**Scottish Parliament Region: Glasgow**

**Case 200603801: Greater Glasgow and Clyde NHS Board - Acute Services Division**

**Summary of Investigation**

***Category***

Health: clinical treatment/diagnosis

***Overview***

The complainant (Mrs C) felt that the death of her husband (Mr C) could have been avoided had staff of Greater Glasgow and Clyde NHS Board (the Board) been more proactive in diagnosing his condition. She complained that Mr C's assigned consultant (Consultant 1) should have been more directly involved in his care.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) Mr C was not seen by Consultant 1, the consultant that he was referred to at Glasgow Royal Infirmary (*not upheld*);
(b) the diagnostic process was unnecessarily delayed (*upheld*); and
(c) ward staff did not deal with Mr C respectfully (*no finding*).

***Redress and recommendations***

The Ombudsman recommends that the Board:

(i) consider asking the clinical team to review the circumstances of this case to see if there are any lessons to be learned regarding communication with patients and relatives;
(ii) apologise to Mrs C and her family for the additional distress and suffering caused by the delays to Mr C's diagnosis; and
(iii) revise their procedures to include written notice to the referring consultant of all failed scan results.

The Board have accepted the recommendations and will act on them accordingly.

## Main Investigation Report

### Introduction

1. The aggrieved (Mr C) was referred to Glasgow Royal Infirmary (the Hospital) by his GP in May 2006 having been suffering back pain, limited mobility and foot drop. His referral was to see an orthopaedic consultant (Consultant 1). Mr C's wife (Mrs C) said that Consultant 1 was not present during the initial consultation, nor did he ever meet personally with Mr C during the course of his treatment. She complained that extended periods of absence on the part of Consultant 1 and his lack of personal involvement in Mr C's care led to delays to, and poor management of, the diagnostic process. Mr C was diagnosed on 29 August 2006 as having non-Hodgkin's lymphoma, a form of blood cancer affecting the white blood cells.

2. Mrs C complained to Greater Glasgow and Clyde NHS Board (the Board) in September 2006 raising these points and further concerns about the state that she had found Mr C in during visiting times on two occasions. She was dissatisfied with the Board's response to her complaints and brought the matter to the Ombudsman's office in March 2007.

3. The complaints from Mrs C which I have investigated are that:

(a) Mr C was not seen by Consultant 1, the consultant that he was referred to at the Hospital;

(b) the diagnostic process was unnecessarily delayed; and

(c) ward staff did not deal with Mr C respectfully.

4. Mrs C's complaint commented heavily on the performance of Consultant 1 and his suitability to manage Mr C's care. I have not considered any aspects of the complaint relating to personnel issues and have instead concentrated on the clinical aspects of the case and the diagnostic process.

### Investigation

5. In order to investigate this complaint, I have reviewed all of the complaint correspondence between Mrs C and the Board. I have also sought professional medical advice from an independent professional adviser (the Adviser) and reviewed the Board's clinical records for Mr C.

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

**(a) Mr C was not seen by Consultant 1, the consultant that he was referred to at the Hospital; and (b) the diagnostic process was unnecessarily delayed**

7. Mr C attended his GP practice in early April 2006 suffering from symptoms similar to sciatica. Over the following weeks he developed back pain, a reduction in mobility and foot drop. By mid-April he was unable to walk without a walking stick and he experienced extreme pain at all times. He was referred to a physiotherapist and an appointment was arranged for 4 May 2006, however, upon examining him, the physiotherapist felt that she may make his condition worse and, therefore, did not provide any treatment.

8. On 4 May 2006, Mr C's GP wrote to an orthopaedic surgeon at the Hospital who had treated Mr C in 2002 for a prolapsed disc. The referral letter, marked as urgent, noted that his previous condition caused right-sided symptoms and that he was now experiencing left-sided symptoms which had worsened over the past month and particularly the past two weeks. Mr C's symptoms were described as foot drop, pain radiating from the left buttock to the left knee, a loss of sensation in his left calf, tenderness in his lower lumbar region and left sided saddle area numbness (numbness from the left buttock to the left thigh). The tenderness in Mr C's lower lumbar was noted to be over the L4/5 and S1 region, which was the region affected by his disc prolapse in 2002.

