Scottish Parliament Region: South of Scotland

Case 201300651: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; diagnosis and treatment; communication; complaints handling

Overview

The complainant (Mrs C) complained that a lengthy list of errors and omissions by various specialist services and a failure to co-ordinate her care and treatment caused her stress and ultimately led to a delay in her being diagnosed with multiple sclerosis and her starting treatment.

Specific complaints and conclusions

The complaints which have been investigated are that Ayrshire and Arran NHS Board (the Board) unreasonably failed to:

(a) adequately assess Mrs C's condition (*not upheld*);
(b) ensure that the various departments involved in Mrs C's care monitored her care and treatment appropriately (*upheld*);
(c) ensure that the various departments involved in Mrs C's care co-ordinated and communicated appropriately with each other (*upheld*); and
(d) ensure that the responses Mrs C received to her complaints were accurate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings identified in this report;	19 November 2014
(ii) provide evidence of the improvements that have been made to the Board's out-patient's appointment systems;	19 November 2014
(iii) consider developing a pathway regarding all suspected genetic disorders seen within Dermatology Services, so as to streamline access to geneticists;	22 January 2015
(iv) ensure that the comments of the Dermatology	5 November 2014

	Adviser, in relation to record-keeping and the Board's action plan, are brought to the attention of the relevant staff within Dermatology Services;	
(v)	in cases involving several health boards, consider implementing the copying of clinical correspondence to a patient, so as to improve communication and provide the patient with the opportunity to be aware of the progress of their care;	22 December 2014
(vi)	consider reviewing the systems for Radiology referrals between hospitals;	22 January 2015
(vii)	review spinal magnetic resonance imaging (MRI) protocols to: identify which part of the recall protocol failed in Mrs C's case; ensure where abnormalities are detected they are appropriately reported; and ensure appropriate consideration is given to examining the patient's whole spine in one scan;	22 January 2015
(viii)	carry out an audit to ensure there is a clear system for prioritising MRI scan requests according to the degree of clinical urgency;	22 January 2015
(ix)	ensure that communication protocols between Radiology Services and other clinicians are optimal;	22 January 2015
(x)	ensure that the comments of the Radiology Adviser and the Neurology Adviser are shared with the appropriate staff; and	5 November 2014
(xi)	advise of the present position in respect of the planned move to digital case notes.	22 December 2014

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

Main Investigation Report

Introduction

1. Mrs C attended several Ayrshire Hospitals (Ayr Hospital, Crosshouse Hospital, Kilmarnock, and Ayrshire Central Hospital) and was referred to two Glasgow Hospitals (Southern General Hospital and Gartnavel General Hospital) and also to St John's Hospital, Livingston, for various tests and treatment. This involved several specialist services: ophthalmology, neurology, dermatology and radiology. Mrs C complained to my office that a lengthy list of errors and omissions by these various specialist services and a failure to co-ordinate her care and treatment caused her stress and ultimately led to a delay in her being diagnosed with multiple sclerosis (MS) and starting treatment.

2. Ayrshire and Arran NHS Board (the Board) have acknowledged that there were a number of failings in Mrs C's care and treatment. The Board identified errors in their handling of consultations she attended. The Board also accepted that there were a number of administrative and system failures and communication problems, involving both Ayrshire and Glasgow health services, which contributed to delays in appointments and processing test results. While the Board have apologised to Mrs C, she remains dissatisfied.

3. The outcome Mrs C seeks from this office is a full investigation into her complaint and to find out if changes have been made and implemented and lessons have been learned by the Board.

4. The complaints from Mrs C which I have investigated are that the Board unreasonably failed to:

(a) adequately assess Mrs C's condition;
(b) ensure that the various departments involved in Mrs C's care monitored her care and treatment appropriately;
(c) ensure that the various departments involved in Mrs C's care co-ordinated and communicated appropriately with each other; and
(d) ensure that the responses Mrs C received to her complaints were accurate.

Investigation

5. My complaints reviewer reviewed a copy of Mrs C's clinical records and the Board's complaint file and also the information Mrs C provided to this office. Independent advice was obtained from three medical advisers to the

Ombudsman: an adviser who provided me with advice in relation to Mrs C's ophthalmology and neurology treatment (the Neurology Adviser); a dermatology adviser (the Dermatology Adviser); and a radiology adviser (the Radiology Adviser). I was satisfied that the Neurology Adviser had the relevant expertise to provide me with ophthalmology advice in relation to Mrs C's complaints.

6. 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. As Mrs C's complaint involved hospitals in Glasgow, which she attended for treatment following referrals from the Board, Greater Glasgow and Clyde NHS Board were also given an opportunity to comment on a draft of this report.

(a) The Board unreasonably failed to adequately assess Mrs C's condition

Mrs C's Ophthalmology and Neurology treatment

7. Mrs C told my office that she had suffered chronic migraines for a number of years, which had become more severe and frequent. In May 2012 she had a severe migraine which left her with reduced vision in her right eye. When her vision had not improved she was referred to Ayr Hospital to see the on-call ophthalmologist, who diagnosed optic neuritis (an inflammation of the optic nerve) and arranged for her to have a review appointment. In June 2012 Mrs C saw a consultant ophthalmologist (the Ophthalmology Consultant) at Crosshouse Hospital, who arranged for her to have a magnetic resonance imaging (MRI) scan of her head to rule out that she had MS and/or a brain tumour.

8. In June 2012 Mrs C had new symptoms of right sided facial weakness which had spread into her right upper limb and right lower limb. Mrs C was admitted to Ayr Hospital with a suspected stroke and was discharged the next day, as she was due several days later to have the MRI scan ordered by the Ophthalmology Consultant, referred to above. At subsequent consultations with a consultant physician (Doctor 1) at Ayr Hospital, and later with the Ophthamology Consultant in June and July 2012, Mrs C was told the results of the MRI scan had confirmed that she had not had a stroke and she did not have MS.

9. Mrs C was then referred by the Ophthalmology Consultant to Gartnavel General Hospital, Glasgow, for in-depth electrodiagnostic tests due to a lack of

improvement in the vision in her right eye and as she was having frequent migraines. The results showed Mrs C had sustained ischaemic damage (caused by poor blood supply) to her right optic nerve.

10. However, as Mrs C's symptoms were continuing she asked for a referral to Neurology. Mrs C's first appointment was in August 2012 with a consultant neurologist at Crosshouse Hospital (the Neurology Consultant), who arranged for her to have a MRI scan of her cervical spine. The scan was carried out at Ayr Hospital in November 2012. In the same month, Mrs C's general practitioner (the GP) referred her to another consultant neurologist at Crosshouse Hospital (Doctor 2), who had a special interest in headaches, to try and answer whether her eye symptoms were related to the migraines she was suffering. Mrs C said she was very dissatisfied with this consultation because it lasted less than ten minutes and Mrs C considered Doctor 2 had been dismissive towards her.

11. In December 2012 Mrs C saw the Neurology Consultant for the results of the MRI scan. Mrs C said that the Neurology Consultant did not tell her that she had demyelation of the cervical spine and possible MS but explained there was a lesion on her cervical spine and that the Radiology department at Ayr Hospital should have called her back for a second MRI scan with dye to confirm the findings. Mrs C says that the Neurology Consultant told her not to worry. The follow-up MRI scan was subsequently carried out in January 2013. Mrs C says that during this appointment the radiologist suggested that she bring forward the date of her next appointment with the Neurology Consultant.

