SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: South of Scotland

Case 201304866: Ayrshire and Arran NHS Board

Summary of Investigation

Category
Health: Hospital; care and treatment; consent; communication

Overview
The complainant (Mr C) complained to Ayrshire and Arran NHS Board (the Board) about the care and treatment he received at Crosshouse Hospital, Kilmarnock (the Hospital) in connection with surgery for the removal of duct stones.

Specific complaints and conclusions
The complaints which have been investigated are that the Board unreasonably failed to:

(a) obtain consent for the specific procedure that was carried out on Mr C (*upheld*); and
(b) remove duct stones at the time of Mr C's first operation (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failings identified in complaint (a) of this report;	19 March 2015
(ii) provide evidence of the action taken as referred to paragraph 16 of this report;	20 April 2015
(iii) carry out a significant event analysis of what happened in Mr C's case and report the findings to my office;	20 April 2015
(iv) provide evidence that they have addressed the issues of (i) consent being obtained by medical staff not competent to carry out the surgical procedure the patient is being consented for; and (ii) obtaining written consent on occasions other than the day of the patient's surgery;	20 April 2015
(v) ensure that the comments of the advisers are	20 April 2015

brought to the attention of the relevant staff;

(vi)	issue a written apology to Mr C for the failings identified in complaint (b) of this report; and	19 March 2015
(vii)	provide evidence of the action taken to address the failings identified in respect of the removal of Mr C's residual right sublingual gland.	20 April 2015

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

Main Investigation Report

Introduction

1. Mr C said that he had consented to the removal of duct stones under his tongue, which were to be removed through his mouth or, if necessary, just under the chin line, at an out-patient pre-operative assessment appointment at Crosshouse Hospital, Kilmarnock (the Hospital). However, when Mr C woke up from the surgery, which was carried out under general anaesthetic in August 2013, he learned that an incision had been made into his neck and his submandibular gland had been removed. However, the duct stones had not. Mr C then had to undergo a subsequent procedure in September 2013 to have the duct stones removed, which were removed under local anaesthetic.

2. Mr C wanted to know why the surgery was changed from what had been discussed with him at the pre-operative assessment appointment held prior to the surgery. Mr C also wanted to know why the duct stones under his tongue were not removed during the surgery.

3. The complaints from Mr C which I have investigated are that Ayrshire and Arran NHS Board (the Board) unreasonably failed to:

(a) obtain consent for the specific procedure that was carried out on Mr C; and

(b) remove duct stones at the time of Mr C's first operation.

Investigation

4. During the course of the investigation of this complaint, my complaints reviewer examined copies of Mr C's clinical records and the Board's complaint correspondence. In addition, my complaints reviewer also examined the information that Mr C provided to my office. Independent clinical advice was also obtained from three hospital consultants, two of whom are consultants in maxillofacial/head and neck surgery, who I shall refer to later in this report as Adviser 1, Adviser 2 and Adviser 3.

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

(a) The Board unreasonably failed to obtain consent for the specific procedure that was carried out on Mr C

What Mr C told SPSO

6. Mr C said that he had waited five years for the surgery to remove the duct stones because of his fear of being left with a scar. Mr C attended a pre-operative assessment appointment at the Hospital in June 2013, where he discussed his concerns with a doctor. Mr C said that he understood that he had agreed and consented for the removal of duct stones which were under his tongue, which were to be removed through his mouth or, if necessary, by an under chin incision.

7. The date for the surgery was postponed. Mr C was then invited to attend a second pre-operative assessment appointment but was subsequently told he did not require to attend this appointment. Mr C said that he understood that what had been discussed and agreed at the pre-operative assessment appointment he had attended still applied.

8. Mr C attended for the surgery at the Hospital at the end of August 2013. When Mr C woke up from the surgery, he learned an incision had been made into his neck and his submandibular gland had been removed. Mr C said the removal of the gland had not previously been mentioned or discussed with him prior to the surgery and he had not consented to this. The duct stones under his tongue had not been removed and he required to return to the Hospital the following week, when the duct stones were removed by local anaesthetic.

