Scottish Parliament Region: Lothian

Case TS0105_04: Lothian NHS Board - Lothian University Hospitals Division

Introduction and summary of complaint

1. On 31 July 2003 my office received a complaint from a woman (referred to in this report as Mrs C) against Lothian University Hospitals NHS Trust[6] about the care and treatment her late daughter (Ms C) received at the Western General Hospital (WGH) in Edinburgh. Mrs C was also dissatisfied at the outcome of an Independent Review Panel (IRP) into her original complaint.

2. The core of Mrs C's complaint relates back to a consultation on 27 June 2001 and the interpretation of her late daughter's CT scan by a consultant neurosurgeon (Consultant 1). Mrs C was of the view that an error of judgement was made by Consultant 1 and that he gave an over-optimistic interpretation of her daughter's condition. Her complaint was referred to an IRP which reported in May 2002.

3. The specific aspects of the complaint examined by my Complaints Investigator concerned:

(a) Consultant 1's comments during the consultation with Mrs C and Ms C on 27 June 2001;

(b) Consultant 1's interpretation of the CT scan;

(c) explanations for differences in interpretation of the CT scan;

(d) speed of reporting on emergency imaging and conveying reports to the relevant clinician;

(e) review and filing of reports by clinicians;

[6] Lothian University Hospitals NHS Trust (the Trust) was established by the Lothian University Hospitals NHS Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under the Lothian University Hospitals NHS Trust (Dissolution) Order 2003 which came into force on 1 January 2004. On the same date an Order transferring the liabilities of the Trust to Lothian Health Board (the 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. However, the recommendations within this report are directed towards the Board.

(f) actions of the IRP Convener;

(g) the Trust's response to the IRP report.

4. After taking advice from two clinical advisers and finalising his investigation, my Complaints Investigator wrote to Mrs C on 24 June 2005 setting out his decision on her complaint. Mrs C responded to his letter on 4 July and noted her concern about the time taken by my office to look into her complaint and recorded her view that a number of important issues had not been answered to her satisfaction. Mrs C received a reply from my office on 22 July in which it was confirmed that no further action would be taken.

5. Mrs C then made a complaint to my Service Quality Manager on 3 August about the delay and the way in which her case was handled. A detailed response was sent to Mrs C on 23 September and I offered to meet with her to discuss aspects of her case. Following that meeting on 3 November, I decided to re-open the investigation. Mrs C argued, and I accepted, that my office had failed to address fully some aspects of her complaint. In re-opening the investigation, I decided also to consider in more detail:

(h) the conduct of a meeting between Consultant 1 and Mrs C which Mrs C's son and Ms C's father also attended on 29 August 2001.

6. Following the investigation of all aspects of this complaint I came to the following conclusions:

(a) and (b)	Partially upheld – see paragraphs 34 to 43.
(c)	No finding – see paragraphs 34 to 43.
(d)	Not upheld – see paragraphs 44 to 56.
(e)	Upheld – see paragraphs 44 to 56.
(f) and (g)	Upheld – see paragraphs 57 to 61.
(h)	Upheld – see paragraphs 62 to 70.

7. In the light of these findings I recommend that:

Complaints (a) and (b) - Consultant 1 apologise to Mrs C for the shortcomings I have identified.

Complaint (d) - the Board consider the issue of the availability of clinical notes in reviewing the lessons that can be learned from this complaint; and whether their system of electronic record keeping and reporting can be used to reduce the time between the writing and typing of clinical reports.

Complaint (e) - the Board apologise to Mrs C for the shortcomings identified; review their current process for arranging holiday leave to ensure there is sufficient cover to maintain the high quality of care and service; and reinforce the importance of the pre-clinic sessions when shared care is being provided and ensure that they take place.

Complaints (f) and (g) – the Board apologise to Mrs C for the failure of the Trust to write to her following receipt of the IRP report and for their failure to explain why they did not do so.

Complaint (h) - the Board apologise to Mrs C for their failure to communicate her requests to Consultant 1, and Consultant 1 apologise to Mrs C for the way in which he handled the meeting. I also recommend that the Board give further consideration to taping meetings that are likely to be highly sensitive and to issuing guidance to staff with regard to handling such meetings.

8. I am pleased to report that the Board and Consultant 1 have agreed to these recommendations.

Background to the complaint

9. On 29 August 2001 Mrs C wrote to the Patient Liaison Manager at the Trust stating that she wished to lodge an official complaint against the Department of Clinical Neurosciences (DCN) at the WGH. In her letter she set out the background to the complaint. She explained that her daughter was diagnosed with a malignant brain tumour in 1997. Following an operation carried out by Consultant 1, Ms C received radiotherapy. She enjoyed reasonably good health for around three years until recurrence of her tumour in 2000. She then received three sessions of PCV chemotherapy but this treatment was stopped

because her blood count did not come up to the required level. An MRI scan was done after the third session and this showed that the tumour had shrunk considerably. Ms C remained in reasonably good health for another year.

