Scottish Parliament Region: Mid Scotland and Fife

Case 200904350: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her husband (Mr C) by Forth Valley NHS Board (the Board) at Stirling Royal Infirmary (the Hospital) from 3 April 2006 until his death on 27 July 2006. Mrs C also raised concerns about the way in which the Board handled her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Consultant's actions denied Mr C the opportunity to make informed choices about treatment and end of life care and the Board failed to follow the Liverpool Care Pathway (*upheld*);

(b) the Board failed to acknowledge the failings of the Consultant or to make changes or improvements to address the failings (*upheld*);

(c) there was an unnecessary and lengthy delay in the Board's handling of the complaint (*upheld*);

(d) the notes taken at a meeting with the Board's representatives did not fully and accurately detail the depth of Mrs C's concerns and the outcome she wished to achieve (*upheld*); and

(e) Mrs C's request for a meeting with the Consultant was refused unreasonably (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake an external peer review in the Hospital, to include:	
• the procedures relating to the management of biopsies, including communicating biopsy results;	18 November 2011
• the current strategy for the policy of Living and	

	Dying Well, with particular reference to the implementation of the Liverpool Care Pathway and the role of consultants; • the education and training of staff, particularly consultants, relating to end of life care;	
(ii)	ensure that the failings identified in this report are raised with the Consultant during his next appraisal, to ensure lessons have been learned from this case;	18 June 2011
(iii)	provide evidence about how feedback from complaints is used as part of the consultant appraisal process;	18 June 2011
(iv)	review their procedures to ensure they investigate complaints fully, in accordance with the NHS Complaints Procedure, with particular reference to timescales; and	18 June 2011
(v)	apologise to Mrs C for the failures identified in this report.	18 June 2011

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

Main Investigation Report

Introduction

1. On 8 February 2010, Mrs C complained to the Ombudsman about the care and treatment provided to her late husband (Mr C) by Forth Valley NHS Board (the Board) from 3 April 2006 until his death on 27 July 2006. During this period, Mr C had three admissions to Stirling Royal Infirmary (the Hospital), numerous tests and investigations and a stomach bypass was carried out. Mrs C has complained that there were serious failings in the care and treatment Mr C received in the months leading up to his death. These included failures by a consultant (the Consultant) to: obtain and manage biopsy specimens appropriately; to reach a definitive diagnosis about Mr C's condition; to fully and appropriately communicate with them about Mr C's diagnosis; and to manage appropriately Mr C's nutrition and weight.

2. Referring to her complaint about communication, Mrs C said that following the stomach bypass on 27 April 2006, two members of the surgical team had told Mr and Mrs C that the tumour was cancerous, but then the Consultant told the family on 2 June 2006 that Mr C did not have cancer and the mass was left over from a pancreatic cyst. The family was also told on 1 July 2006 that the results of a CT scan of the mass taken on 23 June 2006 showed only a slight change. However, subsequently the Consultant telephoned Mrs C at home on 20 July 2006 saying the change in scan was significant, that Mr C had a cancerous tumour, and advised her not to tell Mr C until after his stent operation the following day. Following the operation, the Consultant told Mr C on 24 July 2006 in an open ward that he had cancer and that the Consultant had been aware of this from 27 April 2006. He then left Mr C to have a meeting with Mrs C. He advised her that he had not told Mr C and the family during the consultation on 2 June 2006 that Mr C had cancer to give Mr C quality time with his family. Mrs C said that the Consultant also failed to tell them that the biopsies taken during the stomach bypass had been lost.

3. Mrs C said that, as a result of the failures by the Board, Mr C had been denied the opportunity to make choices in relation to his end of life care and that he did not receive support from the palliative care team. Furthermore, he was not given the time to prepare for his death and neither he nor his family had the time to say goodbye properly. Mrs C said that she now had to cope not just with Mr C's death, but also the pain and distress arising from the serious failings

in the care and treatment Mr C received. Mrs C said she wanted to ensure that what happened to Mr C did not happen to anybody else.

4. On 15 September 2006, Mrs C complained to the Board by letter. Mrs C met the Board to discuss her complaint and received the Board's formal response on 5 January 2007. Mrs C and the Board met again on 8 March 2007. A note of this meeting was drafted by the Board and amended several times to take into account Mrs C's comments and provide further information. On 4 November 2008, the Consultant wrote to Mrs C to apologise for failures in communication. Mrs C's final meeting with the Board took place on 13 January 2009. On 14 April 2009, the Board wrote to Mrs C saying the complaint process had now been exhausted. Mrs C remained dissatisfied with the Board's responses and complained to my office.

