S.195/01-02

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

South Glasgow University Hospitals NHS Trust (the Trust)

Complaint as put to the Ombudsman

1. In this report I refer to the complainant as Mrs J and to her husband as Mr J. The account of the complaint provided by Mrs J was that on 5 May 1999, Mr J was admitted to the Victoria Infirmary, Glasgow (the Infirmary) where he underwent an elective reversal of colostomy (a surgical operation to bring part of the colon through the abdominal wall) and repair of a hernia. In addition to the colostomy, Mr J's previous medical history included chronic obstructive pulmonary disease and atrial fibrillation (irregular heart and pulse rate). Following his surgery, Mr J was admitted to the intensive care unit for 48 hours. Subsequently he was transferred to a normal dependency ward. When Mr J's stitches were removed there was a large hole in his wound. On 19 May, Mr J was discharged home into the care of his GP and district nursing staff. Mrs J was concerned that Mr J had been discharged from the Infirmary with a large wound, which was discharging fluid, and with leg oedema (swelling) which was sufficient to cause him difficulty in walking. Following his discharge home, Mr J's condition deteriorated and he was readmitted to the Infirmary on 5 June. The clinical diagnosis on readmission was congestive cardiac failure. Mr J's previous hospital clinical records could not be accessed when he was readmitted because they were located in an office within the Infirmary which was locked during weekends. On 6 June, Mr J suffered a fatal cardiac arrest.

2. In July 1999, Mrs J complained to Greater Glasgow Health Board (GGHB) about the circumstances of her husband's discharge from the Infirmary on 19 May and about several aspects of his GP and district nursing care. (Note: Greater Glasgow Primary Care NHS Trust (the PCT) are responsible for dealing with the complaint against the GP and district nurses and their actions are not subject to this investigation). As Mrs J was dissatisfied with GGHB's co-ordinated response she separately pursued her complaints with each of the NHS Trusts involved. In May 2000 Mrs J raised additional matters of complaint

with the Trust in relation to the care and treatment Mr J received on his readmission to the Infirmary on 5 June 1999. However, she was dissatisfied with the Trust's response to those matters and its further response to her original complaint.

3. On 9 January 2001 Mrs J wrote to the Trust's convener to request an independent review of her complaint. The Trust acknowledged receipt of Mrs J's request on 10 January. Between 2 March and 9 July, Mrs J telephoned the Trust on six occasions to ask about progress with her independent review request. Because the convener who originally received the request (the first Convener) knew Mrs J she passed the request to another convener (the second Convener). On 11 July the second Convener wrote to Mrs J to apologise for the delay in responding to her independent review request; to explain that he had taken no action as he had been under the misapprehension that the Ombudsman was investigating her complaint against the Trust; and to advise her that he would now deal with her request as expeditiously as possible. On 8 October another convener (the third Convener) wrote to Mrs J to explain that he was now considering her independent review request as the second Convener was no longer working with the Trust; and to say that he would progress her request as soon as possible. On 9 November the Trust sent Mrs J a holding letter. On 9 and 10 January 2002 Mrs J telephoned the Trust to again ask about progress on her independent review request. On 11 January the Trust sent Mrs J a further holding letter. On 18 February Mrs J received a letter (dated 12 February) from the third Convener refusing her independent review request.

4. The complaints subject to investigation were that:

(a) there was inadequate assessment of Mr J's fitness for discharge on 19 May 1999;

(b) following Mr J's readmission to hospital on 5 June 1999, there were failures in care and communication in that:

(i) Mrs J was not told that her husband was suffering from cardiac failure;

(ii) Mr J's previous hospital clinical records were inaccessible as they were located in a locked office; and

(iii) following Mr J's death, a senior house officer (the SHO) inappropriately asked Mrs J what entry she should make on Mr J's death certificate; and

(c) the handling of Mrs J's independent review request was dilatory and unsatisfactory.

Investigation

5. The statement of complaint for the Ombudsman's investigation was issued on 19 April 2002. The Trust's comments were obtained, and relevant papers were examined. Oral evidence was taken from Mrs J and Trust staff. Two professional assessors - a consultant surgeon and a medical director - were appointed to advise on the clinical aspects of the case. Their report is reproduced in full at Annex A. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Complaints (a) there was an inadequate assessment of Mr J's fitness for discharge, (b)(i), (b)(ii) (b)(iii) failures in care and communication

6. **Mrs J** said that her main concern was that she felt her husband was not fit for discharge on 19 May 1999 yet medical and nursing staff did not think that there was a problem. Mrs J thought that the doctors had allowed Mr J insufficient time to recover from his operation. She compared that admission with the previous admission in 1998 when Mr J was admitted as an emergency with hernia problems. At that time, Mr J was left with the colostomy but he had spent several weeks in hospital, including a time in the High Dependency Unit and underwent rehabilitation.

7. Mrs J believed that her husband was making a slow recovery from the operation and that he had not regained sufficient mobility. As Mr J had to move his bowels for the first time in a year, he had frequent accidents and would not make it to the bathroom in time and he would soil his pyjamas. However, he would not tell the nurses and he would put his pyjamas in a carrier bag to give to Mrs J when she next visited. Mrs J said that Mr J did not

like being in hospital and that he would have said anything to nursing staff to ensure that he was discharged as soon as possible.

8. Mrs J was present on 15 May when Mr J's elasticated stockings were removed. She noticed that his ankles and legs were swollen. The swelling did not improve and despite Mrs J bringing her concerns about the swelling to the nurses' attention, the decision was made that Mr J could be discharged home on 19 May. Mrs J thought that her husband should not have been discharged until the swelling was under control. On the day of discharge, Mrs J had to assist her husband to walk to the car. She walked in front of him and he walked behind and placed his hands on her shoulders for support. While Mr J was at home, Mrs J helped him move about the house in the same manner. Mr J's condition deteriorated in the second week after discharge when the swelling from his ankles had reached as far as his thighs. Mr J had also become breathless, confused and was lethargic. Mrs J reported her concerns to the GP and the district nurses who visited on a daily basis.

9. Mrs J took it upon herself to contact the Emergency GP Service on 5 June. The GP who visited said that Mr J's chest was noisy and that he had to be admitted to hospital. Mrs J felt that a weight had been lifted from her shoulders and that finally Mr J would receive some help. Mrs J said she was told by hospital staff that a x-ray had shown Mr J had fluid in his lungs which would take 3-4 days to clear and then they would check to see if there was any damage to his heart. Mrs J said that hospital staff did not tell her that Mr J was in cardiac failure because if they had, she would not have left his side. The following day, Mrs J received a telephone call to say that Mr J had collapsed. She went to the Infirmary with her son and shortly afterwards Mr J died. Mrs J said the SHO approached her and asked what would she like entered on the death certificate as the cause of death. Mrs J was shocked that she should have been asked such a question. The SHO said that she supposed that she could put down heart failure. Mrs J felt that perhaps something strange had happened to Mr J while he was in hospital and it might be covered up by her agreeing for heart problems to be put on the death certificate. Mrs J demanded that a post mortem be carried out which would establish the cause of death.

