Scottish Parliament Region: South of Scotland

Case 201201464: Borders NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency; clinical treatment; diagnosis

Overview

The complainant (Mrs C) questioned the care and treatment given to her late husband (Mr C) on 3 October 2011. Mr C died early the next day.

Specific complaints and conclusions

The complaints which have been investigated are that staff at the Accident and Emergency (A&E) Department of Borders General Hospital (the Hospital):

(a) failed to thoroughly assess and treat Mr C during his first attendance on 3 October 2011 *(upheld);* and

(b) unreasonably discharged Mr C home on 3 October 2011 *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise sincerely to Mrs C for their failures concerning the care and treatment given to Mr C; and	20 March 2013
(ii) apologise to Mrs C for unreasonably discharging Mr C on the evening of 3 October 2011.	20 March 2013

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

Main Investigation Report

Introduction

1. Mrs C is the widow of Mr C, who died on 4 October 2011 as a consequence of a ruptured abdominal aortic aneurysm. On the evening of 3 October 2011, Mr C, who was aged 70 at the time, was admitted to the Accident and Emergency (A&E) Department of Borders General Hospital (the Hospital) but was later discharged home. It was thought that he had a Urinary Tract Infection (UTI). Later, the same evening, Mr C was readmitted to A&E as an emergency. His diagnosis was unclear but after a scan it became evident that Mr C had suffered a ruptured abdominal aortic aneurysm and he died at 03:29 on 4 October 2011.

2. The complaints from Mrs C which I have investigated are that staff at A&E Department of the Hospital:

(a) failed to thoroughly assess and treat Mr C during his first attendance on 3 October 2011; and

(b) unreasonably discharged Mr C home on 3 October 2011.

Investigation

3. As part of the investigation, all the information provided by Mrs C and by Borders NHS Board (the Board) has been given careful consideration. This included all the complaints correspondence and Mr C's relevant clinical records. An independent clinical opinion was obtained from an Emergency Medicine specialist adviser (the Adviser) and this too has been taken into account.

4. 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 have been given an opportunity to comment on a draft of this report.

(a) Staff at the A&E Department of the Hospital failed to thoroughly assess and treat Mr C during his first attendance on 3 October 2011

5. Mrs C said that on the evening of 3 October 2011 Mr C became ill and lost consciousness. She and her son, therefore, called an ambulance and Mr C was taken urgently to the Hospital. He was admitted to A&E where he was examined by a doctor (Doctor 1) and, after examination, it was concluded that Mr C had a UTI. He was sent home with antibiotics and painkillers and with the advice that if they were anxious at any time to bring Mr C straight back to A&E. Mrs C said that within a short time of their return home, Mr C was again

experiencing a great deal of pain and started to lose consciousness once more. An emergency call was made and Mr C was returned to the Hospital.

6. Mrs C followed the ambulance with her son and said that when they arrived there was some confusion about Mr C's condition but later she was advised that Mr C had suffered an aneurysm and that there was little the Hospital could do for him as surgery could only be performed in Edinburgh. Regrettably, Mr C died at 03.29 on the morning of 4 October 2011.

7. Mrs C was concerned at the circumstances of Mr C's death and on 14 November 2011 she complained to the Board. She questioned the care and treatment he received and said that more should have been done for him at his first visit. She believed that he should have been scanned and said that Doctor 1 did not give Mr C a proper examination. Mrs C stated that she had difficulty in accepting that Mr C should have been allowed to go home because even she could see that his blood pressure was very low.

The Board's comments

8. The Board's Chief Executive replied to Mrs C's complaint by letter of 13 December 2011. He said that Doctor 1 was a very experienced member of the medical staff within the Emergency Department and that as part of the Board's investigations, Doctor 1 had made a full clinical report providing the details of his examination, diagnosis and treatment of Mr C. This was provided for Mrs C's information.

9. Doctor 1's recollection of events was that as the Emergency Department Speciality Doctor on duty, he saw Mr C about an hour after he was admitted to A&E (at about 22:00). He said that Mr C had been admitted with sudden onset sharp, lower, left sided abdominal pain which caused nausea and vomiting and an episode of collapse. Mr C was pale on arrival with a low blood pressure (BP) in the 90s/70s. At that time he was noted not to be in distress and his BP was in the 120s/80s. Doctor 1 said that Mr C's only reported medical problem was hypotension. Given this history and a physical and urine test, Doctor 1 said he made a diagnosis of cystitis, and/or possible early pyelonephritis (kidney infection). He said that he discussed Mr C with the triage nurse concerned to ensure that she had not seen or heard anything of concern and that his diagnosis of Mr C's condition and the treatment plan proposed sounded prudent. He said that when Mr C was discharged, he was in no apparent distress.

10. Doctor 1 said that Mr C was brought in later the same night in respiratory arrest after a sudden onset of severe pain which was described as 'both much worse than and different quality to the previous episode'. The Chief Executive added in his letter, in relation to this, that when Mr C was readmitted, senior doctors for Surgery and Anaesthetics were called to assess him but his diagnosis was unclear. The Chief Executive said that it was only when a Consultant Radiologist scanned Mr C's abdomen that it became apparent he had a ruptured abdominal aortic aneurysm. However, the Board acknowledged that Mrs C may still have had questions to ask about Mr C's treatment and, therefore, offered to arrange a meeting for her with staff.