10. In 200l Ms C suffered increasingly from headaches and began to have more frequent seizures. At a routine clinic on 20 June, she was seen by a doctor (Doctor 1) who initially agreed to arrange an MRI scan but following discussion with a radiologist (Radiologist 1) it was decided to go ahead with a CT scan as it could be done more quickly. Mrs C said that when she told Doctor 1 that Ms C's previous CT scans had always been followed by an MRI scan, Doctor 1 said that the waiting list for an MRI scan was about two to three months. The CT scan was done on 25 June and an arrangement made for Ms C to attend the clinic on 27 June to get the result. Her mother accompanied her to the clinic, and they were seen by Consultant 1. It is Mrs C's view that when Consultant 1 discussed the scan with them he said he had good news as he could find no trace of the tumour. When she raised the question of her daughter's seizures, he considered that these could be caused by stress and anxiety.

11. Shortly after her meeting with Consultant 1, Ms C's condition worsened and she began to suffer more frequent seizures and headaches. Mrs C telephoned the WGH on 2 August to seek advice. She left a message on an answerphone. The Clinical Nurse Specialist (Clinical Nurse 1) called back the next day and advised that Ms C should increase her medication. Clinical Nurse 1 said that she had consulted with a doctor (Doctor 1) and said she would telephone at the beginning of the next week to enquire about Ms C's progress. When she called on the Monday (6 August) Mrs C informed her that her daughter's condition was getting worse and that she could hardly walk. Clinical Nurse 1 said that a CT scan would be organised but called back later that day to say that the scanner had broken down. She advised that Ms C should attend the clinic on the Wednesday afternoon (8 August) to see Doctor 1.

12. Mrs C said that at the consultation on 8 August, Doctor 1 stated that she saw a deterioration in Ms C's condition and was almost certain that the tumour had recurred. Mrs C said she asked Doctor 1 to produce her daughter's CT scan taken on 25 June, and that Doctor 1 pointed out the existence of a tumour. Both she and her daughter stated that the scan did not look like the one Consultant 1 had shown them on 27 June.

13. Doctor 1 said she would arrange for an MRI scan to be done immediately. Clinical Nurse 1 telephoned Mrs C to say the MRI scan was arranged for 16 August and that the results would be available for Consultant 1 on his return from holiday on 20 August. Because of problems with the scanner, the MRI scan was delayed for one day. After the MRI scan on 17 August a meeting was arranged with another doctor (Doctor 2) for Monday, 20 August, as Consultant 1 was still on holiday. Mrs C said that, at that meeting, Doctor 2 informed them that the MRI scan showed that Ms C's tumour had spread to the back of the head. Her daughter was then treated with a new chemotherapy drug.

14. Mrs C then asked for a meeting with Consultant 1 in order for him to explain the comments he made to her and her daughter when they met with him on 27 June. As she anticipated that it might be an emotional meeting, she had asked Clinical Nurse 1 if she could tape the meeting and was informed that this would not be a problem. However, when she and her son, and Ms C's father met with Consultant 1 on 29 August he refused to allow Mrs C to tape the meeting.

15. Mrs C said that at the meeting Consultant 1 stated that, in his opinion, he had read her daughter's scan correctly and confirmed his remarks that there was no trace of a tumour. When she asked him for sight of Radiologist 1's report on the CT scan, Consultant 1 read out the words 'there was evidence of a tumour recurrence'. She asked him why he had not queried his findings against those of Radiologist 1, and she said that Consultant 1 replied that he had not seen Radiologist 1's report prior to meeting with her and her daughter on 27 June. She understood that the normal practice was for the cancer team to discuss the various files in advance of the Wednesday afternoon clinic. Mrs C then asked what had happened to the team's input on the afternoon in question. She also queried why Consultant 1 had not followed up to check his findings against those of Radiologist 1, to which she says that he replied that he went on holiday. When she also asked if Doctor 1 or Doctor 2 should have read Radiologist 1's report in his absence, Consultant 1 stated that they were also on holiday. Mrs C was aggrieved that it appeared that Radiologist 1's report had not been picked up by anyone and that her daughter could have been receiving treatment some eight weeks earlier if the discrepancy between that report and Consultant 1's interpretation of the CT scan had been noticed.

16. On the same day as lodging her formal complaint to the Trust, Mrs C also wrote to Radiologist 1 asking what had happened to his report of her daughter's CT scan taken on 25 June and when it had actually appeared in her file.

17. Mrs C received a written response to her complaint from the Principal Nurse/Assistant General Manager of the Surgical and Associated Services Division of the Trust (Principal Nurse 1) on 11 October 2001. Following receipt of this letter Mrs C remained dissatisfied with the explanations she was given and a meeting was arranged with Radiologist 1 to review Ms C's neuro-radiology films. Following the meeting on 2 November, Mrs C received a letter from Principal Nurse 1 dated 23 November in which she stated that, if Mrs C felt that the Trust had not addressed her concerns, she could request an Independent Review of her case.

18. Mrs C's daughter died on 6 December 2001.

19. Mrs C wrote to the Convener of the Trust on 19 December 2001 requesting an Independent Review of her complaint. On 28 January 2002 the Convener informed Mrs C that he had decided not to agree to her request but that he had raised certain issues with the Trust relating to the interpretation of the CT scan, the filing of reports, and the taping of conversations between consultants and patients and their relatives in oncology cases. The Trust wrote to Mrs C on 20 April 2002 addressing the points made by the Convener.