9. Mr C said that due to the incision in his neck he had been left with a scar which has caused part of his neck to feel numb. Mr C said that he had to take additional time off work because he required a longer period of recuperation after the surgery. From December 2013 to February 2014 Mr C said he contracted two separate infections in his mouth. While the first infection cleared up within a week following a course of antibiotics, the second infection required him being admitted to the Hospital for four days and he had to take further time off work when he was discharged.

The Board's comments

10. The Board said they were sorry that Mr C had cause to complain and the issues of concern he had raised had been reviewed by a consultant oral maxillofacial surgeon (Consultant 1), and a healthcare manager with the Board.

11. The Board stated that Mr C was originally seen at the Hospital's out-patient clinic in June 2013 by Doctor 1, a speciality doctor, who noted that Mr C had symptoms from his right submandibular duct with recurrent duct stones. Mr C was put on a waiting list for the removal of submandibular calculus (duct stones) and the possibility of the removal of the submandibular gland.

12. A pre-operative assessment appointment for a day case procedure was arranged, at which no surgeon was present. The Board explained that day surgical cases are seen and consent is obtained from the patient on the day of the surgery. Where a patient is having an in-patient surgical procedure, they are seen by a surgeon at a pre-assessment clinic and the operation to be performed is discussed more fully with the patient and their consent is obtained at that time.

13. However, in the interim, Mr C's x-rays, which showed a two centimetre stone in the deep part of the submandibular gland, were shown to Consultant 1 who considered Mr C's submandibular gland needed to be removed. Therefore, Consultant 1 asked for Mr C to be transferred to the in-patient waiting list as this type of surgery was not suitable for day surgery. Although Mr C was moved from a day case to an in-patient waiting list, the original plan for Mr C's pre-operative assessment was not altered, for which the Board apologised.

14. The Board said that on the day of Mr C's planned surgery, it was intended to admit him to the day surgery unit but with the surgery being carried out in the main operating theatre. Had this plan remained, Mr C would have been seen by the surgeon who was carrying out the surgery and who would also have obtained consent from Mr C in advance of the surgery. However, on the day of Mr C's admission the day surgery unit was full and so Mr C was admitted to Ward 5A. A senior house officer in the Oral and Maxillofacial Surgery department (Doctor 2) was sent to the ward to obtain Mr C's consent for the surgery and to warn him of the complications of the submandibular excision. The Board said that Doctor 2 had assumed the duct stones would be removed at the same time. Unfortunately, there was a lack of clarity between what Doctor 2 described and consented Mr C for and what Mr C's expectations were of the surgery he was having.

15. The Board accepted that communication with Mr C had been poor and was compounded by the change to his place of admission on the day of the surgery. The Board said that it was clear that Mr C should have had a meeting

with the surgeon who was carrying out the surgery at some stage before the surgery was carried out.

16. The Board had reflected on and discussed the issues of concern Mr C had raised with them and as a result said they were taking the following actions:

(i) Where a junior or speciality doctor sees a patient on behalf of a consultant, they would ensure the case was discussed with the consultant before the patient was listed on the waiting list. A management plan was to be agreed in relation to whether the patient was a day case or an inpatient. Arrangements would also be made for the operating surgeon to see a patient either at the pre-operation clinic or an early admission time would be arranged, so that the surgeon would see the patient in advance of the surgery starting.

(ii) The Board also said they would discuss Mr C's experience at their next clinical governance meeting to ensure there was shared learning and to seek views on any additional action that needed to be taken.

17. The Board said they were extremely sorry for the most unfortunate situation that had occurred and they extended their sincere apologies to Mr C.

18. In response to a written enquiry from my office, the Board said that Doctor 2 who consented Mr C to the surgery when he was in Ward 5A had confirmed that she had explained to Mr C that he would be having a submandibular gland excision and had described the risks involved. When the consent was obtained from Mr C for the surgery, Doctor 2 had assumed that the duct stones would be removed during the surgery and this was discussed with him. Regrettably, the surgeons who were operating that day did not meet with Mr C prior to the surgery and were unaware that duct stones were to be removed. The Board said that Mr C had consented for the procedure which was carried out. However, they accepted that communication regarding the procedure was inadequate, both with Mr C and the clinical team.

