SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Central Scotland

Case ref: 201601215, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary

Mrs C complained about the care and treatment provided to her brother, (Mr A) by Lanarkshire NHS Board (the board). Mr A had been experiencing pain in his legs, feet and ankles. He was referred to the deep venous thrombosis (DVT) service at Hairmyres Hospital (the hospital) by his general practitioner and DVT was ruled out as a cause of his symptoms.

Mr A later had a circulation assessment at one of the board's community clinics (the clinic). Staff at the clinic were unable to find a pulse in Mr A's foot. Attempts were made to contact the vascular service at the hospital by telephone but there was no reply and a message was left on an answering service. Mr A returned home. Five days later, however, one of his toes turned black and Mrs C took him directly to the hospital.

A scan showed that Mr A had a blockage in one of the arteries in his thigh and a procedure was suggested to remedy this. The procedure was not carried out for a further three days during which time Mr A became increasingly unwell. This deterioration continued after the procedure and Mr A had to undergo an above the knee amputation of his leg.

During our investigation, we took independent advice from a consultant physician and a vascular surgeon. While we found no issues with the DVT service examination, we identified that the referral pathway from the clinic to the vascular service had failed. We found that this and the delay in conducting the procedure meant that the board had failed to take appropriate, timely action to try to save the limb. While unable to definitively determine that the loss of Mr A's leg was avoidable, we considered more urgent action would have given him the best chance of a different outcome. We upheld Mrs C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mrs C and Mr A:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
The referral pathway from the Claudication Clinic to the Vascular Service failed for Mr A	Provide a written apology which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter By: 16 August 2017
There were delays in the provision of appropriate treatment to Mr A	Provide a written apology for the delays and the impact this had on Mr A's prospects which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter By: 16 August 2017

We are asking the Board to improve the way it does things:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
The referral pathway from the Claudication Clinic to the Vascular Service failed for Mr A	Ensure it has in place an effective referral pathway which has a failsafe, so that urgent appointments are arranged when needed	Evidence that the referral pathway for urgent care of critical ischemia from the Claudication Clinic to the Vascular Service has been reviewed and, where needed, improved By: 11 October 2017

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
There were delays in the provision of appropriate treatment to Mr A	Ensure timely action is taken when treating critical limb ischemia	Evidence that this case has been reviewed for learning and improvement within the Vascular Service. This should include any action, or planned action, to apply learning identified By: 11 October 2017

Feedback for the Board

Adviser 2's comments on the subjectivity of clinical judgement in assessing pulses should be circulated to relevant staff for learning purposes.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned.

Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C and her

brother, to whose care the complaint relates, as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to my office about the care and treatment provided to her brother (Mr A). Her concerns related to pain that Mr A was experiencing in his legs, feet and ankles.

2. The complaint I have investigated is that Lanarkshire NHS Board (the Board) failed to provide Mr A with appropriate clinical treatment for his reported leg problems (*upheld*).

Investigation

3. My complaints reviewer carefully considered all the information provided by Mrs C and the Board. Independent medical advice was also obtained from a consultant physician (Adviser 1) and a consultant vascular surgeon (Adviser 2).

4. In this case, I have decided to issue a public report on Mrs C's complaint due to the significant personal injustice suffered by Mr A and failures in the referral care pathway, highlighted by the investigation.

5. This report includes the information required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but can confirm all of the information provided during the course of the investigation was reviewed. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed to provide Mr A with appropriate clinical treatment for his reported leg problems

Background

6. Mr A began to experience pain in his legs, ankles and feet which worsened whilst he was walking. He visited his general practitioner (GP) a number of times regarding these symptoms. At one of these consultations, on 8 September 2015, Mr A reported pain in his calves and swelling in his right foot. Following examination, the GP sent a routine referral to the Board's Community Claudication Clinic (the Claudication Clinic) for his circulation to be assessed. Claudication is a term used to describe cramp-like pain caused by interference with the blood supply to the muscles of the legs. Intermittent claudication can cause severe pain in the legs when walking.

7. Mr A attended his GP practice again the following day, 9 September 2015, complaining of issues with his right calf. He was referred directly to the Board's Deep Venous Thrombosis (DVT) service at Hairmyres Hospital (the Hospital).

