THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

St. Andrew's House
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NHS Circular:
MEL(1993)2

15 January 1993

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General Manager, Common Services Agency

General Manager, State Hospital

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(epitomes only)
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To be copied to Unit Managers for action

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Dear Colleague

REPORT OF THE HEALTH SERVICE COMMISSIONER: SELECTED INVESTIGATIONS COMPLETED APRIL-SEPTEMBER 1992

Summary

1. The enclosed report by the Health Service Commissioner highlights shortcomings in the provision of health care. The report is published to enable all those involved in health care to learn from the cases investigated by the Commissioner.

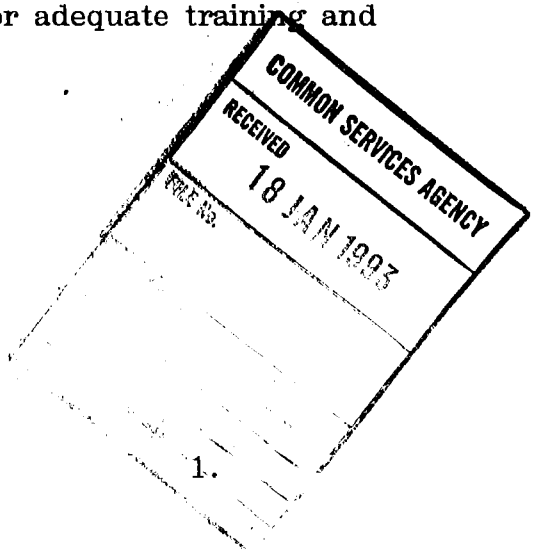
Background

2. The Commissioner's 6 monthly reports give detailed accounts of a selection of cases investigated and reported on during the period. The shorter summary version (epitomes) included in the report are suitable for a wide distribution among staff. A separate copy of the epitomes is enclosed for copying purposes.

3. The press release issued by the Commissioner's office identifies poor systems and ineffective procedures as factors in a number of cases investigated. The Commissioner considers that senior staff should ensure not only that the necessary procedures are in place but also that the procedures are understood and put into practice. A copy of the first page of the press release is enclosed.

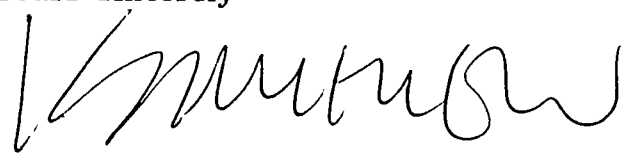
Action

4. General Managers and Chief Executives are asked to distribute the epitomes and press notices widely within their organisations and to encourage reviews of procedure where necessary. These should focus particularly on the Commissioner's comments on the need for adequate training and guidance to junior staff.



5. General Managers should also consider more general lessons arising from these cases and should be aware that this may be followed up in the Accountability Reviews.

Yours sincerely



ISABELLE LOW
Director of Health Care

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HEALTH SERVICE COMMISSIONER OMBUDSMAN ENGLAND SCOTLAND WALES

press notice

BACKGROUND NOTE FOR THE LOBBY 10 DECEMBER 1992

NOT FOR PUBLICATION, BROADCAST OR USE ON CLUB TAPES BEFORE 14.30 HOURS ON THURSDAY 10 DECEMBER 1992. THIS DOCUMENT IS ISSUED IN ADVANCE ON THE STRICT UNDERSTANDING THAT NO APPROACH IS MADE TO ANY ORGANISATION OR PERSONS ABOUT ITS CONTENTS BEFORE THE TIME OF PUBLICATION.

"Poor systems block progress towards higher standards of service", says Health Service Ombudsman

Mr William Reid, the Health Service Commissioner (or Ombudsman), found examples of poor systems or procedures in many of the health authorities featuring in 16 cases selected today for publication from the total of 52 investigations completed between April and September 1992*. The volume contains both a summary and the full text, in anonymised form, of each of the 16 cases.

Commenting on his report Mr Reid said:

"Improvements to the service given to patients are blocked if there are poor systems or ineffective procedures in place. Several of my investigations have been into admission procedures to hospital. They show clearly that lack of system and poor communications can result in distress and inconvenience to patients and their relatives. Some of my investigations reveal a sorry catalogue of ineptitude. This is particularly to be deplored when so much helpful guidance has been issued by professional bodies to their members in the NHS as well as by Health Departments.

"Many of the members of staff providing care or implementing procedures are quite junior. Unless they are adequately trained, supported and supervised, things can go badly wrong. Senior staff have a responsibility to instruct and guide them, and the junior staff should put into practice the well-thought out guidance they receive from their professional bodies.

