Scottish Parliament Region: North East Scotland

Case 200600110: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Ms C) raised a number of concerns about the diagnosis and treatment given to her father (Mr A) on his admission to Aberdeen Royal Infirmary as an emergency by his General Practitioner. In particular, she feels that had medical staff correctly diagnosed Mr A's condition, they could potentially have saved his life.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) medical staff failed to diagnose an aortic abdominal aneurysm or carry out an appropriate scan to allow them to discount this condition (*no finding*); and

(b) Grampian NHS Board failed to investigate Ms C's complaint in a timely manner (*upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 18 January 2005 at 19:45 the complainant (Ms C)'s father (Mr A) was admitted to Ward 33 of Aberdeen Royal Infirmary as an emergency admission with a pain in his right groin. He had been lifting some heavy objects earlier that morning. He was in severe pain and was distressed as a result of this. His blood pressure, blood oxygen level and pulse were checked and seemed to be normal and he was given two injections for pain and nausea at 21:00. At around 23:00 he had abdominal and chest x-rays taken which were both normal.

2. At 03:00 on 19 January 2005 Mr A was found by nurses lying on the floor next to his bed. He told them that he had slipped off the bed. As he appeared pale and confused at this time, it was decided to carry out a further set of observations. This indicated that his blood pressure had fallen. As a result, nursing staff contacted the doctor, who prescribed intravenous fluids. An electrocardiogram (ECG) was also taken which was normal. By 03:40 Mr A's blood pressure had risen slightly but was still lower than normal. He was, therefore, maintained on fluids and a further chest x-ray was taken, which was again reported as being normal. He was then observed every quarter of an hour on his return from the x-ray.

3. At 06:45, after some severe pain, nursing staff were about to administer intraveinous morphine when Mr A became unresponsive. The Cardiac Arrest Team were called and they spent about an hour trying to resuscitate Mr A but were, unfortunately, unsuccessful.

4. Subsequent to the cardiac arrest, fluid had been drawn from Mr A's abdomen to try and establish what had caused the cardiac arrest. At this stage fresh blood was aspirated which indicated that Mr A had suffered from an intraperitoneal ruptured aortic aneurysm.

5. On 22 March 2005 Ms C along with her mother (Mrs A) met with the consultant surgeon (the Consultant) to try and establish why Mr A had died. During this meeting the Consultant confirmed that there had been an incorrect diagnosis when Mr A was admitted.

6. Ms C was not satisfied with the explanation provided at this stage and raised her concerns formally through Grampian NHS Board (the Board)'s complaints procedure. This culminated in a response from the Chief Executive of the Board on 20 April 2006.

7. Prior to this, on 6 April 2006, Ms C raised her concerns with the Ombudsman's office.

8. The complaints from Ms C which I have investigated are that:

(a) medical staff failed to diagnose an aortic abdominal aneurysm or carry out an appropriate scan to allow them to discount this condition; and

(b) the Board failed to investigate Ms C's complaint in a timely manner.

Investigation

9. I have obtained the clinical records in respect of this case as well as the complaints files held by the Board. I have also sought clinical advice from an independent professional adviser (the Adviser). I have set out, for each of the headings of Ms C's complaint, my findings of fact and conclusions.

10. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Medical staff failed to diagnose an aortic abdominal aneurysm or carry out an appropriate scan to allow them to discount this condition

11. When Mr A was initially admitted, the referral letter from the admitting General Practitioner suggested a possible diagnosis of an obstructed right inguinal hernia and indicated that there was a swelling in Mr A's right groin.

12. On admission to hospital the Board have stated that Mr A was reviewed, in the usual way, by the Resident House Officer (RHO) and Specialist Registrar. The clinical records of this examination state 'no aneurysm' and so indicate that this was considered as a possible diagnosis but was discounted.

13. The Adviser has told me that it was proper for an aneurysm to be considered as a possible diagnosis. An aneurysm is a localised, blood filled dilation or bulge of a blood vessel caused by disease or weakening of the vessel wall. Blood is pumped by the heart through the blood vessels to all parts of the body. It is this pumping mechanism that can be felt by the clinician when

he palpates (examines the abdomen with his hands). The same pulsating/throbbing would not be felt if the mass was related to some other origin. The Adviser has told me that an abdominal scan should only have been carried out if an aneurysm was palpable or if the lump in the groin was not characteristic of a hernia.

