Scottish Parliament Region: Highlands and Islands

Case 200602779: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; clinical treatment

Overview

The complainant (Mrs C) raised concerns about her husband's care and treatment at Dunoon General Hospital (Hospital 1) on 14 June 2006. She complained that medical staff did not consider a diagnosis of acute meningitis when they were considering her husband's diagnosis, and that his transfer to Inverclyde Royal Hospital (Hospital 2) was delayed. Following the decision to transfer her husband (Mr C), he became very unwell and, sadly, he died in Hospital 1 on 14 June 2006.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) an alternative diagnosis of acute meningitis was not considered when a diagnosis of stroke was given to the family on Wednesday 14 June 2006 (*not upheld*); and

(b) there was a delay by Hospital 1 in arranging Mr C's transfer to Hospital 2 on 14 June 2006 (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Highland NHS Board (the Board):

(i) ensure that the local redesign process currently being undertaken between the Board and the Scottish Ambulance Service covers the need for medical staff to have access to the most up-to-date details of inter-hospital transfer times and with all the relevant transportation matters clearly established at the time (of arranging the transfer); and

(ii) review their acute unit transfers policy to take account of changing patterns of acute stroke management.

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

Main Investigation Report

Introduction

1. The complainant (Mrs C)'s husband (Mr C) was admitted to Dunoon General Hospital (Hospital 1) on 10 June 2006 with severe back pain. He was admitted at 03:50 via ambulance, following the request of a general practitioner (GP) who carried out a house visit. He was initially seen at the Accident and Emergency Department with presenting symptoms of severe back pain and difficulty getting out of bed. He was then admitted to Ward 2 initially for nursing care, mobilisation and physiotherapy. During his admission the duty doctor (Doctor 1) on Ward 2 advised to stop bed rest and encourage mobility with a zimmer frame, which Mr C did during the following 24 hours.

2. On 13 June 2006 at 07:00 there is a record that Mr C was complaining, at that time, of neck pain with some radiation down his right arm. He was seen during a ward round by the doctor on duty that day (Doctor 2), who recommended rest, ice pack and elevation of the arm. He indicated he would review the situation in 24 hours.

3. At 00:30 on 14 June 2006, Mr C was observed to be feeling hot and sweaty, and assisted to return to bed. From that point Mr C's health deteriorated. By 01:30 the clinical notes indicated he was breathing heavily and not responding to the nurse. Doctor 2 was contacted and Mr C was seen on the ward at 01:45. It was considered that he had suffered a stroke (Cerebral Vascular Accident - CVA) and an ambulance was ordered to transfer Mr C to Inverclyde Royal Hospital (Hospital 2) via the ferry at 06:30 that morning. The clinical notes recorded that Mrs C was contacted and made arrangements to get to Hospital 1. There is a record that at 04:30 the staff noted appearance of jaundice and that Mr C remained cold and clammy.

4. The ambulance control was contacted by ward staff to check arrangements for Mr C's transfer and the ward staff were informed an ambulance from Greenock was being called and it would not be at Hospital 1 until 08:00. Mr C's condition was monitored, however, his health deteriorated and he sadly died at 07:00.

5. Mrs C was unhappy with the arrangements that had been in place for the care of her husband given she had expected him to have been able to go to Hospital 2 for further treatment. Mrs C's son initially complained in a letter

dated 29 June 2006 to Highland NHS Board (the Board) about aspects of Mr C's care prior to his death on 14 June 2006 at Hospital 1. The Board responded to Mrs C's son on 15 September 2006. Mrs C remained unhappy with the response and escalated her complaint to the Scottish Public Services Ombudsman on 7 December 2006.

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

(a) an alternative diagnosis of acute meningitis was not considered when a diagnosis of stroke was given to the family on Wednesday 14 June 2006; and

(b) there was a delay by Hospital 1 in arranging Mr C's transfer to Hospital 2 on 14 June 2006.

Investigation

7. As part of this investigation, I have seen the medical records related to this particular episode of Mr C's care and the complaint correspondence from the Board. The Board responded to a series of questions I asked them and I have sought independent clinical advice about those responses from an adviser to the Ombudsman (the Adviser) and about the care Mr C received prior to his death on 14 June 2006.

