Scottish Parliament Region: Highlands and Islands

Case 200703044: Western Isles NHS Board

Summary of Investigation

Category

Health: Hospital; Neurology

Overview

The complainant (Mr C) raised a number of concerns about the treatment which his wife (Mrs C), who was suspected of having multiple sclerosis (MS), received from a consultant neurologist (Consultant 1) at Western Isles Hospital (the Hospital) between October 2006 and February 2007. Mr C also complained about the behaviour of Consultant 1 and the Western Isles NHS Board (the Board)'s handling of the complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) between 18 October 2006 and 21 February 2007 Consultant 1 provided Mrs C with an inadequate level of treatment (*not upheld*);

(b) Consultant 1 behaved inappropriately when he learned that Mrs C had made a complaint against him (*upheld*); and

(c) the Board's handling of the complaint was unsatisfactory (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) Consultant 1 apologise to Mrs C for the comments he made about her in his letter to the GP dated 22 August 2007; and that the Board:

(ii) ensure that this report is shared with Consultant 1's appraiser and is discussed at Consultant 1's next annual appraisal;

(iii) carry out an audit to ensure that complaints are being dealt with in accordance with the timescales as stated in the NHS complaints procedure;

(iv) remind staff who deal with complaints or are subject to complaints of their obligations to act in accordance with the guidance as stated in the NHS complaints procedure; and

(v) apologise to Mr and Mrs C for the failings which have been identified in this report.

The Board have accepted recommendations (ii) to (v) and will act on them accordingly. As at the date of issue of this report Consultant 1 has not accepted recommendation (i).

Main Investigation Report

Introduction

1. On 3 March 2008 the Ombudsman received a complaint from Mr C about the treatment his wife, Mrs C, who was suspected of having multiple sclerosis (MS), received from a consultant neurologist (Consultant 1) at Western Isles Hospital (the Hospital) between October 2006 and February 2007. Mr C also complained about the behaviour of Consultant 1 and Western Isles NHS Board (the Board)'s handling of the complaint.

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

(a) between 18 October 2006 and 21 February 2007 Consultant 1 provided Mrs C with an inadequate level of treatment;

(b) Consultant 1 behaved inappropriately when he learned that Mrs C had made a complaint against him; and

(c) the Board's handling of the complaint was unsatisfactory.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers who is a consultant gastroenterologist (Adviser 1) and an externally appointed consultant neurologist (Adviser 2) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Adviser 1 explained that there is no specific test by which MS can be reliably diagnosed. The symptoms of MS are many and varied and usually develop over quite a prolonged period of time. Any individual symptom is non-specific, meaning that the symptoms can occur in a number of different diseases or conditions. With time, the accumulation of a number of symptoms arising from different areas of the brain gives rise to a pattern that becomes identifiable as suggesting MS as the likely diagnosis. However, such patterns can also occur in a number of different diseases or pathological processes. It is

therefore necessary to perform a number of special investigations to confirm the diagnosis. There is no single investigation that would, in isolation, specifically confirm a diagnosis of MS, since each abnormal test result can have several possible causes other than MS itself. The investigations performed are therefore intended not just to be compatible with a diagnosis of MS but also, when taken together, to exclude the other diagnoses with which MS may be confused. Clearly, an accurate diagnosis is essential since the treatment of these various conditions is quite different.

