SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Central Scotland

Case ref: 201607558, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C complained about the care and treatment his late wife (Mrs C) received from the Emergency Department at Monklands Hospital (the hospital) when she attended with abdominal pain. Mr C was concerned that Mrs C had been discharged home during the early hours of the morning without being assessed properly and that she was in pain.

We took independent advice from two clinical specialists, including a consultant in emergency medicine and a consultant in emergency general surgery. We considered that the clinical assessments and record-keeping by two different doctors who reviewed Mrs C fell below a reasonable standard. In addition, we found that there was no evidence to demonstrate that Mrs C had been offered pain relief despite it having been documented that she was experiencing moderate to severe pain.

We also found that a significantly abnormal blood test result had been overlooked by the board on three separate occasions: at the time Mrs C was discharged from hospital; when providing clinical information to the Crown Office and Procurator Fiscal Service's forensic pathologist; and when investigating Mr C's complaint. We considered that, had a more senior doctor overseen Mrs C's care, and due attention been given to this test result, she would have been admitted to hospital which may have avoided her death.

In terms of Mrs C being discharged home during the early hours of the morning, we considered this unreasonable given Mrs C was an elderly, frail woman with multiple health problems. We were critical that hospital staff did not communicate with Mr C about the discharge and that the paperwork which prompts such discussions had not been completed appropriately.

We upheld both complaints and made a number of recommendations to address the issues identified. The Board have accepted the recommendations.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) and (b)	I found that there were unreasonable failings in Mrs C's care and in the Board's investigation of the complaints	Provide a written apology to Mr C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at https:www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 24 January 2018

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The quality of the clinical assessments and documentation by both doctors was of an unreasonable standard	Patients should receive a full assessment with all relevant information documented including: medical and medication history; and observations	Confirmation that both doctors have been made aware of the findings and had the opportunity to discuss and learn from them, including reference to any learning and development, or training, identified By: 21 February 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Staff failed to perform a 12-lead ECG.	A 12-lead ECG should be used in the assessment of abdominal pain in similar cases	Evidence that relevant staff have undertaken educational activities to better understand cardiovascular disease in women and what action to take in future By: 21 February 2018
(a)	Mrs C's discharge from hospital was not overseen by a more senior doctor and an important blood test result was overlooked	Patients should not be discharged without senior doctor oversight in similar cases. All relevant results should be taken into account	Confirmation that Doctor 2 has been made aware of the findings and had the opportunity to discuss and learn from them, including reference to any learning and development, or training, identified By: 21 February 2018
(a)	The Board failed to provide COPFS with the serum amylase test result	All relevant test results should be identified and provided to COPFS	Evidence that the Board have now sent this result to COPFS Evidence that staff have been reminded of the importance of providing all relevant information at the relevant time By: 21 February 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	The Board's investigation of the complaints was not robust and failed unreasonably to identify the abnormal serum amylase test result	Clinicians providing input to complaint investigations should thoroughly review the care provided	Evidence that these findings have been shared with Doctor 3 with appropriate support By: 21 February 2018
(b)	It was unreasonable to discharge Mrs C without contacting Mr C in advance	The discharge section of the clinical records should be completed in terms of relative/next of kin contact in all cases	Evidence that the Board has a process in place for auditing discharge documentation Evidence that my decision has been shared with relevant staff with appropriate support By: 21 February 2018

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 Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to the Ombudsman about the care provided to his late wife (Mrs C) by Lanarkshire NHS Board (the Board). Mr C raised concern that, after Mrs C had attended the emergency department (ED) at Monklands Hospital (the Hospital) with symptoms of abdominal pain, she died suddenly around 48 hours later. Mr C believed that Mrs C had not been properly assessed and treated.

2. The complaints from Mr C I have investigated are that the Board:

(a) did not provide an appropriate standard of care when Mrs C attended the Hospital (*upheld*); and

(b) unreasonably discharged Mrs C in the middle of the night and sent her home by taxi without any notification (*upheld*).

Investigation

3. In order to investigate Mrs C's complaint, we reviewed all of the complaint correspondence, copies of Mrs C's clinical records and the Post Mortem Report provided by the Crown Office and Procurator Fiscal Service (COPFS). We obtained independent clinical advice in relation to Mrs C's care from a consultant in emergency medicine (Adviser 1) and a consultant in emergency general surgery (Adviser 2).

