Scottish Parliament Region: North East Scotland

Case 201102801: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; accident and emergency; clinical treatment and diagnosis; complaints handling

Overview

The complainant (Mrs C) complained about the care, treatment and diagnosis her daughter (Ms A) received at an out-of-hours service at Peterhead Hospital (Hospital 1) in May 2011. Mrs C also complained about the responses she received from NHS Grampian (the Board) in relation to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the out-of-hours doctor (the Doctor) incorrectly explained that Ms A had not presented with photophobia despite her complaining of this to a nurse, and shielding her eyes with her hood (*not upheld*);

(b) the Doctor inappropriately failed to mention in his letter of response to Mrs C's complaint that Ms A had presented with a headache (*upheld*);

(c) the Doctor unreasonably reached an incorrect diagnosis (*not upheld*); and

(d) the Chief Executive issued a dismissive response to Mrs C's complaint which reflected the lack of investigation into her concerns (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence to the Ombudsman that they have reviewed their complaints handling procedure in relation to complaints about its out-of-hours service, to ensure a proactive approach is taken; and	18 July 2012
(ii) issue a full apology to Mrs C for the failures identified within this report	4 July 2012

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

Main Investigation Report

Introduction

1. Ms A is 28 years old. She was admitted to Peterhead Hospital (Hospital 1) on the evening of 8 May 2011 via ambulance. She had described symptoms of photophobia, chronic fatigue, muscle pain and persistent thirst. Prior to this, at the end of March 2011, Ms A had been admitted to Aberdeen Royal Infirmary (Hospital 2) with similar symptoms, and had been diagnosed with a viral infection.

2. Ms A was reviewed by an out-of-hours GP (the Doctor) at Hospital 1. Following a consultation with Ms A, the Doctor diagnosed a urinary tract infection, prescribed antibiotics and analgesia, and sent Ms A home. The following day, Ms A was admitted to Hospital 2, having been referred there after attending at her own GP surgery, and remained there for five days. She underwent a range of tests within the Infection Unit at Hospital 2.

3. Ms A's mother (Mrs C) complained to Grampian NHS Board (the Board) on 31 May 2011. She complained that she had been unable to speak with the Doctor about her daughter's medical history prior to the diagnosis being made. She was dissatisfied that the Doctor had diagnosed a urinary tract infection given Ms A was admitted to Hospital 2 the following day, and given she had had to undergo a range of tests during this admittance. She felt this demonstrated that Ms A had not been properly examined by the Doctor.

4. The Board responded to Mrs C's complaint on 13 July 2011 by forwarding her a direct response from the Doctor. On 25 August 2011 Mrs C wrote back to the Board via email expressing dissatisfaction at a number of aspects of the Doctor's response. She laid out this email in bullet point form. On 8 September 2011 the Chief Executive responded to this by addressing each of the bullet points in turn. Mrs C remained dissatisfied with this response and brought her complaints to my office.

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

(a) the Doctor incorrectly explained that Ms A had not presented with photophobia despite her complaining of this to a nurse, and shielding her eyes with her hood;

(b) the Doctor inappropriately failed to mention in his letter of response to Mrs C's complaint that Ms A had presented with a headache;

(c) the Doctor unreasonably reached an incorrect diagnosis; and
(d) the Chief Executive issued a dismissive response to Mrs C's complaint which reflected the lack of investigation into her concerns.

Investigation

6. In order to investigate Mrs C's complaints, my complaints reviewer reviewed Ms A's medical records, in particular the examination notes pertaining to the Doctor's consultation with Ms A at Hospital 1. She also considered the correspondence between Mrs C and the Board in relation to Mrs C's complaints, and made further enquiries of the Board, to which she received a response on 17 January 2012. My complaints reviewer also obtained advice from one of my advisers, a general practitioner (the Adviser).

7. 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 Doctor incorrectly explained that Ms A had not presented with photophobia despite her complaining of this to a nurse, and shielding her eyes with her hood

8. Ms A was taken to Hospital 1 by ambulance on the evening of 8 May 2011. Her symptoms included increasing thirst, tiredness and muscle pain. She had experienced similar symptoms in March 2011 and at that time had been admitted to Hospital 2 with suspected meningitis; however, she had been subsequently discharged later the following day with a diagnosis of a virus.

9. On the evening of 8 May 2011, Ms A arrived at Hospital 1 at approximately 21:30. She was initially assessed by a nurse (the Nurse) from the point of her admission until approximately 21:50. The Doctor thereafter examined Ms A from approximately 22:00 until 22:45.

