Case 200500775: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category
Health: Hospitals; Clinical treatment

Overview
The complainant (Mrs C) raised a complaint that Greater Glasgow and Clyde NHS Board (the Board) failed to provide a satisfactory explanation into why, after an operation to remove part of his lung, her husband's condition rapidly and unexpectedly deteriorated, leading to his death. Additionally, she was concerned that a post-mortem had not been carried out and that the Death Certificate did not appear to be correctly completed. Mrs C pursued her complaint through the NHS complaints system. When she received the final response to her complaint she remained dissatisfied with the outcome and further aggrieved at the time taken to investigate her complaint.

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) Mrs C has never been given a satisfactory explanation for the cause of her husband's death *(upheld)*;

(b) a post-mortem examination was not performed and that the Death Certificate was not correctly completed *(upheld)*; and

(c) the investigation of the complaint was delayed unsatisfactorily *(upheld)*.

Redress and recommendations
The Ombudsman recommends that the Board:

(i) carry out a review of their record keeping in respect of clinical treatment and of how clinicians communicate with patients and their relatives;

[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

(ii) carry out a review of their procedures in respect of requesting post-mortem examinations and the completion of Death Certificates and consider training requirements to ensure staff are aware of their responsibilities in this area; and

(iii) provide a full written apology to Mrs C and her family for the failures identified with regard to heads (a) and (b) of the complaint.

Main Investigation Report

Introduction

1. On 2 March 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) that Greater Glasgow and Clyde NHS Board (the Board) failed to fully disclose the reasons behind the unexpected death of her husband (Mr C), that they failed to address the issues raised via their own complaints procedure in a timely manner, and that, as a result of this, the Board had prolonged the stress and upset caused to Mr C's family.

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

(a) Mrs C has never been given a satisfactory explanation for the cause of her husband's death;

(b) a post-mortem examination was not performed and that the Death Certificate was not correctly completed; and

(c) the investigation of the complaint was delayed unsatisfactorily.

Background

3. Mr C was admitted to the Cardio-Thoracic Unit on 7 August 2002 in preparation for a lower left lobectomy as a result of a diagnosis of bronchial carcinoma. It had been decided that this form of treatment was more appropriate in this case than chemotherapy. The operation took place on 8 August 2002 with initially, what appeared to be, satisfactory results.

4. On 10 August 2002 Mr C reported that he was feeling increasingly unwell. The next day he was suffering from constipation and vomiting and had become somewhat vague and agitated. His condition deteriorated over the next few days and as a result of the deterioration in his respiratory function, he was transferred to the Intensive Therapy Unit (ITU) on 14 August 2002.

5. Mr C's condition continued to deteriorate despite ongoing treatment with antibiotics, diuretics and dialysis until, on 22 August 2002 he sadly died. The Death Certificate initially gave the cause of death as 'multi organ failure and septicaemia'

6. On 29 August 2002 Mrs C first raised her concerns about her husband's

treatment in a telephone call to the hospital. She then proceeded to pursue her concerns through the NHS Complaints Procedure. The informal resolution stage was exhausted after a meeting on 10 December 2002 and Mrs C requested that an Independent Review Panel (IRP) be set up to consider her complaint.

7. The IRP met on 24 March 2004. The Terms of Reference agreed at the panel and approved by Mrs C were: 'To determine, if possible, the most likely cause of septicaemia setting in after surgery and to establish whether the treatment for it was appropriate'.

8. During the course of the IRP Mrs C stated her main concerns to be:

- The cause of the diarrhoea and vomiting
- The post-mortem examination
- The Death Certificate
- The origin of the infection

9. The overall conclusions of the IRP were:

- From a clinical perspective, everything possible had been done for Mr C and that the treatment given had been satisfactory.
- The case records were incomplete. Recording of clinical observations were patchy, laboratory results, particularly relating to microbiological investigations were not filed or noted adequately, treatment decisions and their rationale were not recorded adequately and communication with relatives was seldom recorded in the case notes.
- It was not clear who was the point of reference for the family to talk freely and address questions. It was apparent that they talked to many health professionals, but that only generated confusion regarding the explanations concerning the infection process and about the decisions for transferring to intensive care. Had there been a 'point of reference' person identified this may have alleviated this problem.

10. The IRP went on to recommend to the Board that the Medical Director and the Director of Nursing examine their findings and recommendations to prevent a recurrence of these issues in the future.