12. Following the second MRI scan, at the request of Mrs C, her next appointment with the Neurology Consultant was brought forward from February 2013 to January 2013. During this appointment the Neurology Consultant told her that she had demyelination of the cervical spine and possible MS. Mrs C said that this was the first time she had been told of the possibility that she had MS. The Neurology Consultant explained that further tests, including a lumbar puncture and another MRI scan, would be required. Mrs C was, therefore, to be admitted as a day patient to Southern General Hospital at the beginning of March 2013 for these tests. Mrs C was, thereafter, referred to a consultant in Neuro-Rehabilitation (the Neuro-Rehabilitation Consultant), who specialised in MS care at Ayrshire Central Hospital, Irvine in early May 2013. Mrs C said the letter she received from the Board to attend the appointment with the Neuro-Rehabilitation Consultant was the first confirmation

that she had a definite diagnosis of MS. However, as some of the tests results were not available from Southern General Hospital, Mrs C had to wait until the end of May 2013 before the Neuro-Rehabilitation Consultant had these results and could start her on disease modifying medication. Mrs C believes there was an unreasonable delay in diagnosing her with MS.

The Board's response

13. In response to her complaint about her ophthalmology care, the Board stated that the Ophthalmology Consultant had referred her to Gartnavel General Hospital in October 2012 for in-depth diagnostic tests, which she attended in January 2013. Also in October 2012, the Ophthalmology Consultant had referred her to the Colorimetry clinic where she was seen in November 2012 and provided with coloured overlays. Mrs C was also seen by the Orthoptic team in February 2013 and discharged after assessment.

14. According to the Board, the view of the Ophthalmology Consultant was that a diagnosis of MS was 'less likely' and he did not recall advising Mrs C that a diagnosis of MS was unlikely but rather it was a possibility (I note Mrs C disputes this). The Ophthalmology Consultant subsequently recognised, however, that he was wrong in his view as further tests arranged by the Neurology Consultant and the Neuro-Rehabilitation Consultant confirmed the diagnosis of MS. However, the Ophthalmology Consultant considered that he was thorough in his investigation and treatment of Mrs C's symptoms.

15. With regard to Mrs C's neurology care, the Board stated that the Neurology Consultant had initially seen Mrs C in August 2012 following a referral from the GP for possible optical neuritis with facial numbness. By then, Mrs C had already been seen by the Ophthalmology Consultant. The Ophthalmology Consultant arranged for Mrs C to have an MRI scan of her brain, the results of which were unremarkable. The Neurology Consultant arranged for Mrs C to have visual evoked potentials examinations (tests which measure the electrical activity of the brain) at Southern General Hospital. Due to Mrs C's responses to these examinations, the Neurology Consultant copied the Ophthalmology Consultant into a letter he sent to Mrs C's GP with a suggestion that she should have further examinations carried out at the Department of Ophthalmology at Gartnavel General Hospital, if the Ophthalmology Consultant thought this would be useful. The Neurology Consultant continued to treat Mrs C for migraine.

16. The Neurology Consultant saw Mrs C again in December 2012. At this consultation, the Neurology Consultant noted that Mrs C's migraines had improved, were less frequent and also less severe and also discussed with her the findings of the MRI scan of her cervical spine which he had earlier instructed. The Neurology Consultant explained to her that the scan had shown an abnormality which appeared to be demyelination, which required further investigation (Mrs C disputes this was what she was told). It was noted that the Radiology department, who had carried out this scan, had said they would invite Mrs C back for a further MRI scan but as this had not taken place by the time the Neurology Consultant saw her, he undertook to contact the department about this. The Neurology Consultant also suggested that she attend Southern General Hospital for further investigations. An MRI scan carried out at Southern General Hospital in March 2013 indicated a diagnosis of MS. Investigation of the cerebral fluid reinforced the diagnosis.

17. Following the intervention of Mrs C's GP, she was then referred to the Neuro-Rehabilitation Consultant at Ayrshire Central Hospital in April 2013. The Board explained that their Neurology service was provided on an outreach basis by consultant neurologists based at the regional centre at Southern General Hospital. As some tests were not available locally, patients had to travel to Glasgow for specialist care. However, the Board had a comprehensive neuro-rehabilitation service based at Ayrshire Central Hospital and the Neuro-Rehabilitation Consultant specialised in MS care. The Neuro-Rehabilitation Consultant saw Mrs C at his clinic in early May 2013.

18. As Mrs C was still suffering with migraines, the Neuro-Rehabilitation Consultant offered to refer Mrs C to Doctor 2 for a specialist opinion. However, as Mrs C had previously seen Doctor 2 in November 2012, following a referral from her GP, and had been dissatisfied with the consultation, she declined this offer. The Board stated that Doctor 2 had confirmed that he had been asked to see Mrs C specifically in relation to whether her visual symptoms were related to migraine. Doctor 2 did not consider, in his clinical opinion, that they were related. Doctor 2 was sorry that Mrs C had been dissatisfied and had not accepted the apology he had offered her.

19. The Board concluded that from their investigations into Mrs C's complaint that a number of clinical services in Ayrshire and Glasgow had actively and appropriately been involved in investigating Mrs C's symptoms and managing her care and treatment over a number of months.

Greater Glasgow and Clyde NHS Board's response

20. Greater Glasgow and Clyde NHS Board stated that the report from Gartnavel General Hospital indicated that the results of the electrodiagnostic tests would be more consistent with ischaemic damage rather than inflammation of Mrs C's right optic nerve.

Advice obtained from the Neurology Adviser

21. The Neurology Adviser noted from Mrs C's medical records that a working diagnosis of optic neuritis was made by the Ophthalmology Consultant, when he saw Mrs C at his clinic in June 2012, and had arranged for an MRI scan of her optic nerves and brain to be undertaken within four weeks. Shortly thereafter, Mrs C had complained of migraine headaches and new symptoms of right arm and facial weakness and numbness. Mrs C was reviewed by the Ophthalmology Consultant in July 2012, who found that she still had reduced visual function in her right eye, though the back of the eye appeared normal when viewed with an ophthalmoscope. The Ophthalmology Consultant noted that she was struggling with severe migraines and that the MRI scan of her brain and optic nerves was 'essentially normal'. The optic nerve at the back of her right eye appeared pale, which suggested damage to the nerve and was consistent with a diagnosis of optic neuritis. There was no mention of any symptoms of right sided numbness or weakness. As Mrs C was very concerned about her eyes and chronic headaches, the Ophthalmology Consultant had referred her to the headache clinic despite his understanding that another doctor had already requested a neurology appointment for her about her concerns. The Neurology Adviser noted that the Ophthalmology Consultant again reviewed Mrs C in August 2012 and that she was due to have some optic nerve conduction tests at the Southern General Hospital in the same month.

