S.181/01-02

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

Borders General Hospital NHS Trust (the Trust)

Complaint as put by Mrs F

1. The account of the complaint provided by Mrs F was that while in the Middle East she sustained a fracture of the right femur which was fixed internally with screws by a surgeon at a local hospital. On return to Britain Mrs F had continuing pain and attended the Borders General Hospital. There a consultant orthopaedic surgeon (the Consultant) found that the screws had entered the acetabulum. The Consultant decided that a hip replacement was necessary and the operation was performed on 1 May 2000.

2. For the next five months Mrs F continued to have pain and a limp. This was investigated for infection with x-rays and blood tests, and because of a raised ESR (erythrocyte sedimentation rate – a possible indication of infection), a labelled white cell scan was performed. At a consultation on 3 October 2000 the Consultant decided to wait a further six weeks as x-ray and scan results were normal. At this consultation the question of a second opinion was raised by Mrs F, who was concerned that the delay in identifying and treating the cause of her pain presented a risk to the long-term condition of her hip. She made a private appointment with a consultant in London (the Private Consultant) who carried out a further hip replacement, since when Mrs F has been pain-free.

3. The matter subject to investigation was that post-operative management between May and October 2000 was inappropriate.

Investigation

4. The statement of complaint for the investigation was issued on 26 February 2002. The Trust's comments were obtained and relevant documents including Mrs F's clinical records were examined. The Ombudsman's investigating officer

took evidence from Mrs F and the Consultant. The actions of the Private Consultant are not within the Ombudsman's jurisdiction but the investigating officer took evidence from her in order to put the complaint into context. A Professional Assessor was appointed to advise on the clinical issues in this case and his report is reproduced in its entirety in paragraph 11 below. A glossary of the medical terms used in this report is attached as an annex. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Evidence of Mrs F

5. Mrs F set out her concerns in a letter to the Trust's Chief Executive on 18 December 2000. These included:

> 'On March 23rd I fell off a horse and sustained a fractured neck of femur … although I wished to be transported back to [Britain] … the … doctor overruled and therefore I was stuck. On March 25th I was taken to the operating theatre for four hours, where he inserted and reinserted four 3 ½" screws, X rays revealing that at least two had gone through to the acetabulum … I was flown home and came directly to the [Trust] on March 31st. [The Consultant] saw me on April 1st. X-rays taken on 2nd April 2000 revealed "at least two of the screws appear to protrude beyond the bony margin of the femoral head and at least two of the screws appear to have bent …". On seeing these x-rays [the Consultant] told me that 1st there was a risk of infection and that 2nd the only way to treat the hip now was to give me a total hip replacement which he would do in two weeks time. I was discharged home on April 6th in a great deal of pain …
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> 'On April 30th I was admitted … I was at the end of my tether with pain … On May 1st … I was taken to theatre … May 8th discharged home.
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> 'I saw [the Consultant] for my 7 week check-up on June 19th. He noted that I had quite a marked limp and knew I was still taking [pain relieving medication]. He said that he would see me again in May 2001 …
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> 'On August 21st I'd had enough … and phoned [the Consultant] and persuaded him to see me … the following day … August 22nd x-rays and bloods were taken. [The Consultant] remarked that the x-rays looked OK and said "changes in bone are the last thing to notice". He also stated that I should not be getting any pain – indeed, that I should never have

had any. On August 24th I phoned [the Consultant] for the result of my blood test. The E.S.R. was at 66. He said it was possibly an infection – he wasn't sure what could be done about it as infections were difficult to treat …

'I feel that [the Consultant] initially was slow to relieve me of extreme pain and did not take due care to ensure that there was no infection before he gave me the [hip replacement] on May 1st. No specific blood tests were performed i.e. E.S.R. or C.R.P. [C'Reactive protein] prior to the operation. No tissue culture or swabs taken. He did not take into account at 7 weeks post-op that I was still taking [pain relieving medication] … and walked with a pronounced limp. After repeated visits with a suspicion of infection he did not do anything or make any specific move to relieve me of the pain and difficulties that I was experiencing.

'I saw [the Consultant] again on August 29th and he arranged for me to have a bone scan on September 1st … September 5th [he] phoned me … to tell me no infection was seen on the bone scan and that he would see me again in one month. On October 3rd I saw [him] again. X-rays and more bloods. E.S.R. is 54. He said I'll see you again November 14th …

'On October 7th I went to see [the Private Consultant] … Very quickly having looked at the x-rays – copies of which [the Consultant] had given me – she told me the cup was loose and there was infection. She told me that the whole hip replacement needed to come out. I would need to be in traction confined to bed for 3 weeks and be given heavy duty antibiotics. After which, she would put in a new prosthesis.

