Scottish Parliament Region: Glasgow

Case 200700770: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Miss C) was concerned that the cause of her abdominal pain was not diagnosed despite several admissions to Victoria Infirmary (the Hospital) and that not all necessary investigations had been carried out. Miss C also raised issues regarding Greater Glasgow and Clyde NHS Board (the Board)'s communication with her and her mother and regarding the accuracy of the Board's response to her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to diagnose the cause of Miss C's abdominal pain and to carry out all necessary investigations (*not upheld*);

(b) the Board failed to communicate properly with Miss C and her mother during an admission between 22 February 2007 and 5 March 2007 (*partially upheld to the extent that Miss C's return to the ward on 5 March 2007 was not adequately managed*); and

(c) the letter responding to Miss C's complaint contained inaccuracies (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 14 June 2007, the Ombudsman received a complaint from a woman, referred to in this report as Miss C, that the cause of her abdominal pain was not diagnosed despite several admissions to Victoria Infirmary (the Hospital) and that not all necessary investigations had been carried out. Miss C also raised issues regarding Greater Glasgow and Clyde NHS Board (the Board)'s communication with her and her mother and regarding the accuracy of the Board's response to her complaint.

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

(a) the Board failed to diagnose the cause of Miss C's abdominal pain and to carry out all necessary investigations;

(b) the Board failed to communicate properly with Miss C and her mother during an admission between 22 February 2007 and 5 March 2007; and

(c) the letter responding to Miss C's complaint contained inaccuracies.

Investigation

3. The investigation of this complaint involved obtaining and reading all the complaint correspondence between Miss C and the Board. I also obtained copies of Miss C's clinical records and sought the advice of one of the Ombudsman's medical advisers (the Adviser) on the clinical aspects of the case.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to diagnose the cause of Miss C's abdominal pain and to carry out all necessary investigations

5. In her complaint to the Ombudsman, Miss C said she had been suffering from severe abdominal pains since April 2006. She said that despite several admissions to the Hospital, she still did not know what was causing the pain. She said that following her latest admission to the Hospital between 22 February 2007 and 5 March 2007, she sought treatment at a private hospital (the Private Hospital). She said that, at the Private Hospital, she had a Computerised Tomography scan (a CT scan), a colonoscopy (a test that looks into the large bowel using a narrow, flexible, tube-like telescope called a

colonoscope) and a barium meal and follow-through test (where barium sulphate is ingested and an x-ray subsequently taken) but that none of these had been offered at the Hospital. Miss C, therefore, believed that the Hospital had not done enough to try to uncover the source of her stomach pain.

6. The Board, in responding to my investigation, accepted that a definitive diagnosis of Miss C's condition was not reached. They said, however, that many of the possible serious conditions which she could have had with her symptoms had been excluded. The Board said the following investigations were undertaken by the Hospital:

- multiple blood samples were taken, which were normal;
- two ultrasound scans of her abdomen and pelvis, which were normal;
- three specimens of urine were sent for culture, all of which were clear;
- three urinalysis tests (tests that determine the content of urine) which were normal;
- a gynaecology assessment and diagnostic laparoscopy (a test using a laparoscope – a thin, lighted tube – to look at and take tissue from the body) which were normal;
- two pregnancy tests which were negative;
- an abdominal x-ray and a meckels scan (an investigation where images of the abdomen are taken after a patient is injected with a small quantity of radioactive material) – the first showed constipation, the second was normal; and
- a barium enema x-ray (an investigation where barium sulphate is given via the anus to allow x-ray examination of the lower intestinal tract) which was normal.

7. The Board noted that Miss C went on to have further investigations at the Private Hospital, which included a CT scan, a colonoscopy, and a barium meal and follow-through. The Board said all these tests were associated with their own risks. They said a CT scan gave much higher doses of radiation to a patient than an x-ray. They said the consultants responsible for Miss C's care believed that to accept this dose of radiation there needed to be very good indications for a scan. They said the same applied to a colonoscopy where there was a risk of perforation of the colon of 1 in 1000 during the procedure. In Miss C's case, the Board said they were not convinced that the risks of either a CT scan or a colonoscopy outweighed the possible benefits. They said a barium meal and follow-through involved multiple x-ray pictures and radiation exposure.

