Case 200301943: Grampian NHS Board[5]

A Deputy Ombudsman with the delegated authority of the Scottish Public Services Ombudsman has carried out this investigation.

Introduction

1. On 22 March 2004 the Ombudsman received a complaint from Mrs C about the care and treatment her late Mother, Miss C, received at Dr Gray's Hospital, Elgin (the Hospital) and the way in which her subsequent complaint was handled.

2. The late Miss C was admitted to Ward 5 of the Hospital on 3 April 2003 with a history of worsening jaundice. An ultrasound of her abdomen that day found stones in her dilated common bile duct. The ultrasound report also noted a possible unrelated invasive gall bladder tumour. Another scan on 7 April confirmed these results. Miss C had three stones extracted from her bile duct on 9 April. She was breathless during this first stay in hospital and also complained of calf pain and swelling in her legs. Miss C was discharged from Ward 5 on 11 April and readmitted as an emergency patient to Ward 8 on 13 April. Further tests on 14 and 15 April 2003 found that Miss C had blood clots in her left leg and lungs. She received drug treatment for these clots and was discharged from the Hospital on 26 April. Sadly, Miss C was re-admitted to another hospital with worsening swelling and pain in her leg, later developed gangrene and she died on 17 May 2003. The cause of death stated on her death certificate is Deep Vein Thrombosis Left Leg.

3. The complaints from Mrs C which I have investigated are:

(a) failure to diagnose a DVT and carry out a scan before Miss C was discharged from Ward 5 of the Hospital on 11 April 2003;

[5] Grampian University Hospitals NHS Trust was established by The Grampian University Hospitals National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The National Health Service Trusts (Dissolution) (Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to Grampian Health Board came into effect. To avoid confusion, this report continues to refer to 'the Trust' when describing actions taken by, or on behalf of the Trust or its successor.

(b) failure relating to Miss C being declared fit for discharge on 11 April 2003;

(c) failure to provide Miss C with appropriate accommodation when she was readmitted to the Hospital on 13 April 2003;

(d) failure in the handling of her complaint.

4. Following the investigation of all heads of this complaint I came to the following conclusions:

(a) Upheld, see paragraphs 29 to 35;

(b) Upheld, see paragraphs 36 to 39;

(c) Partially upheld, see paragraphs 43 to 44;

(d) Upheld, see paragraphs 62 to 69.

5. Specific recommendations I am making resulting from this investigation are that the Board of NHS Grampian should:

i. introduce a Protocol for the Management of suspected DVT's;

ii. clarify responsibilities for patients awaiting discharge;

iii. revise the Hospital Discharge Protocol in the light of this complaint;

iv. apologise to Mrs C for the shortcomings identified in this Report and the manner in which her complaint has been handled;

v. carry out a review of their internal procedures for handling complaints;

vi. provide Mrs C with a full update of the lessons learned, actions taken and changes that have resulted as a consequence of her complaint.

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

Complaint as put to the Ombudsman

7. Mrs C complained to the Ombudsman on 22 March 2004 about the treatment received by her Mother and the way in which her complaint had been handled by the Hospital. Her complaint was considered by a Complaints Investigator in this office. Based on the information made available to this office at the time, it was decided not to conduct an investigation into this complaint. The reasons for this decision were set out in a letter sent to Mrs C on 15 June 2004 and copied to the Trust on the same day.

8. Mrs C continued to write to this office in relation to her complaint. As a result, the decision not to investigate was reviewed and confirmed by a Complaints Manager in November 2004. I subsequently carried out a second review of the complaint in January 2005. The outcome of my second review was that I agreed with the reasons for the original decision reached by the Complaints Investigator.

9. Part of my response to Mrs C was that the Trust had provided an explanation and/or apology in relation to pertinent aspects of her complaint, together with information (where relevant) of the measures they had or intended to put in place. Therefore, I agreed with the decision that the Ombudsman could not achieve any more by looking further into her complaint. However, Mrs C continued to complain that the Trust had provided her with assurances on a number of matters but that she had not yet had a response in relation to these. I wrote to the Trust to ask for a progress report on the matters that the Trust had told Mrs C would be put in place.

10. A medical adviser (referred to in this report as the adviser) and I also met Mrs C and her husband about her continuing concerns. Mrs C told us at this meeting how her Mother had experienced a painful and distressing death as a result of the infection in her leg that resulted from the DVT. After acknowledging that Mrs C remained very dissatisfied with many issues relating to her complaint, it was agreed that I would give further consideration to a number of her specific concerns. After additional correspondence with the Trust, I decided to investigate these concerns.

Investigation and findings of fact

11. The investigation of the complaints involved obtaining and reading all the relevant documentation, medical records, nursing records and complaint files relating to the late Miss C and obtaining the opinion of an adviser. Further

written enquiries were made to the Trust. I also spoke to the Medical Director of the Trust.

12. I now set out, for each of the four heads of Mrs C's complaint, my findings of fact and my conclusions. Where appropriate, my recommendations are set out at the end of the sections dealing with individual heads of complaint. I have not put into this report every detail investigated but I am satisfied that nothing of significance has been overlooked. Mrs C and the Trust have been given an opportunity to comment on the draft report. A summary of terms used is contained in Annex 1. A glossary of medical terms is contained in Annex 2.

(a) Failure to diagnose a DVT and carry out a scan before Miss C was discharged from Ward 5 of the Hospital on 11 April 2003 and (b) Failure relating to Miss C being declared fit for discharge on 11 April 2003

13. These two heads of complaint were investigated together.

Medical Background

14. A deep vein thrombosis (DVT) is a blood clot (thrombus) that develops in a deep vein, usually in the leg. This can happen if the vein is damaged or if the flow of blood slows down or stops. About one in 2,000 people in the UK develops a DVT each year. If the clot breaks away and travels up the vein to block a blood vessel in the lung, this is called a pulmonary embolism and can be life threatening. The most common symptoms of a DVT in the leg are swelling and pain in the affected leg. These symptoms are caused by the accumulation of blood that is unable to get past the clot in the vein and the resulting leakage of fluid from the blood into the muscle. Many other conditions exhibit symptoms similar to those of a DVT, for example, muscle strains and inflammation of superficial veins. A DVT can be difficult to diagnose. A number of screening and diagnostic tests can be used in the diagnosis of DVT.