'All this was duly carried out - November 6th the [hip replacement] removed and the new one inserted on November 27th … I returned home on December 8th and have been totally pain free since December 4th the first time since March 23rd.'

Evidence of the Private Consultant

6. The **Private Consultant** provided a copy of a letter which she had written to Mrs F's GP on 9 October 2000 which included:

'She has had a persistently high ESR of 66, 40 and now 54 … We do not have a C'Reactive protein [CRP]. There are x-rays of the hip taken in May

and again in August and by August the socket does look as though it has some demarcation.

'She continues to have difficulty in walking and to be in pain with the hip, which feels weak. Given the combination of the loose looking socket and the high ESR one would suspect that she has an infection behind the socket. I think, to confirm this, one should get new x-rays and a [CRP] done but if this is the case I, myself, would suggest that she had a … revision [a further hip replacement] …'

7. In letters to the Ombudsman the Private Consultant said that she had performed the further hip replacement 'which, at operation, looked infected, the cultures grew Staph[ylococcus] Epidermidis … I see no reason at all to have any doubt that Mrs F's hip was infected and that the correct treatment given that she had an infected hip with a loose socket was to revise it'. She further explained that she had taken five swabs, from different sites at the time of Mrs F's revision. She provided copies of the pathology reports on the results of the swabs and said 'The fact that all five samples grew Staph[ylococcus] Epidermidis and that three of them had some pus cells, I think to my mind indicates that this was infected …'.

Extracts from Mrs F's clinical records

8. Mrs M's clinical records included the following:

[4 May 2000 – radiology report by a Trust doctor] 'The position of the prosthesis appears satisfactory'.

[20 June 2000 – the Consultant's notes] 'Seven weeks post op. This lady is making good progress. Wound soundly healed. Good movement in the joint. Still walks with a slight limp … Advised with regards to exercise. Increase level of activity. See for review one year …'.

[22 August 2000 – radiology report by a Trust doctor] 'Compared to the film of 4.5.00 there is possibly a little increased translucency around the acetabular component of the prosthesis'.

[22 August 2000 – the Consultant's notes about that day's radiology report] '[Radiographs] obtained today show no obvious sign of any infection or loosening although there is a 1mm bone cement interface

change incompletely in relation to the acetabular component. The cause of this lady's right hip pain is worrying and of uncertain aetiology. In view of the obvious concern that there may be underlying sepsis, for an FBC [full blood count] and ESR sent today … for review in a weeks time with results of investigations'.

[22 August 2000 – letter from the Consultant to Mrs F's GP] 'Radiographs of the hip today are unremarkable. In summary the cause of this lady's hip pain remains uncertain and I have in the first instance taken blood for an FBC and ESR to pursue the possibility of underlying infection'.

[29 August 2000 – the Consultant's notes] 'Non-progressive symptoms. ESR raised at 66. Possibility of deep infection has been raised and in the first instance, to proceed to white cell labelled scan with subsequent aspiration and biopsy if this is abnormal'.

[1 September 2000 – radiology report by a Trust doctor of the white cell labelled scan] '… Appearances are entirely normal with no evidence of increased uptake around the prosthesis. There is therefore no evidence of infection'.

[3 October 2000 – the Consultant's notes] '… Has continuing pain … Clinic examination confirms some general tenderness … Wound remains soundly healed … I understand her ESR repeated by her GP is now 40 and I have repeated her full blood count and ESR today. Her white cell labelled scan was quite normal and at the present time, although the cause of her pain remains uncertain, I do not think there is any convincing evidence of any sepsis … and I will see her for review in six weeks with a further x-ray AP [anterior and posterior] & lateral right hip for prosthesis on arrival'.

[10 November 2000 – the Consultant's notes] 'Patient has elected to have hip replacement reviewed with [the Private Consultant]'.

Trust's response to statement of complaint

9. In the Trust's formal response to the Ombudsman the **Chief Executive** included:

'The Consultant saw and examined Mrs [G] on 1st April and confirmed the history of injury to her right hip which she has sustained [abroad] 9 days previously. On his examination, he found Mrs [G] to be fatigued but afebrile with no clinical anaemia. She appeared to have an isolated injury to her right hip where there was moderate residual swelling in her thigh and a healing surgical wound over the lateral aspect of the hip joint. Review of the radiographs, which Mrs [G] had brought back from the hospital [abroad], confirmed an intra-capsular fracture of the right hip with fixation with two apparent cancellous screws.