8. Mr A was seen by a consultant physician (Consultant 1) at the DVT service that day. Following examination, Consultant 1 ruled-out DVT as a cause of Mr A's symptoms. Consultant 1 recorded that Mr A's pulses were normal and that there was no evidence of a clot in his leg.

9. On 29 September 2015, Mr A was seen at the Claudication Clinic. The nursing staff who assessed Mr A were unable to find the pulse in his right foot and attempts were made to contact the Vascular Service at the Hospital by telephone. There was no answer and so a message was left on the answering service. Mr A returned home.

10. On 4 October 2015, Mrs C took Mr A to hospital as one of his toes had turned completely black. Following admission, he was seen by a consultant vascular surgeon (Consultant 2). Consultant 2 found that Mr A was suffering from severe critical limb ischemia (obstruction of the arteries that reduces blood flow to the extremities) and the start of gangrene (a serious condition where loss of blood supply causes body tissues to die) in his toe.

11. A special type of scan (a computerised tomography (CT) angiogram) was carried out to examine Mr A's blood vessels on 5 October 2015. This showed that he had a blockage in the superficial femoral artery (one of the arteries in the thigh) and arterial disease in the vessels from the knee to the toes.

12. The scan report suggested that an attempt could be made to open up the artery using a balloon inserted into the vessel (a procedure known as angioplasty). This report was reviewed by a vascular specialist registrar (the Registrar) on 5 October 2015.

13. Mr A started to become more unwell and developed signs of sepsis (a serious complication of infection). Antibiotics were administered to treat this and Mr A's angioplasty took place on 8 October 2015.

14. Sadly, the deterioration continued and Mr A had to undergo an above the knee amputation of his right leg on 11 October 2015.

15. Mr A was shocked by the loss of his leg and Mrs C wrote to the Board to complain in a letter dated 28 October 2015. This was acknowledged on 2 November 2015 and an interim response was sent on 30 November 2015.

16. The Board issued its complaint response on 9 December 2015. Mrs C wrote to the Board again on 2 May 2016 highlighting some outstanding issues and a further response was issued on 10 June 2016. Mr A and Mrs C remained dissatisfied with the outcome of their complaint and brought their concerns to my office for further investigation.

Key concerns

17. Mrs C complained that Consultant 1 had dismissed Mr A's concerns about pain, discolouration and weak pulse in his right leg at the DVT service on 9 September 2015. Mrs C questioned why Mr A had been allowed to leave the Claudication Clinic on 29 September 2015 when staff had been unable to locate a pulse, rather than advising that he should go to hospital. Mrs C was concerned that action had not been taken swiftly enough following the scan on 5 October 2015 and considered that the outcome for Mr A might have been different if action had been taken earlier in his patient journey.

The Board's response

18. The Board advised that, on 9 September 2015, Mr A was referred to the DVT service at the Hospital by his GP. It explained that Mr A was initially assessed by nursing staff who took blood for routine investigations and also for specific DVT testing, including d-dimer (a test which measures a substance that is released when a blood clot breaks up). The Board went on to say that Consultant 1 assessed Mr A on receipt of the test results and noted that he was complaining of discomfort/swelling in his right leg. It advised that Consultant 1 found no evidence of swelling or any real tenderness. The d-dimer test was negative and the Board said that this ruled out a DVT. The Board commented that Consultant 1 had noted Mr A had chronic leg pain which hurt when he walked but that, on examination, his peripheral pulses were normal, with nothing to suggest that his discomfort was due to major impairment of the blood supply. The Board advised that there was no evidence of problems with blood supply to the toes and that Mr A had been asked to contact his GP should his symptoms worsen.

19. In relation to the Claudication Clinic, the Board confirmed that on 29 September 2015 it was not possible to obtain pulses. It went on to advise

that it is normal practice and in line with the Board's referral pathway for a telephone referral to be made to the Vascular Service for an urgent appointment. The Board said that as there was no reply to the telephone call, a message was left on the answering machine. It went on to say that Mr A had been reassured that the message would be followed up the next day and he would be contacted regarding an appointment. The Board explained that the Claudication Clinic secretary was contacted the next day. It also said that the member of nursing staff who saw Mr A at the Claudication Clinic received advice that the Vascular Service secretary was on holiday. The Board explained that the Claudication Clinic secretary advised that she would arrange the appointment and contact Mr A.