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

(a) the Consultant's actions denied Mr C the opportunity to make informed choices about treatment and end of life care and the Board failed to follow the Liverpool Care Pathway[1];
(b) the Board failed to acknowledge the failings of the Consultant or to make changes or improvements to address the failings;
(c) there was an unnecessary and lengthy delay in the Board's handling of the complaint;
(d) the notes taken at a meeting with the Board's representatives did not fully and accurately detail the depth of Mrs C's concerns and the outcome she wished to achieve; and
(e) Mrs C's request for a meeting with the Consultant was refused unreasonably.

Investigation

6. The investigation of Mrs C's complaint involved reviewing Mr C's clinical records relating to the events in addition to the complaint correspondence. My complaints reviewer sought the views of a specialist medical adviser (the Adviser) and considered the NHS Complaints Procedure. Finally, my complaints reviewer considered the progress the Board had made on implementing recommendations my predecessor had issued in report 200602412 about Living and Dying Well and End of Life Care in Scotland.

[1] The Liverpool Care Pathway is a model of best practice to ensure that all dying patients, and their relatives and carers, receive a high standard of care in the last hours or days of patients' lives. It is a mechanism for identifying and addressing the needs of dying patients.

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

(a) The Consultant's actions denied Mr C the opportunity to make informed choices about treatment and end of life care and the Board failed to follow the Liverpool Care Pathway; and (b) the Board failed to acknowledge the failings of the Consultant or to make changes or improvements to address the failings

Clinical Background

8. Mr C had three admissions to the Hospital from 3 April 2006 until his death on 27 July 2006. He was first admitted to the Hospital on 3 April 2006 for weight loss, vomiting and generally being unwell. Numerous tests and investigations were undertaken. On 5 April 2006, a CT scan showed that Mr C had dilated intra liver ducts. A gastroscopy and stomach biopsies taken on this date showed abnormal tissue which could be either inflammatory or malignant. A barium x-ray showed a stomach outlet obstruction and the Consultant decided to carry out a further gastroscopy and a parenteral nutrition. Mr C was discharged on 15 April 2006.

9. Mr C was readmitted on 20 April 2006 with similar symptoms. He had further investigations including gastroscopy, blood tests and a CT scan. On 27 April 2006, he underwent a laparotomy and a stomach bypass operation to relieve the outlet obstruction previously noticed on the barium x-ray. Some biopsies were taken during this operation but these did not reach the pathology laboratories. The operation note said the Consultant found a large tumour in the stomach area which he and a consultant colleague thought was an inoperable cancer and hence offered a palliative procedure of a stomach bypass operation. Mr C was discharged on 9 May 2006 but readmitted again on 26 June 2006.

10. On 23 June 2006, another CT scan of the mass was taken which showed a change, suggesting the mass was most likely an advancing tumour. Mr C then underwent a stent procedure (insertion of tube into the obstructed stomach to facilitate passage of food). No additional treatment or palliative care was provided. Mr C's condition deteriorated quickly and he died on 27 July 2006.

Board's response to Mrs C's complaint

11. In the Board's response to Mrs C's complaint, they said that there was no record of Mr C's weight being recorded in his medical notes, for which they apologised. The Board said the Consultant had explained that although he did not have a definitive diagnosis, based on Mr C's symptoms, the Consultant believed Mr C had a malignancy, but due to his past medical history he could not rule out the possibility of an inflammatory condition. Referring to the biopsies, the Board said although a biopsy had been taken, it was not sufficient to submit for pathology. Mr C was not referred to a palliative care team because they had not made a definitive diagnosis. The Board said staff had not expected Mr C to deteriorate so rapidly and this had impacted on their communication with Mrs C.

12. Mrs C met the Board on 8 March 2007 to discuss her concerns about the Board's response, her outstanding concerns arising from her complaint and the outcome she wished to achieve by pursuing her complaint. During this meeting, the Board said Mrs C's complaint would be taken seriously and that a full and thorough investigation would be undertaken. The Board subsequently provided further information in response to Mrs C's complaint through letters and meetings. Following a review of Mr C's surgical management by their Head of Clinical Governance, the Board said the Consultant's surgical management had followed accepted practice and procedure. However, the Board acknowledged that there were many failures in the care and treatment provided to Mr C and apologised for these.

