Scottish Parliament Region: North East Scotland

Case 201205005: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Radiology & Orthopaedics; clinical treatment; diagnosis

Overview

The complainant (Miss C) raised a number of concerns that her sister (Ms A) had been provided with inadequate care and treatment in that the symptoms with which she was presenting between October and November 2011 were not appropriately investigated and treated. A Critical Incident Review (CIR) of the events surrounding Ms A's care and treatment was held in May 2012 by Tayside NHS Board (the Board) following Ms A's death in April 2012. Miss C complained that the Board failed to provide the family with a copy of the CIR report despite repeated requests and failed to arrange a meeting with the family.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) between October and November 2011, staff at Ninewells Hospital failed to provide Ms A with appropriate medical treatment in view of the symptoms with which she presented (*upheld*); and

(b) staff at the Board failed to provide the family with a copy of the CIR report despite them making repeated requests and failed to take steps to arrange a meeting with the family (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence that appropriate action was taken to address the mis-reporting of the Magnetic Resonance Imaging scan of 10 October 2011;	26 April 2014
(ii) ensure that future Radiology Discrepancy and Complications Meetings are minuted and the minutes appropriately circulated;	26 April 2014
(iii) review the application of the 'three day guidance' to	26 June 2014

	ensure that staff appropriately assess patients before referring back to their GP and where necessary provide refresher training;	
(iv)	ensure that staff on the Acute Medical Unit are reminded of the need to be proactive in addressing patients pain;	26 April 2014
(v)	continue to work towards producing a care pathway to improve the treatment of patients who present with un-resolving and/ or deteriorating symptoms, including improved communication with primary care providers (GPs);	26 May 2014
(vi)	remind staff dealing with complaints about the usefulness of meetings at an early stage of the complaints process as per their Complaints Management Procedure; and	26 April 2014
(vii)	issue a written apology to Ms A's family for the failings identified in this report.	26 April 2014

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

Main Investigation Report

Introduction

1. Miss C complained that staff at Ninewells Hospital failed to appropriately investigate the symptoms which her sister (Ms A) who was a 32-year-old woman, reported of continuing back pain, originally from a fall in May 2011. Ms A had physiotherapy and was prescribed pain relief to no effective result. Her General Practitioner (GP), therefore, referred Ms A for a Magnetic Resonance Imaging (MRI) scan which was performed on 10 October 2011 and originally reported by a radiologist as essentially normal.

2. Ms A then self-referred to the Accident & Emergency (A&E) Department at Ninewells Hospital on 26 October 2011 reporting increasing back pain. She was referred back to her GP under Tayside NHS Board (the Board)'s 'three-day guideline (set out in Annex 3) which states that patients whose injury or illness has been present for more than three days and/or have already consulted with their own GP about the condition, should be redirected to their GP.

3. Ms A was then seen in the Orthopaedic/Physiotherapy clinic on 8 November 2011 as the original 'Urgent' referral from her GP had been downgraded to 'Routine' at Consultant level. At this time it was noted that Ms A was also reporting weight loss of four stone on a supervised diet but this was not considered to be a 'red flag' symptom (a symptom which should prompt immediate action) due to the findings reported on the MRI scan.

4. Ms A was reviewed by the Neurosurgery Team (dealing with disorders of the spinal cord and/or brain) on 15 November 2011 and advised to maintain the conservative (non-interventional) approach to her treatment and increase her pain medication. On 23 November 2011 she was seen by her GP and referred to the Acute Medical Unit (AMU) at Ninewells Hospital. While in the AMU the following day the MRI scan of 10 October 2011 was reviewed by one of the Neurosurgery Team and an abnormality was pointed out. This was discussed with a radiology registrar and Computerised Tomography (CT) scans of Ms A's chest; abdomen; and pelvis were ordered. Advanced ovarian cancer was then diagnosed. Ms A subsequently died on 1 April 2012.

