Scottish Parliament Region: North East Scotland

Case 201004234: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital – General Surgical; clinical treatment; diagnosis; complaints handling

Overview

The complainant (Miss C) had difficulties with recurrent ear infections due to a perforated right eardrum. In November 2010, she underwent a myringoplasty in order to treat this. Miss C experienced significant problems following the procedure, including balance problems, sickness and significant hearing loss in her right ear. In January 2011 she underwent a hearing test which confirmed the hearing loss, with limited options for treating this. Miss C complained to Tayside NHS Board (the Board) in January and March 2011 about the treatment she received including the treatment following the myringoplasty, but did not receive a final response until June 2012.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to carry out appropriate surgery and follow-up treatment following the myringoplasty on 5 November 2010 (*not upheld*);

(b) failed to explain that the risks of surgery could result in hearing loss or balance problems (*not upheld*); and

(c) failed to respond to Miss C's complaints in accordance with the NHS complaints procedure (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) offer Miss C an appointment with a senior otologist to discuss possible surgical options;	12 June 2013
(ii) provide evidence that staff on Ward 26 are aware of the procedure that should be followed when patients report post-operative problems;	19 June 2013
(iii) amend their Informed Consent Policy to ensure	4 September 2013

	that patients who sign a consent form prior to treatment are given the option of receiving a copy;	
(iv)	remind the medical staff involved in this complaint of the need to confirm consent as per the Informed Consent Policy;	5 June 2013
(v)	conduct an audit of their internal complaints handling process to ensure that all complaints received are properly handled as per the Board's complaints procedure; and	31 August 2013
(vi)	give a full and sincere apology to Miss C for the outcome of the myringoplasty, and for all the failings identified within this report.	5 June 2013

Main Investigation Report

Introduction

1. Miss C is thirty years old. She had had problems with her ears from childhood due to Eustachian tube dysfunction, with had resulted in grommet insertion. This in turn, however, led to perforation of the right eardrum, which meant Miss C was experiencing frequent recurrent ear infections and conductive deafness. In June 2010, she attended an appointment with a Professor of Otolaryngology (the Professor), who referred Miss C for an appointment with an Ear, Nose and Throat Consultant (Consultant 1) at Ninewells Hospital (the Hospital) in September 2010, during which the option of a myringoplasty was discussed. Miss C agreed to go on the waiting list for this procedure whilst she continued to consider whether she would definitely like to opt for surgery.

2. Miss C decided to proceed with the myringoplasty, and underwent the procedure on 5 November 2010. Miss C described that she subsequently left the Hospital in a very poor state of health, with significant balance problems. She said that over the next two days she continued to feel very unwell with nausea and vomiting in addition to her difficulties with balancing. She also had significant hearing loss in the right ear. She explained she requested to be admitted back into the ear, nose and throat ward (Ward 26) at the Hospital on several occasions over the next fortnight but this was refused by the Registrar on duty. Miss C was seen by Consultant 1 again on 19 November 2010, and again on 6 January 2011, where a hearing test confirmed considerable loss of hearing in Miss C's right ear, with there being little chance of this improving. Miss C said she felt this had arisen directly as a result of the surgical procedure, and was not due to a coincidental episode of labyrinthitis, which was given as a possible explanation by Consultant 1 during the November 2010 appointment.

3. Miss C complained to Tayside NHS Board (the Board) on 11 January 2011, and also formally sought a copy of her medical records. She also requested a second opinion. It was her position that she had been advised this was a procedure with little or no risk, yet she had been left with a significant disability, which had a lasting and enormously distressing impact upon her life, both personally and professionally. The Board responded on 8 February 2011, detailing and explaining the care Miss C had received. Miss C was not satisfied with this response and complained again on 28 March 2011, asking that the second opinion she had requested be arranged. She also noted that she had

undergone an magnetic resonance imaging (MRI) scan, which had ruled out the possibilities for the cause of the hearing loss that Consultant 1 had given to her. She said in her opinion this confirmed the cause was due to a lack of care and skill during the procedure itself.

