Scottish Parliament Regions: Glasgow and Highlands and Islands

Cases 200700183 & 200700300: Greater Glasgow and Clyde NHS Board and Western Isles NHS Board

Summary of Investigation

Category

Health: Hospital; Neurology (Clinical Judgement) and Complaints Handling

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment he received from Western Isles NHS Board (Board 1) and Greater Glasgow and Clyde NHS Board (Board 2) following a sudden onset of severe leg pain in November 2005. Mr C also complained about the handling of his complaints by both Boards.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Board 1 failed to provide timely or appropriate care and treatment to Mr C (*not upheld*);

(b) Board 1 failed to promptly or adequately address Mr C's complaints *(not upheld*);

(c) Board 2 failed to provide timely or appropriate care and treatment to Mr C (*not upheld*) and;

(d) Board 2 failed to promptly or adequately address Mr C's complaints *(not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 19 April 2007 the Ombudsman received complaints from Mr C about the care and treatment he had received from NHS Western Isles NHS Board (Board 1) following a sudden onset of severe leg pain in November 2005 and the care and treatment he had received from Greater Glasgow and Clyde NHS Board (Board 2) following a neurology referral by Board 1 in May 2006. Mr C also complained about a lack of timely and appropriate response to his complaints from both Boards. Mr C first complained to Board 1 on 7 March 2007 and Board 2 on 15 October 2006. He received a final response from Board 1 on 15 May 2007 and Board 2 on 2 April 2007. Mr C remained dissatisfied with the responses and approached this office on 19 April 2007.

2. The complaints from Mr C which I have investigated are that:

(a) Board 1 failed to provide timely or appropriate care and treatment to Mr C;

(b) Board 1 failed to promptly or adequately address Mr C's complaints,

(c) Board 2 failed to provide timely or appropriate care and treatment to Mr C; and

(d) Board 2 failed to promptly or adequately address Mr C's complaints.

Investigation

3. Investigation of this complaint has involved reviewing all the papers supplied by Mr C, Board 1 and Board 2 (including Mr C's relevant medical records). I have sought the views of a Medical Adviser to the Ombudsman (the Adviser) and further comments from Mr C and both Boards. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C, Board 1 and Board 2 were given an opportunity to comment on a draft of this report.

Investigation Note

4. The elements of this complaint are inextricably linked and the divisions in this report are representative of the main issues of Mr C's complaints. The clinical episodes and the complaints arising from these episodes were dynamic events and I have set out an extensive chronology and background to reflect this. A significant number of facts in this case are in dispute. There are material differences between Mr C's recollection and the Boards' (based on the contemporaneous clinical records and the views of staff). These differences cannot be independently verified in all circumstances and this is reflected in the

findings and conclusions. Because of the overlap between events and complaints the conclusions to complaint (a) are also of significant relevance to the three further complaints.

Chronology and Background to Complaints

5. Mr C had a sudden onset of crippling pain in his right leg in late November 2005. The first reference to this, in the clinical records of Board 1, refers to the pain starting following a slip on black ice which caused Mr C to jerk his lumbar spine but later medical reports indicate there was no underlying cause. At that time Mr C was unable to walk unaided. Mr C visited the Accident and Emergency department at the Western Isles Hospital (Hospital 1) on 2 December 2005 as he was still experiencing considerable pain and was referred to the Orthopaedic Clinic on 9 December 2005. Mr C was reviewed then by Physiotherapist 1 who arranged for a lumber spine x-ray because of his concern that the problem might be spinal stenosis. Physiotherapist 1 wrote to Mr C's GP after the clinic outlining his review and advising that he would ask Consultant 1 to review Mr C the following week when the x-ray results were available. Consultant 1 reviewed Mr C on 12 December 2005 and noted the x-ray showed spondylolysthisis and chronic disk degeneration and that, as he too suspected spinal stenosis, he would arrange for Mr C to have an MRI Scan at Glasgow Royal Infirmary (Hospital 2) (performed on 27 February 2006). Consultant 1 also noted that Mr C was in less pain than previously on that particular day.