13. Turning first to the communication with Mr and Mrs C about the diagnosis, the Board said there had been difficulty in providing a definitive diagnosis and communicating the extent of Mr C's surgical condition. However, the Consultant deeply regretted that a more direct conversation did not take place during the meeting of 2 June 2006, particularly after laparotomy findings of 27 April 2006 which suggested a tumour and not chronic pancreatitis[2]. Furthermore, the results of the CT scan of the mass taken on 23 June 2006 showed a change, which suggested the mass was most likely an advancing tumour rather than inflammation. The Consultant also regretted the delay in informing the family about this. Finally, the Board said the Consultant had accepted that his decision not to tell Mr and Mrs C about the diagnosis of cancer was wrong.

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[2] It is clear from the Board's complaint file that the Consultant was convinced at the time that Mr C had an extensive malignancy.

14. Turning now to the management of the biopsies taken during Mr C's operation on 27 April 2006, the Board acknowledged that the biopsy samples had never been forwarded to the laboratory because a member of the surgical team believed they were insufficient and would not provide a definitive diagnosis. The Board said this was a significant error, which the Consultant only became aware of some time later as the doctor had acted in isolation and had not discussed his actions with the Consultant. However, with hindsight, the Board said too much emphasis was placed on the biopsy results and as a result the system failed Mr C. Nonetheless, the Consultant also acknowledged Mrs C's concerns that the delay in obtaining the biopsy results should have alerted him that something was wrong and that action should have been taken sooner.

15. The Board also acknowledged there was a delay in recognising the need for specialist palliative care for Mr C and this should have been arranged. The Board said the Liverpool Care Pathway could have been commenced for Mr C and that their practice had improved since Mr C's treatment.

16. Referring to Mrs C's complaint about the management of Mr C's weight and nutrition, the Board said the medical records were not clear on what happened in this regard, including decision-making on feeding by total parenteral nutrition. They accepted Mrs C's concerns and apologised. Furthermore, the Board could not establish if staff had actively monitored Mr C's weight and acknowledged that staff had failed to provide detailed information to Mrs C regarding this aspect of his care and treatment. The MUST[3] tool was now in use to support staff.

17. Another failure in record-keeping acknowledged by the Board related to communication with the family. Referring to Mrs C's complaint about the Consultant informing her that Mr C had cancer during a telephone conversation on 20 July 2006, the Board said the Consultant had no recollection of the telephone call and there was nothing documented about it in the notes. The Board also said there was poor documentation regarding discussions about the diagnosis on 24 July 2006 between the Consultant and Mr and Mrs C and agreed that the matter had not been dealt with in an ideal way.

[3] Malnutrition universal screening tool used to assess patients' nutritional needs.

18. Turning now to the Board's handling of Mrs C's complaint, they said that her concerns had not been managed well in the initial stages of the complaints process and that her complaint should have been resolved far earlier in the process. They apologised for the delays and said that they had made changes to prevent such delays in the future. The Board said they had discussed the role of the Ombudsman in the complaints process, but Mrs C responded she did not want to go to the Ombudsman because she would have to go through the whole procedure again.

19. The Board said it had implemented many changes to address the failures highlighted by Mrs C's complaint. A more formal system to manage patients with major cancers was now in place: there was a formal weekly multi-disciplinary team review of all major cancers, which included discussion with an upper gastro intestinal cancer consultant in Glasgow and national cancer pathways have been set up as part of the national drive to improve the overall care of patients. This also meant that patients were more likely to be referred to the palliative care team whether or not a malignant tumour was confirmed. The Board said they had appointed cancer coordinators/trackers to follow up on biopsy results etc, to keep GPs informed and to progress patient appointments. The Board said that the changes they had implemented in relation to end of life care since Mr C's admission should prevent what happened to Mr C happening to somebody else.

Advice received

20. My complaints reviewer asked the Adviser to comment on the clinical aspects of the complaint. Referring to Mr C's discharge from the Hospital on 15 April 2006, the Adviser said that no adequate explanation was offered as to why Mr C had been sent home on 15 April and the stomach bypass had not been carried out earlier. Furthermore, the operation note of the stomach bypass on 27 April 2006 contained very few details. It said the Consultant found a large tumour in the stomach area which he and consulting colleagues thought was an inoperable cancer and hence offered a palliative procedure of a stomach bypass operation. The operation note did not say if there was any secondary cancer or if the Consultant took any biopsy of the supposed cancer and sent them for testing.

