nervous system (within the brain). The pathology report

identified the cause of death as a haemangioblastoma, which was considered to be secondary to an acute hydrocephalus (an abnormal accumulation of fluid) associated with this tumour.

(a) The Practice failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported

Concerns raised by Ms C

14. Ms A's family raised concerns that she had been ill for many months before her death, and that the Practice had not done enough to help her. They said she was prescribed various medications and painkillers which were not of use to her.

The Practice's response

15. In response to Ms A's parent's complaint, the Practice provided a summary of Ms A's care. The Practice considered that appropriate care and treatment was provided.

Relevant policies

16. The Scottish Intercollegiate Guidelines Network (SIGN) has published guidance on 'Diagnosis and management of headache in adults' (SIGN 107, November 2008). SIGN 107 states (at page three):

> 'Patients who present with headache and red flag features for potential secondary headache should be referred to a specialist appropriate to their symptoms for further assessment.
>
> … Red flag warning features highlight which patients require further investigation for potential secondary headache.'

17. SIGN 107 also provides information on the red flags for potential secondary headaches which require further investigation:

> 'SECONDARY HEADACHE
>
> Secondary headache (ie headache caused by another condition) should be considered in patients presenting with new onset headache or headache that differs from their usual headache. Observational studies have highlighted the following warning signs or red flags for potential secondary headache which requires further investigation:
>
> Red flag features:
>
> - new onset or change in headache in patients who are aged over 50

- thunderclap: rapid time to peak headache intensity (seconds to 5 mins)
- focal neurological symptoms (eg limb weakness, aura <5 min or >1 hr)
- non-focal neurological symptoms (eg cognitive disturbance)
- change in headache frequency, characteristics or associated symptoms
- abnormal neurological examination
- headache that changes with posture
- headache wakening the patient up (NB migraine is the most frequent cause of morning headache)
- headache precipitated by physical exertion or valsalva manoeuvre (eg coughing, laughing, straining)
- patients with risk factors for cerebral venous sinus thrombosis
- jaw claudication or visual disturbance
- neck stiffness
- fever
- new onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
- new onset headache in a patient with a history of cancer.'

18. The Scottish Referral Guidelines for Suspected Cancer (Published October 2013, updated August 2014) also refer to signs which could suggest an underlying brain tumour, and which require urgent referral. These signs are:

- Focal neurological deficit (progressive neurological deficit (including personality or behavioural change) in the absence of previously diagnosed or suspected alternative disorders (such as multiple sclerosis))
- Change in behaviour
- Seizure; and
- Headache (patients with headache, vomiting and/or papilloedema)

19. The Adviser noted the General Medical Council (GMC) guidance on Delegation and Referral (2013) states:

> '… You are not accountable to the GMC for the actions (or omissions) of those to whom you delegate care or make referrals. You will be accountable for your decisions to transfer care and the steps you have taken to make sure that patient safety is not compromised.'

Medical advice

20. My complaints reviewer sought advice from Adviser 1 (a GP) in relation to the care and treatment the Practice provided to Ms A from when she first presented to the Practice with a headache on 28 March 2014.

21. Adviser 1 noted that, in March 2014, a GP felt the headache was due to a sinus infection, and treated Ms A appropriately for this. In May 2014, the Practice referred Ms A to ENT as they considered her pain was due to her sinuses. Adviser 1 considered that the care the Practice provided to Ms A between March and May 2014 was reasonable.

22. Adviser 1 considered that the care provided to Ms A was unreasonable from 30 July 2014, when she again presented at the Practice with headaches. Adviser 1 said it was evident on 30 July 2014 that, despite the ENT referral and investigation, Ms A's headaches had not improved. Moreover, ENT had written to the Practice, stating that they did not feel the headaches had an ENT cause and suggesting a possible neurology referral. Adviser 1 said there was evidence of red flag features which should have prompted an urgent referral before Ms A's admission to hospital. Following admission, Ms A's ongoing symptoms should have prompted the Practice to upgrade the existing referral to urgent instead of routine.

SIGN 107 – red flag features

23. Adviser 1 considered there was evidence of red flag features in the GP records in respect of a number of consultations which were consistent with those specified in SIGN 107.

24. First, Adviser 1 noted that the guidance identifies 'focal neurological symptoms' and 'abnormal neurological examination' as red flag features. Adviser 1 considered there was evidence Ms A had reduced mobility and a change in her motor ability, with, at times, an inability to walk (as documented in the medical records for 25 August 2014 and 29 August 2014). Adviser 1 noted that, despite potential neurological symptoms, the GPs did not carry out a neurological examination, which should have been recorded. In their comments on a copy of the draft report, the Practice said they considered that on 29 August 2014, Ms A's declining mobility was due to tramadol, a medication she had been prescribed. Adviser 1 noted that the clinical entry recorded this opinion, however, they considered that the GP did not take into account the whole patient picture in terms of Ms A's pre-existing red flag symptoms. Adviser

1 considered that a reasonable GP would have investigated and taken action urgently in relation to a 'loss of walking ability' in a patient such as Ms A with headaches and vomiting, rather than assuming it was due to a side effect of tramadol.

25. The Practice also disagreed that there was no neurological examination carried out on 29 August 2014. They noted that the clinical entry recorded 'full range of eye movement', which is a summary of an examination of the cranial nerves, important in the assessment of possible brain tumour. While Adviser 1 accepted that the clinical entry recorded this, they explained that checking the eye movement is one small part of a neurological examination, but would not be sufficient in a patient who had lost the ability to walk with associated symptoms of headache. In this case, Adviser 1 considered a neurological examination involving examination of the power, tone and sensation of all limbs, plus an assessment of coordination should have been carried out.

26. Second, Adviser 1 considered there was evidence of a 'headache that changes with posture' in the clinical entry of 8 August 2014.

27. Finally, Adviser 1 considered that 'change in headache frequency, characteristics or associated symptoms' was evident insofar as the chronology of the number of contacts for headaches and associated symptoms increased markedly, with 11 contacts with clinical services (including a hospital admission) in the month before Ms A's death.

Scottish Referral Guidelines for Suspected Cancer

28. Adviser 1 also considered the medical records evidenced signs which could suggest an underlying brain tumour under the 'Scottish Referral Guidelines for Suspected Cancer', and thus required urgent referral.

29. First, Adviser 1 said there was evidence of 'progressive neurological deficit' in that the records indicated Ms A's normal walking deteriorated (as noted above).