6. The MRI was reported by Dr 1 but apparently not received at Hospital 1 until 10 April 2006 and then only after GP 1 (at Mr C's request) contacted Consultant 2 (an orthopaedic consultant) to chase up the result for Mr C. GP 1 wrote again on 10 May 2006 as Mr C had still not heard from Consultant 2 and an appointment was arranged for 22 May 2006 at Hospital 1 with (Consultant 2) to discuss the results of the MRI. Following this appointment Consultant 2 referred Mr C to Consultant 3 (a neurosurgeon) at the Southern General Hospital, Glasgow (Hospital 3) on 24 May 2006, noting the results of the MRI showed 'significant central canal stenosis' and seeking Consultant 3's view on whether any surgical intervention might be of benefit. Mr C's contact with physiotherapy also re-commenced at this time. The referral letter was received at Hospital 3 on 2 June 2006 and an appointment was arranged for 12 September 2006. This appointment was later cancelled by Hospital 3 (the exact reason for this cancellation is in dispute) but rearranged for 2 October 2006.

7. In his later correspondence with staff at Board 1 (7 December 2006 and 7 March 2007) Mr C indicated he had in fact met with Consultant 1 on 22 May 2006 not Consultant 2 and that Consultant 1 had indicated a referral to a neurologist not a neurosurgeon was needed. The medical records indicate it was Consultant 2 who met with Mr C that day and that he considered a referral to a neurosurgeon was appropriate. I have verified this latter view indirectly with Physiotherapist 1 who was present that day.

8. By 2 October 2006 Mr C had been experiencing a reoccurrence of severe back pain for 10 days. Mr C was reviewed by a specialist registrar (SpR 1). In his follow-up letter to GP 1, typed on 2 October 2006, SpR 1 noted that the MRI scan had not been available to him although the reported results were. SpR 1 noted that while he would request and review the original MRI, he had advised Mr C that he did not consider there was a role for surgery at that time and did not plan to review Mr C routinely. He noted that he would write to Mr C and GP 1 once he had received and reviewed the scans. SpR 1 stated he had advised Mr C to take analgesia (Mr C had indicated he was not currently taking any significant pain relief).

9. Mr C later complained that SpR 1 had not examined him thoroughly, had told him Consultant 3 was too busy to see him and that as the MRI scan was missing he could not review his case properly but that in any event his case was not one for neurosurgery. He also complained that SpR 1 had sent him away in considerable pain with no attempt to provide him with any pain relief.

10. On 3 October 2006 Mr C presented at the Accident and Emergency department of Hospital 3 at approximately 11:40 with increased pain and immobility. Mr C explained that he was not returning home for several days and that the clinic had not been able to give him any pain relief the previous day. Mr C was reviewed by Consultant 4 (an Accident and Emergency Consultant) who noted that Mr C was not happy with the previous day's consultation and wanted to know what the neurology plan was. Consultant 4 telephoned SpR 1 to discuss Mr C's case. Consultant 4 noted that SpR 1 had advised they were planning to retrieve and review the MRI and would contact Mr C when this was completed but that surgery was not likely. Consultant 4 explained this to Mr C and noted in the records that he was 'happy' with this. Consultant 4 arranged for analgesia immediately and for Mr C to take home following his discharge at 13:50.

11. On 4 October 2006 Mr C telephoned Consultant 3 to raise a number of concerns about the appointment on 2 October 2006 – namely that he had been seen by an specialist registrar not a consultant as he had expected, that the MRI had not been available, that he had not been given pain relief despite his obvious debility and that he had been discharged without follow-up. (See also paragraph 36.)

12. Also on 4 October 2004 Consultant 4 reviewed Mr C's notes and because of his concern that Mr C's pain may be a symptom of an acute aortic dissection; a condition which was a known complication of coronary angiography (which Mr C had had performed one week previously), he obtained Mr C's telephone number from his cardiologist and called Mr C on the morning of 4 October 2006 and asked him to return to the hospital. Consultant 4 reviewed Mr C again at 13:30 and noted that the pain being experienced was NOT (his emphasis) the same as previous sciatica pain. Consultant 4 listed a number of possible diagnoses including spinal stenosis but noted that he was unclear where to send Mr C next and that he had asked for an orthopaedic review in the first instance but that a further neurology review might also be needed. Consultant 4 later noted that he discussed Mr C's case with Mr C's cardiologist and they both felt that aortic dissection was unlikely. Consultant 4 also noted that Mr C was having considerable trouble mobilising even compared to the previous day. At Consultant 4's request Mr C was reviewed by a Senior House Officer in Orthopaedics and admitted to Hospital 3 for further review by Consultant 5 (an orthopaedic consultant) the next day. A further lumbar x-ray was also performed that day and consideration given to a further MRI the following day.

