SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case ref: 202307762, Lanarkshire NHS Board

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

The complainant (C, an advocate) complained to me on behalf of A's family about the standard of medical care and treatment provided to A by Lanarkshire NHS Board (the Board) when A was diagnosed with a bleed in the brain.

A had undergone surgery for cancer and while recovering at home, they began to experience symptoms that were later found to be due to a subarachnoid haemorrhage (a type of bleed in the brain). A was admitted to hospital and medical staff sought advice from a neurosurgical team at another health board. That team advised that A should have a stroke review, a CT angiogram (a type of x-ray used to examine blood vessels) and an MRI (a type of scan used to see inside the body) to find out the cause of the bleeding.

A had the CT angiogram but did not have an MRI and was discharged home after two days with a severe headache. A was readmitted the following day when their condition deteriorated. After emergency surgery at another hospital, and a long hospital admission, A died.

The Board said in their response to C that, overall, they considered A's care was appropriate; they had sought and followed specialist neurosurgical advice. On the day of discharge, A was clinically stable and medical staff contacted the neurosurgical team who advised that no follow-up was necessary and to discharge A home.

C complained to me that A should not have been discharged from hospital when medical staff knew A had a subarachnoid haemorrhage and a severe headache.

During my investigation I sought independent advice from a Consultant Physician in Acute Medicine. Having considered and accepted the advice I received, I found that:

- A's initial management, including planned care and treatment, was reasonable and in line with the relevant guidelines
- the standard of medical care and treatment provided to A on the day of discharge was below that which A and their family were entitled to expect; there was an unreasonable failure to follow the advice of the neurosurgical team, and relevant guidelines, and perform an MRI. Nor was there clear evidence that a full stroke review occurred contrary to the neurosurgical team's advice
- there was also an unreasonable failure to discuss A's discharge with the neurosurgical team beforehand, and
- in the absence of further advice from the neurosurgical team, the responsibility for discharge lay with the Board, and the decision itself to discharge A was unreasonable.

Taking all of the above into account, I upheld C's complaint about the standard of medical care and treatment provided to A.

Complaint handling

Having considered the Board's complaint file and the evidence from the clinical records, I also found that the Board's complaint handling was unreasonable and made recommendations to address this, in doing so I drew attention to my concern that my office had made a number of similar findings about the Board's complaint handling in previous investigation cases.

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:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point (a) I found that the standard of medical care and treatment was unreasonable in that before discharging A the Board failed to: • perform an MRI; • consult with the neurosurgical team; and • ensure a clear stroke	Apologise to C for the failings identified in this investigation in relation to the standard of medical care and treatment and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 23 August 2025

Rec. number	What we found	What the organisation should do	What we need to see
	review was carried out. Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • evaluate the evidence by checking the clinical records; • obtain input from another health board; • collate all the relevant information so that the facts were established before responding to the complainant; • acknowledge clear errors and significant clinical failings; • reflect and learn from the clinical and complaint handling failings.		

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

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint point (a) I found that the standard of medical care and treatment was unreasonable in that before discharging A the Board failed to: • perform an MRI; • consult with the neurosurgical team; and • ensure a clear stroke review was carried out.	Patients who suffer from an SAH should receive care and treatment that is line with the relevant guidelines and advice from specialist teams. If departing from relevant guidelines and/or specialist advice, this should be clearly documented including the reasons for doing so. Reviews carried out (e.g. stroke review) should be fully documented.	Evidence that the findings of my investigation have been fed back to the relevant clinical staff, in a supportive manner, for reflection and learning. By: 23 August 2025 Evidence that the Board have reviewed their systems to ensure the relevant guidelines for treating SAH are embedded in working practices and that reviews carried out are fully documented. Evidence that the Board have monitored awareness of and compliance with the relevant

Rec. number	What we found	Outcome needed	What we need to see
			guidelines in relation to this. For example, by the carrying out of an audit, and identifying and addressing training needs. By: 23 October 2025

We are asking the Board to do to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • evaluate the evidence by checking the clinical records; • obtain input from another health board; • collate all the relevant information so that the facts were established before responding to the complainant; • acknowledge clear errors and significant clinical failings; • reflect and learn from the clinical and complaint handling failings.	Complaints should be investigated fairly and fully and in line with the requirements of the NHS Model Complaints Handling Procedure. Complaint responses should be accurate, complete and address all the points raised in line with the NHS Model Complaints Handling Procedure. All relevant information in relation to an SPSO investigation should be provided at the outset of our enquiries. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1)	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. By: 23 August 2025 Evidence that the Board have reviewed their procedures for complaints handling to ensure that all relevant evidence is obtained (including from other organisations) and evaluated during the investigation. Evidence that the training needs for complaint handling staff have been

