Scottish Parliament Region: Glasgow

Case 200603139: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; complaints handling; medical care and treatment

Overview

The complainant (Ms C) complained about the care and treatment she received while attending Inverclyde Royal Hospital (the Hospital) on 8 June 2006. She also complained that Greater Glasgow and Clyde NHS Board (the Board) failed to satisfactorily respond to her in good time, following the concerns she raised about the care and treatment she received from the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms C received inadequate care and treatment from the Hospital on 8 June 2006 (*partially upheld to the extent that there were failings in obtaining consent and in communicating with her regarding the administering of the local anaesthetic (LA)*);

(b) the Board's final response, dated 5 June 2007, did not address Ms C's complaint satisfactorily (*upheld*); and

(c) the Complaints Department of the Board failed to respond to Ms C in good time, after she complained to them about the care and treatment she received at the Hospital she attended for recurring breast cancer surgery (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Ms C for the way in which the decision to administer the LA was communicated to Ms C;

(ii) remind staff of the correct procedures to be followed when obtaining consent prior to surgery taking place;

(iii) apologise to Ms C for their unsatisfactory final response to her complaint; and

(iv) apologise to Ms C for the delay in responding to her complaint.

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

Main Investigation Report

Introduction

1. The Ombudsman received a complaint from Ms C, who attended Inverclyde Royal Hospital (the Hospital) on 8 June 2006 to undergo surgery for recurring breast cancer. According to Ms C, she received unsatisfactory care and treatment from the Hospital on that day. In particular, Ms C said she was given a local anaesthetic (LA) by the Hospital doctor (Doctor 1) who performed the operation. She said she had not received the general anaesthetic (GA) she had been told she would receive, by a doctor at the clinic she attended on 22 May 2006, (Doctor 2) who diagnosed this surgery as necessary. Furthermore, Ms C said that the operation performed by Doctor 1 on 8 June 2006 by LA was traumatic and painful. Ms C stated she was also upset by the offhand manner she felt Doctor 1 displayed towards her, during and after her operation.

2. On 27 July 2006 Ms C formally complained to a Complaints Manager at the Hospital (the Manager) about the events which occurred on 8 June 2006. During this period of the complaints process, Greater Glasgow and Clyde NHS Board (the Board) acknowledged their delay in responding to Ms C's concerns. Thereafter, the Director of Acute Services (the Director) responded to Ms C's complaint on 15 November 2006.

3. However, Ms C was dissatisfied with this reply and a meeting was arranged between herself, the Manager and the Hospital Consultant Surgeon (the Consultant) on 6 December 2006. Ms C remained dissatisfied after this meeting and she wrote to the Complaints Department on 31 December 2006 about this. Ms C did not receive a reply to her complaint letter until 6 June 2007. In Ms C's view, the Board's response to her complaint was both delayed and unsatisfactory.

4. The complaints from Ms C which I have investigated are that:

(a) Ms C received inadequate care and treatment from the Hospital on 8 June 2006;

(b) the Board's final response, dated 5 June 2007, did not address Ms C's complaint satisfactorily; and

(c) the Complaints Department of the Board failed to respond to Ms C in good time, after she complained to them about the care and treatment she received at the Hospital she attended for recurring breast cancer surgery.

Background

5. In accordance with the NHS Complaints Procedure, a complaint should be acknowledged within three days and fully responded to within 20 working days. Thereafter, another 20 working days can be allowed for further investigative enquiries to be made. After this period has lapsed, agreement for any further extension of time has to be reached between the complainant and the Board.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Ms C and the Board. I have had sight of the Board's complaint file and Ms C's medical records. Advice was also obtained from the Ombudsman's medical adviser (the Adviser) who reviewed all relevant documentation and medical records.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms can be found at Annex 2. A timeline of correspondence between Ms C and the Board is outlined at Annex 3. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Ms C received inadequate care and treatment from the Hospital on 8 June 2006

8. In her initial complaint letter to the Board dated 27 July 2006, Ms C raised concerns about the medical care and treatment she had received as a patient at the Hospital on 8 June 2006. She said that, on that day, she had attended the Hospital for an operation for recurring breast cancer and she had been told previously that this surgery would be performed under GA (see paragraph 1).