13. Mr C was reviewed on 5 October 2006 by Consultant 5 who also contacted SpR 1 to discuss Mr C and noted that Mr C was aware that no surgical intervention was planned. Consultant 5 did not consider a further MRI was needed and the plan was to continue analgesia and seek physiotherapy input. Mr C was discharged on 9 October 2006 with no follow-up planned.

14. On 26 October 2006 Consultant 3 wrote to Consultant 2 to advise him of his telephone call with Mr C on 4 October 2006 and noting that because of Mr C's distress he had agreed to review Mr C again within two months and in the meantime he would place him provisionally on the waiting list although he did not expect there to be a need for surgery unless Mr C's present symptoms

changed. Consultant 3 noted they had talked for some 20 to 30 minutes and Mr C had remained unhappy but agreed to the arrangements.

15. Following his discharge form Hospital 3 on 9 October and his return home Mr C visited GP 1 and requested a further referral to Consultant 2 in order that he could in turn arrange a further referral to a neurosurgeon other than Consultant 3. GP 1 wrote a routine referral letter to this effect to Consultant 2 on 23 October 2006 and an appointment was arranged with Consultant 2 for 24 November 2006. Mr C was reviewed on that date by Consultant 2 who noted in his subsequent letter to GP 1 (dated 1 December 2006) that Mr C had indicated his back pain had improved but he would like to see another neurosurgeon after a forth-coming planned heart operation.

16. On 21 November 2006, Mr C was sent a further appointment with Consultant 3 for 5 December 2006. Mr C wrote refusing this appointment as he did not wish to meet Consultant 3 and because no further MRI had yet been arranged. At this point the original MRI had in fact been found and sent to Hospital 3 but Mr C would not have been aware of this.

17. On 30 November 2006 the Clinical Services Manager of the Department of Neurological Science (DNS) at Hospital 3 (where Consultant 3 and SpR 1 both worked) sought to arrange a second opinion in December 2006 for Mr C from another neurosurgeon who specialised in spinal injuries (Consultant 6). Consultant 6 agreed to this but stated he would require a medical referral and could not see Mr C in clinic before March 2007. DNS also arranged a radiological review of the original MRI scan by Professor 1 on 4 December 2006.

18. Separately to these previous events and in response to Mr C's on-going complaint, Mr C was contacted by telephone by the Head of Nursing (Mr D) on 5 December 2006. Mr C advised Mr D that he had incorrectly been referred to a neurosurgeon when he needed to see a neurologist (see paragraph 42 & 43 for the complaints background). Mr D discussed where the appropriate referral might be (DNS) and how this could be achieved by a GP referral. Mr C visited GP 1 on 7 December 2006 and asked him to arrange a direct referral to DNS to see a neurologist not a neurosurgeon. GP 1 faxed a request to DNS that day and an appointment was arranged with Consultant 7 (a consultant neurologist) on 14 December 2006.

19. Mr C was reviewed by Consultant 7 on 14 December 2006. Consultant 7 wrote to GP 1 on 21 December 2006 noting that he had not seen any previous correspondence from Board 1 or the original MRI report but did have Professor 1's report which noted significant spinal canal stenosis. Consultant 7 noted there was little to find on examination of Mr C but in view of the MRI report he would be referring Mr C to a spinal specialist neurosurgeon (Consultant 8).

20. Consultant 8 received the request on 21 December 2006 and emailed the Clinical Services Manager at DNS on 22 December 2006 noting that it was her understanding that Consultant 6 had already offered to see Mr C and that she was not in fact a spinal specialist so felt a referral to her was not appropriate. The Clinical Services Manager confirmed the existing referral to Consultant 6 (with a preliminary date in April 2007) on her return to work on 8 January 2007 and asked that Consultant 8 confirm this fact to Consultant 7 and GP 1. Consultant 8 did so by letter on 8 January 2007.

21. On 19 April 2007 Mr C was reviewed by Consultant 6 (a consultant neurosurgeon specialising in spinal injuries). Consultant 6 wrote to GP 1 on 30 April 2007 and noted that Mr C had had a sudden onset of severe pain in his right leg some 18 months previously which had left him unable to walk and that he had experienced episodes of pain ever since which had recently resolved completely. Consultant 6 noted that the MRI showed degenerative disc disease and he concluded that Mr C had had an unusual presentation of lumbar canal stenosis which does not usually have a sudden onset or resolve spontaneously as Mr C's condition had. Consultant 6 arranged to review Mr C again in October 2007.

