Scottish Parliament Region: Lothian

Cases 200800557 & 200800997: Lothian NHS Board and A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health: Hospital – Oncology: Clinical treatment/diagnosis Health: Hospital – General: Complaints handling; Health/FHS - GP & GP Practice/Clinical treatment/Diagnosis; Health/FHS - GP & GP Practice/Complaints handling

Overview

The complainant (Mrs C) raised a number of concerns that her mother (Mrs A) had not been reasonably cared for or treated by medical staff at St John's Hospital (the Hospital) or her GP practice (the Practice) in the months before her death, and that the responses to Mrs C's enquiries and complaints by Lothian NHS Board (the Board) and the Practice had not been appropriate and had been unnecessarily distressing to her.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board did not provide reasonable care and treatment to Mrs A between May 2007 and February 2008 (partially upheld to the extent that the investigation, diagnosis, care and treatment of Mrs A from November 2007 to February 2008 was not reasonable);

(b) the actions taken by the Board in response to Mrs C's complaints about the care and treatment of Mrs A were not reasonable *(upheld)*;

(c) Mrs A did not receive adequate care and treatment from the Practice between November 2007 and February 2008 (*partially upheld to the extent that the Practice did not reasonably address or follow-up the symptoms that Mrs A displayed which can be linked to cancer, that the Practice's prescription of pills rather than other forms of treatment to Mrs A was not reasonable, that the Practice did not reasonably take into account changes in Mrs A's condition and that the level of information recorded in Mrs A's notes was not comprehensive*); and

(d) the Practice's responses to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing (*partially upheld to the extent that, although the Practice appropriately responded to some of Mrs C's*

enquiries and complaints, some of the Practice's responses, or lack of responses, to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs A's family that the chest x-ray of 26 November 2007 was mis-reported and that this led to a delay in the diagnosis of Mrs A's cancer;

(ii) remind medical staff that letters to GPs should be dictated immediately after consultations with patients;

(iii) encourage the practice of discussing patients with atypical clinical features at multi-disciplinary meetings;

(iv) take steps to assure themselves of the quality of their chest x-ray reporting service;

(v) apologise to Mrs C that the investigation of her complaints did not uncover the mis-reporting of the chest x-ray of 26 November 2007; and

(vi) ensure that investigations of similar complaints in the future consider the possibility that x-rays, scans, test results or similar may have been mis-reported.

The Ombudsman recommends that the Practice:

(i) apologise to Mrs A's family for those aspects of her care and treatment that were not reasonable;

(ii) produce a plan for reviewing their adherence to national guidelines. This plan should be minuted and form part of the Practice's clinical governance meetings. The minutes should be inspected by the Board's clinical governance lead to ensure that the Practice have identified areas for improvement and taken action to address these issues;

(iii) ensure that national guidelines are readily available to all practitioners;

(iv) undertake a review of clinical record-keeping using the Royal College of General Practitioners (Scotland) template on section 3D (2) of the Revalidation Toolkit. The review should be discussed with the Board's clinical governance lead to ensure that the Practice have identified areas for improvement and taken action to address these areas;

(v) apologise to Mrs C that their responses to her enquiries and complaints were inappropriate and unnecessarily distressing; and

(vi) review their complaints handling procedure to ensure that complainants are given direct answers to reasonable direct questions, that individual circumstances, distress and stated preferences are reasonably taken into

account when suggesting meetings with correspondents and complainants, that it is made clear to correspondents how to set in motion the Practice's complaints procedure and that avoidable errors are reasonably eliminated, taking into account the individual circumstances of a complaint.

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

Main Investigation Report

Introduction

1. On 30 May 2008 the Ombudsman received a complaint from Mrs C, about the care and treatment her mother, Mrs A, had received from Lothian NHS Board (the Board) between May 2007 and February 2008, and also about the actions the Board had taken in response to the complaints Mrs C had submitted. During discussion about this complaint, Mrs C said that she was also pursuing a complaint about the care and treatment her mother received from her GP practice (the Practice) between November 2007 and February 2008. This complaint was received by the Ombudsman on 10 July 2008, and also included a complaint about the responses the Practice had made to her complaints.

Complaints about the Board

2. Mrs C complained about the actions of the Board as follows:

- Relating to consultations in May and June 2007:
  - that the Board had not reasonably investigated Mrs A's symptoms;
  - that the diagnosis the Board had reached was not reasonable; and
  - that the care, treatment and advice given to Mrs A as a result of these consultations was not reasonable.
- Relating to a consultation on 26 November 2007:
  - that the remark made by a consultant cardiologist (Consultant 1) in a letter to Mrs A's GP that Mrs A was 'pursuing an active lifestyle without restriction' was not reasonably supported by evidence;
  - that the Board did not reasonably investigate Mrs A's symptoms;
  - that the diagnosis the Board had reached was not reasonable; and
  - that the care, treatment and advice given to Mrs A as a result of this consultation was not reasonable.
- Relating to an admission to St John's Hospital (the Hospital) between 16 and 21 January 2008:
  - that the Board's investigation of Mrs A's symptoms, and diagnosis of her condition, was not reasonable; and
  - that the Board's discharge of Mrs A on 21 January 2008 was not appropriate in the circumstances.
- Relating to an admission to the Hospital between 29 January and 2 February 2008:

- that the Board did not investigate Mrs A's symptoms reasonably. Mrs C was particularly concerned that no new CT scan was undertaken during this admission.

- that the Board's discharge of Mrs A on 2 February 2008 was not appropriate in the circumstances.

3. The Board responded to Mrs C's complaints, and the Board's Acting Director of Operations (the Director) assured Mrs C that she would 'ensure that your thoughts and experiences are shared with members of the multidisciplinary team'. Mrs C complained to the Ombudsman that the action taken by the Board was not reasonable.

Complaints about the Practice

4. Mrs C complained that the Practice did not give Mrs A adequate care and treatment between November 2007 and February 2008. Specifically, Mrs C was concerned about the following issues:

- that the Practice did not appropriately refer Mrs A to specialists during this period;
- that those symptoms that Mrs A displayed which can be linked to cancer were not properly addressed or followed up;
- that Mrs A was unreasonably repeatedly prescribed pills rather than other forms of treatment;
- that the Practice did not reasonably respond to changes in Mrs A's condition during this time; and
- that the level of information recorded in Mrs A's notes was not reasonable.

5. The Practice responded to Mrs C's complaints but she felt that these responses were inappropriate and unnecessarily distressing. She was particularly concerned about the following issues:

- that the Practice did not adequately respond to her enquiries about the symptoms that her mother had presented with;
- that the Practice continued to suggest a meeting with Mrs C after she had declined this suggestion, and explained the reasons why;
- that the Practice did not make clear that, though they had dealt with her enquiries as they would a complaint, they did not process them through their formal complaints procedure;
- that the Practice supplied her with the records of another patient; and

- that the Practice stated, in a letter to Mrs C, that Mrs A had attended the respiratory clinic on 18 February 2008. This was distressing to Mrs C because Mrs A had passed away on 17 February 2008.

