Scottish Parliament Region: Glasgow

Case 200501303: Greater Glasgow and Clyde NHS Board [1]

Summary of Investigation

Category

Health: Hospital; care and treatment

Overview

The complainant, Ms C, raised a number of concerns about the care and treatment provided to her mother, Mrs A, in the Vale of Leven Hospital (Hospital 1) between 26 August 2004 and 6 September 2004. Mrs A was subsequently admitted to Gartnavel General Hospital (Hospital 2) on 10 September 2004 but, sadly, died on 19 September 2004.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) a renal ultrasound scan was not performed on admission to Hospital 1 and when one was done at Hospital 2 the results were not acted upon (*upheld*);

(b) communication with Consultant 2 at Hospital 2 was inadequate (*upheld*);

(c) Mrs A was inappropriately noted as having 'no medical issues' when allowed home on weekend pass (*upheld*);

(d) Mrs A was discharged from Hospital 1 without appropriate action (*upheld*); and

(e) the discharge letter was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) this case be discussed urgently with Consultant 1 and formally recorded at her next annual appraisal;

[1] At the time of Mrs A's admission to the Vale of Leven Hospital it was managed by the Argyll and Clyde NHS Board. That Board ceased to exist on 1 April 2006 and responsibility for the management of the Vale of Leven Hospital then transferred to Greater Glasgow and Clyde NHS Board (the Board). For convenience I refer to the Board throughout this report although it should be noted that many of the actions complained of were those of its predecessor organisation. The Board also manages Gartnavel General Hospital.

(ii) the clinical team responsible for Mrs A's care in Hospital 1 consider and act on the lessons to be learned as a result of the failings identified in this report;

(iii) Greater Glasgow and Clyde NHS Board (the Board) remind staff of the need for accurate records to be kept;

(iv) the Board share with the Ombudsman a copy of the regular audit of communications which is presented to the NHS Board's Clinical Governance Committee; and

(v) the Board apologise fully and formally to Ms C for the failings identified in this report.

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

Main Investigation Report

Introduction

1. In 2002 Mrs A was diagnosed with cancer of the colon and kidney stones. She had an operation to remove the cancer, from which she made a good recovery, and tests subsequently disclosed no further cancerous growth. When Mrs A again became unwell, she was seen in Vale of Leven Hospital (Hospital 1) on 23 March 2003. She was referred to the Urology Department at Gartnavel General Hospital (Hospital 2), where she received treatment for renal problems.

2. On 26 August 2004 Mrs A's General Practitioner referred her to Hospital 1, suffering from anorexia, diarrhoea, ketotic breath and neutrophilia. She was admitted under the care of a Consultant Physician (Consultant 1) and treated for a urinary tract infection and anaemia. During her stay in Hospital 1, Mrs A attended Hospital 2 for a pre-arranged renal ultrasound scan. The results were received by Hospital 1 on 1 September 2004. Mrs A was allowed to go home for the weekend on 4 September 2004 and she was subsequently discharged following her return to Hospital 1 on 6 September 2004.

3. Ms C said that because of her concerns about her mother's health, she telephoned Mrs A's Consultant Urologist (Consultant 2) at Hospital 2 on 10 September 2004. Consultant 2 returned the call and, following a telephone conversation with Mrs A, he decided to admit her as an emergency. Despite treatment, Mrs A's condition deteriorated and, sadly, she died on 19 September 2004 of renal failure and septicaemia.

4. On 12 March 2005 Ms C complained to Hospital 1 about the care and treatment provided to her mother. Ms C remained dissatisfied with responses she received and she subsequently complained to the Ombudsman.

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

(a) a renal ultrasound scan was not performed on admission to Hospital 1 and when one was done at Hospital 2 the results were not acted upon;
(b) communication with Consultant 2 at Hospital 2 was inadequate;
(c) Mrs A was inappropriately noted as having 'no medical issues' when allowed home on weekend pass;
(d) Mrs A was discharged from Hospital 1 without appropriate action; and
(e) the discharge letter was inadequate.

