

Scottish Parliament Region: Glasgow

Cases 200501444 & 200502544: Greater Glasgow and Clyde NHS Board and a GP, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital and GP; Treatment and diagnosis

Overview

The complainant, Mr C, complained about various aspects of the treatment of his brother, Mr A, prior to Mr A's death in the Southern General Hospital, Glasgow (the Hospital). In particular, Mr C complained that Mr A's general practitioner (the GP) failed to diagnose Mr A's brain tumour, and that the care and treatment Mr A received in the Southern General Hospital, Glasgow (the Hospital) was inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that there was:

- (a) inadequate treatment by the GP (*not upheld*); and
- (b) inadequate treatment by the Hospital (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The complainant, who I shall describe as Mr C, complained about various aspects of the care and treatment of his late brother (Mr A) by Mr A's general practitioner (the GP) and the Southern General Hospital, Glasgow (the Hospital). A reminder of these abbreviations and others used in this report are at Annex 1. Although Mr C complained about two separate authorities (Mr A's GP practice and an NHS Board), because the complaints were so closely linked, I have decided to report both together here.

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

- (a) inadequate treatment by the GP; and
- (b) inadequate treatment by the Hospital.

3. Mr C, however, made 13 separate points of complaint (four relating to the GP, nine relating to the Hospital) as follows:

- (i) failure of the GP to diagnose the symptoms of a brain tumour;
- (ii) failure of the GP to diagnose pneumonia;
- (iii) failure of the GP to arrange a second opinion about Mr A's illness;
- (iv) failure of the NHS to provide a system so that patients with an illness that a local GP cannot diagnose can be assessed completely;
- (v) failure of the Hospital to investigate the underlying cause of Mr A's illness and the possibility of a tumour;
- (vi) aggressive and unsympathetic attitude of a doctor within the Hospital;
- (vii) failure of the Hospital to prevent Mr A contracting MRSA;
- (viii) failure to answer satisfactorily Mr C's written questions regarding the MRSA infection and whether it contributed to Mr A's death;
- (ix) failure of the Hospital to consult with the GP;
- (x) the premature movement of Mr A from a high dependency unit in the Hospital to a general ward;
- (xi) the failure of the Hospital to prevent Mr A's perforated ulcer from becoming a source of infection;
- (xii) failure of the Hospital Complaints Department to accurately report what was said at a meeting which was held to discuss events surrounding Mr A's death; and
- (xiii) failure of the Hospital to adequately explain why Mr A's condition deteriorated.

4. My investigation has sought to cover the two broad aspects of complaint, but also to address each of Mr C's specific points.

Investigation

5. In conducting my investigation, I examined all correspondence provided by Mr C, and the correspondence generated by Greater Glasgow and Clyde NHS Board (the Board) and the GP in responding to Mr C's complaints and the subsequent enquiries of the Ombudsman's office. I also examined Mr A's clinical records. In addition, and in order to provide Mr C with a full and proper determination of the clinical aspects of his complaint, I sought advice from three independent clinical advisers, one a GP specialist (Adviser 1), one a hospital specialist (Adviser 2), and the third a specialist neurologist (Adviser 3). The Advisers' role was to explain, and give an opinion on, the clinical aspects of the complaint. In line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in all the circumstances, at the time in question, that is, not using hindsight as a measure.

6. I have not included in this report every detail investigated (and I am conscious that Mr C may think this is a relatively short document given that it involves the very sad death of his brother) but I am satisfied that no matter of significance has been overlooked. Mr C, the Board and the GP practice were given an opportunity to comment on a draft of the report.

7. I turn now to Mr A's complaints and the events in question. I would normally cover the actions of the two authorities (namely the GP and the Hospital) separately. In this case, because they are interlinked, it makes sense to set out a brief history of Mr C's condition and treatment covering the issues as they arise.