30. Second, Adviser 1 said the clinical entry of 21 August 2014 recorded 'shaking episode this morning and near collapse', which Adviser 1 considered was highly suggestive of a seizure. In their comments on a draft of this report, the Practice said the attending GP considered the diagnosis of seizure, but the episode was not typical, so the likely diagnosis at that time was thought to be a

vasovagal or fainting episode. Adviser 1 clarified that they had not identified a specific failing with the GP's assessment or diagnosis at the time; rather this formed part of the overall clinical picture which should have further alerted the Practice to the need to consider a seizure as a likely cause for the episode collapse.

31. Finally, Adviser 1 noted that 'headache with vomiting' was evidenced in the documentation from attendances on 30 July 2014, 2 August 2014 (record of out-of-hours attendance), 10 August 2014 (record of out-of-hours attendance), 11 August 2014 (record of out-of-hours attendance), and 12 August 2014 (record of out-of-hours attendance).

Urgency of referral

32. Based on the above, Adviser 1 considered there was evidence of signs and symptoms suggestive of an underlying brain tumour recorded in the medical records by a number of GPs at the Practice. Adviser 1 considered these should have been identified as red flag features under SIGN 107 and the Scottish Referral Guidelines for Suspected Cancer. Therefore, Adviser 1 considered the Practice failed to recognise the significance of these red flag signs and the need for urgent referral from 30 July 2014 onwards.

33. Adviser 1 noted that Ms A was referred to neurology in a referral dated 11 August 2014. However, this was a routine referral. The Adviser considered an urgent referral would have been appropriate on 11 August 2014, given the presence of significant red flag signs in the period before the referral was sent. Adviser 1 considered the care and treatment provided in this respect was unreasonable. Adviser 1 considered that while the Practice did refer Ms A to neurology, they did not provide all the clinical information that would suggest the referral was urgent, or send the referral urgently to avoid delay in assessment.

34. In their comments on a draft of this report, the Practice said a routine referral was appropriate as the patient had been admitted acutely at this time. However, Adviser 1 considered that at the time of referral on 11 August 2014 the patient was already exhibiting 'headache with vomiting and progressive neurological deficit' and, as such, urgent referral was warranted. Adviser 1 did not consider that acute admission should change the indications for referral. In this context, they noted that Ms A was admitted to a surgical ward for vomiting, not for neurological investigations. Moreover, Adviser 1 noted that although the Neurologist was asked to review Ms A whilst she was admitted, the Practice

would not have known this until Ms A had been discharged on 18 August 2014. Adviser 1 was of the view that if the GP felt neurological referral was necessary, then the appropriate guidelines should have been adhered to.

35. Following the referral (and Ms A's admission to the Hospital), Adviser 1 said Ms A had numerous contacts at which she presented with additional evolving red flag signs. As such, Adviser 1 said the Practice should have upgraded the referral to an urgent status.

Neurological examinations

36. Adviser 1 also raised concerns about the extent to which the Practice carried out and recorded neurological examinations for Ms A when she was seen over this period. Adviser 1 said it was important to record a neurological examination in patients with progressive reduced mobility (of a possible neurological cause). Adviser 1 said the GPs should be aware of a change in the frequency of patient consultation and be alert to potential underlying pathology in patients with multiple attendances.

37. In their comments on a draft of this report, the Practice commented that a neurological examination was performed on 8 August 2014, and documented in the referral letter to neurology. Adviser 1 noted the contemporaneous medical record showed no evidence of the GP recording a neurological examination on 8 August 2014. Adviser 1 noted the clinical entry was brief and stated only that Ms A was experiencing pain on occiput, which was aggravated by moving her head or lying on it, and that her vomiting had now settled. However, Adviser 1 noted that the GP recorded details of a reasonable neurological examination in the referral letter of 11 August 2016. In that context, Adviser 1 said the evidence suggested a neurological examination was carried out, but the GP failed to record this in the clinical consultation record. Adviser 1 considered the failure to record this in the clinical consultation record was not ideal, but not of itself unreasonable.

Other comments

38. The Practice said that my draft report did not take into account that following discharge from hospital they worked on the basis of the neurology advice, which influenced management of Ms A. Adviser 1 accepted that it was reasonable that the neurology advice would influence the management of Ms A. However, Adviser 1 said their advice that the care and treatment was unreasonable was based on the deteriorating clinical picture, despite this

neurology advice, and the actions of the GPs in responding to that deteriorating picture following hospital discharge (in particular Ms A losing her ability to walk).

Conclusion

39. In conclusion, Adviser 1 considered the Practice did not provide a reasonable standard of care in relation to the examination and referral of Ms A's headache symptoms. Adviser 1 said there appeared to be a lack of identification of the urgency of the symptoms, and a lack of alertness to the change in frequency of the attendance.

(a) Decision

40. Ms C complained that the Practice failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported.

41. The advice, which is outlined in detail, identified failings in the care and treatment Ms A received from 30 July 2014 onward. In particular, I am advised that red flag signs were documented in the clinical notes from 30 July 2014, but the Practice failed to recognise these and take appropriate action, as required under the guidance.

42. During the time period in question, Ms A experienced increasingly severe headaches, vomiting, and deterioration in her mobility. Based on the advice I have received, I consider the Practice failed to recognise the red flag signs and features associated with Ms A's headaches from 30 July 2014. I am also concerned that the GPs in question did not appear to be familiar with the requirements of the relevant guidance on these red flag signs and features. I consider that in failing to recognise the nature of the symptoms Ms A was experiencing, and to make an urgent referral to neurology specialists, the Practice failed to provide Ms A with a reasonable level of care and treatment.

43. For the reasons outlined above, I do not consider the Practice provided Ms A with appropriate clinical treatment in view of the symptoms which were reported. Therefore, I uphold the complaint.

(a) Recommendations

44. I recommend that the Practice:	*Completion date*
(i) apologise to the family for the failings this investigation has identified;	23 December 2016

(ii)	conduct a significant event analysis for review by my office; and	23 January 2017
(iii)	confirm that the staff involved will discuss this issue as part of their annual appraisal identify, including identifying the relevant SIGN and Scottish Cancer referral guidance as a learning.	23 December 2016

45. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Practice 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.

(b) The Board failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported

Concerns raised by Ms C

46. The concerns Ms C raised related to when Ms A was admitted to the Hospital from 12 to 18 August 2014 with abdominal pain, during which time she was under the overall care of general surgery.