9. Mr C's case appears to have gone through an internal triage process at the Hospital and an appointment was arranged for him at Consultant 1's orthopaedic clinic on 18 May 2006.

10. Upon attending the Hospital on 18 May 2006, Mr C was seen by an Extended Scope Practitioner Physiotherapist (ESPP) who arranged an x-ray. Mrs C told me that Mr C was advised that Consultant 1 was 'too busy to see him', however, the ESPP spoke to Consultant 1 and confirmed that Mr C would require an MRI scan. Mr and Mrs C were told that this would be carried out as soon as possible and in the meantime an appointment would be made to fit Mr C with a splint to support his dropped foot.

11. Two appointments were made for 20 June 2006, one for the foot splint and one for the MRI scan. Mr and Mrs C were told that the scan results would be available in seven to ten days.

12. Mrs C called Consultant 1's secretary on 27 June 2006 to enquire as to when the MRI results would be available. The secretary advised her that Consultant 1 was about to go on annual leave and would be back on 25 July 2006. The results would be communicated then.

13. Mrs C called Consultant 1's secretary again on 25 July 2006. She said that on this occasion, the secretary had no record of Mr C's MRI scan but that she would investigate and call Mrs C back. Mrs C reportedly did not receive a call so she called back the following day. She was advised that the MRI scan had failed as Mr C had been in too much pain to lie still for long enough.

14. Mr C visited his GP practice on 27 July 2006. His physical condition had deteriorated severely enough to prompt his GP to fax Consultant 1 the following day expressing his concern that no progress had been made since the failed MRI scan.

15. Mr C's GP practice contacted Mrs C on 2 August 2006 to advise her that Mr C would require blood tests and another x-ray. Mr C had an appointment to see Consultant 1's senior house officer (Doctor 1) on 8 August 2006 and he took the test results with him. Doctor 1 examined Mr C on 8 August 2006. The clinical records for this consultation record that Mr C had manifest weight loss, that there was a large firm swelling of the left buttock and that Mr C had complained of sciatica. Doctor 1 arranged for Mr C to be admitted to hospital directly from the out-patient clinic for further investigation. Mr and Mrs C said that they were advised the following day that Consultant 1 was on annual leave again.

16. On 11 August 2006 Mr C underwent a CT scan of his chest, abdomen, pelvis and lumbar spine. This showed that his vertebrae were relatively normal (some minor disc bulging was present), however, a vertical fracture was found on the left side of the sacrum along with marked destruction of the sacrum. This was shown to have been caused by the growth of a large lobulated mass extending through the sciatic foramen into the gluteus muscles (a tumour had grown through his pelvis and into his left buttock, destroying part of the pelvis).

17. Following the CT scan it was recommended that Mr C's case be referred to a consultant orthopaedic surgeon (Consultant 2) at the Western Infirmary. Consultant 2 asked that a second MRI scan be arranged to obtain scan images of Mr C's pelvis and sacrum. Another MRI scan was arranged for 18 August 2006. Mr C was to be sedated so that he could lie still in the scanner. This scan was to be carried out at the Western Infirmary as the Hospital did not have the necessary equipment to perform an MRI scan with a patient under sedation.

18. By 14 August 2006 Mrs C was concerned that Mr C had to date not been seen by Consultant 1. She telephoned Consultant 1's secretary to request a meeting with Consultant 1 to discuss Mr C's care. She said that she was later telephoned by Doctor 1 and advised that everything was being done that could be done and that a second MRI scan would be carried out soon.

19. On 17 August 2006, before the MRI scan could be carried out, Mr C became acutely unwell. Overnight he was found to have developed urinary retention and a urinary tract infection. His bladder was catheterised and two and a half litres of urine were drained from it. Mrs C called the hospital at around 09:00 on 18 August 2006 and was advised by ward staff that they were just about to contact her, as Mr C was very ill. She was later told that he had reacted badly to the sedatives that he had been given in preparation for his MRI scan and that he had a massive bladder infection which had refluxed back into his kidneys. Mrs C told me that she saw the catheter bag and that it was filled with blood. She also told me that she was told that Mr C may not survive the infection.