6. The complaints from Mrs C which I have investigated are that:

(a) the Board did not provide reasonable care and treatment to Mrs A between May 2007 and February 2008;

(b) the actions taken by the Board in response to Mrs C's complaints about the care and treatment of Mrs A were not reasonable;

(c) Mrs A did not receive adequate care and treatment from the Practice between November 2007 and February 2008; and

(d) the Practice's responses to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing.

Investigation

7. In order to investigate this complaint I have had access to Mrs C's clinical records from both the Practice and the Board and the complaint correspondence from both the Practice and the Board. I have received clinical advice from three advisers to the Ombudsman, one of whom is a consultant in respiratory and general internal medicine (Adviser 1), while the others are GPs (Advisers 2 and 3). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1 and a glossary of terms is in Annex 2. Mrs C, the Practice and the Board were given an opportunity to comment on a draft of this report.

8. In July 2006 Mrs A, a 53-year-old smoker, went to the Practice complaining of episodes of double vision and dizziness. The GP who saw her referred her to the Hospital for tests for transient ischaemic attack, or mini-stroke. An appointment was made for 10 August 2006 but a few days before, on 5 August 2006, Mrs A was admitted to the Hospital as an emergency following further episodes of dizziness and palpitations. During investigation a heart murmur was heard and her heavy smoking and very high blood pressure were identified as arteriosclerosis risk factors. She was discharged the following day with appointments for further out-patient investigations by a cardiologist.

9. Over the winter of 2006 Mrs A underwent further investigations. She was given treatment and advice about lowering her cholesterol and blood pressure

and encouraged to give up smoking. A chest x-ray was taken in November 2006, which was reported as being normal. A CT scan was also undertaken which showed emphysema, but no blood clots.

10. On 17 May 2007, Mrs A was seen by a specialist registrar. Mrs A had reduced her smoking and, consequently, gained weight and found herself increasingly breathless. A physical examination showed reduced breath sounds and further lung function tests were arranged.

11. Mrs A was seen by the same specialist registrar on 21 June 2007 who told her that the lung function tests showed no impairment of breathing, but evidence of early airway obstruction. A probable diagnosis of emphysema was reached. She was given inhaled bronchodilator and cortico-steroid drugs and the importance of stopping smoking altogether was emphasised to her.

12. Mrs A went to the Practice just over three months later, on 1 October 2007 because she found herself shaking and coughing up green sputum. The GP (GP 1) prescribed inhalers and amoxicillin. On 7 November 2007, Mrs A saw GP 1 again. She reported that the inhalers had stopped the shaking but the green sputum had continued. GP 1 renewed the prescription for inhalers and changed the prescription for amoxicillin to erythromycin.

13. Mrs A was reviewed at the Hospital's heart clinic on 26 November 2007 by Consultant 1. The examination of Mrs A showed a weight reduction from 65.7 kilograms in June 2007 to 62.6 kilograms. An echocardiogram was taken and showed no change, and a chest x-ray was arranged. Consultant 1 concluded that there had been no overall change to Mrs A's condition, repeated advice that she stop smoking completely, prescribed lisinopril and arranged for a further appointment in a year.

14. Consultant 1 wrote to Mrs A's GP about this appointment in a letter dated 4 December 2007. In the letter Consultant 1 stated that Mrs A was 'entirely well and pursuing an active lifestyle without restriction'.

15. Mrs A saw her own GP (GP 2) at the Practice on 29 November 2007. Mrs A was concerned that she remained breathless and that the coughing had continued. GP 2 noted side effects from the lisinopril prescribed by the Hospital and, on examination, found a chest infection. He reassured Mrs A that the medications she had been prescribed were adequate.

16. Mrs A saw GP 1 at the Practice on 12 and 19 December 2007. At both these consultations records show that Mrs A complained of depression and, at the second consultation, anti-depressants were prescribed to Mrs A.

17. Mrs A saw GP 2 on 4 January 2008, complaining again of the persistent coughing. GP 2 prescribed co-amoxiclav to Mrs A on this occasion. Mrs A saw GP 1 on 8 January 2008 complaining of the persistent cough, along with a sore chest, dysphagia and blood in her stools. GP 1 prescribed ciprofloxacin on this occasion. Mrs A spoke to another GP (GP 3) by telephone on 10 January 2008, again she complained of persistent coughing. GP 3 suggested Mrs A take paracetamol. Mrs A advised GP 3 that she would attend at the Practice later that afternoon, however, she did not.

18. On 16 January 2008, Mrs A was admitted to the Hospital with shortness of breath, a chronic cough and feverish symptoms. An examination was made and a chest x-ray taken. The x-ray showed shadowing and volume loss in the right lung. A working diagnosis of pneumonia was reached. A more serious underlying disease was considered and a CT scan undertaken in December 2006 was noted as having been normal. Mrs A was kept in the Hospital for five days and treated with antibiotics. No fever developed, her general condition improved and she was discharged on 21 January 2008. An out-patient appointment was made for 3 March 2008, with instructions that a chest x-ray should be arranged for a few days previous to that. In the discharge summary to the Practice it was noted that the chest x-ray undertaken in November 2007 had been normal.

19. Mrs A went to the Practice on 24 January 2008, where she was seen by a locum GP. Mrs A's blood pressure was taken at this consultation, the lisinopril prescription was stopped, as it can cause chronic coughing and bendroflumethiazide was prescribed.

20. Mrs A was re-admitted to the Hospital on 29 January 2008, complaining of chest pain, persistent breathlessness and coughing green sputum. A chest x-ray and other tests were undertaken. These produced similar results to her previous tests, with the exception of the liver function test, which was now abnormal. Pleural fluid was twice removed from the right pleural space and the working diagnosis reached was that this pleural fluid was a complication of the pneumonia. On 2 February 2008 Mrs A told staff she felt much better, was not

breathless and was happy to go home. She was discharged with arrangements for medical review a month later.

21. On 5 February 2008, Mrs A saw GP 2. The notes record that GP 2 provided a medical certificate to Mrs A and prescribed further antibiotics.

22. On 7 February 2008, the pleural fluid microscopy was reported as 'atypical cells with features consistent with metastatic adenocarcinoma' and the results 'favour origins from a primary lesion in the lung'. Arrangements were made for her to be seen in the chest clinic.

23. Mrs A was re-admitted to the Hospital following her appointment with the chest clinic on 13 February 2008. Tests on 13 February, including a chest x-ray, and a CT scan on 14 February 2008 showing a tumour around Mrs A's right main bronchus and lower windpipe led to a diagnosis of cancer. Due to Mrs A's clinical condition, she was considered unfit for chemotherapy and started on palliative treatment for her symptoms. This was explained to Mrs A and her family on 14 February 2008. On 15 February 2008, Mrs A fell while getting out of bed and was found to have left side weakness consistent with a stroke. The family were advised that the outlook was very poor and it was agreed that she should be treated symptomatically. Sadly, Mrs A passed away on 17 February 2008.

24. On 28 February 2008, Mrs A's daughter, Mrs C wrote to the Practice and the Board. Mrs C explained that she, and the rest of Mrs A's family, had been shocked and aggrieved at the sudden passing of Mrs A and wanted the Practice and the Board's explanations of the circumstances leading to her death. Mrs C explained that the family's view was that Mrs A had been reporting her symptoms for some time to the Practice and the Board and that her death could have been prevented if cancer had been detected sooner. Mrs C explained that Mrs A's husband (Mr A) recalled accompanying Mrs A to an appointment at the Practice a few months previously where she had been told that she did not have cancer. The family were concerned that this was at odds with the Consultant Chest Physician at the Hospital telling them that Mrs A had had cancer for some time. At the same time as complaining, Mrs C requested copies of Mrs A's medical records from the Practice and the Board.