Rec. number	What we found	Outcome needed	What we need to see
		and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses	assessed and that relevant staff have access to online training and other tools to improve complaint handling and their approach to our investigations and findings. Evidence that the Board have monitored compliance with the Model Complaints Handling Procedure and SPSO legislation, for example, by the carrying out of an audit. By: 23 October 2025

Feedback for Lanarkshire NHS Board

My investigation has found that the standard of communication between clinicians may have been a contributary factor to why the planned MRI was not undertaken. I encourage the Board to reflect on this with clinicians.

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

Introduction

1. C, an advocate, complained to me on behalf of A's family about the standard of medical care and treatment provided to A by the Board when A was diagnosed with a bleed in the brain. A was discharged home after their diagnosis but readmitted the following day when they deteriorated. After emergency surgery and a long hospital admission, A died.

2. The complaint from C I have investigated is that:

   (a) The Board failed to provide a reasonable standard of medical care and treatment to A on 10-13 July 2023 (***upheld***).

3. During the investigation, my complaints reviewer identified concerns about the Board's complaint handling and notified the Board that under my complaints handling powers (see paragraph 31) this would also be subject to investigation, namely that:

   (b) The Board failed to deal with C's complaint in a reasonable way (***upheld***).

Investigation

4. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation provided by C and the Board in response to enquiries made of them. I also obtained independent advice from an appropriately qualified medical adviser, a Consultant in Acute Medicine (the Adviser) and considered the relevant guidelines, including the NHS Model Complaints Handling Procedure.

5. I have decided to issue a public report on C's complaint given my concerns about the serious clinical and complaint handling failings in this case. The lack of reflection and learning from the Board on these failings, which is a recurring theme (see paragraphs 42 - 44), was also a critical factor in my decision to issue a public report, especially in light of the significant personal injustice that occurred.

6. This report includes the information that is required for me to explain the reasons for my decision on this case. It also contains some technical medical terms and descriptions which I have considered necessary to include in order to provide the

appropriate level of detail both in relation to A's condition, and to the advice I have received and taken into account. Wherever possible, explanations for these terms are provided in the report and / or in annex 1.

7. While 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.

8. Key events:

Date of event	Details of event
6 July 2023	A underwent keyhole surgery for cancer.
8 July 2023	A was discharged home with medication[1] to reduce the risks of clots (deep vein thrombosis or pulmonary embolism) forming.
10 July 2023	A presented with debilitating headaches to the emergency department of a hospital in the board area (Hospital 1).
11 July 2023	A was admitted at 01:20 to a medical ward for assessment and had a CT scan, which showed they had suffered from a subarachnoid haemorrhage (SAH). Clinicians contacted the neurosurgical team at a hospital in another health board area (Hospital 2) for advice. The neurosurgical team advised that A should have a computerised (CT) angiogram and an MRI. A CT angiogram was undertaken.
12 July 2023	A was discharged home.
13 July 2023	At 20:41, A was admitted to Hospital 1 by emergency ambulance after their condition deteriorated at home. Later,

[1] Heparin, an anticoagulant that increases the risk of bleeding.

Date of event	Details of event
	at 23:13, A was transferred to Hospital 2 and taken directly to the operating theatre for an emergency procedure. The operation note for the surgery noted a significant bleed.
14 September 2023	A was transferred to Hospital 1.
27 September 2023	A died.

(a) The Board failed to provide a reasonable standard of medical care and treatment to A on 10-13 July 2023

Concerns raised by C

9. C raised the following concerns:

i. A should not have been discharged home on 12 July 2023 because they had recently had surgery and developed a bleed on the brain, but the Board did not take A's condition seriously.

ii. When a doctor said that A had a small bleed on the brain but could be discharged, A and their spouse were surprised as they believed this would be treated as a serious matter and that A would be kept in. However, A and their spouse trusted the doctor's diagnosis that A could go home. Before leaving, they asked for pain relief for A's severe headache and were given paracetamol.

iii. A and their spouse went home but A's pain did not subside and, on 13 July 2023, A's spouse was so concerned about A's demeanour they called an ambulance and A was taken back to Hospital 1.

iv. A's condition deteriorated, but the Board delayed unreasonably in transferring A to Hospital 2 for emergency brain surgery which escalated their deterioration.

v. The family were at a loss without A and A's spouse had lost their soul mate, they still could not believe what happened to them.