(a) Between 18 October 2006 and 21 February 2007 Consultant 1 provided Mrs C with an inadequate level of treatment

6. In her letter of complaint to the Board dated 13 June 2007 Mrs C said that, after seeing Consultant 1 on 18 October 2006, she had a MRI brain scan in Glasgow on 12 January 2007 and that the scan team told her the results would be on Consultant 1's desk in 48 hours. Mrs C was concerned to know the results and telephoned Consultant 1's secretary to ask if they had arrived. She said she was told Consultant 1 only worked one day a week at the Hospital and it would be some time before he looked at the results. Mrs C contacted her GP (the GP) who then telephoned Consultant 1's secretary to find out when Mrs C would be followed up by Consultant 1 and was told it would be at the end of June 2007. The GP thought that was too long to wait and arranged an earlier appointment for 21 February 2007. Mrs C continued that at that appointment Consultant 1 said the scan result showed signs indicative of MS and not definitely MS, as she believed he had told the GP when he wrote to the Practice on 30 January 2007 with the results (paragraph 12 refers). She said he had told her she would require further tests in Glasgow. Mrs C said she found Consultant 1's attitude to be extremely intimidating and condescending. She said he also told her not to telephone his secretary for the results and that he would write to the GP.

7. Mrs C said Consultant 1 indicated that another possibility was that she had Lyme's disease, which can mimic the symptoms of MS, but he did not offer to do a blood test. (Mrs C arranged for the GP to carry out the blood test and it was negative for the disease.) Mrs C said Consultant 1 also said she would need a lumbar puncture but she refused as she believed it was an inconclusive test and that it could have serious side effects. Mrs C said that Consultant 1 then became offhand; that he terminated the consultation; and said that if she did not have the test he would be unwilling to give a diagnosis.

8. Mrs C said she attended a hospital in Glasgow on 1 May 2007 for the further tests (see paragraph 6) and she said staff were surprised that Consultant 1 had not completed the preliminary blood tests on 21 February 2007 or requested that she be seen by a specialist MS consultant (Consultant 2). Mrs C then asked the GP to transfer her notes to the MS team which the GP agreed to do when he had received the test results from Consultant 1. However, some six weeks had passed since she had attended Glasgow and Consultant 1 had still not sent the results to the GP. She requested that the Board arrange for her notes to be transferred to the MS team.

9. Adviser 2 said that Mrs C attended the Practice on 11 August 2006, where it was recorded that she was having problems with her right leg; finding that after walking for ten minutes she experienced weakness behind the right buttock and the upper leg and at the same time her right foot everted and she was unable to walk properly. There was no history at this time of numbness or pins and needles and examination revealed normal power in her legs with the reflexes being absent at the ankle, a finding that had been found previously and was considered normal. A referral for a neurological opinion was made on 14 August 2006.

10. Adviser 2 told me that Consultant 1 saw Mrs C in Stornoway on 18 October 2006 and in a letter to the Practice he explained that he had noted the past history of previous neurological episodes involving double vision in 1995, possible right optic neuritis in 2002 and now weakness and heaviness of the right leg, which became more severe after exposure to heat and exercise. Consultant 1 noted that Mrs C's history did hint at MS and yet there was a lack of objective abnormal neurological signs on examination and that the lower limb reflexes were more or less absent, this having been known for a very long time. Consultant 1 recorded that Mrs C was aware that her history was suggestive of MS but he had pointed out to her that the diagnosis must not be regarded as confirmed on the basis of the current evidence. Arrangements were made for Mrs C to undergo a MRI brain scan, with advice that it could take about two months.

11. Adviser 2 continued that the MRI brain scan was performed in Glasgow on 12 January 2007. The brain scan was reported as showing multiple small lesions, the appearance of which was consistent with demyelination but clearly not diagnostic. (Demyelination is the process which produces the disease MS

but it also appears in other disease processes). Adviser 2 said other differential diagnoses had to be considered, such as vasculitis and granulomatous disease.

12. Adviser 2 noted that Consultant 1 wrote to the Practice on 30 January 2007. He said that unfortunately the MRI brain scan showed features which were in keeping with demyelination, with a probable diagnosis of MS. However, as the brain scan appearances were non-specific an investigation programme should be completed which may turn up an alternative diagnosis. Consultant 1 said he would review Mrs C at the neurology clinic locally and would discuss with her a brief admission for investigations, which would include examination of cerebral spinal fluid, visual evoked potentials and a group of blood tests. Consultant 1 added that, as Mrs C had been keen to discover the results of the scan, he had telephoned the results to the Practice on 19 January 2007.