47. In her complaint to my office, Ms C raised concerns about the care and treatment the Neurologist provided on 15 August 2014. Ms C said Ms A was admitted to the Hospital to have her headaches and loss of balance, as well as non-specific abdominal pain, investigated. Ms C said the abdominal pain was successfully investigated and treated; however, the headaches persisted and a neurological opinion was sought. Ms C said Ms A was seen for approximately five minutes by the Neurologist. She raised concerns that the Neurologist was dismissive of Ms A's symptoms and questioned his decision not to arrange further investigations.

48. Ms C observed that the diagnosis of haemangioblastoma is made by CT scan. In this context, she raised concerns that there was a missed opportunity to provide Ms A with a CT scan during her admission to the Hospital in August 2014. In this regard, Ms C considered the Neurologist failed to fully investigate Ms A's symptoms.

The Board's response

49. The Board described Ms A's condition in detail in their complaint response. In respect of the consultation on the ward on 15 August 2014, the Board considered the clinical symptoms were suggestive of neuropathic pain (pain caused by damage or disease affecting part of the nervous system) and occipital nerve neuralgia (a condition in which the occipital nerves (nerves that run from the top of the spinal cord up through the scalp) are inflamed or injured), taking into account:

- the tender point on occipital nerve on examination, and the paraesthesias (altered sensation) affecting the parietal and face region (symptoms which the Board said were not associated with haemangioblastoma);
- history of previous neuropathic pain episodes with a similar clinical picture; and
- the absence of focal neurological signs and symptoms.

50. The Board considered the burning pain Ms A experienced on touching her occipital nerve was very characteristic of occipital nerve neuralgia. The Board noted this neuropathic pain was very severe and stabbing. They considered this type of neuralgic pain (pain in a nerve or nerves) is not expected to be found in people with brain tumours.

51. The Board said the CT scan of the sinuses, face and base of the skull requested by ENT in July 2014 was reported as normal 'with no hydrocephalus [a build-up of fluid on the brain] or dilation of the ventricles in the brain [expanding in the cavities of the brain that produce cerebrospinal fluid] being evident'.

52. The Board said, unfortunately, there were no clinical signs or symptoms to suggest the presence of the cerebellar haemangioblastoma and there was no clinical indication that brain imaging should have been performed.

The Board's response to my office's enquiries

53. During the course of the investigation, Adviser 1 raised concerns about the standard of care and treatment provided by the out-of-hours nurse practitioner (OOH Nurse 1) who saw Ms A on 10 August 2014, and the out-of-hours GP (OOH GP1) who saw Ms A on 11 August 2014. In particular, Adviser 1 was concerned that the practitioners did not identify and act on Ms A's red flag features, and also that Ms A was given morphine on 10 August 2014, which was not appropriate in view of her symptoms. In view of the seriousness of

these concerns, my complaints reviewer sought the Board's comments on these issues.

54. The Board provided detailed comments on each of the out-of-hours consultations. In respect of the two nurse practitioners, the Board said these were both Band 7 unscheduled care practitioners. The Board said the nurse practitioners were working within their role and remit. Overall, the Board considered that the medications provided at the consultations were reasonable, and that appropriate clinical treatment was provided on each occasion. In relation to the morphine administered on 10 August 2014, the Board said it was not unusual for the out-of-hours service to provide analgesia on a watch and wait basis. The Board said it was not unusual to use morphine for a migraine type headache that had not responded to simple analgesics, especially when associated with vomiting. The Board noted that Ms A was being managed by her GP for her ongoing health concerns, and they did not consider emergency admission was required at the time of the out-of-hours consultations.

GP Advice (the consultation of 10 August 2014)

55. Adviser 1 raised concerns about the out-of-hours care provided to Ms A at the consultation on 10 August 2014.

56. Adviser 1 raised particular concerns about the decision to give a morphine injection to Ms A in the context of persistent / unremitting headaches and vomiting. Adviser 1 said this treatment was not in keeping with any management guideline they were familiar with, and risked masking serious underlying pathology and symptoms which could suggest a deterioration in Ms A's condition. Adviser 1 said they would not consider it safe practice to prescribe morphine injections in the community for patients with intractable headache, vomiting, and red flag symptoms. Adviser 1 considered this was a significant learning point, and that the administration of morphine to Ms A was not reasonable.

57. Adviser 1 also raised concerns about an entry in the medical records for the consultation which stated Ms A's sinus operation was 'carried out last month', whereas this occurred six months previously.

58. In summary, Adviser 1 also considered, based on the presentation recorded, Ms A should have been admitted to hospital on 10 August 2014. Adviser 1 considered the care and treatment provided was not reasonable.

Nursing Advice (the consultations of 2 and 10 August 2014)

59. As the concerns Adviser 1 raised about the consultation of 10 August 2014 related to OOH Nurse 1, my complaints reviewer sought clinical advice from Adviser 2 (a nurse) in respect of the care provided by two out-of-hours nurse practitioners on 2 and 10 August 2014.

60. As a preliminary point, Adviser 2 said it was important to be aware of the role of nurse practitioners and the scope of their practice. Adviser 2 explained there is no specific scope of practice, and a nurse practitioner works to the Nursing and Midwifery Council (NMC) Code and a job description, which sets out their scope of practice. Adviser 2 explained that a nurse practitioner generally works in a more specialist role, which has a higher required level of experience, training, and development. This extended role often includes roles and tasks that may be carried out by other healthcare professionals, including doctors. Adviser 2 said in out-of-hours care, a nurse practitioner works to a similar scope as a GP. In their comments on a draft of this report, the Board confirmed that the nurse practitioners in this case worked at advanced practice level. Adviser 2 noted that the NMC Code states: 'You must recognise and work within the limits of your own competence'.

61. Adviser 2 reviewed the medical records for the consultation of 2 August 2014. Adviser 2 noted that Ms A was seen by a different nurse practitioner (OOH Nurse 2) from 12:47 to 13:18. The notes from this consultation indicated an assessment was done, including a check of Ms A's vital signs. The note stated 'not in distress. Pain is 10/10', and Adviser 2 explained that this was contradictory, as a pain score of 10/10 indicates the individual has identified this as the worst possible pain. Adviser 2 noted OOH Nurse 2 provided Ms A with anti-inflammatory analgesic and anti-sickness medication. OOH Nurse 2 documented that the medication 'had some effect prior to leaving'. OOH Nurse 2 noted Ms A was due to see her GP the coming Friday, and was advised to return if there were further concerns.