21. There is an entry in the clinical records on 8 May 2006 that the Consultant remembered about the 'tru cut biopsy samples' but the Adviser pointed out that the records did not say who took the biopsy samples, who collected them and

who sent them to the laboratory. Furthermore, the pathology laboratory said it never received these biopsy samples. During the meeting between the Board and Mrs C on 8 March 2007, the Board said a member of the surgical team believed that the biopsy material was insufficient and did not send it to the laboratory. The Adviser said that this was an unusual and even dangerous action. Moreover, it is not clear if the sample was discarded with or without the advice from the Consultant, or why the Consultant did not attempt a further biopsy as the abdomen was open at the time. The Board also failed to say whether the doctor who had discarded the biopsy sample was offered proper training in the handling of human tissues biopsies.

22. Turning to the impact of the discarded stomach biopsies, the Adviser said a cancer diagnosis is often confirmed through clinical examination, radiological investigation and biopsy results. Of these, the biopsy result is the most important investigation as it carries maximum sensitivity and specificity of all the diagnostic tests. Except in exceptional circumstances like a brain tumour, it is mandatory to have the biopsy results to confirm a cancer diagnosis. In Mr C's case, the Consultant said he remembered taking biopsies of what clinically appeared to be an inoperable stomach cancer, which the Board later said were discarded by a member of the surgical team. So the most important tool in making the diagnosis was lost and with it, making an accurate diagnosis. The Adviser emphasised that the biopsy might not always provide the diagnosis, especially if the specimen sent was not of sufficient quality and quantity. However, this should be decided by the pathology doctors and not by the surgeons; it is good practice to send whatever material was obtained through biopsy to the laboratory.

23. Referring to the communication between the Consultant and Mr C and his family, the Adviser said the clinical notes written from the time of the operation on 27 April 2006 until Mr C's discharge on 9 May 2006 failed to say what the Consultant had explained to Mr and Mrs C: what type of operation was carried out; the operative findings; the possible/definitive diagnosis; and the postoperative treatment, etc. Furthermore, there was no evidence of any direct postoperative letters written by the Consultant to Mr C's GP. This was contrary to General Medical Council Good Medical Practice guidelines on information sharing with a patient's GP. The Adviser went on to say that the medical records suggested that on 27 April 2006, the Consultant indicated to Mr C that 'in his opinion [Mr C] had a cancerous tumour', but it was noted in the medical records on 24 May, that he seemed to have implied 'that the patient did not

have cancer'. At the same time, two members of the surgical team told Mr C that he did have cancer. There were also questions about the Consultant's telephone conversation with Mrs C; what was discussed and what diagnosis was conveyed. The Adviser said it was not good practice to discuss the diagnosis of cancer on the telephone and that it should be done in person and in the clinic. Another worrying aspect to the Consultant's communication was the Board's statement to Mrs C that the Consultant was still endeavouring to get a biopsy report on 2 June 2006. This directly contradicted the entry in the clinical notes dated 8 May 2006, which clearly stated that the Consultant knew on this date that the biopsy assessment was discarded and hence the pathology laboratory did not receive the biopsy specimens.

24. The Adviser pointed out that another aspect of the communication between the Consultant and Mr and Mrs C was that the Consultant appeared to suggest that Mr C should not be told about the terminal illness so that he could have a better quality of life. Although this might look like a humane gesture, the Adviser said it was not in keeping with good medical practice; patients should be told in simple clear English about the exact diagnosis and management. This should only be withheld from the patient if the patient had expressed a wish not to be told of the diagnosis. There was no indication that Mr and Mrs C had requested they should not be told of a painful and devastating diagnosis of cancer. If anything, it appeared the opposite from the complaint letters, which showed that they desperately wanted to know the diagnosis. The Adviser said it was apparent that conveying important news about the cancer diagnosis or lack of it was not handled very well nor was a proper explanation offered to Mr and Mrs C

25. The Adviser stated that an accurate diagnosis of cancer or lack of it might have facilitated a better treatment pathway for Mr C. He was discharged home on 9 May 2006 following his operation on 27 April 2006. However, he was readmitted on 26 June 2006 and died on 27 July 2006. During this period, he did not seem to have received any treatment. The Adviser concluded that referral to a cancer specialist might not have been appropriate as the diagnosis of cancer was not established. However, he said a referral to the palliative care team and nutritional assessment team would have been both reasonable and appropriate. This did not happen. Furthermore, the Liverpool Care Pathway should have been implemented earlier.

