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: Central Scotland

Case ref: 201400643, Lanarkshire NHS Board
Sector: Health
Subject: Clinical treatment; diagnosis

Summary
Mrs C complained about the care and treatment provided to her late husband Mr A. Mr A was admitted to Wishaw General Hospital on 24 February 2014 and died there on 6 March 2014. Mr A had been unwell for some time prior to admission and cared for by family members at home. In the days leading up to his admission his condition had deteriorated and he had been hallucinating and unable to swallow. Mrs C complained about a number of the aspects of care provided to Mr A. In their response to her complaint, the board accepted some failings and apologised. Mrs C remained unhappy and asked the SPSO to investigate. I took independent advice from a consultant physician and a nursing adviser.

My investigation found that although her complaint had been upheld, the complaints process had only looked at Mr A's care in a superficial manner. Not all the clinical staff involved in the case had commented and may have been left unaware of the outcome of the board's investigation. I also found a number of significant failings. There was a lack of any overall plan for Mr A's care and treatment, and the treatment he did receive fell well below a level that Mr A should have expected on a number of points. There was no specific assessment of his swallowing difficulties or monitoring of the dehydration that he presented with on admission. Significantly, there was evidence of confusion between staff about whether Mr A was being provided with active or end of life care. Mr A was being proposed for referrals and investigations just two days before palliative care and a possible transfer to a hospice was considered although there was no apparent change in his condition. One doctor noted on file that Mrs C wrongly believed Mr A was dying. However, there is also evidence that other staff did think Mr A was dying and the board acknowledged in their investigation that end of life care would have been more appropriate throughout this admission. Mrs C told us she received conflicting information about his condition and received a call from occupational therapy about physical aids she may need to care for him at home when it should have been clear he would not be discharged. Alongside the failings in the treatment and the confusion around this, I was also critical that there was no evidence Mr A's

family were appropriately involved in decision-making. On the day he died, Mr A had a gastroscopy to investigate some of his symptoms. We found that there had been no clear assessment of the risks of such a procedure and further, that, at the time, Mr A did not have the capacity to consent to such a procedure. A certificate of incapacity was in place that allowed medical staff to provide general treatment as Mr A could not legally consent to this. It did not provide for this specific procedure which would normally require additional consent and Mrs C and her family should have been involved in this decision. This means that Mr A was denied safeguards put in place by legislation to protect adults with incapacity when the decision whether or not to go ahead with the gastroscopy was made. Mr A did not recover well from this procedure and, while there was some treatment following his return to the ward, there was little evidence this deterioration was properly assessed.

I found there were also failings around the very sensitive issue of when Mr A had died and who should be informed of his death. The records indicate Mr A died around 13:40 to 13:50. However the death certificate recorded the time as 15:13. This difference happened because it was not until then that a doctor confirmed the death. However, advice by the Chief Medical Officer makes it clear that this approach is wrong and that doctors should seek to put on the certificate as accurate an actual time as possible based on the available information and not simply the time they confirm the death. Following Mr A's death, the decision was made not to notify the procurator fiscal. This assessment was made using a standard checklist. I found no problems with the checklist but it had been wrongly completed and said there were no reasons for Mr A's death to be reported. In fact, Mr A potentially met two criteria – deaths which were clinically unexplained and which may be due to an anaesthetic. Mr A died from unknown causes on the day he had had an invasive procedure and there was evidence he had deteriorated following that procedure. I made a number of recommendations as a result of my investigation. They reflect that some action had been taken by the board prior to my investigation and the significant changes to the procedures around certification of death introduced on 13 May 2015.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs C for the failure to report her husband's death to the Procurator Fiscal and the	17 June 2015

