Scottish Parliament Region: Lothian

Case 200700444: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Cardiac

Overview

The complainant (Mr C) did not consider that Lothian NHS Board (the Board) had taken seriously, or learnt from, the death of his 46-year-old son (Mr A).

Specific complaint and conclusion

The complaint which has been investigated is that the Board's response to Mr A's death was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C for: the failure to provide convincing evidence of a thorough investigation, with lessons learnt; the impression at various times that no action would be taken in response to his son's death; the poor quality of some of the complaint responses; and the delay in giving him a definitive response to a complaint meeting and letter of early 2005; and

(ii) ensure that, where appropriate, this investigation drives further service improvement in future complaints.

Main Investigation Report

Introduction

1. Mr C's 46-year-old son, Mr A, was referred to the Royal Infirmary of Edinburgh (the Hospital) by his general practitioner (GP) in September 2003 because of suspected internal bleeding. Various tests were done, on an in-patient basis, and some heart abnormality was discovered. Following a brief discharge and a readmission, it was decided to discharge Mr A some days later and to do a transoesophageal echocardiogram (TOE) on an out-patient basis, to examine further the abnormality. A TOE was done in October 2003, and it was decided to consider the results at another out-patient appointment, which was arranged in November 2003 for February 2004. On Friday, 12 December 2003, Mr A re-visited the GP because of increasing breathlessness, and she arranged x-rays for him for 15 December. Very sadly, Mr A died on the 13 December, after collapsing in the street. A post mortem gave the cause of death as an infection called subacute bacterial endocarditis, which had fatally weakened Mr A's heart. This was already in poor condition from chronic rheumatic mitral valve disease, which was a heart condition also found at the post mortem.

2. A consultant cardiologist (the Consultant) had been involved in Mr A's care at the Hospital. He felt that, although endocarditis was rare and difficult to diagnose, the Hospital should have considered it as a possibility during the September admission and that Mr A's death might have been avoidable. Over the next few years, Mr C and Lothian NHS Board (the Board) corresponded and met many times. However, Mr C felt that he had been let down and that his son's death had been in vain because no good had come from it. This was because, given that someone had died at a young age, he would have expected an investigation, lessons learnt and action to try to avoid a recurrence. Instead, he felt that little seemed to have happened beyond 'counselling' a doctor (who no longer even worked at the Hospital) for not meeting a ten-day correspondence target.

3. The complaint from Mr C which I have investigated is that the Board's response to Mr A's death was inadequate. Two questions lie at the heart of this: whether the Board's actions in response to the shortcomings which they had identified were adequate and whether they communicated those actions adequately to Mr C.

4. Mr C also complained about the death itself, feeling that the Hospital had simply labelled his son (who had a history of alcohol excess) as an alcoholic, not worth bothering with, and that they could have saved his life. However, I have not investigated Mr A's death. This is because it is not the usual practice of the Ombudsman's office to investigate events where, as in this case, a Health Board had acknowledged fault before the complaint was made to this office. In essence, the role of an Ombudsman investigation is to establish the facts, consider whether there was unreasonable fault and, if so, consider what action to take. Where fault has already been established and acknowledged, there would be little, if any, purpose to an investigation. Through a review of the main clinical records, our clinical adviser (the Adviser - see next paragraph) considers there were no significant faults that the Board had not acknowledged. It was, therefore, clear that the investigation should focus on the action taken by the Board following Mr A's death, rather than on the death itself.

Investigation

5. I was assisted in the investigation by the Adviser, whose role as a medically qualified professional was to explain to me, and comment on, medical aspects of the complaint. We considered the detailed information given by Mr C in a telephone conversation with me, together with a file of papers which Mr C provided, which included complaint correspondence between him and the Board and his son's clinical records. Information which we considered from the Board included internal complaint correspondence and responses to my enquiries. The purpose of the investigation was to use this information to establish the Board's actions in response to Mr A's death and to consider whether those actions fell within the range of what would be considered to be reasonable practice, in the circumstances.