The Board's response to C's complaint

10. The main points of the Board's complaint response were:

i. Overall, the Board considered that A's care was appropriate; they had sought and followed specialist neurosurgical advice (from a team based at another health board) and there was no unreasonable delay in transferring A to Hospital 2.

ii. A had been discharged on 8 July 2023 with heparin following surgery, which increased the risk of a brain bleed.

iii. A attended the emergency department on 10 July 2023 and the results of the CT scan performed the following day (11 July 2023) were discussed with the neurosurgical team at Hospital 2 by a consultant in emergency medicine (Consultant 1). The neurosurgical advice was to: stop the heparin medication; undertake a CT angiogram and an MRI. A was reviewed by a stroke consultant who confirmed that no stroke input was necessary.

iv. A was clinically stable, and so, on 12 July 2023, a consultant in general medicine (Consultant 2) contacted the neurosurgical team to ask if any further radiological investigation or follow up was required. The neurosurgical team advised that no follow up was necessary and to discharge A home.

v. A was taken to Hospital 1 on 13 July 2023 and seen immediately. A further CT scan was undertaken due to their neurological symptoms - it showed a new large bleed on the brain. The intensive care team assisted the emergency department clinicians when A deteriorated. The neurosurgical team advised transfer as soon A was stabilised. Following medication, intubation and anaesthesia, A was transferred later that day.

11. Consultant 2 provided a statement to the Board's complaints team about their involvement in caring for A that informed the complaint response. They said:

i. A was appropriately discussed with the neurosurgical team. A CT angiogram was advised, which was performed showing normal cerebral vessels.

ii. Next day, on 12 July 2023, the neurosurgical team was contacted, updated and enquired about any further subsequent radiological investigation or follow up in due course. The neurosurgical team advised them to discharge A with worsening advice[2] and with no future follow up needed.

iii. Unfortunately, A was admitted again on 13 July 2023 with a large parietal bleed which required transfer to Hospital 2. In all this scenario their decision from admission to discharge (on 12 July 2023) was guided by neurosurgery based at Hospital 2. All radiological investigations, Inpatient ongoing management and discharge with any follow up was not Consultant 2's decision.

12. In response to my complaint reviewer's enquiries, the Board said:

i. Once A had been referred to a medical ward from the emergency department on 11 July 2023 with a confirmed SAH, a clinical fellow in acute medicine (Specialist Registrar) completed a medical assessment. Consultant 1 had documented an initial discussion with the neurosurgical team who advised that a CT angiogram and MRI should be undertaken and that neurosurgical input was unlikely.

ii. Once the CT angiogram was performed, the Specialist Registrar then discussed the results with the neurosurgical team. The team reviewed the CT angiogram and confirmed no neurosurgical input was planned but advised admission to Hospital 1 for consideration of stroke review and MRI. A was subsequently admitted to the medical assessment unit.

iii. Following a discussion between the Specialist Registrar and Consultant 2, the neurological team were contacted again who advised that no further

[2] i.e. advice about what to do if A's condition worsened.

radiological investigation or follow-up was required. Consultant 2 recalled this discussion with the Specialist Registrar but noted it had not been recorded in the clinical records.

iv. The Board's Deputy Chief of Medical Services reviewed A's clinical records as part of the Board's complaint handling process and felt it had been reasonable to discharge A based on their improved symptoms.

13. In a subsequent statement provided to my office, the Specialist Registrar said:

i. They had completed A's initial medical assessment and discussed the results of A's CT angiogram with the neurosurgical team. The team reviewed the CT angiogram and confirmed no neurosurgical input was planned and advised admission for consideration of stroke review and MRI.

ii. A was subsequently admitted to the medical assessment unit and they had no further involvement in A's management after 11 July 2023.

14. In response to further enquiries from my office, the Board said:

i. Regarding the follow up (on 12 July 2023), Consultant 2 was under the impression the Specialist Registrar had contacted the neurosurgical team again and the feedback was that no follow up was required – however, this was not documented and the Specialist Registrar did not recall having such a conversation.

ii. Consultant 2 also did not document this subsequent conversation with the Specialist Registrar about a second discussion with the neurosurgical team. The Board accepted there was a discrepancy and a lack of documentation on this matter.

