Scottish Parliament Region: Glasgow

Case number 200700814: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment; diagnosis

Overview

The complainant (Mr C) raised a number of concerns regarding the clinical treatment that his father (Mr A) received whilst under the care of Greater Glasgow and Clyde NHS Board (the Board). He believed that staff at Glasgow's Victoria Infirmary failed to give due consideration to Mr A's previous medical history and that, had they done so, his death in December 2006 could have been avoided. Mr C also complained that the medication prescribed for another of Mr A's conditions was unsuitable and that it potentially contributed to his deterioration.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board inappropriately treated Mr A with Methotrexate (*not upheld*);
(b) the Board failed to take adequate note of Mr A's past medical history when treating him (*upheld*);
(c) the Board failed to proactively seek information relating to Mr A's past medical history (*upheld*);
(d) the Board inappropriately reduced Mr A's steroid dosages before the full extent of his illness was known (*upheld*); and
(e) Mr A's death certificate did not accurately reflect the cause of death (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) formally apologise to Mr C and his family;
(ii) remind all staff of the importance of sourcing and reviewing historical clinical records;
(iii) review their record-keeping practices and introduce procedures to ensure the prompt identification, sourcing and provision of historical clinical records;

(iv) considers ways to promptly source specific records relating to relevant information raised by patients and their families; and
(v) ask the clinical team to review the circumstances of this case to see if there are any lessons that can be learned regarding the diagnosis and treatment of organising pneumonia.

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

Main Investigation Report

Introduction

1. In 1995, the complainant (Mr C)'s father (Mr A) was admitted to Glasgow's Victoria Infirmary (the Hospital). He was diagnosed as having bronchiolitis obliterans organising pneumonia (BOOP). BOOP is an inflammatory lung disease, whereby the small airways in the lungs become swollen. Although the symptoms of BOOP are similar to pneumonia, it is not caused by bacterial or viral infection as is typically the case with community acquired pneumonia (CAP). The condition is often caused by a pre-existing chronic inflammatory disease, such as rheumatoid arthritis. Mr A was treated with a course of a corticosteroid, Prednisolone, which resolved his BOOP in January 1996.

2. Over the following years, Mr A experienced joint pain and stiffness. He was diagnosed, in 1997, as having probable psoriatic arthritis. This was treated with Methotrexate from October 2005.

3. In October 2006, Mr A was again admitted to the Hospital with a swollen left hand and right sided pneumonia. The pneumonia was initially treated as bacterial, however, Mr A did not respond to treatment and he was subsequently prescribed corticosteroids. Following a progressive reduction of his steroids, Mr A's condition deteriorated. He was admitted to the Hospital's intensive care unit (ICU) where he died on 22 December 2006.

4. Having extensively researched Mr A's condition, Mr C wrote to Greater Glasgow and Clyde NHS Board (the Board) in February 2007 to raise a number of questions over the handling of Mr A's care. He noted that Mr A had a history of BOOP but that this had not been considered upon his admission to the Hospital. Mr A's past clinical records had not been available to the consultants caring for him and Mr C felt that, despite his family raising concerns about a recurrence of BOOP, these were not acted upon. Mr C also raised specific concerns over the treatment of Mr A's condition and the use of Methotrexate to treat Mr A's psoriatic arthritis, as this drug has been linked to the onset of chronic respiratory conditions. Dissatisfied with the explanations provided by the Board, Mr A brought his complaint to the Ombudsman in June 2007.

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

(a) the Board inappropriately treated Mr A with Methotrexate;

(b) the Board failed to take adequate note of Mr A's past medical history when treating him;
(c) the Board failed to proactively seek information relating to Mr A's past medical history;
(d) the Board inappropriately reduced Mr A's steroid dosages before the full extent of his illness was known; and
(e) Mr A's death certificate did not accurately reflect the cause of death.

Investigation

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

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

(a) The Board inappropriately treated Mr A with Methotrexate

8. On 25 October 2005, Mr A's GP referred him to the Hospital's Rheumatology department. He had been attending the Rheumatology department regularly for a number of years due to his existing psoriatic arthritis. The GP's referral letter noted that Mr A had recently been having trouble with his left knee. His range of movement was limited and the joint was warm and swollen. Mr A had recently been diagnosed with deep vein thrombosis (DVT – the formation of blood clots deep in the veins) and was taking Warfarin (a drug used to reduce the likelihood of blood clots). His GP was, therefore, hesitant to aspirate (draw fluid out of) or inject his knee and asked whether it would be possible for Mr A to be seen by Rheumatology sooner than was previously planned.