8. The Board said it was possible that the threshold for ordering such investigations within the private sector was different from the NHS. They said that if a definitive diagnosis had been reached at the Private Hospital, the Board would then need to re-evaluate their threshold for doing such investigations. They said that if no diagnosis was reached at the Private Hospital then Miss C may have been exposed to unnecessary risks which she would have avoided by remaining under the Hospital's care.

9. Clinical records obtained from the Private Hospital showed that investigations carried out there did not lead to a more definitive diagnosis for Miss C. The Private Hospital concluded that Miss C was likely to be suffering from irritable bowel syndrome, which confirmed the Hospital's findings.

10. I asked the Adviser for his comments on this complaint. His advice is summarised at paragraphs 11 to 24 below.

11. On 4 April 2006, Miss C attended her General Practitioner (the GP) complaining of abdominal pain. She initially attended the out-of-hours service when she was seen by a doctor who diagnosed irritable bowel syndrome. As a consequence of her ongoing symptoms, she saw the GP on 6 April 2006 and he referred her to the Hospital.

12. Miss C was admitted to the Hospital on 6 April 2006. She was seen by a doctor who identified the presence of right iliac fossa pain (pain affecting the right inferior part of the abdomen) that was described as sharp, stabbing and constant. There were no major abnormalities in a history review and, on examination, Miss C was haemodynamically stable (refers to the stability of blood circulation). She had some tenderness in the right iliac fossa on palpation (examination with hands or fingers) and the rest of the assessment was unremarkable. The following day Miss C underwent an ultrasound examination which revealed a small pool of free fluid within the Pouch of Douglas (a small sac-like structure between the rectum and the uterus). No other abnormality was identified.

13. On the basis of these assessments, it was considered that Miss C might have a gynaecological problem and a consultation was requested from the gynaecology (the branch of medicine that deals with conditions of women's

reproductive systems) service. The current diagnosis at that stage was of a ruptured ovarian cyst (a cyst inside the ovary). Miss C was discharged home.

14. The GP then referred Miss C to a consultant gynaecologist at the Hospital and she was seen by him on 3 May 2006. Clinical examination revealed a small amount of tenderness in the right iliac fossa. At this point, Miss C had been taking antibiotics for pelvic inflammatory disease (an infection that involves the fallopian tubes and nearby pelvic structures). Following this consultation in the gynaecology department arrangements were made to carry out a diagnostic laparoscopy.

15. The laparoscopy was performed as a day case on 30 May 2006 and was entirely normal with no evidence of infection or endometriosis (a condition in which normal endometrial tissue – the lining of the uterus – grows outside the uterus). Miss C was, therefore, discharged back to the GP.

16. As Miss C's symptoms persisted, the GP then referred her to a consultant surgeon at the Hospital. Miss C was seen at the Hospital on 9 August 2006 and the history of pain and the various investigations was once again recorded. Clinical examination was unremarkable other than persistent mild tenderness in the right side of the abdomen. No obvious diagnosis was arrived at and it was explained to Miss C that the next step would be to carry out a barium enema.

17. On 22 February 2007, Miss C was seen again at the Hospital because of persistent right iliac fossa pain. There was a clinical note of assessment in the records that seemed to be from the Accident and Emergency department which led to Miss C being admitted to the Hospital. Later that day, Miss C was reviewed by the doctor on-call. A more detailed clinical history and examination was then included in the records. No obvious or specific diagnosis was made and Miss C was placed on intravenous fluids. A range of investigations were performed including routine blood tests and urine analysis. All these investigations showed normal results. A further ultrasound scan was requested.

18. Over the next few days, Miss C remained in the Hospital and was haemodynamically stable with no evidence of pyrexia (a rise in the temperature of the body). Her pain fluctuated in severity but the day after her admission she was described as being much more settled.

19. Later that day, Miss C's mother asked to speak with the doctor in charge. She was described as being very unhappy that nothing appeared to have been done despite the multiple admissions.

20. Because Miss C's tenderness persisted with worsening abnormal pain, she was commenced on Diclofenac (an anti-inflammatory drug) 5 milligrams every eight hours and Lactulose (a synthetic sugar used in the treatment of constipation). This was because the abdominal x-ray had suggested a degree of colonic loading (where the colon is filled with faecal mass).