Investigation

6. In order to investigate this complaint I have had access to Mrs A's clinical records from both Hospital 1 and Hospital 2 and the correspondence in relation to the complaint. I have corresponded with Ms C and with Greater Glasgow and Clyde NHS Board (the Board). I have received advice from a consultant nephrologist (Adviser 1) and additional advice from a consultant urologist (Adviser 2). In addition the Ombudsman met with Ms C and her brother (Mr C) and discussed the case with the Chief Executive of the Board.

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

(a) A renal ultrasound scan was not performed on admission to Hospital 1 and when one was done at Hospital 2 the results were not acted upon

8. Ms C said that, when her mother was admitted to Hospital 1 on 26 August 2004, the initial plan included ultrasound of her mother's renal tract but this was never done (the Hospital notes dated 26 August 2004 confirm that an ultrasound scan was included in the initial care plan). This procedure was performed when Ms C's mother attended a pre-arranged appointment at Hospital 2 on 31 August 2004 while she was still an in-patient at Hospital 1. The results were received and recorded by Hospital 1 on 1 September 2004 but no further action was taken by Hospital 1. Ms C is of the view that the failure to arrange a scan following admission to Hospital 1 as planned or to act on the significant results once they were received from Hospital 2 led to her mother suffering renal failure and septicaemia. She said that the medical advice she had received was that 'the inevitability of this outcome is in proportion to the delay in relieving the obstruction'. Ms C, therefore, believes that her mother's death was caused by the inaction.

9. In response to the complaint, Consultant 1 said that Mrs A had previously been in her care in September 2002 when she had been treated for a severe urinary tract infection. Consultant 1 had ordered an ultrasound scan of Mrs A's kidneys at that time, which showed kidney stones in the lower part of the left kidney which was unobstructed. Mrs A had been referred to the Urology Department at Hospital 2, where she continued to be reviewed up to and beyond her admission in 2004. Consultant 1 said that, in March 2003, the

ultrasound by the Urology team showed the left kidney to be obstructed. There had been a discussion regarding a drainage procedure but she could find no record of this having taken place. Consultant 1 believed that the kidney remained obstructed (however, this view is not supported by the information in Mrs A's clinical notes). The result of the scan carried out on 31 August 2004 showed the same result, left kidney obstructed. No action was taken. Consultant 1 said that she thought it likely that Mrs A was suffering from chronic sepsis but, as she was improving with antibiotics and transfusion, she did not consider it necessary to repeat the ultrasound scan.

10. Adviser 2 said that it is of vital importance that imaging is performed as part of the routine investigation of urinary sepsis. He described the fact that Mrs A had a previously arranged appointment to have this done at Hospital 2 as fortuitous. Adviser 2 said that to justify the failure to request urgent imaging on the basis that Mrs A's symptoms were improving (see paragraph 9) was, at best, disingenuous. Consultant 1 should have known that antibiotic treatment can give temporary respite but that infection will always return if the source is not removed.

11. Adviser 2 noted that Consultant 1 was aware that when the ultrasound scan was reported, abnormalities were found but she believed that these abnormalities were longstanding and that the Urologists at Hospital 2 were aware of them. Adviser 2 said that there was no evidence, however, that Consultant 1 had attempted to follow up these beliefs. Adviser 2 said that Consultant 1 owed a duty of care to Mrs A, an elderly lady who had been admitted severely ill. He said that, while it is acceptable for a general physician to have little or no knowledge of the finer points of urinary stone disease, Consultant 1 should have checked that the Urologists were happy to leave Mrs A with an obstructed kidney. Adviser 2 also noted that the clinical notes available to Consultant 1 contained the result of a scan performed five months earlier (15 March 2004), which showed that the left kidney was not obstructed at that time. Consultant 1 should have recognised that this was a new episode of obstruction. Adviser 2 said that he considered it likely that, if Consultant 1 had telephoned the Urologists at Hospital 2 to make them aware of the ultrasound findings from the scan taken on 31 August 2004, they would have arranged for Mrs A to be transferred immediately to their care. Adviser 2 said that, although he could not say definitely, he considered it highly probable that Mrs A's death could have been avoided if she had received earlier decompression of the left ureteric obstruction at Hospital 2.