Medical Background

22. The Adviser has provided me with the following overview of Mr C's medical condition (originally a working diagnosis of spinal stenosis subsequently reconfirmed in April 2007) and the management of this condition:

> 'The spinal cord and the nerves arising from the cord are situated in the boney spinal canal. The canal is the hole between the main body of each vertebra and the arches of bone that meet at the back to enclose the cord and nerves. Variations in the size and shape of the canal are common. Narrowing of the canal is 'spinal stenosis' and can result in pressure on the spinal cord and the nerve roots. It leaves less room for the canal to accommodate abnormalities that develop with age. Spinal stenosis, when

presenting later in life, is common and often results from a combination of causes – congenital narrowing, arthritis, prolapsed discs or (rarely) tumour.

The presenting symptoms are usually pain in one or both legs that does not have the typical distribution of sciatica. Leg pain often occurs without back pain making the diagnosis difficult. The pain often starts or is made worse by walking. Neurological signs are uncommon and surgical intervention is rarely warranted unless there is evidence of nerve damage. Treatment usually relies on a short period of rest with adequate pain relief during the acute phases and physiotherapy. Spontaneous resolution of the severe pain is usual, often followed by quite long periods free from symptoms but with eventual episodic recurrence.'

(a) Board 1 failed to provide timely or appropriate care and treatment to Mr C

23. Mr C complained to the Chief Executive of Board 1 on 7 March 2007 that Board 1 and Consultant 2 in particular, had failed to provide him with appropriate and timely care and treatment. He noted that it was 15 months since he had first had an episode of debilitating pain but that he had suffered 'months of suffering, hospitalisation, collapsing in the street and many other excruciating episodes' all because Consultant 2 had lost the MRI scan and failed to send this to Consultant 3. Mr C noted that this had caused him to attribute the failure erroneously to Consultant 3 and delayed his receiving an appropriate review by a neurologist (which Mr C considered to be the necessary referral). Mr C also noted he had eventually seen a consultant neurologist from Board 2 on 14 December 2006 (Consultant 7) who had informed him of the reasons for the lost MRI and that as he in fact visited the Board 1 area he could have seen Mr C there at a much earlier stage. Mr C commented that Consultant 7 had told him that Professor 1 had reviewed the x-ray report from Hospital 1 and the original MRI report from Hospital 2 and disagreed with them both. Mr C stated that he had tried on several occasions between 7 and 13 December 2006 (prior to his meeting with Consultant 7) to obtain simple information from Consultant 2 but that Consultant 2 had refused to answer these and deliberately avoided all the issues and blame. Mr C noted he eventually received a written response on 13 December 2006 from a staff member.

24. In his correspondence with Board 2 (15 October 2006) Mr C noted that Consultant 1 had told him in December 2005 that the nerves in his back or spine was being periodically nipped and this was causing the pain. Mr C also stated that when he met with Consultant 1 following the MRI in February 2006 (at which point his pain had resolved although it later returned) and Consultant 1 had reviewed the MRI scan and told him that the three lower discs of his spine were out of line and they might be the cause of the nerve being periodically pinched. Mr C noted that there was no mention of arthritis or disease by Consultant 1. Mr C said that when he subsequently met with Consultant 2 on 22 May 2006 he advised no treatment could be given until there had been a neurosurgery review.

25. In their response to Mr C's complaint Board 1 noted that there had been an error in the filing of Mr C's MRI scan and that they had taken steps to address the error for the future. The error was not discovered until Consultant 2's secretary tried to find the MRI scan following receipt of SpR 1's letter of 2 October 2006 as it had previously been assumed by staff in the x-ray department that the MRI scan had been sent to Hospital 3 in preparation for the appointment with Consultant 3.

26. The Adviser told me that Physiotherapist 1, Consultant 1 and Consultant 2 had all noted the likely diagnosis of spinal stenosis. The original MRI report noted this along with some degenerative disease of the facet joints and a degree of spondylolysthisis. The Adviser noted that Professor 1's report on the MRI also concluded there was spinal canal stenosis. The Adviser noted that while it was Mr C's conviction that Consultant 7 and, reported through him, Professor 1 disagreed with the original MRI report and advice given subsequent to that there is no evidence in the clinical records to suggest any disagreement and the 2 MRI reports are substantively the same.