14. The clinical records of this examination state 'no aneurysm' and so indicate that this was considered as a possible diagnosis but was discounted. They also indicate that the lump in Mr A's groin was consistent with a hernia.

15. The Adviser has, however, said that it would not be appropriate for an RHO to discount the possibility of an aneurysm without consulting a more senior doctor. This is because it requires considerable skill and experience to detect if an aneurysm is palpable, and even an experienced doctor may not detect an aneurysm which is present. The Adviser said that the correct diagnostic procedure would require that the abdomen was examined and confirmation of the diagnosis given by a sufficiently experienced doctor, in this case the Specialist Registrar who was on duty.

16. The Board have detailed that whilst there are mechanisms in place to allow for contact with consultant surgeons if required, this is not an automatic process. Where there is suspicion of ruptured aortic aneurysm, there are recognised pathways for the immediate referral to a consultant vascular surgeon. This referral would be undertaken in conjunction with urgent confirmatory investigations and the notification of theatre and the blood transfusion service.

17. The clinical note does not indicate which doctor made the finding of no aneurysm which is recorded. It is in the handwriting of one doctor but does not name the doctors involved and is unsigned.

18. One of Ms C's central concerns was that Mr A was not given a scan which could have identified the aneurysm at an earlier stage and possibly allowed for surgical intervention.

19. As has been detailed above, had an aneurysm been suspected, there were appropriate pathways to follow which would have allowed for further investigations to be carried out and the relevant surgical teams to be alerted. Unfortunately, a diagnosis of possible aneurysm was not made.

20. From the initial correspondence between the Consultant and Mrs A it has been explained that the diagnosis of a strangulated hernia was incorrect. However, the investigations and management of Mr A's care was carried out on the basis of this diagnosis. Chest and abdominal x-rays were carried out, he was given appropriate pain medication and was booked for theatre with the hernia diagnosis in mind. Because of this diagnosis, further investigations at an early stage, such as scans, would not have been carried out because there was no suspicion of an aneurysm.

21. The Board fully accept that in this case the wrong diagnosis was made. Had the correct diagnosis been made the outcome of Mr A's illness may have been very different. The Adviser has commented that once Mr A collapsed, it is likely that no intervention would have saved him.

(a) Conclusion

22. From the evidence I have examined, including complaints correspondence and the clinical records, it is clear that the wrong diagnosis was made by clinical staff on admission.

23. From the advice I have received I am satisfied that the Board had adequate procedures in place which should have ensured that Mr A was examined properly.

24. In the nursing cardex (notes) it was recorded at 20:10 on 18 January 2005 that Mr A's pain started in the lower back before moving to include the front of the abdomen and groin. This history, if elicited by the doctors, may have alerted them to actively seek to exclude the potential diagnosis of a ruptured aneurysm and I am critical of this aspect of the diagnostic process.

25. The Board have advised that the initial assessment was made, in the usual way, by the RHO and the Specialist Registrar. However, the entries in the clinical records of the admission were only made by one of them and signed by neither.

26. If the records had shown clearly that the diagnosis by the RHO had been confirmed by the Specialist Registrar in line with the diagnostic procedure, the appropriate action to try to correctly diagnose would have taken place. In this case we would not have upheld the complaint.

27. Equally, had we been able to establish that the RHO had made the diagnosis without review by the Specialist Registrar then he would have failed to comply with the diagnostic procedures and we would have upheld the complaint.

28. The records do not detail clearly whether the RHO's diagnosis was supported by the Specialist Registrar. Although we know that Board had proper procedures in place, and that the Specialist Registrar was present, we cannot fully establish the Specialist Registrar's role in the diagnostic process in this case. Because of this we are unable to make a finding on this aspect of the complaint.

(a) Recommendation

29. From the earlier correspondence between Ms C, Mrs A and the Board, it is clear that the Board have accepted that the incorrect diagnosis was made. The Ombudsman's office has requested details from the Board of actions they have taken as a result of this misdiagnosis. The Board have advised that this case has been discussed at ward level morbidity and mortality meetings with the importance of consultant contact by junior staff for difficult cases and unstable patients reinforced.