25. When Mrs C received the medical records she had requested from the Board, they included a completed Hospital Anxiety and Depression Scale

questionnaire. This questionnaire was not a copy and a sticker with the name and address of another patient had been attached to it.

26. On 5 March 2008, GP 2 wrote to Mrs C, although the letter is incorrectly dated 5 February 2008. In the letter, GP 2 expressed condolences on behalf of the Practice for the death of Mrs A and gave a summary of Mrs A's recent attendances at the Practice and the Hospital. He said that the Practice had not yet received letters from the Hospital regarding Mrs A's final admission. GP 2 gave a brief summary of Mrs A's contact with the Practice and the Hospital from February 2006 onwards. In summing up the Practice's contact with Mrs A, GP 2 gave his view that he felt strongly that she was treated and referred to hospital appropriately. GP 2 also invited Mrs C, or Mr A, to contact the Practice if they wanted any further information or clarifications, and suggested this would best be done at a meeting.

27. Also on 5 March 2008 the Board acknowledged Mrs C's letter to them. The Board also expressed their condolences to Mrs A's family, explained who would deal with the issues Mrs C had raised, and sought clarification of the Board's understanding of her complaints.

28. Mrs C responded to the Board on 10 March 2008. She clarified some specific points she wanted the Board to respond to, these were: a full explanation of what happened to Mrs A in the last few days of her life, an explanation why cancer was not diagnosed before February 2008, whether any medical staff had suspected Mrs A had cancer and whether any action was taken to confirm such suspicions, whether Mrs A's cancer should have been obvious to medical staff and a full explanation for why Mrs A was discharged on 2 February 2008.

29. On 20 March 2008 the Board advised Mrs C that a full response to her complaint would be delayed due to the time taken to collate all the information required. The Board apologised for this delay.

30. On 26 March 2008 Mrs C responded to the Practice. She explained that she was having difficulty understanding the technical language in the documents she had been sent and asked for them to be translated into 'layman's terms' to enable her to reach a better understanding of them. Mrs C asked for details of when Mrs A had been referred to hospital, what the referrers' concerns had been and what the outcome of the referrals had been.

She noted that Mrs A had been prescribed a number of different medicines and asked if there had been any concern as to why the various medicines were not helping her mother. Mrs C also asked if any of the GPs had suspected more serious underlying issues, and whether any action had been taken to confirm or deny these. Mrs C listed the symptoms that Mrs A had presented with to the Practice; shortness of breath, cough, wheezing, a persistent chest infection, pain in the chest, dysphagia, blood in the stool, fatigue, vomiting, weight loss and early finger clubbing. She asked GP 2 what he associated these symptoms with and whether they were the symptoms of cancer. Mrs C also noted the suggestion that Mrs A take paracetamol (see paragraph 17) and asked what symptoms GP 3 had felt the paracetamol would alleviate. She also asked for an explanation for several dates on which appointments for Mrs A were noted, but no details of the appointment were recorded, and vice versa.

31. The Practice responded to Mrs C's letter on 8 April 2008 and explained that the letter had been discussed at a partners' meeting. The Practice appreciated Mrs C's wish to fully understand the situation prior to her mother's death and explained that they felt the best way to provide Mrs C with the explanations she sought was in a face-to-face meeting. Mrs C was provided with contact details of the Practice Manager and asked to contact him so that a mutually convenient meeting could be arranged.

32. Mrs C wrote to the Practice on 11 April 2008. She thanked the Practice for the contact details and offer of a meeting, but explained that she was very sensitive about the subject of her mother and did not feel she could retain her composure during a telephone conversation. Similarly, she felt that a meeting to discuss these matters would be very emotional for her and that she would become upset. She was also concerned that this would mean such a meeting would last longer than necessary and would, consequently, take more of the GPs' time that would be better spent dealing with patients. Mrs C, therefore, declined the offer of a meeting.

33. On 21 April 2008, the Board wrote to Mrs C again, and apologised that there would be a further delay in their response to her.

34. GP 2 wrote to Mrs C on 1 May 2008. He said that he understood Mrs C's feeling that a meeting would be too distressing to undertake and explained that the Practice had made the offer as it was sometimes easier to give explanations that way. He told Mrs C that the Practice had not yet received a final summary

from the Hospital of Mrs A's final admission, and so could not comment on that. GP 2 explained that Mrs A was only referred once to hospital, to a cardiologist in early 2007, and that subsequent appointments had been made by the cardiology department, not as referrals by the Practice. He explained that Mrs A had been prescribed several courses of antibiotics to address her cough and chest problems, but that it was not uncommon for someone with emphysema to require several courses of antibiotics to clear a persistent infection. He also noted that lisinopril is known to cause a persistent cough. He told Mrs C that 'the thought of cancer formation clearly goes through one's mind on a regular basis', but this had not been explored further by the Practice because of the facts that a persistent chest infection can take some time to clear, that the chest x-ray in late 2007 had been reported as normal, and that Mrs A had not consistently presented with the same symptoms in late 2007 and early 2008. GP 2 gave his view that GP 3's suggestion of taking paracetamol was a short-term measure to help any aches and pains associated with respiratory infection. GP 2 also explained to Mrs C that accessing the computer record of a patient can generate an entry indicating that the patient has been seen in normal surgery, and that these entries are not always subsequently deleted. In closing, GP 2 told Mrs C that, as a result of his reviewing of the care and treatment of Mrs A, he had learned not to be particularly trusting of chest x-rays reported as normal and would have a lower threshold to request scans of the lungs, or refer to a chest clinic, in the future. He also said that a meeting had been held by the Practice to discuss all aspects of Mrs A's illness and that the Consultant Chest Physician would be approached to give a talk to the Practice on the latest features of respiratory treatment.

35. Mrs C contacted the Board on 12 May 2008, seeking an update on the progress of their investigation of her complaints. She was advised that the Board were hopeful a response would be sent by 16 May 2008. Having not received a response by 19 May 2008, Mrs C contacted the Board again. She was told the response was being reviewed by a senior manager and that she would be updated by 23 May 2008 if the response was not sent by then. Mrs C contacted the Board again on 22 May 2008. She was told the senior manager had asked for further information before the response was sent. Mrs C said that she was not happy with the time the Board had taken to respond to her complaint and that she would approach the Ombudsman if she had not received a response by 28 May 2008.

36. On 27 May 2008, Mrs C wrote to the Practice. She thanked GP 2 for his letter of 1 May 2008 but felt there were three points in her earlier letter that had not been answered; whether any of the GPs had suspected more serious underlying issues, whether any action had been taken to confirm or deny these, what GP 2 associated Mrs A's symptoms with, and whether they were the symptoms of cancer, and two particular entries in Mrs A's medical record relating to follow-up investigations of depression and blood pressure. She also sought clarification whether the Practice felt that all Mrs A's symptoms were due to emphysema and why it seemed no action was taken in regard to the symptoms of cancer that Mrs A presented with.