	use of an inaccurate time of death;	
(ii)	notify the Crown Office and Procurator Fiscal Service of the omission to report Mr A's death to the Procurator Fiscal on 6 March 2014;	17 June 2015
(iii)	ensure that all relevant staff are aware of the current requirements for reporting a death to the Procurator Fiscal;	1 July 2015
(iv)	ensure that relevant staff are aware of the Code of Practice for practitioners authorised to carry out medical treatment under Part 5 of the Adults with Incapacity (Scotland) Act 2000;	1 July 2015
(v)	present this case and the findings of this report at a medical/respiratory departmental meeting; and	15 July 2015
(vi)	ensure that this case is included in the appraisals of the relevant consultants and the educational portfolios of relevant trainee staff.	15 July 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (Mrs C) complained about the care and treatment that her husband (Mr A) received at Wishaw General Hospital (the Hospital). Mr A suffered from idiopathic dilated cardiomyopathy, ankylosing spondylitis and chronic anaemia. He had a longstanding reduction in his appetite and associated weight loss which resulted in him being very frail. Mr A was cared for at home by Mrs C and their daughter. He was unable to leave the house and was largely bed bound prior to these events. Mr A was usually coherent but there had been a deterioration in this over the two days prior to his admission to the Hospital.

2. On the evening of 24 February 2014, Mr A was shaking, hallucinating and refusing to swallow liquids. The family called NHS 24 and an on-call doctor attended. He advised that Mr A should be given plenty to drink and to call their own GP in the morning. A further call was made to NHS 24 later as his symptoms had not improved and an ambulance was sent out. Mr A arrived at the Hospital in the early hours of 25 February 2014 and was admitted suffering from malnutrition, reduced oral intake and confusion. His blood pressure was low and he had a reduced respiratory rate. Mr A was given intravenous (IV) fluids and was subsequently transferred to Ward 7 (a medical/respiratory ward) at the Hospital. Mrs C has said that prior to Mr A's transfer, she was advised that all staff could do was keep him comfortable. A further assessment was carried out on 26 February 2014 and an initial plan for treatment recorded. It was also noted that Mr A's GP had recently made adjustments to his morphine based pain relief, changing from short to long release but that this change had not coincided with his increased confusion/hallucinations.

3. On 27 February 2014, Mr A's hallucinations were noted to have stopped; however, Mrs C has advised that in her view this was not the case and they had in fact worsened. A senior doctor (Doctor 1) was to deal with the prescription of medication to manage the hallucinations if they recurred and there was a plan to discharge Mr A home that day. Assessments were carried out by occupational therapy and physiotherapy. Occupational therapy considered that Mr A was far from a functional level where his family could assist him at home and arrangements were to be made for equipment (medical aids) to help them.

4. On 28 February 2014, Doctor 1 noted that Mr A had not had any further hallucinations and was pain free. She also noted that Mrs C was keen to speak with the consultant physician (Consultant 1) in charge of Mr A's care regarding

his prognosis. Doctor 1 noted that Mrs C was under the misapprehension that he was dying/unlikely to be able to leave hospital. Doctor 1 met with Mrs C and her daughter later that day. Mrs C has advised that she found Doctor 1's manner unprofessional during this contact. Whilst Mrs C was still at the Hospital, Mr A suffered from further hallucinations which were treated with lorazepam (a medicine used to ease symptoms of anxiety). Mr A continued to suffer from hallucinations and confusion over 1 and 2 March 2014. On 3 March 2014, he was seen by Doctor 2 who considered that a computerised tomography (CT) scan was required. A middle-grade doctor (Doctor 3) spoke to the family later that day and advised that the CT scan was essentially normal. He also advised that they needed to consider a dementia diagnosis and possibly Parkinson's disease.

5. On 4 March 2014 Mr A had an episode of melaena (black tarry stools due to bleeding in the gastrointestinal tract). A treatment plan was noted by Doctor 3 which included IV fluids with clinical assessment after each treatment. A referral was made to assess whether some of Mr A's other symptoms could be related to Parkinson's disease. The following day, on 5 March 2014, a letter was sent to a consultant in gastroenterology (Consultant 2) by a junior doctor (Doctor 4) for input on care of Mr A. Doctor 4 noted that Consultant 2 had seen Mr A in his out-patient clinic in 2012 following an upper gastrointestinal (GI) endoscopy. He particularly asked for Consultant 2's views on whether repeat endoscopy or imaging was needed. An attempt was made to catheterise Mr A but this was unsuccessful.

