Scottish Parliament Region: Glasgow

Case 200600011: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Clinical Treatment; Appointment and Biopsy Result delays

Overview

The complainant (Ms C) raised a number of concerns about clinical treatment and delays in appointments and results.

Specific complaints and conclusions

The complaints which have been investigated are that Greater Glasgow and Clyde NHS Board (the Board) failed to:

(a) perform the correct biopsy in the first instance (*upheld*);
(b) arrange timely follow-up (*upheld*); and
(c) report biopsy results in a timely manner (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board make a written apology to Ms C for all the identified failures.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 23 January 2007 the Ombudsman received a complaint from the complainant (Ms C) that Greater Glasgow and Clyde NHS Board (the Board) failed to provide her with appropriate and timely treatment from February 2005. Because of this failure Ms C suffered unnecessary physical and emotional distress in pursuing and resolving the matter. Ms C first complained to the Board in June 2005 and received a final written response in November 2005. The Board apologised to Ms C for the error in performing the biopsy and the delay in obtaining an appointment and explained what action was being taken to help avoid any repetition of these errors. Ms C first approached the Ombudsman's office in April 2006. Ms C's complaint was not received in this office until January 2007 by which time Ms C had additional concerns which had not been addressed by the Board.

2. The complaints from Ms C which I have investigated are that the Board failed to:

(a) perform the correct biopsy in the first instance;
(b) arrange timely follow-up; and
(c) report biopsy results in a timely manner.

Investigation

3. Investigation of this complaint involved obtaining and reviewing Ms C's clinical records and the NHS complaints file. I also reviewed all the documentation supplied by Ms C. Because not all the matters complained of had yet been considered by the Board I sought their comments on the outstanding issues. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to perform the correct biopsy in the first instance

4. Ms C was referred by Consultant 1 (a consultant at the Victoria Infirmary, Glasgow (Hospital 1)) for a right-side vulval biopsy under general anaesthetic at the day surgery unit at the Southern General Hospital, Glasgow (Hospital 2) on 23 February 2005. Ms C complained that this operation was performed in error on the left-side. Ms C realised the error the following day but waited for her four week follow-up appointment with Consultant 1 to confirm or clarify the matter. Ms C's follow-up appointment was delayed until July 2005 (see complaint (b)) at

which time she raised the question of which side the biopsy had been taken from with Consultant 1 who confirmed that there had been an error and apologised for this. Consultant 1 explained that the error had occurred due to a misunderstanding by staff as to whether the operation request referred to the right-side of the patient or the staff member performing the biopsy. Consultant 1 also informed Ms C that discussions had taken place to ensure that this misunderstanding did not happen again. Consultant 1 made arrangements for the correct procedure to be carried out under local anaesthetic on 22 September 2005 at Hospital 1. The result of this second biopsy showed non-malignant changes which required further follow-up.

5. In their response letter of 7 October 2005 the Board apologised for the 'obvious additional distress' caused by the error in performing the biopsy on the wrong side. In their response of 11 November 2005 the Board advised Ms C that the error would be discussed at the next Gynaecological Risk Management Group and procedures would be reviewed to ascertain what action might be taken to ensure that there was no repeat of this problem. The Board apologised again for the distress caused.

(a) Conclusion

6. The facts of this complaint are not in dispute; there was an error in performing the biopsy on the wrong side and this caused additional and avoidable distress for Ms C. I note that the Board and Consultant 1 have apologised for this and action has been taken to ensure lessons are learned from the error. I uphold this complaint but as action has already been taken to apologise and address the underlying problem the Ombudsman has no further recommendation to make.

(b) The Board failed to arrange timely follow-up

7. Ms C told me that she had expected to receive her follow-up appointment four weeks after her initial biopsy. When this did not arrive she made numerous attempts to find out why and eventually contacted Consultant 1's secretary. Staff advised that there were delays being caused by a new computer system. Ms C was told that a follow-up appointment would be sent for July 2005 (in the event it was received for 4 August 2005).

8. In their response dated 7 October 2005 the Board stated that following the biopsy in February 2005 an appointment card was forwarded to the Gynaecology out-patient reception at the Hospital. In April and May 2005 the

computerised hospital patient information systems for Hospital 1 and Hospital 2 were being merged and there were delays in actioning some appointment requests. However, it had not been possible to determine whether the appointment request card had ever been received by out-patient reception so it was not clear why the delay had occurred. The Board apologised for any upset and distress caused by the delay.

(b) Conclusion

9. It has not been possible to determine whether the appointment delay was caused by a failure in the referral to the out-patient reception or the new computer system being installed or indeed both. Whatever was the case there was an excessive delay (beyond the timescales Ms C had been led to expect) in arranging the appointment and I uphold this complaint. As the Board have apologised for the delay and the transfer to the new computer system was a discrete event which is now complete, the Ombudsman has no recommendation to make.

(c) The Board failed to report biopsy results in a timely manner

10. Following the biopsy in February 2005 Ms C did not receive the results of this (incorrect) biopsy. At her appointment in August 2005 she asked Consultant 1 for the result but he was not able to give this to her as he could not find it in her medical record. Ms C asked for the results again on 22 September 2005 at her second biopsy but again the results could not be found in her records. Following Ms C's surgery on the right-side she continued to experience pain on the left-side and was referred to Consultant 1 again by her GP on 28 March 2006. On 30 March 2006 Ms C had an appointment with Consultant 1 and once more asked for the results of the biopsy of February 2005. A more detailed search of her records found the result which indicated that the first (incorrect) biopsy had been positive for pre-cancerous cells. Ms C had an operation to remove the affected area on 19 April 2006. Ms C complained that it took over a year for her to be advised of this result despite requesting the information on numerous occasions. This delay had caused her to experience physical pain, emotional distress and resulted in the eventual operation being more extensive than would originally have been necessary.

11. As the Board had not specifically addressed this complaint in their responses to Ms C, I sought their comments on this point. In a letter of 24 April 2007 to me they advised that the results of the February 2005 biopsy

were filed in error in an earlier volume of Ms C's records and the result was not noted. Consultant 1 apologised for this error. The Board told me that the system now in place is such that a copy of the pathology report is also sent to the referring Consultant (when he is based at another hospital) to ensure there is no delay in the receipt of the report (which could happen when records are transferred back to the referring hospital).

(c) Conclusion

12. I uphold this complaint but note action has already been taken to address the underlying problem. I also note that various apologies have been made for the individual failings identified in this report but that these do not address the cumulative distress, physical and emotional, experienced by Ms C because of such repeated failings.

(c) Recommendation

13. In light of this and the other failings identified in this report the Ombudsman recommends that the Board make a written apology to Ms C for both the specific errors in her care and treatment and the additional distress this number of errors caused her over many months.

14. The Board have accepted the recommendation and will act on it accordingly.

22 August 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	NHS Greater Glasgow and Clyde
Consultant 1	Ms C's consultant throughout these episodes of care
Hospital 1	The Victoria Infirmary, Glasgow
Hospital 2	The Southern General Hospital, Glasgow