5. Miss C originally complained to the Board about her sister's care and treatment on 25 February 2012 and received an acknowledgement and request

for Ms A's consent to act on her behalf. Due to Ms A's condition, she was unable to give consent at that time. Miss C wrote to the Board again on 9 May 2012 and the complaints process was continued. Mr C (Miss C's and Ms A's father) wrote a second letter of complaint to the Board on 1 June 2012. Mr C's letter made a request to be informed of the outcome of the Critical Incident Review (CIR) that had taken place and he also gave his permission for the Board to correspond with Miss C on his behalf.

6. Mr C's letter was acknowledged on 15 June 2012 and holding letters were then sent to Miss C on 13 and 27 July; 14 August; 11 September; 5 October; and 22 November 2012. A response to the complaint was sent to Miss C on 21 December 2012. The family were dissatisfied with the response from the Board, including the failure to provide them with a copy of the CIR report and asked my office to review their complaints.

7. The complaints from Miss C which I have investigated are that:

(a) between October and November 2011, staff at Ninewells Hospital failed to provide Ms A with appropriate medical treatment in view of the symptoms with which she presented; and

(b) staff at the Board failed to provide the family with a copy of the CIR report despite them making repeated requests and failed to take steps to arrange a meeting with the family.

Investigation

8. My complaints reviewer carefully reviewed all the documentation provided by Miss C and the Board; reviewed relevant national and local guidance; and took independent advice from five of my advisers. The advisers were a consultant radiologist (Adviser 1); a consultant in emergency medicine (Adviser 2); an orthopaedic surgeon (Adviser 3); a consultant physician (Adviser 4) and a senior nurse (Adviser 5).

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

(a) Between October and November 2011, staff at Ninewells Hospital failed to provide Ms A with appropriate medical treatment in view of the symptoms with which she presented

10. Ms A began to suffer from back pain in May 2011 following a fall which gradually intensified over a period of about five months. Mr C, in his letter to the Board of 1 June 2012, described the pain as becoming excruciating and stated that Ms A also suffered a loss of strength and sensation in her right leg. Mr C described Ms A as having gone from being an active woman to having to walk with crutches and being barely able to walk. She also needed increasingly strong painkillers which provided her with limited relief.

11. Ms A was being regularly reviewed by her GP and on 27 September 2011 the GP sent a request for a MRI scan of Ms A's spine. The scan took place on 10 October 2011 and was initially reported as being essentially normal.

12. Ms A was still experiencing severe pain and on 26 October 2011 she went to the A&E department at Ninewells Hospital as she had been unable to get through to the GP practice that day. Ms A was seen by a Triage Nurse (triage is an assessment of the seriousness of a patient's condition) and then an A&E consultant who referred her back to her GP under the Board's 'three day guideline'.

13. The GP also referred Ms A to the Orthopaedic Team and sent an 'Urgent' referral on 22 October 2011. This was triaged at consultant level on 25 October 2011 and downgraded to 'Routine'. Ms A was seen in the Orthopaedic/ Physiotherapy clinic on 8 November 2011. She was seen by an advanced physiotherapy practitioner (APP) who considered that Ms A's weight may have been a contributing factor to her pain. Ms A at this time was also reporting weight loss of four stone on a supervised diet and the APP was aware of this so this weight loss was not considered to be a 'red flag' symptom in view of the MRI report.

14. Ms A was also seen by a specialist registrar from the Orthopaedic Team and was referred on to the Pain Clinic for urgent review. Ms A's condition was reviewed by the Neurosurgery Team on 15 November 2011 and a telephone discussion with the GP that day confirmed that no surgical intervention was considered to be beneficial. The GP was advised to continue with the current conservative treatment.

15. Ms A continued to be reviewed by her GP and needed increasingly strong pain relief which had little effect. On 23 November 2011 the GP had discussions with the on-call neurosurgeon and on-call physician at Ninewells Hospital. It was agreed that Ms A should be admitted to Ward 15, the AMU. During this admission, on 24 November 2011, Ms A was reviewed by a member of the Neurosurgery Team who reviewed the actual MRI scan that had been done on 10 October 2011. At this time an abnormality was detected and discussed with the Radiology department. CT scans of Ms A's chest, abdomen and pelvis were recommended. Following these scans cancer, which was at a terminal (incurable) stage, was diagnosed.