Medical Notes and Imaging Department Reports

15. Medical notes, which are created and updated by medical staff, record a patient's medical diagnosis and treatment following admission to hospital. Miss C was admitted to Ward 5 of the Hospital on 3 April 2003 under the care of Consultant 1. Relevant information and extracts from General Surgery Case Sheets (medical notes) and Imaging Department reports relating to the first stay in hospital are set out below. The words in 'quotes' are a direct extract from the medical notes:

Notes on 3 April 2003 (on admission) record on examination 'a firm non-tender mass' in the upper right quadrant of her abdomen. Miss C had an ultrasound of her abdomen on 3 April 2003. The Notes for 3 April also record an oral report from this abdomen ultrasound – 'stones in dilated CBD. Possible tumour of the gallbladder infiltrating into liver and possible lymph nodes of head of pancreas.'

The Imaging Department Report on the 3 April abdominal ultrasound (report dated 7 April) concluded: 'The overall appearances suggest a combination of obstructing distal common duct stones and an almost 'incidental' gallbladder carcinoma invading the adjacent liver.'

Notes on 4 April included: 'WR [Ward Round] (Consultant 1) 'Still pain free. for CT abdomen. Refer to (Consultant 2) on 7/4/3 when back from holiday.'

Notes for 5 April included: 'Pat[ient] got up to go to the bathroom & became breathless on going back to bed' and 'Sats were 88% on av but improved to 95% on 4L' and 'She has had an MI in February' and 'Slow down IV fluids.'

Miss C had a CT Scan on 7 April. The related Imaging Department Report, dated 8 April, concluded: 'The overall appearances remain very suggestive of an invasive gallbladder carcinoma and an unrelated distal common duct obstruction. ERCP is suggested for initial further assessment.'

Notes dated 10.30pm on 9 April, (written by Consultant 2), confirmed that Miss C underwent ERCP in theatre that day and three stones were extracted from her bile duct.

Notes dated 10 April headed WR [Ward Round] [Specialist Registrar], included: 'Complaining of oedematous ankles today', 'No signs of DVT' and '[Specialist Registrar] to talk to [Miss C] + her daughter re CT scan results today [about the] tumour of gall bladder spreading into the liver – not causing biliary obstruction.'

Miss C was discharged from Ward 5 on 11 April. Medical notes dated 11 April headed WR [Ward Round] [Consultant 3] included: '- well today'

and '– home today.'

16. Miss C was readmitted to Ward 8 of the Hospital on 13 April. The Admissions Form showed her time of arrival as 22.30 and that she was a:

> 'GP referral with complaints of increasing leg oedema and SOB over the past 48 hours. Rt leg swollen and thigh area warm to touch and painful on movement. Calf measures: Lt calf 40.5 Rt calf 42.'

17. Relevant information from General Medical – In-Patient medical notes and extracts from Imaging Department reports relating to the second stay in hospital are set out below:

> '[Miss C] had a Duplex Scan Left Leg Veins on 14 April. The Imaging Department Report (dated 15 April) concluded 'As suspected clinically there is an occluding thrombus in the proximal superficial and profunda femoris veins extending into the common iliac and external iliac veins where there is only minor marginal flow from a patent long saphenous vein. The common iliac vein and IVC are clear.'
>
> [Miss C] had a CT Pulmonary Angiogram on 15 April. The Imaging Department Report (dated 17 April) included: 'The patient has extensive pulmonary embolic disease. A large embolus is present bridging the main pulmonary arteries producing the so-called Saddle embolus. Further embolus is present within the lobar arteries with further embolus in several of the segmental vessels bilaterally. The patient has a large pulmonary embolism.'

18. Mrs C continues to have a concern that no urgency was placed on the need for a scan when her Mother was readmitted to the Hospital in the late evening of 13 April and that the scan was only carried out in the late afternoon of 14 April after her insistence. The Trust does not agree with Mrs C on these issues. Medical notes indicate that Miss C was treated with a specific 'clot-busting' drug on 15 April 2003. The medical notes also indicate that Miss C was discharged from the Hospital to stay with Mrs C on 26 April 2003.

Nursing Records

19. Nursing records, which are created and updated by nursing staff on duty, indicate nursing interactions with a patient, the outcome of such nursing

interactions and problems relating to patient needs. Relevant extracts from nursing notes relating to the first stay in hospital are set out below (the words in 'quotes' are a direct extract from the notes):

> 05/04/03: 'Patient walked to the toilet at 0400 and appeared very breathless when back in bed.'
>
> 06/04/03: 'Appears breathless. Offered catheter to be inserted due to breathlessness but p[atien]t declined this'. Later same day – 'Breathless this morning – nebuliser given, sats 99% post nebuliser. Continues to have 4L O_2 via face mask.'
>
> 08/04/03: 'noted to remain breathless despite oxygen therapy.'
>
> 09/04/03: 'Settled evening. Awaiting for ERCP tonight. Oxygen administered as required. Patient c/o left calf pain. Both legs appear to be very swollen. Legs measured, right leg 38.5 inches and left leg 40.5 inches. [The Pre-Registration House Officer] informed and is arranging a [missing word].'
>
> 10/04/03: 'Settled morning. Observations satisfactory' and 'For discharge home Friday/Saturday. No complaints offered.'

