Scottish Parliament Region: North East Scotland

Case 200702821: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; paediatrics; clinical treatment; diagnosis

Overview

The complainants (Mr and Mrs C) raised a number of concerns that, during four attendances at Ninewells Hospital (Hospital 1) during July and August 2007, Tayside NHS Board (the Board) had not taken their concerns for the health of their infant daughter (Child C) seriously, that Child C had not been adequately examined and that her condition had not been investigated appropriately. They were also concerned that the Board's handling of their subsequent complaints was not adequate due to the time taken to respond to the complaints. They also felt the quality of the review the Board undertook was poor and the Board's conclusion that there had been a change in Child C's clinical condition, following her final attendance at Hospital 1, was not supported by the written evidence. Following Child C's final attendance, the Board sent a letter to Child C's GP. Mr and Mrs C complained that this letter contained inaccurate and unnecessary comments, and that sending it was inappropriate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board did not appropriately examine, diagnose and treat Child C at four attendances in July and August 2007 *(partially upheld to the extent that further investigations of Child C's condition should have been undertaken in August 2007 and she should have been admitted on 16 August 2007)*;

(b) the Board did not respond appropriately to Mr and Mrs C's complaint of 24 August 2007 *(partially upheld to the extent that the Board's conclusion that there had been a change in Child C's clinical condition, following her final attendance at Hospital 1, was not supported by the available written evidence)*; and

(c) the Board's letter of 3 September 2007 to Child C's GP was inappropriate in the circumstances (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr and Mrs C that further investigations of Child C's condition were not undertaken and that she was not admitted on 16 August 2007;

(ii) review the decision-making in this case with the appropriate Board staff at their next appraisals; and

(iii) apologise to Mr and Mrs C that the conclusion that Child C's clinical condition had changed between 16 August 2007 and 17 August 2007 was not supported by the available written evidence.

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

Main Investigation Report

Introduction

1. On 11 February 2008 the Ombudsman received a complaint from Mr and Mrs C, the parents of an infant child (Child C) who had suffered ill health the previous summer. Mr and Mrs C had taken Child C to Ninewells Hospital (Hospital 1) on four occasions during July and August 2007. They had been dissatisfied with the care and treatment their daughter had received and, following the final attendance on 16 August 2007, took her to Royal Aberdeen Children's Hospital (Hospital 2), where she was admitted and a diagnosis of either a partially treated bacterial meningitis or a viral meningitis was made. Mr and Mrs C complained that Tayside NHS Board (the Board) had not taken their concerns for the health of Child C seriously, that Child C had not been adequately examined and that her condition had not been investigated appropriately. They were also concerned that the Board's handling of their subsequent complaints was not adequate due to the time taken to respond to the complaints. They also felt the quality of the review the Board undertook was poor and the Board's conclusion that there had been a change in Child C's clinical condition following her final attendance at Hospital 1 was not supported by the evidence. Following Child C's final attendance, the Board sent a letter to Child C's GP. Mr and Mrs C complained that this letter contained inaccurate and unnecessary comments, and that sending it was inappropriate.

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

(a) the Board did not appropriately examine, diagnose and treat Child C at four attendances in July and August 2007;

(b) the Board did not respond appropriately to Mr and Mrs C's complaint of 24 August 2007; and

(c) the Board's letter of 3 September 2007 to Child C's GP was inappropriate in the circumstances.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical records from both the Board and Grampian NHS Board, correspondence between Mr and Mrs C and the Board and the Board's complaints file. This included internal correspondence of the Board during the investigation of Mr C's complaints. I also sought the views of a clinical adviser to the Ombudsman with specialist knowledge of paediatrics (the Adviser). I have set out my findings of fact and conclusion. I have not included in this

report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Annex 1 and a glossary of the medical terms used is noted in Annex 2. Mr and Mrs C and the Board were given an opportunity to comment on a draft of this report.

4. In late July 2007 Child C, then a six month old infant, became unwell. Her parents were concerned that she was becoming increasingly quiet and lethargic and that she had vomited several times over the course of a few days. On 28 July 2007, Child C vomited twice following feeding and Mr and Mrs C took her to Hospital 1. Child C was examined and a possible diagnosis of viral gastroenteritis was reached. Child C was kept in Hospital 1 overnight and the next day, following assessment, Child C was discharged home.