12. Following receipt of an earlier draft of this report, the Board challenged the statement of Adviser 2 in relation to the cause of Mrs A's death, and said that they had obtained advice from a Consultant General Physician. In his report, the Board's adviser said that he felt that it was 'impossible to say that her [Mrs A's] death was probably caused by the delay in her admission to Gartnavel'.

13. In line with the practice of this office, the comments from the Board were shared with Adviser 2 so that he could be given the opportunity to respond. He stated that his specific comments on the outcome might be altered to the extent of saying that 'it is possible that her [Mrs A's] death from sepsis was preventable'. However, he concluded that he agreed with our report as drafted and stated that he saw 'no reason to change my own assessment based on examination of hospital records'.

14. Amendments were made to the wording of the second draft of the report to reflect Adviser 2's subsequent comments. Ms C noted her strong objection to these changes, particularly the substitution of the word 'possible' for the words 'highly probable'. She was concerned that the advice received by the Board was not independent and should not be used to influence the independent findings of the Ombudsman.

15. The Ombudsman met with Ms C and Mr C to discuss their concerns. At the meeting they also noted their dissatisfaction with the way the Board responded to Ms C's complaint and the draft report of the investigation.

16. In responding to the final draft report the Board noted their view that it was not solely Consultant 1's responsibility to ensure that the Urologists at Hospital 2 were aware of the results of the examination and that Consultant 2 also had a responsibility to independently follow up the results of the ultrasound scan. Ms C's complaint to the Ombudsman was about the care her mother received at Hospital 1 and that has been the focus of this investigation. For this reason, Consultant 2 has not been subject of an investigation by the Ombudsman. The Board may wish to consider whether they should follow up the involvement of Consultant 2 in this case.

(a) Conclusion

17. As noted in paragraph 14 above, Ms C was concerned that the advice received by the Board should not be used to influence the independent findings

of the Ombudsman. In reaching my conclusions I have relied on the independent advice given to me by my advisers. However, I considered it appropriate to make Adviser 2 aware of, and to allow him to comment on, the opinion of the Board's adviser.

18. Adviser 2 said that, in view of Mrs A's symptoms and history, Consultant 1 should have arranged an ultrasound scan as a matter of urgency but she had not done so. Adviser 2 speculated that perhaps Consultant 1 had known that Mrs A had a previously arranged appointment for a scan. I note that in response to the complaint, however, Consultant 1 wrote on 15 June 2005 that she had not been aware that Mrs A was due to have an ultrasound scan at Hospital 2 and she had not been aware until afterwards that Mrs A had had it done. It is clear from what Consultant 1 said that she did not consider that a scan was necessary and did not intend to arrange one unless Mrs A's symptoms worsened. Having received the results, Consultant 1 assumed that Mrs A's kidney had been blocked since a previous episode. Such an assumption is not supported by the information in Mrs A's clinical notes. Adviser 2 said that Consultant 1 should have considered the previous scan result, which showed no blockage five months earlier. She should also have contacted the Urologists at Hospital 2 to ensure that they were aware of the results and were happy to leave Mrs A's kidney as it was. Consultant 1 took no action when she received the results. In these circumstances, given the failure to arrange an urgent scan and, subsequently, the failure to take action when the results of the scan were received, I uphold this complaint.

19. As stated above, there is a difference of view between the Ombudsman's independent adviser and the Board's adviser with regard to the outcome for Mrs A, ie whether it was highly probable that her death was caused by the failings in the care she received. This difference does not affect my conclusion that there were failings by Consultant 1 in not arranging and not following up the results of the scan, and my finding that the complaint is upheld.