10. Within his response to Mrs C's initial complaint to the Board, the Doctor had stated that 'Ms A did not have any overt meningism or photophobia or indeed any abnormal neurological findings'.

11. In her email to the Board of 25 August 2011, Mrs C asked why the Doctor had said in his response to her complaint (as forwarded directly to Mrs C) that Ms A had no signs of photophobia, given that when Mrs C attended at

Hospital 1, Ms A had the hood of her top pulled down over her face as she said the light was hurting her eyes. Mrs C said Ms A had asked the Nurse undertaking the initial assessment if the light could be turned down or off for that reason. Mrs C said the Nurse had said that that was not possible, and Mrs C stated this demonstrated the staff were not unaware of this symptom.

Advice obtained

12. The Adviser noted that Ms A's clinical records were in the form of an out-of -hours computer printout. He said the initial entry by the Nurse at 21:31 noted 'symptoms: weakness, tired, muscle pain, kidney pain'. In the main section, a further history was taken in two parts, the second part being preceded by the Doctor's name, suggesting that the further history was taken by the Doctor and that the first section was recorded by the Nurse, the first section including the statement '… patient has become photophobic'. The Adviser stated this suggested a history of photophobia was given to the Nurse and duly recorded, and that in his view this would have been considered by the Doctor.

13. The Adviser said the term photophobia was often recorded in triage documents; that sometimes the patient or a relative would use the term and sometimes it would be recorded by NHS 24 staff. He described it was commonly seen in a number of conditions, but recent publicity on early detection of meningitis had raised awareness of it. The Adviser explained that the degree of light sensitivity was important in clinical practice. He stated that in true photophobia, patients are sensitive to even dull ambient light and examination of the eyes is difficult because pain is induced by testing pupil reactions. He went on that a lesser degree of light sensitivity is seen in a number of conditions including viral infections, tension and cluster headaches and migraines. The Adviser concluded that in his view, although the term photophobia had been used by the Nurse in the history, it appeared the Doctor had reached the conclusion that the clinical signs of true photophobia as described above were not present in Ms A's case. The Adviser said this would also explain the use of quotations marks (ie 'photophobia') in the Doctor's subsequent notes from the consultation.

(a) Conclusion

14. In reaching a decision on this complaint, I have considered whether the Doctor was incorrect to state in his response to Mrs C that Ms A had not presented with photophobia. Although I accept Mrs C's position that Ms A had been complaining about the lights given the recordings of the Nurse in the

clinical notes, and do not doubt that Ms A had an element of sensitivity to light, I also accept that during his consultation the Doctor found that there was no clinical evidence of true photophobia, the difference between true photophobia and light sensitivity having been explained by my adviser.

15. On that basis, I do not find it unreasonable that the Doctor stated that Ms A had not presented with photophobia, therefore, I do not uphold this complaint. I note that it would have been preferable if the response to Mrs C's complaint in this regard had been clearer and had explained the issue of photophobia more fully; however, the complaints handling aspect of this case will be considered later within my report.

(b) The Doctor inappropriately failed to mention in his letter of response to Mrs C's complaint that Ms A had presented with a headache

16. In her email to the Board, Mrs C also complained that in his response to her initial complaint the Doctor had failed to mention that Ms A had presented with a headache. Mrs C said that at the time the Doctor had advised her to give Ms A paracetamol for this when they got home. In her complaint to this office, Mrs C also stated that Ms A's subsequent admission to Hospital 2 the following day had been due to a 'violent headache'.

17. In his letter of response to Mrs C's complaint, the Doctor had stated the symptoms he had noted during his consultation with Ms A, which he said had been a 'history of tiredness, feeling week (sic), passing urine more frequently than normal, bilateral renal angle pain and blood on urine dipstick testing'.

Advice obtained

18. The Adviser noted that the Doctor had used the term 'sore head' in his section of Ms A's clinical history, and stated that it was thus logical that the response to Mrs C's complaint should have contained a full exposition of the clinical history as recorded in the contemporaneous notes.

(b) Conclusion

19. The issue raised in this complaint is straightforward – the response to Mrs C's complaint should have contained all the relevant information about Ms A's clinical presentation and symptoms, particularly given the basis of the complaint. The presence of a headache was noted in Ms A's records, and Mrs C was given instructions to give Ms A analgesia to treat this, yet this symptom was not mentioned in the response to Mrs C's complaint. For that

reason I uphold this complaint. This issue again bears significance to the manner in which Mrs C's complaints were responded to in general, which as previously stated will be dealt with later in my report.