9. Mr A was reviewed by a Staff Grade Rheumatologist (Rheumatologist 1) on 28 October 2005. Rheumatologist 1 wrote to Mr A's GP following this review, noting his recent knee problems. She explained that Mr A had no major crepitus (grinding of the bones) in his knee and that she had found no signs of infection or any reason not to aspirate fluid from the knee and inject steroids. Rheumatologist 1 further explained that Mr A's arthritis had mainly affected his knees historically and that his recent problems were likely to represent a flare-up of his existing condition. She noted that Mr A's medication, Sulphasalazine,

had been fairly ineffective in the past and considered that it may be appropriate to change this to Methotrexate. Rheumatologist 1 said that, given the decision to change Mr A's medication to Methotrexate, she would arrange for pulmonary function tests (PFT) to be carried out. She arranged for these tests and a chest x-ray to be carried out. No mention was made in the accompanying notes of Mr A's previous history of BOOP.

10. In a letter to Mr A's GP dated 28 December 2005, Rheumatologist 1 reported that his PFT results had shown a restrictive defect with mild airflow obstruction. Oxygen saturations were at 97% and transfer factor was noted as being good at 87% of the predicted level. Rheumatologist 1 explained that this was simply a baseline reading and not a contraindication to using Methotrexate.

11. A Rheumatology Clinical Nurse Specialist (Rheumatologist 2) at the Hospital reviewed Mr A's progress on 27 January 2006. She wrote to his GP following the consultation stating that Mr A had reported a slight improvement in his joints since starting the course of Methotrexate. She explained that Mr A continued to experience some pain and reduced range of movement in his joints, but noted that there had been no side effects resulting from the use of Methotrexate. Rheumatologist 2 increased Mr A's dose of the drug, proposing that it be raised again after four weeks if he continued to do well on it.

12. Mr A was reviewed by a Consultant Rheumatologist (Consultant 1) on 3 March 2006. Consultant 1 recorded that Mr A was doing well and noted that he had stopped taking Sulphasalazine in favour of Methotrexate. He said that taking both together had previously been considered, however, that this was now unnecessary given Mr A's progress on Methotrexate alone. Consultant 1 was pleased with Mr A's progress and, acknowledging Rheumatologist 2's proposal to increase the dosage, noted that this remained a possibility for future treatment, however, he was happy for Mr A to continue on his current dosage.

13. Mr A's GP wrote to the Hospital on 26 April 2006 asking that he be seen again as soon as possible, as he had been taking Methotrexate for six or seven months with 'no benefit whatsoever from this drug'. Rheumatologist 2 examined Mr A on 26 May 2006. She recorded that Mr A's main complaint was his left knee and that she aspirated 20ml of inflamed fluid from that joint. Mr A's Methotrexate dosage was increased. His dosage was further increased following review by Rheumatologist 2 on 11 August 2006. She noted that he

had responded well to recent treatment, however, she felt that further improvements to his condition were possible.

14. Mr A continued to take Methotrexate until 11 October 2006, at which point this treatment was stopped, following his admission to the Hospital with a swollen left hand and right sided pneumonia.

15. Mr C wrote to Consultant 1 on 12 February 2006. He questioned the use of Methotrexate to treat his father and said: 'During my extensive research into my father's condition … it was brought to my attention that there is a solid history of chronic respiratory conditions being brought on by Methotrexate. BOOP was more often than not mentioned as one such side effect of Methotrexate'. Mr C specifically asked whether Mr A's history of BOOP had been taken into account when reaching the decision to prescribe Methotrexate and whether Mr A's clinical records had been consulted during a period of assessment for his suitability to use the drug. He noted that his research indicated that Methotrexate should not be prescribed in cases where the patient has lung damage or lung disease and that it should only be used where all other treatment options have been exhausted. Mr C also explained that it had taken more than two weeks to source Mr A's past clinical records following his admission to the Hospital on 10 October 2006. He surmised that this meant that the notes were not readily available and asked whether Methotrexate would still have been prescribed if BOOP was noted in Mr A's medical history.

16. Consultant 1 conceded that there was no evidence within Mr A's clinical records confirming that his previous records relating to his BOOP in 1995 had been considered at the time of prescribing Methotrexate. He said, however, that it was likely that they would not have been checked. Consultant 1 explained that, normally, patients would be asked if they had chest problems and would be told about the potential side effects of Methotrexate. Rheumatology staff would not always go through the past clinical records. Consultant 1 said that it is not the case that Methotrexate should not be prescribed in rheumatoligical cases if the patient shows signs of lung damage. He noted that the use of PFTs as a baseline measurement allows medical staff to spot any changes in the patient's condition that may have been caused by the Methotrexate, and to identify whether those changes are drug related, or whether there is a different cause, such as viral infection.

17. In response to Mr C's concerns over the suitability of Methotrexate, Consultant 1 explained that it is the preferred medication for rheumatoid arthritis and psoriatic arthritis in America, however, in the UK, Sulphasalazine is used in the first instance. As Mr A was not responding to Sulphasalazine, it was considered appropriate for him to try Methotrexate. Consultant 1 said that the link between Methotrexate and chest disease is not usually with BOOP and that Methotrexate can, in fact, be used to treat BOOP.