Written evidence of Mrs C

20. Mrs C has written to both the Trust and this office in detail in relation to her complaint and has consistently raised the same concerns. In her original complaint to the Hospital, dated 14 April 2003, Mrs C said:

> 'My Mother had a scope and procedure to crush gallstones on Wednesday 9th April at about 10.30 pm. Prior to this I phoned at about 8 pm and was told that my Mother was waiting to see a doctor because of pain in her leg and swelling of her ankles. I was told by the nurse that they would do a scan the next day to see if there was a clot but this was never done.'
>
> On Thursday 10th April I was called to the hospital as a doctor wanted to speak to my Mother and myself about a complication they had found…. She [the Specialist Registrar] then said "you're fine and you don't need hospital anymore would you like to go home tomorrow?" My Mother said yes but asked about the breathlessness and her ankles. I also expressed

concern about the swelling of her ankles which were really big by this time. The doctor dismissed this and said that everyone in hospital gets it. She said to lie with her feet up at home for a week and she would be alright.'

Throughout Thursday my Mother kept asking nurses and doctors about the swelling and when she would be getting the scan…… She also asked on Friday but nothing was done.'

When I went to pick her up to take her home on Friday 11th April her ankles and feet were enormous and she could not even get shoes or slippers on by this time and was very sore while walking and her breathing was very bad by then. She had been seen by [Consultant 3] and pronounced fit to go home.'

21. In relation to the concern about to the failure to scan, Mrs C made the following points in her letter to this office dated 16 August 2004 (extract):

'As I have said previously and which was raised in the initial complaint dated 14th April 2003 my Mother had been complaining of severe pain and swelling in her leg on Wednesday 9th April 2003. I was told that a doctor would see her and a scan would be arranged to see if she had a DVT or not. I was subsequently told on 10th April 2003 when I telephoned at about 8.00am in the morning that my Mother did not have a DVT. I presumed the scan had been done. This of course was not the case and she was refused a scan by [the Specialist Registrar].'

22. In relation to the discharge of Miss C from Ward 5 of the Hospital on 11 April 2003, Mrs C gave the following account in her letter of 22 January 2004 to the Convener (who had been considering her request for an Independent Review of her complaint – the now abolished second stage of the NHS complaints process):

'[The Nurse Manager] said the reason my Mother was forced to sit in a chair for eight hours was due to staff shortages and a shortage of beds. I do not see any relevance in this. My Mother was sitting on a chair next to her bed. So the fact that she was not in the bed was of no benefit because they would not have been able to allocate her bed to someone until she had left anyway. My Mother told the nurses that she was tired and her leg was sore and asked if she could lie on top of the bed but she was told that

she could not. I said in June that I was not satisfied with this explanation and this still remains the case. Also I have raised the matter that even if they did "turf" a very ill elderly woman out of her bed to sit on a chair for eight hours why did they not provide her with a stool so she could at least elevate her leg. My Mother had been told the day before being 10th April by [the Specialist Registrar] (in my presence) that when she went home she had to lie on the settee for a week with her leg elevated yet they did not see fit to do this in hospital.'

23. Mrs C also wrote in relation to the first discharge, in a letter to this office dated 17 June 2004 (extract):

'I note with interest that you do not state that [Consultant 3] saw my Mother on 11th April. My Mother always stated to me that she never saw [Consultant 3] but I never pursued this matter. I would be grateful if you would now clarify at this point whether [Consultant 3] saw my Mother or not before declaring her fit to be discharged.'

Written evidence of the then Chief Executive

24. The then Chief Executive of the Trust wrote to Mrs C on 2 June 2003, in response to her initial complaint. Points from this letter relevant to the concerns investigated (extracts) follow:

'On the 10th April on a ward round there was a note that your Mother reported that her ankles were swollen. She was examined by the medical staff but no signs of a DVT were identified. The staff regret any miscommunication about whether or not your Mother should have a scan of her legs at this point. The ankle swelling was thought to be due to a degree of cardiac failure. Her intravenous fluids were therefore slowed down …'

'On the 11th (April 2003) she [Miss C] was seen by [Consultant 1's] colleague, [Consultant 3], and the notes report that she was well that day and a decision was made to send her home.'

'Having not been present at this time [Consultant 1] found it difficult to comment on your complaints, but he had to say that there did not seem to be overwhelming evidence of a deep venous thrombosis at the time of [Miss C's] discharge … She was in fact seen by an experienced Specialist

Registrar who categorically stated that there was no evidence of a DVT.'

Notes from a Meeting held on 27 June 2003

25. Mrs C and her husband attended a meeting at the Hospital on 27 June 2003 to discuss her complaint with the Associate Medical Director and the Nurse Manager. Relevant extracts from the notes of this meeting follow:

> '[Mrs C] said that a nurse had advised her on 9th April that they would do a scan the next day. [The Nurse Manager] said that it was only a doctor who could decide on a scan and the nurse should not have said this. She apologised for this and confirmed that she was to speak to the nurse regarding this.'
>
> 'On the evidence presented [the Associate Medical Director] felt that [Miss C] should not have been discharged but the notes reported that she was well that day and a decision was made to send her home. [The Nurse Manager] apologised for the fact that [Miss C] had been taken from her bed, which was required for an emergency case due to staff shortages that day. There was also a large amount of staff sickness and staff were trying to be pro-active to help the next shift.'
>
> '[The Associate Medical Director] invited [the Specialist Registrar] to attend for part of the meeting … She [the Specialist Registrar] felt that [Miss C's] legs were equally swollen and did not think that one was larger than the other. If one leg was bigger than the other she would have arranged a scan.'

