Scottish Parliament Region: Mid Scotland and Fife

Case 201003402: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns regarding the care and treatment of her late mother (Mrs A) during an admission to Queen Margaret Hospital in Dunfermline (the Hospital) between 12 April 2010 and her death on 5 May 2010.

Specific complaints and conclusions

The complaints which have been investigated are that Fife NHS Board (the Board):

(a) failed to continue with antibiotic treatment after the course of Amoxicillin (an antibiotic) was completed at 22:00 on 1 May 2010, despite Mrs A's rapidly deteriorating condition (*upheld*);

(b) failed to act on the concerns Mrs C raised on 2 May 2010 (*upheld*);

(c) were unaware that Mrs A was expectorating thick green sputum (matter coughed up from the lungs) on 1 May 2010, when this is documented in the medical records (*upheld*);

(d) failed to inform Mrs C about Mrs A's deteriorating condition (*upheld*);

(e) failed to ensure that oral medication administered to Mrs A when she was in a semi-conscious state did not remain in her mouth from 08:00 on 5 May 2010 until Mrs C pointed this out at 14:00 on 5 May 2010 (*not upheld*);

(f) failed to provide an Incident Report regarding when Mrs A was inappropriately handled and spoken to (*upheld*);

(g) failed to ensure complaint (f) was investigated (*upheld*);

(h) disagreed about the cause of death after the Death Certificate was issued and registered (*not upheld*); and

(i) made inconsistent statements in their original complaint response to those made at a face-to-face meeting - specifically about the presence of infection (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	provide me with an update regarding their implementation of the measures described in their letter to my office dated 24 March 2011;	14 March 2012
(ii)	review the means by which the clinical judgements of HAN members who see patients independently are monitored;	14 March 2012
(iii)	conduct a review of information handover from team to team, with a view to identifying how this can be strengthened;	14 March 2012
(iv)	consider Adviser 2's comments on the failings in Mrs A's nursing care and draw up and implement an action plan to address these failings;	14 March 2012
(v)	apologise to Mrs C for the failure to investigate complaint (f) properly;	15 February 2012
(vi)	ensure that serious complaints are appropriately recorded and investigated;	15 February 2012
(vii)	inform me of the outcome of their discussions with regard to completing death certificates and tell me what measures they have taken to ensure that, in future, the cause of death listed on a death certificate is accurate; and	15 February 2012
(viii)	ensure that clinical records are thoroughly reviewed as part of their investigation process and prior to providing responses to complaints.	15 February 2012

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

Main Investigation Report

Introduction

1. On 12 January 2011, the Ombudsman received a complaint from Mrs C about the care and treatment received by Mrs A, her late mother, during an admission to Queen Margaret Hospital in Dunfermline (the Hospital) between 12 April 2010 and 5 May 2010. Mrs A, an 83-year-old woman, was referred to the Hospital by her GP to address fluid retention, assess kidney function and improve her mobility. Mrs A was admitted to the Hospital with cardiorespiratory (heart and breathing) symptoms. After a period of gastrointestinal (stomach and intestines) illness due to an outbreak in the Hospital of the norovirus infection (a virus that causes stomach and intestines infections) that Mrs A contracted, her breathing deteriorated and she died at the Hospital on 5 May 2010.

2. The complaints from Mrs C which I have investigated are that Fife NHS Board (the Board):

(a) failed to continue with antibiotic treatment after the course of Amoxicillin was completed at 22:00 on 1 May 2010, despite Mrs A's rapidly deteriorating condition;
(b) failed to act on the concerns Mrs C raised on 2 May 2010;
(c) were unaware that Mrs A was expectorating thick green sputum on 1 May 2010, when this is documented in the medical records;
(d) failed to inform Mrs C about Mrs A's deteriorating condition;
(e) failed to ensure that oral medication administered to Mrs A when she was in a semi-conscious state did not remain in her mouth from 08:00 on 5 May 2010 until Mrs C pointed this out at 14:00 on 5 May 2010;
(f) failed to provide an Incident Report regarding when Mrs A was inappropriately handled and spoken to;
(g) failed to ensure complaint (f) was investigated;
(h) disagreed about the cause of death after the Death Certificate was issued and registered; and
(i) made inconsistent statements in their original complaint response to those made at a face-to-face meeting - specifically about the presence of infection.