6. Mr A was seen by a dietician on 5 March 2014 who noted that there was a poor prognosis for the patient. Mrs C has advised that despite being nil by mouth since the previous afternoon, her husband spat out a pea during visiting that evening. She also advised that a junior doctor had dismissed her concerns that Mr A was too frail for a gastroscopy to be carried out. Mrs C said that at that time, the same junior doctor had decided to have Mr A taken for a scan on a wheelchair. On 6 March 2014 a gastroscopy was planned and it was noted that Mr A's prognosis was to be discussed with his family including the possibility of palliative care or a hospice. The gastroscopy took place that morning and Mr A returned to the ward at 11:00. Mr A had a seizure and was given diazepam (a medicine used to treat seizures) at around 12:30. Mrs C and her family were contacted and advised about his deteriorating condition. They attended at the Hospital and sadly, Mr A died that afternoon. Mrs C has

advised that Mr A passed away at 13:50. Mr A's death was not reported to the Procurator Fiscal.

7. Mrs C met with Consultant 1 and the Ward 7 charge nurse (the Charge Nurse) on 19 March 2014 to discuss Mr A's care and treatment. Consultant 1 agreed that the decision to go ahead with the gastroscopy was possibly wrong. Mrs C was dissatisfied with the explanations provided and made a formal complaint to Lanarkshire NHS Board (the Board) on 24 March 2014.

8. The complaint from Mrs C I have investigated is that the Hospital unreasonably failed to provide the proper care and treatment when the late Mr A was admitted to the Hospital in February 2014 (*upheld*).

Investigation

9. In order to investigate Mrs C's complaint, my complaints reviewer considered all the information received from Mrs C, the Board's medical records for Mr A and relevant guidance. Independent advice was also obtained on this case from a consultant physician (Adviser 1) and a nursing adviser (Adviser 2). In this case, we have decided to issue a public report on Mrs C's complaint due to the significant personal injustice suffered by Mr A at the end of his life.

10. 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.

Complaint: The Hospital unreasonably failed to provide the proper care and treatment when the late Mr A was admitted to the Hospital in February 2014

Concerns raised by Mrs C

11. Mrs C detailed the events leading up to Mr A's death in her complaint to the Board and asked a number of questions about the care and treatment that he received. Mrs C was particularly concerned by conflicting reports of her husband's condition by medical staff, the attitude of Doctor 1, the decision to go ahead with a gastroscopy and a lack of attention on the part of a junior doctor to the family's concerns about this on 5 March 2014. Mrs C also highlighted that the time of death on Mr A's death certificate was incorrect; that a call had been received about delivery of medical aids when it was clear that Mr A would not be discharged; and the incident involving the pea found in Mr A's mouth.

The Board's response

12. The Board noted that Mrs C had met with Consultant 1 and the Charge Nurse to discuss her concerns. They said that it was clear from her complaint and their communication with Consultant 1 that the end of life care provided to Mr A was not satisfactory. The Board apologised for this and the distress caused to Mrs C and her family.

13. The Board said that Mr A had been admitted to hospital for investigation of hallucinations and confusion. They said that after admission, it was clear that the presenting complaint was attributed to changes that his GP had made to his opiate drugs to manage the pain from his ankylosing spondylitis. The Board outlined Mr A's condition at the time of his admission to the Hospital and confirmed that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order had been completed. They noted that Mr A had not been responding to treatment and that it was considered that he may have been dying.

14. The Board went on to advise that Mr A was admitted to the Emergency Care Unit before being transferred to Ward 7 under the care of Consultant 1. They informed Mrs C that medical staff were aware that Mr A had been investigated over recent months by a number of specialists but that no cause had been identified for his decline. The Board advised that from their complaints investigation, it was clear that medical staff were aware that Mr A's condition was serious and that his prognosis was poor, however, as no formal diagnosis had been made to explain his decline, staff focussed on further investigations. They went on to say that with hindsight, it would have been more appropriate for medical staff to have made the decision to provide palliative care only and allowed the family time to come to terms with the situation.

