Scottish Parliament Region: Glasgow

Case 200601268: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant Mr C raised a number of concerns about the treatment his wife (Mrs C) received at the Vale of Leven Hospital (the Hospital) during two admissions in September 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment which Mrs C received was inadequate(*not upheld*);

(b) there was a delay in carrying out a CT scan (*not upheld*); and

(c) there was poor communication concerning the need to inform the Procurator Fiscal of Mrs C's death *(upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 28 July 2006 the Ombudsman received a complaint from Mr C about the treatment Mrs C received at the Vale of Leven Hospital (the Hospital) during two admissions in September 2005. Mr C felt that in the second admission staff did not take into account what had happened in the first admission; there was a delay in carrying out a CT scan; and there were failures in communication. Mr C complained to Greater Glasgow and Clyde NHS board (the Board). He remained dissatisfied with their response and brought his complaint to the Ombudsman.

2. The complaints from Mr C which I have investigated are that:

(a) the treatment which Mrs C received was inadequate;

(b) there was a delay in carrying out a CT scan; and

(c) there was poor communication concerning the need to inform the Procurator Fiscal of Mrs C's death.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser) on the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

Clinical Background

5. Mrs C was a 75-year-old woman with a past history of dementia, high blood pressure and Transient Ischaemic Attacks. She was admitted to the Hospital on 2 September 2005 following a seizure at home. She was reviewed by a consultant who prescribed anti-epileptic medication and requested a CT scan of the head to exclude a stroke (CVA) or brain tumour as there was evidence of left hemiplegia. Mrs C was also commenced on co-amoxiclav. On 5 September 2005, although Mrs C was confused she was fully mobile and was discharged on 6 September 2005. Mrs C was re-admitted to the Hospital just

before midnight on 8 September 2005 following a further seizure and weakness in the left arm and face. She also had problems with altered speech and swallowing. Mrs C was seen by a doctor after admission and a CT scan which was performed within 12 hours identified a large haemorrhage in the right side of the brain. At the morning ward round (9 September 2005) a consultant increased the anti-epileptic dose and altered Mrs C's medication for high blood pressure. A neurosurgical opinion was requested over the telephone, which was that surgical intervention would not be advisable partly because of Mrs C's co-morbidity but also the technical difficulty of the operation made this hazardous. The decision was taken, after discussion with the family, that should Mrs C deteriorate then she would not be resuscitated. Mrs C was fed and treated by steroids (to reduce intracranial pressure) inserted via a naso-gastric tube. When the tube became dislodged it was replaced with some difficulty until a PEG tube could be inserted to maintain Mrs C's nutrition. On 25 September 2005, Mrs C's chest was noted to be noisy and an infection was suspected, therefore, metronidazole was prescribed. Mrs C was reviewed in the early hours of 26 September 2005 but she continued to deteriorate and she died at 06:15.

(a) The treatment which Mrs C received was inadequate

6. Mr C complained to the Board that following his wife's first admission she had only been prescribed aspirin and yet she was re-admitted three days later having had a stroke, therefore, he questioned whether the original diagnosis, treatment and decision to discharge were correct. He wondered whether staff involved in the second admission had fully taken into account what had happened during the first admission and had that had a bearing on the treatment she received and whether it had been appropriate. He noted that Mrs C had been admitted just before midnight on the second admission (paragraph 5) yet it was not until just after 09:00 that Mrs C was reviewed by a doctor and he arranged for a CT scan to be performed.

7. The Board's Director of Service Delivery (the Director) responded to Mr C. She explained that medical staff were fully aware of Mrs C's medical history. During the first admission it was felt that Mrs C might have had a stroke although epilepsy could not be ruled out. Medication was prescribed to prevent her seizures and control her agitated state. A CT scan was reported on 5 September 2005 and the findings were consistent with a patient of Mrs C's age who suffered from dementia. It was appropriate to prescribe aspirin and discharge Mrs C home. During the second admission, Mrs C was reviewed by

a consultant at 09:00 on the morning following admission where she was found to be unconscious and unresponsive. Mrs C would not have been a candidate for surgical intervention whatever the outcome of a CT scan. However, an urgent CT scan was requested; it took place the same day and it revealed that Mrs C had suffered a massive brain haemorrhage.

8. The Adviser said that, given Mrs C's medical history, it was appropriate for medical staff to prescribe valporate and order a CT scan on Mrs C's first admission. As Mrs C had recovered from her seizure and temporary weakness and was independently mobile it was reasonable to discharge her home on 6 September 2005. The records do not indicate that there was any evidence of the massive haemorrhage which was noted on 9 September 2005. The Adviser was critical, however, that no detailed neurological or physiotherapy assessment was recorded before discharge.

9. The Adviser told me that on the second admission the stroke was more pronounced and the brain damage progressed to left sided paralysis and eventually to a coma. He felt the clinical records were reasonable and indicated that Mrs C was kept under review. The Adviser thought that Mrs C's assessment and care would have been challenging in view of her confusion, agitation and paralysis and that nursing and medical staff had provided a reasonable and appropriate level of care. He continued that Mrs C had been assessed by a doctor within 30 minutes of her admission and by a consultant at 09:00 the following morning which would be the usual practice for such an admission.

(a) Conclusion

10. Mr C was concerned that his wife received inadequate care and treatment during the two hospital admissions. The advice which I have received and accept is that medical staff prescribed appropriate medication for Mrs C and arranged suitable investigations during the first admission and that it was reasonable to discharge her home once she had regained mobility. I note the Adviser's comments about the lack of recording of any detailed neurological or physiotherapy assessments prior to the discharge. Staff may like to reflect on this issue and consider whether there are any lessons to be learned from this case. It was clear that Mrs C's condition was more serious when she was admitted for the second time and this would have been challenging for medical staff. Nevertheless I am satisfied that Mrs C received a reasonable and appropriate level of care. Accordingly I do not uphold this aspect of the

complaint.