20. The Board apologised for the distress that this process had caused and hoped the explanation provided reassurance that staff had followed the correct procedures in making an urgent referral to the Vascular Service.

21. The Board advised that on 4 October 2015, Mr A had been seen by Consultant 2 and that it was very evident that he was suffering from severe critical limb ischemia which was not acute but that his toe was becoming gangrenous. It explained that, in such cases, it is necessary to carry out imaging to determine the nature of the arterial blockage and that this was best done by CT angiogram (imaging scan to visualise the blood vessels of the arterial system). The Board advised that this was arranged urgently and was performed on the afternoon of 5 October 2015, revealing a long blocked superficial femoral artery in the arteries from the knee down to the toes. It considered that multi-level arterial disease of this nature is rarely possible to fix.

22. The Board went on to say that Consultant 2 had advised that the blockages were not attended to on 5 October 2015 as there was no clinical urgency which made it likely that early intervention would be of benefit. It considered that Mr A had already had a heavy dose of x-ray intravenous contrast (a substance injected into a blood vessel to highlight the heart and blood vessels during imaging) and that further arteriography (imaging of the arteries) would only have been performed in exceptionally unusual circumstances. The Board explained that the attending team had taken time to discuss the merits and risks of balloon catheter treatment, given the difficulties in fixing this problem, and the risks to Mr A of this intervention.

23. The Board said that it was considered worthwhile to attempt the use of a balloon catheter to open the blockages and that this was performed on 8 October 2015. However, it advised that Mr A's foot had deteriorated and was septic with infection. The Board acknowledged that Mr A was reluctant to go ahead with amputation surgery but that this was recommended to stop the life threatening risk of spreading infection. It advised that it did not believe that earlier diagnosis during the preceding period, when Mr A had been reporting symptoms to his GP etc, would have made any difference to the eventual outcome.

Medical advice

24. Adviser 1 explained that the Scottish Intercollegiate Guidance Network (SIGN) provide guidelines for the prevention and management of venous thromboembolism in SIGN guideline 122.

25. Adviser 1 considered that the care provided at the appointment with the DVT service on 9 September 2015 was reasonable. They advised that appropriate examination and investigations were performed, including a d-dimer test. Adviser 1 also noted that a Wells score (a clinical prediction aid) had been carried out. They advised that as the d-dimer was negative and the Wells score was low, no further investigations to exclude DVT were required.

26. Adviser 1 considered it was reasonable to state that Mr A did not have a DVT, as a low Wells score and a negative d-dimer test make a clinically significant DVT highly unlikely (lower than one percent probability). They advised that an appropriate algorithm for the management of suspected DVT was followed and was similar to that used in hospitals across the country.

27. In relation to other causes for Mr A's symptoms, Adviser 1 commented that there was no evidence of this from the records. They advised that Mr A's calf was noted to be swollen compared to the other by half a centimetre in circumference, which was not considered to be concerning. Adviser 1 found that the records made by Consultant 1 noted that no abnormality was demonstrated and pulses had been identified.

28. Adviser 1 considered that no follow-up was necessary on the basis of the clinical picture at that time and that it was appropriate to advise Mr A to see his GP if again if he experienced continuing problems.

29. Adviser 2 explained that the National Institute of Health and Clinical Care Excellence (NICE) provide relevant national guidance in their peripheral arterial disease quality standard QS 52.

30. Adviser 2 was asked to consider whether it was reasonable, on the basis of Mr A's assessment at the Claudication Clinic on 29 September 2015, that no urgent appointment was made with the Vascular Clinic or that Mr A was not recommended to attend at an accident and emergency department.