16. Following a query from my complaints reviewer, the Board stated that the mis-reporting of the MRI scan of 10 October 2011 was 'definitely' reported to the Radiology Discrepancy and Complications Meeting (RDCM) Co-Ordinator. However, the response continued that no minutes of the meeting at which it was discussed were available as the meetings were not usually minuted.

Advice obtained

17. Adviser 1 reviewed the MRI scan and the report and stated that they were surprised that the abnormality was missed on first reporting. Adviser 1 described the abnormality as being 'conspicuous' and although the diagnosis of extensive cancer and a blocked kidney would not be expected in a young woman of Ms A's age, Adviser 1 was of the view the abnormality should have been picked up.

18. Adviser 1 noted that this failure had properly been reported to the RDCM. Adviser 1 stated that such meetings should be minuted and should record whether the mis-reporting was a 'one-off' in a normally competent practitioner. Other possibilities that should be noted are whether it was part of a trend from a practitioner causing concern; and/or whether there were any contributing factors such as poor equipment; lighting; and/or caseload problems. Any resulting remedial action should also be recorded and the minutes circulated to relevant departments and Board members.

19. Adviser 2 was of the view that the 'three day guidance' policy used by the A&E department at the Board is a reasonable one if appropriately applied. However, Adviser 2 commented that taken in isolation, the first two criteria would not be safe. For example, a patient with heart problems may well have had the condition for more than three days and to have consulted their GP

about the problem previously. In these circumstances it would not be safe to refer the patient back to their GP. Similarly, a patient with an undiagnosed fracture requiring hospital treatment may have sustained the injury three or more days previously and/or may have consulted with their GP and been told they had, for example, sustained a bad sprain. If the patient was still having problems, such an un-resolving condition would still require investigation at A&E rather than referral back to their GP.

20. Adviser 2 noted that the policy involves assessment by a senior doctor and that Ms A was seen by the consultant in A&E. Nonetheless, Adviser 2 was of the view that Ms A's symptoms had been underestimated. In particular, there was no record of any pain triage and Adviser 2 stated that a patient reporting un-resolving pain for more than six weeks, despite treatment with multiple and increasing painkillers, should be a 'red flag' symptom requiring immediate further investigation.

21. Adviser 2 said that such a 'red flag' symptom would normally prompt investigation by way of plain x-rays and blood tests for raised inflammatory markers (markers in the blood indicating an undiagnosed infection). Adviser 2 stated that while x-rays would have been superfluous in Ms A's case as she had had a MRI scan (albeit mis-reported) the inflammatory markers were significantly raised the following month when Ms A was admitted to the AMU. Testing for these markers when she attended A&E in October 2011 would have been, in the view of Adviser 2, likely to have returned an abnormal result which, again, should have prompted further investigation at that stage.

22. Adviser 2 also stated that had the A&E consultant asked Ms A about pain at night; pain unrelieved by lying down; and/or a lack of response to moderate painkillers, this may have also prompted further investigation. There was no evidence of such an enquiry or of relevant examination such as testing for tenderness of the spine or nerve root irritation (by testing leg raising) or neurological examination (to test for weakness or numbness in the limbs).

23. Adviser 2 stated that the scenario of a young woman presenting to A&E with severe pain due to advanced cancer is rare and the clinicians in the A&E department would not have been expected to have made that diagnosis. However, the failure to formally assess Ms A and the underestimation of her pain together with the inappropriate application of the 'three day guidance' meant that an opportunity for the diagnosis to be made was missed.

24. Adviser 2 considered that the eventual outcome for Ms A would have been unlikely to have changed, but she may have had the benefit of an earlier diagnosis and consequent access to specific and effective symptom control.

25. Adviser 3 reviewed Ms A's clinical records and was of the view that based on the clinical information on the 'Urgent' referral letter from the GP, it was not unreasonable for the referral to have been downgraded to 'Routine' as there were no 'red flag' symptoms included. Adviser 3 continued that the triaging consultant would have relied on the paper report of the recent MRI scan and would not have been expected to have reviewed the actual scan. However, it was noted that the referral was recorded as being downgraded because the MRI scan was (at that time) reported as excluding serious or urgent problems.

