Scottish Parliament Region: Glasgow

Case 200800569: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment/diagnosis

Overview

The complainant (Mrs C) complained that Greater Glasgow and Clyde NHS Board (the Board) did not correctly diagnose her misplaced vertebra when she attended the Western Infirmary with back pain and 'neurological symptoms'. She was further concerned that the Board did not offer treatment once her condition was diagnosed. Mrs C was also disappointed by the Board's handling of her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to correctly diagnose the severity of Mrs C's spinal problems (*not upheld*);
(b) the Board failed to treat Mrs C's spinal symptoms (*not upheld*); and
(c) the Board's complaint handling was poor (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) consider reviewing Mrs C's case with a view to identifying any aspects of the communication between consultants and her GP that could be improved; and
(ii) consider how NHS Scotland's publication: *Can I help you? Learning from comments complaints and suggestions* should be taken into account when making decisions on complaint time limits.

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) was referred by her GP to the Western Infirmary (Hospital 1), and attended their orthopaedic department in June 2005. She presented with back pain and a pins and needles sensation in both legs. After initial examination, she was referred for an MRI scan. The scan showed signs of degeneration in her lower spine and a previously healed fracture of one of her vertebrae. Mrs C was examined by a staff grade doctor (the Doctor) who advised her that spinal surgery would not help her symptoms. Mrs C continued to experience back pain and, in June 2006, was again referred by her GP to Hospital 1. A consultant orthopaedic and spinal surgeon (Consultant 1) reviewed Mrs C and similarly concluded that spinal surgery would be inappropriate. He requested blood tests to exclude nerve damage and advised that referral to a neurologist would be appropriate should any of the results be abnormal.

2. Mrs C was subsequently referred to a Neurologist at the Southern General Hospital (Hospital 2) in June 2007. Another MRI scan was carried out in July 2007 and highlighted degenerative spondylolisthesis (forward slippage of one vertebra over another). As a result of this, Mrs C underwent decompression and instrumental fusion surgery on 20 December 2007.

3. Mrs C complained that her spondylolisthesis was not diagnosed by consultants at Hospital 1 and that her neurological symptoms had been ignored. She complained to Greater Glasgow and Clyde NHS Board (the Board) in May 2008, however, the Board considered her complaint to be outside their six month time limit and did not undertake an investigation. Disappointed with her treatment at Hospital 1 and the Board's lack of response, Mrs C brought her complaint to the Ombudsman in June 2008.

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

(a) the Board failed to correctly diagnose the severity of Mrs C's spinal problems;
(b) the Board failed to treat Mrs C's spinal symptoms; and
(c) the Board's complaint handling was poor.

5. In her complaint to the Ombudsman, Mrs C raised further concerns about delays to her MRI appointment and the absence of her clinical records during

one of her consultations. These complaints related to events that took place more than 12 months prior to the submission of her complaint and were, therefore, time barred. This was explained to Mrs C at an early stage of my investigation.

Investigation

6. In order to investigate this complaint, I reviewed Mrs C's clinical records and sought the opinion of the Ombudsman's medical adviser (the Adviser). I also obtained detailed comments from the Board. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to correctly diagnose the severity of Mrs C's spinal problems; and (b) The Board failed to treat Mrs C's spinal symptoms

7. Mrs C was referred by her GP to Hospital 1's orthopaedic department. There, she was examined at Consultant 1's clinic on 8 June 2005 by the Doctor. Mrs C advised the Doctor that she had been experiencing lower back pain for around three years. She also explained that she had been experiencing a 'pins and needles' sensation radiating down both legs, more severely in her right leg. During the consultation, the Doctor recorded that Mrs C's back pain had started following a fall in 2002, which injured her back. He noted that she had previously been diagnosed with osteopenia (a reduction in the mineral density of the bones), affecting her spine, pelvis and hips. The Doctor examined Mrs C's lumbar spine (the lower spine) and found that she had limited movement in all directions. She was found to have no neurological deficits in her legs, however, manipulation highlighted that shooting pain limited her right leg being raised to around 40 degrees and back pain limited her left leg being raised to around 60 degrees. In a letter to Mrs C's GP, dated 8 June 2005, the Doctor stated that he was unsure as to what was causing Mrs C's symptoms. He suggested that it may be related to her osteopenia, or possibly the result of a degenerate disc in the lumbar region of her spine. The Doctor arranged for an MRI scan to be carried out.