19. The Board also told my office that Consultant 1 had confirmed that Mr C had small stones in his anterior duct and a large stone in his posterior duct which was presumed to be in the submandibular gland or very posterior duct. The appropriate surgery for removal was submandibular gland removal. The Board said that trying to remove the large stone through Mr C's mouth would have had the significant risk of leaving him with a numb tongue and bleeding.

Clinical Advice received

20. Independent advice was obtained from three medical advisers to the Ombudsman. A consultant in maxillofacial/head and neck surgery (Adviser 1); a consultant in maxillofacial/head and neck surgery (Adviser 2); and an experienced hospital consultant (Adviser 3).

Adviser 1

21. Adviser 1 noted Mr C had originally been seen in 2008 when a diagnosis of a right submandibular calculus (stone) was made but no further treatment was carried out at that stage. In June 2013 Mr C was referred by his GP to the Hospital's Oral and Maxillofacial Surgery department, where he was seen by Doctor 1 who was a speciality doctor in this department. Doctor 1 had noted that Mr C had a history of recurrent swelling in the right submandibular area. Doctor 1 had placed Mr C on a waiting list. However, Adviser 1 considered that in all but the most straightforward cases, it was appropriate for a patient to be seen again in the pre-operative assessment clinic by a more experienced doctor before being placed on the waiting list.

22. Adviser 1 told my complaints reviewer there were a number of options which should have been considered prior to the surgery. While Adviser 1 said that the removal of the duct stones alone would not always lead to the resolution of the symptoms, it was well known that patients who have multiple stones, stones within the submandibular gland or long standing symptoms over many years may need to have the submandibular gland itself removed, not just the stones. In the case where the stone(s) were within the submandibular gland itself, Adviser 1 was of the view that most surgeons would proceed to remove the submandibular gland.

23. However, in the case of a single larger stone palpable in the mouth, Adviser 1 considered it would have been reasonable to remove the stone and reassess the situation at a later date to see if the situation had resolved, if that is what the patient preferred. This was provided the patient had been suitably counselled and informed that if the stone were removed the situation may not improve and a second procedure would be required. This was especially the case where the patient was trying to avoid a scar in the neck. Adviser 1 also said that some patients, however, would opt to have the submandibular gland removed from the outset in an attempt to avoid a second procedure.

24. Adviser 1 said that all of these options should have been discussed with Mr C prior to the surgery.

25. Adviser 1 reviewed the consent form signed by Mr C on the day of the surgery. The form stated that Mr C had consented for the 'removal of the right submandibular gland'. The consent form was countersigned by Doctor 2, who had seen Mr C following his admission to Ward 5A.

26. Adviser 1 told my complaints reviewer that mistakes were made during the process of obtaining Mr C's consent to the proposed surgery. Adviser 1 referred my complaints reviewer to the General Medical Council Guidance on consent: *Patients and doctors making decisions together, June 2008 (the GMC Guidance)* which states:

> '26. If you are the doctor undertaking an investigation or providing treatment, it is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:
>
> a. is suitably trained and qualified
>
> b. had sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
>
> c. understands, and agrees to act in accordance with, the guidance in this booklet.'

27. Adviser 1 said that, in terms of consenting a patient for surgery, it was accepted that, ideally, the person who was to carry out the operation should obtain the consent of the patient. If this was not possible, then the person who was obtaining the patient's consent should be able to competently carry out the intended procedure, as this would enable a thorough discussion with the patient about the risk, benefits and possible alternatives to the planned procedure. In Mr C's case, Adviser 1 noted that he was consented by Doctor 2, who was a dentally qualified senior house officer, who Adviser 1 considered was very unlikely to have ever carried out the operation to which Mr C was consenting. Furthermore, Adviser 1 noted that Doctor 2 was not in the operating theatre when the surgery took place.

28. Adviser 1 also said that one of the surgical team who was operating on Mr C (either the lead surgeon or one of his assistants) should have obtained Mr C's consent to the planned surgery before it took place. In this way any discussions with Mr C could then have been discussed with the surgeon who

was carrying out the surgery, to ensure there was no misunderstanding about the planned procedure.

29. Adviser 1 referred to the following section from the GMC Guidance, which states:

> '27. If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment.'