13. On 16 February 2007, the GP wrote to Consultant 1 as Mrs C was anxious to find out if she had MS and when she would be reviewed. The GP said Mrs C had contacted Consultant 1's out-patient clinic and was told she was scheduled to be seen in June 2007. The GP felt that this must have been a mistake as the purpose of the review was to confirm a diagnosis of MS and therefore he arranged for Mrs C to attend Consultant 1's clinic on 21 February 2007 with a view to arranging confirmatory tests in Glasgow thereafter.

14. Adviser 2 said it was recorded that Consultant 1 saw Mrs C on 21 February 2007 and discussed with her what appeared to be a highly likely diagnosis of MS. Mrs C had agreed to be admitted briefly to have additional investigations, including visual evoked potentials and a group of blood tests. It was also recorded that a discussion took place with regard to the cerebral spinal fluid examination but that Mrs C was reluctant to have the investigation. It was also noted that Mrs C had problems with lower limb spasms at night and that Consultant 1 had proposed a trial of Baclofen which the GP could increase at his discretion, taking into account effectiveness should there be any adverse effect.

15. On 13 June 2007, Consultant 1 sent a discharge letter to the Practice following Mrs C's one-day admission on 1 May 2007 to hospital in Glasgow. Consultant 1 said that 'Visual evoked potentials were abnormal-delayed latency on both sides. They support a diagnosis of demyelination. [Mrs C] further declined to have a lumbar puncture. Peripheral blood examination was

unremarkable and was extensive, and included blood urea, electrolytes, glucose, liver function, protein, electrophoresis, thyroid function, angiotensin converting enzyme and CRP. Also included: ESR, full blood count, and vitamin B12 and serum folate acid. The anti-glycolipid antibody titres were negative as was the antinuclear factor, rheumatoid factor, ANCA and complement C3/C4 were all normal. Whereas a diagnosis of MS is likely to be correct, it is noted that [Mrs C] had declined to be investigated fully'. Consultant 1 then noted a proposal (from the GP) that Mrs C be referred to one of the dedicated MS clinical groups and a referral had been made to Consultant 2. Consultant 1 continued that as a general rule, he would wish to place a diagnosis of MS beyond reasonable doubt, prior to discussion about long term management.

16. Adviser 2 noted a referral letter to the Urology Department at the Hospital from the GP dated 9 October 2007, which indicated that Mrs C had bladder hesitancy and poor emptying, with a provisional diagnosis of MS. It was noted in this letter that the neurologist had recommended that Mrs C have a urological review, to offer advice regarding her bladder hesitancy and poor emptying. It was recorded in the GP records at that time that Mrs C was taking Tizanidine 2mgs a night, which were tablets for leg spasms. She was also taking Clonazepam 0.5mgs at night, again possibly to reduce spasms. Mrs C was seen by a locum consultant surgeon on 7 January 2008, who said Mrs C had told him she was diagnosed as having MS although this was not 100 percent proven. Mrs C was going to have a further scan in a year's time. Her main urinary symptoms were urgency micturition and occasional incontinence. The locum consultant discussed with Mrs C her symptoms which he said could be helped by botulinum toxin injections straight into the bladder. Mrs C told the locum consultant that her symptoms were not that bad and she would rather wait and see before commencing treatment. She was given a further appointment to be reviewed in the combined neurology clinic in May 2008.