15. In relation to the gastroscopy, the Board advised that Consultant 1 had apologised when he met with Mrs C and advised that in hindsight, this may not have been the right decision given that Mr A was ill. They went on to say that it was difficult, however, to allow Mr A to die from uncontrolled gastrointestinal bleeding, especially as this was potentially treatable.

16. The Board acknowledged that it would have been upsetting to have received a telephone call from an occupational therapist about medical aids given that Mrs C had previously been told that Mr A's condition was life threatening. They went on to explain that the occupational therapy department

were of the view that although his prognosis was poor, they did not expect him to die in hospital. The Board also apologised that Mrs C perceived Doctor 1's manner as unprofessional during their contact and that Mrs C's daughter had overheard Doctor 1 using inappropriate language whilst speaking to colleagues. They advised Mrs C that the junior doctor she had spoken to on 5 March 2014 was Doctor 4. The Board informed Mrs C that Doctor 4 could not recall the conversation but apologised for any upset caused. The Board also apologised that a pea was found in Mr A's mouth on 5 March 2014 and expressed regret that this had not been highlighted at the time to allow staff to investigate.

17. The Board addressed a number of specific questions raised by Mrs C and apologised that the experience had impacted on the family's ability to grieve for the loss for Mr A.

Advice received

18. My complaints reviewer asked Adviser 1 whether the decisions taken regarding Mr A's diagnosis and treatment were reasonable on the basis of the symptoms he presented with. Adviser 1 noted the sequence of events and that no review was carried out of Mr A over the weekend of 1 and 2 March 2014 despite his deterioration the previous day. He advised that Mr A's care was complex and that there was no clear unifying diagnosis before or during his admission to the Hospital. He commented that there has been out-patient investigation but no clear cause for Mr A's symptoms had been found. Adviser 1 said that while it was not possible to speculate on possible diagnoses as previous investigations could have excluded conditions, he was critical that there was not a specific assessment of Mr A's swallowing difficulties by speech and language therapists. Overall, he advised that the decisions taken and treatment provided were well below a level that Mr A could expect and were unreasonable.

19. Adviser 1 was asked to comment on whether fluids were used appropriately in Mr A's treatment. He advised that it was difficult to deduce the clinical decisions made about IV fluids but he found that the monitoring of Mr A's hydration, urine output and fluid intake was not considered in sufficient detail on a day-to-day basis. Adviser 1 noted that there was no specific monitoring of Mr A's blood tests for dehydration even though this was present on admission and was why IV fluids had initially been prescribed. He advised that in this aspect, Mr A's care fell below a level he could expect and was unreasonable.

20. Adviser 1 considered that Mr A's proposed discharge on 27 February 2014 was premature. He advised that Mr A's symptoms had not settled and that there was no clear diagnosis to explain the reason for his admission. Adviser 1 commented that Mr A's overall condition was deteriorating but no further plans for investigation or treatment were made at that time. He advised that this care fell below a level that Mr A and his family could expect and was unreasonable.

21. Adviser 1 noted that Mr A's gastroscopy was performed at 09:45 on 6 March 2014 and showed some inflammation of his stomach but no significant bleeding such as from an ulcer. He commented that Mr A's recovery from the procedure was poor with low oxygen levels and that he required treatment to reverse his sedation. Adviser 1 found that Mr A's death did not appear to have been caused solely by internal bleeding. He advised that the findings of the gastroscopy were relatively minor and that although the cause of death was not clear from the medical records, he considered it unlikely that bleeding from the stomach or bowel was the sole cause of death.

22. My complaints reviewer asked Adviser 1 to comment on whether there was any indication before the gastroscopy procedure was carried out that the risks outweighed the benefits. He advised that there was not a clear assessment of this at the time and that the notes made by Consultant 1 read 'OGD [oesophago-gastro-duodenoscopy] to be conducted and if negative no further investigations of weight loss'. Adviser 1 also noted that another doctor has questioned the appropriateness of the procedure earlier that week.