Clinical Background

8. Mr A, aged 43 at the time, was admitted to the Hospital in June 2004 with a community acquired pneumonia (CAP) and he was discharged after ten days. He was seen in out-patients for follow-up in August when a head computerised tomography scan (CT scan) was ordered and this was performed on 6 October 2004. The scan revealed a brain tumour, and Mr A was admitted to the neurosurgical unit of the Hospital immediately. He had surgery the following day, but ten days later developed a perforation of a stomach ulcer. Two further operations were needed over the next three weeks, but after the third

abdominal operation, Mr A developed septicaemic shock and respiratory failure and, sadly, died of cardiac arrest on 11 November 2004.

9. Prior to his admission to the Hospital in June 2004, records show that Mr A had been attending the GP with symptoms of lethargy, associated with giddiness and vertigo. A tachycardia had been found (fast heart rate) and he was treated with a beta-blocker (atenolol) and referred to a cardiologist (a heart specialist). He had also been referred by the GP to an ear, nose and throat (ENT) specialist because of dizziness he was experiencing. A series of blood tests had been carried out by the GP, all of which were normal. He had also had some vomiting and reflux in April that year and records show that the GP had prescribed some Ranitidine, which was later changed to Rameprazole. Both of these drugs are used to treat ulcers in the stomach and duodenum, but are also frequently given for gastric symptoms in the absence of proof by endoscopy that any ulcer is present, and Mr A did not have an endoscopy test.

10. The episode of pneumonia in June 2004 started suddenly with cough, fever and breathlessness. Mr A saw the GP on the afternoon of 29 June 2004 complaining he was unwell. The GP diagnosed an upper respiratory chest infection and prescribed Amoxicillin, a commonly used antibiotic. However, Mr A's condition deteriorated rapidly after visiting the GP and he was admitted to the Hospital that evening. He was breathless and tired. While he was in the Hospital, he repeatedly complained that he had been unwell for the previous six to eight months and a number of tests were performed, particularly in relation to immunity. A possible neurological cause for his symptoms was not considered, although a psychiatric referral was made. No significant psychiatric abnormality was found. Mr A was discharged after ten days in the Hospital and on the day of discharge records show that a discussion was held between Mr A, Mr C and a Senior House Officer (Dr 1). It was explained that no underlying cause for Mr A's pneumonia had been found and he was considered well enough to go home. There is no mention of any complaint or disagreement arising from this meeting.

11. Mr A was seen in the Hospital's out-patient department on 25 August 2004 by a Consultant Physician (Dr 2). Dr 2 noted mild abnormalities in testing co-ordination of Mr A's legs and suspected the possibility of a brain tumour. Dr 2 ordered a CT scan of Mr A's head. This scan was performed six weeks later, on 6 October 2004. As mentioned above, the scan revealed a brain tumour and

Mr A was referred and admitted to the neurosurgical unit in the Hospital immediately.

12. When seen by a neurosurgeon (Surgeon 1), Mr A was found to have raised intra-cranial pressure (ICP), that is, raised pressure in the fluid-filled brain cavities, or ventricles. He gave a history of some visual disturbance and intermittent headache, typical of raised ICP. His condition was treated urgently and he was given steroids and a drain was inserted into the ventricle. The following day, Mr A's tumour was removed surgically. The tumour was situated at the foramen magnum, which is the exit hole for the spinal cord from the skull. Records show the operation went successfully and was not associated with any significant nerve damage (this is a hazard of all brain surgery, particularly in the posterior part of the brain).