4. In this case, I have decided there is wider public interest to issue a public report on Mr C's complaint due to significant failings identified in relation to the assessments carried out, including the decision to discharge Mrs C home.

5. This report includes the information that is required for me to explain the reasons for my decisions on this case. Every detail investigated has not been included in this report 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.

Background

6. Mrs C was taken by ambulance to the Hospital's ED ED at 21:58 on 2 May 2016 and was seen by a middle grade ED doctor (Doctor 1) at 00:00 on 3 May 2016. Mrs C had been experiencing abdominal pain for approximately 48 hours and reported a recent history of vomiting. Her previous medical history was notable for high blood pressure, pulmonary hypertension, cardiac pacemaker and previous major abdominal surgery with colostomy. Doctor 1

assessed Mrs C and queried the possibility of a blockage or perforation of the intestine. Further investigations were carried out and Mrs C was referred to the on-call surgical team for a specialist opinion at 00:20. A junior member of the surgical team (Doctor 2) reviewed Mrs C and concluded at 01:21 that she was fit to be discharged home on the basis of a range of normal tests and examination. Doctor 2 documented gastroenteritis as the likely diagnosis. Within the following hour, Mrs C was discharged from the Hospital and died at home on 5 May 2016. A Post Mortem Report found the main cause of death to be ischaemic and valvular heart disease.

(a) The Board did not provide a reasonable standard of care when Mrs C attended Monklands Hospital on 2 May 2016

Concerns raised by Mr C

7. Mr C complained that Mrs C's abdominal pain was not properly explored prior to her being discharged home. He was concerned that she should have been referred to a surgeon to rule out obstruction or perforation; that the Post Mortem Report had concluded that she had died of ischemic heart disease but no cardiovascular examinations were done; and that she was discharged home without being monitored properly. Mr C highlighted that Mrs C never managed to get out of bed after returning home and he believes she died in pain.

The Board's response

8. In the Board's response to the complaint, they outlined that Doctor 1 had recorded that Mrs C had pain in her stomach around the site of her stoma bag; that the pain was worse if she moved; and that she had vomited three times. They said that her previous history of having a cardiac pacemaker, three previous heart attacks, type 2 diabetes, chronic obstructive pulmonary disease (COPD), high blood pressure and stroke had all been documented. However, the Board apologised that a full drug history had not been recorded and said that a debrief would be held with relevant staff to ensure the appropriate standards are met at all times.

9. The Board went on to say that examination of Mrs C's heart and lungs were found to be normal and the concern was that her abdominal area was painful perhaps due to a blockage of the intestine. Therefore, Doctor 1 arranged blood tests; x-rays of the chest and abdomen; and referred Mrs C to Doctor 2 who came to review her in the ED at 01:21. The Board further advised that Mrs C's x-rays were reviewed at this time and found to be normal. Her blood tests showed mild changes that might be associated with vomiting but

nothing else significantly abnormal. Furthermore, a single lead ECG carried out was noted to be of normal rhythm, her observations were normal and the stoma was active. Thus, Doctor 2 discharged Mrs C from the Hospital. The Board's investigation did not identify any significant concerns about Mrs C's care.

Medical advice

10. Adviser 1 considered that the quality of clinical assessment, physical examination and record-keeping by Doctor 1 were not of a reasonable standard for the following reasons:

- Although documented elsewhere in the nursing records, Adviser 1 explained that, Doctor 1 failed to record significant aspects of Mrs C's past medical history in the medical section of the clinical records, including: bowel cancer; stroke; COPD; ischemic heart disease; hypothyroidism; and type 2 diabetes.
- There was no drug history documented despite Mrs C being on multiple medications. The Board had acknowledged this omission in their response to Mr C's complaint.
- The record of examination by Doctor 1 did not include physiological parameters including respiratory rate, oxygen saturations, temperature, blood pressure, pulse rate and level of consciousness that were recorded elsewhere on the nursing observation chart. These six physiological parameters are used to ascertain an early warning score that can be used to categorise severity of illness, identify deterioration and guide an appropriate clinical response.
- The record of examination of Mrs C's respiratory system, cardiovascular system and abdomen was very brief and lacking in detail. Adviser 1 explained that examination of Mrs C's respiratory system stated 'air entry equal' but there was no mention of her breathing rate, oxygen saturation or the quality of breath sounds. Examination of Mrs C's cardiovascular system was limited to heart sounds only and there was no mention of pulse, blood pressure or peripheral perfusion. Also, the abdominal examination did not mention the presence or absence of tenderness, masses or guarding (tensing of the abdominal wall).
- Whilst Doctor 1 had requested appropriate blood tests and x-rays of Mrs C's abdomen and chest, Adviser 1 considered it was unreasonable that Doctor 1 did not record their interpretation of these x-rays.
- There was no record of Mrs C's blood sugar level being measured despite the fact that she was diabetic.

11. Adviser 1 also considered it was unacceptable that Doctor 1 had not offered or administered any pain relief despite having recorded that Mrs C had a pain score of seven out of ten (which indicated that she was in moderate to severe pain).

12. Adviser 1 noted that Mrs C's care was referred to the surgical team as Doctor 1 had requested a surgical opinion regarding the possibility of a blockage of the intestine. Adviser 1 concluded that the quality of medical assessment and documentation by Doctor 1 was of an unreasonable quality.

Surgical advice

13. Adviser 2 noted that the surgical opinion was provided by Doctor 2, a Foundation Year 2 doctor, commenting that they are relatively junior and inexperienced. Adviser 2 explained that the minimum expected level of seniority of surgical opinion is ST3 (a doctor in speciality training who has at least two years of surgical experience more than an FY2). Whilst a Foundation Year 2 doctor is an important member of a surgical team, Adviser 2 said that they are not considered by the Royal College of Surgeons to be experienced enough to give an appropriate surgical opinion in this context. The Royal College of Surgeons' Emergency Surgery Standards for Unscheduled Care published in 2011 state that:

> 'a patient for whom an emergency surgical assessment is required will receive the same within 30 minutes of referral being made in the case of a life or limb threatening emergency, and within 60 minutes for a routine emergency referral. The member of the on-call surgical team responding to the request is at ST3 level or above, or a trust doctor with equivalent ability (ie MRCS with ATLSR provider status). Should the designated first on-call surgeon be unable to attend due to other emergency duties (eg emergency theatre or dealing with a separate life threatening emergency elsewhere in the hospital), protocols are in place for another member of the surgical team, of similar or a greater level of competence, to be available to attend the ED, within the above time scale.'

14. Adviser 2 noted that Doctor 2 had reviewed Mrs C's history and recorded her pre-existing diagnoses of type 2 diabetes and ischaemic heart disease (not previously documented by Doctor 1). Doctor 2 established that Mrs C had undergone surgery for colon cancer in the past which had been complicated by anastomotic leak. However, Adviser 2 highlighted that some of Doctor 2's

record-keeping lacked relevant details. Whilst Doctor 2 documented Mrs C's temperature, pulse, blood pressure, respiratory rate and oxygen saturation, an early warning score was not recorded although it would have been zero (not a cause for concern). Doctor 2's record of examination documented that Mrs C's abdomen was soft and non-tender and her stoma was working. However, Doctor 2 did not record the presence of any abdominal wall hernias which had been documented by the nurse and Doctor 1.

15. Adviser 2 went on to say that there was no cause for concern from the x-rays taken of Mrs C's chest and abdomen. Doctor 2 had noted from a single lead ECG performed that Mrs C was in 'sinus' (normal heart rhythm) and internal correspondence at the Board when reviewing the care indicated that there was no indication to perform an ECG. However, given Mrs C had a history of ischaemic heart disease and type 2 diabetes, both Adviser 1 and Adviser 2 considered that a 12-lead ECG should have been performed in the full assessment of abdominal pain because certain types of heart attack can present with abdominal pain, particularly in women. Adviser 2 explained that the European Cardiology Society's policy statement published in 2006 stresses that:

> 'Gender differences in the clinical manifestation of coronary heart disease have been demonstrated in several studies. Women have a greater tendency to present with atypical chest pain or to complain of abdominal pain, dyspnoea (breathlessness), nausea and unexplained fatigue.'