Written evidence of the Medical Director

26. The Medical Director, who had by then assumed responsibility for the complaint and chaired the second meeting at the Hospital, sent a letter to Mrs C on 28 November 2003, setting out the issues discussed at the meeting. A relevant extract from this letter follows:

> 'Your Mother had been complaining of a painful swollen leg before the first discharge from Hospital on the 11th April. She was seen by [the Specialist Registrar] who considered that no scan was necessary because there were no signs of deep vein thrombosis on clinical examination. However shortly after discharge your Mother was re-admitted and found to have extensive deep vein thrombosis. It was agreed by the hospital

representatives at the meeting that it was highly likely that the thrombosis had been present already at the time of first discharge of your Mother from Hospital. The Representatives of the Hospital agreed that physical examination alone cannot exclude the possibility of deep vein thrombosis in the legs and that a scan would have been necessary to exclude this risk. The Trust representatives agreed that because your Mother had been diagnosed with cancer she was at high risk of thrombosis and therefore a scan should have been carried out. On behalf of the Hospital I wish to apologise for this course of events and any suffering that has resulted from the failure to diagnose deep vein thrombosis before the first discharge on 11 April 2003.'

27. In response to my enquiry relating to the failure to scan, the Medical Director responded in a letter dated 22 August 2005 (extracts):

'[Miss C] was assessed by [the Specialist Registrar] who believed that the bilateral leg swelling was due to dependent oedema relating to Congestive Cardiac Failure rather than due to a venous blood clot. [The Specialist Registrar] judged that a leg scan was therefore not necessary and it was decided to allow the patient home. [Miss C] was readmitted a short time later with a clot on the lung and with hindsight it has to be concluded that it would have been highly likely that a venous clot in the leg was present at the time of her discharge on 11 April.'

'As we have indicated to [Mrs C] during our meeting and summarised in my letter of 28 November 2003, we believe that it would have been better if a leg scan, to exclude venous clot, had been done before discharge on 11 April 2003.'

'We have apologised for this to [Mrs C] and [Consultant 1] has discussed the importance of Doppler ultrasound scanning with [the Specialist Registrar] and [the Pre-Registration House Officer], who were the junior staff involved around the discharge of [Miss C] on 11 April 2003. Also, the role of Doppler ultrasound scanning in high risk patients is emphasised as part of the regular departmental training programmes at both Dr Gray's and Aberdeen Hospitals.'

'According to the information available to us it is correct that [the Pre-Registration House Officer] was informed on 9 April 2003 about

[Miss C's] leg swelling. [The Pre-Registration House Officer] had discussed the circumstances with [the Specialist Registrar], who went on to clinically examine the patient. She reported her findings and her course of action to [Consultant 3] who did not personally examine [Miss C] for the swelling in her legs. It is quite common practice in Dr Gray's and indeed in other hospitals across the United Kingdom for Specialist Registrars to act on their findings independently informing the Consultant of their course of action.'

28. In response to my further enquiries relating to the failure to scan and the first discharge, the Medical Director responded in a letter dated 23 November 2005 (extract):

'Discharge of [Miss C] from Hospital on 11 April 2003: [Consultant 3] was the duty Consultant on call for 12 and 13 April 2003. In view of this [Consultant 3] asked [the Specialist Registrar] on 11 April 2003 to brief him on all of [Consultant 1's] remaining patients. On [Miss C], [the Specialist Registrar] informed [Consultant 3] that [Consultant 2] had carried out an ERCP, that a CT scan had showing a possible neoplastic liver lesion had been carried out, and that [Miss C] had a follow-up appointment to see [Consultant 1] on his return from leave. She also told [Consultant 3] that she had talked in detail to [Miss C's] relatives and that her discharge from Ward 5 had been arranged for that day. [Consultant 3] did not see or examine [Miss C] and was not told of any clinical concerns regarding her condition. The entry written in her notes dated Friday 11 April simply refers to this conversation between [Consultant 3] and [the Specialist Registrar] because it took place during [Consultant 3's] Ward round. At no point was [Consultant 3] directly involved in the care of this patient and he would only have become involved had he been asked to see her by [the Specialist Registrar] or [Consultant 2].'

'I believe that this direct account from [Consultant 3] is compatible with the account I gave you by telephone on 19 August 2005, and I hope that this answers your query.'

'Decision whether to carry out a scan: the computerised nursing records have been checked in relation to them cutting off at the point you highlighted. The report that printed off at that time cut off some of the text and this fault was only discovered as a result of the investigation into

[Mrs C's] complaint. Since then the new report writer has been rectified but unfortunately does not have the ability to report on retrospective care plans.'

'I apologise for the incompleteness of the nursing record. However, it is clear from the X-Ray records that the scan [Mrs C] is referring to in the context of her telephone conversations on 9 and 10 April 2003, never took place. Nor do the nursing records make any mention of a negative scan on 10 April 2003.'

(a) Failure to diagnose a DVT and carry out a scan before Miss C was discharged from Ward 5 of the Hospital on 11 April 2003: Conclusion

29. Mrs C's complaint is that the Specialist Registrar failed to diagnose a DVT and carry out a scan before Miss C was discharged from Ward 5. Evidence from the nursing notes of the evening of 9 April 2003 confirms that Miss C had swollen legs and that she was complaining of left calf pain. The nursing notes indicate that leg measurements had been taken that evening and that her left leg was more swollen than her right leg. The notes actually say that the left leg measured 40.5 inches and right leg 38.5 inches. It is assumed that these measurements should have been in centimetres but, whatever the situation, it is clear that the left leg was slightly larger than the right.

30. It is also clear from the nursing notes of the evening of 9 April 2003 that PRHO had been informed that Miss C had swollen legs and had taken some action as a result. Unfortunately, the computerised nursing records cut off some of the text, so we only know that the PRHO was 'arranging a [missing word or words]'. I note that this difficulty with the nursing notes has now been resolved. I can only speculate that this missing word or words included 'scan' but I have no reason to doubt that when Mrs C telephoned Ward 5 at 8pm on 9 April she was told by a nurse that her Mother was waiting to see a doctor because of pain in her legs and would receive a scan the next day. I consider it unlikely that a nurse would have told her this if the nurse had not understood it to be the case.