9. Prior to this, on 22 May 2006, Ms C attended the Hospital Breast Clinic (the Clinic) as an out-patient and was told that the cancer she had had removed by mastectomy 11 years previously had returned. According to Ms C, Doctor 2 told her that she would need surgery under GA, as a large amount of tissue required to be taken. On 8 June 2006 Ms C was admitted to the Hospital for the operation and, as Doctor 2 told her she would receive a GA, Ms C had not consumed any food or drink since the previous night.

10. Ms C said:

> ‘[On 8 June 2006] a different doctor [Doctor 1] came to me and said it was a simple op. And he would do it by [LA] as it would be better for me. No-one ever came during the hours waiting to talk to me about it, and eventually at about 2.30 I was taken to the operating theatre. The same doctor said 'you have decided to have a [LA]'. I thought it had already been decided, so said nothing. After inserting several needles he started to cut and I called out. He asked what was the matter, and I told him I could feel it. I said it was pain and it felt like a knife. He said he would put some more needles in and did so. It was about 45 minutes later that he finished and I could feel him scraping on my bones. It was quite traumatic.’

11. Ms C stated that she left the Hospital the following morning and, as she continued to suffer a lot of pain, she was prescribed paracetamol by her GP.

12. Ms C’s complaint centred on the following two key areas:

(a) that no-one had told her about the change of plan to perform her operation under LA instead of GA, as she had expected (see paragraph 8); and

(b) that the operation was traumatic and painful and caused her great distress (see paragraphs 1 and 10).

13. The Adviser noted that Ms C had a mastectomy for right sided breast cancer 11 years previously (1995).

14. He observed from the Hospital records that, on 22 May 2006, Ms C was seen at the Hospital by Doctor 2 (a staff grade in the Clinic) and diagnosed with a nodule in the mastectomy scar. The Adviser considered statements made by Doctor 2 in a clinical letter dated 22 May 2006. He had outlined the need for ‘an excision of the nodule’ and in order to get a ‘good wide local excision’ he noted it would be worthwhile doing it under GA. Furthermore, the Adviser noted that, according to this letter, Ms C had agreed to this. I have seen this letter, dated 22 May 2006, from Doctor 2 addressed to Ms C’s GP. Doctor 2 stated:

> ‘I have explained to [Ms C] that we would need to do an excision of the nodule so as to get a full firm diagnosis and would therefore need to re-stage her again. In order to get a good wide local excision I think it is worthwhile to do this under [GA] rather than a [LA]. I have fully informed her of the diagnosis and the planned intervention. She is happy to go ahead with this.’

15. The Adviser noted that the next recorded entry, dated 8 June 2006, outlined that Ms C had been clerked in as for a surgical patient and had an abdominal ultrasound that day. Additionally, the procedure for removal of the nodule appeared in the medical notes from theatre. The signature was Doctor 1 and he described the removal of a small nodule from the old scar and wound closure with vicryl sutures and subcuticular sutures to the skin (see paragraph 31). No further comments were recorded by Doctor 1 and, according to the Adviser, this suggested that the procedure was uneventful.

16. Following this procedure, the Adviser observed that the pathology report described an elliptical 38mm x 15mm skin specimen with 10mm depth of fatty tissue and 20mm x 13mm of muscle beneath this.

17. The Adviser noted that entered on the consent form was 'wide local excision of nodule right breast' and signed by Ms C and a junior house officer (the JHO) on 8 June 2006 alongside the section which confirmed that an explanation of the procedure and the type of anaesthetic available had been given. I have seen the consent form and note that alongside the entry 'description of type of operation, investigation or treatment' was added in handwritten script, 'at site of ® mastectomy scar'.

