Scottish Parliament Region: Mid Scotland and Fife

Case 200503366: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Gastro-intestinal; Genito-urinary (Urology); Communication, staff attitude, dignity, confidentiality

Overview

The complainant (Ms C) claimed that the conduct of a rectal/intestinal examination at Falkirk and District Royal Infirmary (the Hospital) was inappropriate and also raised concerns about the subsequent handling of her complaint by Forth Valley NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the conduct of a rectal/intestinal examination at the Hospital was inappropriate, in particular that lubricant was not used (*not upheld*[1]); and

(b) the Board failed to deal with Ms C's complaint appropriately (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Ms C in writing for their failure to conduct as thorough an investigation of her complaint as was required in this situation; and

(ii) reflect on how they obtain evidence from all parties involved in a complaint and ensure that key staff always provide statements, and that those statements deal with the specific issues raised by complainants. The Board should send the Ombudsman the outcome of this reflection and a copy of any consequent amendments to guidance or procedure.

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

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[1] It is the practice of this office not to uphold if we are satisfied that the body complained about had already apologised prior to our involvement and taken action which we consider, in all the circumstances, was reasonable.

Main Investigation Report

Introduction

1. On 6 March 2006 the Ombudsman received a complaint from a member of the public (Ms C) against Forth Valley NHS Board (the Board) alleging that the conduct of a rectal/intestinal examination at Falkirk and District Royal Infirmary (the Hospital) was inappropriate and also raised concerns about the subsequent handling of her complaint by the Board.

2. The complaints from Ms C which I have investigated are that:

(a) the conduct of a rectal/intestinal examination at the Hospital was inappropriate, in particular that lubricant was not used; and

(b) the Board failed to deal with Ms C's complaint appropriately.

Investigation

3. I was assisted in the investigation by two of the Ombudsman's medical advisers, both medically qualified professionals, one with experience as a senior nurse (Adviser 1) and the other a surgeon (Adviser 2). We considered the information provided by Ms C and the Board, which included comments on the complaint from both parties as well as correspondence between Ms C and the Board and Ms C's clinical records. The purpose of the investigation was to use this information to establish the actions of staff within the Board in carrying out the examination and to consider whether those actions fell within the range of what would be considered to be reasonable practice, in the circumstances.

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

(a) The conduct of a rectal/intestinal examination at the Hospital was inappropriate, in particular that lubricant was not used

5. On 3 October 2005 Ms C was admitted to the Hospital's Accident and Emergency Department (A&E) as a result of pain in her right side and the presence of blood in her urine. The A&E notes recorded that Ms C was suffering from renal colic. Three hours after admission to A&E Ms C was transferred to a Hospital ward. The medical records noted that Ms C was known to one of the Consultants (Consultant 1) as she had a clot in a kidney two years previously. The medical notes from the ward recorded a provisional

diagnosis of renal colic, and she was allocated to the care of another consultant (Consultant 2). Ms C had a computerised tomography (CT) scan on 4 October 2005 which showed bilateral renal cysts, right-sided renal calculi and a possible rectal stricture. On the basis of the CT scan results, a rigid sigmoidoscopy was requested with the intention of excluding a rectal tumour. A surgeon (Surgeon 1) explained the CT scan results and the possible rectal stricture to Ms C on 5 October 2005 and carried out a digital rectal examination. She was scheduled for the sigmoidoscopy on 6 October 2005, however, due to an administrative oversight the appointment was re-scheduled for 7 October 2005. The sigmoidoscopy (also referred to in this report as the procedure), which is the subject of Ms C's complaint, was carried out by another surgeon (Surgeon 2) on 7 October 2005 and she was discharged the following day.

6. Ms C wrote to the Chief Executive of the Board's Acute Operating Division (Officer 1) on 10 October 2005 to complain about how the sigmoidoscopy was carried out. She said that Surgeon 2 did not introduce himself, explain the procedure to her, or reassure her. Ms C went on to say that the digital rectal examination and sigmoidoscopy carried out by Surgeon 2 was done without any lubrication and with excessive force and, after exclaiming that she was being hurt and crying, Surgeon 2 eventually abandoned the procedure. Ms C said that:

> 'The incident has left me feeling humiliated, degraded, frightened and deeply traumatised.'

