

Case 200904100: The Golden Jubilee National Hospital

Summary of Investigation

Category

Health: Hospitals – Oncology; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns on behalf of her mother (Mrs A) about the care and treatment her late father (Mr A) received while a patient in the Golden Jubilee National Hospital, Clydebank (the Hospital). Mr A had been referred to the Hospital following a diagnosis of lung cancer and died there, several days after surgery.

Specific complaints and conclusions

The complaints which have been investigated are that:

- (a) there were unreasonable shortcomings in Mr A's care and treatment in the Hospital (*upheld*); and
- (b) there has been an unreasonable lack of clarity by the Hospital in explaining why Mr A died (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Hospital:

	<i>Completion date</i>
(i) apologise to Mrs A and her family for the failings identified in complaint (a);	10 May 2012
(ii) consider a review of the wording of the consent form a patient signs prior to surgery, so as to include the main operative risks;	31 July 2012
(iii) reflect on the comments of Adviser 1, in relation to the advice given on treatment options and the carrying out of a preoperative physiological assessment;	31 July 2012
(iv) reflect on the comments of Adviser 1, in relation to Mr A's postoperative nutritional management;	31 July 2012
(v) revise their nursing action plan, so as to address the failings identified in this report;	31 July 2012

- (vi) apologise to Mrs A and her family for the failings identified in complaint (b); and 10 May 2012
- (vii) consider obtaining a copy of the post mortem report, where a patient dies and a post mortem is instructed by the Procurator Fiscal, so as to inform the clinicians who cared for the patient and to be able to discuss the findings with the patient's family, if required. 31 July 2012

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

Main Investigation Report

Introduction

1. The complaint concerns the care and treatment Mr A received in the Golden Jubilee National Hospital (the Hospital), where he was a patient from 29 August 2010 to 9 September 2010, when he died. Mr A, following a diagnosis of lung cancer, had been referred by Inverclyde Royal Hospital to the Hospital. He was admitted on 29 August 2010 for a lobectomy, which was carried out on 30 August 2010. According to Mrs C, Mr A's operation appeared to be a success. However, four days after surgery Mr A's condition began to deteriorate and he died six days later. Mrs C and her family raised a number of concerns about Mr A's care and treatment with the Hospital. They were dissatisfied with the response to their complaint. Therefore, Mrs C, on behalf of her mother (Mrs A) complained to this office.

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

- (a) there were unreasonable shortcomings in Mr A's care and treatment in the Hospital; and
- (b) there has been an unreasonable lack of clarity by the Hospital in explaining why Mr A died.

Investigation

3. Investigation of the complaints involved reviewing the Hospital's medical records for Mr A and other documents received from Mrs C and the Hospital. As the complaint included clinical issues and nursing issues, my complaints reviewer also obtained clinical advice from a consultant thoracic surgeon (Adviser 1) and a senior nurse currently working within cardiothoracic surgery (Adviser 2).

4. 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. A glossary of terms used in this report is contained in Annex 2. Mrs C and the Hospital were given an opportunity to comment on a draft of this report.

(a) There were unreasonable shortcomings in Mr A's care and treatment in the Hospital

5. Mrs C and her family raised a number of concerns with the Hospital about the care and treatment Mr A received. This included a lack of proper

supervision and care by medical staff; delay in moving Mr A to a high dependency unit; failure or delay to carry out particular procedures and treatment; and a failure by staff to communicate with her and her family about Mr A's condition. Mrs C and her family considered that Mr A was suffering from an underlying condition in the last six days of his life which medical staff failed to detect, despite them raising persistent concerns to staff on a daily basis.

6. In their response to the complaint, the Hospital said that Mr A's medical care was closely supervised; there was no delay transferring him to a high dependency unit; and there was no failure or delay to carry out particular procedures and treatment.

7. However, the Hospital accepted it was clear from Mrs C's complaint correspondence that Mr A's experience fell below her expectations and had caused her and her family significant distress, for which they sincerely apologised. They also apologised that Mrs C and her family were not given full and appropriate information regarding Mr A's condition and informed her that her concerns would be fed back to staff involved.

8. During our investigation, the Hospital shared with this office and with Mrs C a nursing action plan which they are implementing in Ward 4 west of the Hospital, where Mr A was a patient, in order to improve future care.