31. When Mrs C telephoned the Ward at 8am on 10 April 2003, she was told that her Mother did not have a DVT. She quite understandably presumed from this information that a scan had taken place to eliminate the possibility of a DVT. It is known that the Nurse Manager told Mrs C that the nurse should not have said this, as only a doctor could decide on a scan, but this is missing the

point. Mrs C had been led to believe that a scan had been carried out, so although still concerned that her Mother had pain and swollen legs, she was reassured by this information.

32. The evidence set out above is clear that the Specialist Registrar had decided, after physically examining Miss C, that there was no evidence of a DVT and had concluded that the leg swelling was oedema. Therefore, no scan was considered necessary. Advice received from our adviser is that it can be difficult to diagnose a DVT and it is understood that, as a general rule, anything less than a 3cm difference in leg measurement is not regarded as clinically significant. However, as the Trust have already recognised, the fact that Miss C was at high risk of thrombosis (because of diagnosed presence of a tumour) does not appear to have taken into account and they have acknowledged that the risk of a DVT could not be excluded by physical examination alone.

33. It is worthy of note that Mrs C's trust in the Hospital had been shaken by the attitude and approach of the Specialist Registrar during her Mother's first stay in the Hospital. Mrs C disputes that the Specialist Registrar spoke to herself and her Mother 'in detail' as described in the letter dated 23 November 2005 from the Medical Director (see paragraph 28). Mrs C is clear that, when the Specialist Registrar spoke in an over-familiar manner to her Mother on 10 April 2003, her Mother was told that she had a growth in her liver but that the Specialist Registrar did not think it was cancer. This conversation took place at the bedside in front of other patients on the Ward.

34. After complaining about these issues in April 2003, Mrs C received a written apology from the Specialist Registrar in July 2003 about her over-familiar manner when treating her late Mother. I also note that Mrs C had been advised by the Medical Director in his letter of 23 November 2003 that the Trust intended to take the issue of appropriate communication forward with the Specialist Registrar as a training issue. The Trust also intended to look into the situation of 'breaking bad news' at the Hospital and to ensure that this very important aspect of communication would be handled appropriately in the future. However, as set out in paragraph 67 to this Report, Mrs C has not received any update on these proposed actions.

35. I uphold this head of complaint. I note that, before this complaint came to this office, the Trust had acknowledged that a scan should have been carried out. Also, that the Medical Director had already apologised on behalf of the

Hospital to Mrs C for any suffering that resulted from the failure to diagnose DVT before the first discharge on 11 April 2003 and had set out the actions that the Trust intended to take as a result of this complaint (see paragraph 26). It was for these reasons that this office decided not to investigate the complaint further when Mrs C first brought it to this office. However, I understand that NHS Grampian does not have a Protocol for the Management of suspected DVTs and my investigation has identified further shortcomings relating to this head of complaint. I recommend that the Board takes steps to introduce a Protocol for the Management of suspected DVTs and makes a further apology for the misunderstandings identified in this report.

(b) Failure relating to Miss C being declared fit for discharge on 11 April 2003: Conclusion

36. Mrs C had been told from first raising her complaint with the Trust that it was Consultant 3 who had considered her Mother to be fit for discharge on 11 April 2003. This was despite her Mother assuring her that she had never seen Consultant 3 that day. The 23 November 2005 letter from the Medical Director (see paragraph 28) makes it clear that Consultant 3 had not seen or examined Miss C. The Medical Notes for 11 April 2003 are headed WR [Ward Round] [Consultant 3], which may have led those investigating the complaint to believe that Consultant 3 actually saw Miss C and so to misadvise Mrs C about this. The Medical Director explained that the entry written in her notes on 11 April simply referred to a conversation between Consultant 3 and the Specialist Registrar, because it took place during Consultant 3's ward round.

37. It is clear, therefore, that Miss C was right in her assertion that she had never seen Consultant 3. Misrepresentation of this fact has led to on-going confusion throughout the history of this complaint and has added to the distress and frustration experienced by Mrs C.

38. The Trust have explained that Miss C was left sitting by her bedside all day on 11 April 2003 because of a shortage of staff and a shortage of beds. However, Mrs C remembers without a doubt that, when she collected her Mother from the Hospital in the afternoon, her Mother had been sitting in a chair by her empty bed for 8 hours and told her that she had not been allowed to lie on the bed.

39. I uphold this head of complaint. I note that the Trust have already offered apologies for Miss C being left sitting in a chair. However, I am unclear as to

who has responsibility for discharging patients, what has been learned from this complaint and whether there have been any improvements in how patients are looked after as they wait to go home. I recommend that the Board clarifies the responsibilities for patients awaiting discharge and revises the Hospital Discharge Protocol in the light of this complaint.

(c) Failure to provide Miss C with appropriate accommodation when she was readmitted to the Hospital on 13 April 2003

40. Mrs C has expressed concern that her Mother was admitted on the night of 13 April 2003 to a room within Ward 8 that was used for storage and was continually disturbed during the night by staff coming in to obtain supplies. I made an additional enquiry to the Trust on 27 July 2005 about this complaint. The response from the Medical Director, in a letter dated 22 August 2005, was that Mrs C had received a letter from the Ward Manager on Ward 8 on this issue, dated 17 August 2004. The letter stated (quoted in full):

> 'I am responding to your complaint about the room in which your Mother was accommodated on the 13th April 2003 within Ward 8.
>
> According to our records your Mother was admitted to Ward 8 as an emergency admission on 13th April 2003 and was transferred to Ward 9 Female on the 17th April 2003.
>
> As this occurred more than two years ago, I can only envisage from your description that your Mother was admitted into Room 2 within Ward 8. Room 2 is used as an admission/assessment room, which we utilise to assess our patients clinically. It is the largest room within the ward environment and has been custom made to allow us as healthcare professionals to assess and treat our patients before transferring out into the ward environment.
>
> Unfortunately if the ward is busy and there are not beds out in the ward the patient who is in room 2 has to stay there until a bed can become available. By your description this appears to have been the case. Room 2 is not a storage room, however it does have a small cupboard that we house vital haemodynamic monitoring equipment.
>
> I can only apologise that your Mother was disturbed during the night by staff who might have had to go into the cupboard to get a piece of this

equipment. Although I have never received a complaint about this to date, I take on board your concerns and will try to alleviate this occurring again.'