37. Also on 27 May 2008, the Board wrote to Mrs C. The Board gave a detailed outline of Mrs A's final admission to the Hospital before giving detailed answers to the complaints that Mrs C had raised. The Board explained that their medical staff's observations of Mrs C, and the results of tests undertaken up to November 2007, were indicative of emphysema. The Board told Mrs C that during Mrs A's first admission there was suspicion of an underlying malignancy but that the chest x-ray was reported as showing pneumonia and this was supported by the abnormalities observed in her blood tests. In dealing with Mrs A's second admission, the Board told Mrs C that discussion with Mrs A and her family was noted, and their concern regarding the deterioration in her health over the past five months was recorded. The Board explained that the decision to discharge Mrs A on 2 February 2008 took into account that Mrs A had felt much better at the weekend ward round, that her shortness of breath had improved and that she had been happy to go home. The Board told Mrs C, however, that the consultant whose care Mrs A had been under during her first and second admissions, agreed that it would have been preferable to keep Mrs A in hospital until the cytology results were available. In response to Mrs C's query whether it would have been obvious that Mrs A had cancer during her admissions, the Board explained that there were worrying signs in relation to Mrs A's weight loss, but that there was no record of any difficulty in swallowing and no evidence of malignancy in the CT scan from December 2006 or in the x-rays. For this reason, the Board explained, no further investigations were carried out.

38. Mrs C submitted her complaint against the Board to the Ombudsman on 29 May 2008. Included in her complaint submission was a draft letter to the Board seeking further clarification of their letter of 27 May 2008. On 3 June 2008 I discussed Mrs C's complaint with her and we agreed that it would

be most appropriate for her to request the further clarification she sought directly from the Board.

39. On 4 June 2008 the Practice responded to Mrs C's letter of 27 May 2008. GP 2 told Mrs C that the Practice had met again to discuss Mrs A's illness and that the Practice strongly felt that to answer Mrs C's questions required a face-to-face meeting and invited her to contact the Practice to arrange this.

40. Mrs C wrote to the Board on 24 June 2008. She explained that the letter of 27 May 2008 had raised a few questions for her and she asked the Board for their response to them. She asked what tests had been carried out in May and June 2007 to ascertain the cause of Mrs A's wheezing and breathlessness and what the likelihood was of Mrs A having had cancer at this point. She asked for an explanation of why Consultant 1 had described Mrs A as 'entirely well and pursuing an active lifestyle without restriction' in his letter to the Practice of 4 December 2007, and an explanation of what examinations, investigations or tests were carried out at the appointment on 26 November 2007, and their results. Mrs C asked for similar details for the admission on 16 January 2008 and whether the Board felt it was appropriate to discharge Mrs A on 21 January 2008, as the family's recollection of her general state of health at that point was that it was very poor. Mrs C requested details of the investigations carried out during Mrs A's admission from 29 January 2008 and asked whether the Board felt it was reasonable that no further CT scan or x-ray was carried out at this point. She also asked what action the Board had taken to prevent similar events recurring in the future. Mrs C also contacted the Board by telephone on 25 June 2008. The Board acknowledged receipt of this letter on 2 July 2008.

41. On 10 July 2008, Mrs C submitted her complaint about the Practice to the Ombudsman.

42. The Board responded to Mrs C's letter of 24 June 2008 on 21 July 2008. They provided Mrs C with a breakdown of the tests and examinations of Mrs A from May 2007 to 2 February 2008. The Board told Mrs C that Consultant 1 felt that there was no evidence in mid-2007 to suggest that cancer was present. The Board explained that the chest x-ray report from late 2007 stated that the heart, lungs and middle of the chest cavity were normal. In regard to Mrs A's discharge on 21 January 2008, the Board said that on that weekend, Mrs A felt much better, her blood results were improving and her chest and cough

sounded better. The Board apologised if Mrs C felt that Mrs A should not have been discharged at this point and the Board's Acting Director of Operations would ensure that Mrs C's thoughts and experiences were shared with members of the multi-disciplinary team. The Board reiterated their previous responses regarding the admission of Mrs A from 29 January 2008.

43. As part of my consideration of Mrs C's complaints, on 8 August 2008 I asked the Practice for copies of Mrs A's medical records and their correspondence with Mrs C. The Practice Manager contacted me on 18 August 2008 and told me that the Practice had been puzzled by my request because they did not believe Mrs C had made any complaints to them. He explained that, in the Practice's opinion, the letters that Mrs C had sent were enquiries. This was reiterated in the Practice's written response to my letter. My understanding, as a result of my discussion with the Practice Manager, was that a formal complaint would set in motion a particular process that may result in a slightly different outcome.

44. I advised Mrs C of the Practice's view on the letters she had sent them and explained that, under the terms of section 7(9 & 10) of The Scottish Public Services Ombudsman Act 2002, she would require to make a formal complaint to the Practice before the Ombudsman could investigate her complaint.

45. Mrs C formally complained to the Board on 9 September 2008. She raised many of the issues she had previously corresponded with the Practice about and outlined those questions she felt had not been adequately answered, including what GP 2 associated Mrs A's symptoms with, and whether they were the symptoms of cancer.

46. The Practice responded initially to Mrs C on 16 September 2008. The Practice told Mrs C that they would meet again to discuss the contents of her letter and respond in full thereafter. The Practice again stated their view that a meeting with Mrs A's family would be best way to answer the questions raised.

47. The Practice wrote again to Mrs C on 6 October 2008. GP 2 began this letter by stating 'We have in fact treated all your correspondence in just the same manner as if they related to a formal complaint. The reason the [Ombudsman] did not wish to be involved is that they do not perceive it as a formal complaint'. GP 2 then briefly described the history of Mrs A's contact with the Practice and the Hospital from November 2007 onwards. Included in

this history was the statement '[Mrs A]'s next attendance was the respiratory clinic on the 18th of February after which she was admitted for the third and final time'. GP 2 also recounted the history of Mrs C's contacts with the Practice subsequent to her mother's death and addressed some of the questions that Mrs C had asked in her letter of 9 September 2008. No direct reference was made to the question of what GP 2 associated Mrs A's symptoms with and whether they were the symptoms of cancer.

(a) The Board did not provide reasonable care and treatment to Mrs A between May 2007 and February 2008

48. Mrs C complained that, during consultations in May and June 2007 (see paragraphs 10 and 11), the Board had not reasonably investigated Mrs A's symptoms, that the diagnosis the Board had reached was not reasonable and that the care, treatment and advice given to Mrs A as a result of these consultations was not reasonable.

49. In response to Mrs C's enquiries about the investigation, diagnosis and treatment of Mrs A at these appointments, the Board told Mrs C that Mrs A's main problem at this time was noted to be breathlessness. Examination at this time showed Mrs A had poor air entry, but no wheeze or other added sounds, and a blood test proved negative for anaemia. Lung function tests were carried out and, as a result, Mrs A was advised that dramatically reducing her smoking was the most important thing that she could do to help, inhalers were diagnosed and a probable diagnosis of emphysema was reached. The letter sent to Mrs A's GP noted that long-term cardiac review was ongoing and made clear that the Board would be happy to see her back at the chest clinic if there were any further problems.