31. Adviser 2 considered that this was not reasonable and commented that this was the major problem with Mr A's care in this case. They advised that the staff at the Claudication Clinic had correctly identified that there were no pulses and no arteries identified on the Doppler test (a type of ultrasound test that identifies blood flow). Adviser 2 also commented that the notes from the Claudication Clinic logged that Mr A's leg was more seriously ischaemic than would be expected from a patient who was only suffering from claudication. Adviser 2 noted that staff had recorded that they thought one pulse could be felt but that nothing was audible on the Doppler. They advised that this is the reason that the Doppler devices are used, as subjective clinical judgement of pulses can be inaccurate.

32. Adviser 2 noted that a check box had been completed indicating that Mr A had critical ischemia. They advised that this meant an automatic urgent referral, as the definition of the term means that if the blood supply is not improved, the limb will be lost. Adviser 2 commented that there were other signs, such as Mr A's pain, which indicated this was serious and urgent.

33. In relation to the Board's explanation of the actions around follow-up of the Claudication Clinic attendance, Adviser 2 did not consider this to be reasonable. They referred to a timeline supplied in the Board's complaint file:

- Tuesday 29 September 2015
  Mr A was seen at the Claudication Clinic in the afternoon. After critical ischemia was suspected, the nurse tried to call a Vascular Service secretary and as there was no answer, left an answering machine message. Mr A returned home with reassurance.
- Wednesday 30 September 2015
  The nurse from the Claudication Clinic called the secretary at the Vascular Service again in the morning and left another voicemail message. On the afternoon of 30 September 2015, the nurse called the Claudication Clinic

secretary and passed on the details to request an urgent Vascular Service appointment. The Claudication Clinic secretary advised she would deal with it and contact Mr A.

- Friday 2 October 2015
  The nurse at the Claudication Clinic received a telephone call from another member of the Vascular Service secretarial staff who apologised for the delay in getting back to them about Mr A. They advised that the Vascular Service secretary had gone on annual leave and not put an 'out of office' setting on, therefore none of the messages had been picked up.

34. Adviser 2 commented that it was clear that an urgent referral pathway that was reliant on an answering machine which was not regularly checked was unsafe. In relation to the reference to the vascular secretary not having set an 'out of office' message, they advised that a failsafe pathway is required. Adviser 2 commented that it was unreasonable for the Board to say in its complaint response that the correct procedures were followed when they had clearly failed in Mr A's case.

35. Adviser 2 was asked whether it was possible that the final outcome of Mr A requiring amputation surgery could have been avoided if he had had an urgent appointment at the Vascular Service or gone directly to the accident and emergency department after the Claudication Clinic assessment on 29 September 2015. Adviser 2 considered it was likely that if he had been seen and assessed earlier, the infection in his ischaemic foot would not have developed or spread as it did. They advised that the artery was reconstructible by angioplasty and that the problem was that, by the time the procedure was carried out, it was too late. Adviser 2 commented that putting a good blood supply into dead, infected tissue would not be successful.

36. Adviser 2 noted that Mr A was admitted as an emergency on 4 October 2015 and seen by Consultant 2 the same day, with an appropriate urgent CT angiogram being arranged. They advised that this had been carried out within a reasonable timeframe on 5 October 2015. Adviser 2 explained that the radiology report for the CT angiogram suggested that opening the artery with a balloon was worthy of an attempt. The alternative would have been an open bypass and Adviser 2 found this had all been noted by the Registrar on 5 October 2015.

37. Adviser 2 explained that it was after this that things began to go wrong with Mr A developing signs of sepsis (a raised temperature) and antibiotic treatment being started. They advised that the angioplasty was not done until 8 October 2015, by which time Mr A was septic and the foot had deteriorated badly. Adviser 2 considered that the window of opportunity had passed and that, consequently, the above knee amputation on 11 October 2015 was necessary to control the sepsis and save Mr A's life. They advised that although the clinical decision making was correct, the application of the decision was delayed such that there was no hope of Mr A's leg being saved. Adviser 2 considered that the Board's comment that the complete block of Mr A's artery was not correctable was wrong. They advised that the angioplasty was successful, just carried out too late.

38. Adviser 2 concluded that Mr A's leg was quite possibly retrievable but there was delay, or misdiagnosis, in appreciating the severity of his problem. They advised that the staff at the Claudication Clinic recognised critical ischemia but the referral pathway did not result in Mr A being seen as an emergency.