26. Finally, the Adviser said that the review by the Board's Head of Clinical Governance concluded there was a lack of coordination in clinical care. The Adviser said this lack of coordination, and hence the clinical care, was not in keeping with the principles and ethos of clinical governance.

(a) Conclusion

27. Mrs C has complained to this office about the care and treatment provided to her husband by the Board. There are four aspects to her complaint: failures by the Consultant to obtain and manage biopsy specimens appropriately; to reach a definitive diagnosis about Mr C's condition; to fully and appropriately communicate with them about Mr C's diagnosis; and to manage Mr C's nutrition and weight. I have decided that in each of these aspects there were serious and fundamental failures by the Consultant and the Board. I go on to explain my decision on each aspect of Mrs C's complaint below.

28. Turning first to the Consultant's management of the biopsy samples and his failure to reach a definitive diagnosis, in reaching my decision I have taken into account the fact that Mr C's clinical condition was complex. However, the advice which I have received and accept is that by failing to send the biopsy sample or obtain an adequate one, the Consultant lost a crucial tool in making an accurate diagnosis. This was a fundamental error. I am also extremely concerned about the Board's statement that a member of the surgical team discarded the specimen, an action which has been described by my Adviser as 'dangerous' (see paragraph 21). Furthermore, there are discrepancies in the Consultant's account of his clinical management of the biopsies. The entry in the clinical notes dated 8 May 2006 stated clearly that the Consultant knew on this day that the biopsy specimen had been discarded and that the pathology laboratory had not received the biopsy specimens. However, the Board told Mrs C that the Consultant was still endeavouring to get biopsy results on 2 June 2006.

29. I am very concerned that the Consultant failed to take any action from 8 May 2006, when he knew the biopsy specimens had been discarded, to investigate this failure. Moreover, at best misleading, and at worse, false information was provided to Mr and Mrs C on such a significant issue. The Consultant could and should have acted sooner. The Board said the doctor who had discarded the biopsies had acted in isolation and had not discussed their actions with the Consultant and that the loss of the biopsy specimens was a systems failure. I do not accept this. The Consultant failed to manage the

biopsy specimens and the surgical team appropriately. This in turn led to his failure to reach a definitive diagnosis, which had devastating consequences for Mr and Mrs C (see paragraph 33).

30. I turn now to the Consultant's communication with Mr and Mrs C, relating to his failure to reach a definitive diagnosis. Mr and Mrs C were given contradictory information about the diagnosis by the Consultant and members of the surgical team. This led to an increasingly uncertain and distressing situation for Mr and Mrs C. There is clear evidence from the clinical records and the surgical team that the Consultant (and a fellow surgeon) believed Mr C had cancer from when he carried out the stomach bypass on 27 April 2006. The Board does not dispute this. I accept that at this point the Consultant did not have a definitive diagnosis in the absence of pathology evidence, but he could and should have been more specific about the likely prognosis. This would have better prepared Mr and Mrs C for what was to follow.

31. Following the operation, it was left to members of his surgical team to convey the likely prognosis to Mr and Mrs C. In addition, further discussion with the Consultant on 2 June 2006 led the family to believe that Mr C did not have cancer. The Consultant later said he had not been more direct during this meeting - despite being aware of further medical evidence that Mr C had a malignant tumour - to give Mr and Mr C quality time together. I am extremely critical of the Consultant's actions in this regard. When the Consultant did inform Mrs C of the seriousness of Mr C's condition on 20 July, it was during a telephone call. A clinician discussing a diagnosis of cancer on the telephone is highly improper. Furthermore, Mrs C said he asked her during this conversation to delay telling Mr C. This put Mrs C in an unacceptable and untenable position. Again, I am highly critical of the Consultant's actions, which not only demonstrated poor practice, but also poor judgement. I note that the Consultant does not recall this telephone call. However, Mrs C's account is compelling and given the lack of any record of this telephone call in the clinical notes, there is no evidence to contradict Mrs C's account.