13. Records also show that Mr A appeared to be making a good post-operative recovery, but on 23 October 2004 he suddenly deteriorated. Acute peritonitis, due to perforation of the bowel, was diagnosed and an abdominal exploratory operation (a laparotomy) was essential. That exploratory operation identified that Mr A had a perforated gastric ulcer and this was oversewn. Eight days later, Mr A again deteriorated and a second laparotomy identified that the wound was breaking down internally. A feeding tube was inserted into Mr A's small bowel, but he developed an acute abdomen again two weeks later. A third laparotomy was done and showed that the feeding tube which had previously been inserted into Mr A's small bowel had become dislodged. Over the next 24 hours, Mr A developed septicaemia and respiratory failure. He became increasingly difficult to ventilate due to his lungs filling with fluid, his oxygen levels fell and his heart stopped. It was not possible to resuscitate Mr A and he very sadly died of cardiac arrest on 11 November 2004.

14. I am sorry if this clinical background has been distressing for Mr C to read.

(a) Inadequate treatment by the GP; and (b) Inadequate treatment by the Hospital

15. I will deal with these two complaints together. But first, I want to give Mr C the full benefit of the detailed opinions I received from Advisers 1, 2 and 3, based on Mr A's medical records. In particular, I want to set out here the Hospital specialist's response to Mr C's 13 specific points of complaint. Paragraphs 16 to 26 below are the Hospital specialist's replies.

(i) Failure of the GP to diagnose the symptoms of a brain tumour

16. With hindsight it is easy to see that symptoms of the brain tumour were present for some eight months before the diagnosis was made in October 2004. However, posterior fossa tumours are rare and the average GP may see only one case in a professional lifetime. Most brain tumours are in the front part (anterior fossa) and cause local signs such as weakness of a limb. Raised pressure within the brain ventricles usually causes severe headache and this was not a prominent feature of Mr A's illness. It also causes lethargy, visual disturbances, vomiting and occasionally hiccup, all of which Mr A did have. The signs of raised ICP are seen by examining the back of the eye (the fundi) and there is no record of the GP doing this until shortly before the CT scan. When this was done (30 September 2004) the papilloedema (non-inflammatory congestion of the optic disc) was not diagnosed although it was present when he was examined by the neurosurgeons eight days later. Inexperienced doctors often have difficulty recognising papilloedema especially when it is not particularly prominent as was the case here. In this instance raised ICP was not considered by the GP as a possible cause for Mr A's eight month illness and he was, therefore, referred to a cardiologist and an ENT specialist.

(ii) Failure of the GP to diagnose pneumonia

17. Mr A's pneumonia clearly advanced rapidly and in a rapidly changing clinical situation, such as rapidly progressing infection, a patient can appear quite well at one time, and then desperately ill a few hours later. This is a recognised occurrence.

(iii) Failure of the GP to arrange a second opinion about Mr A's illness

18. In fact the GP did refer Mr A to a cardiologist and ENT specialist, but did not recognise that this was in fact a neurological problem.

(iv) Failure of the NHS to provide a system so that patients with an illness that a local GP cannot diagnose can be assessed completely

19. Specialisation has now reached a stage where the diagnostic role of the general physician has been subsumed by GPs and whereas the diagnosis of Mr A's brain tumour was straightforward once the neurologist had seen him and seen the scan, the symptoms have to be recognised for what they are, ie neurological, before referral is made to the correct specialist. The GP cannot specifically be blamed for this delay as neither Dr 2, who is a rheumatology specialist, nor the cardiologist, recognised the symptoms as neurological ones.

During the ten days in the Hospital in June/July a full neurological examination or examination of the fundi (back of eye), were never performed. Even when the CT scan was ordered on 25 August 2004 Dr 2 did not record looking at the fundi, and despite finding neurological signs in the legs, thought, according to her letter, that a psychiatric cause was still the most likely explanation for his symptoms.

(v) Failure of the Hospital to investigate the underlying cause of Mr A's illness and the possibility of a tumour

20. The Hospital did seek an underlying cause for the pneumonia, but looked mainly for impaired immunity. It is unusual for raised ICP to present as a chest infection and in seeking a cause for pneumonia a head CT scan is not a routine investigation. After finding nothing wrong in the blood results, referral was made to the psychiatrist as the lethargy and slow mental state was thought possibly to be due to depression.

