Scottish Parliament Region: Mid Scotland and Fife

Case 200501851: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Vascular Surgery/Cardiology

Overview

The complaint brought by Mrs C concerns an alleged failure to promptly diagnose her late father's abdominal aneurysm. Mrs C believed that this delay made her father's condition inoperable and his death inevitable.

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to diagnose Mr A's abdominal aneurysm (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 11 October 2005 the Ombudsman received a complaint from the complainant (Mrs C) that Fife NHS Board (the Board) had failed to correctly and promptly diagnose her father's (Mr A) abdominal aneurysm. Mrs C believed that this failure precluded her father from having surgery to correct the problem and made his death shortly thereafter unavoidable.

2. The complaint from Mrs C which I have investigated is that the Board failed to diagnose Mr A's abdominal aneurysm.

Medical Background

3. Aortic aneurysms are bulges in the main artery which carries blood from the heart to the limbs and other organs. They are caused usually by hardening of the arteries and aggravated by high blood pressure. They are very common in this age group. Around 5% of men over 60 have one and this rises to over 8% at 80. It becomes life threatening only when it ruptures (bursts/leaks). Surgery for a ruptured aneurysm is very hazardous and survival rates are very poor even in fit patients. If discovered and operated on before rupture, survival is better but in the elderly and frail surgery is very risky.

Investigation

4. Investigation of this complaint involved reviewing the relevant medical and nursing records and the complaint file. I have also obtained the opinion of a medical adviser to the Ombudsman (the Adviser). I have not included every detail in this report but am satisfied that no matter of significance has been omitted. Mrs C and the Board have had an opportunity to comment on the draft report. A summary of terms used is contained in Annex 1.

Complaint: The Board failed to diagnose Mr A's abdominal aneurysm

5. Mr A, then aged 84, was admitted to the Accident and Emergency (A&E) department of Queen Margaret Hospital, Dunfermline (Hospital 1) on 20 February 2004 complaining of dizzy spells, lower back and groin pains. An ECG showed his pacemaker to be malfunctioning and this was thought to be the cause of his symptoms. Though his aorta could be felt at the time it was not

thought to be significantly dilated and there were no signs of leaking aneurysm. Mr A was admitted at 15:21 and seen by the A&E Senior House Officer (SHO) who sought advice from the medical team on call. The medical registrar attended at 18:00 and the medical records indicate that Mr A was stable and pain free at that time although Mrs C told me that Mr A was still in pain at this time. Mr A was transferred to the coronary care unit at Victoria Hospital, Kirkcaldy (Hospital 2) for replacement of his pacemaker. On arrival at Hospital 2 Mr A's condition had deteriorated and he was found to have a leaking aortic aneurysm. Since the vascular unit was located at Hospital 1, he was immediately transferred back and readmitted. Unfortunately Mr A was not considered to be fit for surgery and very sadly died the following day.

6. Mrs C complained that the doctors in Hospital 1 failed to diagnose a leaking aneurysm and that this resulted in unnecessary and uncomfortable transfers and delays without proper pain relief and with inappropriate care. Mrs C also complained that the delay prevented her father being suitable for an operation to remove the aneurysm. Mrs C also questioned whether a scan should have been carried out prior to Mr A's transfer as this would have shown the aneurysm.

7. The Adviser noted that on admission to Hospital 1, apart from a dry mouth and slow pulse, Mr A's observations were normal. The Adviser told me that it was noted in the medical record that Mr A had no history of aortic aneurysm and that an appropriate examination was performed which did not indicate anything sinister and revealed a soft abdomen with bowel sounds present. The records indicate that the aorta could be felt through the skin but was not found to be expanding with each pulse (which would have indicated an aneurysm). The ECG, however, showed abnormalities of conduction which were not being corrected by the pacemaker. The Adviser noted that the ECG was discussed with the medical registrar, who confirmed the findings of the earlier examinations and it was agreed that transfer to coronary care was needed.

8. The Adviser concluded that the notes and actions recorded by A&E staff seem careful and comprehensive. The normal observation, lack of abdominal tenderness or obvious aneurysm, good groin pulses, combined with the evidence of pacemaker malfunction would lead to the reasonable conclusion that the prime

cause of the symptoms was cardiac and that the patient was in need of urgent replacement/resisting of his pacemaker.