10. When Mrs J later examined Mr J's clinical records, she noticed that on his readmission to hospital on 5 June that his clinical records, which contained details of his complex medical history, were not available. The records were locked in the consultant's secretary's office and could not be obtained until Monday 7 June. Mrs J thought that a copy should have been available so that doctors could refer to them if required and ensure that appropriate treatment could be given. Mrs J was also surprised about the reference in the post mortem report to Mr J's heart problems. She was aware that he had been prescribed Digoxin in 1998 but she understood that would only continue until the operation to reverse the colostomy. She also knew that his heart skipped a beat at times but that it was not life threatening.

The Trust's comments

11. In response to the Ombudsman's statement of complaint, the Trust's director of nursing wrote:

> 'Mr J was assessed by the medical staff who were particularly pleased that there was no evidence of any infection before the time of his discharge. He was considered ambulant, comfortable and mobile and a decision [to discharge] was only reached when it was judged that he had reached a safe situation. An awareness existed of his occasional wheezy and breathless state and medical staff were aware of his long-standing previous history of asthmatic obstructive airways disease and hypertension as well as previous auricular fibrillation. Indeed it was this clinical background that had meant he had been observed for the best part of a year before being re-admitted for a second operation.
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> '... [A physician responsible for Mr J's care on 5 June 1999 (the Physician)] notes that [Mr J] was on a number of cardio-respiratory medications when he was admitted for the final time. Clinical examination and diagnosis on the casesheet is one of cardiac failure confirmed by X-ray. Fluid retention and shortness of breath on the 2 days prior to admission indicated that [Mr J] was ill. He was given standard medication on the presumption he would improve. Medical staff cannot predict sudden deterioration with cardiac arrest and subsequent death. [The consultant who carried out Mr J's operation, (the Consultant)] comments that the decision to delay his second operation for a full year from the time of his original life saving

operation is testimony to the fact that his overall "athletic" fitness was a matter of long standing doubt. To that extent it would be wrong to describe Mr J's heart as "strong".

'... When patients are admitted acutely ill, it is the acute illness that is tackled and this in the main can be done without reference to notes. However, it is admitted that if the backgrounds have been complicated and problematic then of course there would be distinct advantages in knowing what went before.

[The Physician] was unable to comment [about the discussion between Mrs J and the SHO] due to not being present during the discussion.'

Evidence from Trust staff

12. The **Consultant** said that he knew when Mr J was admitted on 5 May 1999 that he had lost about five stone in weight since his previous operation, but he did not think that was due to any underlying disease. One of the hazards of surgery is obesity and in that context, Mr J was a high-risk patient. Mr J was keen for the colostomy reversal to take place and was determined to lose weight which would increase his chances of surviving the operation. It was part of a definite plan for Mr J to get himself into better physical shape and he received a great deal of encouragement from Mrs J. The Consultant felt that the amount of weight loss was sufficient to bring down the risk of Mr J not surviving surgery. He was aware that Mr J had a complex medical history and it was for that reason that Mr J was observed for a year before being readmitted for the colostomy reversal.

13. The Consultant noted that there was reference in the clinical records to Mr J suffering from mild hypertension (high blood pressure) but he felt that it had been overstated as the diastolic readings (pressure readings when the heart is relaxed) were not overly high. The Consultant was aware that Mr J had also shown evidence of anaemia (lack of red blood cells) but that could have been caused by his dietary regime. The Consultant did not feel that Mr J warranted further investigation of these issues prior to the operation. Mr J appeared bright and breezy and had played his part by losing weight and the Consultant thought it was reasonable to proceed with surgery. Prior to the operation, the Consultant had a long discussion with Mr J about the reversal of

the colostomy and told him that he would also repair his hernia at the same time to avoid a further operation.

14. The Consultant was surprised to find from the post mortem report that Mr J had developed bacterial endocarditis (the presence of vegetation (small infected growths) on the heart valves). He had no reason to believe that Mr J had been suffering from a serious illness prior to the operation. The Consultant did not know when Mr J developed bacterial endocarditis and there were no signs at the time of the operation to indicate that that was the case. There was no evidence of febrile illness (fever) in the clinical notes between the surgery which was performed in 1998 and the operation to reverse the colostomy in 1999. If Mr J had been suffering from a serious illness, the Consultant would have expected signs such as distended neck veins or other indications of congestive cardiac failure. In summary, the Consultant was not considering a fit man for surgery but a man who was fit enough for surgery.

15. The Consultant thought that Mr J was fit for discharge on 19 May. He had been an inpatient for 14 days which was an indication that he was a vulnerable patient and they had not discharged him home without there being signs that he had safely recovered from surgery. It would not be normal practice to keep a patient in hospital for such a length of time following such an operation. The Consultant said that Mr J had spent two days in intensive care following the operation and when it was noted that he did not require assisted ventilation or intensive monitoring, he was transferred to the general surgical ward for normal observations and treatment. The Consultant thought that the swelling on Mr J's ankles and legs was due to his posture following the operation and the removal of the elasticated stockings and it would settle in time. Mr J's hernia repair entailed the bringing together of the large abdominal muscles of his anterior abdominal wall and drains had been placed outside the muscle but under the skin. Although this gave the appearance of an apparent large visible hole, it was only superficial and did not extend deep into the muscles or into Mr J's abdomen. It was appropriate for the wound to be dressed under the supervision of either the GP or district nurses. Mr J was also told to contact the Ward if he had any concerns after discharge. The Consultant was satisfied that a senior member of medical staff had regularly reviewed Mr J after the operation. (Note: I have seen from Mr J's clinical records, that he was regularly reviewed by senior medical staff between his

return to the ward after the operation and the date of discharge. It is also recorded that Mr J was gently mobile around the Ward and that medical staff were aware of his ankle and leg oedema). The Consultant had also reviewed Mr J after the operation. As Mr J had regained some mobility and there was no indication of infection of the abdominal wound, there was no reason to delay the discharge further.