4. Miss C was seen by another ear, nose and throat consultant (Consultant 2) on 18 April 2011. She was also referred to a hearing therapist within the Audiology Department at the Hospital. The Board had also written to Miss C on 11 April 2011 advising they would conduct a formal investigation regarding her concerns.

5. However, Miss C was required to continue writing to the Board's Complaints and Advice Team with regards to her request for medical records and the outcome of the formal investigation. She also sought assistance from the Board's Chairman in obtaining a response. The medical records were not forthcoming until December 2011, nearly one year after Miss C's request. Furthermore, Miss C did not receive a full response to her second letter of complaint until June 2012, fifteen months later. Miss C brought her complaints to my office in June 2012. She described that her hearing loss was now considered to be severe, she faced the prospect of wearing a hearing aid for the rest of her life, she continued to be afflicted with ear infections, balance problems and bouts of nausea, was unable to participate in sport and exercise as she had done before, and had a polyp and perforation in the affected ear which both continued to be monitored. She described the post-operative care she had received, as well as the Board's complaint handling, as 'appalling'. Miss C said she wanted the Board to accept responsibility for her hearing loss.

6. The complaints from Miss C which I have investigated are that the Board:

(a) failed to carry out appropriate surgery and follow-up treatment following the myringoplasty on 5 November 2010;

(b) failed to explain that the risks of surgery could result in hearing loss or balance problems; and

(c) failed to respond to Miss C's complaints in accordance with the NHS complaints procedure.

Investigation

7. In order to investigate Miss C's complaints, my complaints reviewer obtained and reviewed the complaints correspondence between Miss C and the Board. She also obtained and reviewed Miss C's medical records, and sought

independent clinical advice from one of my advisers, a consultant ear, nose and throat surgeon (the Adviser).

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

(a) Failed to carry out appropriate surgery and follow-up treatment following the myringoplasty on 5 November 2010

9. Miss C was of the opinion that the significant problems she experienced post-surgery were as a result of the surgery being carried out without the appropriate care and skill. She wanted the Board to accept responsibility for this.

10. In the Board's response of 8 February 2011, they said the procedure was carried out by a specialist registrar, assisted by Consultant 1. They said the Specialist Registrar was very senior and had a special interest in ear surgery. They said there was no record of any problems with the anaesthetic, and the operation was very straightforward and proceeded with no apparent difficulties, which was why Consultant 1 had been so surprised by the symptoms Miss C subsequently experienced. The Board also said that, because Miss C had been well enough to be discharged the day following the surgery, Consultant 1 had had no suspicions of any serious complications. They said, however, that Consultant 1 accepted Miss C's balance problems may have been linked to the surgery. In their second response letter of 5 June 2012 though, the Board said:

> 'there is insufficient evidence to respond to the underlying question of whether or not the operation was the cause of [your] hearing loss and imbalance, as these are associated risks with this type of surgery.'

11. My complaints reviewer asked the Adviser whether, in his opinion and from the records, the myringoplasty had been performed appropriately. He said that the operation being performed by a senior trainee and supervised by a consultant throughout was reasonable, and that in fact it would not have been unreasonable for a trainee of this experience to work unsupervised on a procedure of this kind. The Adviser said the procedure was well documented, with a written record of the sequence of the surgery noting standard practice (including one hour of operating time) and no adverse events. He noted that unfortunately, however, the graft had failed to take, therefore, the primary intentions of an intact eardrum and prevention of infections in the future had not

been achieved, but this did not mean the operation was performed inappropriately. He noted that Miss C had had a lifetime of poor ear function, and that the Professor had noted scarring in the ear during his initial assessment of Miss C, all of which could compromise a successful outcome to the procedure.