5. Child C began vomiting again at 18:00 that evening and the following day, 30 July 2007, Mr and Mrs C again took her to Hospital 1. Child C was examined and a diagnosis of infectious vomiting was recorded. Child C was kept in Hospital 1 overnight and, following assessment, discharged home the following day.

6. Over the next few days, Mr and Mrs C became more anxious about Child C's state of health. They said that Child C was continually vomiting, often screaming seemingly in agony, not sleeping and otherwise very lethargic. On 3 August 2007 Mr and Mrs C consulted Child C's GP who referred her to Perth Royal Infirmary where various blood samples were taken and Child C was transferred to Hospital 1 that afternoon. Following examination a possible diagnosis of urinary tract infection (UTI), reflux and intussusception (a blockage of the intestine) was reached. Tests were carried out, including examination of the anterior fontanelle (the soft spot towards the front of the skull). This was felt to be normal and meningism was ruled out. Child C was kept in Hospital 1 and observed until 5 August 2007 when she was discharged home with a seven day course of medication for a bacterial infection.

7. According to Mr & Mrs C, throughout the course of medication and following its completion, Child C continued to vomit once per day. On 16 August 2007, seven days after completing the medication course, she began vomiting profusely again and was otherwise pale and lethargic. Mr and Mrs C again took Child C to her GP who referred her to Hospital 1 again, suspecting a recurrence of UTI. Child C was examined and it was decided that admission

was not necessary, that a urine test should be undertaken and that a review appointment should be made. Mr and Mrs C were unhappy with this and told me that they pleaded for further investigations to be undertaken. The medical staff did not agree to this and Mr and Mrs C returned home.

8. The following day, 17 August 2007, Child C's condition had not improved. Mr and Mrs C felt that their concerns had not been taken seriously by Hospital 1 and, therefore, decided to take Child C to the Accident and Emergency Department of Aberdeen Royal Infirmary. Examination and tests were undertaken and Child C was transferred to a medical ward in Hospital 2 where a diagnosis of either a partially treated bacterial meningitis or a viral meningitis was made and a course of treatment begun.

9. On 22 August 2007 a Consultant Paediatric Endocrinologist (Consultant 1) at the Board dictated a letter to Child C's GP outlining the Board's understanding of Child C's attendances at Hospital 1 and at Hospital 2. This letter was typed and sent on 3 September 2007.

10. On 24 August 2007, Mr and Mrs C wrote to Consultant 1. They requested that an Adverse Significant Incident Review (ASIR) be undertaken following what they described as 'the repeated failure of [Hospital 1] to diagnose bacterial meningitis' in Child C. This letter was also copied to the Board's Medical Director. The Board's Clinical Group Director (the Director) was given responsibility for responding to this letter and he contacted Mr and Mrs C on 4 September 2007 to advise them that a review would be undertaken. Mr and Mrs C wrote to the Director on 5 September 2007 detailing their concerns about the care and treatment Child C had received.

11. Correspondence between Mr and Mrs C and the Board continued whilst the review was ongoing. The completed review was provided to Mr and Mrs C on 21 December 2007. The conclusion of the review was that Child C was 'assessed, investigated and managed appropriately' by the Board and that there was no evidence that Mr and Mrs C's views were not taken seriously by the Board. The consultant paediatrician who carried out the review (the Reviewer) made clear he was willing to discuss any aspect of the review further if Mr and Mrs C wished.

12. Mr and Mrs C requested a meeting with the Reviewer and the Director and this was held on 1 February 2008. At the meeting Mr and Mrs C expressed

continued dissatisfaction with the care and treatment Child C received and raised concerns about what they considered to be inadequacies and inaccuracies in the review. They sent a letter detailing their concerns to the Board on 2 February 2008 and raised their complaints with the Ombudsman on 8 February 2008. On 26 February 2008 the Board confirmed that the review and meeting constituted their final response to Mr and Mrs C's complaints.