32. In relation to Mrs C's additional concerns about the provision of care and treatment to Mr C including management of his weight, the advice which I have received and accept is that: it is not clear why Mr C was discharged home on 15 April 2006, only to be readmitted on 20 April 2006; the Board failed to carry out any nutritional assessment and did not record Mr C's weight; parenteral nutrition (special feeding) was never started, although discussed, and the Board

failed to offer any explanation as to why this did not take place. These failures, together with the failures in managing the biopsies and communication, represent an overall level of care to Mr C which was totally unacceptable.

33. In summary, there was a catalogue of serious and fundamental errors by the Consultant and members of his surgical team in reaching a diagnosis, in communication and in managing Mr C's condition. This had a number of severe and significant consequences for Mr and Mrs C. It meant that the Board failed to commence Mr C on the Liverpool Care Pathway and that Mr C was not referred to a palliative care team and nutritional assessment team as he should have, which impacted adversely on the end of life care he received. It also meant that Mr and Mrs C were unprepared for Mr C's deteriorating condition leading to his death and that Mr C did not have the opportunity to make choices about his end of life care or to say goodbye properly to his family. In all the circumstances, I uphold the complaint. I have made a number of recommendations to address these failures (see paragraph 36).

(b) Conclusion

34. I outlined the numerous and significant failures by the Consultant in paragraphs 27 to 33. Mrs C has complained that the Board failed to acknowledge the Consultant's failures or to make changes or improvements in their procedures to address them. It is clear that during the local resolution process, the Board acknowledged many of the concerns Mrs C had about the care and treatment provided to Mr C and they have implemented numerous changes to their procedures to address what they saw as system failures (see paragraph 19). The Board also apologised for these failures. However, the Board failed to explain why many of these failures took place, what lessons had been learned and how learning would be disseminated to staff to ensure that what happened did not happen again. Moreover, the Board failed to acknowledge some of the failures by the Consultant which I have outlined, the most significant of which relate to the surgical management of Mr C. Indeed, the Board has stated that the Consultant's surgical management of Mr C followed accepted practice and procedure, despite the conclusion by their Head of Clinical Governance that there was a lack of coordination in clinical care. I therefore uphold the complaint.

35. I have made a number of recommendations relating to the failures outlined in paragraphs 27 to 34.

(a) and (b) Recommendations

36. I recommend that the Board:	*Completion date*
(i) undertake an external peer review in the Hospital, to include: • the procedures relating to the management of biopsies, including communicating biopsy results; • the current strategy for the policy of Living and Dying Well, with particular reference to the implementation of the Liverpool Care Pathway in the role of consultants; • the education and training of staff, particularly consultants, relating to end of life care;	18 November 2011
(ii) ensure that the failings identified in this report are raised with the Consultant during his next appraisal, to ensure lessons have been learned from this case;	18 June 2011
(iii) provide evidence about how feedback from complaints is used as part of the consultant appraisal process; and	18 June 2011
(iv) apologise to Mrs C for the failures identified in this report.	18 June 2011

(c) There was an unnecessary and lengthy delay in the Board's handling of the complaint

37. On 15 September 2006, Mrs C complained to the Board by letter. On 21 September 2006, Mrs C met the Board to discuss her complaint. Following this meeting, Mrs C received several interim responses from the Board before receiving their first substantive response to her complaint on 5 January 2007. On 31 January 2007, Mrs C responded saying that she was dissatisfied with the response because it had failed to answer the questions she had raised in her letter of complaint and it contained a number of inaccuracies. Mrs C and the Board met on 8 March 2007. A note of this meeting was drafted by the Board. It was amended on a number of occasions to take into account Mrs C's comments and provide further information (see paragraph 45). Correspondence relating to the note was exchanged from 22 March 2007 until Mrs C's final meeting with the Board on 13 January 2009. There were a number of action points arising from this final meeting, some of which related to concerns Mrs C had raised in her letter of complaint of 15 September 2006 about the actions of the Consultant. Prior to the meeting of 13 January 2009,

the Consultant wrote to Mrs C on 4 November 2008 to apologise for his communication failures and offered a meeting, which Mrs C accepted. On 14 April 2009, the Board wrote to Mrs C saying the complaint process had now been exhausted. Mrs C wrote to the Board on 15 November 2009 asking them to facilitate a meeting with the Consultant, but the Board responded saying that a further meeting would not be helpful.