21. The ultrasound examination was performed on 27 February 2007 and was fundamentally normal. There was no evidence of free fluid in the pelvis. The records indicate that Miss C then went home on 'weekend leave' before returning to the Hospital on Monday 5 March 2007. Arrangements were made for Miss C to have a Meckel's scan as an out-patient with a view to ruling out Meckel's diverticulum (a small bulge in the small intestine). The scan was performed on 13 March 2007 and was normal. This was communicated to Miss C by letter.

22. The Adviser concluded that, in his opinion, there was no evidence of mismanagement in Miss C's care and treatment. The first time Miss C attended a doctor concerning her symptoms, a diagnosis of irritable bowel syndrome was made and this seemed the most likely diagnosis given the evidence in the records and considering the history and pattern of symptoms. There was no reason to think that anything further should have been done during Miss C's admission to the Hospital in April 2006. Having carried out reasonable investigations, it was perfectly reasonable to discharge Miss C back into the care of the GP.

23. The Adviser said he could fully understand why Miss C and her mother were frustrated at a lack of diagnosis and the apparent lack of action. However, this was simply the nature of the condition and it was probably correct to say that that frustration should be directed at the condition rather than the investigating doctors. The Adviser also noted, relating to Miss C's admission to the Hospital in 2007, that the clinical records indicate a degree of tension between Miss C and her family and the doctors involved in her care. The Adviser said that, in his experience, this was not an uncommon phenomenon in relation to an emergency admission where a diagnosis was not rapidly achieved.

24. The Adviser concluded that Miss C's management was reasonable and had followed a pattern that would be repeated in many hospitals in 2007. Unsatisfactory though it might seem, it was simply a fact of clinical practice that not all symptoms could be attributed to a definitive diagnosis.

(a) Conclusion

25. The Adviser, whose advice I accept, considers that Miss C's care and treatment at the Hospital were reasonable. Although no definitive diagnosis was made by the Board, the Adviser has explained that it is often impossible to reach such a diagnosis.

26. With regard to whether further investigations, such as those carried out at the Private Hospital, should have been carried out at the Hospital, I am satisfied that the Board acted reasonably. As the Adviser has stated, the investigations carried out by the Board were reasonable and in line with what he would expect to see in other hospitals in 2007. In addition, I note that the Board have provided a reasonable explanation as to why the tests carried out at the Private Hospital were not carried out by them and I note that the results of those tests support the Board's position.

27. In all the circumstances, therefore, I do not uphold this complaint.

(b) The Board failed to communicate properly with Miss C and her mother during an admission between 22 February 2007 and 5 March 2007

28. Miss C was concerned that she had not been told what was happening on 22 February 2007 prior to the decision being taken to admit her. She was also concerned that she had been given no explanation about the investigations that were planned to be carried out to determine the cause of her abdominal pain. She said that on 1 March 2007 no consultant was available when her mother called asking for advice. In addition, Miss C was concerned that the Hospital failed to communicate properly with her in relation to her coming back to the Hospital on Monday 5 March 2007, which meant that Miss C was made to come back to the Hospital, wait for two hours to see a doctor, and then be discharged, even though she was told that further tests were needed.

29. The Board said the consultant responsible for Miss C's care (the Consultant) regarded communication with patients and their families as vitally

important. The Board noted that Miss C and her family felt that communication was poor and they said, for that, the Consultant apologised unreservedly.

30. The Board said that the Consultant tried to give Miss C as much time as she needed to ask questions and her impression was that Miss C was happy with the explanations given at the time. They said the Consultant met with Miss C's mother twice during ward rounds and the Consultant's impression was that Miss C's mother was anxious about her daughter and frustrated that investigations were not being arranged as quickly as she would like. They said the Consultant understood that Miss C's mother felt that nothing was happening and that she wanted an answer as to why Miss C was unwell. The Board said this was understandable, but that the Consultant believed that one of the most important 'investigations' that could take place was observation over time. They said it was the Consultant's practice to see how a case evolved and investigate a step at a time rather than arranging a lot of investigations immediately, some of which were associated with risks.