62. Adviser 2 noted Ms A was seen by OOH Nurse 1 on 10 August 2014 between 22.55 and 23.10. The medical records documented that vital signs, and pupils were recorded. A further note stated 'no neurological deficit from headache'. Adviser 2 was unsure, based on the record, whether a neurological assessment was carried out, or whether this information was obtained from Ms A's clinical history. Adviser 2 also said the record incorrectly noted the sinus

operation was carried out one month previously (whereas it was carried out six months ago). Adviser 2 also noted Ms A was given an intramuscular injection of morphine (a strong opiate drug) and cyclizine (anti-sickness medication) and told to attend the GP surgery in the morning.

63. Adviser 2 emphasised that nurse practitioners are required to act within their scope of practice. This means they recognise and work within the limits of their competence. This is specified in the NMC Code, which states that nurses must:

> '13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care
> 13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment
> 13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence'

64. Adviser 2 said that this means a nurse practitioner is expected to provide a similar standard of care expected of any practitioner providing out-of-hours care (including a GP or hospital doctor). If a nurse practitioner is required to work outwith the limits of their competence, then it is their duty to refer to a more experienced practitioner (in this case a GP or hospital service).

65. Adviser 2 considered that Ms A had signs and symptoms listed in SIGN 107 and the Scottish Cancer Referral Guidelines as red flag features on 10 August 2014, therefore, further advice should have been taken. While Adviser 2 noted Ms A's history was complex, Adviser 2 said this was even more reason that further assessment advice should have been taken. In their response to a draft of this report, the Board commented that they considered onward referral to Ms A's GP was advised and this was an appropriate action in the circumstances, as the GP would know Ms A and be familiar with her complex medical history. However, Adviser 2 considered given the red flag signs Ms A was experiencing, including significant headache or migraine, they would have expected OOH Nurse 1 to have sought immediate advice from an out-of-hours GP, or hospital emergency department.

66. Adviser 2 considered the decision to treat Ms A's headache was within the scope of practice of OOH Nurse 1 and OOH Nurse 2. However, Adviser 2

considered that the prescribing and administration of morphine for a headache by OOH Nurse 1 on 10 August 2014 was unreasonable (and they noted Adviser 1 also expressed concerns about this aspect of Ms A's care).

67. First, Adviser 2 noted that SIGN 107 states that 'opioid analgesics [such as morphine] should not be routinely used for the treatment of patients with acute migraine …'. Adviser 2 also noted that SIGN 107 indicates that, in secondary headache (ie a headache attributed to an underlying condition), red flag features should prompt further referral for investigation.

68. Second, Adviser 2 noted opioid analgesia is not used routinely in patients with any neurological symptoms, as the opiate can mask the true conscious level of a patient, and the assessment of the conscious level is a significant part of the assessment of the neurological system (consistent with the comments made by Adviser 1). In their comments on a draft of this report, the Board noted that there was no evidence of an altered conscious level in this case. However, Adviser 2 explained that opiate drugs can mask the conscious level if there is a change in the patient, and therefore should not have been given.

69. In summary, Adviser 2 considered OOH Nurse 1 who attended Ms A on 10 August 2014 acted unreasonably in their assessment and care. Adviser 2 considered they should have sought immediate advice from an out-of-hours GP or the emergency department given the symptoms that Ms A was experiencing. Adviser 2 was particularly concerned about the administration of morphine on 10 August 2014. Adviser 2 was also critical of the pain assessment performed by OOH Nurse 2 on 2 August 2014.

GP Advice (the consultations of 11 and 12 August 2014)

70. As previously noted, Adviser 1 raised concerns about the care the out-of-hours GP (OOH GP1) provided to Ms A on 11 August 2014. My complaints reviewer sought detailed comments on this issue. Adviser 1 had no concerns about the care provided to Ms A by the out-of-hours GP that saw Ms A on 12 August 2014 (OOH GP2).

71. Adviser 1 considered OOH GP1 on 11 August 2014 documented a very brief history in the medical records, stating the patient was 'alert', had no acute abdominal pain, and had vomited while waiting to be seen. Adviser 1 noted OOH GP1 gave Ms A an injection of metoclopramide (anti sickness medication) and discharged her home for further follow-up by her own GP. Adviser 1 noted

that OOH GP1 documented their view that there was nothing on examination of Ms A's condition that suggested that she needed an emergency admission, and OOH GP1 made no reference to the other symptoms described by the patient.

72. Adviser 1 had a number of concerns about the consultation. Adviser 1 observed that OOH GP1 was provided with a history by NHS 24. Adviser 1 considered this history made clear several symptoms that a reasonable GP would find to be of concern. Adviser 1 also noted OOH GP1 recorded that Ms A's headache did not respond to morphine. Adviser 1 considered that the history provided would have alerted a reasonable GP to consider an alternative diagnosis to 'acute abdomen'. Adviser 1 considered that, once OOH GP1 had ruled out an 'acute abdomen', they failed to address the other presenting symptoms. Adviser 1 explained that the symptoms of concern were that Ms A was suffering persistent headache, which was not responding to morphine; neck stiffness, a two week history of worsening vomiting that was unresponsive to sickness medication; and abdominal pain. Adviser 1 also noted the NHS 24 sheet for that evening stated Ms A reported having difficulty putting her chin on her chest, which reflected a routine question used by NHS 24 staff to diagnose neck stiffness. Adviser 1 noted this was not detailed in the subsequent clinical assessment, and was critical that OOH GP1 did not assess or check this in their examination findings.

73. Adviser 1 considered that, based on these symptoms, a reasonable GP would have carried out a thorough history and examination of the patient, particularly, as two of the symptoms described are noted to be significant signs for 'urgent referral suspicion of cancer' under the Scottish referral guidelines for suspected cancer.

74. Adviser 1 noted that there is no evidence in the medical records that OOH GP1 carried out any basic examination of Ms A's blood pressure, pulse or temperature. Adviser 1 would have expected all of these to be recorded. In addition, Adviser 1 said there was no recorded assessment of dehydration or urine assessment, despite the history from NHS 24 stating that there was a 'reduced fluid intake and urine output'.

75. Adviser 1 considered that, where a patient has headache and irretraceable vomiting, they would have expected a GP to check the patient's eyes for signs of papilloedema (swelling of the optic disc area). Adviser 1 observed there was no record of this. Adviser 1 considered if there was evidence of papilloedema,

this may have led to emergency admission to Hospital on the evening of 11 August 2014.