26. Adviser 3 also told my complaints reviewer that it is common practice within the NHS for patients to be seen firstly by a physiotherapist when referred for a musculo-skeletal consultation. Adviser 3 commented that in view of the findings of the APP, it was reasonable for Ms A and her GP to have been advised to continue with the conservative treatment.

27. However, Adviser 3 also stated that a review of Ms A's condition by the orthopaedic specialist should have recognised the mismatch between Ms A's continuing and deteriorating symptoms, as reported by the GP and Ms A, and the MRI reported results. Adviser 3 stated that this should have prompted further investigations, including blood tests, chest x-ray and a discussion with a consultant radiologist about the MRI scan result as eventually happened.

28. Adviser 4 also commented on the care provided to Ms A in the A&E department and agreed that while the 'three day guidance' may be an appropriate tool in some cases, in others, such as Ms A's, it could lead to a delay in diagnosis. Adviser 4 was of the view that no adequate assessment of Ms A's specific condition and on-going symptoms was made in A&E on 26 October 2011.

29. Adviser 4 reviewed the care and treatment provided to Ms A in the AMU and was satisfied that from a medical viewpoint they were appropriate. Ms A was seen by a doctor within three hours of her admission and a consultant within 18 hours of being admitted. She was reviewed by the Neurosurgery

Team; and was given her diagnosis the day after admission. She was then seen by appropriate specialists later that day and the next day.

30. Adviser 4 acknowledged Miss C's concerns that Ms A's pain was not adequately managed in the first few hours of her being on the AMU, however, Adviser 4 stated that due to the nature of the underlying, but at that stage undiagnosed, cause of Ms A's pain, it was not unreasonable that it took some time to achieve effective control of her pain.

31. Adviser 5 reviewed the nursing notes and established that a full nursing assessment had been undertaken when Ms A was admitted to the AMU. The second entry, which was untimed, referred to Ms A being in pain, but that the nurse was unable to locate a doctor to prescribe the required medication. Ms A, therefore, had to wait some two and a half hours for pain medication to be prescribed once the doctor had reviewed her. Adviser 5 was of the view that this was an unacceptable time for a patient to wait in pain. Adviser 5 considered that in the specialist AMU there should have been a member of staff with the necessary skills to have been able to prescribe painkillers for Ms A.

32. Adviser 5 commented that there is no record of the three conversations Miss C states she had with staff on this issue, nor what the nursing staff were doing to try to obtain pain relief for Ms A, but that this level of detail would not normally be expected. However, overall, Adviser 5 considered that the nursing staff on the AMU involved in Ms A's care on 24 November 2011 had not been sufficiently proactive in obtaining pain relief for Ms A.

(a) Conclusion

33. The standard by which we judge when making decisions on complaints is 'reasonableness'; that is, were the actions of those involved reasonable in the circumstances and based on the information available at the time. In this case, based on the evidence and advice available to me, they were not.

34. One of the key issues in this case was that the MRI scan performed on 10 October 2011 was mis-reported. This may have given false reassurance to some of the clinicians who saw Ms A in the following weeks. It has also been shown that this had an influence in the downgrading of the GP's urgent referral letter. However, my advisers have highlighted that Ms A was a young woman who had previously been relatively active but within a period of a few months became almost unable to walk.

35. The various clinicians who saw Ms A during October and November 2011 appeared not to take sufficient cognisance of the un-resolving and increasing symptoms reported by Ms A and her GP.

36. Her GP, who knew Ms A and the history of her condition best, recognised that her pain was not only unresolved but increasing; despite significant and escalating pain medication. The GP persistently tried to obtain specialist advice with the aim of getting a definitive diagnosis for Ms A. Indeed, it seems that it was the persistence of the GP that was the catalyst in finally obtaining the diagnosis.

37. While it is not possible at this stage to say whether the outcome for Ms A would have been any different, Ms A would have had earlier access to symptom control. She and her family would also have had more time to take in the diagnosis and prepare for the outcome.