17. Adviser 2 told me that, in view of Mrs C's history, it seemed very likely that she has MS, based on multiple neurological symptoms and signs scattered in time and place. The diagnosis was essentially confirmed by the MRI brain scan. Further confirmation was obtained by a secondary laboratory investigation, namely the visual evoked potentials. Adviser 2 continued that neurologists who have been in post for some years would still request a lumbar puncture but this is currently being performed less and less by newly qualified staff, if the clinical picture and the MRI scans and visually evoked potentials are positive. Although Adviser 2 did not feel the lumbar puncture was essential, it

would have been useful. He continued that if this was neurosarcoidosis, then the cerebral spinal fluid might have shown an excess of white cells and a very high protein, which it did not. He noted that Consultant 1 did check the appropriate blood tests for this and other causes of vasculitis. Adviser 2 said someone with Mrs C's neurological history, going back many years, was highly likely to have MS by the time she was seen by Consultant 1 and indeed he did discuss the diagnosis with her.

18. Adviser 2 continued that Consultant 1 had seen Mrs C soon after the initial referral and knew that she was aware that MS was in the back of her mind and indeed had been considered by previous consultants in 1999. It was also not unreasonable that Mrs C waited between two and three months for her MRI brain scan. Consultant 1 also went to some lengths to make sure that the GP received the result of the MRI brain scan. Adviser 2 said that Consultant 1 appropriately considered alternative diagnoses, including Lyme's disease, and that it would be reasonable to expect the GP to carry out such a test, although most hospital neurologists would have arranged a blood test on the day of the consultation but if the GP was content to do the test then this was appropriate.

19. Adviser 2 felt that it was acceptable for Consultant 1 not to refer Mrs C to the MS team, partly because he felt he had not come to a definite diagnosis; although, in retrospect, Adviser 2 could not see that there was an alternative. It was perfectly reasonable that Consultant 1 pursued the diagnosis by excluding conditions such as granulomatous disease and such as neurosarcoidosis. Consultant 1 thought that Mrs C's diagnosis should be robust before making a referral. Adviser 2 told me that in his experience it is not unreasonable to refer patients such as Mrs C to the MS team for support rather than diagnosis because there is no specific test for MS; the MS team are aware that it is based on signs and symptoms suggesting scattered lesions throughout time and space. However, in summary, Adviser 2 felt that Consultant 1's assessment and management of Mrs C was of an acceptable standard of competent medical care.

(a) Conclusion

20. I have been told that there is no specific test to diagnose MS, the symptoms of which are many and varied. Some patterns or symptoms can suggest MS is a likely diagnosis but, equally, these can occur in a number of other diagnoses. Consultant 1 did consider differential diagnoses and made arrangements for Mrs C to undergo various examinations. The advice which I

have received is that, in view of Mrs C's history, it seems likely that she had MS based on numerous neurological signs and symptoms over a prolonged period. I have also been advised that the investigations carried out by and suggested by Consultant 1 were appropriate. Adviser 2 has explained that it would be a matter of clinical judgement whether to perform a lumbar puncture and the medical opinion was divided on this issue. He also said it would assist in reaching a diagnosis and could exclude other causes of Mrs C's symptoms. I have noted that a lumbar puncture was offered to Mrs C by Consultant 1. Adviser 2 has also said that, while it would not have been unreasonable to refer Mrs C to the MS team without a definite diagnosis, it was acceptable for Consultant 1 not to refer her to the team in the circumstances. Taking all this into account, I accept the advice which has been given, in that Consultant 1's assessment and management of Mrs C's symptoms was of an acceptable standard and I do not uphold this complaint.

(a) Recommendation

21. The Ombudsman has no recommendations to make.

(b) Consultant 1 behaved inappropriately when he learned that Mrs C had made a complaint against him