76. Adviser 1 noted the GP recorded 'no acute abdominal pain' but has failed to document details of her examination. In addition, Adviser 1 said there was neither urinalysis (analysis of a urine sample) nor a pregnancy test (which Adviser 1 would have expected to be carried out in a patient of child bearing age with abdominal pain).

77. Adviser 1 considered a reasonable GP would have provided a more thorough assessment and examination of a patient in Ms A's circumstance and would have recorded their clinical findings in more detail. In this connection, Adviser 1 referred to the General Medical Council's guidance on Good medical practice (2013), which states (at page nine):

> 'Record your work clearly, accurately and legibly
> 19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
> …
> 21. Clinical records should include:
> a. relevant clinical findings
> …'

78. In conclusion, Adviser 1 considered OOH GP1 did not carry out nor record a thorough history and examination of Ms A on 11 August 2014, instead providing the patient with an anti-sickness injection without taking notice of the associated concerning signs. In this context, Adviser 1 considered OOH GP1 appeared to have focussed on ruling out an 'acute abdomen' rather than assessing all of Ms A's presenting symptoms. Adviser 1 also considered OOH GP1 failed to carry out a full examination, as previously noted.

79. Adviser 1 considered that although there is no evidence that the clinical contact on 11 August 2014 had a direct effect on Ms A's eventual outcome, the care provided by OOH GP1 fell below a reasonable standard as there were failings in the clinical recording of the patient's history, the clinical examination (and recording of this) and in the failure to arrange further investigations.

Neurology Advice

80. My complaints reviewer sought the advice of a consultant neurologist (Adviser 3) on the care and treatment provided to Ms A at a consultation with the Neurologist on 15 August 2014 during her admission to the Hospital from 12 to 18 August 2014.

81. Adviser 3 reviewed the medical records available in respect of the consultation of 15 August 2014. Adviser 3 noted the clinical note from the Neurologist was undated, although it was written in the records for 15 August 2014 and it was signed by the Neurologist. Adviser 3 said the note indicated Ms A had a trigger point (a very sensitive area in skeletal muscle) on the left sub-occipital region (the lower part of the head at the back, where the head joins the neck) and constant daily pain, but no symptoms of migraine or cluster headache. Adviser 3 noted there was no other written documentation to show the extent of any neurological assessment such as taking a history (asking the patient about relevant clinical background) or examination of cognitive state (ie capacity/memory/intellect), cranial nerves (the nerve supply to the head including looking at the back of the eyes to assess any raised pressure within the skull), or limb or gait (walking) analysis, which could be used to confirm the absence of red flag symptoms or signs (as outlined in SIGN 107). Adviser 3 also noted that Ms A's history of red flag features did not appear to have been obtained or recorded by the Neurologist in the clinical note (although he noted it is not possible to know what symptoms were described to the Neurologist by Ms A, staff, or family).

82. In the course of providing this advice, Adviser 3 noted that the response from the Board to Ms C reflected the clinical note; however, it also included the statement: 'in addition, no red flags suggesting intracranial hypertension [for example, headache worse lying down, worse coughing, laughing, straining, physical exertion or visual disturbance] were present and no neurological deficit [that is to say, no abnormality of the examination] was detected'. Adviser 3 observed that these statements are not seen in the original clinical entry on 15 August 2014. Adviser 3 considered that, as the examination was not evidenced in the clinical note, the statements in the Board's complaint response are unsupported by the contemporaneous clinical note.

83. My complaints reviewer asked Adviser 3 whether the investigations carried out following the Neurologist's assessment were reasonable. Adviser 3 said the clinical notes indicated Ms A had occipital nerve pain, and the management

plan would be reasonable for this diagnosis. Adviser 3 said there were no suggested investigations documented in the Neurologist's clinical note, and Ms A's subsequent investigations related to other medical issues. Although a CT scan was suggested on 13 August 2014 (as a possibility after seeking the neurological opinion) and there was some reference to an MRI scan on 18 August 2014, this was not requested in Ms A's discharge notification or discharge summary. However, Adviser 3 explained that no investigations are usually required for occipital nerve pain so the lack of investigations would be reasonable based on the Neurologist's diagnosis.

84. As Ms A's parents raised concerns that delays in the scans Ms A received caused her death, my complaints reviewer asked Adviser 3 to comment on when Ms A should have received an MRI and/or CT scan. Adviser 3 noted that Ms A had a CT scan of the sinuses on 14 July 2014, which was reported as being normal. Adviser 3 noted this scan was referred to in a GP referral letter dated 11 August 2014, which also described worsening symptoms, including that Ms A was 'now very unsteady on her feet', there was 'vomiting that lead to worsening of her pain', and that 'recently the unsteadiness on her feet has become much more marked'. Adviser 3 considered these symptoms would be red flags in that they referred to progressive neurological symptoms, and or headache suggestive of raised pressure within the skull. However, Adviser 3 said it was unclear if the Neurologist had seen or had access to the letter when he saw Ms A (although the referral letter was submitted on 13 August 2014). Adviser 3 considered, from the GP referral, it appeared the CT report on Ms A's sinuses was construed as being a reassuringly normal CT scan of the brain. In this connection, Adviser 3 questioned whether the CT scan of Ms A's sinuses may have shown evidence of abnormality (prompting my complaints reviewer to seek additional advice on this point from a neuroradiologist (Adviser 4)). Adviser 3 said, in the context of a new progressively severe head pain with worsening disability, an MRI or CT scan should have been performed during Ms A's admission. The previous CT scan of the sinuses was, in Adviser 3's opinion, inadequate to exclude a serious neurological cause for Ms A's headaches.

85. Adviser 3 shared Ms A's parents concern that the failure to review the original CT of the sinuses, and/or perform dedicated brain imaging led to a failure to detect a condition that caused Ms A's death.

86. Given concerns raised by Ms A's family, my complaints reviewer asked Adviser 3 to comment on whether there was any lack of information, consideration, or explanation at the consultation. Adviser 3 observed that the clinical note written by the Neurologist was brief. Adviser 3 explained this is often the case when patients are seen at ward consultations, when there is limited time to document completely what is done and explained. Adviser 3 noted that one option is to immediately dictate a letter describing in more detail any ward consultation as if there were a typical out-patient consultation (although not all hospitals do this). Adviser 3 also noted the Board's complaint response said the Neurologist explained matters to Ms A and her mother and gave no indication of miscommunication.