22. The Ophthalmology Consultant had reviewed Mrs C again in October 2012 and referred her for some more detailed neurophysiological tests to a consultant clinical scientist (Doctor 3) based at the Electrodiagnostic Imaging Unit at Gartnavel General Hospital, because of her visual loss, her headaches and as the tests undertaken at Southern General had been inconclusive. The Ophthalmology Consultant also arranged for Mrs C to see an Orthoptist at Ayr Hospital, where she was provided with some yellow coloured overlays. The Neurology Adviser noted that Doctor 3 had reported to the Ophthalmology Consultant that the results were suggestive of ischaemic

damage than demyelination (inflammation of the nerve). By this time Mrs C had been seen by the Neurology Consultant, who appeared to be providing further continuity of care.

23. The Neurology Adviser considered that the Ophthalmology Consultant's assessment of Mrs C had been professional and thorough and the investigations he had ordered were appropriate. The Neurology Adviser noted that, between the appointment in June 2012 and the Ophthalmology Consultant's review in July 2012, Mrs C had been seen with new symptoms of right sided sensory change and weakness in her right arm and leg. It appeared from her medical records that she had discussed these symptoms with the Ophthalmology Consultant at her review in July 2012 and at a subsequent review with the Neurology Consultant in August 2012, when they were described as transient (Mrs C disputes this and says that she had constant weakness in both her upper and lower limbs). The Neurology Adviser told me that if such symptoms were present only transiently, it would have been reasonable to attribute them to migraine. The Neurology Adviser could find no evidence that the Ophthalmology Consultant had ruled out that Mrs C may have had MS in June 2012. In the view of the Neurology Adviser, on the basis of the information available to the Ophthalmology Consultant in July 2012, Mrs C's symptoms were most likely to be due to migraine and there was no evidence at that time that her symptoms were caused by MS. The Neurology Adviser, therefore, considered the diagnosis made by the Ophthalmology Consultant at that time appeared reasonable.

24. The Neurology Adviser noted that, as stated above, the Neurology Consultant had initially seen Mrs C in August 2012, following a referral from the GP. According to the Neurology Adviser, the Neurology Consultant appears to have made a thorough assessment of Mrs C's symptoms when he saw her. Although his examination of Mrs C had revealed some sensory abnormality, the Neurology Adviser noted that the Neurology Consultant considered it likely that Mrs C's symptoms were most likely consistent with migraine. The Neurology Adviser said that the Neurology Consultant's view of the likely cause of Mrs C's symptoms had been bolstered by his knowledge that the MRI scan of her brain a few months earlier was normal.

25. According to the Neurology Adviser, the Neurology Consultant had then appropriately arranged for Mrs C to have an MRI scan of her spinal cord, which was undertaken in November 2012 and had revealed an abnormality. The

Neurology Adviser had noted the delay in communicating this result to Mrs C and in arranging for a further repeat imaging scan, which was carried out in January 2013 and which confirmed the abnormality. The Neurology Adviser noted that Mrs C had been seen by the Neurology Consultant promptly the week after the repeat scan had been carried out, when he had discussed the likely diagnosis with her.

26. In the opinion of the Neurology Adviser, the delay in carrying out the further scan in January 2013 was of no clinical significance. The Neurology Adviser told my complaints reviewer that he considered a delay between an initial and repeat imaging scan can be helpful in assessing progression of a lesion which has been identified. In the opinion of the Neurology Adviser, emotional stress does not influence the course of progression of MS and he was not aware of any evidence that would support such a view. While it was plausible that the delay in recalling Mrs C for a further scan could temporarily have exacerbated her discomfort, the Neurology Adviser could find no evidence that Mrs C's MS was adversely affected by any delay.

27. The Neurology Adviser explained to me that MS is a chronic condition. Based on the medical records received from the Board, there was no evidence that Mrs C's condition was particularly aggressive or rapidly progressive, a view that was supported by the normal appearance of the MRI scan of her head. However, it was possible that if Mrs C had been diagnosed at the earliest possible time then disease modifying treatment for her MS could have been started a few weeks earlier. However, the Neurology Adviser was of the view that such treatment for MS is of only modest prognostic and symptomatic benefit, although it reduces frequency of MS relapse by approximately one third. The Neurology Adviser noted that when Mrs C was reviewed by a consultant neurologist (Doctor 4) at St John's Hospital Livingston in July 2013, having been referred by the Neuro-Rehabilitation Consultant, she had not experienced a further relapse of her MS at that time (although Mrs C disputes this).

28. The Neurology Adviser concluded that there was no significant delay in assessing Mrs C and the delay in the diagnosis of MS was not clinically significant or unreasonable. Overall, the Neurology Adviser was of the view that Mrs C had received a good level of ophthalmological and neurological assessment.

Mrs C's Dermatology treatment

29. In August 2012 the GP removed a small lump from the right side of her nose which was diagnosed as a small non-specific benign tumour. Mrs C was, therefore, referred to a consultant dermatologist at Crosshouse Hospital (the Dermatology Consultant) who saw her in November 2012. Mrs C had a lump on her left thigh removed by a nurse practitioner in January 2013. The Dermatology Consultant subsequently told Mrs C in February 2013 that she may have tumours in her heart and kidneys. Therefore, she would need to have a scan to determine this as a matter of urgency. Mrs C said she received this news in a telephone call from the Dermatology Consultant while she was at work and the day before she was due to attend Southern General Hospital for a lumber puncture and MRI scan. However, the scans of her heart and kidneys were negative. Mrs C said that the Dermatology Consultant did not mention the name of the condition he suspected she might have and she was certainly not told that she may have suspected tuberous sclerosis (TSC). (However, I note that Mrs C provided this office with a copy of a letter she delivered to the Board, dated 3 May 2013, in which she says the Dermatology Consultant told her in the aforementioned telephone call that she had suspected TSC.) Mrs C complained about the standard of care she received from the Board in respect of her dermatology treatment.

The Board's response

30. The Board asked the Dermatology Consultant to comment about Mrs C's complaint. The Dermatology Consultant stated that he first saw Mrs C in November 2012. A colleague had already explained to Mrs C that the lesion on her nose was benign but could be found in the context of other lesions or other conditions. The Dermatology Consultant believed that he also had a similar conversation with Mrs C about this. The Dermatology Consultant said that he had asked Mrs C about a family history of similar problems and had examined her for any lesions suggestive of TSC, from memory, the Dermatology Consultant recalled that Mrs C was not keen for investigations to be carried out at that time and she said she had been undergoing eye investigations. The Dermatology Consultant said that he arranged to review the histology from Mrs C's nose biopsy at a pathology meeting to confirm if there was a real concern about the possibility of TSC, At the same time he arranged for excision of the lesion on Mrs C's thigh to exclude any lesion suggestive of TSC, The Dermatology Consultant also alerted the Ophthalmology Consultant, by letter, to the suggestion of Mrs C having TSC, When Mrs C attended for the excision of the lesion in January 2013 he spoke to Mrs C and discussed with her the

uncertain implications of the histology of the lesion which had been excised from her face and made an entry in Mrs C's medical notes to that effect.