8. The MRI scan was carried out and Mrs C attended another orthopaedic clinic on 16 February 2006 to learn the results of the scan. Again, she was seen by the Doctor, rather than the lead consultant. The scan results showed degenerative changes in the lumbar region of her spine and a slight narrowing of her fifth lumbar nerve foramen (a gap in the vertebra where the spinal nerves

exit the spine). The Doctor noted that this was causing some irritation to one of the nerve roots. The scan results also showed an old, healed, fracture of the 12th thoracic vertebra, which was presumably caused by Mrs C's fall in 2002. The Doctor concluded that surgery would not help Mrs C's back pain, only her leg pain. In a letter to Mrs C's GP, the Doctor noted that she had advised him that her leg pain occurred infrequently and was not bothering her too much. Accordingly, the Doctor advised against surgery and suggested that she exercise regularly. No further appointments were made to review her condition.

9. In her complaint to the Ombudsman, Mrs C said that, during the consultation on 16 February 2006, she stressed to the Doctor that prior x-rays had highlighted her fractured vertebra and that she was experiencing neurological symptoms that were causing disability.

10. Mrs C was referred by her GP to Hospital 1 again on 2 June 2006. In his referral letter, the GP explained that Mrs C's pain appeared to have worsened. He noted that she was now able to walk less distance, which was affecting her ability to exercise as recommended by the Doctor. He also noted that she had developed intermittent parasthesia (a burning or prickling sensation) and numbness in the distribution of L5 on the left side (numbness in the areas serviced by nerves exiting the L5 vertebrae). Consultant 1 replied to Mrs C's GP on 3 August 2006, advising that he would be arranging a further consultation with her. In the letter, he stated that he had reviewed the scans and notes from her previous consultation with the Doctor and could find no indication of a neurological cause of her leg symptoms.

11. Mrs C was examined by Consultant 1 on 7 November 2006. He had reviewed her previous MRI scan results with a radiological colleague and noted multilevel degenerative changes in her spine, which he said explained her back pain. He further noted significant arthritis in her lumbar spine and considered it likely that Mrs C was experiencing some 'referred' pain in her legs (pain caused by the arthritis in the spine but mediated by the same nerves that control pain sensation in the legs, causing back pain to be felt in the legs). Consultant 1 did not consider Mrs C's arthritis and spinal degeneration to be of a significant enough level to cause spinal stenosis (a condition where the openings of the vertebrae narrow to such an extent that the exiting nerves are compressed). He noted that Mrs C was overweight and had begun taking measures to lose weight. Consultant 1 concluded that there was no surgical solution to Mrs C's symptoms, but noted a neuropathic (relating to the nerves) element to her leg

pain. He asked Mrs C's GP to arrange some blood tests to confirm or eliminate this diagnosis and suggested that Mrs C be referred for a neurological opinion.

12. Mrs C was examined by a Consultant Neurosurgeon (Consultant 2) at Hospital 2 on 14 June 2007. He found that she had some loss of sensation over the skin area served by the S1 nerve (the sacral nerve that runs from the little toe, up the outside edge of the foot and up the back of the leg to the buttock). Consultant 2 considered Mrs C's symptoms to be significantly different from the previous year and ordered a further MRI scan. Mrs C told me that her symptoms remained the same but had become substantially more severe. The MRI scan was carried out on 18 July 2007 and showed more narrowing of the L4/5 exit foramen and spondylolisthesis. Consultant 2 discussed the surgical options available to Mrs C and she underwent spinal decompression and instrumental fusion surgery (a procedure whereby two vertebrae are 'fused' together and held in position by being clamped together) on 12 October 2007.

13. In her complaint to the Ombudsman, Mrs C expressed her concern that she was not referred for a neurological assessment immediately upon presenting with neurological symptoms in her legs. She explained that she had worked in the health sector for a number of years and understood this to be a specific policy of the Board. She said that her neurological symptoms were dismissed during her consultations with the Doctor and that, as a result, she had been left disabled, with a 'frozen' left foot.

14. I asked the Adviser to review Mrs C's clinical records and to provide his comments as to whether earlier surgical intervention would have been appropriate for Mrs C. I also asked him to consider whether her presenting symptoms should have highlighted her neurological condition, and whether any alternative treatments should have been prescribed when surgery was deemed not to be an option. The Adviser was satisfied that Mrs C's complaints of neurological symptoms in her legs had been properly recorded and taken seriously by the Doctor and Consultant 1. The Adviser explained that the MRI scans supported the Doctor's conclusion that the spinal degeneration highlighted in the first MRI scan was relatively minor and not causing any nerve impingement. He acknowledged, however, that from Mrs C's point of view, her symptoms remained unchanged but became more severe between the first consultation in June 2005 and her referral to Consultant 2 two years later. He felt that it was, therefore, unsurprising that she should conclude that earlier

surgical intervention would have prevented two years of increasing pain. The Adviser noted, however, that spinal surgery carries significant risk and the success rate, in terms of improving symptoms, is relatively low. Many orthopaedic and neurosurgeons are, therefore, reluctant to submit patients with mild or non-disabling symptoms for surgery to resolve back pain. He further noted that research has shown that the risk of surgical complications increases relative to the degree of obesity of the patient. Mrs C's body mass index was recorded as being high and she had been advised to lose weight.