87. Adviser 3 noted the complaint raised concerns that the Neurologist saw Ms A for approximately five minutes, during which time a history, neurological examination, diagnostic formulation, and explanation were all performed. Adviser 3 noted that Association of British Neurologists guidelines suggest 30 to 60 minutes for a ward referral, as ward cases may be more complex. Adviser 3 considered it is entirely possible to make an accurate assessment in a much shorter time than 30 to 60 minutes if a patient describes characteristic symptoms and displays relevant physical signs on examination. Adviser 3 considered this was apparently the kind of consultation that the Neurologist documented in the clinical note. In their comments on a draft of this report, the Board said the Neurologist recalled that they were with Ms A and her mother for at least 20 minutes.

88. Given the concerns of Ms A's family that her symptoms had not changed in the Hospital and that she was unwell on discharge, my complaints reviewer asked whether Ms A should have been discharged on 18 August 2014.

89. Adviser 3 noted that Ms A had been admitted on the basis of abdominal pain and vomiting. These symptoms were reported to have resolved by the time of Ms A's discharge. However, Adviser 3 said the neurological symptoms associated with Ms A's headache (for instance imbalance) reported in the GP referral does not appear to have been identified during the admission as red flag signs. If they had, Adviser 3 said Ms A could have been referred to a medical team for further investigation of these symptoms.

90. Adviser 3 provided an outline of the symptoms of a haemangioblastoma, and commented on whether Ms A displayed these symptoms. Adviser 3 noted

cerebellar haemangioblastomas may have no symptoms or may cause local symptoms by compression of brain structures, bleeding, or paraneoplastic complications (an effect where the presence of a tumour can have an effect on another part of the body, even though it has not spread to that part). In the case of cerebellar haemangioblastoma, the patient may have an abnormally high blood count (erythrocytosis).

91. Adviser 3 said Ms A's vomiting and reported unsteadiness may have been caused directly by the tumour and/or a build-up of fluid within Ms A's brain caused by the tumour blocking drainage of cerebrospinal fluid. Adviser 3 explained that it is also possible for tumours to cause intermittent blockage of cerebrospinal fluid, and if this were the case for Ms A then there may have been no clinical signs between episodes of blockage.

92. Adviser 3 noted the GP referral of 11 August 2014 indicated that vomiting worsened Ms A's head pain, and said this may also be interpreted as evidence supporting, but not proving, the presence of raised intercranial pressure (pressure inside the skull).

93. Adviser 3 considered whether the Board should have diagnosed that Ms A was suffering from a haemangioblastoma while she was in the Hospital. Adviser 3 said on the basis of the Neurologist's clinical note, and the explanation of the consultation provided by the Board, the answer would be no. Adviser 3 said the description provided by the clinical records (together with the Board's explanation) Ms A had a typical history, positive supportive physical findings and a reassuring absence of concerning physical findings, so the conclusion would have been acceptable. However, Adviser 3 said the contemporaneous clinical note did not show that a complete neurological examination was carried out and failed to document examination of the eyes looking for evidence of raised pressure within the skull (papilloedema) or other features such as assessment of Ms A's walking. Adviser 3 also noted the Board's statement (in the complaint response) that there was an absence of abnormal physical signs was not contemporaneously documented in the medical record.

94. Adviser 3 said, on the basis of the referral letter from Ms A's GP (11 August 2014), they would have had a low threshold for arranging urgent imaging, which would have identified her tumour, or at least reviewed the previous CT scan to check the accuracy of the report. Adviser 3 could not

establish from the records how Ms A's GP was informed of the CT result, and whether it was presented as a normal CT brain scan or a normal CT sinus scan. Irrespective of this, Adviser 3 considered the Neurologist should have documented at least an attempt to look for papilloedema to help exclude raised intercranial pressure from, for example, clotting of blood vessels in the brain (a cerebral venuous thrombosis, a rare but dangerous treatable cause for headache).

95. Adviser 3 also noted that the Neurologist may not have been aware of the progressive nature of Ms A's neurological symptoms. Ms A had a history of medical problems (mild learning disability, autism, deafness, ME, asthma) that may have clouded the clinical picture and made the diagnosis more difficult to achieve. In this context, an abnormal pattern of walking may have been ascribed to her past medical problems rather than the progressive unsteadiness described in the GP referral of 11 August 2014.

96. Adviser 3 also said there was no record as to whether the Neurologist had seen the GP referral (which detailed Ms A's red flag features). However, Adviser 3 said the Neurologist could have taken a neurological history, or obtained one from an informant such as a relative (noting Ms A's mother was present at the consultation). The Adviser noted it was possible that the Neurologist was given a history suggestive of occipital nerve pain and formed an appropriate conclusion, and the examination may have been unremarkable; however, this was not contemporaneously documented.

97. Adviser 3 noted the Neurologist saw Ms A in the context of admission with abdominal pain and vomiting and any acute symptoms relating to this may have also clouded the clinical story obtained. Adviser 3 considered that if Ms A had been admitted with symptoms of headache, vomiting, and worsening balance (as opposed to abdominal pain), her subsequent investigation and diagnosis may have been very different.

98. In summary, Adviser 3 expressed concerns that the medical records did not show a complete neurological examination was carried out. Adviser 3 was also concerned about the failure to review the original CT scan of Ms A's sinuses, and/or perform dedicated brain imaging. Adviser 3 noted no serious incident review was carried out, and on that basis, questioned the Board's commitment to investigation of complaints and concerns.

Neuroradiology Advice

99. My complaints reviewer sought the advice of Adviser 4 (a neuroradiologist) in relation to whether the CT scan taken on 14 July 2014 was reported appropriately.

100. Adviser 4 noted the imaging request was for 'nasal sinuses' and requested by an ENT consultant. The scan was performed and reported on 14 July 2014, approximately a month prior to the emergency admission. Adviser 4 noted that the clinical details provided were limited to 'severe pain to back of head'.

101. Adviser 4 explained that the technical method of imaging the sinuses is very different from those of imaging the brain. The nasal sinuses are essentially bone (which is very dense) and air (which is of very low density). Accordingly, very thin images (188 of them), of less than one millimetre in thickness each (0.625 millimetres) are acquired at a low mAs (milliamperage second (mAs), a unit of measure of exposure). Adviser 4 explained that this means the images designed to study the sinuses are not good for assessment of the brain, as the image resolution of soft tissue is poor.

102. Taking the above factors into account, Adviser 4 considered the report provided on 14 July 2014 was correct and adequate as far as a scan of the nasal sinuses is concerned.