She said that nursing staff present were very concerned about what was happening and that when she was taken to the recovery room after the procedure one of the nurses said 'he is a nasty man'. Ms C also said that she did not want Surgeon 2 to have any further involvement in her care. Ms C compared this experience with the digital rectal examination carried out by Surgeon 1 on 5 October 2005:

> 'The examination went well and I experienced the minimum of discomfort. [Surgeon 1] explained the procedure to me and stated that I would experience the same degree of minimal discomfort when I had a further rectal examination … I was reassured by these words.'

7. The Board's Director of Nursing (Officer 2) responded to Ms C on 15 November 2005 noting her concerns about the care she had received,

apologised for any distress this might have caused her, and expressed regret if Ms C felt that a member of staff had not met the standards expected in terms of politeness and support. Officer 2 said she had been advised that Consultant 2 had explained the procedure to Ms C in the ward prior to theatre, that nursing staff had noted that Ms C was anxious on arrival at theatre and had explained the procedure to her there, and that Surgeon 2 had said to nursing staff that the procedure would be carried out without the need for Ms C to be sedated. Officer 2 said that staff had given assurances that lubricant was used, as was normal in such procedures, and that the nurses advised Surgeon 2 of the discomfort she was experiencing and so he decided to finish the procedure. Officer 2 added that the nurse alleged to have said that Surgeon 2 was 'a nasty man' stated that no such conversation took place and that other staff present had no recollection of such comments. Officer 2 concluded by saying that Ms C's comments about Surgeon 2 would be passed to Consultant 2. The following day Officer 1 wrote to Ms C to advise that if she had further concerns she could contact the Board again. On 5 December 2005 Surgeon 2 wrote to Ms C to:

> '… convey my sincere apologies, if I have in any way contributed to any distress that you have experienced.'

He explained his normal practice in dealing with patients, in terms of greeting them and explaining procedures, and noted that his:

> '… previous clinical practice has been applauded by my colleagues and by my trainers.'

Finally, Surgeon 2 offered his apologies again and said that he would be happy to meet Ms C and offer his apologies in person.

8. Ms C wrote to Officer 2 on 5 December 2005 (the same day she was sent the written apology from Surgeon 2) to say that she was disappointed with the response she had received. She asked if the Board could provide confirmation that Surgeon 2, did or did not, introduce himself to her and explain the procedure, and if there was an entry in the medical records to prove that lubricant was used. She reiterated her position that no lubrication was used, and questioned the manner in which her complaint had been investigated (see section (b) of this report). She also said that she was:

> '… disappointed that the named nurse has not had the courage to admit that the conversation took place. However I can appreciate her difficulty in

being truthful given the environment in which she has to continue to work. She will however have to live with her response.'

9. Officer 2 responded to Ms C on 19 December 2005, although Ms C has advised me that she did not receive this response. Officer 2 confirmed that Ms C had been sent a written apology by Surgeon 2 and reiterated that the nursing staff present at the procedure had no recollection of the 'nasty man' conversation in the recovery room. She also said that lubrication of the colonoscope before a sigmoidoscopy was standard procedure which had been followed on 7 October 2005. Ms C was not content with the Board's response and complained to the Ombudsman. In terms of Surgeon 2's letter, she said:

'… the contents of which I have great difficulty in reconciling with my recollection of events but at least he has responded to my concerns albeit after having been pressed to do so.'

