Scottish Parliament Region: North East Scotland

Case 200903204: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; medical, clinical treatment; diagnosis

Overview

The complainant (Mrs C), who is an advice worker, raised a number of concerns on behalf of her client (Ms A) about the treatment which she received following an admission to Dr Gray's Hospital (the Hospital) during the period 12 July 2008 to 14 July 2008. Ms A was readmitted to the Hospital on 16 July 2008 where it was found that she was suffering from cerebral lymphoma.

Specific complaint and conclusion

The complaint which has been investigated is that the treatment which Ms A received at the Hospital from 12 July 2008 to 14 July 2008 was inadequate *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) remind staff of the importance of good record-keeping;	30 July 2010
(ii) share this report with the staff concerned, in order that they can reflect on their actions; and	30 July 2010
(iii) apologise to Ms A for the failings which have been identified in this report.	30 July 2010

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

Main Investigation Report

Introduction

1. The complainant (Mrs C), who is an advice worker, raised a number of concerns on behalf of her client (Ms A) about the treatment which she received following an admission to her local hospital (the Hospital) during the period 12 July 2008 to 14 July 2008. Ms A was readmitted to the Hospital on 16 July 2008 where it was found that she was suffering from cerebral lymphoma. Mrs C complained to Grampian NHS Board (the Board) but Ms A remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that the treatment which Ms A received at the Hospital from 12 July 2008 to 14 July 2008 was inadequate.

Investigation

3. In writing this report my complaints reviewer has had access to Ms A's clinical records and the complaints correspondence with the Board. He also met with Mrs C and Ms A and made a written enquiry of the Board. Advice has been obtained from one of the Ombudsman's professional medical advisers (the Adviser) regarding the clinical aspects of the complaint.

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

Complaint: The treatment which Ms A received at the Hospital from 12 July 2008 to 14 July 2008 was inadequate

Clinical background

5. In June 2008 Ms A underwent surgery, following a broken nose, and was unwell afterwards. Her general medical practitioner (the GP) treated her with antibiotics for presumed sinusitis. On 12 July 2008 Ms A attended the Accident and Emergency Department at the Hospital at 21:50. Her symptoms included headache, vomiting, weakness, unsteadiness on her feet, tiredness, poor appetite and an episode of collapse earlier in the day. Physical examination showed dehydration, possible abnormal behaviour, tenderness to the frontal

sinuses, no fever, no neurological signs and no other findings. The initial diagnosis made by an Accident and Emergency doctor (Doctor 1) was 'dehydration' and '??Sinusitis' following Ms A's recent surgery. A discussion took place with the on-call Ear, Nose and Throat Department doctor (Doctor 2), who advised that sinusitis following the previous surgery would be rare and that a medical referral should be made to consider other possibilities. The possibility of meningitis was considered. Ms A was admitted to the Hospital, treated with intravenous fluids and antibiotics and transferred to the care of the medical team.

6. Ms A was examined by a doctor from the Medical Team (Doctor 3) at 01:15 on 13 July 2008. The clinical findings were as stated by Doctor 1. Later that morning Ms A was seen by a medical consultant (Consultant 1). Her headache was described as sharp and dizziness on standing was noted. A temperature of 37.5 degrees (low grade fever) was recorded. A differential diagnosis of '? Vertigo benign positional vertigo, ? labyrynthitis' was recorded. Later that day Ms A's temperature was recorded as being within normal limits. Repeat neurological examination was satisfactory but Ms A felt dizzy on standing. The diagnosis listed was 'Labyrynthitis' and symptomatic treatment was given. The nursing notes recorded that Ms A was unsteady on her feet. Ms A was reviewed by another consultant (Consultant 2) on 14 July 2008 and her condition was found to be satisfactory. She was discharged home to complete a course of antibiotics and for follow-up by the GP. The discharge diagnosis was given as 'labyrinthitis / ?sinusitis'.