"I ask all NHS senior staff please to pay close attention not just to ensuring that there are proper procedures but also to seeing that those procedures are understood and put into practice. Adequate training and guidance are essential if staff are to deliver improved services to patients in the NHS. The admission of a patient to hospital should be a routine and well-ordered matter but for the patient it is usually a major event. That is why communications need to be clear, and the procedures and the actions of staff need to be well organised in order to avoid unnecessary worry and confusion for the patient and relatives concerned".

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*Report of the Health Service Commissioner: Third Report, Session 1992/93. Selected Investigations completed April 1992 - September 1992. HMSO £14.25 HC 302

HEALTH SERVICE COMMISSIONER
THIRD REPORT TO PARLIAMENT FOR SESSION 1992–93 HC302
EPITOMES OF SELECTED CASES FOR
THE PERIOD APRIL TO SEPTEMBER 1992

1. Failures of communication before and after an admission for surgery – W.149/91–92

Matters considered

Contradictory information before admission – arrangements on later admissions – confusion over transport arrangements and purpose of an appointment – failure of a later appointment.

Summary of case

A woman was due to have varicose vein surgery. She complained that she had been given contradictory information about whether to continue her anticoagulation treatment before her operation, and about a change in the date of admission. About a month after her operation she was readmitted. The consultant was away and she was discharged without the treatment she was expecting. When she was admitted yet again, she complained about the completion of an admission sheet, the absence of an identification bracelet and the interval before seeing a doctor. She was referred to another hospital for tests but there was confusion about the transport arrangements. When she arrived, she found that the professor in question did not have a clinic that day and that the tests could not be carried out. A month later she was expecting an appointment with him at a third hospital: arrangements for it fell through.

Findings

My investigation revealed serious failures of communication among staff and between staff and the woman. A registrar had not seen it as his responsibility to ensure that the woman was advised about her anticoagulation treatment. He had not made his intentions clear about the date of her first re–admission. The consultant, who had agreed the next admission with the woman, did not tell either the ward staff or the registrar of these arrangements, or of her expected treatment, before he went on leave. I found that during her next admission an admission sheet had been completed and she had been seen by members of the consultant's team more often than she recalled; she had not been given an identification bracelet. What happened on the day of the woman's visit to the hospital typified spectacularly inept communications. Ambulance transport was booked but did not arrive in time; the appointment had been made by the registrar in the mistaken belief that the consultant only wanted further tests to be done; the tests could not be carried out because of her clinical condition. Finally, I could not establish why the later appointment at the third hospital had fallen through, although the consultant was not to blame for what had happened.

Remedy

The health authority concerned apologised for the shortcomings and agreed to my recommendations about improving communications by stressing to medical staff the importance of clear communications both with patients and between specialties, and of documenting plans clearly in clinical records; action by a resource group on admission arrangements; clarifying policy on the use of identification bracelets; agreeing a policy on use by in–patients of their own transport; and the regular audit of a communications policy.

2. Care of an elderly patient – W.190/91–92

Matters considered

Development and management of a pressure sore – nutrition – delay in prescribing drugs – staffing levels – handling of complaint by the health authority.

Summary of case

An elderly woman fractured her hip and was admitted to hospital. The operation she needed was postponed several times, and she developed a deep pressure sore and became depressed. She died in the hospital five weeks after her admission. The woman's daughter complained that her mother's pressure sore had been allowed to develop in hospital and had been poorly managed, that she had been inadequately fed, that there had been delays in prescribing drugs for her depression and that there had been too few nurses to provide the necessary standard of care. The daughter raised these matters during a meeting with the health authority but did not feel that all her questions had been answered.

Findings

Several factors at the hospital had contributed to the development of the woman's pressure sore – she had spent too long on a trolley in the accident and emergency department, there had been a shortage of pressure-relieving equipment and she had not been turned as often as she should have been. Repeated cancellations of the hip operation had meant that the woman's food intake was limited during her first few days in hospital. Thereafter, she had frequently been unwilling to eat and, because of competing demands upon them, nurses had been unable to spend as much time encouraging her as they would have wished. Delays in referring the woman to a psychogeriatrician had meant that an expert assessment of whether she should be prescribed anti-depressants had never taken place. Nurse staffing levels had been inadequate and the woman had not received the degree of attention her medical condition demanded. The meeting with the woman's daughter had been poorly handled and some of the points she had raised had not been addressed.