27. The Adviser also told me that the records indicate the original decision by Consultant 2 recorded in the medical notes was to refer to a neurosurgeon rather than a neurologist and that in his view this was the appropriate one. He noted further that this was also the conclusion of Consultant 7, the neurologist who reviewed Mr C on 14 December 2007, who referred Mr C to a neurosurgeon.

28. The Adviser also noted that there is an increasing awareness amongst the medical profession that the use of surgery for lower back problems should be

restricted to those patients with clear neurological signs of spinal cord compression (a role predominantly performed by neurosurgeons rather than orthopaedic surgeons). The Adviser told me that the medical records indicate that was never any doubt or dispute between medical professionals as to the diagnosis or management of Mr C's spinal stenosis. The main clinical issue was in respect of possible surgery depending on whether there was any evidence of spinal compression. Since neither clinical investigation nor MRI scanning produced any indication of nerve involvement at the time there was no indication for surgery.

29. While concluding that the clinical actions taken Consultant 2 were entirely appropriate the Adviser did consider that there had been poor communication with Mr C throughout. There is no indication in the records of any explanation being offered to Mr C of what was wrong, why neurosurgery might be appropriate but was later rejected and what he might expect in terms of the natural history of his condition (episodic pain which self-resolves).

(a) Conclusion

30. It is important in this whole complaint to distinguish between the strictly diagnostic issues and the broader clinical questions. In diagnostic terms the medical evidence in the records and the views of the Adviser are clear - that Mr C's working diagnosis from the outset was spinal canal stenosis, the treatment of which is limited to pain relief and rest with consideration of neurosurgery if nerve damage was implicated. In that respect I conclude Mr C was provided with appropriate care and treatment by Board 1 and Board 2 throughout.

31. However, the complexity of this whole complaint lies in the ongoing and increasing gap between Mr C's understanding and expectations and the actions and understanding of the medical and complaints personnel dealing with his concerns. In reviewing the correspondence between all parties it is immediately apparent that there are a number of occasions where Mr C's views on who he met, what was said and what the ongoing plan was are significantly different to the contemporaneous views contained in the medical records.

32. There are instances where Mr C's contrary view can be explained, for example, his belief that Hospital 3 had lost the MRI scan when in fact it was Hospital 1's error but other occasions where there is no explanation, for example, his view that his original referral should have been to a neurologist

rather than neurosurgeon and that he met with Consultant 1 following his MRI in February 2006. Where Mr C's specific complaints about the actions of Consultant 2 can be explained; namely that Consultant 2 had lost the MRI, I don't uphold Mr C's complaint (the administrative error underlying this complaint is, however, referred to in paragraph 25). Mr C also complained that Consultant 2 was incorrect in arranging a referral to a neurosurgeon and here I note that Mr C was also of this view in his earliest complaints correspondence with Board 2; the question of a neurologist referral only arising in his later correspondence. I conclude that the surgical referral was the appropriate one.

33. Overall I conclude there was a minor administrative error which caused the MRI to be misfiled and not available on 2 October 2006 but no other failure on the part of Board 1. Board 1 has apologised for the administrative error and the medical advice I have received is that the error was not clinically significant. I, therefore, do not uphold this aspect of the complaint.

(b) Board 1 failed to promptly or adequately address Mr C's complaints

34. Mr C complained to the Chief Executive of Board 1 on 7 March 2007. The Board acknowledged his complaint on 8 March 2007 and following some further correspondence provided a response on 2 April 2007, which included a detailed explanation of how, when and why the original MRI scan had gone missing and what action had been taken to avoid a repeat of the problem. Mr C disagreed strongly with the Board response and wrote to them on 12 April 2007. He received a further, final response on 15 May 2007, advising him that referral to the Ombudsman's office was the appropriate next step.

35. Mr C had also raised concerns directly with Consultant 2's staff on 7 December 2006 and was unhappy that it had taken until 13 December 2006 for these to concerns to be answered. Mr C had indicated he needed the information before he could meet with Consultant 7 on 14 December 2007. In their response to Mr C's complaint the Board noted that Mr C had received a number of emails from staff during this period and had been advised that Consultant 2 was busy with clinics and working away so could not immediately respond. Mr C was not satisfied with this response as he considered the information he had requested should be readily available.