18. Mr C also asked Consultant 1 whether Mr A had had a chest x-ray prior to Methotrexate being prescribed and whether his chest condition should have been monitored more closely. Consultant 1 noted that Mr A's chest was x-rayed on 28 October 2005 (the day that the decision to use Methotrexate was taken). The x-ray results gave no cause for concern and, although Mr A's PFT showed a slight restrictive defect and mild airflow obstruction, Consultant 1 explained that this is reasonably common and would not contraindicate the use of Methotrexate. Again, he noted that the results act as a baseline reading that can be referred to should a patient develop symptoms of possible side effects in the future.

19. Consultant 1 noted that Mr A started taking Methotrexate in October 2005. The first signs of any chest problem came in October 2006. He said that Mr A's symptoms suggested a chest infection but with the possibility of clots in the lungs. His symptoms were not indicative of Methotrexate-induced chest problems, which cause pneumonitis (inflammation all over the lungs). As a precaution, however, Mr A's Methotrexate medication was stopped on 11 October 2006.

20. When investigating Mr C's complaint, I asked the Adviser to comment on the use of Methotrexate and the appropriateness of this treatment given Mr A's past history of BOOP. The Adviser explained that Methotrexate pneumonitis has been identified in patients with rheumatoid arthritis but that the frequency of this is quite rare. He added that pneumonitis can itself be a complication of rheumatoid arthritis. The Adviser said that patients at greater risk of contracting Methotrexate pneumonitis, such as smokers or those with underlying lung disease, could be identified before prescribing the drug, by carrying out chest x-rays and PFTs. He explained, however, that pneumonitis has been identified in many patients with normal PFT results, therefore, all patients commencing this treatment should be made aware of the need to report new respiratory symptoms such as a persistent cough or shortness of breath.

21. In Mr A's case, the Adviser acknowledged his previous history of BOOP and asthma and the mild defect highlighted in his PFT results, but considered that there was no absolute contraindication to the use of Methotrexate. He noted that other medications had been prescribed without any benefit to Mr A and commented that in all situations, the risks and benefits of treatment have to be weighed and at the time the decision was made to prescribe Methotrexate, Mr A was symptomatic from his arthritis.

(a) Conclusion

22. It is clear from Mr A's clinical records that his psoriatic arthritis caused him significant discomfort and that initial treatment with Sulphasalazine did not improve his condition. The Adviser agreed with Consultant 1's decision that Methotrexate was a suitable option to try and progress Mr A's care and relieve his symptoms.

23. Before a patient is prescribed Methotrexate, PFTs and a chest x-ray should be carried out to identify any pre-existing lung problems and to record baseline readings should the patient's condition later change. Rheumatologist 1 arranged these tests accordingly and the results showed no contraindications to the use of Methotrexate.

24. The decision to use Methotrexate was taken in light of Mr A's arthritic pain and reduced range of movement and records show that his condition improved over the course of this treatment. Mr A attended his GP and the Hospital's Rheumatology department regularly, between October 2005 and October 2006 with no indication of chest problems until October 2006. The symptoms that he presented with in October 2006 were not consistent with Methotrexate pneumonitis and I have seen no evidence within Mr A's clinical records to indicate a direct link between the use of Methotrexate and his subsequent chest problem.

25. I consider the decision to prescribe Methotrexate to be appropriate given Mr A's lack of response to other treatments and the lack of any contraindications for the drugs resulting from his PFT results and chest x-ray. The drug is shown to have improved his condition and was withdrawn as a precautionary measure as soon as he advised medical staff of a new chest problem in October 2006. I am satisfied that Rheumatology staff at the Hospital

checked Mr A's suitability for Methotrexate and approached its use responsibly. As such, I do not uphold this complaint.

(a) Recommendation

26. The Ombudsman has no recommendations to make.

(b) The Board failed to take adequate note of Mr A's past medical history when treating him; (c) The Board failed to proactively seek information relating to Mr A's past medical history; and (d) The Board inappropriately reduced Mr A's steroid dosages before the full extent of his illness was known

27. On 10 October 2006, Mr A was admitted to the Hospital with a swollen left hand and right sided pneumonia. The pneumonia was initially considered to be a CAP and was treated with antibiotics. These failed to improve Mr A's condition and he was subsequently prescribed Prednisolone from 27 October 2006 to allow for a possible diagnosis of BOOP. Mr A's discharge letter from the Hospital stated a possible diagnosis of BOOP. Again, Mr A's condition failed to improve and his Prednisolone dosage was reduced. He subsequently required a further acute admission to the Hospital and was transferred to the ICU where he died on 22 December 2006. On 12 February 2007 Mr C wrote a letter of complaint to the Consultant Physician in Respiratory Medicine (Consultant 2), who had managed Mr A's care at the Hospital. He complained that Mr A's previous BOOP in 1995 was not considered when he was treated in October 2006 and that his clinical records from 1995 were not available to consultants in 2006. He believed that Mr A's symptoms were very similar to those of 1995 and that his prognosis may have been better had his consultants been able to refer to the past medical history.