18. From the medical records, the Adviser noted that the intraoperative and recovery notes were complete and stated '[they] certainly do not suggest any untoward distress or abnormality'. Furthermore, the recovery chart also suggested Ms C was comfortable and not in pain. The Adviser stated that, in his experience, it would have taken a serious untoward event to have warranted any additional recording being entered 'as free text', on this type of pro forma record.

19. The Adviser observed that Ms C remained in the Hospital overnight although, in his view, he felt this was not planned. He also observed that, according to Ms C, she said she was in pain overnight and was unable to sleep.

20. The Adviser noted that Ms C was discharged home the following day, on 9 June 2006, with a supply of Co-codamol tablets which she had been given regularly and appropriately on the ward for post-operative pain.

21. On 19 June 2006 Ms C attended a post-operative consultation at the Hospital with Doctor 2, who told her that her nodule was malignant. Thereafter,

Consultant 2 told Ms C that her follow-up treatment was planned in the Oncology Clinic.

22. Subsequently, Ms C attended an out-patient clinic at the Hospital on 27 June 2006 at her own request, because she detected the presence of a lump in the lateral part of the scar which had formed following her operation on 8 June 2006 (see paragraph 15). It was diagnosed that she required a fine needle aspirate of the scar. I have seen the letter dated 27 June 2006 from the Clinic addressed to Ms C's GP, which outlined that Ms C was advised that this procedure had shown a fat necrosis.

23. The Adviser considered the feasibility and indications for performing Ms C's procedure under LA (see paragraph 12(a)). He said that there were advantages, in terms of recovery and less systemic upset, if a procedure can be performed under LA. In his view there were no absolute or relative contra-indications to a GA for Ms C and there did not appear to be reasons, either social or clinical, for Ms C not to have a GA. Nevertheless, the Adviser stated there are definite advantages to the patient and to the operating theatre throughput, for administering LA 'provided the correct surgical objective is achieved – in this case adequate removal of tissue for a diagnosis and prevent local tissue breakdown and possible ulceration.'

24. In the Adviser's view it was a relatively small lesion for removal and, accordingly, it should have been technically possible to remove such a tissue mass without great discomfort. He stated:

> 'the 15 ml volume of local anaesthetic of 1% lignocaine that is described in the operation note could have been theoretically adequate, if applied in an accurate and timely fashion. As the solution contained adrenaline, [Doctor 1] could have been more generous with the volume and, with care, used even up to 30 mls. The failure of this technique would more likely be due to inadequate time for the anaesthetic to work. The time of the onset of analgesia is not recorded. If the lignocaine had been infiltrated some time prior to skin preparation and draping of the surgical site, there might have been sufficient time for anaesthesia to be effective.'

25. The Adviser noted that Ms C said that the procedure took 45 minutes, however, due to this information not being recorded in the theatre documentation, the Adviser could not confirm this. He stated 'It is possible that

lignocaine would require additional infiltration after this time as it is relatively shorter acting and the LA effect could possibly be wearing off'.

26. Nevertheless, the Adviser said that even the best applied LA can still allow a degree of sensation such as gross movement – pulling and tugging. He said:

> 'The sharp pain nerves will be blocked, but not nerves carrying sensation of movements. In a nervous dehydrated patient who has not had an adequate explanation of exactly what sensations to expect, and one who has lost confidence in the process, there is likely to be an increased level of discomfort, which might be perceived as increased pain or (even more frightening) the anticipation of worsening pain.'

27. The Adviser considered the issues of communication and consent and said that informed and valid consent for any procedure should include a discussion of the type of anaesthetic being considered. He noted that the JHO had signed a form to the effect that such an explanation had been given to Ms C (see paragraph 17).