(vi) Aggressive and unsympathetic attitude of a doctor within the Hospital

21. The discussion between Dr 1, Mr C, and Mr A is documented on 9 July 2004 in the notes and there is no suggestion of any rudeness, disagreement or complaint.

(vii) Failure of the Hospital to prevent Mr A contracting MRSA; and (viii) Failure to answer satisfactorily Mr C's written questions regarding the MRSA infection and whether it contributed to Mr A's death

22. There is a high incidence of MRSA in high dependency units in general. This is because of the compromised immune state occurring in patients in high dependency units and spreads more easily there. It is not the transfer of uninfected patients that causes MRSA to spread. It is the transfer of infected patients that causes the spread.

(ix) Failure of the Hospital to consult with the GP

23. Mr A was on treatment from the GP with Ranitidine and later Rabeprazole. Both of these are used to treat ulcers. However, an ulcer was not diagnosed in Mr A. He did not have an endoscopy test. These tablets are often used to treat gastric symptoms of vomiting and reflux in the absence of diagnosed ulcers. The GP did not inform the Hospital that she had used these tablets. On the other hand, the symptoms are non-specific and may have been thought to have been the result of the raised ICP rather than an ulcer. The ulcer that developed and perforated after surgery was a stress ulcer precipitated by a combination of

the stress of surgery plus the steroids that are routinely given in cases of raised ICP and to cover the oedema (swelling) caused by neurosurgery. It is customary to give 'anti-ulcer' drugs concurrently with the steroids and Mr A was prescribed regular doses of Ranitidine after the operation along with the Dexamethasone (steroid).

(x) The premature movement of Mr A from a high dependency unit in the Hospital to a general ward

24. This is routine practice when high density nursing is no longer required. It was not 'for administrative reasons' and the recognition of his perforation was immediate.

(xi) The failure of the Hospital to prevent Mr A's perforated ulcer from becoming a source of infection

25. Whenever the bowel perforates there is always a risk of infection from bowel contents. This is the natural course of the illness and has nothing to do with hospital-acquired infection.

(xii) Failure of the Hospital Complaints Department to accurately report what was said at a meeting which was held to discuss events surrounding Mr A's death; (xiii) Failure of the Hospital to adequately explain why Mr A's condition deteriorated

26. Both of these were dealt with at the meeting.

27. Adviser 1 also gave a detailed response, after examining all correspondence, documents and Mr A's clinical records.

28. In Adviser 1's opinion, despite the large number of contacts between Mr A and the GP, Adviser 1 did not think an obvious brain tumour presentation was missed. Looking through the GP notes in detail, Adviser 1 could not see any particular stage a diagnosis should have been made or a neurology referral made. Clearly, the GP was considering other avenues and in Adviser 1's opinion, the GP's decision to refer Mr A to an ENT specialist was a reasonable and appropriate course of action. Adviser 1 presented me with a very detailed note about brain tumours and their presenting features. I have attached that note for Mr C's benefit at Annex 2.

29. I asked Adviser 1 to focus his opinion on the central issue of whether the GP's care was adequate and, in particular, whether the GP's failure to diagnose a brain tumour or to make a neurology referral was unreasonable.

30. In reaching his opinion, Adviser 1 had regard to the GP contacts during what he considered was the most relevant time frame – 25 March 2004 until Mr A's admission to the Hospital.

31. Paragraphs 32 to 38 contain Adviser 1's detailed comments.

32. There are a large number of consultations going back over many months. With hindsight I think the blurring of vision, the ear pain, the dizziness and the nausea/vomiting symptoms were all related to the growth of the meningioma (tumour) inside his head. However, as one reads through the presenting features, I do not feel that a clear and obvious diagnosis was missed or ignored here. In very general terms the gradual increase in size of a tumour of this sort usually causes progressive symptoms. That is not an invariable picture and one can see stepwise deteriorations in some cases. In this case a clear recording of some of the symptoms, improving at times, I think provided the GP with false reassurance.