15. The Board later explained:

i. A was reviewed by a speciality doctor within the stroke team (Consultant 3) on 12 July 2023 and found that a stroke review was unnecessary. Regrettably,

there was no specific documentation about whether an MRI scan was recommended.

ii. Then, Consultant 2 made an appropriate plan to speak to the neurosurgical team about an MRI scan and management. Consultant 2 believed they had instructed the Specialist Registrar to undertake this task and that they reported back, but the Specialist Registrar did not recall any such further involvement after 11 July 2023. Also, there was no documentation of any further discussion with the neurosurgical team having taken place.

iii. The Board accepted that this made it unlikely any further conversation happened. However, given the findings of the CT angiogram, they could not be certain the decision to discharge was unreasonable.

iv. The Board did not accept there had been a delay in transferring A to Hospital 2 on 13 July 2023 which had contributed to their deterioration. A required intubation, ventilation and stabilisation before transfer due to their condition. However, they recognised how distressing this would have been.

Relevant guidelines

16. In providing their advice, the Adviser took account of the NICE guideline[3] on SAH, which states:

> Be aware that urgent investigation to confirm a diagnosis of subarachnoid haemorrhage facilitates early treatment to prevent rebleeding from a ruptured aneurysm and minimises disability and death…
>
> Ensure that people with suspected subarachnoid haemorrhage seen in acute hospital settings such as emergency departments are reviewed urgently by a senior clinical decision-maker to assess the person and think about alternative diagnoses…

[3] National Institute for Health and Care Excellence (NICE) guideline [NG 228] - Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management (2022).

Refer the person for an urgent non-contrast CT head scan if review in secondary care by a senior clinical decision-maker confirms unexplained thunderclap headache, or other signs and symptoms that suggest subarachnoid haemorrhage. Be aware that the diagnostic accuracy of CT head scans is highest within 6 hours of symptom onset...

Urgently discuss with a specialist neurosurgical centre the need for transfer of care of a person with a diagnosis of subarachnoid haemorrhage to a specialist neurosurgical centre...

If CT angiography of the head does not identify the cause of the subarachnoid haemorrhage and an aneurysm is still suspected, consider digital subtraction angiography, or magnetic resonance angiography if digital subtraction angiography is contraindicated.

Advice obtained

17. The Adviser told us:

i. SAH was one of the core medical emergencies that doctors were taught to recognise, particularly as patients could present relatively well initially but deteriorate quickly - some patients could collapse and die instantly from a SAH. Recognising SAH was particularly important as it could present similarly to migraine, tension headaches etc. so an early diagnosis helped identify the correct management.

ii. SAH has a high risk of early death and long-term disability if not diagnosed and treated promptly. Some SAHs were caused by an underlying abnormality of a blood vessel in the brain, called an aneurysm, which could rupture causing bleeding into the brain. In particular, an initially small SAH caused by an aneurysm has a high risk of rebleeding and death. SAHs are considered a medical emergency.

iii. An early and accurate diagnosis may facilitate early intervention to prevent complications such as spasms of the blood vessels in the brain (vasospasm),

which could lead to delayed cerebral ischaemia[4] (causing an effect similar to an ischaemic stroke) and further neurological deterioration.

iv. Identifying SAH enabled urgent neurosurgical or endovascular (radiology-based technique using scans) interventions, such as 'clipping' or 'coiling' of aneurysms, to reduce the risk of further or future bleeding.

v. The initial care for A was in line with the relevant guidelines: a CT scan was performed and demonstrated SAH, and A's case was discussed with a neurosurgical team. This team recommended further assessment of the reasons for the SAH occurrence by performing a CT angiogram and a specific type of MRI scan (to look at different aspects of brain structure and function). The team also said A should have a stroke review and there was no need for neurological intervention at this point.

vi. Turning first to the planned stroke review, there was no evidence in the clinical notes of a clear review by the stroke team: the entry on 12 July 2023 stated 'history noted – localised SAH. Not for stroke review'. Consultant 2 then noted 'not reviewed by stroke physician'.

vii. Turning now to the CT angiogram that was performed, this was reported as not showing a cause for A's bleeding. The Board's clinical records indicated this was discussed with the neurosurgical team on 11 July 2023; however, the neurosurgical team's records indicated that they only discussed the need for a CT angiogram with Board clinicians, not that they were involved in the results. Even so, the plan by the Board's admitting clinicians was in line with the guidelines, which was to: undertake an MRI scan to assess A in more detail and to stop the anticoagulant medication to reduce the risk of bleeding.

viii. The recommendation for an MRI scan was important because the presence or absence of a specific cause for bleeding such as an aneurysm altered the management of a patient.