22. On 22 August 2007 Consultant 1 wrote a letter to the GP and copied it to Mrs C. In this letter to the GP, Consultant 1 referred to a letter sent to him from the GP dated 10 May 2007 which stated 'Now that [Mrs C's] diagnosis of MS has been confirmed'. Consultant 1 noted that the GP had written to Consultant 2 also on that date saying that Mrs C's diagnosis of MS was 'apparently confirmed'. Consultant 1 deemed the difference in wording to be that Mrs C had lied to the GP about the diagnosis and that the GP was aware that the information from Mrs C may not be reliable. Consultant 1 continued that as he was required to answer a formal complaint from Mrs C there would be no more diplomacy. Consultant 1 said it was always his first duty to provide his patients with an accurate diagnosis but that he had not fulfilled that with Mrs C as she had not followed his advice. He said that failure to examine cerebro-spinal fluid meant failure to exclude such conditions as vasculitis, small vessel disease and sarcoidosis. Consultant 1 also noted the GP had arranged an appointment at the MS clinic for Mrs C on 5 September 2007 and requested that they keep Mrs C under regular review. However, Consultant 1 said that when the diagnosis was unconfirmed, it was unrealistic and unreasonable to expect the MS clinic to take on that role. Consultant 1 then explained why he did not refer Mrs C to the MS clinic and added 'that if [Mrs C] is prepared to lie

to reach the MS clinic, it is axiomatic that she is prepared to lie at the MS clinic'. Consultant 1 continued '[Mrs C]'s credibility is clearly compromised within this department. I propose that you cancel her appointment at the MS clinic and that you refer her to another centre where she makes a fresh start.'

23. On 31 August 2007, Mr C wrote to the Board's Director of Nursing (the Director) and asked if it was acceptable for a member of staff subject to a complaint (Consultant 1) to write directly to the complainant and other health professionals (Mrs C and the GP) dealing with that case. Mrs C had received the letter dated 22 August 2007 from Consultant 1 (see paragraph 22). Mr and Mrs C had contacted the GP and looked at the GP's letter to Consultant 1 dated 10 May 2007. They said the phrase relating to the diagnosis of MS was made by the GP and not Mrs C. The GP also showed them the records of a telephone call from Consultant 1 to the GP and Mr C said it was clear that the information regarding the diagnosis of MS came from the GP and not Mrs C.

24. The GP wrote to Consultant 1 on 30 August 2007 to say that he was sorry that the situation had arisen between Consultant 1 and Mrs C and he hoped it could be resolved to the satisfaction of both parties. The GP was taken aback at Consultant 1's rather frank allegation in his letter that Mrs C was 'a liar'. The GP went on to say that this had upset Mrs C a great deal. While it could have been that there had been a breakdown in communication or one side had misunderstood the other he (the GP) was surprised at the allegation. The GP was also concerned with Consultant 1's assertion that the complaints process could hamper Mrs C's future care in Glasgow. The GP continued he would expect that her care in Glasgow be as good as anyone else's and that this process must in no way get in the way of future care for Mrs C. He stated that it was a basic principle of a complaints process that the complaint is kept completely separate from clinical care, to prevent the complaint impacting on future treatment of the patient. The GP then explained his contact with Mrs C regarding the diagnosis (Note: the GP's record of a home visit to Mrs C on 19 January 2007 stated 'Seen with husband following tel[ephone] message to us from [Consultant 1] giving diagnosis of MS …') and said that it was reasonable to suppose that Mrs C assumed at that stage she had MS. In support, the GP referred to a letter dated 10 May 2007 from a MS specialist nurse who stated 'as you are aware [Mrs C] has been diagnosed with relapsing/remitting MS …'.

25. On 2 October 2007, in a follow up to a telephone call on 3 September 2007, the Director wrote to Mr and Mrs C and apologised for the contents of the letter which Consultant 1 had sent to Mrs C and the GP.

(b) Conclusion

26. The formal complaint from Mr C, on behalf of Mrs C, was made on 13 June 2007 and, following this, Consultant 1 wrote to Mrs C and the GP on 22 August 2007 (see paragraph 22). In this letter Consultant 1 stated that he believed Mrs C had lied by purporting to the GP that the diagnosis of MS had been confirmed, whereas a letter sent by the GP to Consultant 2 said that the diagnosis was apparently confirmed. Mrs C has denied that at any time had she said the diagnosis was definite and that the information regarding the diagnosis came from the GP and not from her. The GP was surprised at Consultant 1's allegations that Mrs C was a liar and suggested that perhaps there had been a breakdown in communications.