Investigation

3. As part of the investigation, my complaints reviewer obtained copies of Mrs A's clinical records and the complaints correspondence from the Board.

Advice was sought from one of my independent medical advisers (Adviser 1) and one of my independent nursing advisers (Adviser 2).

4. 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 Board failed to continue with antibiotic treatment after the course of Amoxicillin was completed at 22:00 on 1 May 2010, despite Mrs A's rapidly deteriorating condition; and (b) The Board failed to act on the concerns Mrs C raised on 2 May 2010

5. As they are closely interlinked, I am dealing with complaints (a) and (b) together in this report.

6. In her letter of complaint to the Board dated 13 May 2010, Mrs C questioned why no further antibiotic treatment had been administered to Mrs A after Amoxicillin was found to be ineffective and her chest condition had got worse. She said that antibiotics were only administered following requests from Mrs A's family. Mrs C stated that this treatment was provided only at the instigation of family members, who raised concerns about the clinical judgement associated with Mrs A's treatment. Mrs C also said that the Board failed to act on the concerns that she raised on 2 May 2010 regarding Mrs A's treatment.

7. After accessing Mrs A's clinical records and during a meeting with the Board on 26 October 2010, Mrs C noted that a sample of Mrs A's sputum had been sent for analysis and that the results of this analysis showed that Amoxicillin was not the correct antibiotic to prescribe Mrs A. Mrs C said that the results were available on 30 April 2010 but were not accessed over that weekend. She said that these results showed that Mrs A had an infection that had required antibiotic treatment. Mrs C considered that the Board had been negligent in not providing antibiotic treatment sooner.

The Board's response

8. In responding to Mrs C's initial complaint, the Board explained that the doctor in charge of Mrs A's care and treatment (Doctor 1) considered that, prior to 3 May 2010, a wheeze was Mrs A's predominant problem. Doctor 1 found little evidence of significant infection, with no fever, no abnormal blood results and no convincing chest x-ray changes. The Board explained that this was the reason why Mrs A was not treated with more aggressive antibiotics sooner.

They said it was not until the physiotherapist managed to clear the thick, green secretions from Mrs A's chest on 3 May 2010 that it was considered appropriate to treat a significant infection and prescribe further antibiotics.

9. The Board said that it was good clinical practice for staff to know what they were treating before prescribing antibiotics if a patient was well enough to wait. In Mrs A's case, they said that the only clinical observation which was not normal was a raised breathing rate and this could be explained by a number of reasons, including an upset stomach and fluid on the chest. The Board said that elderly patients were particularly prone to developing antibiotic related complications and Mrs A had already received one course of antibiotics while in hospital, which would make her more vulnerable. The Board said that, in these circumstances, the decision to hold off administering antibiotics was understandable and reasonable.

10. During a meeting between the Board and Mrs C's family on 26 October 2010, the Board accepted that antibiotics might have been prescribed sooner but that it was not necessarily wrong that this did not happen. The Board also accepted that the sputum analysis results should have been accessed, although they reiterated that no clinical markers of infection had been observed.

11. On 24 March 2011, in responding to my complaints reviewer's request for information, the Board provided additional comments following a further review of Mrs A's clinical records conducted by their Medical Director. The Board accepted that two laboratory results showing evidence of infection were not accessed. They said that these were available from 30 April 2010. The Board said they wished to offer an unreserved apology that these results were not accessed. They said that, in the face of a deteriorating patient with purulent sputum (sputum containing pus) who had been on an antibiotic to which the infection was resistant, most clinicians would have opted to start with an alternative antibiotic on 30 April 2010.

12. The Board said it was impossible to say whether this would have made any difference to Mrs A in the long term. The Board explained that the last chest x-ray taken on 3 May 2010 showed evidence of a pleural effusion (fluid in between layers of tissue in the lungs), peripheral vascular engorgement (secondary distention with fluids), granuloma (inflammation) on the right apex and Kerley B lines in the left mid zone (an x-ray finding indicating heart

disease). They said that with the exception of the granuloma these were all features of left ventricular failure (a type of heart failure) and which suggested that Mrs A's death may have been more related to cardiac (heart) issues rather than respiratory (breathing) issues.

13. The Board said that, with regard to Mrs A's clinical assessment in early May 2010, a more senior review should have taken place. They said that there was no evidence that the management plan initiated on 1 May 2010 was reviewed at all on 2 May 2010. They said that the recorded evidence of a medical review was 36 hours after the review on 1 May 2010. The Board said that it was difficult to say whether this would have affected the outcome for Mrs A, but that it explained why Mrs A's family were concerned about her care.