20. Mr C's urinary infection was treated with intravenous antibiotics and he was transferred to the Western Infirmary on 23 August 2006 under the care of Consultant 2. By this time he had become incontinent of urine and faeces. A biopsy of the tumour was carried out on 25 August 2006 and the results showed that Mr C was suffering from a non-Hodgkin's lymphoma. Mr C was then transferred on 30 August 2006 to Gartnavel General Hospital where he underwent a course of chemotherapy.

21. Chemotherapy carries with it an increased risk of infection, as the treatment can lead to a reduction in white blood cells - the body's main defence against infection. Such a reduction in white blood cells is called neutropenia.

Mr C developed bilateral pneumonia when in a neutropenic state and was unable to recover from it. Sadly, Mr C died on 4 January 2007.

22. In her complaint to the Ombudsman's office, Mrs C attributed Mr C's death to delays in reaching a diagnosis of non-Hodgkin's lymphoma and the fact that his treatment subsequently took place during the winter months, when colds and flu are widespread. She felt that this, combined with his weakened state, increased the chances of becoming infected when neutropenic.

23. Mrs C noted that it took 18 weeks from Mr C's first attendance at the Hospital until his cancer was diagnosed and said that she believed Consultant 1's five week annual leave directly led to delays to scans that would lead to diagnosis. She also believed that, as Consultant 1 did not meet with Mr C in person at any stage, he was unable to efficiently manage his care. Mrs C highlighted what she felt were unacceptable delays at two specific points in the diagnostic process: the time taken to realise that Mr C's first MRI scan had failed (and the subsequent perceived delay to progressing his treatment) and the time taken for action to be taken following Mr C's GP's fax to Consultant 1 on 28 July 2006.

24. When investigating Mrs C's complaint, I asked the Adviser whether he felt the lack of personal involvement on Consultant 1's part would have had an impact on Mr C's care.

25. Mr C was initially seen by an ESPP, rather than Consultant 1, who was named in his appointment letter. The Adviser explained that ESPPs are used by a number of orthopaedic services nationwide to expedite the investigation and treatment process. ESPPs generally receive training within the service in which they work and from the consultant under whose 'umbrella' they work.

26. The Adviser has specifically considered whether, given the symptoms he had, it was appropriate for Mr C to be seen only by an ESPP at his first appointment. Mr C's symptoms included back pain, sciatica, and foot drop and the Adviser concluded that the use of an ESPP in such a case would be appropriate. However, Mr C also had left sided saddle numbness, which could indicate cauda equine syndrome (impairment of nerves that control bladder, bowel and sexual function). The Adviser said that in these circumstances, the decision to use an ESPP would depend on the consultant's knowledge of the ability of the ESPP. This is not something that I can accurately gauge,

however, the Board have confirmed that consultations take place at the same time and location as Consultant 1's clinic and that Consultant 1 was available to discuss cases with the ESPP should this have been necessary. Mrs C noted in her complaint that the ESPP did discuss Mr C's case with Consultant 1 before concluding that an MRI scan was the appropriate follow-up.

27. The MRI scan, carried out on 20 June 2006, failed as Mr C was in too much pain to lie still in the scanner. The resultant images were blurred and could not be used for diagnostic purposes. This was not discovered quickly and Mr and Mrs C were led to believe that scan results would be available following Consultant 1's return from annual leave on 25 July 2006. Upon contacting Consultant 1's secretary for the results they were advised in the first instance that the results could not be found and then that the scan had failed. Mrs C considers that Consultant 1's absence resulted in a significant delay to Mr C's treatment and that procedures should have been in place to pick up on the fact that the MRI scan had failed, allowing a further scan to be attempted without having to await Consultant 1's return.

28. I asked the Board what the normal procedure would be for reporting a failed scan. The Board told me that this would depend on the individual case. If a scan fails completely it would usually be reported back to the referring consultant in writing. However, if there are clinical concerns or urgent issues then alternative diagnostic routes may be investigated. These would be discussed with the referring consultant along with a verbal report of the failed scan.

29. The Board further advised me that, in Mr C's case, no diagnostic information could be obtained from his MRI scan. They told me that the consultant radiologist (Consultant 3) was concerned about his symptoms, as reported by the scanning radiographers and, therefore, made direct contact with Consultant 1's office to inform them verbally of the aborted MRI scan and to advise them that a CT scan should be carried out with appropriate pain relief and sedation. Correspondence within the clinical records supports this description of events.

