SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case ref: 201701356, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mrs C complained to me about the care and treatment she received from Lanarkshire NHS Board (the Board). Her concerns relate to the treatment she received following her operation to form a stoma (an opening in the stomach to divert bodily waste through so it can be collected in a bag).

Mrs C was admitted to Monklands Hospital (the Hospital) on a number of occasions after this operation, with on-going symptoms of nausea and stomach pain. In the last admission, Mrs C's small bowel perforated (a hole formed in it) and she developed sepsis (a severe complication of infection). Mrs C received emergency surgery from which she recovered, however, she developed neurological problems which have left her partially sighted and with a weakness down her left side. Mrs C raised concerns that there was a delay in recognising the seriousness of her condition and in performing surgery to treat it. Mrs C felt that if earlier action had been taken, she might not have developed these neurological problems.

We took independent advice from a general and colorectal surgeon, which we accepted.

We found that Mrs C had an incomplete small bowel obstruction (blockage) where the stoma was formed, caused by tissue swelling. We found that Mrs C's symptoms, her repeated admissions to the Hospital and the results of the investigations carried out were all suggestive of this. We considered it was unreasonable that the Board did not recognise this at the time. We also considered it was unreasonable Mrs C was not referred for surgery at an earlier point, particularly when her condition worsened. We concluded that if surgery had been carried out earlier, Mrs C would probably not have developed severe sepsis, which is the likely cause of her neurological problems. We were concerned that the Board's review did not identify any failings in the care provided to Mrs C.

We upheld Mrs C's complaint. We made a number of recommendations to address the issues identified. 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.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

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

What we found	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
There were failings in diagnosing Mrs C's incomplete bowel obstruction and an unreasonable delay in referring her for surgery, despite her worsening condition	Apologise to Mrs C for the failings in diagnosing and treating her incomplete bowel obstruction	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 20 August 2018

We are asking the Board to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There were failings in diagnosing Mrs C's incomplete bowel obstruction and an unreasonable delay in referring her for surgery, despite her worsening condition	The results of hospital tests and investigations should be carefully reviewed and in similar cases, earlier surgical intervention should be considered	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails By: 18 September 2018
Mrs C's stoma activity and output was not properly assessed and/or documented during her admissions to the Hospital	After a loop ileostomy, stoma activity and output should be clearly assessed and documented, as it is important for assessing the stoma and bowel function	Evidence that this decision has been shared and discussed with relevant staff in a supportive manner. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails By: 18 September 2018

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
The Board's own investigation did not identify the significant failings in the care provided to Mrs C	The Board's complaints handling system should ensure that failings (and good practice) are identified, and that it is using the learning from complaints to inform service development and improvement (where appropriate)	Evidence that the Board have demonstrated learning from this case and complaints in general By: 18 September 2018

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. 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 me about the care and treatment she received from Lanarkshire NHS Board (the Board). Her concerns relate to the treatment she received following an operation in August 2016 to address stomach pain and constipation. Mrs C was admitted to Monklands Hospital (the Hospital) on a number of occasions after this operation, with on-going symptoms of nausea and stomach pain. In September 2016, Mrs C's small bowel perforated (a hole formed in it) and she developed sepsis. Mrs C received emergency surgery from which she recovered, however, she developed neurological problems which have left her partially sighted and with a weakness down her left side.

2. The complaint I have investigated is that, in August 2016 and September 2016, the Board failed to give Mrs C appropriate treatment (*upheld*).

Investigation

3. I and my complaints reviewer considered the information provided by Mrs C and the Board. This included Mrs C's relevant medical records and the Board's complaints file. We also obtained independent advice from a general and colorectal surgeon (the Adviser) on the clinical aspects of the complaint.

4. I have decided to issue a public report on Mrs C's complaint due to the serious failings identified and the significant personal injustice to Mrs C, as a result.

5. This report includes the information that is 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 I can confirm that all 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.

Background

6. Mrs C had chronic long-term constipation and stomach pain. On 1 August 2016, she had an operation to address this, called a loop ileostomy. This is where a loop of the small bowel is pulled out through a cut in the stomach. It is then opened up and stitched to the skin forming a stoma. The waste exits the body, through the stomach opening, into an external stoma bag.