14. The Board stated that this case had indicated two areas they were working to improve within their Emergency Care Directorate. These issues were: a failure to respond to and rescue deteriorating patients; and the issue of handover between clinical teams. The Board said they were looking at improving responses to deteriorating FEWS (Fife Early Warning System) scores and also looking at other ways to monitor deterioration. The Board said that even though Mrs A was clearly deteriorating, the FEWS score would not have been a good trigger for intervention in this case. They said that the only time that Mrs A's FEWS score would have triggered medical review was at 16:00 on the day of her death. The Board said they were discussing modifying the FEWS score to take into account those patients who become dependent on additional oxygen to maintain their oxygen saturation. They explained that this would certainly have triggered an earlier review of Mrs A.

15. With regard to the failure to access the laboratory results, the Board said that although the IT system made individual results available at ward level, it did not generate a daily ward list of results. The Board said they were looking for a solution to this and envisaged that in future they would try to develop a mechanism whereby wards downloaded a full list from the laboratory computer every morning.

Adviser 1's comments

16. Adviser 1 prefaced his comments by saying that he agreed with the Board that there was a failure to access laboratory results and that a more senior medical review should have taken place on 1 May 2010.

17. Adviser 1 said that Mrs A's deterioration and death was dominated by the presence of wheeze and progressive breathlessness. He said it was likely that Mrs A's clinical condition was due to a combination of cardiac failure, asthma and pulmonary infection. He said that the relative contribution of these factors varied at different points in her clinical course.

18. Adviser 1 said that purulent sputum was first noted and commented on in the clinical record on 25 April 2010 by a junior doctor, who suggested that sputum samples be sent for analysis. He said that most clinicians would prescribe an antibiotic as part of the treatment of an elderly patient with wheeze and breathlessness, if purulent sputum or other markers of infection were present. He said that in Mrs A's case there was purulent sputum, worsening wheeze and breathlessness and an increase in the neutrophil (type of white blood cell) count in the blood (although this might relate to the concurrent steroid treatment) all compatible with infection.

19. Adviser 1 said the clinicians did decide, at the onset of cardiorespiratory symptoms, that antibiotic treatment was indicated and this decision was endorsed by a consultant. Adviser 1 said he concluded from this that the clinicians must have felt at the time that bacterial infection was at least a contributory factor in Mrs A's symptoms. Given this, he said that when Mrs A started to deteriorate on or around 1 May 2010, the possible role of persistent ongoing infection – perhaps due to a resistant organism – should normally be considered. He said this would particularly be the case in a patient who was due to stop (and did stop) a course of antibiotics already prescribed (see paragraph 6).

20. Adviser 1 said that the failure to consider the need for further antibiotics was particularly concerning, given the fact that the sputum samples suggested by the junior doctor had actually been given and sent for analysis, and that two out of the three had, by 1 May 2010, shown infection with an organism resistant to the prescribed antibiotic and known to cause refractory infection in patients with pre-existing lung disease. Adviser 1 said that the fact the laboratory results were not accessed showed that continuing infection was not seriously considered as a cause of Mrs A's deterioration. He said that, in the presence of purulent sputum and given the clinical deterioration of the patient, most clinicians would have prescribed further and broader spectrum antibiotics.

21. Adviser 1 concluded that the failure to consider further antibiotic treatment on 1 May 2010, and the failure to consider the existence of relevance of laboratory results, fell below the standard of care that could reasonably be expected. He stressed, however, that had the antibiotics been changed or recommenced earlier this may not have had any effect on the outcome for Mrs A.

22. Adviser 1 commented on two areas where he felt the Board could improve their performance. He said that his comments related to the Hospital at Night (HAN) team. He explained that HAN systems were common in the NHS and provided a means to deliver out-of-hours (nights and weekends) care in many hospitals. He said that handover of information to the HAN team when it came on shift and from the HAN team when it finished its shift was critical to ensure safe and effective operation. Adviser 1 said that it was not clear that the handover of information from the HAN team to the day teams was, on all occasions, as effective as it needed to be.