(c) The Doctor unreasonably reached an incorrect diagnosis

20. Mrs C complained that following Ms A's consultation she had attempted to speak with the Doctor about Ms A's previous clinical history, but that he had refused to speak with her. She also explained that she was a nurse with 40 years experience, and had never heard of a urinary tract infection presenting with photophobia, a stiff neck and headache, especially as there was only blood in Ms A's urine rather than, for example, leucocytes, nitrates or protein. Mrs C also noted the Doctor had made no reference to Ms A's persistent thirst. Mrs C also stated that a sample of Ms A's urine which had been taken that night for culture and sensitivity testing had come back as negative. Mrs C explained that Ms A had undergone a range of tests during her subsequent admission into Hospital 2, including a lumbar puncture to exclude viral meningitis, a Computerised Tomography scan of her head, and blood cultures. Mrs C also explained Ms A was placed on an increased amount and quantity of analgesia. Mrs C concluded it was just as well she had taken Ms A to see another doctor the following day, to 'ensure that she had correct medical care'.

21. The Board asked the Doctor to respond to Mrs C's complaints. He stated that on that evening he had not had time to listen to Ms A's full history again as relayed by Mrs C, as he had spent a considerable length of time speaking with Ms A herself, during which he described Ms A as 'perfectly able' to give a full and comprehensive history, and to explain about her previous admission in March 2011, investigations and ongoing management. The Doctor said he had explained Ms A's physical findings to Ms A, as well as his diagnosis and management plan. The Doctor said he understood Mrs C was concerned for Ms A, and said he realised Mrs C had disagreed with his management plan and felt Ms A should be admitted to hospital.

22. The Doctor went on that Mrs C's suggestion in her original complaint that he needed a 'refresher course in diagnostics' was 'frankly absurd'. He said he agreed with Mrs C's position that she had never heard of a urine infection presenting with 'photophobia, a stiff neck and headache'. He went on that Mrs C had not been present during the consultation, during which (as noted within complaint (b)) Ms A had given a history of 'tiredness, feeling week (sic), passing urine more frequently than normal and had bilateral renal angle pain

coupled with blood on urine dipstick testing'. He stated that on that basis his diagnosis of a urinary tract infection was a very reasonable working diagnosis. He also stated that Ms A 'did not have any overt meningism or photophobia or indeed any abnormal neurological findings. Her chest was also clear, she was haemodynamically stable and I thought had a large psychological overlay to her whole presentation'. The Doctor went on that he did not think Ms A had been unwell enough to admit to hospital, and stated that the fact Ms A's subsequent extensive investigations were all normal 'further supports my clinical accuracy and diagnostic skills'.

23. The Doctor also stated he had suggested to Ms A she could either attend him or her regular GP for a follow-up appointment, and that at the time Mrs C and Ms A had appeared happy with this arrangement.

Advice obtained

24. The Adviser considered the consultation between Ms A and the Doctor by referring to the clinical notes. He noted that the consultation was recorded as 48 minutes, and commented that this was lengthy, particularly for an out-of-hours consultation. He said it could be reasonably inferred that such a consultation would have involved a full discussion of the symptoms and time for clinical examination. The Adviser said the notes of the clinical history appeared to capture the salient points including details of the recent admission. He went on to consider the examination notes, and said they recorded basic parameters; no fever was recorded, and pulse and blood pressure were normal. The Adviser noted the term 'sl odd affect' was used – he stated this was a comment on Ms A's mood, ('affect' meaning mood) suggesting it was 'slightly odd'. The Adviser said this was not a clinical term and no amplification of this finding was given.

25. The Adviser noted that pupil reactions were tested, and the finding of 'no overt meningism' was recorded. The abdomen was examined and some tenderness in the kidney area was noted. The urine was tested and a trace of protein was detected, and there was no note of other abnormalities in the urine. The Adviser said he noted that Mrs C's complaint had stated there had been blood in the urine, but this was not confirmed in the contemporaneous record. The Adviser also noted that the nursing admission note showed a finding of blood in the urine, and that the clinical history taken suggested Ms A was menstruating at that time. The Adviser commented that no menstrual history was present in the consultation notes.

26. The Adviser said that in the first instance he found the history taken to be reasonable, with key issues recorded. He said the examination findings were reasonable in terms of the basic parameters, but lacked details in terms of the abdominal examination and neurological assessment. He said a comment was made regarding 'speech normal', but no other mental state examination was made.

