Scottish Parliament Region: Mid Scotland and Fife

Case 200501079: Forth Valley NHS Board

Introduction

1. On 1 August 2005 the Ombudsman received a complaint from a man (referred to in this report as Mr C) that Forth Valley NHS Board (the Board) failed to provide him with appropriate diagnosis and treatment following his initial admission to the Stirling Royal Infirmary (SRI) on 4 February 2005.

2. Mr C had a number of admissions and out-patient appointments following 4 February 2005. He raised a formal complaint with the Board on 30 March 2005 but was not satisfied with aspects of the responses.

3. The complaints investigated *(and my conclusions)* are:

(a) inappropriate diagnosis and treatment *(not upheld – see paragraphs 19 to 22)*;

(b) poor communication by staff *(upheld – see paragraphs 27 to 28)*;

(c) an inadequate response to letters of complaint *(not upheld – see paragraph 32)*;

(d) inaccuracies in Mr C's medical record and errors in providing him with a copy of this (*not upheld – see paragraph 39)*.

4. The recommendation the Ombudsman is making resulting from this investigation is that the Board should review the procedures for arranging MRI and other scans to ensure that it is clear which test is being requested and that the patient's medical records contain sufficient details of tests arranged.

5. Mr C and the Board have been given an opportunity to comment on a draft of this report. Following sight of the draft report the Board have accepted this recommendation and will act on it accordingly. Mr C does not agree with my findings on Complaints (a), (b) or (d) and considers that the failures in communication identified in this report are also evidence of inappropriate diagnosis and treatment.

Investigation and findings of fact

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, medical records and complaint files. I have sought the view of a medical adviser (referred to in this report as the adviser). A number of written enquires have been made of Forth Valley NHS Board who have provided me with copies of policies and documents referred to in this report. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

7. A number of the issues giving rise to Mr C's complaint concerned a difference of view over the exact nature of what was said or done by members of staff or Mr C, and the accuracy of the ensuing medical record. On a number of issues I did not find sufficient evidence to reach a clear conclusion on differing views of events. Where relevant these issues are addressed as they arise in my findings.

Medical Background to the Complaint

8. Mr C experienced dizziness, headache, involuntary spasms on his left side and loss of voice on 2 February 2005. He attended his general practitioner (GP1) on 4 February 2005 to discuss this incident. GP 1 contacted the SRI and discussed Mr C's case and referred him to the accident and emergency department for exclusion of subarachnoid haemorrhage or space occupying lesion in the brain. On the day Mr C was admitted to the accident and emergency department it was very busy and he was transferred to Ward 29 following assessment by a nurse. Mr C was examined by a doctor on Ward 29 who then discussed his condition with Consultant 1. At that time the plan was to perform a CT scan and lumbar puncture if the result of the CT scan was negative. Mr C was kept in over-night for observation. The treatment plan was confirmed by Consultant 1 the following day and the CT scan was performed. The CT scan was negative and a lumbar puncture was performed which did not reveal any abnormality. These tests excluded the possibility of subarachnoid haemorrhage and space occupying lesion.

9. Following this Mr C was discharged from hospital on 5 February 2005. Subsequently Mr C developed severe headaches and other debilitating symptoms and was readmitted on 7 February 2005. The headaches were later attributed to post lumbar puncture headaches (PLPH). As Mr C continued to be unwell in the following weeks, further tests (including an MRI scan) and a

referral to a neurologist (Consultant Neurologist 1) were arranged by GP 1. Mr C's underlying medical condition was finally diagnosed as 'left vertebral artery dissection with a right cerebellar infarct' giving rise to the original episode of illness on 2 February 2005. The eventual diagnosis was made by Consultant Neurologist 1 following an MRI and MRA on 5 April 2005. At the time of reporting Mr C continues to experience debilitating headaches and is on long term pain medication.

10. A lumbar puncture is a procedure in which spinal fluid is withdrawn by means of a needle inserted into the membrane space in the region of the lower back. Post lumbar puncture headaches (PLPH) occur in 25% of cases without there necessarily being any fault in the procedure itself.