28. Mr A's admission to the Hospital was accompanied by a referral letter from his GP. In the letter, his GP explained that Mr A had been unwell for the past week or so with what had initially been considered a chest infection. Over the course of the week, Mr A had developed a painful swelling of his left hand. He was noted to be experiencing recurrent sweating episodes and difficulty sleeping and eating. The referral letter detailed the medication that Mr A was taking and his past history of DVT, psoriatic arthritis and a knee replacement. No mention was made of his BOOP in 1995.

29. Rheumatologist 1 reviewed Mr A on 11 October 2006. She made notes following more than one visit with him that day. One of the notes recorded the

results of microscopy tests carried out on fluid aspirated from Mr A's wrist that morning. At the end of the note, in brackets, Rheumatologist 1 has noted 'Says [history] of BOOP aged 10'. I understand this to refer to Mr A having contracted BOOP ten years previously. Rheumatologist 1 noted that Mr A's Methotrexate dosage should be stopped.

30. Mr A's clinical records record that he continued to experience chest pain over the following days. It was noted that his C-Reactive protein (CRP) levels were increased (an indicator of inflammation) and that it was likely that this was related to his chest rather than his wrist. On 13 October 2006 Rheumatologist 1 reiterated her request that Mr A's Methotrexate medication be stopped.

31. Mr A's chest problem was considered to be CAP and was treated with antibiotics. His progress was monitored in the clinical records with little change being identified until 20 October 2006. On this date he is recorded as experiencing sharp pain across his chest, exacerbated by movement. The pain had been present all day. The pain was reduced by Glyceryl Trinitrate spray and was completely resolved after Mr A was given an oxygen facemask.

32. A further note made on 20 October 2006 makes reference to Mr A having BOOP '10 years ago'. Later that day it is noted that Mr A's CRP levels continue to be increased and that BOOP is being considered. It is stated that treatment with antibiotics should continue 'while treating with corticosteroids if appropriate'.

33. The next note in the clinical records for 20 October 2006 is made by a Respiratory Physician (Consultant 3), who examined Mr A and acknowledged his history of BOOP. He noted that Mr A's old clinical records were not available. Consultant 3 recorded that he did not believe Mr A's current condition to be BOOP. Instead, he considered Mr A to have CAP which had been inadequately treated. Consultant 3 proposed that Mr A continue to be treated with antibiotics for the time being.

34. On 24 October 2006, a conversation between medical staff and Mr A's family is recorded. This record states that the family raised concerns that Mr A had BOOP, as the pattern of events was very similar to those of 1995. They felt that he would benefit from steroid treatment. The note for this discussion records that the family were advised that Consultant 3 was involved in Mr A's care and that he was aware of the previous history of BOOP.

35. At Consultant 3's request a CT scan of Mr A's chest was taken on 26 October 2006. The purpose of this scan was to exclude pulmonary emboli (blockages of the pulmonary artery). The scan showed no evidence of interstitial lung disease, however, slightly enlarged lymph nodes in the chest cavity were highlighted as well as extensive consolidation of the right lung (it had become inflamed to the point of hardening). Pleural effusion was also noted (fluid collecting around the lungs). It was suggested that a bronchoscopy (examination of the airways using a fibre-optic camera [bronchoscope]) be carried out.

36. On 27 October 2007, Prednisolone was prescribed for Mr A. The clinical records indicate that Mr A was to continue to be treated for CAP, however, the corticosteroid was to be added alongside his antibiotics to allow for the possibility of BOOP.

37. Mr A was initially prescribed a daily dosage of 50mg of Prednisolone, which was to be reduced over the following weeks. His condition was noted as improving over the following days and he was discharged from the Hospital on 2 November 2006. The discharge letter stated that there had been concerns regarding a reactivation of Mr A's BOOP, however, it was considered that his symptoms were more typical of a CAP. The letter noted that Mr A had been prescribed a reducing dose of Prednisolone to cover the possibility of BOOP until he was next seen as an out-patient, four weeks later. The discharge letter also noted that Mr A had undergone a bronchoscopy during his stay at the Hospital but that the results of this were normal. Under the diagnosis section of the letter, Mr A was listed with probable CAP and possible reactivation of BOOP.