7. Around a week after the operation, Mrs C began to experience stomach pain and nausea. She attended the Hospital and was given medication to manage her symptoms at home. A couple of days later, Mrs C went back to the

Hospital as her symptoms continued. An x-ray was carried out and Mrs C was discharged home. Later the same month, Mrs C had two further short admissions to the Hospital and tests were carried out into her symptoms, including a CT scan. At the end of August 2016, Mrs C had a further admission to the Hospital. This time, she was kept in for a longer period of observation and a further CT scan was carried out. Mrs C was told she might have Crohn's disease and she was given steroid treatment. Although, it was thought her condition had improved, her symptoms then worsened.

8. In September 2016, Mrs C's small bowel perforated and she developed severe sepsis. She was taken for emergency surgery, in which part of her small bowel was removed. Afterwards, she was critically ill and in intensive care. Mrs C experienced neurological problems, which means she is now partially sighted in her left eye and has a weakness in the left side of her body.

Key concerns

9. Mrs C complained that the Hospital did not take her symptoms seriously enough. Mrs C said her first CT scan showed she had a bowel obstruction but this was not acted on. Mrs C considered this lack of action led to her bowel perforating. Mrs C questioned whether her steroid treatment also contributed to this. Mrs C said she was not given an adequate explanation for her bowel perforation, as she was told it was just bad luck.

10. Given the CT scan results, Mrs C was dissatisfied with the explanation for her bowel perforation. Mrs C explained that after her emergency surgery, she was in a coma and her family was told she only had a 25% chance of survival. Mrs C further explained that, because of her neurological problems, she can no longer work. She takes pain medication, sleeping tablets and injects herself every day to avoid blood clots. Mrs C also has anxiety and depression. She considered that if the Hospital had taken appropriate action in response to her symptoms, she might not have these health problems.

The Board's response

11. The Board said their investigations into Mrs C's symptoms had at times shown evidence of a small bowel obstruction. They explained her first CT scan showed an obstruction where the stoma was formed on her stomach wall. However, they explained they were able to easily insert a camera into her stoma to carry out an ileoscopy (a procedure where a small camera is used to examine

the small bowel). As a result, it was considered she did not have an obstruction. The Board commented that Mrs C's symptoms settled without the need for intervention.

12. Mrs C then attended the Hospital again at the end of August 2016 with similar symptoms as before. At that point, the Board considered her symptoms were consistent with Crohn's disease. However, they acknowledged it was now clear she did not have this. The Board stated that during Mrs C's emergency surgery, they found no evidence she had a small bowel obstruction. In addition, they said there appeared to be no underlying cause for her small bowel perforating. The Board considered she may have experienced a malrotation (twist) of the small bowel, which eventually led to it perforating.

Medical advice

13. The Adviser said that after Mrs C's loop ileostomy on 1 August 2016, her stoma appeared healthy and was active. However, they explained that on 3 August 2016, her stoma output was recorded as 100 millilitres and then 50 millilitres, with no other activity recorded. The Adviser said this was an unusually small volume of output for a newly formed stoma, as the usual volume would be between 500 millilitres and one litre. The Adviser observed that the lack of stoma output did not appear to raise concern and Mrs C was discharged home.

14. Mrs C went to the Hospital on 14 August 2016, as she had begun to experience stomach pain, vomiting and watery discharge in her stoma bag. She was given advice and medication to manage her condition at home.

Medical advice: first admission

15. Mrs C attended the Hospital on 16 August 2016, as her symptoms had continued. It was noted that her stoma had worked around four or five times and her stoma bag was around a quarter full when it emptied. The Adviser considered these symptoms suggested she had delayed bowel emptying. They explained that a conclusive stomach x-ray was taken, which did not show any significant abnormality in her bowel function. The Adviser said that as the x-ray did not show a need to escalate Mrs C's treatment, it was reasonable she was discharged home that same day. However, it would have been better if the Hospital had documented Mrs C's stoma activity during this admission but this was not done.

Medical advice: second admission

16. Mrs C attended the Hospital again the following day, with the same symptoms. The Adviser said it was recorded that her stoma was working but the volume of stoma output was decreasing or was watery. The Adviser explained that a further stomach x-ray was taken. This showed increased faecal loading (a large volume of stool) in Mrs C's small bowel. The Adviser explained this was probably caused by a build-up of fluid in her small bowel. They considered the x-ray was not enough by itself to diagnose her underlying condition of an incomplete bowel obstruction. However, the Adviser said that the combination of her symptoms and x-ray results did suggest this. The Adviser explained that the lack of stoma output also suggested she had an incomplete small bowel obstruction.