23. He went on to advise that there was a further specific failure of care around the gastroscopy as the consent form had not been completed. Adviser 1 noted that a written note had been highlighted at the top of the form stating 'Adult with Incapacity'. He said that this referred to the fact that Mr A lacked capacity to make decisions about his care and that the Adults with Incapacity certificate completed for Mr A stated that he was incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) to make a decision about 'all medical treatment and investigations'. Adviser 1 noted that there was no indication that this had been discussed with Mr A's family.

24. Adviser 1 considered that the correct process for this situation is clear. He referred to the relevant Code of Practice for Adults with Incapacity:

'2.22 No treatment plan of this sort can authorise interventions that would normally require the signed consent of the adult. A separate certificate of incapacity will be required for each intervention of this type. For example, if the adult in paragraph 2.21 needs heart surgery, this will not be included in the authority to treat under "coronary heart disease" and will require a separate certificate and separate consultation. Note also that, no treatment specified in regulations as needing special safeguards can be included in the treatment plan.

…

Annex 5

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Notes on completion of treatment plan

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

Include all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B) …

Exclude all interventions that would ordinarily need the signed consent of the patient. Interventions of this sort need a separate certificate of incapacity. For example, if you write "coronary heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, or treat disease with anti-hypertensive drugs, but not operate to bypass blocked arteries.'

25. Adviser 1 advised that a specific treatment plan or certificate should be completed for a gastroscopy, not just the continuing use of a certificate of incapacity with more general treatments described. A procedure like this would normally require a specific consent process for an adult with capacity and as such, is not included within a generic certificate or healthcare treatment plan. Adviser 1 commented that Mr A did not even have a treatment plan at that time and that the only documentation on this issue for him was the certificate of incapacity for general treatment.

26. Adviser 1 considered that Mr A's family should have been more involved in the discussion about the merits and risks of the gastroscopy procedure than they were. He advised that the generic treatment options granted by the

certificate of incapacity should not have been used for the gastroscopy and that this should have been considered specifically in more detail than it was. Adviser 1 noted that Mrs C had described a very poor level of care in her letter of complaint when she expressed concern to medical staff about Mr A being too frail for the procedure. He advised that Mr A had experienced an unreasonable level of care and that this denied him the safeguards of the adults with incapacity legislation. Adviser 1 accepted that decisions like this are complex, particularly for patients who lack capacity but he considered that better levels of discussion with Mr A's family would have helped with the decision making process. He noted that this had not happened and that Mrs C's legitimate concerns appeared to have been dismissed. Adviser 1 said that the 2000 Act is clear on this point and in Principle 4 states:

'Principle 4 – consultation with relevant others

1.12.4 In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of the views of:

- the nearest relative and the primary carer of the adult;
- any guardian, attorney or welfare attorney of the adult who has powers relating to the proposed intervention;
- any person whom the sheriff has directed should be consulted; and
- any other person appearing to the person responsible for authorising or effecting the intervention to have an interest 2 in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible.

in so far is it is reasonable and practicable to do so.'

Adviser 1 found that clinicians caring for Mr A did not do this, representing a failure to recognise the 2000 Act and its principles, and denying him the safeguards of the legislation.

27. My complaints reviewer asked Adviser 1 to comment on the time of death given on various documents with the records and correspondence as this varied from 13:40 to 15:21. Adviser 1 said that nursing notes recorded that Mr A died at 13:40, however, a medical note certified the time the doctor confirmed Mr A's death as 15:13. He considered that Mr A died at approximately 13:40 to 13:50. Adviser 1 explained that there is often a delay between the time of death and confirmation and that this is common, particularly where medical staff may not be able to attend immediately. He advised that medical staff document the time they certify death, not what is reported to them as the actual time of death by

other staff or relatives. Adviser 1 commented that this can be a cause of confusion and distress. He went on to advise that this practice is contrary to advice from the Chief Medical Officer which states that:

> 'you should record the time of death as accurately as possible. This can be needed for legal reasons. Please do not use instead the time when life was pronounced extinct. If a nurse or relative was present when the person died, you may record reliable information they give you about the time of death. Otherwise, give your best estimate based on all the information available to you.' [1]

Adviser 1 considered that the doctor should have recorded both the time the nurses told them Mr A had died and the time that they personally certified this, rather than using the latter alone. He advised that the guidance indicates that the death certificate they then complete should use the time given by the nurses and relatives.