Remedy

The authority apologised for the shortcomings I had identified. Before my investigation began there had been improvements in the supply of pressure-relieving equipment and in staffing levels. They assured me that the NHS Trust, which now administer the hospital, would ensure that wards continued to be adequately staffed to meet the needs of patients with pressure sores and that nurses kept comprehensive records of the care given to such patients. The Trust also agreed to re-examine procedures for allocating theatre time; to ensure that food was available for patients whose operations were unavoidably delayed; to ensure that where nutrition was of particular importance proper records were maintained of food intake; and to remind staff of the importance of providing written responses to all points of concern raised by complainants.

3. NHS care provided in a private nursing home – W.217/91–92

Matters considered

Handling of the complaint by the health authority concerned.

Summary of case

A woman's father, who had previously received care within the NHS, was admitted for two weeks respite care to a former NHS nursing home the management of which had been taken over some two months earlier from the health authority by a charity. When he was discharged two burn–like marks were discovered on the inside of his left thigh. The woman wrote to the general manager of the charity about the marks and to seek clarification of a statement, in a letter sent to her father after his discharge, that any future respite care provided at the nursing home would be subject to charges. She copied her letter to the authority's registration officer for nursing homes. The woman was subsequently told that the marks had been caused by the way her father tended to grip his leg, and the general manager proposed a meeting at which a senior nurse from the authority would be present so that any further questions could be answered. The woman complained to me that she had received no satisfactory explanation for the marks on her father's leg or for the fact that respite care formerly provided by the NHS had become subject to charges. What was more, no–one from the authority had attended the arranged meeting.

Findings

I found no evidence to suggest that there was any other explanation for how the woman's father had developed the marks on his thigh. I criticised the fact that no–one had told the man's family, while he was still in the nursing home, about the damage he had been causing to himself. I discovered utter confusion about whether patients in the same position as the woman's father were entitled to respite care free of charge after the charity had assumed responsibility for the management of the nursing home – though from detailed study of the relevant agreements I was satisfied that the admission in question was under the NHS. Few if any of the staff involved in implementing the new arrangements had a clear – or shared – understanding of the man's status or of what respite care at the nursing home was to be funded by the NHS at the material time. I was not surprised, therefore, that neither the authority nor the charity had been able to explain to the woman why the question of fees had arisen in her father's case. I upheld her complaint. The authority had not been represented at the arranged meeting and I was not persuaded that adequate attempts had been made to ensure that. I upheld that aspect of the complaint also.

Remedy

I looked to the authority to clear up the confusion about charges evident in this case, and they apologised for the shortcomings I had identified. They agreed to ask the charity to remind all nurses of their duty to record unusual incidents and to inform relatives about any untoward developments in a patient's condition at the earliest opportunity.

4. Failures in admission procedures – W.255/91–92

Matters considered

Twice called for admission at unsuitable times – refusal by staff to identify themselves – inadequate response to complaint.

Summary of case

A man was called for admission to hospital while he was on holiday though he had previously

telephoned to tell them he would be away. On his return he telephoned for a new date for surgery but was told that, because three consultants were involved, that might take some time to rearrange. Six months after the first admission date he received a letter telling him to come on a date six months ahead. On arriving there the man was told that the surgeon was on leave and that his operation was not scheduled. He complained orally and was told that the matter would be investigated and brought to the attention of one of the consultants on his return from leave. The complainant telephoned the hospital several times for a new admission date, but his calls were not returned and those to whom he spoke would not give their names. He wrote a letter of complaint requesting a new date to the hospital's general manager who apologised for the unsatisfactory admission arrangements, but did not answer the specific complaints about the difficulties in the admission procedure or offer a new date for surgery.

Findings

I found chaos. Because there was no procedure for making a note of telephone calls about admissions, the man's holiday dates had not been recorded. I was unable to establish why the letter of admission had not been sent out until a few days before the intended date for surgery, even though that date had been set three months earlier. When the man failed to keep the appointment the consultant responsible for his care considered that he was no longer his patient. I deplored the consultant's discourtesy in not telling the man of that or formally asking another consultant to take over responsibility for his care. The registrars working for the different consultants were confused about who had responsibility for confirming the admission. Later the admissions office altered the date from 1990 to 1991, with the result that the man was called for admission again exactly one year after the first date. Every month the admissions office sent each consultant a list of his operating schedules, but in this case a registrar believed the discrepancy in dates to be a clerical error and took no further action. I upheld the complaints. I recognised that some staff felt vulnerable about giving their names over the telephone and I did not uphold the complaint about that. The hospital did not have an acceptable complaints procedure, and I criticised the general manager for his failure to investigate the complaint adequately and his ineffectual response.