31. The Dermatology Consultant stated that he wrote to Mrs C in February 2013 with the result of the lesion excised from her thigh and asked her to contact him to discuss the option of further investigations as he had previously discussed with her. A number of days later, Mrs C emailed him and asked that he contact her at her place of work. The Dermatology Consultant said he subsequently spoke with Mrs C by telephone and he suggested arranging scans of her kidneys and heart to exclude any abnormalities. The Dermatology Consultant said he would not have had any reason to suggest that these scans were urgent.

32. The Board stated that they were sorry to learn of Mrs C's concerns about the care she had received from their Dermatology Service and the distress caused to her. As stated above, the Board had concluded that from their investigations into her complaint, the investigation of her symptoms and the management of her care and treatment over a number of months had been managed appropriately.

Advice Obtained from the Dermatology Adviser

33. The Dermatology Adviser noted that Mrs C had a lesion removed from her nose in July 2012 by a GP with a specialist interest in dermatology. The lesion was diagnosed as an adenoma sebaceum (more commonly known as an angiofibroma (a lesion)). The histopathology report suggested that the lesion was associated with a genetic condition known as TSC, which the Dermatology Adviser explained is a genetic disorder that can lead to growths in various organs of the body, with the brain, eyes, heart, kidney, skin and lungs most commonly affected. The Dermatology Adviser explained that these growths may also be referred to as tumours but they are not cancerous. When they cause problems it is mainly because of their size and where they are in the body. TSC growths have different names depending on which organ they are found in.

34. The Dermatology Adviser explained to my complaints reviewer that the impact of TSC varies considerably, with some people being relatively mildly affected (they may not even know they have TSC) and others being more significantly affected. This impact may be evident in the early years or not until adulthood. A routine referral was, therefore, made to the Dermatology

Consultant and it was noted Mrs C was seen three months later in the Dermatology out-patient clinic. The Dermatology Consultant felt that Mrs C did not have any of the other features of TSC but arranged to review the original pathology specimen with the pathologist. This was done a month later and the suggestion was made that Mrs C may have adenoma sebaceum, a diagnostic feature of TSC, and a note was made querying genetic testing. A letter was sent to the GP stating that the Dermatology Consultant would consider further testing after a benign nodule was removed from her thigh. The Dermatology Consultant had written to Mrs C in February 2013 and informed her that no further treatment was required for her right thigh lesion (a benign dermatofibroma) and that there was the option of further investigation regarding the lesion excised from her nose. The Dermatology Adviser noted that Mrs C was invited to contact the Dermatology Consultant to discuss this. Mrs C had emailed the Dermatology Consultant a week later stating that she had been trying to contact his department and that she was disappointed that further investigations may be required as she thought that the matter had been concluded.

35. The Dermatology Adviser further noted that, between March 2013 and April 2013, Mrs C had an ultrasound of her kidneys and also a cardiac echocardiogram. Mrs C was reviewed by a junior doctor in the Dermatology clinic in April 2013 and contacted by letter in May 2013 informing her that no further follow-up was required regarding her nasal lesion. The Dermatology Consultant contacted the GP to pass on her kidney and cardiac test results, which were normal. The Dermatology Consultant also wrote to Mrs C to say that the results were normal but that there was an option of a genetic test to give absolute certainty that the growth removed from her nose had no wider significance. Mrs C was invited to discuss this with the Dermatology Consultant by telephone. The Dermatology Consultant then made a referral to a consultant clinical geneticist, at Southern General Hospital (the Genetic Consultant) in July 2013 as he felt that there was a low probability of Mrs C having TSC but that advice was required as to whether genetic testing was appropriate. A letter to Mrs C's GP stated that the Dermatology Consultant had been in email contact with Mrs C and that she was willing to attend a consultation with the Genetic Consultant. However, as genetic testing may not be appropriate the letter suggested that Mrs C be referred to the Genetic Consultant for an initial clinical assessment. A letter from the Genetic Consultant to Mrs C (dictated in September 2013 and sent a month later in October 2013) summarised Mrs C's

case and stated that the Genetic Consultant considered that genetic testing was not necessary and that the diagnosis was unlikely to be TSC.

36. Having reviewed Mrs C's Dermatology records, the Dermatology Adviser told my complaints reviewer that, in his opinion, the Dermatology Consultant had undertaken all appropriate and reasonable investigations following the review of Mrs C's pathology result. The Dermatology Adviser also considered the medical aspects of Mrs C's care were appropriate and that the Dermatology Consultant had performed his duties diligently in suspecting a diagnosis of TSC and undertaking the investigations and referrals required to exclude this serious condition. Therefore, the diagnosis by the Dermatology Consultant that Mrs C may have had suspected tumours in the heart and kidneys was reasonable. The Dermatology Adviser also considered that it had been reasonable for the Dermatology Consultant to have referred Mrs C to the Genetic Consultant for an assessment. This was because, although the probability of Mrs C having TSC was very low, geneticists are the experts in making these types of diagnosis.

(a) Conclusion

37. The basis upon which my office makes our decisions is 'reasonableness', that is, were the actions taken, or not taken, reasonable in the circumstances and in light of the information available to those involved at the time. I have set out above the specialist advice I have received in relation to both Mrs C's ophthalmology and neurology treatment and also her dermatology treatment.

Mrs C's Ophthalmology and Neurology treatment

38. The advice that I received from the Neurology Adviser, which I accept, is that, based on Mrs C's presenting symptoms in 2012, it was reasonable that the Ophthalmology Consultant and the Neurology Consultant had initially attributed these symptoms as being most likely consistent with migraine rather than MS. The assessments and treatment Mrs C received from the Ophthalmology Consultant and the Neurology Consultant and also Doctor 2 had been very thorough and of a high standard. Furthermore, the investigations ordered by the doctors treating Mrs C had been appropriate and there were no clinically significant delays in the assessment of her symptoms.

Mrs C's Dermatology treatment

39. The advice of the Dermatology Adviser is that the Dermatology Consultant had acted diligently in suspecting a diagnosis of TSC and had undertaken the necessary investigations and referrals required to exclude this serious

condition. In particular, it had been reasonable to refer Mrs C to the Genetic Consultant for assessment for genetic testing. I accept that advice.

40. I appreciate that, understandably, this has been and continues to be a very distressing and anxious time for Mrs C, who has seen a variety of doctors and undergone a range of different tests and procedures at a number of different hospitals in Ayrshire and Glasgow. However, having reviewed the documentation and the medical advice from the three specialist medical Advisers, I have not seen evidence there was a failure by any of these services to adequately assess Mrs C's condition and I am satisfied that the treatment Mrs C received from the Board's Ophthalmology, Neurology and Dermatology services was appropriate and reasonable. Therefore, I do not uphold this complaint.

(b) The Board unreasonably failed to ensure that the various departments involved in Mrs C's care monitored her care and treatment appropriately

Mrs C's Ophthalmology and Neurology treatment

41. As I referred to in complaint (a), in October 2012 the Opthalmology Consultant referred Mrs C to Gartnavel General Hospital, Glasgow, for in-depth electrodiagnostic tests due to a lack of improvement in the vision in her right eye and as she was having frequent migraines. Mrs C said that she was never given the results of these tests, which were carried out in January 2013. According to Mrs C, it was only after she complained to the Board that the tests results were followed up. Mrs C believes that the reason the test results were not followed up was because she had been discharged by the Opthalmology Consultant from his clinic. When Mrs C met with the Opthalmology Consultant in June 2013, he apologised that she had been under the impression that she had been discharged from his clinic and she had not received a follow-up appointment after her attendance at Gartnavel General Hospital. Mrs C said that the Opthalmology Consultant did not tell her that the report from Gartnavel General Hospital was suggestive of ischaemic damage to her right eye.

