Scottish Parliament Region: Glasgow

Case 200800128: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; General Surgical

Overview

The complainant (Mr C) raised a number of concerns about the treatment which his wife (Mrs C) received leading up to and following a planned left nephrectomy (kidney removal) for transplant, which took place on 22 June 2007. The nephrectomy operation was started but was not completed because the clinicians involved deemed Mrs C's donor kidney was unsuitable for transplantation. Mr C had concerns that the clinicians should have been aware prior to the planned nephrectomy that the kidney was not suitable and this would have prevented Mrs C from having to undergo the operation. Mr C also had concerns about the treatment which Mrs C received following the operation and the way Greater Glasgow and Clyde NHS Board (the Board) handled his complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the process used by the Transplant Team to identify Mrs C's suitability for the nephrectomy prior to the operation was inadequate (*not upheld*);
(b) the decision to abort the nephrectomy on 22 June 2007 was unreasonable (*not upheld*);
(c) Mrs C's post-operation management was inadequate (*upheld*); and
(d) the Board's handling of the complaint was unsatisfactory *(upheld)*.

Redress and recommendations

The Ombudsman recommends that:

(i) the clinicians reflect on the Adviser's comments about the level of clinical information which has been entered in the clinical records;
(ii) the Board apologise to Mrs C for the failings identified in her post-operation management;

(iii) the Board review their discharge arrangements for surgery of this type and take steps to ensure there is appropriate post-surgery discharge planning in each case; and

(iv) the Board remind staff of their obligations to manage complaints in line with the NHS complaints procedure and take action to ensure that information about the NHS complaints procedure which is held locally in hospitals and clinics is up to date.

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

Main Investigation Report

Introduction

1. On 30 June 2008 the Ombudsman received a complaint from Mr C about the treatment which his wife (Mrs C) received leading up to and following a planned left nephrectomy (kidney removal), which took place on 22 June 2007. The nephrectomy operation was started but was not completed because the clinicians involved deemed Mrs C's donor kidney was unsuitable for transplantation. Mr C had concerns that the clinicians should have been aware prior to the planned nephrectomy that the kidney was not suitable and this would have prevented Mrs C from having to undergo the operation. Mr C also had concerns about the treatment which Mrs C received following the operation and the way Greater Glasgow and Clyde NHS Board (the Board) handled his complaints and subsequently he brought his complaint to the Ombudsman.

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

(a) the process used by the Transplant Team to identify Mrs C's suitability for the nephrectomy prior to the operation was inadequate;

(b) the decision to abort the nephrectomy on 22 June 2007 was unreasonable;

(c) Mrs C's post-operation management was inadequate; and

(d) the Board's handling of the complaint was unsatisfactory.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (The Adviser), who is a consultant transplant surgeon, regarding the clinical aspects of the complaint. I also made a written enquiry of the Board.

4. 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 used in this report can be found in Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The process used by the Transplant Team to identify Mrs C's suitability for the nephrectomy prior to the operation was inadequate; (b) The decision to abort the nephrectomy on 22 June 2007 was unreasonable; and (c) Mrs C's post-operation management was inadequate

5. Mrs C, who lives in England, had agreed to donate a kidney for transplant to her sister (Mrs D), who lives in Glasgow, in 2002. However, at that time Mrs D's condition was stable and it was decided to postpone the transplant should her condition deteriorate in future. Unfortunately, Mrs D's condition deteriorated in 2007 and Mrs C was admitted to the Western Infirmary Glasgow (Hospital 1) on 21 June 2007 in preparation for a left nephrectomy on 22 June 2007. During the operation clinicians found that Mrs C's left kidney had multiple arteries, which made it unsuitable for transplantation and the procedure was aborted. When Mrs C was discharged from Hospital 1, she returned to her home area, in order that any follow-up treatment could be carried out there.