15. The Adviser found the Doctor's advice to Mrs C to be reasonable. He said that, in the absence of evidence of nerve encroachment, there was no indication for surgical intervention. This would have been the case even if her symptoms had been more pronounced or persistent.

16. Although the Adviser found the decision not to operate on Mrs C's spine to be appropriate and the suggestion that she should lose weight and exercise regularly to be reasonable, he was concerned that no other treatment was suggested. He noted that Mrs C had undergone a course of physiotherapy in 2005 and felt that further physiotherapy may have offered some degree of pain relief. He also felt that Mrs C could have been offered some form of analgesic medication or non-surgical intervention, such as chiropractic intervention, posture training or spinal rehabilitation.

17. When commenting on a draft copy of this report, Mrs C told me that Consultant 1 asked her about the analgesic medication that she was taking for her pain. She said that, upon advising that she was taking eight co-codamol per day, Consultant 1 'looked at me unpleasantly and asked why I was taking such a dose'.

18. With regard to the fact that Mrs C was diagnosed with degenerative spondylolisthesis following referral to Consultant 2, requiring subsequent surgical intervention, the Adviser was satisfied that, even with the benefit of hindsight, the results of the first MRI scan in 2005 did not indicate any positive signs of nerve encroachment. Furthermore, whilst the second MRI scan showed a small slip of the L4/5 vertebrae, this was not present on the first scan. He noted that Mrs C's symptoms were considered by her GP to have worsened in June 2006. Consultant 1 reviewed her initial MRI scan in August 2006 and commented in November 2006 that he still considered those scans to be clear of any nerve encroachment. The Adviser considered that further examination

by Consultant 1 in November 2006 may have highlighted a loss of sensation, as was found by Consultant 2 in June 2007. He noted, however, that this may not have been apparent at the time of Consultant 1's examination. That said, the Adviser further noted that the worsening of symptoms, described by Mrs C's GP, related to the same area of the spine that had been highlighted by the first MRI scan as being abnormal. The Adviser felt that this could have given Consultant 1 cause to arrange a repeat scan.

19. During my investigation into this complaint, I asked the Board for their comments as to the treatment options considered for Mrs C in light of the fact that surgical intervention was unsuitable. They provided comments made by Consultant 1. He explained that surgery was not feasible for Mrs C as a potential cure for her back pain. Consultant 1 said that his practices follow guidelines published by the Clinical Standards Advisory Group. These promoted encouraging the patient to stay active and continue normal activities as far as possible as the best means of recovery from back pain. Consultant 1 also noted that he generally leaves the management of medication to the patient's GP, as they have a better personal knowledge of the patient and are better placed to monitor the results. Consultant 1 was provided with a copy of the Adviser's comments and acknowledged the suggestion that chiropractic treatment or muscle relaxants could have been offered to Mrs C. Consultant 1 explained that these were suitable treatments for acute back pain (pain that is short-lived and resolves over time), however, Mrs C suffered from chronic back pain (longer-term, ongoing pain). He considered the treatments suggested by the Adviser to be ineffective for Mrs C's condition and was satisfied that his initial advice of weight reduction and exercise was appropriate. The Adviser reviewed Consultant 1's comments and found his approach to have been reasonable.

20. Mrs C was also provided with a copy of the Adviser's comments. Noting his opinion that there was no evidence of spondylolisthesis on the first MRI scan, but that it was clearly visible on the second, she said that the circumstances of each scan were slightly different. She said that, during the first scan, a pillow was placed under her spine for support. No pillow was provided during the second scan. She speculated that the pillow may have caused her spine to curve, hiding the spondylolisthesis, which was then apparent when her spine was scanned in a straight position. She further noted that her back pain was reduced when she bent forward. I asked the Adviser whether the fact that Mrs C's spine was curved could have hidden the presence

of a slipped vertebra. He said that this would not be the case. Although the displacement is described as 'forward slippage', it is in fact fixed and does not slide back and forth. He concluded that the displacement was definitely not present in the first MRI scan.