17. The Adviser was asked what would have caused Mrs C's condition. They explained that an incomplete obstruction at the stoma site is an unusual condition but that it can occur there for many reasons. The Adviser explained there can be a very tight opening or swelling where the stoma is formed. They also said that there can be ischaemia (inadequate blood supply) or swelling where the stoma passes through the stomach wall. The Adviser explained that Mrs C's symptoms, x-ray results and CT results, all suggested her bowel was obstructed. However, her loop ileostomy had worked and she had a partially functioning stoma. Therefore, she did not have a complete bowel obstruction.

18. The Adviser explained she had an incomplete bowel obstruction, which gives a mixed picture of symptoms and this makes the diagnosis more difficult.

19. Mrs C had a mildly raised temperature on 18 August 2016 and 19 August 2016. However, blood tests were taken and were unremarkable. The Adviser explained that the results showed high blood lactate levels (a substance in the blood that can be detected when there is a lack of oxygen). However, there can be several reasons for this including dehydration or infection. The Adviser said Mrs C was then appropriately referred for a CT scan on 19 August 2016. The Adviser explained it showed dilated and fluid-filled loops of small bowel, with a 'cut off' where the exit to her stoma was formed. The Adviser further explained this indicated there was at least a partial obstruction of the loop of her small bowel, where it passed through her stomach wall.

20. Given the CT scan results showed this obstruction at the exit to the stoma, the Adviser explained the need to refashion her stoma should have been

considered. However, the Adviser did not find evidence that this was considered at that time. In addition, there was a note of a stoma output on 19 August 2016 but the volume of the output was not recorded. The Adviser explained that the stoma activity and output should have been recorded as it is important in assessing bowel function.

21. It was noted medical staff considered Mrs C should have been kept in Hospital to observe and manage her condition. However, she was keen to go home and she told medical staff she was drinking adequately. Mrs C was reviewed by the colorectal surgeon before being discharged home on 19 August 2016. The Adviser considered it would have been advisable for Mrs C to remain in the Hospital, as they said it was likely her symptoms would worsen. However, the Adviser explained she was not in any danger and noted her stoma was still working. The Adviser also explained that her wish to go home would have influenced the Hospital's decision to discharge her. The Adviser considered it was appropriate that the Hospital arranged a follow-up appointment with Mrs C, to see if her symptoms settled. However, the Adviser also said a full charting of her stoma activity was not carried out during this admission and that would have been helpful in reaching a diagnosis.

Medical advice: third admission

22. Mrs C was readmitted to the Hospital on 22 August 2016. She had colicky stomach pain, nausea, a decreased appetite and she was vomiting bile. The Adviser explained her stoma was working and at least 900 millilitres of thick, brown fluid of stoma output was recorded that same day. The Adviser said it was noted there was no obvious narrowing of her stoma from a digital (finger) examination of Mrs C's stoma. However, the Adviser explained that a digital examination is not particularly sensitive and would not preclude an incomplete stoma obstruction.

23. The Adviser explained that a further stomach x-ray was carried out during this admission, which was noted to be unremarkable. However, the Adviser said this x-ray showed dilated loops of small bowel, as well as a fluid-filled bowel with little gas. The Adviser explained that would be the typical appearance of a small bowel that was chronically obstructed over a period of weeks. In addition, the Adviser noted the x-ray report stated there appeared to be a degree of obstruction to Mrs C's small bowel. The Adviser explained this was consistent with the earlier CT scan report, which had noted she had dilated loops of small bowel. Despite this, Mrs C was discharged home on 25 August 2016.

24. The Adviser considered Mrs C should have been kept in the Hospital for a longer period of assessment at this time. They noted Mrs C had now had repeated admissions to the Hospital, within a short period of time, with the same symptoms. The Adviser also noted these symptoms had only developed after Mrs C's loop ileostomy. In these circumstances, the Adviser said medical staff should have considered the possibility that her symptoms were caused by a complication of her loop ileostomy. Specifically, by a narrowing or swelling at the exit of the stoma, which was affecting her bowel function. The Adviser said there were various investigations that could have been carried out to assess her condition during this admission including:

- a further CT scan;
- a full regular charting of Mrs C's stoma output and consistency;
- a tube could have been introduced into Mrs C's stoma to help drain its contents;
- an x-ray using oral gastrografin (a contrast agent) could have been used to identify any small bowel obstruction.