6. Mr C complained to the Board in writing on 8 and 12 October 2007 about the treatment provided to Mrs C. Mr C listed 36 issues, most of which he said were minor, but he had listed them to show what he believed to be incompetence by the Board.[1] His main concern prior to the surgery was that Mrs C had to undergo a second scan because she had been told the first one (2002) was lost and blurred. A consultant surgeon (Consultant 1) had said a new scan was required so that the clinicians could see the kidney. Mrs C said that Consultant 1 had drawn a mark on her body showing where the operation cut would be and it would be about 3.5 inches whereas in reality it was substantially more. She said Consultant 1 and another doctor had also drawn a plan on a piece of paper showing Mrs C's kidneys. They had explained what they were looking for, including that they could see everything clearly and they stated that it was perfect for transplant. Mr C added that, more recently, Mrs C had attended her local hospital and a doctor who took a simple hand held scan said that he could clearly see three arteries in Mrs C's left kidney, therefore, Mr C questioned why Mrs C had to have a full scan and why the surgeons had apparently failed to see the third artery prior to the aborted nephrectomy.

[1] It was explained to Mr C that this investigation would not include consideration of some issues he had raised as it was not felt that anything further would be achieved either for him or the Board.

7. Mr C also raised concerns that, prior to the operation, Mrs C had had to travel nearly 500 miles for a blood test instead of it being available locally. He also complained that Mrs C had been discharged from Hospital 1 with paracetamol as the only analgesia and that there were problems in accessing follow-up treatment when she was discharged to her home area.

8. In response to the complaint, the Board's Director of Regional Services (the Director) wrote to Mr C on 13 November 2007 and 14 April 2008. He said that Mrs C first became known to the Transplant Team in 2002 when, at that time, Mrs C was investigated as a potential kidney donor for Mrs D by a consultant nephrologist (Consultant 2) from Glasgow Royal Infirmary (Hospital 2). Mrs C was first referred to the Transplant Team in March 2002, having already undergone various investigations to assess her suitability to donate a kidney to Mrs D. Since all the preliminary investigations were satisfactory, Mrs C proceeded to have a MR angiogram performed in 2002 to delineate the anatomy of her kidneys. However, he was advised Mrs C had not held her breath for the full duration of the scan, so it was reported as showing two renal arteries to each kidney but with the proviso that the detail was suboptimal and that there was a suspicion of an early branching of one of the arteries on the left. Mrs D's renal function remained stable at that time and the decision was made in 2003 to wait until it was clear that her renal function was deteriorating and that renal replacement was imminently required.

9. The Director explained that Consultant 2 remained in contact with Mrs C and in February 2007 both Mrs C and Mrs D were seen at the live donor surgical assessment clinic, as Mrs D's renal function had deteriorated and dialysis was imminent (within six months). The Director said that, contrary to what Mr C had stated in his letter, the first scan (2002) was not 'lost or blurred' and by that time the results of Mrs C's renal function were out-of-date and needed to be repeated. In the light of the suboptimal definition of the scan Consultant 1 requested that the investigation be repeated, taking into account that with a faster, newer MR scanner, a shorter period of breath-holding would be required. Unfortunately, despite extensive coaching by radiographic staff, Mrs C was again unable to hold her breath for these examinations. The pictures were again suboptimal and reported as showing two arteries to each kidney. The Director said Consultant 1 did not recall saying to Mrs C that the scan results were perfect nor would she have said this as they were not. Consultant 1 recalled that she went to great lengths to explain to Mrs C that the arterial anatomy as described, with two arteries, was not ideal but that a

transplant was possible after further surgery on the kidney once it had been removed.