38. By the time of his discharge, Mr A had completed his course of antibiotics and was on 40mg of Prednisolone. This was reduced to 25mg on 9 November 2006. Mr A was next seen as an out-patient at the Hospital on 27 November 2006. Consultant 2 wrote to Mr A's GP following the consultation and explained that he found Mr A's condition to be puzzling. He summarised Mr A's presenting history of an apparent CAP with the subsequent additional steroid treatment in light of his history of BOOP. On 27 November 2006 Mr A continued to experience breathlessness and substantial areas of shadowing were visible on chest x-ray. His CRP levels remained high. Consultant 2 said that if Mr A had a pneumonitis, such as BOOP, it should respond to steroid

treatment. As there was no significant improvement in Mr A's condition, he asked Mr A to 'tail off' the Prednisolone over the following two weeks and arranged for a further CT scan for 13 December 2006. He added that there was no specific evidence of either a cause of infection or an alternative inflammatory diagnosis. Mr A was due to attend for a follow-up appointment in December 2006, however, Consultant 2 suggested that readmission to the Hospital would be appropriate should his condition deteriorate prior to that.

39. Mr A was reviewed by Consultant 1 on 15 December 2006. Consultant 1 acknowledged Consultant 2's treatment plan to gradually reduce Mr A's Prednisolone dosage to 0mg, however, noted that his joints had become increasingly painful. These should have improved with the Prednisolone. Consultant 1 considered it appropriate to maintain Mr A's Prednisolone dosage at its current level (10mg) and further medication was introduced to address his joint pain.

40. Mr A's condition deteriorated and he was readmitted to the Hospital during the evening of 18 December 2006. He was admitted to the ICU on 19 December 2006 and his condition was monitored. Mr A suffered from shortness of breath and dry coughing over the following days and was again treated with antibiotics for pneumonia with steroids for possible BOOP. His condition deteriorated further on 22 December 2006 and, sadly, Mr A died.

41. Mr C wrote to Consultant 2 on 12 February 2007 and asked a number of questions about the approach taken toward Mr A's care. He asked why his family's concerns over the possibility of a recurrence of Mr A's BOOP were ignored over a period of more than two weeks, why the historic clinical records detailing Mr A's previous BOOP treatment were not sought immediately and why Mr A's steroid dosage was reduced without his condition being monitored by staff at the Hospital.

42. Mr C explained that, due to the rarity of the condition, when Mr A contracted BOOP in 1995 he was asked to keep a diary of events that could be used to help medical students at the Hospital. After his admission to the Hospital on 10 October 2006, with no improvement in his condition after the first few (approximately five) days, Mr A asked his family to retrieve the notes that he had taken in 1995. Mr C said that, after reviewing the notes and reflecting on his current condition, Mr A discussed the similarities between his symptoms and those that he experienced ten years previously. Mr C said that Mr A also

explained that the antibiotics that he was taking were having little effect, which was also the case ten years previously. Mr C felt that Mr A's comments were being ignored, as diagnostic tests for BOOP, such as bronchoscopy and lung biopsy were not initially carried out. He was disappointed that Mr A's historic records had still not been sourced after Mr A had been at the Hospital for ten days.

43. Mr C said that he raised his concerns about BOOP in a meeting with two consultants at the Hospital around 25 October 2006. He reportedly listed symptoms that Mr A was experiencing and pointed out that antibiotic treatment was having no effect. Mr C acknowledged that Mr A's symptoms were indicative of a number of illnesses, however, also noted that they were widely regarded as possible factors in diagnosing BOOP. He felt that this should have led to BOOP being a consideration much earlier in Mr A's treatment.

44. Mr C acknowledged, in his complaint to Consultant 2, that Mr A's history of BOOP had been recognised at an early stage but that staff at the Hospital had chosen to pursue the apparent diagnosis of CAP initially. He expressed his concern, however, at the length of time dedicated to treating CAP, without improvement, rather than testing for BOOP.

45. Mr C further complained that it had taken almost two weeks for Mr A's clinical records to be sourced. He commented that almost immediately after they became available, a CT scan and bronchoscopy were performed and the possibility of BOOP investigated. He also noted that this happened shortly after his meeting with consultants on 25 October 2006.

46. There is no evidence contained within the Board's records to indicate whether staff at the Hospital actively pursued the recovery of Mr A's historic records, or exactly when these became available to the staff caring for him in 2006.

47. Mr C believed that, had Mr A's clinical records from 1995 been sourced immediately upon Mr A's admission to the Hospital in October 2006, BOOP would have been pursued as a possible cause of his symptoms earlier. Furthermore, he suggested that the clinical records would have highlighted Mr A's symptoms and treatment at that time, highlighting similarities in his current symptoms, lack of reaction to antibiotics and details of the steroid treatment provided in 1995.