50. I sought the opinion of Adviser 1 on these issues. He told me that while it could be argued that the specialist registrar who saw Mrs A at these appointments should have arranged for more detailed lung function tests or discussed the case with a consultant, the care Mrs A received at these appointments was not below a level to be reasonably expected, that the diagnosis was justifiable and that the treatment of inhalers and long-term cardiac review was appropriate.

51. In regard to a consultation on 26 November 2007 (see paragraphs 13 and 14), Mrs C complained that Consultant 1's remark that Mrs A was 'entirely well and pursuing an active lifestyle without restriction' was not reasonably

supported by evidence. Mrs C's recollection was that, at this time, Mrs A was wheezing, breathless, had a productive cough, required to take breaks during simple housework tasks such as hoovering, and constantly looked exhausted. Mrs C also felt that the Board did not reasonably investigate Mrs A's symptoms at this consultation, that the diagnosis the Board reached was not reasonable and that the care, treatment and advice given to Mrs A as a result of this consultation was not reasonable.

52. In response to her enquiries about the consultation of 26 November 2007, the Board told Mrs C that a chest x-ray and an echocardiogram were carried out and that the echocardiogram was essentially unchanged from the previous one, showing moderate long-standing leakage from the valves. Consultant 1 advised no change in Mrs A's treatment and reiterated the importance of stopping smoking altogether.

53. The x-ray report was not available to Consultant 1 on 26 November 2007, but a note on the Board's copy of the letter he sent to Mrs A's GP reads 'CXR normal' and the discharge summary sent to the Practice for Mrs A's admission on 16 January 2008 stated that the x-ray report said that the heart, lungs and chest cavity had been normal. The Board also mentioned this in their letter to Mrs C of 21 July 2008 (see paragraph 42).

54. I sought the opinion of Adviser 1 on these issues. In regard to Consultant 1's remark that Mrs A was 'entirely well and pursuing an active lifestyle', he told me that there was conflicting evidence from Mrs C's recollection of how breathless Mrs A was and the medical records. He explained that Consultant 1's written note of the consultation was brief, but that the more detailed letter would be acceptable as a contemporary record if it was dictated immediately after the consultation, with no other activity of any sort taking place between the consultation and the dictation. Adviser 1 also noted that it was recorded on 16 January 2008, nearly two months later, that Mrs A's usual exercise tolerance was good and that she was able, at that time, to work as a carer. His view, on balance, was that Consultant 1's remarks were supported by the evidence in the medical records.

55. I asked the Board when Consultant 1's letter was dictated. They told me that Consultant 1 would have dictated this letter either immediately after he saw Mrs A or during the late afternoon of the same day.

56. In regard to the investigation of Mrs A's symptoms, the diagnosis reached and the care, treatment and advice given to her, Adviser 1 told me that key issues were that the chest x-ray was not available to Consultant 1 at the consultation and that the chest x-ray was eventually reported as normal. Given these facts, Adviser 1 said that it would be unreasonable to criticise Consultant 1 individually. However, Adviser 1's opinion of the chest x-ray was that it was definitely abnormal, as the root of the right lung was now prominent and there had been a borderline loss of volume of the right side of the chest. Adviser 1's view was that this was indicative of lung cancer. He told me that this meant there had been an avoidable delay in the Board's diagnosis of Mrs A's cancer and a loss of opportunity to provide effective palliative treatment for the cough and breathlessness. Adviser 1 was clear, however, that the extent of the disease meant that, even if the Board had diagnosed it at this stage, the ultimate outcome would have been the same. Adviser 1's view was that, had the chest x-ray been reported correctly, Mrs A should have been urgently referred to the chest clinic.

57. Mrs C complained that during Mrs A's admission to the Hospital between 16 and 21 January 2008 (see paragraph 18), the Board's investigation of her symptoms and diagnosis of her condition were not reasonable, and that the Board's discharge of Mrs A on 21 January 2008 was not appropriate in the circumstances.

58. The Board told Mrs C that, during this admission, consideration had been given to Mrs A having an underlying malignancy. However, the chest x-ray taken on 16 January 2008 showed pneumonia and the results of blood tests performed were consistent with this. It was felt that Mrs A's emphysema may well have been the cause of her weight loss. By 21 January 2008, Mrs A's blood test results were improving, as were her chest and cough. Given this, and the fact that Mrs A was feeling better, she was discharged.

59. I sought the opinion of Adviser 1 on these issues. He told me that there was evidence in Mrs A's records that consideration was given to the presence of underlying malignancy, but the 16 January 2008 x-ray showed extensive shadowing in the lower half of the right chest, which obscured the prominence of the root of the right lung. This x-ray, taken alone, is consistent with pneumonia and an associated pleural effusion. He also noted, however, that it had been more than a year, at this point, since a CT scan had been made. He said that, in these circumstances, some specialists might have given the

pneumonia the chance to resolve over a period of around six weeks before investigating further. His own view, however, was that, given the prolonged symptoms, weight loss, Mrs A's relative good health at the time and a proper consideration of the November x-ray, a bronchoscopy and a CT scan should have been undertaken without delay. He noted that it would be good practice that such cases be discussed in multi-disciplinary meetings but there is no evidence that this was done or that the November x-ray was reviewed at this point. Adviser 1 also commented that the ultimate outcome for Mrs A would not have been different. Adviser 1 also said that, in his view, the discharge of Mrs A on 21 January 2008 was reasonable because, in the circumstances, the Board did not believe she required treatment that could not be given at home, or immediate further investigation, or that she was unable to cope at home.

60. Mrs C complained that, during Mrs A's admission to the Hospital from 29 January 2008 to 2 February 2008 (see paragraph 20), the Board did not investigate Mrs A's symptoms reasonably and she was particularly concerned that no new CT scan was undertaken during this admission. Mrs C also complained that the Board's discharge of Mrs A on 2 February 2008 was not appropriate in the circumstances.

61. The Board told Mrs C that, at this admission, her mother was noted to have right pleural effusion and that the results of liver function tests were abnormal. Mrs A received a pleural tap and the results were sent to cytology for examination. The Board told Mrs C that her family's concern that Mrs A had been discharged too early at her previous admission had been noted and explained that the decision to discharge Mrs A on 2 February 2008 took into account that Mrs A had felt much better at the weekend ward round, that her shortness of breath had improved and that she had been happy to go home. The Board told Mrs C, however, that the consultant whose care Mrs A had been under during her first and second admissions, agreed that it would have been preferable to keep Mrs A in hospital until the cytology results were available.

62. I sought the opinion of Adviser 1 on these issues. He gave his view that, given the evidence of the failure of the pneumonia to resolve, and the development of abnormal liver function tests that could not reasonably be attributed to infection, consideration of lung cancer should have been made at this stage. In his view a bronchoscopy and CT scan should have been undertaken at this stage, although subsequent events show that a diagnosis of lung cancer at this stage would have made no difference to the outcome.

Adviser 1 also said that discharge on 2 February 2008 was reasonable in the circumstances, for the same reasons as on 21 January 2008 (see paragraph 59).