'The Consultant advised Mrs [G] that further detailed radiographs were required to determine whether the reduction of the fracture was adequate. On 2nd April 2000 he reviewed Mrs [G] again, and the radiographs of the right hip. The further radiographs confirmed that, unfortunately, the fracture position had been lost and the four internal fixation screws, which had been inserted, were ineffective. In consideration of the time since her injury, the Consultant did not consider that further operative treatment to reduce and provide further internal fixation of the fracture would offer any real potential for uncomplicated union. He advised Mrs [G] that a primary hip arthroplasty, once the wound had soundly healed would be appropriate. Mrs [G] was advised to continue with analgesia with or without traction for a few days but could subsequently mobilise with a view to discharge home and readmission when her surgery could be arranged.

'On 5th April 2000 the Consultant saw Mrs [G] and noted that her sutures had been removed, and her wound was continuing to heal without obvious complication. Mrs [G] was beginning to mobilise with a high pulpit walking aid and was reasonably comfortable. Mrs [G] was advised that she could go home with a review to be in 10 days time. At this time, she was listed for removal of the screws and a conversion to right hip replacement as a matter of urgency. Mrs [G] was seen at the clinic on 18 April 2000, her wound appeared to be healing well, with no evidence of any infection. The Consultant confirmed that arrangements had been made for her admission for hip arthroplasty in 12 days time. On 1st May, Mrs [G] underwent an Exeter cemented right total hip replacement.

'On 20 June, Mrs [G] was reviewed by the Consultant in the outpatient clinic, 7 weeks post operatively. He felt at this point that Mrs [G] was making good progress, the wound was soundly healed and there was good movement in the right hip joint. The Consultant also reported that Mrs [G] was walking with a slight limp and had therefore retained a stick. At this stage, he considered that Mrs [G]'s recovery was satisfactory, and he advised her regarding appropriate exercise and increase in her level of activity. An arrangement for review in one year's time was made as a matter of routine, and the Consultant wrote to her General Practitioner (GP) to this effect on this date. Mrs [G] requested her original radiographs from [abroad] at this consultation, and these were provided for her.

'On 18 August, the Consultant received a letter from Mrs [G]'s GP informing him that, although initially she had made slow improvement in her symptoms, she had continued to experience pain in her hip. Mrs [G] herself then telephoned the Consultant on 21 August 2000 about this and he subsequently arranged to see and review her in the clinic the next day - 22nd August 2000. The Consultant noted that she had continuing pain in her right hip, her wound was soundly healed, that she walked with a painful hip limp with no acute spinal symptoms apparent. Further radiographs obtained on that day showed no obvious signs of infection or loosening although it was noted that there was a 1mm bone cement interface change in relation to the acetabular component which was incomplete. The Consultant considered that the right hip pain was a cause of concern but was of uncertain aetiology.

'In view of this concern that it may represent an underlying infection, a blood specimen was obtained and sent for a full blood count and ESR. The Consultant arranged to review Mrs [G] in one week's time with the results of these investigations. The Consultant again wrote to the GP on this date and indicated the possibility of deep infection in the prosthesis and advised that a white cell labelled isotope scan should be performed in the first instance, which is a sensitive test for bacterial infection.

'This scan was performed on 1st September 2000. The results showed an entirely normal appearance with no evidence of increased uptake around the prosthesis, and the conclusion was therefore that there was no

evidence of infection in relation to the prosthesis. This report was received by the Consultant on 4th September 2000 and he telephoned Mrs [G] on that date to explain the result of the scan, and that consideration of a planned aspiration and biopsy of the hip in an attempt to identify possible infection was, at that stage, not required in view of the normal scan. He advised that she continue to mobilise with appropriate simple analgesia and walking aids with a further review in the clinic. The Consultant also wrote to the GP informing him of this advice given to Mrs [G] on the same day. Following this, the GP had telephoned the Consultant to discuss Mrs [G]'s continuing symptoms, it was suggested that a repeat blood count and ESR be arranged.

'The Consultant then reviewed Mrs [G] in the clinic on 3rd October, five months after her hip operation. He noted that she had continuing pain in the trochanteric area of her right hip, referred to her thigh which, although non-progressive, was present day and night and for which she took intermittent analgesia. Also noted was a fairly free range of pain free movement in the right hip joint with some pain on straight leg raising and noted that the ESR undertaken by her GP was reportedly improved but still elevated at 40mm/hr.