27. If Consultant 1 had an issue with the discrepancies in the wording of the GP's letters to Consultant 2 and himself then the appropriate course of action would have been for him to contact the GP and ask for clarification. There is no evidence that the information contained in the GP letters came from Mrs C.

28. Whatever the reason for the difference in wording, I find it completely unacceptable that Consultant 1 should write to Mrs C and the GP in the terms that he did. This was unprofessional and undoubtedly caused Mrs C great concern and distress. I am also concerned that Consultant 1 chose to make reference to Mrs C's future medical treatment, as the complaints process should be completely separate from clinical issues. I have noted that the Board have already apologised for the contents of Consultant 1's letter. I uphold this complaint.

(b) Recommendation

29. The Ombudsman recommends that Consultant 1 apologise to Mrs C. She also recommends that the Board ensure that this report is shared with Consultant 1's appraiser and is discussed at Consultant 1's next annual appraisal.

(c) The Board's handling of the complaint was unsatisfactory

30. The Scottish Executive1 guidance on the NHS complaints procedure, which came into force on 1 April 2005, includes:

> 'It is important that a timely and effective response is provided in order to resolve a complaint, and to avoid escalation. An investigation of a complaint should, therefore, be completed, where possible, within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint, and anyone named in the complaint, must be informed of the reason for the delay and an indication of when a response can be expected. The investigation should not normally be extended by more than a further 20 working days.
>
> While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days … they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected.'

31. Mrs C complained to the Board on 13 June 2007 about the attitude and treatment she had received from Consultant 1 and that he had not referred her to the MS team or forwarded results of tests to the GP. The Director acknowledged the complaint on 22 June 2007 and said a response would be sent within 20 working days. The Director sent an update letter on 3 August 2007 apologising for the delay as she was waiting for comments from Consultant 1. On 31 August 2007, Mr C wrote to the Director and asked if it was acceptable for a member of staff subject to a complaint (Consultant 1) to write directly to the complainant and other health professionals (Mrs C and the GP) dealing with that case (see paragraph 22). Mr C said that they had not yet received a response to their original complaint, which could easily have been concluded with an explanation for time delays and a word of regret from Consultant 1. However, with Consultant 1's letter to Mrs C and the GP with an attempt to interfere with Mrs C's future treatment, the matter may have to be taken further.

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[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive.

32. On 2 October 2007 the Director wrote to Mr and Mrs C and apologised for the contents of the letter which Consultant 1 had sent to Mrs C and the GP (see paragraph 22). She said that the Acting Chief Executive was taking the matter forward. The Director also wrote to Consultant 1 and asked him for comments on the further complaint mentioned in Mr C's letter of 31 August 2007. On 4 October 2007, Mr C emailed the Board to request that Consultant 1 have no further involvement with Mrs C.

33. On 30 October 2007 and 28 November 2007, Mr C sent emails to the Board asking for an update on the complaint. On 21 December 2007, the Director wrote to Mr and Mrs C and explained that she had met with Consultant 1 and that he was confident that all appropriate consultations and treatment were satisfactory and in accordance with best practice. She continued that it would appear that the best possible outcome in this case was an assurance that Mrs C would not be referred to Consultant 1 in the future. Mr C sent the Director an email on 7 January 2008 saying that if the Board response related to the first complaint then although it was unsatisfactory they would accept it. However, they had not received a response to their complaint that Consultant 1 accused Mrs C of lying and attempted to have her hospital appointments cancelled because of the original complaint. An apology from Consultant 1 was the least they would expect. The Board acknowledged the email on 9 January 2008 and said further enquiries would be made. The Board sent a further email on 13 February 2008 in which it was explained they were waiting for a response from Consultant 1. As Mr C had not received a response from the Board he contacted the Ombudsman on 28 February 2008.