48. In 1995, Mr A was admitted to the Hospital with a general feeling of being unwell, flu-like symptoms, a dry cough and shortness of breath. Upon being diagnosed with BOOP, he was prescribed Prednisolone at 75mg per day, which led to some improvement and resolution of his fever. His Prednisolone dosage was reduced to 25mg over the following three weeks. He began to experience chest pain and general tiredness and it was considered by staff at the Hospital that his Prednisolone dosage had been reduced too rapidly. The steroid dosage was then increased to 50mg per day with a more gradual reduction in dosage until Prednisolone was withdrawn in January 1996.

49. Mr C considered that the continued reduction of Mr A's Prednisolone dosage, despite a deterioration in his condition, could have contributed to his death. He suggested that, had a similar decision to that taken in 1995 – to increase the dosage before a more gradual reduction – been taken, Mr A may have recovered.

50. Consultant 2 wrote to Mr C on 2 March 2007 and responded to the concerns that he had raised. He noted that Mr A's past history of BOOP had been recognised at the time of his admission to the Hospital but that it was not considered likely at that time that the condition had returned. Consultant 2 acknowledged Mr C's concerns about the length of time Mr A had been treated with antibiotics without improvement. He said that it would be normal for a period of one to two weeks to be used to look for an initial response to antibiotics. A lack of any response to antibiotics would lead to further investigations, including bronchoscopy. Consultant 2 noted that the exact timing of bronchoscopy was dependent on the availability of the procedure, which is performed twice per week at the Hospital.

51. Consultant 2 said that a diagnosis of an organising pneumonitis became likely once Mr A reacted well to a combination of antibiotics and corticosteroids during the last week of his stay at the Hospital. He explained that there are various recognised dosage regimes for the use of Prednisolone with the starting dose varying between 40mg as a fixed dose and 1mg per kg of body weight. Consultant 2 considered Mr A to have a persistent, but not necessarily progressive, respiratory problem and sought to carry out a further biopsy and CT scan. He received the scan results on 18 December 2006, the date of Mr A's readmission to the Hospital. Consultant 2 said that the scan results would have resulted in further review of Mr A's condition, but, by that time, his

clinical deterioration had overtaken any planned review. The CT scan results showed an improvement of the areas of consolidation in Mr A's lungs highlighted in the previous CT scan, however, new areas of extensive consolidation were visible. The summary section of the scan report stated that eosinophilic pneumonia (a pneumonia caused by white blood cells blocking the normal air spaces in the lungs) should be considered, and that cryptogenic organising pneumonia (COP) was also possible. COP and BOOP are the same condition with the former being the name given to cases of BOOP where the cause is not known.

52. Consultant 2 conceded that an alternative treatment path could have been considered following the out-patient review of 27 November 2006. At that time, it was his impression that the Prednisolone had not produced a maintained clinical response and he, therefore, reduced the dosage. He said that the Prednisolone treatment could have continued and a biopsy carried out, however, he noted that Mr A's precise diagnosis and the extent to which his symptoms were steroid-responsive remained uncertain. With the benefit of hindsight, Consultant 2 expressed his regret that a biopsy was not carried out whilst Mr A remained on a higher Prednisolone dose and that the dose reduction regime from the end of November 2006 may have contributed to Mr A's clinical deterioration.

53. I asked the Adviser for his comments on the absence of Mr A's historical records and the steroid treatment. Having reviewed Mr A's clinical records, the Adviser agreed that, even with knowledge of a previous case of BOOP, the initial suspicion of CAP was correct and that antibiotic treatment was appropriate in the first instance. Lung biopsy would not be carried out at an early stage. Failure to respond to antibiotics would then raise the possibility of BOOP. The Adviser noted that Mr A's BOOP in 1995 was acknowledged by staff at the Hospital, however, not recorded under the 'Past Medical History' section on the day that he was admitted. He was treated for CAP with antibiotics and when these did not improve his condition Prednisolone was added to address the possibility of BOOP. The Adviser was satisfied that treatment plan was appropriate.

54. The Adviser was concerned that, as BOOP was suspected in Mr A's case, a high resolution CT scan should have been arranged early in the diagnostic process. The CT scan of 26 October 2006 was to eliminate the possibility of pulmonary embolism. Although Mr A began treatment for possible BOOP on

27 October 2006, a high resolution CT scan to confirm this diagnosis was not carried out until 13 December 2006.

55. The Adviser acknowledged that, although Mr A's clinical records from 1995 were not initially available to staff in 2006, the prior diagnosis of BOOP was known to the treating physicians. He noted, however, that generally, where possible, previous medical notes should be scrutinised if they contain information that is not available from other sources, such as the GP's records or the patient. He said that this is not always possible, particularly in an emergency situation, however, every attempt should be made to consult the records to glean additional information. Whilst Mr A was able to inform staff of his previous BOOP diagnosis, further information was contained within the historic records that may have been helpful to the treating physicians. Examination of the course of treatment that Mr A underwent in 1995 may have led to an earlier request for high resolution CT scan of the lungs and possibly a high dose of Prednisolone for a longer period of time, given the favourable effect that this had in 1995. With this in mind, the Adviser considered that Mr A's past records were important and should have been sought.