'At this consultation, the Consultant discussed fully with Mrs [G] the possible causes of her symptoms and considered that, as her white cell labelled scan had been quite normal that at that time, the cause of her pain remained uncertain. The Consultant did not think there was any convincing evidence of infection and advised that she continue to mobilise with analgesia with a further review in 6 weeks time, at which stage a further radiograph assessment of the hip prosthesis would be obtained.

'During this consultation, Mrs [G] informed the Consultant that she had, prior to attending the clinic, arranged for a second opinion from a surgeon who she considered had a particular expertise. Mrs [G] was provided with copies of her radiographs from the Borders General Hospital so that they were available to the [Private Consultant] who she planned to visit. A further blood count and ESR taken on this date confirmed a normal blood count but continued elevation of the ESR level at 54mm/hr.

‘Mrs [G] subsequently telephoned the Consultant informing him that she had seen the [Private Consultant], and the possibility of loosening the acetabular component and possible infection had been discussed. She also informed the Consultant that it was her wish to undergo treatment under the [Private Consultant’s] care. A follow up letter from Mrs [G]’s GP was received regarding this decision and that she would not be attending for the planned further follow up. The Consultant then wrote to Mrs [G] confirming that the arrangements for further follow up care with him had been cancelled.

‘Mrs [G]’s post-operative progress in the initial stages appeared to be satisfactory, therefore the follow up arrangements were made at the routine intervals for this type of surgery. On being informed by both the GP and Mrs [G] about the continued pain she was having, the Consultant saw her without delay in his clinic. At this time, he discussed the possible causes of her continued symptoms and in particular, the possible presence of infection. The investigations carried out thereafter were appropriate and were done without any significant delay. The possible presence of infection, which had been considered as a cause of the pain and raised ESR, had not been substantiated by the subsequent white cell labelled scan which would normally be expected to be a sensitive test for significant deep infection.

‘The Consultant had indicated to Mrs [G] that, if the scan had been abnormal, further investigation with an aspiration and soft tissue biopsy in an attempt to pursue the possible presence of infection would have been undertaken. The Consultant considered that the results of the investigation of her pain, i.e. full blood count, serial ESRs, radiographs and subsequent scans were inconclusive and the particular difficulties in obtaining a diagnosis were fully discussed with Mrs [G].

‘If indeed Mrs [G]’s symptoms had been due to early septic loosening of the prosthesis, it is likely that this would have become apparent as a result of further investigation and, in particular, further radiographs which had been planned for her clinic attendance on 14 November 2000. Had the presence of septic loosening been subsequently confirmed, then revisional surgery … would have been considered appropriate and undertaken at the Borders General Hospital.

'It is the opinion of the Consultant that, although inconclusive, the investigations of her symptoms were appropriate. Therefore the Trust takes the view that the post operative management of Mrs [G] was appropriate.'

Evidence of the Consultant

10. The **Consultant** explained at interview that he had been confident there was no infection when he operated on Mrs F on 1 May 2000. He had not done a bacterial swab at that time because there was no pus present. There was some granulation tissue where the screws from the operation abroad had entered the bone but this was not in an area of real relevance. He was confident that there was no clinical evidence of sepsis and as such had no reason to take a swab sample. He suggested a white cell labelled scan which was undertaken on 1 September to find out more although it had its limitations. He had since spoken to the doctor who conducted the scan and he now wondered if an organism had perhaps been present but in insufficient quantity to show up on the scan. At his last examination of Mrs F (3 October 2000), she had continuing symptoms which he would not have expected five months after the hip replacement, however, these did not necessarily indicate the presence of infection.

Report of the Ombudsman's Professional Assessor

11. I now set out the assessor's report.

Basis of report

(i) *This report is based on the documentation provided by the Ombudsman's office. This included the original complaint documentation, medical records and other correspondence, together with the account of Mrs F's oral evidence to the investigating officer. It is also based on an interview with the Consultant conducted by the investigating officer and myself.*

Background

(ii) *Mrs F travelled abroad in March 2000 to participate in a charity event. The event involved travel on horseback. On 23 March 2000 she fell off a horse and sustained injury to her right lower limb. She was taken to hospital. After investigation a diagnosis of displaced*

subcapital fracture of the proximal right femur was made. She subsequently underwent operation to reduce the fracture, the reduction being maintained by internal fixation utilising screws.