28. In relation to Mr A's death, Adviser 1 was asked whether it was appropriate that no referral was made to the Procurator Fiscal. Adviser 1 noted that the Board have a checklist for reporting to the Procurator Fiscal and that this had been ticked to indicate that none of the criteria applied in Mr A's case. However, Adviser 1 considered that some of the criteria did apply and that Mr A's case should have been referred to the Procurator Fiscal. He advised that the relevant criteria were: deaths which are clinically unexplained and deaths which may be due to an anaesthetic. Adviser 1 said that he would have expected Mr A's death to have been discussed with the Procurator Fiscal as he died from unknown causes on the same day that he had an invasive procedure with sedation. Adviser 1 found that the procedure caused a deterioration in Mr A's condition and noted that he required specific treatment for this. Adviser 1 commented that Mr A was only 61 years old at the time of his death and that although death at a younger than expected age is not a specific reason for a referral, he considered that this made a difference to the level of certainty required for death certification. He went on to highlight that the process for death certification in Scotland is changing with new procedures set to be introduced this year. Adviser 1 considered that use of the new Medical Certificate of Cause of Death (MCCD) will prompt increased reporting of deaths to the Procurator Fiscal.

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[1] Guidance on Completion of Medical Certificate of the Cause of Death from the Chief Medical Officer 29 September 2009

29. My complaints reviewer asked Adviser 1 to comment on the information recorded in Mr A's medical notes prior to his death. Adviser 1 noted that there was no reference in the multi-disciplinary notes to the circumstances that led to Mr A's death. He advised that this is not an acceptable level of documentation of care. Adviser 1 found that Mr A had specific recovery problems after the gastroscopy that were noted in the gastroscopy records. He commented that Mr A did not have a specific or detailed review recorded after his return to the ward and that there is no evidence that the gastroscopy department communicated the information about his problems to the medical staff on the ward. He also advised that that there was no evidence that the person who carried out the gastroscopy was subsequently made aware that Mr A had died that afternoon. Adviser 1 found that the nursing notes describe instructions from medical staff about allowing Mr A to eat and drink, and that there was no documented medical review from the time he left the endoscopy unit until his death certification. He noted that Mr A had been given medication to control a seizure at 12:30 on 6 March 2014 but that the doctor who had prescribed and administered this had not made a specific note about this in the medical notes.

30. Adviser 1 said that Mr A should have been specifically assessed by medical staff at this time but was not. He considered that this represented a very poor level of care by medical staff and also noted that there was a very poor standard of record-keeping. Adviser 1 was clear that a detailed clinical review by medical staff of Mr A should have taken place at this point. He advised that even if medical staff were convinced that Mr A was now dying, this should have been an active process, documented in the notes and involving his family.

31. In conclusion, Adviser 1 commented that the narrative of Mr A's case notes makes it clear that there were several different staff members caring for him but there was not a coherent diagnostic and treatment plan in place. He advised that because there was no overall plan for treatment agreed with Mr A and his family, some medical staff seemed to have been left unsure if they were providing active treatment or palliative care. Adviser 1 said that they also seemed unsure if Mr A was going to return home or was considered too unwell for this to happen. He commented that referrals to specialists, such as the Parkinson's disease team, and investigations, such as a CT scan of Mr A's head, were organised by one doctor but that two days later, palliative care and

the possibility of transfer to a hospice was being proposed, even though his condition had not changed significantly.

32. In addition, Adviser 1 commented that the complaints handling process had discussed Mr A's care in a relatively superficial way with no detailed analysis of his care and no specific action taken, even though the Board upheld the complaint. He found that only the comments provided by Consultant 1 during the complaints investigation appeared reflective about the overall process of care and noted that whilst some of the doctors in this case have reflected on their involvement, others had not commented. Adviser 1 considered that they may have been left unaware of the outcome in Mr A's case and the subsequent complaint.