10. The Director continued that it is possible to transplant a kidney with two arteries after back-bench arterial reconstruction and this was explained to Mrs C and Mrs D. The decision was taken to proceed to organ donation and kidney implantation and both patients were admitted to Hospital 1 on 21 June 2007 and Mrs C went to theatre the following day for a left nephrectomy. The operation started with Consultant 1 making a small incision but when she reached the stage of the operation where she was required to dissect the blood vessels, it looked as if there were more than two arteries. In order to demonstrate clearly the vascular anatomy both anteriorly and posteriorly, it was necessary to extend the incision with a view to discerning the anatomy, to decide if it was possible to transplant this kidney. Once the renal vessels were clearly visualised, it was evident that there were three very narrow calibre arteries going into the left kidney. Consultant 1 contacted the surgeon responsible for the implantation operation to transplant the kidney into Mrs D (Consultant 3). Consultant 3 agreed that, since the kidney had three narrow arteries, any attempt to transplant that kidney (after vascular reconstruction) would have an unacceptably high failure rate. Mrs C's kidney was left in place with all its connections intact, the wound was closed and the operation ended. Consultant 1 had informed Mrs C of the outcome when she woke up and at various times during her post-operative stay in Hospital 1.

11. The Director said that, during one of Mrs C's pre-surgery clinic visits, Consultant 1 had discussed the operation and actual incision with her. Consultant 1 recalled indicating either on Mrs C's abdomen or between two fingers the anticipated length of the incision which would, if the anatomy was as described on the scan, give adequate surgical exposure. Consultant 1 stated that she did not tell Mrs C the wound would be three and a half inches but that was perhaps how Mrs C had interpreted it. The Director was sorry that Mrs C felt she had been disfigured but it was documented in her case-notes that the wound looked satisfactory throughout her post-operative stay in hospital.

12. The Director added that Consultant 1 and the Living Donor Co-ordinator (the Co-ordinator) had informed him that at the Transplant Clinic, during all the pre-admission discussions, Mrs C had been told she should stay in the Glasgow area for about two weeks after discharge from hospital. This was so that her early post-operative follow-up could be done at Hospital 1 and also in case

there were any post-operative problems. The Director was told that when the Co-ordinator contacted Mrs C after her discharge from Hospital 1 she was surprised to discover that Mr and Mrs C had returned to their home area. On discovering this the Co-ordinator, at Mrs C's request, contacted the local hospital to organise follow-up there. When the Co-ordinator telephoned Mrs C's local hospital a secretary gave her the name of a consultant nephrologist (Consultant 4). The Co-ordinator faxed all the details and post-operative results to Consultant 4's secretary. The Director understood that Mr C had telephoned a few days later to say that Mrs C had received no word from her local hospital. The Co-ordinator had then telephoned the local hospital again and sent another fax with the details and she believed that an appointment had been made for Mrs C to attend. The Director said that the Co-ordinator had also been told by Mrs C that her GP had not been told about the operation so she telephoned him initially and on 6 July 2007 she sent him information and confirmed with Mrs C that this had been done.

13. The Director also addressed the follow-up appointment at her local hospital, where Mrs C underwent a scan of her kidney by way of a hand held scanner and that Mr C had said that three arteries could be clearly seen. The Director said that Consultant 1 had confirmed that three arteries would now be prominent due to the result of the surgery with the area around the kidney having been fully dissected.

14. The Director also referred to the other issues which Mr C had raised in respect of administration issues. He said the final cross match blood tests (to be taken 10-14 days prior to transplant) required blood to be taken from the donor and recipient on the same day and arrive at Hospital 2 tissue typing lab that day. This was because there was too big a risk of a sample being delayed, for example, for the blood to be taken elsewhere and sent on to Hospital 2 and had been explained to Mrs C at the time. The Director advised that Mrs C was expected to stay in Glasgow for two weeks after discharge from Hospital 1, therefore she was not discharged to her home nearly 250 miles away. It was also documented in the notes that Mrs C was on oral paracetamol prior to discharge and that she was comfortable with this.