Remedy

The health authority apologised for the shortcomings I found and agreed to review their admission procedures and clarify the way in which patients were transferred between consultants. They undertook to clarify policy about the telephone disclosure of staff names, to appoint a designated officer for complaints and to produce a local complaints procedure which conformed with guidance from the Department of Health.

5. Misleading information about position on waiting list – W.358/91–92

Matters considered

Information given to complainant – attitude of staff – communications among staff – staff training – handling of complaint.

Summary of case

At an out–patient clinic in January 1990 a woman was told that she could expect to wait about three to four months for a hip replacement operation. From April onwards her son telephoned the hospital to check what was happening, and he was told in June that she was at the top

of the waiting list. Despite regular telephone calls after that his mother was still not called for her operation. The woman attended the clinic again in March 1991, and the consultant referred her for treatment to another hospital where she had to join another waiting list. The son complained that he had been given misleading and inaccurate information by the consultant's secretary and that she had failed to pass information to the consultant. He was also dissatisfied with the health authority's response to his complaint.

Findings

Although the consultant's secretary had told the man his mother's position on her section of the list, she had failed to set that in the context of the competing demands of other sections of the consultant's waiting list. The information was therefore misleading. I was persuaded that the secretary had relayed the man's messages to the consultant, but her lack of experience and assertiveness meant that she had not conveyed to him the man's increasing concern. She was in her first job, was given little time for dialogue with the consultant and had no support from her managers. For such a demanding post that was very unsatisfactory, and I criticised the authority for failing to provide adequate training and support. My investigation also revealed an unexplained failure to arrange an intended follow up appointment ordered in an unsigned entry in the records after the clinic in January 1990, and I criticised that. Had that appointment been made the woman might well have received treatment much sooner. As to the handling of the complaint, the responses were unduly delayed and their content did not match up to the criteria demanded in the authority's own procedures. I noted with approval that they had introduced revised procedures for monitoring the handling of complaints, and I upheld both aspects of the man's concerns.

Remedy

The authority apologised for their shortcomings and agreed as a matter of urgency to implement induction and skills training for new secretarial staff, and to remind staff of the importance of signing and dating entries made in the medical records.

6. Delay in locating records – W.369/91-92

Matters considered

Ward cover for obtaining medical records for an emergency admission –explanations and assurances to complainant.

Summary of case

A woman was admitted as an emergency to a hospital run by a NHS Trust, but her medical records had still not been found by the time of her death some one and a half hours later. Her husband complained that the delay had resulted from administrative shortcomings, and that the Trust had not been able to assure him that steps were being taken to improve the administration of medical records.

Findings

A reorganisation of staff duties had left the medical wards without clerical support in the afternoons. This meant that ward staff needing records urgently had to rely on the out-patient clinic clerks, an informal arrangement depending on goodwill. On the day in question no-one

was at first available to look for the records. When a search took place a little later they could not be found, having apparently been incorrectly routed when being returned from an out-patient clinic. Immediately after clerical cover was provided for the wards in the afternoons. I recommended that staff in the out-patient clinics should be reminded of the need for care in ensuring that records were correctly dispatched. I criticised the Trust for being less than truthful in the explanations they gave to the complainant about the cause of the failure, but I was satisfied that he had been correctly told of the steps taken to prevent a recurrence.

Remedy

The Trust apologised for their shortcomings and agreed to implement my recommendation.

7. Provision of radiologist's report a condition of taking a private x-ray - W.384/91-92

Matters considered

Provision of radiologist's report - information to private patient about charges for treatment - liability for charges.

Summary of case

A private patient was referred by his dentist for an x-ray in a NHS hospital's radiology department. He was charged for both the x-ray and a radiologist's report, despite the dentist's instruction that no report was required. The complainant contended that the authority's view that carrying out the x-ray was conditional upon providing a report as well was without justification.

Findings

The dentist said that he had no need for a report as he considered himself capable of interpreting the x-ray. The radiologists' position was that they were trained to interpret x-rays, and that a report was an integral part of a high quality service - a view supported by the Royal College of Radiologists. The radiologists had clinical responsibility for the radiology service, so I saw no maladministration in the health authority's acceptance of their professional views. However I found that, contrary to guidance by the Department of Health on the management of private practice in NHS hospitals, the complainant had not been told in advance of *all* the charges for which he would be liable. He had not been told that he would have to pay for the radiologist's report. Moreover, he had signed only a radiology department form and not a prior 'agreement to pay'. There was clear evidence of maladministration, the authority collecting for a commission consultants' fees as well as hospital charges. I upheld the complaint.