10. In response to my enquiries, Ms C cited reasons why she was certain that lubricant was not used during the sigmoidoscopy procedure. These included the level of pain and discomfort she experienced, the lack of a sensation of wetness around her rectal area, that no excess lubricant had to be cleaned from her after the procedure, that she did not find any residual lubricant when performing an act of personal hygiene shortly after the procedure, and that Surgeon 2 had not offered verbal reassurance that lubricant was being used. Ms C said that the procedure was explained to her on the ward by the Anaesthetist and that on this basis she understood the procedure and signed the form. She also said that Surgeon 2's:

'… first and only words to me were 'Turn on your left side and put your knees up'. This instruction was not prefaced even with the word 'Please'.'

She stated her view that Surgeon 2 should have introduced himself and explained the procedure as he was performing it. In terms of Surgeon 2's letter of apology, Ms C said that:

'I did not meet with [Surgeon 2]. It was patently obvious from his letter of 5 December 2005 that he had no intention of accepting that his actions were anything other than correct … I concluded that there would be little to gain from such a meeting.'

11. In response to my enquiries the Board provided a copy of Ms C's medical records, a copy of their file on the complaint, and answers to specific questions.

The medical records for 7 October 2005 show that Ms C signed a Consent To Anaesthesia, Operation, Investigation or Treatment Form (the Consent Form) before the procedure. The Consent Form was also signed by Surgeon 2 and noted that the proposed procedure was a rigid sigmoidoscopy, a possible flexible sigmoidoscopy, and a biopsy. The Consent Form stated that Surgeon 2 had fully explained the procedure, appropriate alternatives that were available, and the relevant risks associated with the procedure. The form also stated that Ms C understood the procedure which had been explained to her by the doctor named on the Consent Form, in this case Surgeon 2, that the procedure may not be carried out by the doctor who had been treating her so far, and that she agreed to it taking place. The Theatre Care Plan noted that the procedure was to be a flexible sigmoidoscopy and an examination under anaesthetic (EUA) of the rectum, that Ms C was positioned on her left side by theatre staff, and that the equipment used was a sample bottle and a bellows/eye piece. A report on the procedure noted the staff in attendance (Surgeon 2 and five nursing staff), the materials used (the colonoscope and a sample bottle), and the procedures carried out (a flexible sigmoidoscopy and an EUA of the rectum). The report also noted that:

> 'Flexible sigmoidoscopy up to 20 [centimetres] was only possible [patient] was in discomfort tight angulation at sigmoid scope unable to negotiate the curve … procedure abandoned …'

12. The complaints file provided by the Board included statements from nursing staff present at the procedure. The anaesthetic nurse (Nurse 1) said that Surgeon 2 had advised that no sedation was required for Ms C. She also said that Ms C was:

> '… visibly very nervous … I held [Ms C's] hand during the procedure and she told me it was uncomfortable so I passed this information onto the surgeon. Minutes later she was very sore and I told the surgeon again who said he was finished.'

The scrub nurse (Nurse 2) also said that she 'set and checked' the colonoscope, that Surgeon 2 had said that sedation was not required, and that Ms C:

> '… was uncomfortable and anxious despite reassurance from nursing staff. The surgeon was informed twice of the patient's discomfort. He then stated, after being informed for the second time, that he had finished the procedure.'

The senior staff nurse (Nurse 3) said that:

> '… we positioned her onto her left side, explaining everything as we did it. [Nurse 2] checked the colonoscope, lubricated the end with KY Jelly and handed it to the surgeon who commenced the procedure. Again explanations were given to the patient to reassure her. The procedure was very short but the patient found it uncomfortable. [Nurse 1] relayed this to the surgeon twice who, when told the second time, said it was ok as he was finished.'

A memo from the Theatre Manager (Officer 3) to the Surgical Co-ordinator (Officer 4) about the complaint said that the nursing staff:

> '… could all remember this patient due to her level of anxiety and distress.'

Officer 3 also said that nursing staff explained the procedure to Ms C, but that:

> 'They have not been able to corroborate the information regarding [Surgeon 2's] alleged lack of explanations.'