11. Mrs C was not happy with the response and so she wrote again on 16 January 2012. She considered that Doctor 1's report contained inaccuracies and she contested whether Mr C had been fully assessed and examined on his first admission. She questioned the reasons why he had not been transferred to another hospital for an operation. Mrs C said that she awaited the Board's further comments but felt that a meeting should be arranged.

12. A meeting took place on 20 March 2012 between Mrs C and her son and a senior clinician from the Emergency Department (Doctor 2) together with a senior manager. The Chief Executive wrote on 5 April 2012 to confirm the details of what had taken place: Doctor 2 had checked Mr C's health care record. He said that, with hindsight, he had concluded that there were symptoms present which could have indicated an aneurysm but other symptoms indicated another cause. He said that although Mr C's cause of death was a ruptured abdominal aortic aneurysm, it was likely that the actual rupture was of the iliac artery, which was the large artery coming from the aorta. He added that this was a rare type of aneurysm, accounting for only 2 percent of all inter abdominal aneurysms. He said they were difficult to diagnose and that in Mr C's case it required a consultant radiologist to be called in to make the diagnosis. In response to Mrs C's claim that Mr C should have been scanned on his first admission, Doctor 2 said that it was not routine to scan all patients presenting with abdominal pain and that the decision on whether or not to do so would be a matter of clinical judgement, based on the patient's symptoms at the time and the doctor's clinical findings. He added that if a scan had been taken, it would have been likely to have identified an aneurysm but he went on to tell Mrs C that there was an 85 percent fatality rate in patients suffering ruptured abdominal aneurysms. Nevertheless, Doctor 2 said that as a result of Mrs C's

concerns he had taken steps to raise awareness of the symptoms and signs of a ruptured abdominal aortic aneurysm, not only in the Emergency department but throughout the region. He had also conducted several teaching sessions on the subject with medical and nursing staff and had written to all local GPs.

Advice received

13. My complaints reviewer obtained independent clinical advice about the complaint and the Adviser told her that Mr C was a 70-year-old man who had a history of hypertension (high blood pressure). He said that when Mr C was admitted to the Hospital on the evening of 3 October 2011, he was assessed by a triage nurse who recorded that he looked pale and hypotensive. His BP was 96/71, his pulse was 60 and his temperature 36, oxygen saturation 94 percent. The Adviser said that Mr C's respiratory rate and pain score were not recorded; nor was the time of triage, the effect of analgesia (he was given moderate pain analgesia at 21:40) or his triage category (the urgency of need to be assessed by a doctor).

14. The Adviser explained that, in his view, the presence of hypotension at triage placed Mr C in the 'immediate' (red) triage category requiring immediate referral to and assessment and treatment by a doctor who would then update the records accordingly. He said that his review of Mr C's clinical notes did not show that this had taken place and there was not an appropriately detailed history and examination note. Rather, in his view, the records were limited and rudimentary. He said that the contemporaneous documentation did not provide information to show that Mr C's hypotension had been addressed either by the triage nurse or by the attending doctor. In the Adviser's view, the notes recorded for Mr C were not fit for purpose to properly assess him and exclude critical pathology (the science of the cause and effect of diseases). He added that these shortcomings could have been expected to have contributed to the failure to diagnose the abdominal aortic pathology.

15. In this connection, it was further explained that it was established medical practice in Emergency Medicine that when a patient's illness had reached the stage where they sought help of, or attended, an Emergency Department (particularly when presenting by emergency ambulance), the presenting complaint was assumed to be due to substantive pathology until proven otherwise. The Adviser went on to say that on Mr C's first admission, the diagnosis of cystitis was not in itself incompatible with the limited information recorded but it was not reasonable overall as there should have first been an

exclusion of more serious pathologies. He said that the available notes did not demonstrate that this occurred and so, in his view, there was no evidence that this issue was addressed. The Adviser's view was that it would have been appropriate, on this first admission, to have considered a diagnosis of abdominal aortic pathology in Mr C's case, in light of his history of acute abdominal pain, faint/collapse, hypotension on arrival, past history of hypertension and his age. He said he would have expected this to have led to intravenous access being established, with administration of intravenous fluids and an urgent ultrasound being arranged. It was the Adviser's view that an ultrasound scan should have been taken to rule in or out what could have been a serious and life threatening pathology.

16. The Adviser's professional opinion was that the treatment given to Mr C was not reasonable, as a more serious pathology had not been ruled out. In the circumstances, his discharge was neither reasonable nor appropriate. He went on to say that the indications in Mr C's clinical record and his discharge letter were that Doctor 1 attributed the hypotension to Mr C's medication. While the Adviser agreed that this was one of the possible causes of hypotension, it was essential, first of all, to exclude more serious pathologies. He said there was no evidence in the contemporaneous medical records that this had been addressed.