7. Ms A returned to the Accident and Emergency Department on 15 July 2008, having collapsed again at home. She was noted to be very slow in reacting to verbal commands and in speaking. She had no fever and, although she was not able to co-operate fully with a neurological examination, no abnormalities were found. Blood test results showed no evidence of infection. During a ward round carried out by a consultant (Consultant 3), it was noted that Ms A was unsteady in her gait and was incontinent. In addition, her four limbs were noted to be weak although the reflexes were normal. The clinical impression was 'Guillane-barre Syndrome ? non-organic'. A CT scan of the brain carried out that afternoon showed hydrocephalus. Ms A was transferred to a specialist unit at another hospital where the fluid was drained from her brain and a subsequent biopsy revealed a diagnosis of high grade B cell lymphoma of the brain. This was treated appropriately with radiotherapy and chemotherapy.

Complaint

8. In the complaint to the Board, and in subsequent discussions with staff and my complaints reviewer, Mrs C and members of Ms A's family explained that three weeks prior to the first hospital admission, Ms A had been complaining of a severe headache and spent most of the time at home in bed. On arrival at the Accident and Emergency Department at the Hospital on 12 July 2008, Ms A was persistently asked by Doctor 1 whether she had taken drugs and this was deeply upsetting for her. Ms A was admitted to the Hospital and remained on observations and routine bloods were taken before the decision was made to discharge her from the Hospital. Before discharge on 14 July 2008, Ms A said she was incontinent and unable to move from her bed. A relative arrived at the Hospital to take Ms A home and she noticed that Ms A was still unwell and disorientated and required help to get dressed. Ms A wondered if the nurses had told the medical staff that she was still not feeling right. While at home, Ms A continued to deteriorate and her disorientation and incoherence increased. Ms A's mother spoke to Ms A on the telephone and noticed that Ms A appeared to be incoherent. She telephoned the Hospital to explain the seriousness of her daughter's condition, only to be told that staff had not found anything wrong. Another relative visited Ms A at home on 15 July 2008 and also became concerned about her condition and that she had not eaten properly for over a week. The relative immediately took Ms A back to the Hospital and she was re-admitted. Ms A believes that during the first admission a thorough medical examination had not taken place and that staff had not taken her symptoms seriously. She considered that the delay in the diagnosis could have proved fatal.

9. In response to Mrs C's complaint, the Board said that on the first admission the duty doctor on-call had found no clear abnormal neurological findings other than that Ms A was unsteady on her feet. The presumed diagnosis was either of problems relating to the recovery from her previous operation or of sinusitis and labrynthitis. There was no mention in the records of any suspicion of drug abuse and an apology was made if any offence was taken by the questioning as none was intended. The Board said that it is important that staff ascertain any drug or medication use if a patient is admitted and their behaviour is abnormal. It was recorded in the nursing notes that Ms A's behaviour varied, in particular when the nurses repeatedly asked Ms A not to use her mobile phone in hospital. The nurses commented on Ms A's

intermittent disorientation and abnormal behaviour but said that this improved when reviewed by a consultant the following morning.

10. The Board continued that Ms A was discharged on 14 July 2008 but because she did not improve and more dizziness occurred, she returned to the Accident and Emergency Department at 22:07 on 15 July 2008. Ms A saw Doctor 1 and because she appeared to be more unwell with confusion, she was admitted to the Hospital in the early hours of 16 July 2008 with the suspicion of meningitis. Again, no focal neurological signs were noted although she was still disorientated the following day. The clinical diagnosis was still unclear, with the results of blood tests showing negative for infection. Contact was made with Ear, Nose and Throat specialists who suggested that Ms A be treated for infection and to perform a CT scan. The result of the scan was that there were features of hydrocephalus and Ms A was transferred to a specialist unit for surgery. The Board said that Ms A's medical management did not seem unreasonable and that hydrocephalus from cerebral lymphoma is rare. Although they understood that Ms A's relatives probably had a different perspective on Ms A's symptoms, it was stated that these were not communicated to the medical team. They went on to comment that Ms A was intermittently and mildly confused and may not have described her symptoms completely. The Board felt it would have been easy to assume the symptoms were post-operative and innocent. Upon readmission it was recognised that Ms A was more ill and a CT scan was performed and hydrocephalus was found.