15. The Adviser said that most transplant centres use either CT angiography or MR angiography to delineate the anatomy of the kidneys to make the decisions (a) to go ahead with the donor nephrectomy and (b) to select which kidney to use for the donor transplant. Traditionally, the left is the kidney of

choice as it has the longer renal vein. However, other criteria can be used to decide which kidney to use. He said the better kidney should be left with the donor. Therefore, if the left kidney had significantly better function, the right would be taken, provided both kidneys were supplied with single arteries and veins. There is general agreement that, provided both kidneys have single vessels and have roughly equal split function, the left kidney would be taken. However, if the left kidney had multiple vessels, the right kidney with single vessels would be used.

16. The Adviser told me that although two arteries in a single kidney used to be a relative contraindication to living donation, with improved microvascular techniques, it is not uncommon nowadays to remove kidneys with multiple vessels for transplant. Such cases would involve removal of the kidney by the donor clinicians and restructuring work on the arteries would take place (back-bench surgery) prior to passing the kidney on to the recipient kidney clinicians. The decision would rest with the donor surgeon's assessment of his/her skill level and prior results for microvascular surgery and thus will vary from one unit to another. The Adviser noted that discordance between the MR/CT angiogram findings and findings at surgery are not uncommon. He said the discordance rate can be as high as 10%. In other words, although the results of the MR scans may indicate that surgery would be appropriate, it can become apparent at surgery, where the kidneys are inspected, that that is not the case.

17. The Adviser said that he found it difficult to make a judgement on the decision to proceed with the donor nephrectomy, as documentation in Mrs C's notes about the decision making process was negligible. The procedure carried out with Mrs C on the lead up to surgery was, however, in accordance with accepted protocols in that MR scans and blood tests were carried out.

18. The Adviser said that, on the two MR angiogram scans (2002 and 2007), the radiologist had warned of technical difficulties because of the bilateral paired arteries. There was no record of how much credence was given to the warnings. It was difficult for the Adviser to judge how much weight should have been given to the warnings, as no measurements of the length and diameters of the vessels were given in the reports.

19. The Adviser was surprised that there was no mention in the records of the possibility of having to perform back-bench surgery, as in both MR angiography reports (2002 and 2007) at least two arteries were defined. The consent form

did not mention the possibility of back-bench surgery or increased risk of failure in the event that back-bench surgery was required nor did it mention the possibility that the donation may be aborted. The Adviser could find no documentation to suggest that the possibility of such eventualities was considered by the surgeons, despite the MR angiography reports. The Adviser noted that the operation notes mentioned that the three renal arteries were very narrow. It was difficult for the Adviser to judge how much of the narrowing was due to vasospasm secondary to manipulation. The MR angiogram reports were not helpful in resolving this issue as, again, no measurements were given.

20. The Adviser felt that decision to abort the operation when the surgeons were faced with the problem of having to transplant a living donor kidney with three arteries was reasonable and justified if it was the judgement of the surgeons that the risk of technical failure was too high. There is a major difference between a nephrectomy to remove a kidney for transplantation and a nephrectomy to remove a diseased kidney. In the former case, the surgeons have to ensure that the kidney is removed in a state that allows it to be transplanted and to function after the transplant. This factor, together with the importance of not harming the donor, makes living donor transplant a very stressful procedure for the surgeons.

21. The Adviser said that it was also not possible to say what information was provided about the expected length of the incision, as there was no documentation which would substantiate what was discussed. However, as the incision site had to be extended to allow better visualisation of the arteries, then it would be reasonable for the length to be in excess of that originally notified. The Adviser noted that pain relief appeared to be an issue during Mrs C's post-operative care at Hospital 1. Patient controlled analgesia (PCA) was only resumed when a pneumothorax (collection of air in the chest cavity) was diagnosed and Mrs C was in severe pain (10/10 pain score) on 25 June 2007, which was three days post surgery. The Adviser continued that the complication of a pneumothorax after an open donor nephrectomy is not uncommon. What was of concern, however, was that there was a delay in making the diagnosis. The Adviser questioned why a chest x-ray was not requested earlier, as it would be common practice in most transplant units to undertake a routine post-operative chest x-ray to confirm or exclude a pneumothorax.