(a) Inappropriate diagnosis and treatment

11. Mr C complained that his underlying medical condition was not diagnosed until he was referred to Consultant Neurologist 1 in March 2005. Mr C complained that he was not offered any explanation of the lumbar puncture procedure and in particular that he was not advised of the possible side-effects of such a procedure. Mr C complained to the Board that the doctor carrying out the lumbar puncture procedure (Doctor 1) was inexperienced and did not discuss the process with him beforehand or advise him of the appropriate after-care and warning signs. He also complained that Doctor 1 failed to make a proper record of the procedure in the medical notes. Mr C raised a concern that he was twice discharged from hospital when he was not in a fit state. He stated that Consultant Neurologist 1 told him that his condition was evident on the original scan performed on 5 February 2005 and that he should have been referred to Neurology at an earlier stage. Mr C said that it was only at the insistence of his GP that he was eventually referred. Mr C complained that there was an unnecessary delay in considering the need for a blood patch to address his PLPH and that in the event this action was not discussed with Consultant Neurologist 1 by Consultant Anaesthetist 1 (who performed the blood patch). Mr C also complained that an MRI Scan was insufficient despite his insistence at the time that the scan should be more extensive and include a spine scan as well as a head scan.

12. During the NHS investigation of this complaint, the Board stated that Mr C's lumbar puncture procedure was carried out by a suitably qualified doctor (Doctor 1) using a needle of the correct type and size. I note that the medical record makes no reference to any information being given to Mr C or to the

types and sizes of needles used for this procedure. This latter information was later supplied by Doctor 1 during the NHS investigation of this complaint. I also note that the records do not contain any GP Discharge Note for the first admission and consequently there is no record on file of any follow-up advice. The Board apologised that Mr C had not been given the information he needed or the relevant written information. The Board also stated that on 9 February 2005, following Mr C's readmission on 7 February 2005, the consultant on call and an anaesthetist reviewed Mr C in light of his ongoing headaches and considered the possibility of PLPH but judged that this was not indicated by Mr C's symptoms. The Board concluded that it was only with the passage of time and the further test results that Mr C's true underlying condition was detected and commented that most PLPH resolves within 6 weeks – only being treated where symptoms continue beyond this time period. The Board also advised Mr C that his case had been fully discussed over the phone with a neurologist providing neurology support to the SRI on 8 February 2005.

13. During the NHS investigation of this complaint Consultant Neurologist 1 provided a response to Mr C's concerns to the NHS Complaints Officer. In this Consultant Neurologist 1 stated that the CT scan on 5 February was almost certainly normal and that while in retrospect the first MRI did show the cerebellar infarct, this was only apparent when compared with the more obvious abnormality in the subsequent MRI scan as the infarct had evolved. Consultant Neurologist 1 did note that she felt Mr C should have been referred for further investigation of his original event. The Board have told me that they considered that the involvement of the Neurology support service on 8 February 2005 was the appropriate course of action in these circumstances. Consultant Neurologist 1 stated that her initial view of Mr C's condition (as reported to her over the phone by GP 1) was that it was a vertebral artery dissection; she later altered her view when she reviewed his notes. It was only subsequently that she made a clear diagnosis following discussion with a neuroradiology colleague of the results on the second MRI and the MRA conducted on 5 April 2005. Consultant Neurologist 1 also stated that it was her view that a six week wait before performing the blood patch was reasonable.

14. The hospital discharge record prepared for GP 1 following Mr C's second admission on 11 February 2005, states 'Advise Neurology referral if problem persists'. This is also recorded in Mr C's medical record on 11 February 2005 although Mr C told me that he himself was not given this advice.

15. In response to my enquiries the Board provided me with a copy of the written material which should be routinely given to patients having a lumbar puncture. The adviser reviewed this and considered it to be appropriate.

16. The medical record contains a lengthy entry from Consultant Anaesthetist 1 dated 18 March 2005 (written retrospectively because Mr C's notes were not available for the consultation). The record details the discussion held with Mr C, including an assessment of the risks and limited benefits of a blood patch to address the PLPH.

17. The adviser commented that when a patient presents with Mr C's initial symptoms and history the principal concern is to eliminate a diagnosis of subarachnoid haemorrhage (SAH). This is done first by a CT scan which, if inconclusive, is followed by a lumbar puncture. 10% of SAH are not detected by a CT scan. The adviser commented that there is no one correct needle that is used in lumbar puncture procedures. The size and type of needle chosen will vary according to personal preference and there are benefits and drawbacks to each size. The adviser told me that while some hospitals used sterilised lumbar puncture packs which contain a variety of needles the system of separate needles used by the SRI is consistent with reasonable practice and widely used elsewhere. The adviser stated that vertebral artery dissection is a rare condition and it would be quite usual for a patient with Mr C's symptoms to be admitted under the care of a general physician for exclusion of suspected SAH. The adviser is of the view that a general physician would not be expected to consider this as a diagnosis and that the actions taken during this first admission were reasonable (subject to the concerns about the provision of information about lumbar puncture). The adviser concluded that there was no clear medical reason to keep Mr C in hospital longer. I note that staff did not record Mr C's view that he was not well enough to return home. This omission added to Mr C's sense of grievance that his views were not being considered.