56. The Adviser was careful to stress that he had the benefit of hindsight and that he had reviewed the records from 1995 and knew the ultimate course of Mr A's illness. With this in mind he noted the course of treatment in 1995: Mr A was started on a 75mg dose of Prednisolone which was reduced to 25mg by the time he was seen one month later. As his symptoms had worsened, the dose was increased to 50mg followed by a more gradual reduction. Whilst recognising that there are different approaches to the use of Prednisolone and no definitive guidelines on dose or duration, the Adviser considered that the corticosteroid dose should be at a high level for a longer period of time than was administered to Mr A in 2006. He suggested that it was possible that the lack of any clinical benefit seen at Mr A's out-patient appointment on 27 November 2006 could have been due to the rapid reduction of corticosteroid dosage. This would be consistent with the pattern of events in 1995. In November 2006, the corticosteroid dose was reduced further due to a lack of improvement in Mr A's condition and the dose was to be reduced further with a view to carrying out a high resolution CT scan and lung biopsy. In the Adviser's opinion, a high dose of Prednisolone should have been maintained for longer and a lack of clinical improvement may have suggested a need for a higher dosage. He noted that, at the time of the out-patient appointment in November 2006, it was vital to obtain a clear diagnosis through CT scan and

lung biopsy. He considered the length of time taken to carry out these investigations to be excessive.

(b) Conclusion

57. Mr A made staff at the Hospital aware of his past diagnosis of BOOP and it is referred to a number of times within the clinical records by different treating clinicians. It is clear that his history of the condition was acknowledged by staff at the Hospital from an early point following his admission on 10 October 2006. I am satisfied that this history was considered as part of the diagnostic process, as it is specifically recorded by Consultant 2 and Consultant 3 that they were aware of the history of BOOP but that they did not consider this to be his diagnosis at that time. As I have seen no evidence to suggest that the absence of Mr A's historic records meant that his history of BOOP was ignored, I have considered this complaint with a mind to establishing whether the absence of the records directly impacted on Mr A's chances of recovery.

58. Mr A's symptoms were such that a diagnosis of CAP was a reasonable assumption and I am satisfied that the initial decision to treat only with antibiotics was correct. I consider the two week period taken to test Mr A's reaction to the antibiotics to be acceptable, however, I acknowledge Mr C's concerns about this in light of his family's assertion to hospital staff that BOOP was the probable diagnosis. A lack of reaction to antibiotics should have led to steroid treatment for BOOP and the clinical records show that this was done despite continued doubts over the source of Mr A's condition.

59. As both the Adviser and Consultant 2 noted, BOOP responds favourably to corticosteroids. Consultant 2 saw no maintained improvement in Mr A's condition when he was on Prednisolone and decided to reduce the dosage so that further investigations could be carried out. The Adviser felt that a higher dosage of Prednisolone should have been prescribed and for a longer period before being reduced. In 1995 Mr A presented with similar symptoms to those that he experienced in October 2006. He reacted well to a higher dosage (75mg per day as opposed to the 50mg prescribed by Consultant 2). I accept that there is no set regime in terms of dosage and duration that should be used when prescribing Prednisolone and I do not consider Consultant 2's treatment plan, itself, to have been misguided.

60. It is impossible to know whether increasing Mr A's Prednisolone dosage and maintaining it over a longer period would have led to him making a full

recovery. Following the out-patient consultation on 27 November 2007, the decision was made to further reduce, and ultimately cease, Mr A's Prednisolone dosage. I cannot confirm whether Mr A's historical records were available to Consultant 2 at that time, however, I have seen no evidence within the clinical records to suggest that Mr A's treatment was influenced by the knowledge of his previous successful treatment and I, therefore, consider it likely that the records remained unavailable. Had Consultant 2 had access to the historical records, at that time, they would have shown the similarities in Mr A's symptoms and his favourable reaction to a higher dosage of Prednisolone. This may have led to a different course of treatment and ultimately to a better prognosis for Mr A.

61. The clinical staff treating Mr A made reasonable decisions regarding his treatment and followed an appropriate diagnostic path, bearing in mind the possible diagnosis of BOOP. The decision to reduce Mr A's Prednisolone dosage was reasonable based on his presenting symptoms and reaction to treatment at that time. With the benefit of hindsight, as Consultant 2 accepted in his letter to Mr C, one can conclude that the reduction in Prednisolone dosage may have contributed to Mr A's deterioration. Had his historical records been available to clinical staff in 2006, Mr A's positive reaction to an alternative Prednisolone regime would have been evident and his prognosis may have been improved. As such, I uphold this complaint.