41. In response to receiving a copy of the above letter, Mrs C has let me know that she had never at any time received any letter from the Ward Manager. Mrs C did complain to the Hospital on 14 April 2003 about her Mother being in a store room but had no further contact with the Hospital in relation to this particular complaint. Mrs C is clear that her Mother was in the room from midnight until 4pm the following day, at which point Mrs C made her complaint. Mrs C also disagrees with the explanation that there was a shortage of beds, as the bed occupied by Miss C in room 2 was wheeled onto the ward with her. Mrs C also pointed out the inconsistency that the letter was dated 17 August 2004 but stated that the incident happened more than two years ago.

42. The Chief Operating Officer of NHS Grampian wrote to Mrs C on 1 October 2005, letting her know that the Ward Manager had been asked to look into the matter of her Mother's accommodation. He explained that the Ward Manager had provided the information in draft letter format, that it had not been made clear to the Medical Director that this was for his information and that the letter had not been sent. The Chief Operating Officer apologised for the confusion that reference to this letter had caused and confirmed to Mrs C that the letter had not been sent to her. I made further enquiries to the Trust in order to understand the reason for the 17 August 2004 date on the letter. The explanation provided was that the date on the letter was wrong and that it should have been 17 August 2005.

(c) Failure to provide Miss C with appropriate accommodation when she was readmitted to the Hospital on 13 April 2003: Conclusion

43. I partially uphold this head of complaint. I consider that the Trust have provided an acceptable explanation of the reasons for the temporary accommodation but I also note the observations from Mrs C on the explanation provided about the shortage of beds. I am critical of the way in which this head of complaint has been handled and the confusion that has ensued as a result.

44. I am concerned about the lack of care and responsibility in the handling of this head of complaint. The date on the letter should have been correct and the letter should have been marked as draft. I am also concerned about the apparent breakdown of communication between the person drafting the letter and the person issuing it. I recommend that the Board carries out a review of

their internal procedures for handling complaints in the light of the lessons to be learned from these findings. There are lessons to be learned about the number of people involved in the investigation of a complaint and the importance of a consistent response. A multi-person approach can result in different versions and interpretations of events being conveyed to a complainant. It is understandable, particularly in the event of a bereavement, that a family member will question the medical and nursing treatment provided and will be expecting clear and rational explanations. It is also understandable that their feelings of shock and disbelief may turn to anger if they experience a number of staff dealing with their complaint in what appears to be an inconsistent manner.

(d) Failure in the handling of her complaint

45. The final head of complaint related to the concerns that Mrs C had raised, as part of her original complaint to this office, about the manner in which her complaint had been handled by the Trust. The Guidance on the NHS procedure, 'The NHS Complaints Procedure: Guidance for Hospital and Community Health Services Complaints' (revised May 1999), in force at the time of Mrs C's complaint, stated under the heading of 'Local Resolution' that 'A full investigation of a complaint should be completed, wherever possible, within twenty working days. Where this target is not being met, the complainant must be informed of the delay'. I have set out a summary of the main events relating to this head of complaint below.

46. Mrs C initially complained to the Hospital on 14 April 2003 on behalf of and with the consent of her Mother. She received an acknowledgement letter in response. Sadly, Miss C died on 17 May and on 22 May Mrs C prompted the Hospital for a reply to her complaint.

47. On 2 June 2003, the Chief Executive replied in writing to Mrs C, who contacted him to express her dissatisfaction with his response. As a result, a meeting took place on 13 June, attended by Mr and Mrs C, the Associate Medical Director and the Clinical Nurse Manager, at which a number of concerns were identified.

48. A further meeting between the parties to the 13 June meeting took place on 27 June, to discuss the Trust's response to the concerns identified. However, Mrs C remained dissatisfied. At the end of the meeting, the notes record that Mrs C was advised that the next step would be to contact the Local Health Council and seek advice. The notes also record that booklets were

handed to Mrs C, explaining that the next stage (under the NHS complaints procedure then in force) would be to ask the Convener of the Independent Review Panel to look at her complaint.

49. On 1 July, Mrs C contacted the Local Health Council for advice on what steps to take next. Their response, dated the following day (2 July), advised that the next step would be to request an Independent Review of her complaint and enclosed a relevant complaints leaflet. Mrs C wrote to the Associate Medical Director on 8 July, referring to the complaints booklet she had received from the Local Health Council:

> 'This states quite clearly that I cannot request an Independent Review until I have received a "full written response" at the end of the Local Resolution. It also states that there are strict time limits i.e. four weeks from the date of receiving said response. You may recall, and indeed it should be minuted, that I did ask for a written response but I was not aware at the time that this was compulsory in order to progress matters. I would be grateful if you could now send me a full written response.'

50. On 24 July the Chief Executive wrote to Mrs C, stating that if she remained dissatisfied she had a right to apply for Independent Review. Enclosed with this letter was a copy of the minute taken at the meeting on 27 June 2003.

51. Mrs C wrote to the Convener of the Independent Review Panel on 31 July, requesting an Independent Review. Her letter was acknowledged on behalf of the Convener on 7 August and this response included information on the three options open to the Convener: to convene a panel, return the complaint to the Chief Executive of the Trust for further local resolution or to determine that no further action was to be taken. It also explained that, where clinical issues were involved, the Convener would seek appropriate professional clinical advice in reaching her decision. Guidance on the NHS complaints procedure at the time set a target time of 20 days for a response to a request for an Independent Review.