(b) Conclusion

36. The Board responded to Mr C's formal complaints in a timely and appropriate manner. While the issues raised by Mr C in December 2006 were

not formal complaints I consider that these were also dealt with in an appropriate manner and with commendable speed. I do not uphold this aspect of Mr C's complaint.

(c) Board 2 failed to provide timely or appropriate care and treatment to Mr C

37. Mr C complained to the Chief Executive of Board 1 on 15 October 2006 following his appointment with SpR 1 on 2 October 2005, his telephone call with Consultant 3 on 4 October 2005 and his admission to Hospital 3 the same day. Mr C complained that Consultant 3 had not made himself available at the appointment on 2 October 2005 although he had been able to see other patients who did not seem to be as ill as he himself was. Mr C also complained that despite the very obvious, severe pain he was experiencing that day SpR 1 had done nothing to assist him but simply stated he could do nothing for him as the MRI scan was missing. Mr C said he had asked for strong painkillers and crutches to assist with walking but SpR 1 had said he did not have the authority to do this and suggested he see his own GP once he had returned home. Mr C said he had called Consultant 3 on 3 October 2006 but had not received call back until 4 October 2006 when Consultant 3 had referred to a report from Hospital 1 which indicated he had arthritis. Mr C had denied that such a report existed and challenged Consultant 3 about the lack of any follow-up but Consultant 3 had hung up on him. Mr C complained that he had received no treatment for his condition but only been given advice on pain killers.

38. In his letter of complaint Mr C also noted that Consultant 1 had advised him that he would be referred to a neurosurgical consultant and that when he had later met with Consultant 2 he had also stated a neurosurgery referral was needed. Mr C concluded his letter by asking for a further referral to a neurosurgeon other than Consultant 3 (but that this would need to be after he had his impending heart surgery). I note there was no reference by Mr C at this point to a neurologist referral being the correct course of events.

39. The Board's response of 1 December 2006 apologised that Mr C had originally received 2 appointment dates in error and that it had not been made clear in the appointment letter that patient's could not be guaranteed to be seen by a named consultant. The Board advised the letter would be amended to make this clearer in the future. The response indicated that SpR 1 was not aware at the time that Mr C was unhappy about not seeing Consultant 3 and that the MRI was missing. SpR 1 and Consultant 3 noted in their comment to

the complaints staff dealing with the complaint that they had not considered surgery was an option but did plan to review the MRI scan once it was available. SpR 1 noted that he had not been aware of Mr C's unhappiness with the consultation until he was contacted by Consultant 4 the following day. Consultant 3 confirmed that he had terminated the telephone call as it had lasted more than 20 minutes, he had repeated the advice given to Mr C at the clinic but Mr C was still not satisfied and he had another appointment to attend. The response concluded that Mr C could ask his GP to arrange a second opinion if he wished.

40. Following his appointment with Consultant 7 Mr C continued to raise very detailed complaints stating that Consultant 7 had totally disagreed with the previous advice and opinions and that Mr C should be seen by a neurosurgeon specialising in back conditions. Mr C eventually saw such a specialist in April 2007 (Consultant 6) who confirmed the original diagnosis of spinal stenosis and that the only treatment was symptomatic pain relief and rest.

41. The Adviser specifically noted that although Mr C regarded SpR 1's examination as inadequate the contemporaneous record indicates an appropriate neurological examination including the assessment of the tone, power reflexes and sensation in the lower limbs. The Adviser told me that it was not unreasonable (or unusual) for Mr C to be reviewed by SpR 1 rather than Consultant 3 and that the advice of analgesia but no planned follow-up was appropriate for spinal stenosis. The Adviser noted that while SpR 1 did indicate analgesia was appropriate to Mr C he made no arrangements or suggestions to enable Mr C to obtain pain relief although Mr C was not due to return home (and thus to his own GP) for several days.

(c) Conclusion

42. It is not unusual in cases reviewed in this office for two accounts of the same event to be notably at odds. Where this is the case and there is no independent third party witness or other record of the event available for corroboration it is often not possible to reach a clear conclusion as to what actually occurred. On other occasions it may be possible in-light of other relevant factors to reach a conclusion 'on balance'. I have already referred to the difficulties in this case in my conclusion to complaint (a) (paragraph 31) and to my conclusion that the clinically appropriate steps were taken by Board 1 and Board 2 (paragraph 29). I do consider that SpR 1 could have been of more assistance in directing Mr C to obtain pain relief while away from home

(although I accept that it was not possible for SpR 1 to issue a prescription) but based on the medical advice I have received I consider that the action of SpR 1 and Consultant 3 were clinically appropriate and not at odds with any subsequent actions taken by other medical staff. I do not uphold this aspect of the complaint.