Clinical Advice obtained

Adviser 1

9. Adviser 1 has told my complaints reviewer that, in considering if there were unreasonable shortcomings in Mr A's care and treatment, five areas required consideration. These were as follows: advice given on treatment options; pre-operative physiological assessment; operative risk; operative process; and post-operative management.

Advice given on treatment options

10. As he did not see Mr A's original thoracic diagnostic Computerised Tomography scan(CT scan) or his Positron Emission Tomography scan(PET scan), Adviser 1 has based his advice to me on the assumption that these investigations showed Mr A had a T1bN1 tumour in the right upper lobe of lung.

11. Adviser 1 explained that normally, before a lung resection for lung cancer is carried out, treatment options together with their advantages and

disadvantages would be discussed with the patient. This was in order to provide the patient with appropriate information so that they can make an informed decision. Adviser 1 could not find in Mr A's medical records any clinical notes from his consultation with Doctor 1 (a consultant cardiothoracic surgeon at the Hospital), nor a copy of his letter to Doctor 2 (a consultant respiratory physician at Inverclyde Royal Hospital), outlining his proposed treatment plan.

12. When commenting on the draft of this report, the Hospital provided this office with a copy of a letter from the lung cancer nurse specialist at Inverclyde Royal Hospital dated 6 August 2010 to Doctor 1, which is the referral letter to Doctor 1. This letter stated that Mr A had been advised of the extent of his disease and the possibility of surgical resection at a nurse led results clinic and provided with written information on lung cancer and lung cancer surgery. The Hospital stated this was agreed following diagnostic CT scanning and a multi-disciplinary team review at Inverclyde Royal Hospital, at which Doctor 1 and Doctor 2 were present. The letter stated 'should [Mr A] not be suitable for surgery I would be grateful if you could advise me and I will arrange for him to be referred to a Consultant Clinical Oncologist'.

13. The advice received from Adviser 1 is that the lung cancer nurse specialist would not have been able to carry out a full assessment of Mr A's respiratory physiology or disease extent. In Adviser 1's view, the nurse specialist was expecting Doctor 1 to do this. While Adviser 1 considered that the lack of documentary evidence did not mean that Doctor 1 did not discuss these matters with Mr A, he considered that if these discussions, which were important, took place then there should have been a written record made of these. However, Adviser 1 considered that offering Mr A a lung resection, possibly by a more conservative segmentectomy if the tumour location allowed this rather than by lobectomy, was not of itself unreasonable. This was provided a full risk assessment and adequate discussion with Mr A had taken place.

Pre-operative physiological assessment

14. Adviser 1 told my complaints reviewer that he had not seen Mr A's original diagnostic CT scan. It was, therefore, difficult for him to comment on the degree of Mr A's emphysema or pulmonary fibrosis. Adviser 1 said that both of these conditions would have had a bearing on the relationship between Mr A's lung function and outcome and the likelihood that a lesser lung resection, such as a segmentectomy rather than a lobectomy, would reduce the operative risk.

15. Mr A's performance status (a general measure of his physical activity and well being) appeared to have been graded as 1. This meant he was restricted in physical strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. It was noted that Mr A could walk several hundred metres on the flat but could only manage 40 steps (four flights of stairs). According to Adviser 1, this would constitute a significant restriction in relation to surgical risk.

16. Adviser 1 considered that the appropriate lung function studies were performed. These tests showed that Mr A had limited lung function and that this was more probably related to pulmonary fibrosis than to emphysema, for which there was only modest evidence, or obstructive lung disease (bronchospasm), for which there was no evidence.

17. However, given the results of these tests and Mr A's reduced lung function, Adviser 1 said he would have expected a further assessment of Mr A's fitness for a lung resection to have been carried out. This would have been done by performing a six minute walking test or measurement of VO₂ max and, in addition, a transthoracic echocardiogram. The reason for this is that these tests would have allowed a better risk assessment of the surgical treatment options.