[4] A decrease in blood supply to tissues.

ix. When A was reviewed the following day, on 12 July 2023, Consultant 2 noted in A's clinical records the plan was to discuss with the neurosurgical team about a further CT or MRI scan and management. However, nothing further was done and A was discharged home with paracetamol for their worsening headache.

x. It was unclear why the advice to perform an MRI was not followed and at this point A's care did not follow the neurosurgical team's advice or the guidelines. The guidelines are clear about the need for the assessment of underlying abnormalities even if the initial CT angiogram was normal. It was also of note that A had a persistent and increasing headache.

xi. In relation to the delay in transferring A to Hospital 2 on 13 July 2023, given the need for CT scanning, ventilation and stabilisation, leaving Hospital 1 within three hours was reasonable. A had deteriorated by 21:15 with a reduction in level of consciousness which required sedation and ventilation. It was also of note that A was transferred directly to an operating theatre as this highlighted the urgency of A's care at that time.

18. The Adviser considered the Board's response to my complaints reviewer's enquires and said:

i. The Board said there was no specific documentation about whether further imaging i.e. an MRI scan was recommended. However, the evidence from the clinical records was that the MRI recommendation was clearly documented by several doctors on several occasions. This was also recorded in the neurosurgical advice[5] that was documented. This means that the guidelines were not followed, which was, in their view, unreasonable.

ii. A was meant to have further investigation in the form of an MRI scan, and further discussion with the neurosurgical team. This was clearly documented in A's clinical notes and would have been in line with the guidelines and clinical practice. A's care in this respect was unreasonable.

[5] This evidence was obtained from the second health board during the course of this investigation.

iii. The communication between Board medical staff and the neurosurgical team was not of a reasonable standard. While the initial recognition of A's SAH and communication with the neurosurgical team was in line with the guidelines and clinical practice, discharging A without further discussion with the neurosurgical team, and without an MRI, was not. This aspect of A's care was therefore unreasonable. It appeared that medical staff did not communicate in sufficient detail with each other to ensure the communication with the neurosurgical team occurred.

iv. In this respect, the Board was emphatic in their complaint response that discharge with no MRI or follow up occurred on the basis of advice from the neurosurgical team. Consultant 2 was clear in their initial statement that discharge was not their decision, it was based on further contact with the neurosurgical team. However, this has been contradicted by the evidence from the clinical records and a subsequent submission by the Board about the Specialist Registrar's recollection. The Board now acknowledged that there was no documented evidence of a further conversation with the neurosurgical team and accepted it was unlikely that it actually happened.

v. Moreover, the Board's reference to the normal CT angiogram in their response to SPSO enquiries was misleading given the clear advice to perform an MRI as well.

vi. Reasonable care for A would have been for A to have remained in the hospital and received an MRI scan with ongoing discussion with the neurosurgical team about the results of this. Discharging A without this further action was unreasonable. It was also the case that A's ongoing and worsening headache should have made medical staff more cautious about discharge. More reasonable care could have led to the identification of possible causes of bleeding that might have responded to treatment and led to a better outcome. However, it was not certain the outcome would have been different. Even so, given the possibility of a better outcome and for the sake of patient safety,

adherence to guidelines and investigation of cases like A where a poor outcome occurred is important.

19. I accept this advice.

(a) Decision

20. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

21. C complained to me about the standard of medical care and treatment provided by the Board to A when they attended Hospital 1 and found to have SAH. In reaching my decision, I have carefully considered C's account, the evidence from A's clinical records and the advice I have received which I accept in full.

22. I am satisfied from the advice I have received that A's initial management, including planned care and treatment, was reasonable and in line with the relevant guidance.