6. 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 reminder of the abbreviations and terms used is in the annexes.

Complaint: The Board's response to Mr A's death was inadequate

7. The Consultant met Mr C in March 2004. In a letter later that month to Mr A's GP, he said that he had told Mr C and his wife, amongst other things, that endocarditis was rare and difficult to diagnose because, for example, it could be hidden in patients suffering from long-term alcohol excess, but that he felt bad that their son had been discharged without the diagnosis.

8. Following a meeting with the Board, Mr C made a formal complaint, asking, for example, whether his son's death had been avoidable and about the delay in the out-patient appointment which had been arranged in November 2003 for February 2004 by a senior cardiology registrar (the Registrar) to consider further the results of the October 2003 TOE. (There were also other delays in respect of Mr A's out-patient treatment, which Mr C put to the Board later and which they accepted.)

9. In line with usual NHS complaint handling, the Consultant was asked by complaints staff at the Board to comment on the questions raised at the above meeting so that the Board could reply to Mr C. In an internal letter of September 2004, the Consultant gave his comments, together with a copy of the letter which he had sent to the GP (see paragraph 7). Amongst other things, he said that the Registrar had prioritised the out-patient appointment as routine, not urgent, because the possibility of endocarditis was not being considered. (He gave reasons for this which are not relevant here as this investigation has not considered the clinical care.) He also said:

> 'I explained [to Mr A's parents at the March 2004 meeting] that I felt badly that we had let [Mr A] go without making a definitive diagnosis of endocarditis … With hindsight we should have arranged blood cultures and other assessments of ongoing inflammation to exclude active endocarditis in a patient who had such a visibly deformed valve … The [TOE] showed … We should have entertained the possibility that this represented active endocarditis and with the power of hindsight I realise that we should have instituted investigations at this time [October 2003]. If we had thought that he might have active endocarditis we would not have sent him such a delayed out-patient appointment. [Mr A]'s death might have been avoidable if he had successfully undergone treatment of any infection affecting the heart valve and [if] he had successfully undergone cardiac surgery. He did however have significant disability in relationship to his alcohol excess and I think most cardiac surgeons would not have wished to take him on for cardiac surgery unless excessive drinking was no longer an issue.'

10. The Board replied to Mr C's complaint in a letter of September 2004 from a General Manager (Manager 1). He passed on the Consultant's offer to meet Mr C and his wife again but only some of the Consultant's other information. He did not acknowledge any of the shortcomings identified by the Consultant. Nor

did he give any indication that Mr A's death had been analysed, with a view to considering whether there were lessons to be learnt. He merely repeated some of the facts and passed on condolences.

11. Mr C asked for an Independent Review Panel (IRP) to investigate his complaint as Manager 1's letter had not addressed his questions and had raised further ones. (IRPs no longer exist but, at the time, were part of the NHS Complaints Procedure. They were independent from, although linked to, the Health Boards.) The IRP convener instead asked the Board to meet Mr C to answer his questions. (This option was in line with IRP procedures.)

12. A meeting was duly held in February 2005. The meeting notes said that the Consultant and the Associate Medical Director (Manager 2) attended. They both acknowledged delays in Mr A's out-patient investigation, following his discharge from the Hospital, saying that they were unacceptable but that such situations tended to be caused by an accumulation of reasons. Nothing was recorded in the notes about any action to try to avoid a recurrence. Manager 2 said he would have expected blood tests (an abnormal result could have confirmed endocarditis) and that he would look into this. They explained the difficulties in diagnosing endocarditis and the reasons for not having done so in this case, saying that Mr A's death had, possibly, been avoidable, that it might have been caused by system failure, that the system could have worked better and that they would not want a repetition. Manager 2 intended to review the whole process. It was decided at the meeting that the systems would be reviewed (partly by discussion with the clinicians involved in Mr A's care), that Manager 2 would identify whether blood tests were done and acted upon and that Mr C would be given a copy of an action plan, which the Board would produce. It was also decided that Mr C's concerns would be brought to Manager 1's attention. (Presumably the purpose of this was unclear to Manager 1, because he simply responded by asking a colleague to write to Mr C, saying that he (Manager 1) had been sorry to learn of Mr C's dissatisfaction with his complaint response.)