(a) The Board did not appropriately examine, diagnose and treat Child C at four attendances in July and August 2007

13. Mr and Mrs C complained that, during all four attendances in July and August 2007, the Board had not taken their concerns for the health of their infant daughter seriously, that Child C had not been adequately examined and that her condition had not been investigated appropriately.

14. Specifically, Mr and Mrs C felt that the attitudes and actions displayed by the Board's staff during the four attendances indicated that their concerns were not taken seriously. They were especially concerned about the attendance on 16 August 2007, when they felt their pleading for further investigation was dismissed without serious consideration.

15. Mr and Mrs C also felt that a systematic neurological examination of Child C should have been undertaken at each of the attendances. They were concerned that an absence of signs of meningism had been mentioned by only two clinicians, one of whom was a junior doctor, whose view, in their opinion, could be disregarded. They were also concerned that the conclusions drawn, and actions taken, as a result of tests on urine samples from Child C were not reasonable.

16. I sought the opinion of the Adviser on this complaint. He said that the medical records of the first and second attendances, in July 2007, appeared satisfactory and that Mr and Mrs C's anxiety was recorded in the medical notes. He told me that he would expect that on Child C's admission, clinicians would have been looking for signs of meningitis and that, in a six month old infant, this would normally consist of assessing the size and consistency of the fontanelle (the soft spots on the top of an infant's skull) and looking for any neck rigidity. He told me that the anterior fontanelle was examined at the first, third and fourth attendances and recorded as normal on all occasions. He also pointed out that a test for Kernig's Sign (difficulty in straightening the knee when the hip is flexed) was carried out at the fourth attendance and was negative. He gave his

view that he would not have expected any other examination of Child C at the first three attendances. He disagreed with Mr and Mrs C's view that the opinion of a junior doctor could be disregarded.

17. The Adviser also commented on the conclusions drawn, and actions taken, by the Board as a result of tests on urine samples from Child C. He felt that, in view of the possible urine infection, the arrangement of an ultra sound scan on 3 August 2007 was reasonable. He told me that the sample did not show a UTI on 5 August 2007 and it was, therefore, reasonable for the specialist registrar to decide that no further investigation of the urinary tract was required. He gave his view, however, that further investigations to identify the source of Child C's infection should have been considered at this point. He also felt that Child C should have been admitted on 16 August 2007 for further investigation to determine the cause of the persistent vomiting, lethargy and pallor.

(a) Conclusion

18. As the Adviser has said, throughout the records of Child C's attendances in July and August 2007, her parents concerns about her health were noted. While there had clearly been a breakdown in Mr and Mrs C's confidence in the Board's clinicians, I cannot see any evidence that their concerns for the health of their daughter were not taken seriously. The Adviser was also of the opinion that the Board carried out and recorded appropriate and adequate neurological examination of Child C during her first three attendances in July and August 2007, and his opinion is that this is supported by the medical records. The Adviser was concerned, however, about the Board's actions after a UTI had been ruled out by tests on Child C's urine sample. I accept the views of the Adviser that the Board should have made further investigations to identify the source of Child C's infection at this point and I also his view that Child C should have been admitted on 16 August 2007 for further investigations to determine the cause of her persistent vomiting, lethargy and pallor. Given all of the above, I partially uphold the complaint to the extent that further investigations of Child C's condition should have been undertaken in August 2007 and she should have been admitted on 16 August 2007.

(a) Recommendations

19. The Ombudsman recommends that the Board:

(i) apologise to Mr and Mrs C that further investigations of Child C's condition were not undertaken and that she was not admitted on 16 August 2007; and
(ii) review the decision-making in this case with the appropriate Board staff at their next appraisals.

(b) The Board did not respond appropriately to Mr and Mrs C's complaint of 24 August 2007

20. Mr and Mrs C complained that the Board's handling of their complaints was not adequate due to the time taken to respond to them. They also felt the quality of the review the Board undertook was poor and that the Board's conclusion that there had been a change in Child C's clinical condition following her final attendance at Hospital 1 was not supported by the evidence.