(c) Conclusion

34. The NHS complaints procedure is quite clear that, where possible, investigations should be concluded within 20 working days and, if not, explanations must be given for the delay and the investigation extended for no more than a further 20 working days. In this case the original complaint was made on 13 June 2007 about the treatment provided by Consultant 1. A formal response had not been made by the time a second complaint was made on 31 August 2007. Despite Mr C asking for updates, the first formal response was on 2 October 2007, when it was said that the Acting Chief Executive was taking the matter forward. It was left to Mr C to send further reminders to the Board and on 21 December 2007 the Director said she had met with Consultant 1, who was confident he had treated Mrs C appropriately. However, this did not address the issue of Consultant 1's letter to Mrs C or reference to

her future treatment and by the time Mr C had contacted this office (13 March 2008) the Board had still not addressed these issues.

35. The NHS complaints procedure is there to give complainants an assurance they will receive a prompt and robust response to the concerns which they have raised. I appreciate that as Consultant 1 did not work at the Hospital on a full-time basis this may have had an effect on the Board's ability to meet the timescales. However, although contact with Consultant 1 may not have been as straightforward as with staff on site, there can be no excuse for the delays which Mr and Mrs C have endured and the lack of a formal response to the issues which they had raised. I can fully understand why Mr and Mrs C felt compelled to approach this office when their complaints were not being dealt with in a timely manner. I uphold this aspect of the complaint.

(c) Recommendation

36. The Ombudsman recommends that the Board:

(i) carry out an audit to ensure that complaints are being dealt with in accordance with the timescales as stated in the NHS complaints procedure;

(ii) remind staff who deal with complaints or are subject to complaints of their obligations to act in accordance with the guidance as stated in the NHS complaints procedure;

(iii) apologise to Mr and Mrs C for the failings which have been identified in this report.

37. The Board have accepted recommendations (ii) to (v) and will act on 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
Mrs C	Mr C’s wife
MS	Multiple sclerosis
Consultant 1	Consultant nephrologist who treated Mrs C
The Hospital	Western Isles Hospital
The Board	Western Isles NHS Board
The Practice	Mrs C’s GP practice
Adviser 1	Ombudsman’s professional medical adviser, a consultant gastroenterologist
Adviser 2	Ombudsman’s professional medical adviser, a consultant neurologist
The GP	Mrs C’s GP
Consultant 2	MS consultant from MS Clinic
The Director	The Board’s Director of Nursing

Annex 2

Glossary of terms

Baclofen	Antispasmodic medication used to relax muscles
Cerebral spinal fluid	A thin layer of fluid that surrounds the brain. Certain diseases alter the cellular or chemical components.
Demyelination	The term given to the destruction of myelin, the material which surrounds and insulates the nerve itself. Demyelination is the process that produces the disease MS but it also occurs in other disease processes.
Granulomatous disease	A group of diseases in which the pattern of inflammation, when seen under the microscope, appears in a whirl-like arrangement called a granuloma
Lumbar puncture	The insertion of a thin needle into the membranes surrounding the spinal cord in order to obtain a sample of the cerebral spinal fluid
Lyme's disease	An infectious disease transmitted through tic bites which, in its chronic form, can affect the brain tissues
MRI brain scan	Magnetic Resonance Imaging of the brain: a sensitive method of visualising damage in the brain affected by MS (the white matter). In Mrs C's case the multiple small lesions of prolonged T2 signal in the white matter were very suggestive of MS but were not specific to the diagnosis.

Neurosarcoidosis	Sarcoidosis: a granulomatous inflammation, affecting the nervous system
Optic neuritis	Inflammation of the main nerve to the eye; a common presenting symptom in MS
Vasculitis	Inflammation of the blood vessels of any cause
Visual evoked potentials	Measurement of the speed and magnitude of the optic nerve's electrical response to external visual stimuli