Remedy

The authority apologised for the shortcoming and at my recommendation made the complainant an ex-gratia payment in respect of the report fee.

8. Handling of complaint by family practitioner committee - W.496/91-92

Matters considered

A request that a complaint be handled informally was disregarded.

Summary of case

A woman wrote to a Family Practitioner Committee, as it then was, seeking information about the source of medication received by her mother before her death. The Committee told her how that information might be obtained and asked how she wished to proceed. The woman said that she wanted the matter to be dealt with initially by a lay conciliator under the informal procedure. She was subsequently invited to attend a medical service committee under the formal procedure. The woman complained to me that her initial wish had been disregarded.

Findings

Guidance on the handling of complaints was issued by the Department of Health in April 1990. The woman's request that her case be handled under the informal procedure was quite clear. I found that an officer of the Committee incorrectly presumed that, as there was no-one available for lay conciliation in the area in which the woman lived, informal handling was not an available option. The chairman might have acted as conciliator, and that possibility should have been explored before the case was referred to the chairman of the medical service committee. By putting the case directly to the chairman of the medical service committee the officer closed off the option of informal handling. That was not explained to the woman, nor was she given the chance to object. I criticised the failure to establish effective arrangements for lay conciliation and I upheld the complaint.

Remedy

The family health services authority, as the Committee became, apologised for the shortcomings and told me that they were to consider, in September 1992, the conclusions of a review of complaints procedures. I recommended that the review should identify areas for improvement and in particular that (a) it should be made clear to staff that complainants ought be told when, and why, their request for a complaint to be dealt with in a particular way could not be accommodated and given the opportunity to express a view before irrevocable action was taken; and (b) lay conciliation should be made available for the whole of the authority's area.

9. Failure to monitor patient's condition and to respond to requests for discussion with doctor - W.507/91-92

Matters considered

Monitoring of patient's condition - attitude of senior house officer and supervision of him by consultant - action by nurse on requests to see a doctor - adequacy of records.

Summary

An elderly woman was admitted to hospital as an emergency after becoming breathless at home. She was examined shortly after her arrival by the senior house officer. Neither the woman nor her husband was given any information about a possible diagnosis or treatment, or how long she might expect to stay in hospital. The woman was transferred to a second

ward where her husband stayed with her for most of each day. They asked the nurses repeatedly if they could speak to the consultant or another doctor about her condition. Right up to the consultant's ward round *six days later* they were given conflicting information about the availability of medical staff to see them. The woman died unexpectedly that evening. Her husband complained that she had been seen only once by a doctor, that a subsequent claim by the hospital that his wife had been monitored regularly by the medical team was not supported by entries in the clinical records, and that repeated requests to speak to a doctor about her condition had not been met.

Findings

I found that the woman had been examined on admission by the senior house officer, by another doctor the next evening after her transfer to the second ward and, on the day of her death, by the consultant during his ward round. The clinical records contained no entries between those made on her admission and those written up after the ward round six days later. The consultant attributed that to her stable condition and said he had been satisfied with the level of medical monitoring the woman had received. I would normally have regarded that as a matter of clinical judgment but, contrary to the assertions of the consultant and the senior house officer, the evidence did not convince me that any medical examinations had taken place in the intervening period. Surprisingly there was no mention in the nursing records of the frequent requests which the couple had undoubtedly made to see a doctor. The senior house officer could only recall receiving one request from nurses but admitted that persistent requests of that kind could be annoying and that he tended to 'blank' them out. I found his attitude and behaviour wholly unacceptable, and the consultant's supervision of his work ineffectual. Whether or not the woman and her husband should have been told by either of them about the diagnosis of lung cancer, they were entitled at the very least to a discussion with one of the doctors responsible for providing care. I upheld the husband's complaints.

Remedy

The authority apologised for the shortcomings I found and agreed to inform me what the Trust (which now administer the hospital) would do to satisfy themselves that such failures in service would not be repeated. I was told that the consultant had dealt formally with the behaviour of the senior house officer, that all consultants would be reminded of their responsibilities for supervising junior medical staff and of the importance of good record keeping, and that the nurses would be reminded of the need to maintain accurate records.

10. Provision of ambulance services – W.508/91-92

Matters considered

Failure to provide pre-arranged ambulance transport – reimbursement of taxi fares – handling of the complaint.