42. Mrs C also considered that there was a failure to monitor her vitamin B12 levels. Mrs C said she had learned from the Neurology Consultant that her levels were low in June 2013. The Neurology Consultant had told her that he had, therefore, written to her GP concerning this. According to Mrs C her low levels of vitamin B12 were detected in January 2013 when she had blood taken whilst attending Crosshouse Hospital but her GP Practice had not been advised

of this at the time. Mrs C considered that the delay in checking her vitamin B12 levels caused the levels to reduce further and contributed to her migraines and MS fatique symptoms. As a result Mrs C required vitamin B12 injections and it took nearly a year for her B12 levels to return to normal.

The Board's response

43. In response, the Board stated that the Ophthalmology Consultant had advised Mrs C at her October 2012 appointment that he intended to see her again three months later. This request had been logged on the patient management system but unfortunately it was not actioned at the time. The Ophthalmology Consultant also advised the GP that he would arrange a three month follow-up review and he was sorry that she had not received this appointment. In a further delay, the report from Gartnavel General Hospital following the tests carried out there was not sent to the Ophthalmology Consultant at the time. This report was chased up when Mrs C got in touch to find out if she had been discharged from the clinic in April 2013. The Board said that if the Ophthalmology Consultant had received the report from Gartnavel General Hospital sooner he would have seen that Mrs C was still awaiting a repeat assessment. The Ophthalmology Consultant also regretted that Mrs C had the impression she had been discharged from his care.

44. The Board apologised to Mrs C for the administrative failings, including delays in their appointments system and the related delayed communications. They stated that local improvements had been made to the Board's out-patient's appointment systems which would reduce the risk of such errors occurring in the future. Senior clinical staff were also reflecting on Mrs C's experience and considering how to improve the coordination of complex investigations in the future.

Greater Glasgow and Clyde NHS Board's response

45. Greater Glasgow and Clyde NHS Board stated that the service provided by Gartnavel General Hospital is a specialist service which provides a comprehensive range of investigations that are not available elsewhere in Scotland. To enable patients with need of urgent imaging to be reported at short notice they have urgent and non-urgent reporting times. If a referring consultant requests an urgent appointment these patients will receive an appointment and be reported on within two months, and generally sooner. There was no such request in the case of Mrs C from her referring consultant and as such it was treated as a non-urgent referral. Greater Glasgow and

Clyde NHS Board also stated they had no record of the report on Mrs C being 'chased up'.

Advice obtained from the Neurology Adviser

46. The Neurology Adviser told my complaints reviewer that the Neurology Consultant's request to Mrs C's GP to recheck her vitamin B12 levels and treat as necessary is standard practice and was appropriate, as this is a task which would normally be dealt with by her GP practice. The Neurology Adviser explained to my complaints reviewer that low vitamin B12 levels or failure to supplement vitamin B12 are not plausible causes of migraine or exacerbation of MS. The Adviser also said there was no evidence suggesting that the delay in supplementing Mrs C with vitamin B12 adversely affected her symptoms. The Neurology Adviser further considered that Mrs C's level of vitamin B12, as recorded in her medical notes, was not sufficiently low to be a plausible cause of damage to her nervous system.

Mrs C's Dermatology treatment

47. Mrs C attended the Dermatology Consultant's clinic in April 2013 to learn the results of several investigations which had been carried out. However, Mrs C said that not only was there a delay before she was seen but the Dermatology Consultant was not present, as she had expected. In addition, the doctor she saw, a clinical medical officer (Doctor 5), knew nothing about her or her test results and appeared to be under the impression that she had removed the lesion from her nose herself. Mrs C considered the appointment to be a waste of her time.

48. Mrs C said she had then understood that all investigations in relation to her dermatology treatment were concluded, until she received a letter from the Dermatology Consultant in June 2013 advising that he had arranged for her to have genetic testing at Southern General Hospital. Mrs C said she was not told the reason for this and did not know what condition the Dermatology Consultant suspected she may be suffering from.

The Board's response

49. The Dermatology Consultant considered that when he saw Mrs C in January 2013, when she attended for the excision of the lesion, he had discussed the possibility of her having TSC but that he felt she was not likely to have this condition. He was of the view that the entry made by him in Mrs C's case notes at the time indicated this.

50. The Dermatology Consultant said that when Mrs C had met with Doctor 5 at the clinic she had been keen to be discharged. There appeared to have been a misunderstanding between himself and Doctor 5 regarding the need for Mrs C to undergo further investigations. The Dermatology Consultant said the ultimately the Genetic Consultant did not feel that it was appropriate to perform a genetic test for TSC because of the negative investigations arranged by him and other consultants.

51. The Board had apologised to Mrs C that the Dermatology Consultant had not been available when she attended his clinic in April 2013 and that the doctor who was covering the clinic, (Doctor 5) seemed unaware of the details of her case.

52. The Board had also apologised that the clinic was running late and explained that this was because some appointments took longer than planned but that Mrs C should have been kept up to date in the clinic while she was waiting and an explanation and apology offered to her. The Board said this had been brought to the attention of relevant clinic staff.

53. In response to Mrs C's complaint that she was upset at receiving a telephone call at work from the Dermatology Consultant about her condition in February 2013, the Dermatology Consultant said he had contacted Mrs C in response to an email from her asking that he contact her at her place of work and he had not thought the conversation would have upset Mrs C as this was a follow-up conversation to issues which had previously been discussed with her. The Dermatology Consultant noted that Mrs C had stated in her initial letter of complaint to the Board in May 2013 that she had been told that she had suspected TSC during this call. However, the Dermatology Consultant apologised for the upset caused to Mrs C.

54. Doctor 5, who had seen Mrs C at the clinic in April 2013 also apologised that he had thought Mrs C had removed the lesion from her nose herself. This was a misunderstanding by Doctor 5, for which he apologised. As a result, the Board had introduced a quality improvement plan in July 2013 in which a reminder had been sent to medical, nursing and reception staff about the importance of keeping patients informed when clinics are running behind schedule. In addition, consultants were asked to reinforce to their junior clinical staff the importance of reading a patient's details before a consultation begins.

The Dermatology Consultant and Doctor 5 also apologised for the misunderstanding which had led to Mrs C receiving the letter concerning her having genetic testing.