13. In March 2005, Mr C wrote to Manager 1, acknowledging receipt of an initial action plan (that is, one which listed the actions intended but not the outcome, as it was too soon for that) and requesting a reply to four questions which he had asked to be addressed at the February 2005 meeting and which he now realised had not been covered.

14. In response to the letter at paragraph 13, Manager 2 wrote to Mr C in March 2005, giving more information about the delays in Mr A's out-patient care and commenting on their unacceptability. He said that blood tests had been requested by a doctor but did not seem to have been done as the laboratory had no record of receiving the blood for testing. He reminded Mr C that the plan at the February 2005 meeting had been for him to discuss the situation with three of the doctors; he said there was a delay in this as the Registrar now worked elsewhere but that he would write to Mr C again as soon as possible.

15. The Board's complaint file between March 2005 and December 2005 shows many attempts to get the doctors together for the intended meeting and, later, attempts to meet Mr C again. A meeting arranged with Mr C for October 2005 was cancelled by Mr C because of other serious concerns in his life at that time; a note of a telephone call from him said he just wanted a reply to his letter of March 2005 and an update on the actions from the February 2005 meeting.

16. In December 2005, the Board's Head of Service for cardiology, respiratory and cardiac surgery (Manager 3) replied to Mr C. She answered the points from Mr C's March 2005 letter (see paragraph 13) and said the Registrar had been 'counselled' for not meeting a ten-day correspondence target. She said that the cardiology department felt that the systems in place to treat and manage suspected endocarditis were robust and that there had been 'a series of problems in terms of communication between individuals and between teams'. She did not specify these problems, nor mention any action to prevent a recurrence. Nor did she say how the conclusion of robust systems had been reached. She said that the blood tests had been requested and that clinical records had been ticked to show blood as having been taken but that the laboratory had no record of receiving it. Again, she did not give any indication of action to prevent a recurrence. She said that, in any case, the tests would not necessarily have diagnosed endocarditis. In conclusion, she said there had been 'collective' failures, such as failure to take the blood tests and delays in arranging appointments and, on behalf of the department, she apologised to Mr C for these.

17. The completed, final, version of the action plan was enclosed with Manager 3's letter. It repeated the actions listed in the initial plan of March 2005 (see paragraph 13). These were: a meeting with clinicians to discuss Mr A's death; a systems review; initiation of change if appropriate; and

investigation of the blood test issue. The completed plan gave the findings of the blood test investigation. The only other difference from the initial plan was that the other actions were marked as having been done. No indication was given as to what precisely they had comprised (for example, what had been done by way of systems review), what the outcome was or what the reasons behind the outcome were.

18. A note by the Board of a telephone call from Mr C said that he was very dissatisfied with Manager 3's letter, that he had expected some action to be taken to try to prevent a recurrence of his son's experience and that the blood test error could surely not simply be acknowledged, but not actioned, to prevent a recurrence. The file shows telephone contact and general correspondence over the following months between Mr C and the Board and a meeting in February 2007 between Mr C and Manager 2's replacement (Manager 4). The notes of that meeting recorded them as discussing various clinical issues and said that Manager 4 acknowledged that Mr A's care had not been perfect and asked Mr C what they could do now to make a difference for Mr C. Mr C was recorded as expressing profound dissatisfaction with the completed action plan and as saying he was anxious for the Board to learn from what had happened but that he remained unconvinced about this. He asked why there was no system to flag up non-actioned blood test requests, to which Manager 4 replied that a new electronic system would soon be installed for that purpose and that out-patient appointments were now handled by an electronic system. Manager 4 agreed to ask Manager 2 (who now worked elsewhere) why it had taken from March 2005 to December 2005 to reply to Mr C's March 2005 letter as he still did not understand that delay.