31. The Board said the Consultant was available to speak with relatives. They said that most relatives who wished to see the Consultant spoke to ward nurses and made an appointment. They said that a time would be arranged for the Consultant to see relatives or she would telephone them. The Board said the Consultant did not receive any requests for an appointment with Miss C's mother and that she was not asked to phone her at any time.

32. The Board said they accepted that Miss C's return to the Hospital on 5 March 2007 was poorly managed and they apologised for any distress or inconvenience caused. They said the Consultant would be reviewing the ward's policy in that regard.

(b) Conclusion

33. Miss C feels that the Consultant did not adequately explain what was planned for her care. While the Consultant has apologised that Miss C and her family felt communication was poor, it is clear that her recollection of events is different from Miss C's as she remembers giving her time to ask questions and recalls her being happy with information provided. Unfortunately, it is not possible for me to determine whether communication was, or was not, appropriate in this case. That is because Miss C and the Consultant's recollections are at odds and there is no impartial and independent evidence available to me to reach a finding one way or the other. Similarly, there is no

record of Miss C's mother making a call to speak with the Consultant and I am, therefore, not able to make a finding in that respect.

34. With regard to Miss C's return to the ward on 5 March 2007, the Board have acknowledged there were problems and, consequently, I uphold that part of the complaint.

35. Although I partially uphold the complaint, I have no recommendations to make, as I am satisfied that the action taken by the Board in apologising to Miss C and reviewing their policy constitutes an appropriate remedy to the failing identified here.

(c) The letter responding to Miss C's complaint contained inaccuracies

36. Miss C said the response to her complaint from the Board contained a number of inaccuracies. She said that: she was not seen by the Consultant on the day of her discharge; the laxatives prescribed to her did not help her pain; and no appointment letter for 2 May 2007 was received.

37. The Board said that their complaint response did not state that the Consultant had seen Miss C on the day of her discharge. They said the comment that laxatives seemed to help Miss C's pain was taken from the nursing and medical notes and that an out-patient appointment letter for 2 May 2007 was booked into their system and sent out. They apologised that Miss C did not receive the letter.

(c) Conclusion

38. I agree with the Board that their letter to Miss C did not state that the Consultant was present on the day of Miss C's discharge. I have also confirmed that the comment in the letter about laxatives was factually accurate in that it accurately represented a comment in the clinical records. With regard to the appointment letter, I am satisfied that the letter was sent to Miss C and I must assume that the fact that it did not reach her was due to a failure in the postal service. In all the circumstances, therefore, I do not uphold this complaint.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
The Hospital	Victoria Infirmary
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	One of the Ombudsman's medical advisers
The Private Hospital	A private hospital at which Miss C received treatment
CT scan	A Computerised Tomography scan
The GP	Miss C's general practitioner
The Consultant	The consultant in charge of Miss C's care during her admission in February 2007

Annex 2

Glossary of terms

Barium enema	A test where barium sulphate is given through the anus to allow x-ray examination of the lower intestinal tract
Barium meal and follow-through	Tests where barium sulphate is ingested and an x-ray subsequently taken
Colonic loading	Where the colon is filled with faecal mass
Colonoscopy	A test that allows to look into the large bowel using a narrow, flexible, tube-like telescope called a colonoscope
Diclofenac	An anti-inflammatory drug
Endometriosis	A condition in which normal endometrial tissue – the lining of the uterus – grows outside the uterus
Gynaecology	The branch of medicine that deals with conditions of women's reproductive systems
Haemodynamically stable	Refers to the stability of blood circulation.
Lactulose	A synthetic sugar used in the treatment of constipation
Laparoscopy	A test using a laparoscope – a thin, lighted tube – to look at and take tissue from the body
Meckel's diverticulum	A small bulge in the small intestine

Meckel's scan	A test where images of the abdomen are taken after a patient is injected with a small quantity of radioactive material
Ovarian cyst	A cyst inside the ovary
Palpation	Examination with hands or fingers
Pelvic inflammatory disease	An infection that involves the fallopian tubes and nearby pelvic structures
Pouch of Douglas	A small sac-like structure between the rectum and the anus
Pyrexia	A rise in the temperature of the body
Right iliac fossa pain	Pain affecting the right inferior part of the abdomen
Urinalysis test	A test that determines the content of urine