In relation to the use of lubricant, Officer 3 said that:

> '… [Nurse 2] followed standard procedure at set up by lubricating the tip of the scope. However the staff are unable to state whether the surgeon used lubricant prior to the EUA … More experienced staff have over the years discovered that if you wipe a large amount of lubricant around the external opening of the rectum on the inner aspects of the cheeks as well as lubricating the actual scope then it passes easier because what tends to happen is that although it enters okay the rubber tube drags on the dry skin of the cheeks and ends up with more tugging and pulling.'

Finally, in terms of the alleged conversation that took place between Ms C and nursing staff in the recovery room regarding Surgeon 2 being 'a nasty man', Officer 3 said that the named nurse responsible for Ms C in recovery (Nurse 4) had stated that:

> '… this conversation did not take place with her and she has no recollection of anyone else stating this.'

However, I have not been supplied with a copy of a statement that was taken directly from Nurse 4.

13. I asked a number of questions of the Board, including the use of lubricant and recording this in the medical records. The Board advised me that:

> 'The use of lubricant for rectal examination is not logged. Staff have reviewed the position nationally as regards this practice and confirm that other hospitals within the UK do not log its use. From a practical point of view it is very difficult to carry out a rectal examination without lubricant and staff feel it would be inconceivable that this was not done … There are no specific recommendations regarding the use of lubricant. Some operators lubricate the scope, while others lubricate the patient, and it appears to be a matter of personal preference of the attending practitioner.'

In relation to if, and how, the procedure was explained to Ms C, the Board said:

> 'As to whether this was discussed in detail with [Ms C] unfortunately, due to the passage of time and a lack of clear documentation I am unable to confirm if this was the case other than it was stated on the consent form as a potential and signed by [Ms C].'

The Board also advised me that, in terms of the discomfort likely to be experienced by a patient and the need to carry it out, as well as Surgeon 2 persisting with the procedure despite Ms C's apparent discomfort:

> 'The operator has to balance between the discomfort and completing the procedure thereby achieving the objective of the procedure ie to make a diagnosis of normality or disease. At the time of the complaint, guidelines did not exist with respect to early termination of endoscopic procedures by the patient. Senior clinical staff have recently reviewed potential guidelines to cover this situation. It is acknowledged that [Surgeon 2] continued with the procedure after the first indication from nursing staff that the patient was in discomfort. Clinical staff feel that this is not entirely unreasonable as normally one would try to reassure the patient in order to complete the examination. It is noted that [Surgeon 2] did not proceed beyond the second indication of discomfort given by nursing staff. I understand that a senior member of clinical staff did have a discussion with [Surgeon 2] regarding the procedure in general following receipt of the complaint however no formal action was taken.'

The Board explained that no decision was made to remove Surgeon 2 from future involvement in Ms C's care, but that it was relatively easy to ensure that

he did not have clinical contact with Ms C, if necessary, unless an emergency situation arose, and that he had subsequently left the Hospital's Surgical Department.

14. The outcome of the Board's investigation into Ms C's complaint was to partly uphold it and to apologise for distress caused and clarify issues relating to the examination.

15. Adviser 1 told me that the consent form appeared to show that there was some level of interaction between Surgeon 2 and Ms C, but it did not, and could not, give an indication as to the quality or nature of that interaction. Her view was that the procedure was the correct one in the circumstances but that, by its nature, was likely to be uncomfortable. Adviser 2 told me that a sigmoidoscopy is invariably painful, unpleasant, indelicate and extremely uncomfortable and the patient's dignity will always suffer because of where and how the examination has to happen. He said that the reason for this procedure being difficult and uncomfortable was the shape of the bowel, as the word 'sigmoid' indicates, which resembles the lower-case Greek letter sigma (ς), or 'S' shaped. Despite this, Adviser 2 said that this procedure is not normally carried out under sedation, but that the term EUA is used as it might require anaesthetic if the surgeon deemed it necessary on the basis of their clinical judgement. In terms of lubrication, he said that it would be standard procedure to lubricate the instrument generously before insertion and in some cases a surgeon might add more lubricant as the procedure takes place. He said that while it would be totally unreasonable to use no lubricant at all, the amount required would vary, often depending on the size of the patient, was not a precise science, and that a rectal stricture would only make the procedure even more difficult. He noted the use of the words 'personal preference' in the Board's advice to me and felt that the words 'professional judgement' would have been more helpful. He also said that the use of lubricant would not normally be noted in the medical records as it was such a standard requirement, akin to rubber gloves.