22. The Adviser continued that there was no record in the clinical or nursing records to indicate where Mrs C would live after discharge other than to her own home, which was nearly 250 miles from Glasgow. There was also no evidence of a post-surgery discharge plan prior to surgery, despite the distance Mrs C had to travel. The Adviser was surprised that Mrs C was dispatched on such a long journey with what he believed to be inadequate pain relief. He noted from the correspondence that, although there had been an intention to follow-up Mrs C in Glasgow, there was no documentation of any practical alternative arrangements for her to have an affordable stay in Glasgow and, therefore, she had no option but to return home.

23. In response to my enquiry the Board maintained that they were comfortable with the details contained in the consent form as it related to the donor and information relating to back-bench surgery or subsequent complications would have been relevant and appropriate to list on the consent form pertaining to the recipient. They mentioned that detailed conversations took place in 2003 and 2007, when Mrs C would have been informed of possible complications and the need for back-bench surgery. The Board continued that the reason a chest x-ray was not performed earlier than 25 June 2007 was that Mrs C had not shown any symptoms which would be concurrent with a pneumothorax. With regard to Mrs C's pain relief, it was explained that during the admission Mrs C's pain score recorded a maximum of three and a minimum score of zero, which was indicative of some pain but not an excessive amount. The Board accepted there was no evidence of a post-surgery discharge plan within the case records but said that post discharge arrangements were explicitly discussed at the pre-operative clinic visits and that the agreed plan was that Mrs C would remain in Glasgow for two weeks and that arrangements would be made for follow-up treatment outwith Glasgow.

(a) Conclusion

24. Mr C believed that the treatment which Mrs C received prior to the aborted nephrectomy was inadequate, as the clinicians should have been aware that Mrs C's kidney was unsuitable for transplant. The advice which I have received, and accept, from the Adviser is that the process adopted by the clinicians to identify Mrs C's suitability was in line with accepted protocols. It would be appropriate for the clinicians involved to arrange for an angiogram to take place so that an assessment could be carried out to establish the suitability of a kidney for donation. In this case, it was noted that the results of the scans carried out in 2002 and 2007 were suboptimal, as Mrs C was unable to hold her

breath for the required time, which would have made the results of the scans clearer.

25. I have also taken into account that the Adviser has commented that he has concerns about the recorded documentation in the clinical records and consent form, as fuller documentation would have assisted in establishing the clinicians' decision making process and how much credence they had placed on the results of the scans. However, the Adviser had no concerns that the clinicians had not followed recognised protocols and on balance I do not uphold this aspect of the complaint.

(a) Recommendation

26. The Ombudsman recommends that the clinicians reflect on the Adviser's comments about the level of clinical information which has been entered in the clinical records and consent form.

(b) Conclusion

27. Mr C believed that the decision to abort the nephrectomy was unreasonable and should have been taken prior to 22 June 2007 and would have saved Mrs C the trauma of having to undergo an unnecessary operation. I have already commented that, prior to the planned nephrectomy, the clinicians had acted in accordance with recognised protocols. However, it only became clear to the clinicians once the nephrectomy operation had begun and the area around the kidney was being dissected, that there was a risk that the transplant would not be successful. Consultant 1 discussed the matter with Consultant 3 and it was decided that the risk of failure was too great and the decision was taken to abort the nephrectomy. It was for the clinicians involved to exercise their clinical judgement on whether to proceed to nephrectomy and, in the absence of any evidence to suggest that it was taken inappropriately, I have decided not to uphold the complaint.

