SPSO decision report

SPSO Scottish Public Services Ombudsman

Case:	**201301604, Grampian NHS Board**
Sector:	health
Subject:	clinical treatment / diagnosis
Outcome:	upheld, recommendations

Summary

Mrs C's son (Mr A) suffered from epilepsy. When Mr A began feeling increasingly unwell, his GP had requested a scan. However, the hospital consultant declined to carry this out. A couple of months later, a specialist registrar saw Mr A. He also requested a scan, but again, the consultant declined. The following year, Mr A's condition was worse and he was seen by another consultant who recommended a change in medication. However, within a few months, Mr A died suddenly. Mrs C believed that if Mr A had had a further scan, the outcome for him could have been different. She said insufficient investigations were made into his worsening condition and that he had been prescribed medication which made this worse.

We obtained independent advice from one of our medical advisers, who is a consultant neurologist (a specialist in diseases of the nerves and the nervous system), and carefully considered all the available documentation and the relevant clinical records. Our investigation found that, generally, the care and treatment given to Mr A was appropriate. The reason that he was not recommended for a further scan was that some years earlier he had had an MRI scan (Magnetic Resonance Imaging - a scan used to diagnose health conditions that affect organs, tissue and bone), which showed only some evidence of brain atrophy (wasting away). Because of this, and because there were no new neurological symptoms, it was not necessary to repeat the scan. The clinical records showed that Mr A had been given advice about his drug regime and that recommended doses were proportionate to his symptoms.

However, our investigation also revealed that, some years earlier, nursing notes had recorded an abnormal EEG (electroencephalography - a technique that records the brain's electrical activity). This was never picked up in Mr A's clinical notes and the EEG had not been carried out again, as our adviser would have expected in the circumstances. Similarly, after a specialist epilepsy nurse lost phone contact with Mr A, no action was taken to contact him. We noted that, although Scottish health guidelines suggest that these specialist nurses should have continuing involvement with epilepsy patients, there was no evidence that Mr A had been referred back to them for help or review. We, therefore, upheld Mrs C's complaint that Mr A's treatment had not been reasonable.

Recommendations

We recommended that the board:

- formally apologise to Mrs C for the omissions; and
- emphasise to appropriate neurology staff, in accordance with the Scottish Intercollegiate Guidelines Network guidance, the importance for patients of the assistance of specialist epilepsy nurses.