38. The Board's complaint correspondence showed that a complaints officer put Mrs C's letter of complaint to the Consultant who, on 30 November 2006, provided a general overview of Mr C's diagnosis and treatment in response, but failed to respond to her specific questions about nutrition, palliative care and oncology referral describing them as 'academic'. It also showed that the Consultant was provided with a copy of correspondence from Mrs C about the inadequacy of the Board's response to her complaint and that he met the Associate Medical Director in June 2007. During this meeting, the Consultant acknowledged shortfalls in communication and delay in recognizing the need for special palliative care. The outcome of the meeting was shared with Mrs C in a letter dated 18 June 2007. Mrs C responded to that letter on 25 June 2007 enclosing a list of outstanding issues that she said had been lifted from previous correspondence. A meeting was then held with Mrs C at her home 7 November 2007. Mrs C e-mailed the Board that day following the meeting with a list of questions that remained outstanding. The complaints officer put Mrs C's questions to the Consultant in a question and answer format on 10 December 2007 and the Consultant responded on 27 February 2008.

39. Section 57 and 58 of the NHS Complaints Procedure states:

> 'It is important that a timely and effective response is provided in order to resolve the complaint, and to avoid escalation. An investigation of the complaint should therefore be completed, wherever possible, 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 reason for the delay with an indication of when a 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. The letter should also indicate that the Ombudsman may be able to review the case at this stage if they do not accept the reasons for the requested extension.'

(c) Conclusion

40. Mrs C has complained that there was an unnecessary and lengthy delay in the Board's handling of the complaint. I have decided that there were failures by the Board in its handling of this complaint. In reaching my decision, I have taken into account that this was a complex complaint which raised a number of significant and serious issues relating to the provision of end of life care to Mr C. From the complaints correspondence, it is clear that the Board were highly motivated to resolve the complaint to Mrs C's satisfaction and that she had expressed her desire in seeing the complaint resolved locally without referral to my office. It is proper that the complaints process gives the body complained about an opportunity to put things right and it is clear that the Board made numerous and significant changes to its clinical procedures as a result of the failures highlighted in this case (see paragraph 19). However, it is also clear that the Board could not resolve some of Mrs C's concerns about the actions of the Consultant, which were fundamental to her complaint and that this was apparent much earlier in the complaints process than 14 April 2009.

41. Some of the issues discussed in the final meeting between Mrs C and the Board on 13 January 2009 related to concerns about the actions of the Consultant which Mrs C had first raised in her letter of complaint of 15 September 2006 and throughout her contact with the Board. Furthermore, much of the delay was of the Board's own doing. Mrs C complained on 15 September 2006 but only received the Board's first substantive response on 5 January 2007 and it is clear that it did not address the many issues Mrs C had raised. The evidence from the Board's complaints correspondence showed that the Board made more effort to investigate and resolve the complaint following the meeting with Mrs C on 8 March 2007, and vigorously attempted to resolve the complaint to Mrs C's satisfaction from December 2007; but this was 13 months after Mrs C's letter of complaint and 11 months after the Board's formal response. That the Board failed to conduct a full and thorough investigation prior to their formal response to Mrs C's letter of complaint was conceded by them when, during the meeting of 8 March 2007, they said a full and thorough investigation would now take place.

42. In view of all the circumstances, I uphold the complaint. Given the significance of the failures I have identified relating to the Consultant and his surgical team, I am extremely concerned at the apparent lack of urgency shown by the Board to investigate the complaints raised against the Consultant. While the Board has apologised to Mrs C about how they handled her complaint, I recommend that they review their procedures to ensure they deal with complaints in accordance with the NHS Complaints Procedure and that they take steps to ensure a situation like this does not reoccur.

(c) Recommendation

43. I recommend that the Board:	*Completion date*
(i) review their procedures to ensure they investigate complaints fully, in accordance with the NHS Complaints Procedure, with particular reference to timescales.	18 June 2011

(d) The notes taken at a meeting with the Board's representatives did not fully and accurately detail the depth of Mrs C's concerns and the outcome she wished to achieve

44. Following the Board's formal response to Mrs C's letter of complaint on 15 September 2006, Mrs C met representatives of the Board on 8 March 2007 to discuss her concerns about their response, her outstanding concerns arising from her complaint and the outcome she wished to achieve by pursuing her complaint. In summary, Mrs C's main concerns were about the Consultant's actions relating to the diagnosis and/or lack of it, communication failures and biopsies. Mrs C wanted the Board to: respond to her queries; acknowledge and address the failures in her husband's care and treatment so that what happened to Mr C and his family did not happen to anybody else; and inform her of the changes the Board had made and the result of the Board's monitoring of the changes.