20. Mrs C remained dissatisfied with the Trust's response and their failure to implement the Convener's recommendations. A meeting was arranged for 19 June and was followed up by a letter from the Trust on 12 July. Minutes of the meeting were enclosed with the letter and Mrs C was informed that, if she remained dissatisfied, she could write again to the Convener or to the Health Service Commissioner[7]. Mrs C replied to the letter on 26 July drawing the Trust's attention to a letter written by Consultant 1 to her daughter's GP dated 28 June 2001 which she had found after accessing Ms C's records. In that letter Consultant 1 stated that he was 'happy to report that [Ms C] has a very satisfactory CT scan. Rather remarkably this is almost totally free of any disease …'. As she did not receive a reply to her letter of 26 July, despite making numerous telephone calls, Mrs C wrote to the Chief Executive of the Trust on 18 October 2002 asking him to look into the matter on her behalf. He

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[7] The Ombudsman responsible for considering complaints about the NHS in Scotland before my office was established in October 2002.

did not respond but she received a reply to her letter of 26 July from Principal Nurse 1 dated 27 October 2002. Mrs C then wrote to the Convener of the Trust on 16 November requesting an Independent Review of her complaint and followed this up on 3 December with a detailed letter setting out the reasons for her request. She also wrote to my office on 5 December seeking guidance and noting her view that the Convener had exceeded his role. She received advice from my Complaints Investigator on 13 December 2002.

21. Mrs C received a letter from the Convener on 16 January 2003 informing her that he had decided to grant her request and to appoint an Independent Review Panel to consider her complaint. Some correspondence between them followed relating to Mrs C's concerns about the terms of reference given to the IRP which covered the consultation with Consultant 1 on 27 June 2001, the delay in commencing chemotherapy treatment for Ms C, the filing of the report from Radiologist 1, and the Trust's handling of the complaint.

22. Mrs C attended the IRP which took place on 31 March 2003 at the WGH. The Chairman's Report was sent to Mrs C on 16 May 2003. Mrs C then wrote to my office on 31 July 2003 requesting that her complaint be investigated and setting out the reasons why she remained dissatisfied.

Mrs C's complaint to the Ombudsman

23. Following receipt of her complaint, my office wrote to Mrs C on 1 August 2003 requesting her consent for my staff and advisers to have access to her late daughter's clinical records. The records and other papers were then reviewed by my Complaints Investigator and subsequently by clinical advisers. Mrs C informed my Complaints Investigator on 23 December 2003 that she had still not received a letter from the Chief Executive of the Trust following the conclusion of the IRP.

24. My Complaints Investigator wrote to Mrs C on 4 February and 7 April 2004 informing her that, following a discussion of her complaint with one of the clinical advisers, he intended to write to the Trust making further enquiries and giving them an opportunity to clarify and comment on specific issues. In her response dated 19 April, Mrs C noted her concern at the delay. My Complaints Investigator wrote to the Acting Chief Executive of NHS Lothian – University Hospitals Division on 21 April. The letter included a request for further clarification and consideration of several aspects of Mrs C's complaint (i. Consultant 1's comments during the consultation on 27 June 2001;

ii. Consultant 1's interpretation of the CT scan; iii. explanations for differences in interpretation of the CT scan; iv. speed of reporting on emergency imaging and conveying reports to the relevant clinician; v. review and filing of reports by clinicians; vi. actions of the Convener; vii. response to IRP report); notification of his preliminary conclusion that the Convener had exceeded his role; and notification that he had decided not to take further action on the aspect of Mrs C's complaint that her daughter's life may have been shortened by a delay in commencing treatment. He wrote to Mrs C on the same day enclosing a copy of his letter.

25. Following numerous telephone and email exchanges, a response to the enquiry letter was received from the Divisional Chief Executive on 18 August 2004 and Mrs C was informed and sent a copy of the letter. She replied on 28 August stating that she was angry and disillusioned with the reply and commenting on the different points made. Mrs C was informed on 9 September that my clinical advisers had been asked to comment on NHS Lothian's response and that NHS Lothian had been asked to supply copies of the CT and MRI scans so that specialist opinion could be sought. My Complaints Investigator wrote to Mrs C on 2 November to update her and let her know that two specialist advisers – one a neurosurgeon and the other a neuroradiologist – had agreed to assist with his consideration of her complaint. It was not until April 2005 that he received reports from both advisers.

26. Having considered all the written evidence and clinical advice received, my Complaints Investigator wrote to Mrs C on 24 June setting out his conclusions on her complaint and his reasons for deciding not to take further action. He wrote to the Chief Executive on the same date informing him of his decision. In this letter he noted that he did have considerable concerns that the Trust, and latterly NHS Lothian, had handled Mrs C's complaint poorly. He requested that NHS Lothian review its mechanisms for the handling of complaints in the light of these concerns with a view to ensuring that such a situation did not recur.

27. Mrs C replied to my Complaints Investigator's letter on 4 July stating her concern at the time it had taken for my office to consider her complaint and her disappointment with the conclusion that had been reached. She considered that the most fundamental issues had been overlooked both by my Complaints Investigator and by the IRP, namely the review and filing of reports by clinicians. She received a response to her letter on the 22 July following which she made a complaint to my Service Quality Manager on 3 August. He sent a detailed reply

to Mrs C on 23 September in which he upheld aspects of her complaint. He also referred the case to me for consideration.