23. Adviser 1 also pointed out that HAN teams that utilise the skills of non-medical staff such as Advanced Nurse Practitioners should have clear systems to ensure that staff are adequately supported and that their judgements are backed up by medical staff where appropriate. He said that, in Mrs A's case, the assessment conducted on 1 May 2010 could usefully have been complemented by a further medical assessment, however, a doctor did not review Mrs A for 36 hours following the assessment by an Advanced Nurse Practitioner. Adviser 1 stressed again that it could not be said whether such a review would have led to a different outcome for Mrs A. He advised that the Board could usefully review the means by which the clinical judgements of HAN members who see patients independently are monitored and how the handover of clinical information from team to team can be strengthened.

Adviser 2's comments

24. On reviewing the clinical records, Adviser 2 said that there was no record of Mrs C having raised concerns with the Board's staff on 2 May 2010. However, commenting generally on the nursing notes, Adviser 2 said that they were barely acceptable. She said the records provided minimal information about some of the technical aspects of Mrs A's care and that communication with Mrs A's family had been minimal and only when asked.

(a) Conclusion

25. The Board have accepted that antibiotics should have been prescribed to Mrs A after she completed her course of Amoxicillin on 1 May 2010. The Board have also accepted that laboratory results which should have been accessed were not accessed and that Mrs A should have been reviewed by a more senior doctor. Adviser 1 has agreed with this assessment and is critical of the inadequate care and treatment provided to Mrs A, and of the failures to access laboratory results, conduct a more senior review and prescribe Mrs A with antibiotics. I am satisfied that these were significant failings in this case and, consequently, I uphold complaint (a).

(b) Conclusion

26. With regard to complaint (b), Adviser 2 stated that there are no entries in the nursing records to indicate the concerns Mrs C had about Mrs A on 2 May 2010. However, I have no reason not to believe that Mrs C had raised her concerns with the Board's staff or that her account of these concerns she had outlined in her complaint to the Board was inaccurate. I also note Adviser 2's comments on the overall inadequate quality of the nursing notes. This suggests to me that the concerns which were raised by Mrs C may not have been appropriately recorded. This, combined with Adviser 1's view that the Board should have done more to treat Mrs A's deteriorating condition between 1 and 3 May 2010, leads me to the view, on balance, that Mrs C did raise concerns with the Board and these were not acted on. Taking all these factors into account, I uphold complaint (b).

27. With regard to recommendations, I welcome the actions that the Board have said they will take in light of the complaint (see paragraphs 14 and 15). I have asked the Board to update me on the implementation of those measures. I am also making recommendations in light of Adviser 1's concerns regarding the HAN team.

(b) Recommendations

28. I recommend that the Board:	*Completion date*
(i) provide me with an update regarding their implementation of the measures described in their letter to my office dated 24 March 2011;	14 March 2012
(ii) review the means by which the clinical judgements of HAN members who see patients independently	14 March 2012

	are monitored; and	
(iii)	conduct a review of information handover from team to team, with a view to identifying how this can be strengthened.	14 March 2012

(c) The Board were unaware that Mrs A was expectorating thick green sputum on 1 May 2010, when this is documented in the medical records

29. Mrs C was concerned that the Board's response to her complaint dated 20 July 2010 stated that Mrs A did not expectorate thick green sputum until she was seen by the physiotherapist on 3 May 2010. Mrs C said this was incorrect and that the clinical records showed she had been expectorating thick green sputum since 1 May 2010.

The Board's response

30. During a meeting with Mrs A's family on 26 October 2010, the Board accepted that their response had been inaccurate and the records showed clearly that green sputum was noted as being present on 1 May 2010.

(c) Conclusion

31. It is clear that the Board's original response to Mrs C's complaint contained an inaccuracy. As a result, I uphold this complaint.

32. I am pleased to note that the Board accepted that a mistake had been made when Mrs C pointed this out to them. As the Board have accepted this, I have no recommendation to make.

(d) The Board failed to inform Mrs C about Mrs A's deteriorating condition

Adviser 2's comments

33. Adviser 2 said that the first record of a meeting between Mrs C and the Board's staff was on 1 May 2010. She said the nursing notes recorded on 3 May 2010 that a doctor had spoken with the family and a Do Not Resuscitate form was completed by Mrs A's daughters, in consultation with a doctor. Adviser 2 said that the medical records corresponded with this. On 5 May 2010 the medical records noted, in an untimed entry, that a junior doctor's plan of care for Mrs A was to 'inform relatives' although there is no record of the doctor contacting the family. Adviser 2 said the family were not contacted until death was imminent and, therefore, the family did not arrive until after Mrs A had died.