Advice

11. In commenting on the case, the Adviser drew attention to the Scottish Intercollegiate Guideline Network 107 Diagnosis and management of Headache in adults (2008) which identifies 'red flag' symptoms, the presence of which indicate the need for brain imaging tests to rule out important underlying disease. These symptoms include, for example, focal neurological symptoms, headache changing with posture, patients with risk factors for cerebral venous sinus thrombosis and neck stiffness. The statement '… brain CT should be performed in patients with headache who have unexplained abnormal neurological signs' is also made. He noted that this guideline was not in force in July 2008 but advised the general principles would still have applied.

12. The Adviser said that it was important to acknowledge that this was a very rare and difficult case and that he would not have expected the staff to specifically consider a diagnosis of cerebral lymphoma at presentation on

12 July 2008. The Adviser firstly addressed the issues of the initial diagnoses which were made. He said that it was reasonable to consider whether there might be a connection with Ms A's recent operation. There was some evidence of sinusitis, in that facial tenderness was recorded, but on the other hand there was little evidence of infection. Sinusitis would be unusual following surgery for a broken nose. He did not think that the suggestion of sinusitis was well founded. The Adviser also said that meningitis was an important condition and with headache and abnormal behaviour it was reasonable to consider it. However, Ms A's history was rather longstanding for bacterial meningitis (although it could have been modified by the prescribed antibiotics). He said that there was no indication clinically of meningeal irritation and again there was little evidence of infection. The Adviser noted that the clinical team felt the need to commence appropriate antibiotic treatment but not to investigate further. The Adviser felt that the next step would have been to arrange a CT scan of the brain and, if that was reported as normal, then to carry out other investigations. On balance, the Adviser did not feel that the suggestion of meningitis was well founded.

13. The Adviser continued that the mentioned diagnosis of benign positional vertigo (see paragraph 6) would not have explained the symptoms of headache, altered behaviour or urinary incontinence. He believed such a diagnosis was also not justified. The Adviser explained that labyrinthitis is an inflammatory condition of the inner ear, usually viral, causing severe giddiness, nausea and vomiting. Headache is not often a prominent feature and it would not explain the altered behaviour or urinary incontinence. The Adviser stated that labyrinthitis is usually accompanied by the physical sign of nystagmus which is a rapid involuntary eye movement on looking towards the affected side. The absence of that sign in an illness as severe as was suggested would make the condition most unlikely and the Adviser again felt that the potential diagnosis was not well founded.

14. The Adviser concluded that no well founded diagnosis was made by the clinical team and that, in the presence of symptoms which might indicate serious underlying disease (headache with altered behaviour and the nurses noting that Ms A was unsteady on her feet), a CT scan of the brain should have been arranged for 13 July 2008. The Adviser considered that, given the lack of a well founded diagnosis and lack of a CT scan, there had been a serious shortcoming in care.

15. The Adviser said that, given his comments, Ms A should not have been discharged on 14 July 2008. He told me that he had no concerns about the care and treatment which was provided to Ms A when she was readmitted on 16 July 2008. He added that Ms A's lymphoma would have been present for many months before the diagnosis was made and it was not likely that the three day delay in diagnosis would have affected the final outcome. The Adviser also mentioned that he had some concerns about the standard of the medical notes, in that there was a lack of detail in the description of the signs and symptoms reported; a lack of evidence that the nurses had communicated the important observation of Ms A's unsteadiness to the doctors; and a lack of justification of the diagnoses which were considered.

16. The Adviser summarised that Ms A had presented with complex clinical features including headache, unsteadiness with collapse and abnormal behaviour. A number of diagnoses were considered but none substantiated. No CT scan was arranged and, therefore, in the Adviser's opinion that represented a serious shortcoming of care.

17. In response to the enquiry by my complaints reviewer, the Board said that a CT scan was not requested during the first admission because the context of the case and a lack of hard neurological signs meant the index of suspicion for serious pathology was initially low. Ms A had had a previous history of sinusitis and was being treated by the GP for sinusitis. A neurological and fundal examination was recorded, which indicated no abnormal findings, and Ms A was apyrexial and seen to be dehydrated. Ms A was started on intravenous fluids and antibiotics; her central nervous system was observed; and tests including an electrocardiograph (ECG), chest x-ray, blood test and urinalysis were performed. Ms A was also reviewed at consultant level before discharge. Only when Ms A returned to the Hospital did this trigger increased suspicion.