(a) Conclusion

17. Mrs C was of the clear view that Mr C was not properly assessed on his first admission to hospital on 3 October 2011. The Board's view was that, with hindsight, Mr C did have symptoms which could have indicated an aneurysm but that the type of aneurysm experienced by Mr C was difficult to diagnose. They said he had other symptoms and, ultimately, it required the expertise of a consultant radiologist to diagnose an aneurysm. Furthermore, it was not routine procedure to scan all patients with abdominal pain. This decision was for the doctor concerned, using his clinical judgement.

18. However, the advice given to my complaints reviewer was that when a patient presented as an emergency complaining of the symptoms Mr C was experiencing, in diagnosing him it was necessary to first exclude the most serious pathologies. The Adviser said that there was no evidence this had happened. Although hypotension was also identified when Mr C first arrived in the Hospital, the Adviser stated that this was not addressed either by the triage nurse or Doctor 1. The documented history fell short of what could have been

expected, as did the documented examination. There was no evidence in the contemporaneous A&E medical records that serious pathology was sought and excluded, prior to diagnosing cystitis and hypotension secondary to antihypertensive medication. It was the Adviser's opinion that this diagnosis lacked weight and credibility, in the light of the rudimentary history and examination.

19. Careful consideration has been given to all the available evidence and, while I noted the Board's comment about hindsight (see paragraph 12), the advice given was that in determining a diagnosis the most serious possibilities should be excluded first. There was no evidence that this had happened despite, the Adviser said, Mr C having symptoms (and being of an age) which suggested to him that intravenous fluids and an urgent ultrasound were appropriate. The Adviser also commented that Mr C's medical notes were 'limited and rudimentary' and not fit for the purpose of assessing him and to exclude critical pathology. It was his view that these contributed to the failure to diagnose Mr C's condition properly on his first hospital admission on 3 October 2011. In view of this advice, I uphold Mrs C's complaint.

20. The Board should now apologise sincerely to Mrs C for their failures concerning the care and treatment given to Mr C. However, in providing his advice to me, the Adviser maintained that while the outcome was that Mr C's diagnosis was delayed and an opportunity was lost to possibly achieve a better outcome for him, Mr C may well have died regardless of the timing of the diagnosis and treatment. However, earlier intervention might have improved the possibility of survival.

21. The Adviser also commented about the steps the Board had put in place as a consequence of Mrs C's complaint (see paragraph 12) and it was his view that they were both reasonable and fit for purpose. This being the case, I have no further recommendations to make with regard to this complaint.

(a) Recommendation

22. I recommend that the Board:	*Completion date*
(i) apologise sincerely to Mrs C for their failures concerning the care and treatment given to Mr C.	20 March 2013

(b) Staff at the A&E Department of the Hospital unreasonably discharged Mr C home on 3 October 2011

23. Mrs C considered that Mr C's condition was such that he should not have been discharged home on 3 October 2011 and she raised this with the Board when she first complained to them about the care and treatment given to Mr C in November 2011. The Board replied that they were always concerned when a patient was readmitted to the Emergency Department and that staff were very concerned when a patient died in their care. In the circumstances, the Board said, the Emergency Department Team and colleagues had reviewed all the events, processes and information in respect of Mr C's care, diagnosis and treatment with a view to ensuring that actions were taken to improve services. They said that this included information and training for all staff, sharing learning and ensuring that staff had access to all the guidelines and policies they needed.

24. I have already concluded in complaint (a) that Mr C's care and treatment was not as it should have been. The decision to discharge him was made on the basis of his recorded diagnosis (cystitis and hypotension secondary to hypertensive medication – see paragraph 9). However, his discharge was not reasonable or appropriate before excluding more serious pathologies. In reviewing this aspect of the complaint, the Adviser expressed the view that the indications in the clinical records and discharge letter were that Doctor 1 attributed Mr C's hypotension to Mr C's medication and while this was one possibility, it should have been essential to first exclude other, more serious, possible diagnoses.

(b) Conclusion

25. On the basis that I have already found that the Board failed to thoroughly assess and treat Mr C on the evening of 3 October 2011, it follows that it was not appropriate to discharge him. I, therefore, uphold Mrs C's complaint that Mr C was unreasonably discharged that night.

26. The apology provided to Mrs C (see paragraph 22 (i)) should also apologise to her for this and for the distress and anxiety this caused her. However, as before, I make no recommendations given the advice that the actions since taken by the Board in response to Mrs C's complaint were reasonable.

(b) Recommendation

27. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for unreasonably discharging Mr C on the evening of 3 October 2011.	20 March 2013

28. 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
Mr C	The complainant's late husband
A&E	Accident and Emergency
The Hospital	Borders General Hospital
UTI	Urinary Tract Infection
The Board	Borders NHS Board
The Adviser	The independent clinical adviser
Doctor 1	The receiving doctor in the Emergency Department
BP	Blood pressure
Doctor 2	The Clinical Lead of the Emergency Department

Annex 2

Glossary of terms

Aortic aneurysm	the aorta is the main artery to the left side of the heart. An aneurysm is a bulge which can occur in the wall of the aorta
Hypertension	high blood pressure
Hypotension	low blood pressure
Pathology	the science of the cause and effect of diseases
Pyelonephritis	kidney infection