34. Adviser 2 noted that it was difficult to assess when a patient deteriorated and when it was the appropriate time to call the family. She said that nursing staff would not want to distress families by calling them to visit unnecessarily. She said there were no hard or fast rules about this. However, Adviser 2 said that communication with Mrs A's family appeared to be minimal and only provided when asked. She said that even in Mrs A's final hours, she could find little evidence in the records to indicate that death was expected. She said that Mrs A's family was not afforded important time to say their goodbyes to her.

(d) Conclusion

35. I agree with Adviser 2's view that communication with Mrs A's family was minimal. Full and timely communication with her family should have taken place, particularly towards the end of Mrs A's life, and I am not convinced from seeing the clinical records that this occurred. I accept that it can be difficult to identify when deterioration occurs and that informing relatives promptly needs to be balanced with avoiding causing them unnecessary distress. However, in this case, the fact that there is no evidence that the untimed entry from the doctor to 'inform relatives' was carried out, along with the fact that communication with the family was generally minimal, leads me to the conclusion that the Board did not do enough to inform Mrs A's family about her deteriorating condition. Consequently, I uphold this complaint.

(e) The Board failed to ensure that oral medication administered to Mrs A when she was in a semi-conscious state did not remain in her mouth from 08:00 on 5 May 2010 until Mrs C pointed this out at 14:00 on 5 May 2010

36. In her letter of complaint to the Board dated 13 May 2010, Mrs C said that on the day of her death Mrs A's tongue, gums and lips were coated with a white substance. A member of the clinical staff was alerted to this and said that it was 'just her tablets'. Mrs C said that, at this point, Mrs A was semi-conscious and the fact that she was given medication orally was concerning. She said that, not only was this not effective, but it could also have led to Mrs A choking on or inhaling parts of the tablet.

The Board's response

37. The Board's response to Mrs C's complaint dated 20 July 2010 stated that entries in the nursing notes recorded that Mrs A's responsiveness was variable. They said that nursing staff assessed her ability to take anything orally on all occasions and would not have given her anything by mouth had they assessed

that she would have been unable to do so. In the subsequent meeting the Board held with Mrs A's family on 26 October 2010, the Board said that they had investigated the matter and Mrs A had been assessed as being able to take her medication.

Adviser 2's comments

38. Adviser 2 said that, according to the drug administration chart, Mrs A was given Aspirin and Predisolone (a steroid) at 08:00 on 5 May 2010. She said that she could not be sure the tablets were still in Mrs A's mouth at visiting time, but there was no reference to nursing staff providing mouth care to Mrs A until 16:15 on 5 May 2010. Adviser 2 said that after her deterioration, Mrs A was having oxygen therapy, which dries the mouth, and that she was reported as not tolerating fluids. She said, therefore, that her mouth would be very dry and she would have expected nursing staff to provide total care for Mrs A at this time as she was unable to drink, receiving oxygen and unable to tend to her own personal hygiene. Adviser 2 said the nursing response to this situation should have involved a nursing plan including regular washes and daily bed bath, two-hourly mouth care and pressure area care, and assistance with eating and drinking. Adviser 2 said that the records did not indicate that this level of nursing care was provided and she was, therefore, critical of the care Mrs A received in her final days.

(e) Conclusion

39. I agree with Adviser 2 that it is impossible to say, at this distance from the described event, whether tablets remained in Mrs A's mouth from the time they were administered until 14:00 and whether they were responsible for the white coating on Mrs A's mouth, lips and tongue. In the absence of evidence that this did occur, I do not uphold this complaint.

40. I am, however, concerned at the failings in nursing care identified by Adviser 2. Whether or not tablets had been in Mrs A's mouth from 08:00 to 14:00 on the day of her death, the nursing records show that, overall, an insufficient level of care was provided to Mrs A with regard to her mouth care and her nursing care. I share Adviser 2's concerns about this and am, therefore, critical of the nursing care provided to Mrs A in this case.