Summary of case

On two occasions in the same month in 1990 ambulance transport arranged through a general practitioner failed to arrive to take a man's elderly mother to an appointment at a pacemaker clinic. Because the man was concerned that his mother should not miss the second appointment, he took her to the clinic by taxi at a cost of £23.00. He complained to the chief executive of the ambulance service about what had happened but he was dissatisfied with the

response he received two months later. He therefore wrote again repeating his complaints and seeking reimbursement of the taxi fare. He was visited twice by a member of staff from the ambulance service before being told, *eight months later*, that there was no facility to reimburse claims for travel costs.

Findings

I found that, contrary to what the ambulance service had told the man, they did have a record of the first request for transport but had failed to act upon it. Transport arranged for the second appointment had had to be cancelled at short notice as no ambulance was available. The chief executive volunteered that the level of service had been unacceptable at the time. I upheld the complaint. When the man asked the ambulance service for reimbursement of the taxi fare he was told to apply through a Department of Health scheme for the refund of hospital fares. I found that advice was wrong, as the deadline for such a claim had long since passed and the scheme did not apply to someone who had needed ambulance transport on medical grounds. There was nothing in writing to guide staff on how to deal with ex-gratia payments and I criticised the ambulance service for that, particularly as such payments had previously been made. I also upheld the complaint about the ambulance service's poor handling of the man's complaints. Their investigation had failed to establish that they had received the first request for ambulance transport, and their response to the man's further representations piled delay on delay. I noted with approval that the ambulance service had introduced new guidance for the handling of complaints.

Remedy

The ambulance service (a) agreed to make an ex-gratia payment to the man for the expenses he had incurred and to issue guidance to staff about such payments; (b) agreed to ensure that staff involved in complaints work were trained in operating the revised procedures; and (c) apologised for the shortcomings I had identified.

11. Damage caused by an absconding patient - W.525/91-92

Matters considered

Health authority's immediate response to the breakage of window in a house near the hospital - consideration of financial loss.

Summary of case

One night a patient who was in a psychiatric unit for assessment became very disturbed and left by throwing himself naked through a window. He then crashed through the window of a family's home causing considerable distress and damage to himself and the property. Later that day a nurse manager from the hospital, who was aware of the damage caused, told the family by telephone that the hospital was not responsible for the patient's actions because he was an informal patient and free to leave the hospital grounds at any time. No help was offered to the family who pursued the matter with the authority but were dissatisfied with their response. They complained to me that no one from the authority had visited them, no support or counselling had been offered and insufficient consideration had been given to the uninsured loss they had suffered.

Findings

The main obstacle to staff visiting and providing support to the family had been what I regarded as a narrow consideration that to have done so could have implied acceptance of responsibility. The authority's proclaimed policy was that care and concern should be demonstrated to all members of the public. I criticised them for failing to live up to it and upheld the complaints that no one had visited or offered support or counselling. My investigation revealed that the legal advice which they received was that, because of the informal status of the patient, they had no legal duty to pay compensation to the family, though they could make an ex-gratia payment without admission of liability. Despite that advice, the chairman chose not to pay. Patients have informal status unless or until they are detained under a section of the Mental Health Act 1983, but when the man left the hospital he had still not been assessed. I considered that in those circumstances the authority had a higher duty of care, and that they had taken a view which would seem nonsensical to the layman. The circumstances of the patient's departure were a long way from what might be expected of an informal patient. I invited the authority, as an act of grace, to make a payment without acceptance of liability.

Remedy

The authority apologised for the shortcomings but I noted without enthusiasm that they agreed to make a payment, without prejudice, equivalent to only half of the family's uninsured loss.

12. Delayed notification of death to next-of-kin and inadequate handling of complaint -W.806/91-92

Matters considered

Staff access to hospital records – disposal of patient's property – handling of the complaint.

Summary of case

An elderly woman was taken to the accident and emergency department of a hospital where she died a few hours later. A neighbour had said that she had relatives somewhere, but a policeman could not find any addresses at the flat. A local authority officer visited the flat a week later and found an address book containing details of three relatives. He contacted the woman's niece. She complained to the hospital that she had not been told of her aunt's death for 10 days, and that the hospital staff should have been able to trace her through the clinical records as her aunt had been an in-patient at that hospital six months earlier. She also complained that the hospital had not handed over her aunt's belongings until she enquired about a wedding ring which she had noticed to be missing. Six months after seeing the director of nursing services about the delay in telling her about the death she had still heard nothing, despite oral reminders, so she invoked the help of a local councillor. A reply, which the complainant thought inadequate, was received five months later.