(d) Board 2 failed to promptly or adequately address Mr C's complaints

43. Mr C's complaint of 15 October 2006 was acknowledged on 19 October 2006. He received a further letter dated 14 November 2006 indicating that there was a delay in obtaining all the information needed to respond to his complaint. Mr C received a response on 5 December 2006. Mr C was dissatisfied with this and called the Board on 6 December 2006 but could not speak to the Director of Regional Services (DRS) who had signed the Board's response letter and spoke instead to Mr D, the Head of Nursing. Mr C spoke with Mr D and explained to him his view that in fact he needed a referral to a neurologist not a neurosurgeon. Mr D contacted DNS by telephone on 6 December 2006 and asked that an appointment be arranged with a neurologist (see paragraph 17). The referral from GP 1 was faxed through on 7 December 2006 and DNS arranged the appointment with Consultant 7.

44. Mr C wrote to the DRS on 13 December 2006 at some length expressing his extreme dissatisfaction with the Board's response and noting that it was only because of the call from Mr D that he had an appointment to see a neurologist (see paragraph 17). Mr C complained within this letter about the considerable numbers of complaints staff and other personnel who he had variously spoken to and received correspondence from with no explanation as to who they were and why each communication came from another person. The letter reiterates Mr C's previous concerns that he should never have been referred to a surgeon in the first place and that the lack of care and treatment from SpR 1 and Consultant 3. Mr C concluded intimating he was seeking financial compensation and would be taking the matter further. The DRS responded on 28 December 2006 advising of the appropriate steps to be taken in seeking compensation through the Central Legal Office.

45. Mr C wrote to the DRS again on 18 January following his meeting with Consultant 7 and raised further concerns alleging that Consultant 7 and Professor 1 had totally disagreed with the original MRI report and that he had concluded surgery was necessary. Several further exchanges of correspondence ensued and ultimately Mr C was advised on 2 April 2007 that

he could approach this office with his complaints and the Central Legal Office for compensation claims.

(d) Conclusion

46. Mr C received prompt and timely responses to the issues he raised, including telephone replies. It was understandably confusing that he was in verbal and written communication with a number of individuals without necessarily having an explanation as to whose these individuals were and I would ask Board to consider how this might best be avoided in future complaint handling. However, I conclude that the Board took appropriate steps to address both Mr C's complaints and his on-going medical concern regarding a further referral and I do not uphold this aspect of the complaint.

19 December 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Board 1	Western Isles NHS Board
Board 2	Greater Glasgow and Clyde NHS Board
The Adviser	Medical adviser to the Ombudsman
Hospital 1	The Western Isles Hospital
Physiotherapist 1	The Physiotherapist at Board 1 who reviewed Mr C in December 2005
Consultant 1	A locum orthopaedic consultant with Board 1
MRI	Magnetic Resonance Imaging
Hospital 2	Glasgow Royal Infirmary
Dr 1	The radiologist with Board 2 who originally reviewed the MRI
GP 1	Mr C's GP
Consultant 2	An orthopaedic consultant with Board 1
Consultant 3	A neurosurgery consultant with Board 2
Hospital 3	The Southern General Hospital , Glasgow

Spr 1	A specialist neurosurgery registrar with Board 2
Consultant 4	An accident and emergency consultant with Board 2
Consultant 5	An orthopaedic consultant with Board 2
DNS	Department of Neurological Sciences, Hospital 2
Consultant 6	A neurosurgery consultant with Board 2 (specialising in back pain)
Professor 1	A consultant radiologist with Board 2 who reviewed the MRI in December 2006
Mr D	The Head of Nursing at Hospital 2
Consultant 7	A consultant neurologist with Board 2
Consultant 8	A neurosurgery consultant with Board 2
DRS	Director of Regional Services

Annex 2

Glossary of terms

(Spinal) Canal Stenosis	See Paragraph 22
Chronic disk degeneration	An ongoing condition where a disc in the spine degenerates
Magnetic Resonance Imaging	A scan which produces an internal image
Spondylolysthisis	Slipped disks as a specific point in the spine