Operative risk

18. Adviser 1 explained that, in general, the risk of death within 30 days of a lobectomy is 1 percent to 2 percent. However, given Mr A's past medical history (of vascular disease coronary artery disease, myocardial infarction, peripheral vascular disease), his reduced performance status, mild restrictive lung disease and reduced gas transfer, his mortality risk was at least 2 percent to 4 percent. Nevertheless, Adviser 1 considered that, given the better long-term outcome from a lobectomy, some level of risk to Mr A was fully justified to produce a better prognosis.

19. Adviser 1 told my complaints reviewer that he was unable to express an opinion as to what Mr A was told concerning the risks and benefits of surgery. This was because there were no clinical notes of the initial consultation between Mr A and Doctor 1 and no clinic letter from Doctor 1 to Doctor 2 in the medical records supplied to this office by the Hospital. The letter from the lung cancer nurse specialist at Inverclyde Royal Hospital (see paragraph 12) stated that Mr A had been advised of the extent of his disease and the possibility of

surgical resection and provided with written information on lung cancer and lung cancer surgery. Adviser 1 stated he had not seen a copy of this written information so could not offer an opinion on its effectiveness in relation to Mr A being in a position to give informed consent, Nevertheless, he had no reason to doubt that it contained accurate and appropriate information. However, Adviser 1 stated that although the nurse specialist would be able to provide general information about surgery for lung cancer she would not be able to provide the required information for informed consent, as she was not competent to perform the operation. While Adviser 1 considered that the information provided by the Hospital in relation to providing general advice on lung cancer to Mr A confirmed a reasonable process was in place, this did not extend to confirming the actual advice given by Doctor 1 to Mr A.

20. On Mrs C's concerns over the lack of discussion of treatment alternatives, Adviser 1 noted that the Hospital had stated that it was Doctor 1's practice to go through alternative treatments and operative risks with his patients when obtaining consent. Adviser 1 has no reason to believe this was not the case. However, Adviser 1 considered that the risk/benefit part of informed consent could only be properly undertaken when the physiological assessment was complete. On the basis of the information supplied concerning assessment, advice and the consent process, Adviser 1 told my complaints reviewer there was an absence of documentary evidence to show that these processes were properly carried out. While Adviser 1 considered that this lack of documentary evidence did not mean that Doctor 1 did not discuss these matters with Mr A, Doctor 1 was unable to prove that he did. Adviser 1 believed this was not an individual failing on the part of Doctor 1 but he considered it a failure of the Hospital's systems to require some written record of these important discussions. Whilst it was Adviser 1's opinion that there should be some written record of the information discussed with patients during a pre-operative consultation he was not aware of any obligation to do this other than as part of good medical practice. It appeared to Adviser 1 that the Hospital had followed their normal processes.

21. Furthermore, the consent form signed by Mr A stated only that the procedure, important risks and appropriate alternatives had been explained to him by the doctor/nurse/dentist on the form. Adviser 1 commented that this differed from the standard consent form in England, which required the main operative risks to be listed in the appropriate space on the consent form.

Operative process

22. Adviser 1 has told my complaints reviewer that he could find no evidence to suggest that there was any shortcoming in the operative process, either surgically or anaesthetically.

Post-operative management

23. The view of Adviser 1 was that the venothromboemolism treatment, perioperative antibiotics treatment, post-operative analgesia, post-operative fluid management, post-operative physiotherapy and mobilisation, bowel care and antiemetic treatment provided to Mr A were all of a completely reasonable standard. The same care would have been provided by the majority of thoracic surgeons.

24. Mr A's clinical notes recorded a request for advice from the dietician on 4 September 2010 but that advice was not received until 8 September 2010. A review by the dietician on 8 September 2010 confirmed that Mr A had a poor appetite and was only managing puddings and that he was not meeting his nutritional requirements. A high protein diet and resource energy drinks twice a day were recommended. However, it was also recorded that he felt that his appetite and eating were gradually improving, although this was disputed by Mrs C and her family. In response to our investigation, the Hospital stated that the nursing notes recorded that Mr A's Malnutrition Universal Screening Tool (MUST) scores on 5, 6 and 7 September 2010 were zero (no nutritional concerns) but he had a MUST score of two on 8 September 2010.