16. Adviser 2, therefore, considered that it was unreasonable not to undertake a 12-lead ECG in an elderly woman with type 2 diabetes, ischaemic heart disease and abdominal pain, as a single lead ECGis insufficient as a diagnostic test.

17. Adviser 2 further noted that Doctor 2's record at 01:21 indicated that they were happy for Mrs C to be discharged on the basis that her examination and test results were normal. However, there was no evidence that Doctor 2 validated their decision with a senior surgical member of staff which Adviser 2 considered represented poor care. Adviser 2 further noted that at 01:50, nursing staff took Mrs C's temperature which showed worsening fever. A pain score of three out of four was also recorded at this time which indicated that Mrs C was in severe pain. Adviser 2 was critical that there was no record of Mrs C having been offered pain relief and it had only been documented that she had been 'encouraged to take co-codamol pessaries at home'. Adviser 2

considered that to discharge Mrs C with worsening fever and unresolved pain was unsafe and represented very poor care.

18. Adviser 2 also highlighted significant concerns about an important serum amylase blood test that had been requested but overlooked by Doctor 2. Adviser 2 noted that there was no contemporaneous record of the result contained within the records provided by the Board. We, therefore, sought a copy of this information from the Board which showed that the serum amylase result was 512 U/L (normal range 0-100 U/L). Adviser 2 explained that the accepted upper limit for a diagnosis of pancreatitis is three times the upper limit (300) of normal. Thus, this indicated that the most likely diagnosis for Mrs C's pain was acute pancreatitis.

19. Adviser 2 explained that acute pancreatitis is a serious condition where the pancreas gland becomes acutely inflamed. It is most commonly caused by gallstones, alcohol or a reaction to certain medicines. Adviser 2 said that, in many people, acute pancreatitis can be a relatively mild, self-limiting condition but in others it can be serious and even fatal. The characteristic symptoms of pancreatitis are abdominal pain and vomiting. Treatment is supportive with fluids, rest, pain relief and nursing attention until the inflammation in the gland settles. Adviser 2 further highlighted that, given the serum amylase test result was authorised by the laboratory at 00:42 on 3 May 2016, it should have been available to Doctor 2 when he examined Mrs C at 01:21. Adviser 2 considered that Mrs C would have been admitted to the Hospital for in-patient care had the serum amylase of over 500 been recognized and/or if she had been reviewed by a more senior and experienced surgical doctor. Adviser 2 concluded that it was very poor care not to have followed up on an important blood test that had been requested.

20. Adviser 2 expressed additional concerns that the Board's investigation of Mr C's complaint was not thorough in that it failed to recognise the abnormal serum amylase test result. Adviser 2 said that there appears to have been no due diligence in reviewing the facts of the case given a consultant general surgeon (Doctor 3) appears to have simply recounted what had been documented by Doctor 2.

21. Adviser 2 said that the oversight of the serum amylase test result has highlighted another important aspect, in that, a forensic pathologist (the Forensic Pathologist) who carried out the Post Mortem did not have this

information to inform their opinion about the cause of death. Adviser 2 considered that, if the Forensic Pathologist had been alerted to evidence of pancreatitis, it would be reasonable to suggest that signs of acute pancreatitis might have been identified and that this may potentially have altered the Forensic Pathologist's opinion as to the cause of death.

22. Adviser 1 concluded that, although we cannot definitively say that Mrs C's death was avoidable due to the Post Mortem having shown severe triple vessel coronary artery atheroma and valvular heart disease, there was strong evidence that it may have been.

(a) Decision

23. The basis I make my decisions on is 'reasonableness'. I look at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

24. From the advice I have received, and which I accept, is that the clinical assessments and record-keeping by both doctors fell below a reasonable standard. Given Mrs C was an elderly woman with a history of ischaemic heart disease and type 2 diabetes, a 12-lead ECG should have been performed in the full assessment of abdominal pain. In addition, it was unreasonable that there was no evidence of Mrs C having been offered pain relief when she had notable pain on two occasions which I am critical of.