38. On the matter of the mis-reporting of the MRI scan, the Board have stated that while the matter was definitely reported to the RDCM, there are no minutes of the meeting available to confirm this or to show whether this was a 'one-off' event; part of a trend; or the result of some physical limitations in the department at the time. Nor is there any evidence of whether any remedial action was thought necessary and/or undertaken. I note Adviser 1's comments that minutes should have been taken and circulated as appropriate.

39. I note from the copy of the CIR report provided to my office that the Board have acknowledged the failing in regard to the mis-reporting of the MRI scan, but the report does not make it clear what, if any, remedial action was taken.

40. The CIR report also acknowledged the failure of Board staff to take a holistic view of Ms A's symptoms and condition. There is an action plan that the Medical Director had undertaken to formulate, in conjunction with relevant parties, including Ms A's GP, a care pathway to improve the treatment of patients, such as Ms A, with deteriorating and un-resolving symptoms that appear to be at odds with clinical findings. This action is currently on-going.

41. Having considered all the evidence and advice available to me, I uphold this complaint.

(a) Recommendations

42. I recommend that the Board:	*Completion date*
(i) provide evidence that appropriate action was taken to address the mis-reporting of the MRI scan of 10 October 2011;	26 April 2014
(ii) ensure that future RDCMs are minuted and the minutes appropriately circulated;	26 April 2014
(iii) review the application of the 'three day guidance' to ensure that staff appropriately assess patients before referring back to their GP. Where necessary provide refresher training;	26 June 2014
(iv) ensure that staff on the AMU are reminded of the need to be proactive in addressing patients pain; and	26 April 2014
(v) continue to work towards producing a care pathway to improve the treatment of patients who present with un-resolving and/ or deteriorating symptoms, including improved communication with primary care providers (GPs).	26 May 2014

(b) Staff at the Board failed to provide the family with a copy of the CIR report despite them making repeated requests and failed to take steps to arrange a meeting with the family

43. Miss C complained initially to the Board in February 2012 while Ms A was still in hospital and the complaint centred on the treatment Ms A received on the AMU (then known as Ward 15). Following Ms A's death, Miss C asked the Board to continue the complaint investigation and this letter was acknowledged on 11 May 2012. The Board's letter included a request for permission from the next of kin for Miss C to act on their behalf.

44. Mr C wrote to the Board confirming the issues of concern for the family and giving his permission for the Board to deal with Miss C on his behalf. His letter of 1 June 2012 included a request to be informed of the outcome of the CIR (referred to by the Board as a Significant Clinical Event Analysis Review (SCEAR)).

45. Miss C's complaint to my office stated that the Board had not informed the family that a CIR was taking place in May 2012 and that once they knew about it via Ms A's GP they requested a copy of the report, but this was not sent to

them. In a telephone call in March 2013 with my complaints reviewer, Miss C confirmed that in addition to the written request for a copy of the CIR report in her father's letter, she had telephoned the complaints department of the Board in January 2013 to repeat this request but it was still not sent.

46. In the same call to the Board's complaints Team she discussed having a meeting with Board staff to discuss the case but again, Miss C's complaint stated that this had not happened. My complaints reviewer provided a copy of the CIR report to Miss C in May 2013.

47. In a response to my office dated 6 June 2013, the Board provided my complaints reviewer with documentation relating to telephone contact from Miss C on 5 October 2012; 24 and 28 December 2012; and, 7 January 2013, but there were few details of what was discussed. The response continued that the request for a meeting was passed from the complaints Team to the Significant Clinical Event Analysis Team as soon as the request was made. The response stated that a provisional date for a meeting had recently been identified and the team were awaiting confirmation from Miss C that she still wished to meet.

48. In a further response dated 12 February 2014, the Board have acknowledged that there was an unacceptable delay in arranging a meeting, which was partly due to the difficulty of fitting in with the clinicians' diaries. The Board have also provided my complaints reviewer with a copy of a letter sent to Miss C following a meeting which took place on 3 July 2013 between Miss C, her aunt and a member of the clinical staff of the Board. The letter refers to the matters discussed and that Miss C had agreed to provide comments to the Board on a draft information leaflet dealing with SCEARs.