(b) Recommendations

62. The Ombudsman recommends that the Board:

(i) formally apologise to Mr C and his family;

(ii) remind all staff of the importance of sourcing and reviewing historical clinical records;

(iii) review their record-keeping practices and introduce procedures to ensure the prompt identification, sourcing and provision of historical clinical records; and

(iv) considers ways to promptly source specific records relating to relevant information raised by patients and their families.

(c) Conclusion

63. I have seen insufficient evidence to determine what action, if any, was taken by staff at the Hospital to retrieve Mr A's historical records. Whether staff actively sought to provide the clinical team with the historical records or not, I consider the time that elapsed before they became available to be excessive. I, therefore, uphold this complaint.

(c) Recommendation

64. The Ombudsman has no further recommendations to make.

(d) Conclusion

65. For the reasons detailed under Conclusion (a), I uphold this complaint.

(d) Recommendation

66. The Ombudsman recommends that the Board ask the clinical team to review the circumstances of this case to see if there are any lessons that can be learned regarding the diagnosis and treatment of organising pneumonia.

(e) Mr A's death certificate did not accurately reflect the cause of death

67. Mr C complained to the Board that Mr A's death certificate was inaccurate. The death certificate listed Mr A as having:

i. Hypoxic respiratory failure
ii. Cryptogenic Organising Pneumonia (COP)
iii. Chronic lung disease

Mr C questioned the third condition, as he did not believe Mr A to have had chronic lung disease at any point.

68. Chronic lung disease does not appear to have been considered during Mr A's treatment at the Hospital, however, it is mentioned in one record dated 19 December 2006, shortly following his final admission to the ICU. No comment is made about this, other than its inclusion in a list of Mr A's symptoms at that time.

69. Consultant 2 responded to Mr C's concerns about the death certificate. He confirmed that the label of chronic lung disease did not seem to be appropriate.

70. The Adviser also commented on the death certificate. He noted that hypoxic respiratory failure and COP were appropriate inclusions and are supported by clinical events. He explained that the term COP is sometimes used for the broad category of patients with organising pneumonia and that this diagnosis was highly likely despite it never being confirmed by Mr A's clinical team. Mr A's clinical course was consistent with such a disorder. The Adviser said that chronic lung disease seemed inappropriate. There was no evidence of

this condition in Mr A's previous medical history. He further noted, however, that this particular diagnosis would not have had any influence on Mr A's treatment during his stay in the ICU or during his earlier admissions to the Hospital.

(e) Conclusion

71. I accept that chronic lung disease should not have been listed on Mr A's death certificate. It would appear that its inclusion resulted from an inaccurate entry in Mr A's clinical records at the time of his admission to the ICU on 19 December 2006. Whilst I acknowledge the disappointment that this error would have caused Mr C and his family, and the further questions it may have raised regarding Mr A's treatment, I am satisfied with the Adviser's conclusion that the correct causes of death were recorded and that this additional entry would not have impacted on the treatment that Mr A received at the Hospital.

72. I would draw the Board's attention to the importance of making accurate records within the clinical notes and on death certificates, however, on balance, given that this was obviously a simple error with no impact on Mr A's care, I do not uphold this complaint.

(e) Recommendation

73. The Ombudsman has no recommendations to make.

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's father
The Hospital	Victoria Infirmary, Glasgow
BOOP	Bronchiolitis obliterans organising pneumonia
CAP	Community acquired pneumonia
ICU	Intensive Care Unit
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	A professional medical adviser to the Ombudsman
DVT	Deep-vein thrombosis
Rheumatologist 1	A Staff Grade Rheumatologist at the Hospital
PFT	Pulmonary function test
Rheumatologist 2	A Rheumatology Clinical Nurse Specialist at the Hospital
Consultant 1	A Consultant Rheumatologist at the Hospital
Consultant 2	A Consultant Physician In Respiratory Medicine at the Hospital

CRP	C-Reactive protein
Consultant 3	A Respiratory Physician at the Hospital
COP	Cryptogenic organising pneumonia

Annex 2

Glossary of terms

Bronchiolitis obliterans organising pneumonia (BOOP)	An inflammatory lung disease, whereby the small airways of the lungs become swollen
Community acquired pneumonia (CAP)	A bacterial infection of the lungs
C-Reactive protein	A protein produced by the liver. Its levels increase dramatically in the presence of inflammation and it is, therefore, an indicator of this
Deep-vein thrombosis	The formation of blood clots in the deep veins
Methotrexate	An antifolate drug used in the treatment of autoimmune diseases, including psoriatic arthritis
Pneumonitis	Inflammation of the lung tissue
Prednisolone	A corticosteroid drug used in the treatment of BOOP and other organising pneumonia
Psoriatic arthritis	A type of inflammatory arthritis
Pulmonary embolism	A blockage of the pulmonary artery or one of its branches
Sulphasalazine	A drug used in the treatment of autoimmune diseases, including psoriatic arthritis