18. Mr C had an MRI scan (without contrast) on 8 March 2005. This was reported as normal by a consultant neurologist. It is not clear from the records whether the MRI was ordered with contrast or not as there is no documentation of the referral. It is clear that an MRI of the spine was ordered but not carried out.

(a) Inappropriate diagnosis and treatment: Conclusion

19. Mr C was not given adequate information prior to the lumbar puncture procedure or following it. The medical records do not indicate any information was given to Mr C or all the details of the lumbar puncture procedure. The available information that should have been provided to him is adequate but staff failed to provide him with this. Based on the medical advice I received I have concluded that Mr C's treatment, including the lumbar puncture, was appropriate, timely and properly carried out. The failure to communicate adequately with the patient during the first admission gave rise to many of the ensuing problems and is addressed in complaint (b).

20. I do not consider the time-gap between the lumbar puncture and the blood patch was unreasonable or attributable to any error on the part of staff. Consultant Neurologist 1 had not yet taken over Mr C's care and it was reasonable for Consultant Anaesthetist 1 to proceed without further discussion. There is no evidence in the file to clarify exactly what tests were ordered for 8 March 2005 but it is clear that the tests were not carried out as intended. I consider that there is evidence to support Mr C's view that the MRI on 8 March 2005 was not carried out as required and despite his expressing doubts at the time. I do not consider that this failure contributed to any delay of diagnosis.

21. Overall I do not uphold this complaint but note that there were failures in communication which I refer to in (b) and a lack of clarity in the procedure for ordering the MRI scan.

22. In light of this conclusion the Ombudsman recommends that the Board review the procedures for arranging MRI and other scans to ensure that it is clear to the radiographer which test is being requested and that the patient's medical record contains sufficient details of tests being arranged.

(b) Poor communication by staff

23. Mr C complained that GP 1 had contacted the SRI before referring him on 4 February 2005 and had advised him he would have a CT scan but on his arrival the receiving doctor was not expecting him and the CT scan was not performed until the next day. He further complained that it was only due to the repeated intervention of GP 1 and his own interventions that the necessary tests and referrals were arranged.

24. During the local resolution stage of this complaint, the Board response of 7 June 2005 stated that the usual practice on admission was to assess and examine the patient and then decide the priority for a CT scan. The Board recognised the importance of communication between staff and patients and between staff themselves. The Board specifically apologised that Mr C had not been given the appropriate information about lumbar puncture. Following this complaint a reminder was issued to the relevant staff that lumbar puncture information should be given to all patients and that the patient's consent to the procedure should be formally noted on the appropriate form.

25. The adviser commented that Mr C's initial assessment was carried out in line with good practice and in reasonable time.

26. I noted in (a) the reference within the GP Discharge Note to 'refer to Neurology if symptoms persist' and noted that this was a reasonable course of action. It is usual for a GP to be proactive in making referrals to specialist services in this way. I noted in (a) that there were confusions over the first MRI scan and that this contributed to Mr C's anxiety over future tests. I noted failures in written and oral communication in my conclusions to Complaint (a). These failures occurred at an early and crucial point in Mr C's care and led to understandable, raised anxiety on his part that his medical condition was not being taken seriously and that staff could not be relied upon to act promptly or efficiently in his on-going care.

(b) Poor communication by staff: Conclusion

27. There were acknowledged failures to provide Mr C with the necessary information about lumbar puncture procedures. I note the action taken by the Board to reinforce with staff the need for information and consent. There was a failure to communicate with Mr C about his concerns over his fitness for discharge. The referrals and tests were in general appropriately arranged but early communication failures led to unnecessary but understandable anxiety on Mr C's part. I uphold this aspect of the complaint.

28. In light of the action already taken by the Board and the apology already given by the Board, the Ombudsman has no further recommendation to make.

(c) Inadequate response to Mr C's letters of complaint

29. Mr C complained to the Board on 30 March 2005 and raised additional concerns in an email of 25 May 2005. He received an acknowledgement of his complaint on 5 April 2005, a notification of delay and an apology for this delay on 2 May 2005 and a written response on 7 June 2005. On 9 June 2005 Mr C was advised of his right to approach this office.

30. Mr C was not satisfied with the quality of the response which he considered had not addressed all his issues and was often inaccurate.

31. The Board have supplied me with a copy of the correspondence and background information in relation to this complaint. The relevant members of staff were contacted and asked to comment on Mr C's complaint.