39. Adviser 2 commented that when Mr A was finally admitted to hospital on 4 October 2015, he was rapidly diagnosed but then the correct treatment plan was delayed by three to four days. They advised that by then, although the artery was opened up, it was realised that Mr A had too much dead and infected tissue to recover.

Decision

40. The basis that we reach decisions on is reasonableness. Our investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. We do not apply hindsight when determining a complaint.

41. Adviser 1 identified no failings in the DVT assessment that took place and noted that Mr A's medical records did not suggest that he was suffering from any other condition. I accept this advice.

42. I accept the advice received on the failure in the referral care pathway when pulses could not be identified at the Claudication Clinic on 29 September 2015 and note Adviser 2's comments that expedited action at this time could potentially have resulted in a different outcome.

43. Adviser 2 was clear that while the diagnosis reached once Mr A was admitted to hospital on 4 October 2015 was reasonable, there was a delay taking the appropriate action, and I accept Adviser 2's comment that the blockage in the artery was correctable.

44. I am critical that delays and failure to grasp the severity of Mr A's condition potentially led to him requiring amputation of a limb that Adviser 2 considered could have been saveable. While we cannot definitively determine that the loss of Mr A's leg was avoidable, I do not consider it reasonable that the Board failed to take appropriate, timely action to attempt to preserve the limb.

45. I am deeply concerned that the Board's own complaint investigation did not recognise the failure of the care pathway for an ischaemic limb after this was identified at the Claudication Clinic. I am also concerned that Mrs C was told that the situation would have been unchanged by earlier diagnosis, when the advice I have received is clear that earlier action would have afforded Mr A the best chance of an alternative outcome.

46. Taking all of the foregoing into consideration, I uphold this complaint.

Recommendations

47. What we are asking the Board to do for Mrs C and Mr A:

What we found	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
The referral pathway from the Claudication Clinic to the Vascular Service failed for Mr A	Provide a written apology which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter By: 16 August 2017

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
There were delays in the provision of appropriate treatment to Mr A	Provide a written apology for the delays and the impact this had on Mr A's prospects which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter By: 16 August 2017

We are asking the Board to improve the way it does things:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
The referral pathway from the Claudication Clinic to the Vascular Service failed for Mr A	Ensure it has in place an effective referral pathway which has a failsafe, so that urgent appointments are arranged when needed	Evidence that the referral pathway for urgent care of critical ischemia from the Claudication Clinic to the Vascular Service has been reviewed and, where needed, improved By: 11 October 2017
There were delays in the provision of appropriate treatment to Mr A	Ensure timely action is taken when treating critical limb ischemia	Evidence that this case has been reviewed for learning and improvement within the Vascular Service. This should include any action, or planned action, to apply learning identified By: 11 October 2017

Feedback for the Board

48. Adviser 2's comments on the subjectivity of clinical judgement in assessing pulses should be circulated to relevant staff for learning purposes.

49. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved
the Board	Lanarkshire NHS Board
Adviser 1	a consultant physician
Adviser 2	a consultant vascular surgeon
GP	general practitioner
the Claudication Clinic	a Community Claudication Clinic
DVT	deep venous thrombosis
the Hospital	Hairmyres Hospital
Consultant 1	a consultant physician
Consultant 2	a consultant vascular surgeon
CT	computerised tomography
the Registrar	a vascular specialist registrar
SIGN	Scottish Intercollegiate Guidance Network

Annex 2

Glossary of terms

angioplasty	a procedure to open up the artery using a balloon inserted into the vessel
claudication	cramp-like pain caused by interference with the blood supply to the muscles of the legs
computerised tomography (CT) angiogram	imaging scan to visualise the blood vessels of the arterial system
d-dimer test	a test which measures a substance that is released when a blood clot breaks up
Doppler	a type of ultrasound test that identifies blood flow
DVT	a blood clot forming in a deep vein such as those in the legs or pelvis
sepsis	a serious complication of infection
severe critical limb ischemia	obstruction of the arteries that reduces blood flow to the extremities
Wells score	a clinical prediction aid used in assessing DVT