(a) Recommendation

20. The Ombudsman recommends that:

(i) this case be discussed urgently with Consultant 1 and formally recorded at her next annual appraisal; and

(ii) the clinical team responsible for Mrs A's care in Hospital 1 consider and act on the lessons to be learned as a result of the failings identified in this report.

(b) Communication with Consultant 2 at Hospital 2 was inadequate

21. Ms C said that Consultant 1 knew that Mrs A had been under the care of Consultant 2 at Hospital 2 for some time but Consultant 1 had not informed Consultant 2 that Mrs A had been admitted to Hospital 1. When Mrs A attended Hospital 2 for the pre-arranged scan, Consultant 1 had not told Consultant 2 that Mrs A was currently an in-patient at Hospital 1 and had not copied the discharge letter to him.

22. Consultant 1 said that Mrs A had first come under her care in September 2002 and she was aware that Mrs A had been followed up by the Urologists at Hospital 2 since that time. Following admission to Hospital 1 on 26 August 2004, Mrs A's symptoms had improved and Consultant 1 did not consider that a referral to the Urologists was appropriate. In response to the complaint on 15 June 2005 Consultant 1 said that:

> '[Mrs A] improved with antibiotics and transfusion and did not complain of pain to staff prior to discharge. There was no indication for referral back to the urologist at that stage.'

23. Following discharge, Mrs A had returned to the care of her General Practitioner and a discharge summary had been sent to him.

24. Adviser 2 said that Consultant 1 had a duty of care to ensure that Consultant 2 was aware of Mrs A's admission with an episode of severe infection. It was not sufficient to assume that Mrs A would at some stage receive appropriate urological care because she continued to be seen at Urology Out-patients. Adviser 2 said that it would have been preferable for Consultant 1 to arrange for Consultant 2 to see Mrs A when she attended Hospital 2 for the scan. Adviser 2 said that, in the circumstances, Consultant 1 should have been proactive and telephoned Consultant 2, particularly when the result of the ultrasound scan became available. In the event, Adviser 2 said that Mrs A was left in limbo until someone from the Urology Department at Hospital 2 saw the report.

(b) Conclusion

25. It is clear from the evidence that Consultant 1 could not have asked Consultant 2 to see Mrs A when she attended Hospital 2 for the scan because Consultant 1 did not know that Mrs A had an appointment until after her return (see paragraph 18). When Consultant 1 received the scan results, she

assumed that the Urologists at Hospital 2 would see the abnormal result and deal with it when they next saw Mrs A at Out-patients. (In fact, Mrs A's next Urology Out-patient appointment had not been scheduled until six months later.) Adviser 2 clearly considered that Consultant 1 had a duty to communicate Mrs A's current symptoms and the results of the scan to Consultant 2, to ensure that he was aware of the position and knew that he was expected to provide Mrs A with care. Consultant 1 failed to do this. I, therefore, uphold this complaint.

(b) Recommendations

26. The Ombudsman recommends that:

(i) this case be discussed urgently with Consultant 1 and formally recorded at her next annual appraisal; and

(ii) the clinical team responsible for Mrs A's care in Hospital 1 consider and act on the lessons to be learned as a result of the failings identified in this report;

(c) Mrs A was inappropriately noted as having 'no medical issues' when allowed home on weekend pass

27. Ms C said that on 4 September 2004 her mother was reviewed by the Senior House Officer (SHO). He recorded his findings as:

'No particular medical issues. Can go home on weekend pass.'

28. Ms C said that her mother was suffering from abdominal pain, variable bowel function and anorexia.

29. In response to the complaint, the Director Designate from NHS Argyll and Clyde said that the comment 'no further medical issues' referred precisely to medical treatments. Mrs A's symptoms were improving and the decision was made that she had no further medical issues which required to be dealt with by medical staff in Hospital 1 at that time. Any further treatment necessary would be carried out by the Urologists.