Findings

The department's staff did not think they had any means of obtaining information about next-of-kin. In those circumstances it was reasonable to involve the police who, as they were unable to locate relatives, notified the local authority in accordance with normal procedure. I found that the hospital had a computerised patient registration system which could have told

the accident and emergency staff that the aunt had previously been treated at the hospital. None of them knew how to operate the computer and no attempt was made to get someone else to interrogate the system or make a search for clinical records, which would have shown details of the woman's next-of-kin. The woman's soiled clothing had been destroyed and her wedding ring removed for safe keeping. The woman's niece collected the wedding ring, and I could not exclude the possibility that, had she not made her own enquiries, it would have remained even longer in the hospital's custody. There was no evidence that she was told about the clothing.

The director of nursing services claimed that she had replied promptly to the niece's original enquiry, but there was no evidence of that and I doubted that she had done so. After the councillor's intervention she was once again charged with the main responsibility for the investigation, despite being known to be under pressure. She took no effective action before going on long term sick leave. The acting unit general manager was aware of these problems but allowed matters to drift for some months before sending a reply. Her letter, which apologised for the unacceptable delay, was accurate as far as it went but reflected a lack of depth and thoroughness in the local investigation. I upheld all the niece's complaints.

Remedy

By the time my investigation was concluded, the authority had installed a new computer system which allowed staff immediate access to information about a patient's previous attendances and about known next-of-kin. They apologised for the shortcomings I found and agreed (a) to establish a procedure for tracing relatives in such circumstances; and (b) to remind officers of the need to respond quickly and accurately to complaints and to take effective action when problems were revealed by the monitoring process.

13. Delay in arranging an independent professional review - W.834/91-92

Matters considered

Clinical complaints procedure - reasons for delay.

Summary of case

A man complained that a regional medical officer had refused to consider whether to grant an independent clinical review of his wife's treatment unless they first attended a meeting with the consultant concerned. The man thought that unreasonable, as he had nothing to add to his written complaint and he considered that such a meeting would be a waste of time.

Findings

I learned that the regional medical officer's attempts to persuade the man to meet the consultant stemmed from his belief that the Joint Consultants Committee required such a meeting before they would carry out their role in nominating independent consultants to undertake a review. The responsibility for deciding whether to arrange such a review lay with the medical officer, and I considered that he should have based his decision on his assessment of the nature of the complaint and not on his understanding of the Committee's views on preliminary meetings. The nationally-negotiated clinical complaints procedure does not make a meeting a pre-condition of granting such a review, and I considered that the regional medical officer had erred in persisting for so long in trying to press for one. If he had

encountered problems after making a formal request to the Committee, he could have taken them up with the Department of Health who are responsible for the national guidance. The regional medical officer maintained that he had not refused point blank to take the complaint further without a meeting, and towards the end of my investigation he set in motion arrangements for a review. He could have done so much sooner, and I upheld the complaint.

Remedy

The health authority apologised for their shortcomings in the handling of the complaint.

14. Refusal of maternity care – SW.2/91–92

Matters considered

Denial of obstetric care because of previous complaint – arrangements for consultant cover – handling of the complaint by the health board concerned.

Summary of case

When a woman, whose earlier complaint about incidents at an ante–natal clinic during her first pregnancy had been investigated and upheld by my predecessor, tried to obtain care at the same hospital during her next pregnancy she found that the consultant obstetricians at the hospital would not accept her as a patient. Because of that she had to attend another hospital. She believed that that situation had arisen because the consultant whom she had seen for the first pregnancy had put pressure on his colleagues, and she complained that discrimination against her had resulted in a failure in the service provided by the Board.

Findings

The hospital's five consultant obstetricians operated a rota system each taking clinical responsibility for one week day and, in turn, at weekends. Because of the previous events the first consultant was unwilling to be involved further in the woman's care. Consequently, when she was referred successively to two of his colleagues, both declined her booking because under the rota system she might need to be attended by the first consultant. I considered it wholly unacceptable that a patient should be refused care because of an earlier complaint, and that the five consultants could not find a way of ensuring that she was provided care. I also thought it strange, given the emphasis on continuity of care in pregnancy, that an expectant mother had only a one–in–five chance of seeing her own consultant if urgent problems arose. The Board's senior officers took the same view as I did about the failure to provide the woman with the service she was seeking. The chief administrative medical officer subsequently issued an instruction to all consultants that, if a similar situation appeared to be arising in future, management should be consulted. I was critical of the Board's officers for their failure to advise the obstetricians of an assurance they had given the woman that, if she became pregnant again, there would be no difficulty about her care at a hospital. Had they done so, they would have heard of her later problems and had the opportunity to intervene. I found no fault with the Board's handling of the complaint but unfortunately, by the time the woman complained, it was too late for the situation to be retrieved.