16. The **SHO** said that the Trust had not asked for her comments in relation to Mrs J's complaint. She remembered speaking to Mrs J and some of her family in a long conversation about the probable cause of Mr J's death. The SHO said that in the case of a sudden death occurring in hospital, it is normal practice to ask the family for permission to conduct a post mortem. If the family refused permission and the doctor who attended at the time of death was reasonably certain of the cause of death, then a death certificate would be issued accordingly. In Mr J's case, the SHO approached Mrs J in order to obtain permission for a post mortem although she was sure that Mr J died of heart failure. The SHO remembered that Mrs J asked her if she was prepared to issue a death certificate, what would she put down as the cause of death? The SHO said that she thought that the cause of death was heart failure and she explained to Mrs J why she thought this. The SHO denied that she would ever ask a family what she should enter on a death certificate. She could understand that to discuss the matter of a post mortem at such an emotional time could have led to a misunderstanding of what had been said. The SHO said Mrs J was keen to have a post mortem conducted to establish the cause of death.

Findings (a)

17. In reaching my findings, I have taken into account the report compiled by the professional assessors at Annex A. Mrs J complained that her husband was not fit for discharge on 19 May 1999 and that doctors had not allowed him sufficient time to recover from the operation to reverse his colostomy and repair his hernia which took place on 6 May. When the elastic stockings were removed from Mr J's legs, Mrs J noticed that his legs and ankles were swollen. She did not think that Mr J should have been discharged until the swelling was under control. Mrs J noticed that Mr J's condition deteriorated in the second week after discharge when the swelling had spread from his ankles as far as his thighs. Mr J had also become breathless, confused and lethargic.

18. The Consultant has said that Mr J was a high-risk patient. Mr J was keen for the operation to reverse the colostomy to proceed and had played his part by reducing his weight. The operation had been delayed for a year due to Mr J's complex medical history. The Consultant was surprised to learn from the post mortem report that Mr J had developed bacterial endocarditis and he had no reason to believe that Mr J was suffering from a serious illness prior to the operation. The Consultant believed that Mr J was fit for discharge on 19 May. Mr J had been kept in hospital for 14 days to allow him time to recover from the operation. The Consultant thought that Mr J's ankle and leg oedema would settle in time. During his stay in hospital, senior medical staff including the Consultant regularly reviewed Mr J and as Mr J had regained some mobility and there was no indication of infection at the wound, it was appropriate to discharge him into the care of the GP and district nursing staff.

19. The assessors have explained that Mr J had a complex medical history and that he was fortunate to survive the operation on 8 May 1998 which resulted in the formation of a colostomy. Mr J had a number of risk factors for operation such as bronchial asthma, chronic obstructive pulmonary disease, hypertension, obesity and atrial fibrillation. Mr J was reminded that he had been through a life threatening situation and that before consideration could be given to the reversal of the colostomy or to effect a further incisional hernia repair then he would have to lose a substantial amount of weight. Mr J was successful in reducing his weight to such a level that in March 1999, the decision was taken that the operation should proceed. The operation took place on 6 May and Mr J remained in hospital until his discharge on 19 May. The assessors have taken the view that following the operation, Mr J was regularly reviewed by senior medical staff. He was also reviewed on a daily basis and was adequately assessed on the day of discharge by the Specialist Registrar. An appointment had been made to review Mr J at the Surgical Outpatient Clinic in three weeks and he had been told that if problems arose then he was to contact the Ward. The assessors believe that Mr J was adequately assessed prior to his discharge on 19 May. I accept the advice which was provided by the assessors in this respect. I consider that by 19 May, there was no clinical reason for Mr J to remain in hospital and that it was appropriate to transfer his continuing care to the GP and district nursing staff. Accordingly, I do not uphold this aspect of the complaint.

Findings (b)(i)

20. Mrs J said that when she read the post mortem report, she was surprised to learn that Mr J had suffered from serious heart problems. She knew that sometimes his heart missed a beat. When Mr J was readmitted to hospital on 5 June, hospital staff did not advise Mrs J that Mr J was in cardiac failure. The assessors have explained that there are entries in Mr J's clinical records which indicate that in 1998, medical staff told his family that he had heart problems. However, insofar as the admission on 5 June 1999 is concerned, Mr J suffered an unexpected cardiac arrest which could not have been predicted and therefore medical staff would not have had the need or opportunity to inform Mrs J that Mr J was in cardiac failure. Again, I accept the advice of the assessors in that there was not a failure by medical staff to provide Mrs J with information about Mr J's condition. Therefore, I do not uphold this aspect of the complaint.

Findings (b)(ii)

21. Mrs J complained that Mr J's clinical records were unavailable on Mr J's readmission to hospital on 5 June. She felt that doctors should have been able to refer to them to ensure that appropriate treatment was given. The assessors have said that the Physician and his team who attended to Mr J on 5 June dealt with his acute illness with full knowledge of his previous medical history and accurate details of his current drug treatment. I am satisfied that Mr J's clinical management was not affected by the unavailability of his previous clinical records and therefore I do not uphold this aspect of the complaint.

Findings (b)(iii)

22. Mrs J complained that she was approached by the SHO shortly after Mr J's death and asked what she should like to be put on the death certificate. The SHO has said that she had a long conversation with Mrs J and some of her family shortly after Mr J had died. She denied that she had asked Mrs J what she could enter on the death certificate but did remember that Mrs J had asked her what she would put down as the cause of death. The SHO then explained that she thought Mr J had died of heart failure. The SHO could understand that to discuss the matter of a post mortem at such an emotional time could have led to a misunderstanding of what was actually said. I think that that

clearly happened on this occasion. Mrs J and the SHO both agree that the SHO said that she could enter heart failure as the cause of Mr J's death. However, the matter in dispute is whether the SHO asked Mrs J what she would like to be entered as the cause of death. In view of the time which has elapsed since the conversation, I am unable to establish the exact form of words used by the SHO. However, it is evident that due to the different recollections that there has been a breakdown in communication and it is to that limited extent that I uphold this complaint. I am critical that the Trust did not ask the SHO for comments when they responded to Mrs J's complaint. If they had done so then it is possible that this issue could have been addressed when it was fresher in the minds of those involved.

Complaint (c) The handling of the request for independent review

National guidance on dealing with complaints

23. The Scottish Executive Health Department (formerly the Scottish Office Department of Health) issued revised guidance in May 1999 on the operation of the complaints procedure, entitled 'The NHS Complaints Procedure: Guidance for Hospital and Community Health Services' (the guidance). The guidance states that the target timescale for the convener to issue a decision on whether to set up a panel, or not, is 20 working days from receipt of the complainant's request. The guidance also states that the convener must consult an independent panel lay chairman and take appropriate clinical advice where the complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement.