21. Mr and Mrs C wrote to Consultant 1 on 24 August 2007. They requested that an ASIR be arranged following what they described as 'the repeated failure' of the Board to diagnose bacterial meningitis in Child C. The Board supplied me with a memo from the Director dated 4 September 2007. In this memo he said that Consultant 1 had been on leave and, therefore, had not responded to the letter. The Director said that another Consultant (Consultant 2) had been given responsibility for organising the review. The Director also said that he had contacted Mr and Mrs C and told them that Child C's case would be reviewed. On 5 September 2007 Mr and Mrs C wrote to the Director with a list of questions they felt should be considered as part of the ASIR. The Director acknowledged this letter on 10 September 2007. The Director explained that he had passed Mr and Mrs C's letter to Consultant 2. There is a note on the Board's copy of this letter from the Director to Patient Services asking the Patient Services department for advice on how to co-ordinate responses to Mr and Mrs C as part of the Board's complaints procedure.

22. On 7 September 2007, Consultant 2 wrote to Mr and Mrs C advising that she had been asked to organise the significant event analysis into the attendances of Child C and requesting Mr and Mrs C's permission for the Board to receive information about Child C's admission to Hospital 2. Consultant 2 omitted a letter from Child C's first name in this communication.

23. On 13 September 2007, the Board's Complaints and Advice Co-ordinator wrote to Mr and Mrs C explaining that the Board were investigating the issues

raised in their letter of 24 August 2007 and that this would be responded to via a written response from the Chief Executive, or his deputy, within four weeks.

24. On 17 September 2007 Mr and Mrs C wrote to the Director in response to the letters of 7 and 10 September. They said that they were disappointed that Consultant 2 indicated that a significant event analysis, rather than an ASIR, would be carried out and that her error in Child C's first name did not inspire their confidence in her. These issues, together with the fact that Consultant 2 had been involved in Child C's care at Hospital 1, meant that Mr and Mrs C did not believe she was a suitable organiser of the review. Mr and Mrs C also advised that they did not believe that access to the records of Child C's care and treatment at Hospital 2 was essential for the Board to carry out a review and, therefore, did not give their permission for the Board to receive information about it. They gave a brief synopsis of Child C's admission to Hospital 2.

25. The Director spoke to Mr C on 25 September 2007 and recorded details of this conversation in a memo to Consultant 1 and Consultant 2. He said that he had explained to Mr C's satisfaction that significant event analysis, rather than ASIRs, are undertaken in paediatrics and that Consultant 2 would not be carrying out the review, but had been co-ordinating it. He explained to Mr C that organising a meeting of all the appropriate staff was challenging and that it was likely to be October before such a meeting could be held. The following day the Complaints and Advice Co-ordinator wrote to Mr and Mrs C to advise them that the investigation of their complaints was continuing and that it was hoped the complaint could be responded to within the four-week timescale indicated in the letter of 13 September 2007.

26. On 4 October 2007 the Board's Medical Director wrote to Mr and Mrs C, in response to their letter of 17 September 2007. He confirmed the information contained in the Director's memo and explained that it may take some time to set up the review panel. He gave Mr and Mrs C a named contact point should they wish to discuss their complaints further and enclosed a leaflet explaining the Ombudsman's role in the complaints process.

27. The Board provided me with email records showing the Board's attempts to organise a meeting to discuss the review with the staff involved in Child C's care. The Director wrote to Mr and Mrs C on 19 October 2007 explaining that the review would now be held during November 2007. Mr and Mrs C acknowledged this letter on 25 October 2007.

28. On 20 December 2007 the Reviewer wrote to Mr and Mrs C enclosing a copy of the findings of his review. He also offered to meet with Mr and Mrs C if they wished. The review concluded that Child C's management by Hospital 1 had been 'reasonable given the history and clinical findings'. The Reviewer also responded directly to the questions in Mr and Mrs C's letter of 5 September 2007.