30. Adviser 2 said 'medical issues' did not normally refer to 'medical treatments'. He was perplexed that the SHO said that there were no medical issues. The day before, Mrs A still had an elevated white cell count, a very high platelet count and had undergone an abdominal x-ray on the suspicion that her constipation and diarrhoea were due to high faecal impaction.

(c) Conclusion

31. It may have been the case that the decision had been made to provide Mrs A with no further medical treatment, in which case that is what should have been stated in the records. It was clearly not the case that Mrs A had no medical issues when she was allowed home for the weekend. I uphold this complaint.

(c) Recommendation

32. The Ombudsman recommends that the Board remind staff of the need for accurate records to be kept.

(d) Mrs A was discharged from Hospital 1 without appropriate action

33. Ms C complained that her mother was discharged from Hospital 1 without appropriate action being taken to deal with her ongoing problems.

34. The Director Designate from NHS Argyll and Clyde responded that Mrs A had been admitted with a sepsis problem and had responded to the treatment. Mrs A's blood tests had returned to normal, which indicated that she could be discharged without further antibiotics. Consultant 1 felt that the Urologists would decide the appropriateness of further intervention.

35. Adviser 2 said that Consultant 1 treated Mrs A for her obvious septic illness, which Consultant 1 correctly ascribed to her urinary tract infection. Adviser 2 also noted that Consultant 1 was aware that Mrs A had been admitted two years previously, also as a result of a urinary tract infection. Adviser 2 detailed the considerable activity by the Urologists at Hospital 2 between March and November 2003 but said that there was no evidence in Hospital 1's records that Consultant 1 was aware of this. Consultant 1 was not aware that the previous obstruction had been cleared or that the previous scan result, which was in the records, showed that to be the case five months earlier. Mrs A had suffered a severe attack of left-sided pyelonephritis with considerable systemic manifestations. Her symptoms had certainly not resolved. An ultrasound scan carried out on 31 August 2004 had shown evidence of obstruction of the left kidney. Mrs A had, however, been discharged on 4 September 2004 from Hospital 1 with only ferrous sulphate and senna.

36. Adviser 2 said that the guidelines on the treatment of acute pyelonephritis were vague but he believed that most physicians would have continued antibiotic treatment for a full fortnight, therefore, for at least a week after Mrs A's

discharge. Adviser 2 said that it was wrong to assume that improvement in the blood inflammatory markers indicated that the illness and propensity to relapse had subsided. Consultant 1 had a duty to arrange appropriate follow-up from the Urologists. Instead, Adviser 2 said that Consultant 1 had wrongly used the fact that Mrs A was being seen at Urology Out-patients as a reason to discharge her.

37. Because she was concerned about her mother's condition after discharge, Ms C contacted Hospital 1 on two occasions by telephone and asked to speak to Consultant 1. She was advised by Consultant 1's Secretary to report her concerns to her mother's General Practitioner. Following a telephone call by Ms C to Consultant 2 to apprise him of Mrs A's state of health, he telephoned Ms C back and spoke to her mother, who was staying with Ms C at the time. He then decided to admit Mrs A as an emergency.

38. By the time the Urologists had admitted Mrs A to Hospital 2 as an emergency on 10 September 2004, she had already suffered a symptomatic relapse of her urinary tract infection. Adviser 2 noted that Mrs A was given no follow-up appointment with Consultant 1 either. Adviser 2 said that Consultant 1 should have ensured that Mrs A was followed up to anticipate the risk of a gram-negative septicaemia, a condition which has 40% mortality.

(d) Conclusion

39. It is clear from the evidence that Consultant 1 did not make any arrangements for Mrs A to continue to receive antibiotics or to be seen at either her clinic or by the Urologists at Hospital 2. Consultant 1 simply discharged Mrs A back to the care of her General Practitioner. The advice I have received, which I accept, is that this was not reasonable in the circumstances and I, therefore, uphold this complaint.