27. The Adviser stated that on one level the diagnosis of a urinary tract infection was reasonable, given there was renal angle pain and tenderness on examination, and therefore, was not incorrect as such. He said that on this basis the Doctor had assessed the symptoms presented in good detail and had performed appropriate examinations, and that the decision to prescribe the antibiotic trimethoprim at the dosage noted was reasonable, as were the follow up arrangements mentioned. The Adviser went on, however, that some of the symptoms were consistent with general malaise or infection, although he did note that at the same time no fever or fast pulse had been present. He said that although the diagnosis of a urinary tract infection was supported by the findings recorded, it was not the only possibility. He said that given the level of symptomatology present, he would have expected consideration of other diagnoses, particularly given the recent history of a previous admission. He said there was little evidence of any further consideration of this nature in the clinical records, that there was a lack of examination detail in some aspects, and that the overall care in this regard was deficient.

28. The Adviser also considered Mrs C's request to discuss Ms A's condition and symptoms with the Doctor. The Adviser noted that both accounts of events of that evening referred to this request. The Adviser said this had been refused by the Doctor, and no clear reason for that had been given. The Adviser said he acknowledged that there had already been a lengthy consultation and that the exchange took place late in the evening, but that nevertheless this was difficult to understand. He concluded from the information available to him that the refusal of the Doctor to discuss the case with Mrs C was not reasonable. He said that Mrs C's concerns should have alerted the Doctor to a lack of agreement of the management plan (which the Doctor had already acknowledged) and should have prompted reflection of this. The Adviser said that such reflection may have prompted a different management plan, but even if this reflection resulted in no changes to the plan, this process would have allowed reassurance of all concerned. He also commented that such improved

communications with Mrs C may have prevented a need for escalation of the complaint.

(c) Conclusion

29. In considering this complaint, which is that the Doctor unreasonably reached an incorrect diagnosis, I accept that in general the Doctor performed an adequate examination and formulated a reasonable management plan. The advice given to me is that the diagnosis of a urinary tract infection was reasonable given the symptoms described of renal angle pain and tenderness in the kidney area, and was supported by the findings recorded. On that basis, I do not uphold this complaint.

30. However, the advice I have received indicates that more consideration could have been given to other diagnosis possibilities, and that some aspects of the examination could have been given more attention. This is particularly so given Ms A's very recent previous admission with similar symptoms, and has led my adviser to conclude that the care was lacking in this respect.

31. I have also noted the Doctor's refusal to discuss Ms A's case with Mrs C. Although I accept the Doctor had spent some considerable time with Ms A, it was reasonable of Mrs C to expect to be able to discuss her concerns with him. Whilst not upholding the complaint, I would draw these comments to the attention of the Doctor and the Board.

(d) The Chief Executive issued a dismissive response to Mrs C's complaint which reflected the lack of investigation into her concerns

32. Mrs C received the first response to her complaint on 13 July 2011. This consisted of a cover letter from the Chief Executive of the Board, stating he enclosed the Doctor's response. The cover letter also stated 'I hope the enclosed information answers your concerns and reassures you that [the Doctor] treated your daughter appropriately with the symptoms she presented with at the time'. The Board had thereafter enclosed a photocopy of a letter written by the Doctor, much of the contents of which has already been referred to within this report. At the bottom of this letter, the Doctor had stated 'I would like [this reply] to be sent to the complainant verbatim and unaltered'.

33. On 25 August 2011 Mrs C responded via an email to a member of the Board's Feedback Service, as she had been directed to do within the Chief Executive's cover letter in the event that she had any remaining concerns. She

raised eight further questions in bullet point form. The Feedback Service asked the Doctor, also via email, for comment on these further questions. The Doctor responded by providing an answer to each of the bullet points in the corresponding order. Three of the responses stated 'as per my letter of reply'. On 8 September 2011, a further letter was sent to Mrs C, signed by the Chief Executive. This letter was a verbatim copy of the email the Doctor had sent back to the Feedback Service.

34. When investigating Mrs C's complaints, my complaints reviewer wrote to the Board asking whether they would usually allow an individual member of staff to respond directly to a complaint made about them to the Board, or whether the Feedback Service would be expected to draft a response on behalf of the Board explaining the staff member's position. The Board responded that the Doctor was a self-employed, independent GP contractor working for the Board's out-of-hours service, and that it was his specific request that his response was sent unaltered to the complainant. They said this request was accepted given that the complaint was a personal one against him. They confirmed the usual practice would be for a response to a complaint to be drafted by the Feedback Service and signed by the Chief Executive.

Advice obtained

35. The Adviser said he did not accept the Board's position that the Doctor was allowed to respond directly because the complaint was about him personally. He noted that the Doctor was working on a sessional basis within the Board's own managed service, and the complaint had been accepted and handled within the NHS complaints procedure. The Adviser said he had studied the Doctor's response carefully, and noted it failed to acknowledge the concerns expressed and could be summarised as 'I am right: you are wrong'. The Adviser stated that in terms of a technique for complaints handling this was poor. He was surprised that the Board allowed this response to be sent to a complainant unaltered, and said that the Doctor's request that the response be sent unaltered should have been the subject of some discussion, and that it should have been the decision of a manager within the Feedback Service as to the final content of the response.