19. The final significant letters on file are from Manager 4 to Mr C about the above delay in replying to his March 2005 letter. In the first, she said she had written to, and had a reply from, Manager 2 but that she had no information for Mr C. After Mr C queried this cryptic message, her second letter clarified that Manager 2 had told her that there had been 'ongoing communication' between March and December 2005 and that this would be documented in the Board's file. There was no indication that Manager 4 had looked in the Board's file to give Mr C any supporting evidence of this. As Manager 2 now worked elsewhere, he, clearly, could not access the file himself for this purpose.

20. After putting enquiries to the Board, I received some information about the new electronic system (see paragraph 18) from them:

'… [this] is currently [July 2007] being rolled across Lothian, after a pilot study which took place in November 2006. The electronic patient record records when a laboratory order is placed and its current status, whether the order has progressed (ie reached the laboratory), its collection time and date. Eventually this system will be available across Lothian and results from all sources will be accessible across all sites. The system also records the current status of a patient's clinic appointments and admissions, whether or not a patient has been referred and the status of the referral – urgent, soon or routine – and who made the referral'.

21. Later I detailed my concerns to the Board about their response to Mr A's death and below I summarise the main points of their reply:

'The complaint reply of September 2004 [from Manager 1] (see paragraph 10): We acknowledge that this does not meet our current standards and agree with you that, if it had reflected more of the Consultant's views, Mr C's concerns might have been resolved. Since then, we have made a number of positive changes in the way we write complaint responses – for example, identifying the issue, investigating that issue, presenting our findings, and, where appropriate, apologising and stating the steps we have taken to prove that lessons have been learnt and that practice has changed. We enclose our complaints management booklet, issued in October 2006, to show this.

We also acknowledge, and apologise for, the lack of clarity in [Manager 4]'s letters (see paragraph 19); these do not meet our current response standards.

The complaint reply of December 2005 [from Manager 3] (see paragraph 16): [Manager 3] said that the systems in place to treat and manage suspected endocarditis were robust because our investigation had shown that the care pathway for such cases was appropriate. In Mr A's case, that particular care pathway was not relevant because the possibility of endocarditis had been considered and dismissed. In other words, he did not display the set criteria of signs and symptoms which would have indicated endocarditis.

It was only with the benefit of hindsight, reflection and the information in the post mortem report that the Consultant was able to comment on further tests that might have been helpful in diagnosing endocarditis.

Counselling the Registrar about dealing with correspondence was an appropriate response. We agree with you that it would have been useful to have provided audit information to [Mr C] to demonstrate correspondence performance and improvement to him. However, the clinical judgement at the time of making the out-patient referral [arranged in November 2003 for February 2004 – see paragraph 8] was that there was no evidence to support an urgent review of [Mr A].

We are sorry for the delay in sending [Mr C] the completed action plan in December 2005. We acknowledge that this was unacceptable, that it did not contain the depth of information that [Mr C] required and that it caused additional distress to [Mr C]. New Board guidelines on managing complaints and learning lessons from cases such as this mean that all complaints which are upheld or which require action to improve service must now have a completed action plan and demonstrate that lessons have been learnt. However, we consider that the actions in the action plan address the contributing factors relative to this case and that they highlight the areas for shared learning and service improvement. We consider that the amount of detail in the action plan is acceptable, especially as it was supported by the letter from [Manager 3], which expanded on the points of the action plan. Additional communication, letters and telephone calls, involving [Mr C] also demonstrate continued action regarding resolution of his complaint and completion of the action plan'.