(a) Conclusion

63. In commenting on this complaint, Adviser 1 has made clear that the error in the reporting of the chest x-ray taken on 26 November 2007 was crucial. This error meant that there was an unnecessary delay in the diagnosis of Mrs A's cancer. In the Adviser's view, while this delay would not have affected the ultimate outcome, it did mean a loss of opportunity for Mrs A and her family to have more time to come to terms with their inevitable loss. Adviser 1 felt that previous to November 2007 the investigation, diagnosis, care and treatment of Mrs A was reasonable, and I accept his views. The matter of whether the remark in Consultant 1's letter that Mrs A was 'entirely well and pursuing an active lifestyle without restriction' was reasonable, is one where I have not been able to reach a conclusion, as there were clearly differing views held by the Board and Mrs C's family about Mrs A's state of health at that time, and no objective record on which a definitive conclusion can be reached. Regardless of this, I am concerned that Consultant 1 may not have dictated his letter immediately after he saw Mrs C. The mis-reporting of the chest x-ray makes it more difficult to assess how reasonable the investigation, diagnosis, care and treatment of Mrs A by the Board in early 2008 was. However, I agree with Adviser 1's view that further investigations should have been carried out during Mrs A's admissions to the Hospital in January 2008 and that the case should have been discussed at a multi-disciplinary meeting. Having considered all the evidence, I agree with Adviser 1 that it was reasonable for the Board to decide that the criteria for keeping Mrs A in hospital had not been met on these occasions. Given all of the above, I partially uphold the complaint to the extent that the investigation, diagnosis, care and treatment of Mrs A from November 2007 to February 2008 was not reasonable.

(a) Recommendations

64. The Ombudsman recommends that the Board:

(i) apologise to Mrs A's family that the chest x-ray of 26 November 2007 was mis-reported and that this led to a delay in the diagnosis of Mrs A's cancer;

(ii) remind medical staff that letters to GPs should be dictated immediately after consultations with patients;

(iii) encourage the practice of discussing patients with atypical clinical features at multi-disciplinary meetings; and

(iv) take steps to assure themselves of the quality of their chest x-ray reporting service.

(b) The actions taken by the Board in response to Mrs C's complaints about the care and treatment of Mrs A were not reasonable

65. Mrs C complained that the only action the Board advised her they would take as a result of her complaints and their investigations was that the Acting Director of Operations would ensure that her thoughts and experiences were shared with members of the multi-disciplinary team.

66. I sought the opinion of Adviser 1 on this complaint. He told me that, while the action the Board proposed was reasonable as far as it went, it fell short of what he would consider to be a comprehensive response to the issues raised by the investigation of Mrs C's complaints. He felt that action should have been taken to facilitate the transfer of the care of patients with complicated pneumonia to chest consultants, to encourage the practice of discussing patients with atypical clinical features at multi-disciplinary meetings and to assure the Board of the quality of its chest x-ray reporting service.

(b) Conclusion

67. I accept the views of Adviser 1 that the Board's investigation of Mrs C's complaints should have considered the possibility that the chest x-ray of 26 November 2007 had been mis-reported and reconsideration of that x-ray should have uncovered the mis-reporting. Therefore, I uphold the complaint.

(b) Recommendations

68. The Ombudsman recommends that the Board;

(i) apologise to Mrs C that the investigation of her complaints did not uncover the mis-reporting of the chest x-ray of 26 November 2007; and

(ii) ensure that investigations of similar complaints in the future consider the possibility that x-rays, scans, test results or similar may have been mis-reported.

(c) Mrs A did not receive adequate care and treatment from the Practice between November 2007 and February 2008

69. Mrs C was concerned that, between November 2007 and February 2008, the Practice did not appropriately refer Mrs A to specialists, that those symptoms that Mrs A displayed which can be linked to cancer were not properly addressed or followed up, that Mrs A was unreasonably repeatedly prescribed

pills rather than other forms of treatment, that the Practice did not reasonably respond to changes in Mrs A's condition, and that the level of information recorded in Mrs A's notes was not reasonable.

70. Mrs C was concerned that her mother contacted the Practice several times between November 2007 and February 2008 but she was not referred to any specialists by the Practice during this period.

71. Following a review of Mrs A's records, GP 2 told Mrs C that his view was that the Practice's decisions on referring Mrs A between February 2006 and February 2008 had been appropriate.

72. I sought the advice of Adviser 2 and Adviser 3 on this issue. They told me that Consultant 1's letter to GP 2 of 4 December 2007 would have reassured the Practice that Mrs A's chest was being properly investigated and monitored by the Board, and that, from Mrs A's admission to hospital on 16 January 2008, it was reasonable for the Practice to consider her to be under the care of the Hospital. However, they felt that the frequency of Mrs A's attendance in early January 2008 should have indicated to the Practice that further investigation or discussion with specialists should have been undertaken, though Adviser 2 and Adviser 3 did not consider that there was a particular date on which it became reasonable to formally refer Mrs A to a specialist.

73. Mrs C was concerned that her mother reported, or displayed, many symptoms or signs that she, as a layperson, would have associated with cancer; such as shortness of breath, cough, wheezing, a persistent chest infection, dysphagia, blood in the stool, fatigue, vomiting, weight loss and early finger clubbing. She felt these indicators had not been properly addressed or followed up by the Practice.

74. In response to Mrs C's enquiries about symptoms that can be linked to cancer, GP 2 said 'the thought of cancer formation clearly goes through one's mind on a regular basis', but this had not been explored further by the Practice because of the facts that a persistent chest infection can take some time to clear, that the chest x-ray in late 2007 had been reported as normal, and that Mrs A had not consistently presented with the same symptoms in late 2007 and early 2008.

75. I sought the advice of Adviser 2 on this issue. She gave her view that several of the symptoms Mrs C highlighted were not properly addressed or followed up by the Practice at appointments from November 2007 onwards. Adviser 2 said that, at the appointment on 4 January 2008, when 'bronchitis' was recorded, the examination and management of her condition fell short of expected standards. At the 8 January 2008 appointment, Mrs A presented with symptoms of persistent cough, sore chest, dysphagia and blood in the stool. Adviser 2 gave her opinion that these were not adequately dealt with, and that the blood in the stool and persistent cough was not dealt with in line with relevant SIGN guidance (see paragraph 76). During the telephone consultation on 10 January 2008, Mrs A described a persistent cough. Adviser 2 told me that, in her view, GP 3's suggestion of paracetamol was not reasonable in the circumstances. Adviser 2 felt she could not comment on the adequacy of the Practice's addressing of Mrs A's symptoms at the appointments on 24 January 2008 and 5 February 2008 because the Practice's documentation of these appointments was inadequate, although by this stage the Practice could have reasonably considered that Mrs A was under the care of the Hospital.

76. SIGN guidelines 80, 'Management of patients with lung cancer', state that patients should be referred for a chest x-ray if a cough persists for more than three weeks without an obvious cause. SIGN guidelines 67, 'Management of colorectal cancer', state that GPs should perform a thorough abdominal and rectal examination on all patients with symptoms suspicious of colorectal cancer, these include rectal bleeding without anal symptoms.