(a) Conclusion

16. There is no doubt, given her account of the procedure, that Ms C has been deeply affected by the events of 7 October 2005, and in no way do I underestimate her strength of feeling. She was unhappy that Surgeon 2 did not interact with her, in terms of introduction, explanation or reassurance during the procedure, and she was adamant that the digital rectal examination and the

rigid and flexible sigmoidoscopy were performed without lubricant. This was based on her experience of the procedure and its immediate aftermath, including lack of apparent physical evidence of residual lubricant and an alleged conversation with nursing staff.

17. It is not possible for me to prove that lubricant was not used. As the Board pointed out, and Adviser 2 confirmed, it is not normal for medical records to note the use of lubricant. This leaves me to consider the accounts provided by Ms C and the nursing staff. As there is no independent corroboration of what happened I can reach no finding on this specific aspect of Ms C's complaint. Even if I was to consider a balance of probability judgement it is likely, given the explanation provided to me by both Adviser 1 and Adviser 2, that I would conclude that lubricant was used, but this would then lead to another issue of whether sufficient lubricant was used, and again there are problems with this as Adviser 2 has told me that the amount of lubricant to be used is effectively a matter of individual judgement for the clinician depending on the circumstances of the patient. In relation to the use of the term EUA, Ms C raised concerns with me that there must be an error in the records or a mistake in the procedure as no anaesthetic was used. However, it is clear from the evidence provided by the Board that Surgeon 2 used his clinical judgement to determine that sedation was not required. The Board also advised me that sedation was not normal in such cases, a position supported by Adviser 2's comments.

18. In terms of Surgeon 2's interaction with Ms C, it is also difficult to reach a finding as there is little firm evidence. The statements from the nursing staff do not refer to his manner and attitude, and they and Ms C disagree about whether or not there was a conversation about him being 'a nasty man'. It could be argued that Surgeon 2 did not take Ms C's discomfort into account when he did not stop the procedure when first advised of it. However, the Board have advised that at the time there were no guidelines to cover situations when patients wanted to stop procedures, and that Surgeon 2 had to balance the need to carry out the examination with Ms C's discomfort. It could, therefore, be argued that Surgeon 2 did take account of Ms C's discomfort when he stopped the procedure after being advised for a second time that Ms C was distressed.

19. I note that the Board partially upheld Ms C's complaint and apologised to her, and Surgeon 2 wrote a letter of apology as well, although Ms C latterly cast doubt on the sincerity of the apology. It is the practice of this office not to

uphold if we are satisfied that the body complained about had already apologised prior to our involvement and taken action which we consider, in all the circumstances, was reasonable. Taking this into account, as well as the lack of independent evidence, I cannot uphold this complaint.

20. The proposed version of this report had a recommendation for this aspect of Ms C's complaint. The recommendation was that:

> 'Although this complaint has not been upheld, the Ombudsman recommends that the Board send her a copy of the guidelines that have been drawn up to allow patients to stop endoscopic procedures.'

In response to the proposed report, the Board sent me a copy of the guidelines. The guidelines state that:

> 'It is the responsibility of the Endoscopist and the patient's named nurse to ensure this policy is followed. This procedure provides guidance but each situation should be dealt with on an individual basis after considering all the available facts.'

My reading of the guidelines is that they provide a god framework for dealing with cases where patients wish to stop an endoscopic procedure.

(b) The Board failed to deal with Ms C's complaint appropriately

21. Ms C believed that the Board had not taken her complaint seriously and did not investigate it properly. The exchange of correspondence, where it related primarily to care issues, is covered in section (a) of this report (see paragraphs 6 to 9). The responses from the Board offered apologies and some explanation to Ms C. However, she believed that the responses were not specific enough and often dealt with general issues rather than her situation.