33. It is clear that the GP realised that he was not getting to the bottom of this. The cardiology opinion turned out to be something of a red herring but problems with heart rate and rhythm can cause dizziness and so it was not unreasonable to explore that option. I am not entirely clear from the notes who originally organised the referral to the cardiologist, but I can understand that the GP would have felt that was an avenue to be explored. Referral to an ENT specialist in view of the ear pain and dizziness seems entirely appropriate.

34. Clearly, a lot of the consultations following the pneumonia were to do with on-going respiratory symptoms and from the notes it looks as if other general features were not much discussed. It is difficult for us to form an opinion now about how obvious the deteriorating health was. Clearly Mr C feels there was a very clear clinical picture here.

35. In raising his complaint Mr C was particularly concerned about who had responsibility for Mr A's care. It is correct to say the GP retains an overall responsibility. He does not wash his hands of responsibility once a referral has been made or indeed when a hospital consultant is involved in investigating and

managing a problem. So the situation at this stage was that there was shared responsibility between the GP and at one stage the cardiologist and Dr 2, who was following him up in out-patients after his pneumonia. The same situation would have pertained had he had the ENT appointment. This is a standard arrangement when referring patients to hospital.

Failure of the GP to arrange a second opinion

36. Increasingly hospital consultants have become more and more specialised in smaller and smaller areas of clinical practice. Often it is the GP who is really providing a generalist view of the patient these days. For that reason, GPs may consult with colleagues in the Practice for advice if they feel they are not getting to the bottom of a clinical case. I think that is a more commonly used mechanism than formally sending the patient to see another GP colleague.

Failure to diagnose pneumonia

37. It seems that earlier in the day when he examined the patient there were no chest signs. It is known that a serious infection like pneumonia can develop significantly over the course of a few hours and it is possible that the signs denoting serious illness were absent when the GP examined or it is also possible that the GP missed such signs. I do not think we will ever be able to get to the bottom of that.

Why was there no neurology referral

38. In his response to Mr C's complaint, the GP said that an ENT opinion was appropriate. I think it was an appropriate referral to make. Unexplained ear pain certainly is an appropriate ENT problem. Traditionally ENT surgeons have also been involved in the investigation of dizziness as some of the causes relate to ear problems. Indeed in some large ENT departments they have a specific special dizziness symptom clinic. There would be nothing unusual or odd in a GP sending a problem of dizziness to an ENT consultant. The GP makes the point that other doctors, including the hospital team, did not initially suspect the brain tumour and did not make a neurology referral or arrange a brain scan. That I think fits in with my earlier comments that this was not an obvious diagnosis to make in the early stage of the presentation.

39. I also sought the opinion of a specialist neurologist, Adviser 3. I asked Adviser 3 three specific questions as follows:

- Was it reasonable for the GP to refer Mr A to different specialists which resulted in a delay in the diagnosis of a brain tumour?

- Based on Mr A's presenting symptoms should the GP and Accident and Emergency (A&E) doctors have considered investigating for the possibility of a brain tumour at an earlier stage?
- Are there any other comments you would like to make on the clinical management of Mr A?

40. Once again I do not want to paraphrase the Adviser's opinion and I feel it would be more helpful to Mr C to have Adviser 3's reply in detail. Paragraphs 41 to 53 are Adviser 3's replies.

Was it reasonable for the GP to refer Mr A to different specialists which resulted in a delay in the diagnosis of a brain tumour?

41. Mr A was referred by the GP on 30 April with dizziness and a fast beating pulse and on 11 May 2004 to the ENT department with episodic dizzy spells and left ear pain.

42. At that stage he had no other specific neurological symptoms or any abnormal neurological findings on examination. Indeed, neurological examination by Dr 1 on the ward on 6 July 2004, two months later, when he was an in-patient with a chest infection, is described in great detail and describes no neurological abnormality even then.