25. Adviser 1 has explained that MUST scores are generated by measuring the height and weight in order to calculate the Body Mass Index (BMI) and establishing any unplanned weight loss in the previous three to six months. A MUST score is generated on admission and then at weekly intervals during an admission or more frequently if there are significant nutritional concerns. The MUST should have associated care plans to inform clinical care, depending on the risk of malnutrition calculated. This may include referral to the dietician, but should also detail care to be delivered by nursing staff, for example, food charts to monitor intake, menu choices and use of nourishing fluids. From the clinical notes Adviser 1 has confirmed that Mr A's MUST score on admission on 29 August 2010 was zero (<5 percent weight loss). According to Adviser 1, for the dietician to decide on 8 September 2010 to score Mr A's MUST as two (>10 percent weight loss) meant that Mr A had had at least five days of virtually no food intake or a severely catabolic disease state or that the previous score

was calculated incorrectly by the nursing staff. If it was either of the first two situations these should have been identified by the nursing staff as an impending problem over the days prior to the 8 September 2010. In addition, a proactive approach with additional nutritional support should have been arranged in order to reduce the risk of Mr A achieving a MUST score of two.

26. After the possibility of Mr A's poor nutritional intake was raised on 4 September 2010, Adviser 1 could see no evidence to suggest that any particular increased assistance was given to Mr A with eating or that supervision/monitoring of his food intake was undertaken. Adviser 1 considered both would have been conventional medical and nursing practice. There was clear evidence in the notes that Mr A was nauseated post-operatively and had a poor appetite. However, Adviser 1 considered that, while Mr A's nutritional intake might have been less than adequate, there was no evidence to suggest that this had an impact on his deterioration and death.

27. As a consequence of Mr A's pulmonary fibrosis, the residual part of his right lung was slow to fill the space left by the resection of the right upper lobe. Adviser 1 explained that air may leak from the residual raw surface of the lung into the space between the residual lung and the chest wall. This air comes out through the surgically placed chest drain or sometimes enters the chest wall causing surgical emphysema. Adviser 1 told my complaints reviewer that both of these were occurring after Mr A's operation. Although this can be quite distressing for the patient and the relatives it has no impact on outcome. Adviser 1 considered the management of Mr A's air leak both intraoperatively and post-operatively followed entirely conventional lines.

28. Mr A's post-operative oxygen requirements, as judged by his respiratory rate (RR) and peripheral cutaneous oxygen saturation (SaO₂), were normal until 6 September 2010 when his RR began to rise. By 7 September 2010 he required supplemental inspired oxygen. On 5 September 2010 Mr A was producing purulent (probable infected) sputum and a sample was sent for culture. His chest x-ray that day showed a return of shadowing in the left lower lobe which had been present immediately after his operation but had cleared quickly. As he had no raised temperature, a low but acceptable SaO₂ and a stable RR, physiotherapy was continued and no antibiotic started.

29. Adviser 1 considered it would have been reasonable to have commenced Mr A on an oral antibiotic at this point given his pre-operative respiratory state,

his increasing oxygen requirements, purulent sputum and x-ray changes. In particular, his SaO₂ had been at the lower end of acceptable for two days and there were new inflammatory changes at the left base. However, Adviser 1 also considered that a reasonable body of thoracic surgeons would have withheld antibiotics because of the potential risks of worsening nausea, diarrhoea and increasing the risk of clostridium difficile super-infection.

30. On 7 September 2010 Mr A was started on an antibiotic (co-amoxiclav). On 8 September 2010 he had a temperature of up to 38.0 C but this settled quickly. The sputum culture result from 5 September 2010 was available on 8 September 2010 and showed that he had an infection which was sensitive to ciprofloxacin but not to co-amoxiclav. Mr A's treatment was, therefore, changed to ciprofloxacin. He became progressively more oxygen dependant on 8 September 2010. At this time, Adviser 1 said that he would have considered transferring Mr A to the high dependency unit. Although there were no guidelines to aid in this decision, he believed that many thoracic surgeons would have acted in this way. Transfer to the high dependency unit would have allowed increased physiotherapy and either continuous positive airways pressure or non-invasive ventilation to try to improve Mr A's oxygen saturation and reverse the developing infection in the lower lobe of his lung. However, whilst it was possible that this might have improved Mr A's lung function, there was no certainty that this would have happened. Mr A might have continued to deteriorate to the point when formal mechanical ventilation was required. In response to concerns raised by Mrs C, concerning the chest x-ray changes in Mr A's left lower lobe when his operation was on the right upper lobe, Adviser 1 explained that post-operative pneumonia can occur in any area of the lung and is not confined to the operated side.