Investigation and Findings

11. In investigating Mrs C's complaint, I have reviewed correspondence from her and the Board. I have obtained the clinical records and complaints file from the Board and have sought professional advice from an Independent Clinical Adviser (the Adviser). In addition to the main points raised in the complaint, I have asked the Adviser to consider whether the clinical care provided to Mr C was appropriate for his condition. I have set out, for each of the three main headings of Mrs C's complaint, my findings of fact, and conclusions.

12. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The Board and Mrs C have both had the opportunity to comment on a draft of this report.

(a) Mrs C has never been given a satisfactory explanation for the cause of her husband's death

13. I have sought advice from the Adviser on whether there was an acceptable level of communication during the course of Mr C's illness and subsequent to his death. The Adviser and I agree with the findings of the IRP in this regard. The Adviser states in his report that 'Clinical record-keeping is poor in these case notes. There is scanty documentation of clinical findings, medical decision-making and communication with relatives.'

(a) Conclusion

14. There was clearly a failure on the part of the clinical and nursing staff to plan for effective communication when dealing with the relatives of Mr C and in particular Mrs C. This impacted negatively on the explanation for the cause of Mr C's death.

15. It is appreciated that once a complaint had been registered with the Board, further attempts were made to provide full and satisfactory explanations regarding the circumstances behind Mr C's death, this culminated in the IRP. By this time, however, it is clear that the family's trust in the Board had been lost. It was, therefore, possible that at this stage any explanation provided by the Board would not be accepted. Had communication been better prior to Mr C's death, this situation may not have arisen.

16. Taking into account the Adviser's views and the findings of the IRP I uphold this

complaint.

17. Further, the Ombudsman agrees with the recommendations made by the IRP and requests details from the Board of what actions have been taken by the Medical Director and Director of Nursing in light of the findings of the IRP.

(a) Recommendation

18. The Ombudsman recommends that the Board carry out a review of their record keeping in respect of clinical treatment and of how clinicians communicate with patients and their relatives.

(b) Failure to perform a post-mortem examination and incorrect completion of the Death Certificate

19. Mrs C's daughter (Ms C) explained to the IRP that after collecting the Death Certificate she took it to their GP who advised that it had not properly been completed. It did not include the consultant's name, did not clearly state the secondary cause of death and did not mention the surgery. After returning the certificate to the ITU it was completed, however, there was still no mention of the surgery.

20. The Adviser has considered whether the information provided on the Death Certificate was appropriate. Assuming the clinicians were clear as to the cause of death being infection then the Adviser considers the appropriate details on the certificate should have read:

ia Death due to multi-organ failure secondary to
ib Sepsis.
ii Carcinoma of the lung (operated).

21. The question of whether a post-mortem should have been carried out has been examined both in the informal resolution stage of the complaint handling and by the IRP. At the meeting held on 10 December 2002, as part of the informal resolution process of the complaint handling, Mr A, the Consultant Anaesthetist stated that a post-mortem would have been unlikely to discover the cause of the infection which resulted in Mr C's death. He explained that they had been unable to identify the organism when conducting tests when Mr C was alive and as such, it was very

unlikely they would be able to establish it after death. He did, however, concede that in hindsight, a post-mortem examination may have been beneficial in establishing the cause of death.

22. The IRP concluded that a post-mortem examination would not have been helpful in establishing the exact nature of the infection.

23. It is the opinion of the Adviser that such an examination should have taken place. He states: 'It is possible that a post-mortem may have assisted in establishing the cause of death and if the cause of death was infection, it may have shown the original origin. Indeed there may have been intra-abdominal pathology which resulted in the initial signs and symptoms of diarrhoea, vomiting and constipation …'.

(b) Conclusion

24. The Death Certificate should have been fully completed prior to being given to relatives. The additional upset caused by having to return to request correction to the certificate would do nothing to increase the relatives' confidence in the care given to Mr C. Whilst I appreciate that there are often variations in how Death Certificates are completed, because of the failure to fully complete the Death Certificate initially and also when it was returned, I uphold this aspect of the complaint.

25. On the basis of the advice I have received, I uphold Mrs C's complaint that a post-mortem examination should have been carried out.

(b) Recommendations

26. The Ombudsman recommends that the Board review their procedures in respect of the completion of Death Certificates and provide further guidance to staff on this subject. The Ombudsman also recommends that the Board review their procedures in respect of requesting post-mortem examinations and consider training requirements to ensure staff are aware of their responsibilities in this area.

