Scottish Parliament Region: Highlands and Islands

Case 200503286: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Gastro-intestinal

Overview

The aggrieved (Mr A) raised a number of concerns, through his Member of the Scottish Parliament (Mr C), about the treatment received by his wife (Mrs A) prior to and during an admission to Raigmore Hospital (the Hospital) in 2000.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the hospital admission was caused by the staff's failure to ensure that Mrs A received vitamin B12 injections *(not upheld)*; and

(b) staff incorrectly stated there were traces of benzodiazepines in Mrs A's urine samples and this led to Mr A being interviewed by the police *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 27 February 2006 the Ombudsman received a complaint from Mr A, through his MSP (Mr C), about the treatment received by his wife (Mrs A) prior to and during an admission to Raigmore Hospital (the Hospital) in 2000.

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

(a) the hospital admission was caused by the staff's failure to ensure that Mrs A received vitamin B12 injections; and

(b) staff incorrectly stated there were traces of benzodiazepines in Mrs A's urine samples and this led to Mr A being interviewed by the police.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and complaints correspondence between Mr A, Mr C, and Highland NHS Board (the Board) who have administrative responsibility for the Hospital. I obtained advice from one of the Ombudsman's professional advisers (the Adviser) on the clinical aspects of this complaint and I made a written enquiry of the Board.

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 and a glossary of medical terms is at Annex 2. Mr A and the Board were given an opportunity to comment on a draft of this report.

Clinical background

5. Mrs A had surgery in December 1993 for cancer at the junction between the oesophagus and stomach. The operation necessitated removal of the lower part of her oesophagus and the whole of the stomach. Continuity of the gastrointestinal tract was established by joining the remaining oesophagus to the small intestine ('oesophago-jejunal anastomosis'). Postoperatively, Mrs A was followed-up by her Consultant Surgeon (the Consultant) who in a letter to Mrs A's GP (which I have seen) recommended Vitamin B12 injections from September 1999. However, the first Vitamin B12 injection was not administered until 29 September 2000, one year later. Following an episode of oesophageal thrush that caused difficulty in swallowing, Mrs A lost excessive weight, became somewhat dehydrated and was admitted to the Hospital at the request of her GP on 18 October 2000. She was treated with intravenous fluids and

replacement of essential vitamins and minerals prior to artificial feeding of liquid feed through a small bore feeding tube introduced into the small intestine via the nose (N/J feeding). On 25 October 2000 Mrs A became sleepy and unrousable. At this time, analysis of her urine apparently revealed the presence of a benzodiazepine drug. Since self-medication was denied and none had been prescribed or administered by hospital staff, the police were informed and police statements were taken from Mr and Mrs A. Subsequent examinations of the urine were normal and Mrs A recovered consciousness spontaneously. Mrs A had a prolonged hospitalisation period during which she was given intensive nutritional support by N/J feeding. She was discharged home on 30 December 2000 and followed-up by the Consultant in his out-patient clinic.

(a) The hospital admission was caused by the staff's failure to ensure that Mrs A received vitamin B12 injections

6. On 7 January 2004, Mr A complained to the Board that he had discussed his concerns about his wife's treatment with medical staff on a number of occasions but they had not been able to answer his questions. He wanted to know why had her health deteriorated to such an extent that she had to be admitted to the Hospital as an emergency. He wanted to know what was the trigger that put her in a coma as previously she had followed a normal diet and taken supplements in an effort to maintain her weight. Mr A also felt his wife's GP Practice (the Practice) had been negligent in their failure to ensure that Mrs A received Vitamin B12 injections as advised by the Consultant in September 1999 and had they done so then her subsequent problems would not have arisen. He had also checked the internet for Vitamin B12 deficiency symptoms which seemed to be consistent with Mrs A's condition prior to the hospital admission in October 2000. Mr A said that he had not complained earlier because he had had to care for his wife since her discharge from the Hospital. He said he had complained to the Practice in September 2000 but had not been advised of the complaints procedure or how to progress matters further.