45. A copy of the note of the meeting drafted by the Board was sent to Mrs C on 22 March 2007. Mrs C wrote to the Board outlining her concerns about the note. The Board acknowledged Mrs C's concerns and amended the note, but said it was difficult and impracticable to write a verbatim report of a three and a half hour meeting. A lengthy exchange of correspondence between Mrs C and the Board about the accuracy of the meeting note followed. By December 2008, the note had developed into a 'Question and Answer Paper', which incorporated amendments Mrs C had made to the original note;

questions she felt had been unanswered by the Board; the Board's responses to those questions; and further comments by Mrs C, including actions which Mrs C considered were outstanding by the Board. There were also a number of action points arising from the final meeting between Mrs C and the Board held on 13 January 2009. Some of these related to concerns about the actions of the Consultant which Mrs C had raised in her letter of complaint of 15 September 2006 and throughout her correspondence with the Board about the note of the 8 March 2007 meeting. Before these action points were implemented, the Board decided to bring local resolution to an end on 14 April 2009.

(d) Conclusion

46. Mrs C has complained that the note taken of the meeting held on 8 March 2007 did not reflect the depth of her concerns and the outcome she wished to achieve by pursuing her complaint. As I have said, Mrs C's complaint concerned complex, serious and wide-ranging issues but she has been consistent in her many dealings with the Board about her complaint and the issues on which she sought a response from the Board in relation to the Consultant's actions. This was a particularly important meeting because its purpose was to explore Mrs C's concerns about the inadequacy of the Board's formal response to her complaint and the issues which had not been addressed by them. It is clear that the original note of the meeting did not reflect this, which the Board accepted having amended it on a number of occasions. I consider that the Board should ensure that all parties attending a meeting are aware of the extent of the minute to be taken and, more importantly, the Board should ensure its accuracy from the outset. I have been critical of the Board's handling of Mrs C's complaint (see paragraphs 40 to 42), particularly in the early stages of the process, and the Board's handling of the meeting note is indicative of its overall handling of the complaint.

47. In all the circumstances, I uphold the complaint. The Board acknowledged Mrs C's concerns about the meeting note and took action to address her concerns. I therefore have no recommendations to make.

(e) Mrs C's request for a meeting with the Consultant was refused unreasonably

48. On 4 November 2008, the Consultant wrote to Mrs C to apologise for communication failures and offered to meet her. During the meeting with the Board on 13 January 2009, Mrs C said that she wanted to meet the Consultant, but after he had addressed the outstanding issues she had relating to his failure to tell them about Mr C's cancer diagnosis. On 14 April 2009, the Board wrote to Mrs C saying the complaint process has now been exhausted. Mrs C wrote to the Board on 15 November 2009 asking them to facilitate a meeting with the Consultant, but the Board responded saying that a further meeting would not be helpful.

(e) Conclusion

49. Mrs C has complained that the Board's refusal to facilitate a meeting with the Consultant was unreasonable. I have decided that the Board's decision was, in the circumstances, reasonable. I appreciate that an offer of a meeting had been made to Mrs C several times throughout the complaints process and that this was subsequently withdrawn. However, the Board finally brought local resolution to an end after three years and a meeting with the Consultant would have extended this further with no guarantee that it would have achieved anything more for Mrs C. I do not uphold the complaint.

50. 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

Mrs C	The complainant
Mr C	The complainant's late husband
The Board	Forth Valley NHS Board
The Hospital	Stirling Royal Infirmary
The Consultant	A consultant surgeon at Forth Valley NHS Board
The Adviser	One of the Ombudsman's professional advisers
CT Scan	Computer Tomography scan

Annex 2

Glossary of terms

Barium x-ray	A procedure used to diagnose various gastrointestinal tract disorders
Gastroscopy	Procedure to examine the inside of the gullet, stomach and duodenum
Laparotomy	Large incision made into the abdomen
Pancreatitis	Inflammation of the pancreas (a gland located behind the stomach)
Parenteral nutrition	Special feeding delivered through a tube inserted into a large neck vein

Annex 3

List of legislation and policies considered

Liverpool Care Pathway

NHS Complaints Procedure

Living and Dying Well