(a) Conclusion

21. Given Mrs C's presenting symptoms, I consider it suitable for the Doctor to arrange an MRI scan following her first consultation. The Doctor's initial examination of Mrs C found her back pain to be relatively minor and he found no evidence of spondylolisthesis in the scan results. As such, and with the Adviser's comments in mind, I am satisfied that the decision not to operate on her spine was appropriate. I am also satisfied that the advice given to Mrs C following the first MRI scan – to take regular exercise – was appropriate.

22. Mrs C's worsening symptoms led to her condition being reviewed by Consultant 1 in November 2006. Prior to this consultation, he reviewed the first MRI scan with a radiologist. Content that those results showed no sign of nerve encroachment, Consultant 1 reached a similar conclusion to the Doctor. I acknowledge the Adviser's comment that the change in symptoms may have instigated a further MRI scan at this stage. However, I also note that Consultant 2 recorded in the clinical records that Mrs C's symptoms were 'significantly different' to those that she presented with at Consultant 1's examination. The evidence that I have seen indicates that, whilst Consultant 1 concluded that there was no surgical procedure to address Mrs C's back pain, he acknowledged her neurological symptoms and asked her GP to arrange eliminatory blood tests for neurological conditions. He also advised that referral to a neurologist may be appropriate following the results of those tests.

23. I do recognise that Mrs C's spondylolisthesis may have occurred by the time of her consultation with Consultant 1 and that an MRI scan at that time may have resulted in a quicker diagnosis. In the light of all of the circumstances, however, I found Consultant 1's assessment of Mrs C's condition to be reasonable.

24. Mrs C's referral to Consultant 2 resulted in a second MRI scan and the diagnosis of spondylolisthesis for which surgical treatment was provided. I accept entirely the Adviser's opinion that spondylolisthesis was not present at the time of the first scan and that this was a new injury that occurred sometime between February 2006 and June 2007. With this in mind, I do not consider the

severity of Mrs C's spinal condition to have been misrepresented by the Doctor or Consultant 1 during her initial consultations. Accordingly, I do not uphold this complaint.

(a) Recommendations

25. The Ombudsman has no recommendations to make.

(b) Conclusion

26. The Adviser raised initial concerns over the lack of alternative treatments made available to Mrs C following the decision not to operate on her spine. However, the Board were able to demonstrate that Consultant 1's advice to her to lose weight and take regular exercise was appropriate for her condition and in accordance with widely accepted guidance. The Adviser was satisfied with the Board's comments and found the treatment proposed for Mrs C to be reasonable.

27. Both the Adviser and Consultant 1 recognised that analgesic medication may have been appropriate to alleviate Mrs C's back pain. I am satisfied that Consultant 1's practice of leaving such medication to the patient's GP is reasonable, and that he discussed this treatment with Mrs C. However, the clinical records and letters from Consultant 1 and the Doctor to Mrs C's GP do not indicate whether this was discussed with her GP. The Board may wish to consider whether this practice needs to be communicated to GPs.

28. Generally, I found the decision not to operate on Mrs C's spine to be sound, and the subsequent lifestyle advice to be appropriate. As such, I do not uphold this complaint.

(b) Recommendation

29. Although I did not uphold this complaint, I was concerned that Mrs C's GP may not have been aware of the Board's expectation that he would provide medication for her back pain. The Ombudsman, therefore, recommends that the Board consider reviewing Mrs C's case with a view to identifying any aspects of the communication between consultants and her GP that could be improved.

(c) The Board's complaint handling was poor

30. Mrs C raised her concerns about the Board's assessment and treatment of her spinal problems in a formal complaint dated 6 May 2008. In the letter, she

also raised further concerns regarding delays to her MRI appointment and the absence of her clinical records during one of her consultations. The Board responded on 21 May 2008. They explained that they would be unable to investigate or respond to the points that she had raised, due to the length of time that had passed since the events being complained about. The Board drew Mrs C's attention to their complaints procedure, which states that they will only investigate complaints relating to events that occurred within six months of the date of the complaint. As Mrs C's complaint related to consultations and treatment between April 2005 and August 2007 (the date of the consultation to discuss Mrs C's second MRI scan results), the Board considered her complaint to be well outside their six month time bar.

31. Mrs C noted the speed with which the Board responded to her letter and concluded that little thought had been given to her concerns and the possibility of investigating her complaint. She said that she had only found out about her 'misdiagnosis' in November 2007 and that she complained to the Board as soon as her health would allow following that. Mrs C told me that, upon deciding to raise her concerns with the Board, she initially contacted them by telephone and spoke to a Patient Liaison Manager. She was advised of the six month time bar but invited to submit her complaint in writing, as it could be accepted up to 12 months after the date of the events complained about. She felt that it was inappropriate of the Board to subsequently enforce their time bar so strictly in the light of these circumstances.