29. The Chief Executive of the Board wrote to Mr and Mrs C on 28 January 2008 expressing the hope that a meeting that had been arranged for 1 February 2008 would address all the issues Mr and Mrs C had to raise. He said that if, however, Mr and Mrs C were still dissatisfied after the meeting and did not want to try for further resolution with the Board, they could approach the Ombudsman. After the meeting, Mr and Mrs C wrote to the Board outlining what they felt were inadequacies and inaccuracies in the report. As well as a list of the inaccuracies Mr and Mrs C perceived the report contained about Child C's care and treatment at Hospital 1, they were concerned about certain statements in the report. These included the statement in the report that there was 'continuing uncertainty over [Child C's] overall diagnosis', as Mr and Mrs C believed a clear diagnosis of bacterial meningitis had been reached at Hospital 2. Mr and Mrs C were also concerned that the review concluded that there had been a change in Child C's clinical condition between her presentation at Hospital 1 on 16 August 2007 and her presentation at Hospital 2 on 17 August 2007.

30. The Board advised me that their conclusion that there had been a change in Child C's clinical condition between her presentation at Hospital 1 on 16 August 2007 and her presentation at Hospital 2 on 17 August 2007 was based exclusively on a telephone conversation between the Reviewer and one of the paediatricians in Hospital 2 who had been involved in Child C's care.

31. I sought the opinion of the Adviser on the clinical aspects of this complaint. The Adviser had access to Child C's records from Hospital 1 and Hospital 2, the review and Mr and Mrs C's letters detailing their concerns about it. The Adviser told me that the clinical details in the review were as stated in the records and that the diagnosis reached at Hospital 2 was not a clear diagnosis as Mr and Mrs C stated, but an equivocal diagnosis of either a partially treated bacterial meningitis or a viral meningitis. He was clear, however, that there was no written evidence of a deterioration in Child C's condition between her

presentation at Hospital 1 on 16 August 2007 and her presentation at Hospital 2 on 17 August 2007. He suggested that the difference between the two presentations was the further investigations that were performed at Hospital 2.

(b) Conclusion

32. Mr and Mrs C's complaint to the Board was acknowledged by telephone and, thereafter, they were advised by the various departments and clinicians they had contacted that a co-ordinated response to their complaints was being pursued. This was fully discussed with Mr and Mrs C by the Director and when, on 4 October 2007, they were advised of a possible delay, they were also provided with a named contact whom they could contact if they had any queries or concerns. Mr and Mrs C's correspondence with the Board was promptly and appropriately responded to and the offer and arrangement of a meeting was also appropriate in the circumstances. I conclude, therefore, that the time taken for the Board to respond to Mr and Mrs C's complaint was reasonable.

33. Having had access to all the relevant records and paperwork, the Adviser told me that the review was factually accurate when compared with the medical records. However, the Adviser also told me that there was no evidence that Child C's clinical condition had deteriorated between her presentation at Hospital 1 on 16 August 2007 and her presentation at Hospital 2 on 17 August 2007. I accept the Adviser's view and, therefore, I partially uphold the complaint to the extent that the Board's conclusion that there had been a change in Child C's clinical condition, following her final attendance at Hospital 1, was not supported by the available written evidence.

(b) Recommendation

34. The Ombudsman recommends that the Board apologise to Mr and Mrs C that the conclusion that Child C's clinical condition had changed between 16 August 2007 and 17 August 2007 was not supported by the available written evidence.

(c) The Board's letter of 3 September 2007 to Child C's GP was inappropriate in the circumstances

35. Mr and Mrs C complained that a letter, sent by Consultant 1 to Child C's GP, following Child C's final attendance, contained inaccurate and unnecessary comments, and that sending it was inappropriate.

36. On 22 August 2007 Consultant 1 dictated a letter to Child C's GP. The letter stated that it was typed on 3 September 2007. Mr and Mrs C complained that Consultant 1's statements that they 'were keen for discharge of [Child C]' on 5 August 2007, that Child C's vomiting on 16 August 2007 was 'moderate' and that the dating of the dictation, typing and sending of the letter were not accurate. The letter stated that intravenous antibiotic therapy had begun during Child C's third attendance and that the Board had planned to change to oral antibiotic therapy when appropriate. Mr and Mrs C complained that the medical records indicated that no intravenous antibiotic therapy had begun. The letter stated that Mr and Mrs C 'have homes in both the Dundee and the Aberdeen areas'. Mr and Mrs C felt that it was not necessary for Consultant 1 to make this comment. Mr and Mrs C also felt that writing and sending this letter was inappropriate as Child C was no longer under the care of the Board.