(a) Recommendation

11. The Ombudsman has no recommendations to make.

(b) There was a delay in carrying out a CT scan

12. Mr C complained about the time taken to arrange Mrs C's CT scan. She was seen by a doctor at 09:00 on 9 September 2005 and the scan took place at about 12:30. Mr C believed that the CT scan request was not marked as urgent and that two other patients received a CT scan before Mrs C. Mr C believed that the scan should have been treated as a priority and had it been so then it could perhaps have affected his wife's subsequent treatment.

13. The Director responded that Mrs C was reviewed by a consultant and an urgent request for a CT scan was made. The request was taken to the x-ray Department by hand and was logged as being received at 09:40. Two patients received a CT scan prior to Mrs C as their requirement was clinically more urgent than Mrs C. The scan took place less than three hours from being received in the x-ray Department which is in line with SIGN Guidelines.

14. The Adviser said that Mrs C received her CT scan around 12 hours following admission which is well within the advisable time interval in stroke protocols. Even if a CT scan had been performed earlier and this had identified the progressing haemorrhage nothing could have been done to prevent it continuing. The Adviser mentioned that the SIGN Guidelines state that in the case of a suspected stroke, CT scan should be completed within 48 hours. He said although there are circumstances whereby a CT scan could be carried out more urgently, Mrs C's would not have satisfied the criteria. The Adviser was satisfied that the CT scan had been carried out in a reasonable time.

(b) Conclusion

15. Mr C was concerned about the time taken to carry out the CT scan and that other patients received their scans before Mrs C. Based on the advice which I have received I am satisfied that Mrs C received her CT scan within the time recommended in the national guidelines and that the priority which staff afforded to the request was reasonable. Accordingly I do not uphold this complaint.

(b) Recommendation

16. The Ombudsman has no recommendations to make.

(c) There was poor communication concerning the need to inform the Procurator Fiscal of Mrs C's death

17. Mr C said that although Mrs C was ill he had no idea that her death in the early hours of 26 September 2005 was imminent. He had arrived at the Hospital at lunch time to collect the death certificate and was told that the doctors had had a meeting and had decided not to issue a death certificate and would refer the matter to the Procurator Fiscal the following day as it was a public holiday. He said he was also told that the cause of death was not in dispute but because Mr C had made criticisms about the time taken to arrange a scan the doctors felt it was appropriate to contact the Procurator Fiscal. Mr C demanded that the death certificate be issued immediately and one was issued shortly afterwards. Mr C had not been told that a consequence of him having expressed concerns was that the issue of the death certificate would be delayed pending contact with the Procurator Fiscal. He felt that when this was the case then families should be told in advance that if they voice concerns then this will lead to a delay in the issue of the death certificate. Mr C said that he had received conflicting information from the Hospital as regards the involvement of the Procurator Fiscal following Mrs C's death.

18. The Director responded that the procedure, as directed by the Procurator Fiscal, is that when a family reports concerns about the management and the circumstances of a family member's death, then the case should be discussed with the Procurator Fiscal. It is for the Procurator Fiscal to decide whether a post mortem examination is required. In this case, Mrs C died at a weekend, therefore, the consultant on call was contacted and he gave the instruction to issue the death certificate and to contact the Procurator Fiscal. An apology was made that a proper explanation about the circumstances when the Procurator Fiscal had to be contacted was not provided and for the fact that caused the family some distress. The Director continued that feedback from the complaints process is used to identify issues for improvement in order that corrective action can be taken.

19. The Adviser could understand why the consultant gave instructions to his staff that in the event of Mrs C's death, to report it to the Procurator Fiscal as Mr C had been critical of the treatment afforded to Mrs C. However, it was the way in which this was conveyed to Mr C that caused the problems. It is

necessary for doctors to report a death to the Procurator Fiscal if there is doubt about the cause or suspicion on the part of the doctors that death was associated with matters such as alcohol, self neglect, poison etc.

(c) Conclusion

20. Clearly Mr C received conflicting information from staff as to the circumstances which would necessitate contact with the Procurator Fiscal following the death of Mrs C. I can understand that he would have been distressed when he returned to the Hospital and expected to uplift the death certificate to be told that it could not be issued pending a decision from the Procurator Fiscal. The Board have accepted there was a failing in this regard and have said that feedback from this case is used to identify issues for improvement. Accordingly I uphold this complaint.

(c) Recommendation

21. The Ombudsman has no recommendations to make.

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Hospital	Vale of Leven Hospital
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional medical adviser
The Director	The Director of Service Delivery
SIGN	Scottish Intercollegiate Guidelines Network - Organisation responsible for the development of National Guidelines whose aim is to improve the quality of health care for patients in Scotland

Annex 2

Glossary of terms

CT scan	Computed Tomography Scan: Pictures of structures within the body created by a computer that takes the data from multiple x-ray images and turns them into pictures
Co-amoxiclav	Antibiotic
Dementia	The loss of intellectual functions such as memory, personality, mood or behaviour
Haemorrhage	Bleeding
Hemiplegia	Paralysis affecting one side of the body
Metronidazole	Medication to treat infection
Naso-gastric tube	A tube inserted through the nostril directly to the patient's stomach
PEG tube	Percutaneous Endoscopic Gastrostomy tube. Surgical procedure to provide nutrition directly into the patient's stomach
Stroke or CVA	Interruption of the blood supply to the brain
Transient Ischaemic Attack	Minor stroke which result in neurological deficits which usually resolve within 24 hours
Valporate	Anticonvulsant medication