77. Mrs C felt that the Practice 'fobbed off' her mother with pills rather than other forms of treatment. In response to her enquiry about the treatment the Practice provided to Mrs A, GP 2 told Mrs C that he felt strongly that Mrs A was treated appropriately.

78. I sought the opinion of Adviser 2 on this issue. She told me that, from November 2007 onward, the prescription of pills and inhalers to Mrs A was neither an appropriate nor reasonable action to address her medical issues. Adviser 2 felt that by this stage the diagnosis of a simple chest infection in a patient with emphysema was in question. In her view the Practice should have taken further history, conducted a fuller and wider-ranging examination of the chest, heart and general health, arranged investigations of other possible causes of Mrs A's presenting symptoms or discussed the case with specialists. However, Consultant 1's letter, and Mrs A's admission to Hospital from

16 January 2008, would reasonably have reassured the Practice that Mrs A's condition was being investigated and monitored by the Board at those times.

79. Mrs C felt that her mother visibly deteriorated over the last months of her life, and that the Practice did not reasonably take either individual or cumulative changes in Mrs A's condition into account in providing her with care and treatment.

80. I sought the opinion of Adviser 2 on this issue. She told me that the only change in Mrs A's condition between individual appointments recorded in the Practice's notes was a weight loss recorded on 8 January 2008. Her view was that this was not taken into account in the care and treatment of Mrs A. Adviser 2's review of the records did not show direct evidence of any other changes in Mrs A's health from November 2007 onwards, however, she felt that the frequency and persistence of symptoms could have reflected an overall change in Mrs A's health and these were not reasonably taken into account.

81. On reviewing her mother's medical records, Mrs C was concerned that the notes made by the Practice were not comprehensive.

82. I sought the opinion of Adviser 2 on this issue. She reviewed the medical records and gave her view that the record-keeping standards in the Practice were variable. She felt that GP 1's notes included adequate histories but inadequate descriptions of examinations, diagnoses and management plans, and that GP 2's notes were very brief and did not contain adequate histories, descriptions of examinations, diagnoses or management plans.

(c) Conclusion

83. While the Practice did not refer Mrs A to any specialists between November 2007 and February 2008, a previous referral had resulted in investigation of Mrs A's lungs and appointments with a cardiologist and the Practice were kept informed of the cardiology appointments that Mrs A was attending. As the Practice were aware that this aspect of Mrs A's health was being monitored and investigated by the Board, I consider it was reasonable that the Practice did not refer her to specialists in November 2007. Similarly, from the point of Mrs A's admission to the Hospital on 16 January 2008, it was reasonable for the Practice to consider that Mrs A was under the care of the Hospital and, therefore, it was reasonable that the Practice did not refer Mrs A from that point onwards. I also agree with Adviser 2 and Adviser 3 that the

evidence of Mrs A's attendances at the Practice in December 2007 and early January 2008 indicates that formal referral to specialists was not merited at this time. However, I also agree that the frequency of Mrs A's attendances in early January 2008 should have indicated to the Practice that further investigation may be required and that the Practice should, at that point, have undertaken discussion with those specialists who had been monitoring and investigating Mrs A's health.

84. I turn now to my views on the Practice's addressing and following up of the symptoms that can be linked to cancer which Mrs A reported or displayed, the Practice's prescription of pills rather than other forms of treatment, and whether the Practice reasonably took into account changes in Mrs A's condition. In my view, the Practice's actions in November 2007 and subsequent to 16 January 2008 were reasonable due to the involvement of the Board, but the symptoms reported on 4, 8 and 10 January 2008 were not adequately addressed. At this point the persistent cough had continued for more than three weeks, and this, as well as the reported blood in Mrs A's stool, was not addressed by the Practice in line with SIGN guidelines (see paragraph 76). I agree with the opinion of Adviser 2, that the prescription of pills and inhalers to Mrs A over this period was not appropriate and that further history should have been taken, fuller and wider-ranging examinations of Mrs A should have been made and discussion with specialists undertaken. I also agree with Adviser 2 that the record-keeping standards in the Practice were variable and that the notes made by GP 1 and GP 2 in Mrs A's medical records were not adequate.

85. Given all of the above, I partially uphold the complaint to the extent that the Practice did not reasonably address or follow-up the symptoms that Mrs A displayed which can be linked to cancer, that the Practice's prescription of pills rather than other forms of treatment to Mrs A was not reasonable, that the Practice did not reasonably take into account changes in Mrs A's condition and that the level of information recorded in Mrs A's notes was not comprehensive.

(c) Recommendations

86. The Ombudsman recommends that the Practice;

(i) apologise to Mrs A's family for those aspects of her care and treatment that were not reasonable;

(ii) produce a plan for reviewing their adherence to national guidelines. This plan should be minuted and form part of the Practice's clinical governance meetings. The minutes should be inspected by the Board's clinical

governance lead to ensure that the Practice have identified areas for improvement and taken action to address these issues;

(iii) ensure that national guidelines are readily available to all practitioners; and

(iv) undertake a review of clinical record-keeping using the Royal College of General Practitioners (Scotland) template on section 3D (2) of the Revalidation Toolkit. The review should be discussed with the Board's clinical governance lead to ensure that the Practice have identified areas for improvement and taken action to address these areas.

(d) The Practice's responses to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing

87. After Mrs C had exhausted the Practice's complaints procedure she remained unsatisfied with their responses. She felt that the Practice's responses were inappropriate and, in some cases, unnecessarily distressing.

88. In her letters of 26 March 2008, 27 May 2008 and 9 September 2008 Mrs C repeated the same paragraph, listing the symptoms she felt Mrs A had presented with, asked GP 2 what he associated these symptoms with and whether they were symptoms of cancer. The Practice never responded directly to these questions, although GP 2 did explain to Mrs C, in his letter of 1 May 2008, that 'the thought of cancer formation clearly goes through one's mind on a regular basis' and went on to explain why the Practice had not explored this possibility further in Mrs A's case (see paragraph 34). At the conclusion of the Practice's complaints procedure, Mrs C remained dissatisfied that the Practice had not answered her questions on this matter directly.

89. As noted in paragraphs 26 and 31 above, in letters of 5 March 2008 and 8 April 2008 the Practice suggested that a meeting would be a better way to explain some of the information that Mrs C had enquired about. Mrs C declined this offer in her letter of 11 April 2008, and explained that she was very sensitive about the subject of her mother and did not feel she could retain her composure during a telephone conversation or a meeting. She further explained that she was worried that the arrangement of these would be a waste of her own time and that of the Practice. In their letter of 1 May 2008, the Practice acknowledged Mrs C's reasons for declining a meeting. In a subsequent letter to Mrs C, of 4 June 2008, the Practice told her that they felt strongly that a meeting was required to answer her questions and suggested that such a meeting be arranged with her or other members of the family. Mrs C was

distressed that the Practice continued to suggest a meeting after she had declined one and clearly explained why.

90. As noted in paragraph 43 above, after I contacted the Board in August 2008 they told me that they had not considered Mrs C's letters to be complaints. I advised Mrs C of this, and that, consequently, she would require to make a formal complaint to the Practice before the Ombudsman could investigate her complaint. Mrs C was distressed by this because she would have to write another letter, essentially repeating the points she had previously made, and await a response from the Practice. When the Practice responded on 6 October 2008 she was further distressed by the statement that the Practice had dealt with her letters as they would have done a complaint. Mrs C felt that the response did not contain any significant new information and had served only to prolong her pursuit of the complaints she raised.