33. My complaints reviewer asked Adviser 2 to comment on the nursing care provided to Mr A, particularly oral hygiene. Adviser 2 considered that there was insufficient evidence to say whether the oral hygiene provided to Mr A was a sign of poor nursing care. Adviser 2 commented that the main concerns in this case centred around the lack of care and dignity at the end of life. She advised that this aspect of care is multi professional and that she agreed with Adviser 1's advice.

Decision

34. As acknowledged by the Board, it is clear that the end of life care Mr A received was not reasonable. It is noted that they upheld Mrs C's complaint and have already provided her with an apology for this. The advice I have received is that, although the Board have identified failings in their care and treatment, their investigation was not detailed enough to highlight all the issues of concern.

35. The advice received indicates that medical staff seemed to have been left unsure if they were providing active treatment or palliative care. I note that palliative care was proposed just two days after referrals and investigations were organised, even though there had been little significant change in Mr A's condition. In their response to Mrs C the Board said that with hindsight, it would have been more appropriate to provide palliative care only to Mr A. The advice highlighted the fact that there was a lack of a clear overall plan for Mr A's care and treatment which led to a confused picture for Mrs C and her family. This is well illustrated by the entry in Mr A's notes by Doctor 1 on 28 February 2014 stating that Mrs C was 'under the misapprehension' that he was dying when other staff agreed with her view.

36. The advice received referred to a number of issues with record-keeping that fell below the standard that could reasonably be expected. In relation to the monitoring of Mr A's hydration and fluid balance, I am concerned by the advice that there was no specific monitoring of his blood tests for dehydration even though this was why IV fluids were started following his admission to hospital.

37. I am particularly concerned by the advice regarding consent for the gastroscopy procedure carried out on the day of Mr A's death. The certificate of incapacity used under the 2000 Act provides the wide-ranging medical treatment description of 'all medical treatment and investigations' rather than specific consent for procedure such as gastroscopy. This form also appears to have been incorrectly dated as it states that Mr A was examined on 5 April 2014. This is not a reasonable approach to a certification process that carries such significance. Mrs C and her family should have been directly involved in the decision making process in line with principle four of the 2000 Act.

38. The advice received also highlighted a number of concerning features around the recording of information on 6 March 2014, the day that Mr A passed away. Nursing notes were maintained over this period but medical records have not been reasonably updated. The evidence provided by the Board for this case shows that there was a lack of information recorded in the multi-disciplinary notes after the gastroscopy was carried out with no entries made after Mr A returned to the ward other than the confirmation of his death by Doctor 4 at 15:21. This entry gives the time of death as 15:13 and Mrs C was understandably distressed that this was the time used on the death certificate, given that she understood her husband had passed away around 13:50 with nursing notes recording the time as 13:40. The advice I have received pointed to guidance from the Chief Medical Officer on recording the time of death which has not been followed in this case.

39. The decision not to inform the Procurator Fiscal of Mr A's death is also a significant matter. In Scotland, all sudden and unexplained deaths must be reported to the Procurator Fiscal. Whether or not the cause of death is known, if a doctor is of the view that a death was clinically unexpected, it is described as a sudden death. When the cause of death is not known or is not clear to a doctor, this is described as an unexplained death. Once a person's death is

reported, it is for the Procurator Fiscal to decide what further action will be taken. For example, the Procurator Fiscal could discuss a case with a doctor, agree the cause of death and the death certificate could be issued without further action being taken by the Procurator Fiscal. Alternatively, it is possible that the Procurator Fiscal will decide that additional investigation needs to be carried out.

40. The advice I have received indicates that two of the criteria for reporting could have applied in Mr A's case and that his death should have been discussed with the Procurator Fiscal. Since Mr A's passing, a new MCCD form has been introduced (August 2014) ahead of substantial changes introduced by the Certification of Death (Scotland) Act 2011 which are due to come into force on 13 May 2015. As part on the changes, a death certification review programme is to be introduced which will involve the review of MCCDs by experienced, trained doctors and will be implemented by Healthcare Improvement Scotland (HIS). The changes were passed by the Scottish Parliament with a view to improving accuracy of death certification and providing improved public health information about causes of death in Scotland, as well as streamlining the certification/registration of deaths. Whilst the introduction of new MCCD forms and the HIS review function is intended to improve accuracy in this area, I remain concerned that Mr A's death was not reported to the Procurator Fiscal and I have made a recommendation to the Board in this regard.