(e) Recommendation

41. I recommend that the Board: *Completion date*

(i) consider Adviser 2's comments on the failings in Mrs A's nursing care and draw up and implement an action plan to address these failings; — 14 March 2012

(f) The Board failed to provide an Incident Report regarding when Mrs A was inappropriately handled and spoken to; and (g) The Board failed to ensure complaint (f) was investigated

42. As these issues are closely interlinked, I am dealing with complaints (f) and (g) together in this report.

43. In her complaint to the Board dated 13 May 2010, Mrs C said that nursing staff had been informed of Mrs A's mobility problems but were unable to comprehend what this meant and how they should move her. Mrs C complained that on one occasion this resulted in a staff member shouting at Mrs A and throwing her legs back on the bed and damaging her skin, which then required a dressing to be applied. The Senior Charge Nurse was alerted to the incident, he apologised and agreed that what had happened was not acceptable and the issue would be addressed. Mrs C said there were no further incidents of this kind during Mrs A's stay.

44. Subsequently, when reviewing Mrs A's clinical records, Mrs C noted that there was no entry in the notes about this incident. She asked the Board what action had been taken against the member of staff responsible and why an Incident Form had not been filled out.

45. Mrs C was also concerned that, despite her having raised her complaint on 13 May 2010, the Board did not request a statement from the member of staff responsible until after their meeting on 26 October 2010.

The Board's response

46. In their initial response to this complaint, the Board said that the Charge Nurse had spoken to the member of staff. She had also reminded all staff (i) of their responsibility to adhere to the safe moving and handling of patients; and (ii) on their role in ensuring that information relayed by the patient and their families is adhered to as and when appropriate.

47. Following concerns raised during the meeting with the Board on 26 October 2010, the Board agreed that the incident required further investigation and said they would take a statement from the Bank Nurse in

question. On 8 December 2010, the Board wrote to Mrs C stating that the Bank Nurse had been asked to respond to Mrs C's complaint but that, due to the passage of time, was unable to recollect the incident.

Adviser 2's comments

48. Adviser 2 noted that there was no Incident Report or statement in the clinical records. She said that the only reference to the incident in the nursing notes was an entry which said 'patient reported spoken to inappropriately by nursing auxiliary and reported to daughter'. She said that an Incident Form should have been completed (and could still have been completed when the complaint was made). Adviser 2 said that Mrs C's complaint was a serious one and that an investigation should have taken place.

(f) Conclusion

49. The Board clearly failed to ensure that an Incident Form was completed and to investigate properly what was a serious complaint against a member of its staff. Consequently, I uphold complaint (f).

(f) Recommendation

50. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the failure to investigate complaint (f) properly.	15 February 2012

(g) Conclusion

51. It is also concerning that the Board failed to notice (when Mrs C raised the matter as part of her formal complaint to the Board) that no Incident Form had been filled out and no statement had been taken from the member of staff concerned. While the Board say that they responded to the matter informally at the time, I would question whether this was an appropriate response to a complaint which alleged that an elderly patient was shouted at and handled roughly. While I encourage the informal and early resolution of complaints wherever possible, serious complaints clearly require more robust and formal investigations. Whatever the status of the investigation, the absence of appropriate documentation (the Incident Form and a statement from the member of staff concerned) represents a significant failing. I also agree with Mrs C that the Board could have asked the member of staff concerned for a statement much sooner after the formal complaint was made on 13 May 2010 and this would have shed light on what had happened. In light of these concerns, I uphold complaint (g).

(g) Recommendation

52. I recommend that the Board:	*Completion date*
(i) ensure that serious complaints are appropriately recorded and investigated.	15 February 2012

(h) The Board disagreed about the cause of death after the Death Certificate was issued and registered

53. In her complaint to the Board, Mrs C said that she was shocked to see that the cause of Mrs A's death was recorded on the Death Certificate as being hospital acquired pneumonia, which had never been mentioned to the family.

The Board's response

54. In the Board's subsequent response, they stated that Mrs A's condition did not show evidence of hospital acquired pneumonia. The Board said they were uncomfortable with the Death Certificate and that it did not do justice to Mrs A's condition. They said they would speak to medical staff concerned about the cause of death.

55. The Board said that, following further investigation, they found that the Death Certificate had been completed by a junior member of medical staff and there was no evidence that the Death Certificate was discussed with anyone more senior. They said it was the case that death certificates were sometimes issued immediately as it helped grieving families to make the necessary arrangements but, nevertheless, it was important that the details provided were accurate.

56. The Board said they would discuss the issue with their Medical Director and consider whether their current practice should be reviewed. They said they were aware that in some other health boards every death certificate had to be discussed with the responsible consultant.