Legislation

24. At the time of Mrs J's request for independent review, her complaint fell to be considered by the then Health Service Commissioner for Scotland under the Health Service Commissioners Act 1993. The Act states that normally before the Ombudsman can consider a complaint, it should first have exhausted the NHS complaints procedure. Additionally, the fact that the Ombudsman was considering a complaint did not prevent the complained against from taking further action on the complaint.

Chronology of events

25. The main events during the Trust's attempts to resolve Mrs J's complaints were as follows:

9 January 2001 - Mrs J wrote to the convener and requested an independent review of her complaint. She was dissatisfied with the Trust's response to her complaint. She told the convener that she had contacted the Ombudsman's office and sent her file which had been copied and returned to her. Mrs J asked that the convener acknowledge her letter and whether he required any further information.

10 January - The Trust's Corporate Affairs Manager (the Corporate Affairs Manager) wrote to Mrs J and acknowledged her request for independent review.

10 January - The Personal Assistant in the Corporate Affairs Department (the Personal Assistant) passed Mrs J's request to the first Convener.

12 January - The first Convener informed the Personal Assistant that she could not act as convener because she knew Mr J.

15 January - The Personal Assistant informed the second Convener that Mrs J's complaint had been allocated to him and he arranged to pick up the papers on 17 January.

2 March - Mrs J telephoned the Trust for an update on her request for independent review. Mrs J was told that the convener had said he would look at the case the following week.

30 March - Mrs J telephoned the Trust for an update on her request. The convener was not available.

2 April - The Trust contacted Mrs J and told her that the convener had said he would deal with the request that week.

30 April - The Trust received notification of a lay chairman.

1 May - The second Convener was advised of the name of the lay chairman.

1 May - Copies of Mrs J's papers were sent to the lay chairman.

30 May - Mrs J telephoned the Trust for an update on her request for independent review and was told that the convener would be concluding the matter within the next week.

9 July - Mrs J telephoned the Trust for an update. She was told that the convener had been working on a number of independent review requests and had had difficulty contacting a lay chairman. The convener was actively pursuing the request.

11 July - The second Convener wrote to Mrs J. He told her that the first Convener had withdrawn as she knew Mrs J. He also explained that when he read her papers, he thought that the Ombudsman was investigating her complaint against the Trust and he had not realised that the Ombudsman was only considering the complaint against the PCT. The second Convener personally accepted responsibility for the delay and told Mrs J that as her complaint included clinical issues, he would now seek independent clinical advice.

7 August - Copy papers sent to independent clinical assessor.

27 September - The Trust passed copy papers to the third Convener as the second Convener had left the Trust.

2 October - The third Convener wrote to the independent clinical assessor asking for progress on his consideration of the clinical issues.

2 October - The clinical assessor provided comments on his consideration of Mrs J's complaint.

8 October - The third Convener wrote to Mrs J and advised her that he was now considering her request for independent review following the departure of the second Convener. He also advised Mrs J that he had received the clinical assessor's comments and that he would consider the complaint further.

9 November - The third Convener wrote to Mrs J and apologised for the delay but he was having difficulty arranging a suitable meeting with the lay chairman.

10 January 2002 - Mrs J telephoned the Trust asking for an update on her request for independent review.

11 January - The Corporate Affairs Manager wrote to Mrs J and told her that the third Convener intended to take her complaint forward towards the end of the following week.

12 February - The third Convener wrote to Mrs J refusing her request for independent review.

Mrs J's evidence

26. **Mrs J** was not satisfied with the Trust's responses to her complaints and requested an independent review. She appreciated that the Trust might have had a lot of complaints to consider and she knew that it would take some months to receive a response. However, from March 2001 she telephoned the Trust on numerous occasions for an update on her request for independent review. Mrs J would generally be told that the convener was considering her complaint and that she would receive a response in due course. Mrs J could understand that the second Convener might have thought from her letter requesting the independent review that the Ombudsman was investigating her complaint. However, at that time the Ombudsman was considering her complaint against the GP and district nurses only. In addition, Mrs J put in her letter that if the convener wanted further information that she was to be contacted. It took until February 2002 for Mrs J to receive the letter from the third Convener refusing the independent review. Mrs J felt quite frustrated about the length of time it took for the conveners to consider her request for independent review.

Evidence of Trust staff

27. The **Personal Assistant** explained that at the time of the complaint she had responsibility for providing administrative support for the conveners. She said that normally when a request is made for independent review, she would immediately contact the Health Board for the name of a lay chair. However,

Mrs J's complaint was out of the ordinary as it appeared that the request for independent review had not been made within 28 days of the Trust's response to the complaint. The Personal Assistant sought advice from the second Convener about whether the request was within time and did not realise that a lay chair should have been appointed before the Convener could reach a decision on the request. She was aware that Mrs J's request for independent review was subject to delays and that holding letters were not issued when potential delays were identified. However, it was the convener's responsibility to instruct her to send holding letters. Similarly, it was for the convener to decide when to send papers to the lay chair and to request that a clinical assessor be appointed. The convener would have to tell the clinical assessor what issues needed to be addressed and establish whether the Trust had provided an appropriate response.

28. The **Corporate Affairs Manager** said that the Personal Assistant would regularly speak to her about delays in the convening process and she would speak informally to the conveners and suggest that it might be advisable to send out a holding letter if a further response was going to be delayed. The Corporate Affairs Manager was embarrassed about the length of time that the conveners were taking to consider Mrs J's request for independent review. The Corporate Affairs Manager and the Personal Assistant had to deal with Mrs J's telephone calls and when they contacted the conveners they were told that they would look at the request in a few days. They were constantly hounding the conveners to take action.

29. The Corporate Affairs Manager had spoken to the chief executive about the convening problems and he had spoken to the Trust chairman. A letter was issued to all the conveners about acting in accordance with the NHS complaints procedure guidelines. The Corporate Affairs Manager said that the Ombudsman's report of a previous investigation into delays in the Trust's complaints handling had been copied to the Trust Board, which included the Trust chairman and the executive directors as well as managerial staff. This was to act as a reminder that complaints had to be dealt with promptly at all stages of the complaints process. The Corporate Affairs Manager added that matters had now improved and that the Trust had employed additional conveners on a case by case consultancy basis and this has resulted in no cases waiting to be allocated to conveners.

30. The **second Convener** said he was aware of the guidance in that a convener had 20 working days to reach a decision on a request for independent review. He was aware that the first Convener had withdrawn as she knew of Mrs J and that her request for independent review was passed to him in January 2001. The second Convener did not recollect either the Personal Assistant or the Corporate Affairs Manager contacting him about progress on Mrs J's request for independent review. During the time of Mrs J's request for independent review, he was dealing with about six to eight requests for independent review, which was a heavy workload. He accepted full responsibility for not instructing the Personal Assistant to issue holding letters to Mrs J.