28. Having reviewed the file, I decided to hold a meeting with Mrs C.

Investigation of complaint

29. I met with Mrs C and her son on 3 November 2005 and was accompanied by my Service Quality Manager and my clinical adviser. Following that meeting I decided to re-open Mrs C's case and to investigate it under new complaint handling and reporting procedures adopted by my office in October 2005. Mrs C argued, and I accepted, that my office had failed to address fully some aspects of her complaint. I was of the view that detailed attention had been given to investigating the difference between the two interpretations of the CT scan carried out on 25 June 2001. However, I believed that more could be done to examine some of the wider issues including the handling of Mrs C's concerns at the meeting held on 29 August 2001, and the general handling of the subsequent complaint.

30. I wrote to Mrs C on 3 November 2005 and to the Chief Executive of Lothian NHS Board informing them of my decision. As a considerable amount of written evidence and advice had already been collected and reviewed, I noted my intention to focus my investigation on conducting interviews with key witnesses.

31. I carried out interviews with Doctor 2, Medical Director NHS Lothian (Doctor 3), the Chief Executive and Consultant 1 during December 2005 and January 2006. I was accompanied by my clinical adviser who participated in the interviews.

32. The purpose of these interviews was to hear from those who had been directly involved in treating Ms C and to obtain their account and understanding of events that were the subject of the complaint; also to discuss with hospital managers the key lessons that could be learned in order to improve the processes in place and to prevent similar problems arising for other patients and their relatives. Another key objective was to explore the question of who held overall leadership/responsibility for the care of Ms C during the different stages of her treatment and to investigate the process for dealing with reports and interpretation of CT and MRI scans. I sought also to look at the way the meeting with Mrs C, her son and Ms C's father had been handled as well as the handling of Mrs C's complaint more generally.

33. In addressing the specific heads of Mrs C's complaint, I have grouped them as follows to avoid repetition of key points.

First Aspect of Complaint: (a) Consultant 1's comments during the consultation with Mrs C and Ms C on 27 June 2001; (b) Consultant 1's interpretation of the CT scan; and (c) explanations for differences in interpretation of the CT scan

34. During my interview with Mrs C and her son it became very clear that she was not complaining about the medical care her daughter had received but rather the optimistic information that she and her daughter thought they were given at the consultation with Consultant 1 on 27 June 2001 and the events that followed. Indeed she noted her appreciation of the quality of the care that Ms C had received from Consultant 1 and Doctor 2 in particular, and the fact that she and her family had built up a good and trusting relationship with the medical staff during the course of her daughter's illness. Her remarks at interview were in line with a letter that Mrs C wrote to my Complaints Investigator on 21 May 2004 when she stated: 'In regard to the Ombudsman's Clinical Adviser's comments that my daughter's records indicate that in general she received a very high standard of care during the course of her illness, I would concur with this.' She continued: 'While this has never been an issue, having always appreciated the care she received, my complaint stems from [Consultant 1's] interpretation of my daughter's scan taken on 25 June 2001 and the events thereafter.'

35. The exact details of what was said during the conversation that Consultant 1 had with Mrs C and her daughter on the day of the consultation have been subject to considerable scrutiny by different people throughout the history of this complaint. It remains Mrs C's contention that Consultant 1 spoke in positive terms in interpreting the scan stating that he saw no trace of a tumour. While the scan was on the viewing box Consultant 1 pointed out different stages in Ms C's condition. Following the consultation Mrs C said that both she and her daughter felt elated and were keen to inform other members of the family of what they considered to be good news.

36. For his part, Consultant 1 has continued to dispute some of the language attributed to him. When I interviewed him, he repeated that he would not have used the positive words that Mrs C identified. He said that when he saw Ms C she was really rather well if one took into account the fact that she had suffered

a condition which, when operated on in 1997, was considered to be without a long-term cure. Doctor 2 also made this point when I interviewed her and she said that Ms C had made a relatively good recovery after her initial surgery and in the following three or four years had enjoyed good general health. She did note, however, that Ms C's tolerance to chemotherapy treatment had not been good. It is Consultant 1's view that his interpretation of the CT scan had to be seen within this wider context of the seriousness of Ms C's condition.

37. However, I put it to Consultant 1 that his letter to Ms C's GP on 28 June 2001 also seemed to support a positive interpretation of her CT scan. Consultant 1 wrote: 'I saw [Ms C] and her mother in the clinic today. I am happy to report that she has a very satisfactory CT scan. Rather remarkably this is almost totally free of any disease with no mid-line shift or mass effect. She has however, as you know, had two seizures recently. … Certainly from the clinical and functional point of view, she is doing remarkably well, working almost full time with normal memory. In the clinic today, the only neurological finds were long-standing subtle right-sided shifts in hypo kinesis and mild facial paresis. We shall review in 3 months time or sooner should there be a particular problem.' I note from Ms C's medical records that in his typed record of his consultation with Ms C, Consultant 1 recorded: 'CT today shows a rather remarkable resolution of her lesion. There is no midline shift. There are certainly some changes in the frontal lobe but much of these are long standing. There is no mass effect. There is a suggestion of some subtle enhancement in one cut. Otherwise the scan looks very satisfactory.'

38. I raised with Consultant 1 the difference between his interpretation of the CT scan and that reported by Radiologist 1. In his typed record on the scan performed on 25 June 2001, Radiologist 1 stated: 'There is enlarged irregular recurrent enhancing tumour mass, measuring maximally 7 cm AP and 5 cm transverse x 4 cm high. This is causing minor local mass effect on the adjacent cerebral cortical gyri but no significant herniation of venticular distortion.'