12. The Adviser said it must be accepted, however, that the inner ear deafness and balance problems Miss C subsequently suffered resulted from the surgery. He said this type of complication was extremely rare, yet was a recognised complication, and was not, therefore, necessarily indicative of incompetence. He was concerned, however, that there appeared to have been little or no discussion with Miss C about how the complication might have occurred. He noted a number of possibilities; this included a minutely possible coincidence that a second, unrecognised disease, had been triggered by the surgery. The Adviser noted Miss C had undergone an MRI scan to exclude this. He also referred to a possible inadvertent trauma to the fragile cochlea through excessive manipulation of the ossicular chain (noting that such manipulation was normal custom and practice as part of the procedure, and there was no explanation as to why one patient should then experience such loss of function), and the possibility of a perilymph fistula, which meant the rupture of the membrane between the inner and middle ear, causing imbalance and slow progressive loss of hearing. The Adviser said it was curious that this last possibility was not referred to by the Board, although in his opinion a conservative approach, in terms of potentially diagnosing this and attempting to treat it, was correct in any event.

13. The Adviser concluded he was satisfied that the procedure was performed appropriately, but felt the Board had failed to be frank in their subsequent discussions with Miss C about the possible causes of her hearing loss and balance problems. He also said, although not likely to be an attractive option to Miss C, the possibility of further surgery should not be totally excluded. He said this, whilst still carrying risks, could allow the closure of the small residual perforation and inspection of the middle ear to exclude the possibility of a perilymph fistula. The Adviser recommended this be discussed with Miss C, and, were possible surgical options to be pursued, he suggested referral to a unit with an expert senior otologist. He stressed that he understood the prospect of further surgery may not appeal to Miss C and that the benefits would be limited, but nevertheless they should be considered and offered. The Adviser also commented that he found the failure of Miss C's balance system to

compensate to be unusual. He noted that balance tests were difficult with a perforation, but not impossible. He suggested that sophisticated vestibular testing might be able to quantify the degree of damage to the balance system, and that measures such as a gentamicin labyrinthectomy could still be considered, although this was complex and not without its own risks.

14. With regards to follow-up treatment, Miss C said that she contacted Ward 26 on 7, 9, and 14 November 2010 for help. On the first occasion, she was re-directed to NHS 24 and advised to take anti-sickness medication. On the second, she was advised to contact her own GP, did so, and obtained an alternative anti-sickness medication. On the third, she was again refused admittance back on to Ward 26 and again re-directed to NHS 24. Miss C said she then attended an out-of-hours health centre, at which time a further attempt was made to arrange admittance to Ward 26. However, Miss C said this was once again refused by the registrar on duty; instead, she was given an anti-sickness injection at the out-of-hours health centre and advised to attend her own GP again. Miss C said she felt isolated by this experience and that it seemed as though the Hospital wanted 'nothing further to do with her' having performed the procedure.

15. Miss C said her GP arranged an emergency appointment at the Ear, Nose and Throat Clinic at the Hospital on 15 November 2010. She was prescribed further anti-sickness medication and attended again for a previously arranged consultation with Consultant 1 on 19 November 2010. Miss C said she did not have faith in the diagnosis of labyrinthitis given by Consultant 1.

16. A further consultation was arranged for 6 January 2011. However, Miss C explained she continued to experience serious problems and was unable to return to work until the end of November 2010. She attended her GP as well as her local Accident and Emergency Department during December 2010. Miss C described that her 'worst fears were confirmed' when she found out on 6 January 2011 the extent and permanency of her hearing loss. In her complaint to the Board on 11 January 2011, Miss C requested an urgent second opinion and a MRI scan.

17. In their response of 8 February 2011, the Board said that the day after the procedure, Miss C had been assessed as well enough to go home; if that had not been the case, Consultant 1 may have been more suspicious that a serious complication of surgery had occurred. They said that Consultant 1 was

concerned that he had not been alerted to Miss C's repeated contact with Ward 26. They said this had been discussed with Miss C by Consultant 1 at the appointment on 15 November 2010, that Consultant 1 had sincerely apologised, and was addressing this with the staff concerned. They said this was not usual practice on Ward 26, and any patient with a post-operative problem was 'usually' seen promptly. The Board noted that Consultant 1 carried out fork tests during the appointment on 19 November 2010, but that these had proved inconclusive.