31. The second Convener said that there were other reasons why Mrs J's request for an independent review was subject to delays. Firstly, Mrs J had said in her letter that she had passed her papers to the Ombudsman as she was frustrated by the delays in the consideration of her complaint. The second Convener decided that he would wait for the Ombudsman to advise him whether or not Mrs J's complaint would be investigated. He did not wish to consider the case if the Ombudsman was going to become involved. Secondly, Mrs J's complaint was affected by the involvement at an early stage by GGHB. The second Convener saw that GGHB had taken it upon themselves to collate Mrs J's complaint against the Trust and the PCT. He felt that as GGHB had become involved at the local resolution stage then they should have proceeded to the independent review stage by appointing their own convener who would consider the complaint against the Trust and the PCT. It seemed unfair that Mrs J was then being asked to deal with two Trusts. The second Convener contacted GGHB to advise them of his concerns and at some point, he learned that the PCT were dealing with their complaint separately and therefore he had no option but to resume consideration of Mrs J's request for independent review. He then had to seek clinical advice on the complaint but this had not been received by the time he left the Trust in September 2001.

32. The **third Convener** said that knew that Mrs J's request had been outstanding for a considerable amount of time before it was allocated to him. However, his role as a convener was voluntary and he also had four or five other cases to consider around that time as well as it being a particularly busy

time of the year for his other commitments. Mrs J's request for independent review was the first that he had dealt with. He read the clinical assessor's report but had some difficulty in arranging a meeting with the lay chairman. He could not recall when he actually spoke to the lay chairman about Mrs J's request for independent review. He noted that Mrs J did not receive updates on the progress of his consideration of her request for independent review and that was a matter for which he accepted full responsibility.

Findings (c)

33. Mrs J made her request for independent review in January 2001 but it took until February 2002 for her to receive the letter refusing her request. I have looked at the action or inaction which Trust staff took on receipt of the request for independent review. The first Convener withdrew in January 2001 because she knew Mrs J. It was wholly appropriate for the first Convener to withdraw and the request was passed to the second Convener. The second Convener held the request from January 2001 to September 2001 when he left the Trust. During that time there was a considerable period of inaction because he thought that the Ombudsman was considering Mrs J's complaint. However, I am at a loss to understand why the second Convener did not take action to contact the Ombudsman's office or Mrs J to clarify if that was indeed the case. It can be seen from paragraph 24 that even if the Ombudsman had been considering Mrs J's complaint, it would not have prevented the second Convener from considering Mrs J's request for independent review. The second Convener also thought that as GGHB had been involved in collating Mrs J's complaints against the Trust and the PCT then they should have dealt with the requests for independent review as well. The second Convener contacted GGHB to be told that the PCT were dealing with their complaint separately and he had to resume consideration of Mrs J's request. This meant that he did not seek clinical advice until August 2001. The third Convener took over the case and he had difficulty in contacting and arranging a meeting with a lay chairman which resulted in his letter refusing the independent review request being delayed until February 2002.

34. The guidance (paragraph 23) is clear that the convener has to reach a decision on a request for independent review within 20 working days of receipt. In many instances, that timescale should be achievable but in some complex cases I can understand that it might be difficult to meet that target.

However, when it is evident that a timescale cannot be met, it would be best practice for a holding letter to be issued to the complainant explaining the reason for the delay so that they are not left with the impression that their complaint is being overlooked. Although I accept that there were difficulties caused by the change of conveners, the fact that Mrs J had to wait 13 months to receive a decision on her request for independent review was inexcusable and accordingly I uphold this complaint. I note with approval the action taken by the Trust to address delays in the complaints handling process and I invite the Trust to circulate this report also in an effort to raise staff awareness about the need to adhere to the guidance.

Conclusion

35. I have set out my findings in paragraphs 17-22, 33 and 34. The Trust have asked me to convey to Mrs J - as I do through this report - an apology for the shortcomings which have been identified. The Trust have agreed to act on my invitation in paragraph 34.

Graham Pettie
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services Ombudsman Act 2002

25 March 2003

Report by the Professional Assessors to the Scottish Public Services Ombudsman of the clinical judgments of staff involved in the complaint made by Mrs J

Matters considered

(i) *There was inadequate assessment of Mr J's fitness for discharge on 19 May 1999.*

(ii) *Following Mr J's readmission to hospital on 5 June 1999 there were failures in care and communication in that:*

(a) *Mrs J was not told that her husband was suffering from cardiac failure;*

(b) *Mrs J's previous hospital clinical records were inaccessible as they were located in a locked office; and*

(c) *following Mr J's death, the SHO inappropriately asked Mrs J what entry should be made on Mr J's death certificate.*

Basis of report

(iii) *All the relevant correspondence relating to the complaint was made available together with the case records of Mr J. Interviews with the Consultant and the SHO were conducted by the Ombudsman's investigating officer. One of the professional assessors was present at the interview with the Consultant. The following account correlates the various statements given to provide as accurate a picture as possible of what happened during the admission of 5 May 1999 leading to discharge on 19 May 1999 with subsequent readmission on 5 June 1999 leading to the death of Mr J on 6 June 1999.*

Sequence of events

(iv) *Mr J was admitted on 5 May 1999 for elective closure of colostomy and repair of incisional hernia. In view of his complex medical*

history which preceded his admission on 5 May 1999 this is detailed as follows:

Previous Medical History

Bronchial asthma
Smoking habits -COPD (Chronic Obstructive Pulmonary Disease)

1984 *Repair of para-umbilical hernia. This gave a good result, but the hernia recurred after five years.*

1993 *Mr J was re-referred by his General Practitioner with recurrence of his ventral hernia (A large hernia occurring at the site of the original repair and incision). At that time his weight was 18st 7lb and he was noted to be consuming three bottles of whisky weekly. He was found to have a large ventral hernia with a cough impulse. The hernia was reducible and was noted to be above the transverse scar of his previous para-umbilical hernia repair. At the clinic on 7 January 1994 Mr J was referred for a truss to reduce the protrusion of the hernia and was given a follow-up appointment for 3 April 1994. He failed to attend that appointment and also the following two appointments of 13 May 1994 and 1 July 1994.*