31. Over the night of 8/9 September 2010, Mr A's oxygen requirements increased steadily with a rising inspired oxygen concentration, increasing breathlessness and falling SaO₂. A chest x-ray at 07:33 on 8 September 2010 showed a significant increase in Mr A's lower lobe shadowing and increased respiratory support was required from the early hours of 9 September 2010.

32. At 09:00 on 9 September 2010 Mr A developed right sided weakness and a provisional diagnosis of a cerebrovascular accident was made. Appropriate investigation with a cerebral CT scan was arranged. This was performed at 12:15 and showed no evidence of a major cerebrovascular accident. However, Adviser 1 has explained to my complaints reviewer that the typical radiological

changes of a major cerebrovascular accident might not have developed this early. Appropriate advice was sought from the stroke unit. It would appear that Mr A would have been accepted by the stroke unit if his condition could have been stabilised.

33. As far as Adviser 1 can determine, increased respiratory support was not forthcoming until 14:30 on 9 September 2010, when Mr A was transferred to the high dependency unit. By this time, the additive effects of his reduced respiratory function and his acute cerebrovascular accident were having a major impact. By 18:33, Mr A required to be transferred from the high dependency unit to the intensive care unit for formal mechanical ventilation and generally more aggressive support. While there was further deterioration in Mr A's condition, it was felt that continuing active treatment was not in Mr A's best interest and he was treated palliatively. Adviser 1 has told my complaints reviewer that he agreed completely with this decision.

34. From the clinical, radiological and pathological findings, Adviser 1 remained unsure as to whether Mr A's worsening respiratory function was related to pneumonic changes, which might have been amenable to treatment, or from the development of the adult respiratory distress syndrome triggered by lung infection, which responds very poorly to treatment and carries a very high mortality. Adviser 1 was of the opinion that, on balance and from the information available, it would suggest that Mr A developed adult respiratory distress syndrome and was, therefore, likely to die irrespective of the treatment given to him.

35. In conclusion, Adviser 1 told my complaints reviewer that, on the basis of the information supplied by the Hospital:

- the system for recording information provided to patients such as Mr A, in relation to discussions on the possible treatments available to them for lung cancer and for recording specific important post-operative risks/ complications, appeared poor and should be improved;
- with regard to Mr A's physiological assessment, it was his opinion that he should have had further investigation of his fitness for lung resection by either a six minute walking test or measurement of his VO₂ max and also an echocardiogram;
- the process of full clinical/physiological assessment of patients with less than good lung function appeared to be based on unsatisfactory data and should be improved;

- Mr A's operation was properly performed and his post-operative care was of a satisfactory standard;
- it was possible that earlier, more aggressive, treatment of Mr A's developing lung infection and worsening gas transfer might have changed the outcome. However, it would not be possible to determine this and, on balance, was probably unlikely to have changed the outcome;
- a major cerebrovascular accident or the development of the adult respiratory distress syndrome in the postoperative period after a lobectomy carries a very high risk of death. No immediate additional treatment that might have changed the outcome was missed; and
- Mr A's post-operative nutritional management was not adequate.

Adviser 2

36. Clinical advice was also obtained from Adviser 2, in relation to specific issues raised by Mrs C about the nursing care that Mr A received.

37. Mrs C complained that Mr A did not have a fluid chart prior to 8 September 2010 and had constant sickness. Adviser 2 has told my complaints reviewer that post-operative patients are at increased risk of volume depletion and an accurate assessment of fluid and electrolyte status can be difficult. Therefore, to ensure patients do not suffer with fluid depletion, all fluid intake and output should be measured and charted on a fluid balance chart. If a patient then has prolonged episodes of vomiting, it would be expected that a nursing assessment would ensue, resulting in the need to monitor fluid balance more closely. If Mr A was experiencing prolonged episodes of vomiting post-operatively, then a fluid balance chart should have been commenced on 3 September 2010 and any abnormalities in fluid input or output reported to the medical team. However, monitoring of Mr A's fluid balance did not appear to have been instigated in a timely manner.