30. Adviser 1 said that it was accepted good medical practice that consent for anything but the most basic procedures should ideally be carried out before, and not on the day of, the planned surgery which was not what happened in Mr C's case. According to Adviser 1, if a two stage consent procedure had been carried out (preliminary consent obtained from Mr C before the day of the surgery and the details gone over again with him on the day of the surgery), this would have given more time for any possible confusion over the planned procedure Mr C was having to potentially be resolved.

31. According to Adviser 1, Mr C had the surgical procedure that he had consented to, as the consent form stated that the procedure Mr C was having was the removal of the right submandibular gland and that this was the surgical procedure which was carried out. However, despite the fact that Mr C had the procedure that he signed the consent form for, Adviser 1 noted that Mr C had stated on several occasions that he was under the impression that he was having duct stones removed from his mouth and not having the whole submandibular gland removed through an excision in his neck.

32. While Adviser 1 considered that the Board's actions following their investigation of Mr C's complaint partially addressed some of the concerns which had occurred, Adviser 1 considered there had clearly been a failure in the consent process and was of the view that there had been sufficient confusion, contradiction and uncertainty surrounding Mr C's case that the Board should have carried out a significant event analysis of what had happened.

33. The reasons that Adviser 1 came to this view were as follows:

a) When Mr C was first seen in the out-patient clinic by Doctor 1 in June 2013, his medical records recorded his diagnosis as 'right submandibular stone? lying within the gland'. An ultrasound scan was

arranged and the clinical entry in Mr C's medical records stated 'list for removal right submandibular calculus (stone)? Removal of right submandibular gland.' According to Adviser 1, this suggested the planned procedure was for the removal of the stone, with the possibility of the gland needing removal as well as the stone.

Adviser 1 noted that, in the interim, Doctor 1 had shown Mr C's x-rays, which showed a two centimetre stone in the deep part of the submandibular gland, to Consultant 1 who considered that the gland would definitely need to be removed. According to Adviser 1, this suggested that the surgical treatment planned had definitely changed to the removal of the gland. However, Adviser 1 could not find any evidence in Mr C's medical notes that this had been communicated to Mr C.

b) An ultrasound scan was carried out in early July 2013. However, no stone was identified within the submandibular gland or in the subsequent gland histology. Adviser 1 could not find any documentary evidence in Mr C's medical records that any member of the surgical team had seen and noted the findings of the ultrasound scan before the planned surgery. Adviser 1 said that if they had, it may have been more appropriate that Mr C had been seen again in order to discuss the results with him prior to the planned surgery and may have changed the surgical treatment which was carried out.

c) With regard to the Board's written response to Mr C's complaint that the duct stones should have been removed first and then to have reviewed the submandibular gland, Adviser 1 interpreted this to mean that Mr C's planned procedure should have been the removal of the duct stones alone and not the removal of the submandibular gland itself. If this was the case, then Adviser 1 considered that Mr C should have been consented for the removal of the right submandibular gland stone(s).

d) Adviser 1 noted that the subsequent histological analysis of the right submandibular gland which was removed did not reveal any stone.

34. Adviser 1 said that his review of Mr C's medical records and the Board's response to his complaint showed that there was confusion about Mr C's planned surgical procedure and it was unclear what the planned surgical procedure was supposed to be. Adviser 1 said the clinic letter and the consent

form signed by Mr C suggested the planned surgical procedure was the removal of the right submandibular gland. However, the Board's letter of response to Mr C's complaint suggested the planned surgical procedure was the removal of the duct stone(s) alone. If the planned procedure was supposed to be the removal of the duct stone(s) alone, as stated in the Board's written response, and not the submandibular gland this represented a serious failure of patient safety.

35. Adviser 1 said that the reasons for the choice of operation and the options open to Mr C should have been discussed and explained to him prior to the planned surgery and the reasons for the chosen treatment better documented in Mr C's medical records. Adviser 1 was, therefore, not surprised that Mr C was confused about the surgical procedure he was supposed to have had.

Adviser 2

36. Adviser 2 noted that the Board had accepted there was a breakdown in communication between Mr C and the doctors treating him. Adviser 2 also noted that some confusion seemed to have ensued following Mr C being moved from the day case waiting list to being placed on the in-patient waiting list and then the subsequent change in the place where he was admitted on the day of the surgery. Adviser 2 considered the Board's explanation for this to have been reasonable.