28. In the Adviser's view, however, there was no reason for Ms C to have thought that she would have anything other than a GA, leading up to the surgery. She had been told this at the clinic of 22 May 2006 by Doctor 2 (see paragraph 14); she had been admitted ready for an overnight stay; and, according to the medical records, she had undergone the full pre-operative ritual that included being held 'nil by mouth'.

29. The Adviser considered that it is unclear at what point Ms C realised the lump was to be removed under LA. Ms C had noted Doctor 1's comments regarding LA prior to the procedure (see paragraph 10), however in the Adviser's view, Ms C had no opportunity to challenge it and so it appeared as if she did not fully realise this implication until, according to the Adviser, '[Ms C] was on the table'. The Adviser said theatre staff had assumed Ms C's implied consent, as she had not objected up to that point.

30. According to the Adviser, 'miscommunication is further highlighted by a reported comment made by [Doctor 1], when he suggested that [Ms C] herself had decided on a LA'. The Adviser said 'As she was under the surgical drapes there was little chance for questioning. This will have added to her fears and the vital element of patient cooperation and confidence will have been reduced'. In the Adviser's view he considered that an opportunity was missed post-

operatively to restore this trust. Doctor 1 did talk to Ms C, however, Ms C did not feel this was sufficient to reassure her either as to the conduct or the findings of the procedure.

31. The Adviser considered the issue that Ms C's operation was described as minor surgery (see paragraph 43) and stated it was accurate to describe superficial surgery, such as not invading a body cavity or joint and with minimal physiological disturbance, as being minor. Although he commented that, to a patient being on the receiving end of surgery, with the unpleasant association of cancer, there was no such thing as minor. In any audit, theatre classification, operative coding or risk classification, Ms C's operation would be classified as minor surgery, when used in a dispassionate and clinical sense.

32. The Adviser observed that it was recorded that the type of procedure necessary for Ms C had been discussed at a prior multi-disciplinary team meeting. Furthermore, in his view, the technical level of expertise needed for such a procedure would be well within the surgical capabilities of someone working in the capacity of a surgeon of the level of a staff grade surgeon. I have seen an internal memo, dated 14 March 2007, from the Clinical Services Manager Surgery and Anaesthetics (the Clinical Manager) that stated '[The Consultant] discussed [Ms C's] case at the Multi-disciplinary Team meeting which was attended by the Surgeons, the Nurse Specialist and the Oncologist.'

33. The Adviser considered that the photograph submitted of Ms C's post-operative site showed bruising and stated this was not an indicator of surgical skill or finesse. Furthermore, he said that 'elderly patients will bruise easily and it is illogical to assume that the bruising would be any less under a GA'.

34. According to the Adviser, there had clearly been failings in consent process and some technical aspects, which caused patient discomfort. He considered that the only documented evidence of a pre-operative discussion which included Ms C, was within the clinical letter of 22 May 2006 from Doctor 2 to Ms C's GP, which referred to assurances being given to Ms C that she would receive a GA because of the need for a 'wide excision'. In his view, the Adviser considered that Ms C had understandably taken 'wide' to mean 'large' as she later referred to this as such. The Adviser stated this would have increased Ms C's fears (see paragraph 14).

35. The Adviser noted the minutes of the meeting held on 6 December 2006 and said that the Consultant appeared to recognise some failings of Doctor 1 regarding his communication skills and attitude and, in his view, the Consultant readily accepted the need to speak to Doctor 1. I have seen the minutes and it was stated that the Consultant accepted that there had been communication errors during Ms C's treatment. The Consultant had assured Ms C that he would speak to Doctor 1 regarding his attitude and communication skills. He also noted the Consultant apologised if Ms C was not fully consulted regarding the type of anaesthetic being used and assured Ms C that he would further discuss the matter with Doctor 1.

36. The Adviser considered the consent form signed by the JHO and said this would only form part of a valid consent process if that individual is capable of fully explaining all elements of the procedure (see paragraphs 17 and 27). As there was confusion as to what this exactly was, then this cannot be valid informed consent.