43. On the basis of the symptoms presented by Mr A to the GP at that time both of these referrals, to cardiology for dizziness and fast beating pulse, and to ENT for dizzy spells and ear pain, are entirely reasonable.

Based on Mr A's presenting symptoms should the GP and A&E doctors have considered investigating for the possibility of a brain tumour at an earlier stage?

44. The symptoms presented to the GP would be very atypical for a brain tumour (see below) and as a neurologist I would be concerned to receive a clinical letter that gave ear pain and dizziness as the primary symptoms, symptoms I would expect to be directed to the ENT surgeon.

45. When Mr A presented to A&E he had a significant chest infection and the doctors there will have focused on treatment of that – as they did with success. The development of a severe chest infection raised the possibility of an abnormal immune system, which they investigated.

46. It is of note that it was not until out-patient review by Dr 2 on 28 September 2004 that a neurological basis for his symptoms became clear.

47. Dr 2 reports that:

'I found [Mr A] incredibly difficult to assess. He took a long time to reply to questions and was generally quite evasive. He also mentioned to me symptoms of dizziness and I see he is being investigated by [Surgeon 1] in this regard. He also mentions staggering at times and pain in his left ear. There is no sign of a nystagmus today. However, I felt there was some evidence of dysdiadochokinesia [difficulty performing rapid alternating movements] in his upper limbs and he had great difficulty in heel/toe walking ... he does complain of intermittent headache and I thought it prudent to arrange CIT brain scan to make sure there is nothing more sinister going on and I have asked for posterior fossa views also and will ask ENT to assess him from the left ear point of view.'

48. Investigation was then rapid. On 6 October 2004 the CT brain scan showed obstructive hydrocephalus and a posterior fossa mass. Examination with the benefit of knowing these findings found only an additional history of two month history of occasional vomiting and on examination possible papilloedema and bilateral dysdiadochokinesia with difficulty in heel/toe walking. Subsequently other doctors thought that examination of the optic disc was normal.

49. The GP and A&E doctors would not have been expected to explore the possibility of a neurological cause for some of Mr A's symptoms when they saw him.

Are there any other comments you would like to make on the clinical management of Mr A?

50. Foramen magnum meningiomas are difficult to diagnose. It may seem as if the diagnosis of this foramen magnum meningioma was arrived after some delay. In many respects this is unsurprising. Lesions in the foramen magnum are particularly difficult to diagnose. I quote from *Neurology in Clinical Practice – Principles of Diagnosis and Management* by Bradley, Daroff, Fenichel and Jankovic fourth edition 2004, page 361 'Lesions of the foramen magnum present a most challenging diagnostic problem for the clinician because symptoms are often vague or may be distant from the foramen magnum ... The

neurological signs associated with foramen magnum tumours are also perplexing'.

51. Secondly a meningioma is an extremely slow growing tumour. Thus the actual change in volume in the tumour in the six months from symptoms onset to diagnosis is probably only modest.

52. The diagnosis of meningioma was made when Mr A had few neurological signs. When Mr A was seen by the neurosurgeons his walking was unsteady and he had clumsy arms, but otherwise had no evidence of neurological damage from the tumour. The implication of this in relation to the additional risk of surgery from an early in comparison to a later diagnosis in Mr A is likely to have been modest. His deterioration in September and early October is likely to have been related to the development of hydrocephalus rather than to the direct effect of the tumour.

53. Indeed, immediately following the operation Mr A had minimal neurological deficit, suggesting the potential for good recovery. The difficulties arose because of later complications – that is, perforation of the gastric ulcer and subsequent complications – which led to Mr A's tragic death. These complications are not specific to this tumour type or to the tumour location or indeed this type of operation, but to operations in general, particularly when patients had previously been on steroids.