30. The Board told me that Consultant 3 tried on a number of occasions to confirm with Consultant 1's office the need to carry out a CT scan. On 4 August 2006 he made the referral for a CT scan in anticipation that this would be agreed with Consultant 1. The scan was booked for 28 August 2006,

however, in the meantime Mr C was admitted as an in-patient to hospital and a CT scan was carried out on 11 August 2006. The radiologist report that followed this scan detailed the scan results and made reference to the failed MRI scan and a message left by Consultant 3 to report the failure to Consultant 1's office.

31. The Adviser expressed concern that no written report was generated following the failed MRI scan. The Board explained in their initial response to Mrs C's complaint that the lack of a report being generated after the MRI scan would have led to the lack of available information when she telephoned Consultant 1's secretary for the scan results. The details of successful scans are updated onto the Board's patient information system and reported to the referring consultant, however, this process was not triggered due to the lack of any results for Mr C's scan. This being the case, no information was available on the patient information system when Consultant 1's secretary checked following Mrs C's call.

32. In his absence, the ongoing care of Consultant 1's patients should have been covered by Doctor 1. As no scan results were generated, Doctor 1 was oblivious to the problem affecting Mr C's diagnostic investigations until it was brought to his and Consultant 1's attention by Mr C's GP. It is unclear from the evidence on file whether Consultant 1 left specific instructions for these scan results to be checked, although this seems unlikely given his secretary's advice to Mrs C on 27 June 2006 that the results would be available upon Consultant 1's return from leave on 25 July 2006. Whether through lack of instruction from Consultant 1 to follow-up, or a breakdown in the administrative processes surrounding the communication of scan results, the end result for Mr C was that no action was taken to confirm a diagnosis of his condition between 20 June 2006 and 8 August 2006.

33. Mrs C said that she felt Mr C's diagnosis was delayed further by Consultant 1 not acting on the fax sent by Mr C's GP on 28 July 2006. As I have already mentioned in paragraph 14, the fax asked that Consultant 1 assess Mr C urgently, and recorded that Mr C's condition was deteriorating badly. Following the fax, Mrs C contacted Consultant 1's secretary on 1 August 2006 to enquire as to when an appointment would be arranged (this was arranged for 8 August 2006 with Doctor 1) and again on 14 August 2006 to request a meeting with Consultant 1. Doctor 1 called her to advise that a meeting was unnecessary.

34. When responding by letter to Mrs C's concerns as part of the Board's investigation into her complaint, Consultant 1 detailed the action that he took following receipt of Mr C's GP's faxed letter. He stated:

> '… knowing that I would be on holiday, but keen to institute a more definitive plan under the circumstances, I myself made arrangements for [Mr C] to attend the out-patient clinic to be reviewed personally by [Doctor 1].'

35. He acknowledged that this out-patient appointment led to Mr C being admitted to hospital and further stated:

> 'I should reiterate that the out-patient appointment and admission to hospital for further investigation, was directly instigated by myself in the full knowledge that I was unable to be personally present as promptly as now deemed clinically necessary.'

36. In their correspondence with Mrs C, the Board acknowledged that there was a delay to reaching a diagnosis for Mr C and apologised for the distress that this caused him and his family. During my investigation I was keen to gauge the severity of the delay and asked the Adviser for his comments as to any impact that this would have had on Mr C's prognosis.

37. The Adviser based his advice on records in the Board's complaint file, including an email containing comments from a consultant haematologist. This noted that non-Hodgkin's lymphoma is an aggressive, high-grade lymphoma. It was further noted that when Mr C was transferred to the haematology ward he had signs of neurological dysfunction and was incontinent of urine and faeces, necessitating a permanent catheter. Intensive chemotherapy initially reduced the size of Mr C's tumour but did not help his bladder or bowel function. During treatment Mr C's sciatic pain returned and further imaging showed that that the chemotherapy had not been as successful as medical staff had hoped. In view of this, radiotherapy was planned, however, Mr C became septic during the neutropenic phase following his chemotherapy and died before further treatment could be given. The consultant haematologist's note explains that the lack of response to aggressive chemotherapy suggested that Mr C's tumour was not particularly sensitive to chemotherapy and that the chances of curing his condition were, therefore, poor. The Adviser agreed with the consultant haematologist's conclusion that the delay in reaching a diagnosis of non-Hodgkin's lymphoma is unlikely to have affected Mr C's chances of survival,

however, the degree of suffering and morbidity associated with weight loss and bladder and bowel dysfunction may have been reduced or avoided if an earlier diagnosis had been made.