(c) The investigation of the complaint was delayed unsatisfactorily

27. On 29 August 2002 Mrs C raised concerns about her husband's treatment in a telephone call to the hospital. On 3 September 2002 she then contacted the

Patient Liaison Manager at the hospital to register her concern and to request an explanation into issues arising from her husband's death. Her daughter, Ms C, also raised her concerns in writing in a letter which was received on 12 September 2002.

28. A response to Mrs C's complaint was issued by the Divisional Nurse on 26 September 2002 offering a meeting with clinical staff should she still have outstanding concerns. This letter was also copied to Ms C. Both Mrs C and Ms C wrote to the Patient Liaison Manager to confirm that they remained dissatisfied with the response. Mrs C subsequently contacted the Patient Liaison Manager asking for an IRP to be set up to review her complaint. On 30 October 2002, the Patient Liaison Manager replied offering a meeting to discuss the outstanding concerns.

29. A meeting took place between Mrs C, members of her family, and medical staff on 10 December 2002 to discuss the care and treatment provided to Mr C. Following this meeting, on 10 January 2003, Mrs C contacted the Patient Liaison Manager by letter advising that she still had unanswered concerns about her husband's treatment and that she now wanted an IRP to consider her complaint. A response to this letter was issued on 17 January 2003 advising that her request had been passed to the Trust headquarters for actioning. On 21 January 2003 the Corporate Affairs Officer at the Trust headquarters contacted Mrs C to advise that her papers relating to the complaint would be forwarded to the Convener to decide whether an IRP would be established.

30. The IRP Hearing took place on 24 March 2004. Almost one year later, on 2 March 2005, Mrs C contacted the Ombudsman's office as she had not received the final report. After informal contact with the Board, Mrs C was advised that she should wait for the final report before bringing the complaint to the Ombudsman and had been advised that this would be issued shortly. On 7 April 2005 the draft IRP report was issued for comment which Mrs C subsequently made on 19 April 2005. The final report was issued to Mrs C on 29 June 2005 along with apologies for the delay.

(c) Conclusion

31. The time between the initial complaint to the Board on 29 August 2002 and the issuing of the final report of the IRP on 29 June 2005 was clearly unacceptable.

The delay in responding to the complaint related to the time it took to consider whether an IRP would be established and to the time taken by the IRP itself. There was also a substantial delay in reporting the results of the Review. I, therefore, uphold this complaint.

32. In April 2005 the NHS Complaints Procedure was changed to remove the IRP stage of the Procedure. Once the local resolution stage of the complaints process has been exhausted, complainants can now bring their complaint direct to the Scottish Public Services Ombudsman's Office.

(c) Recommendation

33. There were delays in dealing with the complaint as outlined. However, in light of the changes in the NHS Complaints Procedure since this complaint was made, and in light of the apologies already given by the Board for these delays, the Ombudsman makes no recommendations on this point.

Clinical Care

34. I have not investigated the clinical treatment provided to Mr C, however I am aware that this is a matter of concern to his family. For this reason I am including the following comments in my report in the hope that they offer some reassurance.

35. The IRP did examine whether the clinical treatment was appropriate and reported: 'The panel wish to emphasise that from a clinical perspective everything possible had been done for Mr C and that the multi disciplinary approach between surgeon, intensivists and bacteriologists was entirely satisfactory and adequate.'

36. The Adviser is of the opinion that the conclusion of the IRP in respect of the clinical treatment was correct. The Adviser states: 'On review of the complaint file and clinical records I believe that the clinical treatment provided to Mr C both for his lung cancer and for his subsequent deterioration into multi-organ failure was appropriate and of an adequate standard. I can find no serious errors of judgment in his clinical care ...'.

29 August 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Mr C	The complainant's husband
Ms C	The complainant's daughter
ITU	Intensive Therapy Unit
The Adviser	Independent Clinical Adviser
Mr A	Consultant Anaesthetist
IRP	Independent Review Panel

Annex 2

Glossary of terms

Bronchial Carcinoma	Lung Cancer
Lower left lobectomy	Removal of the lower left lobe of the lung
Sepsis	The presence of pathogenic organisms or their toxins in the blood
Septicaemia	As for sepsis
Intra-abdominal pathology	Disease of the abdomen