1997 *On 15 April 1997 Mr J was referred for upper gastro-intestinal endoscopy (visual inspection by use of a telescope and camera system) following haematemesis (the vomiting of blood) when he dropped his haemoglobin from 15 g/dl to 12.4 g/dl. Upper gastro-intestinal endoscopy showed erosive gastritis and duodenitis (inflammation of the lining of the stomach and duodenum) due to Helicobacter infection (an organism found in a large number of patients with stomach ulcers) but no signs of oesophageal or gastric varices (small varicose veins caused by raised pressure in the blood vessels supplying the gastro intestinal tract). He was treated with a course of eradication therapy for Helicobacter pylori. At that time he was noted to be hypertensive (to have raised blood pressure) and his drug treatment was BENDROFLUAZIDE 2.5 mg daily, SALMETEROL 25 µg MDI two puffs twice daily, BECLOMETHASONE 250 µg MDI two puffs twice daily.*

1998 *On 5 May 1998 Mr J was referred to Accident and Emergency Department of the Infirmary, with a history of vomiting since 23 April 1998. He was initially resuscitated and managed conservatively with a provisional diagnosis of colonic obstruction due to carcinoma or adhesion. On 7 May 1998 an ultrasound (scan using high frequency sound waves to produce an image) of abdomen was performed and naso-gastric aspiration was continued. On 8 May 1998 Mr J proceeded to scheduled emergency operation. The findings at operation showed a non-viable loop of small bowel strangulated within the para-umbilical hernia. There was also a non-viable segment of transverse colon with perforation and contamination. The colonic segment was resected with the formation of an end colostomy on the right side of the abdomen and the distal colon (upper end of the remaining colon) brought out as a mucus fistula (opened on to the surface of the abdominal wall) on the left side of the abdomen. He was taken to Intensive Care Unit after operation and had a very stormy post-operative period. He was treated with intravenous GENTAMYCIN, CEFTRIAZONE, METRONIDAZOLE and NORADRENALINE. He developed atrial fibrillation (uncontrolled rapid heartbeat) treated with AMIODARONE and developed acute on chronic renal failure. By 14 May 1998 he had recovered and was taking a normal diet. However his wound had broken down and required daily dressings, left to heal by secondary intention (no further suturing). By 14 June 1998 he was deemed fit to go home, to be reviewed by the district nurse for wound care and reviewed at the clinic two weeks later.*

(v) *Mr J was reviewed at the clinic on 17 July 1998 where the Consultant made it clear to him that he had been lucky to survive the original operation and subsequent treatment. The hernia had been due to complication of gross obesity and Mr J was advised to reduce his food and alcohol intake in order to make himself a better candidate for possible reversal of colostomy and restoration of gastro-intestinal continuity.*

(vi) *On 9 October 1998 Mr J was seen at the clinic and his weight had reduced from 20st to 16 st.*

(vii) *On 19 November 1998 Mr J was seen by the Dietitian who commented that since September 1998 when he was 101.3 kg with a body mass index of 32 he had now reduced to 99 kg with a body mass index of 30. There had been weight loss of 5 st since March 1998. The Dietitian said she would not advise dramatic dieting as this would compromise Mr J's nutritional status while trying to achieve a weight of 14 st. He was advised to increase exercise and take a low fat sugar free diet.*

1999

(viii) *Mr J was reviewed on 15 January 1999 and there was still a small area of original wound which had not fully healed.*

(ix) *By 12 March 1999 the abdominal wound was now fully healed. A long discussion took place between the Consultant and Mr J and it was recorded that the dangers of infection while undergoing reversal of colostomy and the hernia repair simultaneously were discussed. The local guidelines for deep venous thrombosis prophylaxis (measures taken with the intention of prevention of deep vein thrombosis (blood clotting within the veins)) were noted and implemented. In preparation for reversal of the colostomy a barium enema (the installation of a barium containing liquid into the back passage and lower large bowel which outlines the bowel on an x-ray) was arranged for 12 April 1999 which showed some faecal residue in the distal colon with diverticular disease but otherwise the distal colon was patent to the site of the mucus fistula.*

(x) *Mr J was admitted on 5 May 1999 for elective closure of colostomy and repair of incisional hernia. Prior to this operation he was on DIGOXIN 125 µg daily for atrial fibrillation, and BECLOMETHASONE 250 µg MDI two puffs twice daily and SALMETEROL 25 µG two puffs twice daily for airways obstruction. On admission he was found to have a haemoglobin (red blood cell level) of 9.5 g/dl and was transfused three units of blood pre-operatively. He was found to*

have a C-reactive protein of 83 u/l. His urea was 9.2 mmol/l and creatinine 118 µmol/l.

(xi) *On 6 May 1999 the operation went ahead to anastomose (join) the ascending colon to the distal colon mucus fistula. At the same operation the incisional hernia was repaired using Prolene mesh. Following the operation Mr J's haemoglobin was measured at 9.5 g/dl and he was transferred to the Intensive Care Unit. He was ventilated in the immediate post-operative period and was treated with intravenous CEFUROXIME prophylactically. The following day he was breathing spontaneously, remaining on intravenous fluids, and was transferred to the Ward for further care. On 9 May 1999 his intravenous drip was taken down, urinary catheter removed and he was taking oral fluids. On that day he was noted to have 300 mls draining from his wound drain, the following day 300 mls, the following day 200 mls, the following day 300 mls. On 11 May 1999 his haemoglobin was 9.9 g/dl and he was started on oral iron, FERROUS SULPHATE 200 mg three times daily. On 15 May 1999 the distal end of his wound became infected and showed dehiscence (evidence of breaking down). During this admission his inflammatory marker C-reactive protein rose from 83 to 131, 170, 98, 99 u/l. On 18 May 1999 his ECG (a recording of the electrical activity of the heart) showed sinus rhythm, 78 beats/min, occasional ectopic beats. It was noted that his peripheral oedema was improving. By 19 May 1999 he was discharged home with a stoma bag on the distal end of his wound to collect any further serious discharge.*

(xii) *Following discharge home Mr J was visited twice daily by the district nurse for dressings of his wound dehiscence and during the first week after discharge he was visited on three occasions by the GP, and on the second week on one occasion. During these visits he had diuretic treatment (medication to promote urine excretion) increased to FRUSEMIDE 120 mg daily for persistent ankle oedema. He had an appointment for review in the Outpatient Clinic three weeks after discharge.*

(xiii) *On 5 June 1999 Mr J was admitted as an emergency medical admission through the Emergency GP Service under the care of the Physician. His complaints prior to admission were increasing breathlessness, cough with mucoid sputum and bilateral ankle oedema. He also had been noted to be increasingly lethargic. His drug treatment at home was DIGOXIN 125 µg daily, FERROUS SULPHATE 200 mg three times daily, FRUSEMIDE 80 mg/40 mg daily, BECLOMETHASONE 250 µg MDI two puffs twice daily, SALMETEROL 25 µg MDI two puffs twice daily, SALBUTAMOL MDI 100 µg two puffs as required, CO-PROXAMOL and LACTULOSE. The House Officer records that Mr J had stopped his diuretic tablets* three days prior to admission*. (Note: Mrs J said that Mr J was confused and that information was incorrect).*