103. Adviser 4 said that, in retrospect, with the knowledge that there was a tumour in the posterior fossa (back of the brain), it is possible to review the images using unusual window levels (levels of brightness), and in this case, one can undoubtedly see the lesion. Adviser 4 explained that this was because the abnormality was mainly cystic (ie containing fluid, which is of a very different density to the brain). The abnormality measured 3.3 centimetres and encroached upon the midline of the brain from the left side. Adviser 4 said the tumour resulted in early hydrocephalous with mild dilation (expanding) of the third ventricle and the temporal horns of the lateral ventricle (the ventricles are structures containing fluid which circulate around the brain).

104. Adviser 4 considered whether, beyond reporting the CT scan, the radiologist should have done anything differently in July 2014, such as request further scans.

105. Adviser 4 considered the clinical details provided were brief and did not obviously suggest an abnormality other than one related to Ms A's sinuses and skull base, so it was reasonable that the reporting radiologist did not suggest further imaging at that time. Adviser 4 explained that, if an abnormality had been detected, then the radiologist would have suggested or organised further imagining, either a CT scan with contrast or an MRI.

106. My complaints reviewer asked Adviser 4 to comment on why a review of imagining by a radiologist did not occur during Ms A's admission. Adviser 4 said the service that provided the CT scan provides scope for review and discussion; however, Adviser 4 was unaware of how easily accessible this would be. Adviser 4 also considered red flag signs associated with the headache were not appreciated, which meant a review was not carried out. Adviser 4 also observed that the CT scan of Ms A's sinuses was, in some correspondence referred to simply as a CT scan (such as in the Practice's referral letter). Adviser 4 said this may have led to an assumption that a CT scan of the brain was performed and this was normal.

107. Adviser 4 recognised that Ms A's outcome was very tragic. Adviser 4 said it was very likely that Ms A was suffering from two coinciding conditions presenting with head pains. In particular:

- neuropathic pain related to occipital nerve entrapment, a diagnosis Adviser 4 said was supported by the clinical pattern of the pain, the localised tenderness, and reproduction of the neuropathic pain by focal pressure. Adviser 4 considered this was likely to have been long standing, given the Board's reference to clinical records dating back to 1992 of neuropathic head pain; and
- headache and bouts of vomiting as well as deterioration in mobility due to the presence of the unrecognised inter-cranial brain tumour.

108. Adviser 4 noted that the ability to identify the abnormality through retrospective analysis of the scan (with knowledge of the post mortem findings) had to be valued with caution. In this context, the primary question is how many competent radiologists working under the same conditions and with the same clinical information as that supplied to the original radiologist would provide a different report. Adviser 4 considered, based on published research into discrepancies in radiological reports and the factors previously outlined, this would be less than one in five. However, Adviser 4 said that, if a radiologist with the information that a patient had a scan for the nasal sinuses and she later

had headaches, bouts of vomiting and her balance and walking had deteriorated, then a great majority of radiologists would either find the suspicious abnormality or arrange for a brain examination.

109. Adviser 4 also noted that ward consultations are difficult even at the best of times, and considered that a number of factors may have increased this further. In particular:

- Ms A's clinical background, including physical disabilities, learning difficulties, autism and chronic fatigue syndrome (ME);
- the number of clinicians who had taken a clinical history from Ms A and her parents may have led to 'fatigue' in providing the history (such that important symptoms may not have been repeated to all clinicians);
- Ms A was on strong analgesics (pain killers), which had improved her headache but not her neuropathic head pain; and
- the detailed clinical letter sent following her admission may not have reached the clinical notes by the time of the consultation.

110. During the course of providing the advice, Adviser 4 noted the statement of the Board in their correspondence with Ms C that 'the CT scan was reported as normal with no hydrocephalus or dilation of the ventricles being evident'. Adviser 4 considered this statement was not accurate and was misleading, as this CT scan was intended to view Ms A's sinuses, and not the brain (as explained above).

Neurosurgery Advice

111. My complaints reviewer sought the advice of Adviser 5 (a neurosurgeon) as to whether the tumour would have been operable if it had been detected, and what kind of prognosis Ms A might have had.

112. Adviser 5 noted that the CT scan performed in July showed, in retrospect, a cystic abnormality in the posterior fossa. Adviser 5 said there is no doubt that if the tumour had been discovered in July or early August it would have been operable. In particular, Adviser 5 observed that the tumour in question is a benign tumour which is curable. Adviser 5 said that if Ms A had been operated on, there would have been a 90 percent chance of a full recovery.

113. In the course of providing the advice, Adviser 5 raised particular concern that clinicians did not recognise the seriousness of Ms A's deteriorating ability to

mobilise. Adviser 5 explained that this is a common problem in midline cerebellar lesions and in hydrocephalus, and should have been considered a focal neurologic sign. Adviser 5 considered that if the significance of this symptom had been recognised, then an urgent MRI would have been arranged.

(b) Decision

114. Ms C complained that the Board failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported.

115. Ms A attended the out-of-hours service provided by the Board on several occasions in August 2014, prior to her admission to the Hospital. While Ms C's original complaint did not raise concerns about this service, my investigation has identified a number of failings. The advice I have received from Adviser 2 is that the care provided by OOH Nurse 1 on 10 August 2014 was unreasonable. In particular, Adviser 2 considered OOH Nurse 1 should have sought immediate advice from a GP or hospital based on the headaches she was experiencing when she was seen by them. Adviser 2 also raised concerns about the prescription of morphine on 10 August 2014. In relation to the care OOH GP 1 provided on 11 August 2014, Adviser 1 considered the care and treatment provided to Ms A was unreasonable. In particular, Adviser 1 considered the clinical recording, clinical examination, and failure to arrange certain investigations fell below a reasonable standard. I accept this advice, and I consider the care provided by the out-of-hours service fell below a reasonable standard.

116. Ms A was admitted to the Hospital on 12 August 2014, and reviewed by the Neurologist on 15 August 2014. Taking into account the advice I have received, I recognise a number of circumstances contributed to the outcome of that consultation. In particular, Ms A had been admitted for abdominal pain and was therefore seen on the ward, in a context where the clinical letter from her GP may not have arrived. It also appears that Ms A's history of medical problems and her current medication may have further complicated the clinical picture. However, notwithstanding this, I consider there were failings in the care provided to Ms A.