(a) Conclusion

22. Where a family member has died unexpectedly young, close relatives often have a real need to believe that their relative did not die for nothing, for example, that some good came out of the death by lessons having been learnt that could prevent another death. This can help them to deal with the bereavement. Mr C himself told the Board and the Ombudsman's office that he wanted to be assured that his son's experience would not be repeated. From the many letters and notes of telephone calls and meetings between Mr C and the Board, over several years, I consider that the Board tried hard to answer Mr C's questions and gave him a very significant, and unusual, amount of time. I accept that Mr C does not share this view about the Board's efforts. And I consider it is to the Consultant and Manager 2's credit that they had indicated shortcomings (see paragraphs 7, 9, 12 and 14).

23. Despite all these efforts, it is clear that Mr C was no more reassured at the end of the process than at the start about lessons learnt. At paragraphs 24 to 32, I summarise some examples of weaknesses in the Board's response to Mr A's death. These represent a mixture of:

- lack of action to analyse and, where appropriate, learn from the death;
- failure to give Mr C adequate, convincing, explanations about such action or the reasons why action was not appropriate; and
- some complaint-handling weakness.

24. Manager 1's complaint reply (see paragraph 10) ignored three of the five specific questions to which Mr C had stated he wanted answers. These included the Board's views about whether his son's death had been avoidable or due to any system failure. The reply gave virtually no views, largely recounting a series of events, which Mr C could have established himself by reading the clinical records. The notes of Mr C's meeting with the Board (see paragraph 8) stated that he requested a written response. Instead, Manager 1's reply offered a meeting, saying it could be difficult to address concerns in writing. There was no indication that any action would be taken to see whether there were lessons to be learnt. As the Consultant had indicated regret to Mr C (which Manager 1 was aware of), I consider that Manager 1's silence on this point gives the impression of a downplaying of the seriousness of the death.

25. I welcome the Board's acknowledgement (see paragraph 21) that Manager 1's letter was inadequate. I welcome their account of complaint-handling improvements made, although I am not sure how far they may reach. This is because I note the Board's (welcome) comment that Manager 4's two letters did not meet current standards; however, those letters were sent several months after the Board's issue of the booklet containing the complaint-handling improvements.

26. At the meeting in February 2005 (see paragraph 12), Manager 2 told Mr C he intended to do a review. This statement was made over a year after the death, and the inference must be that no review had previously taken place, or been intended, despite a 46-year-old having died and despite there having been a complaint.

27. Following an initial action plan and an update about the out-patient delays and blood test issues (see paragraphs 13 and 14), Mr C received no definitive response to the meeting of February 2005 or to his letter of March 2005 until

December that year. The file shows many attempts by the Board to find a date when all the doctors were free to meet, as had been planned. But, as excessive time passed, someone should have taken responsibility for a change of approach, such as a telephone discussion instead of a meeting. Further delay was caused by the decision to meet Mr C again and the unsuccessful efforts to find a suitable date. This was a meeting that was not essential and had not been asked for by Mr C. During these months the file also showed reasonable contact with Mr C. However, he made it clear that he felt the delay must mean that nothing was being done. I consider that this was a reasonable conclusion for him to have reached, based on the evidence available to him. I welcome the Board's acknowledgement to me that the delay was unacceptable.

28. The awaited reply from Manager 3, dated December 2005 (see paragraph 16), updated Mr C and enclosed the final, completed, action plan. It is disappointing that the Board still consider (see paragraph 21) that these were acceptable.

29. For example, I believe that, for Manager 3's letter to address the blood test issues by saying that blood tests would not necessarily have produced a diagnosis, missed the point. The point was that:

- a test requested by a doctor had never been actioned;
- no system was in place to alert anyone to that inaction;
- Mr C had been told by Manager 2 at the meeting in February 2005 (see paragraph 12) that he would have expected blood tests to have been done, and, when it was discovered that tests had been requested but not actioned, Mr C, therefore, had a reasonable expectation that such a fault would be remedied.