38. Adviser 2 noted from her review of Mr A's nursing records that Mr A had a raised temperature on 8 September 2010. Adviser 2 considered that Mr A did receive correct care to treat the temperature at this time. However, she could see no evidence in the nursing or medical records that concerns were voiced regarding the increase in temperature. A rise in temperature should have alerted the healthcare team to possible causes of infection. Infection screens, such as a urinalysis, a sputum sample to detect a chest infection and a review of all wounds, drains and intravenous sites to look for visual signs of infection

should have been performed. There was no evidence to suggest that these actions were taken.

39. Mrs C also raised concerns that a nurse practitioner refused to contact the doctors caring for Mr A when asked to do so by her and her family. Adviser 2 has told my complaints reviewer that it would be expected that, if concerns were raised by family members to a nurse practitioner, it would be appropriate for them to assess a patient's condition, document the assessment clearly and refer to medical colleagues with the findings of their assessment and any concerns raised by family members. Adviser 2 has told me that it was not clear from the nursing records of the actions taken by the nurse practitioner or why she did not refer concerns raised by Mr A's family to a senior doctor caring for him.

40. When Mr A was showing signs of deterioration, from 7 September 2010 onwards, his physiological observations, heart rate, RR, systolic blood pressure, level of consciousness, oxygen saturation and temperature, were performed in a timely manner. However Adviser 2 has noted that at 16:15 on 8 September 2010 Mr A's Modified Early Warning Score (MEWS) was four. According to the documentation in Mr A's records, a score of four or more should result in the either the nurse in charge, medical staff and/or hospital at night nurse being informed or the frequency of observations of the patient being increased. Adviser 2 has told me there were no entries in the records to suggest any such action was taken as a result of Mr A's MEWS trigger.

41. Adviser 2 considers that, throughout, Mr A's records were not to the standards expected by the Nursing and Midwifery Council's code on standards of conduct, performance and ethics and record-keeping guidance.

42. The conclusions of Adviser 2 were that it appeared that a number of issues were raised by Mrs C and her family which were dismissed by nursing staff. Adviser 2 considered that these did not appear to have been escalated to the medical team appropriately and timely. The nursing staff did not appear to have instigated simple monitoring of Mr A's fluid balance in a timely manner and an escalation plan following an early warning score was not robust. Adviser 2 has also told my complaints reviewer that she did not consider that the nursing action plan (see paragraph 8) adequately addressed these issues.

(a) Conclusion

43. Mrs C has complained that there were unreasonable shortcomings in Mr A's care and treatment in the Hospital. I accept the advice of Adviser 1 that the process of full clinical/physiological assessment of Mr A appears to have been based on unsatisfactory data.

44. I have carefully considered the information supplied by the Hospital concerning informed consent and the advice received from Adviser 1. Having done so, I am unable to conclude with certainty that a full discussion of the treatment options was undertaken with Mr A and that this was informed by an appropriate physiological assessment. Therefore, Mr A may not have given fully informed consent with regard to whether he wished to have surgical, non-surgical treatment or no treatment. In this respect, the design of the consent form signed by Mr A is particularly weak. I accept the advice of Adviser 1 that, while this is not an individual failing of Doctor 1, it is a failure of the Hospital's systems to require a written record of these important discussions.

45. I further accept the advice of Adviser 1 that Mr A's post-operative nutritional management was not adequate.

46. However, I accept the advice of Adviser 1 that, overall, Mr A's operation was properly performed, his post-operative care was of a satisfactory standard and that other or additional treatment following his surgery is unlikely to have changed the outcome.

47. Nevertheless, I have noted that the Hospital have accepted that it was clear from Mrs C's correspondence that Mr A's experience had fallen below Mrs C's expectations and had caused her and her family significant distress, for which they sincerely apologised.

48. I have also taken account of the advice I received from Adviser 2. Based on this, I find that, for the reasons set out in her advice to my complaints reviewer, there was a failure by nursing staff not only to address concerns raised by Mrs C and her family but to escalate those concerns to the medical team appropriately and timely. Furthermore, there was a lack of fluid balance monitoring by nursing staff and an escalation plan, following an early warning score, was not robust. I have also noted that Adviser 2 does not consider that the nursing action plan produced by the Hospital adequately addressed these issues.