Comment: *In a letter of 18 December 2000 to the Trust Chief Executive, Mrs F stated that she had wanted to be transported back to Britain, and the insurance company had been willing to agree, but she was overruled by the local doctor. She described the hospital as small and ill-equipped.*

Events related to the Consultant and Private Consultant

(iii) *Mrs F was repatriated to the United Kingdom and attended the Trust on 31 March, eight days after the injury. She was admitted under the care of the Consultant, who confirmed the history and documented continuing pain, residual swelling of the thigh with a healing wound on the lateral aspect of the right thigh. Movement of the limb was limited by pain. A skin eruption compatible with insect bites was noted, and x-rays showed loss of position of fixation. Analgesia was prescribed. The Consultant was of the opinion that further fixation would be inappropriate and that hip arthroplasty would be the preferred surgical management once the wound had healed. At clinic review on 18 April the wound was noted to be soundly healed and arrangements were made to remove the fixation and insert a joint replacement. The operation was performed on 1 May. At operation 'there was moderate granulation tissue with no evidence of any infection in the superficial or deep layers'.*

Comment: *This was a correct decision. The fracture was displaced and Mrs F remained in considerable pain. The screws were invading the acetabulum. A delay was suggested in order to ensure there was no infection and that the wound was healed. There were no signs of infection at surgery.*

(iv) *Antibiotics were used peri-operatively and after the operation Mrs F mobilised with a walking aid and was discharged home on 8 May.*

(v) *At clinic review on 20 June, no cause for concern was identified in relation to the clinical progress. Arrangements for review were made.*

(vi) *On 15 August, Mrs F's GP wrote to the Consultant informing him of subsequent progress, noting constant pain and a failure to progress despite physiotherapy. The Consultant reviewed Mrs F again on 22 August, noting unexpected and continuing pain in her right hip. Examination of the wound gave no cause for concern. X-ray showed an incomplete 1mm bone/cement interface change in relation to the acetabular component. The Consultant did not consider this finding significant at that time. However, being suspicious of deep infection, he requested specific blood tests (erythrocyte sedimentation rate – ESR) and arranged to see Mrs F one week later on the 29th. At that visit an elevated ESR was noted (66mm/1hr). The possibility of deep infection was considered and a labelled white cell scan was ordered. (A radioactive 'label' is attached to white cells, reinjected into the blood stream, and the hip is then scanned to see if pus, formed from the white cells, is present.) This was performed on 1 September and reported as normal by a consultant radiologist. Accordingly, the Consultant was of the opinion that there was 'no confirmed evidence of infection to explain her continuing pain and raised ESR'. Review in one month was arranged.*

Comment: *Infection as a cause of the continuing pain was seriously considered. An x-ray showing development of a radiolucent line was suspicious of infection, as was the raised ESR. The negative white cell scan was not confirmatory, but a negative scan does not necessarily exclude infection. The possible hazards of further surgery at this point were weighed against a 'wait and see' policy; the latter choice was made – hence review in a month. This was a reasonable decision and was discussed with the patient.*

(vii) *Mrs F was seen again on 3 October. She had 'non-progressive but continuing pain' in the right hip with tenderness. ESR (repeated by the GP) was 40. No x-ray was taken but the condition was considered to be stable clinically, the Consultant's written note*

stating, 'I do not think there is any convincing evidence of any sepsis'. She was advised to continue to mobilise and would be reviewed again in six weeks. The Consultant noted, 'she is planning to seek a second opinion from [the Private Consultant]'.

(viii) *A week later Mrs F saw the Private Consultant, who recommended a two-stage revision hip arthroplasty. This decision was made as a result of the clinical history, the finding of a repeat ESR of 54mm and from a new x-ray. At surgery, infection was found with pus cells present microscopically, and five separate specimens grew Staphylococcus epidermidis. She has made a good recovery from this surgery.*

Comment: *Infection was confirmed to be present at surgery by the Private Consultant. It was suspected by the Consultant but he interpreted the results of the tests as inconclusive deeming it more safe to wait a further six weeks rather than operate in early October 2000. It is unfortunate that he did not have the benefit of the ESR results or a repeat x-ray when Mrs F was seen on 3 October, but she appears to have already made the decision to seek a second opinion without prior discussion with the Consultant.*