37. The Adviser stated 'Breast surgeons and their teams can be the most supportive and reassuring groups recognising the vulnerability of their patients'. However, according to Ms C, she had undergone a painful surgical procedure, with the discomfort augmented by very indifferent attitude from her carers on that day.

(a) Conclusion

38. I have read carefully all the relevant paperwork and I support the Adviser's view that, taking into account that Ms C had been told to expect a GA and had experienced the pre-operative procedure, when she was advised of Doctor 1's decision to give her a LA, she had no opportunity to challenge this and a LA was administered (see paragraph 29). Thereafter, when the operation followed, her fears increased and her confidence in the process was reduced (see paragraph 30).

39. When the issue of consent is considered, I agree with the Adviser that the signed consent form only becomes part of valid consent if the individual taking consent has fully explained all elements of the procedure to be undertaken to the patient. The advice I have received is that there was evidence of confusion as to what Ms C gave her consent to, therefore her consent cannot be considered as valid informed consent (see paragraph 36).

40. The Consultant made a statement on 6 December 2006 that he would discuss further with Doctor 1 the issue of the type of anaesthetic he used on Ms C and speak to him, regarding his attitude and communication skills. I share the Adviser's view that, given these proposed actions, there was a recognition that failures in communication had occurred.

41. I have identified concerns about the issue of obtaining consent, and the failure of communication with Ms C on 8 June 2006, regarding the administration of the LA. Taking these factors into account I partially uphold this complaint, to the extent that there were failings in obtaining consent and in communicating with Ms C regarding the administration of the LA.

(a) Recommendations

42. The Ombudsman recommends that the Board apologise to Ms C for the way in which the decision to administer the LA was communicated to her; and remind staff of the correct procedures to be followed when obtaining consent prior to surgery taking place.

(b) The Board's final response, dated 5 June 2007, did not address Ms C's complaint satisfactorily; and (c) The Complaints Department of the Board failed to respond to Ms C in good time, after she complained to them about the care and treatment she received at the Hospital she attended for recurring breast cancer surgery

43. On 27 July 2006 Ms C complained to the Hospital about her care and treatment. From 31 August 2006 to 12 October 2006, the Manager advised Ms C there were delays in finalising the Board's reply to her complaint (see Annex 3). Thereafter, Ms C received the Board's response dated 15 November 2006, however, she remained unhappy with this and a meeting was subsequently arranged for 6 December 2006, attended by Ms C, the Manager and the Consultant. Ms C was dissatisfied when she reflected on the outcome of this meeting. In her complaint letter to the Manager dated 31 December 2006, Ms C stated she felt there remained more questions than answers. She also outlined several of her concerns which included the use of medical speak; her operation being described a minor surgical procedure; being told she would receive a GA when she received a LA; and that she considered there were communication issues.

44. According to Ms C, the final reply she received to her complaint dated 5 June 2007 was inadequate and she stated 'this letter could have been written

almost a year ago and does not deal with my complaint at all' (see paragraphs 2 and 3).

45. I have seen the Board's reply dated 5 June 2007 and, although I observed that an apology was given to Ms C for their delay in replying to her, a note of the meeting between Ms C, the Consultant and the Manager that took place on 6 December 2006 was not enclosed as was referenced. Within the letter it stated that Doctor 2 had confirmed that he said Ms C was to receive a GA and that Doctor 1 said he decided to use a LA (see paragraphs 14 and 15). Thereafter, it stated 'There is no steadfast policy regarding the type of anaesthetic used in surgical procedures. This is an individual preference by doctors'. The apology read 'I apologise if your care and treatment at [the Hospital] was less than expected'.

46. As part of my enquiries I wrote to the Board on 22 October 2007 and I received their reply which included a timeline of Ms C's contacts with the Board, on 12 November 2008 (see Annex 3).