22. The Board supplied me with a copy of their file on Ms C's complaint. An initial response from the Board's Patient Relations Officer (Officer 5) on 18 October 2005 set out what the Board understood to be Ms C's complaint, the complaints process and information on where to get independent help with her complaint. An internal email of 21 October 2005 from Officer 4 to the Board's Patient Relations Team noted that the complaint had been sent to some of the staff involved in Ms C's care. This gave rise to the statements from Nurse 1, Nurse 2 and Nurse 3, who present at the procedure on 7 October 2005 and Officer 3. A statement does not appear to have been taken directly from

Nurse 4, although her remarks are referred to in Officer 3's statement. Another internal email of 2 November 2005 from Officer 4 to Officer 5 noted that the complaint was to be sent directly to Surgeon 2 for his comments, although a further internal email of 21 November 2005 from the Assistant Patient Relations Officer (Officer 6) to a Consultant General Surgeon (Consultant 3) and Officer 4 stated that Surgeon 2:

'… failed to provide any information to us during the investigation'

and that if Ms C received an apology from Surgeon 2 she would consider the complaint closed. As noted in paragraph 19, the Board's Comment Summary recorded the complaint as partly upheld and this resulted in Officer 2's letter of 15 November 2005. Officer 1 wrote to Ms C the following day to advise that if she had further concerns she should contact the Board again. Surgeon 2 wrote a letter dated 24 October 2005 to Officer 4, although this date is likely a typographical error that should read 24 November 2005, given that Ms C's complaint was not sent directly to Surgeon 2 until 2 November 2005 at the earliest. The bulk of this letter was copied into Surgeon 2's apology letter to Ms C of 5 December 2005. Ms C wrote to Officer 2 on 5 December 2005 to express her disappointment with the content of the Board's response, the manner in which the investigation had been carried out, and claimed that the Board had failed to respond to her within a 20-day timescale. Officer 2 responded to Ms C on 19 December 2005 (Ms C has advised me that she did not received the response, see paragraph 9) to advise that the response had met the timescale, and apologised that its content had not provided the information Ms C expected. Officer 2 explained the investigation process under the National Health Service (NHS) Complaints Procedure, and advised Ms C that all complaints were treated seriously. Officer 2 also referred to the Board's understanding that Ms C had apparently told the Patient Relations Team that if she received an apology from Surgeon 2 she would regard the matter as settled.

23. In her complaint letter to the Ombudsman Ms C said that she was considering whether or not to accept Surgeon 2's apology or to continue with her complaint about how the procedure was carried out. She subsequently advised me that she did wish to pursue a complaint about the procedure. In response to my enquiries Ms C said that she did not meet with Surgeon 2 (see paragraph 10) as he had offered in his apology letter. She referred in particular to Surgeon 2 having said that his:

'… previous clinical practice has been applauded by my colleagues and by my trainers.'

In response to my enquiries, the Board acknowledged that this sentence in Surgeon 2's letter:

'… was perhaps unhelpful to [Ms C's] individual circumstances.'

(b) Conclusion

24. Given that Ms C was very upset by her experience of the procedure on 7 October 2005, and made this clear to the Board, it would be reasonable to expect that the Board would take the complaint seriously and conduct a thorough investigation. The evidence demonstrates that the Board did meet the appropriate timescales for responding to the complaint, sent acknowledgements where necessary, and provided Ms C with information about how the complaint would be handled. I have no reason to believe that the Board did not take Ms C's complaint seriously, and the fact that they drew up guidelines to allow patients to stop endoscopic procedures demonstrates this. However, I cannot conclude that the investigation was as thorough as it should have been. The statements from the three nurses, while helpful, do not cover in sufficient detail all aspects of the activity that took place before, during, and after, the procedure, given the points that were raised by Ms C in her complaint letter. It appears that a statement was not taken directly from Nurse 4. It is also significant that the Board did not pursue Surgeon 2, as the focus of the complaint, to obtain his statement of what happened during the procedure, and he had no involvement in responding to the complaint until he produced a letter to Officer 4 in late November 2005 which evolved into the apology letter sent to Ms C on 5 December 2005. As also noted, the content of this apology letter was not entirely helpful. In addition, the letter of 15 November 2005 from Officer 2 to Ms C did not always deal with the specifics of Ms C's case, and it is likely that this is because of the nature of the statements from nursing staff and the absence of a statement from Surgeon 2. The failure to obtain enough specific evidence from all the nursing staff and the failure to obtain any evidence from Surgeon 2 leads me to uphold this complaint.