18. In relation to the subsequent confirmation of Miss C's hearing loss, the Board said that formal balance rehabilitation with physiotherapists and audiotherapists may be possible for Miss C, as would the use of a hearing aid, although they noted this was not something Miss C wished to consider at that time. They said that Consultant 1 had arranged for an MRI scan and a second opinion from Consultant 2.

19. Miss C wrote to the Board again on 28 March 2011 to complain that she was yet to receive an appointment for the second opinion. The Board responded on 18 April 2011 saying they understood Miss C had now seen Consultant 2 and had another appointment with a hearing therapist within the Audiology Department at the Hospital.

20. In her complaint to my office, Miss C said she was concerned that the poor post-operative care had contributed to her hearing loss.

21. My complaints reviewer asked the Adviser whether the post-operative care given to Miss C was reasonable. The Adviser said the first point he wished to make was that the damage was done to Miss C's ear during the procedure. He explained that hearing, once lost, rarely recovers, and there is no evidence that anything can be done by medical professionals to influence or reverse that.

22. The Adviser went on to explain that all Miss C's post-operative care was influenced by an understandable failure to appreciate that she had suffered inner ear damage during surgery. He went on, however, that the post-operative care was unreasonable and unsatisfactory in that it was obviously inappropriate to refer a patient, immediately post a specialist operation, to NHS 24. He noted the Board had acknowledged this entirely. He reiterated that the delay in diagnosis of Miss C's symptoms post-surgery made no difference to the outcome for her. He said that, once the complication was recognised, he felt

the medical staff had done all that was possible to palliate the damage done (including the referral to the Audiology Department, the second opinion and vestibular rehabilitation).

(a) Conclusion

23. I have carefully considered this complaint. I acknowledge the very serious impact upon Miss C's life of the consequences of this procedure, and the fact that she will likely suffer hearing loss for the rest of her life. However, I take into account the advice given to me that there is no evidence to indicate that the myringoplasty was carried out inappropriately or incompetently, and that the complication Miss C suffered is a rare, but recognised, one for this type of procedure, particularly when taking into account Miss C's medical history with regards to her ears. I also note the advice given to me that, although the post-operative experience for Miss C, until the follow-up appointment with Consultant 1 on 19 November 2010, was not optimal, this ultimately made no difference to the problems she suffered given the damage was caused during surgery. On balance, therefore, I do not uphold this complaint.

24. However, there are a number of issue here that need to be recognised. I consider that the Board should have been more open with Miss C by acknowledging that the outcomes sought in conducting the procedure had obviously not been achieved, and should have apologised for this in a frank and sincere way, without there being any suggestion of fault on their part during the procedure.

25. Furthermore, although I realise this was a difficult complication to diagnose, I note the advice given to me that the Board could have communicated better with Miss C regarding the possible causes of the problems, in particular the possibility of a perilymph fistula. I also note that there may be further surgical options available. I recognise this may not be something Miss C wishes to pursue. However, if it is something she wishes to obtain more information about, the Board should arrange for this, and indeed, should have done so earlier if Miss C has not stated to the contrary.

26. Furthermore, whilst I understand that post-operative care would not have made any material difference to Miss C's prognosis, there is no doubt that the experience she underwent in the months following her discharge was distressing, and exacerbated by the inappropriate and repeated failure to refer her back to Consultant 1. I note the Board have apologised for this, but I

consider that they need to take further action to prevent this type of situation arising in the future; it is not sufficient to simply state that patients with post-operative problems are usually seen promptly. I make two recommendations, as well as a general recommendation which is detailed at the conclusion of this report.