25. I have significant concerns that the grossly abnormal serum amylase blood test result was not taken into account when Mrs C was discharged from hospital. Had a more senior doctor overseen Mrs C's care and due attention been given to this test result, Mrs C may have been admitted to hospital for a period of in-patient care which may have avoided her death. Similarly, the absence of the serum amylase blood test result from the medical records that were provided to the COPFS may have had further consequences in terms of the cause of death.

26. I consider that if the Board had carried out a robust investigation of Mr C's complaint, this important test result and the failings referred to above, would have been identified sooner.

27. I conclude overall that the Board failed to provide Mrs C with a reasonable standard of care and treatment. I, therefore, uphold the complaint.

(b) The Board discharged Mrs C unreasonably in the middle of the night and sent her home by taxi without any notification

28. Mr C complained that Mrs C was sent home by taxi in her night clothes during the early hours of the morning without him being notified. He said that he found her knocking at the door distressed and in pain.

29. In responding to the complaint, the Board stated that:

> 'It is not unusual for patients who have capacity to be discharged from the ED in a taxi. Had your wife informed any member of staff that she would be unable to manage getting home on her own and asked that a relative be contacted, this certainly would have been facilitated.'

30. In commenting to this office, the Board said that it was not unusual for patients to be discharged home during the night; that patients will not be kept in hospital overnight when there is no medical reason; and that they would have assisted Mrs C if she had asked any of the staff to alert Mr C that she was being discharged home.

Clinical advice

31. Whilst the decision to discharge Mrs C was made by the surgical team, Adviser 1 considered that it was unreasonable to discharge a 78-year-old woman with multiple medical problems by taxi at 02:00. Adviser 1 commented that, even if the staff thought that Mrs C had no emergency condition requiring further investigation and treatment, it would have been reasonable and more appropriate to keep her in a hospital bed until the morning. In addition, Adviser 1 said that if a decision is made to discharge an elderly and frail patient during the night, it would be mandatory to discuss this with their relatives over the telephone prior to the discharge taking place.

32. Adviser 2 explained that the nursing record has a field for 'Discharge Information/Advice' which prompts nurses to confirm that a planned discharge has been discussed with the patient and relative/next of kin. However, this section of the form was blank and Adviser 2 considered that late night discharge in this way without appropriate notification and support was unacceptable and represented very poor care.

33. Adviser 2 considered that the Board's response to the complaint was also very poor considering the hospital's own ED Nursing Record has a section that

explicitly highlights contact with the relatives on discharge to be an important component of the care of patients. I have taken this view on board.

(b) Decision

34. I am mindful of Mr C's comments about finding Mrs C distressed and in pain when she arrived home in her nightwear. However, the Board's response to the complaint did not clearly acknowledge the distress this situation had caused both Mr and Mrs C which I would have expected to see.

35. I have considered the advice I have received, and accept it. I am critical, even shocked, that this situation occurred at all. I am particularly critical that the Board's own complaints investigation failed to identify any concerns about the circumstances involving an elderly and frail patient with multiple health problems being discharged home by taxi in the early hours of the morning. The Board's response lacks any recognition of the fact that the discharge paperwork specifically prompts communication with relatives/next of kin about discharge but this had not been completed by staff.

36. Given these circumstances and my findings under complaint (a), I conclude that it was unreasonable to discharge Mrs C in the early hours of the morning and not to have discussed this with Mr C in advance. I, therefore, uphold the complaint.

37. 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 recommendations 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.

Recommendations

Learning from complaints
The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mr C:

Complaint number	**What we found**	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
(a) and (b)	I found that there were unreasonable failings in Mrs C's care and in the Board's investigation of the complaints	Provide a written apology to Mr C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at https:www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology. By: 24 January 2018