(xiv) *On examination he was noted to be apyrexial (free from fever). BP 135/70. Pulse 116, regular. Heart sounds were normal but a pan systolic murmur was noted for the first time. There was elevation of the jugulo-venous pulse with bilateral leg oedema to the thigh. On auscultation (listening with a stethoscope) of the chest bilateral crepitations (fine crackling sounds indicative of fluid retention within the lungs) were heard. His abdomen was noted to be tender. There were no focal neurological signs (no signs on examination indicating damage in the brain or nervous system) noted.*

(xv) *His ECG was reported as showing narrow complex tachycardia (rapid heartbeat) but was not available in the case notes. Chest x-ray detected pulmonary oedema with right basal effusion (fluid on and around the lung).*

Hb13.1 g/dl, WBC 17.5 x 10^9/1, platelets 173 x 10^9/1
Electrolytes normal. Urea 22.9 mmol/l, creatinine 174 µmol/l

On breathing oxygen he had arterial oxygen tension of 13 kPa, pCO2 4.5 kPa, hydrogen ion 40. His C-reactive protein was 88 u/l.

(xvi) *A diagnosis of biventricular failure (failure of both right and left chambers of the heart) was made and Mr J was treated with IV*

FRUSEMIDE 80 mg twice daily and oxygen therapy. It was planned for him to have a cardiac echo-cardiogram the following day.

(xvii) *On 6 June 1999 at 3.30 am Mr J was noted to be clammy and confused by the nurses and was seen by a Senior House Officer who found him to be apyrexial. Pulse was 80, regular. Heart sounds were normal. Pan systolic murmur again noted. Bilateral ankle oedema. On examination of the chest bilateral crepitations were detected. His abdomen showed tenderness over the wound. At 6.30 am he collapsed and was noted to have no pulse or spontaneous respiration. ECG monitor showed atrial flutter and then ventricular asystole. Cardio-pulmonary resuscitation was undertaken and he received three injections of 1 mg ADRENALINE and ATROPINE 3 mg. Resuscitation was unsuccessful and he was pronounced dead at 6.50 am. The SHO interviewed the family after this episode and consent was gained for a post mortem.*

Post mortem findings

(xviii) *The post mortem confirmed well healed midline scar, two horizontal scars at the site of colostomy and previous colonic mucus fistula. There was biventricular hypertrophy of the cardiac muscle with vegetation of the mitral and aortic valves and left atrium with evidence of biventricular failure and ischaemic heart disease. There was bilateral pleural effusion and there were abdominal adhesions to the scar and Prolene mesh of the hernia repair. The small bowel was noted to be intact following the previous excision. The large bowel was noted to have several adhesions at the site of recent surgery but otherwise was intact.*

(xix) *The summary of the post mortem findings was as follows:*

1. *Congestive cardiac failure.*
2. *Vegetations (small infected growths caused by infection circulating in the blood) mitral valve, aortic valve, left atrium.*
3. *Ischaemic heart disease.*
4. *Biventricular hypertrophy.*
5. *Previous abdominal surgery.*

The heart showed evidence of recent acute extension (scar tissue) of myocardial infarction with patchy muscle fibrosis.

Discussion

(xx) *Mr J had a number of risk factors for operation. Bronchial asthma associated with his smoking habit producing chronic obstructive pulmonary disease, hypertension, obesity and atrial fibrillation. Mr J originally had a para-umbilical hernia repaired in 1984. The repair was successful for five years until the hernia recurred. Recurrent hernias are usually associated with obesity and chronic coughing related to cigarette smoking and chronic obstructive pulmonary disease. Mr J was advised to lose weight, stop smoking and reduce his alcohol intake. Subsequently Mr J failed to attend the outpatient clinic for follow up on three separate occasions.*

(xxi) *In May 1998 Mr J had an emergency admission complaining of intermittent vomiting and abdominal distension suggesting intestinal obstruction. After initial resuscitation he proceeded to scheduled emergency surgery and was found to have "non-viable segment of small bowel and non-viable segment of transverse colon which had caused faecal contamination (A leak of faeces into the peritoneal cavity)". The small bowel was resected and re-anastomosed. The transverse colon was excised and an end colostomy formed with a mucus fistula of the descending colon. He required post-operative intensive care therapy and developed a wound infection despite intravenous antibiotic and treatment for atrial fibrillation. Despite a stormy recovery period he was finally able to be discharged home. When he was reviewed at the clinic the Consultant reminded him that he had been through a very serious life-threatening situation and he would need to try and improve his problem with obesity before any attempt was made to reverse the colostomy, or attempt any further incisional hernia repair. Mr J was advised to increase exercise, lose weight and take a low fat sugar free diet which led to significant weight reduction. On 12 March 1999 a decision was made to proceed to elective surgery and he was placed on the waiting list. Following admission on 5 May 1999 the following day he had re-*

anastomosis of his colostomy and repair of incisional hernia using Prolene mesh. He was prepared for operation with pre-operative blood transfusion, deep vein thrombosis prophylaxis and antibiotic infection prophylaxis. During this admission he made good post-operative progress. However, the distal end of his wound dehisced (broke down) and he developed evidence of bilateral leg oedema.

(xxii) *In 1998 the Scottish Audit of Surgical Mortality recorded 4,331 deaths in Surgical Wards (2,034 male, 2,297 female). Of those who died, 3,014 had been emergency admissions and 1,760 had undergone operations. In the age group 60-69 there were 828 deaths. The most common co-existing factor was cardiovascular disease in 47% of those undergoing emergency operation and in 44% of those undergoing non-emergency operations. The most common diagnoses associated with death in this age group were carcinoma of the colon 107, intestinal vascular ischaemia 79, intestinal obstruction 66, hernia 26, and a large range of other diagnoses making up the remainder. Of all those who died in 1998, 487 or 11% were due to colorectal disease. 240 of these underwent operations and subsequently died and 75% of them were emergency admissions. This short extract from the statistical analysis shows that emergency surgery for colorectal disease in this age group is associated with a serious risk of post-operative death.*

(xxiii) *A subsequent Scottish Audit of Surgical Mortality in 2001 shows that colorectal disease continues to be the second most common cause of post-operative death. 85% of patients who died after surgery had ongoing medical problems with 56% having cardiovascular disease, 33% respiratory disease in addition to the original cause for the surgical admission. 46% of patients who died after operation had a definable post-operative complication but 80% of these were medical rather than surgical and 97% were recognized promptly.*

(xxiv) *Mr J's admission on 5 June 1999 showed evidence of biventricular failure and development of a systolic murmur. Investigations were arranged including echo-cardiography and he was treated with intravenous FRUSEMIDE therapy and anticoagulants. Regretfully the*

following morning on 6 June 1999 he died suddenly following cardiac arrest with atrial flutter and ventricular asystole and cardio-pulmonary resuscitation was unsuccessful.