117. I have outlined the concerns Adviser 3 raised about the clinical note prepared in respect of the consultation, and I am critical that the Neurologist's notes do not evidence a full neurological assessment, including history, examination of cognitive state, cranial nerves, limb or gait analysis, as

necessary to confirm the absence of red flag signs. I consider the Board failed to provide Ms A with appropriate treatment in this respect.

118. Ms C raised specific concerns about whether a CT scan should have been made during Ms A's hospital admission. The Board considered it was not a priority to undertake brain imagining based on the diagnosis of occipital neuralgia, the similarity of Ms A's symptoms to those observed in the past, the result of the CT scan of the sinuses, and their view that Ms A's symptoms had improved. I have outlined the advice from Adviser 3, who expressed concerns about the failure to review the original CT scan of Ms A's sinuses and/or perform dedicated brain imaging. I consider the Board failed to provide Ms A with appropriate treatment in this respect.

119. I have also noted the advice of Adviser 4, who considered that, had the CT scan of Ms A's sinuses performed and reported on 14 July 2014 been reviewed by a radiologist with knowledge of her subsequent headaches, vomiting, and deterioration of her balance and walking, this would have likely resulted in detection of the tumour, or arrangement of a further scan.

120. For the reasons outlined above, I consider the Board failed to provide Ms A with appropriate clinical treatment in view of the symptoms which were reported.

121. Therefore, I uphold the complaint.

122. I have outlined the advice from Adviser 5, who considered that, had the seriousness of Ms A's symptoms been recognised, and her tumour detected earlier, she could have been given surgery, with a very good chance of success. Ms C has described the deep distress of Ms A's family at the untimely death of their daughter, and the advice I have received indicates that the failings in care contributed to this tragic outcome.

123. In the course of providing their advice, a number of the advisers also raised concerns about the information provided by the Board to the family during the complaints process. Adviser 3 considered statements made by the Board in respect of the complaint response were not present in the clinical entry for 15 August 2014. Adviser 4 said the statement of the Board that 'the CT scan was reported as normal with no hydrocephalus or dilation of the ventricles being evident' was not accurate and was misleading. I am also

concerned that the Board did not review the CT scan of Ms A's sinuses as part of the complaints process. In this context, I am concerned about the accuracy and quality of the Board's complaint response.

124. The Scottish Government has published guidance on the handling of complaints (Can I Help You? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services). Section 3.10.1 of the Can I Help You? guidance states that the goal of staff investigating a complaint 'is to establish all of the facts relevant to the points raised and provide a full, objective and proportionate response that represents the definitive position'. Section 3.12.2 states that, in terms of best practice, the complaint response should 'address all issues raised and demonstrate that each element has been fully and fairly investigated'.

125. Noting the concerns outlined above, I do not consider the Board's response has complied with the requirements of the Can I Help You? guidance and I am strongly critical that the Board provided inaccurate and misleading information in their complaint response. By failing to investigate Ms C's complaint fully and fairly, the Board missed an opportunity to identify and address the failings in care and to reflect on and learn from Ms A's experience.

126. In making this decision, I would like to acknowledge the experience of Ms A's family, and how difficult it must have been for them to pursue their complaint at such a time. When Ms C brought the complaint, she said the family were seeking an explanation about what happened to Ms A, as well as for improvement in systems and for health professionals to listen to patients and their families. I hope that my report will provide the explanation the family was seeking and help to answer their questions.

(b) Recommendations

127. I recommend that the Board:	*Completion date*
(i) apologise to the family for the failings this investigation has identified;	23 December 2016
(ii) confirm the out-of-hours staff identified will discuss this case as part of their annual appraisal, including identifying the relevant SIGN and Scottish Cancer referral guidance as a learning point;	23 December 2016
(iii) assess the performance of the out-of-hours staff	23 December 2016

	involved, and identify any training needs;	
(iv)	confirm the Neurologist will discuss this case as part of their annual appraisal;	23 December 2016
(v)	should review arrangements for ward consultations (including considering the availability of previous scans for review and encouraging consultants to dictate letters as if it were an out-patient consultation);	23 January 2016
(vi)	conduct a significant event analysis for review by my office, given the seriousness of this case, and my findings;	23 February 2016
(vii)	provide my office with an explanation of why a serious incident review was not undertaken in this case; and	23 January 2016
(viii)	should review complaints handling in this case to establish why the failings in care were not identified.	23 January 2016

128. 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.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
Ms A	the aggrieved
the Board	Highland NHS Board
the Practice	a medical practice in the Highland NHS Board area
Adviser 1	GP adviser
Adviser 2	nursing adviser
Adviser 3	neurology adviser
Adviser 4	neuroradiology adviser
Adviser 5	neurosurgery adviser
CT	computerised tomography
ENT	ear, nose and throat
the Hospital	Raigmore Hospital
GMC	General Medical Council
MRI	magnetic resonance imaging
the Neurologist	a neurologist who saw Ms A at the Hospital on 15 August 2014
OOH GP 1	an out-of hours GP who saw Ms A on 11 August 2014

OOH GP 2	an out-of hours GP who saw Ms A on 12 August 2014
OOH Nurse 1	an out-of-hours nurse who saw Ms A on 10 August
OOH Nurse 2	an out-of-hours nurse who saw Ms A on 2 August
SIGN	Scottish Intercollegiate Guidelines Network
SIGN 107	Diagnosis and management of headache in adults (SIGN 107, November 2008)
NMC	Nursing and Midwifery Council

Annex 2

Glossary of terms

analgesia	pain relief
computerised tomography (CT) scan	a scan that uses x-rays and a computer to create detailed images of the inside of the body
haemangioblastoma	a tumour of the central nervous system
hydrocephalus	an abnormal accumulation of fluid in the brain
intercranial pressure	pressure inside the skull
	referral
magnetic resonance imaging (MRI)	a scan used to diagnose health conditions that affect organs, tissue and bone
neuropathic pain	pain caused by damage or disease affecting part of the nervous system
occipital nerve neuralgia	a condition in which the occipital nerves are inflamed or injured
occipital nerves	nerves that run from the top of the spinal cord up through the scalp
papilloedema	swelling of the optic disc area
posterior fossa	back of the brain

Annex 3

List of legislation and policies considered

Scottish Intercollegiate Guidance Network, Diagnosis and management of headache in adults (SIGN 107, November 2008)

'Scottish Referral Guidelines for Suspected Cancer' (October 2013, updated August 2014)

General Medical Council, 'Delegation and Referral' (2013)

Nursing and Midwifery Council Code

General Medical Council, Good Medical Practice (2013)

Scottish Government, Can I Help You? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services