37. The medical record for 5 August 2008 noted that Child C 'is tolerating feeds, has had some loose stools and is brighter and more alert, so parents keen for discharge'.

38. The medical records show that oral antibiotic therapy was commenced during Child C's third attendance, and that the Board had been planning to change to intravenous antibiotic therapy when appropriate.

39. I sought the opinion of the Adviser on the medical aspects of this complaint. In regard to the description of Child C's vomiting on 16 August 2008, he noted that the records stated Child C had vomited twice that day, once after lunch and then vomited profusely in the afternoon. His view, taking into account that any view would be very subjective, is that 'moderate' was an appropriate phrase to use. The Adviser raised no concerns about the accuracy of the information in the letter. In regard to the appropriateness of the writing of the record, the Adviser told me that, in his view it was appropriate to write the letter. He said that it was a summary of the admissions to Hospital 1, together with some clinical information from Hospital 2, and such a letter would normally be expected to be written to a GP following the discharge of their patient from hospital.

(c) Conclusion

40. Given what was recorded in the medical notes, it was reasonable for Consultant 1 to make the statement that Mr and Mrs C were keen for Child C to be discharged on 5 August 2007. Taking into account the Adviser's comments

on the evidence of the severity of Child C's vomiting on 16 August 2007, I agree with the adviser that it was reasonable for Consultant 1 to describe this as 'moderate'. While I understand that Mr and Mrs C believe that the letter was not dictated, typed or sent on the days indicated by the Board, I have seen no evidence that would allow me to reach a firm, supportable conclusion on this issue. Given that the medical records indicate that oral antibiotic therapy was commenced during Child C's third attendance, and that the Board had been planning to change to intravenous antibiotic therapy when appropriate, my view is that Consultant 1 made an error in his references to oral and intravenous antibiotic therapy. However, in the overall context of the letter, I consider that this error was minor. Having considered the reference Consultant 1 made to Mr and Mrs C having homes in both the Dundee and Aberdeen areas, I consider this was mentioned only in the context of explaining why they had chosen to take Child C to Hospital 2 as an alternative to treatment at Hospital 1, and that this was a sensible anticipation of a question that may have occurred to the GP in reading the letter. The Adviser gave his opinion that Consultant 1's sending of the letter was appropriate in the circumstances. For the reasons the Adviser gave, I agree with him and, indeed, I would have been concerned if a letter to Child C's GP had not been written by the Board. Given all of the above, I do not uphold the complaint.

41. 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

Mr and Mrs C	The complainants, parents of Child C
Child C	The daughter of Mr and Mrs C
Hospital 1	Ninewells Hospital, Dundee
Hospital 2	The Royal Aberdeen Children's Hospital
The Board	Tayside NHS Board
The Adviser	A medical adviser to the Ombudsman with specialist knowledge of paediatrics
UTI	Urinary tract infection
Consultant 1	A consultant paediatric endocrinologist who was involved with Child C's care from 4 August 2007
ASIR	Adverse significant incident review
The Director	The Board's Clinical Group Director
The Reviewer	A consultant paediatrician who carried out the review of Child C's care by the Board
Consultant 2	The consultant paediatrician responsible for organising the review of Child C's care by the Board

Annex 2

Glossary of terms

Bacterial meningitis	Meningitis caused by a bacterial infection
Fontanelle; anterior fontanelle	The normal gaps between the skull bones in infants; the anterior fontanelle is the largest gap, and the furthest forward
Intussusception	Where a part of the bowel folds inside itself causing a blockage
Kernig's Sign	Difficulty in straightening the knee when the hip is flexed
Neurological examination	A series of questions and tests that provide crucial information about the nervous system
Paediatric endocrinologist	A doctor specialising in the growth and development of children
Reflux	When acid from the stomach leaks into the oesophagus
Urinary tract infection	An infection of the organ system that produces, stores and eliminates urine
Viral meningitis	Meningitis caused by a viral infection