(xxv) *A post mortem revealed evidence of biventricular failure with evidence of valvular heart disease and infective endocarditis with both acute myocardial infarction and evidence of previous myocardial infarction superimposed on hypertensive heart disease. Infective endocarditis was due to coliform and coagulase negative staphylococci.*

(xxvi) *Mr J had had thorough pre-operative assessment and advice prior to his elective admission on 5 May 1999 and had comprehensive counselling on improving his operative risks including increase in exercise, weight loss and low fat sugar free diet. At the time of his admission on 5 May 1999 he had been prepared for his operation with pre-operative blood transfusion, deep vein thrombosis prophylaxis and antibiotic infection prophylaxis. We feel that staff looking after Mr J carried out appropriate individual care for the patient. There is no evidence that the clinical actions of professional staff fell below a standard which the patient could reasonably have expected in the circumstances. Therefore our conclusion is that Mr J followed a reasonable care plan from his original presentation through to his final admission in the Medical Ward.*

<u>Complaints subject to investigation</u>

(a) *<u>There was inadequate assessment of Mr J's fitness for discharge on 19 May 1999</u>*

(xxvii) *Mr J was assessed on the day of discharge by the Specialist Registrar, who had been undertaking his daily review post-operatively. The Specialist Registrar observed that his wound had an area of dehiscence and that the wound would require twice daily dressings by the district nurse and arranged for him to be discharged home. He was to apply a drainage bag over the wound. The Specialist Registrar advised Mr J that if problems arose to contact the Ward. An appointment had been made for outpatient review at the Surgical Outpatient Clinic in three weeks. During his admission*

wound swabs had been sent on 14 May 1999 and 19 May 1999 which showed heavy growth of skin commensal flora (micro-organisms regularly found on the skin which do not commonly cause disease) only but no significant bacterial growth or anaerobes (micro-organisms which do not require oxygen to grow and cause disease). We believe that he had been adequately assessed prior to discharge on 19 May 1999.

(b) *Following Mr J's readmission to hospital on 5 June 1999 there were failures in care and communication in that:*

(i) Mrs J was not told that her husband was suffering from cardiac failure

(xxviii) *Since 1997 Mr J had been suffering from hypertension and was treated with BENDROFLUAZIDE 2.5 mg daily. Subsequently during his illness in 1998 he developed atrial fibrillation and commenced AMIODARONE and then DIGOXIN 125 µg daily. In 1998, in view of his obesity, weight 101.3 kg, body mass index 32, he was commenced on a diet. It is noted in the nursing notes of the admission of 6 May 1998 when he was admitted to Intensive Care Unit in fast atrial fibrillation "condition very poor, family aware". In the notes of 10 May 1998, there is reference to "wife aware of possible transfer to Ward 12".*

(xxix) *During his admission following 5 May 1999 there is reference in the nursing notes to discussion with Mrs J on 6 May 1999. On 15 May 1999 there is reference in the nursing notes of bilateral ankle swelling and that his TED stockings were to be removed. On 18 May 1999 it was observed that "ankle and leg oedema slightly improved". Mrs J at this time was informed of her husband's discharge the following day.*

(xxx) *After discharge home the GP had been treating Mr J for bilateral leg oedema increasing his FRUSEMIDE treatment.*

(xxxi) *On Mr J's admission on 5 June 1999 he had persistent bilateral leg oedema and was again treated with intravenous FRUSEMIDE.*

Regretfully he had cardiac arrest with atrial fibrillation, then ventricular asystole and cardio-pulmonary resuscitation was unsuccessful.

(xxxii) *During the final admission on 5 June 1999 at 1.40 pm until death on 6 June 1999 at 6.30 am there is no evidence in the case notes that Mrs J was informed of her husband's cardiac failure. During this last admission there is no clinical evidence to suggest that a sudden cardiac event would occur. Mr J suffered a cardiac arrest on 6 June 1999 which was unexpected and could not have been predicted by the medical staff. There is no evidence to suggest that the medical team dealing with Mr J were in any way negligent in their management of Mr J during this final admission. After death his cardiac failure was discussed by the SHO and she obtained permission for a post mortem.*

(ii) Mr J's previous hospital clinical records were inaccessible as they were located in a locked office

(xxxiii) *NHS Trusts have a target of discharge summaries to be sent to General Practitioner in ten working days. Following Mr J's admission from 5 May 1999 until 19 May 1999 no discharge had been completed. The case notes may have been in the Consultant's office awaiting that discharge summary. The Records Department must have in place a method of retrieving these case notes twenty four hours, seven days a week, three hundred and sixty five days a year. (Note: Further enquiries by the Investigating Officer revealed that Mr J's clinical records were in the Consultant's secretary's office waiting for a discharge summary to be typed. As it was a weekend, the office was locked for reasons of confidentiality and security. However, if the medical team had urgently required the clinical records then an on-call joiner would have been instructed to break into the office so that the records could be retrieved).*

(xxxiv) *In Mr J's case the Physician and his team dealt with his acute illness on 5 June 1999 with knowledge of his previous medical history and accurate detail of his drug treatment. There is no evidence that the*

unavailability of the clinical records had any adverse affect on the management of Mr J during his admission on 5 June 1999.

(iii) Following Mr J's death, the SHO inappropriately asked Mrs J what entry should be made in Mr J's death certificate

(xxxv) *The SHO met Mrs J and family after Mr J's death and discussed with them the acute cause of death. The SHO stated that the conversation with Mrs J and her family had lasted a long time. She indicated that her practice was to discuss with the family the cause of death and that she thought this was due to heart failure. She denied that she would "ever ask a family what she should enter on the death certificate". As a result of the discussion with the SHO and Mrs J and her family the outcome was that a post mortem was granted and therefore eliminated doubt as to the cause of death, leading to appropriate death certification.*

(xxxvi) *On the basis of the SHO's interview this was reassuring and indicated an appropriate discussion between Mrs J and the SHO leading up to asking Mrs J and her family to give permission for a post mortem. We do not believe that the SHO inappropriately asked Mrs J what entry she should make on Mr J's death certificate.*