54. Paragraphs 55 to 61 summarise further issues raised by Mr C and the relevant evidence.

Failure to investigate underlying cause of CAP

55. The Hospital did seek an underlying cause for Mr A's CAP, however, the evidence shows that, after investigation, the Hospital did not consider there were neurological causes of the CAP. The Advisers' view is that it is entirely reasonable. Adviser 3 confirmed that 'in seeking a cause for pneumonia, a head CT scan is not a routine investigation'. In the circumstances, I do not uphold this aspect of complaint.

Failure to prevent MRSA infection

56. The evidence shows that Mr A was placed on medication to treat his MRSA, which was present in his nose and throat. The medication helped to clear the MRSA and there was no trace of MRSA immediately prior to Mr A's

death. Advisers have told me that the fact that Mr A had been placed in High Dependency Unit meant that he would likely be at more risk of coming in contact of MRSA or other types of infection. There is no evidence to suggest that Mr A's removal from the High Dependency Unit contributed to infection of MRSA or his death and, therefore, I do not uphold this aspect of complaint.

Failure to consult with GP regarding possible ulcer

57. Mr A was being treated by the GP with Rantidine and later Rabeprazole. Both of these forms of medication are used to treat ulcers. However, it is very important to note that Mr A was never diagnosed (prior to surgery) as suffering from an ulcer. Adviser 1 has told me that the medication prescribed by the GP is often used to treat gastric symptoms such as vomiting and reflux in the absence of a diagnosed ulcer.

58. The ulcer that developed and perforated in Mr A appears to have been a stress ulcer precipitated by a combination of the stress of surgery in addition to the steroids that are routinely given when raised ICP is identified and also to cover the oedema (swelling) caused by the neurosurgery. It is common practice to give 'anti-ulcer' drugs concurrently with steroids and Mr A was prescribed regular doses of Ranitidine after the operation along with the Dexamethasone (steroid).

Failure to prevent infection of perforated ulcer

59. With regards to preventing further infection, from perforation either of the ulcer or the bowel, the evidence demonstrates that the Hospital took reasonable action in monitoring, assessing and treating Mr A's condition. The Advisers' view, which I accept, is that when there is perforation, there will always be a risk of infection given the nature of the condition.

Recording of discussion and adequacy of explanation

60. In relation to Mr C's claims pertaining to the failure to accurately record what was said at a meeting between himself, his sister and Hospital staff and also the failure of the Hospital to adequately explain why Mr A's condition deteriorated, I have carefully reviewed the minutes of the meeting. I appreciate that Mr C feels that the minutes are inaccurate, however, unfortunately, without being present at the meeting, and in the absence of other evidence or witnesses to provide an independent view, it is impossible for me to conclude whether or not the minutes are inaccurate. Essentially, I can reach no finding on this point of complaint.

61. Moving on to the adequacy of the Hospital's explanation regarding Mr A's deterioration, I have reviewed the correspondence file and also the minutes of the meeting. This point of complaint is based on Mr C's interpretation of what constitutes an adequate explanation. I have focused on whether or not the explanation provided by staff was reasonable. The minutes of the meeting do indicate that there was much discussion regarding Mr A's care. Both Mr C and his sister had opportunities to ask questions and raise issues which were of importance to them. However, without knowing the full details of the discussion and, again, without any independent evidence to allow me to reach defensible conclusions, I cannot prove what was said.

Conclusions

62. I turn now to set out my conclusions. This is an extremely sad case in which a relatively young man has died of a potential treatable problem. It is easy to see, with hindsight, that the diagnosis of Mr A's brain tumour was delayed by some six to eight months and the reasons were that a neurological explanation for his lethargy, giddiness and general ill health were not considered. Once again, with hindsight, I am sure that the GP would have liked to make a neurology referral at an earlier stage. However, the role of the Ombudsman's office is to judge whether the actions and events were reasonable, in all the circumstances, at the time in question, and not to apply hindsight as a measure.