49. The letter from the Board to my complaints reviewer also confirmed that their Complaints Management Procedure encourages the use of meetings with complainants to try to resolve complaints and/or outstanding issues.

(b) Conclusion

50. The Board have acknowledged that the CIR [SCEA] report was not provided to Miss C as requested. This is a failing. The Board have also acknowledged that their complaints procedure, which I am satisfied complies with the NHS guidance on complaints handling, encourages meetings with staff and complainants, but that this did not happen at an early stage in this case. A

meeting did take place in July 2013 and I understand from the information provided by the Board that the meeting was a positive one.

51. However, it remains the case that the meeting did not take place until a considerable time after it was first requested by Miss C. Had an earlier meeting been arranged, Miss C and her family may have received an earlier resolution to their concerns.

52. Based on the evidence available to me, I uphold this complaint.

(b) Recommendations

53. I recommend that the Board:	*Completion date*
(i) remind staff dealing with complaints about the usefulness of meetings at an early stage of the complaints process as per their Complaints Management Procedure; and	26 April 2014
(ii) issues a written apology to Ms A's family for the failings identified in this report.	26 April 2014

54. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Ms A	The aggrieved
GP	General Practitioner (community doctor)
A&E	Accident & Emergency (department where patients with new and sudden on-set of medical conditions or injuries are treated)
The Board	Tayside NHS Board
Mr C	The father of Miss C and Ms A
APP	Advanced Physiotherapy Practitioner
RDCM	Radiology Discrepancy & Complications Meeting (a meeting held to discuss adverse incidents which have occurred within the Radiology department)
SCEAR	Significant Clinical Event Analysis Review (a review of adverse clinical incidents involving patients within the Board area)

Annex 2

Glossary of terms

Acute Medical Unit (AMU)	a special unit where patients with unexplained medical symptoms are admitted for assessment
Critical Incident Review (CIR)	a process of reviewing, and learning from, the events leading up to a serious medical incident
Computerised Tomography (CT)	an imaging process using specialised computerised images of the patient's body
Consultant	a senior clinician, usually overseeing a team of more junior and/or trainee doctors
Magnetic Resonance Imaging (MRI) scan	a diagnostic scanning process using magnets and computer images to give detailed images of the patient's skeleton and internal organs
Neurosurgery	medical specialism relating to disease or injury to the spinal cord and/or brain
Orthopaedic	medical specialism relating to the bones and limbs
Physiotherapy	manipulation and/or specialist exercise to aid recovery from illness or injury
Radiology	specialism relating to the diagnostic use of various types of imaging including x-ray; MRI and CT scanning
Red flag symptom(s)	a symptom or range of symptoms which indicate a serious medical problem and should prompt immediate action by clinicians

Registrar	a mid-grade doctor
Specialist Registrar	a mid-grade doctor in a specialist field, such as Orthopaedics
Three day guideline	a Board policy under which patients who have had the presenting condition for three or more days and/or who has already seen their GP about the condition, are referred back to their GP
Triage	assessment of a patient or referral form to decide the urgency of the patient's condition and/or request for treatment

Annex 3

The Board's 'Three-Day Guideline'

NHS Tayside – Emergency Department

Information and Advice

You have attended the Emergency department wit

- **A condition that has been present for 3 days**
  Or
- **A condition with which you have already consulted your own General Practitioner**
  Or
- **An illness or health problem which would normally be seen and dealt with by a General Practitioner**

What Happens Now?
The Senior doctor on duty will come and speak to you and make a decision on whether you will be seen in the Emergency Department:

It is likely that you will be advised to make arrangement to see a General Practitioner.

We will attempt to do this as soon as possible but you may have to wait if the Senior doctor is busy attending to Emergency cases.

If you decide to leave and make arrangements to see a GP, please advise a nurse or a member of reception staff.

If the Senior doctor decides that you should be seen in the Emergency department, you will be seen in order of clinical priority and are likely to have to wait.

TO ALLOW US TO DEAL WITH EMERGENCY PATIENTS IT IS ESSENTIAL THAT NON-EMERGENCIES MAKE ARRANGEMENTS TO SEE THEIR GP.