25. The Adviser considered that further investigations should have been carried out to try to establish why Mrs C had these on-going symptoms.

Fourth admission

26. The Adviser noted that Mrs C was admitted to the Hospital again on 31 August 2016, with very similar symptoms to before. The Adviser stated that on this occasion, Mrs C was appropriately kept in the hospital for a longer period to observe and manage her condition. Mrs C was referred for a further CT scan on 31 August 2016. The Adviser said this showed she had a thickened and inflamed small bowel, just before the exit to her stoma. The Adviser noted that an ileoscopy was also performed, which confirmed the earlier CT scan findings. They went on to explain that contrary to the Board's response, the ability to perform an ileoscopy does not preclude the possibility there is a narrowing or poor function in that area.

27. The Adviser noted that following these investigations, Mrs C was diagnosed with Crohn's disease. The Adviser said this could have explained her symptoms. However, they considered Crohn's disease would have been a very unusual diagnosis, as Mrs C had a history of chronic constipation. In addition, the Adviser explained that Mrs C's loop ileostomy was carried out through keyhole surgery and there was no apparent evidence of Crohn's disease at that time. The Adviser

considered Mrs C's symptoms, the ileoscopy results and CT scan results were all consistent with a chronic, although incomplete, small bowel obstruction following her loop ileostomy. The Adviser said that Mrs C's blood tests of 22 August 2016 had shown a high platelet count (tiny blood cells that help the body to heal) and a high CRP count (a blood marker for inflammation), which could indicate Crohn's disease. However, they explained this could also have been caused by a chronic partial obstruction and the inflammation caused by this.

28. Mrs C was started on steroid treatment for Crohn's disease on 31 August 2016. This treatment initially dampened Mrs C's inflammatory response, which was interpreted as an improvement in her condition. The Adviser said this appeared to encourage medical staff to continue with a conservative (non-surgical) approach to Mrs C's treatment. After two to three days of steroid treatment, her symptoms had persisted. The Adviser considered the lack of significant improvement of her symptoms, despite the use of steroids, indicated a need for surgical intervention. However, medical staff continued with a non-surgical approach to her treatment instead.

29. Mrs C had severe stomach pain on 5 September 2016. The Adviser explained that a stomach x-ray was taken the next day, which showed dilatation (abnormal enlargement) to her small bowel. Between 6 September 2016 and 8 September 2016, the Adviser noted there was no activity from Mrs C's stoma and her stomach pain was worsening. A repeat x-ray on 8 September 2016 showed further dilatation to her small bowel. The Adviser explained this was again consistent with a chronic incomplete small bowel obstruction. They explained the obstruction would cause the small bowel to gradually distend, causing it to become thickened and dilated. The Adviser considered that the repeated x-rays suggested medical staff had increasing concern about her condition.

30. The Adviser commented that given Mrs C's worsening condition and the lack of stoma activity, there was now a possibility that her small bowel would perforate. They explained the chronic partial obstruction would cause the small bowel tissue to continue to swell, with a risk of bowel ischaemia caused by the chronic distension, swelling and inflammation of the small bowel tissue. They explained that if this issue is not corrected, there is a risk of small bowel perforation. Even if medical staff thought Mrs C was experiencing intermittent twisting of the small bowel, surgery should still have been considered given the severity of her symptoms and the number of admissions she had to the Hospital.

31. On 9 September 2016, medical staff noted they were considering a further ileoscopy, as well as a refashioning of Mrs C's stoma. However, the Adviser confirmed these actions were not undertaken. Mrs C's condition deteriorated further, as she had worsening blood acidity levels, increased stomach tenderness and no stoma activity. The Adviser explained this continued to show the need for surgical intervention. However, they said surgery was not undertaken, apparently due to the misapprehension that Mrs C had Crohn's disease.

32. Mrs C's bowel perforated on 11 September 2016 and she was referred for emergency surgery. The Adviser considered good care ensured her survival. However, if surgery had been performed at any time prior to her bowel perforation, they said it was likely Mrs C would not have developed severe sepsis. The Adviser explained that her emergency surgery had confirmed both ischaemia and narrowing at the stoma site, where it came through her stomach wall. The Adviser further explained that her bowel was described as having a dusky appearance and this was likely caused by dilatation.