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, the Board and the Scottish Ambulance Service were given an opportunity to comment on a draft of this report. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in the report and in Annex 2.

(a) An alternative diagnosis of acute meningitis was not considered when a diagnosis of stroke was given to the family on Wednesday 14 June 2006

9. Mrs C said she received a telephone call at home in the early hours of 14 June 2006 to say her husband had suffered a stroke and she was asked to go to Hospital 1. Mrs C was told her husband would be transferred to Hospital 2 on the morning ferry. Mrs C remained with Mr C and around 06:45 she spoke to a nurse to let her know her husband's breathing had changed. A doctor was called and Mr C was pronounced dead at 07:00.

10. The events immediately prior to Mr C's death have been described in paragraphs 2 to 4 above. When responding to Mrs C's son, who raised the

complaint initially with the Board, the Board's Chief Operating Officer advised that Doctor 2 visited the ward during the early hours of 14 June 2006 at the request of the nursing staff to see Mr C as his condition had changed and he was found to be unconscious and not responding. Doctor 2 examined Mr C. Observations were taken. The report provided by Doctor 2 indicated Mr C's pulse rate was 110 beats per minute, irregular, with a normal blood pressure of 145/75. An electrocardiogram (ECG) showed atrial fibrillation. Doctor 2 determined the most likely cause of unconsciousness was a CVA. Doctor 2 indicated he asked for Mr C to be transferred to Hospital 2.

11. The Chief Operating Officer went on to say that the diagnosis of Mr C's illness at the time was based on the clinical picture and was consistent with a stroke. The Board have said that due to the deterioration of Mr C, a nurse contacted Mrs C at home at 02:30 to let her know Mr C had deteriorated and she was asked to come into Hospital 1. The notes written by Doctor 2 indicated he visited the ward at 02:00 and on examination, he found Mr C to be 'sweaty, unresponsive to speech, moved to localised pain on all four limbs. Pupil's [sic] equal and reacting, reflexes increased in left arm and leg and left plantar [sole of the foot] going up. Pulse 110, BP 145/75, normal heart sounds. ECG – atrial fibrillation most likely caused by a stroke'.

12. When responding to the complaint to the Board Doctor 2 said he considered his examination and the history of the illness was indicative of a stroke, particularly as Mr C's ECG showed him to be in atrial fibrillation. Doctor 2 had not considered acute meningitis at the time as the clinical presentation did not indicate that. Doctor 2 had noted that whilst meningitis 'appears to have been the cause, this was an extremely unusual way for meningitis to present'.

13. The Post Mortem carried out on 19 June 2006 concluded that Mr C died of acute meningitis with no evidence of a stroke. The note is made in the report that neck pain and stiffness can be a symptom of acute meningitis and one which may have been masked by back pain.

14. The Adviser has read the clinical notes and given me his view which is detailed in this report. He advised Mr C had a history of chronic low back pain with no record of neck pain until the morning of 13 June 2006, and it is not likely that acute meningitis would have been considered given the clinical presentation on this occasion (see paragraphs 11 and 12). The Adviser has

noted that the records indicated Mr C was mobilised during the night of 13 June 2006, with no evidence of head or neck pain on either 11 or 12 June 2006. There is recorded evidence of pain reported as radiating down his left arm on 13 June 2006, and analgesia (pain relief) was prescribed for that, with no apparent link between the back pain or arm pain and a possible diagnosis of acute meningitis.

15. The Adviser has noted that the clinical observations made in the early hours of 14 June 2006, were compatible with that of a stroke and there were no other leading clinical signs. The Adviser also noted that when Doctor 2 saw Mr C again in the early hours of the morning he was 'unrousable', that being consistent with a presentation of a stroke. The Adviser noted that Mrs C was advised the cause of death was acute meningitis after a Post Mortem had been carried out. The Adviser said that acute meningitis is rare in a person over 40 years of age and mortality much higher in patients over sixty years of age.

16. The definite diagnosis of acute meningitis only became apparent after a further intensive laboratory examination was carried out and revealed the discrete underlying condition of acute meningitis.