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The quality of the clinical assessments and documentation by both doctors was of an unreasonable standard	Patients should receive a full assessment with all relevant information documented including: medical and medication history; and observations	Confirmation that both doctors have been made aware of the findings and had the opportunity to discuss and learn from them, including reference to any learning and development, or training, identified By: 21 February 2018
(a)	Staff failed to perform a 12-lead ECG	A 12-lead ECG should be used in the assessment of abdominal pain in similar cases	Evidence that relevant staff have undertaken educational activities to better understand cardiovascular disease in women and what action to take in future By: 21 February 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Mrs C's discharge from hospital was not overseen by a more senior doctor and an important blood test result was overlooked	Patients should not be discharged without senior doctor oversight in similar cases. All relevant results should be taken into account	Confirmation that Doctor 2 has been made aware of the findings and had the opportunity to discuss and learn from them, including reference to any learning and development, or training, identified By: 21 February 2018
(a)	The Board failed to provide COPFS with the serum amylase test result	All relevant test results should be identified and provided to COPFS	Evidence that the Board have now sent this result to COPFS. Evidence that staff have been reminded of the importance of providing all relevant information at the relevant time By: 21 February 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	The Board's investigation of the complaints was not robust and failed unreasonably to identify the abnormal serum amylase test result	Clinicians providing input to complaint investigations should thoroughly review the care provided	Evidence that these findings have been shared with Doctor 3 with appropriate support By: 21 February 2018
(b)	It was unreasonable to discharge Mrs C without contacting Mr C in advance	The discharge section of the clinical records should be completed in terms of relative/next of kin contact in all cases	Evidence that the Board has a process in place for auditing discharge documentation. Evidence that my decision has been shared with relevant staff with appropriate support By: 21 February 2018

Terms used in the report **Annex 1**

12-lead electrocardiograph	the definitive cardiology test that records the electrical activity of the heart using 12 electrode contacts on the patient's limbs and across the chest
acute pancreatitis	a serious medical condition where the pancreas (a gland behind the stomach) suddenly becomes inflamed
Adviser 1	a consultant in emergency medicine adviser to the Ombudsman
Adviser 2	a consultant in emergency general surgery adviser to the Ombudsman
anastomotic leak	a serious complication of surgery, when a surgeon had joined two pieces of bowel together (anastomosis) but the join subsequently breaks down and leaks gas and/or fluid into the abdominal cavity causing infection and/or sepsis
cardiac pacemaker	a small electrical device implanted into the body to regulate heart rate and rhythm
cardiovascular	related to the heart and blood vessels
chronic obstructive pulmonary disease (COPD)	a group of lung conditions that make it difficult to empty air out of the lungs due to airway narrowing
colostomy	a surgical procedure creating an artificial opening from the colon

	through the abdominal wall to divert bodily waste
COPFS	Crown Office and Procurator Fiscal Service
coronary artery atheroma	a build-up of fatty substances in the coronary arteries
Doctor 1	a middle grade doctor
Doctor 2	a junior surgical doctor
Doctor 3	a consultant general surgeon
ECG	electrocardiograph
ED	emergency department
Forensic Pathologist	the doctor who performed the Post Mortem
gastroenteritis	infection of the stomach and intestines
hypothyroidism	a medical condition when insufficient hormones are produced from the thyroid gland (in the front of the neck) and metabolism slows, causing multiple symptoms such as loss of energy
ischaemic heart disease	disease caused by narrowing of the coronary blood vessels leading to symptoms of angina or heart attack
Mr C	the complainant
Mrs C	the aggrieved

perforation of the intestine	a hole in the intestine
post mortem	an examination of the deceased person to determine the cause of death
pulmonary hypertension	high blood pressure within the blood vessels between the heart and the lungs
serum amylase test	a blood test used to diagnose acute pancreatitis
single lead ECG	a basic method to record the electrical activity of the heart using two or three electrode contacts. It can also be used for basic heart monitoring or checking for rhythm disturbances of the heart
stoma bag	a pouch designed to collect bodily waste diverted through an opening in the abdomen
the Board	Lanarkshire NHS Board
the Hospital	Monklands General Hospital
type 2 diabetes	a medical condition where the pancreas does not produce enough insulin or the body cells become resistant to the effect of insulin
valvular heart disease	disease affecting function of the heart valves that can cause reduced efficiency of heart function

List of legislation and policies considered **Annex 2**

Royal College of Surgeons Emergency Surgery Standards for Unscheduled Care (2011)

Cardiovascular diseases in women: a statement from the policy conference of the European Society of Cardiology (2006) policy statement (2006)