7. The Medical Director at the Board responded to Mr A that he would arrange for an independent medical report to be completed by a clinician from outwith the Board area. The report (which I have seen) found that there was a failure in the system and that the Practice had not administered vitamin B12 injections as requested by the Consultant but that this was not the cause of Mrs A's sudden deterioration in the Hospital. The Medical Director wrote again to Mr A and explained that Mrs A did receive vitamin B12 injections from

September 2000 and had three injections prior to the hospital admission in October 2000. It was accepted that there was a failure in the continuity of care because the Practice had not started the injections in 1999. However, this omission was not thought to be the cause of Mrs A's sudden deterioration and admission to the Hospital. Additionally, If Mrs A had been allergic to the injections it would have shown while she was at home. The Medical Director said if the cause of Mrs A being in a coma in hospital was caused by lack of Vitamin B12 injections she would have shown signs of severe anaemia which was not the case. On review, it was felt that Mrs A was suffering from severe protein calorie malnutrition. While she was a patient in the Hospital, action was taken on fluid and mineral replacements. These unmasked deficiencies in other nutrients which led to her rapid deterioration and Mrs A also suffered a chest infection.

8. The Adviser explained that eating is usually difficult following such surgery due, in part, to mechanical problems but also to the impaired digestion and loss of sensations of appetite and satiety. The removal of the whole stomach, therefore, always results in significant weight loss and various nutritional deficiencies which are often sufficient to be called malnutrition. The stomach also produces a protein-like substance ('intrinsic factor') without which Vitamin B12 cannot be absorbed. Vitamin B12 deficiency will always eventually develop following total gastrectomy. When sufficiently severe, Vitamin B12 deficiency causes a) anaemia, b) damage to the peripheral nerves that impairs sensation and causes muscular weakness (paralysis).

9. The Adviser reviewed the clinical notes and found them generally to be of an adequate standard. Mrs A's blood levels of Vitamin B12 were already low on 3 September 1999, six years after her gastrectomy. A consequence of severe Vitamin B12 deficiency is anaemia. When the blood level of Vitamin B12 becomes very low evidence of disturbed sensation and weakness first develops in the legs. Since Vitamin B12 deficiency is inevitable following total gastrectomy, and since the neurological consequences of deficiency can be irreversible, many practitioners recommend replacement Vitamin B12 injections every three months immediately following surgery. In reality, such early treatment is largely motivated by the issues of safety because a normal liver would usually contain sufficient stores of Vitamin B12 for about five years before injections become necessary. Nevertheless, Mrs A's blood levels of Vitamin B12 recorded in September 1999, while low, were not low enough to cause symptoms.

10. The Adviser noted there was a clear failure by the Practice to prescribe Vitamin B12 injections when requested by the Consultant from September 1999 to September 2000. In September 1999, Mrs A had already become very slightly anaemic. There was, therefore, a definite clinical risk associated with the delay in starting her treatment. However, in the absence of severe anaemia or typical neurological signs, there is no evidence to suggest that her admission to the Hospital or her subsequent episode of unconsciousness were caused or precipitated by her Vitamin B12 deficiency. The Adviser said that the clinical correspondence indicates that Mrs A was a relatively slim lady prior to her major surgery for cancer. For the reasons outlined earlier in this report, significant weight loss is almost universal following this type of surgery. Mrs A's present weight and nutritional status would indicate that nutritional supplementation would almost certainly be required long term - but particularly so if food intake is further curtailed by a superimposed problem such as difficulty in swallowing due to thrush. Nocturnal N/J feeding is the most effective, safe and pragmatic way of achieving this long term.

11. In summary, the Adviser believed that the failure of the Practice to prescribe Vitamin B12 injections for Mrs A in 1999 posed a significant risk to her health. However, despite the mildly abnormal blood tests in September 1999, Mrs A appears to have come to no harm as a result of the delayed treatment. Her admission to the Hospital and her subsequent episode of impaired consciousness cannot be blamed on Vitamin B12 deficiency. The Adviser felt Mrs A's clinical management, investigations and treatment in the Hospital were of an entirely appropriate standard.