Advice obtained from the Dermatology Adviser

55. The Dermatology Adviser could find no evidence in letters or medical notes that the Dermatology Consultant ever told Mrs C what condition he suspected she may have been suffering from at the time. The Dermatology Adviser noted there was a reference to telephone calls and emails discussing the rationale for investigation, where the suspected diagnosis may have been discussed, but according to the Dermatology Adviser this is speculation. Also, where communication may have been made with her by telephone, the Dermatology Adviser noted that no written record existed of this in Mrs C's medical notes and, in its absence, the first mention of TSC to Mrs C appeared to have been the Genetic Consultant's letter in October 2013, which is the concluding correspondence in respect of Mrs C's treatment. However, in the Dermatology Adviser's view, the most unsatisfactory communication was the letter from Doctor 5 to Mrs C sent in May 2013. This letter stated that after discussion with the Dermatology Consultant: 'There is no reason why you need to attend at the dermatology clinic for further review.' The Dermatology Adviser considered it was reasonable that Mrs C would infer from this, wrongly, as it turned out, that her case was concluded. While the Dermatology Adviser was of the view that the medical aspects of Mrs C's care had been appropriate, there had been considerable delay (from July 2012 until October 2013) in completing investigations, making a referral and writing to her. The Dermatology Adviser told me that was not a high standard of care.

56. The Dermatology Adviser noted the Board had accepted there were a number of administrative and system failures and communication problems and had supplied a copy of an action plan to improve communication with patients in the Dermatology department. The Dermatology Adviser reviewed the action plan but considered the action the Board had taken did not address the failures identified. The Dermatology Adviser considered that the action plan regarding junior doctors carefully reading notes before seeing patients would be helpful but would not have avoided the errors he had identified. In particular, the Dermatology Adviser considered the action plan would not have stopped the letter from Doctor 5 erroneously reassuring Mrs C that her treatment was concluded from being sent.

57. The Dermatology Adviser also told my complaints reviewer that, in his view, the Board should develop a pathway regarding all suspected genetic disorders seen within the Dermatology department. It would streamline access to geneticists for advice on investigations for making the diagnosis of a given disease and thus may prevent unnecessary investigation and patient distress. The Dermatology Adviser also considered that the issue of a formal letter to Mrs C at the outset about the suspected diagnosis would have been helpful to her.

(b) Conclusion

58. The Board have accepted there were administrative failings in their communications with Mrs C, including delays in their appointments system. However, in my view and based on the clinical advice that I have received, I consider there were also serious failings by the Board in not ensuring that the various departments involved in Mrs C's care monitored her care and treatment appropriately. This had resulted in Mrs C reasonably believing she had been discharged from the Ophthalmology Consultant's care.

59. With regard to Mrs C's dermatology care, it is clearly a matter of dispute between Mrs C and the Dermatology Consultant when Mrs C was told she had suspected TSC. I am unable to reconcile the different accounts of this by Mrs C and the Dermatology Consultant. Where there are conflicting versions of events, as in this case, and no documentary evidence to support what was discussed, it is not possible to come to a conclusion about this. Although it appears likely that the Dermatology Consultant told Mrs C verbally what condition he suspected she may have been suffering from, I am critical there is no written record made by the Dermatology Consultant about this given its importance and on this basis I uphold this complaint.

60. I note that apologies have been made by the Board and the doctors involved in Mrs C's care, and that an action plan was introduced by Dermatology services, a copy of which was supplied to this office. However, I do not consider that I have seen evidence of all of the action taken by the Board to address these failings. In addition, I have also taken account of the advice received from the Dermatology Adviser to address the failings identified in Mrs C's dermatology care. Therefore, I have made a number of recommendations to the Board in respect of this complaint.

(b) Recommendations

61. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings identified;	19 November 2014
(ii) provide evidence of the improvements that have been made to the Board's out-patient's appointment systems;	19 November 2014
(iii) consider developing a pathway regarding all suspected genetic disorders seen within Dermatology Services, so as to streamline access to geneticists; and	22 January 2015
(iv) ensure that the comments of the Dermatology Adviser, in relation to record-keeping and the Board's action plan, are brought to the attention of the relevant staff within Dermatology Services.	5 November 2014

(c) The Board unreasonably failed to ensure that the various departments involved in Mrs C's care co-ordinated and communicated appropriately with each other

62. Mrs C complained that on occasions her medical notes were not available or referral letters and test results had not been received when she attended at various clinics.

Mrs C's Ophthalmology and Neurology treatment

63. Mrs C said that she was never told by the Ophthalmology Consultant that she had been left partially sighted and that he had discharged her from his clinic. She had to learn this information from an orthoptist at Ayr Hospital, to whom she had been referred due to optic nerve damage and worsening dyslexia symptoms and migraines.

64. In January 2013 the Neurology Consultant told her that, as she had demyelination of the cervical spine and possible MS, she would require further tests including a lumbar puncture and MRI scan. She was, therefore, to be admitted as a day patient to Southern General Hospital at the beginning of March 2013 for these tests.

65. Although Mrs C says she was referred to the Neuro-Rehabilitation Consultant in early May 2013, she had to wait until the end of May 2013 before the Neuro-Rehabilitation Consultant could confirm that she had a definite

diagnosis of MS and medication could begin. This was because of a delay in test results from Southern General Hospital.

The Board's response

66. The Consultant Opthalmologist said that, from his recollection, Mrs C would not be considered to be 'partially sighted'. The Board also stated that Neurology services had co-ordinated Mrs C's neurological investigations and Doctor 2, who was a headaches specialist, had investigated Mrs C's headaches and liaised with his colleague, the Neurology Consultant. The Board further stated that the Neurology Consultant confirmed that he advised Mrs C's GP in January 2013 that she had a vitamin B12 deficiency and suggested this be rechecked and that she be provided with a supplement. The Board had checked with Mrs C's GP practice about receipt of the letter from the Neurology Consultant, which had been posted with Mrs C's GP case records, but the practice did not have a copy of the letter. The Board had, therefore, made arrangements to send a duplicate letter to the GP so that he could consider the Neurology Consultant's advice regarding monitoring Mrs C's vitamin B12 deficiency.

67. The Board stated that there was no single specialist service or consultant solely responsible for Mrs C's care. Rather, each service investigated Mrs C's symptoms relating to their speciality and reported the results to the GP. However, the Board accepted there were a number of administrative and system failures and communication problems involving Ayrshire and Glasgow services.

Advice obtained from the Neurology Adviser

68. The Neurology Adviser told my complaints reviewer that it was usually the case that a patient's GP retained primary responsibility for the patient's care unless there were specifically commissioned treatment pathways for the condition suffered by the patient. In the Neurology Adviser's view, once Mrs C was diagnosed as suffering from MS, it was then reasonable to expect her care to be allocated to a consultant led service, which the Neurology Adviser said appeared to have happened with Mrs C. The Neurology Adviser said that he agreed with the Board that it was standard practice that each different specialist service investigated a patient's symptoms in relation to their specialism and reported back to the patient's GP, rather than having a single specialist service or consultant solely responsible for all the patient's care and treatment.

69. The Neurology Adviser considered that the doctors involved in Mrs C's Ophthalmology and Neurology care had made every effort to communicate with her and had, in his view, done so successfully, with two exceptions. These were the Neurology Consultant's referral letter to the Neuro-Rehabilitation Consultant, which although dictated on 22 January 2013 and typed on 23 January 2013, was not received by the Neuro-Rehabilitation Consultant until 15 April 2013, a delay of about ten weeks and, secondly, when the Neuro-Rehabilitation Consultant was unable to trace the result of the lumbar puncture undertaken at Southern General Hospital at the beginning of March 2013. The Neurology Adviser considered these were unreasonable failures in the communication and co-ordination of Mrs C's care. The Neurology Adviser also stated that it was not acceptable that a patient's clinical records were unavailable for clinic appointments.