Conclusion

(ix) *The Consultant adopted a conservative approach to her pain, suspecting sepsis, and was disinclined to interfere in case it was unnecessary. Mrs F refers repeatedly to her severe pain, but pain is not* per se *indicative of sepsis. The raised ESR, x-rays and findings of tenderness suggested, but did not confirm, infection. The white cell scan was non-confirmatory. The Consultant was therefore placed in a difficult position and made a decision in October to wait a further six weeks on the grounds that he considered the condition to be stable and not deteriorating. However, Mrs F sought a second opinion of her own volition, and surgery was advised. This turned out to be successful and the Consultant was shown to have erred on the side of caution. To undertake revision arthroplasty prematurely in this particular situation without definite corroborative evidence could have been fraught with problems and the Consultant's more conservative approach was not necessarily incorrect management.*

(x) *I therefore come to the conclusion that the management of this lady's difficult clinical problem by the Consultant was appropriate for the interval between her initial presentation at the Trust in March 2000 and the final communication from the consultant on 10 October 2000.*

Findings

12. In reaching my findings I have been guided by the advice provided by the Ombudsman's Professional Assessor. Mrs F complained that the Consultant was initially slow to relieve her of the extreme pain she was suffering when she first consulted him. She also felt that he did not take proper care to ensure there was no infection before he performed the hip replacement operation. She considered that when the Consultant saw her on 20 June he did not take into account that she was still taking pain relieving medication and walked with a pronounced limp. Despite repeated visits with suspicion of infection he took no action to relieve the pain and difficulties she was having.

13. The Consultant was presented with a difficult problem with this case from the outset. Mrs F had clearly been managed in a less than optimal way abroad insofar as the initial fixation screws had been badly inserted and had to be removed. It was possible that infection had occurred at the time of insertion of the screws. The Assessor has commented that the Consultant's decision to opt for total hip replacement was correct. Mrs F was prescribed analgesia while awaiting the surgery and a period of observation was appropriate to ensure that there was no infection and that the wound was healed. There were no signs of infection when the surgery was performed. Antibiotics were used peri-operatively and after the operation. At review on 20 June no cause for concern was identified and the Consultant considered her progress satisfactory and planned to review her in one year. However, on 15 August Mrs F's GP advised the Consultant that Mrs F was in constant pain and failing to progress despite physiotherapy. The Consultant saw her on 22 August. The Assessor considers that at this stage infection as the cause of Mrs F's pain was seriously considered. However, the test results neither confirmed nor entirely ruled out infection. The Consultant then had to weigh the possible hazards of surgery against a 'wait and see policy'. The Assessor considers that the Consultant's decision to 'wait and see' at this stage was reasonable. When Mrs F was next reviewed (3 October 2000) the Consultant recorded that there was still no

convincing evidence of infection. He decided not to proceed to a third operation at that stage as her condition was stable and not deteriorating but to wait a further six weeks and repeat the tests then. The Assessor comments that undertaking revision arthroplasty without definite proof of infection could have been premature and fraught with difficulty. Although Mrs F successfully underwent a further hip replacement in November 2000 under the care of the Private Consultant when infection was found to be present, the Consultant's decision on 3 October to wait six weeks before reviewing Mrs F again was not wrong. It is not wrong to delay an important decision, such as this one to operate in October 2000, if the evidence for infection might become clearer after six weeks, and if the delay does not compromise the ultimate recovery. Therefore, I accept the advice of the Assessor and I do not uphold the complaint.

Conclusions

14. I have set out my findings in paragraphs 12 and 13.

Gillian Stewart
Acting Investigations Manager
duly authorised in accordance with
paragraph 11 of schedule 1 to the
Scottish Public Services Ombudsman Act 2002

February 2003

Annex

Glossary of medical terms

acetabulum	the cup-like socket on the external lateral surface of the pelvis to which the head of the femur fits to form the hip joint
afebrile	without fever
arthroplasty	replacement of a joint with an artificial joint
CRP (C'Reactive protein)	a protein the blood whose levels reflect the presence of inflammation in the body
ESR (erythrocyte sedimentation rate)	a possible indication of infection
intra-capsular fracture	a fracture (break) occurring close to the head of the femur within the capsule of the joint sepsis
sepsis	infection by micro-organisms in the body
Staphylococcus Epidermidis	type of bacterium (bug) that normally lives on the skin harmlessly but can get into the body and cause disease when infecting bones
trochanteric	the area of the femur between the main shaft and the head of femur (the round bit that forms the hip joint)
white cell labelled isotope scan	white cells in the blood fight infection and form pus. White cells can be labelled with radioactivity, injected into the blood and the area under investigation (ie hip joint) scanned to see if the radioactivity accumulates. This is a test for an infected joint.