39. The apparent discrepancy between these two accounts was reviewed by two clinical advisers involved in the IRP and by two clinical advisers instructed by my Complaints Investigator during his enquiries into the complaint. Unfortunately no clear conclusions resulted from the reviews as opinion split between the neurosurgeons (engaged by both the IRP and my office) and the radiologists (again engaged by both the IRP and my office), reflecting the differences of opinion between Consultant 1 and Radiologist 1. Such

differences of opinion were of little assistance in reaching a conclusion on the apparent discrepancy between interpretations. Additionally, there are limits to the information available in a CT scan. It was not until Ms C had her MRI scan in August 2001 that the recurrence of her tumour was identified.

40. I explored all of these points with Consultant 1. Given the positive way in which he had reported the results of the CT to Ms C's GP and on her medical records, I asked him if he was sure that he had been reading the correct scan (an issue on which Mrs C had recorded her doubts). He replied that he had been asking himself that question and had gone back to check. Having looked at the scan again, he was still of the view that his interpretation was correct and had to be seen within the wider context of Ms C's condition. Consultant 1 said that when he saw Ms C he was pleased to note that, given her history and diagnosis, she presented as relatively well and he took this into consideration when he looked at the scan. He did accept, however, that he did not contextualise his remarks and as a result may have given a more positive impression of Ms C's condition than was warranted. He regretted that both Mrs C and her daughter left the clinic with an over-optimistic view and accepted that the misunderstanding had contributed to the distress experienced by the patient and her family.

41. I confirmed with Consultant 1 that he did not have the report from Radiologist 1 at the time of his consultation with Ms C. I asked him why he had not sought further evidence to support his interpretation of the CT scan, especially in view of the fact that such a scan is not as reliable as an MRI scan in identifying tumours. In response he said that in hindsight he would have requested an MRI scan at that stage.[8]

42. I am unable to conclude exactly what was or was not said at the consultation in question. However, I am clear that Mrs C and her daughter left that consultation in good spirits as they thought they had heard good news and that Ms C's tumour had not recurred. They both held Consultant 1 in very high regard and they had no reason to doubt his assessment. I am also persuaded that Consultant 1 did not intend to mislead Mrs C and her daughter. Nevertheless he did not use the opportunity to put his remarks in context at the consultation, nor did he do so in writing to the GP and in completing Ms C's

[8] Doctor 1 had originally requested an MRI scan when she saw Ms C at the clinic on 20 June 2001, but because of the waiting list at the time, it was decided that a CT scan would be carried out and this was done on 25 June – see paragraph 10.

medical records. I am pleased to note that Consultant 1 informed me that he has learned from the experience of this case. In writing to a patient's GP or making notes in a patient's record he is very careful to place any comments made in context.

43. As I have indicated, there are differences of view about exactly what was said at the meeting on 27 June, and there are differing medical opinions about the interpretation of the CT scan. It is not possible to resolve these differences. Further, Mrs C has made it clear that she was not complaining about the medical care her daughter had received but about the impression given at the meeting on the 27 June and the events that followed (see paragraph 34). I have, however, identified a key problem of poor communication and Consultant 1's failure to put both his oral and written comments in the wider context of Ms C's medical condition (see paragraph 40). For this reason, I partially uphold complaints (a) and (b) and recommend that Consultant 1 apologise to Mrs C for the shortcomings I have identified. I have made no finding in respect of complaint (c) as it is not possible to offer a definitive answer to this point.

Second aspect of the complaint: (d) speed of reporting on emergency imaging and conveying reports to the relevant clinician; and (e) review and filing of reports by clinicians

44. In pursuing her complaint Mrs C raised questions about the speed of reporting the results of the CT scan on 25 June 2001 and the time taken for the results to be available to the relevant clinician. The delay meant that Consultant 1 did not have Radiologist 1's report when he saw Ms C on 27 June. Mrs C was also concerned about the procedures for reviewing and filing of reports by clinicians. She asked why Radiologist 1's report was filed in her daughter's records without the apparent discrepancy between his interpretation of the CT scan and that of Consultant 1 having been picked up and acted upon.

45. These aspects of Mrs C's complaint were explored by my Complaints Investigator who made written enquiries of the Trust. He received explanations from them in their letter to him dated 13 August 2004. The Trust stated that they considered that there was not an unreasonable delay in completion of the report of the CT scan performed on Monday, 25 June 2001 as it was typed and issued to the Neurosurgery Department within two days. The scan had been done as an emergency and outside the usual arrangements for the Wednesday clinics. The Trust reported that they had commissioned a Radiology Information

System (RIS) to improve the speed and availability of access to radiology reports for clinicians.

46. With regard to the second point, it appeared that Radiologist 1's report was filed in Ms C's records without the apparent discrepancy between the interpretations of the scan having been picked up. My Complaints Investigator ascertained that Radiologist 1's report was received and reviewed prior to having been filed as it had been initialled but it was not possible to determine when this occurred. In their letter of 13 August the Trust confirmed that the 'current process in the Neuro-Oncology Service ensures that investigation reports of any type are only filed once seen and signed by the appropriate clinician' and that the recommendations of the Convener following the Independent Review had been taken forward.