17. The advice I have received is that the clinicians involved in Mr C's care were treating what they observed to be a possible stroke. The patient's signs and symptoms were consistent with that clinical view and Doctor 2's actions in arranging for Mr C's transfer to Hospital 2 for further investigations and treatment were also consistent with this diagnosis. In the absence of symptoms to raise suspicion of what was later discovered to be acute meningitis, and which turned out to be the cause of Mr C's death, Doctor 2's diagnosis and actions were reasonable and consistent with the information he had.

(a) Conclusion

18. There is clear evidence that the underlying condition of acute meningitis was not suspected by the clinicians involved in Mr C's care on 14 June 2006. Doctor 2 had said he wanted Mr C transferred for further investigations (see paragraphs 10 and 17) but this opportunity was succeeded by the progression of Mr C's illness and sadly he passed away at 07:00 that morning. However, the advice I have received is that the clinical signs recorded were consistent with a presentation of a stroke at the time, with no indication of the underlying illness of acute meningitis. Given this and taking into account the clinical evidence available, I do not uphold this aspect of the complaint.

(b) There was a delay by Hospital 1 in arranging Mr C's transfer to Hospital 2 on 14 June 2006

19. Mrs C complained about the delay in the arrangements to transfer her husband to Hospital 2. She said she was advised her husband was going to be transferred to Hospital 2 on the first ferry of the day at 06:30. However, nearer the time of the planned transfer she has said she was told the ambulance had been unable to leave the Peninsula (see paragraph 22) and a crew from Dunoon would arrive to transfer Mr C at about 08:30. Mrs C recalls that at approximately 06:45 she alerted the staff to a change in Mr C's breathing. Doctor 2 was alerted to the change in Mr C's condition and arrived to see him on the ward at 06:45 and when he arrived to see Mr C, his condition had deteriorated.

20. The Board have said the arrangements had been put in place for Mr C's transfer via ferry at 06:30. The Scottish Ambulance Dispatch Centre had been called earlier at 02:30 by the ward staff. It was confirmed that providing the Dunoon crew (D crew) booked on at 06:00, the transfer was confirmed. However, the Board have reported the ward staff contacted the Dispatch Centre again at 06:12 to check the ambulance was still on schedule. The clinical notes recorded at the time indicated the nurse on duty was informed that the D crew would be unable to transfer Mr C but a crew from Greenock (G crew) would be sent and should arrive at approximately 08:00. The nurse told the ambulance control it was very important the patient went on the ferry at 06:30. The Board confirmed that the air ambulance was offered and could have been used. However, any decision to initialise this service is based on clinical judgement. Doctor 2 was aware this service was available had he thought it was needed. Doctor 2 was advised of the transport situation at 06:45. He has indicated, in his experience, the arrangement for air ambulance services would not have been any faster on this particular occasion. The Board advised that, in their view, Doctor 2 could not have anticipated this delay and, therefore, had no view that alternative arrangements might have been made. Doctor 2 has commented that in retrospect it might have been helpful to have made these additional arrangements. Events subsequently overtook any decision to review the transfer arrangements for Mr C as he became more unwell and died at 07:00 that morning.

21. The Board have said that after the decision to transfer Mr C to Hospital 2 was made by Doctor 2 (see paragraph 10) and as he was stable, and further to

a discussion with the medical receiving doctor in Hospital 2, it was agreed at the time to transfer Mr C in the morning on the first ferry at 06:30. When Doctor 2 saw Mr C again in the ward, which was unexpected, he had been advised of the ambulance status (see paragraph 20). Doctor 2 was with Mr C and his family when Mr C died.

22. The Board made enquiries to the Scottish Ambulance Service. The Scottish Ambulance Service reported there had been a call from the nurse who had ordered a level two ambulance to be on the first ferry for 06:30. It had been confirmed that, providing the D crew booked on, the transfer request was confirmed. The Scottish Ambulance Service reported there was a requirement to keep an ambulance on the Peninsula and that the D crew could not be dispatched to carry out the transfer. The Scottish Ambulance Service confirmed to the Board they checked the arrangements for that day and the ambulance was the only Accident and Emergency resource that booked on at 06:00. The member of staff on the ward had called again to check on the transfer and was advised that the G crew was going to be dispatched shortly after 07:00 (see paragraph 20). The Scottish Ambulance Service reminded the nurse of the availability of the air ambulance service.