9. The records for Hospital 2 indicate that on arrival there Mr A had low blood pressure, his oxygen saturation had dropped slightly and he was in pain. Examination revealed slight tenderness of the abdomen and a 10cm pulsing mass could be felt. The Adviser noted that the diagnoses initially under consideration were 'acute urinary retention (though this was doubted because the bladder could not be felt), renal colic (kidney stones) or abdominal aortic aneurysm'. Mr A was reviewed by a senior doctor and whilst beginning treatment it was noted that the pulse in the groin was weakening, the legs were mottling, and the feet were cold. The case was discussed with surgeons and resuscitation with fluids begun during transfer back to Hospital 1.

10. The Adviser concluded that the notes for Hospital 2 were indicative of an observed deterioration. The drop in blood pressure between leaving Hospital 1 and arriving at Hospital 2 could have had a number of causes, but during the continued assessment symptoms more suggestive of abdominal aortic aneurysm evolved.

11. The medical records following Mr A's readmission to Hospital 1 noted that blood pressure was improved and Mr A had good pulses and warm limbs. A pulsing mass was felt but the abdomen was not very tender. At this time the diagnosis was 'aortic aneurysm ?leaking'. The Adviser commented that the notes confirm that there was a definite aneurysm on clinical examination, however, the patient's condition didn't suggest massive ongoing blood loss and it was rightly questioned whether or not it was leaking.

12. The Adviser concluded that, based on the review of the medical notes, there was no evidence of a leaking aneurysm on initial admission to A&E and only unconfirmed evidence of its leaking even on readmission to Hospital 1. The Adviser stated that Mr A clearly deteriorated in transit and clearly had an aneurismal swelling. However, whilst this was one possible cause for his decline it was never conclusively proven to have been the only or, indeed, even the main cause.

13. The Adviser also told me that while Mrs C's concern at the lack of a scan was entirely understandable it would not have been the correct course of action at that time as, based on the doctors' findings, it was more important to get the patient transferred to a coronary care unit where his pacemaker could be attended to. A failing pacemaker is itself a life-threatening condition. The Adviser noted that the decision not to operate or resuscitate was based upon the evidence that Mr A would most probably not survive surgery; and that, while no investigation was carried out to confirm whether the aneurysm was leaking or not, this was appropriate as Mr A was so ill that he was not going to survive and any tests would have been futile and undignified. The Adviser considered that no vascular surgeon would have offered surgery as a treatment even if the aneurysm had been detected routinely. From this point of view, therefore, the presence of an aneurysm which was showing no signs of leakage, even if detected for certain in A&E, would have been academic. The condition which needed treatment was Mr A's malfunctioning pacemaker. In response to the draft report Mrs C told me that it is her understanding that the malfunction in the pacemaker corrected itself and did not require any remedial action.

14. The Adviser was concerned that Mr A was subjected to transfer due to the poor arrangement of services between Hospital 1 and Hospital 2 at the time and considers it unsatisfactory that a hospital with an A&E department receiving this sort of emergency does not have a facility for coronary care and cardiac pacemaking on site. The Adviser considered that had this been the case it would have been easy to continue managing the pacemaker and to obtain the opinion of a vascular surgeon regarding the aneurysm, which would have gone a considerable way to addressing or avoiding the distress experienced by Mr A and the concerns raised by Mr A's family.

15. During the local resolution stage of this complaint about the NHS Mrs C met with representatives of the Board. At this meeting it was recorded that there were plans for the Hospital to move to a single site by 2010, making the need for transfer of such cases unnecessary in the future. The Adviser strongly endorses the need fro this move.

Conclusion

16. Mrs C's distress and anxiety following the sudden and unexpected death of her father is understandable. The medical advice I have received indicates that there was no clinical failure to diagnose Mr A's condition but that this was a rapidly developing medical situation where the medical priorities changed over a short period of time. I do not, therefore, uphold this complaint. However, I am concerned that the transfer between facilities contributed significantly to Mr A's discomfort during his terminal illness and his family distress both at the time and in the many months they have spent pursuing this complaint. I understand that the split in services as outlined in paragraph 14 is due to be rectified in 2010 and I strongly reinforce the need for such action.

27 February 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The aggrieved, Mrs C's father
The Board	NHS Fife Health Board
Hospital 1	Queen Margaret Hospital, Dunfermline
Hospital 2	Victoria Hospital, Kirkcaldy
A & E	Accident and Emergency Department
SHO	Senior House Officer (a doctor in the second year of post-qualification practice)

Annex 2

Glossary of terms

(Abdominal) Aeortic Aneurysm	Aortic aneurysms are bulges in the main artery (of the stomach) which carries blood from the heart to the limbs and other organs
ECG	Electrocardiogram – a test to measure the rate and regularity of heartbeats