37. However, Adviser 2 considered that there had been a number of failures in Mr C's care and treatment. According to Adviser 2, it was apparent that after Doctor 1 saw Mr C she had then discussed his case with Consultant 1 and the decision had been made to proceed with the excision of the submandibular gland. Since Mr C was absent from the discussion between Doctor 1 and Consultant 1, Adviser 2 said that this decision should have been communicated to Mr C in writing.

38. Adviser 2 also referred my complaints reviewer to the GMC Guidance, the relevant sections of which I have detailed at paragraphs 26 and 29 of this report. Adviser 2 said, from his review of the consent form, it appeared that a discussion took place with Mr C regarding the removal of the submandibular gland, rather than just the retrieval of gland stones. However, Doctor 2, the senior house officer doctor who saw Mr C in Ward 5A on the day of the surgery did not appear to have the requisite level of surgical competence to appropriately obtain consent from Mr C for the procedure. Adviser 2 said that it

was widely accepted that written consent should not be obtained on the day of surgery, as occurred in this case, and that consent obtained on the day of surgery was not best practice. Adviser 2 said that even if the surgeon who was carrying out the surgery did not personally obtain Mr C's consent there was no doubt that the lead surgeon should have met with Mr C prior to the operation. This had not happened in Mr C's case. According to Adviser 2, this amounted to deficiencies in Mr C's care and treatment.

39. Adviser 2 was of the view that the Board had addressed the issue of wrong site surgery, in as much as they had admitted that the duct stones were not removed intra-orally at the same time as the submandibular gland excision. Adviser 2 said this error would have been avoided by the operating surgeon meeting Mr C prior to the surgery.

40. Adviser 2 considered that the issue of informed consent had partially been addressed by the Board following Mr C's complaint, as the Board had acknowledged that operating surgeons should meet with patients before their surgery. However, Adviser 2 could find no evidence that the Board had addressed either the issue of consent being obtained by individuals not competent to carry out the surgical procedure they were consenting the patient for or of the need to obtain written consent on occasions other than on the day of the patient's surgery. While Adviser 2 did not consider that the Board should have carried out a significant events analysis, as the Board had appreciated the seriousness of what had occurred in Mr C's case and had taken all the necessary actions to avoid a recurrence, there were still the issues of consent to be addressed.

Adviser 3

41. Adviser 3 told my complaints reviewer that the issue of informed consent was a significant professional issue and was at the core of the patient-clinical relationship. In the view of Adviser 3, this relationship was broken in Mr C's case. Adviser 3 said that where there was an issue of wrong site surgery or where surgery was needed afterwards, as happened in Mr C's case, he was surprised the Board had not undertaken a significant event analysis as there was no certainty that this could not happen again. In the view of Adviser 3, the scope of the Board's actions to prevent this recurring in another case in the future, as set out in their response to Mr C's complaint, was not in his view clearly defined.

(a) Conclusion

42. The Board have accepted that there was a breakdown in communication between Mr C and the doctors providing his care and treatment, prior to carrying out the surgery.

43. Taking account of the advice that I have received from all of the advisers, it is clear to me that not only was there failings in communication by the doctors treating Mr C, but there were serious failings in the consent process for the surgery.

44. I accept that Mr C signed the consent form for the removal of the right submandibular gland on the day of the surgery. However, given the confusion, the breakdown in communication and the failings in the consent process, it was, therefore, understandable why Mr C believed the only surgical procedure he was having was the removal of duct stones from his mouth. I can appreciate Mr C's justifiable concern when he awoke from the surgery to find that he had an incision in his neck and his submandibular gland had been removed. I am satisfied that, based on the clinical advice I have received, the Board unreasonably failed to obtain consent for the specific procedure that was carried out on Mr C.

45. Accordingly, I uphold this complaint.

46. I note that apologies have been made by the Board in respect of Mr C's care and treatment, and of the action they intended to take. However, I do not consider that I have seen evidence of all of the action the Board say they have taken.