33. The Adviser was asked about the neurological issues Mrs C developed after her bowel perforated, such as weakness and a loss of sight. The Adviser noted that Mrs C had several previous surgeries without experiencing these types of issues. Therefore, they considered it was likely her severe sepsis led to these neurological issues. They explained that sepsis is a recognised cause of these types of complications. The Adviser considered that undertaking surgery, at any point prior to 11 September 2016, was likely to have avoided Mrs C's development of these neurological complications.

Decision

34. The basis on which I reach decisions on is reasonableness. My 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. I do not apply hindsight when determining a complaint.

35. The advice I have received and I accept from the Adviser is that Mrs C had an incomplete small bowel obstruction at the exit of her stoma. I was advised this is an unusual but a recognised problem after a loop ileostomy, which can be caused by tissue swelling where the stoma is formed. The advice I have received is that Mrs C's symptoms, her repeated admissions to the Hospital and the results of the investigations were all suggestive of this. I am concerned the Board staff did not recognise this at the time and act accordingly. I am also particularly

concerned that the Board have failed to acknowledge this, even though they subsequently carried out a review of the care Mrs C had received after her bowel perforation.

36. I am of the view that the failings in care my investigation has identified could have and should have been established on review. Not to do so was a further failing in care.

37. The Board acknowledged on review that Mrs C was wrongly diagnosed with Crohn's disease. I have been advised this diagnosis was unlikely given her history and the development of her symptoms after the loop ileostomy. I was also advised this misdiagnosis meant medical staff persisted with non-surgical treatment, even when Mrs C's condition worsened. Given the increasing severity of her stomach pain, her increased small bowel dilatation and the reduced output of her stoma, Mrs C should have been referred for surgery at an earlier point. The advice I have received and I accept is that surgical intervention, at any time prior to her bowel perforation, is likely to have avoided Mrs C's severe sepsis and that this is the likely cause of her neurological complications.

38. Taking all of this into consideration, I uphold this complaint. My recommendations for action by the Board are set out below. 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.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Ms C:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
There were failings in diagnosing Mrs C's incomplete bowel obstruction and an unreasonable delay in referring her for surgery, despite her worsening condition	Apologise to Mrs C for the failings in diagnosing and treating her incomplete bowel obstruction	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 20 August 2018

We are asking the Board to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There were failings in diagnosing Mrs C's incomplete bowel obstruction and an unreasonable delay in referring her for surgery, despite her worsening condition	The results of hospital tests and investigations should be carefully reviewed and in similar cases, earlier surgical intervention should be considered	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails By: 18 September 2018
Mrs C's stoma activity and output was not properly assessed and/or documented during her admissions to the Hospital	After a loop ileostomy, stoma activity and output should be clearly assessed and documented, as it is important for assessing the stoma and bowel function	Evidence that this decision has been shared and discussed with relevant staff in a supportive manner. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails By: 18 September 2018

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
The Board's own investigation did not identify significant failings in the care provided to Mrs C	The Board's complaints handling system should ensure that failings (and good practice) are identified, and that it is using the learning from complaints to inform service development and improvement (where appropriate)	Evidence that the Board have demonstrated learning from this case and complaints in general By: 18 September 2018

Terms used in the report **Annex 1**

Crohn's disease	a long-term condition that causes inflammation of the lining of the digestive system
CT	computerised tomography
dilatation	abnormal enlargement
ileoscopy	a procedure where a small flexible tube is used to examine the small bowel
incomplete bowel obstruction	a blockage limiting the normal movement of bodily waste
ischaemia	inadequate blood supply to an organ or part of the body
loop ileostomy	a loop of the small bowel is pulled out through a cut in the stomach. It is then opened up and stitched to the skin
Mrs C	the complainant
perforated bowel	a hole in the bowel
sepsis	a severe complication of infection
steroid	a drug used to treat inflammation
stoma	an opening in the stomach to divert bodily waste through so it can be collected in a bag
stoma bag	a pouch designed to collect bodily waste
the Adviser	a general and colorectal surgeon

the Board	Lanarkshire NHS Board
the Hospital	Monklands Hospital