47. These matters were raised at the interviews I conducted and a clearer picture of the normal procedures was obtained. Recognising the complex needs of patients, and to reduce the inconvenience to patients in attending separate appointments for scans and consultations on different days, there is a system of parallel clinics which run in the same vicinity at the same time. In order to ensure consistency of management, the team usually hold pre-clinic sessions so that more than one pair of eyes can look at the notes and decide who would be the most appropriate person to see the patient.

48. A number of circumstances appear to have combined which meant that the normal procedures were not followed in Ms C's case. First of all, Ms C had an emergency scan on Monday, 25 June 2001 and had to attend for her consultation two days later. I was informed that as some members of the team were on holiday, the pre-clinic session did not take place. Ms C was seen by Consultant 1 and, as already outlined, he did not have the benefit of Radiologist 1's written report. Had the pre-clinic session occurred, then it is possible that more than one person would have looked at the scan before deciding who was best placed to see Ms C. Mrs C said that she and her daughter had not expected to see Consultant 1 on that day and considered this to be out of the ordinary.

49. It would appear from the evidence gathered during interviews that absences on holiday may also have affected the likelihood of identifying discrepancies between two reports or spotting a report that was unexpected (in terms of the patient's medical history). Therefore, although Radiologist 1's

report went back to the department it does not appear to have been seen until Doctor 2 returned from holiday. The report was initialled before it was filed, but as it was not dated, it is not possible to identify exactly when the report was reviewed. Further, the discrepancy between Radiologist 1's interpretation and that of Consultant 1 was not identified at that stage.

50. In her response to my draft report, Mrs C noted that this picture of events was inconsistent with information contained in two separate letters she received from the Trust dated 11 October and 23 November 2001. For example, the second letter states that the pre-meeting for the Neuro-Oncology clinic (on 27 June 2001) did take place. Mrs C also raised concerns that the Radiologist's report may have sat in someone's in-tray for 4-5 weeks.

51. Given the length of time that has elapsed since the sequences of events, I do not consider that definitive answers can be given to these issues at this stage. The crucial factor is to ensure that systems are in place to avoid similar difficulties arising in the future. I address these matters in my recommendations to the Board.

52. From the evidence I have gathered I have reached the view that the system failed Ms C on this occasion. Although I have not been able to ascertain the precise reasons, it is clear that a number of factors combined in a way that meant that the differences in interpretation of her scan were not identified at the end of June 2001.

53. I do not uphold complaint (d) regarding the speed of reporting on emergency imaging and conveying reports to the relevant clinician. Two days for preparing a written report does not in itself seem unreasonable. However, not having clinical information available at the point of a consultation does contribute to clinical risk. In the absence of a written report, I would expect a consultant to exercise caution in interpreting the results of a CT scan, especially as in this case the patient's long-term prognosis was not considered to be good. I recommend that: the Board consider this point in reviewing the lessons that can be learned from this complaint; and consider whether their system of electronic record keeping and reporting can be used to reduce the time between the writing and typing of clinical reports.

54. I uphold complaint (e) relating to the review and filing of reports by clinicians. In this case the report was filed without being dated and without the

discrepancy between the two interpretations having been picked up. I recommend that the Board apologise to Mrs C for this shortcoming.

55. I was informed during my interview with Doctor 2 that a robust system is now in place and nothing is filed without being signed and dated; also that every effort is being made to make the process patient-centered. I commend the Board for what has been done to improve arrangements for filing and dating reports.

56. I consider that it was highly unfortunate that circumstances conspired in such a way that Ms C did not benefit from the procedures that are normally in place. I am critical, therefore, of the fact that what seems to be a good procedure can break down during holiday periods. I recommend that: the Board apologise to Mrs C for this shortcoming; review their current process for arranging holiday leave to ensure there is sufficient cover to maintain the high quality of care and service; and reinforce the importance of the pre-clinic sessions when shared care is being provided and ensure that they take place.

Third aspect of the complaint: (f) actions of the IRP Convener; and (g) the Trust's response to the IRP report

57. My Complaints Investigator reported to Mrs C that he had arrived at a preliminary decision that the Convener had exceeded his role by reaching a conclusion on both the merits of her complaint and the action that the Trust should take to address it. This was acknowledged by the Trust and they extended an apology to Mrs C in their letter dated 13 August 2004.

58. When Mrs C complained to my office in July 2003 she pointed out that she had not received the Chief Executive's response to the IRP report. This matter was pursued by my Complaints Investigator. While the Trust set out, in their letter dated 13 August, what they had done to implement the recommendations of the IRP, they did not explain why the Chief Executive did not write to Mrs C. My Complaints Investigator was critical of this failure as it was not in line with the Guidance on the NHS Complaint Procedure which was in place at the time. He, therefore, concluded that this was another example of the poor way in which the Trust had handled Mrs C's complaint.

59. Given these findings, I did not investigate these issues further. Based on the evidence identified by my Complaints Investigator, I uphold complaint (f)

regarding the actions of the IRP Convener and (g) relating to the Trust's response to the IRP report.

60. I recommend that the Board apologise to Mrs C for the failure of the Trust to write to her following their receipt of the IRP report and for their failure to explain why they did not do so.

61. I have not made any specific recommendations in respect of the Convener's action and the conduct of the Independent Review. This is because of the changes that have subsequently been made to the process for handling complaints about the NHS. With effect from April 2005 the Independent Review stage of the NHS procedure has been abolished. Instead, a complainant can now bring their complaint straight to my office if they remain dissatisfied after it has been through the internal complaints process of the NHS.