63. It is clear that the kind of tumour Mr A had, and the site of the tumour, is most unusual. The evidence shows that at least three sets of doctors failed to make the diagnosis. However, based on the Advisers' opinions, which I accept, I cannot identify a clear failure of reasonable care by the GP or the Hospital, or that the care and treatment by either the GP or the Hospital were inadequate as Mr C states. Consequently I do not uphold the complaints made by Mr C.

64. This has proven to be an extremely sad case in which a relatively young man of 43 years of age died. The Advisers' views, which I accept, was that the reason for Mr A's death cannot be attributed to failings on the part of medical staff but was a result of a relatively rare tumour and subsequent events that were tragically outwith the control of medical staff.

65. I recognise that Mr C is likely to be disappointed at the outcome of the investigation and my conclusions, but I hope it will be of some reassurance to

him to know that his brother's care and treatment have been reviewed in great detail independently by this office and by our clinical advisers.

24 October 2007

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's brother
The GP	Mr A's general practitioner
The Hospital	The Southern General Hospital, Glasgow
The Board	Greater Glasgow and Clyde NHS Board
Adviser 1	The Ombudsman's GP Adviser
Adviser 2	The Ombudsman's adviser who is a hospital specialist
Adviser 3	The Ombudsman's adviser who is a specialist neurologist
CAP	Community Acquired Pneumonia
CT scan	Computerised tomography scan
ENT specialist	Ear, nose and throat specialist
Dr 1	A Senior House Officer
Dr 2	A Consultant Physician
Surgeon 1	A Neurosurgeon
ICP	Intra-cranial pressure
A&E	Accident and Emergency

General Information relating to Brain Tumours

Intracranial tumours are the sixth most common cancer form in adults (about eight percent of primary tumours). The annual combined incidence for all primary brain tumours is 14–21/100,000 per person per year. That means that you could expect 14–21 new cases if you followed 100,000 people for one year. In the UK about 75,000 individuals have a brain tumour at any time.

Brain tumours can present in a variety of ways but most patients present with one or more of the four basic clinical syndromes:

- Raised intracranial pressure;
- Progressive neurological deficit;
- Seizures;
- Cognitive and behavioural decline.

The presenting features will vary with the tumour location, its type and its rate of growth. Raised intracranial pressure means an increased pressure inside the head and is either caused by the direct effect of the tumour growth of fluid swelling surrounding the tumour or obstructive hydrocephalus (tumour causing blockage of the fluid system that bathes the brain tissue). Headache is a common presenting symptom of raised ICP. Suggestive features of the headache include getting progressively worse, being constant, waking at night, headache worse on waking or certainly present on waking and associated with other neurological deficits. There is a classical picture headache, vomiting and visual problems but this is usually a late stage presentation. Certainly less than one percent of patients presenting with headache have a brain tumour.

Progressive neurological deficit is typically sub-acute and progressive. The patient loses some function perhaps use of one limb or speech and this just progressively gets worse. Seizures are a common presentation of brain tumour and present at some stage in 40–60 percent of cases. Cognitive and behavioural decline is just what it says, a gradual decrease in the higher function of the brain.

Headache is an extremely common problem. A recent epidemiological study showed that 86 percent of women and 63 percent of men suffered at least one

tension type headache in the previous year. The annual prevalence of migraine, a common cause of headache, is 15 percent in woman and 6 percent in men (the figures quoted come from medical magazine 'Medicine', a medical textbook in the form of monthly update magazines and they last published their neurology section in 2004.)

Therefore, the reality is that general practitioners see a lot of patients with headache and it is really truly exceptional for this to be due to a brain tumour. For a GP with a typical list size the number of new cases in brain tumour he or she saw presenting as headache would probably be counted on the fingers of one hand, during the whole of a professional working life.

List of publications

Neurology in Clinical Practice – Principles of Diagnosis and Management by Bradley, Daroff, Fenichel and Jankovic fourth edition 2004, page 361