(b) Recommendations

25. The Ombudsman recommends that the Board

(i) apologise to Ms C in writing for their failure to conduct as thorough an investigation of her complaint as was required in this situation; and

(ii) reflect on how they obtain evidence from all parties involved in a complaint and ensure that key staff always provide statements, and that those statements deal with the specific issues raised by complainants. The Board should send the Ombudsman the outcome of this reflection and a copy of any consequent amendments to guidance or procedure.

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

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	Forth Valley NHS Board
The Hospital	Falkirk and District Royal Infirmary
Adviser 1	The Ombudsman's medical adviser, a qualified nurse
Adviser 2	The Ombudsman's medical adviser, a qualified surgeon
A&E	Accident and Emergency Department
Consultant 1	A Urology Consultant who had treated Ms C in 2003
Consultant 2	A Urology Consultant responsible for Ms C's care in October 2005
CT scan	A computerised tomography scan
Surgeon 1	A surgeon involved in Ms C's care in October 2005
Surgeon 2	A surgeon involved in Ms C's care in October 2005
Officer 1	The Chief Executive of the Board's Acute Operating Division
Officer 2	The Board's Director of Nursing
The Consent Form	Consent to Anaesthesia, Operation, Investigation or Treatment Form

EUA	Examination Under Anaesthetic
Nurse 1	The Anaesthetic Nurse present at the procedure
Nurse 2	The Scrub Nurse present at the procedure
Nurse 3	The Senior Staff Nurse present at the procedure
Officer 3	The Theatre Manager responsible for the operating theatre in which the procedure took place
Officer 4	The Board's Surgical Co-ordinator
Nurse 4	The Nurse responsible for Ms C in the recovery room after the procedure
Officer 5	The Board's Patient Relations Officer
Officer 6	The Board's Assistant Patient Relations Officer
Consultant 3	A Consultant General Surgeon
NHS	National Health Service

Annex 2

Glossary of terms

Biopsy	A small sample of tissue taken from a body for examination
Colonoscope	A flexible, lighted instrument used to view the inside of the colon
Digital rectal examination	An internal examination of the rectum using the finger(s)
Endoscopic	Endoscopic referes to endoscopy to looking inside the body for medical reasons using an instrument such as an endoscope, a colonoscope or a sigmoidoscope
KY Jelly	The brand name for a water-based, water-soluble personal lubricant
Rectal stricture	A narrowing of that part of the bowel
Renal calculi	Kidney stones
Renal colic	An acute, usually severe loin pain often caused by the passage of a stone down the ureter
Renal cysts	A cyst in the kidney. A cyst is an enclosed sac or pouch that usually contains liquid or semisolid material
Sigmoidoscopy (rigid and flexible)	A sigmoidoscopy is a way to look at the inside of the rectum. A rigid sigmoidoscopy uses a small metal or plastic tube inserted into the rectum, through which a type of torch and camera can be threaded. A flexible

	sigmoidoscopy uses a flexible tube. During the procedure, air is puffed through the sigmoidoscope to inflate the bowel to give a clearer view of the lining of the colon
Urology	Urology is the branch of medicine that focuses on the urinary tracts of males and females
Computerised Tomography (CT) scan	A special radiographic technique that uses a computer to assimilate multiple X-ray images into a two dimensional cross-sectional image