(d) Recommendations

40. The Ombudsman recommends that:

(i) this case be discussed urgently with Consultant 1 and formally recorded at her next annual appraisal; and

(ii) the clinical team responsible for Mrs A's care in Hospital 1 consider and act on the lessons to be learned as a result of the failings identified in this report;

(e) The discharge letter was inadequate

41. Ms C complained that the discharge summary sent to her mother's General Practitioner was inadequate.

42. The Director Designate from NHS Argyll and Clyde acknowledged that the discharge letter was inadequate. He said that Hospital 1 had reviewed its system to prevent this from happening in the future. He apologised to Ms C.

43. Adviser 2 said that the discharge summary sent to Mrs A's General Practitioner was woefully inadequate. It had been written by a junior house officer who had no understanding of the situation. Adviser 1 noted that the method of discharge communication had been reviewed as a result of this case and an apology had been given to Ms C.

(e) Conclusion

44. The discharge letter to Mrs A's General Practitioner failed to mention the infection for which she had been treated, the antibiotics she had been given or the results of the scan. I, therefore, uphold this complaint. Although, in response to Ms C's complaint, the Director Designate from NHS Argyll and Clyde said that discharge communication had been reviewed, he did not indicate what had been done and what steps had been taken as a result.

(e) Recommendation

45. In an earlier draft of this report the Ombudsman recommended that the Board audit the effectiveness of the new method of communication on discharge and send her a copy of the results. The Board have advised that they are unable to track back the review of discharge communication referred to by the Director Designate at NHS Argyll and Clyde. The Board have committed to share with the Ombudsman a copy of the regular audit of communications which is presented to the NHS Board's Clinical Governance Committee. The Ombudsman is satisfied with this response.

Summary

46. This investigation has identified that there were a number of serious failings in the care provided to Mrs A during her admission at Hospital 1 and the manner in which she was discharged without appropriate action being taken to deal with her ongoing problems. The Ombudsman acknowledges that it cannot be stated with certainty that the poor care Mrs A received caused her death. Nevertheless, it is a matter of great concern that the independent advice

provided to the Ombudsman is that if Mrs A had received treatment at Hospital 2 earlier then her death might have been prevented.

47. In addition, the Ombudsman is concerned about aspects of the Board's responses to the draft investigation reports which prolonged the process and added further to the distress experienced by Ms C. The Ombudsman agreed with the Chief Executive of the Board that there would be value in a meeting between representatives from the Board and the Ombudsman's office to discuss how lessons can be learned from the way in which this complaint was handled by both organisations.

General recommendation

48. The Ombudsman recommends that the Board apologise fully and formally to Ms C for all the failings identified in this report.

49. The Board have accepted the recommendations 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

Ms C	The complainant
Mr C	The complainant's brother
Mrs A	Ms C's mother
The Board	Greater Glasgow and Clyde NHS Board
Hospital 1	Vale of Leven Hospital
Hospital 2	Gartnavel General Hospital
Consultant 1	Mrs A's Consultant Physician at Vale of Leven Hospital
Consultant 2	Mrs A's Consultant Urologist at Gartnavel Hospital
Adviser 1	Consultant Nephrologist
Adviser 2	Consultant Urologist
SHO	Senior House Officer

Annex 2

Glossary of terms

Anaemia	A low number of red blood cells, which affects the blood's ability to carry oxygen round the body
Anorexia	The uncontrolled lack or loss of the appetite for food
Diarrhoea	The abnormal frequency and liquidity of faecal discharges
Gram-negative septicaemia	Infection of the blood, caused by a certain class of bacteria
Ketotic	A sweet, fruity smell caused when fat is converted into energy by the body because it has insufficient glucose for its energy requirements
Neutrophilia	More than the normal number of a type of white blood cell, which can indicate infection
Platelet count	A test to measure how many blood cells, called platelets, you have in your blood. Platelets help the blood to clot
Pyelonephritis	Kidney infection
Renal	Pertaining to the kidney
Sepsis	Infection of the bloodstream
Septicaemia	Blood poisoning