41. The evidence I have seen in relation to nursing care indicates that oral hygiene was assessed by nursing staff on 4 and 5 March 2014. Although this record exists, the advice I have received is that this is not sufficiently detailed to comment further on the pea found in Mr A's mouth. Unfortunately there are no means after the event to investigate how this happened. I note that the Board apologised for this incident in their response to Mrs C's complaint as well as apologising for the telephone call from occupational therapy about medical aids and any upset caused by Doctor 4 on 5 March 2014.

42. Mr A did not receive reasonable care and treatment at the end of his life and, whilst the Board have apologised, their investigation did not identify a number of significant issues. In view of these findings, I uphold this complaint.

Recommendations

43.	I recommend that the Board:	*Completion date*
(i)	apologise to Mrs C for the failure to report her husband's death to the Procurator Fiscal and the use of an inaccurate time of death;	17 June 2015
(ii)	notify the Crown Office and Procurator Fiscal Service of the omission to report Mr A's death to the Procurator Fiscal on 6 March 2014;	17 June 2015
(iii)	ensure that all relevant staff are aware of the current requirements for reporting a death to the Procurator Fiscal;	1 July 2015
(iv)	ensure that relevant staff are aware of the Code of Practice for practitioners authorised to carry out medical treatment under Part 5 of the Adults with Incapacity (Scotland) Act 2000;	1 July 2015
(v)	present this case and the findings of this report at a medical/respiratory departmental meeting; and	15 July 2015
(vi)	ensure that this case is included in the appraisals of the relevant consultants and the educational portfolios of relevant trainee staff.	15 July 2015

44. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendation by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved
the Hospital	Wishaw General Hospital
IV	intravenous
Doctor 1	senior doctor
Consultant 1	consultant physician
Doctor 2	a doctor who saw Mr A on 3 March 2014
CT scan	computed tomography scan
Doctor 3	a doctor who saw Mr A during this episode of care and completed the Adults with Incapacity certificate
Consultant 2	consultant physician/gastroenterologist
Doctor 4	junior doctor
GI	gastrointestinal
the Charge Nurse	ward sister
the Board	Lanarkshire NHS Board
Adviser 1	consultant physician
Adviser 2	nursing adviser

DNACPR	do not attempt cardiopulmonary resuscitation
OGD	oesophago-gastro-duodenoscopy
the 2000 Act	Adults with Incapacity (Scotland) Act 2000
HIS	Healthcare Improvement Scotland
MCCD	Medical Certificate of Cause of Death

Annex 2

Glossary of terms

anaemia	a condition resulting in a reduction of oxygen being carried in the bloodstream
ankylosing spondylitis	a long-term (chronic) condition in which the spine and other areas of the body become inflamed
CT scan	a scan that uses a computer to produce an image of the body
endoscopy	a medical procedure where a tube-like instrument is put into the body to look inside
diazepam	a medicine used to treat seizures
gastroscopy	a type of endoscopy used to look inside the stomach
Healthcare Improvement Scotland (HIS)	the national healthcare improvement organisation for Scotland and part of NHS Scotland
idiopathic dilated cardiomyopathy	a condition where the heart becomes enlarged and pumps blood less well
intravenous (IV)	directly into the vein
lorazepam	a medicine used to ease symptoms of anxiety, or sleeping difficulties caused by anxiety
melaena	black tarry stools due to bleeding in the gastrointestinal tract
oesophago-gastro-	another term for a gastroscopy or endoscopy

duodenoscopy	
palliative care	care provided solely to prevent or relieve suffering
Parkinson's disease	a condition in which part of the brain becomes progressively damaged over many years

Annex 3

List of legislation and policies considered

Adults with Incapacity (Scotland) Act 2000

Certification of Death (Scotland) Act 2011

Guidance on Completion of Medical Certificate of the Cause of Death from the Chief Medical Officer 29 September 2009

Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act