52. On 27 August the Convener wrote to Mrs C, advising that she was seeking clinical advice before making her decision, that this was taking slightly longer than anticipated to obtain and that she would let Mrs C have her decision by the week commencing 8 September at the latest. On 10 September the Convener referred Mrs C complaint back to the Trust for further local resolution.

53. On 11 September the Chief Executive wrote to Mrs C, referring to the decision that further local resolution should take place, advising that the Medical Director would take the matter forward and that he hoped to offer a date for a meeting within the next two weeks. Mrs C was unable to attend a proposed meeting on 24 September, because of the short notice (a telephone call on 19 September) and another appointment.

54. On 14 October Mrs C wrote to the Trust, saying that she had not heard from them since 19 September. The response from the Trust on 16 October was that the delay resulted from trying to find dates so that key personnel involved in the care of her late Mother could attend and they offered a date of 25 November at 4.30pm for the meeting.

55. The meeting on 25 November was attended by Mr and Mrs C, along with the Medical Director, the Associate Medical Director, the Clinical Nurse Manager, Consultant 1 and Consultant 2. After the meeting, the Medical Director sent a letter to Mrs C dated 28 November, setting out this issues discussed and what the Trust proposed to do in relation to her complaint:

> 'It is clear that during our discussion on 25th November a number of shortcomings in the care delivered to your Mother at [the Hospital] have been identified. We offer our apologies for these shortcomings and we will take the issues forward as summarised in our letter. We would be pleased to provide any further clarification on the issues referred to in the letter and progress on the action taken.'

56. On 22 December Mrs C wrote again to the Convener to request an Independent Review, as she considered that the meeting on 25 November brought no satisfactory conclusion. The Convener wrote to Mrs C on 20 January 2004, refusing her application for an Independent Review, as she considered that sufficient explanations and apologies had been given through correspondence and discussion and that Mrs C had been advised of the steps being taken to ensure that lessons were learnt from her case. The Convener also advised that Grampian Local Health Council was a body independent from the Trust and, therefore, the Trust was not in a position to investigate any concerns about the service that they provide. She enclosed details of the Health Council complaints procedure.

57. Mrs C responded to this letter on 22 January 2004, saying (extract):

> 'In paragraph three of your letter you state that although I had not received a copy of the Minutes [the Medical Director] did write to me within three days of the meeting. Quite frankly I fail to see the connection here. Yes, [the Medical Director] did write to me as he said he would, but I was also assured by [the Clinical Nurse Manager] that he would send me a copy of the minutes by Friday of that week. I have on many occasions previously voiced my concerns both verbally and in writing about the unacceptable time delays on the part of the Trust. It is my right to receive a copy of the minutes and I think it disgraceful that you were sent a copy and I have not.'

58. On 26 January 2004, Mrs C received a letter from the Chief Executive, saying that the Convener had let him know that Mrs C had not received a copy of the minute of the 25 November meeting. He advised that the letter from the Medical Director, dated 28 November 2003 had taken the place of the formal note of the meeting, apologised if Mrs C had been disappointed in not receiving a copy of the formal minute taken and enclosed a copy of the minute. Mrs C responded, pointing out that a copy of the minute had not been enclosed with the letter. A copy of the minute was sent to her on 5 February 2004.

59. Mrs C made her complaint to the Ombudsman on 22 March 2004.

60. As part of my further consideration of her complaint, I contacted the Trust on 27 January 2005 about their complaint handling. I asked for an update on the matters that the Medical Director had told Mrs C, at the meeting on 25 November 2003, would be put in place. Updates were provided on a number of matters.

61. Further correspondence with the Trust on these matters resulted in the following response from the Medical Director, dated 22 August 2005 (extract):

> 'Although the actions indicated in my letter of 28 November 2003, had been taken forward, this was not communicated to [Mrs C] as had been suggested in the letter. I have to take personal responsibility for this. The reason I did not write back to [Mrs C] was that I was aware that she was dissatisfied with the conclusions reached in my letter of 28 November 2003 and the actions proposed. Under these circumstances I thought that it would be futile or even counterproductive to continue to write to [Mrs C]

along the same lines as the letter of 28 November 2003. As I indicated to you over the phone, with hindsight it would have been better if I had specifically written to [Mrs C] indicating that I was aware that she was dissatisfied with my letter of 28 November 2003 but that if she wished to I would keep her informed about the actions taken. I believe that the lesson learned from this case will allow me to deal with future situations better under similar circumstances.'

(d) Failure in the handling of her complaint: Conclusion

62. It is clear from the above narrative that Mrs C needed to prompt the Hospital for an initial response to her complaint made on 14 April 2003 and that their response on 2 June was outwith the required 20 working days. The Trust subsequently arranged meetings on 13 June and 27 June, in an attempt to bring the relevant parties together and to try to resolve the complaint. However, it is unfortunate that Mrs C then needed to ask the Trust (on 8 July) for a full written response, as required by the Independent Review process and it is clear that she had to keep on prompting Trust for a response.

63. Mrs C then asked for an Independent Review of her complaint. I note that the Convener took longer to respond than the required time but she did let Mrs C know that it was taking longer than expected to obtain clinical advice. The complaint was referred back for further local resolution. The meeting proposed for 24 September did not happen and I am concerned that Mrs C again had to prompt the Trust for a response. The difficulty of arranging for senior medical staff to attend a meeting without disrupting service provision is understood but, at the very least, Mrs C should have received an explanation for the delay.

64. Following the meeting on 25 November, a detailed letter from the Medical Director set out the issues discussed and the actions that the Trust proposed to take in relation to identified shortcomings in care. The letter also said that the Trust would be pleased to provide any further clarification on the issues referred to in the letter and progress on the action taken.