*(a) Conclusion*

38. Although I am unable to verify whether Consultant 1 visited Mr C during his period as an in-patient at the Hospital, it is apparent from the evidence that I have seen that Consultant 1 did not personally take part in any of his out-patient consultations leading up to the date of his admission to hospital. However, I consider the key issue in this complaint to be what impact, if any, Consultant 1's absence had on the level of care that Mr C received and whether a diagnosis could have been reached sooner had Consultant 1 met with Mr C himself.

39. The Adviser confirmed that the use of ESPPs during Consultant 1's clinics was appropriate given Mr C's presenting symptoms and Consultant 1's availability for consultation should he be required. I am satisfied, therefore, that it was unnecessary for Consultant 1 to see Mr C personally during his initial consultation.

40. The diagnostic process was delayed by a breakdown in communication between the radiology and orthopaedic departments. I give full consideration to this in paragraphs 43 to 48. I consider the principal reason for this failure to be the Board's policy of not producing written reports following failed scans, rather than Consultant 1's absence.

41. Once Mr C was admitted to the Hospital on 8 August 2006 his care progressed quickly. The referral letter that led to his appointment on 8 August 2006 was faxed by his GP on 28 July 2006 and marked as urgent. Consultant 1 stated that he personally arranged the 8 August 2006 appointment and instigated Mr C's admission to hospital. As he was on annual leave on the day of the appointment it would appear that the decision to admit Mr C to hospital was taken by Doctor 1, however, I accept Consultant 1's involvement in arranging the appointment initially.

42. Taking into account the evidence that I have received, and my findings in paragraphs 43 to 48, I am satisfied that the fact that Consultant 1 did not personally see Mr C before his final admission to hospital did not directly result in any delays to his diagnosis and treatment. I am concerned, however, that, despite Mrs C's repeated attempts to contact him, it was not explained to

Mr and Mrs C that there was no clinical need for Consultant 1 to be present at Mr C's appointments. I also regard it as unfortunate that no opportunity appears to have been taken at the time to discuss with Mr and Mrs C the circumstances of the failed scan and its consequences for Mr C's treatment and prognosis. However, in all the circumstances, I do not uphold this complaint.

*(a) Recommendation*

43. Although I did not uphold this complaint, I was concerned by the apparent lack of communication with Mr and Mrs C regarding the delays caused by Mr C's failed MRI scan and Consultant 1's level of involvement in his care.

44. The Ombudsman, therefore, recommends that the Board considers asking the clinical team to review the circumstances of this case to see if there are any lessons to be learned regarding communication with patients and relatives.

*(b) Conclusion*

45. The Board have already acknowledged in correspondence with Mrs C that Mr C's diagnosis was delayed. I have, therefore, concentrated on the extent of these delays and the impact that they had on Mr C's prognosis.

46. Following Mr C's failed MRI scan, the radiology department correctly followed the Board's procedure for reporting back to the referring consultant. Consultant 3 was concerned about Mr C's condition and, therefore, attempted to advise Consultant 1's team verbally that a CT scan should be considered. Consultant 1's team have no record of receiving this verbal report and no follow-up action was taken as a result. Given the potential importance of MRI scan results, I consider it essential that they can be tracked between the radiology department and the referring consultant.

47. Mr C's failed MRI scan was carried out on 20 June 2006. This failure was not confirmed within Consultant 1's team until 28 July 2006 following contact from Mr C's GP. Consultant 3, having failed to confirm how to proceed with Consultant 1's team took action on 4 August 2006 and made an appointment for a CT scan for 28 August 2006. Had Mr C's GP not contacted Consultant 1 on 28 July 2006, ten weeks would have passed without any action being taken. It transpired that Mr C was admitted to hospital soon after Consultant 3 made the scan appointment and a CT scan was carried out a little more than seven weeks after the initial MRI scan.