30. In addition to the above, early warning observation charts are being introduced on a unit wide basis. Information obtained in local High Dependency Units and Intensive Therapy Units may also be used to provide local guidelines for mandatory referral to senior staff or consultants dependent on the degree or length of change from normal recordings documented on patients' charts.

31. I am of the view that the Board have taken appropriate action as a result of lessons learned from this tragic event. They have, from a very early stage, admitted to Mr A's family that this was a clear case of an incorrect diagnosis. They have apologised appropriately for this and have introduced changes to their processes to reflect the lessons learned from this case. As a result of this, I have no further recommendation to make to the Board.

(b) The Board failed to investigate Ms C's complaint in a timely manner

32. The NHS Complaints Procedure details how complaints should be handled by NHS organisations in Scotland. The NHS operates a system of local resolution whereby it is hoped that on receipt of a complaint, a full

response will be provided at a local level within 20 days. If more time is required, the Board should write to the complainant to advise them.

33. If the complainant feels that the Board is taking too long to respond to their complaint or is not dealing with the complaint appropriately, the complainant has the right to request that the Ombudsman's office investigate.

34. In this case Ms C made her original complaint to the Board on 22 June 2005. This letter was acknowledged on 27 June 2005 and a further letter explaining that the investigation was taking longer than anticipated was issued on 18 August 2005.

35. On 16 September 2005 a further letter from the Board was issued advising that they were not yet in a position to provide their full response, and to apologise for this delay. In addition, at this stage, Ms C was advised of her right to raise her complaint with the Ombudsman's office if she felt the delay was unacceptable.

36. On 24 October 2005 the Chief Executive responded to Ms C's complaint and offered a further formal meeting with the Consultant to discuss any outstanding issues. In response to this letter Ms C wrote to the Chief Executive to detail her dissatisfaction with the previous response on 25 January 2006. This was acknowledged on 31 January 2006 and the Chief Executive responded on 20 April 2006 and again offered a meeting with the Consultant to help to respond to Ms C's outstanding concerns. He also advised that the senior house officer on call the night Mr A died would attend if requested to address any issues which arose as a result of the discussion he had with the family following Mr A's death (he had not, however, been involved in Mr A's treatment). In the meantime, however, on 6 April 2006, Ms C had raised a complaint with our office.

(b) Conclusion

37. It appears from the information available to me that there was an attempt to address Ms C and Mrs A's concerns at an early stage prior to a formal complaint being raised. It was explained that a misdiagnosis had taken place and that as a result of this misdiagnosis, further investigations which would be likely to identify an aneurysm were not carried out. I consider that the Board did take the issues very seriously and did try and address them in writing and through the family's discussions with the Consultant. These initially were

unsuccessful at resolving Ms C's concerns and by the time she had raised a formal complaint, it was likely that trust had broken down between her and the Board.

38. It is clear that the formal complaint was not responded to within the timescales expected within the NHS Complaints Procedure. It took over four months to respond to Ms C's original complaint letter of 22 June 2005 and almost three months to respond to her subsequent concerns. Although initially, Ms C was provided with letters apologising for the lack of progress, the time taken to provide a substantive response in this case was excessive. As a result of this, I uphold this aspect of the complaint.

(b) Recommendation

39. Since Ms C raised her complaint, the management of the acute sector within the Board has been reorganised into units. The management of these units have been strengthened and one of the benefits of this has been that each unit has increased accountability in ensuring a timely response to complaints.

40. In addition to the above, the Boards Feedback Service regularly reviews late complaints with its management team so that action can be taken earlier to address any issues of delay. Because of these changes which have already been implemented at the Board, the Ombudsman makes no further recommendations on this point.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The patient, Ms C's father
Mrs A	Ms C's mother
The Consultant	The consultant surgeon
The Board	Grampian NHS Board
RHO	Resident House Officer

Annex 2

Glossary of terms

Abdominal aortic aneurysm	A dilation of a portion of the aorta
Intraperitoneal	Within the peritoneal cavity, the area which contains the abdominal organs
Inguinal hernia	Hernia of the groin