Fourth aspect of the complaint: (h) the conduct of a meeting between Consultant 1 and Mrs C which Mrs C's son and Ms C's father also attended on 29 August 2001

62. When I met with Mrs C and her son in November 2005, Mrs C explained to me that while her complaint was rooted in the dispute about the comments made by Consultant 1 at the meeting on 27 June 2001, she was also upset at the way her concerns were handled both prior to making a formal complaint and in the handling of her complaint thereafter. Specifically she raised concerns at the way in which Consultant 1 behaved at a meeting she had with him at which her son and Ms C's father were also present. Her expectation was that her questions would be answered at the meeting and there would be no need to pursue matters further.

63. Mrs C told me that she telephoned in advance to make arrangements for a special meeting with Consultant 1. She asked if she could tape record the meeting. Her reason for requesting this was that her daughter was not fit enough to attend the meeting but she wanted to hear the discussion. Mrs C had been informed by Clinical Nurse 1 that this would be possible. Mrs C said that she was, therefore, taken aback when Consultant 1 refused to let her tape the meeting. Mrs C was of the view that Consultant 1 then became very defensive and made reference to litigation and to the courts. The second thing that caused problems for Mrs C was that Consultant 1 had students present during the meeting, although she acknowledged that she raised no objection at the time. She did not think that the student's presence was appropriate, given

the nature of the meeting. At the meeting Consultant 1 reiterated his view that he had read her daughter's CT scan correctly. Mrs C left the meeting very dissatisfied and then lodged a formal complaint.

64. When I interviewed Consultant 1, I asked him for his version of events. He was not aware that Mrs C had sought prior consent for taping the meeting. The first he knew was when Mrs C produced a tape recorder. He accepted that he did not want the meeting to be tape recorded as he did not understand the reason for doing so.

65. With regard to the presence of students, Consultant 1 stated that he would, as a matter of course, have asked Mrs C and her family if they had any objections to the presence of students. He said that it was quite normal to have students present at clinics and he did not know that Mrs C had requested a special meeting. Therefore, he was unaware that the presence of students might not be appropriate.

66. With regard to his behaviour at the meeting, Consultant 1 said that while Mrs C's opinion was that he was defensive, he felt that she was quite aggressive. He considered that his explanations for what had happened at the consultation with Ms C on 27 June 2001 were accepted by her father and brother, but that Mrs C continued to be unhappy. He agreed that this meeting had achieved little in addressing Mrs C's concerns.

67. I pursued the issue of taping meetings and the involvement of students at sensitive meetings with Doctor 3 and with the Chief Executive. Doctor 3 explained that he had previously raised the issue of taping sensitive meetings between medical staff and patients and/or their relatives with the Executive Management Team. At that stage it was considered that the costs of doing so might be prohibitive. However, in the case of Mrs C, the point is that she sought permission to tape the meeting in advance. Yet, when she arrived at the meeting Consultant 1 refused to allow the meeting to be taped. This breakdown in communication was extremely unfortunate and added to the distress experienced by Mrs C. I am critical of the fact that, having made prior arrangements, Mrs C was not allowed to tape the meeting and that Consultant 1 was not made aware that such permission had been sought and agreed to. Neither was an explanation given to Mrs C regarding this matter.

68. Turning to the presence of students, it is not unusual for students to be present during consultations with patients. Doctor 3 stated that in certain circumstances, for example the sensitivity of the issues to be discussed or when handling a difficult complaint, it would be preferable to ask students to leave. Also, when doctors think they may have to handle a difficult situation, they may ask someone else to join the meeting. In this case, there was another breakdown in communication in that Mrs C had telephoned in advance to arrange what she thought was a special meeting with Consultant 1, while Consultant 1 was of the view that she had been given a routine appointment during his clinic.

69. It is unfortunate that what happened at this meeting appears to have led to a formal complaint rather than helped to resolve Mrs C's concerns. Therefore, an opportunity was missed. I am critical of the breakdown in communication prior to the meeting with regard to taping and the special nature of the meeting. If it was not possible for Mrs C to tape the meeting with Consultant 1 then this information should have been conveyed to her before she turned up. The dispute over taping meant that the meeting started off on the wrong foot. In addition, I do not consider it was good practice to allow students to be present at the meeting. Given the nature of Mrs C's concerns and the deterioration in her daughter's health by that time, it was likely that the meeting would be emotionally charged. This aspect is related to the failure to inform Consultant 1 that Mrs C has requested a special meeting. While I accept that there was a failure to communicate Mrs C's requests to Consultant 1, I am critical of the way in which he conducted the meeting. When he realised the nature of Mrs C's concerns, it would have been appropriate to ask the students to leave.

70. I uphold this aspect of the complaint. I recommend that the Board apologise to Mrs C for their failure to communicate her requests to Consultant 1, and that Consultant 1 apologise to Mrs C for the way in which he handled the meeting. I also recommend that the Board give further consideration to taping meetings that are likely to be highly sensitive and to issuing guidance to staff with regard to handling such meetings.