(c) Inadequate response to Mr C's letters of complaint: Conclusion

32. Mr C's complaint was complex in nature and made reference to many issues. The Board response was timely and the Board sought to keep him informed of delays. I acknowledge that Mr C was not satisfied with the response because he did not agree with the Board's view of the necessary timescale of his diagnosis or the appropriateness of all his treatments. These issues are dealt with in (a) and (b) above. I consider that the Board made a reasonable attempt to answer Mr C's many questions in a clear and empathetic way and they made an apology for the failure to provide him with the necessary information about his lumbar puncture. In my view, Mr C's continued dissatisfaction was caused by his disagreement with the views of the Board over the medical events not because of a poor quality of response. I do not uphold this aspect of the complaint.

(d) Inaccuracies in Mr C's medical record and errors in providing him with a copy of this

33. Mr C wrote to the Board on 17 June 2005 requesting a copy of his medical records. Mr C received the copy records on 14 July 2005. Mr C wrote to the Board on 14 July 2005 complaining that the records were incomplete in that they contained only a single page of a larger document pertaining to his complaint as set out in (a) and (b) above. Mr C wrote again on 26 July 2005 raising additional issues about the failure of the Board to allow him to view his records before they were copied as he had requested, the failure of the Board to allow him to view a report for his insurance company before it was sent as he had requested, and several inaccuracies within the record itself.

34. Mr C complained that the medical records did not accurately record the medical events as they had happened and gave a false impression of events. Mr C was particularly concerned that there were a number of omissions in the records where information conveyed to him was not recorded in the file.

35. I advised Mr C of the role of the UK Information Commissioner who is the person appointed by the UK Parliament to regulate and enforce the provisions of the Data Protection Act 1998 – the act which governs access to medical records of living persons in the UK.

36. During the NHS investigation of this complaint, the Board wrote to Mr C on 10 August 2005 and apologised that staff had failed to notice his request to view his medical record and his insurance report prior to dispatch. They also apologised that an incomplete draft of the Board response to his initial complaint had been left in his medical file in error. The Board advised that this had been removed and should not have been included in his medical record.

37. The Board was correct that such a document does not form part of the medical record and had acted correctly in removing it. The Board also advised Mr C that if he had other specific issues he believed were wrongly recorded then these could be corrected. They advised that changes could only be made to factual inaccuracies not to the opinions of those involved in his care.

38. I reviewed the specific instances raised by Mr C in relation to errors in his medical record. A number of these are addressed elsewhere in this report. The adviser commented that the overall quality of the medical record is reasonable and I do not consider there is any likelihood of resolving the further differences. While I acknowledge that these remaining issues are important to Mr C, I do not consider these to be clinically significant.

(d) Inaccuracies in Mr C's medical record and errors in providing him with a copy of this: Conclusion

39. Mr C received the copy of his records within the prescribed timescale. It is regrettable that staff did not act on Mr C's request to view his medical records and insurance report prior to dispatch. However I note that the Board apologised for this and offered assistance if he still wished to view his medical record. I consider this to be a reasonable response to this error. I also note the Board's apology and explanation for the incomplete complaint response copied

in Mr C's medical record. In all the circumstances, I do not uphold this aspect of the complaint.

30 May 2006

Annex 1

Explanation of abbreviations used

Consultant 1	The consultant involved in Mr C's care during his first admission
Consultant Anaesthetist 1	The anaesthetist who performed the blood patch on 18 March 2005
Doctor 1	The doctor who performed the lumbar puncture procedure on 5 February 2005
GP 1	Mr C's general practitioner
Mr C	The complainant
(Consultant) Neurologist 1	The consultant neurologist who took over Mr C's care in March 2005
SRI	Stirling Royal Infirmary
The Board	Forth Valley NHS Board

Annex 2

Glossary of terms

Cerebellar infarct	An area of tissue death in the area at the back of the brain due to a local lack of oxygen
CT Scan	An imaging technique that uses a computer to combine multiple x-ray images into a two-dimensional cross-sectional image
Lumbar Puncture	The insertion of a hollow needle beneath the arachnoid membrane of the spinal cord in the lumbar region to withdraw cerebrospinal fluid for diagnostic purposes
MRA	Magnetic Resonance Angiography - an image of one or more blood vessels using MRI techniques
MRI	Magnetic Resonance Imaging - a test which uses an external magnetic field instead of x-rays to visualize different tissues of the body
PLPH	Post lumbar puncture headache
Space Occupying Lesion	Abscesses which form in an area where there is little room for expansion and compress the normal structures in the area: frequently they occur in the skull
Subarachnoid haemorrhage	Bleeding into the subarachnoid space surrounding the brain
Vertebral artery dissection	A separation of the tissue in the key artery located in the back of the neck that carries blood from the heart to the brain

With contrast (media)	Contrast media are x-ray dyes used to provide contrast between blood vessels and other tissue