(b) Recommendations

28. The Ombudsman has no recommendations to make.

(c) Conclusion

29. I now turn to the issue as to whether Mrs C's post-operation management was inadequate. It was difficult for me to reach a decision on information which Mr C said Mrs C received from the clinicians about the length of the incision prior to surgery. Consultant 1 did not recall telling Mrs C what the size of the

incision would be but accepted that Mrs C's interpretation may have been different to hers. In any event, the incision had to be extended so that Consultant 1 would be in a position to visualise the anatomy of the kidney. The Adviser has highlighted concerns that following the operation Mrs C suffered a pneumothorax and he felt there was a delay in making a diagnosis, as a chest x-ray was not requested earlier as would be common practice in transplant units. The Adviser also had a concern about the level of analgesia which was provided to Mrs C. The analgesia was only resumed when the diagnosis of pneumothorax was made and, on discharge, the level of analgesia which was prescribed was inadequate.

30. With regard to administration issues, there clearly was a breakdown in communications, in that Mrs C decided to return home whereas the Board were under the impression that she was going to live locally for at least two weeks. I have seen no written evidence to support the view that Mrs C was informed that she should stay in Glasgow for two weeks following discharge from Hospital 1 or that there was a post-surgery discharge plan. Taking all the above factors into account, I have decided that Mrs C's post-operation management was inadequate and I uphold this aspect of the complaint.

(c) Recommendation

31. The Ombudsman recommends that the Board apologise to Mrs C for the failings identified in her post-operation management. The Ombudsman further recommends that the Board review their discharge arrangements for surgery of this type and take steps to ensure there is appropriate post-surgery discharge planning in each case.

(d) The Board's handling of the complaint was unsatisfactory

32. The NHS Complaints Procedure was revised on 1 April 2005 and set out the timescales that a complaint should be acknowledged or an initial response issued in writing within three working days of receipt. An investigation of a complaint should normally be completed within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint must be informed of the delay with an indication of when the response can be expected. The investigation should not normally be extended by more than a further 20 working days. While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days, they should be given a full explanation

in writing of the progress of the investigation, the reason for the requested further extension and an indication of when a final response can be expected.

33. Prior to 1 April 2005, the NHS Complaints Procedure included a process whereby if a complainant was dissatisfied with the health board's final response to their complaint they had recourse to request an Independent Review of their complaint. This involved consideration of the complaint by a complaints convenor and, should they remain dissatisfied following the convenor's decision on whether to conduct an Independent Review, then complainants were able to contact the Ombudsman at that stage. The Independent Review Process was abolished from 1 April 2005 and from then complainants were able to contact the Ombudsman following the health board's final response to their complaint.

34. In this case, Mr C complained to the Board on 8 and 12 October 2007. The Board acknowledged the complaint on 2 November 2007 and the Director responded to Mr C's complaint on 13 November 2007. The Director hoped that his response had addressed the issues which had been raised but said that if Mr C remained unhappy he could contact the Patient Liaison Manager (the Manager) within one month. On 16 November 2007 Mr C (not yet having received the Director's response) wrote to the Board's complaints convenor (the Convenor) and requested an Independent Review of his complaint. Mr C wrote to the Director on 20 November 2007 and told him he had referred the matter to the next upward level of complaint. This was before he had received the Director's response dated 13 November 2007. Mr C then set out his concerns in a letter to the Convenor dated 21 December 2007. Mr C sent a reminder to the Convenor on 8 January 2008, as his previous letters had not been acknowledged. The Manager then wrote to Mr C on 29 January 2008 and explained that she had received his letter of 21 December 2007 to the Convenor on 15 January 2008; that the Independent Review Process had been removed from the NHS Complaints procedure some time ago; and that the address to which Mr C had sent his letter to the Convenor was no longer used as a Board Management Building. The Manager apologised that Mr C had received incorrect information and said that the Board were currently investigating his ongoing concerns and that they aimed to reply within one month.