65. Mrs C remained dissatisfied and again requested an Independent Review. The Convener refused this request on the basis that sufficient explanations and apologies had been given already and Mrs C had been advised of the steps being taken to ensure that lessons were learnt from her case. It is regrettable

that Mrs C then needed to point out that she had not received the minutes of the 25 November meeting and that she had to write again to Trust to obtain them.

66. In her letter dated 20 January 2004, the Convener clearly set out the role of Grampian Health Council and explained why the Trust could not investigate any concerns about its service. However, the issue here is that the Clinical Nurse Manager had told Mrs C that he would investigate her concerns about the Health Council and would write to her about this. In the event, he did neither. I accept that the Trust could not investigate the actions of the Health Council but Mrs C should either not have been told that they could or, if the position had been misunderstood, someone should have contacted Mrs C to explain the actual position. As a result, Mrs C was denied the opportunity to pursue her concerns with the Health Council (which has now been abolished along with other Health Councils), a situation that was both unsatisfactory and frustrating for her, and also unfortunate for the Health Council, who were not given opportunity to address her concerns.

67. I criticise the Trust for their lack of response and delays in dealing with Mrs C's complaint. However, I note that they took positive steps to have meetings, set out responses and advised on actions that would be taken as a result. These responses, and the comprehensiveness of their proposed actions, were the main reasons for not carrying out an investigation into Mrs C's complaints when she first made her complaint to this office. However, I criticise the Trust in particular for not telling Mrs C, as they said they would, about the progress of the actions that they intended to take as a result of her complaint. This meant that her complaint was not remedied. I acknowledge, but do not condone, the explanation from the Medical Director that he had thought it futile or even counterproductive to continue to write to Mrs C because of her dissatisfaction with the Trust. The point here is that he said he would do something and he should have kept his word.

68. I uphold this head of complaint. I recommend that the Board apologise to Mrs C for the manner in which her complaint has been handled and provide Mrs C with a full update of the lessons learned, actions taken and changes that have resulted as a consequence of her complaint (including those detailed in the 23 November 2003 letter from the Medical Director). I realise that these recommended actions can in no way recompense Mrs C for the loss of her Mother but they may give her some small comfort to know that changes have resulted as a result of her continued pursuance of her complaint.

69. There are wider lessons that can be learned from the handling of this complaint by others both within and outwith the Trust. These include the importance of keeping a complainant advised as to what is happening, letting the complainant know if stated dates cannot be met, giving reasons for delays and letting the complainant know what will happen next and when.

Summary of recommendations

70. Following the investigation of all aspects of this complaint, the Deputy Ombudsman recommends that the Board should:

i. introduce a Protocol for the Management of suspected DVTs;

ii. clarify responsibilities for patients awaiting discharge;

iii. revise the Hospital Discharge Protocol in the light of this complaint;

iv. apologise to Mrs C for the shortcomings identified in this Report and the manner in which her complaint has been handled;

v. carry out a review of their internal procedures for handling complaints;

vi. provide Mrs C with a full update of the lessons learned, actions taken and changes that have taken resulted as a consequence of her complaint.

Further action

71. As noted in paragraph 5, the Board have accepted the recommendations and will act on them accordingly. The Deputy Ombudsman asks the Board to notify her when and how the recommendations are implemented.

30 May 2006

Annex 1

Explanation of abbreviations used

All names used in this report have been anonymised in line with the requirements of the Scottish Public Services Ombudsman Act 2002:

Mrs C	The complainant
Miss C	The late Mother of the complainant
Associate Medical Director	The Associate Medical Director who attended the meeting with the complainant on 27 June 2003
Clinical Nurse Manager	The Clinical Nurse Manager who attended the meeting with Mrs C on 25 November 2003
Consultant 1	The Consultant Surgeon responsible for the care of Miss C during her first stay in hospital
Consultant 2	The Consultant who carried out the ERCP procedure and stone extraction
Consultant 3	The duty Consultant on call during the first discharge from the Hospital
Convener	The Independent Lay Convener
Medical Director	The Trust Medical Director
Nurse Manager	The Nurse Manager who attended the meeting with the complainant on 27 June 2003
Pre-Registration House Officer	The Pre-Registration House Officer involved in the care of Miss C during her first stay in the Hospital

Specialist Registrar	The Specialist Registrar involved in the care of Miss C during her first stay in the Hospital

Annex 2

Glossary of Medical Terms

Term	Definition
CBD	Common Bile Duct
CT scanner	Computurised Tomography Scanner is a type of X-ray machine used to produce pictures of the inside of the body. Unlike an ordinary X-ray, which is developed on film, a CT scan creates images of sections of the body on a computer screen. The images are black, white and grey, like ordinary X-rays, but are much more detailed and can be viewed in three dimensions.
Doppler ultrasound scanning	Special ultrasound machines, known as Doppler flow machines, are able to show how blood is flowing through the vessels and can detect blood clots.
Duplex scan	A non invasive test to establish blood flow in a vessel
DVT	Deep vein thrombosis
Embolus	A blood clot that moves through the bloodstream until it lodges in a narrowed vessel and blocks circulation
ERCP	Endoscopic Retrograde Cholangio-Pancreatography is an X-ray examination of the pancreatic and bile ducts, which are injected with a dye beforehand to make them show up. The purpose of the examination is to detect any diseases or irregularities in the bile or pancreatic ducts.
IVC	Inferior Vena Cava (vein in the leg)

Neoplastic	Neoplastic transformation is the conversion of normal cells into tumour cells. Neoplastic refers to both benign and malignant growths.
Oedema	Excessive accumulation of fluid in the body tissues
Pulmonary angiogram	An angiogram is an X-ray of the blood vessels that shows blockages or other abnormalities in veins or arteries. It uses a contrast dye which is a liquid that helps blood vessels show up clearly on X-rays. A pulmonary angiogram examines arteries supplying blood to the lungs.
Pulmonary embolus	A pulmonary or lung embolus occurs when a blood vessel supplying the lung becomes blocked by a clot.
SOB	Shortness of breath