Summary conclusions and recommendations

71. This was a very sad case of a young woman who was diagnosed with an irrecoverable brain tumour in 1997. While she initially responded well to treatment and kept in relatively good health, her condition worsened in the summer of 2001 and she subsequently died in December 2001. Unfortunately

the distress suffered by her family was heightened by the fact that they believed that they had received a positive interpretation of a CT scan carried out in June 2001. The patient's mother, Mrs C, decided to pursue her complaint through the NHS procedure, an Independent Review and to my office because she considered that she had not received a satisfactory explanation for the events surrounding the death of her daughter.

72. I have investigated the different aspects of the case. I have reached the following conclusions and recommendations:

First Aspect of Complaint: (a) Consultant 1's comments during the consultation with Mrs C and Ms C on 27 June 2001; (b) Consultant 1's interpretation of the CT scan; and (c) explanations for differences in interpretation of the CT scan.

(a) and (b) Partially upheld.
Recommendation: Consultant 1 should apologise to Mrs C for the shortcomings I have identified.

(c) No finding.

Second aspect of the complaint: (d) speed of reporting on emergency imaging and conveying reports to the relevant clinician; and (e) review and filing of reports by clinicians.

(d) Not upheld.
Recommendations: the Board should consider the issue of the availability of clinical notes in reviewing the lessons that can be learned from this complaint; and whether their system of electronic record keeping and reporting can be used to reduce the time between the writing and typing of clinical reports.

(e) Upheld
Recommendations: the Board should apologise to Mrs C for the shortcomings identified; review their current process for arranging holiday leave to ensure there is sufficient cover to maintain the high quality of care and service; and consider the importance of the pre-clinic sessions when shared care is being provided and ensure that they take place.

Third aspect of the complaint: (f) actions of the IRP Convener; and (g) the Trust's response to the IRP report.

(f) and (g) Upheld
Recommendations: the Board should apologise to Mrs C for the failure of the Trust to write to her following receipt of the IRP report and for their failure to explain why they did not do so.

Fourth aspect of the complaint: (h) the conduct of a meeting between Consultant 1 and Mrs C which Mrs C's son and Ms C's father also attended on 29 August 2001.

(h) Upheld
Recommendations: the Board should apologise to Mrs C for their failure to communicate her requests to Consultant 1, and Consultant 1 should apologise to Mrs C for the way in which he handled the meeting. I also recommend that the Board give further consideration to taping meetings that are likely to be highly sensitive and to issuing guidance to staff with regard to handling such meetings.

73. I fully understand why the family considers that if there had not been this delay of eight weeks that Ms C's life may have been extended beyond 6 December 2001. Having considered this matter, I do not feel able to comment as to whether this extension of life would have been possible. However, having taken clinical advice, I am satisfied that the eventual outcome, namely the death of Ms C within a relatively short period, was inevitable.

74. In addition there are wider lessons that can be drawn from this particular complaint. The first relates to the way in which Mrs C's initial concerns were dealt with, the handling of the formal complaint at its early stages and the lack of a proper internal investigation. Also if the team had met with Mrs C and had been more open and less defensive in providing an explanation and offering an apology it is likely that the complaint would not have arisen and escalated in the way that it did. The power of making an apology in such circumstances should not be under-estimated. It is evident that what had been a positive relationship between members of the team and Mrs C broke down when the difficulties arose and communication was poor.

75. Secondly, the opportunity was missed to identify and address the failures in procedures and processes over the holiday period and to help ensure that other patients would not be affected in a similar way in the future. It has not been possible to clarify all the events particularly in relation to the pre-clinic meeting and the review and filing of Radiologist 1's report. It is vital, therefore, that there is confidence that the new procedures and processes in place will reduce the risk of a recurrence.

76. A further lesson that can be learned, which extends beyond this particular Board, relates to the issues surrounding joint care and who has overall responsibility for a patient at different points in the treatment provided. There are obvious advantages of a team approach to treatment and care and it is clear that, prior to the events of June 2001, Ms C very much benefited from this approach. This case has, however, highlighted an important point relating to minimising risks that can occur when different people are involved in the patient's journey. In such circumstances, good communication and record keeping are essential.

77. Finally, I wish to apologise to Mrs C for the time taken by my office in its initial handling of her complaint. Lessons have been learned and improvements made to our processes. I hope that Mrs C is satisfied that the matters she raised have now been investigated fully.

30 May 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Ms C	Mrs C's daughter who died on 6 December 2001
Clinical Nurse 1	The Clinical Nurse Specialist who responded to Mrs C's telephone message in August 2001
Consultant 1	Consultant neurosurgeon who performed the operation on Ms C in 1997 and against whom aspects of the complaint by Mrs C have been made
Doctor 1	The doctor who saw Ms C at a routine clinic on 20 June 200l; and again at the clinic on 8 August 2001 and who arranged for her to have an MRI scan
Doctor 2	The doctor who saw Ms C on 20 August 2001 and gave her the results of her MRI scan
Doctor 3	Medical Director, NHS Lothian
Principal Nurse 1	Principal Nurse/Assistant General Manager of the Surgical and Associated Services Division of the Trust
Radiologist 1	The radiologist who performed the CT scan on 25 June 2001

Annex 2

Glossary of terms

CT scan	Computerized tomography scan: Pictures of structures within the body created by a computer that takes the data from multiple X-ray images and turns them into pictures
MRI scan	Magnetic resonance imaging: A special radiology technique designed to image internal structures of the body using magnetism, radio waves, and a computer to produce the images of body structures
PCV chemotherapy	A chemotherapy regimen consisting of three drugs for the treatment of brain tumour