70. According to the Neurology Adviser, the Board should, therefore, consider implementing, as a matter of routine, the copying of clinical correspondence to a patient, so as to reduce miscommunication and so provide the patient with the opportunity to monitor the progress of the investigation and treatment of their illness or condition. In addition, the Board should consider reviewing their systems for referral between specialists and hospitals so as to ensure, as far as possible, that there is no recurrence of the delay suffered by Mrs C in actioning referrals to other specialists or hospitals.

Mrs C's Radiology treatment

71. Mrs C said that she only learned in December 2012, when she saw the Neurology Consultant for the results of the MRI scan, that the Radiology Department at Ayr Hospital should have called her back for a second MRI scan with dye to confirm the findings of the first scan. The second MRI scan was not then carried out until January 2013. Mrs C felt let down by this error and considered that the stress of this could have exacerbated her MS symptoms.

The Board's response

72. The Board explained that a consultant radiologist at Ayr Hospital (the Consultant Radiologist) had requested that Mrs C be invited to return for a second assessment, following the cervical spine MRI scan carried out in November 2012. The Board explained that when a radiologist makes a request for an additional scan this is actioned. The Board said that, regrettably, on this occasion the radiologists had not followed this protocol and as a result a request for a follow-up MRI scan was not received by the administrative staff

who would have made the appointment. This error had been raised with the radiologist concerned and the Board sincerely apologised for this failing.

73. The second MRI scan was not carried out until January 2013. The Board said that both Crosshouse and Ayr Hospitals had been under pressure as a result of a significant increase in demand. Nevertheless, even allowing for the Christmas period, it accepted that the second scan could have been carried out sooner and they apologised for this. They stated they understood why Mrs C felt she had not had a good service from Radiology Services.

Advice obtained from the Radiology Adviser

74. The Radiology Adviser explained that the diagnosis of MS cannot be made using one single test or clinical feature. A patient's symptoms and signs characteristically vary over the course of time and may worsen, lessen or become progressive. The diagnosis is made using a combination of the patient's clinical signs and symptoms, laboratory investigations (for example, examination of cerebrospinal fluid) and MRI scan of the brain and spinal cord. In particular, MRI findings alone are not absolutely diagnostic and correlation with clinical features and laboratory findings is necessary to confirm the diagnosis. In some patients, additional MRI sequences and use of an intravenous contrast agent may be needed to supplement initial standard images.

75. The Radiology Adviser firstly explained the usual vetting procedures which are carried out when an MRI request is received. Normally the MRI request is vetted by a radiologist, who will select a protocol for the MRI examination and indicate the degree of urgency for the appointment depending on the clinical information supplied. The MRI examination protocol indicates which parts of the body are to be examined and which type of MRI sequences will most likely demonstrate the suspected pathology. Most MRI examinations are performed without a radiologist being present. Where some examinations require a radiologist to review images at the time the scan is carried out, the patient will be placed on a supervised list so that a designated radiologist is available to do so. Inevitably, some patients whose MRI scans were performed on an unsupervised list will need to be recalled for further MRI sequences once the initial images have been reported by a radiologist. In some instances, the radiographer/technician performing the MRI examination may notice an abnormality on the MRI images as they are obtained and then ask a radiologist to review these images at the time of the examination. However, this would

depend on a radiologist being available at the time. Formal reporting of the MRI images is not generally the role of the radiographer/technician.

76. In Mrs C's case, the Radiology Adviser explained that the clinical information, as recorded on the report of the MRI scan on Mrs C's cervical spine performed in November 2012, did not indicate that MS was suspected by the referring clinician, the Consultant Neurologist. Thus, the radiologist who was vetting the MRI request would not have been prompted to suggest additional specific MRI sequences or arrange for the examination to be performed at a time when a radiologist would be available to review the images.

77. The Radiology Adviser explained that it is the responsibility of the referring health care professional to view, act upon and record the results of imaging studies that are requested. The Consultant Radiologist who reviewed Mrs C's MRI scan was, in the view of the Radiology Adviser, following best practice by electing to arrange the second MRI scan rather than simply advising the Consultant Neurologist that further imaging should be rearranged. Unfortunately, the Consultant Radiologist failed to action this by the usual local procedure and the Consultant Neurologist had correctly requested a further MRI scan, having seen Mrs C in the out-patient clinic in December 2012. The Radiology Adviser was unable to determine from the records if the Consultant Neurologist had indicated any degree of urgency in this request. Nevertheless, the Radiology Adviser considered that it would have been reasonable for the radiologist who vetted this second request from the Consultant Neurologist to have expedited the repeat MRI scan. The repeat MRI scan was not performed until January 2013, approximately nine weeks after the initial scan and just over three weeks since Mrs C had last been seen by the Consultant Neurologist in December 2012. Even allowing for the Christmas holiday period when the imaging department would have been under pressure, the Radiology Adviser considered it would have been reasonable to expect that Mrs C's repeat MRI scan would have been performed sooner. However, the Radiology Adviser told my complaints reviewer that, in their opinion, the delay in obtaining a diagnosis due to the time interval between the two scans was unlikely to have been of critical significance.

78. The Radiology Adviser noted that the Board had acknowledged that the radiologist had not followed the usual protocol for arranging a repeat MRI scan and had also acknowledged that the repeat MRI scan could have been performed at an earlier date. As a result, the radiologist concerned and other

staff were reminded of the process for requesting follow-up scans. However, the Radiology Adviser considered that the Board's response to this part of Mrs C's complaint, although in general adequate, did not indicate which part of the recall protocol had failed. Therefore, from the information provided by the Board, the specific underlying cause for the failure to recall Mrs C had not been identified. If this has not been identified by the Board and rectified then the Radiology Adviser was concerned that the same problem may recur. Accordingly, the Radiology Adviser considered that the Board should, if they have not already done so, arrange a meeting with the appropriate staff to discuss the failure.

79. The Radiology Adviser was also of the view that a consultant radiologist should be available to support radiographers/technicians in the event that they observe an abnormality on images during an MRI examination. The Radiology Adviser also considered that radiographers/technicians should be encouraged to alert radiologists to possible abnormalities they see during MRI examinations.

80. The Radiology Adviser further considered that the system for vetting of imaging requests should be reviewed. In the Radiology Adviser's opinion, there should be an audit carried out to assess if there is any significant delay in vetting requests and to ensure there is a clear system for prioritising requests, according to the degree of clinical urgency, which is understood by all staff.

81. The Radiology Adviser noted that Mrs C had undergone an MRI scan of her thoracic and lumbar spine at Southern General Hospital at the beginning of March 2013. The Radiology Adviser questioned whether this scan could have been performed at the same time as the repeat MRI scan that took place in January 2013. The Radiology Adviser had, therefore, suggested that departmental spinal MRI protocols are reviewed, since in several disorders presenting with neurological symptoms there may be abnormality at multiple levels in the spinal cord or vertebral column. In such patients, it may be simplest to examine the whole spine at the first examination, which on the most recently installed MRI units is straightforward, although the Radiology Adviser has acknowledged this may be time consuming in older MRI units.