(a) Conclusion

12. Mr A had great concerns that the lack of Vitamin B12 injections from September 1999 to September 2000 had led to Mrs A's deteriorating condition and admission to hospital in October 2000. However, the advice which I have received and accept is that the consequence of the type of surgery which Mrs A endured previously would have led to her significant weight loss and nutritional deficiencies. If Mrs A had developed severe Vitamin B12 deficiency she would have shown evidence of anaemia and damage to the peripheral nerves. This was not the case and her hospital admission was as a result of other factors.

13. However, I am concerned that the Practice did not begin the Vitamin B12 injections as directed by the Consultant in September 1999 and that the Adviser

has stated that this omission posed a significant risk to Mrs A's health. I have not considered the reasons why this did not happen as technically the complaint against the Practice was time-barred but I am aware that Mr A raised this issue through the Board. Therefore, I invite the Board to share this report with the Practice to highlight my concerns and that they should review their procedures to see if the omission to action the Consultant's request to prescribe Vitamin B12 injections was a result of a procedural failing and that they take corrective action to prevent a similar occurrence. In summary, I am satisfied that the lack of Vitamin B12 injections was not the cause of the hospital admission and accordingly I do not uphold this aspect of the complaint.

(b) Staff incorrectly stated there were traces of benzodiazepines in Mrs A's urine samples and this led to Mr A being interviewed by the police

14. Mr A complained that he wanted information from the Board relating to events subsequent to Mrs A's admission to the Hospital which involved a police investigation into his background.

15. In correspondence to Mr A and Mr C, the Chief Operating Officer explained that the initial urine test found traces of benzodiazepine (which I have seen) but a more in-depth analysis failed to identify a benzodiazepine and the police investigation was concluded. It was appropriate for staff to contact the police although it was not possible to explain why the original results showed a trace of benzodiazepine. The Medical Director had also informed Mr A that the independent medical report had commented that Mrs A's urine test was positive for benzodiazepine but he agreed with the subsequent forensic science view that benzodiazepines were not present. The Medical Director said it was thought doctors may have been distracted by the report of benzodiazepines but there was no evidence this caused her coma.

16. The Adviser told me it was clear that the apparent presence of benzodiazepine in Mrs A's urine represented a clinical risk to her. The clinical records indicate that considerable thought and effort went into trying to establish the source of the urinary findings and the problem was appropriately discussed with the Medical Director. Under the circumstances, and with a positive urine test report, the clinical team would have no option but to contact the police.

(b) Conclusion

17. Mr A wanted to know the circumstances which resulted in one of Mrs A's urine tests reading positive for benzodiazepine drugs and that he was subsequently interviewed by the police. While I appreciate that Mr A would have been concerned about the positive result and police involvement I can understand why staff acted as they did. They undertook thorough enquiries and in the absence of an explanation for the positive result (i.e. staff had not prescribed benzodiazepine drugs) then they were obliged to contact the police. Had the staff not taken appropriate action then they would have been open to justified criticism. (Note:- I should point out that it has not been possible to establish why the original result at the Hospital lab a showed positive result, which was confirmed by the police forensic lab, yet subsequent more in-depth analysis failed to identify a benzodiazepine).

18. The Board informed me that they did not have a policy which covered such an occurrence as it happens rarely but they would produce written guidance for staff to follow in future. Accordingly I have decided not to uphold this aspect of the complaint.

19. Although I have not upheld the complaints I hope Mr A will be assured that his complaints have been considered independently and that he has obtained explanations relating to his concerns.

20 June 2007

Annex 1

Explanation of abbreviations used

Mr A	The aggrieved
Mr C	The complainant
Mrs A	Mr A's wife
The Hospital	Raigmore Hospital, Inverness
The Board	Highland NHS Board
The Adviser	The Ombudsman's medical adviser
The Consultant	The Consultant surgeon responsible for Mrs A's care and treatment
The Medical Director	The Hospital Medical Director
The Chief Operating Officer	The Chief Operating Officer at the Hospital
The Practice	The GP Medical Practice where Mrs A was registered as a patient

Annex 2

Glossary of terms

Benzodiazepine drugs	Sedative drugs
Gastrectomy	Operation to remove the stomach
Intravenous	Into the vein
Oesophagus	Gullet
Thrush	Fungal infection