It was inappropriate that no indication was given to Mr C that anything would be done to prevent the blood test failures again, and, in fact, Mr C does not appear to have been told about action taken to address the blood test issues until a meeting with Manager 4 (see paragraph 18) in February 2007 – over a year after Manager 3's letter. (The action to address this (see paragraph 20) is welcome, although it suggests little urgency.)

30. I now turn to the correspondence target. I accept the Board's view (see paragraph 21) to me that it was appropriate to counsel the Registrar about his correspondence performance. But I consider that that appears an inadequate response, for various reasons. For example, Mr C was given that information in

Manager 3's letter, which also indicated that a doctor's request for blood tests had untraceably vanished. I believe that, to say that an unmet correspondence target had been actioned, but not a serious problem with blood test requests, gave the impression of reducing Mr A's death to a correspondence target. I also believe that, when the Board decided to take action on the correspondence issue, it would have been more convincing to Mr C if they had decided, for example, to review the various delays which they had acknowledged as unacceptable, to discuss the issue with appropriate staff, then to do an assessment to identify whether there had been any improvement – ie a proper audit process - culminating in telling Mr C the results. I welcome the Board's agreement with me about this (see paragraph 21). The Board's letter to me also said that Mr A had not been considered to need an urgent out-patient appointment and, therefore, a prompter letter from the Registrar would not necessarily have made a difference. I consider that this misses the point and that the point is that Mr C had been told in early 2005, by the Consultant and Manager 2 (see paragraphs 12 and 14) that there were unacceptable delays in Mr A's out-patient investigations. In other words, Mr C was led to believe that there were faults concerning the out-patient issues and he had, therefore, a reasonable expectation that they would be remedied. That expectation would be unlikely to be satisfied by an eventual comment that a doctor had been counselled for not meeting a correspondence target.

31. The Board's letter to me also explained the conclusion in Manager 3's letter that the systems in place for suspected endocarditis were robust. In effect, the Board said to me that these systems were not applicable in Mr A's case because he was considered not to have endocarditis. I agree: he was considered not to have it. But that must lead to a conclusion that it was, therefore, irrelevant for the action plan or Manager 3's accompanying letter to mention those systems.

32. Finally, it was inappropriate for the final action plan to contain little more, in comparison with the initial one, than a statement that the actions had been completed. Mr C had made it very clear that he wanted lessons to be learnt to prevent a recurrence; he had been led to believe that there were lessons to be learnt; and he had been waiting a long time to hear them. He should, therefore, have received persuasive information about what had been done and not done, in order to demonstrate convincingly to him that there had been a thorough investigation and show him why nothing further was being done. After waiting

for this information for nine months, it is not surprising that Mr C felt that his son's death had not been taken seriously.

33. I am satisfied that there were significant inadequacies in the Board's actions in response to the shortcomings that they had identified and in their communication of those actions to Mr C. In all the circumstances, I uphold the complaint.

Recommendation

34. The Ombudsman recommends that the Board:

(i) apologise to Mr C for: the failure to provide convincing evidence of a thorough investigation, with lessons learnt; the impression at various times that no action would be taken in response to his son's death; the poor quality of some of the complaint responses; and the delay in giving him a definitive response to a complaint meeting and letter of early 2005; and

(ii) ensure that, where appropriate, this investigation drives further service improvement in future complaints.

35. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	Mr C's son
The Hospital	Royal Infirmary of Edinburgh
GP	General practitioner
TOE	Transoesophageal echocardiogram
The Consultant	A consultant cardiologist at the Hospital
The Board	Lothian NHS Board
The Adviser	The Ombudsman's clinical adviser
The Registrar	A senior cardiology registrar at the Hospital
Manager 1	The General Manager who replied to the complaint in September 2004
IRP	Independent Review Panel
Manager 2	The Associate Medical Director who attended the February 2005 meeting
Manager 3	The Head of Service who wrote to Mr C in December 2005
Manager 4	The Associate Medical Director who attended the February 2007 meeting

Annex 2

Glossary of terms

Endocarditis	An infection which fatally weakened Mr A's already-compromised heart