82. The Neurology Adviser also considered that there should be a review of the circumstances which led to the delay in the repeat neuroimaging that Mrs C underwent, to ensure that communication protocols between Radiology Services and other clinicians were optimal.

The Board's overall response to this complaint

83. The Board accepted that there had been a number of administrative and system failures and communication problems between the Ayrshire and Glasgow services. This had involved a number of specialists and locations which had contributed to delays in appointments and processing results. The Board, therefore, had upheld Mrs C's complaint in relation to deficiencies in the administrative coordination of her clinical care and had apologised sincerely for the uncertainty and worry this had caused her.

(c) Conclusion

84. It is clear from my review of the evidence and the clinical advice I have received that Mrs C has raised justifiable concerns. The Board have accepted there were a number of failures in the communication and coordination of Mrs C's care and poor communication between the various services in Ayrshire and Glasgow.

85. While I acknowledge the advice that I have received that the doctors involved in Mrs C's Ophthalmology and Neurology care had made every effort to communicate with her, I am satisfied, as with complaint (b), that a number of failings have been identified including not only poor communication and coordination of services but also unreasonable delay by the various departments involved in Mrs C's care. In this complaint, I have also dealt with the concerns Mrs C has raised about her radiology treatment. Similarly, further failings have been identified which, although unlikely to have been of critical significance, clearly caused her worry and upset at an already difficult time for her and led to delay in her treatment. I, therefore, uphold this complaint.

86. The Board have provided details of action they have taken to address the failings they identified. However, I do not consider all of the failings identified in this report have been addressed by the Board. I, therefore, make the following recommendations.

(c) Recommendations

87. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings identified;	19 November 2014
(ii) in cases involving several health boards, consider	22 December 2014

	implementing the copying of clinical correspondence to a patient, so as to improve communication and provide the patient with the opportunity to be aware of the progress of their care;	
(iii)	consider reviewing the systems for Radiology referrals between hospitals;	22 January 2015
(iv)	review spinal MRI protocols to: identify which part of the recall protocol failed in Mrs C's case; ensure where abnormalities are detected they are appropriately reported; and ensure appropriate consideration is given to examining the patient's whole spine in one scan;	22 January 2015
(v)	carry out an audit to ensure there is a clear system for prioritising MRI scan requests according to the degree of clinical urgency;	22 January 2015
(vi)	ensure that communication protocols between Radiology Services and other clinicians are optimal; and	22 January 2015
(vii)	ensure that the comments of the Radiology Adviser and the Neurology Adviser are shared with the appropriate staff.	5 November 2014

(d) The Board unreasonably failed to ensure that the responses Mrs C received to her complaints were accurate

Mrs C's complaint to the Board

88. Mrs C wrote to the Board on 10 June 2013 stating that the Board's letter to her of 28 May 2013, in response to her complaint, had contained several inaccuracies concerning her care and treatment.

The Board's response

89. The Board responded in a letter to Mrs C dated 3 July 2013. The Board said that it was 'unfortunate' that there had been inaccuracies in their reply to her complaint and could understand 'how it must have further shaken her confidence in the health care provided to her'. The Board said that difficulty in obtaining her case notes had contributed to these errors as she was being seen by a number of different consultants around the same time and her medical notes were in different locations.

90. In future, the Board planned to move to digital case notes, which would assist communication across different sites and between specialities. Nevertheless, the Board accepted there was 'no excuse' for the errors that had been made in their reply to her, for which the Board apologised.

(d) Conclusion

91. The Board clearly made a number of errors, which they have admitted, when responding to Mrs C's complaint. Amongst the errors, the Neurology Consultant had wrongly stated that Mrs C had been sent to Southern General Hospital for electrodiagnostic investigations and had been found to have diabetic neuropathy. Also, that Mrs C had surgery for carpel tunnel syndrome, which she had not.

92. I note that, in particular, Mrs C disputes conversations between her and the Neurology Consultant and also with Doctor 2 at consultations she attended. There are clearly differing accounts of the conversations that took place between Mrs C and these two doctors. Having considered the matter carefully, I am unable to reconcile the different accounts of what occurred at these consultations. That is not to say that I disbelieve Mrs C's version of events.

93. I accept the Board have acknowledged the errors in their response to Mrs C's complaint and the effect this will have had on her. However, I do not accept that difficulty in obtaining Mrs C's case notes can excuse the errors in the Board's response. The errors, in my view, point to a lack of diligence in checking the accuracy of the response before it was sent to Mrs C. Understandably, given all that has occurred in Mrs C's dealings with the various services, I also appreciate the upset and frustration she has endured. Accordingly, I am satisfied that the Board failed to ensure that the responses Mrs C received to her complaints were accurate. Therefore, I uphold this complaint.

94. To address these failings, I have also made the following recommendations to the Board.

(d) Recommendations

95. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings identified; and	19 November 2014

(ii)	advise of the present position in respect of the planned move to digital case notes.	22 December 2014

96. 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
the Board	Ayrshire and Arran NHS Board
MS	Multiple sclerosis
the Neurology Adviser	a clinical adviser to the Ombudsman
the Dermatology Adviser	a clinical adviser to the Ombudsman
the Radiology Adviser	a clinical adviser to the Ombudsman
the Ophthalmology Consultant	a Consultant Ophthalmologist at Crosshouse Hospital
MRI scan	Magnetic Resonance Imaging Scan
Doctor 1	a Consultant Physician at Ayr Hospital
the Neurology Consultant	a Consultant Neurologist at Crosshouse Hospital
the GP	Mrs C's General Practitioner
Doctor 2	a Consultant Neurologist at Crosshouse Hospital, with a special interest in headaches
the Neuro-Rehabilitation Consultant	a Consultant in Neuro-Rehabilitation at Ayrshire Central Hospital, who specialises in MS care
Doctor 3	a Consultant Clinical Scientist based at the Electrodiagnostic Imaging Unit at

	Gartnavel General Hospital
Doctor 4	a Consultant Neurologist at St John's Hospital, Livingston
the Dermatology Consultant	a Consultant Dermatologist at Crosshouse Hospital
TSC	Tuberous sclerosis
the Genetic Consultant	a Consultant Clinical Geneticist at Southern General Hospital
Doctor 5	a Clinical Medical Officer at Crosshouse Hospital
the Consultant Radiologist	a Consultant Radiologist at Ayr Hospital

Annex 2

Glossary of terms

Adenoma sebaceum	a lesion
Cardiac echocardiogram	a test that uses sound waves to create moving pictures of the heart
Colorimetry	the science of measuring colours
Demyelination	inflammation of the nerve
Lumbar puncture	a medical procedure where a needle is inserted into the lower part of the spine
Optic neuritis	an inflammation of the optic nerve
Orthoptist	a health professional who diagnoses and manages disorders of binocular vision
Tuberous sclerosis	a genetic disorder that can lead to growths in various organs of the body; with the brain, eyes, heart, kidney, skin and lungs most commonly affected
Visual evoked potentials examinations	tests which measure the electrical activity of the brain