(a) Recommendations

27. I recommend that the Board:	*Completion date*
(i) should Miss C request this, offer an appointment with a senior otologist to discuss possible surgical options; and	12 June 2013
(ii) provide evidence that staff on Ward 26 are aware of the procedure that should be followed when patients report post-operative problems.	19 June 2013

(b) Failed to explain that the risks of surgery could result in hearing loss or balance problems

28. Miss C said that during her consultations prior to the procedure, she had been 'reassured this was a very routine operation, with little or no risk'. In her complaint to my office, Miss C said that she had not been advised, prior to the procedure, of the likelihood (whether remote or not) that it could result in severe hearing loss, associated balance problems and other debilitation.

29. The Board said that, during Miss C's consultation with the Professor, he had given her a patient information leaflet about the procedure which explained more about it, including the risks. They said that, at the second consultation, the records demonstrated that Consultant 1 had discussed the possibility of hearing loss at the time that consent was obtained. They also said:

> 'he [Consultant 1] is certain that he mentioned the risk of hearing loss was remote, particularly in the case of the specific operation [Miss C] underwent, but that hearing loss may result from any middle ear surgery'.

30. My complaints reviewer asked the Adviser to review Miss C's clinical records and comment on whether there was evidence that the risks of the procedure were adequately discussed. He noted that a consent form had been signed by Miss C during the consultation on 6 September 2010. He said this was common practice, but allowed very little time for the patient to study its contents. The Adviser said he would assume that Miss C received a copy of

the consent form to take home, but he could not find any mention of such practice in the Board's Informed Consent Policy 2011 – 2013.

31. The Adviser said that with this proviso, the consent form explained the intended benefits and listed complications as 'bleeding, infection, hearing loss, taste disturbance, graft failure'. He said that balance disturbance and tinnitus due to inner ear damage were omitted; however, he reiterated as per his advice in relation to complaint (a), these are extremely rare complications.

32. The Adviser said the information in the patient information leaflet given to Miss C was brief, but thorough. He said it stated the operation was elective ie non-essential. He said it described the risks as well as the procedure, and gave what he described as an 'over-cautious' failure rate of 10 to 40 percent. He noted the leaflet said 'this can cause a loss of hearing, dizziness and weakness of the face. These complications are very rare'. The Adviser said he agreed entirely with this statement.

33. The Adviser said other evidence of informed consent came from the Professor's letter to Miss C's GP following their appointment, which stated 'I have indicated that because of the scar tissue in the eardrum the success rate would be considerably short of 100%'. He also noted Consultant 1's letter to Miss C's GP following their consultation which stated 'we have discussed the operation of myringoplasty at some length. She still finds it difficult to make decision etc'. The Adviser said it was his opinion that this was presented as a relatively simple operation, with a good success rate but no guarantees, and with no compulsion to proceed. He said that if all the documentation was read and understood, then the impression would also have been of a very rare possibility of complications of damage to the inner ear.

(b) Conclusion

34. I have carefully reviewed the evidence available in relation to the provision of information about risks to Miss C prior to the procedure. I am satisfied that Miss C was given reasonable notice of the risks associated with the procedure during the consultations with the Professor and Consultant 1 in June and September 2010 respectively, as well as within the patient information leaflet provided to Miss C, of which I have seen a copy.

35. I acknowledge that the consent form that Miss C signed did not refer to the possibility of balance problems, although I note possible 'dizziness' was referred

to within the patient information leaflet. Whilst recognising that this is no comfort for Miss C, I must also take into account the advice I have already received that the complications she has experienced are extremely rare. Giving regard to usual and reasonable medical practice, I would not have expected them to be explicitly detailed in the patient information leaflet or consent form. In all the circumstances, I do not uphold this complaint.

36. However, I have noted some points from the advice I received regarding the consent form. It is not clear whether Miss C was given a copy of the consent form to take away with her to consider, but I find this would have been of benefit and allowed Miss C further time to consider the risks outlined. I have also considered the Board's Informed Consent Policy and note the provisions for 'multi-stage' consent:

> 'in cases where written consent is being sought, treatment options will generally be discussed well in advance of the intervention being carried out. These discussions can take place over several occasions, and with a number of different health professionals. Patients arriving for treatment with consent forms already signed must have their understanding of the intervention confirmed.'