91. As noted in paragraph 25 above, when copies of Mrs A's records were sent to Mrs C, the package included an original document related to another patient of the Practice. Mrs C was distressed by this as it created doubt in her mind about the Practice's processes for ensuring the confidentiality of the information they held, which included information about her family.

92. I asked the Practice whether they had investigated how the other patient's document had been sent to Mrs C. The Practice explained that electronic scans of all patient documentation are created and held electronically by the Practice. Hard copies are returned to the GP for filing in the paper record, which is kept for only a short period of time. In this case the document had been returned to GP 1 and become entangled among the large amount of correspondence intended to be sent to Mrs C whilst GP 1 was reviewing that correspondence. The Practice said that secretaries had been instructed to check all correspondence prior to posting to ensure that only correspondence relating to that patient has been enclosed.

93. As noted in paragraph 47 above, GP 2, in his letter of 6 October 2008, stated that Mrs A had attended at respiratory clinic on 18 February 2008. Mrs C was distressed by this because Mrs A had passed away on 17 February 2008.

94. I asked the Practice for an explanation of this error. They told me that the error had occurred because the Hospital's letter to the Practice relating to

Mrs A's attendance at the clinic on 13 February 2008 had been written on 18 February 2008. The Practice apologised for this misreading of dates.

(d) Conclusion

95. The Practice clearly spent a great deal of time and effort discussing and compiling their responses to Mrs C's enquiries and complaints. It is regrettable, therefore, that Mrs C was dissatisfied with the correspondence she received from them and in reaching my conclusions on the issues Mrs C raised as part of this complaint, I have taken into account the various pressures on the time and resource of a general medical practice as well as the understandable distress of a daughter coming to terms with the sudden loss of her mother. The Practice did comment upon the list of symptoms that Mrs C first included in her letter of 26 March 2008, but Mrs C's repetition of that particular paragraph made clear that she sought a direct answer to the direct questions she asked. In my view, this was a reasonable request, and the Practice's repeated failure to provide direct answers was not reasonable. Similarly, I can understand the reasons why the Practice felt that a meeting with Mrs C would be the best way to address some of the points she raised in her letters. However, once Mrs C had clearly stated her reasons for declining these offers, my view is that it was not reasonable for the Practice to send her the letter of 4 June 2008 that repeated the suggestion of a meeting and did not provide any further information in response to Mrs C's letter of 27 May 2008.

96. During my telephone conversation with the Practice Manager in August 2008, he explained to me that the Practice had not considered Mrs C's letters to be complaints. My understanding, as a result of the discussion, was that a formal complaint to the Practice would set in motion a particular process that may result in a slightly different outcome (see paragraph 43). As this meant Mrs C's complaints could potentially be resolved between herself and the Practice, I decided that it was reasonable for Mrs C to be required to complete the Practice's formal complaints process before I considered the complaint further. It was surprising, therefore, to read in GP 2's response to the formal complaint that Mrs C subsequently sent to the Practice, that her correspondence had been treated in just the same manner as if they related to a formal complaint. While this letter was fairly lengthy, it contained no substantial new information and it is understandable that Mrs C felt it served only to prolong her pursuit of information about the care and treatment of her mother and, consequently, her distress. Given all of the above, my view on this issue is that it was unreasonable for the Practice not to make clear, previous to

October 2008, that they had dealt with Mrs C's enquiries as they would do a complaint.

97. It is regrettable that errors were made in dealing with Mrs C's requests for information and correspondence. The Practice have explained how the other patient's record was sent to Mrs C and what they have done to ensure the chance of such an error being repeated is minimised, and the Ombudsman commends them for this. The Practice have not, however, appropriately apologised to Mrs C for the distress that this error caused her. In contrast, the Practice have apologised for their error over the date of Mrs A's attendance at the respiratory clinic but they have not given any reassurance that the repetition of such errors will be minimised in the future. My view is that, although the Practice appropriately responded to some of Mrs C's enquiries and complaints, some of the Practice's responses, or lack of responses, to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing. Given all of the above, therefore, I partially uphold the complaint.

(d) Recommendations

98. The Ombudsman recommends that the Practice;

(i) apologise to Mrs C that their responses to her enquiries and complaints were inappropriate and unnecessarily distressing; and

(ii) review their complaints handling procedure to ensure that complainants are given direct answers to reasonable direct questions, that individual circumstances, distress and stated preferences are reasonably taken into account when suggesting meetings with correspondents and complainants, that it is made clear to correspondents how to set in motion the Practice's complaints procedure and that avoidable errors are reasonably eliminated, taking into account the individual circumstances of a complaint.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant, daughter of Mrs A
Mrs A	Mrs C's mother
Mr A	Mrs A's husband
The Board	Lothian NHS Board
The Practice	Mrs A's GP practice
Consultant 1	A consultant cardiologist
The Hospital	St John's Hospital
The Director	The Board's Acting Director of Operations
Adviser 1	A medical adviser to the Ombudsman, with knowledge of respiratory and general internal medicine
Adviser 2	A medical adviser to the Ombudsman, with knowledge of general practice
Adviser 3	A medical adviser to the Ombudsman, with knowledge of general practice
GP 1	A general practitioner at the Practice
GP 2	A general practitioner at the Practice, Mrs A's named GP
GP 3	A general practitioner at the Practice

Annex 2

Glossary of terms

Amoxicillin	An antibiotic
Arteriosclerosis	Hardening of the arteries
Bendroflumethiazide	A diuretic used to treat hypertension
Bronchodilator	A medication that facilitates airflow in obstructive lung diseases
Bronchoscopy	A technique to allow a patient's airways to be examined
Bronchus	A passage of airway in the respiratory tract that conducts air into the lungs
Ciprofloxacin	An antibiotic
Co-amoxiclav	An antibiotic
Cortico-steroid	A steroid hormone produced in the adrenal cortex
CT scan	Computed tomography scan; a medical imaging method used to produce a three-dimensional image of the inside of the body
Cytology	The study of cells
Dysphagia	The symptoms of difficulty in swallowing
Echocardiogram	An imaging technique used to produce images of the heart

Emphysema	Damage to the lung substance usually caused by smoking and causing chronic obstructive pulmonary disease
Erythromycin	An antibiotic
Finger clubbing	A deformity of the finger and fingernail, associated with some diseases of the heart and lungs
Lisinopril	A drug used in the treatment of hypertension and congestive heart failure
Metastatic adenocarcinoma	A cancer spreading from a tumour originating in glandular tissue
Pleural effusion	Excess fluid that accumulates in the space that surrounds the lungs
Transient ischaemic attack	Temporary brain symptoms lasting for less than 24 hours; sometimes known as a mini-stroke

Annex 3

List of legislation and policies considered

The Royal College of General Practitioners (Scotland) Revalidation Toolkit

Scottish Intercollegiate Guidelines Network Guidelines 67: Management of colorectal cancer

Scottish Intercollegiate Guidelines Network Guidelines 80: Management of patients with lung cancer

The Scottish Public Services Ombudsman Act 2002