49. In light of the failures identified, I conclude that there were unreasonable shortcomings in Mr A's care and treatment in the Hospital and I, therefore, uphold this complaint.

50. In light of these findings, I am making the following recommendations to the Hospital.

(a) *Recommendations*

	<i>Completion date</i>
51. I recommend that the Hospital:	
(i) apologise to Mrs A and her family for the failings identified;	10 May 2012
(ii) consider a review of the wording of the consent form a patient signs prior to surgery, so as to include the main operative risks;	31 July 2012
(iii) reflect on the comments of Adviser 1, in relation to the advice given on treatment options and the carrying out of a pre-operative physiological assessment;	31 July 2012
(iv) reflect on the comments of Adviser 1, in relation to Mr A's postoperative nutritional management; and	31 July 2012
(v) revise their nursing action plan, so as to address the failings identified in this report.	31 July 2012

(b) There has been an unreasonable lack of clarity by the Hospital in explaining why Mr A died

52. Mr A's death was reported to the Procurator Fiscal, as Mrs C and her family were unhappy with the care Mr A had received at the Hospital and because, at the time he died, the exact cause of his death was unknown. The Procurator Fiscal instructed a post mortem to be carried out.

Clinical advice received

53. Adviser 1 has told my complaints reviewer that initially the medical staff providing care for Mr A in the intensive care unit at the time of his death were not sure as to the cause of the cerebrovascular accident. Also, they were unsure of the degree to which Mr A's post-operative pneumonia (chest infection) had impacted on the cerebrovascular accident and the cause of the right ventricular distension seen on the transoesophageal echocardiogram, which raised the possibility that there had been some problem with the stent in

the right coronary artery (either a blockage or movement). Adviser 1 has told my complaints reviewer that he assumed this uncertainty was picked up by Mrs C and her family.

54. Adviser 1 could find no mention in Mr A's clinical notes about what information was given to Mrs C and her family during the afternoon and evening of 9 September 2010. Adviser 1 also could find no evidence in the intensive care communications log of what information was provided to them. It was recorded that Doctor 3 spoke to Mr A's family at about 18:30 on 9 September 2010. However, Adviser 1 has not seen a record of what was said and there was no record of any other meetings that afternoon or evening in Mr A's notes. Adviser 1 says that he would have expected Mr A's family to have been told that it was not possible to establish a certain cause of death with such a sudden deterioration. However, they should have been told that the main cause of death might have been the cerebrovascular accident, rapidly developing pneumonia, a myocardial problem or a pulmonary embolus, with any of the others having a contributory effect.

55. According to Adviser 1, an initial clinical cause of death is simply the best medical assessment that can be made on the available evidence. Mr A's death was reported to the Procurator Fiscal because of medical uncertainty as to the cause of his death, which Adviser 1 says is a far commoner event than might be expected and because of the concerns which Mr A's family had about his care.

56. Adviser 1 has told my complaints reviewer that the initial post mortem result gave the cause of death as pneumonia and cerebrovascular disease but did state that further investigations were underway. The final post mortem results showed that the cause of death was:

1a - acute cerebral infarction: loss of blood supply to an area of brain with complete failure of that area of brain, a cerebrovascular accident or stroke. The cerebral infarction was diagnosed from the changes seen on the microscopic examination of the brain tissue and severe cerebrovascular disease was seen. Adviser 1 assumed that there were no obvious macroscopic (naked eye) changes, as would be expected if death occurred early after the loss of blood supply and before obvious macroscopic change had become obvious. This explained the initial post mortem finding where cerebral infarction is not mentioned;

1b - diffuse alveolar damage: reported as consistent with the adult respiratory distress syndrome superimposed on a background of chronic lung fibrosis and with changes of lower lobe pneumonia; and

1c - pulmonary thromboemboli: these, according to Adviser 1, were very small and were really an incidental finding and not part of the cause of death.

57. There was no evidence of any failure of the technical aspects of the surgery and no evidence of a problem with the coronary stent.

58. Adviser 1 considered that the final cause of Mr A's death was quite clear. Although Adviser 1 considered there was nothing to suggest that there was any deliberate attempt to mislead Mrs C and her family as to the cause of Mr A's death. However, he was of the opinion that a copy of the post mortem report should have been obtained by the Hospital, both to inform the clinicians caring for Mr A in his final illness and to check if Mr A's family wished to discuss the findings.