36. The Adviser also commented that given the second response to Mrs C was an unaltered 'cut and paste' copy of the Doctor's email correspondence, there was no evidence of any formal discussion or investigation of the case. Given the protracted nature of the complaint and the fact that Mrs C was not

satisfied with the initial response from the Board, he stated it would have been reasonable for a meeting or further discussion to have taken place.

37. The Adviser also commented that there appeared to be a simple acceptance of the Doctor's version of events, and that the Board's stance was reactive even when the first response did not satisfy Mrs C. The Adviser concluded the complaints handling was poor and the decision to allow the verbatim account by the Doctor to be sent unaltered was highly questionable, and undoubtedly caused Mrs C offence and further frustration.

(d) Conclusion

38. This is one of the poorest examples of complaints handling I have seen. It appears that the Board took the position that given the Doctor was an independent GP contractor, and the complaint was about him, they would merely send the Doctor's response to Mrs C directly. At the same time, the Doctor was providing a service via the Board's own managed service, and the Board had accepted the complaint was suitable for the NHS complaints procedure. On that basis, it is not acceptable that the Board simply allowed the Doctor to respond directly, without any effort to formulate a more appropriate response on behalf of the Board.

39. The tone of the Doctor's letter was defensive and abrupt. I appreciate that the Doctor may have found this a difficult and challenging situation to deal with given the issues raised in the initial complaint, and I consider that the Board itself should have taken the decision not to forward this letter on to Mrs C despite the Doctor's request. I share my adviser's surprise that this happened. The Board should have taken responsibility for carefully considering his comments as part of their investigation. One of the purposes of a complaints handling procedure, and of a specific team to deal with complaints, is to allow for detailed and impartial investigation of complaints brought, in an effort to acknowledge and resolve concerns, demonstrate fairness, provide full explanations, acknowledge and apologise for any shortcomings identified, and to advise of steps taken to prevent future recurrences, again when appropriate. The way in which this complaint was dealt with did not allow for any of this to happen, and resulted in Mrs C's complaint escalating.

40. I am also concerned by the second response of the Board to Mrs C. Again, this demonstrated a lack of investigation into and dismissal of the concerns raised by Mrs C, and an acceptance of the position of the Doctor.

41. The NHS Complaints Procedure guidance[1] states that 'It is important to ensure impartiality in an investigation. The investigation must not be adversarial and must be conducted in a supportive, blame free atmosphere that demonstrates the principles of fairness and consistency'. Both of the Board's responses failed to adhere to these standards.

42. For all of the reasons given I uphold this complaint. As will be clear from my findings, I am very critical of the Board for their failings in relation to the handling of Mrs C's complaint. I would expect the Board to adhere to much higher standards in relation to their complaints handling than those demonstrated in this case, and have two recommendations to make.

(d) Recommendation

43. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman that they have reviewed their complaints handling procedure in relation to complaints about its out-of-hours service, to ensure a proactive approach is taken.	18 July 2012

General Recommendation

44. I recommend that the Board:	*Completion date*
(i) issue a full apology to Mrs C for the failures identified within this report.	4 July 2012

45. 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.

[1] Scottish Government's NHS Complaints Procedure guidance: *'Can I Help You?: Learning from Comments, Concerns and Complaints',* section 60

Annex 1

Explanation of abbreviations used

Ms A	The aggrieved
Hospital 1	Peterhead Hospital in Grampian
Hospital 2	Aberdeen Royal Infirmary
The Doctor	The out-of-hours GP based at Hospital 1
Mrs C	The complainant and the aggrieved's mother
The Board	NHS Grampian
The Adviser	The Ombudsman's GP adviser
The Nurse	The nurse who initially examined Ms A upon her admission

Annex 2

Glossary of terms

Analgesia	Pain relief without loss of consciousness
Bilateral renal angle pain	Pain in the area of both kidneys
Haemodynamically stable	The circulation of blood round the body is stable
Leucocytes	White blood cells
Lumbar puncture	A procedure in which cerebrospinal fluid is removed from the spinal canal for diagnostic testing or treatment
Meningism	A condition in which signs and symptoms suggest meningitis, but clinical evidence for the disease is absent
Photophobia	A condition in which the eyes are extremely sensitive to light, possibly causing pain and tearing