23. Nevertheless, it is clear from the advice I have received that the standard of medical care and treatment provided to A on 12 July 2023 was below that which A and their family were entitled to expect, in that there was an unreasonable failure to follow the advice of the neurosurgical team, and the guidelines, and perform an MRI. Nor was there clear evidence that a full stroke review occurred, which, again, was contrary to the neurosurgical team's advice.

24. Finally, there was an unreasonable failure to discuss A's discharge with the neurosurgical team beforehand and the advice I have received (and accept) is the decision to discharge without an MRI and ongoing neurological discussion was unreasonable.

25. The Board have provided varying accounts from the medical staff involved during the course of my investigation about this matter and it was only after repeated enquiries by my office that it became apparent to the Board that the neurosurgical team had not

been consulted before A's discharge. Even then, the Board said they could not be certain the decision to discharge was unreasonable in light of the CT angiogram results. I am extremely concerned that when the Board provided these accounts to this office, they did not identify the serious clinical failings in this case, particularly in relation to the circumstances of A's discharge - including that the relevant guidelines were not followed - and the potential impact on A and other patients. I am critical of this failure.

26. The advice I have received, and accept, is that the standard of communication between Consultant 2 and the Specialist Registrar may have been a contributary factor to why the planned MRI was not undertaken. As noted above, although the Board were unequivocal in their complaint response that discharge with no MRI or follow-up occurred on the basis of advice from the neurosurgical team, the evidence does not suggest this to be the case. Instead, it appears the responsibility for A's discharge lay with Consultant 2 in the absence of further advice from the neurosurgical team. The advice I have received is that the decision to discharge was unreasonable. The Board failed to recognise and identify this themselves, which is concerning.

27. While the Board said there was no specific documentation about whether an MRI scan was recommended, there are several documented entries recorded in A's clinical records by two doctors, as well as in the neurosurgical team's records, about the need for an MRI scan (see paragraph 18 above). Given the seriousness of A's condition, again, I am highly critical not only that an MRI was not carried out but also the lack of reflection and learning by the Board on this matter. I consider this in more detail under complaint point (b).

28. Turning now to the time it took to transfer A from Hospital 1 to the Hospital 2 on 13 July 2023, the Adviser considered that this was reasonable given A's condition and the need to stabilise them before the transfer. I accept that advice. I also welcome the Board's recognition of how distressing this would have been for A and their family.

29. In relation to the injustice as a result of the clinical failings, the advice which I received, and accept, is that it is not certain if the outcome would have been different had A received a reasonable standard of care from the Board. Having said that, it is clear

that an opportunity was missed to identify the cause of A's bleed which may have responded to treatment and led to a better outcome or experience.

30. I uphold this complaint.

(b) The Board failed to deal with C's complaint in a reasonable way

31. During the course of my investigation, my office identified concerns about the way the Board handled this complaint. Section 16 G of The Scottish Public Services Ombudsman Act 2002 requires the Ombudsman to monitor and promote best practice in relation to complaints handling. This means we can make recommendations on complaints handling issues without a specific complaint having been made by the complainant.

32. My complaints reviewer informed the Board that complaint handling would form part of our investigation and said the reasons for our concerns were that:

i. The Board failed to provide a clear and accurate account of what happened; the subsequent statements from relevant clinicians in response to SPSO enquiries differed significantly from the Board's complaint response.

ii. The Board's statement in their complaint response was that they discharged A on the advice of the neurological team at another Board when this advice was not evident from the records.

iii. The Board's response did not appear to be reasonable and was not supported by the clinical records in relation to, amongst other things, the circumstances around A's discharge on 12 July 2023.

The Board's response

33. In response to my complaint reviewer's enquiries, the Board said that:

i. While the complaint response was approached on a proportionate basis, with the benefit of hindsight, there was an anomaly in the statement provided by Consultant 2 which was not picked up.

ii. Comments were normally provided on a proforma which specifically asked if the comments provided reflect the clinical record. Regrettably, this was not used here and comments were provided by email. Complaints handlers reviewed statements and requested clarification etc as required. However, there was no reason for complaint handlers to have doubted the information provided by Consultant 2.

iii. They proactively liaised with other health boards when the need arose.

iv. They have alerted senior medical staff of the inaccurate account provided by Consultant 2 to share this with them and referred the matter to the Patient Affairs & Complaints Lead for reflection.

v. They apologised for the additional distress this failure caused A's family.