47. I have also taken account of the advice received from the Advisers to address the failings identified in Mr C's care and treatment. I acknowledge that while my two of my advisers, Adviser 1 and Adviser 3, were clearly of the view that the Board should have carried out a significant events analysis, one of my advisers did not consider this was necessary. Given the serious failings in the consent process and failings in communication by the doctors treating Mr C, and based on the advice I have received from all three of the advisers that the Board have not addressed all of the failings identified, I am of the view that the Board should have carried out a significant events analysis. The benefit of carrying out such an analysis is that lessons can be learned and action taken to prevent a recurrence of what has occurred in Mr C's case.

48. Therefore, I have made a number of recommendations to the Board in respect of this complaint.

(a) Recommendations

49. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failings identified in complaint (a);	19 March 2015
(ii) provide evidence of the action taken as referred to in paragraph 16 of this report;	20 April 2015
(iii) carry out a significant event analysis of what happened in Mr C's case and report the findings to my office;	20 April 2015
(iv) provide evidence that they have addressed the issues of (i) consent being obtained by medical staff not competent to carry out the surgical procedure the patient is being consented for; and (ii) obtaining written consent on occasions other than the day of the patient's surgery; and	20 April 2015
(v) ensure that the comments of the Advisers are brought to the attention of the relevant staff.	20 April 2015

(b) The Board unreasonably failed to remove duct stones at the time of Mr C's first operation

What Mr C told SPSO

50. As stated in complaint (a), Mr C complained that the Board had failed to remove duct stones during the surgery. Mr C said that it appeared to him that the surgeon had not looked at his medical notes prior to carrying out the surgery. Mr C questioned whether it was acceptable for a surgeon not to be familiar with a patient's medical records before carrying out surgery.

51. Mr C was also concerned that he had been told the surgery had to be carried out under general anaesthetic but he later found out this was not the case, as his duct stones were later removed by local anaesthetic.

52. Mr C had to take additional time off work because he required to attend further clinic appointments, which he considered would not have been necessary if the duct stones had been removed during the surgery.

The Board's comments

53. The Board said that Consultant 1 had reviewed Mr C's x-rays prior to the surgery and was in no doubt the removal of the submandibular gland was technically the correct procedure. Doctor 1's clinic letter, the operating list and the consent form Mr C had signed confirmed this. Unfortunately, the surgeons who were operating on the day of the surgery were unaware Mr C's duct stones required to be removed. Consultant 1 had confirmed that the duct stones should have been removed during the surgery. The Board said, however, that if the submandibular gland had not been removed at that time, it was highly likely that Mr C would have eventually needed to have the gland removed at some time.

54. Following a post-surgical meeting with Mr C in September 2013, Consultant 1 offered to remove the duct stones. Mr C was subsequently admitted to the Hospital in early September 2013 when five small stones were removed. Consultant 1 had also advised that Mr C may still have problems in the future as other duct stones come to light.

55. The Board accepted that Mr C had been under the assumption that the duct stones would be removed during the surgery. They acknowledged that communication with Mr C was poor prior to the surgery and that this had resulted in Mr C having to have a second procedure. The Board said they sympathised with Mr C and it was regrettable that their communication with him was not as adequate as it should have been. This had resulted in Mr C not being sure of and understanding the planned surgical procedure. The Board had, therefore, fully upheld Mr C's complaint.

56. Mr C's complaint had been discussed at a clinical governance meeting in October 2013; a copy of the minutes of this meeting was provided by the Board. The Board also said that communication had been improved so that where a junior or speciality doctor sees a patient on behalf of a consultant, they will ensure the case is discussed with the consultant before adding the patient to the in-patient list to agree a management plan. Arrangements had also been made for the operating surgeon to see a patient either at the pre-operation clinic or in advance of the theatre list starting, so as to improve communication and minimise risk of any misunderstanding of the planned procedure and the risks involved.

Clinical advice received - Adviser 2

57. Adviser 2 noted from Mr C's medical records that he had similar problems in 2008 and the problems seemed to have been both recurrent and longstanding. Adviser 2 explained that stones which occur in the anterior (front part) of the submandibular duct could be removed orally (via the mouth). Stones placed further back in the mouth, as identified in Mr C's x-ray in June 2013, usually required removal under general anaesthetic. Likewise, it was usual for the submandibular gland removal to take place under general anaesthetic. Given the size and position of the calculus (stone), it would have been easily retrievable at the time of the surgery through the neck incision or intra-orally. However, Adviser 2 said there was no evidence in Mr C's medical notes to substantiate any discussion with Mr C about the anaesthesia to be used for the surgery.