47. In his reply to me, the Corporate Administration Officer (the Officer) outlined a statement he had received from the Complaints Department:

> 'it is evident that there has been a significant delay in [Ms C's] overall response being provided. There were many contributing factors to this scenario, in particular, long-term staff sickness absence and annual leave. It is also evident that the bring-forward system in place was not robust. Hence this particular file was placed in another filing cabinet, outwith the normal bring forward system within the office. As a result of this and human oversight, there was a significant delay in the meeting notes and overall response being written. As a further result of this, holding letters were not always issued at the appropriate time. On reflection and review, it is recognised and accepted by the Complaints Department that systems in place were inadequate. Since processing this complaint, systems have been reviewed and modified to reduce the possibility of a recurrence.'

48. Thereafter, the Complaints Department had incorporated a detailed action summary as follows:

- 'Complaints Department Staff given an opportunity to review and reflect on current practice and help develop action plan.
- Daily manual bring forwards will be undertaken by the Complaints Administrator with direction and support from the Complaints Managers,

who now have responsibility for a defined workload (attached to Directorates). Electronic bring forward system generated by Datix to be printed off daily to support manual system by identifying actions required to be taken.

- Complaint Managers now have responsibility for service areas, which allows clearer continuity of the administration of individual complaints and ensures that appropriate priority is given to workload. The reason for delay in holding letter will be more clearly defined by the Complaints Administrator under the guidance of the Complaint Manager.
- Regular system review meetings to be set up fortnightly specifically to review practice and reinforce improvements required for maximum performance.'

49. Within the complaint correspondence I received from Ms C, I have seen copies of the letters she wrote to, and the replies she received from, the Board (see Annex 3 and paragraph 6). Additionally, in Annex 3 I have included a supplementary timeline which takes account of the period when Ms C first complained to the Board that commenced from 27 July 2006.

(b) and (c) Conclusion

50. Ms C's complaint to the Hospital (about the inadequate care and treatment she received there), failed to elicit a final response from the Board in good time. Furthermore, when she received this response, it did not adequately address her complaint.

51. Given the evidence outlined above, and having carefully reviewed the relevant documentation, it is clear that the Board failed to respond to Ms C's complaint in good time and failed to comply with the NHS Complaints procedure in this regard. Furthermore, as this chain of events followed closely after Ms C's distressing surgical experience, her upset was prolonged by the inadequate manner the Board dealt with her complaint.

52. I have taken into consideration that, in their response to me, the Board acknowledged there was a significant delay in their final complaint response being sent to Ms C. I have also taken into account the factors which the Board said contributed to this delay (see paragraph 47).

53. I have also carefully considered the Board's final response of 5 June 2007 and, in my view, this was inadequate both in the manner it addressed Ms C's complaint and the wording of its apology (see paragraph 45).

54. I am pleased to note that the Board have accepted that the complaints systems they had in place at the time Ms C complained were inadequate and they have subsequently reviewed and modified these (see paragraph 47). However, as stated above, the Board failed to address Ms C's complaint adequately or to address it in good time. Taking all these factors into account, I uphold complaints (b) and (c).

(b) and (c) Recommendations

55. The Board have now implemented a policy to ensure that their Complaints system operates effectively. The Ombudsman considers that the Board have outlined adequate steps to remedy the failings identified by this complaint. However, she recommends that the Board:

(i) apologise to Ms C for their unsatisfactory final response to her complaint; and

(ii) apologise to Ms C for the delay in responding to her complaint.

56. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Hospital	Inverclyde Royal Hospital
LA	Local anaesthetic
Doctor 1	The Hospital doctor who operated on Ms C on 8 June 2006
GA	General anaesthetic
Doctor 2	The doctor who saw Ms C at the Hospital clinic she attended as an outpatient on 22 May 2006
The Manager	The complaints personnel who dealt in writing with Ms C's complaint, ie, Managers and Administrators
The Board	Greater Glasgow and Clyde NHS Board
The Director	The Director of Acute Services
The Consultant	The Hospital Consultant Surgeon
The Adviser	Ombudsman's medical adviser
The Clinic	The Hospital Breast Clinic
The JHO	The Junior House Officer
The Officer	The Corporate Administrative Officer