Advice obtained

34. The Adviser told us:

i. The Board's complaint response was emphatic that A had been discharged on the basis of specialist neurological advice. In their response to SPSO enquiries, the Board stated that in reality it was highly unlikely this advice from the neurosurgical team happened and the evidence from the records held by the neurosurgical team confirmed it did not happen.

ii. The Board did not acknowledge this error and how misleading it was. This was a significant failing as the Board should have reflected fully on this and on action to stop this happening again. The complaint response was based on clinician statements, which was not supported by the evidence from the clinical records.

iii. The Board's failure to acknowledge their initial error in their complaint response about the advice to discharge and their communication with the neurosurgical team was concerning. If C had not brought their complaint to SPSO, then what happened may not have been brought to attention. This was a

major failing of the complaints process and required more refection from the Board and action taken to reduce the risk of this occurring.

NHS Model Complaints Handling Procedure

35. The NHS Model Complaints Handling Procedure states the report of the Board's investigation should:

i. address all the issues raised and demonstrate that each element has been fully and fairly investigated;

ii. include an apology where things have gone wrong;

iii. highlight any area of disagreement and explain why no further action can be taken.

(b) Decision

36. In reaching my decision on about the way the Board handled and responded to C's complaint, I took into account the NHS Model Complaints Handling Procedure, the Board's responses and the advice I received and which I accept.

37. Under the NHS Model Complaints Handling Procedure, the Board should address all the issues raised and demonstrate that each element has been fully and fairly investigated. I do not consider this happened in C's case. It appeared the complaints team accepted consultant statements as a matter of fact and there was no attempt to verify and ensure they reflected, and were substantiated by, the clinical records or other corroborating source. Nor did they consider obtaining input from another health board when they stated in their complaint response that their management of A was based on advice from that health board. I believe they should have considered doing so, especially given the implication was that any error would have been down to the other health board.

38. In response, the Board said procedures were not followed and consultant statements were provided by email rather than by a proforma which included a reminder that comments should reflect the clinical records. The reason for not following

procedures is unclear; however, I consider it is reasonable to expect all clinicians who provide statements during the course of an investigation to ensure their comments are accurate, regardless of the process by which they were obtained.

39. I also consider it reasonable for statements to be quality checked, particularly in significant cases such as this prior to a complaint response being issued. That check would depend on the circumstances of the complaint, but in this case, even a simple enquiry to the clinicians to ask for confirmation that they had consulted records, might have prompted self-review by the clinicians themselves. I accept we can never know this for certain the point being that whatever the mechanism for obtaining statements (and other information), an essential element of NHS complaints handling is ensuring complaint responses accurately reflect the clinical records, and I have not seen any evidence that this was done.

40. The Board also provided varying accounts from the medical staff involved in response to our enquires during our investigation. This information should have been collated as part of a thorough investigation by the Board from the outset so that seemingly contradictory evidence was fully considered and reconciled and the facts of the matter established before they responded to C. The advice I have accepted is that on a key element of the complaint, the advice to discharge and communication with the neurosurgical team, the Board failed to acknowledge this error and how misleading it was especially to C and A's family. I agree with the Adviser that this was a significant failing, which the Board should reflect fully on and take action to prevent a recurrence.

41. As such, I find that the Board's complaint handling was unreasonable and I uphold this complaint.

42. In investigating this case and making my findings and recommendations, it is of considerable concern to me that my office has issued a number of recent decision reports and a public report into complaints about the Board where my office have made a number of similar findings[6]. These include, amongst other things:

[6] Case references 202304348, 202307773, 202310183, 202300512 – see reports on SPSO website.

i. Providing incomplete and / or inaccurate information to complainants and my office;

ii. Failing to address all the issues raised in complaint responses including the most significant or important issue;

iii. Failing to demonstrate each element of a complaint has been fully and fairly investigated; and

iv. Failing to identify and action appropriate learning.

43. It appears that in these cases the Board are failing to meet the requirements of the NHS Model Complaints Handling Procedure. As I stressed in a previous public report (202300512), complaints are important and when handled appropriately, they inform learning and improvement which help to improve services. Handled badly, they erode public confidence and trust in public services and can add avoidable stress and trauma for complainants (and those supporting them). I am drawing attention here to these cases given my concerns about the Board's performance in relation to complaints handling.

44. It is important that the Board has in place complaint handling procedures that support complaints handlers in conducting robust investigations, with appropriate levels of training, support and escalation routes. I consider the Board needs to review its procedures and training needs to address this as a matter of urgency. I also see this as an opportunity for the Board to learn from previous findings and recommendations to fully address their complaint performance and improve their practice. My recommendations for action are set out below.