23. The Board have indicated there is ongoing collaborative work being undertaken between them and the Scottish Ambulance Service to consider the measures needed to improve the ambulance services to residents on the Peninsula as medical staff do have to consider the additional travel considerations of the ferry when they are making any clinical decisions required in a patient's care and treatment.

24. The Adviser has indicated the arrangements made for Mr C were consistent with his presenting clinical condition and where Doctor 2 had considered that further opinion and treatment was required, he had made the required arrangements for Mr C to be transferred to Hospital 2 for those clinical purposes. The Adviser has suggested the clinical presentation had not, until the very last moment, presented as a medical emergency. It is very regrettable that the outcome was so sad, but Mr C had not shown any signs of deterioration until quite suddenly in the early hours of 14 June 2006 and the actions taken to arrange his transfer reflected his clinical presentation at the time. The sudden onset and the rapid deterioration left little time to review the options available for transfer to Hospital 2.

(b) Conclusion

25. It is the case that there was a delay in Mr C's expected transfer to Hospital 2, but I am satisfied this was not as a direct result of any failure to act on the part of the Board's staff involved in Mr C's care in the early hours of 14 June 2006. The ambulance did not arrive to transfer Mr C to Hospital 2 as a result of factors outside the control of the Board. The Scottish Ambulance Service reported they had to maintain a presence on the Peninsula and were unavailable until later that morning (08:00) to carry out the transfer request. The availability of the air ambulance service was mentioned, however, this alternative was not taken up. The advice I received is that the clinical presentation, until the last moments, had not presented as a medical emergency. I appreciate this was a very distressing time for Mrs C and her family after being called to her husband's bedside and then to wait beyond the time agreed for the transfer. I understand Mrs C was informed of the delays as they arose whilst she was sitting with her husband.

26. I understand there had been a concern for Mr C from the early hours of 14 June 2006. Measures had been taken to alert Mrs C to the concerns the ward had and the intention to have Mr C transferred to Hospital 2. Whilst the outcome was very sad for Mr C's family and all those involved in Mr C's care, the advice I have received is that appropriate measures were put in place to secure Mr C's transfer with the resources available. I appreciate that further collaborative work is underway between the Scottish Ambulance Service and the Board aims to improve the services for those who have the additional consideration of a ferry transfer between Hospital 1 and Hospital 2 as they live in this area of Scotland (see paragraph 23).

27. In view of the information available to me and the advice I have received, I consider there were matters that arose which were outside the control of the Board, and the Scottish Ambulance Service were unable to meet the request made by the Board on this occasion. I have, therefore, not upheld this aspect of the complaint against the Board. The Ombudsman has, however, made the following recommendations, particularly in view of her knowledge of collaborative work currently being undertaken between the Board and the Scottish Ambulance Service, to improve services on the Peninsula and would appreciate knowing how this is implemented by the Board.

(b) Recommendations

28. The Ombudsman recommends that the Board:

(i) ensure that the local redesign process currently being undertaken between the Board and the Scottish Ambulance Service covers the need for medical staff to have access to the most up-to-date details of inter-hospital transfer times and with all the relevant transportation matters clearly established at the time (of arranging the transfer); and

(ii) review their acute unit transfers policy to take account of changing patterns of acute stroke management.

29. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that she is advised of the way the recommendations are implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's husband
GP	General Practitioner
Hospital 1	Dunoon General Hospital
Doctor 1	Staff grade physician
Doctor 2	Hospital duty Doctor
CVA	Cerebral Vascular Accident
Hospital 2	Inverclyde Royal Infirmary
The Board	Highland NHS Board
The Adviser	One of the Ombudsman's professional advisers
ECG	Electrocardiogram
D Crew	Dunoon ambulance crew
G Crew	Greenock ambulance crew

Annex 2

Glossary of terms

Acute meningitis	Inflammation of the meninges (the surrounding membranes of the brain and spinal cord)
Atrial fibrillation	A condition where there is disorganised electrical conduction in the atria, resulting in ineffective pumping of blood into the ventricle
Blood Pressure	The force that the circulating blood exerts on the walls of the arteries
Electrocardiogram (ECG)	A recording of the electrical activity of the heart
Stroke (CVA)	Cerebrovascular accident. The sudden death of some brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain. A CVA is also referred to as a stroke

Annex 3

List of legislation and policies considered

NHS Complaints Procedure