35. Mr C wrote to the Manager on 31 January 2008 and complained that Mrs C had been given information about the outdated complaints process when she was in hospital in June 2007; procedures should have been put in place to

deal with complaints that were addressed to the Convenor; and that, although the Manager had received his letter to the Convenor on 15 January 2008, it took her 14 days to acknowledge it. The Manager responded on 6 February 2008 that the complaints process changed some time ago and the complaints leaflets were amended accordingly. She added that when she had acknowledged Mr C's original complaints she would have included a leaflet which explained the current NHS Complaints Procedure. The Manager reiterated her apologies and explained she was still waiting for information from the relevant staff about his complaint. Mr C subsequently acknowledged that the Manager had in fact sent him a copy of the current complaint information leaflet but he and Mrs C had not realised it was different from the one which Mrs C obtained on discharge from Hospital 1 in 2007. Mr C advised the Manager on 27 February 2008 that unless he received a final reply by 7 March 2008 he would contact the Ombudsman. The Manager responded on 29 February 2008 and explained staff had been on leave and that it was hoped to have the final response issued within the next two weeks.

36. Mr C sent the Board a further reminder on 23 March 2008, as he still had not received a response. The Manager responded on 23 March 2008 and apologised for the further delay as information was still waited from a member of staff. Mr C contacted the Ombudsman on 7 April 2008 as he still had not received the Board's final response. He was advised that, as the Board's consideration of his complaint was nearing an end, it was appropriate that he should wait for their final response and that he could contact the Ombudsman again should he remain dissatisfied. The Director responded to Mr C on 14 April 2008 and addressed the concerns which had been raised and directed Mr C to contact the Ombudsman should he remain dissatisfied with the response. Mr C formally complained to the Ombudsman on 29 May 2008.

(d) Conclusion

37. The NHS Complaints procedure has clear guidelines about acknowledgements and response times with regard to complaints. The Board have failed in this regard, in that the guidelines were breached both in terms of late acknowledgements to the complaints and the time taken to provide a final response. Matters were then further complicated with the involvement of Mr C's correspondence to the Convenor, a process which had not been in force since 1 April 2005. It was most unfortunate that Mrs C was provided with out of date literature from the Board to contact the Convenor and matters were then compounded by the delay by the Board in writing to Mr C and explaining that

the process had been amended some years previously. Although Mr C has acknowledged that information about the current NHS complaints procedure was indeed provided when his formal complaint was acknowledged in November 2007 before he wrote to the Convenor on 16 November 2007, nevertheless the Board only contacted Mr C in January 2008 to explain the independent review process had been removed. In all the circumstances, I have decided that, overall, the Board's handling of Mr C's complaint was unsatisfactory and I uphold this complaint.

(d) Recommendations

38. The Ombudsman recommends that the Board remind staff of their obligations to manage complaints in line with the NHS complaints procedure and take action to ensure that information about the NHS complaints procedure which is held locally in hospitals and clinics is up to date.

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's wife
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional medical adviser
Mrs D	Mrs C's sister
Hospital 1	Western Infirmary Glasgow
Consultant 1	Consultant surgeon at Hospital 1 responsible for Mrs C's treatment
The Director	The Board's Director of Regional Services
Consultant 2	Consultant nephrologist at Hospital 2
Hospital 2	Glasgow Royal Infirmary
Consultant 3	Consultant nephrologist responsible for Mrs C's sister's treatment
The Co-ordinator	Living Donor Co-ordinator
Consultant 4	Consultant nephrologist in Mrs C's local area
PCA	Patient controlled analgesia

The Manager	Patient Liaison Manager
The Convenor	Board’s complaints convenor

Annex 2

Glossary of terms

Arterial anatomy	The details of the structure and arrangement of arteries, i.e., blood vessels taking blood to an organ (kidney)
CT angiography	Computerised Tomography Angiography: computerised x-ray of arterial blood flow with use of contrast
MR angiography	Magnetic Resonance Angiography: computerised x-ray of arterial blood flow without use of contrast
Nephrectomy	Kidney removal
Paracetamol	Analgesia
Pneumothorax	Air within chest cavity
Vascular anatomy	The description of both the arterial anatomy and the structure and arrangement of veins, i.e., blood vessels taking blood away from an organ (kidney)
Vasospasm	Sudden constriction of a blood vessel