58. Adviser 2 said that the non removal of the duct stones necessitating further surgery was a failure in Mr C's care and treatment. However, even if the duct stones had been retrieved as a first step, Adviser 2 considered it highly likely that the submandibular gland would have needed to have been removed even if the initial treatment had been the removal of the duct stones alone. Therefore, on balance, Adviser 2 was of the view that Mr C had not undergone unnecessary surgery.

59. Adviser 2 accepted that the symptoms Mr C described, including numbness in his neck and additional time off work to recuperate, were commensurate with the surgery.

Additional concerns raised by Mr C

60. Following Mr C's complaint to us, he told my complaints reviewer in March 2014 that he was due to have further surgery and had attended a pre-operative assessment appointment in early March 2014. Mr C said he had spoken to a doctor at the meeting, who said that surgery was to be carried out on the left side of his face. Mr C said he had to correct the doctor as his surgery was to be on the right side of his face. Mr C said he found it astonishing that the Board were still getting things wrong.

The Board's comments

61. We asked the Board to comment about this. The Board said that Consultant 2, a consultant oral maxillofacial surgeon, first saw Mr C in November 2013 and agreed to review the situation two months later in clinic.

Mr C was admitted to the Hospital prior to the review clinic appointment and Consultant 2 reviewed Mr C in January 2014 in the ward and agreed that the residual right sublingual gland needed to be removed and that there was no need for Mr C to attend the pre-arranged clinic appointment the following week. The error had occurred when the speciality doctor who completed the paperwork on behalf of Consultant 2 had incorrectly referred to 'left sublingual' in both Mr C's case sheet and the dictated letter, resulting in the error on the pre-operative paperwork and on the waiting list entry. This had resulted in some confusion at the pre-operative assessment meeting in March 2014. However this was corrected when Mr C was seen and consented by Consultant 2, who was the operating surgeon.

(b) Conclusion

62. The advice I have received is that the removal of Mr C's submandibular gland would have eventually been required if it had not being removed during the surgery and that, on balance, Mr C had not undergone unnecessary surgery. Nevertheless, according to Adviser 2, the non-removal of the duct stones during Mr C's first operation necessitating further surgery was a failure in Mr C's care and treatment. Therefore, I uphold this complaint.

63. The reasons for the failure to remove Mr C's duct stones at the time of the surgery and the recommendations I have made to address this failing are set out in complaint (a).

64. Understandably, Mr C was again concerned when further errors and confusion arose in relation to the removal of his residual right sublingual gland. While, fortunately, the errors was corrected it is of concern that such failings again occurred in Mr C's case. In view of this, I have, therefore, made the following recommendations to the Board:

(b) Recommendations

65. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mr C for the failings identified; and	19 March 2015
(ii) provide evidence of the action taken to address the failings identified in respect of the removal of Mr C's residual right sublingual gland.	20 April 2015

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

Annex 1

Explanation of abbreviations used

Mr C	the complainant
the Hospital	Crosshouse Hospital
the Board	Ayrshire and Arran NHS Board
Consultant 1	a consultant oral maxillofacial surgeon at Crosshouse Hospital
Doctor 1	a speciality doctor in the Oral and Maxillofacial Surgery department at Crosshouse Hospital
Doctor 2	a doctor in the Oral and Maxillofacial Surgery department who consented Mr C for the surgery
Adviser 1	a medical adviser to the Ombudsman
Adviser 2	a medical adviser to the Ombudsman
Adviser 3	a medical adviser to the Ombudsman
Consultant 2	a consultant oral maxillofacial surgeon at Crosshouse Hospital

Glossary of terms

duct stones	chemicals in saliva that crystallise into stones
General Medical Council (GMC) Guidance	guidance on consent: patients and doctors making decisions together, June 2008
submandibular gland	a salivary gland below the jaw bone
sublingual gland	a salivary gland located on the floor of the mouth

Annex 3

List of legislation and policies considered

General Medical Council Guidance on Consent: patients and doctors making decisions together (2008)