Conclusion

18. The complaint which was made by Mrs C was that the staff had not carried out a thorough examination or taken Ms A's concerns seriously and that the consequences could have proved fatal. It can be seen from this report that the staff involved reached a number of potential diagnoses and discharged Ms A with a course of antibiotics only for her to be readmitted to the Hospital the following day. The advice which I have received and accept is that it was reasonable for the staff to consider the probable diagnoses, although there were features in the symptoms with which Ms A presented which threw doubt

on the validity of the diagnoses. The question which I have considered is whether Ms A received a reasonable standard of treatment during the period 12 July 2008 to 14 July 2008. I have also taken into account that Ms A presented with a rare and difficult case and that the Adviser would not have expected the staff to have reached the definitive diagnosis of cerebral lymphoma on 12 July 2008. Nevertheless, the Adviser was of the opinion that there had been a serious shortcoming of care and that, due to Ms A showing abnormal physical signs with unsteadiness on her feet and a constant headache, then that would be an indication that a CT scan was required on 13 July 2008. Ms A was only out of the Hospital for one day and was then readmitted with similar symptoms, which led to a CT scan being carried out on 16 July 2008, which resulted in the diagnosis of hydrocephalus.

19. Ms A had been displaying the symptoms for a couple of weeks and I feel that it was unlikely that her condition would have changed dramatically during the short period that she was home, prior to the CT scan. The Adviser also drew my attention to his concerns about the standard of the medical notes in that there was a lack of detail in the description of the signs and symptoms which were reported and a lack of evidence that the nurses had communicated to the doctors about Ms A's unsteadiness.

20. I have given careful consideration to this complaint and I have decided that, although the staff gave reasonable thought to the cause of Ms A's problems, I am persuaded that the diagnoses were not well founded and that additional investigations, such as a CT scan of the brain, were required during the admission on 12 July 2008. Therefore, I uphold this complaint.

Recommendations

21. I recommend that the Board:	*Completion date*
(i) remind staff of the importance of good record-keeping;	30 July 2010
(ii) share this report with the staff concerned, in order that they can reflect on their actions; and	30 July 2010
(iii) apologise to Ms A for the failings which have been identified in this report.	30 July 2010

22. 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
Ms A	The aggrieved
The Hospital	Dr Gray's Hospital, Elgin
The Board	Grampian NHS Board
The Adviser	The Ombudsman's professional medical adviser
The GP	Ms A's general medical practitioner
Doctor 1	Accident and Emergency doctor who saw Ms A on 12 July 2008
Doctor 2	Ear, Nose and Throat doctor
Doctor 3	Doctor from the medical team who examined Ms A on 13 July 2008
Consultant 1	Medical consultant who reviewed Ms A on 13 July 2008
Consultant 2	Medical consultant who reviewed Ms A on 14 July 2008
Consultant 3	Medical consultant who reviewed Ms A on 17 July 2008

Annex 2

Glossary of terms

Antibiotics	Medication to treat infection
Apyrexial	Fever
Benign positional vertigo	Problems in the inner ear which can be affected by position
Cerebral lymphoma	Brain tumour
Chemotherapy	Chemical treatment for tumours
CT scan	Computerised tomography scan which takes multiple pictures (X-rays) of the body
Dehydration	Lack of fluid in the body
Electrocardiograph (ECG)	Test which records the electrical activity of the heart
Guillane-barre syndrome	Inflammatory condition of the peripheral nerves
Hydrocephalus	Enlargement of the spaces in the brain which contain fluid
Labyrinthitis	Inflammation of the inner ear
Meningitis	Inflammation of the meninges of the brain
Nystagmus	Rapid involuntary eye movement
Radiotherapy	Radiation treatment for tumours
Sinusitis	Inflammation of the lining of the sinuses

Symptomatic treatment	Medical therapy of a disease which affects the symptoms but not the cause