(b) Conclusion

59. I am satisfied that there was initial uncertainty by medical staff about the cause of Mr A's death because of his sudden deterioration. I, therefore, accept that medical staff would not have been in a position, at the time Mr A died, to provide Mrs C and her family with a certain cause of death. Adviser 1 has told my complaints reviewer, however, that he would have expected that medical staff would have clearly explained to Mr A's family the reasons why it was not possible to establish a certain cause of death at the time Mr A died and what the main cause of his death might have been.

60. However, given the lack of information in Mr A's medical records about what information was given to Mrs C and her family, Adviser 1 has told my complaints reviewer that he is not able to say how well this was explained to Mrs C and her family in the period after Mr A's death.

61. Furthermore, I accept the advice of Adviser 1 that the clinicians caring for Mr A in his final illness should have obtained from the Procurator Fiscal a copy of the post mortem report, not only to inform the clinicians about the causes of Mr A's death but also to see if Mr A's family required further information or a meeting to answer their questions concerning Mr A's deterioration and death.

62. Therefore, while I accept the advice of Adviser 1 that there is nothing to suggest that there was any deliberate attempt to mislead Mrs C and her family as to the cause of Mr A's death, I have concluded there was an unreasonable lack of clarity in explaining to them why Mr A died. For this reason; I uphold this complaint.

(b) Recommendations

63. I recommend that the Hospital:	Completion date
(i) apologise to Mrs A and her family for the failings identified; and	10 May 2012
(ii) consider obtaining a copy of the post mortem report, where a patient dies and a post mortem is instructed by the Procurator Fiscal, so as to inform the clinicians who cared for the patient and to be able discuss the findings with the patient's family, if required.	31 July 2012

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

Explanation of abbreviations used

Mr A	Mrs C's late father and the subject of the complaint
The Hospital	The Golden Jubilee National Hospital, Clydebank
Mrs C	The complainant
Mrs A	The aggrieved, the mother of Mrs C and the wife of Mr A, the subject of the complaint
Adviser 1	The Ombudsman's surgical adviser
Adviser 2	The Ombudsman's nursing adviser
CT scan	Computerised tomography scan
PET Scan	Positron emission tomography scan
Doctor 1	A consultant surgeon at the Golden Jubilee National Hospital
Doctor 2	A consultant respiratory physician at Inverclyde Royal Hospital
MUST	Malnutrition Universal Screening Tool
MEWS	The Modified Early Warning Score (MEWS).
Doctor 3	A consultant anaesthetist at the Golden Jubilee National Hospital

Glossary of terms

Antiemetic treatment	Treatment to prevent or alleviate nausea and vomiting
Catabolic disease	A condition characterised by weight loss and loss of fat and skeletal muscle mass
Cerebrovascular accident	A stroke
Echocardiogram	A test that used ultrasound waves to create an image of the heart
Emphysema	A chronic lung disease
Infective consolidation	When a part of the lung becomes infected and filled with fluid
Lobectomy	Surgical removal of a lobe of the lung
Lung resection	Surgical procedure to remove a portion or the whole of a lung
MEWS score	A modified early warning score system in use at the Hospital
Perioperative	The period of time from the hospitalisation of a patient for surgery until the time of discharge
Peripheral cutaneous oxygen saturation (SaO ₂)	The percentage of available haemoglobin which is saturated with oxygen
Pulmonary fibrosis	A scarring of the lungs due to chronic inflammation

Pulmonary thromboemboli	Blood clots which cause blockage of blood vessels in the lung
Respiratory rate(RR)	The number of breaths taken within a set amount of time, typically a minute
Segmentectomy	Surgical removal of a part of the lung
T1bN1 tumour	The stage of Mr A's tumour
Transoesophageal echocardiogram	A diagnostic test using an ultrasound device to create a clear image of the heart muscle and other parts of the heart
Transthoracic echocardiogram	A diagnostic test which shows whether there is any ventricular dysfunction causing limitation in physical activity
Venothromboemolism treatment	Prevention of a blood clot in a vein
VO2 max	This measures the gas transfer function of the lungs