I do not find any evidence that the last sentence of this section of the policy was applied in Miss C's case. On this basis I have two recommendations to make to the Board.

(b) Recommendations

37. I recommend that the Board:	*Completion date*
(i) amend their Informed Consent Policy to ensure that patients who sign a consent form prior to treatment are given the option of receiving a copy; and	4 September 2013
(ii) remind the medical staff involved in this complaint of the need to confirm consent as per the Informed Consent Policy.	5 June 2013

(c) Failed to respond to Miss C's complaints in accordance with the NHS complaints procedure

38. Miss C submitted her first formal complaint to the Board on 11 January 2011. This included a formal request to obtain a copy of her medical records. The Board provided a response to the complaint on

8 February 2011, and a copy of the medical records on 15 February 2011. However, Miss C wrote again on 28 March 2011 stating the records she had been provided with were not complete, and reiterated her request for them. She wrote on the same date under separate cover to the Complaints and Advice Team saying she was still awaiting the second opinion. The Board responded on 11 April 2011 saying they were sorry they had not provided a satisfactory response to the issues Miss C had raised, and had initiated a formal investigation.

39. The Board then wrote again on 18 April 2011 noting that Miss C had since had her appointment with Consultant 2, and stating that they were awaiting some notes from her records to be transcribed, and that they would be sent to her shortly. The Board said they hoped this information would assist Miss C.

40. Miss C wrote again on 13 June 2011. She said she was still awaiting the outcome of the formal investigation referred to by the Board, as well as her medical records. Miss C outlined the problems she continued to experience following the procedure and asked for a response no later than the end of June 2011. The Board responded on 20 June 2011 enclosing a copy of the letter of 18 April 2011.

41. Miss C wrote back on 24 August 2011 advising she was confused with the Board's correspondence process. She said she did not believe that the letter of 18 April 2011 could constitute the outcome of a formal investigation. She also noted she was still awaiting her medical records. She said she was very aggrieved by the way the Board was handling her complaint, 'with no regard to urgency or clarity of response'.

42. The Board did not acknowledge this letter until 10 October 2011, and apologised for the 'inordinate delay'. They said they were progressing the matters Miss C had raised and would respond as soon as the investigation was complete.

43. On 8 November 2011 Miss C wrote to the Chairman of the Board (the Chairman) seeking assistance in obtaining a response from the Board. The Chairman wrote back on 16 November 2011 thanking Miss C for bringing the matter to his personal attention, and advising he had passed the matter to the Chief Executive of the Board.

44. On 2 December 2011, Miss C received the copy of her medical records that she had initially requested on 11 January 2011.

45. Miss C thereafter received a series of 'holding' letters from the Complaints and Advice Team, dated 4 and 24 November 2011, 2 December 2011, 8 and 20 February 2012, and 27 April 2012. Each letter said the Board was not yet in a position to respond, variably because they were awaiting information and due to 'delays within the complaints process'.

46. Miss C wrote to the Chairman again on 14 May 2012 advising she had still not yet received a response. She said each time she received a further letter from the Board she hoped it would be the full response. She said she had been extremely patient, and her hearing and related health issues remained the same. She said it was very unfortunate that the Board had compounded matters, and felt the Chairman should be aware of this.

47. The Chairman responded on 23 May 2012 saying he had been passed Miss C's letter of 14 May 2012 that day and was very disappointed to note she had not yet received a response. He said that, although he did not have any formal role in the complaints process, he had had a discussion with the Chief Operating Officer who had advised a response would be issued as a matter of urgency.

48. Miss C wrote to my office on 30 May 2012 having not received any further response.

49. The Board wrote to Miss C on 5 June 2012 with their final response. They said they were aware there had been significant delays in issuing the response to Miss C, and said there had been poor internal management of her case, for which they sincerely apologised.