45. I welcome that, in commenting on a draft of this public report, the Board have provided details of actions they have already implemented to improve their complaints handling. This action, together with the action set out in my recommendations in this case, should have a positive impact on the Board's complaint handling.

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:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point (a) I found that the standard of medical care and treatment was unreasonable in that before discharging A the Board failed to: • perform an MRI; • consult with the neurosurgical team; and • ensure a clear stroke	Apologise to C for the failings identified in this investigation in relation to the standard of medical care and treatment and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 23 August 2025

Rec. number	What we found	What the organisation should do	What we need to see
	review was carried out. Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • evaluate the evidence by checking the clinical records; • obtain input from another health board; • collate all the relevant information so that the facts were established before responding to the complainant; • acknowledge clear errors and significant clinical failings; • reflect and learn from the clinical and complaint handling failings.		

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

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint point (a) I found that the standard of medical care and treatment was unreasonable in that before discharging A the Board failed to: • perform an MRI; • consult with the neurosurgical team; and • ensure a clear stroke review was carried out.	Patients who suffer from an SAH should receive care and treatment that is line with the relevant guidelines and advice from specialist teams. If departing from relevant guidelines and/or specialist advice, this should be clearly documented including the reasons for doing so. Reviews carried out (e.g. stroke review) should be fully documented.	Evidence that the findings of my investigation have been fed back to the relevant clinical staff, in a supportive manner, for reflection and learning. By: 23 August 2025 Evidence that the Board have reviewed their systems to ensure the relevant guidelines for treating SAH are embedded in working practices and that reviews carried out are fully documented. Evidence that the Board have monitored awareness of and compliance with the relevant

Rec. number	What we found	Outcome needed	What we need to see
			guidelines in relation to this. For example, by the carrying out of an audit, and identifying and addressing training needs. By: 23 October 2025

We are asking the Board to do to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • evaluate the evidence by checking the clinical records; • obtain input from another health board; • collate all the relevant information so that the facts were established before responding to the complainant; • acknowledge clear errors and significant clinical failings; • reflect and learn from the clinical and complaint handling failings.	Complaints should be investigated fairly and fully and in line with the requirements of the NHS Model Complaints Handling Procedure. Complaint responses should be accurate, complete and address all the points raised in line with the NHS Model Complaints Handling Procedure. All relevant information in relation to an SPSO investigation should be provided at the outset of our enquiries. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. By: 23 August 2025 Evidence that the Board have reviewed their procedures for complaints handling to ensure that all relevant evidence is obtained (including from other organisations) and evaluated during the investigation. Evidence that the training needs for complaint handling staff have been

Rec. number	What we found	Outcome needed	What we need to see
		our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses	assessed and that relevant staff have access to online training and other tools to improve complaint handling and their approach to our investigations and findings. Evidence that the Board have monitored compliance with the Model Complaints Handling Procedure and SPSO legislation, for example, by the carrying out of an audit. By: 23 October 2025

Feedback for Lanarkshire NHS Board

My investigation has found that the standard of communication between clinicians may have been a contributary factor to why the planned MRI was not undertaken. I encourage the Board to reflect on this with clinicians.

Terms used in the report **Annex 1**

A	the aggrieved
the Adviser	a consultant in emergency medicine
C	the complainant, an advocate who brought the complaint on behalf of A's family
Consultant 1	a consultant in emergency medicine
Consultant 2	a consultant in general medicine
Consultant 3	a speciality doctor within the stroke team
CT angiogram	a type of x-ray used to examine blood vessels
CT scan	computerised scan - a scan that takes detailed pictures of the inside of a body.
SAH	subarachnoid haemorrhage, a bleed that is below one of the layers that surrounds the brain. It is a life threatening medical emergency that requires urgent intervention to prevent severe complications or death.
the Board	Lanarkshire NHS Board
Hospital 1	a hospital in the Lanarkshire NHS Board area
Hospital 2	a hospital in another health board area
MRI	magnetic resonance imaging, a type of scan used to see inside the body.
Specialist Registrar	a clinical fellow in acute medicine

List of guidelines considered **Annex 2**

National Institute for Health and Care Excellence (NICE) guideline [NG 228] - Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management (2022)