32. I asked the Board for their comments as to why they did not investigate Mrs C's complaint. They noted that Mrs C's spondylolisthesis was diagnosed in August 2007 and that she underwent surgery in October 2007. On the basis that this would be the latest point at which Mrs C would have known the extent of her spinal problems, the Board felt that too much time had passed between October 2007 and May 2008 for them to exercise any leniency in the complaints procedure.

33. NHS Scotland offer guidance on complaint procedures in their publication *Can I help you? Learning from comments complaints and suggestions* (the Guidance). The Guidance states:

> 'When can a complaint be made?
>
> Complaints are normally made at the time a patient becomes aware of an issue or a concern. Wherever possible they should be dealt with immediately to reduce the chance that the passage of time, with inevitable

staff changes etc, could hamper resolution. However, it is not always possible for the patient to make a complaint immediately. In clinical complaints, for example, a complication or other issue may not become apparent to the patient for sometime after the procedure.

Given the difficulties that the passage of time can make to the resolution of a complaint, the **recommended** timescale for accepting a complaint is:

- up to 6 months after the event which is the cause for the complaint, or
- up to 6 months from the patient becoming aware of a cause for complaint;
- but, normally, no longer than 12 months from the event.

However, NHS organisations must operate these guidelines flexibly and accept a complaint where it would have been unreasonable for the patient to make it earlier and where they believe it is still possible to investigate the facts. A decision not to extend these timescales should be agreed by the Chief Executive.'

(c) Conclusion

34. I accept Mrs C's reasons for not complaining to the Board sooner. I acknowledge that she was not aware that she had cause for complaint about her diagnosis until she received the results of the second MRI scan, and possibly only once the surgical treatment was discussed. That said, I also acknowledge that the Board have a clear policy on complaint investigation. It is important that a time limit be set for the acceptance of complaints and I find it reasonable that this time limit should be enforced unless it can be proven that a complainant was prevented from complaining due to special circumstances.

35. I am satisfied that the Board took a reasonable view when determining that Mrs C would have been in a position to submit her complaint within the six-month timescale. Furthermore, I note that whilst Mrs C was not substantially over the six month deadline for her complaints about her diagnosis, the other points that she raised in her formal complaint referred to events that took place significantly earlier. These could have been raised at the time and by not doing so, Mrs C denied the Board the opportunity to carry out a thorough and worthwhile investigation.

36. The evidence that I have seen is unclear as to whether the Board reached their decision with the Guidance in mind. I have seen no evidence, for example,

of flexibility in the six-month rule, or of consultation with the Chief Executive. Whilst I draw the Board's attention to the Guidance, I acknowledge that they had the discretion to decide whether the complaint was accepted, and accept that flexibility is not appropriate in all cases. Generally, I am satisfied that the Board did not unreasonably decline to investigate Mrs C's complaint. I, therefore, do not uphold this complaint.

(c) Recommendation

37. Although I did not uphold this complaint, the Ombudsman recommends that the Board consider how NHS Scotland's publication: *Can I help you? Learning from comments complaints and suggestions* should be taken into account when making decisions on complaint time limits.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Hospital 1	The Western Infirmary
The Doctor	A staff grade doctor for the Board
Consultant 1	A consultant orthopaedic and spinal surgeon for the Board
Hospital 2	The Southern General Hospital
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	A professional medical adviser to the Ombudsman
Consultant 2	A consultant neurologist for the Board
The Guidance	NHS Scotland's publication: Can I help you? Learning from comments complaints and suggestions

Annex 2

Glossary of terms

Acute pain	Pain that is short-lived and resolves over time
Chronic pain	Long-term, ongoing pain
Decompression and instrumentation fusion surgery	A procedure whereby two vertebrae are 'fused' together and held in position by being clamped together
Degenerative spondylolisthesis	Forward slippage of one vertebra over another
Lumbar spine	The lower part of the spine
Nerve foramen	A gap in the vertebra where the spinal nerves exit the spine
Neuropathic	Relating to the nerves
Osteopenia	A reduction in the mineral density of bones
Parasthesia	A burning or prickling sensation
S1 nerve	The sacral nerve that runs from the little toe, up the outside edge of the foot and up the back of the leg to the buttock
Spinal stenosis	A condition whereby the openings of the vertebrae narrow to such an extent that the exiting nerves are compressed

Annex 3

List of legislation and policies considered

Can I help you? Learning from comments complaints and suggestions