(c) Conclusion

50. I have reviewed the handling of Miss C's complaint with concern. Although I acknowledge that the Board did provide a timely initial response which included details of my office to contact should Miss C remain dissatisfied, the course of events thereafter makes for very unfortunate reading.

51. Miss C had cause to keep corresponding with the Board after their response of 8 February 2011 because she was still awaiting a copy of her

medical records and a second opinion as requested. When Miss C expressed her continuing dissatisfaction as part of this request, the Board advised they would initiate a 'formal investigation'. I am critical of the Board for this; their response of 8 February 2011 was the final stage in their internal complaints procedure, and the promise of a further 'formal investigation' led to the following months of protracted correspondence and Miss C's understandable expectation that a further full and substantive response was forthcoming. On this basis I find that the Board did not handle Miss C's letter of 28 March 2011 appropriately; instead, Miss C should have been signposted to my office again and advised her continuing complaints could now be considered by me. This could have saved Miss C over a year of further anxiety.

52. I can understand why Miss C could not accept that the letter of 18 April 2011 contained the findings of a formal investigation, as it simply detailed the treatment she had had in the interim. The delays thereafter are unexplained, unacceptable and were entirely avoidable. Effectively, Miss C had to wait a further fifteen months from her second letter of complaint until the Board's full and final response. The Board has provided no explanation as to why Miss C was issued with so many holdings letters with no substantive response being forthcoming.

53. I can fully appreciate why this experience will have made matters additionally distressing for Miss C, and will have compounded her extremely difficult experiences following the procedure. I consider it was only due to her tenacity in making contact with the Chairman again in May 2012 to seek help that she ensured herself a proper response, prior to making contact with my office. It should never be the case that a complainant has to make such repeated efforts to receive a response.

54. I uphold this complaint. I am very critical of the Board for their handling of this matter, and want to ensure that no other complainant undergoes a similar experience. I have a recommendation to make; the general recommendation made at the end of this report also clearly refers to this complaint.

(c) Recommendations

55. I recommend that the Board:	*Completion date*
(i) conduct an audit of their internal complaints handling process to ensure that all complaints	31 August 2013

received are properly handled as per the Board's complaints procedure.

General Recommendation

56. I recommend that the Board:	*Completion date*
(i) give a full and sincere apology to Miss C for the outcome of the myringoplasty, and for all the failings identified within this report.	5 June 2013

57. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
The Board	Tayside NHS Board
The Professor	Professor of Otolaryngology
Consultant 1	The Ear, Nose and Throat Consultant who performed the myringoplasty on Miss C
The Hospital	Ninewells Hospital in Dundee
Ward 26	The Ear, Nose and Throat Ward at the Hospital
Consultant 2	The Ear, Nose and Throat Consultant who saw Miss C for a second opinion
The Adviser	The Ombudsman's adviser, a Consultant Ear, Nose and Throat Surgeon
The Chairman	The Chairman of Tayside NHS Board

Annex 2

Glossary of terms

Conductive deafness	when the inner ear functions normally, but there is a problem which prevents getting the sound into it (in Miss C's case, the perforation)
Eustachian tube dysfunction	a major cause of symptoms such as deafness and earache in children
Fragile cochlea	the hearing part of the inner ear
Gentamicin Labyrinthectomy	a procedure during which gentamicin injections are put through the eardrum into the middle ear and inner ear; this can help with balance function but there is a risk of worsening hearing
Grommet	a tube inserted into the eardrum to allow air to pass through into the middle ear, release pressure build up and help clear excess fluid within
Magnetic resonance imaging (MRI) scan	scan which provides detailed images of the inside of the body
Labyrinthitis	a condition that affects the hearing and balance systems in the inner ear
Myringoplasty	surgical procedure to repair a perforated eardrum with a patch
Ossicular chain	The three bones connecting the drum to the delicate inner ear
Perilymph fistula	Rupture of the membrane between the inner and middle ear, causing imbalance and slow progressive loss of hearing

Vestibular rehabilitation	an exercise based programme designed to promote central nervous system compensation for inner ear deficits