(h) Conclusion

57. I note that, on reviewing Mrs A's case following Mrs C's complaint, the Board had concerns about the cause of death as recorded on the Death Certificate. I note that the Board did not feel the Death Certificate was a true reflection of Mrs A's condition and that this was due to the certificate being completed by a junior doctor without a more senior review. In these circumstances, I consider it acceptable for the Board to disagree with the cause

of death on the certificate and, on reflection and following more senior review, to take a different view. Consequently, I do not uphold this complaint.

58. I acknowledge that it would have been upsetting and confusing for Mrs A's family that the Death Certificate, as originally completed, did not properly reflect Mrs A's condition. I note that the Board said they would discuss whether their practice should be changed in the future. I am recommending that the Board inform me of the outcome of these discussions and advise on the measures they have taken to ensure that the cause of death listed on a death certificate is accurate.

(h) Recommendation

59. I recommend that the Board:	*Completion date*
(i) inform me of the outcome of their discussions with regard to completing death certificates and tell me what measures they have taken to ensure that, in future, the cause of death listed on a death certificate is accurate.	15 February 2012

(I) The Board made inconsistent statements in their original complaint response to those made at a face-to-face meeting - specifically about the presence of infection

Adviser 1's comments

60. Adviser 1 said it was common for clinicians to have uncertainty about diagnosis but that the presence of such uncertainty did not imply incompetence or sub-standard care. He said that the presence of inconsistencies in the complaint correspondence in this case related, in part, to the fact that clinicians could not be sure exactly what was happening to the patient, in life or after. Adviser 1 said he did not feel this uncertainty could be criticised or avoided.

61. Adviser 1 said, however, that the inconsistencies also related to the fact that the Board were not aware that sputum samples had been sent for analysis, were abnormal and had not been accessed before the first complaint response was issued. Adviser 1 said it appeared that the Board were not aware of these results until Mrs A's family (who had by then seen the clinical records) raised the issue at a meeting with the Board.

62. Adviser 1 said that he felt the Board should consider the means by which they review clinical records, following a complaint, to ensure that all relevant

information is included and that accurate initial complaint responses are produced.

(i) Conclusion

63. It is clear that there were inconsistencies in the Board's complaints response relating to the presence of infection. Had the Board thoroughly reviewed Mrs A's clinical records prior to responding to Mrs C's complaint, they would have realised that sputum samples showing infection had not been accessed by their staff and that this was highly relevant to the complaint. It is likely that this would have avoided the inconsistencies that occurred in this case.

64. In addition to failing to conduct a thorough review of the clinical records as part of their complaints response, I note that the further review conducted by the Board on 24 March 2011 (on receipt of a request for information from my office) identified failings which had not been clearly identified as part of the Board's initial investigation. While I commend the Board for conducting this further review and being willing to identify and learn from any mistakes, it is clear that a more thorough review as part of the initial complaint handling would have been beneficial.

65. In light of the above, I uphold this complaint.

(i) Recommendation

66. I recommend that the Board:	*Completion date*
(i) ensure that clinical records are thoroughly reviewed as part of their investigation process and prior to providing responses to complaints.	15 February 2012

67. 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
Mrs A	The aggrieved, Mrs C's late mother
The Hospital	Queen Margaret Hospital, Dunfermline
The Board	Fife NHS Board
Adviser 1	One of the Ombudsman's clinical advisers
Adviser 2	One of the Ombudsman's nursing advisers
Doctor 1	The doctor in charge of Mrs A's care and treatment
FEWS	Fife Early Warning System
HAN team	The Hospital at Night team

Annex 2

Glossary of terms

Amoxicillin	An antibiotic
Cardiac	Relating to the heart
Cardiorespiratory symptoms	Heart and breathing symptoms
Gastrointestinal illness	Stomach and intestines illness
Granuloma	An inflammation
Kerley B Lines	An x-ray finding indicating heart disease
Left ventricular failure	A type of heart failure
Neutrophil	A type of white blood cell
Norovirus	A virus that causes stomach and intestines infections
Peripheral vascular engorgement	Secondary distention with fluids
Pleural effusion	Fluid in between layers of tissue in the lungs
Predisolone	A steroid
Purulent sputum	Sputum containing pus
Respiratory	Relating to breathing
Sputum	Matter coughed up from the lungs