48. I am satisfied that investigations into Mr C's condition followed an appropriate and timely path from initial consultation until the MRI scan of 20 June 2006. Given that his presenting symptoms were still consistent with sciatica by the time of his GP's faxed letter of 28 July 2006, I also consider the time taken to arrange the appointment for 8 August 2006 to be acceptable albeit undesirable. Following his admission to hospital, diagnosis was swift and Mr C's care again followed an appropriate path.

49. The Board's procedure for communicating failed scan results between departments did, however, lead to delay and confusion. The Adviser considered that, had the radiology department generated a written report on the failed MRI scan, then there would have been a clear delegation of responsibility to Consultant 1's team to make further arrangements for Mr C's ongoing diagnosis. On this occasion, it is clear that the hospital's procedure of reporting failures verbally led to this important information being lost between departments.

50. The Adviser told me that the timing of Mr C's treatment is unlikely to have increased the likelihood of infection when neutropenic. A consultant haematologist who cared for Mr C during his stay at the Western Infirmary and the Adviser concurred that Mr C's lack of response to chemotherapy meant that it was ultimately unlikely that he would survive his non-Hodgkin's lymphoma. However, they concluded that had the seven week delay to his diagnosis been avoided, Mr C may have been spared some of the complications that he experienced, such as bladder infection and double incontinence. Accordingly, I uphold this complaint.

*(b) Recommendations*

51. The Ombudsman recommends that the Board:

(i) apologise to Mrs C and her family for the additional distress and suffering caused by the delays to Mr C's diagnosis; and

(ii) revise their procedures to include written notice to the referring consultant of all failed scan results.

**(c) Ward staff did not deal with Mr C respectfully**

52. Mrs C said that when she visited Mr C at the Hospital on 19 August 2006 she found him lying naked on his bed with his hospital gown over his shoulder. Mr C was in a ward with three other patients. Mrs C was the first visitor to arrive

at the ward but she was upset that ward staff had apparently not checked that he was decent before visiting time commenced.

53. Upon visiting Mr C on 25 August 2006 at the Western Infirmary, Mrs C again found Mr C lying exposed on the bed. Again, she was the first visitor to the ward and was able to cover him up before others arrived. However, she told me that Mr C's bed was visible from the ward's front desk and that, after she commented on the matter, staff quickly offered assistance to make Mr C more comfortable. Mr C was changed into a pair of pyjamas shortly afterward. Mrs C told me that Mr C had six pairs of pyjamas in his bedside locker.

54. Mrs C told me that she felt that both of the above incidents showed a lack of respect for Mr C's dignity and poor patient care by the ward staff.

55. The Board investigated Mrs C's complaint with their ward staff. Although staff did not confirm the specific circumstances surrounding these events, they reported that it was likely that a conscious decision had been taken to nurse Mr C in a gown rather than pyjamas, as this was likely to be more comfortable for him. As Mr C had a high temperature, the ward staff believed that he may have removed his bed sheets and gown himself in order to cool down. Mrs C did not agree with this conclusion, as she felt Mr C's condition had deteriorated to such an extent that he would be incapable of moving his sheets or gown without assistance.

*(c) Conclusion*

56. Given the nature of this complaint, I am unable to confirm the circumstances at the time of Mrs C's visits. I accept her description of events, however, it is not possible for me to comment on whether or not Mr C removed his gown and sheets himself and there are no records to indicate how frequently Mr C was checked by ward staff. As such, there is insufficient evidence available for me to reach a useful conclusion. I, therefore, have no finding on this complaint.

*(c) Recommendation*

57. The Ombudsman has no recommendations to make.

The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks the Board notify her when the recommendations have been implemented.

**Annex 1**

**Explanation of abbreviations used**

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| Mr C | Mrs C's husband, the aggrieved |
| The Hospital | Glasgow Royal Infirmary |
| Consultant 1 | An orthopaedic consultant at Glasgow Royal Infirmary |
| Mrs C | The complainant |
| The Board | Greater Glasgow and Clyde NHS Board |
| The Adviser | An independent professional adviser |
| ESPP | Extended Scope Practitioner Physiotherapist |
| Doctor 1 | A doctor working under Consultant 1 |
| Consultant 2 | An orthopaedic consultant at the Western Infirmary |
| Consultant 3 | A consultant radiologist at Glasgow Royal Infirmary |