Annex 2

Glossary of terms

Adrenaline	Adrenaline was added to the local anaesthetic solutions because it constricts blood vessels and so prevents the agent being washed away. As a result, more can be used as it does not get into the general system so quickly. The constriction also reduces bleeding at the operative site
Abdominal ultrasound	A special x-ray of the abdomen
Analgesia	Pain control/treatment to control pain
Clerked in	The process of taking a patient's history and recording it in the notes, when admitting to hospital
Excision	Removal/cutting out
Necrosis	The death of cells in a tissue or organ caused by disease (or injury)
Lignocaine	A strong local anaesthetic applied by infiltration with a fine needle of the tissue to be operated on
General anaesthetic	An anaesthetic which produces loss of sensation in the whole body, together with unconsciousness
Lesion	A cut
Local anaesthetic	A drug, usually given by injection, which eliminates pain, though not necessarily all sensation, in a particular area of the body, without affecting consciousness
Mastectomy	The surgical removal of one or both breasts, usually as a treatment for breast cancer

Needle aspirate	To remove liquid or gas by suction/needle, usually from a body cavity
Malignant	Describes a tumour which invades the tissue around it and which may spread to other parts of the body
Nodule	Lump
Oncology/Oncologist	The branch of medicine/the specialist that deals with the study and treatment of malignant tumours
Paracetamol/co-codamol tablets	Drugs in tablet form used for the relief of pain and fever
Subcuticular sutures	Material used to close a wound or connect tissues, eg, catgut, thread or wire
Tissue mass	Groups of cells
Vicryl sutures	A stitch material used to close a wound – catgut and wire are other types – not interchangeable

Annex 3

Timeline of Correspondence between Ms C and the Board as compiled and supplied by the Board's Complaints Department
(see paragraph 17)

15 November 2006	'Response to original complaint issues – Complainant invited to meet with consultant to further discuss the response and her concerns.'
27 November 2006	'Complainant called to confirm happy for meeting to be arranged and suggested 6/12/2006.'
6 December 2006	'Meeting held to further discuss response at which time complainant indicated that she was satisfied and matter concluded.'
4 January 2007	'Letter received from complainant raising further concerns as had an opportunity to further consider matters.'
8 January 2007	'Complainant's letter acknowledged.'
14 February 2007	'Correspondence received from Glasgow indicating complainant has been in contact with the SPSO as unhappy that no response provided yet.'
15 February 2007	'Holding letter sent to complainant and email sent to Consultant and Clinical Services Manager requesting additional info.'
20 February 2007	'Consultant requested further copy of original correspondence for review and consideration.'
1 March 2007	'Report/statements received from Consultant.'
19 April 2007	'Holding letter sent to complainant.'

15 May 2007	'Further correspondence received from Ombudsman's Office re final response.'
5 June 2007	Notes of meeting & letter providing answers to additional issues sent to Director of Clyde Acute Services for signature.'

Additional timeline of correspondence between Ms C and the Board, which takes account of the period which commenced when Ms C first complained to the Board

27 July 2006	Ms C's complaint letter dated 27 July 2006 addressed to the Manager
2 August 2006	The Manager's acknowledgement of Ms C's complaint
31 August 2006	The Manager advised Ms C that the investigation of her complaint remains ongoing and apologised for the delay
6 September 2006	Ms C's letter to the Manager which stated there were errors in a letter her GP received from the Beatson Oncology Department
9 October 2006	The Manager referred to her letter dated 31 August 2006, and advised their complaint response was not finalised and, unless Ms C advised otherwise, would take it Ms C agreed to an extension of time
12 October 2006	The Manager acknowledged Ms C's letter of 9 October 2006 and stated they hoped to provide a full complaint response as soon as possible

Annex 4

List of legislation and policies considered

NHS Complaints Procedure