Remedy

The Board repeated the apologies they had already extended to the woman.

15. Tests unduly delayed – refusal of an independent professional review – SW.73/91-92

Matters considered

Delay in arranging tests and misfiling of test results – training of medical secretaries – refusal of an independent professional review.

Summary of case

A woman, who was subsequently found to have an inoperable lung tumour, complained that the result of a bronchoscopy was not seen by her consultant physician until four weeks later when her general practitioner telephoned to ask about it. Because of that, arrangements for further tests were held up. She also complained that the Board's chief administrative medical officer, in obtaining advice from medical staff at another health board, had not acted appropriately in the way he arrived at his decision to refuse an independent review of her treatment.

Findings

I found that a report on the woman's test results had been available on 10 December and that the consultant's secretary, who had been in that post for only four weeks, had apparently put the report in error with the woman's medical records and sent them for filing instead of bringing it to the consultant's attention. Because of her inexperience, I put the delay in taking action on the results down to what I discovered to be an absence of any structured training or monitoring programme for medical secretaries. The chief administrative medical officer had come to the conclusion that the woman's clinical complaint was not substantial and therefore did not merit an independent review, but because he lacked experience in dealing with such matters and did not have relevant clinical expertise he sought expert advice informally from his opposite number at another board and a consultant physician at that board. I considered that the whole point of an independent review was that it provided for a full and impartial review, and that by his actions the medical officer had substituted the advice of the other two persons whom he consulted – whose views might not be seen necessarily as independent – for the views of two independent consultants chosen after consultation with the Scottish Joint Consultants Committee in conformity with guidance issued by the Scottish Office Home and Health Department. I found it quite understandable that his departure from the formal procedure had led the woman to feel that her complaint had not been dealt with correctly and fairly.

Remedy

The Board apologised for the shortcomings I had found and agreed to take immediate steps to clarify the responsibility for training medical secretaries and how it should be organised.

16. Alleged confusion of a patient's ultrasound scan results with those of another patient – WW.10/91-92

Matters considered

Procedures for carrying out ultrasound scans and processing the results – handling of a

complaint by the health authority concerned.

Summary of case

A man's wife, who was nearly four months pregnant, was given an ultrasound scan at a hospital. Three weeks later they were both told that the scan had revealed a large ovarian cyst, and a consultant gynaecologist advised an operation to remove it. Two days after the operation he informed the woman that he had not found any sign of the cyst, and he apologised for the apparently unnecessary operation. Later, the couple met the gynaecologist to discuss the possibility that the scan results had been confused with those of another patient. The man complained and asked for an investigation. He and his wife remained dissatisfied with the authority's replies, which had contained factual errors.

Findings

My detailed examination of the procedures for receiving patients at the x-ray department and mechanically labelling each set of films with the patient's name satisfied me that there had been no mistake over the woman's identity or scan results. A consultant radiologist confirmed that the scan bearing her name showed a 9 cm ovarian cyst. From her own examination of the radiography records of 43 of the 47 patients who had been scanned on the day in question, my officer was able to confirm that there was no evidence to suggest that there had been confusion between the woman's scan and that of any other patient; and that the source of the complaint lay in a failure to adjust the automatic timer for British Summer Time on one of the two machines in use that day – the one on which the woman had been scanned. The authority have since introduced revised procedures for identifying patients before examination and for a daily check of the automatic timer on all scanners within the x-ray department. As I did not find that there had been any mix-up of scan results, I did not uphold the complaint about that. I found that the authority's initial reply to the man had been based on a superficial investigation by another consultant radiologist, whose failure to notice the timing discrepancies resulted in incorrect statements being made about the timings of patients' appointments. He nevertheless had no doubt that the cyst shown on the woman's scan could have resolved naturally. The man and his wife found the reply unacceptable. I commended the authority for having visited the complainants in their home which had led to a more searching check of the records and revealed the previous factual errors. The authority had sent the couple a reasonably full and detailed letter and unreserved apology for those errors and the resulting distress, but had not made clear whether the apology extended to distress caused by the wife's operation. I upheld the complaint about the way the original complaint had been handled.

Remedy

The authority apologised for the shortcomings I had identified in their handling of the man's complaint. They agreed to remind staff of the need to investigate thoroughly before responding to complainants, and to address all the issues raised.